Policy for the Digital Removal of Faeces by Registered Nurses - CG326

Approval and Authorisation

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<tr>
<th>Approved by</th>
<th>Job Title</th>
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<tr>
<td>Policy Approval Group</td>
<td>Chair, Policy Approval Group</td>
<td>April 2015</td>
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Change History

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<tr>
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<td>Jackie Ross, Practice Development Nurse</td>
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<td>Karen Barnard, Advanced Trauma Nurse Practitioner</td>
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Policy Lead: Director of Nursing
Location: Corporate Governance shared drive – CG326
Digital Removal of Faeces Policy

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1.0 Purpose

The purpose of this policy is to ensure that all patients who require digital removal of faeces whilst in hospital have this procedure carried out in a timely and safe manner by a competent practitioner.

2.0 Policy content / scope

This policy is applicable to:

- All adult patients using The Royal Berkshire NHS Foundation Trust (RBFT) services
- This policy must be followed by all registered nurses employed by the RBFT including agency and bank staff whilst working on Trust premises.

3.0 Introduction

Manual evacuation, or the digital removal of faeces, is an invasive procedure that is rarely undertaken as a method of bowel care in NHS acute Trusts.

In most cases the need for digital removal of faeces is preventable by using a systematic approach to the management of constipation and should only be practiced when all other methods of bowel evacuation have failed.

For example, people with established spinal cord lesions such as those with spinal cord injury (SCI), cauda equina, spina bifida and multiple sclerosis, digital removal of faeces is an integral part of their routine bowel management. This essential routine is often interrupted when these patients are admitted into a general NHS hospital that does not specialise in treating spinal injuries because nurses lack sufficient knowledge and expertise to competently perform a digital removal of faeces.

Evidence shows that failing to support individuals who require digital removal of faeces can place them at risk of developing autonomic dysreflexia.

The National Patient Safety Agency identified that patients with an established spinal cord lesion are at risk because their specific bowel care needs are not always met in acute trusts (September, 2004).

4.0 Definitions

4.1 Autonomic Dysreflexia

A syndrome unique to people with a spinal cord injury (level Thoracic vertebra 6 (T6) or above) which is a sudden and exaggerated autonomic response to unrelieved stimulation of sensory receptors below the level of the cord lesion. This can be triggered by a full rectum or bladder when over distension occurs or in female patients in labour. It can be a life threatening condition with potential damaging outcomes such as cerebral haemorrhage, myocardial infarction or seizures.

4.2 Digital Rectal Examination (DRE)

An examination of the rectum by the insertion of one gloved lubricated finger.
4.3 Digital Removal of Faeces (DRF)

The manual removal of faeces from the rectum by the insertion of one gloved lubricated finger.

5.0 Accountabilities

5.1 All managers of clinical staff have the responsibility for ensuring that all staff are made aware of the content and recommendations within this policy and where appropriate attend education and training in the digital removal of faeces.

5.2 Registered nurses undertaking digital removal of faeces must have attended training provided by the NHS Berkshire West Continence Advisory Service or can provide evidence of equivalent training e.g. as part of a recognised spinal injuries/orthopaedic course.

5.3 All nursing staff caring for patients requiring digital removal of faeces must be aware of the implications and possible complications for the patient if this procedure is not carried out.

5.4 The registered nurse looking after a patient requiring digital removal of faeces is responsible for locating a nurse competent to perform the procedure, if they are not competent to do so. If no registered nurse is available when the patient needs DRF, then this must be reported immediately to the medical team responsible for the patient and the manager.

5.5 The Clinical Education and Practice Development team will be responsible for keeping an up-to-date register of registered nurses within the Trust who can perform digital removal of faeces. This will be available on the Trust Intranet and by contacting the Clinical Education and Practice Development Team.

5.6 All staff must follow the guidance and recommendations contained within the policy and ensure that incidents are appropriately reported through the Trust’s incident reporting system.

6.0 Reasons for Undertaking Digital Rectal Examination and Digital Removal of Faeces

6.1 Reasons for undertaking a DRE include (Royal College of Nursing (RCN), 2012):
- Establishing whether there is faecal matter in the rectum, how much and the consistency
- Assessing anal pathology
- Identifying the need for manual removal of faeces
- Assessing anal and rectal sensation
- Identifying the need for and effects of rectal medication
- Stimulating defaecation
- Assessing anal tone and the need for pelvic floor exercises
- Establishing the outcome of rectal or colonic washout or irrigation

6.2 Reasons for performing DRF include (Royal College of Nursing (RCN), 2012):
-
• When other methods of bowel emptying have failed or are inappropriate
• Faecal impaction or loading
• Incomplete or inability to defecate
• Neurogenic bowel dysfunction
• In some patients with spinal injury

6.3 DRE and DRF should only be performed when necessary as they are invasive procedures.

6.4 Extra care should be taken by nurses performing these procedures with patients who have the following:-
• Crohns disease, ulcerative colitis and diverticulitis
• Recent radiotherapy to the pelvic area
• Rectal or anal pain
• Rectal surgery or trauma to the anal or rectal area
• Obvious rectal bleeding
• If the patient has a known history of abuse
• Fragile tissue due to age, radiation, loss of muscle tone in neurological diseases or malnourishment

7.0 Exclusions and contraindications for undertaking DRE AND DRF (RCN, 2006)

7.1 DRE and DRF should not be undertaken if the patient has not given consent (written, verbal or implied). Please see Section 9.6 for more details on consent and capacity.

7.2 The patient’s Consultant has given specific written instructions that these procedures should not be carried out.

8.0 Digital Removal of Faeces Procedure

8.1 This procedure will only be carried out by registered nurses who have undergone appropriate training and who are competent to carry out this procedure.

