NHS GRAMPIAN

RESOURCE PACK

ON

BOWEL MANAGEMENT - ADULTS

Bladder & Bowel Specialist Service
NHS Grampian

July 2017
Date of review July 2019

NHS GRAMPIAN
RESOURCE PACK ON BOWEL MANAGEMENT
CONTENTS

SECTION 1

INTRODUCTION TO RESOURCE PACK

PAGES 1 - 2

NHS GRAMPIAN

INTRODUCTION TO RESOURCE PACK

BACKGROUND

Recently there has been increasing professional interest in the neglected area of bowel and anorectal function. It is often not appreciated by health professionals how common bowel dysfunction's such as constipation and faecal incontinence are and that patients are reluctant to seek help. Control of continence is a basic human need. Any disorder or abnormality will affect the person's quality of life and could lead to or be an indicator of other underlying conditions. Constipation is a common problem for many people. It can cause discomfort and if not treated can lead to faecal impaction and bowel obstruction.
A consistent approach to Bowel Management is pertinent in all clinical areas in NHS Grampian.

This Bowel Management Resource Pack can be used by any health care professional with an interest in this area (although it will be mainly nurses that will be undertaking the assessment). The resource pack is divided into different sections and will act as a reference document.

NHS GRAMPIAN ASSESSMENT FORM GUIDELINES

The AIM of these Guidelines is to outline good practice in bowel management and provide a resource that will be updated according to new research and developments.

The NHS Grampian Bowel Assessment Form, bowel chart and three-day food and fluid chart should be adopted as standard practice. The assessment should be undertaken by a registered nurse but non-registered nurses can be allocated appropriate duties relevant to their experience under the guidance of the registered nurse.
The Guidelines that are included within this Resource Pack will also give practical advice, which will ensure consistency in approach for patient care, based on evidence-based research where possible.

BOWEL PROCEDURES

If a patient requires any bowel procedures this section provides the information that is required to undertake them safely.
The Bowel Procedures have been set out by the Royal College of Nursing – www.rcn.org.uk and
The Royal Marsden Hospital Manual of Clinical Nursing Procedures 9th Edition.
These procedures will also be on the Intranet site.

TRAINING SESSIONS

Staff should keep themselves up-to-date and attend relevant training sessions (which would be linked to the NHS Grampian learning and development plan) to ensure they are aware of how to assess patients, provide treatment and manage patients who have bowel problems.

INFORMED CONSENT

Patients must give informed consent as per the NHS Grampian Informed Consent Policy before any investigation, treatment or procedure is undertaken.

Any treatment provided or refused should be documented in the patient's notes either in the home, ward or care home setting.

STAFF SHOULD ADHERE TO

- **The Nursing and Midwifery Council Code of Professional Standards of Practice and Behaviour for Nurses and Midwives 2015**
- **Management of Lower Bowel Dysfunction, including DRE and DRF 2012** www.rcn.org.uk

At the rear of the Resource Pack is a Further Reading/References Section **(Appendix 10)** that can be used for client assessment and background reading

SECTION 2
ASSESSMENT

Planning a Bowel Programme

PAGE 3

PLANNING A BOWEL PROGRAMME

Following assessment and careful planning, a bowel programme should result in achieving bowel continence and adequate evacuation. This should be undertaken as a package of care rather than a single intervention.

Prior to commencing a routine bowel programme it is essential that any constipation or impaction be resolved otherwise it may be difficult to establish a predictable pattern.

The following should be considered as part of the programme:

- Diet and fluid intake
- Current and previous bowel habit
- Exercise/Mobility
- Medication which may cause constipation or aperients being used
- Evacuation techniques
- Toileting Facilities/Ability to sit on the toilet
- Is gastro-colic reflex being utilized? (See last paragraph of this section)
- Is there a package of care in place, will this need to be reviewed as a result of intervention.

If the above aspects have been reviewed and there are still difficulties other interventions may be necessary:

Timed oral aperients may be used in conjunction with rectal medication such as suppositories or micro enemas.

Trial and error is often required to find the best approach for individuals. It is important to be consistent with approach, meal times, sitting on the toilet, privacy, timing of medication etc. to allow the programme to work. It is also important not to make too many changes at once.

Where there is known nerve damage, long term interventions may require to be implemented e.g. in conditions such as Multiple Sclerosis and Spinal Cord Injury.

The aims of the programme would be:-

- Regular planned bowel movements (At least 3 times weekly)
- Appropriate techniques will be used following assessment
- Minimise episodes of faecal incontinence

It may be useful to continue charting timing of oral, rectal medicines, consistency of stool, timing of bowel movements and any accidents when establishing the bowel programme. This allows careful adjustments to medication, or timing of interventions. It will also demonstrate the effectiveness of the programme.

GASTRO-COLIC REFLEX

Peristalsis in the gut is normally continuous throughout the day but is further stimulated by the taste, smell of food, or eating and drinking. This increase in peristalsis in the gut aids propulsion of stool through the bowel. The best time to take advantage of this as part of a bowel programme is thought to be 20-40 minutes after a meal. Literature suggests it may be stronger after the first meal of the day.

SECTION 2
ASSESSMENT

Guidelines on Completion of Bowel Assessment Form

PAGES 4 - 9

GUIDELINES TO COMPLETION OF BOWEL ASSESSMENT FORM

The AIM of these guidelines is that all patients in NHS Grampian with bowel problems are assessed and treated on an individual basis. This will provide a quality service ensuring effective delivery of care.

INTRODUCTION TO ASSESSMENT

The purpose of the assessment is to help identify the many different causes and contributing factors resulting in bowel problems.

In the majority of cases these symptoms can be improved or cured by identifying and treating the underlying causes. From a full assessment treatment/management of the patient's problem can be implemented.

THE PATIENT/CLIENT MUST BE ASSESSED BY A TRAINED NURSE USING THE BOWEL ASSESSMENT FORM AND GUIDELINES

GUIDELINES & INFORMATION ON COMPLETION OF BOWEL ASSESSMENT FORM

If patient/carer unable or refuse to answer any questions please document this on Assessment Form

Refer to:- QIS BEST PRACTICE STATEMENT & BLADDER AND BOWEL RESOURCE PACK
RED FLAGS – APPENDIX 8

1.PATIENT DETAILS	
Name	
Address	
Postcode	**Tel No. (incl.STD Code)**
D.O.B.	**Unit/CHI Number** ***01/01/1911 1234***
Occupation	**Work Number**
Hobbies/Activities ***e.g. play golf, walk***	
GP DETAILS	
GP	
Surgery Address	
Tel No. (incl. STD Code)	
CONSULTANT DETAILS	
Consultant	
Address	
Tel No. (incl STD Code)	
REFERRAL DETAILS	
Referred by	
Tel No. (incl. STD Code)	
Reason for Referral	
ASSESSMENT DETAILS	
Assessed By / Date	
Tel No. (incl. STD Code)	
Location of Assessment	

2. FACTORS AFFECTING INDIVIDUALS ABILITY TO COPE: APPENDIX 3

A. M.S.Q. SCORE OR 4AT Single Assessment Tool

Low score may result in poor compliance

B. DOES PATIENT LIVE: ***will provide information on home circumstances***

Alone:	**With Family:**
Residential Home:	**Nursing Home:**
Supported Accommodation:	**Other:**

C. COMMUNICATION (Please record any problems)

Speech	**Sight**	**Hearing**
Swallowing/speech difficulties, Dentures - ?do they fit properly	***Do they wear glasses? Can they see to access toilet?***	***Is client hard of hearing? Is the client deaf and do they wear a hearing aid?***

D. MANUAL DEXTERITY (Please record any problems)

Help Required

Can the client hold their own cutlery/cup/glass? Can the client dress/undress themselves? Can the client undo zips/buttons/fastenings?

E. MOBILITY (Specify help and aids required)

Independent	***Can the client get out of the chair/bed unaided?*** ***Does the client use a walking aid/wheelchair?*** ***Does the client require to use a hoist?***

F. USING THE TOILET (Specify help and aids required)

Can you sit on the toilet?	***Is the client able to access the toilet/commode unaided?*** ***Can the client get to the toilet in time?*** ***Can the client get on/off the toilet unassisted and clean him or herself?*** ***Are the client's feet supported whilst on the toilet?*** ***Would the client from an O.T./Physiotherapy assessment?***

G. OTHER AGENCIES INVOLVED

Do they have - ? Care Manager, Home Care, Community Psychiatric Nurse Support Worker or Private Agency input

3. PAST MEDICAL HISTORY (please tick if applicable and date if known) Record date illness commenced

These may affect the client's ability to maintain continence or contribute to urinary/faecal incontinence

Neurological Disease		**Gynaecological Problems/Surgery**	
Diabetes		**Rectal Surgery**	
Thyroid Disease		**Urological Surgery**	
Dementia		**Urinary Problems**	
Cardiac Problems		**Other Surgery**	
Respiratory Problems		**Menopause State**	
Depression		**Bowel Disease**	
Learning Difficulties		**Haemorrhoids**	
Other		**Fissures**	

4. ANY SEXUAL HEALTH / LIFESYLES ISSUES

Is bowel problem having an effect on relationships or lifestyle

5. GENERAL CURRENT HEALTH ISSUES

6. OBSTETRIC HISTORY ***May contribute to nerve or tissue damage to pelvic floor or sphincters***

Give details of how many children, weights of babies, forceps delivery

Number of Births		**Type of Delivery**	
Heaviest Weight		**Episiotomy**	
Tear		**Other** ***e.g. follow up treatment/wound Infections, re-suturing***	

