Aneurin Bevan University Health Board

MANUAL EVACUATION OF FAECES FOR ADULTS & DIGITAL RECTAL EXAMINATION POLICY

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents:

1 Executive Summary

This policy for manual evacuation of faeces (M.E.F.) and guidelines for digital rectal examination (D.R.E.) are largely based on the recommendations of the Royal College of Nursing (2014). It should be used in conjunction with Digital Removal of Faeces NICE and MASCIP Guidelines (2012). See reference list.

With advances in oral, rectal and surgical treatments, the need for manual evacuation has reduced. However there may be circumstances as described in this policy when manual evacuation is necessary. Nursing staff caring for patients in need of this procedure must ensure their practice is evidence based, and within correct ethical and legal frameworks in order to be accountable for the care they give.

1.1 Purpose

This policy describes:-

a) The circumstances under which manual evacuation of faeces may be necessary
b) The client groups for which it may be necessary
c) The training requirements for staff undertaking the procedure

2 Policy Statement

This policy aims to assist the practitioner by providing specialist knowledge and guidance necessary to meet the needs of patients who require manual evacuation of faeces.

3 Aims/Objectives

3.1 Objectives

The objectives of the policy are:

a) To ensure that nurses are aware of their training needs
b) To ensure the safety of patients
c) To ensure that practice is consistent across the Aneurin Bevan Health Board.

4 Responsibilities

4.1 Client Group

This policy relates to all adult patients of Aneurin Bevan Health University Board (who are 18 years of age and over). Manual evacuation must not be performed on a child.

4.2 Staff Group

This policy applies to:

- Continuing care staff and health and social care workers who have been authorized by the Aneurin Bevan Health Board - (Clinical Learning Schedule – Appendix 1)
- All employed registered Nurses
- Any other healthcare professional who is trained and competent to carry out the procedure – (Clinical Learning Schedule – Appendix 1)

4.3 Location

This policy will apply in all appropriate work environments. This includes:

- Patient own homes
- In-patient wards
- Private and residential homes

5 Training

Nurses who carry out the procedure must have received training and must always work within the guidelines of the NMC code of professional conduct (NMC 2018). Manual evacuation of faeces is a procedure predominantly carried out by community nurses on patients with spinal cord injury or a neuropathic bowel. It must be recognised that community nursing as a whole possess the greatest body of experience and practical skills in this area and are therefore deemed the '*experts*' in manual evacuation of faeces. A shared collaborative approach to training and supervision must be adopted throughout district nursing teams. Nurses who currently carry out the procedure and already possess the skills and training will be expected to and called upon to share and disseminate these skills amongst colleagues. It is recommended that nurses in both hospital and community settings seek out and access specialist training in this area.

Community Nurses who possess an educational role may wish to provide localised cascade training sessions for district/community hospital Nurses. These Nurses could link with practice/education and training co-ordinators to arrange local training and dissemination to colleagues within the community and hospital environments. The local Continence Advisors and Colorectal Specialist Nurse will delivery training workshops – they will be schedule twice per year. It is acknowledged that there may be a necessity for reactive training.

- Below is an example of recommendations designed to assist with any ongoing training and competency issues: Clinical Learning Schedule – Appendix 1

- Attendance of a recognised training course by selected borough based nominated community nurses who would then return to their locality with course information pack.

- Trained nurses making formal links with community nurse trainers to arrange local training and dissemination of information and skills to colleagues.

- Collaboration with local continence advisors and colorectal nurse specialist (based at Nevill Hall Hospital) for support with training sessions and to request theoretical input.

- Visits to Rookwood Hospital (the local spinal injury unit in Cardiff) to observe and gain practical skills if required.

- Community Nurses who have planned manual evacuation of faeces on their caseload can be approached for shadowing and supervision.

- It is acknowledged and accepted that clinical competencies may be gained through the use of a simulator.

6 Implementation

6.1 When to perform manual evacuation

MEF may be undertaken in the following circumstances:

- When other methods of bowel emptying fail or are inappropriate
- Faecal impaction or loading
- Incomplete defecation
- Inability to defecate

- **Neurogenic bowel dysfunction in many patients with spinal cord injury**

MEF as an acute or ongoing intervention

When performing a MEF 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 MEF the following should be performed or observed for:

- Distress, pain, discomfort
- Bleeding
- Collapse
- Stool consistency
- **Blood pressure in Spinal Cord Injury patients who are at risk of AD, prior to and at the end of the procedure, a baseline blood pressure is advised for comparison**; for such patients where this is a routine intervention and tolerance is well established, the routine recording of blood pressure is not necessary.

