

Bowel Care

Management of Lower Bowel Dysfunction,
including Digital Rectal Examination and Digital
Removal of Faeces

CLINICAL PROFESSIONAL RESOURCE

Acknowledgments

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This publication is supported by:



This publication is due for review in September 2022. To provide feedback on its contents or on your experience of using the publication, please email publications.feedback@rcn.org.uk

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This publication includes updates on best practice and provides guidance for all nursing staff, and incorporates knowledge of bowel function and the essentials of assessment, treatment and management of lower bowel dysfunction.

Publication date: September 2019 Review date: September 2022

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Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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Foreword

Bowel care is a fundamental area of patient care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients and residents, many of whom are hesitant to admit to bowel problems or to discuss such issues.

The popularity of previous RCN publications relating to digital rectal examination and the manual removal of faeces has demonstrated the strength of interest in the issue of good bowel management and the urgent need for this type of information.

Since its first inception in 1995, the publication has developed over the years and remains an invaluable practice and educational resource for nurses.

This 2019 edition includes updates on best practice and provides guidance for all nursing staff, plus incorporates knowledge of bowel function and the essentials of assessment, treatment and management of lower bowel dysfunction. The publication promotes a positive/proactive approach to care delivery for the essential and fundamental needs of bowel function and management of bowel disorders.

The National Occupational Standards (NOS) relating to lower bowel dysfunction have been incorporated throughout, where relevant, to continue to support delivery of best practice.

Jane Fenton

Teaching Fellow, Keele University

On behalf of the RCN Continence Care Forum, I would like to express our gratitude to the lead authors, Jane Fenton and Karen Irwin, for their willingness and keenness to undertake the update of this document. We are also very grateful to all clinical contributors for sharing their clinical expertise.

This is a document that has always been used by practitioners in their day-to-day care of patients and by others looking for guidance in the formulation of policies and teaching plans. We look forward to having this valuable resource at our fingertips once again.

We are also very grateful to B. Braun, Coloplast and Wellspect for their support.

Alison Wileman

Chair RCN Bladder and Bowel Forum

I am delighted to be able to support the relaunch of this guidance which has been updated to ensure that nursing staff have access to the information they need to support best practice. I would like to express my appreciation to everyone who has given a significant amount of time and expertise to this work and, in particular, to Jane Fenton who has co-ordinated the update.

Amanda Cheesley

RCN Professional Lead for Long-Term Conditions and End of Life Care

1. Introduction

Background

In 2006, the Royal College of Nursing (RCN) and Skills for Health (SfH) jointly identified a need for competencies related to continence care. On completion of scoping, development, field testing and approval processes, a competence suite – containing 13 competencies for continence care – was produced.

The National Occupational Standards (NOS) are approved by UK government regulators and specify UK standards of performance that people are expected to achieve in their work, and the knowledge and skills they need to perform effectively. They provide a source of information to help people make informed decisions about:

- the demands of employment
- good practice in employment
- the coverage and focus of services
- the structure and content of education, training and related qualifications.

The following areas relating to bowel care were included into the competency suite:

CC01 – assess bladder and bowel dysfunction

CC08 – care for individuals using containment products

CC09 – enable individuals to effectively evacuate their bowels

CC11 – Implement toileting programmes for individuals

CC12 – enable individuals to undertake pelvic floor muscle exercises

CC13 – enable individuals with complex pelvic floor dysfunction to undertake pelvic floor muscle rehabilitation.

The competencies are designed to be used by all health care professionals and a full insight into NOS can be found at the SfH website at www.skillsforhealth.org.uk

Document aims

The aims of this revised publication reflect the original document aims – to provide a review of lower bowel dysfunction in adults, digital rectal examination and guidance on the digital removal of faeces.

It expands on the SfH continence care competencies relating to lower bowel dysfunction, presenting them in a more usable format and creating a benchmark for lower bowel dysfunction that provides RCN endorsement and approval.

Produced, consulted on and endorsed by a team of expert practitioners from the four UK countries using the SfH NOS development methodology, this publication brings together and links directives from the RCN, SfH, Essence of Care (EOC), the National Institute for Health and Care Excellence (NICE) and UKCS Minimum Standards for Continence Care (UKCS).

Using this publication

This document is written primarily for a nursing audience to be used in all care settings, across the UK and refers to ‘nurses’ throughout the publication. However, it can also be used by other health care professionals to support them in undertaking a wide range of activities relating to many aspects of lower bowel dysfunction.

Many of the statements contained in this document reflect essential nursing care and are not of an advanced or complex nature. It is not intended to be a comprehensive document on lower bowel dysfunction or a literature review.

At the start of each section there is a statement (in bold) taken from the SfH continence care competencies which relate to lower bowel dysfunction. The section then expands on these, making them easier to use and understand while informing the reader of the key drivers that underpin the critical thinking supporting this publication. It provides a resource and framework for practice that can be used in a variety of ways, including:

- a practical guide to help understand the NOS at a clinical level within nursing

- setting a bowel care standard for best practice in all care settings for nurses
- forming a benchmark to be used to reflect and compare competence and practice within nursing
- a point of reference to support academic work related to bowel care for nurses
- a nursing resource to support the development of guidelines, policies and protocols related to lower bowel dysfunction at local level
- a guide for the development of lower bowel dysfunction-related clinical procedures
- supporting bowel care related nursing assessment
- as a framework on which to develop lower bowel dysfunction-related teaching material, programmes of learning and courses
- to stimulate nursing audit and research activity in lower bowel dysfunction.

Mapping SfH competencies

At the end of the majority of sections, examples of SfH competencies from other SfH competency suites are provided that relate to the aspect of practice. These can be referred to for further knowledge in this aspect of care. These examples were accurate at the time this document was produced.

Who should use this guidance?

This document has been produced to support nurses in a wide range of activities related to the assessment, treatment and management of lower bowel dysfunction.

Those who may find it of value include health care professionals involved in the management of lower bowel dysfunction and nurses:

- delivering lower bowel care as part of their role – from the assessment of bowel dysfunction to the delivery of specific lower bowel care interventions
- developing lower bowel dysfunction risk assessment tools
- working within any care setting where lower bowel care is provided
- producing guidelines, protocols, policies and procedures related to lower bowel dysfunction before administration of medicine
- in management posts who supervise, recruit, develop and appraise staff working within lower bowel dysfunction
- developing programmes of learning, teaching and courses which encompass lower bowel dysfunction
- developing, using and measuring quality bowel care nursing indicators
- undertaking bowel care audit and/or research.

2. Anatomy and physiology

Knowledge and understanding

You will need to know and understand:

- the anatomy and physiology of the male and female lower gastrointestinal tract in relation to lower bowel function and continence status.

Colon functions

The normal colon has five main functions.

1. **Storage:** the colon stores unabsorbed food residue. Within 72 hours, 70% of this has been excreted. The remaining 30% can stay in the colon for up to a week.
2. **Absorption:** sodium, water, chloride, some vitamins and drugs, including steroids and aspirin, are absorbed from the colon.
3. **Secretion:** mucus is secreted and used to lubricate the faeces.
4. **Synthesis:** a small amount of vitamin K is produced.
5. **Elimination:** peristaltic movement of faecal matter into the rectum, where its presence is detected by sensory nerve endings and a sensation of fullness is experienced, followed by a desire to defecate.

Stool production and what influences this

Normal stool output per day is around 150–200g. The proximal colon defines the consistency and volume of delivery of faeces delivered to the rectum. Bowel frequency in a healthy person may vary between three times a day to three times a week. Stool consistency can vary (refer to the Bristol stool form scale, Heaton et al., 1992) and its production is influenced by gender, diet and health.

Normal defecation

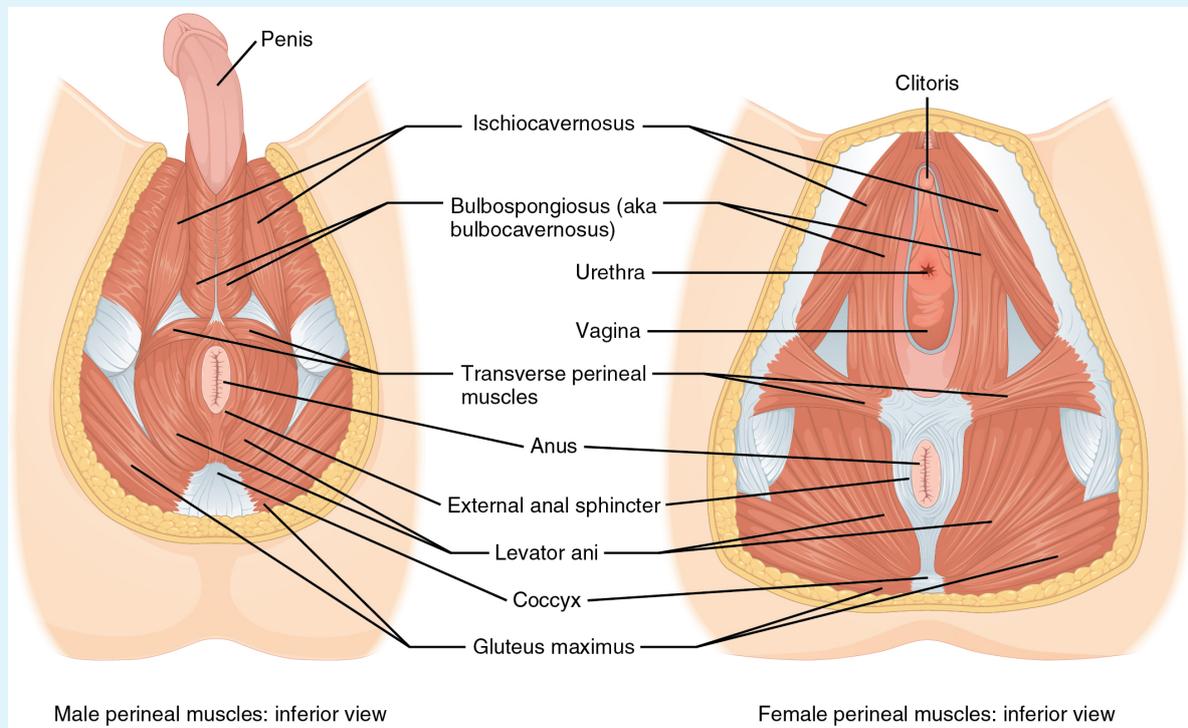
The process of rectal emptying is usually initiated voluntarily. Movement of faeces into the rectum causes rectal distension that evokes the desire to defecate and is known as the 'call-to-stool'. Under the appropriate circumstances, the person adopts a sitting or squatting position,

which allows straightening of the anorectal angle and relaxation of the external anal sphincter and puborectalis muscle. Abdominal pressure is raised causing the muscles of the anterior abdominal wall to tense and funnels the pressure down to the pelvis. The stool then enters the lower rectum, initiating a spontaneous rectosigmoid contraction, pushing the stool through the relaxed anal canal. This is repeated until the rectum is empty; once the last bolus of stool is passed the closing reflex of the external sphincter is stimulated which allows continence to be maintained after the act of defecation.

The nervous system

The rectum and internal anal sphincter receive an extrinsic autonomic innervation from lumbar (sympathetic) and sacral (parasympathetic) nerve roots. This innervation conveys information in each direction between the hindgut (lower bowel) and the brain. Additionally, there is a dense network of local enteric neurons (ENS) in the gut wall which mediate the fine processing of the information from brain to rectum and anus. The ENS is also responsible for the intrinsic organisation of peristalsis and coordinating the whole process. The motor nerve supply to the striated (voluntary) muscle of the external anal sphincter is from the second to fourth sacral spinal cord segments, via the pudendal nerve. The neurological control of the bowel is the result of an intricate balance between the extrinsic and enteric nervous system, and the intestinal smooth muscle cells. Reflex pathways from the central nervous system to the intestine and colon both facilitate and inhibit gut motility.

The pelvic floor muscles



Credit: OpenStax https://commons.wikimedia.org/wiki/File:1116_Muscle_of_the_Perineum.jpg

Comprising two layers of muscle; a superficial layer and a deep layer – referred to as levator ani (literal translation meaning ‘lift the anus’). The levator ani has fascial attachments, via the arcus tendineus, levator ani and the arcus tendineus fascia pelvis. The puborectalis muscle component of the pelvic floor contributes to maintenance of the anorectal angle that is important for maintaining continence; appropriate relaxation is essential to the process of defecation.

Anal sphincters

The internal anal sphincter (IAS) is a smooth muscle that maintains tonic contraction for long periods of time. This sphincter contributes about 85% of the resting anal sphincter tone, which in health is between 60 and 110cm H₂O. Weakness of the IAS may result in passive faecal incontinence. The external anal sphincter (EAS) is a striated muscle under voluntary control, which contributes only 15% towards resting anal tone. The EAS is responsible for the voluntary contraction of the sphincter; squeeze pressure in health is between 60 and 250cm H₂O. Weakness or disruption by trauma of the EAS may result in urge faecal incontinence.

Reflex actions

The gastrocolic reflex is initiated when food and/or drink is ingested and sets off movement of the upper and lower gastrointestinal tract. It can be used when teaching patients bowel emptying techniques by suggesting that half an hour after a meal they sit on the toilet to encourage a natural pattern of defecation.

The anal reflex occurs when touching the skin by the anus; it contracts then relaxes.

