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**Bowel Care**

**Policy and Procedures**

**(Adults)**

**February 2024**

**Document Profile**

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**Version Control/Changes Made**

|  |  |  |  |
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| **Date** | **Version** | **Summary of changes** | **Author** |
| Feb 2024 | 2 | Removal of:   * CNS responsibilities * [Appendix Trans Anal Irrigation Pathway](#_Toc43280133) * [Appendix Trans Anal Irrigation Referral and Assessment](#_Toc43280134)   Addition of Abdominal massage protocol  Addition of recommended treatment of constipation in adults (NICE)  Glossary of terms updated  References updated | Fiona Le Ber |

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# INTRODUCTION

## Rationale

“Bowel care is a fundamental area of patient care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients and residents, many of whom are hesitant to admit to bowel problems or to discuss such issues” (RCN 2023). Bowel care may include rectal interventions, this should only be carried out when there is a specific and adequate clinical indication.

The aim of bowel care interventions is to achieve a regular and predictable emptying pattern of the bowel at a socially acceptable time and place, avoiding incontinence, constipation and associated complications, while aiming to improve quality of life. (Spinal Cord injury Association (SIA) 2022).

## Scope

The policy applies to all clinical staff involved in adult bowel care. Bowel care covered by this policy includes rectal interventions such as:

* digital rectal examinations (DRE)
* digital rectal stimulation (DRS)
* digital removal of faeces (DRF)
* management of constipation
* faecal incontinence
* promotion of normal bowel habit

This policy does not cover rectal examination for the purpose of prostate assessment nor assessment of anorectal abnormalities.

This policy does not apply to stoma care.

## Role and Responsibilities

**The Chief Executive Officer (CEO)**

The CEO has overall responsibility for effective management of risk within the organisation. As accountable officer, the CEO is responsible for the effectiveness of the organisation’s systems of internal controls.

**Operational Leads**

Operational leads have responsibility for ensuring that the required structures and resources are in place to enable effective care for patients requiring DRE/DRS/DRF.

**Team leaders**

Team leaders have responsibility to ensure their staff are aware when it is appropriate to carry out these procedures and how to seek advice/guidance from clinicians competent to carry out the interventions.

They are also responsible for:

* enabling staff to attend training
* monitoring ongoing competence of staff
* overall care of the patient ensuring appropriate delegation of care where relevant

**Clinical Staff**

Clinical staff caring for patients who require DRE/DRS/DRF are responsible for:

* ensuring that this essential care is undertaken in compliance with this policy
* identifying learning needs
* maintaining competence

# POLICY

Bowel care should be carried out in a safe and consistent manner according to Family Nursing & Home Care’s (FNHC) Community Bowel Care Pathway (Appendix 1)

All care should be delivered with adherence to other relevant FNHC policies and procedures such as:

* Consent Policy
* Hand Hygiene and the use of Personal Protective Equipment Policy and Procedures

Staff will also act in accordance with relevant legislation and professional codes, including, amongst others, The Mental Capacity Act (MCA) 2005 and Nursing and Midwifery Council (NMC) Code (2015)

A high standard of bowel care, including assessment, treatment and management as well as rectal interventions should be carried out in accordance with this policy and its accompanying procedures. All clinicians undertaking bowel care should be competent in this area of practice.

The risk of complications associated with bowel management should be identified and managed appropriately

Practice should be standardised by clinical staff adhering to the requirements of this policy and accompanying procedures. All practice should be evidence-based, relevant and appropriate.

# PROCEDURE

The requirements of this policy will be achieved through the monitoring and maintaining of competence and compliance.

