Royal Free London NHS
NHS Foundation Trust

Digital Rectal Examination
&
Digital Removal of Faeces
Guidelines for Adults

May 2015

positively welcoming actively respectful clearly communicating visibly reassuring

Validation Grid	
Title	Guidelines for digital rectal examination and digital removal of faeces
Author	Lead nurse, continence & gastrophysiology
Associate Author	Lead nurse, practice development Lead nurse, practice development
Target Audience	Qualified nursing staff
Commissioning body	Clinical practice group
Stake holders consulted	Clinical practice group Continence & gastrophysiology **Directorates**: UC, TASS, SASS, W&C, PP via divisional nurse directors
Clinical/Advanced Practice	Clinical Practice
Associated Policies / Documents	Administration of medicines Infection Control standard precautions Administration of suppositories and enemas Anaphylaxis guidelines Patient consent policy Privacy and dignity policy Chaperoning policy
Guideline Replacement	Yes: Digital rectal examination and digital removal of faeces 2012 (RFH version) DRE & digital removal of faeces clinical guideline 2014 (BH & CFH version)
Significant changes to practice	No significant changes to practice Harmonisation of guideline for all trust sites
Implementation plan (incl. dissemination plan and audit plan if significant change to practice)	Dissemination by email to managers Availability of updated guideline on Freenet Audited as part of quality road map
Date of Submission	May 2015
Approval	CAEC: 19.06.15
Date for Review	May 2018
Key Words	Digital, rectal, faeces, digital, constipation, impaction, spinal cord injury, autonomic dysreflexia.

Version control			
Date	**Version**	**Author**	**Comment**
Oct 2007	1		New guideline
Feb 2012	2		Review and update
May 2015	3		Periodic review and update of guideline. Harmonisation of practice across all trust sites into one guideline

This guideline has been based on the following key documents:

- Royal College of Nursing Management of lower bowel dysfunction, including Digital Rectal Examination and Digital Removal of Faeces: Guidance for nurses (2012)
- Multidisciplinary Association of Spinal Cord Injured professionals (2012) Guidelines for management of neurogenic bowel dysfunction in individuals with Central Neurological Conditions.
- Worcestershire Primary Care Trust. Bowel care guidelines (adult) (June 2007)

For nurses working with children and young people please refer to: RCN 2005 Digital rectal examination guidance for nurses working with children and young people

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1. Abstract

The most frequently used assisted bowel elimination techniques include dietary/fluid modification, oral medication, suppositories and enemas. More recently, rectal irrigation is being used successfully for both constipation and faecal incontinence in patients with severe, longstanding problems. However, some patients, such as those with spinal cord injuries, may need further interventions, such as digital rectal stimulation (**DRS**), or digital removal of faeces (**DRF**) as an integral part of their routine bowel care. Failure to maintain this bowel care routine can lead to severe constipation and impaction in this group of patients with potential for autonomic dysreflexia which is a medical emergency and potentially fatal. Digital rectal examination (**DRE**) is used prior to rectal interventions and to assess constipation. This guidance describes the procedure for carrying out digital rectal examination, digital rectal stimulation, and digital removal of faeces.

2. Definitions

DRE: Digital rectal examination is an invasive procedure that can be carried out as part of a nursing assessment, by a registered nurse who can demonstrate competence to an appropriate level in accordance with the NMC Code (2015). The procedure involves the nurse inserting a lubricated gloved finger into the rectum.

DRS: Digital rectal stimulation is an invasive procedure involving stimulation of the rectal wall using a lubricated gloved finger. This should only be performed when necessary and after individual assessment (RCN 2012).

DRF: Digital removal of faeces is an invasive procedure involving the removal of faeces from the rectum using a gloved finger. This should only be performed when necessary and after individual assessment (RCN 2012).

3. Background / Supporting Information

Normal bowel function includes the need for regular defecation without complications such as constipation or diarrhoea. Constipation is a common disorder affecting an individual's normal bowel function and is a common reason for GP consultations (Effective Health Care, 2001). First line treatments include dietary / fluid modification, oral laxatives (bulking agents, stool softeners, osmotic agents, stimulants), suppositories and enemas. A small number of patients may require further interventions such as DRE, DRS or DRF (NICE 2007). More recently, rectal irrigation has been effective for both constipation and faecal incontinence in people with spinal cord injury (Emmanuel et al 2013).

Many nurses are unsure about the professional and legal aspects of undertaking such invasive procedures, and are worried about accusations of abuse following two professional conduct cases reviewed by the UKCC involving inappropriate use of such procedures. This guideline serves to ensure that staff are equipped with relevant knowledge and good practice information.

Recent medical advances have reduced the need for DRE and digital removal of faeces. However, for certain patients, these procedures are necessary and for other patients/clients they form part of their regular bowel care regime. Nurses need to be reassured that it is legitimate to carry out these procedures safely and competently.

Failure to carry out these procedures on patients who require them can lead to severe consequences for the patient and could be a breach of the Nursing and Midwifery Code of Conduct.

The National Patients Safety Agency (NPSA 2004) has highlighted that some people with an established spinal cord lesion are dependent on DRF as their routine method of bowel care. Failing to perform the procedure for such individuals can place them at risk of developing autonomic dysreflexia. This is a medical emergency that unresolved may give rise to serious consequences such as cerebral haemorrhage, seizures or cardiac arrest (see complications, pg 15).

