Northern Devon Healthcare NHS Trust

Title			
Bowel Care for Adults Policy			
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Directorate Specialist Services		**Department** Bladder & Bowel Care Service	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
1.1	15/12/2015	Draft	First revision of 2011 NHS Devon Policy on the Assessment and Treatment of Bowel Symptoms for Adults. Revised version for consultation
1.2	27/01/2016	Draft	Revised to reflect review by Bladder and Bowel Band 7 group
1.3	03/03/2016	Revision	Feedback from Debbie Yarde, Clinical Lead Bladder & Bowel
1.4	07/04/2016	Revision	Feedback from Karena Mulcock, Lead Pharmacist Community
1.5	07/04/2016	Revision	Feedback from Sally Jarmain, Non –medical Prescribing Lead
1.6	07/04/2016	Revision	Feedback from Sarah Garnsworthy Senior Nurse and Jane Watson, Clinical Lead Community Nursing
1.7	27/04/2016	Revision	Feedback from Sarah Green, Specialist Nurse, Bladder & Bowel
1.8	27/04/2016	Revision	Feedback from Jacqui Fairweather, Specialist Nurse, Bladder & Bowel
2.0	31/05/2017	FINAL	Approved for publication

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Lead Director
Director of Specialist Services
Superseded Documents
(NHS Devon) Policy on the Assessment and Treatment of Bowel Symptoms for Adults Version 9 07/02/2011

Issue Date	**Review Date**	**Review Cycle**
May 2017	May 2020	Three years

Consulted with the following stakeholders:

- Infection Control
- Patient Safety
- Prescribing
- Colorectal
- Community Nursing

Approval and Review Process

- Group/Committee

Northern Devon Healthcare NHS Trust

Local Archive Reference G:\Corporate Governance/Compliance Team/Policies/Published/B&B Service **Local Path** G:\Bladder&Bowelfolder **Filename** Bowel Care for Adults Policy v2.0 Nov16	
Policy categories for Trust's internal website (Bob) Workforce, Bladder & Bowel	**Tags for Trust's internal website (Bob)** Constipation, faecal incontinence, spinal cord injury, dementia, end of life, palliative, rectal, laxatives, suppositories, enema, neurogenic bowel, anal, continence

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1. Purpose

1.1. To identify the responsibilities and processes for providing bowel care to adults, ensuring that this care complies with evidence based best practice and legal responsibilities.

1.2. Bowel care covered by this policy includes rectal interventions such as digital rectal examinations (DRE), digital rectal stimulation (DRS) and digital removal of faeces (DRF), management of constipation, faecal incontinence and promotion of normal bowel habit

1.3. This policy does not cover rectal examination for the purpose of prostate assessment nor assessment of anorectal abnormalities.

1.4. This policy does not apply to stoma care.

1.5. (See Associated Documentation for links to Trust website sections)

All care will be delivered according to the Trust Consent Policy, Infection Control Policy, Assessment and Maintenance of Clinical Competences Policy; and in accordance with relevant legislation and professional codes, including, amongst others, The Mental Capacity Act (MCA) 2005 and Nursing and Midwifery Council (NMC) Code (2015)

1.6. The policy applies to all clinical staff employed by the Trust.

2. Definitions

DRE – Digital Rectal Examination

DRS – Digital Rectal Stimulation

DRF – Digital Removal of Faeces

3. Responsibilities

3.1. **The Director of Nursing** is responsible for the provision of safe nursing care, including access to relevant guidance and training for staff.

3.2. **Managers** are responsible for the implementation of this policy within their ward/department, including ensuring staff are aware of the policy; have access to relevant education and achieve competence.

3.3. **Each Healthcare Professional** is accountable for his/her own practice and will be aware of the legal and professional responsibilities relating to their competence and work within their job description and within the Code of Practice of their professional body.

3.4. When a **Registered Nurse** delegates bowel care to a non-registered healthcare worker or carer, the registered nurse will remain accountable for this decision (NMC The Code. *Professional standards of practice and behaviour for nurses and midwives*, 2015) including the appropriateness of the delegation, ensuring the person who does the work has the competence and understanding to follow your instructions, is able to achieve the required standard, and that adequate supervision and support is provided.

The Bladder and Bowel Care Service provide specialist guidance, support and education. The Service can be contacted at

Franklyn House (for Exeter, East and Mid Devon)
Franklyn Drive
St Thomas
Exeter EX2 9HS
Tel 01392 208478
ndht.bladderandbowel@nhs.net

Crown Yealm House (for North Devon)
Pathfields Business Park
South Molton
EX36 3LH
Tel 01769 575182

Newton Abbott Hospital (for South Devon)
West Golds Road
Jetty Marsh
TQ12 2TS
Tel 01626 324685

4. Knowledge, skills and understanding needed for bowel care

Bowel care is a fundamental area of patient care.

Healthcare professionals should acquire knowledge, understanding and skills relating to the delivery of lower bowel care, including (from RCN guidance for nurses *Management of lower bowel dysfunction, including DRE and DRF.* Sept 2012 3rd ed.):

- consent, privacy, dignity (which may include consideration of best interest decisions in line with the Mental Capacity Act (MCA) 2005)
- anatomy and physiology of the lower gastrointestinal tract
- definitions and causes of bowel dysfunction
- assessment, investigations (including DRE) diagnosis and prognosis
- interventions to improve and maintain bowel function (including DRF)
- pharmacology and prescribing
- bowel emergencies and complications
- risk assessment
- infection control

4.1. Suggested sources of learning

Recommended resources include the following, it is important to ensure the most up-to-date versions are accessed. The best way to do this is online:

- www.rcn.org.uk :

  RCN guidance for nurses *Management of lower bowel dysfunction, including DRE and DRF.* Sept 2012 3rd ed.
  RCN guidance for nurses *The management of diarrhoea in adults* 2013

- www.mascip.co.uk :

  Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. Initiated by the Multidisciplinary Association of Spinal Cord Injured Professionals. Sept 2012.

- Management of Constipation, via BOB Northern and Eastern Devon Formulary and Referral Site.

  http://northeast.devonformularyguidance.nhs.uk/formulary/chapters/1.-gastronintestinal/constipation

- rcnendoflife.org.uk/ (Nov 2015) includes advice on symptom management at end of life including bowel dysfunction.

