

BOWEL CARE POLICY FOR ADULTS

(To be read in conjunction with
 Consent and Capacity to Consent to Examination or Treatment Policy)

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1 INTRODUCTION

- 1.1 “Bowel care is a fundamental area of patient/client care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients/clients, many of whom are hesitant to admit to bowel problems or to discuss such issues.” (Royal College of Nursing (RCN) 2008)
- 1.2 Bowel care may include rectal interventions. This should only be carried out when there is a specific and adequate clinical indication. It is the policy of Somerset Partnership NHS Foundation Trust that bowel care should be carried out in a safe and consistent manner according to Trust procedures for bowel care (see Appendices A - G).

2 PURPOSE AND SCOPE

- 2.1 To ensure a high standard of bowel care, including assessment, treatment and management including rectal interventions.
- 2.2 To ensure safe, competent practice by all clinicians undertaking bowel care and reduce risk of complications associated with bowel management.
- 2.3 To standardise practice across Somerset Partnership NHS Foundation Trust and the wider healthcare community.
- 2.4 To ensure that all practice is evidence-based, relevant, appropriate and to minimise harm.
- 2.5 The policy will apply to all staff undertaking bowel care for adults, with the exception of stoma care.
- 2.6 In order to carry out invasive bowel care all staff should attend relevant training, achieve competency, and be working within their job description.

3 DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has a duty to care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents and delegate’s responsibility as appropriate.
- 3.2 The **Executive Lead** is the Director of Nursing and Patient Safety with delegated responsibility to ensure this policy is reviewed at least once every three years or sooner if national or local procedures change.
- 3.3 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.
- 3.4 **All staff** working with patients where bowel care is an issue should be familiar with the procedures detailed in the document and other related policies. All staff that carry out bowel care must be trained and assessed as competent prior to undertaking that skill.
- 3.5 **Line managers** are responsible for ensuring all staff providing care related to bowel care are conversant with this policy and related policies.

3.6 **The continence team** are responsible for providing training and assessment of competence in for bowel care assessment and interventions.

4 **EXPLANATIONS OF TERMS USED**

4.1 **Digital Rectal Examination**

4.1.1 Digital rectal examination (DRE) is an invasive procedure and should only be performed after completion of a full assessment of constipation. It involves observing the perianal area and inserting a lubricated gloved finger into a patient/client's rectum. Its intimate nature and fears of litigation/accusation of abuse have led to confusion among nurses about their professional and legal responsibilities (RCN 2008).

For full procedure refer to Royal Marsden Manual

4.2 **Manual Evacuation of Faeces**

4.2.1 In most cases the need for the digital removal of faeces is preventable by using a stepped approach to the management of constipation (RCN 2008). The digital removal of faeces is an invasive procedure and should only be practiced when necessary, and after a comprehensive assessment (SSH CC01 and RCN 2008).

4.2.2 For some patients/clients such as those with spinal cord injury, cauda equina, spina bifida and multiple sclerosis the digital removal of faeces is an integral part of their routine bowel management. Only a competent practitioner should carry out this procedure (Kyle et al 2008).

For full procedure refer to Royal Marsden Manual.

4.3 **Digital Stimulation**

4.3.1 Stimulation of the anus or anal sphincter can aid some patients/clients with defecation. It is suggested that this procedure can be effective when used together with techniques to enhance defecation such as, adopting the correct position on the lavatory and taking hot drinks and food 20-30 minutes prior to instigating bowel care, to take advantage of the gastric colic reflex which is strongest after the first meal of the day but can be stimulated at other times. In spinal injury patients/clients with a lesion above cauda equina, it's usually possible to stimulate a defecation reflex using Digital stimulation (Powell and Rigby 2000). This stimulated reflex may be insufficient to completely empty the bowel and a digital removal of faeces may still be required (Kyle et al 2008).

For full procedure see Appendix A.

4.4 **Suppositories**

- 4.4.1 A suppository is a medicated solid formulation prepared for insertion into the rectum. Once inserted the temperature of the body will melt the suppository from its solid form to a liquid.

Digital rectal examination should be performed prior to administration to assess the need for rectal medication.

For full procedure refer to Royal Marsden Manual.

4.5 **Enemas**

- 4.5.1 Before considering the use of an enema for treatment of constipation please consider treating with high dose Macrogol.

- 4.5.2 An enema is a liquid preparation that is introduced into the body via the rectum for the purposes of producing a bowel movement or administering medication.