8.2 Examples of appropriate training for this procedure include:-
- A spinal injuries course or previous work in a spinal injuries unit
- A specific training programme with assessment

8.3 When undertaking the procedure nurses should follow The Procedure for the Digital Removal of Faeces Guidelines 2008 (Kyle et al) (available on Trust Intranet and a hard copy is available on all adult inpatient wards and departments). Nurses should also follow the guidance in Bowel care, including digital rectal examination and manual removal of faeces (Royal College of Nursing, 2012) and The Royal Marsden Hospital Manual of Clinical Nursing Procedures 9th Edition (online) Chapter 5: Elimination: altered faecal elimination (available on Trust Intranet).

9.0 Prior to Undertaking Digital Removal of Faeces
9.1 The decision to carry out digital removal of faeces must only be made following a full bowel assessment which is documented in the patient records.

9.2 Other treatment options should be considered fully with the clinical team members.

9.3 The patient will be provided with relevant information including the options and risks involved in a timely manner and in an appropriate format.

9.4 The patient must be given time to consider this information, and be actively involved in the decision making process regarding their bowel care and treatment.

9.5 The patient’s knowledge regarding their own condition will be respected by staff and self-care will be promoted where applicable.

9.6 Staff will be aware of the legislation regarding mental capacity, ensuring that if a patient lacks capacity to make a specific decision they remain at the centre of decision making and are fully safeguarded.

The individual’s capacity or lack of, needs to be documented as part of the gaining consent process. It must be ascertained initially whether the individual has a temporary or permanent impairment of brain function and whether that impairment affects the ability of the individual to make a decision.

The individual will be unable to make a decision if they cannot:

– Understand the information relevant to the decision, including understanding the likely consequences of making or not making the decision.
– Retain the information.
– Weigh up the information as part of the decision making process.
– Communicate their decision by whatever means appropriate for the individual. (Mental Capacity Act 2005: Making decisions – a guide for people who work in health and social care 2007).

If there is any concern about the individual’s mental capacity to consent or refuse the procedure then an Assessment of Capacity form must be completed. This is available on the Trust intranet under Safeguarding Adults.

If the individual is deemed to lack capacity then a discussion should be held with the next of kin or family members, if at all possible. Following this, then a decision can be made to proceed in the best interest of the patient and should be documented clearly in the medical notes following completion of the best interest check list.

If, following completion of an Assessment of Capacity, the individual is deemed to have capacity and refuses the procedure, this decision must be respected and documented in the medical notes.

9.7 Consent for the procedure to take place will be gained from the patient as per the Consent to examination and treatment policy CG26

9.8 Consent will be gained from the patient prior to examination and observation of procedures by students or non-essential staff e.g. for teaching purposes.

10.0 During the Procedure

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<tr>
<th>Author:</th>
<th>Karen Barnard</th>
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<tr>
<td>Job Title:</td>
<td>Advanced Trauma Nurse Practitioner</td>
<td>Review Date:</td>
<td>April 2017</td>
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10.1 All patients undergoing DRE and DRF will be chaperoned according to the Trust Chaperoning Protocol GC090

10.2 All patients undergoing this procedure will be examined in a private area such as:-
  o In a single room with the door shut
  o Behind closed screens/curtains in a bay type accommodation in a ward or department

10.3 All patients undergoing this procedure will be examined with:-
  o The minimum number of essential personnel/staff present.
  o No interruptions from other staff entering the room or opening curtains/screens.

10.4 The patient will be appropriately clothed and covered to maintain their dignity and modesty.

10.5 A range of continence aids will be available for individual patients as required.

11.0 Consultation

The following staff groups were consulted in the development of this policy: - Assistant, Director of Nursing, Care Group Directors of Nursing & Matrons, Ward Sisters/Charge Nurses (Caversham, Kennet & Loddon, Adelaide Annexe), Practice Educators, Colorectal Clinical Nurse Specialists, Trauma Coordinator, Learning Disability Co-ordinator, Multiple Sclerosis Nurse Specialist, Continence Services Manager NHS Berkshire West, Consultant Gastroenterologists, Consultant Colorectal Surgeons, Consultants in Elderly Care Medicine.

12.0 Dissemination / Circulation

This policy will be circulated electronically to all relevant ward / department managers who are expected to circulate information to their staff and ensure that all existing staff have read the policy. The policy will be available on the Trust Intranet and Internet sites.

13.0 Monitoring of compliance and effectiveness

Audit and monitoring of this policy will take place incorporating information from:-

- Data from the electronic Clinical Incident reporting system.
- Complaints and PALS

14.0 Policy review

This policy will be reviewed annually.

15.0 Data protection

When passing patient information to other agencies, staff must adhere to the Data Protection Act 1998 and follow Caldicott Principles which covers confidentiality, security and sharing of personal information which in turn safeguards individuals. Prior to sharing information, consent...
16.0 Equality Impact Assessment Documentation

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Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?

No

Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?

No

Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?

No

Is there potential for or evidence that the proposed policy will affect different population groups (age, disability, race, sexual orientation, gender, religion or belief) differently (including possibly discriminating against certain groups)?

No

Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups (age, disability, race, sexual orientation, gender, religion or belief)?

No

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must be obtained from the patient concerned unless obtaining there consent could prejudice the purpose of divulging. Further details relating to the Data Protection Act can be found on the Trust intranet.
Based on the information set out above I have decided that a full equality impact assessment is not necessary.

**Name, Job title and signature:** Jackie Ross, Practice Development Nurse

**Department:** Clinical Education & practice Development

**Date:** 25th January 2011

### 17.0 References

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<tr>
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