Management Guidelines for Lower Bowel Dysfunction in Adults within Primary Care

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THE MANAGEMENT GUIDELINES FOR LOWER BOWEL DYSFUNCTION IN ADULTS WITHIN PRIMARY CARE

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Policy for
The Management Guidelines for Lower Bowel Dysfunction in Adults within Primary Care

Procedural Document Statement

Background
The purpose of this guidance is to deliver clear integrated evidence based pathways for adults presenting with lower bowel dysfunction problems and to highlight the role of conservative primary care based management of incontinence.

Statement
This policy will conform to Lincolnshire Community Health Service statutory and organisational requirements and National guidance to promote holistic and safe practice. As such, it will be formally approved and ratified, disseminated through approved channels and implemented.

Responsibilities
Compliance with the policy will be the responsibility of clinical Lincolnshire Community Health Service staff.

The policy has been developed after consultation with Primary and Secondary Care Practitioners with expertise in this speciality.

Training
LCHS provide training courses to support all levels of clinical practice within this speciality. The training complements all aspects of bowel dysfunction, treatment and management specified within this document. Practitioners undertaking bowel assessment and bowel care should have completed the appropriate training and competencies identified within this document.

Dissemination
Website, Email, Identified in LCHS Staff Newsletter, Training website.

Resource implication
The policy has been developed in line with the NHS Litigation Authority guidelines to provide a framework for staff within NHS Organisations to ensure the appropriate production, management and review of organisation wide policies.

Consultation
The guidance has been developed in line with the NHS Litigation Authority Guidelines to provide a framework for staff within NHS organisations to ensure the appropriate production, management and review of organisation wide policies.
NHSLA Monitoring Template

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

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1. **INTRODUCTION**

This policy aims to standardise care and provide an agreed framework for referral from primary to secondary care, in line with the concept of integration required by Good Practice in Continence Services (DH, 2000), the National Service Framework for Older People (DH, 2001a) & NICE guidelines (DH, 2006, DH, 2010).

During recent years, bowel continence has seen its profile raised with the publication of two new documents, Skills for Health (SfH) (2008) and the RCN guidance for nurses on bowel care (2012) an updated and more comprehensive guide to bowel dysfunction that incorporates the national occupational standards for continence care outlined in SfH (Ness 2009). Community nurses have a pivotal role in the promotion of bladder/bowel continence with particular emphasis on supporting patients and their caregivers to manage these intractable symptoms. Thereby nurses are ideally placed to initiate conservative management and treatment and to refer for appropriate investigations and treatment (Chelvanayagam & Norton 1999).

This document is underpinned by the current available evidence, or where this is lacking, expert opinion. Evidence-based health care is defined as the conscientious, explicit and judicious use of current best evidence in making decisions about patient care (Sackett et al, 1996). The application of the best available evidence is a recognised method of improving clinical outcomes for individual patients (Williams et al, 2002).

This document is intended as a guide for practitioners, in order to enhance the care provided to patients with lower bowel dysfunction.

This guidance does not obviate the requirement to exercise clinical judgement, or to recognise the patient as an individual.

2. **PURPOSE**

- To deliver clear integrated evidence based pathways for adults presenting with lower bowel dysfunction problems.

- To clearly identify those who can conservatively be managed in the primary care setting and promote appropriate referrals for the remainder.

- To ensure uniformity in delivering care for this group of patients across primary care and in the primary to secondary care interface.

- To highlight the role of conservative primary care-based management of bowel incontinence.

- To develop best practice in continence care for all levels of Practitioners using competency frameworks to ensure effective and safe practice.

- To clearly identify the various practitioners who are involved in the care of adults with bowel problems and recognise their scope and limitations. This should facilitate liaison with each other to optimise care.

- This document is particularly relevant to support bowel care provided by community nurses in Primary Care, but should also aid General Practitioners in their decision making process regarding bowel dysfunction.
The algorithms in this document are intended to guide Primary Care Practitioners in assessing patients who have problems with lower bowel dysfunction. The document is not intended as a comprehensive guide to the management of Lower Bowel Dysfunction.

3. DEFINITION, CAUSES AND PREVALENCE OF CONSTIPATION AND FAECAL INCONTINENCE

Constipation and incomplete emptying

There is no one definitive definition of constipation, but the most prolifically cited definition describes constipation as “straining at stool more than 25% of the time or passing two or fewer stools per week” according to the Rome III criteria (Rome Foundation 2006). Constipation consists of predominantly two main types, slow colonic transit (failure of colonic propulsion) and evacuation difficulties that can often co-exist. Colonic transit may be reduced by the impairment of the intrinsic nerves of the gut wall (myenteric plexus) or abnormalities of the gut neurotransmitters (Emmanuel 2004; Norton 1996). Constipation can also incorporate other symptoms such as dulled or loss of urge to defecate, the need for digitations and incomplete emptying (Gardiner 2009).

It has been stated that approximately 10-18% of the adult population report frequent straining on defecation and less than 4% admit to three bowel actions per week (Best Practice 1999). It is also said by Norton (1996) to result in almost half a million general practitioner consultations per year with an increased prevalence reported in older people (Annells & Koch 2002). However, it is generally considered that identifying the causes of constipation is a complex activity and involves other multi-factorial influences. These include a slow transit bowel, low residue diet, lack of fibre or inadequate fluid intake, immobility and medication particularly opioids, neurological conditions, psychological problems and metabolic disorders (Collins & Burch 2009; Duncan 2004; Kamm & Lennard Jones 1994).

Bowel habits and the perception of what constitutes normal bowel habits can vary considerably making constipation difficult to define, thus differing methods have been designed to overcome this difficulty such as The Rome III Tool that developed a range of symptoms to explain constipation;

Two or more of the following symptoms should be present for at least 3 months and onset of symptoms at least six months before diagnosis

- Straining at least 25% of defecations
- Lumpy hard stool at least 25% of defecations
- A sensation of incomplete evacuation for at least 25% of defecations
- Three or fewer bowel movements per week
- Sensation of anorectal obstruction/blockage for at least 25% of defecations
- Manual manoeuvres to facilitate at least 25% of defecations, such as digital evacuation or support of the pelvic floor.
- Loose stools rarely present without use of laxatives
- Insufficient criteria for irritable bowel syndrome

(Rome Foundation 2006)
Alternatively Barnes (1986) offers another definition;

Ninety-nine percent of the population has a bowel frequency ranging from three bowel movements per day to three per week.'

Individuals presenting with bowel continence problems often report a reduced quality of life and have a tendency to become isolated, thereby inducing feelings of loneliness and shame (Norton, 1996).

Certain groups of people have an increased risk of experiencing bowel dysfunction problems. These include women, those with or have sustained obstetric trauma and/or learning disabilities and people with neurological conditions (DoH, 2000).

Main types of constipation

People with constipation usually fall into two categories, those with an inability or difficulty in defecating (obstructed defecation) or those with a transit abnormality (Frizell & Barclay 2007). These two groups can be further divided into several subgroups.

Transit abnormalities can be classified as primary/idiopathic constipation, secondary constipation, functional constipation or faecal impaction. Obstructed defecation can be further sub classified as due to prostates, descending perineum syndrome, muscle dyssynergia (Chiarelli 2008).

Primary or idiopathic constipation
This generally has no known cause and is not associated with any other conditions. However, it may be attributed to lifestyle factors such as reduced mobility, inadequate diet, slow transit of colon and pelvic floor abnormalities (RCN 2012).

Secondary constipation
Secondary to another condition; either neurological, metabolic, hormonal or psychological

Functional constipation
This presents as infrequent, difficult or incomplete evacuation. This includes two or more symptoms for 25% of defecations and to have been present for 3-6 months:

- Straining at stool
- Lumpy or hard stools
- Sensation of incomplete evacuation
- Sensation of anorectal obstruction/blockage
- Digital removal of faeces, support of pelvic floor to aid evacuation by manual means overlaps with prolapse
- Fewer than three evacuation per week
- Loose stools rarely present without use of laxatives (Longstretch et al 2006).

Faecal Impaction
This is when the rectum and the lower colon is full of hard or soft faeces and the person is unable to evacuate their bowel unaided. This can result in faecal impaction with overflow spurious diarrhoea, which is common in the elderly (Harari 2004) and in individuals with neurogenic bowel dysfunction. It may be misdiagnosed as diarrhoea and treated inappropriately (RCN 2012).

Prolapses
Alterations to the anatomy of the rectum causes difficulty defecating. There are several types of prolapses:
• Intussusceptions – circular rectal wall infolding 4mm of the rectal mucosa during straining
• Enteric prolapses – sigmoidocele and enteroceleare prolapsed of the colon into the rectovaginal fossa
• Anterior rectal wall (rectocele). – prolapse through the rectovaginal septum and posterior vaginal wall into the vagina
• Rectal prolapse – procidentia of the full thickness of the rectum through the anal canal

(Agachan et al 1996)

**Descending Perineum Syndrome**
This is when the perineum upon straining extends below the ischial tuberosities. This means the loss of “funnel” that allows stools to be evacuated (Chiarelli 2008).

**Muscle Dyssynergia**
This is a paradoxical sphincter contraction instead of relaxing the anal sphincter to aid defecation. This is known also as disordered defecation, anismus or paradoxical puborectalis contraction (Chiarelli 2008). This is sometimes a hidden cause of chronic constipation and needs to be considered when carrying out a bowel continence assessment.

The second types of muscle dyssynergia are patients are unable to generate an adequate propulsive force within the pelvis. This is evidenced by a feeling of anal blockage on more than 1-4 occasions and prolonged defecation or need for self-digitation on any occasion (Harari 2004) often seen in patients with neurogenic bowel dysfunction.

**Prevalence rates in constipation:**

• Higher prevalence in the over 65’s, people with depression & anxiety and with poor health perception (Harari, 2002)
• 3% - 20% of adults complain of constipation - women > men (Taylor, 1990)
• 6% children; boys > girls (Chiarelli & Markswell, 1992)
• Approx.50% of people admitted as an emergency
• 80% older people in residential care are constipated

(Chiarelli & Markswell, 1992)

**Faecal Incontinence**
Faecal incontinence is referred to as “the involuntary or inappropriate passage of faeces” (Royal College of Physicians 1995)

Alternatively Chelvanayagam & Norton (1999) include the inability to control flatus in their definition of anal incontinence that contends that it is “any involuntary leakage from the anus, whether of stool, liquid or flatus”

Faecal incontinence and anal incontinence are terms that are often used interchangeably within the literature that are used equally by both generalist and specialist nurses working within the community with patients experiencing bowel problems. For the purpose of this document the term faecal incontinence will be used predominantly by the author.
Faecal incontinence covers the following symptoms:

- Lack of control of flatus
- Urgency of the bowels with no related leakage
- Urgency of the bowels and related leakage
- Passive Soiling

(Norton 2008)

A major cause of faecal incontinence is due to an obstetric injury/trauma to the anal sphincters.

**Obstetric Injuries**

An obstetric injury is defined as an injury to the anal sphincter that occurs during childbirth and is recognised as one of the most common causes of faecal incontinence (Fowler 2009). It affects 40,000 mothers a year (Glazener et al 1998) who report symptoms of faecal incontinence, urgency of the bowels and decreased control of flatus (Sultan et al 1994). Obstetric injuries are either classified as a tear or an occult obstetric injury. Tears to the skin, perineum and anal sphincters that occur during childbirth are officially classified as first to fourth degree tears:

- First degree tears - injury to the perineal skin
- Second degree tears - injury to the perineum that involves the perineal muscle
- Third degree tears - injury to the anal sphincter that are further categorised as;
  - 3A < 50% of the external anal sphincter
  - 3B > 50% of the external anal sphincter
  - 3C - the external and internal anal sphincter
- Fourth degree - the complete anal sphincter complex and the anal epithelium

(RCOG 2001)

It is the third and fourth degree tears that are the injuries which can lead to faecal incontinence. These tears are repaired in theatre by the medical team. Following the repair people are generally given antibiotics prophylaxis and laxatives. Upon discharge they are reviewed by a consultant gynaecologist after 6 weeks and offered physiotherapy to increase pelvic floor strength. (RCOG 2007).

Investigations done by Sultan et al (1993) with endoanal ultrasound reported up to 35% of women were found to have had damage to the anal sphincter following childbirth that had gone unnoticed at the time of delivery and was never surgically repaired. These injuries are more likely to occur after forceps delivery. With a forceps delivery an episiotomy (incision into the perineum) is usually done which results in further stretching and this can potentially damage the anal sphincter (Fowler 2009).

