Royal Cornwall Hospitals
NHS Trust

Adult Neurogenic Bowel Management Policy

V3.0

October 2025

Summary

This guideline gives the details for managing Adult Neurogenic Bowel dysfunction for digital Rectal Examination and Digital Removal of Faeces.

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. “Bowel care is a fundamental area of patient/client care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients/clients” (Royal College of Nursing 2012, page 4.) Due to the advances in clinical care, there has been a reduced need for digital removal of faeces, however for individuals with neurogenic bowel dysfunction this remains the only effective method of bowel management (RCN 2012, National Patient Safety Agency 2004).

1.2. Failure to commence bowel intervention within the acute phase post injury can cause difficulties further along the path of rehabilitation (Pardee 2012). Ineffective bowel care can be viewed as neglect (Multidisciplinary Association of Spinal Cord Injured Professions 2012) and is a breach of the Nurse and Midwifery Code (2015) in failing to provide essential patient care. The effect of bowel dysfunction is a leading cause of reduced quality of life caused by faecal incontinence and time spent undertaking bowel care (Pardee 2012). Without adequate support and care, patients can become constipated and impacted (Ness 2013). Constipation increases the risk of developing autonomic dysreflexia which is a medical emergency and can be life threatening.

1.3. Many nurses are unsure about the legal and professional aspects of undertaking digital rectal stimulation and digital removal of faeces (Kyle 2010.) Accusations of abuse remain a concern for many nurses following two professional conduct cases reviewed by the NMC involving appropriate use of such procedures (Casteldine 2000, Kyle 2010). These guidelines aim to ensure staff members are equipped with the relevant knowledge and good practice information and are limited to adult patients.

1.4. These guidelines are based on national standards for neurogenic bowel dysfunction management produced by The Royal College of Nursing (RCN 2012) and Multidisciplinary Association of Spinal Cord Injured Professionals (MASCIP 2012).

1.5. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of these guidelines is to inform staff of the expected standards to promote high quality and safe care to individuals with neurogenic bowel dysfunction who require digital rectal examination, digital rectal stimulation, and digital removal of faeces. Nursing staff should be prepared to deliver bowel care to patients admitted with a new spinal cord lesion and any patient admitted with an established spinal cord lesion, irrespective of the division they are admitted to (NSPA 2004).

3. Scope

This policy applies to all permanent, locum, agency and bank clinical staff involved in patient assessment, treatment, and care in all patient areas. This includes emergency, elective, and day case areas. All professional groups are accountable to their professional bodies at all times.

4. Definitions / Glossary

4.1. Neurogenic bowel dysfunction

Neurogenic bowel dysfunction is defined as dysfunction of the colon caused by damage or disease to the central neurological system resulting in loss of normal sensory control and/or motor control (MASCIP 2012).

4.2. Digital rectal examination

Examination of the rectum by insertion of lubricated gloved finger into rectum. Digital rectal examination can be used as part of a nursing assessment, but due its invasive nature it should not be used as a first line investigation into the assessment and treatment of constipation (RCN 2012).

Indications:

- To assess the state of the rectum and identify any contra-indications to performing digital rectal stimulation and digital removal of faeces.
- To ascertain the presence of faecal matter in the rectum and its consistency
- To assess the need for digital simulation or digital removal of faeces.
- To assess anal tone and sensation.
- To administer rectal medications.
- To evaluate the effect of rectal medications, digital rectal stimulation and digital removal of faeces.

(RCN 2012, Dougherty and Lister 2015)

4.3. Digital rectal stimulation

The digital stimulation of the anal-rectal reflex to trigger peristalsis and aid defaecation, through the inserted of a gloved lubricated finger into the rectum via the anus, followed by 20-30 seconds of circular movements of the inserted finger. (MASCIP 2012) This should only be performed when necessary and after individual assessment.

Patients with tetraplegia and paraplegia who have a spinal cord injury/lesion T12 or below, generally have a reflex bowel, this reflex can be triggered by the act of digital rectal stimulation and/or the insertion of suppositories (MASCIP 2012.)

4.4. Digital removal of faeces

Defined as the removal of faeces from the rectum using a lubricated gloved finger (MASCIP 2012), should only be performed when an individual is unable to evacuate their bowels without intervention following a spinal cord injury and after individual assessment.

Digital removal of faeces is an accepted and routine method of management for patients with a spinal cord injury/lesion above T12 level. Their bowels will not empty in a reflex response to rectal stimulants or suppositories.