7. MEDICATION

Record side-effects of medication, which relate to bladder/bowel dysfunction

B.N.F. – www.bnf.org **DRUG SUMMARY PRINTOUTS CAN BE ATTACHED**

Medication (Including Over the Counter Medicines)	**Side Effects / Refer to BNF**
Is patient taking any alternative remedies	

8. ALLERGIES

Document any known allergies e.g. Latex, Lanolin, Peanut Allergy (Arachis Oil Enema)

9. DESCRIBE YOUR BOWEL PROBLEMS *Document to indicate how quality of life has been affected – Has it stopped them going to the shops, clubs, playing golf etc.*	
What for you is the worst thing about your bowel problem?	*Embarrassment, Don't go out, Odour*
When did the problem start?	*Was it related to a specific event – Following surgery, following childbirth, due to medication, due to injury/illness/stressful time in life*
Have you had any investigations for this problem?	*Any recent or previous investigations such as rectal examination, barium meal, sigmoidoscopy*
What medication has been tried?	*This should include any over the counter medication or alternative therapies* *Has it been effective or not? Check if doses were therapeutic*
What helps / aggravates the problem?	*Any coping mechanisms being used at the moment which are helpful*
Do you use pads or protective clothing?	*Are they used for faecal/urinary incontinence? Is it actual incontinence or fear of being incontinent? What type of pad is used? How often are they changed? Is the pad always soiled when changed? Is there any leakage onto their clothes/bed etc.? Does patient buy them or are they provided by a Health Professional?*
Are they effective?	
Has your bowel pattern changed recently	*If there are significant changes such as a change in normal pattern, rectal bleeding or mucus, +ve FOB, abdominal bloating or discomfort inform GP (Sign Guideline 67)* *Could there be other identifiable causes for this:* • *Change in toilet facilities e.g. bedpan/commode* • *Change in diet* • *Change in home circumstances* • *Change in medication*

10. PRESENTING BOWEL SYMPTOMS	
	COMMENTS
How often do your bowels move?	*Is there frequency or constipation?* *Anything between 3 x daily or 3 x weekly is considered normal*
What is the consistency of your stool? **(Bristol Stool Chart) APPENDIX 4**	**(Please circle)** **1 2 3 4 5 6 7** *Use of the Bristol Stool Form Scale Chart will identify stool consistency and will ensure consistent reporting of bowel habit. Patients find it easier to look at a chart than trying to describe their stool.* *Ideally this should be between 3 or 4* *1 > 2 are hard dry stool so could indicate constipation* *5 > 7 are loose and for some patients bulking the stool may lessen risk of incontinence.* *Loose stool may be indicative e.g. inflammatory bowel disease, tumour or overflow impaction, or due to rectal prolapse, fistulas or after pelvic radiotherapy*
Do you get a desire to open your bowels	*Is the patient aware of the pressure to pass stool* *This may be absent or reduced in neurological damage/disease or in chronic constipation. Ignoring the urge to defecate may lead to faecal loading and impaction. In conditions such as dementia the desire to defecate may be absent but the patient may have automatic emptying at the same time each day i.e. after breakfast, so initiating toileting at this time could reduce the risk of incontinence.*
Are you able to delay?	*If there is external sphincter weakness ability to delay defecation may be considerably reduced. Patient may not have enough voluntary squeeze to stop stool from leaving rectum. This can be worse if stool is loose or if Irritable Bowel Syndrome or Inflammatory Bowel Disease is present.* *Is there urgency? Is it because they have frequent episodes of incontinence or because they have had some episodes and are fearful of it happening again*
How long for?	

Do you lose control of stool or flatus?	***Identify if incontinent of stool or flatus*** ***How often does this happen?*** ***Can they tell the difference between flatus or needing a bowel movement?*** ***May be as a result of e.g. Neurological damage, Obstetric trauma, Congenital conditions such as imperforated anus, following haemorrhoidectomy*** ***If inflammatory disease is present, high pressures in the bowel and diarrhoea can make maintenance of continence impossible.***
What quality of stool do you lose control of?	***Is it soiling of underwear or do they lose an entire stool?*** ***Does the consistency vary?***
Do you feel you empty your bowels completely?	***Evacuation difficulties may be as a result of e.g. weakened sphincters or obstructive defecation.*** ***Does passive soiling occur after a bowel movement – Internal sphincter may not close anal canal and stool will leak out*** ***Incomplete emptying may be as a result of e.g. a Rectocele following childbirth or due to excessive straining*** ***Some female patients will describe inserting a finger into their vagina to aid expulsion of stool, this expels faeces trapped in rectocele***
How long do you sit on the toilet to open your bowels?	
Do you strain?	
Do you use manual assistance?	
Do you have any pain or bloating?	***Is this associated with opening their bowels?*** ***If it is with an urge to defecate and is relieved by opening bowels, it may be due to Irritable Bowel Syndrome or Inflammatory Bowel Disease*** ***Pain as stool is passed is likely to be due to haemorrhoids or fissure***
Do you pass blood or mucus?	***If blood or mucus is a feature this should be reported to medical staff in case the cause is Inflammatory Bowel Disease, malignancy or caused by haemorrhoids, fissures etc.*** ***Excessive mucus may be caused by e.g. villous adenoma, or Inflammatory Bowel Disease***

11. INFORMATION FROM BOWEL AND DIET DIARY/FIBRE SCORING SHEET

Information from these charts should be recorded in Section 11 and 13 on the Bowel Assessment Form

Is the patient on Gastrostomy feeding? If so refer to dietician for further assistance
Is there enough fibre in diet? This can be calculated by using the fibre scoring sheet -
Is eating pattern regular throughout the day e.g. eating three meals a day?
The patient's functional ability to feed must be considered as this may lead to inadequate fibre or fluid intake, which can exacerbate constipation.
Is the intake of fibre spread evenly throughout the day or is it consumed at one meal?
Fluid intake should be between 1500-1800mls.

12. CONSIDER NEED FOR DIGITAL RECTAL EXAMINATION (Refer to RCN Guidelines

See RCN document on RCN – Management of Lower Bowel Dysfunction including DRE and DRF
Remember to gain consent from the patient before undertaking any examination or procedure – nurse must be trained and competent before undertaking any procedure or examination
Provide the reason as to why it is necessary
Patient should be offered opportunity to have a chaperone present during examination

Consent for Rectal Examination obtained	**.....** **(Nurse Signature0**
Outcome of Rectal Examination	**Rectum loaded - YES / NO** **Action:**
(Discuss outcome with Doctor)	**Stool consistency .....** **(Bristol Stool Scale)**

12b. STOOL SPECIMEN SENT? *If stool specimen is sent, document the reason why*	
Date sent:	**Result:**

12c. FOB TEST CARRIED OUT?	
Date:	**Result:**

13. PROBLEMS IDENTIFIED FROM ASSESSMENT

Please record information on main problems identified from assessment e.g.

- *POOR ORAL INTAKE*
- *CONSTIPATION/DIARRHOEA*
- *FAECAL INCONTINENCE*
- *ASSISTED EVACUATION*
- *IRRITABLE BOWEL SYNDROME*
- *POST-DELIVERY LACERATION ETC.*

FURTHER INFORMATION FOR THIS SECTION MAY REQUIRE TO BE ADDED ON AN EVALUATION SHEET

14. PLAN OF ACTION (see Management Guidelines) **A TREATMENT PLAN WILL REQUIRE TO BE INSTIGATED**

PLEASE TICK SELECTED LITERATURE GIVEN	INFORMATION / LITERATURE GIVEN	REVIEW DATE
Fluid Intake / Dietary Advice	*Give advice on how much to drink* *Give appropriate leaflets*	
Medication Review	*Review side –effect of medication – speak to Dr/ G.P./Pharmacist as necessary*	
Information on positioning / environment	*Provide diagram and explanation on this*	
Advice on general exercise	*Give appropriate advice according to patient condition ? Referral to Physio*	
Stress / Emotional Management	*Talking about their problem. Offer support.* *Refer to specialist services may be required*	
Aperient Advice	*Speak to Dr/G.P./Nurse Prescriber – this will depend on Assessment, Bowel charts etc. – ongoing review*	
Bowel Programme / Gastro colic Reflex	*This will depend on Assessment and Bowel charts* *Advice on going to the toilet after meals*	
Referral to other Specialist(s)	*If required e.g. Dietician, Physiotherapy, Speech Therapy via G.P. Advice on toilet*	

FURTHER INFORMATION FOR THIS SECTION MAY REQUIRE TO BE ADDED ON AN EVALUATION SHEET
A TREATMENT PLAN WILL REQUIRE TO BE INSTIGATED

15. MANAGEMENT PLAN – **RECORD INFORMATION ON WHAT IS PRESCRIBED**

	Product /Type	Per Day	Code No.
Commode	*e.g. Available from Central Stores or to buy*		
Pads	*Refer to Bowel Assessment Form and Chart for correct type and quantity of pad to be issued*		
Stretch Fit Pants	*To be worn with Form Plus and Extra Plus pads but patients should be encouraged to wear their own close fitting underwear. 5 pairs provided every 6 months.*		
Anal Plugs	*These are available from Coloplast on prescription in two sizes. These patients must be assessed to determine which size is most appropriate and given the appropriate literature*		
Faecal Collector	*This is available from Hollister on prescription. Samples are available from the Bladder and Bowel Specialist Service.*		

PLEASE SIGN AND DATE ASSESSMENT FORM

Signature ……. Date……

SECTION 3

DIETARY ASPECTS OF BOWEL MANAGEMENT

PAGES 10 - 11

DIETARY ASPECTS OF BOWEL MANAGEMENT

An inadequate intake of food, dietary fibre and fluid may all contribute to the development of constipation.

