

Digital Rectal Examination and Digital Removal of Faeces For Healthcare Professionals as part of Adult Bowel Management

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

2024 review

- RCN Guidelines DRE reviewed
- RCN Guidelines for Bowel care DRE & DRF reviewed
- Policy is up to date in line with RCN guidelines
- Policy sent for circulation of MDT
- Section 5.1 added staff can request a chaperone.
- Appendix 1 section 14 added Abnormalities such as masses, bleeding, discharge or prolapse should be reported to medical staff before proceeding any further
- Added Samantha Arnull Specialist Nurse Practitioner to the policy
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KEY WORDS

Digital Rectal Examination, DRE, Digital Removal of Faeces, DRF, Bowel Management

1 INTRODUCTION AND OVERVIEW

- 1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust policy and procedures for Digital Rectal Examination (DRE) and Digital Removal of Faeces (DRF) for healthcare professionals, limited for adult patients, as part of bowel management. The document outlines the professional and legal aspects of DRE in relation to bowel management for patients and is based on standards from the Royal College of Nursing “Management of lower bowel dysfunction, including DRE and DRF” (RCN 2019) and “The Royal Marsden Management of Clinical Nursing Procedures tenth edition”. Nurses must always practise with the best available evidence, maintaining their knowledge and skills for safe and effective practice (Nursing and Midwifery Council 2015).
- 1.2 Practitioners are in a strong position to improve the management of bowel care, and by implementing simple steps, can provide patients with the appropriate advice and information about their symptoms and treatment. DRE may be used as part of an assessment to establish the presence of the stool in the rectum and to establish the appropriate treatment programme; a care plan will outline the nursing intervention required for the patient. ***Contraindications to performing DRE and DRF are considered and guidance on how to perform the DRE & DRF procedure is provided. It is important that the underlying causes for any identified bowel management dysfunction are investigated and plans made to prevent future problems or reoccurrence.
- 1.3 DRE and DRF are invasive procedures and should only be performed when necessary and after individual assessment. With advances in oral, rectal and surgical treatments in recent years, the need to use DRF has reduced but for a small group of patients e.g. patients with; spinal injuries, spinal cord lesions, neurological conditions, faecal impaction and patients in Intensive Therapy Units, Brain Injury Units, these procedures may remain a part of their bowel management or as part of acute intervention (RCN, 2019; Ness 2013).
- 1.4 The Patient Safety Alert – Resources to support safer bowel care for patients at risk of Autonomic Dysreflexia (ref number: NHS/PSA/RE/2018/005) identified that patients with spinal cord injuries dependant on DRF are at risk of developing Autonomic Dysreflexia if delays occur during admission in their bowel management regime. Please see Autonomic Dysreflexia Treatment Guideline For Adult Spinal Patients with Spinal Cord Injuries (Trust reference B1/2019)
- 1.5 Chronic Spinal Injury patients can be admitted to acute general wards, with other medical/surgical conditions, requiring continuity of their long-standing bowel management interventions such as DRF to reduce the risk of Autonomic Dysreflexia. Many of these patients will be experts in their own care and maintenance of their normal bowel regime must be facilitated and assistance provided as appropriate. For some patients, the cause of their admission may result in their normal bowel management regime needing to be amended.

2 POLICY SCOPE – WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

- 2.1 This policy applies to all adult patients (aged 18 years and older) who require a DRE.
- 2.2 This policy applies to those adult patients who require intervention to maintain regular bowel emptying and who have DRF agreed as part of their acute care management on the Spinal Injuries wards/units

- 2.3 This policy applies to adult patients (aged 18 years and older) who require DRF as part of acute intervention in faecal impaction.
- 2.4 This policy applies to patients admitted to acute adult wards requiring DRE and DRF for continuity of their long-standing bowel management.
- 2.5 This policy does not cover DRE and DRF in children.
- 2.6 This policy excludes midwives and pregnant women and digital rectal examination for perineal repair, please refer to UHL Perineal or Genital Trauma Following Childbirth UHL Obstetric Guideline (INsite Document number C99/2008)
- 2.7 The purpose of the policy is to inform staff of the expected standards of care to maintain the safety of and promote high quality care to patients requiring DRE for bowel management, which may include DRF.
- 2.8 This policy applies to medical and registered nurses and registered nursing associates who are competent and able to undertake this role, and who are employed by the University Hospitals of Leicester NHS Trust.
- 2.9 UHL is a teaching hospital and provides placement or work based learning for Pre- registration students such as Medicine, Nursing, Midwifery, Paramedic, Radiography, Physiotherapy, Occupational Therapy and Pharmacy and Trainees in the workplace such as Assistant Practitioners and Nursing Associates. This policy applies to these learners in the following circumstances:
 - a. If DRE/DRF is a specific competency requirement of their placement or programme then the pre-registration student / trainee is able to perform the skill under direct supervision of their mentor / supervisor once they have received the relevant underpinning theory and passed a simulated practice
 - b. If the pre-registration student / trainee has passed an LCAT competency assessment in practice they may be able to perform the skill with indirect supervision at the discretion of their mentor / supervisor and the Registered Professional delegating the task.
 - c. If DRE/DRF is not a specific competency requirement of their placement or programme then the pre-registration student / trainee must only participate in the process as an observer.
 - d. Please also see section 6 for education and training requirements