Patients with Spinal Cord Injuries

For some patients, such as those with spinal cord injuries (SCI), MEF is an integral part of their routine. This essential routine should not be interrupted, regardless of the setting in which care is provided. If this procedure is questioned for a particular patient, before making any changes in bowel management and to prevent distress in the individual concerned, it may be helpful to discuss the proposed change with the patient's spinal cord injury centre to ensure that other methods of evacuation are suitable. The Care at Home Team may wish to continue a patients bowel regime if admitted to hospital.

The National Patient Safety Agency (NPSA, 2004) has supported the use of MEF in spinal cord injured patients, particularly when admitted to general health care settings. Health care staff must recognise that many individuals with an SCI utilise and are dependent on MEF as part of their established bowel management programme. The failure to support people with a spinal cord injury who need MEF results in ineffective bowel management. This inevitably results in faecal loading and impaction, increasing the risk of autonomic dysreflexia.

6.2 Who should perform manual evacuation

- Registered Nurses who have received appropriate training

- Continuing care staff employed by the Aneurin Bevan University Health Board who have received appropriate training
- Health and social care workers who have received appropriate training
- Nurses with experience and current skills in manual evacuation may continue but must seek theoretical training
- Any other healthcare professional who is trained, confident and competent to carry out the procedure

6.3 Assessment prior to manual evacuation

Assessment should commence from the basis of discussion with the patient (or carer in cases of lack of capacity) to obtain their informed consent to the procedure in accordance with Aneurin Bevan Health Board Consent Policy – (implied consent).

Practical aspects to be covered in the assessment are:

- normal bowel pattern for the individual
- diet and fluid intake
- laxative usage
- medications
- previous bowel management
- level of mobility
- cognitive problems, speech, memory, language
- ability to chew and swallow
- environmental issues – space, equipment, etc
- awareness of potential complications related to condition e.g. autonomic dysreflexia
- history of complications e.g. autonomic dysreflexia in patients with spinal lesions above T6
- discuss any relevant alternative bowel management options.

Above accounted in nursing documentation.

6.3.1 Circumstances where extra care is required/Autonomic Dysreflexia

Patients with spinal cord injury or neurological conditions may have neurogenic bowel dysfunction, which often means they depend on routine interventional bowel care, including the digital (manual) removal of faeces (DRF).

Some of these patients, especially those with spinal cord injury above T6, are particularly susceptible to the potentially life-threatening condition autonomic dysreflexia, which is characterised by a rapid rise

in blood pressure, risking cerebral haemorrhage and death. A small number of patients who have had a severe stroke or who have severe forms of Parkinson's disease, multiple sclerosis, cerebral palsy, or spina bifida may also be susceptible to autonomic dysreflexia.

Autonomic dysreflexia can be caused by non-adherence to a patient's usual bowel routine or during or following interventional bowel care. For all of these patients, bowel care is vital for their health and dignity.

Particular caution should be taken and/or refer to a doctor if the following are applicable:

- active inflammatory bowel disease
- recent radiotherapy to the area
- recent surgery to area
- has a known history of abuse
- rectal pain obvious rectal bleeding or taking anti-clotting medication
- spinal injury at thoracic T6 (autonomic dysreflexia)

NB. A chaperone must be offered when performing both DRE and MEF in accordance with Aunerin Bevan Health Board policy.**

7 Consent

Verbal informed consent must be obtained prior to each procedure. Where the client is unable to give informed consent due to cognitive impairment, please refer to Aneurin Bevan University Health Board policy on consent for vulnerable adults.

8 Information given to patients

The patient will be given a full explanation of the reasons for the procedure. Follow up information will be provided where applicable on diet and bowel management to prevent recurrence of an acute episode of impaction. The person carrying out the procedure should be satisfied that the patient is able (wherever possible) to give the professional verbal feedback which demonstrates their understanding.

9 The Procedure

9.1 Digital Examination of the rectum

Equipment that may be required: disposable examination gloves, water-soluble lubricant, tissues and a small clinical waste bag.

Following a rectal examination, the patient may require to defecate and so the provision of a commode or bedpan may be needed for those patients unable to use a toilet.