LIMITED INTAKE OF FOOD

A poor intake of food results in an inadequate volume of colonic contents and this may lead to constipation. When dietary intake is considered insufficient try encouraging with small, well presented nourishing meals and regular snacks between meals (The Best Weight is Up) – this is available by contacting Community Dietetic Department (01224) 655577. Suggestions regarding suitable foods can be given to carers/relatives who may be able to provide these and encourage intake. MUST screening should be carried out and appropriate actions put in place according to the MUST action plan.

DIETARY FIBRE

Dietary fibre includes the edible parts of cereals, fruit and vegetables which are resistant to digestion and absorption in the small intestine, meaning it passes into the large intestine where it is completely or partially broken down by bacteria. This is important in both treating and preventing constipation. Dietary fibre increases stool weight, reduces bowel transit time and absorbs water which results in the formation of a softer stool which is easier to pass. Wholegrain cereals, pulses and some vegetables and fruit are high in dietary fibre and are recommended in particular because they are also valuable sources of several other nutrients. A high fibre diet is also linked to a lower risk of heart disease, diabetes and colorectal cancer and plays a role in reducing high blood cholesterol and blood pressure levels.

Dietary fibre intake needs to be increased gradually, to allow the bowel time to adjust, and to avoid problems such as wind, bloating and abdominal discomfort.

Individuals with chewing and swallowing problems, ill fitting dentures or those who do not wear their dentures may have difficulty chewing some high fibre foods and therefore may avoid them. High fibre foods suitable for a texture modified diet should be encouraged where required.

The use of unprocessed bran is not advised as a way of increasing fibre intake. Individuals should be encouraged to eat a varied diet including foods which are naturally high in fibre.

The recommended dietary fibre intake for adults is 30g per day. When reading food labels a food product is considered ‘high fibre’ if it contains at least 6g of fibre per 100g and a ‘source of fibre’ if it contains at least 3g fibre per 100g.

In order for individuals to achieve higher fibre intakes the following foods can be encouraged:-

FIBRE CONTAINING FOODS	
BREAKFAST CEREALS	High fibre breakfast cereals e.g. Branflakes, Weetabix, Shredded Wheat, All Bran, Porridge Oats, Muesli
BREAD, BISCUITS AND CRACKERS	Wholemeal, Wholegrain or Seeded Bread, wholemeal crackers, Oatcakes and Crispbreads, Flapjacks, Cereal Bars, High Fibre Biscuits.
PASTA AND RICE	Wholemeal Pasta, Brown Rice
POTATOES	Potato with skin, Sweet Potato
BEANS AND PULSES	Baked Beans, Butter Beans, Peas, Chickpeas and Lentils
NUTS AND SEEDS	Linseed, Chia Seeds, Almonds, Hazelnuts, Peanuts
FRUIT AND VEGATABLES	Aim for at least 5 portions per day of fruit and vegetables including: Pears, Apples, Berries, Plums, Prunes, Bananas, Oranges, Dried Fruit, Fresh, tinned or Stewed Fruit Carrots, Sweetcorn, Broccoli, Green Beans, Parsnips

For more information on dietary fibre see the British Dietetic Association Food Fact Sheet on Fibre
http://www.bda.uk.com/foodfacts/fibrefoodfactssheet.pdf

FLUID

An adequate fluid intake is important to help avoid constipation. If fluid intake is poor dietary fibre is unable to absorb enough water to soften the stool sufficiently. Stools can become hard, compacted and difficult to pass.

An adequate fluid intake is essential for health. Aim for a fluid intake of 8-10 cups (1500-2000mls) per day.

Fluid can be taken as water, tea, coffee, milk, milky drinks, fruit juices or squashes.
To achieve the recommended fluid intake, fluids should be offered regularly throughout the day.

Some individuals may have a fading sense of thirst and they will require prompting to consume fluids at regular intervals. Fear of incontinence may also lead to an insufficient quantity of fluids being consumed. For those concerned about nocturnal incontinence, sufficient fluids should continue to be encouraged during the daytime.

For more information contact your local Dietetic Department:

Woodend	(01224) 556248 or Extn 56248
Aberdeen Royal Infirmary	(01224) 552145 or Extn 52145
Community Dietetics	(01224) 655577
Adult Learning Disabilities	(01224) 558312 or Extn 58312
Moray	(01343) 567350 or Extn 67350

SECTION 4

PHARMACEUTICAL ASPECTS OF BOWEL MANAGEMENT

PAGES 12 – 16

Pharmaceutical Aspects of Bowel Management (Adults)

1. CONSTIPATION

Introduction

1.1. Before initiating any drug for the management of constipation, it is essential that an appropriate assessment of the causes for the constipation is undertaken **(See Assessment Form)**

Consideration should also be given as to whether lifestyle changes alone (diet, fluids, and exercise) and change to drug therapy may be sufficient in relieving the constipation or whether these lifestyle changes should accompany the prescribing of laxatives.

Prescribers should always consult the latest edition of the British National Formulary (BNF) www.bnf.org/bnf and the relevant Summary of Product Characteristics (SPC) www.medicines.org.uk/emc

When prescribing within palliative care then refer to the Scottish Palliative Care Guidelines on Constipation
http://www.palliativecaregudielines.scot.nhs.uk/guidleines/symptom-control/Constipation.aspx

The Grampian Joint Formulary is also available to aid clinicians when prescribing laxatives
http://www.nhsgrampian.org/hnsgrampian/GJF_general_new.jsp?pContentID=4659&p_applic=CCC&pElementID=522&pMenuID=464&p_service=content.show&

Drugs which can cause constipation

1.2. Many drugs can cause constipation so always check the BNF or SPC. The following are the most common drugs that cause constipation:

- **Iron tablets for anaemia**
- **Opioid analgesics** (e.g. Morphine, Fentanyl, Tramadol, Dihydrocodeine, Co-codamol)
- Drugs with **anticholinergic side-effects** (e.g. Oxybutynin, Amitriptyline, Hyoscine, Chlorpheniramine)
- **Loperamide** for diarrhoea
- **Diuretics** – if dehydration occurs (e.g. Frosemide, Bendroflumethiazide)
- **Calcium channel blockers** (e.g. Verapamil, Diltiazem, Amlodipine)

1.3 **Laxative drug summary (adult)**

Please see BNF for full information on dose, side-effects, cautions and contra-indications. Most commonly used are in **bold**.

DRUG GROUP	WHEN TO CONSIDER USING	DRUG	DOSE	ONSET	OTHER INFO
BULK FORMING Increase faecal mass which simulates peristalsis	When there are small, hard stools and an increase in dietary fibre cannot be achieved. Only suitable for patients who can maintain a good fluid intake – risk of intestinal obstruction if not.	**Ispaghula husk** (Fybogel, Ispagel)	1 sachet up to twice daily	2-3 days	Can be used in the management of patients with colostomy, ileostomy, haemorrhoids, anal fissure, chronic diarrhoea associated with diverticular disease, IBS and in ulcerative colitis.
		Methycellulose (Celevac)	3-6 tabs up to twice daily		
		Sterculia (Normacol)	1-2 sachets/spoons up to twice daily		
STIMULANT Increase intestinal motility by directly stimulating the colonic nerves	For short term treatment of acute constipation OR long term for opioid induced constipation. Constipation in frail immobile patients is most often due to lack of push and stimulant laxatives are then most useful. Avoid in pregnancy; avoid senna in breast-feeding mothers.	**Senna**	1-2 tabs up to twice daily (standard dose = 1-2 tabs daily)	8-12 hours	All stimulant laxatives are unsuitable for long-term use. They can precipitate the onset of an atonic non-functioning colon and significant electrolyte imbalance.
		Bisacodyl (tablets & suppositories)	10mg in the morning	10-12 hours 20-60 mins for suppositories	
	Only to be used for bowel evacuation before an investigative procedure or surgery.	Sodium Picosulfate (Dulco-lax)	5-10ml at night	6-12 hours	
	Only to be used in patients who are terminally ill	Dantron (codanthramer/ codanthrusate)	See BNF/palliatve care guidance	6-12 hours	
	For acute constipation	Glycerol suppositories		15-60 mins	Must moisten before using – use as per manufacturers guidelines
SOFTNER Allows fluid to penetrate the stool, thereby softening the stool.	Docusate also acts as a weak stimulant laxative. Useful for patients with anal fissures, haemorrhoids and in older patients.	**Docusate (Dioctyl)**	Up to 500mg daily in divided doses	1-2 days	Large doses used in constipation induced by opioids in palliative care.
	For faeces that have impacted higher than the rectum and other methods have failed.	Arachis oil enema	1 as required	Left overnight	Contraindicated in peanut allergy. Warm before use.
	Considered a product less suitable for prescribing.	**Liquid paraffin**	**SEE BNF**	**1-2 days**	**Anal seepage and irritation**