4.5. Autonomic dysreflexia

Autonomic dysreflexia can occur in patients with a spinal cord injury/lesion at T6 or above. Autonomic dysreflexia arises as a result of an autonomic sympathetic reflex that occurs as a result of perceived pain or discomfort below the level of the lesion.

The reflex creates extensive vaso-constriction below the level of the lesion causing a pathological rise in blood pressure.

4.6. ASIA score

An assessment to determine the level and severity of a patient's spinal card injury and assists to rehabilitation and recovery needs.

5. Ownership and Responsibilities

5.1. Role of the Chief Executive

The Chief Executive has overall responsibility for ensuring there are guidelines and protocols in place to provide care for patients with a neurogenic bowel.

5.2. Role of the Management Teams

To ensure that the team for which they are responsible, complies with this policy.

5.3. Responsibilities of Ward Managers, Department Managers and Consultants

- To ensure that all staff who undertake digital rectal examination, digital rectal stimulation and digital removal of faeces receive training and complete competence in these clinical skills.

- To ensure that they keep a record of all staff who have received training.

5.4. Role of Individual Staff

- All registered staff undertaking digital rectal examination, digital stimulation and digital removal of faeces should have attended the bowel management study day, have undertaken supervised practice within the clinical area and be assessed as competent before undertaking the procedures.

- Staff that have been assessed as competent in digital rectal examination, digital stimulation, and digital removal of faeces via another organisation need to show documentation of this before undertaking the procedure.

- Adult neurogenic bowel management champions are available, and a list of these staff members are available on the Sisters shelf, or asking for a Surgical Care Practitioner via switch board.

6. Standards and Practice

6.1. Bowel Assessment

All patients with a spinal cord lesion should undergo a bowel assessment, including usual bowel habits and routine, this should be documented within the patients care plan. Specifically, the plan of care for bowel management and the rationale to perform the procedure should be clearly documented (See Appendix 4). An ASIA score should be undertaken by the medical team to ascertain the level of injury and the effect on the bowel. Patients with an existing spinal cord lesion are experts in the management of their bowels even if they are unable to perform the task themselves (NSPA 2004).

6.2. Consent

6.2.1. Obtaining consent is essential before carrying out invasive bowel care procedures, nurses must ensure patients fully understand the information being given to them (NMC 2015). Verbal consent should be sought by the nurse undertaking the procedures and documented within the nursing notes.

6.2.2. The Mental Capacity Act (2005) provides a framework to empower and protect vulnerable individuals aged 16 and over who are not able to make informed decisions. Situations may arise where there is a need to undertake these procedures deemed in a patient's best interest. In these circumstances, there should be a discussion with members of the multidisciplinary team and family/carer if appropriate and the outcome documented in the medical notes.

6.2.3. Patients should be informed of their right to request a chaperone when undergoing digital rectal stimulation and digital removal of faeces. If a chaperone cannot be provided the patient must be informed and asked if they wish to continue with the procedure. Their decision should be recorded in the patient's records.

6.2.4. Cultural and religious beliefs or restrictions the patient may have should be respected at all times.

6.2.5. The use of professional interpreters may be required for patients in whom English is not their first language, to ensure consent is valid.

6.3. Assessment prior to undertaking digital rectal interventions

6.3.1. The perianal area should be checked for any of the following and results should be documented and reported:

- Rectal prolapse.
- Haemorrhoids.

- Anal skin tags, lesions.
- Wounds dressings, discharge.
- Areas of skin breakage, pressure damage.
- Bleeding and colour of blood.
- Foreign bodies.

6.3.2. If examination leads to concern, advice should be sought from a medical practitioner before undertaking these interventions, unless the nurse feels confident and is competent to do so.

6.4. **Contra-Indications to performing digital rectal interventions**

- Lack of consent.
- Patient has undergone recent rectal/anal surgery/trauma.
- Presence of abnormalities of the perianal area are observed as list above.

6.5. **Cautions**

- Active inflammation of the bowel, including Crohn's disease, ulcerative colitis, and diverticulitis.
- Recent radiotherapy to the pelvic area.
- Rectal/anal pain.
- Previous rectal surgery/trauma to the anal/rectal area within the last 6 weeks.
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment.
- Obvious rectal bleeding or patient taking anti-clotting medication.
- If the patient has a known or suspected history of abuse.
- Risk of autonomic dysreflexia.