The closing reflex occurs at the end of rectal evacuation; the anal sphincter snaps shut to help maintain continence. Patients can enhance this by squeezing their anal sphincter at the end of defecation.

The rectoanal inhibitory reflex results when there is a distension of the rectum, where IAS relaxes and EAS contracts.

3. Definitions and causes of bowel dysfunction

Knowledge and understanding

You will need to know and understand:

- the causes of poor bowel emptying, and constipation
- how to classify stools by use of an appropriate chart
- the impact of other bowel conditions.

Constipation and poor bowel emptying

Bowel habits and perception of bowel habits vary widely, making constipation difficult to define. Symptoms can be considered in two ways, those with:

- difficulty defecating (but normal bowel motion frequency)
- a transit abnormality (which can present as infrequent defecation).

Individuals experiencing constipation generally experience an impaired quality of life, compared with the general population.

Primary or idiopathic constipation is not usually associated with any other complaint and has no pathological cause. However, immobility, poor diet, slow colonic transit and pelvic floor abnormalities can be linked. Incidence is greater in women (NICE, 2015a).

Secondary constipation is secondary to another disorder; whether this is a metabolic, psychological, or neurological disorder – there is a cause for the constipation that can be identified.

Functional constipation is a functional bowel disorder that presents as a persistently difficult, infrequent, or seemingly incomplete defecation. This includes two or more of the following symptoms for at least 25% of defecations; symptoms need to have been in evidence for between three to six months:

- straining during defecation
- lumpy or hard stools

- sensation of incomplete evacuation
- sensation of anorectal obstruction/blockage
- manual manoeuvres to facilitate defecation (for example, digital evacuation, support of the pelvic floor)
- fewer than three defecations per week
- loose stools are rarely present without the use of laxatives
- insufficient criteria for irritable bowel syndrome.

NICE, (2013 updated 2019); Constipation flow chart (Rome IV criteria, Douglas, et al., 2017).

Obstructive defecation syndrome is a failure to relax the anal sphincter or pelvic floor muscles while trying to defecate. It is experienced by many women as a consequence of pelvic floor damage following childbirth, and in individuals with neurogenic bowel dysfunction.

It is demonstrated by a feeling of anal blockage on more than one in four occasions and prolonged defecation (more than 10 minutes to complete evacuation) (Harari et al., 2004), or the need for self-digitation on any occasion. This condition often improves with pelvic floor exercises.

Anismus is an inappropriate contraction (paradoxical sphincter contraction) rather than relaxation of the anal sphincter or puborectalis muscle during defecation. This is sometimes a hidden cause of chronic constipation and needs to be considered when assessing patients.

Faecal impaction or loading is when the rectum, and often the lower colon, is full with hard or soft stool and the patient is unable to evacuate the bowel unaided. This can result in impaction with overflow spurious diarrhoea, which is common in frail older people (Harari, 2004) and in individuals with neurogenic bowel dysfunction. The impaction can lead to diminished rectal sensation and resultant faecal incontinence. It may be misdiagnosed as diarrhoea and, therefore, treated incorrectly.

Faecal incontinence

Most people acquire bowel control at a very young age and take the process very much for granted. When something goes wrong, and leakage occurs, it can be very embarrassing and people are reluctant to seek help.

Much is known about the many causes and best management of bowel dysfunction. However, difficulties frequently arise in linking specific symptoms and causes due to the subjective nature of self-reporting. As faecal incontinence is a symptom it is important to diagnose the specific problem and the cause(s) for the individual before treating (NICE, 2007).

It is likely that 0.5–1% of adults experience regular faecal incontinence that affects their quality of life. Faecal incontinence is closely associated with age (a prevalence of about 15% of adults aged 85 years, living at home) and is more common in residential and nursing homes (prevalence ranges from 10–60%) (APPG, 2011).

Definitions

- Faecal incontinence (FI) – the involuntary loss of liquid or solid stool that is a social or hygienic problem.
- Anal incontinence (AI) – the involuntary loss of flatus, liquid or solid stool which is a social or hygienic problem (Bliss et al., 2017).
- Passive soiling (liquid or solid) occurs when an individual is unaware of liquid or solid stool leaking from the anus; this may be after a bowel movement, or at any time.

Causes

- Faecal urgency – the individual has to rush to the toilet, or is unable to get there in time, resulting in a bowel accident; external anal sphincter weakness or defect is a common cause, often due to obstetric trauma (Lone, Sultan and Thakar, 2012).
- Passive soiling – poor internal anal sphincter pressure is the most likely cause. This may be a result of inadvertent surgical damage, for example, following a haemorrhoidectomy.
- Diarrhoea – where increased gut motility causes loose stools.

- Inflammatory bowel disease (IBD).
- Irritable bowel syndrome (IBS).
- Anorectal pathology – including rectal prolapse, fistula, haemorrhoids.
- Neurological disease – spinal cord injury, cauda equina syndrome, multiple sclerosis (MS), spina bifida, dementia.
- Lifestyle and environmental issues – poor toilet facilities, diet, dependence on a carer for mobility and managing clothing.
- Functional – idiopathic or unknown cause. The diagnosis of a functional bowel disorder should be based on a thorough history (positive criteria) and following investigative screening to exclude somatic disease (Häuser et al., 2012).

Diarrhoea

Acute diarrhoea is a common problem that presents as a sudden onset, lasts less than two weeks and usually resolves on its own, without special treatment. Diarrhoea can be caused by: a bowel infection, a food allergy, alcohol consumption, inflammation, Coeliac disease or appendicitis.

Symptoms include:

- watery or loose stool
- stomach cramps
- feeling sick and vomiting
- headache
- no appetite.

Also, check all medication for possible side effects as some drugs can cause diarrhoea. Always advise patients to drink plenty of fluids to avoid dehydration (RCN, 2013).

Inflammatory bowel disease (IBD)

IBD is characterised by symptoms such as: diarrhoea, abdominal cramps, tiredness and fatigue, loss of appetite, and feeling generally unwell. Anaemia may also be present due to passing blood in the stool, malabsorption of nutrients and the side effects of medication. Weight loss can occur because of inflammation in the gut, leading to an inability to absorb nutrients. The two main types of IBD are colitis and Crohn's disease.

IBD can sometimes affect other parts of the body, and patients may experience arthritis or inflammation of the joints. This is when fluid collects in the joint space causing painful swelling; it usually affects the large joints of the arms and legs, including the elbows, wrists, knees and ankles (NICE, 2013; 2012; 2015b).

Irritable bowel syndrome (IBS)

IBS is characterised by recurrent abdominal pain or discomfort, which may be associated with defaecation and a change in bowel habit.

Symptoms may include constipation or diarrhoea (or both) and abdominal distention; and can be present with varying profiles.

It includes recurrent abdominal pain or discomfort for at least three days each month in the last three months and the presence of two, or more, of the following symptoms:

- improvement with defaecation
- onset associated with a change in the frequency of stool
- onset associated with a change in the form (appearance) of stool.

If the above criterion is present, with symptom onset for the previous six months, diagnosis can be made (NICE, (2008 updated 2017)).

4. Assessment, investigations (including DRE), diagnosis and prognosis

Assessment

Knowledge and understanding

You will need to know and understand:

- the types of bowel assessment that are relevant to your area of practice
- how to adapt bowel assessment to the health status of the presenting individual, for example:
 - o chronic long-term conditions
 - o post-childbirth
 - o infective diarrhoea
 - o spinal cord injury
 - o disability
 - o end of life care
- how to make a differential diagnosis following a bowel assessment.

In the assessment of patients with bowel dysfunction use a structured approach with reference to evidence-based guidance (NICE, 2007). Clinical examination and accurate history taking are fundamental to identifying the most effective treatment (Collins and Bradshaw, 2016). Ensure that the environment is suitable, the equipment is clean and that the practitioner is competent.

The assessor should initiate the discussion with sensitivity in order to minimise the patient's embarrassment and aim to develop a therapeutic relationship throughout (Collins and Bradshaw, 2016). As part of the bowel assessment, the assessor should be able to select, administer and interpret self-assessment questionnaires and scales.

Signs of underlying pathology may include:

- rectal bleeding

- change of bowel habit for six weeks
- unintentional weight loss
- pain before, during, or after defecation
- faecal leakage
- faecal urgency.

(NICE, 2007)

Risk factors

It is important to incorporate a risk assessment during the process in order to identify high-risk individuals, such as those with:

- bowel cancer (NICE, 2011a)
- severe faecal impaction
- an obstruction
- Clostridium difficile
- a spinal cord injury.

Signs and symptoms

Include the patient's own account of the condition. The three most common indicators of bowel function are:

- frequency of passage of stools
- consistency of stools – according to the Bristol stool scale (Heaton et al., 1992)
- ease of passage.

Where possible, encourage the patient to use a bowel diary to engage them in the assessment process and help identify the current bowel routine. The bowel diary should include:

- frequency
- consistency
- effort/ease of passage/urgency
- amount
- colour

- incontinence and time of episode(s)
- if able to use/sit on the toilet with or without assistance.

Once specific bowel symptoms have been identified the assessment should adopt a holistic approach to include personal details and the patient's history. This should cover:

- surgical
- medical
- obstetric
- sexual history
- family
- neurological
- psychological
- functional capabilities
- medication
- allergies.

When assessing diet and fluid intake, the assessor should review the patient's current diet in terms of types of foods, meal preparation and routine, and any existing therapeutic diets (NICE, 2007). Identifying a patient's BMI, alongside observations from their food and fluid diary, can help to pinpoint potentially contributing factors to bowel dysfunction symptoms and management. This may vary in different groups, for example, spinal cord injury (SCI) patients.

Other areas to consider include:

- prescribed and over the counter medication – these should be reviewed and evaluated to identify any link to bowel function
- lifestyle issues, including smoking status
- home and social circumstances – particularly when reviewing functional capabilities and the need for assistance with bowel care.

Alongside this, assess the impact of the bowel dysfunction on the patient's quality of life (using a recognised QoL tool) and identify or signpost the patient to appropriate resources.

Outcome and findings

Outcome and findings of the assessment should be summarised and discussed with the patient, including: likely causes, implications, risks, and differential diagnosis. If the need for examination and/or further investigations is clinically indicated, this should be explained and documented.

Mapping SfH competencies to this aspect of practice

- Assess bladder and bowel dysfunction CCo1.
- Plan assessment of an individual's health status CHS38.
- Plan interdisciplinary assessment of the health and wellbeing of individuals CHS52.
- Assess an individual's health status CHS39.
- Provide advice and information to individuals on how to manage their own condition GEN14.
- Determine a treatment plan for an individual CHS41.
- Agree a plan to enable individuals to manage their health condition PE4.
- Monitor and assess individual following treatment CHS47.

Investigations

Knowledge and understanding

You will need to know and understand:

- the further investigations and interventions that may be required for bowel dysfunction.

Nurses need to understand why the following investigations are performed, what they involve, what information can be gained from them, and how they can aid diagnosis.

- Digital rectal examination (DRE).
- Stool observation, including consistency, frequency (Bristol stool scale), colour and amount.
- Stool specimen.
- Bowel diary and food diary.
- Visualisation, such as proctoscopy, sigmoidoscopy, colonoscopy.
- Anorectal physiology testing, which may include: anal manometry, rectal sensation using balloon distension.
- Radiographic investigations and scans, for example, endoanal ultrasound, proctogram, barium enema or meal, plain abdominal, transit studies, magnetic resonance imaging scan and computerised tomography scan.

Digital rectal examination (DRE)

Core skills, knowledge and qualifications

A digital rectal examination (DRE) can be undertaken by a registered nurse who can demonstrate professional competence to the level determined by the Nursing and Midwifery Council (NMC) in its Code of professional conduct (NMC, 2015a).

This requires registered nurses to practice competently, possessing the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision; to acknowledge the limits of their professional competence; and only to undertake practice and accept responsibilities for those activities in which they are competent.

A registered nurse who can demonstrate competence to this professional level may be expected to delegate care delivery to others who are not registered nurses or midwives such as health care workers and carers. Such delegation must not compromise existing care but must be directed to meeting the needs and serving the interests of patients and clients. The registered nurse remains accountable for the appropriateness of the delegation, for ensuring that the person who carries out the task is able to perform it, and that adequate supervision or support is provided.

When to perform DRE

DRE should be performed as part of the assessment of bowel dysfunction, and in conjunction with the assessment process. DRE is indicated in the following circumstances.

Establish the presence of faecal matter in the rectum; the amount and consistency.

Assess anal tone and sensation by testing:

- the individual's ability to initiate a voluntary contraction and to what degree
- sensation when inserting a gloved finger
- signs of pain spasm and discomfort on insertion of gloved finger
- progress of anal sphincter exercise teaching.

Evaluate:

- the general status of the anal and rectal area prior to administration of rectal interventions
- the need for, and effects of, rectal medication in certain circumstances
- the assessment of anal pathology for the presence of foreign objects
- bowel emptiness in neurogenic bowel management
- prior to investigative procedures, for example, sigmoidoscopy or colonoscopy.

Identify the need for further interventions:

- prior to the administration of suppositories or an enema
- prior to the placement of an anal plug/insert
- prior to using trans anal irrigation
- when determining if digital removal of faeces (DRF) or digital rectal stimulation (DRS) is required.