Another cause that can result in an occult obstetric injury is a prolonged second stage of labour (the pushing stage). The stretch to the pelvic floor to form the birth canal places a stretch on the pudendal nerve that can lead to long term damage. The nerve becomes stretched and tethered. This is further exacerbated by the fact that with a prolonged second stage then the need for intervention such as forceps is required and further damage occurs (Fowler 2009).

The long term of many obstetric injuries is that they can be asymptomatic for many years. Once a woman reaches the menopause the loss of oestrogen decreases the pelvic floor strength and results in the pressure drop in the anal sphincter tone resulting in faecal incontinence. It is important
that any assessment into faecal incontinence in women includes questioning of the obstetric history. However the assessor must recognise that women may not remember or be aware that they have had a third or fourth degree tear.

Other factors such as faecal impaction, poor mobility, neurological disease and congenital anorectal abnormalities can also result in problems with faecal incontinence and constipation (Kamm 2003).

Studies regarding faecal incontinence in older adults imply a correlation between FI and increasing disability in both men and women, with a reported 53% in men and 60% in women (Edwards & Jones 2001). However, other literature purport that ascertaining the causes of FI in older adults is a complex activity and involves other multi-factorial influences. These include medication, cognitive ability, socio-economic, environmental factors, diseases of the central nervous system and gastrointestinal systems (Potter et al 2002; Barrett 1993).

The National Institute for Health and Clinical Excellence, in the clinical guidance for faecal incontinence, indicates that 0.5-1.0% of adults with persistent faecal incontinence report a negative impact on their quality of life (NICE 2007).

Prevalence rates in Faecal Incontinence (FI):

Affects approximately 1-2% of the total population (Soffer & Hull 2000; Perry et al 2002)

FI is a devastating episode in the lives of individuals, family members and caregivers causing embarrassment and affecting their quality of life (Cotterill et al 2008; Stenzelius et al 2007). As many people believe that it is something that they will just have to live with, consequently it may go unreported due to the negative connotations it arouses and is thus considered a taboo subject. Therefore it has the potential to create a lasting psychological effect that may result in social isolation due to the unpredictability of symptoms that may occur when pursuing social activities (Stenzelius et al 2007; Edwards & Jones 2001; Bugg et al 2001; Norton & Chelvanayagam 2000). It has also been advocated that the prevalence of faecal incontinence can be comparable and as debilitating as other chronic and long-term conditions (Collings & Norton 2005).

4. THE IMPORTANCE OF ASSESSMENT AND IMPLICATIONS FOR BOWEL CONTINENCE EDUCATION

‘Comprehensive and accurate assessment is a major determinant of patient care.’ (Audit Commission, 1999)

The Audit Commission (1999) advocated that the potential implications of poor or incomplete assessments could result in delays in access to treatment, delays in amelioration of symptoms and proposed that the development of condition specific assessment tools could improve and standardise care. Moreover, it has been mooted that the assessing nurse needs to have a sound knowledge base and relevant clinical competencies to be able to adapt the bowel assessment to individuals regardless of their gender, culture and socioeconomic status and to also transfer and adapt to differing care settings (Skills for Health 2008; RCN 2012).

Good Practice in Continence Services’ (DoH, 2000) suggests that all patients presenting with incontinence should be offered an initial continence assessment, performed by a suitably trained healthcare professional. Therefore it is important that all Community Nursing staff take responsibility for performing continence assessments. Patients should be able to access a suitably trained Health Care Professional within the Primary Care arena.
All patients will receive a comprehensive assessment performed by an appropriately qualified competent professional (SFH www.skillsforhealth.org.uk 2008).

To prepare Health Care Professionals for this role there are both In-service training to support initial generic continence assessment designed to identify a working diagnosis, exclude red flags and any contributory factors. There are also Countywide and local Business Unit Link Nurse/Champions meetings and staff are encouraged to disseminate continence updates and national and local policies to their respective teams. Staff groups are responsible for keeping up to date with their knowledge, skills and competencies in line with local and national policies (Way, 2002, SFH, 2008).

5. **THE ASSESSMENT PROCESS**

   “A thorough assessment is the most crucial component of effective continence care provision and the importance of developing good assessment skills, learned through experience should not be underestimated.” (Getliffe, Dolman 2007).

   The current tool in use within Lincolnshire Community Health Services (LCHS) was designed by a multi-disciplinary working party, and is in an electronic format and has been developed as part of the SystmOne applications. SystmOne has a suite of evidence based templates and care plans pertaining to both bladder and bowel continence care to support the assessment process. Latterly, a symptom profile questionnaire has been developed to aid the assessment process, which can be forwarded to patients prior to the consultation (Appendix E).

   It is recommended by the author as best practice that the initial assessment should be preceded by a symptom questionnaire, bowel diary and a quality of life indicator questionnaire (RCN 2012; Cotterill et al 2007; Bugg et al 2001; Norton & Chelvanayagam 2000; Vaizey et al 1999) to potentially overcome the well documented evidence that implies reluctance of patients to disclose faecal incontinence or evacuation difficulties due to the stigmatising nature of this condition (Kalantar et al 2002; Bugg et al 2001; Norton & Chelvanayagam 1999; Irvine 1996). It also has the added benefit for the community practitioner as an outcome measure or audit tool (Bugg et al 2001).

   An initial continence assessment should take a minimum of one hour (Getliffe, Dolman, 2007). The assessment may require several home visits/clinic appointments to complete, in order to ensure all the necessary information is obtained


   Completion of the assessment tool should not be perceived as an end in itself, as this does not automatically lead to a working diagnosis. The information gathered during the assessment process requires interpretation. This can only be effectively achieved by a practitioner with underpinning knowledge of normal bowel function and an understanding of the causes, types and contributory factors associated with bowel dysfunction and faecal incontinence. This evidence is supported by evidence based treatment algorithms that will direct staff once a diagnosis has been achieved (Appendix 11-16)

   A multi-disciplinary approach helps to ensure the patient receives the optimum level of assessment (Winder 1996, Pomfret 2003). Nurses and General Practitioners each have a sphere of expertise relevant to the understanding of the potential cause(s) of the problem. A
comprehensive picture can best be achieved by working in partnership, together with the patient. In this way, it is possible to maintain high quality care to achieve collaborative working as well as engage the patient with a shared decision opportunity (Getliffe, Dolman, 2007)

The assessment process should enable the practitioners involved to identify and agree on a provisional working diagnosis. The appropriate care algorithm can then be accessed within the primary care setting (DoH, 2000) or a referral for further investigation initiated.

Products to manage incontinence (absorbent pads, anal plugs, faecal collectors etc.) may be considered during the assessment process. However, it should be born in mind that psychological dependence on containment products can develop if these are offered prematurely and the motivation to regain continence may be compromised (NICE 2007).

5.1 SUMMARY: ASSESSMENT IN PRIMARY CARE

History

- Review of onset and symptoms “The Patients Story” their expectations and why they are presenting now?
- Change in diet
- Use of laxatives and other bowel medication (including over the counter medication)
- Any changes in usual bowel action
- Exclude any red flags – See S1 bladder/bowel templates
- The presence of blood, mucus or an offensive odour
- Medical and surgical history
- Obstetric history
- Pain and discomfort on defecation
- Effect on quality of life
- Desire for treatment
- Identification of conditions which may worsen symptoms e.g. chronic cough, smoking, anal-rectal surgery or previous radiotherapy/chemotherapy
- Manual dexterity and mobility
- Assessment of environment
- Activities of daily living assessment
- Medication review

Physical Examination

- Abdominal examination
- Pelvic examination
- Pelvic floor assessment
- Identification of neuropathic bowel problems e.g. absence of relaxation of puborectalis muscle
Identification of loss of cortical control
Weight
BMI (NICE, 2006)
Digital Rectal Examination assessing for faecal matter, stool consistency and anal tone
Visual assessment of perineum and buttocks
Observe skin integrity for pressure damage and/or contact dermatitis

Investigation
• Bowel/Food Diary
• Stool specimen and urine specimen when indicated.

5.2 BOWEL CARE INTERVENTIONS FOR NEUROGENIC BOWEL DYSFUNCTION

“Neurogenic bowel” is a term to explain dysfunction of the colon (constipation, faecal incontinence and disordered defecation) due to loss of both normal and sensory function and/or motor control as a result of neurological damage or disease (Chung & Emmanuel 2006).

Damage to the spinal cord and brain disrupts the nerve pathways and therefore the outcome will vary dependent on the location and severity of the damage or injury. Thus, neurogenic function may be classified as either reflex, areflexic or mixed bowel function.

Therefore loss of sensory and motor control can impair defecation leading to faecal incontinence and chronic constipation in individuals with central neurological conditions including:

• Spinal cord injury
• Multiple Sclerosis
• Spina Bifida
• Cauda Equina Syndrome
• Cerebral palsy
• Stroke
• Parkinsons Disease

The presentation of the bowel dysfunction in these conditions may vary; the underlying cause is the same, damage to the central nervous system control of the bowel. (MASCIP 2012).

Reflex Neurogenic bowel dysfunction (NBD) affects those with Spinal Cord injuries above T12/L1

• If patients have spasm in their legs or experience penile erection then it is likely they have Reflex NBD.
• **Chemical stimulation** is when a substance is inserted into the rectum to provoke a reflex response (i.e. defecation). This can be a suppository or a Microenema (Relaxit, Norgalax. Rectal Bisacodyl Solution is a rather more specialised approach requiring equipment developed for the purpose. Details can be found in the Bisacodyl Solution Service Operating Plan attached to this document (Page 68).

• **Digital stimulation** is where the finger is introduced into the rectum to stimulate defecation

**Areflexic NBD (also known as ‘flaccid’ bowel)**

• Usually affects those with spinal cord injuries below T12/L1

• If patients have no spasm in their legs, and stay dry on intermittent self catheterisation (ISC) without medication, and do not get erections of any kind (if they are male), then it is likely that they have Areflexic NBD

• In Areflexic NBD, the anal sphincter does not contract in response to stimulation.

• In Areflexic NBD the sphincters and rectum have no reflex connection; therefore there is no benefit in using a reflex stimulus such as a suppository or microenema

• The bowel can only be emptied satisfactorily by either removing faeces with your finger (Digital Removal of Faeces (DRF), commonly referred to as ME (Manual Evacuation)), or washing it out using an irrigation device

• People with areflexic NBD usually have stool that is firmer than normal

• This is because the absence of reflexes means that stool takes longer to move through the colon, which removes water from the stool

• This is beneficial in that it makes the stool easier to remove digitally, and offers some protection against the accidental passing of stool when they cough, or transfer, or otherwise increase the pressure in their abdomen

• The idea is to keep the stool firm without it becoming too hard to remove digitally

**Mixed NBD in spinal cord injury patients**

• If patients have an incomplete injury, they may have some sensation in their bowels but will be unable to either pass stool when the urge occurs, or delay it until they can get to a toilet etc.

• In fact ‘mixed’ type NBD is very variable and can be difficult to manage, particularly if sensation is normal but digital interventions or rectal stimulants are still required to empty the bowel

**The principles of problem solving with neurogenic bowel dysfunction**

• When problems arise, it is important that you respond systematically and calmly; when this happens people become (understandably) anxious and often change several aspects of their bowel routine drastically without really allowing time to see what the effect is

• The result of this is often a ‘see-sawing’ between constipation and incontinence that causes a complete break-down in routine
• Use a bowel diary or look back to try and work out the most likely cause of the problem (change in diet or other lifestyle habits, change of medication, change of carer etc)

• Change only one thing at a time regarding bowel management

• Allow at least one week to decide on the effectiveness of that adjustment before you change anything else

• If in doubt, seek help or advice from Specialist Nurse, GP and/or spinal cord injury unit.

**Bowel management in neurogenic bowel dysfunction has three main goals:**

• Maintaining continence (passing stool at an appropriate time without having accidents)

• Avoiding constipation

• Establish a regular bowel emptying regime that can be completed within a timeframe acceptable to the patient.

(Ash 2005)

5.3 **BOWEL CARE IN THE COMMUNITY OR DURING ADMISSION TO A GENERAL HOSPITAL**

• It is recommended as Best Practice that all NHS organisations have a policy for manual evacuation of stool and have suitably trained staff available if the patient needs this (NRLS 2012)

• Failure to meet the needs of individuals, for their elimination needs, may be seen as neglect, under the definition of abuse in the NMC statement on ‘Practitioner-Client Relationships and the Prevention of Abuse’ (NMC 2002).