## Knowledge, Skills and Understanding

Bowel care is a fundamental area of patient care. Healthcare professionals should acquire knowledge, understanding and skills relating to the delivery of lower bowel care, as recommended in Bowel Care Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of Faeces (RCN. 2023). This should include:

* Anatomy and physiology
* Definitions and causes of bowel dysfunction
* Assessment, investigations (including DRE), diagnosis and prognosis
* End of life: Guidance for bowel care
* Conservative management and interventions to improve and maintain bowel function (including DRF and rectal irrigation)
* Pelvic floor muscle training, sphincter exercises, biofeedback, electrical stimulation and percutaneous tibial nerve stimulation
* Pharmacology and prescribing
* Surgical interventions
* Risk assessment

Healthcare professionals can acquire knowledge, understanding and skills in bowel care through training delivered by the FNHC Education Department and through independent study. Updates should be attended every 3 years.

## Assessment of Competence in Bowel Care

All practitioners undertaking bowel care must be able to demonstrate competence in bowel care assessment and interventions by being assessed as competent. In order to carry out invasive bowel care all staff should attend relevant training, achieve competency, and be working within their job description.

All community staff should have completed the following Adult Community Nurse Competencies:

* Competency Document for Digital Rectal Examination and administration of suppositories/ enema (Appendix 2)
* Competency Document for Digital Removal of Faeces/ Digital Rectal Stimulation (Appendix 3).

Acceptable performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff as per the FNHC Monitoring Clinical Practice Procedure policy. The NMC (2019) Standards and Proficiency for Registered Nurses declares “manual evacuation” as an essential skill for all nurses.

Bowel care, including digital rectal interventions, can be given by a personal assistant (PA), carer, nurse or another person chosen by or acceptable to the individual. A caregiver provided by a statutory agency or care agency should have received appropriate training, provided by a qualified healthcare practitioner competent in this area of care, and be deemed capable to meet the individual’s bowel care needs and promote their autonomy” (NMC 2019)

## Bowel Assessment and Management

“Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person’s capacity for independence and self-care and initiating appropriate interventions” (NMC 2018). Digital Rectal Examination (DRE) should be performed as part of the assessment of bowel dysfunction, and in conjunction with the assessment process (RCN 2023).

The first assessment includes a history of bowel continence and function and relevant clinical examinations. This requires a knowledge and understanding of the causes of poor bowel emptying, including types of constipation and faecal incontinence.

The use of rectal insertion of water or enemas using irrigation syringes, nasogastric (NG) tubes, red rubber catheters or urinary catheters are not recommended due to existing safety issues with these current practices: including the risk of injury to the rectal mucosa (Macygin 2018). Nurses must be aware of any potential harm associated with enema administration, such as trauma to the anal mucosa, and must be accountable for their actions (NMC 2018).

If the initial holistic Health & Social Care assessment identifies bowel dysfunction, healthcare staff will complete: The Community Bowel Care Pathway (Appendix 1) which includes:

* Bowel Assessment (Appendix 4)
* Signs and Symptoms Questionnaire (Appendix 5)
* Symptom Profile/ management Checklist (Appendix 6)
* 14 day bowel diary (Appendix 7 )
* Initiating a care plan for the:
* management of Neurogenic Bowel (Appendix 8)
* management of constipation (Appendix 9)
* management of bowel incontinence (Appendix 10)
* management of opioid induced constipation in palliative care (Appendix 11)

## Bowel Care in Neurogenic Conditions (including spinal cord injury)

Damage to the central nervous system (brain and spinal cord) has a profound impact on the function of the large bowel and on the maintenance of faecal continence.

“Neurogenic bowel dysfunction” is the term used for the combination of impaired continence (caused by impairment of the sensory and motor control of the ano-rectum) and risk of severe constipation (caused by slowing of stool transit through the bowel). Without intervention, faecal incontinence and chronic constipation may occur, with reduced life quality and secondary complications. Neurogenic bowel management aims to deliver planned interventions to achieve effective bowel evacuation at specific frequency to avoid faecal incontinence and constipation, (Spinal Injury Association 2022) (Appendix 12)

Central neurological conditions include:

* Multiple sclerosis
* Parkinson’s disease
* Stroke
* Cerebral palsy
* Cauda equina syndrome
* Spina bifida
* Spinal cord injury (SCI) (traumatic or infection, inflammation, vascular events or malignancy (MASCIP 2022)