DRUG GROUP	WHEN TO CONSIDER USING	DRUG	DOSE	ONSET	OTHER INFO
OSMOTIC Retain fluid in the bowel by osmosis or alter the pattern of water distribution in the faeces	Use second or third line/ when other laxatives unsuitable. (Also used for hepatic encephalopathy)	**Lactulose**	15ml twice daily then adjust	1-3 days	Must drink adequate amounts of fluid.
	For chronic constipation or faecal impaction	**Macrogol** (Movicol, Laxido)	1-3 sachets daily for up to 2 weeks then max of 2 daily thereafter (Higher doses for impaction – see BNF)		Caution with doses in cardiovascular impairment. Reconstituted solution can be kept in a fridge for up to 6 hours. Refer to Bristol Stool Chart when amending dose
	A small volume stimulant enema suitable where large-volume enemas are contra-indicated	Sodium citrate enemas (Micolette, Micralax, Relaxit)	SEE BNF	1-5mins	
	Not recommended due to electrolyte disturbance. **For pre-operative bowel clearance and where the rectum and lower colon contain soft faeces, or in patients where dehydration is a problem.**	**Phosphate enemas (Fleet)**	**SEE BNF**	**1-5 mins**	**Electrolyte disturbance and local irritation can occur.** **Oral formulation is for hospital use only.** **See Appendix 6**
CHLORIDE – CHANNEL AGONISTS	**Not recommended for use in NHS Scotland and therefore not on the Grampian Joint Formulary.**	**Lubiprostone (Amitiza)**	**24mcg twice daily for 2-4 weeks.** **Discontinue if no response after 2 weeks**	**1 day**	**The manufacturer did not present a sufficiently robust clinical and economic analysis to gain acceptance by Scottish Medicines Consortium.**
SELECTIVE 5-HT4 RECEPTOR AGONIST	**Not recommended for use in NHS Scotland and therefore not on the Grampian Joint Formulary.** **Licensed in women only.**	**Prucalopride (Resolor)**	**1-2mg daily** **Discontinue if no response after 4 weeks**	**3 hours**	**The manufacturer did not present a sufficiently robust economic analysis to gain acceptance by Scottish Medicines Consortium.**
OPIOID RECEPTOR ANTAGONIST	Restricted for **use in hospital by physicians with expertise in palliative care for the treatment of opioid-induced constipation in advanced illness.**	Methynaltrexone bromide SC injection (Relistor)	SEE BNF	30-60 mins	

2. DIARRHOEA

Introduction

2.1 Before initiating any drug for the management of diarrhoea, it is essential that an appropriate assessment of the causes for the diarrhea is undertaken.

The priority in acute diarrhoea is the prevention or management of fluid and electrolyte depletion. The RCN document. "The management of diarrhea in adults", provides appropriate guidance and advice on how acute diarrhea should be managed: http://www2.rcn.org.uk/__data/assets/pdf_file/0016/51721/004371.pdf If clostridium difficile is suspected all antidiarrhoeals are contraindicated.

Patients with chronic diarrhea need individualized treatment including dietary manipulation as well as drug treatment and maintenance of a liberal fluid intake. This will depend on underlying diagnosis.

Antidiarrhoeal drugs should not be given to patients with acute colitis as they may cause toxic megacolon.

Faecal impaction in the frail elderly can give rise to "overflow" diarrhoea, and soiling. This should be excluded before antidiarrhoeals are started.

Prescribers should always consult the latest edition of the British National formulary (BNF) www.bnf.org/bnf and the relevant Summary of Product Characteristics (SPC) www.medicines.org.uk/emc

Drugs that can cause diarrhoea

2.2 Many drugs can cause diarrhoea so always check the BNF or SPC. The following are the most common drugs that cause diarrhoea:

- **Laxatives (**as previous section)
- **Antacids**
- **Proton pump inhibitors** (e.g. Omeprazole, Lansoprazole, Esomeprazole) and **Ranitidine**
- **Chemotherapy and immune suppressants**
- **NSAIDs** (e.g. Ibuprofen, Naproxen)
- **Metformin**
- **SSRI Antidepressants** (e.g. Fluoxetine)
- **Statins** (e.g. Simvastatin, Atorvastatin)

2.3 **Antidiarrhoeal drug summary**

DRUG GROUP	WHEN TO CONSIDER USING	DRUG	DOSE	ONSET	OTHER INFO
ORAL REHYDRATION	To prevent or manage dehydration and electrolyte imbalance in milder cases of diarrhoea.	Oral rehydration sachets (Dioralyte)	200-400ml after every loose motion	Immediate	It stored in a fridge can be kept for 24hours. Severe depletion of fluid and electrolytes requires admission to hospital
ANTIPROPULSIVES	In the management of uncomplicated acute diarrhoea in adults; chronic diarrhoea; or for faecal incontinence**.**	Loperamide	See 'Other Info' column for dosing instructions for acute diarrhoea. Max of 16mg daily in divided doses (chronic diarrhoea/ faecal incontinence)	1 hour	Two capsules immediately and then one capsule after every loose motion as required up to a maximum of 16mg daily for a maximum of 5 days.
	Co-phenotrope is not recommended in NHS Grampian – it frequently causes side-effects and over dosage can be dangerous.	**Co-phenotrope (Lomotil)**	**SEE BNF**		**Co-phenotrope = diphenoxylate HCl and atropine sulphate**
	Considered a product less suitable for prescribing.	**Kaolin & Morphine**	**10ml every 6hours**		**Risk of dependence.**
BULK FORMING LAXATIVES	Bulk-forming drugs, such as ispaghula are useful in controlling faecal consistency in ileostomy and colostomy patients, and in controlling diarrhoea associated with diverticular disease.	SEE BULK FORMING LAXATIVE SECTION			
ENKEPHALINASE INHIBITORS	**Not recommended for use in NHS Scotland and therefore not on the Grampian Joint Formulary.**	**Racecadotril (Hidrasec)**	**SEE BNF**		
INTESTINAL ADSORBANTS	**Considered a product less suitable for prescribing.**	**Kaolin**	**SEE BNF**		

SECTION 5

PROCEDURES

PAGES 17 – 30

ADMINISTRATION OF ENEMAS

Refer to Pharmaceutical Section for details of enemas

DEFINITION

An enema is the administration of fluid into the rectum for the purpose of producing a bowel action or administrating medication.

INDICATIONS

1. To treat severe constipation when other methods have failed
2. To clean the lower bowel prior to surgery or X-ray examination
3. To introduce medication and fluids into the body for absorption
4. To soothe and treat irritated bowel mucosa in chronic inflammatory bowel disease e.g. Crohn's disease
5. To decrease body temperature
6. To stop local haemorrhage
7. To reduce hyperkalaemia (calcium resonium)
8. To reduce portal systemic encephalopathy (phosphate enema)

CONTRAINDICATIONS

1. Paralytic ileus
2. Colonic obstruction
3. Where the administration of tap water or soap and water enemas may cause circulatory overload, water intoxication, mucosal damage and necrosis, hyperkalaemia and cardiac arrhythmias.
4. When the administration of large amounts of fluid are made high into the colon this may cause perforation and haemorrhage
5. Following gastrointestinal or gynaecological surgery, where suture lines may be ruptured (unless medical consent has been given)
6. The use of micro-enemas and hypertonic saline enemas in patients with inflammatory or ulcerative conditions of the large colon
7. Frailty
8. Proctitis
9. Recent radiotherapy to the lower pelvis unless medical consent has been given

TYPES OF ENEMAS

1. EVACUANT

Is a solution introduced into the rectum or lower colon with the intention of it being expelled, along with faecal matter and flatus, within a few minutes e.g. sodium citrate, Phosphate enema

2. RETENTION

Is a solution introduced into the rectum or lower colon with the intention of being retained for a specified length of time, e.g. Arachis oil and Prednisolone

REQUIREMENTS

- Prescription and Drug Recording Sheet
- Prescribed enema
- Non sterile latex disposable gloves as per Glove Guidelines
- Disposable apron
- Paper Tissue
- Lubricating jelly
- Jug
- Disposal bag as per Clinical Waste Guidelines
- Bed protection

NB – Check for Latex, Lanolin. Peanut Allergy

PROCEDURE	RATIONALE
Explain and discuss procedure to patient. Offer chaperone for procedure.	Ensure patient understands procedure and gives consent
Allow patient to empty bladder if necessary	A full bladder may cause discomfort during the procedure
Ensure patient privacy	Provide patient comfort and dignity
Ensure that a bedpan, commode or toilet is readily available	In case the patient feels the need to expel the enema before the procedure is complete
Warm the enema to the required temperature by immersing in a jug of hot water – should be hand hot temperature	Heat is an effective stimulant of the nerve plexi in the intestinal mucosa. An enema heated to body temperature or just above will not damage the intestinal mucosa. To minimise shock and prevent bowel spasms
Assist the patient to remove clothing from the waist down and lay the patient in the left lateral position with knees flexed ensuring they are covered at all times.	This allows ease of passage into the rectum by following the natural anatomy of the colon. In this position, gravity will aid the flow of the solution into the colon. Flexing the knees ensures a more comfortable passage of the enema nozzle or rectal tube
Place bed protection under the patients hips and buttocks	To reduce risk of cross-infection. Reduce potential of soiled linen and avoid embarrassing the patient if the fluid is ejected prematurely following administration
Wash and dry hands thoroughly	Reduce risk of cross-infection
Apply apron and put on gloves	Reduce risk of cross-infection
Place some lubricating jelly on a swab/tissue. Remove cap from enema and lubricate the nozzle of the enema or the rectal tube	To prevent trauma to the anal and rectal mucosa by reducing surface friction