	Stages	**Rationale**
1	Explain the procedure to the patient. The patient will agree/ consent to the examination	The patient will be able to co-operate and relax the anal sphincter. Patient consents to the examination
2	Create privacy.	This will also help the patient to relax. To maintain privacy and dignity.
3	The patient is positioned in the left lateral position with knees flexed so as to expose the anus. Protect the bed. Care should be taken in case of hip replacement.	To expose the anus and allow easy insertion of finger for examination.
4	Wash hands and put on non-sterile examination gloves.	To minimise cross infection and protect hands for examination purposes.
5	Examine the perianal area at this point if required.	
6	Lubricate your gloved index finger.	To facilitate easier insertion and minimise patient discomfort.
7	Warn patient when you are ready to insert your finger and ask them to relax.	To ensure patient is ready and relaxed.
8	Insert gloved finger slowly into the rectum and undertake examination for: presence of faecal matter, amount and consistency, b) anal tone at rest and with a Voluntary contraction.	To minimise discomfort. To ensure nurse only examines within specified criteria. To safeguard patient and the nurse.
9	Slowly withdraw finger from the patient's rectum when finished. At this point rectal medication can be administered if appropriate.	Reduce inconvenience to patient and save time.
10	Wipe the patient's bottom with tissues or wipes and place in clinical waste bag.	To leave patient comfortable and minimise cross infection.
11	Remove gloves and dispose of them in clinical waste bag.	To minimise cross infection.
12	Make patient comfortable and offer the toilet, commode or bedpan if appropriate.	Examination may stimulate patient to defecate.
13	Wash hands.	To minimise cross infection.

	Stages	Rationale
14	Record findings in nursing documentation and communicate findings with the patient/carer and their doctor if appropriate.	To ensure correct care is provided. To avoid duplication of care. To pass care on to other nurses as required. To ensure the patient understands the results of the examination and associated care. To ensure continuation of care.

10 Manual Evacuation of Faeces

Equipment that may be required: disposable gloves, water-soluble lubricant, tissues and a small clinical waste bag. Following a rectal examination, the patient may require to defecate and so the provision of a commode or bedpan may be needed for those patients unable to use a toilet.

Note: Within the scope of professional practice (NMC 2000), a qualified nurse is able to assess, plan and implement rectal care. However, should the nurse feel unqualified or inexperienced, the advice of a doctor must be sought.

	Stages	Rationale
1	Explain the procedure to the patient. The patient will agree/consent to the examination	The patient will be able to co-operate and relax the anal sphincter. Patient consents to the procedure.
2	Create privacy	This will also help the patient to relax. To maintain privacy and dignity.
3	The patient is positioned in the left lateral position with knees flexed in order to expose the anus. Protect the bed. Care should be taken in case of hip replacement.	To expose the anus and allow easy insertion of a finger for removal of the faecal matter.
4	Take the patients pulse rate.	To form a baseline to assess changes in pulse rate during the procedure.
5	Place the protective pad under the patient.	Protection of the bedding from faecal matter and gel.
6	Wash hands and put on non-sterile examination gloves (2 pairs).	To minimise cross infection and to protect your hands. If gloves are very thin then two pairs may be advisable.
7	a) If patient has manual removal of faeces performed on a	To facilitate easier insertion of the finger and removal of faecal

	Stages	**Rationale**
	regular basis, then lubricate finger with gel. b) If patient has not had a manual removal of faeces performed before, then apply an anaesthetic gel to anus and rectum liberally and allow two minutes to lapse for it to take effect.	matter. To facilitate easier insertion of the finger, reduced sensation and discomfort and removal of faecal matter.
8	Warn patient you are about to start procedure.	To ensure patient is ready and relaxed.
9	Insert gloved finger into the patients rectum slowly and a) In scybala-type stool, remove a lump at a time until no more faecal matter can be felt. b) In a solid mass, push finger into the middle of faecal mass and split it, remove small sections until no more faecal matter can be felt. Extra lubrication may be required during the procedure.	To minimise discomfort. To minimise discomfort and make it easier to remove faecal matter. To minimise discomfort and make it easier to remove faecal matter
10	As the faecal material is removed it should be placed in the bedpan or another receptacle	To facilitate appropriate disposal of faecal material at the end of the procedure
11	During the procedure check the patient's heart rate. Stop the procedure if the heart rate drops or rhythm changes.	Vagal stimulation can slow the heart rate. The patient can also become shocked.
12	When all the faecal matter has been removed, wash and dry the patient's buttocks and anal area.	To leave the patient in a comfortable and clean state.
13	Remove the gloves and protective pad and dispose of in the clinical waste bag.	To minimise cross infection.
14	Make the patient comfortable and offer the toilet, commode or bedpan if needed.	Manual removal may stimulate patient to defaecate.
15	Remove the bedpan, or receptacle and its contents and dispose of in appropriate way	To minimise cross infection and correctly dispose of waste.
16	Remove apron, dispose into clinical waste bag and then wash hands.	To minimise cross infection.
17	Take the patients pulse to check	To monitor pulse changes and