Failure to provide digital rectal procedures for SCI patients who require them may lead to:

* Reduced quality of life
* Faecal Incontinence
* Constipation/ Faecal Impaction
* Megacolon/megarectum
* Haemorrhoids
* Rectal Prolapse
* Anal Fissures/ tears
* Perforation of the bowel
* Autonomic Dysreflexia
* Medical emergencies leading to potential damaging outcomes such as haemorhage, seizures and cardiac arrest (Spinal Injury Association 2021, MASCIP 2022) (Autonomic Dysreflexia Alert Card. Appendix 13)

Not meeting this care need could be a breach of the Nursing and Midwifery Council Code of Conduct (The Code 2018). Moreover, failure to meet the needs of individuals for effective bowel management may be neglect, under the definition of abuse in the NMC statement on ‘Practitioner-Client Relationships and the Prevention of Abuse’ (MASCIP 2021)

## Trans-Anal Irrigation

The terms Trans- anal Irrigation and Rectal Irrigation are used interchangeably in current literature. This is a specialist procedure and should only be commenced following consultation with the Hospital Consultant and Colorectal Clinical Nurse Specialist at HCS.

Trans-anal irrigation with warm water is used to facilitate evacuation of stool in a number of scenarios including chronic constipation, faecal incontinence, obstructive defaecation, or neurogenic bowel dysfunction. It is usually initiated once other less invasive methods of bowel management have been tried and deemed unsuccessful.

It is important that a full individualised assessment is undertaken by a specialist nurse prior to commencement this should include checks for any contraindications.

Trans Anal Irrigation should be performed using specialised equipment designed for the procedure.

Patients are encouraged to be self-caring if able, following a period of assessment, training and competence by colorectal Clinical Nurse Specialist at HCS. If the patient is unable to perform irrigation independently then they will remain under the care of the District Nursing team, following a period of training and achievement of competence.

## End of Life Bowel Care

Nursing practice in palliative and end of life care, may differ across various care settings, it is important that nurses adopt a preventive approach through effective monitoring so that when bowel symptoms present, prompt treatment and management is initiated to ensure effective and appropriate interventions.

Constipation is most frequent among patients treated with opioids with 40 to 50% affected. It can significantly impact the patient’s quality of life and may be a cause of restlessness in 80% of end of life patients. Constipation is more common in women and the elderly. Diarrhoea is less common, occurring in less than 10% of palliative patients, (Palliative Care Clinical Practice Council 2018) (Appendix 16)

# MONITORING COMPLIANCE

Attendance at relevant training will be monitored by Line Managers. Effectiveness of practice will be assessed through the use of the FNHC staff competency assessment framework and through discussion of cases with the Team Leader where this is indicated. Compliance with this policy may also be included in the organisational audit programme where a need is identified.

# CONSULTATION PROCESS

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Date** |
| Elspeth Snowie | Head of Quality and Safety | August 2023 |
| Tia Hall | Operational lead Adult Services | September 2023 |
| Katie Ferguson | Colorectal CNS HCS | August 2023 |
| Karkala Pai | Associate Specialist HCS | August 2023 |
| Rachel Foster | Quality & Performance Development Nurse | September 2023 |

# EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and ‘religion, belief, faith and spirituality’ as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

**Always:**

* Putting patients first
* Keeping people safe
* Have courage and commitment to do the right thing
* Be accountable, take responsibility and own your actions
* Listen actively
* Check for understanding when you communicate
* Be respectful and treat people with dignity
* Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See overleaf for the Equality Impact Assessment for this policy.