It is therefore essential that staff providing care to patients with spinal cord injuries can perform digital removal of faeces when necessary.

4. Aim

The aim of these guidelines is to assist staff in carrying out DRE, DRS or DRF with patients who need these procedures. There is a separate policy for the administration of suppositories and enemas.

5. Staff who may undertake these procedures

Within this Trust, **digital rectal examination** is regarded as a clinical practice. Registered Nurses and Midwives who accept accountability of their actions and feel capable to undertake the procedure may do so. This is an aspect of care which will require a period of local, supervised training followed by a competency assessment. Student nurses who have reached Year Two of their training, and who have completed theoretical lectures, may undertake this practice under the direct supervision of a registered nurse competent in this aspect of care and in the supervisory role.

Within this Trust, **Digital Rectal Stimulation** and **digital removal of faeces** are regarded as clinical practices which may only be undertaken by experienced qualified nursing staff who have undertaken specific training and demonstrate competence in this procedure, possessing the knowledge, skills and abilities required for lawful safe and effective practice (RCN 2012). Student nurses and health care assistants are not permitted to perform this, although in other settings, and after proper training, supervision and competency assessment, this may be possible.

There is formal competency assessment for Registered Nurses and Midwives undertaking this practice following additional training, and there may be aspects of care which require a period of supervised guided practice.

Patients or carers may undertake this procedure if this is part of their established bowel routine. It is essential staff recognise that these patients are experts in managing their bowel care, and should be supported accordingly, and encouraged to be independent whilst in hospital (NPSA 2004).

Managers should be aware that The Code 2015 states that N&M staff should only delegate tasks and duties that are within the scope of the other persons competence, ensuing they have fully understood your instructions. The Code requires staff that have had tasks delegated to them, be adequately supervised and supported to

ensure safe and compassionate care and to monitor the task has met the required standard.

The NMC (2015) Code specifies that N&M staff must maintain their knowledge and skills for safe and effective practice and complete the necessary training before carrying out a new role. Nurses and midwives are accountable and responsible for providing optimum care for their patients. Professional accountability demands more than solely being able to perform the procedure correctly, it requires nurses to act on and understanding the clinical relevance of the procedure.

This policy applies to all ward areas with adult patients.

In guidelines laid down by the Nursing & Midwifery Council (NMC 2010; 2015), there should be a health care record for the patient, which is accurate, factual and consistent. This shows evidence of all observations and interventions that have been acted upon and communicated to appropriate members of the multidisciplinary team, including arrangements for future and ongoing care.

	DRE	DRS	DRF
Who	Qualified nursing staff Year 2 Student nurses under direct supervision	Qualified nursing staff	Qualified nursing staff
Training	Local training	Trust study day or equivalent	Trust study day or equivalent
Experience	Has been observed / assessed on three separate occasions	Has been observed / assessed on three separate occasions	Has been observed / assessed on three separate occasions
Competency required prior to independent practice	Yes	Yes	Yes

6. Specific Training Required for DRS and DRF

Study days will be run by the Trust depending on local demand. Localized sessions may be available upon request. Ward managers need to ensure that adequate numbers of experienced staff are available at all times to undertake this procedure (NPSA 2004). The training will include:

- Anatomy and physiology of rectum and gastrointestinal tract
- An understanding of the diseases of the rectum and colon
- The use of medication in bowel dysfunction
- Types of digital rectal interventions
- Indications for digital rectal interventions
- Perianal assessment prior to digital rectal interventions
- Contra-indications for digital rectal interventions
- Principles of bowel care in patients with spinal injuries
- Procedure for DRE, DRS and digital removal of faeces
- Autonomic dysreflexia
- Documentation
- Issues of consent

7. Assessing Competence

Supervised practice is the period of training and supervision under the direction and leadership of a mentor/assessor.
An assessor must fulfil the following criteria:

- Be a registered practitioner
- Be band 6 or above
- Be able to provide evidence that they have completed a course that incorporates the principles of assessment and supervision of practice
- Be an experienced and competent practitioner in the procedure of DRE and digital removal of faeces

8. Digital Rectal Interventions

This guideline covers three procedures:

- Digital rectal examination (DRE)
- Digital rectal stimulation (DRS)
- Digital removal of faeces (DRF)

Unfamiliar or previously distressing procedures may cause anxiety. Reassure the patient and explain the procedure in simple language. Make sure that the patient understands and CONSENTS to the procedure before starting. Failing to obtain consent may constitute assault (Casteldine 2000).

9. Digital Rectal Examination

DRE can be used as part of a nursing assessment when carried out by a qualified nurse who is deemed competent. DRE should not be used as a first line investigation into the assessment and treatment of constipation (RCN, 2012). DRE is an invasive procedure and should only be performed when necessary and after individual assessment. Cultural and religious beliefs must be respected and it is vital to check for allergies prior to undertaking this procedure.