6.6. **Potential Complications**

Autonomic Dysreflexia

This is a medical emergency that unresolved, may give rise to serious consequences such as cerebral haemorrhage, seizures, or cardiac arrest. See Appendix 6).

6.7. **Competence**

6.7.1. Staff undertaking digital stimulation and digital removal of faeces must demonstrate competence before undertaking these procedures (RCN 2012). Staff are required to undertake the Trust's Bowel Management for Spinal Cord Injured Patients study day and be assessed in clinical practice to achieve competence or produce documentation to prove competence has been achieved elsewhere. Attendance of the study day is recommended as a once only attendance requirement unless a specific learning need is identified.

6.7.2. Assessment of competence should take place within 6 months of attending training. Exceptions to this will be practitioners who commenced this practice prior to the availability of formal training. Individuals must, however, ensure they have read and comply with current policy. Staff (Practitioners and Assessors) must maintain their competence through clinical practice, personal study and retraining if competence is not maintained (clinical practice must be undertaken yearly as a minimum).

6.8. The main ward areas undertaking digital stimulation and digital removal of faeces within the Royal Cornwall Hospitals Trust site are ITU, HDU and Pendennis ward. The surgical care practitioners who have undertaken the Bowel Dysfunction study day are also available via switch board. Clinical areas which rarely undertake these procedures should contact these wards for support to ensure safe and effective bowel care is delivered to individuals admitted to all area's hospital.

6.9. The Ward Manager/Practice Educator for areas which regularly undertake the procedures are required to keep a record of staff assessed as competent.

7. Dissemination and Implementation

7.1. This document will be implemented and disseminated through the Organisation immediately following ratification and will be published on the Organisation's intranet sit (document library).

7.2. Dissemination will include staff notification via daily bulletin. Senior clinicians and specialty governance leads will be responsible for notifying their clinical teams of the policy.

7.3. Access to this document is open to all staff.

7.4. Implementation of policy contents will be delivered by the learning and development department as identified on the Trust Training Needs Analysis.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Ensuring staff complete documentation accurately. Ensuring all staff who look after care for spinal cord injured patients attend study day. Ensure that all staff that provides bowel management for spinal cord injured patients is competent. Reporting poor practice and documentation.
Lead	Ward Managers, Lead Nurses, Divisional Leads, Clinical Educators Training Dept, Clinical Matrons.
Tool	• Chart audit Observation of charts on ward rounds. • Recording attendance at training. • Database updated by trained clinical educators. • Daily ward rounds.
Frequency	Monthly and continuously as required.
Reporting arrangements	• Audit Lead, email to senior personnel. • Databases kept centrally, Ward Managers. • On electric database. Datix.
Acting on recommendations and Lead(s)	The DQG is responsible for interrogating required actions and to disseminate a named lead where appropriate. This is documented in meeting minutes.
Change in practice and lessons to be shared	Designated leads will forward where appropriate the lessons to be shared with all the relevant stakeholders.

