CHESHIRE IRELAND learning through listening

Status: Standard Procedure: specifies the procedures to be followed, only in exceptional circumstances should these not be followed.	**Policy No: CLSP 31** **Version No: 2** **Date Approved: 01/03/11** **Date Reviewed: 01/04/12** **Review Date: 01/03/14**
Title: Standard Procedure for Digital Rectal Stimulation (DRS) and Digital Removal of Faeces (DRF)/manual evacuation of faeces.	
Written by: Practice Development Officer and National Risk Manager	
Approved by: Clinical Policies, Procedures and Guidelines Group	
Cross Reference: ICG01, ICG02, CLSP 29, CLSP 30, BPH O2	

This procedure replaces all existing policies from 01/04/2012 onwards and is due for review on 01/04/2014. It will be reviewed during this time as necessary to reflect any changes in best practice, law, substantial organisational, professional or academic change

1.0 Purpose

The purpose of this standard procedure is to ensure safe practice during digital rectal stimulation and digital removal of faeces of the Cheshire Ireland Service User.

2.0 Scope

All staff in Cheshire Ireland services involved in the care of service users requiring digital rectal stimulation and manual evacuation of faeces.

3.0 Responsibility

- It is the responsibility of all staff that perform manual evacuations to follow this standard procedure.
- It is the responsibility of service managers to ensure staff are familiar with the standard procedure and to monitor compliance.

4.0 Definitions:

Digital Rectal Stimulation the digital stimulation of the anal-rectal reflex so as to trigger peristalsis and aid defecation (Wiesel & Bell, 2004)

Digital Removal of Faeces/Manual Evacuation the digital removal of faeces from the rectum using a gloved finger (RCN, 2006).

Autonomic Dysreflexia (Appendix 2) a life-threatening uninhibited sympathetic response of the nervous system to a noxious stimulus after a spinal cord injury at T6 or above (Shergill, 2004)

NOTE 1: Care/support staff must receive training from National Rehabilitation Hospital, Urology Department of a training hospital or specifically trained Cheshire Nurse/PHN. Following formal training, care/support staff require three clinical supervision sessions (to ensure their competencies are signed off) with a nurse prior to performing this procedure independently. The staff member may

require further supervision sessions if deemed necessary by the nurse, service user in question or staff members themselves.

NOTE 2: There must be a nurse/doctor available for supervision and support in a service where this intervention is carried out by care/support staff.

NOTE 3: In line with the Best Possible Health care plan, each service user will have an up to date continence care plan, if required. This will be under the supervision of a Continence Nurse Specialist or Spinal Injuries Nurse Specialist and will be reviewed as required.

5.0 Indications, Contraindications & Precautions:
Indication for Digital Rectal Stimulation (DRS):
Used to stimulate and recto-anal reflex so as to trigger peristalsis and aid defecation in service users with upper motor neuron lesion (RCN, 2006)

Indication for Digital Removal of Faeces (DRF):
Should only be practiced when all other methods of bowel management have failed. For some service users with spinal cord injury, Spinabifida or neurogenic bowel dysfunction, DRF may be an integral part of routine bowel management (RCN, 2006, SCICs 2009).

Contraindications:
- Lack of consent from the service user
- Where service user's GP has given specific instructions that the procedures should not take place
- If the service user has recently undergone rectal or anal surgery or trauma.
- If abnormalities of the perianal or perianal area are observed.

Circumstances where extra care is required:
- Active inflammation of the bowel, Crohn's disease, ulcerative colitis or diverticulitis.
- Recent radioactivity to the pelvic area
- Rectal/anal pain.
- Rectal surgery/trauma to the anal/rectal area.
- Obvious rectal bleeding or service user taking anti-coagulants.
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases.
- If service user has known history of sexual abuse.
- Spinal injury at T6 or above because of danger of autonomic dysreflexia (Appendix 2).
- Where the service user gains sexual satisfaction from the procedure and the carer find this embarrassing, the need for a chaperone may need to be considered.

