

Bowel Management for Individuals with an Established Spinal Cord Injury (SCI)

An Introductory Document for Healthcare Practitioners in the

Hospital Setting



The Princess Royal Spinal Cord Injuries Centre

Sheffield

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Introduction

Individuals with a Spinal Cord Injury (SCI) invariably have neurogenic bowel dysfunction which needs to be managed with an established and individualised bowel management programme. This will incorporate one or a combination of the following interventions on a daily or alternate day basis in conjunction with management of diet and fluids.

• Digital Rectal Examination (DRE)

• Digital Rectal Stimulation (DRS)

• Digital Removal of Faeces (DRF) (previously referred to as Manual Evacuation)

• Trans Anal Irrigation (TAI)

• Oral and/or rectal medications

(MASCIP 2018 )

This document is for advice regarding the bowel management for individuals with Spinal Cord Injury (SCI).

For other individuals please refer to

* Trust intranet
* Royal College of Nursing 2019 Management of lower bowel dysfunction, including digital rectal examination and digital removal of faeces.

<https://www.rcn.org.uk/professional-development/publications/pub-007522>

How does SCI affect Bowel function?

Damage to the spinal cord has a profound impact on all bodily systems including the function of the large bowel and on maintenance of faecal continence.

The effect of SCI on bowel function is individualised and dependant on many factors including

* neurological deficit – i.e. level of injury and completeness of injury
* psychological factors associated with adjustment to SCI
* body image
* environmental factors
* care support available

For all SCI individuals, the enteric nervous system remains functionally intact. Therefore, peristalsis continues, but as there is little or no co-ordination from the brain and spinal cord, peristalsis is less effective, and colonic transit time is extended. This leads to a drier stool and an increased likelihood of constipation.

In the majority of cases, the descending input from the brain to the colon and ano-rectum is lost. These changes result in the loss of sensation of the need for defaecation, loss of voluntary control of defaecation and loss of the brain’s influence over reflex activity.

Sensory and motor control of the ano- rectum is lost leaving the individual unable to feel the need to evacuate the bowel or to control the process of defaecation.

Without intervention, the SCI individual will be incontinent of faeces and chronically constipated.

This will lead to secondary complications such as

• Overflow diarrhoea and faecal impaction

• Loss of appetite

• Increased risk of pressure ulcers and moisture lesions

• Abdominal pain and increased spasm

• Autonomic dysreflexia (this is a risk for individuals with Spinal Cord Lesions at T6 or above)

• Damage to the colorectal structures – common problems include mega colon, haemorrhoids, anal fissure and rectal prolapse

• Abdominal distension leading to respiratory difficulty

• Bladder dysfunction

• Faecal vomiting

• Perforated bowel

Clearly, the function of the lower bowel must be effectively managed to allow the SCI individual to maintain continence and to minimise associated health problems.

Bowel Care Assessment in Spinal Cord Injury Centres

Effective bowel management is fundamental to the rehabilitation process

As with all areas of rehabilitation, the development of a bowel management program is a process that occurs in partnership with the SCI individual and focusses on their needs and wishes and promotes their autonomy.

SCI Individuals will have rehabilitation and ongoing follow up by their responsible Spinal Centre and will be provided with a sustainable bowel care plan which can be reviewed as part of their ongoing follow up.

Once a bowel management programme is established and documented within the individual’s personalised care plan, providers must ensure adequate and timely access for Individuals with SCI to appropriately trained staff/carers to carry out these procedures (NHS England 2018 )

What Is a Bowel Management Program?

A bowel management program is a plan for keeping a SCI individual in control of their bowel function. It is bespoke to them and incorporates:

* Timing – Routine is an essential component of SCI Bowel management. With a reflex neurogenic bowel, bowel care is usually performed daily or every other day and usually in the morning, following breakfast. This is to make best use of the gastrocolic reflex
* Diet and fluid intake —what, how much, and when to eat and drink
* Oral Medications—these include the oral medications to adjust stool consistency or improve bowel function and the rectal medications to stimulate a bowel movement.
* Rectal Medications and bowel stimulation techniques
* Where bowel care is performed
* How much the individual can do independently and/or who provides assistance
* How to monitor for complications
* How to trouble shoot if problems occur

Even independent SCI individuals are likely to be reliant on nursing staff for their bowel care if they are readmitted to hospitals.