10. Indications for Digital Rectal Examination (RCN 2012)

- To assess presence and consistency of stool
- To assess anal tone / reflex / voluntary contraction
- To assess anal sensation
- As part of a prostate assessment
- To assess for haemorrhoids or rectal polyps/lesions in the presence of rectal bleeding
- Prior to specialist procedures such as sigmoidoscopy, colonoscopy, anorectal physiology studies, or urodynamics studies
- Prior to administration of rectal medication
- Prior to digital stimulation and/or digital removal of faeces
- To assess the outcome of rectal/colonic washout/irrigation if appropriate
- To assess for trauma to anal sphincters and anal canal following vaginal birth

11. Digital Rectal Stimulation

Digital rectal stimulation is used to stimulate reflex bowel activity in patients with an upper motor neurone cord lesion (T12 and above). This is achieved by inserting a gloved lubricated finger into the rectum and slowly rotating it whilst maintaining contact with the rectal wall. This procedure is usually carried out by the patient themselves.

12. Indications for Digital Rectal Stimulation

Patients with tetraplegia and paraplegia who have an upper motor neurone cord lesion (T12 and below) generally have reflex bowel activity (Stowell et al 2002); this reflex can be triggered to act by the use of suppositories or by digital stimulation, or both (Zejdlik 1992).

Ingestion and passage of liquid or semi-solid material from the stomach stimulates natural waves of peristalsis in a descending pattern towards the sigmoid colon (the gastro-colic reflex). This reflex is generally strongest following the first meal of the day and therefore, bowel care for these patients is best carried out after a meal or hot drink (usually breakfast) (Zejdlik 1992; Powell & Rigby 2000). This is an ideal time to perform this procedure.

13. Digital Removal of Faeces

Digital removal of faeces from the rectum should be avoided if possible and should only be performed if all other methods of relieving constipation have failed (Dougherty & Lister 2015) or as part of a patient's routine care management (e.g. a person with a spinal injury) or a person suffering from loss of bowel tone (e.g. in the case of advanced Multiple Sclerosis) (RCN, 2012). Decisions to carry out digital removal of faeces should be taken jointly with the patient's medical team and reason for decision documented in the notes.

Digital removal of faeces is an accepted and routine method of management for people with spinal cord lesions above T12 level. Their bowels will not empty in a reflex response to rectal stimulants or suppositories. People with lesions below T12 are usually capable of achieving good reflex bowel emptying without resorting to digital removal of faeces.

Constipation or impaction of the bowel is a common cause of autonomic dysreflexia (see complications, pg 15) and can be further compounded by additional noxious sensations during attempts to alleviate the cause.

Autonomic dysreflexia is a potentially fatal complication for any person living with a spinal cord lesion above T6. It can occur at any time and up to 90% of people with tetraplegia or high paraplegia will experience autonomic dysreflexia at some time in their lives (NPSA 2004).

Digital removal of faeces is a distressing experience for the patient and can often be painful. In severe, acute faecal impaction it may be necessary to consider sedating the patient before carrying out the procedure. In these circumstances, the nurse should seek medical advice.

14. Indications for Digital Removal of Faeces

- Faecal impaction/ loading
- Incomplete defaecation
- Inability to defaecate
- Other bowel emptying techniques have failed
- In patients with spinal injury
- Neurogenic bowel dysfunction.

15. Assessment prior to undertaking digital rectal interventions

The perianal area should be checked for any of the following abnormalities and results should be documented and reported.

- Rectal prolapse
- Haemorrhoids
- Anal skin tags
- Wounds, dressings, discharge
- Anal lesions (malignancy)
- Gaping anus
- Skin conditions, broken areas, pressure sores of all grades
- Bleeding and colour of blood
- Faecal matter
- Infestation
- Foreign bodies

If examination leads to concerns, advice should be sought from a specialist nurse or a medical practitioner before undertaking these interventions, unless the practitioner feels confident and is competent to do so.

16. Contra-indications to performing digital rectal interventions

- Lack of consent from the patient
- Specific instructions from the patient's doctor that the procedure should not take place
- Patient has undergone recent rectal/anal surgery or trauma
- The patient gains sexual satisfaction from these procedures and the nurse performing them finds this embarrassing. In this case, consultation with a doctor is advised, involving the patient in that consultation. You might consider whether there is a need for a chaperone in such circumstances
- Presence of abnormalities of the perianal and/or perineal area are observed (as above)

17. Circumstances when extra care is required

Particular caution should be exercised with patients who have the following diseases/conditions:

- Active inflammation of the bowel, including Crohn's disease, ulcerative colitis and diverticulitis
- Recent radiotherapy to the pelvic area
- Rectal / anal pain

- Previous rectal surgery / trauma to the anal/rectal area
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment
- Obvious rectal bleeding or patient taking anti-clotting medication
- If the patient has a known or suspected history of abuse
- In spinal injury patients because of autonomic dysreflexia
- Known allergies to latex, soap (lanolin), phosphate and peanut (present in arachis oil enemas).