- www.nice.org.uk has pathways, guidance, standards on faecal incontinence.
  NICE Guideline CG49 Faecal incontinence in adults; management
  NICE Guideline CG61 Irritable bowel syndrome in adults: diagnosis and management

- Public Health England have guidance on the reduction of Gram-negative bacteraemias including those caused by E-Coli https://improvement.nhs.uk/uploads/documents/Gram-negative_IPCresource_pack.pdf

- **Alzheimers Society** for dementia resources for continence care

- St Marks Hospital in Harrow, Middlesex, a tertiary bowel hospital www.stmarkshospital.nhs.uk has a comprehensive range of patient information leaflets, e.g. on constipation / diverticular disease in the website Patients and Visitors section.
  Online training / e-learning in bladder and bowel care is available through the **Trust STAR site** and it is recommended that all relevant staff access this module.

4.2. Assessment of competence in bowel care:

Complete Clinical Competencies form at Appendix 15. Acceptable performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff as per the Assessment and Maintenance of Clinical Competency Policy.

5. Bowel assessment and management

5.1 **Elimination assessment in first/holistic assessment**
Bowel care deals with an intimate and private area of the body and requires discretion and sensitivity in the assessment and care delivery process. Embarrassment may prevent patients from reporting/admitting to a problem, so careful and sensitive history taking and monitoring should be undertaken. Bowel dysfunction is very common yet under-reported and can severely impact on lifestyle and quality in life. Problems are often linked to ageing, underlying disease, medical conditions and medications.

First assessment includes a history of bowel continence and function and relevant clinical examinations. This requires knowledge and understanding of the causes of poor bowel emptying, including types of constipation and faecal incontinence.
Best practice includes completion of a **Bowel Signs and Symptoms Questionnaire** (Appendix 3) and **Bowel Diary** (Appendix 6) for all patients if

only to establish normal bowel pattern. If first assessment identifies bowel dysfunction, complete:

5.1.1. **Bowel Continence Care Pathway** (Appendix 1)

The above includes the need to identify red flag symptoms e.g. for suspected cancer (2015 NICE guidelines re suspected cancer referrals https://www.nice.org.uk/guidance/ng12) and bowel care emergencies and complications including faecal impaction, bowel obstruction (see Appendix 2), perforation, Autonomic Dysreflexia (AD), strangulated hernia, undiagnosed rectal bleeding and undiagnosed diarrhoea.

5.1.2. Pathway assessment documents include:

Signs and Symptoms Questionnaire (Appendix 3), Bowel Diary (Appendix 6), Rome Constipation criteria (Appendix 4), Fibre scoring sheet (Appendix 5), Food diary (Appendix 8), medications affecting bowel checklist (Appendix 13)

5.1.3. Pathway bowel management documents

Dietary/lifestyle management (Appendices 10, 11, 12)

For laxatives/suppositories/enema advice consult the North and East Devon Formulary and Referral which can be accessed on BOB at:

https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/favicon.ico

5.1.4. Pathway bowel care interventions guidance

DRE, DRS, DRF, (Appendices A, B and C)

Rectal/trans-anal irrigation

Trans-anal irrigation with warm water is used to facilitate evacuation of stool in a number of scenarios including chronic constipation, faecal incontinence, obstructive defaecation, or neurogenic bowel dysfunction. It is usually tried once other less invasive methods of bowel management have been tried. It is important to carry out a full individualised assessment first, with checks for any contraindications.

6. Bowel Care Emergencies/Complications

Bowel care emergencies and complications are very rare but it is important to be aware of these and to act quickly to reduce further complications.

Bowel obstruction can be associated with no bowel activity or lots of painful activity to try to bypass a mechanical obstruction, abdominal pain and distension, vomiting, possible dehydration and is a serious condition that requires immediate medical attention. Main causes are colon cancer, adhesions, scarring from infection.

Perforation is a hole in the bowel which allows leakage of intestinal contents into the abdominal cavity. Perforation could cause peritonitis which if not treated can cause almost immediate death (Medline Plus, 2007). Causes of perforation include a diverticular or cancerous lesion, colonoscopy or sigmoidoscopy (very rare), ischemia of the bowel possibly caused by a strangulated hernia.

Strangulated hernia occurs when the blood supply to the bowel is cut off and may lead to ischemia, necrosis and gangrene. Main symptoms are nausea, vomiting and severe pain.

Diarrhoea. There are many causes of diarrhoea (for example colitis, small bowel disease, pancreatic, endocrine, infection, antibiotic therapy, drug, diet induced) and it may lead to dehydration and electrolyte imbalance (Steele, 2007). Beware mistaking faecal overflow for diarrhoea. If faecal overflow is a consideration a digital rectal examination and stool charts will be required for diagnosis. Where consent cannot be obtained medical advice should be sought.

Any patient experiencing unexplained diarrhoea requires full assessment and diagnosis before treating. This assessment should consider 'red flag' symptoms of blood, mucous and pain and a medicines review as well as the possibility of the diarrhoea being infectious and contagious. Also ensure dehydration is recognised and appropriately managed. The following Trust policies should be consulted:

Gastro Intestinal Infection Policy April 2014

http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2010/12/Gastro-Intestinal-Infection-Policy-V2-2-22Apr14.pdf

Clostridium Difficile Policy May 2014

http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/12/Clostridium-difficile-Policy-v4.0-22Mar14.pdf

http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2014/09/Patient-Isolation-Staff-Exculsion-Policy-v3.4-28Jan16.pdf

Standard Infection Control Precautions Policy April 2015

http://www.northdevonhealth.nhs.uk/2014/08/standard-infection-control-precautions-policy/

Waste Policy

http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2010/04/Waste-Management-Policy-V4.0-11Apr14.pdf

Long standing or sporadic diarrhoea that has been fully investigated and cannot be rectified may be managed with anti-motility medication given under medical or specialist supervision. Patients with mental capacity may also find anal plugs helpful in managing their symptoms.