3 DEFINITIONS AND ABBREVIATIONS

- a. Anal tone - is the continuous and passive partial contraction of the anal sphincter muscles, or the muscle's resistance to passive stretch during resting state
- b. Bowel management – the medical intervention to manage constipation or faecal incontinence
- c. DRE - Digital Rectal Examination – the examination of the rectum with a finger
- d. DRF - Digital Removal of Faeces – the removal of faeces from the rectum with a finger
- e. LCAT – Leicester Clinical procedure Assessment Tool
- f. UHL - University Hospitals of Leicester NHS Trust

4. ROLES – WHO DOES WHAT

4.1 Executive lead

The Chief Nurse is the Board Director with lead responsibility for this policy

4.2 Clinical Directors, General Managers and Heads of Nursing are the leads for disseminating the policy to staff within their Clinical Management Groups

4.3 The Spinal Injury Nurses will provide training and day to day advice and support where concerns are raised about the ongoing management of patients requiring DRF

4.4 The Continence Nurse Specialists will provide training and day to day advice and Support where concerns are raised about the ongoing management of patients requiring DRE

4.5 Line Managers are responsible for:

- a. Completing a training needs analysis to identify where DRE and DRF training is a requirement
- b. Ensuring all their staff trained in DRE and DRF are aware of their responsibilities regarding these procedures
- c. Identifying and supporting staff to attend the necessary training and complete the assessment of competence in practice
- d. Maintaining HELM records for staff who are competent in DRE and DRF, ensuring that numbers of staff trained meet service need
- e. Ensuring that staff competent in DRE and DRF provide evidence of maintaining their knowledge and skills in the procedure as part of the appraisal process

4.6 Staff who perform DRE

- a. Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role as identified at their appraisal
- b. Have undertaken appropriate education and training in DRE
- c. Be assessed as competent in performing the procedure within their clinical area by an LCAT assessor
- d. Adhere to the clinical care requirements set out in this policy
- e. Must update themselves on any changes in the policy and procedures
- f. Must update themselves on the policy and procedures if they last performed DRE more than 36 months ago – if further support is required, to contact their education team

4.7 Staff who perform DRF

- a. Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role as identified at their appraisal
- b. Have undertaken appropriate education and training in DRF
- c. Be assessed as competent in performing the procedure within their clinical area by an LCAT assessor
- d. Adhere to the clinical care requirements set out in this policy
- e. Must update themselves on the policy and procedures if they last performed DRF more than 36 months ago – if further support is required, to contact their education team

- f. Staff outside of adult trauma orthopaedic units may only come into infrequent contact with chronic spinal cord injury patients requiring DRF. These patients need to be assessed by the Spinal Cord Injury Nurse and DRF performed as per patient care plan Staff can then perform DRF as part of a patient's regular bowel management, if they are already competent in DRE and following training from a LCAT assessor competent in DRF
- g. Patients with chronic spinal cord injury who are admitted to wards/units outside of Spinal Injury wards/units and require DRF as part of their long-standing bowel management regime must be referred to the Spinal Injury Team.
- h. Due to the irregularity of this cohort of patients being on the general wards, nurses on the ward who have completed DRE training & competencies will be taught and assessed for DRF as per appendix 3.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS – WHAT TO DO AND HOW TO DO IT

5.1 Patient Capacity, Consent and Choice

- a. Valid consent must be obtained prior to performing the procedure. Patients must be informed, and involved, with the decisions regarding their care. Refer to trust Information about the procedure must be given to the patient in a way they will understand. [Consent to Examination or Treatment UHL Policy \(Includes consent for Photography\) \(A16/2002\)](#)
- b. The dignity and respect of the patient must be considered at all times including religious and cultural beliefs. DRE is an invasive procedure and should only be performed when necessary, after individual assessment and it is vital to check for allergies prior to undertaking this procedure
- c. Patients should be informed that they and staff have the right to request a chaperone when undergoing this procedure. If a chaperone cannot be provided, the patient must be informed and asked if they wish to continue with the procedure. [Chaperone Policy \(Trust Reference B39/2008\)](#)
- d. When a patient's capacity to consent to DRE / DRF is in doubt, the healthcare professional must undertake a formal mental capacity assessment, in accordance with the Trust [Mental Capacity Act Policy \(B23/2007\)](#). If the patient is deemed to lack capacity to consent to DRE/DRF then the appropriate healthcare professional must decide if it is in the patient's own best interests to undergo DRE/DRF The best interest decision must be made and recorded in accordance with trust policy and reflected within the patient's individual plan of care
- e. If it is deemed to be in the person's best interests to undergo DRE/DRF then the Mental Capacity Act permits the use of proportionate restraint, provided

that the healthcare professional reasonably believes that restraining the person without capacity is necessary in order to prevent them coming to harm. Any restraint must be reasonable and in proportion to the potential harm that may be caused to the incapacitated person if restraint is not used. This must be discussed with the Consultant in charge of the person's care before performing DRE/DRF. Specific guidance about using appropriate restraint can be found in the Trust's restraint guidance which is located within the Trust's Violence and Aggression Policy. Advice can also be sought from the Trust's Adult Safeguarding service on ext. 17703 or adultsafeguarding@uhl-tr.nhs.uk

5.2 Digital Rectal Examination

5.2.1 Indications for performing DRE for bowel management

DRE can be used as part of a clinical assessment as part of a bowel care assessment. Patient history and stool charts should form part of a bowel assessment. DRE should not be used as a first line investigation into the assessment and treatment of constipation.