PROCEDURE	RATIONALE
Expel excessive air from enema tube and introduce the nozzle or tube slowly into the anal canal while separating the buttocks. Introduce tube to depth of 10.0 – 12.5cm (as per manufacturer's instructions)	To prevent distension of colon and minimise spasm of the intestinal wall. To ensure tube/nozzle in rectum
RETENTION ENEMA – Introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is completely finished. Slowly withdraw the nozzle. Leave the patient in bed with the foot of the bed elevated (if possible) for as long as prescribed before evacuating the bowel	To avoid increasing peristalsis and to reduce pressure on rectal walls. Elevating the foot of the bed aids in retention of the enema by force of gravity (if possible) Avoid reflex emptying of the rectum To enhance the evacuant effect
EVACUANT ENEMA – Introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow until the pack is empty or the solution is completely finished. Slowly withdraw the tube or nozzle, request patient to retain enema according to manufacturer's instructions	Avoid pressure on rectal walls and encourage retention of enema Avoid reflex emptying of the rectum
Dry the patient's perineal area with tissue and place in disposal bag	Promote patient comfort and prevent excoriation
Ask the patient to retain the enema for 10-15minutes	To enhance the evacuant effect before evacuating the bowel
Ensure the patient is near the bedpan, commode or toilet and has access to call bell and adequate toilet paper	To enhance patient comfort and prevent excoriation NB May complain of light-headedness – due to vagal nerve stimulator altering its rhythm
Remove gloves, apron and dispose of equipment as per clinical waste guidelines	Reduce risk of cross-infection
Wash and dry hands thoroughly	Reduce risk of cross-infection
Record details of procedure in patients notes/Drug Kardex Type of enema Batch Number Expiry date Amount of enema instilled Result – (colour, consistency, content and amount of faeces produced). Related to Bristol Stool Chart	Provide a legal record and monitor patients bowel function
Observe patient for any adverse reactions	To monitor the patient for complications

NOTES

STEROID ENEMA

Should be given after defecation, preferably at bedtime

COMPLICATIONS OF PHOSPHATE ENEMA

- Trauma to anal/rectal mucosa caused by the enema nozzle
- Topical activity in the local tissue caused by the phosphate
- Some people have a greater risk of localised and systemic complications and are therefore more at risk when other complications occur
- They should not be used in patient's who are elderly, debilitated or have advanced malignancy.
- If there is bleeding after a phosphate enema a surgical opinion should be sought immediately
- Avoid in patient's who have colitis, proctitis, inflammatory bowel conditions, inflamed haemorrhoids, skin tags, acute gastrointestinal conditions, anal or rectal surgical wounds, trauma, recent radiotherapy to lower pelvic area

ADMINISTRATION OF SUPPOSITORIES

Refer to Pharmaceutical Section for details of suppositories – Page 13

DEFINITION

A suppository is a medicated solid formulation that melts at body temperature when inserted into the rectum

INDICATIONS

1. To evacuate the lower bowel/rectum before certain types of surgery and investigations
2. To empty the bowel to relieve acute constipation or when other treatments for constipation have failed
3. To empty the bowel before endoscopic examination
4. To soothe and treat haemorrhoids
5. To administer certain systemic medicine

CONTRA-INDICATIONS

1. Chronic constipation which would require repetitive use
2. Paralytic ileus
3. Colonic obstruction
4. Following gastrointestinal or gynaecological operations, unless specified by a Doctor
5. Malignancy of the perianal region
6. Low platelet count

REQUIREMENTS

- Prescription and drug recording sheet
- Prescribed suppository
- Non-sterile disposable gloves as per Glove Guidelines Policy
- Disposable apron
- Paper tissue
- Lubricating jelly/water for glycerine suppository
- Scissors if required
- Disposal bag as per Clinical Waste Guidelines
- Bed protection

NB – Check for latex, lanolin, peanut allergy

PROCEDURE	RATIONALE
Explain and discuss procedure to patient. If a medicated suppository is being prescribed it is best to do so after the patient has emptied their bowels, offer chaperone for procedure	Ensure patient understands procedure and gives valid consent To ensure that the active ingredients are not impeded from being absorbed by the rectal mucosa or that the suppository is not expelled before active ingredients have been released
Allow patient to empty bladder if necessary	A full bladder may cause discomfort during procedure
Provide privacy to patient	Ensure patient comfort and dignity and to avoid embarrassment to the patient
Ensure that a bedpan/commode or a toilet is readily available	In case of premature ejection of the suppositories or rapid bowel evacuation following their administration
Assist patient to remove clothing from the waist down and lay the patient in the left lateral position with the knees flexed. Ensuring they are covered at all times	This allows ease of passage of the suppository into the rectum by following the natural anatomy of the colon. Flexing the knees will reduce discomfort as the suppository is passed through the anal sphincter
Place bed protection under patient hips and buttocks	To reduce potential of soiled linen and prevent risk of cross-infection Reduce embarrassment to patient if suppositories are ejected prematurely or rapid bowel evacuation following their administration
Wash and dry hands thoroughly	Reduce risk of cross-infection
Put on disposable apron and apply gloves	Reduce risk of cross-infection
Remove suppository from packaging – use scissors if required	
Place some lubricating jelly on swab/tissue on the blunt end of the suppository if it is used to obtain systemic action (Glycerine suppositories should be moistened with water)	Lubricating reduces surface friction and avoid anal mucosal trauma, eases insertion of suppository Stimulates dissolving of suppository
Separate the patient's buttocks, insert the suppository using the index finger into the rectum for about 2 - 4cm. a) Medication that is to be absorbed from the rectum should be inserted with the blunt end first. b) For bowel evacuation the suppository should be inserted pointed end first Repeat this procedure if a second suppository is to be inserted and follow manufacturer guidelines	To ensure suppository is retained Anal canal is approximately 2 - 4cm inserting beyond this ensures that it will be retained

PROCEDURE	RATIONALE
Dry the peri-anal area with tissue and place in Disposal bag	To ensure patient comfort and prevent anal excoriation
Ask the patient to retain the suppository(ies) for 20 minutes or until he or she is no longer able to do so. If the patient has had a medicated suppository given remind patient that its aim is not to stimulate evacuation and to retain suppository for at least 20 minutes or for as long as possible. If the patient experiences pain, bleeding - stop the procedure	To allow the suppository to melt and release the active ingredients Inform the patient there may be some discharge as the medication melts in the rectum
Ensure the patient is near the bedpan, commode or toilet and has adequate toilet paper	To enhance patient comfort
Remove apron and gloves and dispose of equipment as per Clinical Waste Guidelines	Reduce risk of cross-infection
Wash and dry hands thoroughly	Reduce risk of cross-infection
Record details of procedure in patients notes/Drug Kardex Type of suppository (ies) batch, expiry date Result – (colour, amount, consistency and content) Related to Bristol Stool Chart	Provide a legal record and monitor patients bowel function
Observe patient for any adverse reaction	To monitor for any complication

RECTAL MEDICATION

Rectal medication avoids liver metabolism and can have a greater and faster effect than oral medication

NOTES

Glycerine suppositories (lubricant) should be inserted directly into the faeces and allowed to dissolve

Bisacodyl suppositories (stimulant) must come into contact with the mucous membrane of the rectum

There is still little research to state how the suppository should be inserted for the mst effective result, follow manufacturer's guidelines

DIGITAL RECTAL EXAMINATION

Refer to Management of Lower Bowel Dysfunction including DRE and DRF – www.rcn.org.uk
A bowel assessment should be completed before this procedure is performed. Digital Rectal Examination can be undertaken by a qualified nurse who can demonstrate professional competencies to the level determined by the NMC – Code of Conduct. It should not be used as a sole investigation for evaluation and treatment of constipation. Obtaining patients consent is essential.

THIS SHOULD NOT BE PERFORMED

- On a child
- When there is lack of consent from the patient, - written or verbal
- Patient's doctor has given or implied specific instructions that these procedures are not to take place

DEFINITION

Is an evasive procedure that involves the insertion of a finger into a patient's rectum to perform an examination.