## EQUALITY IMPACT SCREENING TOOL

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Stage 1 - Screening** | | | | | | | | | | |
| Title of Procedural Document: Bowel Care Policy for Adults | | | | | | | | | | |
| Date of Assessment | | January 2024 | | Responsible Department | | | | | Adult Nursing Service | |
| Completed by | Fiona Le Ber | | | Job Title | | | Education and Development Co-ordinator | | | |
| **Does the policy/function affect one group less or more favourably than another on the basis of**: | | | | | | | | | | |
|  | | | | | | **Yes/No** | | **Comments** | | |
| Age | | | | | | No | |  | | |
| Disability  *(Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia)* | | | | | | No | |  | | |
| Ethnic Origin *(including hard to reach groups)* | | | | | | No | |  | | |
| Gender reassignment | | | | | | No | |  | | |
| Pregnancy or Maternity | | | | | | No | |  | | |
| Race | | | | | | No | |  | | |
| Sex | | | | | | No | |  | | |
| Religion and Belief | | | | | | No | |  | | |
| Sexual Orientation | | | | | | No | |  | | |
| **If the answer to all of the above questions is NO, the Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 2.** | | | | | | | | | | |
| **Stage 2 – Full Impact Assessment** | | | | | | | | | | |
| **What is the impact** | | | **Level of Impact** | | **Mitigating Actions**  **(what needs to be done to minimise / remove the impact)** | | | | | **Responsible Officer** |
|  | | |  | |  | | | | |  |
| **Monitoring of Actions** | | | | | | | | | | |
| The monitoring of actions to mitigate any impact will be undertaken at the appropriate level | | | | | | | | | | |

# IMPLEMENTATION PLAN

|  |  |  |
| --- | --- | --- |
| **Action** | **Responsible Person** | **Planned timeline** |
| Policy to be uploaded to the Procedural Document Library | Education and Development Administrator | Within 2 weeks following ratification |
| New / updated documents to be uploaded onto EMIS | Head of Information Governance and Systems | Within 2 weeks following ratification |
| Email to all staff | Education and Development Administrator | Within 2 weeks following ratification |
| Upload policy (+/- assessment tool) to Virtual College and allocate to relevant staff | Education and Development Department | Within 2 weeks following ratification |
| Relevant staff to sign (via Virtual College) that they have read and understood policy. | All staff notified via Virtual College. | Within 2 months of notification |
|  |  |  |
|  |  |  |

# GLOSSARY OF TERMS

**Abdominal massage:** ‘Pressure is applied intermittently to the abdomen following the usual lie of the colon in a clockwise direction; using the back or heel of the hand or a tennis ball or similar, pressure is applied and released firmly but gently in a continuous progression around the abdomen’ ‘Abdominal massage significantly shortens total colonic transit times, reduces abdominal distension and increases frequency of bowel movement. 15 mins a day for SCI individuals can reduce transit times’

**Anal abscess:** an acute painful swelling, containing pus, next to the anus. It is caused by an infection in a gland close to the anus. The usual treatment is drainage to let out the pus. To find out more about this condition click here.

**Anal cancer:** a cancer that develops in the lining or skin of the anus itself. It is a different type of cancer from bowel cancer. The commonest treatment is a combination of chemotherapy and radiotherapy. Some people may require surgery. To find out more about anal cancer click here.

**Anal fissure:** a split in anal lining which usually causes pain on passing stools and sometimes bleeding. Most are treated with simple creams a few require surgery. To find out more about this condition click here.

**Anal fistula:** an abnormal connection between the lining on the anal canal (back passage) and the skin near the anus. Most will require surgery. To find out more about this condition click here.

**Anal incontinence:** an inability to control the passage of gas, liquid or solid stools from the back passage. The definition should also include the need to rush to a toilet to prevent having an accident (urgency).

**Anal sphincter:** the ring of muscle surrounding the anus which controls opening and closing of the anus

**Anismus:** also known as pelvic floor hypertonicity, pelvic floor dyssynergia, dyssynergic defaecation, or paradoxical puborectalis contraction, is a condition in which the external anal sphincter and the puborectalis muscle, one of the core pelvic floor muscles, contract rather than relax during an attempted bowel movement

**Anastomosis:** the joining together of two ends of healthy bowel after the section of diseased bowel has been resected by the surgeon.