- 4.5.3 An enema may be required for the following:

- acute disimpaction of the bowel
- bowel clearance before bowel investigations or surgery
- to soothe and treat bowel mucosa in chronic inflammatory bowel disease such as ulcerative colitis and Crohn's disease

- 4.5.4 There are two main types of enemas – evacuant and retention.

4.6 **Trans-Anal Irrigation**

- 4.6.1 The terms Trans- anal Irrigation and Rectal Irrigation are used interchangeably in current literature.

- 4.6.2 This is a specialist procedure and should only be commenced following consultation with the Continence Service.

4.7 **Use of Peristeen Anal Plug**

- 4.7.1 This is a useful device for individuals with passive soiling who can use it on a daily basis or when they want to do sports activities. It is not suitable for patients/clients with frequency of defecation, as it would have to be removed each time. The advantage is that it usually stops soiling, however some patients/clients report discomfort and are unable to tolerate it. Patients/clients with a neurological injury or condition benefit from it, as they frequently lack function in the anal canal. It is used after their normal bowel regime, and is inserted to prevent further soiling. (Chelvanayagam & Norton 2004)

This is a specialist procedure and should only be commenced following consultation with the Continence Service. For full procedure see Appendix B.

5 CAPACITY AND CONSENT

- 5.1 Obtaining consent is essential before carrying out nursing care, treatment or procedures involving physical contact with a patient/client. Without consent the care or treatment may be considered to be unlawful.
- 5.2 When seeking consent, staff must ensure patients fully understand the information being given to them; this may necessitate the use of a professional interpreter to ensure they are able to give informed consent (in line with the Professional Interpreter and Translation Services Policy).
- 5.3 The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people aged 16 and over who are not able to make informed decisions.
- 5.4 The Policy for Consent to Examination and Treatment (Community Health Directorate) should be followed at all times and the Consent and Capacity to Consent to Treatment (Mental Health Directorate).
- 5.5 See Appendix D for suggested type of consent required for bowel management.

6 BOWEL ASSESSMENT

- 6.1 Bowel care deals with intimate and private parts of the body. All interventions relating to assessment and treatment require discretion and sensitivity.
- 6.2 Assessment of bowel continence and function should form part of the holistic patient/client assessment. Bowel assessment includes obtaining a history and carrying out relevant clinical examinations. It also includes carrying out and interpreting relevant baseline physiological observations and tests.
- 6.3 In some exceptional circumstances people will have regular administration of either enemas or suppositories. This will be under the guidance of the prescriber and will be incorporated into the individual person's care plan. It will also only be routine when all other medication has been viewed as not being appropriate or not being of benefit. These individuals will most likely have been on these medications for a long time and now their bowels have developed a habit for only working with this agreed intervention. The agreement should be with the prescriber and any other relevant person, if the client is able to give consent then this should be with them, as part of the agreement for using the intervention.

7 ACUTE AND CHRONIC BOWEL CARE PROBLEMS

- 7.1 Nurses need to know what constitutes a bowel care emergency, and be able to act without delay to prevent further complications. Please see Appendices E and F.

8 UNDERSTANDING FAECAL INCONTINENCE (FI)

Taken from the National Institute for Health and Clinical Excellence (NICE 2007). Faecal Incontinence, The Management of Faecal Incontinence in Adults.

8.1 Assessment –

Initial Management:

Diet

- take into account existing therapeutic diets
- ensure overall nutrient intake is balanced
- consider use of a food & fluid diary
- advise patient/client to modify one food at a time
- encourage people with hard stools and/or clinical dehydration to aim for intake of at least 1.5 litres of fluid per day (unless contra-indicated)
- consider screening people for malnutrition or risk of malnutrition

8.2 Bowel Habit

Interventions should promote ideal stool consistency and predictable bowel emptying.

- encourage bowel emptying after a meal
- ensure toilet facilities are private, comfortable and can be safely used with sufficient time allowed
- encourage people to adopt a sitting or squatting position where possible while emptying the bowel and avoid straining

8.3 Toilet Access

- ensure locations of toilets are made clear and any equipment or help needed to access the toilet is provided
- offer advice on easily removable clothing
- refer for home and mobility assessment if appropriate

8.4 Medication

As per BNF 1.8 Antidiarrhoeals for stoma care.