• An appropriate bowel management programme must be maintained during admission to non-specialist acute healthcare setting or in the community setting

• Many patients with neurological conditions are expert in their own care (NRLS 2012) and maintenance and continuation of existing bowel regimes should be facilitated via provision of suitable facilities and provision of required assistance

• Where current management is not effective an alternative bowel management programme should be planned in collaboration with the individual to meet lifestyle and home environment.

• Where alteration of an existing bowel management is sought this should be discussed with the individual and specialist provider for their care e.g. spinal cord injured patient and spinal cord injury centre (MASCIP 2012). Alteration of an established bowel regime without specialist advice can result in devastating consequences for the client such as autonomic dysreflexia as described below.

5.4 **AUTONOMIC DYSREFLEXIA IN SPINAL CORD INJURY PATIENTS**
Autonomic dysreflexia is a condition that develops after spinal cord injury in which potential life-threatening episodic hypertension is triggered by stimulation of sensory nerves below the site of injury. Autonomic dysreflexia may occur in patients with spinal cord injury, usually above T-6.

Autonomic Dysreflexia which includes: East & North Birmingham Community Health Services Trust fact sheet. For detailed evidence based information please refer to the fact Sheet included as Appendix B.

5.5 TRANS ANAL IRRIGATION

Trans anal or rectal irrigation has recently developed and established momentum in the United Kingdom over the last 5-10 years (Crawshaw et al 2003). The benefits for patients with functional bowel disorders is that it enables them to achieve bowel emptying without the assistance of medication, thereby giving them more control and autonomy over their own bowel regimes reducing dependence on health care professionals to meet their elimination needs (Gardiner 2009).

The advent of an all-in-one irrigation device (Peristeen – Coloplast Ltd) containing a hand held pump, water bag and rectal catheter facilitates bowel emptying without the need for specifically adapted environments, ideal for use in the community under supervision of a Continence Nurse Specialist. The catheter incorporates a balloon which holds the catheter into the rectum and helps to retain the irrigation fluid in the rectum. It works by pumping lukewarm water into the rectum. This gradually distends the rectal wall and normal rectal dynamics stimulate the stretch receptors to initiate the urge to defecate. The water is then emptied from the lower bowel with the bowel contents into the toilet. This process usually takes approximately 30 minutes (Coggrave 2007; Gardiner et al 2004). Alternative new methods can also be used for anal/rectal irrigation via Irypump S (B Braun) or a gravity system using an infusion device (Qufora System-MacGregor Healthcare Limited) where the water may be introduced into the bowel via a cone tip manually held in place in the anus. Rectal irrigation has proved a successful method of relieving functional bowel disorders (Tod et al 2007; Christensen et al 2006). Patients confirmed fewer complaints of constipation and faecal incontinence and improved quality of life, with reduced time spent on bowel management with only transient and mild effects experienced.

The findings revealed that patients with faecal incontinence experienced the most benefit from rectal irrigation as they were more likely to persist with the procedure (Tod et al 2007). Trans anal irrigation should only be considered if other less invasive, conservative methods of bowel management have been tried or failed to control constipation or faecal incontinence (RCN 2012).

This system is only advocated for selected patients following an individualised comprehensive bowel assessment as these systems are not appropriate for all patients. It is imperative that their suitability is also assessed and informed consent obtained (RCN 2012) regarding which anal irrigations meets their clinical needs more appropriately. Best practice suggests that patients over 65 years of age should be encouraged to have a sigmoidoscopy prior to trans anal irrigation to exclude a diagnosis of diverticular disease that is a contra indication to its use.

Written consent from a consultant or general practitioner involved in patient’s care needs to be obtained before procedure is commenced if it is being carried out by the individual and/or community nurse teams. This procedure should be initiated only by a specialist nurse in bladder/bowel care as recommended within NICE faecal incontinence guidelines (2007) and MRHA (2014).

INDICATIONS FOR USE
- Neurogenic bowel dysfunction Spinal cord injury (SCI) spina bifida and Multiple Sclerosis (MS)
- Chronic constipation, including slow transit constipation and evacuation difficulties
- Chronic faecal incontinence

**RELATIVE CONTRA INDICATIONS (IMPLEMENT ONLY AFTER WRITTEN CONSENT FROM PATIENT’S GP OR CONSULTANT)**

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

**ABSOLUTE CONTRA INDICATIONS: IRRIGATION MUST NOT BE USED**

- Acute inflammatory disease
- Known obstructing rectal or colonic mass
- Rectal or colonic surgical anastomosis within last six months
- Severe cognitive impairment

Trans anal irrigation is designed primarily to be self-administered by patients, even if dexterity is poor. To reduce risk it is important that the patient is taught the procedure by a clinical nurse specialist with training and associated competencies in bowel health (NICE 2007).

**5.6 DIGITAL RECTAL EXAMINATION (DRE)**

This procedure may be carried out by a qualified nurse who can demonstrate professional competence to the level determined by the NMC Code of Professional Conduct (2008). This stipulates that registered nurses to practise competently,

“possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision to acknowledge the limits of their professional competence; and only to undertake practice and accept responsibilities for those activities in which they are competent.” (RCN 2012).
DRE and DRF (digital removal of faeces) are invasive procedures and should only be performed when necessary and following individual assessment.

A qualified nurse who can demonstrate competence to this professional level may be expected to delegate care delivery to others who are not registered such as health care workers or carers who are deemed to have training and associated competencies in bowel care. Such delegation must not compromise existing care, but aim to meet the needs of patients and their caregivers. The qualified nurse remains accountable for the appropriateness of the delegation, ensuring their competence is assessed and reviewed as necessary.

CORE SKILLS AND KNOWLEDGE REQUIREMENTS

Before undertaking DRE or digital removal of faeces, staff must be able to demonstrate the following knowledge:

- An understanding of the anatomy and physiology of the gastro-intestinal tract
- An understanding of the diseases of the rectum and colon
- The use of medication in bowel dysfunction
- Assessment of bowel dysfunction
- Awareness of the guidelines for DRE and DRF including:
  - Indications
  - Observation of the perianal area
  - Precautionary measures
  - Procedure
- Accurate documentation
- Issues of consent
- Circumstances for referral to specialist
- An assessment of competency using LCHS competency framework see Appendix H for more detailed information must be undertaken by nurses and health care workers. HCSW/HCAs should only perform DRE/DRF as a delegated procedure on a named patient basis whose health status is deemed as stable following supervised practice.

When to perform DRE

DRE is seen as an integral part of a nursing assessment in conjunction with the assessment process. When performing this procedure the patient should be ideally lying in the left lateral position, so that the anal area can be viewed more effectively (RCN 2012).

DRE can be used in the following circumstances:

- Establish the presence of faecal matter in the rectum; the amount of stool and consistency and the ability to demonstrate a voluntary contraction and relaxation of the anus
- Ascertain anal tone
PRIOR TO UNDERTAKING DIGITAL RECTAL EXAMINATION (DRE) THE NURSE SHOULD ASSESS:

- The general condition of the patient and their ability to tolerate the procedure
- General medical and surgical history
- Specific medical and surgical history related to the anorectal area
- Present and past bowel care regimen
- The patient and/or carers agree to the procedure being carried out
- Medical directives relating to the patient’s care

5.7 Digital Removal of Faeces (DRF)

This sets out the procedure for digital removal of faeces and should be referred to by all qualified nurses. The RCN Management of lower dysfunction, including DRE and DRF guidance for nurses (RCN 2012) should be adhered to and used concurrently with this document. It is recommended that only a competent practitioner should carry out this procedure. To ensure competence the nurse should have successfully completed an in house or university accredited Digital Rectal Examination course based on the recently updated Royal College of Nursing publication. In addition nurses should familiarise themselves with trust/organisational policies and protocols prior to undertaking this procedure and subsequently review their clinical practice via peer review at two yearly intervals.

DRF is an invasive procedure and only should be performed in selected cases and/or when necessary and then only after a full comprehensive individualised bowel assessment. Cultural and religious beliefs need to be taken into account before proceeding with this procedure and the opportunity for a chaperone.

In some individual cases, there may be conflict between the patient, carer or nurse regarding the need for DRF thus in these incidences it is advised that multidisciplinary consultation is undertaken to try to help resolve the difficulties including a referral to a specialist nurse on bowel health.

Due to the advent of new and wide ranging bowel emptying products the need for DRF is often reduced and the use of DRF is sometimes questioned. However, for some individuals this remains a integral part of their bowel care e.g. spinal cord injury patients and it is essential that the routine should not be disrupted regardless of the setting in which care is provided. (RCN 2012).

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**DO**

- complete a full bowel assessment (Bayliss et al 2000)
- consider a collaborative approach with MDT following assessment (Powell & Rigby 2000; NMC 2008)
Inform the patient of treatment options and risks involved. Seek concordance with the patient which involves shared decision making and option appraisal (NMC 2008)

gain valid consent from the patient and document (NMC 2008)

DON’T

- proceed if there is a lack of consent, or if patient refuses and/or discloses a past history of sexual abuse
- proceed if patient’s doctor has given specific instructions not to undertake the procedure
- proceed if patient has recently undergone rectal/anal surgery or trauma
- proceed if you DO NOT feel competent (NMC 2008)

THINK TWICE
if patient has the following diseases and/or conditions

- active inflammatory bowel disease
- rectal pain
- obvious rectal bleeding or patient taking anti-clotting medication (new SCI patients will be anti-coagulated to prevent DVT but still require DRF – seek medical guidance)
- Spinal Cord Injury (SCI) at Thoracic T6 or above. Remember that allowing constipation to occur leads to a greater risk of autonomic dysreflexia developing

When to perform DRF

DRF might be considered in the following circumstances:
- When other methods of bowel emptying have failed or are inappropriate
- Faecal impaction or loading
- Incomplete defecation
- Inability to defecate
- Neurogenic bowel dysfunction
In many patients with spinal cord injury

**DRF as an acute or ongoing intervention**

When performing DRF as an acute or ongoing intervention it is important to carry out an individualised risk assessment. While carrying out DRF it is imperative to observe for:

- Blood pressure (BP) in SCI patients who are at risk of autonomic dysreflexia (AD) should be taken prior to and at the end of the procedure.
- A baseline blood pressure is advised for comparison
- Distress, pain and discomfort
- Bleeding
- Collapse
- Stool consistency

(RCN 2012)

**Remember:**
Bowel management strategies must be constantly reviewed and re-assessed at 3-6 monthly intervals.

**Be proactive, not reactive**
Effective bowel management for patients with a spinal cord injury at all levels is extremely important and at T6 or above, is the best preventative measure for preventing autonomic dysreflexia.

6. **ANAL SPHINCTER EXERCISES**

‘Assessment of a pelvic floor contraction is an essential part of the continence assessment. An incorrect pelvic floor contraction can damage the pelvic floor further by straining, instead of contracting the muscle’ (Haslam, 2000).

It is expected that this examination be done by either a continence physiotherapist or a CNS – Continence. Again this is a very intimate examination and should only be done in an appropriate environment, by a trained and experienced professional who fully understands issues around informed consent in line with Trust and national guidelines. Where possible a chaperone should be used and the patient allowed to dress and undress in privacy (Royal College of Obstetricians and Gynaecologists, 2002).

The anal sphincter muscles form part of the pelvic floor complex and as such it is essential that when anyone does anal sphincter exercises that they contract these muscles correctly.

The sphincter muscle contraction can be done by visual observation of the anus. By observing the anus whilst the participant observed contracts their anal sphincter, the observer will see the anus should retract and the perineum will be drawn inwards (Laycock and Haslam, 2002). Observation of the anus and perineum can be regarded as an intimate examination, therefore the patient needs to be fully informed of the reasons for this and be able to give valid consent (DoH, 2001c).

Palpation of the anal sphincter can be done by digital rectal examinations. A digital examination can assess the strength and tone of the anal sphincter, as well as assessing the puborectalis muscle
part of the pelvic floor muscle and forms the anorectal angle (Laycock and Haslam 2008). A digital rectal examination for the assessment of the anal sphincter and puborectalis should only be performed by a skilled professional who has the knowledge, skills and competencies in assessing the anal sphincter contraction and grade it appropriately.

An assessment of the anal sphincter contraction should only be done by an appropriately trained professional who is aware of how to do a digital rectal examination to assess the anal sphincter strength and puborectalis.

The physical examination should comprise of the following components:

- A neurological assessment for the examination of dermatomes to give information on the integrity of the nerve roots (Laycock, Whelan, Dumoulin, 2008);
- Observation of the perineum for: red, excoriated skin on the upper thighs and perineum; scars following childbirth or surgery or genital prolapse,
- Palpation to assess for the presence of: tone, pain, sensation and sphincter muscles and puborectalis

**Sphincter Exercises**

Once an anal sphincter contraction is achieved satisfactorily then a specific programme of exercises should be given. This programme will work on strength and endurance as well as working both the fast and slow twitch muscle fibres. These exercises have to be performed several times a day for 15 – 20 weeks as recommended for muscle strengthening by the American College of Sports Medicine (Laycock et al, 2001).