During admission clerking, the individual may not respond appropriately when asked about bowel management needs and may answer that they’re independent.

e.g. Many individuals manage their bowel care on the toilet but not all can self-manage if unwell or if they are bedfast.

If admission to hospital is with bowel complications, the current plan of bowel management may need an urgent review before considering if it should ‘continue as plan’

Aims of SCI Bowel Management

The main aims of SCI bowel management are to achieve a program of management that is

• Acceptable to the individual

• Safe

• Sustainable

• Enables the SCI individual to be in control of their bowel function – whether this is independently or with the assistance of a carer.

Types of SCI bowel Dysfunction

Reflex bowel

Reflex bowel occurs in injuries where the nerves in the reflex arc from the cord to the colon and anorectum are not damaged. This usually occurs in individuals who have an injury above T12.

Because the reflex arc is not damaged, there is reflex activity which can be utilised for effective bowel emptying using digital rectal stimulation (DRS) and rectal stimulants (usually micro enemas)

Areflexic bowel

Injuries which result in damage to the reflex arc between the spinal cord and the colon and ano-rectum result in an areflexic bowel (this is sometimes referred to as “flaccid” ).

These are usually injuries to the first lumbar vertebra (LI) and below.

This results in slow stool propulsion through the descending and sigmoid colon and a high risk of faecal incontinence through the lax anal sphincter and pelvic floor . The management for this type of bowel is based on a digital Removal of Faeces ( DRF) , therefore a slightly firmer stool which is easier to remove digitally is advised (Bristol Scale 3).

Incomplete neurogenic bowel dysfunction.

Some individuals with incomplete lesions may have a degree of preserved sensation or residual voluntary control.

* They may or may not have an efficient reflex.
* They may have sensation or even pain.
* They may have awareness of ‘full’ & ‘empty’
* They may have voluntary inhibition

However this may not be sufficient to enable reliable bowel control.

Conus and Cauda Equina Injuries

Individuals with Conus Medullaris Injuries or to the spinal nerves forming the Cauda Equina will usually experience Lower Motor Neurone bowel function because these reflex centres are located in the conus.

Interventions

Establishing a Bowel Management Routine/Programme

Routine is an essential component of Spinal Cord Injury bowel management. Many individuals choose to have their bowel care in the mornings after breakfast as this is when the gastrocolic reflex is strongest (please see gastrocolic reflex).

When developing a bowel management programme, it is essential to incorporate the individual’s other activities, interests and routines as this will make the programme more likely to be sustainable.

The frequency with which the programme is conducted will vary depending on the needs of the individual but is usually daily or every 2 days.

Optimising Diet and fluids and medication

Many individuals with neurogenic bowel dysfunction report that they manipulate their diet to assist their bowel management. Stool consistency can be assessed and the diet adjusted accordingly to achieve an appropriate stool consistency.

Individuals with reflex bowel function are encouraged to aim for a soft-formed stool consistency (Bristol Scale 3 or 4), while those with areflexic bowel function are more likely to avoid faecal incontinence if they aim for firmer stools.

With regard to fluid intake it is advised to drink sufficient fluid to produce ‘pale straw coloured urine.

Gastrocolic reflex

The gastrocolic reflex is a reflexic response to the introduction of food and/or drink into the stomach, resulting in an increase in muscular activity throughout the gut which can result in movement of stool into the rectum ready for evacuation. The individual is advised to take some food and/or hot drink 15-30 minutes prior to commencing other bowel management activities. The reflex response is usually strongest after the first meal of the day but can be stimulated by eating and drinking at any time.

Digital Rectal Stimulation (DRS)

Digital rectal stimulation is a technique used to stimulate the movement of stool into the rectum and to initiate defaecation in individuals with reflex bowel.