Undiagnosed rectal bleeding can have a number of causes, including haemorrhoids, anal fissure, proctitis, diverticular disease, colitis, polyps, ulceration or a life threatening malignancy. The type of blood (fresh or dark) and where seen (on the toilet paper, on wiping, or on the faeces) needs to be ascertained. Recent change in bowel habit, unintentional weight loss, rectal bleeding, anaemia, increased mucus and wind not associated with any lifestyle changes may be due to malignancy, inflammation or ischemia (Steele, 2007). An individual with any of these symptoms should inform their GP, see NICE guidance on suspected cancer https://www.nice.org.uk/guidance/ng12

Faecal impaction is a complication of constipation, and if not treated can cause an obstruction of the bowel. It is not well defined, but “copious formed stool in the colon (not just the rectum) which is not progressing through the colon or which cannot be expelled from the rectum are salient symptoms.” (Coggrave and Emmanuel, 2010). Impaction may be accompanied by “overflow” diarrhoea where looser stool leaks round an unmoving faecal mass. Macrogol 3350 with electrolytes is licensed to treat faecal impaction and may need to be given, on prescription only, in combination with rectal stimulants such as an enema. The Discretionary Medicines Standard Operating Procedure (available on BOB) lists the laxatives, enemas and suppositories currently specified by NDHT that may be administered by registered nursing staff without prescribing by a medical/non-medical prescriber, where a delay would be detrimental to the patient. DRF may be appropriate for patients with impaction.

Autonomic dysreflexia (AD) is an abnormal sympathetic nervous system response to a noxious stimulus below the level of injury which can occur only in people with a spinal cord injury at level sixth thoracic vertebrae (T6) or above Acute episodes may result in rapidly rising blood pressure with accompanying risk of brain haemorrhage and possible death (Kavchak-Keyes, 2000). Among susceptible individuals, 36% report dysreflexic symptoms occasionally and 9% always when they conduct bowel management (Coggrave, 2008). The patient should be observed for symptoms of AD which may include flushing, sweating, chills, nasal congestion and headache while bowel care is being carried out, as acute AD may occur in response to digital interventions; however it is most likely to occur in response to ineffective bowel care due to withholding of essential interventions (Coggrave, 2008). Therefore it is important that all healthcare workers in whatever care setting are aware of this condition and are aware of how it can be treated to reduce to reduce the risk of the above complications occurring. The signs and symptoms of AD are headache, flushing, sweating, nasal obstruction, blotchiness above the lesion and hypertension. The cardinal sign of acute AD is a rapidly developing severe headache. If this occurs DRF should be stopped, medical assessment undertaken and should be treated promptly (Coggrave, 2008).

7. Bowel Care in Neurogenic Conditions (including spinal cord injury)

See www.mascip.co.uk :

Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. Initiated by the Multidisciplinary Association of Spinal Cord Injured Professionals. Sept 2012.

Damage to the central nervous system (brain and spinal cord) has a profound impact on the function of the large bowel and on the maintenance of faecal continence. “Neurogenic bowel dysfunction” is the term used for the combination of impaired continence (caused by impairment of the sensory and motor control of the ano-rectum) and risk of severe constipation (caused by slowing of stool transit through the bowel). Without intervention, faecal incontinence and chronic constipation may occur, with reduced life quality and secondary complications.

Central neurological conditions include:

- Multiple sclerosis
- Parkinson’s disease
- Stroke

- Cerebral palsy
- Cauda equina syndrome
- Spina bifida
- Spinal cord injury

Neurogenic bowel management aims to deliver planned interventions to pre-emptively achieve effective bowel evacuation at specific frequency to avoid faecal incontinence and constipation. Interventions are usually chosen following assessment of individual needs and will usually start with the most simple and least invasive options (defaecation routine and posture, diet and fluids, maximising mobility, teaching to use abdominal muscles, laxatives/constipating medication) and progress as necessary. Development of a care plan is likely to involve specialists, especially in the case of spinal cord injury, where neurogenic bowel care will be planned prior to discharge from the inpatient spinal cord injury centre. A high spinal cord injury (T12 and above) will result in a reflex bowel which may need less intervention, for example suppositories/mini enemas and/or digital rectal stimulation. A low spinal cord injury will result in a flaccid areflexic bowel and may require DRF.

Staff responsible for the bowel management of patients with a spinal cord lesion need to be familiar with the National Patient Safety Agency alert from Sept. 2004 accessed via www.npsa.nhs.uk/advice . Once the individual bowel management programme is established, actual day-to-day bowel care may be delegated to other carers.

Abdominal massage may be helpful.

8. Bowel care for people who may lack mental capacity

Care will be delivered in line with the Trust's Mental Capacity Act Policy http://www.northdevonhealth.nhs.uk/2013/07/mental-capacity-act-policy/. A lack of capacity might be due to injury, a learning disability, mental health problem or a condition such as dementia that may affect the way a person's brain makes decisions.

To have capacity a person must be able to:•understand the information that is relevant to the decision they want to make;•retain the information long enough to be able to make the decision;•weigh up the information available to make the decision;•communicate their decision by any possible means, including talking, using sign language, or through simple muscle movements such as blinking an eye or squeezing a hand. If a person is deemed to lack capacity all care and actions taken must be in the person's best interests as described in the Mental Capacity Act Policy. A person may be able to make decisions about certain aspects of their care even if they are unable to make other, for example financial, decisions

Advise specific to Dementia : difficulties with using the toilet, accidents and incontinence can all be problems for people with dementia, particularly as the condition progresses. However, incontinence is not an inevitable consequence of dementia. Someone with dementia is more likely to have accidents, problems with the toilet or incontinence than a person of the same age without dementia.
There are many reasons including:

- not being able to react quickly enough to the sensation of needing to use the toilet and failure to get to the toilet in time, sometimes due to mobility problems caused by other conditions
- not being able to communicate the need to go to the toilet; inability to find, recognise, or use the toilet
- not understanding a prompt from someone to use the toilet
- not managing the personal activities of toileting, such as undoing clothing and personal hygiene
- not letting others help with toileting – perhaps because of embarrassment or not understanding the offer of help
- not making any attempt to find the toilet – this could be due to lack of motivation or depression, or because the person is distracted
- embarrassment after an accident, which the person unsuccessfully tries to deal with. Wet or soiled clothes or faeces may be put out of sight (for example, wrapped up and put at the back of a drawer) to be dealt with later, but then forgotten.

In addition to help with fluid intake, diet and maximising mobility to manage bowel problems, the following ideas may help someone to find, recognise and use the toilet more easily:

- Help the person identify where the toilet is. A sign on the door, including both words and a picture, may help. It will need to be clearly visible, so place it within the person's line of vision and make sure the sign is bright so it's easy to see. Help the person know when the toilet is vacant; leaving the toilet door open when not in use makes this obvious. Check the placement of mirrors in the bathroom. The person with dementia may confuse their reflection for someone else already in the room, and not go because they believe the toilet is occupied.