DRE can be used to establish the following:

- a. The presence of faecal matter in the rectum, the amount and consistency
- b. Faecal loading/impaction
- c. Presence of anal tone and the ability to initiate a voluntary contraction and to what degree
- d. The need for and type of rectal medication in certain circumstances
- e. The efficacy of enemas, rectal irrigation/washouts in certain circumstances
- f. The outcome of rectal/colonic washout/irrigation if appropriate

5.2.2 Contraindications for performing DRE

DRE should not be undertaken if:

- a. The medical staff have given specific instructions that this procedure is not to take place
- b. Patient consent has not been gained – where the patient is able to give own consent to undergo DRE, the procedure should be explained in full, the need for the procedure and that consent has been gained, should form part of the care plan and be documented on EVERY occasion. If the patient is unable to consent, staff should refer to the [Mental Capacity Act Policy \(B23/2007\)](#)
- c. Febrile/septic neutropenic patients

5.2.3 Circumstances when caution needs to be applied – consult with patient's doctor before proceeding DRE

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

- d. Rectal surgery or trauma to the anal or rectal area (in the last 6 weeks)
- e. Tissue fragility due to age, radiation, or malnourishment
- f. Obvious rectal bleeding – consider possible causes for this
- g. A known history of abuse
- h. Spinal Cord Injury patients with an injury at or above the sixth thoracic vertebra due to the risk of autonomic dysreflexia (see appendices 1 & 2)
- i. Stable neutropenic or thrombocytopenic patients
- j. If the patient is unable to consent, and it is felt to be in the patient's best interest, staff should refer to the UHL Consent Policy and discuss with the multi-disciplinary team
- k. If patient has known history of allergies such as latex

5.3 Digital Removal of Faeces

5.3.1 Indications for performing DRF

- a. When other methods of bowel emptying fail or are inappropriate
- b. Faecal impaction or loading when all methods of bowel emptying have failed or are inappropriate
- c. Incomplete defecation
- d. Inability to defecate
- e. Neurogenic bowel dysfunction
- f. In many patients with spinal cord injury, DRF is an integral part of their routine:
 1. In the early acute phase after spinal cord injury to remove stool from the areflexic rectum to prevent over-distension with consequent damage to later reflex rectal function
 2. A necessary intervention for a majority of chronic spinal cord injured individuals, as part of a well-structured bowel management programme
 3. As a method of choice for long-term bowel evacuation in individuals with areflex bowel dysfunction
 4. Maybe used for removal of stool prior to placing suppositories/enemas in individuals with reflex bowel or to complete evacuation where reflex activity alone is insufficient to empty the bowel

5.3.2 Contra-indications for performing DRF

See contraindications for performing DRE see section 5.2.2

5.3.3 Circumstances when caution needs to be applied – consult with patient's doctor before proceeding DRF

- a. Tetraplegia and higher paraplegia patients will not feel any pain when DRF is performed and will be at risk of acute autonomic dysreflexia refer to the Autonomic Dysreflexia Treatment Guideline For Adult Spinal Patients with Spinal Cord Injuries (Trust reference B1/2019)
- b. Chronic spinal cord injury/neurogenic bowel dysfunction patients may require DRF as part of their normal bowel management regime. Many individuals with neurogenic bowel dysfunction are experts in their own care and maintenance of an existing effective bowel management programme

- c. Should be facilitated. The regime may need to be amended due to a change in the medical or physical condition of the patient which will require expert advice/assessment
 - d. Patients with chronic spinal cord injury who are admitted to wards/units outside of Spinal Injury wards/units and require DRF as part of their long-standing bowel management regime must be referred to the Spinal Injury Team.
 - e. Due to the irregularity of this cohort of patients being on the general wards, nurses on the ward who have completed DRE training & competencies will be taught and assessed for DRF as per appendix 3.
- 5.4 Procedures that support this policy are attached as the following appendices and must be used by all staff within the scope of this policy

Procedure / Process / Standard	Appendix
Digital Rectal Examination	1
Digital Removal of Faeces for Spinal Injury Patients	2
Faecal loading/Faecal Impaction- definition	3
Faecal loading/Faecal Impaction- guidelines for treatment	4
Bristol Stool Chart	5
Adult Bowel Care Pathway	6
DRE completion sticker	7

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Digital Rectal Examination (DRE) for bowel management

- 6.1.1 Medical Staff receive training on how to perform a digital rectal examination pre-registration. This training also incorporates the use of DRE for other assessment and diagnostic purposes. Medical staff are not required to undertake further training unless they have not had this in their pre-registration course
- 6.1.2 Registered Nurses and Registered Nursing Associates
- a. Complete the Trust competency based training and assessment programme, including the learning workbook. Training is provided at local level following a training needs analysis, please see section 4.5a.
 - b. Have completed a period of supervised practice, the time span of which will be agreed by the assessor but to be completed within 6 months.
 - c. Have evidence of assessment and competency signed by an appropriate / LCAT assessor.
 - d. Accept responsibility for updating knowledge and skills and provide evidence of this as agreed with line manager as part of the appraisal process.
 - e. Those staff already performing DRE should ensure that they are up-to-date on current evidence based practice and undergo a one off assessment by an LCAT assessor experienced & competent in DRE.
 - f. Management of the Bowel can be found in appendix 6.