18. Procedure: Digital Rectal Examination

Equipment required:	
Disposable gloves (2 pairs)	Incontinence sheet / pad
Tissues or toilet paper	Lubricant (e.g. KY jelly)
Receptacle for waste (orange plastic bag)	Plastic apron

Intervention	Rationale
Check with patient and hospital notes for any contraindications	To minimize risk of potential problems
Explain the procedure and obtain verbal consent	To reduce anxiety, ensure the patient understands and gain valid consent
Ensure procedure is carried out in the privacy of a cubicle or curtained area* and ensure that a bedpan, commode or toilet is readily available	To maintain patient's privacy and dignity
* Where available and appropriate, ME, DRE and DRF should be performed in the patient's side room or assisted bathroom to protect the privacy and dignity of the patient, and protect other patients from potential malodour.	
Wash hands and put on apron and **double** gloves	Prevent potential contact with body fluids and minimize the risk of cross infection
Position the patient on their left side with their back next to the edge of the bed, and their knees flexed. Place an absorbent pad under the patient and cover the patient with a sheet	This positioning allows ease of entry into the rectum following the natural curve of the colon To reduce potential infection caused by soiled linen. To avoid embarrassing the patient is faecal staining occurs
Examine the perianal area for any abnormalities before proceeding	To ensure that it is safe to proceed.
Palpate the perianal area starting at 12o'clock clockwise to 6 o'clock and then from 12 anticlockwise to 6 o'clock	To assess for any irregularities, swelling, indurations tenderness or abscess in the perianal areas (RCN 2012)
Reassure the patient throughout the procedure	To avoid unnecessary stress or embarrassment and ensure continued consent
Lubricate gloved index finger and insert gently into the rectum. NB nurses nails must be kept short Inform the patient you are about to proceed	To minimise patient discomfort and avoid anal mucosal trauma Informing the patient assists with cooperation with the procedure
Prior to insertion encourage the patient to breath out or talk and / or place a gloved index finger on the anus for a few seconds prior to insertion	To prevent spasm of the anal sphincter on insertion (RCN 2012). Gently placing a finger on the anus initiates the anal reflex causing the anus to contract and then relax.

On insertion of finger, assess anal sphincter control – resistance should be felt	Digital insertion with resistance indicates good internal sphincter tone, poor resistance many indicate the opposite (RCN 2012)
Assess for the presence of faecal matter using the Bristol stool scale (see Appendix 1).	To check for the presence of faecal matter and to establish the consistency of the stool
Slowly withdraw finger from patient's rectum when finished. Check for presence of faeces or blood on glove	To minimize patient discomfort.
Remove top glove, retaining lower glove, and dispose of in clinical waste bag	To minimize risk of cross infection
Wipe residual lubricating gel from anal area ensure the patient is clean	To ensure the patient's comfort and personal hygiene and avoid anal excoriation and irritation
Dispose of gloves, apron and equipment into a orange bag and wash hands	To prevent cross infection
Ensure patient is comfortable and observe for any adverse reactions	To and minimise embarrassment and note adverse reactions
Record that explanation was given and consent sought prior to the procedure. Record procedure/findings (date, time, stool consistency, volume) in nursing documentation. Communicate findings with medical team if appropriate.	To ensure correct care and continuity of care Ensure appropriate corrective action is initiated

19. Procedure: Digital Rectal Stimulation

Equipment required:	
Disposable gloves (2 pairs)	Incontinence sheet / pad
Plastic apron	Tissues or toilet paper
Lubricant (e.g. KY jelly)	Cleaning wipes / soap and water
Receptacle for waste (orange plastic bag)	
Intervention	**Rationale**
Check with patient and hospital notes for any contraindications	To minimize risk of potential problems
Explain the procedure and obtain verbal consent	To reduce anxiety, ensure the patient understands, and gain valid consent
Ensure procedure is carried out in the privacy of a cubicle or curtained area*	To maintain patient's privacy and dignity
* Where available and appropriate, ME, DRE and DRF should be performed in the patients' side room or assisted bathroom to protect the privacy and dignity of the patient, and protect other patients from potential malodour.	
Wash hands and put on apron and **double** gloves	Prevent potential contact with body fluids and minimize the risk of cross infection
Position the patient on their left side with their back next to the edge of the bed, and their knees flexed. Place an absorbent pad under the patient and cover the patient with a sheet	This positioning allows ease of entry into the rectum following the natural curve of the colon To reduce potential infection caused by soiled linen. To avoid embarrassing the patient if faecal staining occurs
Examine the perianal area for any	To ensure that it is safe to proceed

abnormalities before proceeding.	
Palpate the perianal area starting at 12 o'clock clockwise to 6 o'clock and then from 12 anticlockwise to 6 o'clock	To assess for any irregularities, swelling, indurations tenderness or abscess in the perianal areas (RCN 2012)
Reassure the patient throughout the procedure	To avoid unnecessary stress or embarrassment and ensure continued consent
Lubricate gloved index finger and insert gently into the rectum. NB nurses nails must be kept short Inform the patient you are about to proceed	To minimise patient discomfort and avoid anal mucosal trauma Informing the patient assists with cooperation with the procedure
Withdraw index finger to the second joint.	To minimise patient discomfort and avoid anal mucosal trauma
Gently rotate the finger in a clockwise motion for 15 -20 seconds or until internal sphincter relaxes. NB circular motion originates from the wrist, not the finger	To trigger reflex relaxation of internal sphincter and promote emptying of the rectum The pad of the finger to the first joint stimulates reflex relaxation
Do not stimulate for more than one minute	To prevent damage to anal sphincter
Stop if severe spasms of the anal sphincter occur, of if patient shows signs of autonomic dysreflexia	Patient safety
Remove finger to allow faeces to pass	To allow evacuation to take place
Stimulation cycle can be repeated up to 3 times	To facilitate complete evacuation.
Check rectum for presence of faeces. Proceed to digital removal of faeces if faeces present, but no faeces has been passed	To ensure complete evacuation.
Remove top glove, retaining lower glove, and clean patient's perianal area with soap and water	Reduces risk of cross infection. Ensure patient comfort
Ensure anal area is clean and dry Observe skin on completion of procedure	To prevent infection, contamination and excoriation of perianal area
Dispose of gloves, apron and equipment into a orange bag and wash hands	To prevent cross infection
Ensure patient is comfortable and observe for any adverse reactions	To and minimise embarrassment and note adverse reactions
Record that an explanation was given and consent sought prior to the procedure. Record bowel results in nursing documentation and communicate results with patient/carer and medical team if appropriate Consistency, volume, date and time should all be recorded appropriately	To establish effectiveness of procedure To ensure continuity of care Ensure appropriate corrective action is initiated