If the muscles are very weak or the patient is unable to elicit a sphincter contraction, then neuromuscular electrical stimulation can be used. This is a treatment provided by continence physiotherapists by using an anal electrode that cause a series of electrically induced contractions to improve cortical awareness of the sphincter muscle contraction as well as providing a temporary improvement in strength (Laycock et al 2001). Once the patient can do a contraction voluntarily, they are then commenced on a sphincter exercise programme.

Age should not be viewed as a barrier to carrying out pelvic floor exercises. The important factors are that the patient comprehends the reasons for them, knows how to do them effectively, remains motivated and receives ongoing support and encouragement (Wilkinson et al, 2003).

Successful treatment also depends on patient motivation. It is important to educate the patient on the problem and the reasons for their specific treatment. They need to be regularly monitored and encouraged to perform the exercise programme to fit in with their daily life (Chiarelli, 2002).

Not every patient will respond well or be cured by conservative treatment. This may be due to other factors such as denervation of the anal sphincter or an occult obstetric anal sphincter muscles (Fowler 2009).

7. **PROLAPSE**

“The evaluation and classification of pelvic organ prolapse is a crucial component in the initial assessment of a patient” (Khan, Wall, 2008).
Pelvic organ prolapse occurs when one, or a combination of, the bladder, bowel, rectum, uterus or vaginal vault protrude through the vaginal fascia into the vagina or outside the vaginal opening (Townsend, 2008). There can also be a rectal prolapse procidentia of the full thickness of the rectum through the anal canal (Agachan et al 1996).

A vaginal prolapse is classified according to the compartment of the vagina affected. Prolapse of the anterior vaginal wall can include displacement of the urethra and bladder (urethrocele, cystocele), while prolapse of the posterior vaginal wall can displace the rectum or small bowel (rectocele, enterocele). The cervix, uterus, or vaginal vault can also prolapse (Jia et al 2007). Pelvic organ prolapse is more prevalent in the anterior vaginal wall, followed by the posterior vaginal wall and then the apex (Hunskaar et al 2005).

**Assessment**

Assessment relies on accurate vaginal examination and the ability to accurately reproduce the assessment using a validated tool (Townsend, 2008). The Pelvic Organ Prolapse Quantification system (POPQ) is an assessment tool entailing measurement of fixed points within the vagina. These scores can then be correlated with the stages below (Bump et al 1996).

- Stage 0: No prolapse
- Stage 1: More than 1 cm above the hymen
- Stage 2: Within 1cm proximal or distal to the plane of the hymen
- Stage 3: More than 1 cm below the plane of the hymen but protruding no further than 2cm less than the total length of the vagina
- Stage 4: Complete eversion of the vagina

**Treatment options**

Mechanical intervention includes the insertion of a ring pessary into the vagina thus restoring anatomical support for the prolapsing organ/s and relieving any symptoms. These work by relieving the strain on the ligaments which are stretched as the organ prolapses through the vaginal fascia (Townsend, 2008).

Fernando et al (2006) supports the use of pessaries as a temporary measure to control symptoms and Thakar and Stanton (2002) advocate pessaries as a long term option for patients who are unsuitable for surgery. Improvement can be rapid with favourable results after two weeks and success rates of 56-74% (Wu et al, 1997; Handa and Jones, 2002; Clemons et al 2004). Surgical intervention, for the correction of prolapse, aims to restore the pelvic organs to their original location. There are a range of procedures some vaginal and some rectal surgery.

8. **MEDICATION**

“Many drugs, some of which may be sold ‘over the counter’, may influence bladder and bowel function” (Getliffe, Dolman, 2007).

It is essential that, as part of the continence assessment, older people and those with chronic diseases receive a medication review (DoH, 2000).

The prescription of four or more medicines (polypharmacy) is a particular risk factor in the development of drug interactions in older people. Polypharmacy develops over time, often with medicines being added to counter side effects caused by others, or specific medication not being discontinued, when no longer required (DoH, 2001b).
Other medications, which may influence bowel function, include biguanides for treatment of diabetes, antimuscarinics, anti-Parkinsonian drugs, antidepressants and antispasmodics, any of which may cause constipation with overflow incontinence or faecal incontinence (Button et al, 1999).

Drugs capable of causing drowsiness should be avoided if possible, as medications such as hypnotics can accumulate causing confusion, immobility, and eventually incontinence (Button et al 1998; Nazarko 2002). As a medication review in older people usually results in a reduction in the number of prescribed medicines (DH, 2001b), the avoidance of polypharmacy is cost-effective in addition to representing best practice.

**Drugs that might predispose to bowel dysfunction (Getliffe & Dolman 2007)**

- Opioids
- Broad spectrum antibiotics
- Laxatives
- Diabetic Medication
- Antidiarrhoeal
- Antidepressants
- Antihistamines
- Antimuscarinics
- Antacids
- Iron preparations
- Polypharmacy

Reviewing medication or modification of patient’s drug regime may alleviate their bowel dysfunction. Every medication has a potential adverse reaction and any additional medication can contribute to the side effect profile.

**Drugs used to treat bowel dysfunction**

Oral and rectal stimulants are available to treat bowel dysfunction and can be combined with bowel management programmes to encourage a more effective way of emptying the bowel. When considering prescribing bowel medication and/or bowel preparation it is important to remember when prescribing to take into account indications, hierarchy of choice, usage times, duration of treatment, licensed usage, local formularies, types of bowel dysfunction used for, cautions and contra indications, side effects, interactions and expected outcomes (RCN 2012).

**Drugs to promote bowel emptying**

Laxatives recommended:

- When lifestyle measures are insufficient
- For people taking a constipating drug that cannot be stopped
- For people with other secondary causes of constipation
- As a rescue remedy for episodes of faecal loading
- Start treatment with a bulk forming laxative e.g. fybogel
- Maintain good hydration when taking bulk forming laxatives
- If stools remain hard to add or switch to an osmotic laxative e.g. Movicol or Lactulose

**Different Types of laxatives**

<table>
<thead>
<tr>
<th>Type of laxative</th>
<th>Examples</th>
<th>Mode of Action</th>
<th>Potential problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk Forming Laxatives</td>
<td>Methylcellulose, psyllium, wheat bran, ispaghula husk</td>
<td>Increase stool volume or soften consistency of the stool. Considered safe if taken with sufficient water</td>
<td>Flatulence and abdominal distention, if not taken with sufficient water, possibility of intestinal blockage exists (rarely). Benefits of bulking agents decline with time. May also interfere with absorption of some drugs</td>
</tr>
<tr>
<td>Osmotic laxatives</td>
<td>Lactulose, Macrogols</td>
<td>Work by stimulating the secretion of water into the intestine to equalise osmotic pressure</td>
<td>Often poorly tolerated. Bloating and Flatulence</td>
</tr>
<tr>
<td>Salinic laxatives</td>
<td>Magnesium hydroxide, magnesium sulphate (Epsom salts), sodium phosphate</td>
<td>Luminal water binding, increases fluid excretion</td>
<td>May cause electrolyte imbalance and should be used with caution in patients with impaired renal or cardiac function</td>
</tr>
<tr>
<td>Stimulant Laxatives</td>
<td>Bisacodyl, sodium picosulfate</td>
<td>Thought to work by stimulating nerves to produce colonic contractions. Decrease water absorption from large intestine</td>
<td>At high dose can cause diarrhoea or loose stool, which may result in metabolic disturbances in susceptible patients. Can also result in abdominal cramping and dehydration.</td>
</tr>
<tr>
<td>Anthraquinones</td>
<td>Senna, aloe, cascara</td>
<td>Act locally to stimulate colonic mobility and decrease water absorption from colon</td>
<td>Abdominal cramping and dehydration</td>
</tr>
</tbody>
</table>

(Marples G (2011) Adapted from Tack et al (2011))

**Treatment Offered by Specialist Services in Secondary Care**

Once the problems of impaction with overflow, correct stool formation and regulation and diet have been reviewed and has no effect then referral to the specialist service needs to be considered.

Investigations into the anal sphincter have to be done via a referral to secondary care and access to specialist test such as endoanal ultrasound, anal manometry, rectal volume sensation and neurophysiological studies.

To be continent of the bowels requires a working anal sphincter system. Endoanal ultrasound assesses the internal and external anal sphincters. Any damage will only be shown on this test as a disruption in the ring of muscles. A defect in the muscles will prevent an affective contraction of the
sphincter muscle leading to incontinence. This requires surgery to resolve the problem (Kumar 2008).

Anal manometry records the pressure the anal resting tone as well as during a contraction. Reduced anal tone can result in reduced ability to retain stools leading to urgency and urge incontinence of the bowels (Kumar 2008). This is treated by sphincter exercises with or without neuromuscular electrical stimulation and holding on programme of the bowels (Norton 2008). This treatment is offered by continence physiotherapists.

Rectal volume sensation investigations are looking at the volume in the rectum that initiates a desire to defecate. This volume is usually lower in those who suffer from faecal urgency (Kumar 2008). Treatment is done in the form of biofeedback with special latex designed to desensitise the rectum and increase the volume that causes the desire to defecate. This treatment is offered by continence physiotherapists.

Neurophysiological studies are done to look at the nerves that supply the puborectalis muscle and external anal sphincter. Damage to these muscles can be noted and is commonly related to problems with a neurogenic cause (Kumar 2008).

9. TREATMENT OF CONSTIPATION IN OBSTRUCTED DEFCATION

Constipation Massage
The use of massage on the abdomen referred as either constipation massage or abdominal massage has been advocated as a treatment for constipation as there are no side effects, unlike medication for constipation. It has been proven to be an effective treatment of constipation but requires time to be completed in and on a daily basis.

Massage is mooted to increase rectal loading and works by altering the intra-abdominal pressure. In some neurological disorders it is felt that massage stimulates the somato-autonomic reflex and bowel sensation (Liu et al 2005) Abdominal massage can be applied to the patient or by the patient themselves. It takes 15-20 mins and is based on 4 basic massage strokes, stroking, effleurage, kneading and vibration (Emly 2008). Again this is a specialised treatment and should only be undertaken by those trained in massage such as continence physiotherapists.

Treatment of Obstructed Defecation: Prolapses
There is evidence that rectocele can be effectively treated with pelvic floor exercises. The increase in pelvic floor strength results in a better support to the posterior vaginal wall reducing the appearance of the rectocele and consequently restoring the normal anatomy with defecating. The clinician needs to ensure that the patient is doing correct pelvic floor exercises otherwise they could be straining the pelvic floor muscles, thus making the rectocele worse (Bump 1995). The clinician must be able to teach pelvic floor exercises effectively and be trained and competent in assessing teaching these exercises.

Recoceles can be managed by manual pressure on the posterior vaginal wall during defecating, again to correct the anatomy. Some patients find this an embarrassing way to manage the symptoms. Other types of prolapses will need to be referred to a surgeon to correct the anatomy of the rectum.

Treatment of Obstructed Defecation: Descending Perineum Syndrome
This can be managed by a hand on the perineum placing pressure upwards as the patient bears down allowing the external anal sphincter to “funnel” correctly to allow defecation.

Again referral to a colorectal surgeon may be needed.

Treatment Of Obstructed Defecation: Muscle Dyssynergia
With patients who have contraction of the anal sphincter/puborectalis whilst trying to defecate, then treatment is re-education of the defecation dynamics. This can be taught by an appropriate specialist such as a continence physiotherapist or clinical nurse specialist. Defecation dynamics compromise of the following:

- Correct position – Sitting on the toilet with feet supported and knees higher than the hips
- Tighten and relax the sphincter muscles
- The patient needs to be taught how to relax their abdominal muscles then tighten them
- Combine these actions all together

For those who are unable to generate adequate abdominal force can then also be taught how to contract and relax their abdominal muscles, called the pump-brace action, to help generate force to propel the stool from the rectum (Chiarelli and Markwell 1992)

10. MANAGEMENT OF DIARRHOEA

The sudden onset of acute diarrhoea is very common and is usually self-limiting, often lasting only a few days. It sometimes requires no investigation or treatment. Common causes can be:

- Food poisoning
- Traveller’s Diarrhoea
- Allergy
- Dietary indiscretion
- Viral
- Bacterial
- Antibiotic related

In the case of acute diarrhoea, if symptoms are not resolved in 2-3 days the patient should seek medical assistance.