Positioning

When carrying out a DRE procedure the patient should ideally be lying in the left lateral position so that the anal area can be easily viewed.

Observation

First, observe the perineal area for any abnormalities. These need to be documented and reported (as necessary):

- blood – colour
- faecal matter
- rectal prolapse – grade, ulceration
- haemorrhoids – grade, internal or external
- anal fissure
- anal skin tags
- anal lesions – possible malignancy
- anal fistula/induration
- anal tone absent/reduced

- anal reflex present or not
- broken areas or sore/red skin
- pressure sore – grade
- wounds – dressings and discharge
- increased skin conditions (such as psoriasis or eczema)
- scarring – possible previous surgery or damage through childbirth
- infestation
- foreign bodies.

Circumstances when extra care and multidisciplinary discussion is required

Nurses should exercise particular caution when performing a DRE or DRF if the patient:

- has an active inflammation of the bowel, including Crohn's disease, ulcerative colitis and diverticulitis
- has had recent radiotherapy to the pelvic area
- has rectal or anal pain
- has had rectal surgery or trauma to the anal or rectal area (in the last six weeks)
- has tissue fragility due to age, radiation, or malnourishment
- has obvious rectal bleeding – consider possible causes for this
- has a known history of abuse
- has a SCI at, or above, the sixth thoracic vertebra – due to the risk of autonomic dysreflexia
- has a known history of allergies (such as latex)
- is unconscious
- gain's sexual gratification from the procedure.

Exclusions and contraindications for undertaking DRE

Nurses should not undertake a DRE or DRF when:

- there is a lack of consent from the patient – written, verbal or non-verbal
- the patient's doctor has given specific instructions that these procedures are not to take place.

When a nurse specialist may undertake DRE

Nurse specialists may be involved in additional areas of care that involve carrying out DRE. Therefore, a DRE may be undertaken during the following procedures.

- Anorectal physiology studies (for example, anal manometry and rectal sensation).
- Endoanal ultrasound scan.
- The placement of a rectal probe or sensor before undertaking a urodynamic study.
- The placement of a probe used for electrical stimulation of the pelvic floor muscles.
- The placement of rectal catheters used in the treatment of obstructive defecation and/or biofeedback.
- Prior to initiating/prescribing transanal irrigation.
- The placement of an anal plug or insert.
- The placement of an endoscope when undertaking a sigmoidoscopy or colonoscopy.
- To assess prostate size, consistency, mobility and anatomical limits.
- To assess male muscle function and erectile dysfunction (modified lithotomy position may be adopted) (Dorey, 2012).

Diagnosis and prognosis

Knowledge and understanding

You will need to know and understand:

- **the aspects of an individual's (and their family's) past medical history which may be relevant to the assessment and diagnosis**
- **the interpretation of results from further investigations and how these inform a diagnosis for an individual with bowel dysfunction.**

Faecal incontinence or constipation are often symptoms with multiple contributing factors. It is important to avoid making simplistic assumptions that the cause is related to a single primary diagnosis – known as 'diagnostic overshadowing' (NICE, 2007). For example, a patient with multiple sclerosis (MS) may have faecal incontinence as a consequence of a sphincter defect following childbirth, and not as a direct consequence of MS.

Therefore, when making a diagnosis of a suspected health condition it is necessary to have a critical understanding of how to interpret:

- evidence from an individual's history
- baseline observations and tests
- further investigations.

There is a difference between assessment and diagnosis, and one is necessary for the other.

As a nurse, it is essential to contribute to a diagnosis within the multidisciplinary team.

Once a diagnosis has been established, the prognosis needs to be discussed with the patient so they are aware of how this will affect their life. It may be that the problem will not improve and they need to employ coping strategies to manage. If it isn't curable, certain treatments – behavioural, diet or medication – may improve the symptoms to a more manageable level.

Mapping SfH competencies to this aspect of practice

- Assess bladder and bowel dysfunction CCo1.
- Enable an individual to make informed health choices and decisions PE1.
- Establish a diagnosis of the individual's health condition CHS40.
- Prepare individual for health care activities GEN4.
- Determine a treatment plan for the individual CHS41
- Agree a plan to enable the individual to manage their health condition PE4.

5. End of life: Guidance for bowel care

Knowledge and understanding

- to understand the important role of bowel care interventions at end of life.

Nursing practice in palliative care and end of life is a sensitive topic, and practice may differ across various care settings. However, it is important that nurses adopt a preventive approach through effective monitoring so that when bowel symptoms present, prompt treatment and management is initiated. This will ensure effective and appropriate interventions and help avoid unnecessary cognitive deterioration.

Several bowel symptoms can present at end of life, including:

- constipation – more common in patients with advanced cancer and other terminal diseases
- impaction and obstruction
- diarrhoea
- faecal incontinence.

The incidence of these symptoms is increased due to several contributory factors, such as:

- medication that affects muscle tone, and slows down and reduces gut motility
- pathology of underlying disease
- pain management and its effectiveness
- reduced physical activity, mobility and independence
- toilet access
- diet and fluid intake changes
- changes to cognitive function
- lack of privacy.

Associated symptoms arising from constipation may include:

- nausea and vomiting
- confusion
- haemorrhoids and anal fissures

- abdominal pain and distention
- urinary retention.

Where malignancy is the underlying cause of the pathological changes, bowel symptoms may relate to:

- direct invasion of the tumour
- damage to the bowel wall causing obstruction
- spinal cord compression
- hypercalcaemia/hypokalaemia.

Assessment

Assessment of bowel symptoms should be undertaken (including DRE as indicated) to check for: presence of stool in the rectum, sensation, tone, bowel sounds and functional capabilities. Signs of obstruction include:

- no passing of flatus or stool
- abdominal distention
- no bowel sounds present.

Report to the doctor for immediate action.

Monitoring

This should include frequency, stool type and ease of passage and all form an essential part of symptom management.

Medication

Laxatives can be used to manage symptoms. They can:

- ease the passage of stool through the gut
- aid evacuation
- help manage faecal leakage when overflow is indicated
- counteract the actions of opioids (with between 60-90% requiring them).

In patients with opioid-induced constipation, an osmotic laxative (or docusate sodium to soften the stools) and a stimulant laxative is recommended. Bulk-forming laxatives should be avoided.

As end of life draws close, active treatment will transfer to supportive measures to maintain comfort, dignity and skin integrity. There is a continued focus on the management of presenting symptoms and avoidance of bowel obstruction, working in partnership with the patient, family and multidisciplinary colleagues (NICE, 2015c).

Mapping SfH competencies to this aspect of practice

- Assess bladder and bowel dysfunction (CC01).
- Obtain valid consent or authorisation (CHS167).
- Plan assessment of an individual's health status (CHS38).
- Assess risks associated with health conditions (CHS46).

6. Conservative management and interventions to improve and maintain bowel function (including DRF and transanal irrigation)

Knowledge and understanding

You will need to know and understand:

- how lifestyle, diet and fluids affect bowel function
- the simple interventions which can improve or maintain bowel function, and what the desired outcome would be for each individual patient.

Healthy lifestyle advice – this should include: weight management, smoking cessation, fluid advice (including alcohol consumption), diet adjustment, and exercise.

Pelvic muscle/anal sphincter exercises – an individualised programme.

Regular routine for bowel emptying – this should reflect current needs and previous history, where relevant, using a personalised programme of interventions.

Bowel retraining programmes – including toileting.

Timing – maximise gastric colic reflex and natural body functions by suggesting that the patient empties their bowel 30 minutes after a meal.

Rectal medication – including suppositories and enemas.

Equipment – including a foot stool, to help the patient to adopt the correct position for defecation, commodes, aids to wiping and suppository inserters.

Abdominal massage – mechanical stimulation of contents through the large bowel.

Bowel emptying techniques – including DRF, DRS, transanal irrigation (mini and large

volume), positioning and correct defecatory dynamics to reduce incorrect/inappropriate straining techniques.

Medication management – including antidiarrhoeal, laxatives or bulking agents.

Toilet substitutes and adaptations – the National Key Scheme (NKS) offers independent access to disabled people to around 9,000 locked public toilets and is supported by Disability Rights UK.

Just Can't Wait Toilet Card – the size of a credit card, these cards inform others that the person has a medical condition which may mean they need to use a toilet urgently.

Communication – encourage the individual to talk about the problem with friends and relatives (NICE, 2007).

Products – offer advice on continence products and information about product choice, availability and use (NICE, 2007; Association for Continence Advice, 2017).

Skin care – offer advice and signpost to information (NICE, 2007).

Mapping SfH competencies to this aspect of practice

- Care for an individual using containment products CCo8.
- Enable an individual to effectively evacuate their bowels CCo9.

Nutrition

Recommend a diet that promotes an ideal stool consistency and predictable bowel emptying, as well as more general health needs. When addressing a patient's food and fluid intake:

- consider existing therapeutic diets
- consider cultural and religious beliefs
- use a food and fluid diary to help establish a baseline
- screen individuals with faecal incontinence for malnutrition or risk of malnutrition
- ensure that overall nutrient intake is balanced
- advise modifying one food at a time (if attempting to identify potential contributory factors to their symptoms)
- consider the effects of additives (such as sorbitol in ready-made meals) that may be used for convenience or the needs of the individual
- review fibre intake with reference to the Department of Health's recommendations that adults should aim to eat 30g of fibre a day (DH, 2015) and consider the five-a-day initiative.

(NICE, 2007)

Diet advice

Look at the presenting symptoms and consider whether any of the following interventions will improve bowel function.

- Low residue – reducing fibre intake can decrease motility of the gut, making the stool firmer.
- Exclude wheat or dairy – a possible food intolerance can cause loose stools or bloating.
- Exclusion diets – to establish trigger foods that may be cause the dysfunction (such as highly fermenting foods like beans/pulses).
- Bulking agents, such as whole grain cereal or porridge – may increase the stool, to soften hard stool or firm loose stool.

- Improve fibre intake (increase intake of fruit, vegetables and fibre foods, such as wholemeal bread, wholegrain cereals).
- Onward referral to a dietician/nutrition team if more specialised knowledge is required.
- Fibre supplements for loose stools and faecal incontinence (FI); individuals with intolerances to certain foods could make their problem worse.
- A low fermentable oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) diet and the British Dietetic Association irritable bowel syndrome diet sheet (BDA, 2017). For information on FODMAP visit www.theibsnetwork.org/diet/fodmaps
- Probiotics and prebiotics – these may improve the balance of bacteria within the bowel.
- Eating small regular meals rather than one large one.

Foods that may exacerbate bowel dysfunction include:

- spicy foods – they can irritate the bowel, increasing motility
- soluble fibre – can increase bloating
- supplementary feeds – can induce diarrhoea (consider added fibre options).

Fluids advice

The British Dietetic Association (2017) recommends between 1.5-2L of fluid each day for the general adult population, depending on level of activity and prevailing weather conditions. Urine colour is correlated with the concentration of urine; urine of a pale straw colour indicates adequate hydration (BDA, 2017), and is a simple rule of thumb useful to patients.

Fluid advice and guidance should incorporate a review of the following:

- milk – possible intolerance
- coffee and caffeine – may increase motility of the bowel
- diet drinks – may contain sorbitol which could act as a laxative

- herbal teas – peppermint, fennel and ginger aid digestion
- alcohol – excessive quantity can increase bowel motility
- fizzy carbonated drinks – may increase abdominal bloating.

Mapping SfH competencies to this aspect of practice

- Review and monitor a patient's nutritional wellbeing CHS92.
- Agree a dietary plan for an individual with a specified medical condition CHS93.
- Provide food and drink to promote an individual's health and wellbeing SCDHSC0213.
- Support an individual to eat and drink SCDHSC0214.
- Monitor and review an individual's progress in relation to maintaining optimal nutritional status CHS149.

Skin care

Knowledge and understanding

You will need to know and understand:

- **how to advise an individual on skin cleansing and preparation, prior to the fitting of containment products.**

Knowledge of anatomy and physiology of healthy skin, the damage caused by pressure, and predisposing risk factors is necessary when assessing an individual with bowel dysfunction.

Factors which might exacerbate risk of skin breakdown are: poor health, general frailty, immobility, aging, loss of sensation and/or muscle bulk (due to neurological conditions), prolonged periods of sitting on a hard toilet seat, diabetes mellitus, poor nutritional intake, skin dryness, continuous passive soiling or profuse diarrhoea (NICE, 2007), plus those who wear disposable containment products.

Skin care for individuals with faecal incontinence is a routine task that is integral to essential patient care, as faeces can rapidly affect the integrity of perianal skin. Repeated cleansing with alkaline soap, coarse washcloths and prolonged exposure to enzymes from incontinence, decrease the skin's integrity and subsequently put the individual at risk of developing incontinence associated dermatitis (IAD). Skin cleansing and skin protection decreases IAD – choosing an agent that cleans, moisturises and protects the patient's perineal skin following an incontinent episode is important. The overriding aim is to clean, moisturise and protect the patient's skin and avoid skin breakdown. Please refer to your local policy guidance.

NICE (2007) suggests that foam cleansers can be a good alternative to soap and water in preventing skin deterioration. To dry the skin, pat gently with soft toilet paper or a soft towel. Avoid using creams or lotions in the perianal area, unless specifically advised, as these can make the area sweaty and uncomfortable. Be aware of allergies and any hypersensitivity to products.