Anterior resection surgical removal of all or part of the rectum, with a join made between the two ends of the bowel. This is most usually carried out for cancers in the rectum

**Areflexic bowel:** is also known as a flaccid bowel. This refers to injury or damage to the conus medullaris or cauda equina at or below the first lumbar vertebrae.

**Autonomic Dysreflexia:** ‘This is a potentially life-threatening hypertensive medical emergency that occurs most often in spinal cord injured individuals with spinal lesions at or above the 6th thoracic vertebrae’

**Borborygmi:** audible rumbling abdominal sounds due to gas gurgling with liquid as it passes through the intestines.

**Bowel care:** Activity undertaken to regularly evacuate stool from the rectum and sigmoid colon.

**Bowel Management:** Regular, pre-emptive individually developed and prescribed series of interventions carried out by the patient/nurse/attendant/carer to prevent faecal incontinence and constipation, usually in individuals with neurogenic bowel dysfunction.

**Bowel programme:** A combination of interventions in a given order conducted to achieve the predictable evacuation of stool from the bowel.

**Cauda Equina Syndrome:** ‘(CES) is caused by compression of the nerves of the cauda equina, causing one or more of the following: bladder and/or bowel dysfunction, reduced sensation in the saddle (perineal) area, and sexual dysfunction, with possible neurological deficits in the lower limbs (motor/sensory loss, reflex change).’

**Conus Medullaris Injuries:** This occurs at the conical end of the spinal cord around the level of the lower end of the first lumbar vertebrae

**Celiac disease:** is an autoimmune disorder in which gluten triggers a negative reaction. Gluten is a type of protein found in certain grains, including wheat, rye, and barley. Eating gluten when you have celiac disease, causes the immune system to respond by attacking the inner lining of your small intestine.

**Colitis:** Inflammation of the colon which may have several different causes.

**Colonic volvulus:** twisting of the colon.

**Crohn’s disease:** a type of inflammatory bowel disease which can affect both the small and large intestine.

**Diverticular Disease:** a common condition where pouches develop in the lining of the colon.

**Gastrocolic Reflex:** A reflex response to the introduction of food or drink into the stomach, resulting in an increase in muscular activity throughout the gut, which can result in movement of stool into the rectum ready for evacuation. It can be utilised by planning bowel evacuation 15-30 minutes after a meal – it is thought to be strongest in response to breakfast. Patients are advised to make use of the gastrocolic reflex by eating or drinking 15-30 minutes before attempting to empty their bowels.

**Gastroparesis:** Nerve or muscle damage in the stomach leading to delayed gastric emptying.

**Haemorrhoids:** Swellings of the blood vessels within the anus. The common symptoms are bright red bleeding, pain, itching, swelling and prolapse whilst passing a stool or at other times.

**Helicobacter pylori (H. pylori):** a bacterium that can damage stomach and duodenal tissue, causing ulcers and stomach cancer.

**Hemicolectomy:** removal of part of the colon either the right or the left side.

**Hirschsprung disease:** a rare condition where abnormalities in the bowel muscles prevent it from contracting normally and pushing the faecal matter through which results in obstruction and dilation of the bowel.

**Intestinal pseudo-obstruction:** a digestive disorder where the intestines are unable to contract normally and push food through the digestive system. This results in symptoms similar to an obstruction and hence the name pseudo-obstruction. The walls of the affected gastrointestinal tract becomes thin and the muscles that control its motion start to degenerate.

**IBD or Inflammatory Bowel Disease:** a general name for conditions like ulcerative colitis and Crohn’s disease that cause inflammation in the gut. Common symptoms include diarrhoea, weight loss, fatigue and cramping. May be related to problems with the immune system attacking healthy tissue.

**IBS or Irritable Bowel Syndrome:** a long term condition symptoms include constipation, diarrhoea, and abdominal cramps.