Chronic diarrhoea can be characterised as an “abnormal passage of three or more loose or liquid stools per day for more than four weeks” (Thomas et al 2003).

Chronic diarrhoea that persists for longer than two weeks may have a more complex aetiology. In these circumstances referral to a GP or medical team will be necessary to determine treatment options.

Chronic causes include:

- Inflammatory bowel disease
- Diverticulitis
- Neoplasms
- Malabsorption e.g. coeliac disease
- Endocrine disorders
- Intestinal obstruction
- Chemotherapy
• Laxatives
• Antibiotics

**Differential Diagnosis and investigation**

After taking a comprehensive history and examination of the patient it should be possible to establish a differential diagnosis that will determine appropriate investigations for both acute and chronic diarrhoea. This should be carried out using a step wise approach excluding common and easily treated disorders first before more complex and rare conditions are considered.

**Management**

Assessment of chronic diarrhoea by the taking of a good medical history, thorough examination and careful selection of appropriate investigations, is essential to establish the cause and effective treatment.

Treatment for chronic diarrhoea should be specific to the underlying cause. For instance, if the diarrhoea is drug induced, the medication should be reviewed and stopped if necessary or alternate strategies considered.

For those conditions where no specific therapy is available because underlying aetiologies have been exhausted, empirical treatment with anti-diarrhoeal drugs can be effective (Norton and Chelvanayagam 2004).

10.1 **Infection Control (Including Clostridium difficile)**

Unfortunately, due to the constraints of this document it will not be possible to address all of the infection control aspects and readers are encouraged to utilise the LCHS Guidance on the Management of patient with Clostridium difficile associated disease in the community (2011) for more comprehensive advice and management.

However, nurses need to adhere to the following standards when caring for patients with bowel dysfunction:

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

(RCN 2012)

Clostridium difficile (C.difficile) is the major cause of antibiotic associated diarrhoea and colitis, a healthcare associated intestinal infection that mostly affects elderly patients with underlying diseases (DH 2006).
C. difficile is a spore forming, anaerobic bacterium. It is estimated that between 2-3% of healthy adults and up to 36% of hospital patients are asymptomatic carriers of C. difficile in their faecal flora. C. difficile associated disease (CDAD) is frequently associated with antibiotic treatment (Hawker et al 2001).

The diarrhoea associated with this disease can range in severity from mild to severe and can rapidly result in deterioration in the patient’s condition. The complications arising from this disease include: pseudomembranous colitis, toxic megacolon, colonic perforation and death.

Clinical Features

Clostridium difficile is defined as:
- One episode of diarrhoea defined either as stool loose enough to take the shape of a container used to sample it or as Bristol Stool Chart types 5–7
- Not attributable to any other cause, including other medicines and diet
- Occurring at the same time as a positive toxin assay and/or endoscopic evidence of pseudomembranous colitis (PMC) (DH 2008).

Clinical features of C difficile are:

- Mild to severe watery, explosive, foul-smelling diarrhoea
- The smell is acutely characteristic and the stools may have a green appearance.
- Mucus and blood may be present in the stool.
- Diarrhoeal stools
- Abdominal pain/tenderness may also be present.
- Some patients may develop severe pseudomembranous colitis with ulceration of the colon
- Toxic megacolon, perforation or peritonitis, all of which may result in death

- N.B. Diarrhoea may start during a course of antibiotics (can occur as early as one day or as late as two months after discontinuing therapy).
- C. difficile infection should be considered in any patient who presents with diarrhoea, particularly if there has been a history of recent anti-microbial usage

(LCHS Guidance on the Management of patient with Clostridium difficile associated disease in the community 2011)

The Department of Health and the Health Protection Agency have launched 10 key recommendations for health care providers called “Clostridium difficile:” how to deal with the problem (2008) which can be downloaded at www.hpa.org.uk

If a patient presents with diarrhoea it is important to exclude an infectious cause. Patients with suspected potentially infectious diarrhoea should be isolated and a consultation should take place with the infection prevention and control team while determining the cause of diarrhoea. (RCN 2012) particularly for patients within community hospitals and care homes, as they are often the most vulnerable and immune compromised individuals (NICE 2008).
11. **IRRITABLE BOWEL SYNDROME**

Irritable bowel syndrome (IBS) is a chronic, relapsing and often life-long disorder. It is characterised by the presence of abdominal pain or discomfort, which may be associated with defaecation and/or accompanied by a change in bowel habit. Symptoms may include disordered defaecation (constipation or diarrhoea or both) and abdominal distension, usually referred to as bloating. Symptoms sometimes overlap with other gastrointestinal disorders such as non-ulcer dyspepsia or coeliac disease. People with IBS present to primary care with a wide range of symptoms, some of which they may be reluctant to disclose without sensitive questioning.

Patients suffering with IBS present with varying symptoms, most commonly ‘diarrhoea predominant’, ‘constipation predominant’ or alternating symptom profiles. IBS most often affects people between the ages of 20 and 30 years and is twice as common in women as in men. Prevalence in the general population is estimated to be between 10% and 20%. Recent trends indicate that there is also a significant prevalence of IBS in older people. IBS diagnosis should be a consideration when an older person presents with unexplained abdominal symptoms. (NICE 2008)

11.1 IBS Assessment

- Healthcare professionals should consider assessment for IBS if the person reports having had any of the following symptoms for at least 6 months:
  - Abdominal pain or discomfort
  - Bloating
  - Change in bowel habit.

- All people presenting with possible IBS symptoms should be asked if they have any of the following ‘red flag’ indicators and should be referred to secondary care for further investigation if any are present:
  - unintentional and unexplained weight loss
  - rectal bleeding
  - a family history of bowel or ovarian cancer
  - a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years

  Anaemia  Abdominal masses  Rectal masses

  Inflammatory markers for inflammatory bowel disease.

  If there is significant concern that symptoms may suggest ovarian cancer, a pelvic examination should also be considered.

A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with:

- Altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:
  - altered stool passage (straining, urgency, incomplete evacuation)
- abdominal bloating (more common in women than men), distension, tension or hardness
- symptoms made worse by eating
- passage of mucus.

Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis (NICE 2008).

11.2 IBS - Diagnostic Tests

- In people who meet the IBS diagnostic criteria, the following tests should be undertaken to exclude other diagnoses:
  - full blood count (FBC)
  - erythrocyte sedimentation rate (ESR) or plasma viscosity
  - c-reactive protein (CRP)
  - antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).

- The following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria:
  - ultrasound
  - rigid/flexible sigmoidoscopy
  - colonoscopy; barium enema
  - thyroid function test
  - faecal ova and parasite test
  - faecal occult blood
  - hydrogen breath test (for lactose intolerance and bacterial overgrowth).

11.3 IBS – Dietary and Lifestyle Advice

- People with IBS should be given information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication.

- Healthcare professionals should review the fibre intake of people with IBS, adjusting (usually reducing) it while monitoring the effect on symptoms. People with IBS should be discouraged from eating insoluble fibre (for example, bran). If an increase in dietary fibre is advised, it should be soluble fibre such as ispaghula powder or foods high in soluble fibre (for example, oats).

11.4 IBS – Pharmacological Therapy

People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to the clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft, well-formed stool (corresponding to Bristol Stool Form Scale type 4). See Appendix L for more detailed information.
12. FUNCTIONAL INCONTINENCE

As with the urinary system the bowels can also be affected by problems that are not related to the colorectal system.

It is frequently associated with cognitive impairment, such as dementia, or in patients who have developed mobility difficulties, for example, following a stroke, in Parkinson’s disease, or after suffering a fracture (Jirovec, 2000).

Identification of functional incontinence requires a careful history, and exclusion of other types of incontinence. However, it frequently occurs in combination with other causes of incontinence e.g. incontinence may result due to the severe urgency caused by a stroke, but it is the immobility (the functional element) that exacerbates the situation further.

12.1 Cognitive Impairment

Cognitive impairment is a common cause of functional incontinence in care homes because of the prevalence of people with dementia in long-term care (Jirovec, 2000). It may affect the ability to interpret the sensation of a full bladder/bowel. Additionally where memory is affected, an individual may no longer remember accepted social guidelines regarding appropriate behaviour.

The risk of incontinence increases with the severity of the dementia (Jirovec, 2000). However, many people with dementia are not incontinent, as the socialisation around continence is deeply ingrained (Norton, 1996) and responsive, individualised care can help to prevent this occurring.

It is important that incontinence is not seen as inevitable consequence of ageing or of dementia, and that it is identified as a problem and correctly assessed.

For those with cognitive impairment, individualised toileting programmes may be successful. A baseline chart helps to establish the patient’s usual pattern and a programme of prompted; regular toileting is designed around this (Norton 1996). Sometimes incontinence results from disorientation, especially in changed surroundings.

During assessment, it may become apparent that drugs use is exacerbating the problem. Discontinuing unnecessary medication, reviewing individual medications, or decreasing sedation, may help to cure or improve the problem (Swaffield, 1996).

Fluid Intake

It is generally recommended that adults require between 1.5 and 2 litres (3-4 pints) fluid per day (Shah & Leach 1998; Wilkinson et al. 2003).

During the assessment it is vital to ascertain the patient’s health beliefs with regard to fluids and to establish their actual intake.

12.2 Mobility and the Environment

Functional incontinence can be caused or exacerbated by a loss of mobility. Older people may have reduced or decreased sensation regarding the call to stool (Norton, 1996). In these circumstances, easy access to toilet facilities is essential if bowel incontinence is to be avoided.
Cardiovascular or pulmonary disease can lead to a decreased exercise tolerance. If the distance to the toilet is too great, a patient may not be able to reach it in time due to shortness of breath (Pryor & Webber, 1998).

Following a stroke, the ability to walk unaided is recognised as the most important factor in regaining continence (Nazarko, 2003).

Environmental considerations can have a major influence on continence status. The involvement of the multidisciplinary team is essential when, following stroke or other illness, rehabilitation should be aimed at promoting independence including independent toileting wherever possible.

A functional assessment should consider transfer ability, balance, manual dexterity and strength in the arms, eyesight and whether an individual can maintain hygiene following use of the toilet.

The height and access to and from beds, chairs and commodes may all influence whether a person is able to maintain continence or not. The provision of appropriate aids, suited to that individual according to their individual needs, will prove the most successful in promoting continence (Jirovec, 2000).

Clothing should be discussed, as ease of adjustment and replacement are important considerations. Similarly, appropriate footwear may aid mobility and confidence.

The success of any intervention to promote continence will depend on accurate assessment, and identification of any underlying pathology and attention to exacerbating factors.

13. INCONTINENCE PADS

‘Continence products should not be supplied before an initial continence assessment’. (DH, 2000)

Following a bowel assessment, active health promotion strategies such as bowel retraining, toileting programmes, use of laxative or antidiarrheal medication and environmental modification may be helpful. (Simpson, 2001).

Where these measures have been tried unsuccesssfully, or are inappropriate, containment pads may be useful. When correctly sized and fitted, these products can help to promote dignity and self-esteem, contributing positively to a patient’s quality of life.

Products are provided to residents within Lincolnshire Community Health Services via a countywide contract for provision of disposable incontinence products and home delivery.

However, where patients have received an initial continence assessment, in line with these guidelines, and the patient is unable, or declines, to have active treatment, reassessment may be performed on an annual basis. Similarly, in circumstances where a patient has received thorough investigation and intervention (e.g. surgery) which has not been successful or is not possible, a 6-12 monthly reassessment may be appropriate.

Absorbent products may be provided, where clinical need requires the use of a minimum of one to four products in 24 hours, without authorisation from the CNS. Clients will be reassessed if requiring more than 4 products in 24 hours based on clinical need by your Continence Nurse Specialist Nurse.

As the containment products provided via the contract are technologically advanced, and highly absorbent, this is usually sufficient. However, in certain circumstances e.g. intractable faecal
incontinence with a diagnosed aetiology, it may be appropriate to increase provision on an individual patient basis.

Advice on appropriate management, in these more complex situations, is available from the CNS—Continence and/or Product Specialist Nurse.

14. HEALTH CARE ASSISTANTS (HCA) AND HEALTH CARE SUPPORT WORKERS (HCSW) ROLE

Health care assistants working in community settings are able to perform lower bowel functions such as administer micro enemas and laxative suppositories on a named patient basis under delegation from a qualified nurse only when the following conditions have been met:

- The HCA/HCSW has received appropriate training and assessment of competence in the administration of micro enemas and suppositories
- HCA/HCSW is regularly supervised to ensure their competency is maintained to carry out these tasks. **Annual half day study days should be considered as mandatory.**
- The qualified nurse agrees to delegate the lower bowel care task to that particular HCA, and that the patient consents.
- Local policy permits the delegation of these tasks

It is acceptable for the following procedures to be undertaken by a competent HCA/HCSW on a named patient basis:

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

HCAs/HCSWs have an individual responsibility to ensure they feel confident and competent in the knowledge and skills of practice in line with local guidelines, procedures and policies (RCN 2012). Acceptable performance criteria will be met through competency based outcomes through observation and supervision, which should include being supervised by a competent qualified member of staff see Appendix 8.