Regular evaluation and inspection of the at-risk patient's skin by a competent health care professional is paramount in recognising any complications associated with incontinence.

A comprehensive continence assessment, and subsequent effective management of bowel dysfunction, is the best preventive measure. The definitive treatment of IAD is the successful treatment of incontinence.

Individuals with reduced sensation due to neurological conditions are at high risk of pressure damage associated with toileting. The use of padded toilet seats should be considered and prolonged sitting on toilets/commodors/shower chairs should be avoided. Regular inspection of the skin after toileting is essential.

Toilet tongs or a bottom wiper can extend the reach of an individual who may have limited shoulder/hand strength or flexibility. Toilets which include cleansing and drying modalities may be of benefit for individuals with limited arm and hand function.

Mapping SFH competencies to this aspect of practice

- Undertake tissue viability risk assessment for an individual CHS4.
- Care for an individual using containment products CCo8.

Containment

Knowledge and understanding

You will need to know and understand:

- the principles and practice of the management of temporary or intractable bladder and/or bowel dysfunction and how to achieve effective and acceptable social continence status for individuals
- how to educate individuals in recognising skin-related complications and the actions to take in relation to the usage of containment products.

Individuals that have a bowel dysfunction problem may need some kind of containment – anal devices, pads, faecal collectors or bowel management systems – to help them manage their condition with dignity. There are a limited number of products that are both reliable and specifically designed for containment of faecal leakage, and nurses need to be aware of the different products that are available. The smell of faeces is difficult to contain or disguise; using a neutraliser or perfume spray may be helpful.

Anal plugs are made of soft slightly absorbent foam that is inserted into the rectum to open up like a cup shape and reduce faecal leakage.

Anal inserts are made of soft silicone that are inserted into the rectum with a hygienic fingertip applicator, to manage accidental bowel leakage.

When successful these devices may greatly improve the confidence and quality of life for patients.

Pads are available in a range of sizes and the option selected is dependent on the patient's degree of incontinence. Nurses should be aware

of pad suitability and design for faecal leakage/incontinence, and any local agreements relating to pad usage. Also be aware that the use of pads in an individual with a neurological condition that reduces sensation, and who are wheelchair users, may increase the risk of development of pressure ulcers (ACA, 2017).

Faecal collectors are useful for patients with liquid faeces. Originally designed for use in intensive care situations, they are unlikely to work if the user is seated. The collector is a bag with an opening which is cut to fit around the anus. A flange of flexible foam, backed with a skin barrier, attaches to the skin around the anus for containment of liquid stool.

Bowel management systems are used to contain diarrhoea. A tube-like device is placed into the rectum and the liquid stool drains down an opaque tube into an enclosed bag. These are used primarily for bed bound patients with severe diarrhoea, associated with conditions such as *Clostridium difficile*.

Hygiene and skincare kits can be used when an individual is out and about to manage skincare and any accidental leakage. The kit can contain wet wipes (not containing alcohol), a small empty plastic bottle which can be filled with water, a spare pad or device, disposable bag, a peg to hold clothes up, small neutraliser spray and a mirror.

Individuals should be provided with the necessary supporting information to reinforce all the advice given in relation to containment products; including the need for appropriate disposal of associated waste safely and effectively.

Mapping SfH competencies to this aspect of practice

- Care for individuals using containment products CCo8.

Effective bowel evacuation

Knowledge and understanding

You will need to know and understand:

- how to select an appropriate and acceptable bowel emptying technique, or combination, for an individual
- the use of aids, adaptations and foot stools that assist with the use of a toilet, and enhance effective defecation and bowel evacuation
- the correct positioning of the individual related to the particular bowel emptying technique being used.

Nurses need to know the different bowel emptying techniques to enable the individual to evacuate their bowel effectively; which in turn could improve their bowel function and improve their quality of life.

Before initiating any bowel emptying technique, explain the process to the individual and describe what is involved, the expected outcomes, side-effects and any complications.

Be sure that any bowel emptying technique used has an evidence base and, where possible, links to international, national, local protocols, procedures and guidelines. Also, be aware of the particular risks associated with a specific or combination of bowel emptying techniques and select appropriately to provide a manageable and sustainable programme of care.

Bowel emptying techniques

Positioning – where possible (following risk assessment) feet should be elevated on a stool to ensure that knees are above hips, and the patient is able to lean forward inbetween knees, with a straight back and the lower abdomen bulged.

Dynamics of defecation – with the abdominal wall braced to stop anterior movement, the patient should practice and adopt the brace and pump technique. This can be achieved by instructing individuals to use the diaphragm to

increase intra-abdominal pressure from above and, with simultaneous relaxation of the external anal sphincter and puborectalis, will help enable faeces to be expelled through the anal canal that is held in the correct position by the levator-ani muscles (without perineal descent).

Perineal support – while doing the above manoeuvres support with two fingers the skin between the anus and vagina.

Vaginal digitation – usually used when an individual has a posterior vaginal wall prolapse (rectocele). This involves putting the thumb or first finger into the vagina and pushing backwards, this is an accepted way to aid defecation to make lower bowel dysfunction more manageable, especially if surgery is not an option.

Digital stimulation of the rectum (DSR) – carried out by the individual or nurse/health care assistant by inserting a gloved lubricated finger into the anus and slowly rotating the finger in circular movements, maintaining contact with the rectal mucosa and gently stretching the anal canal (Neuro Advisory Board, 2019). This helps to relax the sphincter and stimulates the rectum to contract. It is often used in SCI and other neurological patients with reflex function.

Rectal stimulant medication – the main rectal medications are suppositories and enemas. When prescribing and/or administering rectal medications, the nurse needs to be aware of the contraindications and the associated risks. However, for some individuals (SCI patients), rectal stimulant medication is a routine part of lower bowel care, used to trigger evacuation as part of a regular bowel management programme.

Transanal bowel irrigation (TAI) – anal irrigation is the instillation of warm water into the descending colon and rectum to facilitate evacuation of stools. Water can be introduced by either a cone (manually held in place in the anus) or a rectal catheter (held in place with an inflated balloon) and may be assisted with an electric device when clinically indicated.

It can be considered in a number of clinical conditions, such as chronic constipation, faecal incontinence, obstructive defecation syndrome (ODS) and neurogenic bowel dysfunction. TAI is a bowel care procedure that is usually

considered if other, less invasive, methods of bowel management have failed to adequately control symptoms. It is usually performed by the patient whilst sitting on the toilet or a commode and helps to promote self care. There are also bed systems available to meet the needs of patients who are unable to use the toilet.

Relative contraindications

(Use only after careful discussion with a relevant medical practitioner).

- Pregnant or planning pregnancy.
- Active perianal sepsis.
- Diarrhoea.
- Anal fissure.
- Large haemorrhoids that bleed easily.
- Faecal impaction.
- Past pelvic radiotherapy which has caused bowel symptoms.
- Known diverticular disease.
- Use of rectal medications for other diseases.
- Congestive cardiac failure.
- Anal surgery within the past six months.

Absolute contraindications

(Irrigation should not be used).

- Acute active inflammatory bowel disease.
- Known obstructing rectal or colonic mass.
- Rectal or colonic surgical anastomosis within the last six months.
- Severe cognitive impairment (unless carer available to supervise/administer).

TAI requires assessment by a competent nurse to evaluate for suitability, assess risks and to identify the most appropriate system to meet the needs of the individual, as not one device alone will suit all patients. When successful, it is a very effective method of clearing the bowel and maintaining bowel function and greatly improves quality of life.

Digital removal of faeces (DRF)

DRF is an intimate care intervention (see Appendix 2) and, as a wider range of bowel emptying techniques are now available, its need is sometimes questioned. Therefore, it should only be performed following individual assessment by a competent nurse.

It is essential that the individual clinical assessment includes consideration of any cultural and religious beliefs and, if there is a conflict between the patient or carer and nurse over the need for the DRF, multidisciplinary consultation is advised.

Unfortunately, when a patient is transferred to a hospital or mental health care setting, bowel care intervention is not always provided (NHSI, 2018). This is sometimes due to a lack of staff who are adequately trained and experienced in performing bowel care interventions – particularly DRF.

Patients with neurological conditions and SCIs may have neurogenic bowel dysfunction and be dependent on DRF as a routine element of their bowel care programme. Specifically, SCI patients with injuries above the level T6 are at risk of autonomic dysreflexia (AD) and nurses should be aware that they may require DRF as a necessary and integral part of their bowel care management programme. AD can also be caused during or following bowel care intervention, but most significantly by non-adherence to a patient's usual bowel routine. Therefore, it is essential that bowel care management programmes should be ongoing and uninterrupted whatever the care setting, unless clinically contraindicated. NHSI (2018) recommend that NHS funded care providers identify appropriate clinical leaders to review local policy on bowel care, to enable nurses to access education and training. Local guidance and support should be in place to ensure patients have access to staff who are confident and competent in providing safe bowel care, including intimate care procedures such as DRF.

When nurses can undertake DRF

DRF can be undertaken when:

- other methods of bowel emptying fail or are inappropriate
- there is faecal impaction or loading
- there is incomplete defecation
- there is an inability to defecate
- there is a neurogenic bowel dysfunction
- the patient has a spinal cord injury.

DRF as an acute or ongoing intervention

When performing a DRF as an acute intervention or as part of a regular package of care, it is important to carry out an individualised risk assessment. While undertaking a DRF observe if there is any:

- distress, pain or discomfort
- bleeding
- collapse
- stool consistency.

In SCI patients who are at risk of AD check:

- blood pressure prior to and at the end of the procedure (a baseline blood pressure is advised for comparison)
- pulse prior to procedure (to establish a baseline) and during if indicated.

Where this is a routine intervention and tolerance is well established, the routine recording of blood pressure and pulse may not be necessary.

When DRF is delivered successfully as a part of a bowel management programme, individuals feel supported and report increased confidence and self-esteem.

Mapping SfH competencies to this aspect of practice

- Enable an individual to effectively evacuate their bowels CC09.
- Enable an individual to make informed health choices and decisions PE1.
- Agree a plan to enable an individual to manage their health condition PE4.
- Develop a relationship with an individual which supports them in addressing their health needs PE5.
- Enable an individual to manage their defined health condition PE8.

7. Pelvic floor muscle training, sphincter exercises, biofeedback, electrical stimulation and percutaneous tibial nerve stimulation

Knowledge and understanding

You will need to know and understand:

- how to assess the suitability of pelvic floor muscle rehabilitation for individuals
- how to undertake a digital anorectal examination (Evans, 2015)
- how to develop an appropriate rehabilitation programme.

Individuals who continue to have episodes of faecal incontinence after initial treatment should be considered for specialist assessment, intervention and management. This may involve pelvic floor muscle training, biofeedback and electrical stimulation. Some of these treatments might not be appropriate for people who are unable to understand and/or comply with instructions (NICE, 2007).

Pelvic floor muscle re-education (PFME)

PFME is a progressive and intensive programme of voluntary pelvic floor muscle contractions used to attempt to strengthen, improve the coordination and endurance of, and speed of response of the pelvic floor muscles. It requires an individualised programme of exercises, for a minimum of three months, to produce improvement. Improvement is dependent on many factors, including patient motivation and compliance. The progress of the individual should be monitored by anorectal re-assessment carried out by a competent health care professional (Evans, 2015).

Biofeedback

Biofeedback is a technique that transforms some aspect of physiological behaviour into a visual

or auditory signal to help establish a change in behaviour to help manage the patient's bowel dysfunction (Collins, 2016). It can be used to aid the teaching of voluntary pelvic floor muscle contraction and relaxation of the pelvic floor. Biofeedback techniques have been used for over 20 years for the clinical management of defecation disorders, such as pelvic floor dyssynergia (NICE, 2013).

Neuromuscular electrical muscle stimulation (NMES) may be used where anorectal assessment identifies extremely weak muscles with poor endurance. An electrical stimulus may be delivered to the external anal sphincter and pelvic floor muscles via an electrode. The method of choice is usually an intra-anal electrode, although in certain circumstances external skin electrodes may be used. This treatment should only be administered by a competent specialist nurse or allied health professional (AHP) following individualised assessment.

Percutaneous posterior tibial nerve stimulation (PTNS)

PTNS delivers an electrical current through a needle that is inserted into the posterior tibial nerve. Its mode of action is through stimulus of the same afferent pathway as sacral nerve stimulation (SNS) (NICE, 2011b).

It may form part of a treatment intervention delivered by a specialist nurse or AHP. The specialist nurse is required to inform the clinical governance lead in their trust and audit and review clinical outcomes of all patients having PTNS for faecal incontinence (NICE, 2011b).

Treatment should only be carried out in units specialising in the assessment and treatment of faecal incontinence, and only after unsuccessful PFME and biofeedback interventions.

Summary of interventions

1. First-line treatment is conservative, with measures such as dietary management or antidiarrhoeal medication.
2. Pelvic floor muscle or anal sphincter training (sometimes including biofeedback therapy) may be used.
3. Trans anal irrigation.
4. Percutaneous tibial nerve stimulation for faecal incontinence.
5. Surgical options include: sphincter repair, sacral nerve stimulation, stimulated graciloplasty (creation of a new sphincter from other suitable muscles), anorectal or transabdominal implantation of an artificial anal sphincter, or permanent colostomy.