9. Updating and Review

The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for policy document review. Should they no longer work in the organisation or in the relevant best practice area, then an appropriate practitioner will be nominated to undertake the document review by the designated director.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Adult Neurogenic Bowel Management Policy V3.0
This document replaces (exact title of previous version):	Adult Neurogenic Bowel Management Policy V2.0
Date Issued/Approved:	September 2025
Date Valid From:	October 2025
Date Valid To:	October 2028
Directorate / Department responsible (author/owner):	Nicola Devlin, Senior Surgical Care Practitioner (SCP)
Contact details:	01872 253931
Brief summary of contents:	Guidance for the management of Adult Neurogenic Bowel Dysfunction for Digital Rectal Examination and Digital Removal of Faeces.
Suggested Keywords:	Bowel management, neurogenic bowel, Digital Rectal Examination and Digital Removal of Faeces.
Target Audience:	**RCHT**: Yes **CFT**: No **CIOS ICB**: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Surgical Governance
General Manager confirming approval processes:	Ian McGowan
Name of Governance Lead confirming approval by specialty and care group management meetings:	Suzanne Atkinson
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	Casteldine G. (2000) Professional misconduct case studies. Case 34: patient abuse. Nurse who carried out manual evacuations without consent. British Journal of Nursing. 9 (17): 1123 [Online]. Dougherty, L. and Lister, S. 2015. The Royal Marsden Manual of Clinical Nursing Procedures. 9th Edition. Chichester: Wiley Blackwell: Kyle, G. 2010. Why are nurses failing to carry out digital rectal examinations? Nursing Times. 106(48): 8. Krassioukov, A. Warburton, D.E. Teasell, R. and Eng, J.J. 2009. A systematic review of the management of autonomic dysreflexia. Archives of Physical Medicine and Rehabiliation. 90(4): 682-695. Code of Practice: Mental Capacity Act (2005) available electronically on BSUH info- net – Mental Capacity Act. Multidisciplinary Association of Spinal Cord Injury Professionals. 2012. Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. Aylesbury: MASCIP. [Online]. National Patient Safety Agency. 2004. Patient Safety Information, Spinal Cord Lesions and Bowel Care. [Online] National Patient Safety Agency. Ness, W. 2013. Management of lower bowel dysfunction. Primary Health Care. 23(5): 27-30. [Online]. Nursing and Midwifery Council. 2015. The Code: Standards of conduct, performance and ethics for nurses and Midwives. London: NMC. Pardee, C. Bricker, D. Rundquist, J. MacRae, C. and Tebben, C. 2012. Characteristics of Neurogenic Bowel in Spinal Cord Injury and Perceived Quality of Life. Rehabilitation Nursing. 37(3): 128-135 Royal College of Nursing. 2012. Management of lower bowel dysfunction, including DRE and DRF, RCN guidance for nurses. London: RCN.
Training Need Identified?	Yes, staff will need to carry out training to achieve successful implementation of this policy. The Learning and Development department have been informed and further training is being implemented.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/General Surgery

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
06 February 2019	V1.0	Initial issue	Nicola Devlin, Senior Surgical Care Practitioner
June 2022	V2.0	No changes. New trust template.	Nicola Devlin, Senior Surgical Care Practitioner
September 2025	V3.0	No changes. New trust template.	Nicola Devlin, Senior Surgical Care Practitioner

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Adult Neurogenic Bowel Management Policy V3.0
Directorate and service area:	General Surgery
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Nicola Devlin, Senior Surgical Care Practitioner
Contact details:	01872 253931

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To inform staff on the appropriate management for Adult Neurogenic Bowel dysfunction for Digital Rectal Examination and Digital Removal of Faeces.
2. Policy Objectives	Ensure digital rectal examination and digital removal of faeces is performed for the appropriate management of Adult Neurogenic Bowel dysfunction.
3. Policy Intended Outcomes	Patients will be adequately managed in cases where Adult Neurogenic Bowel dysfunction is diagnosed.
4. How will you measure each outcome?	Monitoring through incident reporting and case discussion at Governance meetings.
5. Who is intended to benefit from the policy?	Patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Consultant Body and nursing staff, General Surgery, Royal Cornwall Hospitals Trust. Guideline implemented in response to a National Patient Safety Alert.
6c. What was the outcome of the consultation?	Guideline agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Nicola Devlin, Senior Surgical Care Practitioner.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3: Procedure for Digital Rectal Stimulation (DRS) in individuals with SCI

Action	Rationale
Ensure prescribed oral aperients have been given, offer warm drink or food.	To promote stool transit and to stimulate the gastro-colic reflex.
Explain the procedure to the individual and obtain consent. Even if the individual consents to the procedure, if they request you to stop at any time, you must do so. A chaperone should be offered.	To obtain informed consent in line with the NMC Code of Conduct (2015).
Ensure a private environment.	To maintain privacy and dignity.
Patients BP should be monitored throughout the procedure if they have a new injury or if the individual displays symptoms or provides history of autonomic response during bowel care interventions.	To monitor for signs of autonomic dysreflexia.
Wherever clinically possible DRE should be undertaken whilst the patient is in a sitting position. However, if this is not possible and not Contraindicated (i.e., unstable cord injuries), position the individual in a lateral position (usually left side) with the knees flexed. If the spinal injury is unstable the procedure should be undertaken during a log roll.	Flexing the knees promotes stability of the individual and helps to expose the anus.
Place a protective pad under the patients.	To maintain infection control.
Wash hands, put on two pairs of gloves and an apron.	To maintain infection control.
Ensure only patient's buttocks are exposed.	To maintain dignity and prevent hypothermia.
Lubricate gloved finger with water soluble gel.	To prevent friction, which can lead to anal trauma.
Inform individual you are about to begin.	To obtain consent.
Insert single gloved, lubricated finger slowly and gently into the rectum.	To open external anal sphincter and prevent trauma.