Competency documentation for DRE/DRF. This should be counter signed and documented by a competent qualified nurse with copies kept by their line manager and/or workforce development team as well as within the HCA/HCSW personal portfolio (RCN 2012). It is postulated by LCHS NHS Trust that nurses and health care workers maintain their digital rectal examination/digital
removal of faeces competencies by performing at least 5-8 digital rectal examinations annually and attend local bowel updates every 2-3 years.

For further NMC guidance on delegating to non-regulated health care staff please visit: www.nmc-uk.org.

15. **GLOSSARY OF TERMS AND ABBREVIATIONS FOR SUITE OF ALGORITHMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
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<tbody>
<tr>
<td>DRE</td>
<td>Digital Rectal Examination</td>
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<tr>
<td>DRF</td>
<td>Digital Removal of Faeces from the rectum</td>
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<td>MX</td>
<td>Management</td>
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<td>MDT</td>
<td>Multidisciplinary Team</td>
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<td>NMES</td>
<td>Neuromuscular Electrical Stimulation</td>
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<tr>
<td>PFMT</td>
<td>Pelvic Floor Muscle Training</td>
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<tr>
<td>QSBS</td>
<td>Queens Square Bladder Stimulator</td>
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**Anal pruritis**: anal itching

**Constipation**: a delayed movement of intestinal content through the bowel, characterised by infrequent, hard dry stools which are difficult to pass

**Clostridium Difficile**: an anaerobic bacteria that can occur in the gut

**Diarrhoea**: an abnormal increase in the quality, frequency and fluid content of the stool and associated urgency, perianal discomfort and incontinence

**Digital rectal examination**: examination of rectum by insertion of finger into rectum

**Enema**: the introduction into the rectum or lower colon of a stream of fluid for the purpose of producing a bowel action or instilling medication.

**Digital Removal of Faeces**: the use of a finger to remove faeces from the rectum

**Suppository**: a solid or semi-solid pellet introduced into the anal canal for medicinal purposes

**Tenemus**: ineffective and painful straining at stool

**Neurogenic bowel**: dysfunction of the colon caused by central neurological disease or damage
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(Appendix A)

Procedure for digital rectal stimulation (DRS)  (MASCIP, 2009: RCN 2012)

Explain the procedure to the patient (if necessary) obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.

- The patient should be asked if they wish to have a chaperone. Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily viewed.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005 his requires five-ten minutes to take effect and lasts up to 90 minutes.

**Note that long term use should be avoided due to systemic effects (BNF, 2008).**

- Lubricate gloved finger with water soluble gel. Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- Turn the finger so that the padded inferior surface is in contact with the bowel wall.
- Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.
- Withdraw the finger and await reflex evacuation.
- Repeat every five-ten minutes until rectum is empty or reflex activity ceases.
- Remove soiled glove and replace, relubricating as necessary between insertions.
- If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matter in an appropriate receptacle as it is removed and dispose of it and any other waste, in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient’s buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Scale (Heaton,1993).
- Record and report abnormalities.

(RCN 2012)

(Appendix B)  AUTONOMIC DYSREFLEXIA IN SPINAL CORD INJURY PATIENTS

45
Autonomic dysreflexia (also known as autonomic hyper-reflexia) is one of the most serious life threatening conditions that affect people with spinal cord injury at or above the level of the sixth thoracic vertebrae. The syndrome develops secondary to any noxious stimulus below the level of injury. As the spinal cord is damaged, signals cannot pass normally to the brain, therefore, the body produces exaggerated abnormal nerve signals, which cause problems above and below the level of the spinal injury. Below the injury, blood vessels go into spasms causing blood pressure to rise. Above the level of the injury, the body senses the high blood pressure and tries to relax the blood vessels (can only influence the blood vessels above the level of the injury) which causes flushing and blotchiness of skin and pounding headache. Autonomic dysreflexia is a condition that develops after spinal cord injury in which potential life-threatening episodic hypertension is triggered by stimulation of sensory nerves below the site of injury. Autonomic dysreflexia may occur in patients with spinal cord injury, usually above T-6.

Symptoms may be mild or severe and patients may present with one or more of the following:

- Pounding headache
- Flushing and/or blotching above the level of cord damage
- Pallor below the level of injury
- Slowed heart rate
- Profuse sweating (above level of injury)
- Palpitations
- Goosebumps
- Blurred vision
- Stuffy nose
- Feeling of doom and gloom, anxiety apprehension
- Hypertension

NB: under normal circumstances a tetraplegic person may have a low blood pressure (eg: 90/60), a rise of 20mm Hg can be quite significant, therefore if the BP rises to 120/80 mm Hg it could become an emergency situation. Hypertension may be severe enough to lead to seizures, strokes or ultimately death.

Bladder problems are the most common cause of autonomic dysreflexia:
- Overfull bladder
- Kidney or bladder stones
- High pressure voiding
- Urinary tract infection
- Blocked catheter
- Defective drainage system (eg: kinked tubing or leg bag too full)
- Constipation/full rectum

Treatment: identify the source of the noxious stimulus; removing the stimulus will cause the symptoms to settle.

- If infection is suspected commence antibiotic therapy.
- Check bowel and check for potential causes and treat appropriately.
- If a full rectum is causing AD disimpact bowel immediately to relieve stimulus.
- If performing DRE/DRF and AD occurs remove finger if rectum empty
Management of diarrhoea in primary care

Patient presents with diarrhoea

Consider possible causes and identify normal bowel pattern

Sudden onset e.g. infection, recent travel, food poisoning

Overflow diarrhoea associated with constipation

Overuse of laxatives or medication induced

Pre-existing medical and surgical condition causing symptoms

If constipation suspected, perform DRE to determine faecal loading and treat for constipation

Offer education and advice on appropriate laxatives and diet. Review medication

See stepped management of constipation (See Appendix 8)

Record and monitor stool type (according to Bristol stool chart), consistency, colour, amount, odour and frequency.

Obtain stool specimen

Consider possible infection control issues and refer to infection control guidelines.

Observe temperature and vital signs.

Encourage adequate fluid intake

Skincare to prevent excoriation/soreness

Consider provision of continence aids

If no improvement in symptoms or deterioration in condition

Seek medical advice

Continue to monitor and assess patient until symptoms have resolved

Seek medical advice if symptoms persist

Seek medical advice
**BOWEL HEALTH RECORD**

**NAME:**

**NHS NO:**

- Type 1 - Separate hard lumps like nuts (difficult to pass)
- Type 2 - Sausage shaped but lumpy
- Type 3 - Like a sausage but with cracks on 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)

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<th>DID YOU HAVE TO STRAIN?</th>
<th>COMMENTS e.g. Blood/mucus</th>
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</tbody>
</table>
Patient Questionnaire

Please complete all parts of this questionnaire (IN BLACK PEN), even if you feel it is not relevant to you.

Please list all the medication/drugs you are taking, please include all vitamins, laxatives, creams, injections, herbal remedies/inhalers.

<table>
<thead>
<tr>
<th>Name of drug and dose</th>
<th>Reason you are taking it</th>
<th>How often you take it</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Do you have any allergies? Yes ☐ No ☐, if you ticked yes please state what you are allergic to

Please answer the following questions about your fluid intake and diet.

List the kind of drinks you have each day | How many of these do you drink each day? | How much do you drink i.e. cup/mug/pint etc?
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

I restrict the amount I drink Yes ☐ No ☐ Why?

I am on a special diet Yes ☐ No ☐ Why?

What foods do you eat in a normal day? (vegetables, fruit, bread etc):-
Faecal Incontinence: Quality of Life Instrument

Q1: In general, would you say your health is:

1 □ Excellent
2 □ Very good
3 □ Good
4 □ Fair
5 □ Poor

Q2: For each of the items below please indicate how much of the time the issue is a concern for you due to accidental bowel leakage. (If it is a concern for you for reasons other than accidental bowel leakage then check the box under Not Applicable (N/A)

Due to accidental bowel leakage:

<table>
<thead>
<tr>
<th>Due to accidental bowel leakage:</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I am afraid to go out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>b) I avoid visiting friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>c) I avoid staying overnight away from home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>d) It is difficult for me to get out and do things like going to a movie or to church</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>e) I cut down on how much I eat before I go out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>f) Whenever I am away from home, I try to stay near a restroom as much as possible</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>g) It is important to plan my schedule (daily activities) around my bowel pattern</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>h) I avoid travelling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>i) I worry about not being able to get to the toilet in time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>j) I feel I have no control over my bowels</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>k) I can’t hold my bowel movement long enough to get to the bathroom</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>l) I leak stool without even knowing it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>m) I try to prevent bowel accidents by staying very near a bathroom</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Q3: Due to accidental bowel leakage, indicate the extent to which you AGREE or DISAGREE with each of the following items. (If it is a concern for you for reasons other than accidental bowel leakage then check the box under Not Applicable (N/A)

<table>
<thead>
<tr>
<th>Due to accidental bowel leakage:</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I feel ashamed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>---------------------------------------------------------------------------</td>
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<td>---</td>
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<tr>
<td>b)</td>
<td>I cannot do many of the things I want to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c)</td>
<td>I worry about bowel accidents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d)</td>
<td>I feel depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e)</td>
<td>I worry about others smelling stool on me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f)</td>
<td>I feel like I am not a healthy person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g)</td>
<td>I enjoy life less</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h)</td>
<td>I have sex less often than I would like to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i)</td>
<td>I feel different from other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j)</td>
<td>The possibility of bowel accidents is always on my mind</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k)</td>
<td>I am afraid to have sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>l)</td>
<td>I avoid travelling by plane or train</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>m)</td>
<td>I avoid going out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>n)</td>
<td>Whenever I go someplace new, I specifically locate where the bathrooms are</td>
<td>1</td>
<td>2</td>
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</table>
Faecal Incontinence: Severity Instrument

Q1: For each of the following please indicate on average **how often in the past month** you experienced any amount of accidental bowel leakage. (*Circle only one response for each item.*)

<table>
<thead>
<tr>
<th></th>
<th>2 or more times a day</th>
<th>Once a day</th>
<th>2 or more times a week</th>
<th>Once a week</th>
<th>1 to 3 times a month</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>a) Gas</td>
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<td>b) Mucus</td>
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<tr>
<td>c) Liquid stool</td>
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<tr>
<td>d) Solid stool</td>
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</table>

Q2: Please indicate how often each of the following occurred on average over the last month due to accidental bowel movements. (*Circle only one response for each item.*)

<table>
<thead>
<tr>
<th>Due to accidental bowel movements how often in the past month have you:</th>
<th>2 or more times a day</th>
<th>Once a day</th>
<th>2 or more times a week</th>
<th>Once a week</th>
<th>1 to 3 times a month</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>a) Stained your underwear</td>
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<tr>
<td>b) Found small pieces of stool in your underwear</td>
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<tr>
<td>c) Had a premature full bowel movement of solid stool in your underwear (i.e. didn’t make it to a bathroom in time)</td>
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<tr>
<td>d) Had a premature full bowel movement of liquid stool in your underwear (i.e. didn’t make it to a bathroom in time)</td>
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</table>

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Lincolnshire Community Health Services NHS Trust

Competency Framework:

Digital Rectal Examination, Digital Rectal Stimulation & Digital Removal of Faeces

To be completed by trained nurse (Health Care Assistant/Assistant Practitioner on named patient basis as a delegated task following assessment by a qualified competent nurse) who is working towards a university accredited lower bowel dysfunction course or has attended the LCHS in-house training course.

Nurses Name: ........................................Contact Address:............................

Assessors Name:.................................Contact Address..............................