**Imperforate anus:** a birth defect in which the anal canal fails to develop, treated surgically.

**Megacolon:** extreme bowel distention.

**Melaena:** abnormal black tarry stool that has a distinctive odour and contains digested blood.

**Mucus:** a natural lubricant produced by the bowel. It can be produced in excess in some conditions such as colitis.

**Neurogenic bowel:** is the term used to describe dysfunction of the colon (constipation, faecal incontinence and disordered defecation) due to loss of sensory and motor control or both as a result of central neurological disease or damage. Neurogenic bowel dysfunction may be reflex, areflexic or mixed.

**Pruritus ani:** a condition that causes intense itchiness around the anus.

**Proctocolectomy:** the surgical removal of the colon and rectum.

**Prolapse:** the protrusion of the rectum (or intestine) through the anus (or abdominal wall). Usually caused by relaxation of normal supporting structures.

**Pinworm** small, threadlike parasitic worms mainly in colon and rectum.

**Radiation proctitis:** bleeding, mucous and bloody discharge, spasm of the rectal wall, urgency, and incontinence due radiation-induced damage to the rectum. Late symptoms result from scarring of the rectal and anal muscles with loss of some of the small blood vessels. The rectum becomes stiff and noncompliant and abnormal blood vessels may develop.

**Reflexic bowel:** A reflexic bowel is also known as a spastic bowel. This refers to injury or damage to the spinal cord or the brain at or above the twelfth thoracic vertebrae

**Rectal stimulant:** These are pharmacology agents used, such as a suppository or enemas, which is inserted into the rectum to stimulate reflex evacuation of stool. Not usually used in individuals with areflexic bowel function.

**Shigellosis:** an infectious disease which affects the intestinal tract and is caused by the Shigella bacteria. The condition may be severe, especially in children, but may be asymptomatic in some cases. The disease can be transmitted through faecal-oral contact.

**Short Bowel Syndrome:** disorder of shortened bowel usually from bowel surgery.

**Stimulant laxative:** Directly stimulates peristalsis which pushes the stool along in the bowel / large intestine. This medication is taken 8-12 hours prior to a planned bowel evacuation.

**Tenesmus:** a persistent (abnormal) urge to empty the bowel.

**Valsalva manoeuvre:** voluntary increasing pressure in the abdominal cavity with the diaphragm and abdominal muscles to bear down on the rectum to facilitate defecation.

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# APPENDICES

| **Appendix** | **Title** | **Document Link** |
| --- | --- | --- |
| **1** | **Community Bowel Care Pathway** |  |
| **2** | **Competency Document Digital Rectal Examination / Insertion of Suppositories / Enemas** |  |
| **3** | **Competency Document Digital Removal of Faeces /Digital Rectal Stimulation** |  |
| **4** | **Bowel Assessment (also on EMIS)** |  |
| **5** | **Signs and Symptoms Questionnaire** |  |
| **6** | **14 Day Bowel Diary** |  |
| **7** | **Digital Removal of Faeces/ Digital Rectal Stimulation** |  |
| **8** | **Care Plan Neurogenic Bowel Dysfunction** |  |
| **9** | **Care Plan for Constipation** |  |
| **10** | **Care Plan for Bowel Incontinence** |  |
| **11** | **Care Plan for Opioid Induced Constipation / Palliative Care** |  |
| **12** | **Neurogenic Bowel Care Pathway** |  |
| **13** | **Autonomic Dysreflexia Flash Card** |  |
| **14** | **End of Life Care Guidance for Constipation** |  |
| **15** | **Medicines Associated with Constipation** |  |
| **16** | **Laxatives for the Treatment of Constipation** |  |
| **17** | **Definition of Constipation and Diarrhoea** |  |
| **18** | **Bristol Stool Chart** |  |
| **19** | **Correct Positioning** |  |
| **20** | **Drugs that Induce Diarrhoea** |  |
| **21** | **Abdominal Massage** |  |
| **22** | **Recommended Treatment of Constipation in Adults (NICE 2023)** |  |

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