- Help the person make their way easily to the toilet. Move any awkwardly placed furniture or prop ajar any doors that are hard to open. The room and the route to the toilet should be well lit, especially at night. Movement sensor lights in the bedroom and bathroom can help at night.
- Make using the toilet easier for people with mobility problems. Aids such as handrails and a raised toilet seat may help.
- Help the person identify and use the toilet. A contrasting colour (eg black seat on a white base) can make it easier to see.
- Help the person undo, remove and replace clothing easily. Trousers with an elasticated waist (eg tracksuit bottoms) are often easier than zips. Some people find Velcro™ fastenings easier to use than zips or buttons.

- If getting to the toilet becomes too difficult because of mobility problems, an aid such as a commode may be useful. Using this will require the person to recognise the commode, be willing to use it, and find it an acceptable piece of furniture

  - The person should have privacy in the toilet, but make sure they don't have difficulty managing locks. Some people with dementia struggle with this. To avoid the person locking themselves in, disable locks or ensure you can open them quickly from the outside.

9. Bowel Care at End of Life

rcnendoflife.org.uk/ covers the fundamentals of nursing care at the end of life and includes advice on constipation. Specialist palliative care professionals will also provide guidance.

Constipation at end of life is very common and can have serious effects on quality of life and worsen other symptoms, especially pain. Patients taking opiate medication are likely to need regular laxatives. Opioid induced constipation needs a regime including osmotic and stimulant laxatives and bulk forming laxatives should be avoided. Co-danthramer is indicated for constipation at end of life (only) as per the North and East Devon Formulary and Referral which can be accessed on BOB at:

https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/favicon.ico

Assessment needs to include bowel routines, access to toilet or commode, pain when the using toilet, difficulty eating and drinking (including mouth ulcers or thrush). Laxatives may help, together with increased fluid intake, offering fluids little and often if necessary, encourage mobility if an option, dietary fibre or purees and fruit juices.

Diarrhoea at end of life may occur due to malabsorption, medications, constipation with overflow, poor appetite, gastrointestinal bleeding. Quality of life considerations are essential. When dietary or pharmacological options are ineffective or not possible, containment in the form of anal plugs (for slight incontinence), pads or faecal collection systems (especially if immobile or unconscious)

10. Infection Control including Clostridium difficile

See Clostridium Difficile Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/12/Clostridium-difficile-Policy-v4.0-22Mar14.pdf

Clostridium difficile infection (*C.difficile*) is a significant cause of health care associated diarrhoea, and outbreaks are problematic for both patients and health care organisations. When certain antibiotics disturb the balance of bacteria in the

gut, *Clostridium difficile* can multiply rapidly and produce toxins which cause illness and diarrhoea.

The Department of Health has produced high impact intervention care bundle guidance (DH,2007b),which is available at http://hcai.dh.gov.uk

How to deal with the problem: Core guidance (HPA, 2009)

It is important that when a patient presents with diarrhoea, the possibility that it may have an infectious cause is considered. Patients with suspected potentially infectious diarrhoea should be isolated.

The Department of Health and the Health Protection Agency have produced 10 key recommendations for health care providers entitled *Clostridium difficile: how to deal with the problem* (2008) which can be downloaded at www.hpa.org.uk

Clinicians should apply the following SIGHT mnemonic protocol when managing suspected potentially infectious diarrhoea such as CDI:

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea.
I	Isolate the patient and consult with the infection control team while determining the case of diarrhoea.
G	Gloves and aprons must be used for all contacts with the patient and their environment.
H	Hand-washing with soap and water should be carried out before and after contact with the patient and the patient's environment.
T	Test the stool for toxin by sending a specimen immediately.

11. Monitoring Compliance with and the Effectiveness of the Policy Standards/Key Performance Indicators

Key performance indicators comprise

- Documentation Audits
- Complaints and incident reports

12. Process for Implementation and Monitoring Compliance and Effectiveness

Implementation and monitoring compliance with this policy will be the responsibility of the Service/Clinical Lead for each service/speciality

Bowel care pathways and care plans will be included in the Trust's nursing documentation audit processes (including consent processes and documentation).

Trust wide patient surveys will include information and feedback on the patient experience, including how well patients were informed about their condition and care plan, procedures and treatments.

Where non-compliance is identified, education, support and advice will be made available (if appropriate) by managers within the framework of an action plan to improve compliance.

13. Equality Impact Assessment

13.1. The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age	Yes	No		Acknowledges age factors
Disability	Yes	No		Accommodated
Gender	No	No	Yes	

Gender Reassignment	No	No	Yes	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment)	Yes	No		Rights covered
Marriage and civil partnership			Yes	
Pregnancy			Yes	
Maternity and Breastfeeding			Yes	
Race (ethnic origin)			Yes	
Religion (or belief)			Yes	
Sexual Orientation			Yes	

14. Associated Documentation

Consent Policy http://www.northdevonhealth.nhs.uk/wp-content/uploads/2012/04/Consent-Policy-v3.5-Mar17.pdf

Gastro Intestinal Infection Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2010/12/Gastro-Intestinal-Infection-Policy-V2-2-22Apr14.pdf

Clostridium Difficile Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/12/Clostridium-difficile-Policy-v4.0-22Mar14.pdf

Patient Isolation Staff Exclusion Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2014/09/Patient-Isolation-Staff-Exclusion-Policy-v3.4-28Jan16.pdf

Standard Infection Control Precautions Policy http://www.northdevonhealth.nhs.uk/2014/08/standard-infection-control-precautions-policy/

Waste Management Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2010/04/Waste-Management-Policy-V4.0-11Apr14.pdf

Mental Capacity Act Policy http://www.northdevonhealth.nhs.uk/2013/07/mental-capacity-act-policy/

Learning Disability Operational Policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/06/Acute-Care-Learning-Disability-Operational-Policy-V4.0-28Oct15.pdf

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Appendix 1 – Bowel Continence Care Pathway

Patient's Name **Date of Birth:**	**NHS No:** **Clinic Base / Ward:**	**Date of Assessment:**
Patient Address:		
GP/Consultant: **GP Address:**		

1. PREVIOUS MEDICAL HISTORY (Tick appropriate box(s)			
Diabetes	Dementia	Urological	Gynaecological
Neurological	Cardiovascular	Learning Disability	Mental Health
Physical Disability	Neoplasm	Back Problems	Arthritis
Allergies / Sensitivities:			
Current Medication:			
Other (State)			
Urinary Problems (If YES please state then go to Urinary Care Pathway) YES / NO			
Recent Surgery: YES / NO (State)		Has the patient had a catheter YES / NO	

WHAT HAS BEEN THE EFFECT ON THE PATIENT'S LIFE?