Action	Rationale
Turn the finger so that the padded inferior surface is in contact with the bowel wall.	To prevent trauma.
Rotate the finger in a clockwise direction for at least 10 minutes, maintaining contact with the bowel wall throughout.	To stimulate rectal contraction.
Withdraw the finger and await reflex evacuation.	To expel stool from the rectum.
Repeat every 5-10 minutes until the rectum is empty or reflex activity ceases. Remove soiled glove and replace, re-lubricating as necessary between insertions.	To ensure complete emptying of the rectum. To maintain infection control.
If no reflex activity occurs during the procedure, do not repeat it more than 3 times. Use digital removal of faeces if stool is present in the rectum.	Patient safety.
During the procedure, the person delivering care may carry out abdominal massage.	Increase abdominal pressure to assist with rectal emptying.
Once the rectum is empty conduct a final digital check of the rectum after 5 minutes.	To prevent faecal incontinence.
Place faecal matter in an appropriate receptacle as it is removed. Dispose of it and any other waste in a suitable clinical waste bag.	To maintain infection control.
When the procedure is completed wash and dry the patient's buttocks and anal area and position comfortably before leaving.	To maintain patient safety and infection control.
Remove gloves and apron and wash hands.	To maintain infection control.
Record outcomes using the Bristol stool chart and bowel management documentation.	Patient safety and on-going assessment.
Record and report abnormalities.	Patient safety.

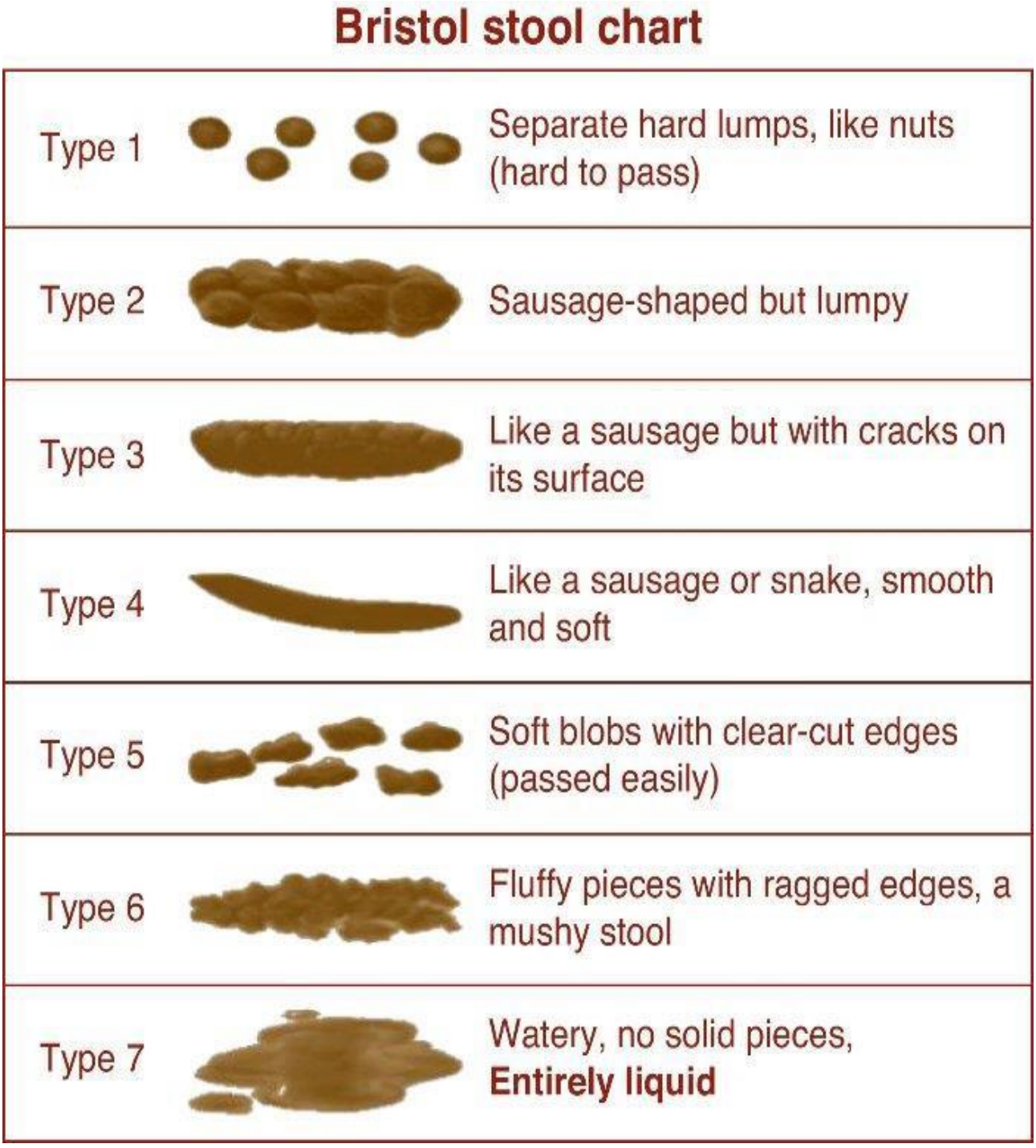
Procedure for Digital Removal of faeces (DRF) in Individuals with SCI