Digital rectal stimulation (DRS) is performed by inserting a gloved, lubricated finger gently through the anal canal into the rectum and slowly rotating the finger in a circular movement, maintaining contact with rectal mucosa. This is reliant upon the presence of reflex bowel activity and therefore it is not appropriate for use for individuals with an areflexic bowel.

DRS can be undertaken by any Registered Healthcare Professional, designated Clinical Support Worker or Nurse Associate as a routine intervention in reflex Spinal Cord Injury bowel management

The SCI individual’s care plan should indicate how much DRS is usually required. Excessive DRS can be harmful to the patient and increase the risk of ano-rectal complications occurring.

Please refer to Appendix 2. Procedural guideline for the reflex evacuation of faeces in individuals with an established Spinal Cord Injury (SCI)

Digital removal of faeces (DRF)

Digital removal of faeces (previously known as manual evacuation) is used for the routine management of areflexic bowel

DRF may also be used for removal of stool prior to placing suppositories in individuals with reflex bowel or to complete evacuation where reflex activity alone is insufficient to empty the bowel.

DRF can be undertaken by any Registered Healthcare Professional, designated Clinical Support Worker or Nurse Associate

• to enable administration of rectal medication

• as a routine intervention in areflexic (flaccid) Spinal Cord Injury (SCI) bowel management

Please refer to Appendix 3 . Procedural guideline for the digital removal of faeces (DRF) in individuals with an established Spinal Cord Injury

Trans anal irrigation (TAI)

Trans-anal irrigation is a procedure which involves the introduction of water into the rectum to facilitate a bowel movement. This is carried out by the use of purpose made devices that are available on prescription.

Appropriate use of trans-anal irrigation can assist some people with problematic conventional bowel management and it is advised that any SCI individual considering TAI should contact their Spinal Centre for advice.

Bowel Management over the Toilet / Commode

SCI Bowel management may be performed on the bed or over a toilet or commode. The location should optimise safety, efficacy and be acceptable for all parties involved.

Most individuals have an understandable preference for toilet use and the evidence suggests that, in most cases, bowel management in the upright position is significantly quicker than when lying down however the benefits need to be balanced against the risks.

It is inappropriate for a practitioner /carer to undertake Digital Removal of Faeces for a SCI individual whist they are sat on a toilet /commode.

A practitioner /carer can only undertake Digital Rectal Examination or Digital Rectal Stimulation for a SCI individual whist they are sat on a toilet /commode when risk assessments deem it safe to do so.

Complications

Autonomic Dysreflexia

Autonomic dysreflexia is a sympathetic nervous system response to a noxious stimulus below the level of injury in individuals with SCI above the sixth thoracic vertebra.

Autonomic dysreflexia associated with bowel management is most likely to occur in response to ineffective bowel care due to withholding of essential interventions and therefore, the likelihood of an episode of AD occurring can be minimised with good preventative care.

During bowel care, the patient should be observed for symptoms of autonomic dysreflexia which include flushing, sweating and blotchiness above the lesion, chills, nasal congestion and headache.

The principal sign of acute autonomic dysreflexia is a rapidly developing severe headache. In this instance bowel management should be stopped and a medical assessment undertaken. If acute autonomic dysreflexia persists after stopping the procedure this should be treated promptly, according to local policy, but usually using glycerine trinitrate spray

Ano-rectal problems should be treated appropriately and steps should be taken to ensure that the bowel care programme is effective and any faecal loading or constipation is eradicated. Bowel management must still be continued on a regular basis and therefore medical assessment should indicate what measures are to be put in place to minimise or eradicate symptoms . A local anaesthetic gel, applied prior to digital interventions may be sufficient to reduce or eradicate the autonomic dysreflexic response though this is not suitable for prolonged use.

Many organisations advise routine recording of blood pressure during each bowel management episode, however, the symptoms described above are usually an adequate indicator of autonomic dysreflexia developing and The Princess Royal Spinal Cord Injuries Centre prioritises symptom management over measurement.

