



## Intimate Bowel Care Policy and Procedure

Notice to employees using a paper copy of this policy  
The company Policies folder on the shared drive holds the most recent version of this document and all employees must ensure that they are using the most recent guidance.

## Document Control

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<b>Author</b>	Karen Hodgkinson
<b>Purpose</b>	To provide policy guidance and procedural support to all staff undertaking intimate bowel care procedures including Digital Rectal Examination (DRE), Digital Rectal Stimulation (DRS) and Digital Removal Faeces (DRF) for individuals with neurogenic bowel dysfunction due to Spinal Cord Injury.
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## Version Control

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1.0		Karen Hodgkinson	New document published

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## Introduction

Individuals with neurogenic bowel dysfunction due to spinal cord injury (SCI) may require intimate bowel care interventions to maintain continence, prevent constipation and associated complications. These interventions can include Digital Rectal Examination (DRE) prior to any further rectal interventions, Digital Rectal Stimulation (DRS) and/or Digital Removal of Faeces (DRF).

NHS Improvement (NHSI) issued a Patient Safety Alert stating that NHS and private organisations require a policy to support staff to undertake these procedures for individuals with neurogenic bowel dysfunction and ensure availability of suitable skilled staff twenty four hours per day, seven days a week. (NHSI 2018)

Failure to provide digital rectal procedures for SCI patients who require them may lead to perforation of the bowel and/or Autonomic Dysreflexia, medical emergencies leading to potential damaging outcomes such as haemorrhage, seizures and cardiac arrest. (Appendix 1)

Not meeting this care need could be a breach of the Nursing and Midwifery Council Code of Conduct (The Code 2015)

## PURPOSE

The aim of bowel care interventions is to achieve a regular and predictable emptying pattern of the bowel at a socially acceptable time and place. Avoiding incontinence, constipation and associated complications.

## SCOPE

This policy applies to individuals with a confirmed diagnosis of spinal cord injury, also diagnosed with neurogenic bowel dysfunction.

This policy applies to all staff providing care to individuals with neurogenic bowel dysfunction due SCI.

## RESPONSIBILITIES

All clinical staff (Registered Nurses and Support workers) within the organisation to an extent consistent with their position are responsible for compliance with this policy.

The Registered Manager has overall responsibility for effective management of risk.

The Clinical Director has responsibility for ensuring that the required structures and resources are in place to enable effective care for patients requiring DRE/DRS/DRF. Ensuring their staff are aware when it is appropriate to carry these out, and how to seek advice/guidance on the procedures from clinicians competent to carry out the interventions.

Regional Clinical Leads with specific knowledge of the procedures are responsible for offering advice when contacted about the appropriateness of DRE/DRS/DRF for specific patients; acting as a resource person for staff concerning DRE/DRS/DRF and ensuring that this essential care is undertaken effectively.

## DEFINITIONS

- **Digital Rectal Examination (DRE):** an intimate care intervention that involves insertion of a lubricated gloved finger into the rectum to determine the presence of faecal matter and any abnormalities or contraindications to performing DRS, DRF or proceed with insertion of a chemical stimulant.
- **Digital Rectal Stimulation (DRS):** an intimate care intervention that involves insertion of a lubricated gloved finger into the rectum to stimulate the recto anal reflex, reduce outlet resistance and trigger defecation.
- **Digital Removal of Faeces (DRF):** an intimate care procedure that involves the insertion of a lubricated gloved finger to remove faecal matter from the rectum.
- **Autonomic dysreflexia:** A potentially fatal complication for SCI patients with an injury above T6 (sixth thoracic nerve) because of an abnormal sympathetic nervous system response to a noxious stimuli below the level of injury to the spinal cord. Symptoms include skin flushing on the upper

trunk and face, goose bumps, profuse sweating, increase in blood pressure above normal base line (note baseline blood pressure can be low in tetraplegia) and bradycardia. The individual themselves may complain of rapid onset severe headache, visual disturbances and acute distress.