6.0 Procedure for Digital Rectal Stimulation:

Equipment

- Disposable apron and gloves
- Water based lubricating gel
- Disposable incontinence pad
- Tissues
- Suitable receptacle
- Waste bag/container

Actions Required

Check that aperients, have been given the night before and subsequent rectal triggers, suppositories/enema given at least an hour prior to the procedure in an effort to promote rectal stimulation

1. Ensure privacy for the procedure.
2. Explain the procedure to the service user.
3. Baseline blood pressure and pulse should be measured on service users with a history of automic dysreflexia and service users who have never had the procedure before.
4. Ask the service user to empty their bladder.
5. Wash and dry hands thoroughly (Ref: Guidelines for Hand Hygiene, ICG02).
6. Apply disposable gloves/apron (Ref: Guidelines for the use of Protective Clothing for Staff, ICG01).
7. Assist service user to adopt a suitable position, if possible the left lateral position with knees flexed.
8. Place the incontinence pad under the buttocks and ensure a suitable receiver is to hand.
9. Observe the perianal area for prolapse, wounds, bleeding or other abnormality.
10. Place lubricating gel on a gloved finger and inform service user of imminent examination.
11. Separate the buttocks and gently insert the lubricated finger (½ to 1 inch) slowly and gently into the rectum, at the same time encouraging the service user to relax.
12. Wait for the anal sphincter to relax, approx. 30 seconds. This may produce a stimulus for the bowel to move.
13. Gently rotate the finger 6-8 times in a circular motion and withdraw. This may be repeated up to 3 times allowing 5-10mins between each stimulation.
14. Repeat the procedure until the bowel is empty i.e.
    a. No passage of faecal material following the last 3 consecutive digital stimulations.
    b. Passing flatus and/or mucous only
15. Clean and dry the perianal area. Inform the service user of the outcome.
16. Wash and dry hands thoroughly.
17. Record the procedure and its effect in the Best Possible Health record of the service user.
18. Report any adverse reactions, blood in faeces, abdominal pain, changes in the frequency, colour and consistency of stool to lead clinical person/line manager /G.P and record in Best Possible health Daily Continuation Sheet.

7.0 Procedure for Digital Removal of Faeces

If there is no passage of faecal material following the 3 consecutive digital stimulations then progress to this procedure:

- Prepare equipment as per Digital Rectal Stimulation (DRS)
- Repeat steps 1-9 as per DRS procedure

10. For type 1 stool - separate hard lumps, like nuts (Bristol Stool Scale) remove one lump at a time until no more faecal matter can be felt.
11. In a solid faecal mass, push finger into the middle of the mass, split it and remove small pieces with a hooked finger until no more faecal matter can be felt.
12. If faecal mass is too hard or larger than 4cm across and you are unable to break it up STOP and refer to medical team who may consider removal of faeces under general anaesthetic.
13. As faecal matter is removed, it should be placed in a suitable receiver.
14. Some service users may require short periods of rest during the procedure or extra lubricant may be required.
15. Observe the service user throughout the procedure and STOP at the first signs of autonomic dysreflexia.
16. When procedure is finished, wash and dry the buttocks and anal area.
17. Inform the service user of the outcome.
18. Remove and dispose of all equipment.
19. Wash and dry hands thoroughly.
20. Record the procedure and its effect in the Best Possible Health record.
21. Report any adverse reactions, changes in the frequency, colour and consistency of stool to lead clinical person/line manager /G.P. Record in Best Possible health Daily Continuation Sheet.

8.0 Extra precautions:

Autonomic dysreflexia (Appendix 2) During both DRS and DRF the service users' condition must be monitored for signs of autonomic dysreflexia such as pounding headache, flushing, profuse sweating, palpitations, goosebumps.
If any signs of distress or autonomic dysreflexia occur:

- Stop the procedure immediately
- Sit the service user upright as this will bring blood pressure down slightly
- Follow guidelines as per service user's Best Possible Health specific care of Autonomic dysreflexia
- Call nearest Emergency Department and an ambulance if transfer is required.
- Contact the senior members of staff
- Contact local Spinal Injuries Centre / Specialist Nurse.

Bowel perforation: As there is a risk, albeit very low of bowel perforation it is important that service users and where appropriate carers are aware to contact the nearest Emergency Department if these signs and symptoms occur:

- Severe and sustained abdominal pain or back pain, especially if combined with fever.
- Sustained anal bleeding.