6.2 Removal of Faeces

- 621 All Medical and Registered Nurses and Registered Nursing Associates who undertakes DRF must:
- a. Complete the Trust competency based training and assessment programme including the learning workbook. Training is provided at local level following a training needs analysis, please see section 4.5a.
 - b. Have completed a period of supervised practice, the time span of which will be agreed by the assessor but to be completed within 6 months.
 - c. Have evidence of assessment and competency signed by an appropriate / LCAT assessor.
 - d. Accept responsibility for updating knowledge and skills and provide evidence of this as agreed with line manager as part of the appraisal process.
 - e. Those staff already undertaking and performing DRF should ensure that they are up-to-date on current evidence based practice and undergo assessment by an LCAT assessor experienced & competent in DRF
- 622 Staff who perform DRF as part of the spinal injury patient's long-standing chronic bowel management must refer to the Autonomic Dysreflexia Treatment Guideline for Adult Patients with Spinal Cord Injuries (Trust Ref: B1/2019)
- a. Ensure the patient is known to Spinal Injury Team to agree treatment regime and plan of care
 - b. Seek advice from Spinal Injury Team if agreed treatment regime is ineffective or patient's condition changes
 - c. Already be competent in DRE
 - d. Undertake competency based training and assessment on DRF
 - e. Have completed a period of supervised practice with a LCAT assessor competent in DRF
 - f. Have evidence of assessment and competency for that patient's bowel management signed by an appropriate / LCAT assessor
- 623 Staff who perform DRF as part of the treatment for faecal impaction must:
- a. Ensure the patient has been reviewed by medical staff to agree DRF treatment and plan of care
 - b. Already be competent in DRE
 - c. Already have completed a period of supervised practice and have evidence of assessment and competency of DRF signed by an appropriate LCAT assessor
 - d. Accept responsibility for updating knowledge and skills and provide evidence of this as agreed with line manager as part of the appraisal process
- 6.3 Staff new to the Trust and/or who have been trained elsewhere must:
- a. Provide evidence of the training and assessment programme they have successfully completed
 - b. Read the relevant Trust policies and undertake additional training relating to DRE and DRF and documentation as required
 - c. Undertake a practical assessment by an appropriate/LCAT assessor within own directorate/ward/unit. DRE training and LCAT competencies are available within University Hospitals of Leicester NHS Trust. Staff who have trained in DRE/DRF outside of UHL or feel that their practice is out of date

need to arrange for their competencies to be checked prior to performing DRE/DRF

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to
Number of staff trained and competent in DRE	Continence Nurse Specialist	HELM	report from HELM annually	Reported to line manager for information and action as required
Investigate incidents/complaints associated with DRE/DRF	Line manager	Investigate incidents/complaints	Datix incident reporting system	Complete Datix reporting system. Report concerns to patient safety team by completing a serious untoward incident checklist

8 EQUALITY IMPACT ASSESSMENT

- 8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
- 8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

- a. Dougherty, L. Lister, S & West-Oram, A (2015) Chapter 5 Elimination: Digital Rectal Examination in: Royal Marsden Hospital Manual of Clinical Nursing Procedures, Ninth Edition. Accessed on Trust Internet. Accessed on trust Internet [Home - Royal Marsden Manual \(rmmonline.co.uk\)](http://Home - Royal Marsden Manual (rmmonline.co.uk) 02/10/18) 02/10/18
- b. Dougherty, L. Lister, S & West-Oram, A (2015) Chapter 5 Elimination: Digital Rectal Examination: Procedure Guideline 5.20 : in: Royal Marsden Hospital Manual of Clinical Nursing Procedures, Ninth Edition. Accessed on Trust Internet [Home - Royal Marsden Manual \(rmmonline.co.uk\)](http://Home - Royal Marsden Manual (rmmonline.co.uk) 02/10/18) 02/10/18
- c. Kyle, G. (2011) Digital rectal examination. Nursing Times, 107(12), 18–19.
- d. Ness, W. (2013) Management of lower bowel dysfunction. Primary Health Care 23(5), 27-30
- e. RCN (2019) Management of Lower Bowel Dysfunction, including DRE and DRF:

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Available at: e. [Professional Development | Royal College of Nursing \(rcn.org.uk\)](https://www.rcn.org.uk/professional-development)
Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions (2012) Initiated by Multidisciplinary Association of Spinal Cord Injury Professionals. Available at <https://www.mascip.co.uk/wp-content/uploads/2015/02/CV653N-Neurogenic-Guidelines-Sept-2012.pdf>

- f. NHS England (2018) Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care. Available at <https://www.england.nhs.uk/wp-content/uploads/2018/07/excellence-in-continence-care.pdf>
- g. Nursing and Midwifery Council (2018) Future nurse: Standards of proficiency for registered nurses. NMC. Available at <https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf>
- h. Patient Safety Alert – Resources to support safer bowel care for patients at risk of Autonomic Dysreflexia (ref number: NHS/PSA/RE/2018/005)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

- 10.1 This document will be reviewed every 3 years, or sooner in response to reported risks or incidences
- 10.2 The updated version if the policy will then be uploaded and available through INSite Documents and the Trusts externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