Action	Rationale
Explain the procedure to the patient and obtain consent. Even if a patient consents to the procedure, if they request you to stop at any time, you must do so. The individual should be invited to have an escort present if they wish.	To obtain informed consent. Legal requirement.
Ensure a private environment.	To maintain dignity and respect
Observe the individual throughout the procedure for signs of autonomic dysreflexia or other adverse events. Blood pressure monitoring is only required if this is the first time the procedure is undertaken or if the individuals display symptoms or provides a history of autonomic response during bowel care interventions.	To ensure early recognition of any adverse harm to the individual
Position the individual in a left lateral position with knees flexed, if safe to do so. IF the spinal cord injury is unstable, bowel management can take place during a log roll to maintain spinal alignment at all times	Flexing the knees promotes the stability of the individual and helps to expose the anus. Maintaining spinal alignment is paramount to prevent any compromise to neurological deficit until spinal clearance is given by the appropriate. clinician.
Place a protective pad under the individual.	To maintain infection control.
Wash hands and put on disposable gloves and apron.	To maintain infection control.
Ensure only buttocks are exposed.	To maintain dignity and prevent hypothermia.
Lubricate gloved finger with water-soluble gel.	To prevent friction this can lead to anal trauma.
Inform patient you are about to begin.	To obtain consent.
Perform digital rectal examination	To establish safe to proceed.
Insert single gloved, lubricated finger slowly and gently into the rectum.	To open external anal sphincter and prevent trauma.
With pad of finger against stool, slowly rotate and remove finger, expelling stool from the rectum at the same time	To prevent trauma to rectal mucosa and anal sphincter.

Action	Rationale
During the procedure, the person assisting may carry out abdominal massage.	To increase abdominal pressure and aid with evacuation of stool.
Once the rectum is empty, conduct a final digital check of the rectum after 5 minutes.	To ensure evacuation is complete.
Place faecal matter in an appropriate receptacle as it is removed. Dispose of in a suitable clinical waste bag.	To maintain infection control.
Wash and dry the patient's buttocks and anal area and position comfortably before leaving.	To maintain dignity.
Remove gloves and apron and wash hands.	To maintain infection control.
Record outcome using Bristol Stool chart	Legal requirement and aid assessment.
Record and report abnormalities.	Legal requirement.

Adapted from Guidelines for Neurogenic Bowel Dysfunction for Individuals with Central Nervous Condition (MASCIP 2012 and Spinal Injuries Association 2017).

Appendix 4: Bristol Stool Chart



Appendix 5: Autonomic Dysreflexia

Commonest Causes

- Any painful or noxious stimuli below the level of the lesion.
- Distended bladder (usually due to a blocked catheter or other outflow obstruction).
- Distended bowel due to a full rectum, constipation, or impaction.
- Ingrown toenail.
- Fracture below the level of the lesion.
- Labour/ childbirth.
- Ejaculation.

Other causes

- Pressure damage.
- Deep Vein Thrombosis.
- Appendicitis.
- Ulcers.
- Surgery.
- Burns.
- Severe anxiety or emotional distress.
- Spinal injured patients with a stoma (debris/mucus/overflow can build up in the rectum).