- consider alternatives to drugs contributing to FI
- prescribe anti-diarrhoeal drugs, in accordance with summary of product characteristics, for people with loose stools and associated FI once other causes have been excluded. Loperamide should be 1st drug of choice.
 - consider Loperamide syrup for doses less than 2 mg
 - offer codeine phosphate (second line), or co-phenotrope (third line), if unable to tolerate Loperamide
 - introduce at very low dose and escalate as tolerated until desired stool consistency is reached

- advise that dose can be altered up or down in response to stool consistency and lifestyle
- do not offer antidiarrhoeals to people with:
 - hard or infrequent stools
 - acute diarrhoea without a diagnosed cause
 - acute flare up of ulcerative colitis

8.5 Coping Strategies

Offer advice on:

- continence products
- emotional and psychological support
- talking to friends and family
- planning travel and carrying a toilet access card or RADAR key

Offer people with FI:

- choice of disposable body-worn pads
- anal plugs
- skin care, odour control and laundry advice
- disposable gloves

Do not generally recommend reusable absorbent products.

8.6 Review

- ask whether FI has improved
- if symptoms persist discuss further treatment options
- if individual does not wish to progress further in care pathway provide long term strategies:
 - advice on preservation of dignity and independence
 - 6 monthly review of symptoms
 - discussion of other management options (including specialist referral)
 - contact details for relevant support groups
 - advice on coping strategies and skin care
- Specific management will be needed for people with the following:
 - faecal loading
 - limited mobility
 - neurological/spinal disease
 - learning difficulties
 - severe or terminal illness
 - acquired brain injury

8.7 **Specialised Management**

Consider specialised management options, which may be provided by a specialist continence service. These may include:

- pelvic floor muscle training
- bowel retraining
- specialised dietary assessment and management
- biofeedback
- electrical simulation
- rectal irrigation

Consider whether people with neurological or spinal disease / injury resulting in FI could benefit from specialised management

8.8 **Specialist Assessment**

Refer patients/clients with continuing FI for consideration for specialist assessment including:

- anorectal physiology studies
- endoanal ultrasound (if unavailable consider MRI, endovaginal ultrasound and perineal ultrasound)
- other tests including proctology as indicated.

9 **DOCUMENTATION**

- 9.1 Ensure that all assessment, care and treatment is documented in line with the NMC guidance, and Somerset Partnership NHS Foundation Trust's Record Keeping and Records Management Policy.

10 **TRAINING REQUIREMENTS**

- 10.1 All practitioners undertaking bowel care must be able to demonstrate competence in bowel care assessment and interventions by being assessed as competent. See Appendix C. Competency assessment must be undertaken by a competent Registered Nurse. Theoretical training is available through the Continence Service Promoting Bowel Health course.
- 10.2 All practitioners will have a working knowledge of relevant current legislation, national guidelines, organisational policies and protocols.
- 10.3 All practitioners will have a working knowledge of working within their sphere of competence and when to seek advice.
- 10.4 All staff must practise the skills regularly to maintain competence. They must refresh their knowledge and skills at least every three years by reassessment of competence.
- 10.5 Staff (practitioners and assessors) must maintain their competence through clinical practice and personal study.

- 10.6 In some areas, unregistered practitioners are involved in carrying out some aspects of bowel care. The relevant bowel care interventions are delegated to the health care assistants by registered nurses. Nurses and midwives are accountable for the decision to delegate care. A nurse or midwife should only delegate an aspect of care to a person who has had appropriate training and whom they deem competent to perform the task. When a nurse or midwife is delegating they must be assured that the person to whom they have delegated (the delegate) fully understands the nature of the delegated task particularly in relation to what is expected of them. The delegate should know their limitations and when to seek advice from the appropriate professional in the event that circumstances change

11 EQUALITY IMPACT ASSESSMENT

- 11.1 All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity lead who will then actively respond to the enquiry.

12. MONITORING OF COMPLIANCE AND EFFECTIVENESS

- 12.1 All complaints, feedback and DATIX incidents related to this policy will be monitored by the Community Hospital Best Practice Group. The group will identify good practice, any shortfalls, action points and lessons learnt, and feedback to the relevant clinical teams.
- 12.2 The faecal incontinence section of this policy (NICE Quality Standard 54) is incorporated into the Trust's Three Year Clinical Audit Plan, and will be appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking the audit and signing off key recommendations is held by the appropriate Best Practice Group, and will be carried out in partnership with team leaders, the continence group, and the clinical audit team. Progress with any recommendations is included within the Best Practice Group six-monthly report to Clinical Governance Group.