No	Action	Rationale
1.	Check that there are no contraindications or cautions to performing the procedure – if there is, discuss with the patient’s doctor.	To protect patient from unnecessary harm
2.	Explain and discuss the procedure with your patient. Include the risks and benefits of the procedure	To gain co-operation from the patient To ensure that the patient understands the procedure and gives his/her valid consent.
3.	Clarify if the patient requires a chaperone If there are any patient concerns staff can also ask for a chaperone.	To provide patient choice and protect patient dignity
4.	Ensure privacy at all times	To avoid unnecessary embarrassment to your patient
5.	Encourage your patient to empty their bladder if appropriate	To reduce any discomfort during the procedure
6.	Take pulse and blood pressure reading prior to the procedure for patients with spinal cord injury patients who are at risk of AD i.e. T6 and above.	To provide baseline reading for comparison. In spinal cord injury, stimulus below the level of injury may result in symptoms of AD including headache and hypertension For such patients where this procedure is routine and tolerance is well established, this <i>may</i> not be required.
7.	Prepare your equipment and bed / couch area. Equipment as follows: <ul style="list-style-type: none"> • Latex free gloves • Apron • Lubricating gel • Gauze squares, tissues or dry wipes • Bed protection 	
8.	Observe the patient throughout the procedure and STOP if any of the following occur: <ul style="list-style-type: none"> • The patient asks you to • There is anal bleeding • Pain persists 	To ensure consent is maintained To protect patient from harm

No	Action	Rationale
	<ul style="list-style-type: none"> Patients at risk of AD complain of headache or have changes in pulse or blood pressure. 	
9.	Assist the patient to lie in the left lateral position with knees flexed, ideally with the buttocks towards the edge of the bed.	This allows ease of digital insertion into the rectum, by following the natural anatomy of the colon (RCN 2012). Flexing the knees reduces discomfort as the finger passes the anal sphincter (Kyle et al. [112], C).
10.	Hand hygiene as per Trust policy and put on pair of disposable latex free gloves and apron. Place disposable bed protection beneath the patient's hips and buttocks.	For infection prevention & to reduce risk of allergic reaction to latex. To avoid embarrassing the patient if faecal staining occurs during or after the procedure.
11.	Place some lubricating gel on a gloved index finger.	To minimize discomfort as lubrication reduces friction and to ease insertion of the finger into the anus/rectum. Lubrication also helps minimize anal mucosal trauma (Kyle et al. 2011)
12.	Inform the patient that you are to begin and that you will be looking and examining the outer and internal area.	Assists with patient co-operation with the procedure
13.	Examine the perianal area for faecal matter, lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood.	Abnormalities such as masses, bleeding, discharge or prolapse should be reported to medical staff before proceeding any further
14.	Palpate the perianal area starting at 12 o'clock, clockwise to 6 o'clock and then from 12 anticlockwise to 6 o'clock.	To assess for any irregularities, swelling, indurations, tenderness or abscess in the perianal area. Abnormalities such as masses, bleeding, discharge or prolapse should be reported to medical staff before proceeding any further
15.	Insert the finger into the anus and on into the rectum slowly and encourage patient to relax – use one finger only. Continue to monitor patient	Patients with neurological conditions may have reduced sensation and may not experience pain.
16.	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.	May establish loaded rectum and indicate constipation; helps in establishing the need of rectal medication; softener or stimulant or the need of digital removal of faeces.

17.	Assess patient's voluntary anal squeeze by asking the patient to use their anal muscles to squeeze your finger. This should be described as none, poor, moderate or strong. If competent and required, relaxation and push effort can be testes and recorded.	This assists in determining the patient's ability to control their bowels.
18.	Clean anal area after the procedure.	To prevent irritation and soreness occurring. Preserves patient dignity and personal hygiene.
19.	Remove gloves and apron and dispose of equipment in appropriate clinical waste bin. Hand hygiene as per Trust policy	For infection prevention.
20.	Position patient comfortably or assist to dress as appropriate. For inpatients, document repositioning on BEST SHOT chart and repositioning chart.	Preserves patient dignity As part of Tissue Viability pressure ulcer prevention programme.
21.	Document findings on the DRE sticker and report to appropriate members of the multidisciplinary team.	To ensure continuity of care and ensure appropriate corrective action may be initiated

No	Action	Rationale
1.	<p>Confirm appropriateness of procedure for patient in accordance of the patient's notes and current plan.</p> <p>Confirm that you are capable and confident in your ability to undertake this procedure safely</p>	To maintain patient safety
2.	<p>Explain and discuss the procedure with the patient.</p> <p>Include the risks and benefits of the procedure</p>	<p>To gain co-operation from the patient</p> <p>To ensure that the patient understands the</p>
3.	The patient should be asked if they wish to have a chaperone	To provide patient choice and protect patient's dignity
4.	Ensure privacy at all times	To avoid unnecessary embarrassment to the patient
5.	Take pulse and blood pressure reading prior to the procedure for patients with Spinal Cord Injury above T6. These group of patients are high risk of Autonomic Dysreflexia	<p>To provide baseline comparison</p> <p>In spinal cord injury patients, DRE can stimulate the vagus nerve and can cause bradycardia. Painful stimulus below T6 lesion can cause Autonomic Dysreflexia</p>
6.	<p>Ensure that all equipment and bed area are prepared</p> <p>Equipment as follows:</p> <ul style="list-style-type: none"> • Latex free gloves • Apron • Lubricating gel • Disposable Bed protection • Gauze swabs, tissues or dry wipes • Clinical Waste Bag (orange bag) 	To maintain hygiene care
7.	<p>Observe the patient throughout the procedure and STOP if any of the following occur:</p> <ul style="list-style-type: none"> • The patient asks you to • There is anal bleeding 	<p>To ensure that consent is maintained</p> <p>To protect patient from any</p>