How much does your bowel problem bother you?

Not at all **a little** **moderately** **a lot** *(circle the choice)*

What has been the effect on your life of your bowel problems?

	COMMENTS REGARDING PATIENT CARE
If patient has any signs of undiagnosed bleeding, or black tarry stool and is not taking ferrous sulphate, stop pathway and refer to doctor immediately	
Using obstruction checklist (Appendix 2), observe patient for any signs of obstruction. If present, stop pathway and refer to doctor immediately.	
Establish patient's bowel activity using Signs & Symptoms Questionnaire (Appendix 3)	
Meets Rome Criteria Questionnaire Constipation? (Appendix 4)	YES / NO

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Fibre Score (Appendix 5) If <13 advise on dietary fibre		
Provide / Review Bowel Diary (inc Bristol Stool Chart) (Appendix 6 & 7z)		
Patient's Name **Date of Birth:**	**NHS No:** **Clinic Base / Ward:**	**Date of Assessment:**
	COMMENTS REGARDING PATIENT CARE	
Establish constipation using signs and symptoms chart and record findings. If constipated as defined by Rome criteria, refer to 5 step management of constipation (Appendix 12).		
Obtain consent to any invasive procedure (e.g. PR or manual evacuation) in line with Trust Policy		
Use Fibre Scoring Chart (Appendix 5) to establish fibre levels. If 12 or less give information sheet and advice on increasing fibre in diet (Appendix 9)		
If patient unable or unwilling to comply, consider fibre supplements.		
If patient is in discomfort consider abdominal massage technique.		
Give patient 'Looking after your bowels' Leaflet (Appendix 11)	☐ (Tick box)	
Review in 2-4 weeks and record any further care in patient's note.		
If any queries or concerns about further care and if no improvement following use of this Care Pathway discuss with Bladder and Bowel Care Team		

FULL NAME (Print)	DESIGNATION	SIGNATURE	DATE

Northern Devon Healthcare NHS Trust

Appendix 2 – Symptoms and Causes of Obstruction

SYMPTOMS AND CAUSES OF OBSTRUCTION				
	SMALL BOWEL	LARGE BOWEL	PARALYTIC ILEUS	STRANGULATED OBSTRUCTION
HISTORY:				
SURGICAL:	Adhesions from previous abdominal surgery	Adhesions from previous abdominal surgery	Recent abdominal surgery	Previous surgery or adhesions
MEDICAL:	Hernia, shock, occlusion of mesenteric arteries, radiation, gallstone migration	Tumour, diverticulitis, volvulus, intussusception, ulcerative colitis, mesenteric occlusion, faecal impaction, radiation	Pneumonia, pancreatitis, kidney infection, spinal cord injury, diabetic ketoacidosis, hypokalaemia, bile irritation	Any type of obstruction can progress to the point where the bowel contorts and cuts off blood suppl.
DRUGS:	Cardiac glycosides, diuretics, opiates, anticholinergics, tricyclic antidepressants	Cardiac glycosides, diuretics, opiates, anticholinergics, tricyclic antidepressants	Cardiac glycosides, diuretics, opiates, anticholinergics, tricyclic antidepressants	Cardiac glycosides, diuretics, opiates, anticholinergics, tricyclic antidepressants
SYMPTOMS:				
ONSET:	Rapid	Insidious	As early as 1-2 days post-operatively or as late as 6 weeks post-op.	Rapid
VOMITING:	Early and frequent if high up, with lower blockage later and may contain faeces	Secondary to distension of small intestine; late onset may contain faeces	Usually not prominent, may only follow eating	Early: infrequent Late: persistent
PAIN:	Cramping in mid to upper abdomen , episodic increases after meals; can be severe	Moderate cramping in suprapubic area	Dull, diffuse, continuous	Severe cramping in epigastric / periumbilical area
SIGNS:				
ABDOMEN:	Non-tender, distension occurs in later stages	Distension in later stages	Distension; tense shiny skin	Distension, rigidity
BOWEL SOUNDS:	Early: high pitched tinkling, intermittent	Early: high pitched tinkling, intermittent	Infrequent or absent	Infrequent or absent

	Later: decreased or absent	Later: decreased or absent		

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Appendix 3 – Signs & Symptoms Questionnaire (Bowels)

Patient Name: **Date of Birth:**	**NHS No:** **Clinic Base / Ward:**		**Date of Assessment:**
SYMPTOM	**VISIT 1**	**VISIT 2**	**VISIT 3**
Have your bowel habits recently changed? If yes, when did it start? (If too loose and/or more frequent stools for 6 weeks or more you need to inform your doctor)			
Do you have an urgent need to open your bowels?			
Do you feel that your bowel motions are not frequent / regular enough? How often do you go and how often would you like to go?			
Do you leak stool / soil yourself before reaching the toilet?			
Do you have any difficulty passing faeces / stool?			
Do you have the feeling that your bowel is not empty or you need to go again quickly?			
Do you drink at least 8 drinks per day?			
Fibre Score (Appendix 5)			

Appendix 4 – Rome Criteria II For Constipation

< 2 or fewer bowel movements per week

OR

> 2 or more of the following symptoms:

I straining on 1 in 4 occasions

II hard stools on 1 in 4 occasions

III feeling of incomplete evacuation on 1 in 4 occasions

Appendix 5 – Fibre Scoring Sheet

Rate for your diet for fibre
Pick the foods you eat at home and find your score:

SCORE FOOD	1	2	3	Write your score here
BREAD	White	Brown	Wholemeal / Granary	
BREAKFAST CEREAL 3 times per week or more	Rarely or never eat or eat sugar coated cereal e.g. Frosties	Corn Flakes Rice Crispies Cheerios Special K	Bran Flakes Weetabix Shredded Wheat Muesli Shreddies	
POTATOES PASTA RICE	Rarely or never eat	Eat potatoes, white rice or pasta most days	Eat potatoes in jackets, brown rice or pasta most days	
PULSES BEANS NUTS	Rarely or never eat	Once a week or less	Three times a week or more	
VEGETABLES All kinds other than pulses, potatoes and beans	Less than once a week	1-3 times per week	Daily	
FRUITS All kinds	Less than once a week	1-3 times per week	Daily	