20. Procedure: Digital Removal Of Faeces

Equipment required: Disposable gloves (several pairs) Plastic apron Lubricant (e.g. KY jelly or instillagel) Bed pan/other suitable receptacle for waste and an orange plastic bag Sphygmomanometer	 Incontinence sheet / pad Tissues or toilet paper Cleaning wipes / soap and water Stethoscope
This is a two person procedure to ensure accurate and timely monitoring of observations during the procedure. Whereas Dynamaps maybe useful in monitoring situations, in this instance manual pulse and blood pressure should be recorded to note rate, rhythm and amplitude. **Record BP prior to / during / at the end of the procedure** **NB: For patients where this is a routine procedure and tolerance is well established monitoring may not be required**	
Check with patient and hospital notes for any contraindications	To minimize risk of potential problems
Explain the procedure and obtain verbal consent	To reduce anxiety, ensure understanding and gain valid consent
Ensure procedure is carried out in the privacy of a cubicle or curtained area* Ensure that a bedpan, commode or toilet is readily available	To maintain patient's privacy and dignity
* Where available and appropriate, ME, DRE and DRF should be performed in the patients' side room or assisted bathroom to protect the privacy and dignity of the patient, and protect other patients from potential malodour.	
Take the patient's pulse rate at rest prior to the procedure	To record baseline pulse and monitor for changes
Take the baseline blood pressure in all spinal injury patients	To record baseline blood pressure and monitor for any changes
Wash hands and put on apron and **double** gloves	Prevent potential contact with body fluids and minimize the risk of cross infection
Position the patient on their left side with their back next to the edge of the bed, and their knees flexed Place an absorbent pad under the patient and cover the patient with a sheet	This positioning allows ease of entry into the rectum following the natural curve of the colon To reduce potential infection caused by soiled linen. To avoid embarrassing the patient if faecal staining occurs
Examine the perianal area for any abnormalities before proceeding	To ensure that it is safe to proceed
For patients receiving this treatment on a regular basis use lubricating gel on the gloved index finger	To minimise patient discomfort and avoid anal mucosal trauma
As an acute procedure ONLY, a local anaesthetic gel (instillagel) may be applied topically to the anal area. Wait for 5 minutes before proceeding • Do not apply if anal mucosa is damaged • Check for contra-indications	To make the patient as comfortable and pain free as possible. To ensure the anaesthetic gel has time to have the required effect
Reassure the patient throughout the procedure	To avoid unnecessary stress or embarrassment and ensure continued consent
Insert lubricated gloved index finger into	To minimise patient discomfort and avoid

the rectum.	anal mucosal trauma
Assess for the presence of faecal matter using the Bristol Stool Scale	To establish rectal loading and the consistency of the stool
In type 1 stool (see appendix 1) remove a lump at a time until the rectum is empty	To minimise discomfort and facilitate easier removal of stool
In type 2 stool (see appendix 1), push finger into the middle of the faecal mass and split it Remove small sections of faeces at a time into appropriate receptacle	To minimise discomfort and facilitate easier removal of stool
Do not overstretch sphincter by using a hooked finger to remove large pieces of stool.	To avoid trauma to the rectal mucosa and sphincter
If top glove becomes very soiled, remove and replace with a new top glove	To avoid excessive soiling of patient's skin To maintain cleanliness
Lubricate gloved finger with each change of top glove Use extra lubrication as required	To facilitate easier insertion and minimize friction and discomfort
If faecal mass is too hard, larger than 4cm across, or you are unable to break it up, **stop** and refer to medical team	To minimise risk of autonomic dysreflexia
If patient becomes distressed or complains of headache, flushing or sweating, check the pulse again and check against the baseline reading; **stop** if pulse rate has dropped, patient is distressed, or if there is pain or bleeding in anal area. Check blood pressure for patients with spinal injury **– rise in pressure could indicate autonomic dysreflexia.**	To monitor condition of patient and stop if necessary
When rectum is empty, remove top glove and clean and dry patient's perianal area	To maintain cleanliness To leave patient comfortable
Ensure skin is clean and dry. Observe skin on completion of procedure	To monitor skin condition Promote patient comfort and hygiene
Dispose of gloves, apron and equipment into a orange bag and wash hands	To prevent cross infection
Ensure patient is comfortable and check pulse (and blood pressure for patients with spinal cord injury)	To observe for any adverse reactions
Record that an explanation was given and consent sought prior to the procedure. Record bowel results in nursing documentation and communicate results with patient/carer and medical team if appropriate. Consistency, volume, date and time should all be recorded appropriately Report any abnormal findings immediately.	To establish effectiveness of procedure To ensure continuity of care Enable appropriate actions to be initiated

21. Potential Complications: Risk Management

a. Autonomic Dysreflexia

This is a medical emergency that unresolved may give rise to serious consequences such as cerebral haemorrhage, seizures or cardiac arrest.