INDICATIONS

1. To assess anal tone and the ability to initiate a voluntary contraction and to what degree
2. Establish anal/rectal sensation
3. To assess if faecal matter is present, amount and consistency
4. The need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex
5. To determine need for manual removal of faeces and evaluating bowel emptiness
6. To assess the need for and effects of rectal medication and/or to evaluate its outcome in patients who are unable to communicate or who have diminished anal/rectal sensation
7. Establish effects of rectal medication
8. The outcome of rectal/colonic washout/irrigation if appropriate
9. Evaluate bowel emptiness in neurogenic bowel management, after use of suppositories, enemas or transanal irrigation

PRECAUTIONS & EXTRA CARE

1. Active inflammation of the bowel, including Crohn's disease, ulcerative colitis
2. Recent radiotherapy to the pelvic area
3. Rectal/anal pain
4. Rectal surgery or trauma to the anal/rectal area (in last six weeks)
5. Patients with tissue fragility and obvious rectal bleeding
6. Patients with known history of abuse
7. Spinal patients with known autonomic dysreflexia
8. Patients with known allergies e.g. latex/soap/phosphate and peanut (present in arachis oil enema)
9. Obvious rectal bleeding or patient taking anti-clotting medication
10. If patient gains sexual satisfaction from this procedure

OBSERVATIONS BEFORE UNDERTAKING PROCEDURE

1. Observe the perineal and perineal area for signs of rectal prolapse and its degree
2. Haemorrhoids, position, grade, internal or external
3. Anal skin tags
4. Anal fissure
5. Wounds, dressings, discharge
6. Anal lesions or swelling – possible malignancies
7. Anal fistula/incluration
8. Anal tone absent/reduced
9. Gaping anus
10. Skin conditions, broken areas, pressure sores of all grades
11. Pressure sore – grade
12. Bleeding and colour, mucus discharge
13. Faecal matter
14. Infestation
15. Foreign bodies

Any of the above abnormalities should be documented and reported
DRE should not be carried out until advice is taken

OBSERVATIONS BEFORE/AFTER PROCEDURE

1. Obtain baseline pulse rate (as vagal stimulation can slow the heart rate)
2. Obtain blood pressure in spinal patients – prior, and at end of procedure
3. Be aware of the signs and symptoms of autonomic dysreflexia

REQUIREMENTS

- Disposable apron
- Non-sterile latex disposable gloves as per Glove Guidelines
- Bed protection
- Paper tissue
- Lubricating jelly
- Disposable bag as per Clinical Waste Guidelines

PROCEDURE	RATIONALE
Explain and discuss procedure with patient Offer a chaperone for procedure	Ensure patient understands procedure and gives consent. Document that consent has been given
Allow the patient to empty bladder if necessary	A full bladder may cause discomfort during procedure
Ensure patient privacy	Provide patient comfort and dignity
Ensure that a bedpan, commode or toilet is available	DRE can stimulate the need for bowel movement
Assist the patient to remove clothing from the waist down and lay them in the left lateral position with knees flexed.	To expose the anus and allow for insertion of finger for examination, follows natural anatomy of bowel
Place bed protection under the patient's hips and buttocks	Reduce risk of cross-infection and reduce potential of soiled linen
Wash and dry hands thoroughly	Reduce risk of cross-infection
Apply apron and put on disposable gloves	Reduce risk of cross-infection
Examine the anal area as in Page 25	
Apply lubricating gel to the gloved index finger or swab	To facilitate easier insertion and minimise patient discomfort
Inform the patient that you are going to perform the procedure, part the buttocks – report if any abnormalities – observe anal area prior to insertion of the finger into anus for evidence of skin soreness.	To ensure the patient is relaxed If patient experiences pain ask if happy to continue if not STOP PROCEDURE
Gently insert one gloved finger slowly into the patient's anus/rectum – 5cm and undertake examination for presence of faecal matter, amount and consistency (using the Bristol Stool Chart) N.B. This may also be required to assess the need for or outcome of rectal medication – note consistency of any faecal matter For assessment of size, consistency of prostate gland (if trained for this)	To minimise discomfort and avoid trauma to anal mucosa and prevent forced over-dilation of anal sphincter (Anal canal is about 5cm long) May indicate constipation, loaded bowel and need for rectal medication To ensure nurse only examines within criteria and competency.
Slowly withdraw finger from patient's rectum when finished N.B. At this point rectal medication can be administered	To minimise patient discomfort
Dry the patient's peri-anal area with tissue and place in disposal bag	Prevent skin irritation or soreness Leave patient comfortable and minimise risk of cross-infection
Make patient comfortable and offer the toilet, commode, bedpan if required	Examination may stimulate the patient to defecate
Remove apron and gloves and dispose of equipment as per Clinical Waste Guidelines	Reduce risk of cross-infection
Wash and dry hands thoroughly	Reduce risk of cross-infection
Record results of examination in patient's notes and communicate with patient/carer/doctor as necessary • Record observations • Findings • Action taken • What information was given to patient written/verbal	Provide a legal record and ensure continuity of care and appropriate action is taken

DIGITAL REMOVAL OF FAECES

Management of Lower Bowel Dysfunction including DRE and DRF www.rcn.org.uk
A bowel assessment should be undertaken including a DIGITAL RECTAL EXAMINATION before this procedure is undertaken. It is an invasive procedure involving digital removal of faeces, which should only be preformed when necessary, generally as a last resort.
Patients are at risk of rectal trauma if these procedures are not preformed with care and knowledge

THIS SHOULD ONLY BE PERFORMED IN THE FOLLOWING SITUATIONS BY A TRAINED NUSE WHO IS COMPETENT

- **It has been identified as an acceptable bowel management method**
- **Faecal impaction/loading**
- **Incomplete defecation**
- **Inability to defecate**
- **All other bowel emptying techniques have failed**
- **Neurogenic bowel dysfunction**
- **In patients with spinal injury**

EXCLUSIONS

- There is lack of consent from the patient
- The patient's Doctor has given specific instructions that these procedures are not to take place
- The patient has recently undergone rectal/anal surgery or trauma
- The patient gains sexual satisfaction from these procedures and the nurse involved find them embarrassing. In this instance consultation with a Doctor is advised.

CAUTION WHEN PERFORMING THIS PROCEDURE IN THE FOLLOWING

- Acute inflammation of the bowel, including Crohns Disease, Ulcerative Colitis and Diverticulitis
- Recent radiotherapy to the pelvic area
- Rectal/anal pain
- Rectal surgery/trauma to the anal/rectal area
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment
- Obvious rectal bleeding
- If patient has known history of abuse
- In spinal injured patients because of autonomic dysreflexia
- If patient has known history of allergies e.g. latex, soap, phosphate and peanut (present in an arachis oil enema)

OBSERVATIONS AND RISK FACTORS

- Pulse at rest during procedure
- Pulse during procedure
- Blood pressure in spinal injuries prior to, during and at the end of procedure. A baseline blood pressure is advised for comparison
- Signs and symptoms of autonomic dysreflexia – headache, flushing, sweating, hypertension
- Distress, pain, discomfort
- Bleeding
- Collapse
- Stool consistency/amount
- Stop if anal area bleeding, pain persists, if patient asks you to stop or if heart rate drops
- At first sign of autonomic dysreflexia – be award of the correct treatment for this

REQUIREMENTS

- Disposable apron
- Non-sterile latex disposable gloves as per Glove Guidelines
- Lubricating jelly
- Anaesthetic gel – do not apply if evidence of anal bleeding or damage, as if applied
- Bed protection
- Paper tissue
- Bedpan/commode
- Disposable bag as per clinical waste guidelines

1. A nurse should **NOT** undertake the manual removal of faeces from a child as it is viewed as being traumatic and disturbing.
2. Manual removal of faeces is viewed as a last resort and should only be used if all other treatments have been tried.
3. If the manual removal of faeces is an established aspect of care, prior examination by a Doctor is not required.

PROCEDURE	RATIONALE
Explain the procedure to the patient. The patient must agree/consent to the procedure. Offer a chaperone to be present.	Ensure the patient understands the procedure, gives consent, if they request you to stop at any time, you must stop
Take the patient's pulse rate. In spinal injury patients a blood pressure should be taken	For a baseline to assess changes in pulse and blood pressure during procedure – stimulation of the vagus nerve in the rectal wall can lead to a reduction in pulse rate
Allow patient to empty bladder if necessary	A full bladder may cause discomfort during procedure
Ensure patient privacy	Provide patient comfort and dignity and will help the patient to relax
Assist the patient to remove clothing from the waist down and lay the patient in the left lateral position with knees flexed in order to expose the anus	Allows ease of digital insertion into the rectum by following natural anatomy of colon
Place bed protection under the patients hips and buttocks	To reduce risk of cross-infection. Reduce potential of soiled linen
Wash and dry hands thoroughly	Reduce risk of cross-infection
Apply disposable apron and gloves	Reduce risk of cross-infection
A) If a patient has manual removal of faeces performed on a regular basis then lubricate gloved finger with gel B) If a patient has not had a manual removal of faeces performed before then apply anaesthetic gel to anus and rectum liberally, adhere to manufacturers instructions for length of time to leave in situ for it to take effect	A) To facilitate easier insertion of the finger and removal of faecal matter B) To facilitate easier insertion of the finger, reduced sensation and discomfort and removal of faecal matter Lubrication helps minimise anal mucosal trauma
Inform the patient you are about to start the procedure	To ensure the patient is ready and relaxed
Observe anal area prior to insertion of the finger into the anus for evidence of skin soreness, swelling, rectal prolapse	May indicate incontinence or pruritus. If any abnormality detected report to medical staff before any examination is undertaken
Insert gloved finger into the patient's anus/rectum slowly and proceed with caution if patient has spinal cord injury: A) **In scybala-type stool** (hard rocks), remove one lump at a time until no more faecal matter can be felt B) **In a solid mass**, push finger into the middle of the faecal mass and split. If faecal mass is too hard or larger than 4cm across and you are unable to break it up STOP and refer to Dr	NB Majority of spinal cord injury patients will not experience any pain A) To minimise discomfort and make it easy to remove faecal matter B) To minimise discomfort and make it easy to remove faecal matter To avoid unnecessary pain