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Competency</th>
<th>Achieved</th>
</tr>
</thead>
</table>
| Clinical Knowledge, Clinical decision-making and diagnosis | An understanding of the anatomy of the lower gastrointestinal tract  
Exclude differential diagnosis  
Evidence is demonstrated of what constitutes normal bowel action  
Understands indications, exclusions and contra indications for DRE, DRS & DRE  
If a patient has a spinal cord injury above T6 observe the patient throughout the procedure for signs and symptoms of autonomic dysreflexia (refer to LCHS NHS Trust) bowel guidelines  
Demonstrates an understanding of common complications and solutions with lower bowel dysfunction  
Legal aspect of lower bowel care provision  
Skin care, when and how to apply products  
Awareness of infection control, hand hygiene and personal protective equipment  
Attends annual mandatory study sessions - |
<table>
<thead>
<tr>
<th>Role</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAs</td>
<td>Patient information and informed consent</td>
</tr>
<tr>
<td></td>
<td>Ensure privacy and dignity maintained at all times</td>
</tr>
<tr>
<td></td>
<td>Ask patient if chaperone required</td>
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<tr>
<td></td>
<td>Evidence is demonstrated to patient why the nurse is performing the procedure</td>
</tr>
<tr>
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<td>Risks and benefits</td>
</tr>
<tr>
<td></td>
<td>Answering patients questions</td>
</tr>
<tr>
<td></td>
<td>Equipment</td>
</tr>
<tr>
<td></td>
<td>Preparation of the patient and equipment</td>
</tr>
<tr>
<td></td>
<td>Infection prevention and/or control</td>
</tr>
<tr>
<td></td>
<td>Wash hands and put on disposable gloves and apron</td>
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<td></td>
<td>Performance of digital rectal examination</td>
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<tr>
<td></td>
<td>Demonstration of competent clinical skills</td>
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<tr>
<td></td>
<td><strong>Performing the procedure</strong></td>
</tr>
<tr>
<td></td>
<td>- Sweep clockwise than anti clockwise and palpate for irregularities internally.</td>
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<tr>
<td></td>
<td>- Assess external anal tone by asking patient to squeeze and hold and thus checking their ability to contract and relax anus</td>
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<td></td>
<td>- Checks for the presence of faecal matter, stool consistency and anal tone</td>
</tr>
<tr>
<td></td>
<td>- Trained Nurse or HCA identifies and understands at what stage to seek medical assistance</td>
</tr>
<tr>
<td></td>
<td>- Waste management adheres to local infection control policies</td>
</tr>
<tr>
<td>Digital rectal stimulation</td>
<td></td>
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<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td><strong>Performing the procedure</strong></td>
<td></td>
</tr>
<tr>
<td>- Insert lubricated finger into the rectum and rotate clockwise for 10 seconds</td>
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<tr>
<td>- Observe for response and repeat after 5 minutes up to 3 times</td>
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</tr>
<tr>
<td>- Once the rectum is empty, conduct a final digital check after 5 minutes to ensure that evacuation is complete.</td>
<td></td>
</tr>
<tr>
<td>- Trained Nurse or HCA identifies and understands at what stage to seek medical assistance</td>
<td></td>
</tr>
<tr>
<td>- Waste management adheres to local infection control policies</td>
<td></td>
</tr>
<tr>
<td><strong>Performing the procedure</strong></td>
<td></td>
</tr>
<tr>
<td>- Perform digital rectal examination</td>
<td></td>
</tr>
<tr>
<td>- Insert lubricated finger into rectum and assess stool consistency</td>
<td></td>
</tr>
<tr>
<td>- If faeces are soft continuous circling of the finger may be used to remove stool.</td>
<td></td>
</tr>
<tr>
<td>- If stool is a solid mass, push finger into centre, splint it and remove sections until none remain</td>
<td></td>
</tr>
<tr>
<td>- Once the rectum is empty, conduct a final digital check after 5 minutes to ensure that evacuation is complete.</td>
<td></td>
</tr>
<tr>
<td>- Trained Nurse or HCA identifies and understands at what stage to seek medical assistance</td>
<td></td>
</tr>
<tr>
<td>- Waste management adheres to local infection control policies</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Interpretation of | Achieves accurate measurement(s) |</p>
<table>
<thead>
<tr>
<th>results</th>
<th>Reflects on and documents findings on S1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and documentation</td>
<td>Identifies appropriate action(s) based on findings</td>
</tr>
<tr>
<td></td>
<td>Communication with patient</td>
</tr>
<tr>
<td></td>
<td>Communication with healthcare team including GP</td>
</tr>
</tbody>
</table>

Signature of Nurse:………………………….Signature of Assessor:………………..  

Date:  .................................................................

Please return to OLM workforce development and line manager on completion of competency.
Lincolnshire Community Health Services NHS Trust

Competency Framework: Digital Rectal Examination

<table>
<thead>
<tr>
<th>Competency</th>
<th>Competency Indicators</th>
</tr>
</thead>
</table>
| Preparation of patient | • Ability to explain procedure to patient  
• Identify allergies  
• Gains informed consent and records  
• Provide opportunity for patient to empty bladder  
• Aware of correct patient positioning  
• Promotes patient dignity  
• Hand Hygiene |
| Selection of equipment | • Assembles correct equipment  
• Identifies the effect of environment on procedure  
• Awareness of cleaning and waste management |
| Interpretation of results | • Correct technique – lubricate index finger  
• Observation of anus and perineum – document skin tags or haemorrhoids  
• Insert gloved finger and carry out examination  
• Identify presence of faecal matter, stool consistency and anal tone  
• Undertakes the appropriate bowel intervention (DRE, DRS & DRF)  
• Wipe away lubricating gel from area  
• Ensure patient comfort and dignity  
• Remove gloves and wash hands  
• Understand what circumstances when you feel it would be appropriate to get a medical opinion  
• Appreciates relevance of findings to inform assessment process and treatment. Documents findings. |
<table>
<thead>
<tr>
<th></th>
<th>Identifies appropriate action including referral where necessary</th>
</tr>
</thead>
</table>
Based on University of Hertfordshire Competency Framework (Anderson, 2003)
Any patient aged 18 years with faecal incontinence

Tier 1-3 Assessment of:-
- Diet
- Fluids
- Bowel Habit
- Stool chart for 2/52
- Environment
- Defecation technique
- Medication review
- Continence aids
- Mobility
- Stool sample
- Urine sample
- DRE as per RCN guidance
- Cognitive assessment

Abnormality detected:
For example diarrhoea, Change in bowel habit
Refer to GP
Exclude impaction

Impaction – Follow impaction pathway 2

Provisional Diagnosis:
Neurological cause
Weak pelvic floor/ anal sphincter weakness
Gastro-intestinal hurry

Tier 1-3 for 6/52
Conservative treatments
Reduce caffeine,
Eliminate cause e.g. medication review
Anti diarrhoeal medication
Dietary amendments
Pelvic floor exercises
Topical oestrogen
Containment products
Bowel Management pathway
Patient education
Modify bowel habit
Toilet access issues
Coping strategies and support
Refer to tier 3

Anorectal physiology studies and other tests

Tier 1-3
Neurological Cause
Refer to the Spinal cord toolkit/ pathway

Tier 3
Pelvic floor training/ biofeedback
Consider trans-anal irrigation
Flexiseal
Bowel training
Dietary assessment
Electrical stimulation

Refer to Bowel Consultant/Surgical Team if unresponsive to treatment
For investigations prior to Trans-anal irrigation eg Sigmoidoscopy in over 65’s
FAECAL LOADING / IMPACTION IMMEDIATE ACTION ALGORITHM 2

A. Presenting symptoms
   Rectum full stool

B. Initial Management
   Oral laxatives
   Glycerine suppositories
   Micro enemas

Assessment to include
   DRE/liaise with GP
   Medical history
   Surgical history
   Bowel problems
   Exclude red flags

Secondary care referral following findings

Put in steps A and B
If above management unsuccessful to use
Phosphate enemas or bisacodyl suppositories

If all above prove ineffective consider the need to
soften and lubricate impacted faeces and promote a
bowel movement. Consider use of arachis oil
enemas

Manual evacuation /digital removal of faeces or anal
irrigation should be used as a last resort when all
other methods of bowel management have been
shown to be ineffective (refer to trust policy)

All patients should be advised on preventing
recurrence of faecal impaction /constipation

Complex patients should be discussed with the CNS
Specialist nurses, GPs and if urgent refer to
secondary care

Yes

Chairman: Dr Don White
Chief Executive: Andrew Morgan
Assessment to include
- Medical history & DRE
- Surgical history
- Bowel problems
- Exclude red flags

Spinal Cord Injury (SCI)

No

Working Diagnosis
- Obstructive defaecation
- Pelvic floor dysfunction
- Normal transit / irritable bowel
- Dyschezia (painful or difficult defaecation)
- Slow transit constipation (chronic)

Chronic Constipation

Follow appropriate pathway / algorithm

Review effectiveness of treatment

No

Yes

Reflex / Areflexic bowel pathway (See Trust guidelines)

Maintain prescribed bowel regime as specified by Spinal Injury Unit

Refer to
- Rehabilitation Medicine
- Parkinsons Disease Consultant
- Neurologist
- Orthopaedics

Faecal loading / impaction
Follow appropriate pathway
IBS - CONSTIPATION PATHWAY  
*(Abdominal pain, Bloating, Constipation)*

- **Any Patient** 18+ With IBS-C
  - **HISTORY - EXCLUDE RED FLAGS**
    - Urinalysis
    - DRE
    - Medication
    - Food Diary
    - Bowel Chart
    - ROME III Criteria
    - Lifestyle
    - Exclude Abnormalities

- **INTIAL ADVICE**
  - Increase fluid/fibre intake
  - Increase mobility/exercise
  - Toilet routine
  - Bowel habit
  - Defecation dynamics
  - Consider anti spasmodics
  - WATCH AND WAIT 8 WEEKS

- **Introduction of oral aperents 3 - 6 months**

- **Stools Hard: Consider Lactulose, Movicol, Docusate Sodium.**
  - Stool Soft: Consider an oral stimulant e.g. Senna, Bisacodyl, docusate sodium or Co-Danthrasate (for use in terminally ill patients only)

- **Good response - review every 6 - 12 months**

- **Poor response**

- **RED FLAGS**
  - Weight loss
  - Rectal bleeding without anal symptoms
  - Fe def. anaemia
  - Abdominal or rectal masses
  - Change in bowel habit to loose stools
  - Raised inflammatory markers

- **REFERAL TO SECONDARY CARE**
  - Gastrointestinal specialist

- **Poor response**
  - Review at month 1 & 3 for response

- **Constella 290 mcg OD (Linaclotide) 30 mins before food**

Chairman: Dr Don White  
Chief Executive: Andrew Morgan
Treatment

- Correct defecation positioning
- Gastro colic reflex
- Regular bowel habit and bowel regime
- Monitor stool consistency – BSFS
- Dietary and fluid modifications
- Relaxation techniques and pelvic floor muscle training
- The Brace
- Oral aperients / Disimpaction

Referral to Secondary Care for
Biofeedback
Anorectal physiology
Obstructive Defecation: Anatomical Algorithm

Establish cause by physical examination
- Prolapse
- Rectocele
- Anal rectal prolapse
- Descending perineal syndrome

Treatment
- Surgery/Vaginal technique
- Pelvic Floor Muscle Training
- Bristol Stool Form Scale (BSFS)
- Defecation Dynamics

Surgery
Any patient aged 18 years with faecal incontinence

Abnormality detected: For example diarrhoea, Change in bowel habit
Refer to GP
Exclude impaction

Tier 1-3: History as per NICE Guidance:
Assessment of:-
- Diet
- Fluids
- Bowel Habit
- Stool chart for 2/52
- Environment
- Defecation technique
- Medication review
- Continence aids
- Mobility
- Stool sample
- Urine sample
- Bladder scan
- DRE as per RCN guidance
- Cognitive assessment

Provisional Diagnosis:
Neurological cause
Weak pelvic floor
Anal sphincter weakness
Gastro-intestinal hurry
Constipation with overflow

Impaction – Follow impaction pathway 2

Tier 1-3 for 6/52
Conservative treatments
Reduce caffeine,
Eliminate cause e.g.
medication review
Anti-diarrhoeal medication
Dietary amendments
Pelvic floor exercises
Topical oestrogen
Containment products
Bowel Management pathway
Patient education
Modify bowel habit
Toilet access issues
Coping strategies and support
Refer to tier 3

Neurological Cause
Refer to the Spinal cord toolkit/pathway

Tier 1-3
Pelvic floor training/
biofeedback
Consider trans-anal irrigation
Flexiseal
Bowel training
Dietary

Refer to Bowel Consultant/Surgical Team
if unresponsive to treatment
For investigations prior to
Trans-anal irrigation eg
Sigmoidoscopy in over 65’s

Chairman: Dr Don White
Chief Executive: Andrew Morgan
ADULT CHRONIC CONSTIPATION ALGORITHM

**Working Diagnosis**
- Obstructive defecation
- Pelvic floor dysfunction
- Normal transit / irritable bowel
- Dyschezia (painful or difficult defecation)
- Slow transit constipation

**Initial Advice:**
- Increase fluid/fibre intake
- Increase mobility/exercise
- Toilet facilities & routine
- Bowel habit
- Defecation dynamics

**Consider use of oral aperients**
- **Stools hard:** Consider Lactulose, Movicol, Docusate Sodium
- **Stools Soft:** Consider a stimulant such as senna, bisacodyl, docusate sodium or danthron *(for use in terminally ill patients only)*.