Autonomic dysreflexia can occur in patients with a spinal cord lesion at T6 or above. Any stimuli that would have caused pain, discomfort or physical irritation prior to the spinal cord lesion may cause autonomic dysreflexia (Glickman & Kamm 1996). The condition arises as a result of an autonomic (Sympathetic) reflex as a response to pain or discomfort (noxious stimuli) perceived below the level of the lesion. The reflex creates a massive vaso-constriction below the level of the lesion causing a pathological rise in blood pressure that can be life threatening if allowed to continue unchecked.

Manifestations of Autonomic dysreflexia

- Severe hypertension
- Bradycardia
- 'Pounding' headache
- Flushed or `blotchy' skin above the level of lesion
- Pallor below the level of lesion
- Profuse sweating above the level of lesion
- Shortness of breath.

Common causes

- Any painful or noxious stimuli below the level of injury
- Distended bladder (usually due to catheter blockage or another form of bladder outlet obstruction)
- Distended bowel (usually due to a full rectum, constipation, or impaction)
- Skin problems / in-growing toenail
- Fracture below the level of lesion
- Labour/childbirth
- Ejaculation (Glickman & Kamm 1996, Wiesel & Bell 2004)

Actions to take

- If symptoms occur whilst carrying out Digital removal of faeces – **stop procedure** and monitor vital signs
- Sit the patient up (where possible) to induce an element of postural hypotension
- Ensure there is adequate urinary drainage (check for kinks/blockage; change the catheter if necessary, do not give a bladder washout/instillation)
- If patient is constipated, consider emptying the rectum by digital removal of faeces (local Anaesthetic gel should be used)
- Blood pressure should be treated until the cause is found and eliminated (administer a proprietary vasodilator e.g. Nifedipine as prescribed)
- If unable to locate cause, or symptoms persist, get help

Autonomic dysreflexia can usually be easily remedied by the removal of the cause of the painful stimuli, use of local anaesthetic and / or use of a vasodilator.

b. Changes to routine bowel habit in patients with spinal cord injury

Regularity means training the bowel to `expect' to be emptied at a fixed time, either daily or on alternate days (Consortium for Spinal Cord Medicine 1998). If bowel care is carried out less frequently too much fluid can be absorbed from the stool resulting in constipation, and the possibility of faecal incontinence (Slater 2003). It is not possible to maintain a good routine if the frequency and time of bowel care episodes are haphazard. If there is a need to change the time of day bowel care is carried out this will need to be changed gradually over a period several weeks, during which time the bowel routine may be less reliable.

Problems with bowel routine are often compounded by poor communication, haphazard changes in management, and inconsistent practice (Consortium for Spinal Cord Medicine 1998). The most common problems encountered are episodes of constipation, faecal incontinence, irregularity, and excessive interventions (often of a pharmacological nature).

c. Constipation

Constipation or impaction of the bowel is a common cause of autonomic dysreflexia and can be further compounded by additional noxious sensations during attempts to alleviate the cause. Particular care should be taken to reduce the risk of constipation in these patients, which could be exacerbated by decreased mobility, alterations to diet and fluid intake and medication (Grundy et al 2002). Bowel results should be monitored and documented to enable early management of any potential problems. It may be necessary to introduce pharmacological measures, for a short period of time. Long-term use of laxatives can perpetuate constipation (Slater 2003), and can be contributing to episodes of faecal incontinence.

d. Faecal Incontinence

Faecal incontinence can have profound physiological and psychosocial consequences for a patient with a spinal cord lesion and it is important to identify the cause.

Causes can be due to:

- Constipation with overflow
- Digital methods being carried out incorrectly leading to incomplete rectal emptying
- Excessive use of oral/rectal stimulants
- Courses of antibiotics
- Severe diarrhoea
- Faecal impaction

If caused by constipation this should be addressed. If faecal incontinence is occurring within a few hours after bowel care it is likely that digital methods have not been carried out effectively, and these should be reviewed.

If the cause is considered to be due to excessive use of oral laxatives or rectal stimulants these should be gradually reduced and then stopped. This will enable the patient's bowel programme to be evaluated during a period of time when basic bowel care methods are used, such as diet, exercise, and digital methods, in conjunction with the patient, multi-professional team, continence advisors and community care team as appropriate.

If the patient has had strong antibiotics or several courses of antibiotics in the past this may have caused the faecal incontinence. The introduction into the patient's diet

of live yoghurt or probiotics, such as lactobaccilus (e.g. Yakult, Acidophilus) can help (Wiesel, P. and Bell, S. 2004).