SCORE GUIDE: **0-12: Increase your fibre** **13-17: Good**		**YOUR TOTAL SCORE:**	

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Appendix 6 – Bowel Diary

NAME: _____ NHS NO: _____

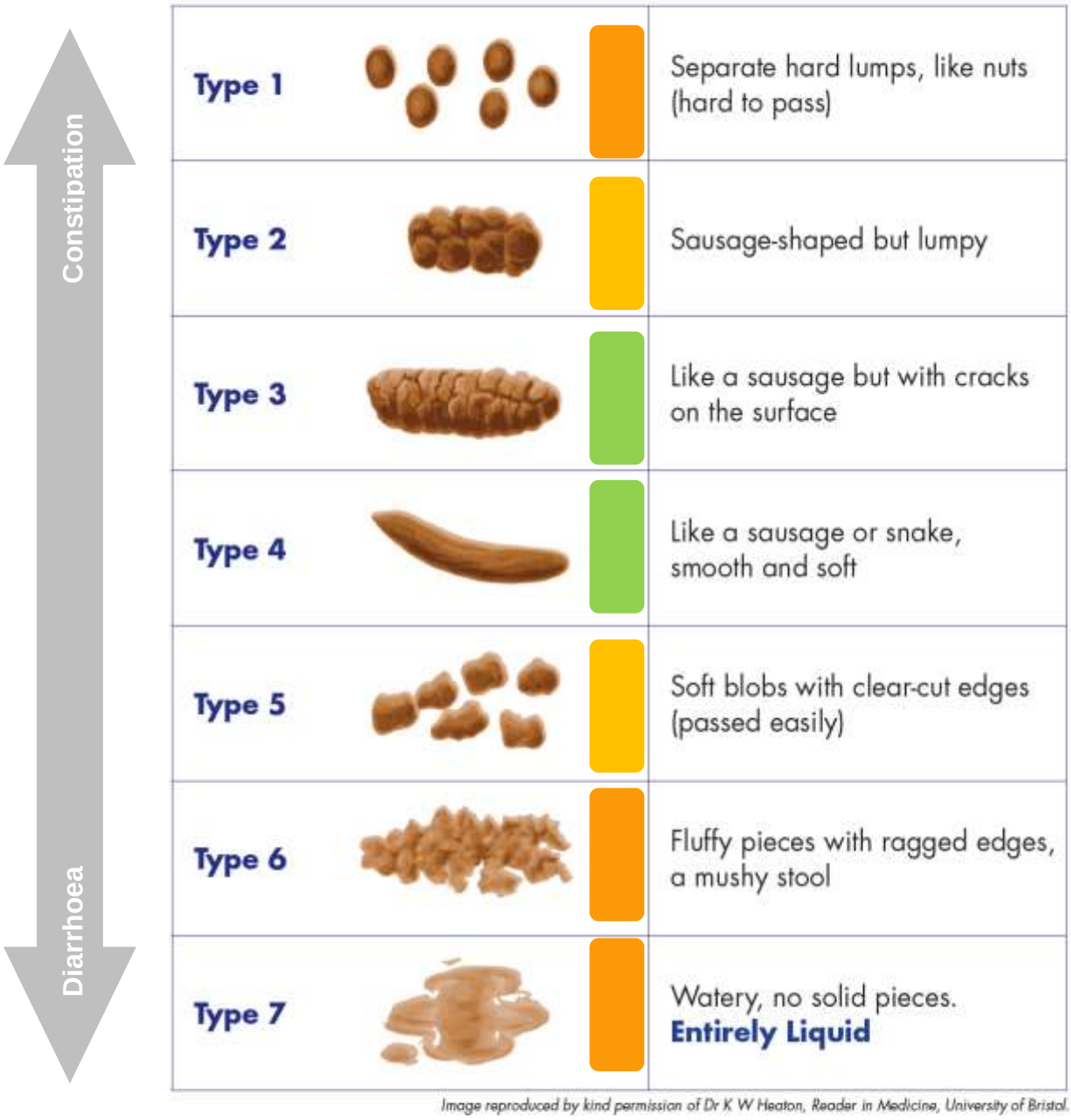
PLEASE FILL IN FOR AS MANY DAYS AS POSSIBLE OR FOR UP TO 14 DAYS

PLEASE TICK THE RELEVANT BOX

DAY/DATE	TIME	BRISTOL STOOL TYPE	ACCIDENT	DID YOU WANT TO GO?		SOILING	ANY OTHER COMMENTS e.g. laxatives, etc
				YES	NO		

Appendix 7 – Bristol Stool Chart

Bristol Stool Chart



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b&bf

B&Bf Helpline: 0845 345 0165 – medical advice
General enquiries: 01536 533255

www.bladderandbowelfoundation.org

Registered charity, no.1085095 BBF/Stool Chart/March 2012

Normal[1]

Abnormal[1]

Appendix 8 – Food Diary

NAME: _____NHS NO: _____

DAY	BREAKFAST	MID-MORNING	LUNCH	TEA	DINNER	ANY SNACKS
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Please list everything that you eat and drink and whether a small, medium or large amount

Appendix 9 – Fibre Content of Everyday Foods

Serving size (grams)	Fibre content (grams)		Serving size (grams)	Fibre content (grams)	
BREAD			**BREAKFAST CEREALS**		
25	1.5	Wholemeal	40	9.6	All-bran
25	0.9	Brown	40	8.8	Bran buds
25	0.8	Hovis	30	3.9	Bran flakes
25	0.4	White	30	3.0	Sultana bran
			30	2.1	Fruit 'n fibre
FLOUR			30	1.8	Country store
25	2.3	Wholemeal	30	2.7	Raisin splitz
25	1.6	Brown Flour	30	0.3	Corn flakes
25	0.8	White Flour	40	2.6	Muesli
25	0.8	Oatmeal – raw			
25	0.5	Rice – brown	**BISCUITS & PASTRY**		
			25	2.9	Crispbread – rye
NUTS			12	0.3	Digestive
25	1.9	Almonds	12	0.2	Gingernuts
25	1.1	Brazils	25	1.5	Oatcakes
25	1.1	Chestnuts	25	0.5	Shortbread
25	1.6	Hazelnuts	50	1.1	Short pastry
25	1.8	Coconut			
25	1.6	Peanuts	**RICE**		
25	1.4	Peanut butter	150	1.2	Brown
25	0.9	Walnuts			
		VEGETABLES			**FRUIT (raw)**
75	1.9	Carrots	100	1.8	Eating apples
75	1.9	Beetroot	75	2.6	Avocado pear
75	2.6	Swedes	100	1.1	Banana
100	1.4	Potatoes – jacket	100	3.1	Blackberries
100	1.1	Potatoes – new	100	0.9	Cherries
100	1.2	Potatoes – peeled & boiled	15	0.5	Dates – dried
100	1.6	Spinach	20	1.5	Figs – dried