	<ul style="list-style-type: none"> • Pain persists • SCI patients with lesion above T6 starts to complain of headache or have changes in pulse and blood pressure 	harm
8.	<p>Assist patient to lie in the left lateral position with knees flexed, ideally with the buttocks towards the edge of the bed</p> <p>UNSTABLE SPINAL INJURY- Bowel management will be conducted during a team roll, maintaining spinal alignment at all times</p>	This allows ease of digital insertion into the rectum, by following the natural anatomy of the colon. Flexing the knees promotes stability of the patients and helps to expose the anus. It also reduces discomfort as the examining finger passes the anal sphincter
9.	<p>Wash hands as per Trust Hand Hygiene Policy</p> <p>Wear protective apron and latex free gloves</p> <p>Place protective pad under the patient if appropriate</p>	<p>For prevention of infection</p> <p>To avoid embarrassing the patient if faecal staining occurs during or after the procedure</p>
10.	<p>If patient suffers local discomfort or autonomic dysreflexia during the procedure, 2% lignocaine anaesthetic gel (instillagel) (unless contraindicated e.g. lignocaine allergy) may be applied prior to the procedure. It should also be considered if this is undertaken as an acute intervention. This requires five-minutes to take effect and lasts up to 90 minutes. Note that long term should be avoided due to systemic effects</p> <p>Inform patient that you are about to begin with the procedure</p>	<p>To minimise discomfort as lubrication reduces friction and to ease insertion of the finger into the anus/rectum</p> <p>To gain patient's cooperation and ensures that patient is ready & relaxed</p>
11.	<p>Observe the perianal area for lesions, such as skin tags, external haemorrhoids, fistula, tumours, warts infestation, foreign body, prolapsed mucosa, wounds, faecal matter, mucous or blood. Observe for any skin redness or excoriation.</p>	<p>Excoriation may indicate incontinence or pruritus. Swelling may be indicative of possible abscess. Anal-rectal abnormalities should be reported to the medical staff before continuing with the procedure</p>
12.	<p>Lubricate gloved finger with water soluble gel</p> <p>Inform patient you are about to begin</p>	<p>To minimise discomfort</p> <p>Lubrication reduces friction and to ease insertion of the finger into the anus/rectum</p> <p>To gain co-operation from the patient</p>
13.	<p>Insert a single, double-gloved lubricated finger slowly and gently into the rectum</p> <p>Note any resistance or reflex contraction of anal</p>	<p>Gentle insertion and removal of the finger utilising appropriate and sufficient lubrication will</p>

	sphincter	reduce the potential occurrence of autonomic dysreflexia
14.	<p>If stool is a solid mass, push finger into the centre, split it and remove small sections until none remain.</p> <p>If stool in separate hard lumps, remove lump at a time.</p> <p>Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces</p> <p>If the rectum is full of soft stool, continuous gentle circling of the finger maybe used to remove stool: this is still digital removal of faeces</p>	<p>Great care should be taken to remove stool in such a way to avoid damage to the rectal mucosa and anal sphincters.</p> <p>Do not over stretch the sphincters by using a hooked finger to remove large pieces of hard stools which may also graze the mucosa</p> <p>Using hooked finger can lead to scratching or scoring of the mucosa and should be avoided</p>
15.	During the procedure, the person delivering care may carry out abdominal massage	To aid with defecation and bowel transit
16.	Once the rectum is empty on examination, conduct a final digital check of the rectum after 5 minutes	To ensure that evacuation is complete
17.	Place faecal matter in an appropriate receptacle as it is removed, and dispose of it in a suitable clinical waste bag	To adhere to Infection Prevention Policy
18.	When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving	To maintain patient's dignity, comfort, hygiene and skin integrity
19.	Remove gloves and apron and perform hand hygiene as per UHL trust policy	To adhere to Trust hand hygiene and infection prevention policies
20.	Record outcome using the Bristol Scale	To effectively monitor bowel patterns
21.	Record and report any abnormalities to medical staff	To ensure continuity of care For appropriate action to be taken

Faecal Impaction - is a solid, immobile compacted bulk of faeces that can develop in the rectum as a result of chronic constipation. It is hard and dry stool which the patient cannot pass naturally. It can usually be felt on digital rectal examination or palpitation of the abdomen. Radiological investigations can also be considered if obstruction is suspected.

Faecal loading - is the retention of large volumes of faeces of any consistency along the length of the colon. It can be in the rectum but can be higher. It may be felt on digital rectal examination or palpitation of the abdomen. Radiological investigations can also be considered if obstruction is suspected.

Overflow (bypass) incontinence - leakage of loose stools around impacted faeces

Guidelines for treating Adult Faecal Loading/ Faecal Impaction

Caring at its best

Acute Medical Wards

GUIDELINES FOR TREATING FAECAL IMPACTION/LOADING (alongside clinical judgement)

SIGNS OF FAECAL IMPACTION / LOADING

can include, but not exclusive to the following:

- BNO for ≥ 3 days +/- faecal smearing
- Suspect overflow "diarrhoea" if Type 6/7 stool – little & often
- Frequent requests to open bowels but passing little
- Change in stool type from hard to liquid

ASSESSMENT MUST INCLUDE:

- History & **Red Flags**
- Review of stool chart
- Digital Rectal Examination (DRE) /between (DRE) Per Rectum examination (PR) to establish stool type & volume
- Palpation of abdomen
- Bowel obstruction? – Abdominal x-ray/colonogram