Mapping competencies to this aspect of practice

- Assess bladder and bowel dysfunction CCo1.
- Enable an individual to undertake pelvic floor muscle exercises CC12.
- Enable an individual with complex pelvic floor dysfunction to undertake pelvic floor muscle rehabilitation GEN13.
- Maintain health, safety and security practices within a health care setting GEN16.
- Communicate effectively in a health care environment GEN97.
- Obtain valid consent or authorisation CHS167.
- Assess risks associated with health conditions CHS46.
- Support an individual undergoing health care activities GEN5.
- Monitor and assess an individual following treatment CHS47.
- Evaluate the delivery of the care plan to meet the needs of the individual CHS53.
- Maintain use of medical devices to assist organ or system function CHS166 and maintain health care equipment, medical devices and associated systems CHS210.
- Plan the maintenance of equipment and medical devices within health care CHS197.
- Decommission medical devices and associated systems within health care CHS211.

8. Pharmacology and prescribing

Knowledge and understanding

You will need to know and understand:

- how certain categories of medication and an individual's current medication may affect bowel function
- the actions and uses of the most commonly used drugs in the treatment of disorders of body systems and clinical conditions relating to bowel function
- the different routes of medicine administration.

Nurses are increasingly prescribing independently, and it is to become an integral part of the standards included in the new NMC standards of proficiency (NMC, 2018) for registration.

Where nurses are not prescribers, group protocols allow the supply and administration of prescription-only medicines by nurses, without the need for prior consultation with, or prescription from, a medical practitioner.

Therefore, the RCN believes that all nurses administering medicines as part of their practice should understand the medication they use, irrespective of whether they have the legal right to prescribe.

The nurse needs to be aware of the ethical, safety, legal and professional implications of recommending complementary therapies, and unlicensed and untested substances, in the treatment of bowel dysfunction.

Drugs that cause bowel dysfunction

Many prescribed drugs may have possible side-effects on gut motility and stool consistency, causing loose stool or constipation. The main groups are:

- opioids
- broad-spectrum antibiotics
- laxatives
- diabetic medication

- obesity medication
- antidiarrhoeal
- antidepressants
- antihistamines
- antimuscarinics
- antacids
- iron preparations
- polypharmacy.

Reviewing medications to change or modify the regimen may help to improve bowel dysfunction. Polypharmacy refers to the use of multiple medications by a patient (Nishtala and Salahudeen, 2015).

Every medication has potential side effects and with every drug added, there is an increase in possible side effects.

Drugs used to treat bowel dysfunction

Oral and rectal pharmacological interventions are available to treat bowel dysfunction and can be combined with bowel emptying techniques to enhance the effectiveness of these for the individual.

When prescribing, recommending and administering rectal or oral medication, consider the indications and risk factors, including:

- type(s) of bowel dysfunction
- choice of route
- administration times
- duration of treatment
- interactions and expected outcomes
- cautions, contraindications and side effects
- licensed usage
- local formularies.

Faecal incontinence (FI) (NICE, 2007)

Anti-diarrhoeal medication

Used to slow down the activity in the bowel and typically used to treat FI. It may be a sole treatment option or an adjunct to another therapy. Loperamide is the most commonly used medication in the treatment of FI and can be given as a regular treatment or on an as-required basis. Introduce at a very low dose and increase until desired stool consistency is reached. Consider loperamide syrup for doses of less than 2mg (NICE, 2007).

Drugs to promote bowel emptying

FI can be secondary to faecal impaction or constipation. Laxatives or rectal evacuates may be used to promote complete rectal emptying.

Constipation

Laxatives should be tailored to the patient's symptoms and type of constipation.

Bulk-forming agents

Available in powder, granule or tablet form. These can help retain water in the stool, facilitating peristalsis and increasing bulk; it is essential to maintain a fluid intake or symptoms of constipation may worsen. They can also be used to give bulk to loose stools.

Stimulants

Stimulating enteric nerve endings directly and inhibiting water absorption, will help induce a bowel movement within 8–12 hours by increasing peristalsis in the colon. Not to be taken if there is a risk of intestinal obstruction.

Osmotic laxatives

These retain fluid in the stool and increase bulk by bacterial fermentation. These work by increasing fluid content of the stool (and help soften stool) by retaining water in the bowel. These agents may take up to 48 hours to act and should be given with plenty of water.

Macrogol

When mixed with water the solution remains in the colon, achieves an increase in faecal bulk that causes stretching of the circular muscle in the bowel wall, triggering peristalsis. Faecal residue is softened, and stools are re-hydrated. Some of these preparations are licensed to treat faecal impaction.

Faecal softeners

These decrease absorption of water from stool, making it softer and facilitating transit. They are used when it is not possible to successfully promote a soft, formed stool through manipulation of diet and fluids.

Other drugs used in constipation

Prokinetics 5-HT₄ agonists

Work by stimulating the 5-HT receptors of the intestine causing an increase in peristalsis (NICE, 2010). Recommended as an option for the treatment of chronic constipation in patients for whom treatment has failed to provide adequate relief; and when invasive treatment for constipation is being considered. It should only be prescribed by a clinician with experience of treating chronic constipation. If treatment is not effective after four weeks, the patient should be re-assessed, and the benefit of continuing treatment reconsidered.

Guanylate cyclase-C agonist

Used to treat irritable bowel syndrome moderate to severe IBS – C. They work by increasing intestinal fluid secretion, which can soften stools and stimulate bowel movements (NICE, 2013).

Peripheral opioid receptor antagonist

These bind to the peripheral opioid receptors, such as those in the gastrointestinal tract and block unwanted effects caused by opioids.

They are not able to penetrate the blood-brain barrier so do not antagonise central nervous system opioid receptors, therefore the analgesic effects of opioids is not affected.

Peripheral opioid receptor antagonists are given with opioids to prevent opioid-induced constipation (NICE, 2015).

Enemas and suppositories

Rectal medications may be used:

- in an acute situation when immediate results are needed to relieve symptoms
- where oral laxatives are insufficient/ ineffective
- before or after surgery
- for chronic conditions when the mechanism of normal bowel emptying is disrupted
- to create a timed bowel movement to prevent faecal incontinence.

Phosphate enemas should be used with caution.

Suppositories

A suppository is a medicated solid formulation prepared for insertion into the rectum. Once inserted the temperature of the body will dissolve the suppository from its solid form to a liquid.

Suppositories may be useful in the management of chronic constipation, particularly when combined with other interventions such as oral laxative agents and preventative measures. They may also be used to empty the rectum in preparation for investigations or procedures.

Enema

An enema is a liquid preparation that is introduced into the body via the rectum for the purposes of producing a bowel movement or for administering medication.

An enema may be required for the following:

- acute disimpaction of the bowel
- bowel clearance before bowel investigations or surgery
- to soothe and treat bowel mucosa in chronic inflammatory bowel disease such as ulcerative colitis and Crohn's disease.

Onset of action is between 15–30 minutes.

Contraindications include:

- intestinal obstruction
- anal and rectal region diseases that can lead to an excessive absorption of carbon dioxide
- hypersensitivity against soy bean and peanut.

In a stepped approach, small volume enemas should be considered before large volume. The nozzle should be lubricated along the whole length with gel and 5mls of solution administered into the rectum. Onset of action is between 5–15 minutes.

Large volume evacuant enemas may be considered in acute constipation scenarios and for evacuation prior to investigative procedures.

Phosphate enemas can cause local irritation and electrolyte disturbance, these should be used with caution in:

- older people and people who are debilitated
- individuals with clinically significant renal impairment.

Contraindications include:

- conditions associated with increased colonic absorption; gastrointestinal obstruction; active inflammatory bowel disease.

Arachis oil retention enemas may be used, when the rectum is empty, to soften and ease the passage of stool in readiness for evacuant suppositories or an enema the following day.

Contraindications include hypersensitivity against peanuts.

Mapping SfH competencies to this aspect of practice

- Administer medication to an individual CHS3.
- Provide advice on symptoms and the actions and uses of medicines PHARMO4.

9. Surgical interventions

Knowledge and understanding

You will need awareness and understanding of:

- the types of surgical interventions used to improve bowel function: the main types of operations, broad main outcomes of specific surgical procedures and be able to select appropriate individuals for surgery.

Nurses need to understand the types of surgery, why these are performed, the implications if carried out, and be able to identify patients who are appropriate for surgery and capable of discussing the expected outcomes with the patient.

Faecal incontinence

Secondary sphincter repair, sacral nerve stimulation, artificial bowel sphincter, graciloplasty, stoma.

Constipation/associated problems

Antegrade continent enema (ACE) procedure, continent colonic conduit, sacral nerve stimulation, subtotal colectomy and stoma.

Bowel prolapse/rectocele

Rectopexy, Delormes operation, rectocele repair, posterior repair, stapled transanal rectal resection (STARR).

Mapping SfH competencies to this aspect of practice

- Contribute to the development of the multidisciplinary team and its members GEN40.
- Agree courses of action following assessment to address health and wellbeing needs of individuals CHS45.
- Monitor and assess an individual following treatment CHS47.
- Provide advice and information to an individual on how to manage their own condition GEN14.

10. Risk assessment

Knowledge and understanding

You will need to know and understand:

- the importance of including risk assessment within the wider assessment process; to identify high-risk individuals with potentially life-shortening conditions such as bowel/bladder cancer, systemic infection or skin breakdown because of incontinence.

The Principles of Nursing Practice (RCN, 2010) describe what constitutes safe and effective nursing care, and nurses are required to be both vigilant about risk and to manage it effectively.

Nurses need to be able to identify patients that are at risk of developing bowel dysfunction. It is vital to check for allergies (latex, soap [lanolin], phosphate and peanut [arachis oil enema]) before going ahead with procedures that include these. Nurses should be competent at using risk assessment tools and questionnaires related to bowel dysfunction.

Individuals at risk of developing bowel dysfunction include those suffering from or with:

- central neurological disease or a trauma such as SCI, MS, Parkinson's disease, stroke
- eating disorders
- end of life care needs
- cognitive impairment or behavioural issues
- acute disc prolapse – cauda equina syndrome
- acquired brain injury
- history of abuse (sexual, physical)
- mobility issues
- prostatic obstruction/hypertrophy
- nutritional issues
- alcohol and drug dependency issues.

As well as:

- frail older people
- individuals in communal settings

- perinatal/pregnant women
- women post-childbirth
- patients post-surgery
- critically ill patients.

High-risk bowel issues which may increase the complications associated with lower bowel dysfunction include:

- active inflammatory bowel disease
- acute diverticular disease/diverticulitis
- rectal pain
- rectal and anal sepsis, abscess and fistula
- recent radiotherapy to pelvic area
- recent rectal or anal surgery
- obvious rectal bleeding
- allergies
- autonomic dysreflexia
- anal tissue fragility
- inflamed and painful haemorrhoids
- anal fistula or fissure
- anal stenosis.

A risk assessment is essential when undertaking an invasive procedure. For example, consider the following key risk areas when administering an enema.

- **Risk awareness** – understand what complications could occur when administering an enema.
- **Risk assessment** – consider risks prior to administering an enema, for example, has the patient had recent anal surgery?
- **Risk importance and priority** – is the clinical need an emergency, have all other options been tried? Does the likely benefit of giving the enema outweigh the possible risks?
- **Risk identification** – for example, a phosphate enema may have more associated complications in certain patients (such as an older frail individual).

- **Risk likelihood and factors** – the patient has dementia and is unable to consent.
- **Risk severity** – for example, administering a phosphate enema to an older patient with poor renal function.
- **Risk prevention** – staff competency.
- **Risk avoidance** – to avoid the risk completely, the enema is not administered, but this must be weighed against the risks of not giving the enema.
- **Risk reduction** – use other rectal medication (such as suppositories).
- May induce hyperphosphatemia (HSU, 2008).

Mapping SfH competencies to this aspect of practice

- Assess risks associated with health conditions CHS46.
- Plan interdisciplinary assessment of the health and wellbeing of an individual CHS52.

11. Lower bowel care emergencies and complications

Knowledge and understanding

You will need to know and understand:

- the situations in which it is necessary to seek further opinion for an individual and how to refer on
- how this should be implemented and how urgently.

Lower bowel care emergencies and complications are very rare, but it is important that nurses are aware of red flags and can act quickly to reduce further complications.

Bowel obstruction

This can be associated with no bowel activity or lots of painful activity to try to bypass a mechanical obstruction. Symptoms include: abdominal pain and distension, vomiting and possible dehydration. If untreated, the bowel may rupture, leak its contents and cause peritonitis and possible death (MedlinePlus, 2018). Main causes: colon cancer, adhesions, and scarring from infection, which may narrow the lumen of the colon and volvulus.

Perforation

This is a hole in the bowel which allows leakage of intestinal contents into the abdominal cavity. Symptoms may include: high fever, nausea and severe abdominal pain which is worse on movement. Intense vomiting may occur and result in dehydration.

Perforation can cause peritonitis which, if not treated, can cause almost immediate death (MedlinePlus, 2018). Causes of perforation include: a diverticular or cancerous lesion, colonoscopy or sigmoidoscopy (very rare), ischaemia of the bowel (possibly caused by a strangulated hernia and surgically induced).

Faecal impaction

This is a complication of constipation and, if not treated, can cause an obstruction of the bowel. Macrogol 3350 plus electrolytes, is licensed to treat faecal impaction and may need to be given

in combination with rectal stimulants, such as an enema. DRF may be appropriate for patients with impaction.