13 COUNTER FRAUD

- 13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

14 RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

14.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

14.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 11:	General
Regulation 12:	Statement of purpose
Regulation 18:	Notification of other incidents

14.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

15 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

15.1 References

Bowel Care, including digital rectal examination and manual removal of faeces (RCN 2008)

Chelvanayagam S, Norton C. 2004 Practical management of faecal incontinence. In Norton C, Chelvanayagam S (eds) *Bowel Continence Nursing*. Beaconsfield

Davies, C (2004). The use of phosphate enemas in the treatment of constipation. *Nursing Times*; 100: 18, 32-35

Faecal Incontinence, The management of faecal incontinence in adults. (NICE 2007)

Guidelines for the use of rectal irrigation (St Marks Hospital 2008) (Norton)

Higgins, D. (2007) Bowel care Part 6 – Administration of a suppository. *Nursing Times*; 103: 47: 26-27 in *Practical Procedures, Bowel Care* (CD-Rom) Norgine 2007

Kyle G, Dunbar T, Prynne P. 2008 The procedure for the digital removal of faeces. Norgine Ltd.

Kyle G. 2007a Bowel Care Part 4. Administering an Enema Nursing Times 103: 45, 26-27 in Practical Procedures, Bowel Care (CD- Rom) Norgine 2007

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Mendoza, J et al (2007), Systematic Review; the adverse effects of sodium phosphate enema. *Alimentary, Pharmacology and Therapeutics*; 26: 9-20

NICE 2007 Faecal incontinence. The management of faecal incontinence in adults. London NICE

Norton 2008. Guidelines for the use of rectal irrigation. Coloplast

Nursing & Midwifery Council 2008 Standards of proficiency for nurse and midwife prescribers <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1645> viewed 29.11.08

Powel, M, Rigby, D (2000), Management of bowel dysfunction, evacuation difficulties. *Nursing Standard* 14 (4): 47-57

RCN 2008 Bowel care, including digital rectal examination and manual removal of faeces. London RCN

Skills for Health National Occupational Standards 2008, available at www.skillsforhealth.org.uk/competences/completed-competences-project/list/continence-care

Wilson L 2005 Understanding Bowel problems in older people. part 2. *Nursing Older People* Vol 17 no 9 p 24-29

15.2 **Cross Reference to other Procedural Documents**

Equality and Diversity Policy

Consent and Capacity to Consent to Examination and Treatment Policy

Development & Management of Organisation-wide Procedural Documents Policy and Guidance

Hand Hygiene Policy

Infection Prevention and Control Policy

Learning Development and Mandatory Training Policy

Medicines Policy

Privacy, Dignity and Respect Policy

Professional Interpreting and Translation Services Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Staff Mandatory Training Matrix (Training Needs Analysis)

Training Prospectus

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

16 APPENDICES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Digital Stimulation
Appendix B	Insertion of Peristeen™ Anal Plug
Appendix C	Competency for assessing Bowel Dysfunction
Appendix D	Suggested Type of Consent for Bowel Care
Appendix E	Acute Bowel Care Problems
Appendix F	Chronic Bowel Problems
Appendix G	Trans-anal Irrigation
Appendix H	Faecal Incontinence Clinical Audit Standards

Digital Stimulation

Equipment:

- plastic-backed absorbent sheet
- non-latex disposable gloves
- gauze swabs
- lubricating jelly

Action	Rationale
A patient/client using digital self- stimulation should be in a comfortable sitting position.	Gravity will aid evacuation (Banwell et al, 1993)
If the procedure is being undertaken by a nurse/carer they should assist the patient/client to adopt the left lateral position with knees flexed.	To expose anus and to avoid damage to the anal canal.
Insert a glove (non- latex) lubricated index finger through the anal sphincter to second joint of finger only.	To facilitate easier insertion and rotation of finger also to prevent trauma to the anal and rectal mucosa.
Gently rotate the finger 6- 8 times in a clockwise motion and withdraw. This may be repeated up to three times allowing 5-10 minutes between each stimulation.	To minimize discomfort and to stimulate ano- rectal reflex. (Spinal Injuries Unit 1999)
Results should be noted and documented.	To establish effectiveness of procedure.

Adapted from

Kyle G, Prynne P, Dunbar T (2008) The procedure for the digital removal of faeces.
Norgine Ltd.

Insertion of Coloplast Peristeen Anal Plug

This is a useful device for individuals with passive soiling who can use it on a daily basis or when they want to do sports activities. It is not suitable for patients/clients with frequency of defaecation, as it would have to be removed each time. The advantage is that it usually stops soiling, however some patients/clients report discomfort and are unable to tolerate it. Patients/clients with a neurological injury or condition benefit from it, as they frequently lack function in the anal canal. It is used after their normal bowel regime, and is inserted to prevent further soiling.