**Review of first and second laxative initiation**

**Prevention of recurrence**
- Laxative withdrawal
- Establish maintenance dose
- Lifestyle changes

**Monitor for 2-4 weeks if no improvement refer to GP/Continence Nurse Specialist to exclude organic disease.**

**Consider trial of prucalopride (resolor) for 4 weeks then review**

**Consider trans anal irrigation – Over 65’s will require sigmoidoscopy to rule out diverticular disease.**

**Referral to Secondary Care;**
If conservative management fails for investigations-
- Slow transit studies
- Anal Physiology
- Abdominal X ray

(Appendix P)
- History
- Urinalysis
- DRE
- Wgt/Hgt
- Medication
- Food Diary
- Fluid intake chart
- Bowel record sheet
- Rome Criteria
- Lifestyle/exercise
- Exclude red flags
- Exclude abnormalities ie prolapse

Chairman: Dr Don White
Chief Executive: Andrew Morgan
### Appendix Q: Delivering Rectal Bisacodyl Solution

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Confirm continued appropriateness of procedure for patient in accordance with patient’s notes and current nursing care plan. Confirm that you are capable and confident in your ability to undertake this procedure safely.</td>
<td>To maintain patient safety prior to procedure. To guarantee that appropriate permission to undertake the procedure is documented in the event that the patient cannot personally give consent at this time.</td>
</tr>
<tr>
<td><strong>2.</strong> Evaluate patient’s awareness and understanding of procedure. Provide further information as appropriate before obtaining verbal consent to proceed.</td>
<td>To satisfy requirements for obtaining verbal consent.</td>
</tr>
<tr>
<td><strong>3</strong> If indicated in the care plan, take and record patient’s blood pressure and/or resting pulse at the beginning of the procedure. Monitor patient’s condition throughout the procedure as indicated in the care plan.</td>
<td>Some patients, with sensory incomplete lesions may experience vaso-vagal symptoms as a parasympathetic response to ano-rectal distension manifesting itself as a significant bradycardia. Patients with spinal lesions above T6 are at risk of developing autonomic dysreflexia during DRS manifesting itself as a significant hypertension.</td>
</tr>
<tr>
<td><strong>4</strong> Wash hands thoroughly. Apply a white apron and two pairs of latex-free examination gloves.</td>
<td>The practitioner is expected to observe universal infection control precautions in relation to use of aprons and gloves throughout the procedure and during the disposal of faeces and soiled items. The frequency of DRS, involving repeated contact with the rectal mucosa places the patient at significant risk of developing a latex allergy.</td>
</tr>
<tr>
<td><strong>5</strong> Assist patient as necessary to achieve their preferred position appropriate to their comfort and ability. This may be lying on the bed or sitting on a toilet/commode. Position sufficient incontinence pads to protect bedsheets as appropriate and arrange sheets or clothing and curtains to maintain privacy and protect patient warmth and dignity.</td>
<td>The left lateral position makes the rectum more accessible for insertion and retention of a rectal stimulant but is not mandatory. Assume a right lateral position if more convenient or if patient’s skin or comfort is compromised. It is often appropriate for a practitioner to undertake this procedure for a patient who is sitting on a toilet / commode due to the limited duration and postural risk.</td>
</tr>
<tr>
<td><strong>6</strong> Undertake digital rectal examination (see DRE procedure) to ensure that no new contra-indicative lesions, bleeding or haemorrhoids exist.</td>
<td>The appearance of new and significant ano-rectal lesions or bleeding must be documented evaluated by a doctor or specialist nurse before continuing.</td>
</tr>
<tr>
<td><strong>7</strong> Check correct dose of BRS and date-of-expiry against prescription in accordance with Trust Medicine Code procedural guidelines before assembling the Rocket rectal injector and drawing up the prescribed amount of BRS from the bottle provided.</td>
<td>To ensure correct identification of patient and safe administration of a rectal medicine. The best time to undertake this procedure is 20-30 minutes after a meal or hot drink, making best use of the gastro-colic reflex.</td>
</tr>
<tr>
<td><strong>8</strong> Lubricate the end of the injector nozzle with lubricating gel. Insert the injector nozzle into the rectum, being careful to maintain the nozzle within the centerline of the rectum to avoid stimulating the rectal wall. Insert rectal stimulant as prescribed The optimum time for undertaking this procedure is by gently depressing the plunger of the syringe until all the BRS has been delivered.</td>
<td>To ensure that the rectal stimulant is administered so that it achieves direct contact with the bowel wall. The nozzle of the rectal injector should be inserted at least 4cm into the rectum before the plunger is depressed. Do not push against any obstruction, instead withdraw the injector nozzle and try again. If faeces were present in the rectum on examination it may be necessary to undertake a gentle digital rectal evacuation to provide sufficient space for the stimulant to work effectively.</td>
</tr>
<tr>
<td><strong>9</strong> After all of the BRS insertion, leave the patient resting in position for 10-15 minutes. If the anal</td>
<td>To allow stimulant time to work.</td>
</tr>
</tbody>
</table>
reflex has developed sufficient strength and co-ordination, it may evacuate some faeces automatically onto the protective pad during this time. Whether or not a reflex bowel action has taken place, further DRS is usually necessary to ensure that the bowel is completely empty.

DRS is a supplement to a chemically induced reflex evacuation.

| 10 | If an excessive amount of faeces remains in the rectum, its presence may be delaying the return of an efficient reflex. In such an event a further gentle DRF may be necessary. Alternatively, a second dose of BRS may be indicated in the care plan. |
| 11 | To perform digital rectal stimulation (DRS):
(a) Insert one gloved and lubricated finger into the rectum.
(b) Turn the finger so that the padded inferior surface is in contact with the bowel wall.
(c) Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.
(d) Withdraw the finger and await reflex evacuation.
(e) Repeat every 5-10 minutes until reflex activity ceases.
(f) In the event of no reflex activity occurring at all, do not repeat DRS more than 3 times. |
| 12 | Dispose of faeces into a clinical waste bag. Wipe finger of glove clean with a moist disposable wipe between insertions or change top glove as required. Dispose of soiled materials in clinical waste bag. |
| 13 | Dispose of faeces into a clinical waste bag. Wipe finger of glove clean with a moist disposable wipe between insertions or change top glove as required. Dispose of soiled materials in clinical waste bag. |
| 14 | At the end of the procedure, wash and dry all soiled skin thoroughly and assist patient as required to achieve a comfortable position. Remove apron and wash hands thoroughly. |
| 15 | Document result in Nursing Notes with reference to Bristol Stool Chart as appropriate. Report any exceptions to the guidelines which occurred during the procedure. |

Undertaking DRF as a singular exception to the prescribed stimulation of the reflex response is less harmful for the patient than excessive DRS. Persistent use of DRF in place of anticipated reflex activity demands a review of the bowel care programme.

No injury to patients has ever been reported using this procedure as described.

Some harm can be caused by excessive stimulation so do not exceed limits described without reference to a more experienced specialist practitioner.

Gentle insertion and removal of the finger utilizing appropriate and sufficient lubrication will reduce the potential occurrence of autonomic dysreflexia.

Aggressive stimulation may actually induce autonomic dysreflexia.

The materials used in the manufacture of modern examination gloves and the lack of powder can make repeated re-gloving within a procedure quite difficult. Choose the most appropriate procedure.

To maintain patient dignity, comfort and skin integrity.

To prevent cross-infection.

To enable consistent reporting and interpretation of results and to monitor the effects of any legitimate interventions or changes to previously established bowel management programme.
Appendix 2  Competency Framework:

COMPETENCY FRAMEWORK FOR THE REFLEX EVACUATION OF FAECES USING BISACODYL RECTAL SOLUTION IN PATIENTS WITH ESTABLISHED SPINAL CORD LESIONS

To be completed by Registered Nurse /Health Care Assistant/Assistant Practitioner by a registered competent nurse who is working towards a university accredited lower bowel dysfunction course. Observation of 1-3 times as required.

Nurses Name: ............................................Contact Address:.................................

Assessors Name:.................................Contact Address.................................

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Competency</th>
<th>Achieved</th>
</tr>
</thead>
</table>
| Clinical Knowledge,                   | An understanding of the anatomy of the lower bowel dysfunction in relation to spinal injury  
                                         | Understands indications, exclusions and contraindications the use of rectal bisacodyl solution  
                                         | Aware of the need to observe patient for signs of autonomic dysreflexia if patient is known to have an injury above T6 |----------|
| Patient information and informed consent | Preparation/consent  
                                         | Ensure privacy and dignity maintained  
<pre><code>                                     | Ask patient if chaperone required |----------|
</code></pre>
<table>
<thead>
<tr>
<th>Equipment</th>
<th>Awareness of infection control, hand hygiene and personal protective equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of rectal Bisacodyl Solution</td>
<td>Check correct dose of Bisacodyl rectal solution and expiry date against prescription and care plan</td>
</tr>
<tr>
<td></td>
<td>Administration of solution accompanied by Digital rectal procedures</td>
</tr>
<tr>
<td></td>
<td>Trained Nurse or HCA identifies and understands at what stage to seek medical assistance</td>
</tr>
<tr>
<td>Interpretation of results</td>
<td>Achieves accurate measurement(s)</td>
</tr>
<tr>
<td>Communication and documentation</td>
<td>Reflects on and documents findings on S1</td>
</tr>
<tr>
<td></td>
<td>Identifies appropriate action(s) based on findings</td>
</tr>
<tr>
<td></td>
<td>Communication with patient</td>
</tr>
<tr>
<td></td>
<td>Communication with healthcare team including GP</td>
</tr>
</tbody>
</table>

Signature of Nurse:………………………………….Signature of Assessor:………………………………Date…………..
### Monitoring Template

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring e.g. audit</th>
<th>Responsible individuals/group/committee</th>
<th>Frequency of monitoring/audit</th>
<th>Responsible individuals/group/committee (multidisciplinary) for review of results</th>
<th>Responsible individuals/group/committee for development of action plan</th>
<th>Responsible individuals/group/committee for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years</td>
<td>Review by CNS Continence</td>
<td>CNS Continence/Quality Scrutiny Group</td>
<td>Annual</td>
<td>Quality scrutiny committee</td>
<td>CNS Continence</td>
<td>CNS Continence/CTL</td>
</tr>
</tbody>
</table>

Appendix 3
(Appendix Q)

<table>
<thead>
<tr>
<th>Name of Policy/Procedure/Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Guidelines for Lower Bowel Dysfunction in Adults within Primary Care</td>
</tr>
</tbody>
</table>

Equality Analysis Carried out by: Diane Walker  
Date: June 2014  
Equality & Human rights Lead: Rachel Higgins  
Date: November 2014  
Director-General Manager: Andrea Blakeley  
Date: November 2014

*In this template the term policy/service is used as shorthand for what needs to be analysed. Policy/service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.*
Section 1 – to be completed for all policies
### A. Briefly give an outline of the key objectives of the policy; what it’s intended outcome is and who the intended beneficiaries are expected to be.

Provision of local guidance and treatment algorithms for Healthcare Professionals to use when treating and managing patients presenting with lower bowel dysfunction (including digital rectal examination and digital removal of faeces).

<table>
<thead>
<tr>
<th>B. Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? <strong>Please give details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No – disability, sexual orientation, gender, race, religious and age neutral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Is there any evidence that the policy/service relates to an area with known inequalities? <strong>Please give details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No – cross population.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Will/Does the implementation of the policy/service result in different impacts for protected characteristics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For medical reasons the policy guidance is necessarily specific to gender but is applied equally regardless of this. It complies with recognised national guidance and standardises accordingly.</td>
</tr>
</tbody>
</table>

| Disability | X |
| Sexual Orientation | X |
| Sex | X |
| Gender Reassignment | X |
| Race | X |
| Marriage/Civil Partnership | X |
| Maternity/Pregnancy | X |
| Age | X |
| Religion or Belief | X |
| Carers | X |

If you have answered ‘Yes’ to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2.

The above named policy has been considered and does not require a full equality analysis.

**Equality Analysis Carried out by:** Suzanne Kinder

**Date:** July 2017