- **Spinal Cord Injury (SCI):** damage to the spinal cord caused by trauma, illness or disease that maybe either incomplete or complete.
- **Bulbocavernosus reflex** is a well-known somatic reflex that is useful for gaining information about the state of the sacral spinal cord segments. When present, it is indicative of intact spinal reflex arcs (S2–S4 spinal segments) with afferent and efferent nerves through the pudendal nerve.
- **Reflex neurogenic bowel dysfunction (Reflex bowel):** usually present in individuals with a spinal cord injury in the cervical or thoracic region; determined by positive involuntary anal wink and bulbocavernosus reflex. This reflex activity is often utilised in bowel care interventions. Without appropriate interventions, the SCI individual will experience constipation and incontinence.
- **Areflexic neurogenic bowel dysfunction (Flaccid bowel):** Usually present in individuals with SCI in lumbar and sacral regions. Damage to conus medullaris or cauda equina (at or below the first lumbar vertebra) results in no involuntary anal tone or bulbocavernosus reflex. Therefore requiring DRF without which the outcome is a high risk of faecal incontinence through the lax sphincter, as well as constipation.
- **Chemical rectal stimulant:** a prescribed medication inserted into the rectum to stimulate recto-anal reflex in individuals with reflex neurogenic bowel function.

## POLICY STATEMENT

Chronic neurogenic dysfunction: patients with established spinal cord injury will usually have established bowel management interventions that must be continued. These may include regular DRE, DRS and/or DRF.

Libertatem Healthcare Group will ensure that all support workers will be trained to deliver the prescribed bowel care routine and will undertake clinical delegation of task with clinical nurse to ensure competency undertaking the advised routine.

If a client is admitted to hospital the support team will confirm with medical and nursing staff the care routine established at home so that it be maintained during the admission. The support team will offer assistance where appropriate and requested.

Further information/guidance on bowel management programmes for SCI patients can be found in 'Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions'. Multidisciplinary Association of Spinal Cord Injured Professionals (MASCIP 2016)

## Digital rectal examination (DRE)

May be performed in the following circumstances:

- To establish the presence/amount/consistency of faecal matter in the rectum prior to DRF.
- Prior to any rectal interventions i.e. administration of PR medications, DRS or DRF.
- Evaluate effectiveness of bowel emptying in neurogenic bowel management e.g. after the use of suppositories, enemas or DRS.

Staff should not undertake DRE when:

- There is a lack of consent from the patient – written, verbal or implied. NB in a patient lacking ability to give consent a 'best practice decision' will be required.
- The patient's doctor has given specific instructions it should not take place.

Procedure for DRE: (See Appendix 2.)

### **Digital rectal stimulation (DRS)**

An intervention to stimulate the movement of stool into the rectum and to initiate predictable defaecation; therefore avoiding constipation and incontinence. It is only appropriate in individuals with reflex bowel dysfunction.

Procedure for DRS: (See Appendix 3)

### **Digital removal of faeces (DRF)**

DRF is an appropriate intervention in the following circumstances:

- Following a diagnosis of areflex neurogenic bowel dysfunction
- As part of established bowel care for specific SCI patients
- Incomplete defaecation for those with reflex neurogenic bowel dysfunction

Procedure for DRF: (Appendix 4)

## **RELATED LEGISLATION AND DOCUMENTS**

Multidisciplinary Association of Spinal Cord Injured Professionals (2016) Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. London: MASCIIP

Royal College of Nursing (2012) Management of lower bowel dysfunction, including DRE and DRF. London: Royal College of Nursing

National Patient Improvement Alert reference NHS/PSA/RE/2018/005

Nursing and Midwifery Council Code of Conduct 2105

## **EDUCATION AND TRAINING**

Libertatem Healthcare Group will provide training and support to support workers involved in delivering any bowel care procedures to our clients. This will include theory and practical training and will be delivered by the clinical nursing team.