This is a medical device, available on prescription

Equipment:

- anal plug
- lubricating gel
- gloves
- apron

Action	Rationale
Discuss treatment with and the Team, justify and document the need for this procedure.	To allow patient/client choice and to ensure optimum treatment (NMC 2008, SFH CC01, CC09).
Be aware of legislation regarding mental capacity (NMC 2008, SFH CC01 and CC09). Explain Procedure. Consider cultural and religious beliefs.	To gain the patient/client's consent and co-operation, you must ensure that the patient/client has the mental capacity to give consent. Valid consent requires three key elements: 1. It must be given freely and voluntarily without coercion or manipulation (SFH CC01, CC09). 2. The patient/client must be appropriately informed of the proposed intervention. 3. The patient/client must be deemed competent to make the decision. Failure to satisfy these three elements will invalidate any consent.
Explain potential risks to the patient/client. Document consent given	So that consent is valid. To comply with legislation.

Ensure privacy and respect the patient/client's dignity.	To help the patient/client relax and minimise embarrassment (NMC 2008, SFH CC01).
Smear a small amount of Peristeen gel on the tip of the Peristeen anal plug	To lubricate and ease insertion
Insert the Peristeen anal plug gently into the anus, just as you would a suppository.	To ensure the plug is placed correctly.
Ensure that the entire Peristeen anal plug is inserted into the rectum. Only the gauze should be visible.	The Peristeen anal plug is now correctly positioned in the rectum and will very quickly (in about 30 seconds) expand to full size as the film dissolves in the body's natural warmth and moisture. It may be left in the rectum for up to 12 hours.
The Peristeen anal plug is removed from the rectum by gently pulling the gauze which is moulded into the plug. Removing the plug will not activate the emptying reflex, so there is no need to hurry.	
A fresh plug may be inserted immediately after removal of the old one.	Each plug must not be left in situ longer than 12 hrs.
After use, put the plug in waste bin not into the toilet.	The plug will swell and could cause blockage of the toilet
The Peristeen anal plug should be changed as often as necessary and must not be left in place for more than 12 hours.	As per manufacturer instructions
Keep out of reach of children.	If placed in a mouth the Peristeen anal plug will expand and may cause choking.

Please see instruction leaflet for further information.

Adapted from
Coloplast Peristeen Anal Plug Instructions for Use.

COMPETENCIES FOR ASSESSING BOWEL DYSFUNCTION

The competencies are to be used in conjunction with: -

- NMC (2008) The Code: standards for conduct; performance and the ethics for nurses and midwives
- NICE Guideline 2 -Infection Control Prevention of Healthcare Associated Infection in Primary and Community Care
- Royal Marsden Manual of Nursing Procedures (Seventh edition) 2011
- NICE guideline 49- Faecal Incontinence Assessment

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners, to ensure safe practice in assessing bowel dysfunction

The self-rating scale is to be used by the individual practitioner for self assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Key for Self-Assessment

1 = No knowledge / experience

2 = Some knowledge / experience

3 = Competent

4 = Competent with some experience

5 = Competent, experienced and able to teach others

Author: Continence Service Manager

Date:

Review:

Assessment of competence for Assessing Bowel Dysfunction

I confirm that I have self-assessed as competent to practice assessment of bowel dysfunction as below:

Practitioner Name:

Practitioner Qualification:

Practitioner Signature: Date:

I confirm that I have assessed the named practitioner above as competent to perform the above skill.

Name & Title:

Signature: **Date:**

Upon successful completion of your assessment of competency please send to your Line Manager and retain a copy for yourself.

KNOWLEDGE and SKILLS for Assessing Bowel Dysfunction		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
1	To have knowledge of national guidelines, organisational policies and protocols in accordance with clinical/corporate governance which affect the assessment of bowel dysfunction.	1				
		2				
		3				
		4				
		5				
2	An understanding of the anatomy and physiology of the male and female lower GI tract in relation to lower bowel function and continence status.	1				
		2				
		3				
		4				
		5				
3	To understand the specific health conditions which have an impact on bowel function. And understand the different types of bowel dysfunction.	1				
		2				
		3				
		4				
		5				
4	To be aware of the importance of respecting individual privacy and dignity in respect to the sensitive nature of bowel assessment and management. Including appropriate consent.	1				
		2				
		3				
		4				
		5				
5	To understand the assessment process and completion of assessment forms and importance of assessment questions.	1				
		2				
		3				
		4				
		5				
6	To demonstrate knowledge of the procedure of digital rectal examination and insertion of rectal suppositories/enemas. And the associated risk factors.	1				
		2				
		3				
		4				
		5				
7	To demonstrate knowledge of the procedure of digital stimulation and manual removal of faeces and the associated risk factors.	1				
		2				
		3				
		4				
		5				

Suggested Consent Required for Bowel Care

Type of Consent – Bowel Care

Bowel care deals with intimate and private parts of the body. All interventions relating to assessment and treatment require discretion and sensitivity. However this does not necessarily equate to the need for written consent.