PROCEDURE	RATIONALE
As the faecal matter is removed it should be placed in the bedpan or another acceptable receptacle	To facilitate appropriate disposal of faecal material at the end of the procedure
Monitor observations and risk factors. Check the patients pulse at least once during the procedure. In spinal injury patients a blood pressure reading should be taken at least once during the procedure – if any change in condition – STOP procedure and administer appropriate medication as prescribed.	Stimulation of the vagus nerve in the rectal wall can lead to a reduction in pulse rate. In spinal cord injury, stimulus below level of injury may result in symptoms of autonomic dysreflexia including hypertension Observe and record any reaction to the anaesthetic gel
When all the faecal matter has been removed, wash and dry the patient's buttocks and anal area	To leave the patient in a comfortable and clean state
Make the patient comfortable and offer the toilet, commode or bedpan if needed	Manual removal may stimulate a patient to defecate
Remove the bedpan or receptacle and its contents and dispose of in an appropriate manner	To reduce risk of cross-infection and ensure correct disposal of body waste
Remove apron, gloves and dispose of as per Clinical Waste Guidelines	Reduce risk of cross-infection
Wash and dry hands thoroughly	Reduce risk of cross-infection
Take the patient's pulse and blood pressure if appropriate to check with the baseline recording	To monitor pulse changes and take appropriate action
Record the findings in the nursing documentation and communicate the results to the patient and doctor if appropriate. Result – (colour, consistency, content and amount of faeces as per Bristol Stool Chart)	To ensure the correct care is provided and to provide a legal record

NB
Advise patients who receive D.R.F. on a regular basis to have a period of rest during the procedure
Patient and nurse education is required to use this technique safely

SECTION 6

APPENDICES

PAGES 31 - 41

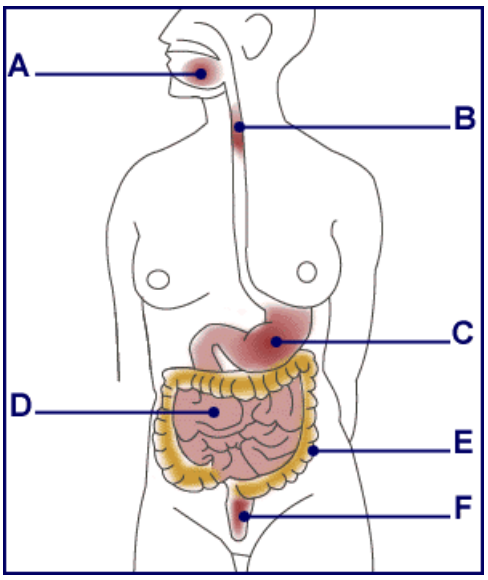
APPENDIX 1

ANATOMY AND PHYSIOLOGY OF NORMAL BOWEL

The main functions of the bowel are

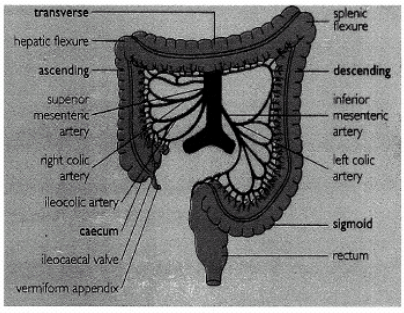
- **Storage of unabsorbed food residue**
- **Absorption**
- **Secretion of mucus**
- **Elimination of waste**

For the purposes bowel management we will focus on the LARGE BOWEL



A – Mouth
B – Oesophagus
C – Stomach
D – Small Bowel
E – Large Bowel
F – Rectum

The large bowel is about 5 feet long and extends from the ILEO-CAECAL VALVE to the ANUS
It consists of the ASCENDING, TRANSVERSE, DECENDING and SIGMOID COLON, the RECTUM and the ANUS.



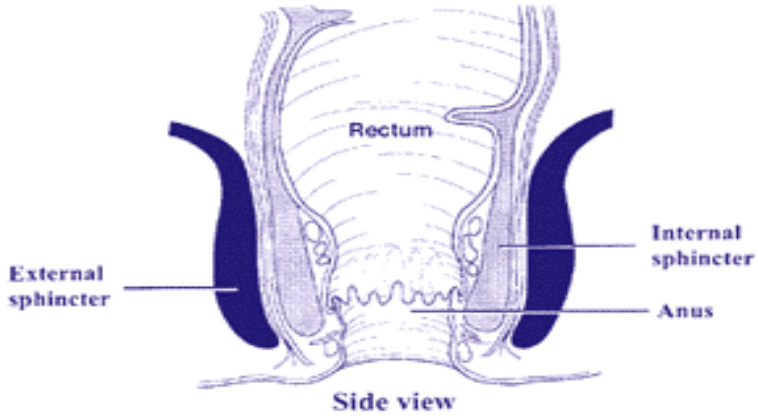
The muscle in the rectum contains sensory nerves, which are thought to detect the presence of faeces.

APPENDIX 1

ANAL SPHINCTERS

2 MUSCULAR SPHINCTERS, the INTERNAL and EXTERNAL SPHINCTERS, surround the anal canal.

- **The INTERNAL anal sphincter is composed of SMOOTH MUSCLE (involuntary)**
- **The EXTERNAL sphincter is composed of SKELETAL MUSCLE (voluntary)**
- **Another important factor in maintaining continence is the role of the pelvic floor muscles, in particular the PUBORECTALIS portion of the LEVATOR ANI MUSCLE, this forms a sling around the rectum and forms an angle known as the ANORECTAL ANGLE.**



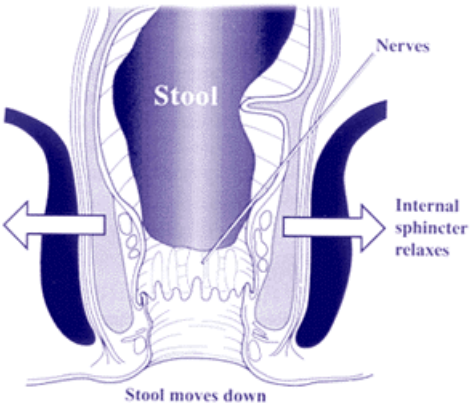
THE PROCESS OF DEFECATION

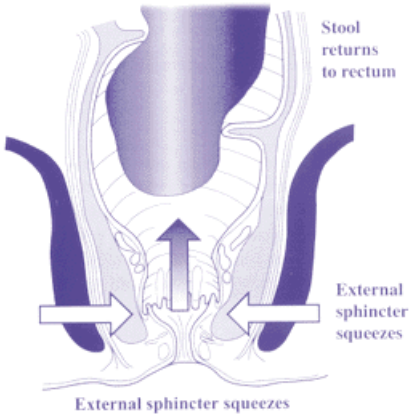
Within the colon lies thick bands of muscle, which contract and relax to form peristaltic waves along the bowel. These strong surges propel waste products along the length of the bowel. These surges often occur after a meal and are known as the GASTRO COLIC REFLEX.
External influences such as exercise, emotion, medication etc can affect this process.
These mass movements propel the faecal mass into the rectum.

Sensory nerve endings are stimulated which triggers the SPINAL REFLEX, the rectum contracts, the internal sphincter relaxes and we experience the desire to defecate

If it is appropriate to defecate the external sphincter relaxes, peristaltic waves increase, the internal sphincter and pelvic floor relaxes the levator ani muscle lifts the rectum and the faeces is expelled through the anus.
Evacuation is assisted by an increase in ABDOMINAL PRESSURE and an increase in thoracic pressure (VALSALVA MANOUVRE), this is also known as BRACE AND BULGE.

If defecation is not appropriate the external sphincter contracts inhibiting the defecation reflex, the walls of the sigmoid colon and rectum relax, as the reflex abates the faecal mass is pushed back up into the colon leaving the rectum in the normal state that of empty.





APPENDIX 2

DEFINITIONS IN BOWEL MANAGEMENT

Constipation

Constipation is defaecation that is unsatisfactory because of infrequent stools, difficult stool passage, or seemingly incomplete defaecation. Stools at often dry and hard, and may be abnormally large or abnormally small. (NICE, 2015)

Faecal Incontinence

Faecal incontinence is defined as the uncontrolled passage of solid food or liquid faeces at socially inappropriate times and places. (Kenefick, 2004)

Diarrhoea

Diarrhoea is the abnormal passing of loose or liquid stools, with increased frequency and/or increased volume.