9.0 References

NICE (2007) Faecal incontinence: The management of faecal incontinence in adults. National Institute for Health and Clinical Excellence.

National Rehabilitation Hospital (NRH), (2005) *Management of Neurogenic Bowel in Adults with Spinal Cord Injury.*

Nicol. M., Bavin, C., Bedford-Turner, S., Cronin, P. & Rawlings-Anderson, K. (2004). *Essential Nursing Skills*. Mosby, United Kingdom.

Shergill M et al. (2004) The importance of autonomic dysreflexia to the urologist. *British Journal of Urology International*, 93:923-926.

Cosgrave, M et al (2009) Managing neurogenic bowel dysfunction in the community after spinal injury – a postal survey in the United Kingdom. *Spinal Cord* 47, 323-333.

HSE West (2012) Guideline for Digital Rectal Examination, Digital Rectal Stimulation and Manual Removal of Faeces in the Community: Adult.

Wiesel P. and Bell, S (2004) Bowel Dysfunction: Assessment and Management in the Neurological Patient in Norton C., Chelvanayagam (Eds) Bowel Continence Nursing Beaconsfield, UK.

RCN (2006) Digital Rectal Examination and Manual removal of Faeces Guidance for Nurses. London.

10.0 Appendices

Appendix 1
Neurogenic Bowel Care Plan Record

Date	Aperients	Date	Rectal medication	Breakfast	Digital stimulation	Bristol stool chart	signature
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Appendix 2

Autonomic Dysreflexia

TREAT AS A MEDICAL EMERGENCY

Autonomic dysreflexia (also known as autonomic hyperreflexia) is one of the most serious conditions affecting people with spinal cord injury at or above the 6th thoracic vertebrae.

The syndrome develops secondary to any noxious stimulus below the level of injury. As the spinal cord is damaged, nerve impulses cannot pass normally to the brain, therefore, the body produces exaggerated abnormal nerve signals that cause problems above and below the spinal injury. Below the injury, blood vessels go into spasm causing the blood pressure to rise. Above the level of injury, the body senses the high blood pressure and tries to relax the blood vessels but it can only influence the blood vessels above the level of injury. This causes flushing and blotchiness of skin and pounding headache.

Symptoms range from mild to sever and patients may present with one or more of the following:

- Pounding headache
- Flushing and/blotching above the level of spinal injury
- Slowed heart rate
- Profuse sweating above the level of injury
- Palpitations
- Goosebumps
- Blurred vision or seeing spots
- Stuffy nose
- Feeling of impending doom, anxiety or apprehension
- Elevated blood pressure.

Under normal circumstances a tetraplegic person may have a low bleed pressure (eg.90/60). A rise of 20mmmHg can be clinically significant so if the BP rises to 120/80mmHg it could indicate an emergency situation. Hypertension can lead to seizures, stroke or ultimately death.

Bladder problems and faecal impaction are the most common cause of autonomic dysreflexia.

This can be caused by:

- Overfull bladder
- Kidney or bladder stones
- High pressure voiding
- Urinary tract infection
- Blocked catheter
- Defective drainage system (e.g. kinked tubing or leg bag too full)
- Faecal impaction

Emergency treatment is to drain the bladder or deal with the faecal impaction quickly (within 2-3 minutes) in order to reduce blood pressure. It is recommended that sublingual Nifedipine 10mg or GTN spray is given if the blood pressure cannot be reduced within the first 2-3 minutes by either of the above mentioned procedures (Shergill et al, 2004).

Shergill M, Arya R, Hamid J, Khastgir HRH, Shah PJR (2004) The importance of autonomic dysreflexia to the urologist. British Journal of Urology International, 93:923-926.

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Document Status i.e. New, Revision , replaced etc.	**Version Number**	**Revision Date**	**Description of changes**
Version	2	01/04/ 2012	Reviewed in line with 2012 HSE guidelines for DRE , DRS and Manual Removal of Faeces in the Community Symptoms of autonomic dysreflexia included Indications and contraindications included Appendix 2: information on autonomic dysreflexia added.