Procedure	Significant Risk	Anaesthesia /Sedation	Clinical Care not Primary Purpose	Significant Consequences for employment, personal or social life	Research purpose	Type of Consent
Digital Rectal Examination	No	No	No	No	No	Verbal/ Implied
Manual removal of faeces	No	No	No	No	No	Verbal/ Implied
Insertion of Suppository	No	No	No	No	No	Verbal/ Implied
Insertion of Micro-enema	No	No	No	No	No	Verbal/ Implied
Insertion of rectal medication eg suppository, foam, micro-enema	No	No	No	No	No	Verbal/ Implied
Insertion of phosphate enema	Yes	No	No	No	No	Verbal/ Implied
Ongoing use of anal irrigation	Thought to be minimal but long term unknown	No	No	No	No	Verbal/ Implied
Use of Anal Plug	No	No	No	No	No	Verbal/ Implied

ACUTE BOWEL CARE PROBLEMS

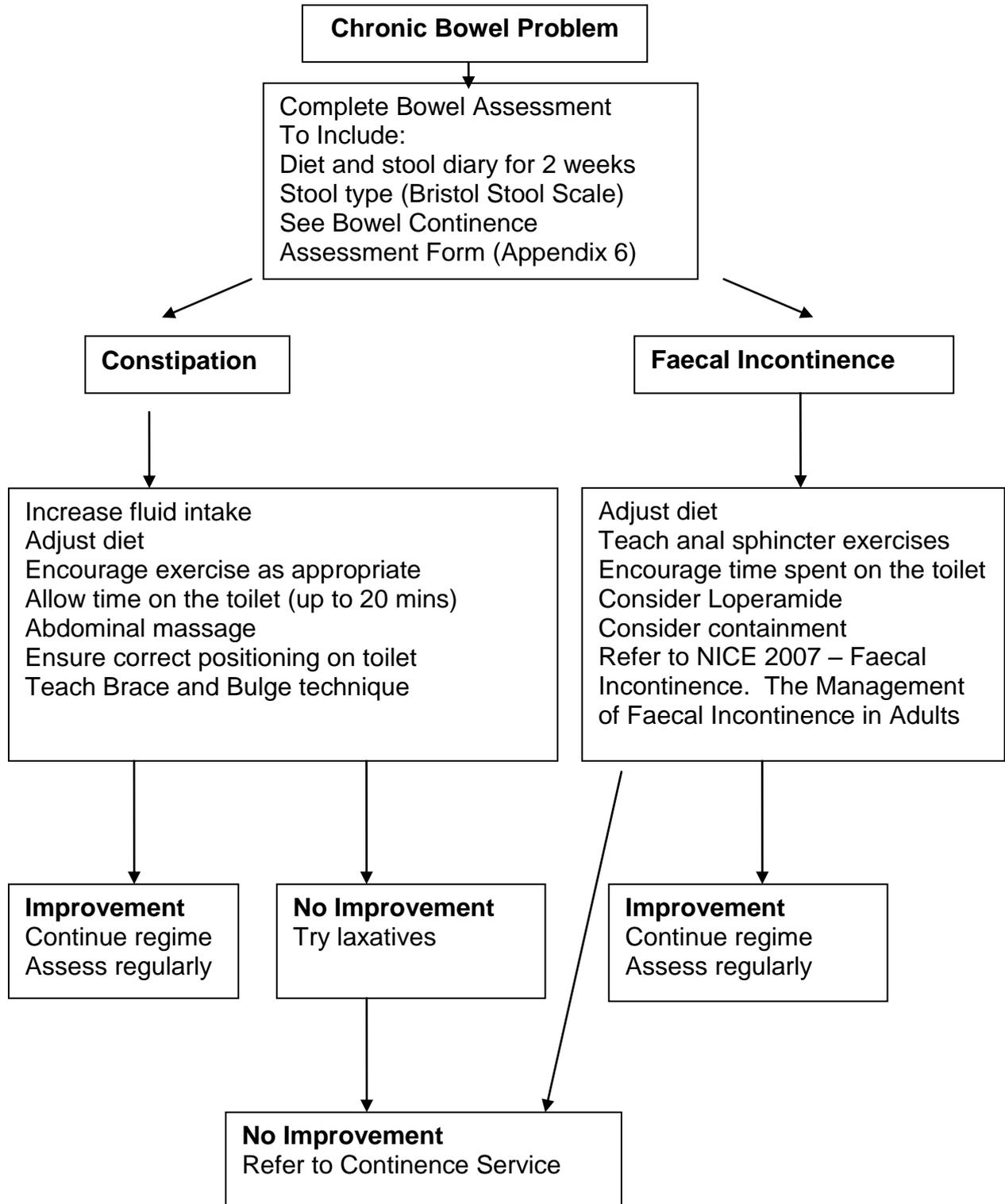
The table below lists the most common bowel care emergencies, presentation and management:

Type of Emergency	Management
<p>Autonomic Dysreflexia. Life- threatening complication of spinal injury, level T6 or above. Abnormal response to pain/ stimulus may result in seizure, stroke and death. Triggers include constipation, digital stimulation, manual evacuation and enemas and irrigation.</p>	<p>Management plan for all patients/clients at risk. Patients/clients and all care staff should be aware of triggers, symptoms and management plan. Refer to Guidelines for Management of Neurogenic Bowel Dysfunction after Spinal Cord Injury (RCN 2009)</p>
<p>Bowel Obstruction No bowel activity Abdominal pain & Distension Vomiting Possible dehydration Serious condition requiring immediate medical attention If untreated, bowel may rupture, leak its contents causing peritonitis.</p>	<p>Seek urgent medical attention</p>
<p>Perforation Hole in the bowel - allows leakage of intestinal contents into abdominal cavity.</p>	<p>Seek urgent medical attention</p>

<p>High fever</p> <p>Nausea</p> <p>Severe abdominal pain, worse on movement</p> <p>Intense vomiting leading to dehydration</p> <p>If untreated causes peritonitis.</p> <p>Strangulated Hernia</p> <p>Blood supply to the bowel cut off</p> <p>May lead to ischemia, necrosis, gangrene</p>	<p>Seek urgent medical attention</p>
<p>Diarrhoea</p> <p>Many causes e.g.:-</p> <p>Colitis</p> <p>Small bowel disease - Crohns</p> <p>Pancreatic</p> <p>Endocrine</p> <p>Infection</p> <p>Antibiotic therapy</p> <p>Drug induced</p> <p>May lead to dehydration,& electrolyte imbalance</p>	<p>Full assessment - history and physical assessment to exclude impaction</p> <p>Exclude impaction - if constipated follow acute constipation plan.</p> <p>Send stool sample for culture</p>
<p>Undiagnosed Rectal Bleeding</p> <p>Many causes e.g.:-</p> <p>Haemorrhoids</p> <p>Anal fissure</p> <p>Proctitis</p>	<p>Full assessment</p> <p>Referral on to medical practitioner.</p>

<p>Diverticular Disease</p> <p>Colitis</p> <p>Polyps</p> <p>Ulceration</p> <p>Malignancy</p>	
<p>Recent Change In Bowel Habit</p> <p>Can include any of the following when not associated with lifestyle changes.</p> <p>Stool consistency</p> <p>Unintentional Weight loss</p> <p>Rectal bleeding</p> <p>Anaemia</p> <p>Increased mucous and wind</p>	<p>Full assessment</p> <p>Referral on to medical practitioner.</p>
<p>Faecal Impaction</p> <p>If not treated can cause an obstruction</p>	<p>Full assessment</p> <p>Macrogol is licensed to treat faecal impaction and should be used to resolve this before giving rectal medication.</p> <p>Phosphate enemas should only be given as a last resort.</p> <p>Manual evacuation may be appropriate for patients/clients with impaction.</p>

(RCN 2008)



Adapted from Southampton City Primary Care Trust, cited in Wilson 2005

TRANS-ANAL IRRIGATION

Trans-anal irrigation has been found in a randomised controlled trial to be effective for both constipation and faecal incontinence in patients/clients with spinal cord injury. In scintigraphic studies anal irrigation has been found to empty stool as far as the splenic flexure. However there is a relatively small evidence base for this procedure at present and so much of the advice given is based on expert opinion and practical experience (Norton 2008).

Trans-anal irrigation must only be tried if other less invasive methods of bowel management have failed to adequately control constipation and or faecal incontinence. This procedure is designed for independent patient/client use, but there are some circumstances where it will need to be carried out by a health professional.

Trans-anal irrigation should only be started and carried out for the first time under the direction of the doctor, nurse or other qualified health care professional. All healthcare professionals who are considering recommending the use of anal irrigation should discuss this with the continence service.