Faecal impaction

Faecal impaction is copious formed stool in the colon (not just the rectum) which is not progressing through the colon or which cannot be expelled from the rectum Impaction is common amongst SCI individuals. Symptoms may include absent or reduced evacuation of stool for a longer period than usual for the individual, abdominal bloating or distension, nausea and pain.

Impaction may be accompanied by ‘overflow’ or ‘spurious’ diarrhoea where looser stool leaks around an unmoving faecal mass, often associated with faecal soiling. Impaction in individuals with compromised respiratory function as in high level SCI may result in breathlessness due to reduced diaphragmatic excursion. Stool will usually be Bristol Scale 1-2 but soft-impaction with putty-like stool may occur.

Any case of faecal impaction should be cascaded as a potential medical emergency to a GP or hospital medical professional for imaging and further evaluation before any treatment regime is attempted.

Haemorrhoids

Haemorrhoids are inflammation and swelling of veins in the anal cushions, a highly vascular area of tissue just inside the anus. Internal haemorrhoids may protrude (prolapse) through the anus. Most prolapsed haemorrhoids will shrink back of their own accord but those that prolapse permanently (3rd degree) may require treatment. Prolapsed haemorrhoids may leave empty redundant skin behind (skin tags) which can cause irritation.

Haemorrhoids present with bright red blood on the stool or toilet paper, or the gloved finger after evacuation or digital rectal stimulation, and may cause pain, itching and autonomic dysreflexic symptoms in individuals with SCI above the sixth thoracic vertebra. Haemorrhoids are associated with chronic constipation or diarrhoea, straining at stool, prolonged toileting and low dietary fibre intake. The individual should be referred to an appropriate specialist for assessment and treatment if the haemorrhoids become problematic.

Megacolon / megarectum

This is associated with a poor bowel routine or use of multiple medications/ laxatives. It may underlie the deterioration in bowel function often seen in chronically spinal cord injured individuals, manifesting as prolonged duration of management and difficulty with evacuation.

Rectal Prolapse

The individual may report a mass protruding from the anus after evacuation which may retract spontaneously or require reduction manually. External prolapse often results in faecal incontinence and increased mucous production/leakage resulting in wetting and soiling of clothing. Internal prolapse may cause a feeling of incomplete evacuation. Onward referral for a surgical opinion is advised.

Anal fissure or tear

A tear or ulcer in the anus and can be extremely painful in those with intact sensation. Anal pain occurs with defecation and is severe and sharp on passing a stool, commonly followed by deep burning pain that can persist for several hours afterwards. In patients with impaired sensation this may manifest as increased spasm and autonomic dysreflexia in those susceptible. Bleeding may occur with defecation and is usually seen as a small quantity of bright red blood on the stool or toilet paper. Fissures are associated with increased anal tone which also hinders healing. The individual’s bowel management should be reviewed and evaluated to ensure that constipation is eradicated and that digital interventions are used appropriately.

The appearance of new and significant ano-rectal lesions or bleeding must be documented and evaluated before continuing.

Who to Contact For Advice

Any bowel management program can become problematic at times and SCI individuals are encouraged to contact their Spinal Centre if problems are not resolved with reasonable adjustments.

Contact Details for The Princess Royal Spinal Cord Injuries Centre, Sheffield are listed below .

Community Liaison Nurses can give advice on bladder and bowel management, talk to your local health services, and visit SCI individuals at home if necessary:

• 0114 271 5617

• 0114 271 5618

Osborn 3 staff are also available to give advice over the phone:

• 0114 271 5636

Osborn 2 staff are also available to give advice over the phone:

• 0114 271 5628/9

Urology Nurses Specialists:

• 0114 271 5624 or 0114 226 6823 (Office)

• 0114 243 4343 and ask for bleep 2494 or 2882

Outpatients Department staff are available Monday to Friday during office hours and can give advice over the phone:

• 0114 271 5677

References :

British Association of Spinal Cord Injury Specialists (BASCIS), Multidisciplinary Association of Spinal Cord Injury Professionals (MASCIP), Spinal Injuries Association (SIA) 2014 Statement on Autonomic Dysreflexia

<https://www.spinal.co.uk/wp-content/uploads/2018/06/Statement-on-Autonomic-Dysreflexia-2017.pdf>

Multidisciplinary Association of Spinal Cord Injured Professionals 2012 Guidelines for management of neurogenic bowel dysfunction in individuals with central neurological conditions.