Undiagnosed diarrhoea

There are many causes of diarrhoea (for example, colitis, small bowel disease, pancreatic, endocrine, infection, antibiotic therapy, drug induced) and it may lead to dehydration and electrolyte imbalance (Metcalf, 2007). Don't mistake overflow for diarrhoea.

Undiagnosed rectal bleeding

This 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 ischaemia (Trotter, Hunt and Peter, 2016). An individual with any of these symptoms should visit their GP, who will then refer onto the appropriate service for further investigation if required (NICE, 2011a).

Strangulated hernia

This occurs when the blood supply to the bowel is cut off. This can lead to ischaemia, necrosis and gangrene. Strangulated hernias are a surgical emergency and require urgent referral. Constipation and excessive straining may cause a hernia to develop where weak muscles are present, and the main symptoms are nausea, vomiting and severe pain.

Autonomic dysreflexia (AD)

This is a medical emergency unique to people with spinal cord injury. Acute episodes may result in rapidly rising blood pressure with an accompanying risk of brain haemorrhage and possible death. It occurs in people with a spinal

cord injury at level sixth thoracic vertebrae (T6) or above and is an abnormal sympathetic nervous system response to a noxious stimulus below the level of injury.

The impulses from the noxious stimulus, such as a distended bowel or bladder, are unable to ascend past the spinal cord lesion and may activate a massive sympathetic reflex causing widespread vasoconstriction of the blood vessels below the level of the injury, resulting in hypertension and other signs of sympathetic stimulation.

Distention of the bowel due to faecal impaction is the second most common cause, with distention or irritation of the bladder accounting for 80% of AD (Neuro Advisory Board, 2019 (due for publication in 2019)). Among susceptible individuals, 36% report dysreflexia symptoms occasionally and 9% always when they conduct bowel management (Coggrave, 2008).

Signs and symptoms include:

- severe headache
- flushing
- sweating
- blotchiness above the lesion
- hypertension.

The patient should be observed for symptoms of AD during bowel care, as acute AD may occur in response to digital interventions. A rapidly developing severe headache is a cardinal sign of acute AD. If this occurs, stop DRF, a medical assessment should be undertaken and the patient should be treated promptly (Neuro Advisory Board, 2019).

Treatment

- Recognise the signs and call for help/assistance.
- Sit the patient up.
- Check blood pressure readings every two to five minutes.
- Administer any prescribed anti-hypertensive medication.
- Check bladder and bowel status/function.

- Identify and treat the cause.

Prevention

- Plan and deliver an effective individualised bowel care programme to manage constipation and avoid faecal loading.
- Treatment of any anorectal problems.
- Apply local anaesthetic gel prior to digital interventions; this can reduce or eradicate the autonomic dysreflexia response during bowel care (Neuro Advisory Board, 2019).
- Continue adherence to the bowel management programme and routine, on a regular basis.

Training

Training and education are highlighted as key issues in the successful management of AD. Employing organisations have a responsibility to provide this to staff who are required to perform interventions for those with identified clinical needs in their care (NHSI, 2018).

AD in summary

AD is most likely to occur in response to ineffective bowel care due to withholding of essential interventions. Therefore, it is vital that nurses (in all care settings) are aware of this condition and how it can be treated to reduce the risk of the above complications occurring.

Mapping SfH competencies to this aspect of practice

- Prioritise individuals for further assessment, treatment and care EUSC07.
- Assess an individual's health status CHS39.
- Review presenting conditions and determine the appropriate intervention for an individual EUSC05.
- Receive requests for assistance, treatment or care GEN58.

12. Infection prevention and control (including *Clostridium difficile*) and care of the environment

Knowledge and understanding

You will need to know and understand:

- the relevant standard infection control precautions legislation and policies covering your area of work, as well as your own role and responsibilities, and the responsibilities of others.

Due to the extent of infection control aspects, it is not possible within the constraints of this document to discuss this topic in depth. However, consider the following aspects of infection control when caring for patients with bowel dysfunction.

- Standard precautions for handling and disposing of any body fluid.
- Good hand hygiene.
- Use of personal protective equipment.
- Care of the environment.
- Decontamination of equipment.
- Care of the patient with diarrhoea.
- Disposal of equipment and containment products.

Clostridium difficile infection

Clostridium difficile infection (C. diff) 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, C. diff can multiply rapidly and produce toxins which cause illness and diarrhoea.

Public Health England (2013) and Health Protection Scotland (2017) have produced

updated guidance on the management and treatment of C. diff infection.

When patients present with diarrhoea (BSS5–7), it is important to consider that it may have an infectious cause. Also check for any pre-disposing medical conditions or factors that may account for the diarrhoea (RCN, 2013).

Conditions

- Inflammatory bowel disease (IBD).
- A history of gastrointestinal surgery.
- Chronic pancreatitis.
- Coeliac disease.
- HIV.

Predisposing factors

- Antibiotic exposure (for example, multiple antibiotic courses).
- Age (is the patient over 65?).
- Previous GI surgery/manipulation.
- A long length of stay in a health care setting.
- A serious underlying illness.
- Use of proton pump inhibitors (PPI)
- A previous C. diff infection.
- Nutritional supplements.
- Contact with another patient with C. diff.

Patients with suspected potentially infectious diarrhoea should be isolated and closely monitored for the frequency and consistency of their stool using the Bristol stool form chart.

Clinicians should apply the following SIGHT mnemonic protocol when managing suspected potentially infectious diarrhoea such as C. diff.

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 cause of the 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 toxins by sending a specimen immediately.

(DH, 2008)

Care of the environment

Knowledge and understanding

You will need to know and understand:

- **the methods of enabling the individual to be as comfortable as possible and maintaining their dignity and privacy, given the constraints of the particular bowel emptying technique and the setting.**

Ensure that risks are managed effectively and, as far as possible, that the environment meets the needs and preferences of the individual. Check:

- the care environment is not cluttered
- individuals can access the care environment easily and safely
- individuals feel comfortable, safe, reassured, confident and welcome.

C. diff poses high contamination risks for the environment; the heaviest contamination occurring on floors, commodes, toilets, bedpans and bed frames (which are subject to faecal contamination). Education around glove wearing and hand washing, with adherence to the SIGHT protocol, is essential.

Mapping SfH competencies to this aspect of practice

- Minimise the risk of spreading infection by cleaning, disinfecting and maintaining environments IPC1.
- Perform hand hygiene to prevent the spread of infection IPC2.
- Clean, disinfect and remove spillages of blood and other body fluid to minimise the risk of infection IPC3.
- Minimise the risk of spreading infection by cleaning, disinfecting and storing care equipment IPC4.
- Minimise the risk of exposure to blood and body fluids while providing care IPC5.
- Use personal protective equipment to prevent the spread of infection IPC6.
- Minimise the risks of spreading infection when storing and using clean linen IPC12.
- Minimise the risk of infection when transporting and storing health and care related waste IPC8.
- Minimise the risks of spreading infection when removing used linen IPC9.
- Provide guidance, resources and support to enable staff to minimise the risks of spreading infection IPC13.

13. Consent, confidentiality, privacy and dignity, chaperoning and safeguarding

Knowledge and understanding

You will need to know and understand:

- how to obtain valid consent, that the individual has the ability to consent and co-operate, and how to confirm that sufficient information has been provided on which to base this judgement
- how to enable individuals to make informed choices and decisions
- how to support patients in bowel care activities in a manner which retains their dignity and is in accordance with their personal beliefs and preferences
- how to promote and manage privacy and dignity of patients in conscious and unconscious states.

Consent

Within the constraints of this document it is not possible to cover everything relating to consent. However, the most important areas on bowel care and informed consent are included. Further reading in this area should be carried out (see References and further reading on pages 55-59).

Nurses need to understand the importance and significance of trust and dignity between the nurse and patient; it is essential for all patients to achieve self-determination and autonomy.

Obtaining informed consent is essential before carrying out nursing care, treatment or procedures involving physical contact with a patient. Without this, the care or treatment may be considered unlawful. Your employer, or you personally, could be sued for compensation by the patient if you have not obtained consent, even if your care or treatment was to the patient's benefit.

Informed consent may be verbal, written or non-verbal, and can only be given by the patient. Your NHS trust or organisation may have a policy setting out when you need to obtain written consent. A signature on a consent form alone does not prove that informed consent has been obtained, although it would indicate that some discussion has taken place and is a record of the patient's decision.

In all instances, you must record the type of consent obtained in the patient's nursing record. It is always best for the person treating the patient to seek the patient's consent. However, consent may be obtained on behalf of a colleague if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

When obtaining informed consent, three requirements must be achieved to ensure case law is satisfied and, therefore, deemed lawful and legal.

Requirement 1: consent should be given by someone with the mental ability to do so.

Requirement 2: sufficient information should be given to the patient.

Requirement 3: consent must be freely given.

You must respect and support an individual's right to accept or decline treatment and uphold their right to be fully involved in decisions about their care, and be aware of the legislation regarding mental capacity ([NMC, 2015b](#); [Mental Capacity Act 2005 Code of Practice, 2007](#)).

Where capacity is not present, the NMC (2015b) states that nurses should adhere to all relevant laws about mental capacity that apply in the country in which they are practising. Ensure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.

Mental Capacity Act 2005

The five key principles of the act need to be taken into consideration when gaining consent from a patient.

1. **A presumption of capacity** – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. **Individuals must be supported to make their own decisions** – a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. **Unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. **Best interests** – an act done, or decision made under the Act for, or on behalf of, a person who lacks capacity, must be done in their best interests.
5. **Least restrictive option** – anything done for, or on behalf of a person who lacks capacity, should be the least restrictive of their basic rights and freedoms.

All decisions made on behalf of an adult with impaired capacity must:

- benefit the adult
- take account of the adult's past and present wishes
- restrict the adult's freedom as little as possible while still achieving the desired benefit
- encourage the adult to use existing skills or develop new skills
- take account of the views of others with an interest in the adult's welfare.

Consent in emergency situations

Significant nursing interventions may take place in an emergency. The law is quite specific about the issue of consent in these situations – where treatment is required to safeguard the life or health of an individual, it is not a legal

requirement that the patient's consent must be obtained. Therefore, if you have provided care to an individual in an emergency, you must be able to demonstrate and document that you have acted in their best interests.

Confidentiality

When obtaining consent, issues of confidentiality should be paramount – especially when dealing with the patient's wishes and beliefs if they do not want the information obtained to be shared with others. All staff working in the NHS must meet the standards of confidentiality within the NHS Code of Practice and accept these as within their terms of employment. It is important that people are informed about how and why information is shared by those who will be providing their care, and that you must disclose information if you believe they may be at risk of harm (DH, 2009).

Privacy and dignity

Nurses need to identify the nature of support the patient needs and respect their privacy, dignity, wishes and beliefs when working with them. In addition, they should help individuals who need assistance to prepare for any clinical activity in a manner which retains their dignity. Care should be provided in a respectful way and in accordance with the individual's personal beliefs and preferences (Equality Act 2010). This includes considering the timing of interventions and a recognition of the individual's sleep pattern and work/life/leisure activities when planning bowel care programmes. This will help them to remain autonomous and independent.

Benchmark standards (DH, 2010)

- People and their carers feel that they matter all of the time.
- People experience care in an environment that encompasses their values, beliefs and personal relationships.
- People's personal space is protected by staff.
- People and their carers experience effective communication with staff, which respects their individuality.

- People experience care that maintains their confidentiality.
- People's care ensures their privacy and dignity, and protects their modesty.
- People and their carers can access an area that safely provides privacy.

The Nursing and Midwifery Council *Code of Professional Practice and Behaviour* (NMC, 2015a) sets out five values/principles that should reflect the care delivery of registered nurses in all care settings.

1. Treat people as individuals and uphold their dignity.
2. Listen to people and respond to their preferences and concerns.
3. Make sure that people's physical, social and psychological needs are assessed and responded to.
4. Act in the best interests of people at all times.
5. Respect people's right to privacy and confidentiality.

Chaperoning and safeguarding

Knowledge and understanding

You will need to know and understand:

- who may accompany the individual (for example, carers and chaperones) and be present during the assessment and how to work with them
- safeguarding issues relating to capacity confidentiality, data protection, and mental capacity legislation.

Chaperoning

Patients should be informed that they have the right to request a chaperone when undergoing any procedure or examination. All providers should have a chaperoning policy in place that is available to patients. If a chaperone cannot be provided, the patient must be informed and asked if they wish to continue with the procedure

or examination. Likewise, the patient has the right to decline a chaperone if offered.

A chaperone is present as a safeguard for both the patient and nurse and is a witness to continuing consent of the procedure (RCN, 2016). Therefore, they should usually be a health care practitioner. The patient may also wish to have a family member or friend present. However, they should not be acting as chaperone. This may require sensitive handling and it is important to consider whether this is done:

- in the patient's best interests
- of their own free will (DH, 2015).

Where intimate procedures or examinations are required, the nurse should be aware of any cultural, religious beliefs or restrictions the patient may have which prohibits this being performed by a member of the opposite sex. False accusations of abuse have been made in rare cases and, to avoid any misunderstanding, it is advised that both the decision made, and the name of the chaperone, should be documented within the patient's record (Griffith, 2010).