Indications for use

- neurogenic bowel dysfunction e.g. spinal cord injury, spina bifida, multiple sclerosis.
- Chronic constipation including the evacuation difficulties and slow transit constipation
- Chronic faecal incontinence

Use with care and close monitoring

Some types of patients/clients require additional supervision or monitoring at least until it is clear that irrigation is not producing any problems. This will depend upon the judgement of the assessing professional but may include:

- spinal cord injury at or above T6, monitor for autonomic dysreflexia until it is clear that the technique is well tolerated and does not promote provoke autonomic dysreflexia
- unstable metabolic conditions (frail, known renal disease or liver disease: may need to monitor electrolytes and possibly use a line rather than water for irrigation)
- under 18 years old (consultant paediatric consultant)
- inability to perform the procedure independently or comply with the protocol in the absence of close involvement of carers (e.g. due to physical disability, cognitive impairments, major mental or emotional disorder). Experience to date with irrigation by a carer suggest that it is no more problematic than self-irrigation forfeited the disabled individuals
- anorectal conditions that could cause pain or bleeding during the procedure (e.g. third-degree haemorrhoids, anal fissure)

Relative contraindications (use only after careful discussion with relevant medical practitioner and continence service)

- Pregnancy - existing or anticipated
- active perianal sepsis
- diarrhoea
- anal fissure
- large haemorrhoids that bleed easily
- faecal impaction
- past pelvic radiotherapy which has caused bowel symptoms
- known severe diverticular disease
- use of rectal medications for other diseases
- congestive cardiac failure
- anal surgery within the past six months

Absolute contraindications (irrigation should not be used)

- acute active inflammatory Bowel disease
- known obstructing rectal or colonic mass
- severe cognitive impairments
- rectal or colonic surgical anastomosis within the last six months

(Norton 2008)

For procedure see Appendix B. However, before commencing Trans-anal irrigation the following information must also be viewed:

Norton 2008 Guidelines for the use of rectal irrigation. Coloplast

Coloplast 2007 A patient/client's guide to Peristeen Anal Irrigation (DVD) Coloplast

Both accessible via the Continence Service or Coloplast 0800 132 787

**Faecal Incontinence Clinical Audit Standards
 As per NICE Quality Standard 54**

13/11/2015

Service area(s) to which standards apply:

	MH Inpatient (CAMHS)		Community CAMHS		CH Specialist Services
√	MH Inpatient (Adult)		C & YP Integrated Therapy		MH Specialist Services
√	MH Inpatient (Older)		School Nursing	√	MH Community Adult
√	MH Rehab & Recovery		Health Visitors	√	MH Community Older
√	Community Hospital		CH Rehab	√	Learning Disabilities
√	MIU		Musculo-Skeletal	√	District Nurses

FAECAL INCONTINENCE CLINICAL AUDIT STANDARDS

Standard		Reference	Compliance	Exceptions	Definitions
1	Adults in high-risk groups for faecal incontinence are asked in a sensitive way, at the time the risk factor is identified and then at times according to local care pathways, whether they have bowel control problems.	NICE QS54 (Quality Statement 1)	100%	None	<p>Audit of process: Proportion of adults in locally relevant groups at high risk of faecal incontinence who have been asked whether they have bowel control problems.</p> <p>High risk groups include:</p> <ul style="list-style-type: none"> • Frail older people • People with loose stools or diarrhoea from any cause
2	Adults reporting bowel control problems are offered a full baseline assessment, which is carried out by healthcare professionals who do not assume that symptoms are caused by any existing conditions or disabilities.	NICE QS54 (Quality Statement 2)	100%	None	<p>Baseline assessment includes:</p> <ul style="list-style-type: none"> • Medical history • Physical examination • Continence Assessment
3	Adults with faecal incontinence and their carers are offered practical support, advice and a choice of appropriate products for coping with symptoms during the period of assessment and for as long as they experience episodes of faecal incontinence.	NICE QS54 (Quality Statement 3)	100%	None	<p>Appropriate products include:</p> <ul style="list-style-type: none"> • Disposable body-worn pads in a choice of styles and designs, and disposable bed pads if needed • Pads in quantities sufficient for the person's continence needs (it is inappropriate to limit the number of pads given) • Anal plugs (for people who can tolerate them) • Disposable gloves • Cleansing and barrier products for

FAECAL INCONTINENCE CLINICAL AUDIT STANDARDS

Standard		Reference	Compliance	Exceptions	Definitions
					skincare.
4	Adults with faecal incontinence have an initial management plan that covers any specific conditions causing the incontinence, and diet, bowel habit, toilet access and medication.	NICE QS54 (Quality Statement 4)	100%	None	A management plan = plan of care
5	Adults who continue to experience episodes of faecal incontinence after initial management are offered referral for specialised management.	NICE QS54 (Quality Statement 5)	100%	None	Specialised management = Continence Service