<https://www.mascip.co.uk/best-practice/mascip-best-practice/>

Multidisciplinary Association of Spinal Cord Injury Professionals (MASCIP), British Association of Spinal Cord Injury Specialists (BASCIS), Spinal Injuries Association (SIA) 2018 Joint Statement on Spinal Cord Injury Bowel Management

<https://www.mascip.co.uk/wp-content/uploads/2019/01/SIA.BASCIS.MASCIP.RCN-Joint-Statement-SCI-Bowel-Management.pdf>

NHS England 2018 Excellence in Continence Care

<https://www.england.nhs.uk/publication/excellence-in-continence-care/>

Royal College of Nursing 2019 Management of lower bowel dysfunction, including digital rectal examination and digital removal of faeces.

<https://www.rcn.org.uk/professional-development/publications/pub-007522>

Appendix 1: an overview of conventional SCI Bowel Management

|  |  |  |
| --- | --- | --- |
| Reflex Bowel |  | Areflexic Bowel |
| Daily or Alternate Days |  | Once daily |
| Aim for Bristol Scale 4 Stool  🡻 |  | Aim for Bristol 3 Stool  🡻 |
| Stimulant Laxative 8 – 12 hours before planned care if indicated in care plan  🡻 | | |
| Gastrocolic reflex | | |
| Rectal Stimulant as prescribed  🡻 |  | 🡻 |
| Digital Rectal Stimulation  🡻 |  |
| Digital removal of faeces if required  🡻 |  | Digital removal of faeces |
| Single digital check to ensure rectum is empty 5 – 10 minutes after last stool is passed |  |  |
| For more information, please follow Appendix 2 . Procedural guideline for the reflex evacuation of faeces in individuals with an established Spinal Cord Injury (SCI) |  | **For more information, please follow Appendix 3. Procedural guideline for the digital removal of faeces (DRF) in individuals with an established Spinal Cord Injury (SCI)** |

**Appendix 2**

**PROCEDURAL GUIDELINE FOR THE REFLEX EVACUATION OF FAECES IN INDIVIDUALS WITH AN ESTABLISHED SPINAL CORD INJURY (SCI)**

**Materials required for standard procedure (others as indicated below):**

* **Latex-free examination gloves**
* **Disposable incontinence sheets**
* **Lubricating gel**
* **Rectal medication as prescribed**
* **Disposable cleaning wipes**
* **Skin cleansing materials**
* **Clinical waste disposal bag**