RECTUM LOADED WITH SOFT STOOLS

- Dependent on stool volume:
 - **Suppositories** (Biscodyl or Glycerine),
 - **Micro enemas or Phosphate enema** (caution in frail & older people/ patients with dehydration & renal impairment)
- Sit out on toilet/commode
- Consider adding oral stimulant laxative such as Senna or bisocodyl

RECTUM LOADED WITH HARD STOOLS

- **Abdomen soft**
Add oral softener laxative – Macrogol x 1 sachet BD (if patient unable to drink large volumes consider Lactulose)
- **Hard stools palpated in abdomen**
consider Macrogol challenge (see below)
- **If rectum impacted with solid hard stool**
consider Arachis Oil enema (check for nut allergy) – ideally administer overnight

MACROGOL CHALLENGE

- **Day 1** Macrogol: x 1 sachet QDS
- **Day 2** PR/DRE - If bowels not clear:
Macrogol: x 6 sachets 1 litre of water, given over 6 hours
- **Day 3** PR/DRE - If bowels not clear:
Macrogol: x 8 sachets 1 litre of water, given over 6 hours

Sit patient on toilet/commode daily
PR/DRE - If bowels still not clear: **refer to Continence Team**
As stools become softer, consider adding enemas

DIGITAL REMOVAL OF FAECES (DRF)

You may have to gently remove some faeces to insert suppository/enema
DRF for bowel clearance **ONLY** to be performed:

- as a last resort when all other of the above methods have proved to be ineffective or are unsuitable
- by a HCP trained/competent in DRF (consider referral to Continence Team)
- if satisfied it is safe to do so

Consider consultation with Surgical On-Call if any concerns

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Bristol Stool Scale

Bristol Stool Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely liquid

The Bristol Stool Scale

A team of gastroenterologists from Bristol devised a stool classification scale in 1997, which defines 7 different types of bowel motion. (See the chart left)

Types 1 & 2 are abnormally hard (i.e. constipation) and result from a slow bowel transit time.

Types 3 & 4 are described as “perfectly normal bowel motions.”

Type 5 is poorly formed, soft and verging on abnormal.

Types 6 & 7 are abnormally loose (i.e. diarrhoea).

Types 1, 2, 6 and 7 are considered abnormal and suggest a current bowel problem or increased risk of developing one in the future.

Patients who have not had their bowels open for at least 3 days or are passing types 1 or 2 stool may need pro-active intervention to reduce the risk of faecal impaction.

Nursing: complete the core nursing assessment for elimination to help you identify the following

Medical Assessment

Type	Symptoms	Care / Management	Medical Assessment
Constipation Bowels not open for over 3 days or producing a Type 1-2 stool	<ul style="list-style-type: none"> Bowels not open for over 3 days. Stool Type 1-2 (See Bristol Stool Chart). Sensation of incomplete bowel emptying. Faecal Incontinence/Smearing. 	<ul style="list-style-type: none"> Assess and identify normal bowel habits – frequency, stool type (NerveCentre). Digital Rectal Examination - Assess stool type and amount. Post-void Bladder scan to assess for urinary retention. Offer the toilet at social times, after waking, pre-meals and bedtime. Ensure privacy and dignity when toileting. Monitor and document bowel pattern on Stool chart daily (including stool type, amount and if BNO). Ensure high fibre diet (Refer to Dietitian if necessary). Ensure adequate hydration 1.5-2 litres a day (unless Medics state otherwise). Administer laxatives as prescribed and monitor effects. Encourage mobility to promote bowel motility. Skin Care – Clinisept wipes and lowest absorbency pad if faecally incontinent. Change pad immediately after each episode of faecal incontinence. Implement any long term bowel management plan that exists if patient is chronically constipated. Refer to Adult Continence Team/Stoma Nurse/Spinal Nurses as appropriate 	<p>Red Flag Symptoms? Blood in stools, change in bowel habits over the last two weeks, significant unintended weight loss.</p> <p>Digital Rectal Examination – Assess stool type, amount, tone, sensation and abnormalities.</p> <p>Physical examination – Abdomen palpation.</p> <p>Investigations:</p> <ul style="list-style-type: none"> Consider need for imaging if bowel obstruction suspected – Abdominal x-ray. Consider need for investigations – Stool sample/sigmoidoscopy/colonoscopy Rule out medical cause for bowel dysfunction – Neurological, Spinal injury, CVA, Dementia, Irritable Bowel Disease. Medications: Review medications and identify any that may cause bowel dysfunction. Treatment: Prescribe appropriate medication and monitor effects. Constipation: <ul style="list-style-type: none"> If DRE indicates hard stool in rectum - prescribe softener e.g.: Macrogol. If DRE indicates soft stool in rectum - prescribe a stimulant e.g.: Senna, Bisacodyl, Sodium Picosulphate. A combination of a stimulant and softener may be needed. Faecal Impaction: <ul style="list-style-type: none"> Follow the Faecal Impaction Flowchart (Appendix 4 UHL DRE/DRF Policy Trust Ref B16/2008). Chronic Diarrhoea: <ul style="list-style-type: none"> Consider bulking agents such as lspaghula Husk. Consider paediatric dose of Loperimide once daily. Infected Diarrhoea: <ul style="list-style-type: none"> Infection Prevention to advise. Source isolation.
Faecal Impaction/ Loading Bowels not open for over 3 days with overflow diarrhoea	<p>Faecal Impaction:</p> <ul style="list-style-type: none"> Bowels not open for over 3 days. Chronic constipation Large amount of hard stool in rectum felt on Digital Rectal Examination. Faecal Smearing Overflow diarrhoea. <p>Faecal Loading:</p> <ul style="list-style-type: none"> Bowels not open for over 3 days. Large amount of Stool felt on Digital Rectal Examination. Stool Type - Could be any consistency. Faecal incontinence/smearing 	<ul style="list-style-type: none"> Assess and identify normal bowel habits – frequency, stool type. Offer the toilet at social times, after waking, pre-meals and bedtime. Ensure privacy and dignity when toileting. Digital Rectal Examination – assess stool and amount present) Consider Prescribing and administering enema – Hard stool: Arachis Oil Enema Soft stool: Phosphate Enema. Digital Rectal Examination - Assess stool type and amount. Post-void Bladder scan to assess for urinary retention. Consider need for Digital Removal of Faeces. Administer laxatives as prescribed and monitor effects. Consider Macrogol Challenge (see appendix 4 UHL DRE and DRF Policy Trust Ref B16/2018). Post-void Bladder scan to assess for urinary retention. Monitor and document bowel pattern on Stool chart daily (including Type, amount and if BNO). Ensure high fibre diet (Refer to Dietitian if necessary). Ensure adequate hydration 1.5-2 litres a day (unless Medics state otherwise). Encourage mobility to promote bowel motility. Skin Care – Clinisept wipes and lowest absorbency pad if faecally incontinent. Change pad immediately after each episode of faecal incontinence. Implement any long term bowel management plan that exists. Refer to Adult Continence Team/Stoma Nurse/Spinal Nurses as appropriate 	
Diarrhoea Loose stools with frequency and urgency	<ul style="list-style-type: none"> Loose stools - Type 6-7 (see Bristol Stool Chart). Frequency of bowel motions. Urgency of bowel motions accompanied with faecal incontinence. 	<ul style="list-style-type: none"> Assess and identify normal bowel habits – frequency, stool type. Offer the toilet at social times, after waking, pre-meals and bedtime and as required. Ensure privacy and dignity when toileting. Digital Rectal Examination – rule out overflow incontinence. Monitor and document bowel pattern on Stool chart daily (including stool type, amount and if BNO). Send Stool Sample for MC&S/Faecal calprotectin Test. Source Isolate patient as per Infection Prevention Guidelines. Review medication. Consider commencing anti-diarrhoeals (Loperimide) or bulk-forming agents (lspaghula Husk) and monitor effects Consider dietary advice. Skin Care – Use Clinisept wipes to cleanse skin. if a Containment device is required utilise lowest absorbency pad to minimise skin damage. Change Pad immediately after each episode of faecal incontinence. 	