100	3.0	Broccoli tops	100	0.7	Black grapes
100	3.6	Spring greens	80	1.0	Grapefruit
100	4.8	Sprouts	150	1.5	Melon
90	1.6	Cabbage	160	2.7	Orange
90	2.2	Cabbage – raw	110	1.7	Peach
90	1.4	Cauliflower	170	3.7	Pear
0	0.3	Celery – raw	24	0.5	Raisins
80	1.4	Leeks	60	1.5	Raspberries
30	0.3	Lettuce	100	1.1	Strawberries
65	3.3	Peas – frozen	24	0.5	Sultanas
85	4.1	Peas – canned	80	1.0	Pineapple
65	2.9	Peas – fresh			
120	7.8	Broad beans			**FRUIT (cooked with sugar)**
60	2.8	Butter beans	140	3.9	Blackcurrants
135	5.0	Baked beans	140	2.7	Gooseberries
90	1.7	Runner beans	140	1.7	Plums
90	3.7	French beans	24	0.6	Prunes
120	2.3	Lentils – split	140	1.7	Rhubarb
125	1.6	Corn-on-the-cob			
60	0.8	Sweetcorn – can			
85	0.9	Tomatoes – raw			
60	1.0	Onions			

Appendix 10 – Sitting Position for Opening Bowels

Correct position for opening your bowels

Step one

Knees higher than hips

Step two

Lean forwards and put elbows on your knees

Step three

Bulge out your abdomen
Straighten your spine

Correct position

Knees higher than hips
Lean forwards and put elbows on your knees
Bulge out your abdomen
Straighten your spine

Reproduced by the kind permission of Ray Addison, Nurse Consultant in Bladder and Bowel Dysfunction.
Wendy Ness, Colorectal Nurse Specialist.

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Appendix 11 – Looking After Your Bowels

DID YOU KNOW?

1. Drinking the correct amount of fluid for your body weight can help constipation. The job of the last part of the gut is to absorb fluid back into the body. It will do this even if you are drinking very little. If you are not drinking enough, this makes the waste hard and makes it difficult for you to get rid of waste. Fluid helps the waste to remain slippery and therefore easier to pass.

I need to drink..... Cups/Mugs per day

2. It is important to make sure that your diet has adequate fibre in it. The best advice is to eat 5 portions of fruit and vegetables a day for health. Your nurse has a useful fibre-scoring sheet for you to see how much you really are eating.

Fibre Score .....

I need to consider this advice to improve my fibre .....

3. Limber up!! Regular exercise, within your limitations, can stimulate the bowel to work regularly.

4. It is important to be in a good position to have your bowels open so… Are you sitting comfortably? Which means being well supported and feeling safe, not slipping or sliding or having trouble getting on and off the toilet.

Your nurse can help you access aids and adaptations to help

5. Bowels benefit from routine. Allow yourself time and privacy to empty your bowels. This can be difficult if you require help and assistance in the toilet, but discuss this with your nurse, they may have some ideas to help.

Appendix 12 – The Management of Constipation

The Management of Constipation
This bulletin describes five steps to managing a constipated patient and provides prescribing information on chosen laxative agents.

STEP 1 Diagnosis
There is considerable variation in the frequency of "normal" bowel movements for individuals, (e.g. from three movements per day to three per week), and it is any deviation from this norm that is important for the diagnosis of constipation. Constipation may also be used to describe the passing of hard, painful faeces or when full evacuation is achieved with difficulty.

STEP 2 Identify a possible cause

2.1 Underlying disease, e.g. endocrine, metabolic or neurological disturbances
2.2 Immobility
2.3 Dietary change
2.4 Dehydration
2.5 Drug treatment, e.g. antacids containing aluminium, anticholinergics, iron salts, opioid analgesics, phenothiazines, tricyclic antidepressants, anti-psychotics, Verapamil. A full list of drugs causing constipation can be found in appendix 13.
2.6 Mechanical obstruction, e.g. tumour, haemorrhoids
2.7 Pregnancy

STEP 3 Educate the patient

3.1 Encourage the patient to "answer the call of a stool"
3.2 Give dietary advice, e.g. a diet which includes fresh fruits and vegetables, wholegrain bread and cereals –supplemented by coarse bran may prevent constipation.
3.3 Encourage mobility where possible
3.4 Encourage an adequate fluid intake i.e. 2 litres a day

STEP 4 Prescribe a laxative
All laxatives MUST be prescribed on the patient's drug chart (if relevant) and recorded when administered: This includes suppositories and enemas. The Discretionary Medicines Standard Operating Procedure (available on BOB) lists the laxatives, enemas and suppositories currently specified by NDHT that may be administered by registered nursing staff without prescribing by a medical/non-medical prescriber, where a delay would be detrimental to the patient. The patient must be reviewed following the administration of a laxative and when the laxative has been ineffective further, medical review should be sought.