## **RELEVANT STAFF CONTACT DETAILS**

Name and Position	Contact details
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## **APPENDIX**

1. Autonomic Dysreflexia leaflet
2. Procedure for Digital Rectal Examination (DRE)
3. Procedure for Digital Rectal Stimulation (DRS)
4. Procedure for Digital Removal of Faeces (DRF)

## APPENDIX ONE – Autonomic Dysreflexia Factsheet

### Autonomic Dysreflexia

#### What is it?

Autonomic Dysreflexia is the name given to a condition where there is a sudden and potentially lethal rise in blood pressure (BP). It is your body's way of responding to a problem. It is often triggered by acute pain or some other harmful stimulus within the body. It is unique to spinal cord injury and most commonly affects spinal cord injured people with injuries at or above T6. This extreme rise in blood pressure (hypertension) can lead to some types of stroke (cerebral haemorrhage) and even death.

#### *It should ALWAYS be treated as a medical emergency*

Studies have shown that it can occur at any time following the onset of spinal cord injury, when the period of spinal shock has subsided. Spinal cord injured people with incomplete lesions are just as likely to experience autonomic dysreflexia as people with complete lesions, (Harris 2001) although it is reported that symptoms are less severe in this group.

#### Why does it occur?

Autonomic dysreflexia occurs in response to pain or discomfort below the level of spinal cord lesion. It is the body's 'fight or flight' response. Your blood pressure rises when your body encounters a harmful stimulus. This is detected by the nervous system, which then responds, via the autonomic nervous system, by dilating blood vessels, therefore lowering blood pressure to try to keep it within the normal range.

When your level of injury is T6 or above, the autonomic nervous system cannot lower raised blood pressure *below* your level of injury, in response to pain or discomfort below the level of spinal cord injury. Hence, your blood pressure continues to rise until the offending stimulus is removed.

However, your autonomic nervous system does attempt to lower your blood pressure *above* your spinal cord injury. This is the source of the symptoms of autonomic dysreflexia which are an invaluable warning mechanism for you to take appropriate action.

If an autonomic dysreflexic episode is not resolved, the continuing surge in blood pressure becomes very dangerous and can lead to a stroke or possibly death.

#### Who is at risk?

- Spinal cord injured people injured at or above the level of T6.
- People with complete injuries are more like to be affected.

#### What are the symptoms?

It should be noted that you may not experience all the symptoms, you might even experience symptoms that are peculiar to you. However, one symptom always present is a pounding, usually frontal, headache **and** one or more of the following most common presenting symptoms:

- Flushed (red) appearance of skin above the level of injury
- Profuse sweating above the level of injury
- Pale coloured skin below the level of injury
- Stuffy nose
- Non-drainage of urine (urine obstruction is the most common cause)
- Severe hypertension (note: SCI people have lower resting blood pressure compared to non- SCI people)
- The sensation of a tight chest
- Bradycardia (slowing of the heart rate)

### **What are the common causes?**

#### **Bladder**

- Distended bladder
- A kink in the catheter
- An over-full leg bag
- Blockage or obstruction that prevents urine flowing from the bladder
- Urinary tract infection or bladder spasms
- Bladder stones

#### **Bowel**

- Distended bowel which can be due to a full rectum, constipation or impaction
- Haemorrhoids
- Anal fissures
- Stretching of rectum or anus or skin breakdown in the area

#### **Skin**

- Pressure ulcer, contact burn, scald or sunburn
- Ingrown toenail
- Tight clothing/leg bag etc.

#### **Sexual activity**

- Over-stimulation during sexual activity
- Ejaculation – can cause a dysreflexic episode, but this can be managed

#### **Gynaecological issues**

- Menstrual pain
- Labour and delivery

#### **Other causes**



- Bone fractures, below the level of injury
- Pain or trauma
- Syringomyelia
- Deep vein thrombosis(DVT)
- Acute conditions such as gastric ulcer, appendicitis
- Severe anxiety (eliminate all possible physiological factors first)

Unless this is the first time you have experienced autonomic dysreflexia, or if you are recently injured, you will usually be familiar with the symptoms of autonomic dysreflexia in the same way a person with diabetes is aware of the early symptoms of hypoglycaemia (low blood sugar). You may well be able to spot the problem yourself and take immediate action or get appropriate help.