Gardner6/2013/068

Discharge Planning

- Bowel Management Plan: Ensure documented on GP Discharge letter and Nursing Transfer Letters including medications and interventions that are to continue.


- Conservative Advice – Dietary/Fluid Advice
- If ongoing continence needs refer to Community Continence Team for assessment via SPA.

- Update patient and family of plans and provide SPAs contact number
- Constipation Patient Information Leaflet

Spinal Patients:

Refer to Spinal Nurses for bowel management plan and Digital Removal of Faeces. Consideration of complications – Autonomic Dysreflexia (see UHL Autonomic Dysreflexia Guidelines for Patients with Spinal Cord Injuries. [Trust Reference B1/2019])

APPENDIX 7: Digital Rectal Examination Sticker (Print Room Code DRE01)

<h1 style="margin: 0;">Digital Rectal Examination</h1>		 University Hospitals of Leicester NHS Trust																				
<p>Complete sticker by a LCAT trained nurse or doctor.</p>																						
<p>Date: Time: Area:</p>																						
<p>S Number:</p>																						
<p>Clinical Indication for DRE:</p>																						
<p>.....</p>																						
<p>Verbal Consent: YES <input type="checkbox"/> NO <input type="checkbox"/> Performed in Best Interest <input type="checkbox"/></p>																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">1. - Explain procedure</td> <td style="padding: 5px;">YES / NO</td> </tr> <tr> <td style="padding: 5px;">2. - Consent obtained</td> <td style="padding: 5px;">YES / NO</td> </tr> <tr> <td style="padding: 5px;">3. - Chaperone present</td> <td style="padding: 5px;">YES / NO</td> </tr> <tr> <td style="padding: 5px;">4. - Clinical findings written in medical notes</td> <td style="padding: 5px;">YES / NO</td> </tr> </table>	1. - Explain procedure	YES / NO	2. - Consent obtained	YES / NO	3. - Chaperone present	YES / NO	4. - Clinical findings written in medical notes	YES / NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Perianal Sensation: <input type="checkbox"/></td> <td style="padding: 5px;">Tone: <input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="padding: 5px;">Stool Type and amount: <input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Voluntary Anal Squeeze: <input type="checkbox"/></td> <td style="padding: 5px;">Prostate: <input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Abnormalities eg: internal/ external: (comments)</td> <td style="padding: 5px; text-align: center;">YES / NO</td> </tr> <tr> <td colspan="2" style="padding: 5px;">.....</td> </tr> <tr> <td colspan="2" style="padding: 5px;">.....</td> </tr> </table>	Perianal Sensation: <input type="checkbox"/>	Tone: <input type="checkbox"/>	Stool Type and amount: <input type="checkbox"/>		Voluntary Anal Squeeze: <input type="checkbox"/>	Prostate: <input type="checkbox"/>	Abnormalities eg: internal/ external: (comments)	YES / NO		<div style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small;">DRE01 06.2021</div>
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