|  |  |  |
| --- | --- | --- |
| **KEY POINTS:**   * **An intervention to stimulate the movement of stool into the rectum and to initiate predictable defaecation; therefore avoiding constipation and incontinence.** * **It is only appropriate in SCI individuals with reflex bowel dysfunction.** * **Reflex SCI bowel management incorporates Digital Rectal Stimulation (DRS) +/- a prescribed rectal stimulant as indicated in the individual’s care plan.** * **The optimum time for undertaking reflex SCI bowel management is 20-30 minutes after a meal or hot drink, making best use of the gastro-colic reflex.** * **It is advised that diet, fluids and stool softeners are adjusted to maintain a type 3 or 4 stool (Bristol Stool Chart)** | | |
|  | **Action** | **Rationale** |
| 1 | Confirm continued appropriateness of procedure for individual in accordance with individual’s notes and current nursing care plan. Confirm that you are capable and confident in your ability to undertake this procedure safely. | To satisfy organisational requirements for maintaining individual safety prior to an intimate procedure. |
| 2 | Evaluate individual’s awareness and understanding of procedure. Provide further information as appropriate before obtaining verbal consent to proceed. | To satisfy organisational requirements for obtaining consent. |
| 3 | If indicated in the care plan, take and record individual’s blood pressure and/or resting pulse at the beginning of the procedure.  Monitor individual’s condition throughout the procedure as indicated in the care plan. | Some SCI individuals, with sensory incomplete lesions may experience vaso-vagal symptoms as a parasympathetic response to ano-rectal distension manifesting itself as a significant bradycardia.  SCI individuals with lesions above T6 are at risk of developing autonomic dysreflexia during DRS manifesting itself as significant hypertension. |
| 4 | Wash hands thoroughly.  Apply a disposable apron and two pairs of latex-free examination gloves.  Do not use polythene disposable gloves either as a first or second layer. | 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 SCI individual at significant risk of developing a latex allergy.  Polythene examination gloves provide insufficient protection against bodily fluids and their raised seams can damage the rectal mucosa. |
| 5 | Assist individual as necessary to achieve a 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 individual warmth and dignity. | 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 individual’s skin or comfort is compromised.  \*SCI reflex bowel care can only be undertaken on the toilet/commode when risk assessments deem it safe to do so  For further advice on SCI bowel management over the toilet, please refer to supportive documentation. |
| 6 | Examine the perineal, perianal and anal skin for evidence of any suspicious swellings, rectal prolapse, significant lesions, bleeding or haemorrhoids not previously noted. | The appearance of new and significant ano-rectal lesions or bleeding must be documented and evaluated by a doctor or specialist nurse before continuing. |
| 7 | Check for the presence of ano-rectal sensation.  If individual is able to tolerate, use water soluble lubricating gel.  If sensation intolerable, – or if indicated in care plan, insert via syringe 11ml of 2% lidocaine (lignocaine) gel before proceeding further. Wait at least 5 minutes for local anaesthetic to take effect before proceeding further. | To reduce individual discomfort during the procedure. The long-term use of lidocaine gel can result in serious health problems. Most SCI individuals can tolerate an occasional DRE without recourse to lidocaine. Over time the ano-rectal area becomes de-sensitised to this procedure sufficient that an individual with a long-established neurological bowel disorder can comfortably tolerate the procedure routinely using only standard water soluble lubricating gel. |