	Stages	**Rationale**
	with the baseline	take appropriate action.
18	Record the findings in the nursing documentation and communicate the results to the patient and the doctor if appropriate.	To ensure correct care is provided. To avoid duplication of care. To pass care on to other nurses as required. To ensure the patient understands the results and associated care.

11 Evidence base for this Policy

National Institute for Health and Clinical Excellence (2007) *Faecal incontinence: the management of faecal incontinence in adults: clinical guideline* CG49, London: NICE.

RCN (2012) Management of the lower *bowel dysfunction, including digital rectal examination and manual removal of faeces: RCN guidance for Nurses.*

MASCIP (2012) *Guidelines for management of neurogenic bowel dysfunction in individuals with central neurological conditions.*

12 Appendix 1 – Clinical Learning Schedule 4 – To Perform Manual Evacuation of Faeces

Name of Practitioner and designation

Work Address and Contact

Name of Clinical Supervisor and designation

Work Address and Contact

Statement of Intent by Practitioner
(Rationale why this will improve your patients' care and practice).

Supervisor Assessment of Practitioner
(Underpinning knowledge base skills and ability to maintain level of practice)

12.1 Observation of procedure (min 3)

Date	Patient / Environment	Comments / DW Supervisor	Signature Practitioner / Supervisor
Supervised Practice (min 3 max 10)			
Date	Patient / Environment	Comments / DW Supervisor	Signature Practitioner / Supervisor
Annual Log Practical Update			
Date	Patient / Environment	Comments / DW Supervisor	Signature Practitioner / Supervisor

13 References

1. National Patient Safety Agency 2004 Patient briefing and patient information notice 'bowel care for patients with established spinal cord lesions' https://www.mascip.co.uk/wp-content/uploads/2016/07/NRLS-0076-Spinal-cord-lesion-PSI-2004-09-15-v1.pdf
2. National Institute for Health and Care Excellence clinical guideline 2014 [CG49] Faecal incontinence in adults: management https://www.nice.org.uk/guidance/cg49
3. National Institute for Health and Care Excellence quality standard 2014 [QS 54] Faecal incontinence in adults https://www.nice.org.uk/guidance/qs54
4. British Association of Spinal Cord Injury Specialists (BASCIS), Multidisciplinary Association of Spinal Cord Injury Professionals (MASCIP), Spinal Injuries Association (SIA) 2014 Statement on Autonomic Dysreflexia https://www.spinal.co.uk/wp-content/uploads/2018/06/Statement-on-Autonomic-Dysreflexia-2017.pdf
5. Royal College of Nursing 2012 Management of lower bowel dysfunction, including digital rectal examination and digital removal of faeces https://www.rcn.org.uk/professional-development/publications/pub-003226
6. Nursing and Midwifery Council 2018. Future nurse: Standards of proficiency for registered nurses https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf
7. Multidisciplinary Association of Spinal Cord Injured Professionals 2012 Guidelines for management of neurogenic bowel dysfunction in individuals with central neurological conditions http://www.mascip.co.uk/wpcontent/uploads/2015/02/CV653N-Neurogenic-Guidelines-Sept-2012.pdf
8. Spinal Injury Association 2013 Patient and professional resources https://www.spinal.co.uk/wp-content/uploads/2017/05/Autonomic-Dysreflexia.pdf
9. NHS Improvement 2018, Resources to support safer bowel care for patients at risk of autonomic dysreflexia webpagehttps://improvement.nhs.uk/resources/resources-to-support-safer-bowel-care-for-patients-at-risk-ofautonomic-dysreflexia

THE BRISTOL STOOL FORM 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