In cases of severe diarrhoea and faecal impaction medical advice should be sought and liaison with the continence advisors and regional Spinal Injuries Centre.

e. Haemorrhoids

Haemorrhoids may cause an increase in spasm, and autonomic dysreflexia (if they are painful). To minimize the risk of autonomic dysreflexia, during bowel care, insert local anaesthetic gel into the rectum and wait for five minutes before commencing care. It may be necessary to seek medical advice if topical cream/suppositories containing corticosteroids and local anaesthetic preparations, or surgery are indicated.

f. Trauma to Skin

Due to complete or incomplete sensory loss a patient with a spinal cord lesion is very susceptible to the development of pressure ulcers (Grundy et al 2002). Care should be taken to avoid skin trauma during these procedures or when transferring patient onto toilet facilities.

Care givers should ensure that their fingernails are kept short to prevent damage to the mucosal membrane, rectum or sphincter. An effective, reliable bowel regime negates the need for incontinence pads.

NB. Digital stimulation and digital removal of faeces may result in a reflex erection. If the patient has a urethral catheter the carer should ensure that the catheter is positioned to prevent trauma to the urethra or meatus during bowel care.

g. Conflict between patient and nurse

In some circumstances conflict between the patient or carer and the nurse over the need for the digital removal of faces can create difficulties. In these circumstances multi-disciplinary consultation is advised including the patient.

h. Latex Allergy

This has been minimised as latex gloves are no longer provided by the trust.

i. Untoward incidents

In the event of an incident this should be promptly reported using the trust incident reporting mechanism

22. Audit

The auditing of staff availability, knowledge and competency has been incorporated into the Quality Road Map undertaken in clinical areas every year.

23. References

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Appendix 1

Digital Rectal Examination (DRE) Supervised Practice Assessment Criteria		
Performance criteria	**Met**	**Not Met**
Knowledge		
Is able to describe: ➢ The anatomy and physiology of the anal canal and rectum ➢ What to look for when carrying out a perianal inspection		
Can list the indications for: Digital Rectal Examination		
Can list the contraindications and exclusions for: ➢ Digital Rectal Examination		
Can list the equipment needed		
Can explain the procedure and rationale for: ➢ Digital Rectal Examination		
Can explain what and where to document the procedure and results of the procedure		
Can describe potential complications and how to respond to these		
Skills		
Is able to demonstrate DRE		
Demonstrates use of principles of infection control (Hand washing)		
Demonstrates safe handling and disposal of waste		
Awareness attitude		
Has had local training to undertake this practice.		
Understands importance of patient consent and documentation of the consent		
Recognises own competency level and can explain implications of accountability when undertaking this practice		
Recognises the individual needs of the patient and deals with them sensitively		
Has been observed / assessed on 1-3 separate occasions performing DRE (may include simulation on one occasion)		

Date	**Supervised practice comments**	**Signature**
	1	
	2	
	3	

Date	**Formal assessment comments**	**Signature**

***I feel I have received sufficient theoretical knowledge and supervised practice to undertake the practice of* DRE.**
Name of practitioner:
Signature Of Practitioner: Date:

This practitioner has successfully met all the criteria for assessment
Name of assessor:
Signature Of Assessor: Date:

One copy of this assessment should be kept in the clinical area where the practitioner works, and one copy should be retained by the practitioner to place in their personal professional profile.

Appendix 2

Digital Rectal Stimulation (DRS) and digital removal of faeces (DRF) Supervised Practice Assessment Criteria		
Performance criteria	**Met**	**Not Met**
Knowledge		
Is able to describe: ➢ The anatomy and physiology of the anal canal and rectum ➢ What to look for when carrying out a perianal inspection		
Can list the indications for: ➢ Digital Rectal Stimulation ➢ Digital removal of faeces		
Can list the contraindications and exclusions for: ➢ Digital Rectal Stimulation ➢ Digital removal of faeces		
Can list the equipment needed		
Can explain the procedure and rationale for: ➢ Digital Rectal Stimulation ➢ Digital removal of faeces		
Can explain what and where to document the procedure and results of the procedure		
Can describe potential complications and how to respond to these		
Can explain signs & symptoms of autonomic dysreflexia &how to respond		
Can explain the reasons for recording observations during digital removal of faeces, and when this procedure should be stopped due to changes in observations		
Skills		
Is able to demonstrate DRS and digital removal of faeces		
Demonstrates use of principles of infection control (Hand washing)		
Demonstrates safe handling and disposal of waste		
Awareness attitude		
Has attended the specific training course to undertake this practice (Insert date:)		
Understands importance of patient consent & documentation of consent		
Recognises own competency level and can explain implications of accountability when undertaking this practice		
Recognises the individual needs of the patient and deals with them sensitively		
Has been observed/assessed on 1-3 separate occasions performing DRS/ digital removal of faeces (may include simulation on one occasion)		

Date	**Supervised practice comments**	**Signature**
	1	
	2	
	3	

Date	**Formal assessment comments**	**Signature**

***I feel I have received sufficient theoretical knowledge and supervised practice to undertake the practice of* DRS and digital removal of faeces**
Name of practitioner:
Signature Of Practitioner: Date:

This practitioner has successfully met all the criteria for assessment
Name of assessor:
Signature Of Assessor: Date:

One copy of this assessment should be kept in the clinical area where the practitioner works, and one copy should be retained by the practitioner to place in their personal professional profile.