Safeguarding

In providing intimate bowel care to patients, nurses may encounter individuals who are considered at risk of abuse, harm or neglect and, because of their needs for care and/or support, are unable to safeguard themselves.

In these situations, nurses should respect their choices and work with the individual to protect their right to live in safety, free from abuse, harm and neglect. This can be through both proactive and reactive interventions to support health and wellbeing, with the engagement of the individual and the wider community.

To respond appropriately to the safeguarding needs of adults, nurses need to be aware of issues relating to:

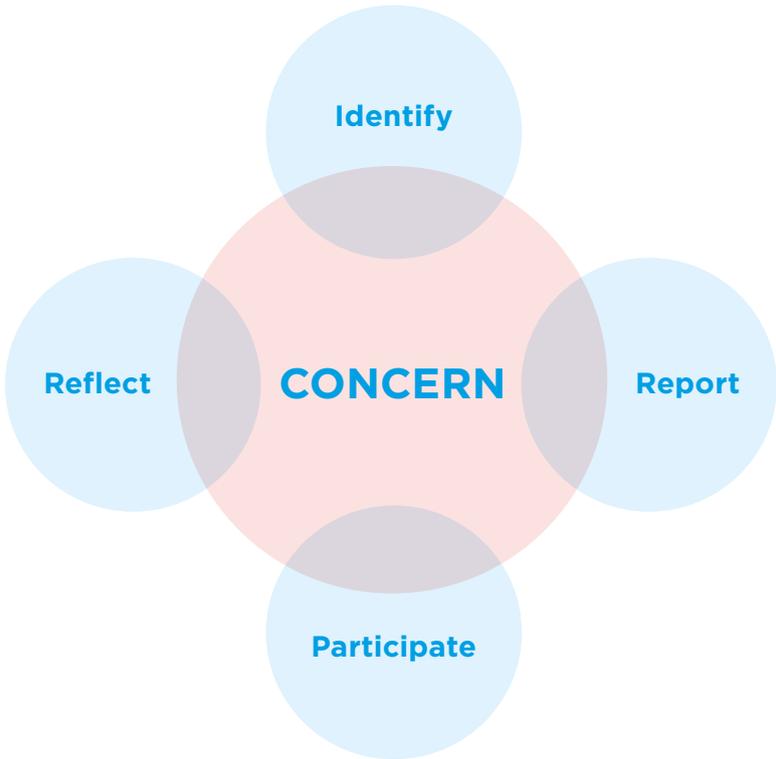
- confidentiality
- data protection
- mental capacity legislation.

To respond effectively to any safeguarding concerns, the RCN recommends that nurses should identify and report safeguarding concerns

(in conjunction with any partner organisations, as required) and participate in any enquiry. Reflection on outcomes and learning will be led by the relevant local authority and contribute

to the development of an organisational safeguarding policy. This will also enhance personal development.

Diagram 1: Responding to safeguarding concerns (RCN, 2018)



All health and social care organisations are required to provide staff with education to ensure they are familiar (suitably skilled and supported) with the relevant associated legislation and guidance that supports adults to make decisions. Such legislation and guidance may be specific to the country in which the professional is practising and the competencies must be applied within the context of that legislation.

Mapping SfH competencies to this aspect of practice

- knowledge and understanding chaperoning cc01 CHS167, PE1).

14. Communication

Knowledge and understanding

You will need to know and understand:

- **how to communicate clearly and coherently, taking into account the needs of the individual, selecting the most appropriate method of communication for them.**

Individuals with bowel dysfunction problems often feel stigmatised and embarrassed about their problem and, because of this, find it difficult to discuss with others. As a health care professional, it is imperative to be empathetic and sensitive (NICE, 2007) to the feelings of these patients, so that they can discuss their symptoms freely without feeling judged or embarrassed. For this reason, it is important to use different types of communication to ensure that the individual understands what is being conveyed to them. This includes giving the patient tools to help them describe their symptoms, for example, using the Bristol stool chart to describe their stool.

There are many ways to communicate with an individual, depending on their needs, ability and preferences. Use appropriate body language, eye contact and methods of listening that will actively encourage individuals to communicate.

Aspects to consider for effective communication include:

- written format – leaflets, booklets
- audible format – adapt language instructions
- visual format – diagrams, models, demonstration, photographs, products.

It is essential to develop a rapport by using active and empathic listening skills and being non-judgemental.

Use appropriate language that allows the patient to understand and avoid jargon. Communication should be in private and with minimum distractions. Use interpreters when working with patients whose first language is not English and audio or Braille when working with people who have a visual impairment.

Mapping SfH competencies to this aspect of practice

- Communicate effectively in a health care environment GEN97.
- Liaise between primary, secondary and community teams GEN44.
- Develop effective relationships with individuals SCDHSC0233.
- Provide clinical information to individuals CHS56.
- Manage information and materials for access by patients and carers PE2.
- Develop relationships with individuals that support them in addressing their health needs PE5.

15. Documentation

Knowledge and understanding

You will need to know and understand:

- **how to produce records and reports that are clear, comprehensive and accurate, and maintain the security and confidentiality of information.**

Nursing staff should keep clear and accurate records which are relevant to their practice. There is no specific document on record keeping – and so all nurses and midwives should refer to the NMC Code (NMC, 2015a). The RCN (2017) also has an information guide that outlines the key facts.

Good record keeping, at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information between members of the multi-professional health care team
- helping to identify risks and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning
- helping to address complaints or legal processes.

The principles of good record keeping apply to all types of records, regardless of how these are held, and can include:

- handwritten clinical notes

- emails and letters to and from other health professionals
- laboratory reports, X-rays, printouts from monitoring equipment
- incident reports and statements, photographs, videos
- tape or digital recordings of telephone conversations, text messages.

With specific reference to documentation of DRE, DRF and DRS, the following details should always be documented:

- consent
- observations
- findings on examination
- outcome of any intervention
- if a referral on has been made.

Record keeping and good documentation is an integral part of nursing. It is a mark of a skilled and safe practitioner. Nurses should be aware that good documentation and record keeping helps protect the welfare of patients and themselves.

Documentation records should use terms that the patient can easily understand, and should not include any abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements.

Practitioners have a duty to protect the confidentiality of the patient and the patient record. The patient's documentation records should be factual, consistent, accurate and unambiguous. The record should be completed as soon as possible after the event has occurred, and the text should be clear and legible. It should be accurately dated, timed and signed, with the name printed alongside. If justifiable alterations or additions need to be made, these should be dated, timed and signed clearly to the attributed named person; the original entry should still be legible.

Patients have the right to access records held about them, in line with local policy. Records can also be scrutinised by other professionals, if need be, to clarify certain issues.

Key principles

- Records should be completed at the time or as soon as possible after the event.
- All records must be signed, timed and dated if handwritten.
- If digital, they must be traceable to the person who provided the care that is being documented.
- Ensure that you are up to date in the use of electronic systems in your place of work, including security, confidentiality and appropriate usage.
- Records must be completed accurately and without any falsification and provide information about the care given, as well as arrangements for future and ongoing care.
- Jargon and speculation should be avoided.
- When possible, the person in your care should be involved in the record keeping and should be able to understand what the record says.
- Records should be readable when photocopied or scanned.
- In the rare case of needing to alter a record, the original entry must remain visible (draw a single line through the record) and the new entry must be signed, timed and dated.
- Records must be stored securely and should only be destroyed following your local policy.

- Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.

Always follow your local policy.

Mapping SfH competencies to this aspect of practice

- Determine a treatment plan for an individual CHS41.
- Develop clinical protocols for delivery of services CHS170.
- Monitor your own work practice GEN23.
- Capture and transmit information using electronic communication media GEN69.
- Monitor the condition of individuals SCDHSC0224.
- Develop models for processing new data and information in a health context HI5.
- Provide authorised access to records SS34.

Countersigning

- Record keeping can be delegated to health care assistants (HCAs), assistant practitioners (APs) and nursing students so that they can document their care.
- As with any delegated activity, the nurse needs to ensure that the HCA, AP or student is competent to undertake the activity and that it is in the patient's best interests for record keeping to be delegated.
- Supervision and a countersignature are required until the HCA, AP or student is deemed competent at keeping records.

16. Health care assistants and nursing associates

Health care assistants

Health care assistants (HCAs) are an important part of the workforce in delivering patient care within health care. The following statements consider some aspects of the role of the HCA in lower bowel care and are not comprehensive. HCAs may undertake a range of lower bowel care procedures, following assessment by a registered competent nurse if:

- they have been deemed competent in the particular lower bowel care task
- the registered nurse agrees to delegate that lower bowel care task to that specific HCA, and that the patient consents
- the task delegated is adequately supervised and supported
- local policy permits the delegation of these tasks.

It is acceptable for the following procedures or tasks to be undertaken by a competent HCA on a named patient basis.

- Digital rectal examination (DRE).
- Digital removal of faeces (DRF).
- Digital rectal stimulation (DRS).
- Wash a patient with a diarrhoea containment product in situ.
- Move a patient with a diarrhoea containment product in situ (manual handling).
- Be aware of, and use, a variety of lower bowel care support equipment.
- Change a diarrhoea containment bag.
- Insert an anal plug/insert.
- Insert a glycerine or other evacuatory suppository, where this is deemed to be low risk.
- Administer an enema, where this is deemed to be low risk.
- Obtain a specimen of faeces to send for culture.

HCAs have an individual responsibility to ensure they feel confident and competent in the knowledge and skills of practice in line with local guidelines, procedures and policies.

Employers need to ensure their staff are trained, supervised and competent in the delegated task.

Developing competence in lower bowel care

The HCA should be actively encouraged to gain clinical development in all aspects of lower bowel dysfunction. The HCA should acquire knowledge, understanding and skills relating to the supervised delivery of lower bowel care, including:

- an understanding of the anatomy of the lower gastrointestinal tract
- the indications, exclusions and contraindications for DRE and DRF
- common complications and solutions associated with lower bowel dysfunction
- legal aspects of lower bowel care provision
- skin care – when and how to apply products
- infection control, hand hygiene, personal protective equipment (PPE).

Acceptable performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff. Such supervision should be documented and counter signed by the supervisory nurse. This should be in some form of competency document kept by the employing organisation, as well as within the HCA's personal portfolio. In addition:

- the importance of accurate documentation relating to lower bowel dysfunction is vital
- annual half-day study sessions should be considered as mandatory
- HCAs needs to be aware of their limitations to practice (difficult/abusive patients)
- HCAs should actively report risks and untoward incidents to qualified staff, in line with local policy guidelines.

This will all ensure competency of the HCA to meet a patient's service needs and is in line with NOS. HCAs should inform their immediate line manager if they feel they are not competent to undertake any form of lower bowel care. Additional training needs can then be identified and facilitated at local level.

Programmes of learning for HCAs, in line with the NOS, must relate to all aspects of lower bowel dysfunction and should be facilitated by competent qualified staff at local level. Such programmes of learning should include consideration of physical, social, sexual and physiological aspects of lower bowel dysfunction to ensure that the patient's care actively achieves social continence status and their privacy, dignity and modesty are protected. However, the assessment of the patient remains the remit of the registered practitioner.

Nursing associates

As of 2019, the Nursing and Midwifery Council (NMC) is the regulator of nursing associates, as well as nurses and midwives; and propose that nursing associates will uphold the same Code as nurses and midwives. The nursing associate role will be regulated in England only.

Nursing associate standards for proficiency include procedures for the planning, provision and management of person-centred nursing care (NMC, 2018) and state, in relation to bowel health, that the associate nurse will provide support with maintaining bowel health in the following ways.

- Observe and monitor the level of bowel continence to determine the need for support and intervention in the level of independence and self-management of care that an individual can manage (5.1).
- Assisting with toileting, maintaining dignity and privacy, and managing the use of appropriate aids (5.2).
- Recognise bowel patterns to identify and respond to constipation, diarrhoea and faecal retention (5.4).
- Administer enemas and suppositories (10.6).

- Recognise and respond to adverse or abnormal reactions to medications, and when and how to escalate any concerns (10.9).
- Collect and observe stool specimens, interpreting findings and reporting as appropriate (1.5).
- Observe and reassess skin and hygiene status using contemporary approaches to determine the need for support and ongoing intervention (3.1).
- Prevent and manage skin breakdown through appropriate use of products (3.4).
- Identify and manage skin irritations and rashes (3.5).

If you are on the NMC register, and someone is delegating aspects of treatment and care to you, it is your responsibility to make sure that:

- you understand the task and can perform it safely
- it is within the limits of your competence
- you understand your role in making decisions about the care or treatment in question
- you are clear about the expectations of the colleague who has delegated treatment or care to you and the circumstances in which you should provide updates and/or escalate to them.

For further guidance on delegating refer to the NMC's *Delegation and Accountability. Supplementary information to the NMC Code (2015b)*.

17. Legislation, policy and good practice

Knowledge and understanding

You will need to know and understand:

- how to apply legislation, policy and good practice; the current international, European, UK and national legislation, guidelines and local policies, protocols and procedures which affect your work practice in relation to bowel care.

The above statement relates to key documents and publications which influence this specific aspect of care and outline your areas of responsibility.

All Party Parliamentary Group (APPG)

All Party Parliamentary Group (APPG) for Continence Care (2011) *Cost-effective commissioning for continence care: A guide for commissioners written by continence care professionals*.