STEP 5 Monitor the patient
Bowel diaries should be kept. A fluid intake chart is also helpful.
Review laxative therapy regularly and stop or reduce when no longer required

Appendix 13 – Medicines Associated with Constipation

Aluminium Antacids Aluminium hydroxide **Anticholinergics** **Atropine** Hyoscine Oxybutynin Tolterodine Propiverine Ipratropium bromide Oxitropium bromide **Antiepileptics** Carbamazepine **Antidepressants** Amitriptyline Clomipramine Dothiepin Imipramine Lofepramine Venlafaxine Nortriptyline Trimipramine Tranylcypromine Moclobemide Phenelzine	**Antiparkinson** Orphenadrine* Benzhexol* Benztropine Procyclidine **Antipsychotics** Chlorpromazine Flupenthixol Haloperidol Perphenazine Prochlorperzine Promazine Thioridazine Trifluoperazine Risperidone Sulpiride Clozapine **Calcium supplements** Calcium gluconate Calcium lactate Calcium carbonate	**Diuretics** Bendrofluazide Chlorothiazide Indapamide Frusemide Bumetanide Amiloride Spironalactone Co-amilozide **Gastrointestinal cytoprotectant** Sucralfate **Iron tablets** Ferrous sulphate Ferrous fumarate Ferrous gluconate **Opiates** Morphine Buprenorphine Codeine Dextropropoxphene Dihydrocodeine Fentanyl Methadone Pentazocine Pethidine Tramadol
This list is not exhaustive, for up to date information check BNF, North and East Devon Formulary and Referral which can be accessed on BOB at:https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/favicon.ico **, or Pharmacy** (* Have anticholinergic properties)		

Appendix 14 – Competencies for the Assessment of Patients Requiring Bowel Care (including Digital Rectal Examination, Digital Rectal Stimulation and Digital Removal of Faeces)

	Competence demonstrated (YES/NO)	Comments eg action required/how competence is demonstrated	Signature and role of Assessor	Signature and role of Health Practitioner	Date
1. To have knowledge of national guidelines, organizational policies and protocols in accordance with clinical/corporate governance which affect the assessment of bowel dysfunction 2. An understanding of the specific health conditions which have an impact on bowel function and of the different types of bowel dysfunction. An understanding of how medications, lifestyle, diet and fluids affect bowel function. 3. An understanding of the anatomy and physiology of the male and female lower gastro intestinal tract in relation to lower bowel function and continence status. An understanding of the causes of poor bowel emptying and types of constipation					

	Competence demonstrated (YES/NO)	Comments eg action required/how competence is demonstrated	Signature and role of Assessor	Signature and role of health practitioner	Date
4. Knowledge and understanding of the assessment process and documents and an understanding of how to adapt continence assessment to the health status of the individual for example, in end of life care, chronic long term conditions, dementia, post childbirth, infective diarrhoea, disability. 5. An understanding and knowledge of interventions to improve or maintain bowel function including lifestyle, the correct position for defaecation, bowel emptying programmes, pelvic floor exercises, abdominal massage, oral medications (laxatives, anti-diarrhoeal, bulking agents), rectal medications (suppositories, enema). 6. An understanding and knowledge of the procedure for digital rectal examination and insertion of rectal medication. 7. (For relevant staff only) An understanding and knowledge of the procedure for digital rectal stimulation and digital removal of faeces.					

Appendix A: – Standard Operating Procedures

Procedure for digital rectal examination (DRE) (MASCIP 2012)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone present.
- Give the patient the opportunity to empty their bladder.
- Ensure privacy and dignity is maintained at all times.
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia (described earlier in the document).
- Wash hands and put on disposable apron and gloves.
- Ask/assist patient to lower any clothing to knees and ask the patient to ideally lie in the left lateral position with knees flexed so that the perianal area can be easily visualised. The left side is preferred as it allows DRE to follow the natural anatomy of the bowel but it is not essential.
- Place protective pad under the patient, and cover the legs/area not to be exposed.
- Inform the patient that you are to begin and that you will be looking and examining the outer and internal area.
- Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood.
- Next palpate the perianal area by starting at the 12 o'clock position moving clockwise to 6 o'clock and then returning to 12 o'clock and moving to 6 o'clock anticlockwise, feeling for irregularities, indurations, tenderness or abscess.
- Lubricate a gloved index finger, part the buttocks and gently insert into the anus to avoid trauma to the anal mucosa, noting tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient feels any pain ensure that they are happy for you to continue with the procedure. It may be easier to ask the Patient to talk or breathe out to prevent spasm or difficulty on insertion. Also work with the anal reflex by putting your finger on the anus gently and wait a few second this will allow the anus to contract and then relax.
- Sweep clockwise and then anticlockwise, palpate for irregularities internally. Noticing the presence of any tenderness, presence and consistency of faecal matter (an assessment of its consistency according the Bristol Stool Form Chart) and any lesions.
- You also assess the external sphincter tone by asking the patient to squeeze and hold. Also ask the patient to push down to assess for relaxation on straining.
- Prostate and advance pelvic floor assessment may also take place at this point if competent to do so.

- Remove finger, clean perianal area of any gel/ faecal matter. Remove gloves and apron disposing of them appropriately then wash your hands.
- Ensure patient's privacy, dignity and comfort at all times.
- Wash hands and allow the patient to dress in private, unless they need assistance.
- Explain your findings and plan.
- Document all observations, findings and actions.
- Consider onward referral to another health care professional if there were any concerns on examination.

Appendix B: – Standard Operating Procedures

Procedure for digital rectal stimulation (DRS) (adapted from MASCIP, 2012)

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should
- ideally be lying in a lateral position, usually on the left, so that the anal area can easily viewed.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel (on prescription only and with caution in long term use due to systemic effects, BNF 2016) may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). Anaesthetic gel is contraindicated with inflamed or broken skin. Adrenaline should be available in case of an allergic reaction to the local anaesthetic gel.
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- Turn the finger so that the padded inferior surface is in contact with the bowel wall. Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.
- Withdraw the finger and await reflex evacuation.
- Repeat every five-ten minutes until rectum is empty or reflex activity ceases.
- Remove soiled glove and replace, re-lubricating as necessary between insertions.
- If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matters in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Stool Scale (Heaton, 1993).
- Record and report abnormalities.

Appendix C: – Standard Operating Procedures

Procedure for digital removal of faeces (DRF) (adapted from MASCIP, 2012)

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at anytime, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can easily visualised.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel (on prescription only and with caution in long term use due to systemic effects, BNF 2016) may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). Anaesthetic gel is contraindicated with inflamed or broken skin. Adrenaline should be available in case of an allergic reaction to the local anaesthetic gel.
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- If stool is a solid mass, push finger into centre, split it and remove small sections until none remain. If stool is in small separate hard lumps remove a lump at a time. Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – in other words do not over-stretch the sphincters by using a hooked finger to remove large pieces of hard stool which may also graze the mucosa. Using a hooked finger can lead to scratching or scoring of the mucosa and should be avoided.
- Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces. If the rectum is full of soft stool continuous gentle circling of the finger may be used to remove stool: this is still digital removal of faeces.
- During the procedure the person delivering care may carry out abdominal massage.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matters in an appropriate receptacle as it is removed, and dispose of it and any other waste in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Scale (Heaton, 1993).
- Record and report abnormalities.