| 8 | Insert one gloved and lubricated finger through the anal sphincter, note any resistance or reflex contraction of anal sphincter. | A positive ano-rectal response to DRE in an SCI individual indicates a potential for reflex bowel emptying exists at this time.  An absent ano-rectal reflex indicates the need for the digital removal of any faeces present at this time (areflexic bowel management) . |
| 9 | Rotate finger gently within the rectum. Note any faeces present or if rectum is distended with gas.  If appropriate to role, take the opportunity presented to check the prostate of mature males. | No injury to SCI individuals using this procedure as described has ever been reported.  Gentle insertion and movement of the finger utilizing appropriate and sufficient lubrication will reduce the potential occurrence of autonomic dysreflexia. |
| 10 | If faeces were present in the rectum on examination it may be necessary to undertake digital removal of faeces (DRF) to provide sufficient space for the stimulant to work effectively | To ensure that the rectal stimulant is administered so that it achieves direct contact with the bowel wall. |
| 11 | Ensure that anal sphincter is still in a contractile (reflexic) state before commencing reflex SCI bowel management. | A negative or weak ano-rectal response to DRE is contra-indicative to the success of reflex bowel evacuation. Consider reassessment of care plan before proceeding. |
| 12 | Insert prescribed rectal stimulant as prescribed. | A suppository should be inserted at least 4cm into the rectum. A micro- enema or rectal injector should be inserted up to the base of the nozzle.  Absence of faeces in the rectum is not an indication to omit a rectal stimulant. It is normal for the rectum to be empty on occasion. Faeces will usually descend from the sigmoid colon after stimulation. |
| 13 | After insertion, leave the individual resting in position for 20-30 minutes. If the anal 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. | To allow stimulant time to work. DRS is a supplement to a chemically induced reflex evacuation.  The care plan should indicate how much DRS is usually required.  Excessive DRS can be harmful to the individual and increase the risk of ano-rectal complications occurring. |
| 14 | To perform digital rectal stimulation (DRS):   1. Insert one gloved and lubricated finger into the rectum. 2. Turn the finger so that the padded inferior surface is in contact with the bowel wall. 3. Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout. 4. Withdraw the finger and await reflex evacuation. 5. Repeat every 5-10 minutes until reflex activity ceases. Wipe finger between insertions. 6. In the event of no reflex activity occurring at all, do not repeat DRS more than 3 times. 7. Repeat insertion of 2% Lidocaine (Lignocaine) gel only as necessary | No injury to SCI individuals using this procedure as described has ever been reported.  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.  To minimise amount of lidocaine used during the procedure |
| 15 | 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 chemical rectal stimulant may be indicated in the care plan. | Undertaking DRF as a singular exception to the prescribed stimulation of the reflex response is less harmful for the individual than excessive DRS. Persistent use of DRF in place of anticipated reflex activity demands a review of the bowel care program. |
| 16 | Dispose of faeces and soiled materials into a waste bag according to policy. Wipe finger of glove clean with a moist disposable wipe between insertions or change top glove as required. | 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. . |
| 17 | At the end of the procedure, wash and dry all soiled skin thoroughly and assist individual as required to achieve a comfortable position.  Remove apron and wash hands thoroughly. | To maintain individual dignity, comfort and skin integrity.  To prevent cross-infection. |
| 18 | Document result in Nursing Notes with reference to Bristol Stool Chart as appropriate. Report any exceptions to the guidelines which occurred during the procedure. | To enable consistent reporting and interpretation of results and to monitor the effects of any legitimate interventions or changes to previously established bowel management program. |