Not all medical staff are aware of autonomic dysreflexia and you, as a spinal cord injured person, are an expert on your condition. You may well find yourself having to educate a health professional as to what is happening to you.

Whilst some SCI people injured at T6 and above, will have experienced at least one episode of autonomic dysreflexia during their rehabilitation in a Spinal Cord Injury Centre (SCIC), this cannot be guaranteed.

Ideally, the best way to experience the symptoms of autonomic dysreflexia for the first time is within the protective environment of a SCIC, where many of the risk factors that influence autonomic dysreflexia are well controlled. At your discharge planning stage, it is appropriate that the Community Care Team and your full time carers have been educated on the causes and effects of autonomic dysreflexia and they, in turn, should establish your own current knowledge and experience for future reference.

### **Treatment**

Early recognition of AD is essential so that treatment can be started immediately. Once raised blood pressure has been confirmed, where possible, together with the typical signs and symptoms of autonomic dysreflexia, the high blood pressure must be treated and the cause identified.

### **What actions should be taken once autonomic dysreflexia is identified?**

- Sit up and drop your feet
- Loosen any clothing and check nothing is putting pressure on the skin
- Perform a quick assessment to identify the cause so that the stimulus can be removed.

Actions should be prioritised as follows:

### **Identify and remove cause**

## **Bladder**

The most common cause of autonomic dysreflexia is non-drainage of urine. This can be due to a blocked catheter, urinary tract infection or overfilled collection bag.

### **Action:**

If you have a Foley or suprapubic catheter, check the following:

- Is your drainage bag full?
- Is there a kink in the tubing?
- Is the drainage bag at a higher level than your bladder?
- Is the catheter plugged?

After correcting the obvious problem, and if your catheter is not draining in 2-3 minutes, your catheter must be changed immediately. If you do not have a Foley or suprapubic catheter, perform a catheterisation and empty your bladder.

***Do NOT attempt a bladder washout as this could increase your blood pressure***

## **Bowel**

If your bladder has not triggered the episode of autonomic dysreflexia, then the cause may be your bowel. This can be due to constipation, anal fissures / haemorrhoids or an infection.

### **Action:**

Insert a gloved finger lubricated with an anaesthetic lubricant such as 2% lignocaine gel, into your rectum. If the rectum is full, insert some lubricant and wait for a minimum of 3 minutes. This is to reduce the sensation in the rectum. This is important because performing digital stimulation and manual evacuation may worsen autonomic dysreflexia. Gently perform manual evacuation.

***If you were doing this when the symptoms of autonomic dysreflexia first appeared, then stop the procedure and resume after the symptoms subside***

## **Other causes**

If an overfull rectum isn't the cause, investigate alternative causes from the list given previously. It is important that if you have an autonomic dysreflexic episode that you remain calm; anxiety can make the problem worse. Once identified, remove the offending stimulus.

Ideally, you, your carers and family members, should know your normal blood pressure. It is important for you to know your normal blood pressure and pulse rate and document them in an obvious place, such as on your care plan, in the event of you having an episode of autonomic dysreflexia.

As people with high-level paraplegia and tetraplegia usually have a low resting blood pressure, (80 or 90 systolic for a cervical injury) a rise to 120 or 130 systolic, could be dangerous. If you have an episode of AD, it is important to be able to give any attendant health professional your normal blood pressure.

#### **If possible record a baseline BP**

If your BP increases by 20 mm/Hg and is accompanied by a lowering of the pulse rate, then you could be having an episode of autonomic dysreflexia.

If appropriate once you have eliminated bladder and bowel distension as the cause of the autonomic dysreflexia, sit up and have frequent BP checks until the episode has resolved.

If you are unable to measure your BP using the appropriate measuring machine (sphygmomanometer) then a good indicator is the severity of your headache. If your BP continues to rise, then your headache will become more intense; when it begins to fall, your headache will be less painful.