- **Acute diarrhoea is that lasting less than 14 days.**
- **Chronic diarrhoea is that lasting for more than 4 weeks.**
  (NICE, 2013)

Faecal Impaction

When the rectum, and often the lower colon, is full with hard or soft stool and the patient is unable to evacuate the bowel unaided. This can result in impaction with overflow spurious diarrhoea, which is common in the frail elderly population (Haran, 2004) and in individuals with neurogenic bowel dysfunction. It may be misdiagnosed as diarrhoea and therefore treated incorrectly.
R.C.N. Management of Lower Bowel Dysfunction including DRE and DRF 2012

APPENDIX 3

MENTAL STATUS QUESTIONNAIRE (MSQ)

Ask the client the following questions

1. **What is the name of this place?**
2. **Where is it located (address)?**
3. **What is today's date?**
4. **What is the month now?**
5. **What is the year?**
6. **How old are you?**
7. **When were you born (month)?**
8. **When were you born (year)?**
9. **Who is the Prime Minister of the United Kingdom?**
10. **Who was the Prime Minister before him?**

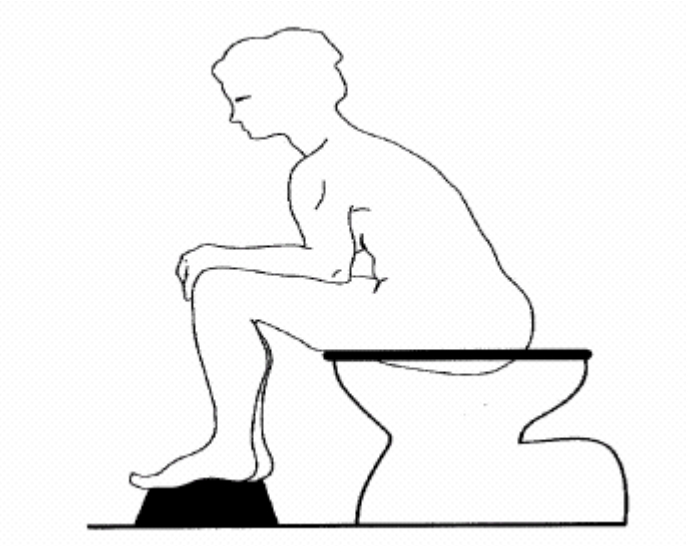
Appendix 9

THE BRISTOL STOOL FORM SCALE

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

APPENDIX 5

POSITION CHART



Each patient must be assessed individually to ascertain whether the above is appropriate, comfortable and **SAFE**
Feet supported or heels raised
Knees above hip joint level, legs apart, lean forward, back straight (neutral spine) and forearms supported on thighs

Perineal Support
Placing a hand on the perineum in front of the anus can aid effective defaecation. This can be particularly helpful for patients with a prolapse, perineal descent or pain.

GUIDELINES FOR THE USE OF PHOSPHATE ENEMAS IN THE TREATMENT OF CONSTIPATION

BACKGROUND

Phosphate enemas are extensively prescribed for bowel evacuation associated with constipation and are generally well tolerated. However, they may rarely cause problems, colostomy (temporary or permanent) being the commonest due to localised severe adverse reactions. In rare situations, perforation of the bowel has been fatal. It is likely that there is under-reporting of complications caused by phosphate enemas for a number of reasons – litigation being perhaps the commonest. Administration of a phosphate enema is not without risks and appropriate precautions should be taken.

Complications associated with Phosphate Enemas are mainly caused by:

1. Trauma to the anal or rectal mucosa by the enema nozzle.
2. The topical and corrosive activity of phosphate on mucus membrane and local tissue.
3. Individuals who are more at risk of localised and systemic complications as listed below.
4. A combination of all the three above factors.

Phosphate Enemas are therefore best avoided in:

1. The frail elderly
2. Malnourished patients due to tissue fragility
3. Debilitated patients
4. Patients with known inflammatory bowel conditions/diseases
5. Patients with inflamed haemorrhoids or skin tags
6. Patients following anal/recta surgery/trauma
7. Patients with sacral pressure sores who are likely to retain a 100ml enema
8. Patients following radiotherapy directly or indirectly involving the anal/rectal area
9. Acute gatro-intestinal conditions

Key Statements:

1. If anal bleeding develops following administration of a phosphate enema, this should be viewed as a medical emergency and colorectal referral is indicated to arrest localised complications.
2. Phosphate enemas have a limited role and should be used with caution.

Produced by:
Ray Addison, Nurse Specialist in Bladder and Bowel Dysfunction;
Wendy Ness, Colorectal Nurse Specialist; Ian Swift, Colorectal Consultant;
Muti Abulafi, Colorectal Consultant;
Simon Badcott, Deputy Chief Pharmacist, Mayday healthcare NHS Trust;
Mark Robinson, Pharmacist, Prescribing Manager, Croydon PCGs.

APPENDIX 7

UPPER AND LOWER MOTOR NEURON BOWELS – EXPLANATIONS

A Neurogenic Bowel can be defined in two ways – Upper Motor Neuron Bowel and lower Motor Neuron Bowel depending on which part of the nervous system is affected by injury or disease.

Upper Motor Neuron Bowel

An upper motor neuron bowel problem occurs in injury or disease in the brain or spinal cord above T12 level e.g. after Head Injury, in Multiple Sclerosis, Parkinson's Disease or Spinal Injury.

On examination anal sphincter tone is maintained and there may be some sensation and voluntary contraction of anal sphincter. The bowel reflexes are all preserved, therefore the bowel contracts and should empty when stimulated.

Often patients in this group can be managed with alternate day bowel movements but this also depends on their previous bowel pattern.

Even though the bowel contracts and should empty when stimulated, often other impairments and disabilities (e.g. immobility, poor fluid intake, drugs for bladder dysfunction) make people prone to constipation. Cognitive impairments with reduced awareness or understanding can also result in faecal incontinence and as well as the bowel management guidelines, behavioural strategies can also be tried.

Lower Motor Neuron Bowel

A lower motor neuron bowel problem occurs due to damage to the lower spinal cord (T12 or below) or from damage or disease of the peripheral nerves. Diseases which may affect the lower cord are Multiple Sclerosis, after injury, Disc disease, infection or tumours. Diseases that can affect the peripheral nerves are Diabetes or injury during abdominal operations.

On examination the anal sphincter is flaccid with little resting tone or active contraction. Although there is some intrinsic peristalsis, it is not usually effective in propelling bowel contents distally. Constipation, impaction, overflow and incontinence often result.

Most patients will require at least daily bowel care in order to keep rectum empty to avoid incontinence later in the day. Some patients will not respond to stimulant suppositories and may require enemas or manual evacuations to completely empty the rectum. Rigorous management is required in order to prevent constipation

APPENDIX 8

RED FLAGS

- **Recent altered Bowel Habit**
- **Weight Loss**
- **Rectal Bleeding**
- **Associated Vomiting**
- **Abdominal Pain**
- **Abdominal Distension**
- **Pregnancy**
- **H/O : Bowel or Rectal CA**
- **Recent Bowel/Rectal Surgery**
- **Worsening of constipation despite management by G.P.**

APPENDIX 9

EXAMPLE OF BOWEL CARE PATHWAY FOR MANAGEMENT OF HEALTHY BOWELS

Exclude All Red Flags – Appendix 8

Complete Bowel Assessment Form, Bowel Chart and Food and Fluid Diary

PATIENT'S DIET AND LIFESTYLE

- **Fluid intake 1500 – 1800mls – unless restricted for medical reasons**
- **Review dietary fibre: at least one fibre rich food per meal – SEE SECTION 3**
- **Increase exercise where safe to do so**
- **Educate care staff as to which drugs can cause/worsen constipation – SEE SECTION 4**
- **Consider review by Dietician – SEE SECTION 3**
- **Consider individual bowel management toileting and planned toileting**
- **Review patients normal vs. current bowel movements from bowel chart**
- **Record to correspond with Bristol Stool Scale – APPENDIX 4**
- **Toilet facilities and access improve if required**
- **Review toileting position - APPENDIX 5**

↓

Confirm abnormal bowel function/altered routine

↓

Constipation Diarrhoea → Exclude Overflow

↓

IDENTIFY CAUSE

Consider e.g.:

- Disease, immobility, fluid and fibre intake, neurological disorder, prolapse, cognitive/behavioural difficulties, drugs known to increase constipation:

TREAT UNDERLYING CAUSE – REVIEW MEDICATION – SECTION 4

↓

If unresolved review current Laxative treatment and if necessary perform a Rectal Examination – SECTION 5 Refer to G.P./Dr as appropriate

↓

ACUTE CONSTIPATION
Refer to prescribing guidelines
SECTION 4

CHRONIC CONSTIPATION
Refer to prescribing guidelines
SECTION 4

IMPACTION
Refer to prescribing guidelines
SECTION 4

CONTINUE MONITORING
For further advice e-mail
Grampian.inveruriecas@nhs.net

APPENDIX 10

FURTHER READING/REFERENCES

Guidelines for Management of Neurogenic Bowel Dysfunction after Spinal Cord Injury April 2009
www.coloplast.co.uk

Continence Adults with Urinary Dysfunction – Quality Improvement Scotland
www.nhshealthquality.org

Faecal Incontinence – NICE QS 54 February 2014
www.nice.org.uk

Multiple Sclerosis, Management of Multiple Sclerosis in Primary and Secondary Care CG 186 2014
www.nice.org.uk

RCN The Management of Diarrhoea in Adult 2013
www.rcn.org.uk/direct

RCN Management of Lower Bowel Dysfunction including DRE and DRF 2012
www.rcn.org.uk/direct

NMC The Code 2015 – Standards of Conduct, Performance and Ethics for Nurses and Midwives

Royal Marsden Clinical PROCEDURES 9th Edition
www.royalmarsdenmanual.com

Bowel Problems and Multiple Sclerosis
www.mstruct.org.uk

Bowel Continence Nursing – Christine Norton 2004

Local NHS Guidelines and Procedures

BNF – www.bnf.org

NES C.Diff Module

NES Continence Management Module

Adults with Incapacity Act