Signs and Symptoms

The commonest presenting symptoms are:

- Severe hypertension.
- Bradycardia.
- “Pounding" headache.
- Flushed or blotchy skin above the level of the lesion.
- Pallor below the level of the lesion.
- Profuse sweating above the level of the lesion.
- Nasal congestion.

Treatment

Treatment must be initiated quickly, and the blood pressure closely monitored:

- The first step of treatment, regardless of the cause, is to sit the patient upright, to induce an element of postural hypotension. If bladder problems are suspected, only sit patient to 45 degrees. Sitting at 90 degrees may cause increased pressure on the full bladder.

- Identify the source of the noxious stimulus (removing the stimulus will cause the symptoms to settle).

- Restrictive clothing such as tight belts must be removed.

- High blood pressure should be treated until the cause is found and eliminated. Administer a prescribed vasodilator e.g., GTN tablets sublingually, or oral nifedipine capsules (capsule to be pierced and the contents put in the patient's mouth)

- If patient is not catheterised and the bladder appears full, catheterise immediately and leave on free drainage. The catheter must be lubricated with an anaesthetic gel prior to insertion.

- If catheterised, empty the bag and untwist any kinked tubing. If the catheter appears blocked, change the catheter immediately. DO NOT ATTEMPT A BLADDER WASHOUT; this will only distend the bladder further with potentially fatal consequences.

- If the above steps do not resolve the issue; and the patient remains hypertensive and symptomatic, then the rectum should be examined and emptied by gentle insertion of a gloved finger, lubricated with anaesthetic gel.

Observations required prior to bowel care interventions

As an acute phase intervention

As an acute intervention or new patient, the following observations and risk factors should be considered and documented.

- Pulse and blood pressure should be monitored before, during and post procedure.

- Signs and symptoms of autonomic dysreflexia.

- distress, pain, and discomfort.

The procedure should be discontinued/not commenced if any of the above factors are identified, and medical advice sought.

As a regular intervention

The following observations should be considered and documented

- Pulse at rest.

- Distress, pain, or discomfort.

- Bleeding.
- Signs and symptoms of Autonomic Dysreflexia.

During the initial bowel assessment, information in regard to autonomic dysreflexia and the patient experiences should be noted. The information obtained and documented should include triggers, signs, and symptoms and how they usually manage it.

Appendix 6. Digital Removal of Faeces / Digital Rectal Examination

	Criteria for Achievement	Date of Self-Assessment and level of initial knowledge and skill	Competence achieved. Nurse / Assessor Signature/Date
1	**Prerequisites** A. Currently working in a ward area which cares for patients requiring these procedures. B. Has attended relevant training with the Trust or has produced confirmation of previous training/competency. C. Demonstrates an awareness of professional accountability and guidelines.		
2	**Rationale** A. Discusses the effect of spinal cord injury on the bowel. B. Demonstrates knowledge and understanding of the anatomy and physiology of the lower gastro-intestinal tract. C. Describes the indication for digital rectal examination. D. Describes the indication for digital removal of faeces. E. Discusses contra-indications for digital removal of faeces and digital rectal examination. F. Able to discuss autonomic dysreflexia, including signs, symptoms, and treatment.		
3	**Prior to procedure** A. Explains and discusses the procedure with the patient/gains consent, chaperone offered. B. Demonstrates the ability to prepare patient/environment and equipment including PPE. C. Patient offered opportunity to empty bladder prior to procedure. D. Discusses the use of appropriate		

	medications prior to procedure.		
4	**Procedure** A. Patient monitored throughout procedure for signs of autonomic dysreflexia. B. Perianal are examined. C. Local anaesthetic gel inserted into the rectum and waits 5 minutes before proceeding. D. One gloved finger lubricated and insert slowly into patients 2- 4cm into the rectum. E. Removes stool correctly in accordance with Bristol stool type. F. Once the rectum is empty, conducts a finial digital check of the rectum after 5 minutes to ensure that evacuation is complete. G. Washes and dries patient's buttocks and anal area. **Post procedure** A. Ensures patient is positioned comfortably. B. Disposes of waste in accordance with Trust policy. C. Findings discussed with patient. D. Findings/result documented within nursing notes. **Complications** Is able to discuss the possible complications of digital removal of faeces and their treatment. Demonstrate knowledge and understanding of when to refer the patient to an appropriate medical practitioner.		

Reflection on Experience	**Candidates Signature**	**Level of current knowledge and skill**
Assessor Feedback/ Action Plan	**Candidates Signature**	**Assessors Signature**