#### **Call your GP**

If the symptoms persist despite interventions, notify your GP and local SCI centre. It is important that you are familiar with your treatment options in the event of autonomic dysreflexia. You should also be provided with an appropriate vasodilator (substance that causes the blood vessels to widen, thereby reducing BP) for use at home, which should be administered if you have an episode of autonomic dysreflexia.

As mentioned previously, since not all medical and healthcare staff are familiar with autonomic dysreflexia and its treatment, you should carry an emergency medical card with you always that describes the condition and the treatment required. You can obtain a free emergency medical card from SIA.

#### **Autonomic Dysreflexia Emergency Kit**

It is also worthwhile to have an AD kit with you at all times.

This would contain:

- Catheter and supplies: if you use intermittent catheterisation, pack a straight catheter, and if you use an indwelling catheter, pack insertion supplies, irrigation syringe and sterile water/saline solution.
- Medicine prescribed for autonomic dysreflexia (usually Nifedipine or Glyceryl trinitrate - GTN) – check this from time to time to make sure it is in date
- Anaesthetic lubricant like 2% lidocaine (lignocaine) gel
- Sterile vinyl gloves
- Wet wipes and disposal bag.

**Warning: postural hypotension (a drop in blood pressure) can occur following medication for AD.**

### **How can the risk of autonomic dysreflexia be reduced?**

Fortunately, there are precautions you can take to reduce the risk of autonomic dysreflexia including:

#### **Bladder**

- Change catheters regularly to prevent blockage
- Keep catheters free off kinks, clean, and follow your intermittent catheterisation regime regularly to avoid an overfull bladder
- Check urine for signs of infection (UTIs)
- Have regular bladder and bowel check-ups with your GP or at your SCIC
- Drink enough fluids.

#### **Bowel**

- Maintain a regular bowel regime (ideally alternate days between bowel evacuations)
- Adequate fibre in diet to help avoid constipation
- Get treatment for haemorrhoids.

#### **Skin**

- Frequent pressure relief when in both chair and bed
- Check skin regularly
- Avoid tight or restrictive clothing
- Avoidance of sunburn / scalds (avoid overexposure, use sunscreen with SPF15 or higher, avoid extreme water temperatures)
- Establish good posture in your wheelchair
- Maintain essential equipment, especially making sure your cushion is fit for purpose.

#### **Other**

- If pregnant or planning to get pregnant, make sure your obstetrician / gynaecologist is aware of your healthcare needs as a SCI person
- Correct dosage and timing of medications
- Be educated in the causes, signs and symptoms, first aid, and prevention of autonomic dysreflexia and make sure those around you, or caring for you, are similarly educated.

#### **In Summary**

- AD is a potentially life-threatening medical problem
- It requires immediate attention by yourself / your carers
- Learn what triggers an episode, how to deal with it and teach those around you the warning signs and treatment
- Have the necessary tools handy to deal with an episode
- Fix the problem, sit up and try to stay calm
- Call for medical attention if the symptoms do not subside.

**For an Emergency Medical Card, ring SIA Advice Line – Tel: 0800 980 0501**

\*Adapted from *Managing Spinal Cord Injury: Continuing Care; Chapter 22 'Autonomic Dysreflexia'* by Paul Harrison & Alison Lamb.

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### **Disclaimer**

This factsheet has been prepared by SIA and contains general advice only which we hope will be of use to you. Nothing in this factsheet should be construed as the giving of specific advice and it should not be relied on as a basis for any decision or action. SIA does not accept any liability arising from its use. We aim to ensure the information is as up-to-date and accurate as possible, but please be warned that certain areas are subject to change from time to time. Please note that the inclusion of named agencies, companies, products, services or publications in this factsheet does not constitute a recommendation or endorsement by SIA.