Appendix 3 Bristol Stool Form Scale

Type 1		Separate hard lumps, like nuts
Type 2		Sausage-like but lumpy
Type 3		Like a sausage but with cracks in the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces

Appendix 4 Equality Analysis

Name of the policy / function / service development being assessed	Digital rectal examination and digital removal of faeces guidelines for adults
Briefly describe its aims and objectives:	• This policy provides a framework for best practice for caring for patients who need these rectal procedures as part of their assessment or treatment plan • The needs and the interests of patients are the leading principle, placing the patient/client at the centre of their care • Its objectives are to provide equitable care across the trust for all patients & provide a resource for staff • The policy was developed in response to NPSA guidance (NPSA, Sept 2004) and their consultation and involvement programme with national groups in order to safeguard patients who need these intimate procedures. The role of the nurse is to ensure that these procedures are only performed on patients who need them following explanations and consent. It also ensures that patients who need these procedures as part of their daily care continue to receive this care whilst in hospital. against unfounded allegations of improper conduct
Directorate and Lead:	Claudia Clayman Transplantation and specialist services division
Evidence sources: DH, legislation. JSNA, audits, patient and staff feedback	• Casteldine G. (2000) Professional misconduct case studies. Case 34: patient abuse. Nurse who carried out manual evacuations without consent. BJN Vol 9 (17): 1123 • Coggrave M (2005) Management of the Neurogenic Bowel. British Journal of Neuroscience Nursing Vol. 1 No 1 • Consortium for Spinal Cord Medicine (1998) Neurogenic Bowel Management in Adultswith Spinal Cord Injury (Clinical Practice Guidelines), Journal of Spinal Cord Medicine Vol 21 pp 248 - 293. • Effective Healthcare Bulletin (2001). Effectiveness of laxatives in adults. NHS Centre for Reviews and Dissemination. University of York • Emmanuel AV et al (2013) Consensus review of best practice of transanal irrigation in adults. Sprinal Cord 51, 732-38 • Dougherty. L and Lister S (Editors) (2015). The Royal Marsden Manual of Clinical Nursing Procedures, Professional Edition, 9th Edition • Glickman, S. and Kamm, M.A. (1996) Bowel dysfunction in spinal cord injury patients. Lancet 347,(9016): 1651-1653 • Grundy, D., Tromans, A., Carvell, J. and Jamil, F. (2002) Medical management in the spinal injuries unit. In Grundy, D. and Swain, A. (eds) ABC of Spinal Cord Injury 4th edition. BMJ • Lewis SJ and Heaton KW (1997) Stool form scale as a useful guide to intestinal transit time. Scand J Gastro Sept 32(9): 920-4 • National Institute for Health and Clinical Excellence (2007) Faecal Incontinence: the management of faecal incontinence in adults. NICE, London.

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Is the Trust Equality Statement present?	Yes

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
Age	Possible negative impact understanding would have been previously assessed and appropriately supported.	Procedural guideline based on national guidance. See reference list	The trust has support structures in place to support communication and physical access needs of patients. Should any additional issues arise where none have been identified, the clinical lead will respond to ensure appropriate access and support	Senior medical and nursing leads in each ward, team or department	Each patient is assessed on admission for their communication needs. Assessment takes into account the patient's physical and sensory status. It is essential patients understand their treatment and patients/relatives who do
Disability	Some groups of people may be particularly vulnerable to a poor bowel care, including people with spinal cord injuries, people with mental health issues				

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
	including dementia, delirium.	Steps are in place to ensure procedures are carried out only if and when they are necessary, and accompanied by full explanations and documented consent. Procedure may need to be carried out by clinical or nursing staff of the same sex as the patient			not speak English as a first language or who have specific communication needs are offered the support of an interpreter/advocate or communication aide to explain the process, facilitate understanding, cooperation, gain consent and the implications of DRE & DRF Language and advocacy support is covered within the trust policies for PAL and interpreting services. Staff are made aware of the need for good communication for all nursing interventions as part of induction and on-going training in the Trust. Patient preferences, religious, spiritual and cultural beliefs/customs are observed and recorded as part of a comprehensive admission assessment.
Gender Reassignment	None identified				
Marriage & Civil Partnership	None identified				
Pregnancy and maternity	None identified				
Race	Possible negative impact language (people for whom English is a second language) and cultural need would have been previously assessed and appropriately supported.				
Religion or Belief	Possible negative impact religion and beliefs would have been previously assessed and appropriately supported.				
Sex	None identified				
Sexual Orientation	None identified				
Carers	No perceived impact as carers needs would have been previously assessed and appropriately				

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
	supported.				This aspect of training is covered as part of the corporate and local induction processes. Equality and diversity training is mandatory for all staff. The purpose is to help staff recognise and prevent any barriers to access and support because of stereotyping, or prejudice associated with age, ethnicity, disability, religion or belief, sexual orientation and gender.

Equality Analysis completed by: (please include every person who has read or commented and approval committee(s). Add more lines if necessary)	Role and Organisation	Date
	Lead nurse, continence and gastrophysiology	14/05/2015
	Lead nurse practice development BH & CFH	May 2015
	Lead nurse practice development RFH	May 2015
Clinical Practice Group (approx. 30 members; register on request)	Royal Free London	May 2015
CAEC	Royal Free London	June 2015
equality and diversity operational manager	Royal Free London NHS foundation trust	May 2015