**Appendix 3**

**PROCEDURAL GUIDELINE FOR THE DIGITAL REMOVAL OF FAECES (DRF) IN INDIVIDUALS WITH AN ESTABLISHED SPINAL CORD INJURY (SCI)**

**Materials required for standard procedure (others as indicated below):**

* **Latex-free examination gloves**
* **Disposable incontinence sheets**
* **Lubricating gel**
* **Disposable cleaning wipes**
* **Skin cleansing materials**
* **Clinical waste disposal bag**

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| **KEY POINTS**  **DRF is an appropriate intervention in the following circumstances:**   * **As routine bowel management following a diagnosis of areflexic neurogenic bowel dysfunction** * **Prior to insertion of rectal stimulant in reflex neurogenic bowel management** * **Prior to insertion of transanal irrigation catheter** * **Following incomplete defaecation using rectal stimulants and digital rectal stimulation in reflex neurogenic bowel management** * **Following incomplete defaecation using transanal irrigation** * **It is advised that diet, fluids and stool softeners are adjusted to maintain a type 3 stool (Bristol Stool Chart)** | | |
|  | **Action** | **Rationale** |
| 1 | Confirm continued appropriateness of procedure for individual in accordance with individual’s notes and current nursing care plan. Confirm that you are capable and confident in your ability to undertake this procedure safely. | To satisfy organisational requirements for maintaining individual safety prior to an intimate procedure. |
| 2 | Evaluate individual’s awareness and understanding of procedure. Provide further information as appropriate before obtaining verbal consent to proceed. | To satisfy organisational requirements for obtaining consent. |
| 3 | If indicated in the care plan, take and record individual’s blood pressure and/or resting pulse at the beginning of the procedure.  Monitor individual’s condition throughout the procedure as indicated in the care plan. | Some SCI individuals, with sensory incomplete lesions may experience vaso-vagal symptoms as a parasympathetic response to ano-rectal distension manifesting itself as a significant bradycardia.  SCI individuals with lesions above T6 are at risk of developing autonomic dysreflexia during DRF manifesting itself as a significant hypertension. |
| 4 | Wash and dry hands thoroughly.  Apply a disposable apron and a pair of latex-free examination gloves.  Do not use polythene disposable gloves either as a first or second layer | 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 DRF, involving repeated contact with the rectal mucosa places the SCI individual at high-risk of developing a latex allergy.  Polythene examination gloves provide insufficient protection against bodily fluids and their raised seams can damage the rectal mucosa.  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. |
| 5 | Assist individual as necessary to achieve a position appropriate to their comfort and ability.  Position sufficient incontinence pads to protect bedsheets and arrange sheets and curtains to maintain privacy and protect individual dignity. | The left lateral position makes the rectum more accessible for DRF for right-handed nurses but is not mandatory. Assume a right lateral position if more convenient or if individual’s skin or comfort is compromised.  It is not appropriate for a SCI individual who requires assistance to have DRF over the toilet/commode .  However, it is appropriate for a practitioner to undertake a single PR check/DRE for an individual who is sitting on a toilet / commode. For further advice on SCI bowel management over the toilet, please refer to supportive documentation. |
| 6 | Examine the perineal, perianal and anal skin for evidence of any suspicious swellings, rectal prolapse, significant lesions, bleeding or haemorrhoids not previously noted. | The appearance of new and significant ano-rectal lesions or bleeding must be documented and evaluated by a doctor or specialist nurse before continuing. |
| 7 | Check for the presence of ano-rectal sensation  If individual is able to tolerate, use water soluble lubricating gel.  If sensation intolerable, – or if indicated in care plan, insert via syringe 11ml of 2% lidocaine (lignocaine) gel before proceeding further. Wait at least 5 minutes for local anaesthetic to take effect before proceeding further.  . | To reduce individual discomfort during the procedure. The long-term use of lidocaine gel can result in serious health problems. Most SCI individuals can tolerate an occasional DRE without recourse to lidocaine. Over time the ano-rectal area becomes de-sensitised to this procedure sufficient that an individual with a long-established neurological bowel disorder can comfortably tolerate the procedure routinely using only standard water soluble lubricating gel. |
| 8 | Ensure that anal sphincter is still in a non-contractile (areflexic) state before beginning DRF procedure by gently inserting one gloved and lubricated finger through the sphincter. Note any resistance or reflex contraction of anal sphincter. | A positive ano-rectal response to DRE is contra-indicative to the need for DRF. Discontinue DRF procedure if contra-indicated at this point |
| 9 | Remove any faeces present by inserting and gently rotating a single gloved and lubricated finger within the rectum. The finger should be crooked slightly away from the bowel wall sufficient to withdraw some of the faeces away in a ‘beckoning’ action as the finger is drawn backwards and out through the anal sphincter. | No injury to SCI individuals using this procedure as described has ever been reported.  Gentle insertion and removal of the finger utilizing appropriate and sufficient lubrication will reduce the potential occurrence of autonomic dysreflexia.  Do not attempt to ‘hook and drag’ faeces as this can damage the bowel wall. If faeces too hard or soft ,adjust diet and medication .. |
| 9 | Dispose of faeces into a waste bag in accordance with local policy. Wipe finger of glove clean with a moist disposable wipe between insertions or change top glove as required. Dispose of all soiled materials into clinical waste bag.  Repeat insertion of 2% Lidocaine (Lignocaine) gel only as necessary | 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 minimise amount of lidocaine used during the procedure. |
| 10 | Repeat actions 5 & 6 above until the rectum is empty, monitoring individual’s condition throughout). |  |
| 11 | At the end of the procedure, wash and dry all soiled skin thoroughly and assist individual as required to achieve a comfortable position. | To maintain individual dignity, comfort and skin integrity. |
| 12 | Remove and dispose of apron into clinical waste disposal bag. Wash and dry hands thoroughly | To prevent cross-infection. |
| 13 | Document result in Nursing Notes with reference to Bristol Stool Chart as appropriate. Report any exceptions to the guidelines which occurred during the procedure. | To enable consistent reporting and interpretation of results and to monitor the effects of any legitimate interventions or changes to previously established bowel management program. |