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## Appendix Two – Spinal Injuries Association procedure on Digital Rectal Examination of Individuals with SCI

(Authors: Carol Adcock & Debbie Green June 2016- SIA)

<b>ACTION</b>	<b>Rationale</b>
Explain the procedure to the individual and obtain consent. Even if the individual consents to the procedure, Consider if chaperone required.	Obtain informed consent. Patient safety.
Wash hands, put on two pairs of disposable gloves and an apron	Infection Control
Ensure a private environment.	Maintain dignity and respect
Recording of B/P is only required if this is the first time procedure is being carried out and or if the individual demonstrates or provides a history of autonomic response during bowel care interventions.	Early recognition of any adverse harm to the individual. If the individual suffers local discomfort or symptoms of autonomic dysreflexia during this procedure, local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa 2008, Cosman 2005). This requires 5-10 minutes to take effect and lasts up to 90 minutes.
If not contraindicated (i.e. in unstable spinal cord injuries) position the individual in a lateral position (usually left side) with knees flexed. If the spinal injury is unstable bowel management will be conducted during a team log roll, maintaining spinal alignment at all times.	Flexing the knees promotes the stability of the individual and helps to expose the anus (Campbell 1993). Maintaining spinal alignment is paramount to prevent any compromise to neurological deficit until spinal clearance is given by appropriate clinician.
Place protective pad under the patient if appropriate	Infection control
Observe peri-anal area for adverse complications.	Infection control, patient safety.
Ensure patient buttocks only exposed.	Maintain dignity. Prevent hypothermia.
Lubricate gloved finger with water-soluble gel.	To prevent friction which cause lead t anal trauma
Inform individual you are about to begin.	Obtain consent
Insert single gloved, lubricated finger (Addison and Smith 2000) slowly and gently into rectum.	To open external anal sphincter and prevent trauma
Observe for any voluntary or reflex contraction of anus and/or rectum.	Assess neurogenic bowel dysfunction
Assess for any sensation experienced by the individual	Assess neurogenic bowel dysfunction
Feel for any obstruction, abnormality.	To prevent trauma
Determine presence of stool and stool type	
Withdraw the finger and observe for any signs of blood on glove.	To stimulate rectal contraction
Document DRE performed and proceed to appropriate intervention if safe to do so.	
Document and report any abnormalities to medic before proceeding with any further interventions.	To ensure complete emptying of rectum

## Appendix Three - Spinal Injuries Association procedure on Digital Rectal Stimulation of Individuals with SCI

(Authors: Carol Adcock & Debbie Green June 2016- SIA)

<b>ACTION</b>	<b>Rationale</b>
Ensure prescribed oral aperients have been given Offer warm drink or food to stimulate gastro-colic reflex.	To promote stool transit.
Explain the procedure to the individual and obtain consent. Even if the individual consents to the procedure, if they request you to stop at any time, you must do so. The individual should be offered an escort present if they wish.	Obtain informed consent.
Ensure a private environment.	Maintain dignity and respect
Monitoring of B/P is only required if this is the first time the procedure is undertaken or if the individual displays symptoms or gives a history of an autonomic response during bowel care interventions	Early recognition of any adverse harm to the individual.  If the individual suffers local discomfort or symptoms of autonomic dysreflexia during this procedure, local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa 2008, Cosman 2005). This requires 5-10 minutes to take effect and lasts up to 90 minutes. Note that long term use should be avoided due to systemic effects (BNF 2008).
Position the individual in a left lateral position with knees flexed, if safe to do so. If the spinal injury is unstable, bowel management should be undertaken during a team roll, maintaining spinal alignment at all times.	Flexing the knees promotes the stability of the individual and helps to expose the anus (Campbell 1993).  Maintaining spinal alignment is paramount to prevent any compromise to neurological deficit until spinal clearance is given by appropriate clinician.
Place protective pad under the patient if appropriate	Infection control
Wash hands, put on two pairs of disposable gloves and an apron.	Infection control
Ensure patient buttocks only exposed.	Maintain dignity. Prevent hypothermia.
Lubricate gloved finger with water soluble gel.	To prevent friction which cause lead t anal trauma
Inform individual you are about to begin.	Obtain consent
Perform DRE	To establish safe to proceed
Insert single gloved, lubricated finger (Addison and Smith 2000) slowly and gently into rectum.	To open external anal sphincter and prevent trauma
Turn the finger so that the padded inferior surface is in contact with the rectal wall.	To prevent trauma

Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the rectal wall throughout.	To stimulate rectal contraction
Withdraw the finger and await reflex evacuation.	To expel stool from rectum
Repeat every 5-10 minutes until rectum is empty or reflex activity ceases.	To ensure complete emptying of rectum
Remove soiled glove and replace, re-lubricating as necessary between insertions.	Infection control
If no reflex activity occurs during the procedure, do not repeat it more than 3 times. Use digital removal of faeces (DRF) if stool is present in the rectum.	Patient safety
During the procedure the person delivering care may carry out abdominal massage.	Increase abdominal pressure to assist with rectal emptying
Once the rectum is empty on examination, conduct a final digital examination of the rectum after 5 minutes to ensure that evacuation is complete.	Prevent faecal incontinence
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.	Infection control
When the procedure is completed wash and dry the patient's buttocks and anal area and position comfortably before leaving.	Patient safety, infection control
Remove gloves and apron and wash hands.	Infection control
Record outcomes using the Bristol Scale (Norgine 1999, Heaton 1993).	Patient safety, ongoing assessment
Record and report abnormalities.	Patient safety



## Appendix Four - Spinal Injuries Association procedure on Digital Removal of Faeces of Individuals with SCI

(Authors: Carol Adcock & Debbie Green June 2016- SIA)

<b>ACTION</b>	<b>Rationale</b>
Explain the procedure to the individual and obtain consent. Even if the individual consents to the procedure, if they request you to stop at any time, you must do so. The individual should be invited to have an escort present if they wish.	Obtain informed consent. Legal requirement
Ensure a private environment.	Maintain dignity and respect
Monitoring of B/P is only required if this is the first time the procedure is undertaken or if the individual displays symptoms or gives a history of an autonomic response during bowel care interventions.	<p>Early recognition of any adverse harm to the individual.</p> <p>If the individual suffers local discomfort or symptoms of autonomic dysreflexia during this procedure, local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa 2008, Cosman 2005). This requires 5-10 minutes to take effect and lasts up to 90 minutes. Note that long term use should be avoided due to systemic effects (BNF 2008).</p>
Position the individual in a left lateral position with knees flexed, if safe to do so. If the spinal injury is unstable, bowel management should be undertaken during a team roll, maintaining spinal alignment at all times.	<p>Flexing the knees promotes the stability of the individual and helps to expose the anus (Campbell 1993).</p> <p>Maintaining spinal alignment is paramount to prevent any compromise to neurological deficit until spinal clearance is given by appropriate clinician.</p>
Place protective pad under the individual.	Infection control
Wash hands, put on disposable gloves and apron.	Infection control
Ensure only buttocks exposed	Maintain dignity. Prevent hypothermia.
Lubricate gloved finger with water soluble gel.	To prevent friction which cause lead t anal trauma
Inform individual you are about to begin.	Obtain consent
Perform DRE to establish safe to proceed.	
Insert lubricated, gloved, single finger slowly and gently into rectum.	To open external anal sphincter and prevent trauma (Addison and Smith 2000)
With pad of finger against stool slowly rotate and remove finger, expelling stool from the rectum at the same time. Avoid a hooked finger.	To prevent trauma to rectal mucosa and anal sphincter
During the procedure the person assisting may carry out abdominal massage.	To increase abdominal pressure and aid with evacuation of stool.
Once the rectum is empty on examination, conduct a final digital check of the rectum after 5 minutes to ensure that evacuation is complete.	To ensure complete emptying of rectum and prevent faecal accidents.

Place faecal matter in an appropriate receptacle as it is removed, and dispose of it in a suitable clinical waste bag.	
When the procedure is completed wash and dry the individual's buttocks and anal area and position comfortably before leaving.	
Remove gloves and apron and wash hands.	Infection control
Record outcome using the Bristol Scale	Legal requirement and aid assessment. (Norgine 1999, Heaton 1993).
<ul style="list-style-type: none"> <li>Record and report abnormalities.</li> </ul>	Legal requirement