Association for Continence Advice (ACA)

Association for Continence Advice (ACA) (2017) *Guidance for the provision of containment products for adult incontinence: A consensus document*.

Department of Health

Department of Health (2005) *Mental Capacity Act Code of Practice – Parts 1 and 2*. London: DH.

Department of Health (2005) *Guidance on the role and effective use of chaperones in primary and community care settings*. London: NHS Clinical Governance Support Team.

Department of Health (2007) *Confidentiality. NHS Code of Practice*. London: DH.

Department of Health (2007) *NHS confidentiality code of practice*. London: DH.

Department of Health (2008) *Health and Social Care Act 2008: code of practice on the prevention and control of infections*. London: DH.

Department of Health (2008) *Clean, safe care: reducing infections and saving lives*. London: DH.

Department of Health (2009) *Clostridium difficile infection: how to deal with the problem*. London: DH.

Department of Health (2010) *Benchmarks for bladder, bowel and continence care*. London: DH.

Department of Health (2012) *Health and Social Care Act*. London: DH.

Department of Health (2013) *Updated guidance on the management and treatment of Clostridium difficile infection*. London: Public Health England.

Department of Health (2014) *Care Act*. London: DH.

Medicines and Healthcare products Regulatory Agency (MHRA)

Medical devices regulations: compliance and enforcement (2014) Updated 2019.

Medical devices regulation and safety.

National Institute for Health and Care Excellence (NICE)

National Institute for Health and Care Excellence (2004) *Sacral nerve stimulation for faecal incontinence* (IPG99). London: NICE.

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National Institute for Health and Care Excellence (2008) *Management of multiple sclerosis in primary and secondary care* (CG8). London: NICE.

National Institute for Health and Care Excellence (2009) *Celiac disease: Recognition, assessment and management* (CG86). London: NICE.

National Institute for Health and Care Excellence (2010) *Prucalopride for the treatment of chronic constipation in women* (TA211). London: NICE.

National Institute for Health and Care Excellence (2011) *Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas* (CG118). London: NICE.

National Institute for Health and Care Excellence (2011) *Percutaneous tibial nerve stimulation (PTNS) for faecal incontinence: clinical guideline* (IPG395). London: NICE.

National Institute for Health and Care Excellence (2011) *Colorectal cancer: the diagnosis and management of colorectal cancer* (CG131). London: NICE.

NHS England

NHS England (2018) *Excellence in continence care*. London: NHS England.

Royal College of Nursing

Available at: www.rcn.org.uk/publications

Royal College of Nursing (2011) *The principles of nursing practice*. London: RCN.

Royal College of Nursing (2017) *Essential practice for infection prevention and control*. London: RCN.

Royal College of Nursing (2017) *Accountability and delegation A guide for the nursing team*. London: RCN.

Royal College of Nursing (2017) *Principles of Consent: Guidance for nursing staff*. London: RCN.

Royal College of Nursing (2018) *Tools of the Trade: Guidance for health care staff on glove use and contact dermatitis*. London: RCN.

Skills for Health

Skills for Health (2015) *National occupational standards*. Bristol: SfH.

United Kingdom Continence Society

United Kingdom Continence Society (2014) *Adult minimum standards document*. Hampshire: UKCS.

Appendices

1. Procedure for digital rectal examination (DRE)

Equipment

Procedure pad.

Disposable apron.

Non-sterile disposable gloves.

Lubricating gel.

- 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.
- Ensure a private environment.
- 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 this 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 easy insertion of the index finger and follows the natural anatomy of the bowel.
- Place protective pad under the patient and a cover over the legs/area so they are not exposed.
- Inform the patient that you are to begin and that you will be observing and examining the outer and internal area.
- Observe and examine the perianal and perineal area for signs of skin conditions, broken areas and ulcers, irregularities, indurations, tenderness or abscess, faecal matter, mucus or blood.
- Assess for voluntary/involuntary anal wink may take place at this point if competent to do so.
- Lubricate a gloved index finger, advise the patient that you are about to begin, part the buttocks and then 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 for the patient if they are asked to talk or breath 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 seconds this will allow the anus to contract and then relax.
- Also assess the external sphincter tone by asking the patient to squeeze upwards and hold. Ask the patient to push down to assess for relaxation on straining and coordination issues.
- 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.
- Prostate and advance pelvic floor assessment may also take place at this point, if competent to do so.
- Withdraw finger (observing for presence of blood on gloves), clean perianal area of any gel/faecal matter. Remove gloves and apron (disposing of them appropriately) and then wash your hands.
- Ensure the patient's privacy, dignity and comfort at all times.
- Allow the patient to dress in private, unless they need assistance.
- Explain your findings and outcomes.
- Document all observations, findings and actions. Consider onward referral to another health care professional if there are any concerns identified on examination.

2. Procedure for digital removal of faeces (DRF)

Equipment

Procedure pad.

Disposable apron.

Non-sterile disposable gloves.

Lubricating gel.

Receptacle.

- Explain the procedure to the patient 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) above T6, observe the patient throughout the procedure for signs of autonomic dysreflexia. Blood pressure and pulse should be taken.
- When carrying out this procedure the patient should ideally be lying in a left lateral position, as it follows the natural anatomy of the bowel and the perianal area can be visualized easily.
- Place protective pad under the patient if appropriate.
- Wash hands, put on disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure, local anaesthetic gel may be instilled into the rectum prior to the procedure (Neuro Advisory Board, 2019). It should also be considered if DRF is undertaken as an acute intervention but long-term use should be avoided due to systemic effects (BNF, 2018).
- Allow enough time for the local anaesthetic gel to take effect before proceeding (follow manufacturer's instructions).
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert gloved lubricated finger slowly and gently into rectum.
- With the pad of the finger against the stool, slowly rotate and remove finger to expel the stool from the rectum.
- Where stool is hard, impacted and difficult to remove, other approaches should be employed in combination with digital removal of faeces.
- If the stool is soft, continuous gentle circling of the finger may be used to remove the stool.
- Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – 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.
- During the procedure the person delivering care may carry out abdominal massage, as part of a planned programme of care.
- Once the rectum is empty on examination, after five minutes conduct a final digital check of the rectum to ensure that evacuation is complete.
- Place faecal matter 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 with reference to the amount and consistency using the Bristol stool form chart.
- Assess for external voluntary contraction of the anus and for reflex contraction of the anal sphincter (may be referred to as anal wink).

3. Procedure for digital rectal stimulation (DRS)

Equipment

Procedure pad.

Disposable apron.

Non-sterile disposable gloves.

Lubricating gel.

Receptacle.

- 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) above T6, 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 be viewed.
- Place protective pad under the patient if appropriate.
- Wash hands, put on a pair of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure, local anaesthetic gel may be instilled into the rectum before beginning, allowing enough time for it to take effect before proceeding (follow manufacturer's instructions).
- Long-term use should be avoided due to systemic effects (BNF, 2018).
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Gently part the buttocks and insert a single, 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 to 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 matter 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 with reference to the amount and the Bristol stool form chart.
- Document and report abnormalities.

4: Procedure for administration of suppositories (following DRE)

Equipment

Prescription and medication recording sheet.

Prescribed suppository.

Disposable apron.

Non-sterile disposable gloves.

Procedure pad.

Paper tissue.

Water based lubricating jelly/water.

Disposal bag.

Bed pan/commode/access to toilet.

- Check the prescription details. Ensure the suppository is within the expiry date and the packaging is intact.
- Establish that the patient has no known allergies
- Explain the procedure to the patient.
- Obtain informed consent and document in nursing notes.
- Ensure privacy and dignity is maintained at all times.
- Read manufacturer's instructions for use, preparation and mode of action (evacuant or retention) of suppository.
- Give the patient the opportunity to empty their bladder.
- A bedpan, commode or toilet should be readily available.
- Ask the patient to remove clothing from the waist down and cover. Offer assistance if required.
- Ask the patient to lie in the left lateral position with knees flexed (if possible) to enable easy passage of suppository into the rectum by following natural anatomy of the colon.
- Wash hands and apply gloves and apron.
- Place a protective pad under the patient's hips and buttocks.
- Explain to the patient that you will be inserting the suppository.
- Lubricate the suppository as per manufacturer's instructions.
- Part the buttocks and gently insert the suppository as per mode of action.
- Repeat this procedure if a second suppository is to be inserted.
- Dry the perianal area of the patient with tissue and place in disposal bag.
- Ask the patient to retain the suppository/suppositories as per manufacturer's instructions. Allowing time for the suppository to dissolve and release its active ingredients.
- Ensure the patient has access to a call bell, toilet/commode/bed pan facilities.
- Remove gloves and apron, disposing as per local guidelines and wash hands.
- Inform/discuss the outcome of the intervention with the patient.
- Document in nursing notes:
 - observations and findings
 - outcome of intervention
 - stool type using Bristol stool form chart
 - ongoing treatment/management
 - any referral made.

5: Procedure for administration of enemas (following DRE)

Equipment

Prescription and medication recording sheet.

Prescribed enema.

Disposable apron.

Non-sterile disposable gloves.

Procedure pad.

Paper tissue.

Lubricating jelly – water based.

Disposal bag.

Bed pan/commode/access to toilet.

Jug.

- Check the prescription details. Ensure the enema is within the expiry date and the packaging is intact.
- Establish that the patient has no known allergies.
- Explain each step of the procedure to the patient, including potential risks and complications, and the benefits.
- Obtain informed consent and document in nursing notes.
- Ensure privacy and dignity is maintained at all times.
- Read manufacturer's instructions for use, preparation and mode of action (evacuant or retention) of suppository
- Offer the patient the opportunity to empty their bladder.
- A bedpan, commode or toilet should be readily available.
- Ask the patient to remove clothing from the waist down and cover. Offer assistance if required.
- Ask the patient to lie in the left lateral position with knees flexed (if possible) to enable easy passage of enema into the rectum by following natural anatomy of the colon.
- Wash hands and apply gloves and apron.
- Prepare the enema (if instructed to warm) in accordance with manufacturer's instructions.
- Place lubricating gel on full length of enema nozzle.
- Expel excessive air from enema prior to administration.
- Gently introduce the nozzle to the depth recommended by the manufacturer and slowly introduce contents.
- Once instilled, slowly withdraw the nozzle to avoid a reflex emptying of the bowel.
- Dry the perianal area of the patient with tissue and place in disposal bag.
- Ask the patient to retain the enema for 10 to 15 minutes before evacuating the bowel.
- Ensure the patient has access to a call bell, commode/bedpan/toilet.
- Remove gloves and apron, disposing as per local guidelines and wash hands.
- Inform/discuss the outcome of the intervention with the patient.
- Document in nursing notes:
 - observations and findings
 - outcome of intervention
 - stool type using Bristol stool form chart
 - ongoing treatment/management
 - any referral made.

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Useful resources and organisations

Age UK

Travis House, 1-6 Tavistock Square
London WC1H 9NA
Tel: 0800 0556112
www.ageuk.org.uk

Alzheimer's Society

43-44 Crutched Friars
London EC3N 2AE
Tel: 0330 333 084
www.alzheimers.org.uk

Association of Continence Advice (ACA)

Fitwise Management Ltd, Blackburn House
Redhouse Road, Seafield, Bathgate
West Lothian EH47 7AQ
Tel: 01506 811077
www.aca.uk.com

Bladder and Bowel UK

Burrows House
10 Priestley Road, Wardley Industrial Estate
Worsley, Manchester M28 2LY
Tel: 0161 607 8219
www.bbuk.org.uk
(Offer free Just Can't Wait Toilet Cards)

Bowel Cancer UK

Unit 202 Edinburgh House, 170 Kennington Lane
London SE11 5DP
Tel: 020 7940 1760
www.bowelcanceruk.org.uk

British Toilet Association

Enterprise House 2-4 Balloo Avenue
Bangor, Co Down
Northern Ireland BT19 7QT
Tel: 02891 477397
www.btalooos.co.uk

Disabled Living Foundation

Unit 1, 34 Chatfield Road
London SW11 3SE
Tel: 020 7289 6111
www.dlf.org.uk

Disabled Living

Burrows House
10 Priestley Road, Wardley Industrial Estate
Worsley, Manchester M28 2LY
Tel: 0161 607 8200
www.disabledliving.co.uk

IBS Network

Unit 1.16 SOAR Works
14 Knutton Road
Sheffield S5 9NU
Tel: 0114 272 3253
www.theibsnetwork.org

Macmillan Cancer Support

89 Albert Embankment
London SE1 7UQ
Tel: 020 7840 7840
www.macmillan.org.uk

Multiple Sclerosis Society

MS National Centre
372 Edgware Road,
London NW2 6ND
Tel: 020 8438 0700
www.mssociety.org.uk

National Association for Colitis and Crohn's Disease

4 Beaumont House, Sutton Road
St Albans
Hertfordshire AL1 5HH
Tel: 0845 130 2233
www.nacc.org.uk

RADAR Key Company

11-13 Church Street
Exmouth
Devon EX8 1PE
Tel: 01395 265543
www.Radrkey.org

Spinal Injuries Association (SIA)

SIA House, 2 Trueman Place
Oldbrook
Milton Keynes MK6 2HH
Tel: 0800 980 0501
www.spinal.co.uk

RCN Bladder and Bowel Forum

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www.rcn.org.uk

This publication is supported by:



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Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

September 2019
Review date: September 2022
Publication code: 007 522

