Title:	**Assessment and Treatment of Bowel Symptoms for Adults**	Ref No: 1900 Version:7
Directorate:	Education/Professional Practice	Classification: Policy
Responsible for review:	Tina Mitchell or Bladder and Bowel Specialist Nurses	Due for Review: March 2018 Document Control
Ratified by:	Care and Clinical Policy Group	
Applicability:	All patients as indicated	

Contents

1 Purpose: This policy aims to provide a framework which will:

1.1 Identify the training, competency and skills required, for Registered Nurses (RN's), Skilled Non-Registered Nurses (SNR's) and Allied Health Professionals (AHP's) to become competent when undertaking bowel care.

1.2 Identify which bowel procedures RN's and SNR's can undertake in general practice.

1.3 Identify specific techniques and practices which require Specialist Nurse Intervention.

1.4 Identify medication pathways.

1.5 Identify patient pathways for continence assessment and care.

2 Introduction: Constipation and faecal incontinence affect people of all ages, and can impact on all aspects of a patient's life. The United Kingdom Continence Society (UKCS) and NHS England Excellence in Continence Care Framework (2015) identifies the need for continence services to be integrated across primary and secondary care 'to effect best care and to guide people to the help they need to manage their bladder and bowel problems'. NHS England also recognises that there can be psychological issues for patients with continence problems which affect body image and personal relationships. They have developed standards for continence care which cover not only staffing and training, but development of resources and services to implement standardised continence care across the country.

2.1 This policy describes the care and interventions that should be delivered to patients with bowel related symptoms:

- To standardise bowel care across the Trust and to ensure practice is evidence based and reflects national Guidelines
- To establish best practice and a framework for education and training to provide optimum bowel care treatment based on patient choice.

3 Roles and Responsibilities: Staff are responsible for accessing clinical skills policies via the intranet, that cover their area of practice, prior to undertaking clinical procedures.

4 Consent: A consent form must always be completed before undertaking invasive bowel procedures. (Appendix 7)

4.1 Staff must refer to the Trust Mental Capacity Act Policy, Trust Consent Policy and Mental Capacity Act via the Trust intranet, if they have any concerns regarding performing clinical skills.

5 Aims and Objectives: This policy will cover assessment, intervention, and evaluation of bowel care procedures for adults. It will identify training availability and content across the Integrated Care organisation (ICO)

6 Assessment Tool and Integrated Care Pathway (ICP)

6.1 The Bladder and Bowel Teams' Bowel Care Pathway (Appendix1) and Constipation Treatment Algorithm (Appendix 6) and related documents for bowel management will be available on the intranet. The Bladder and Bowel Care Specialist Nurses are available for advice and support between 9 – 5 pm Monday –Friday. Telephone 01626 324685.

6.2 **Assessment for Faecal Incontinence/Constipation (ICP):**

The nurse undertaking the admission assessment, should establish a current bowel habit using the Rome II Guideline and Bristol Stool Chart (Appendix 3 and the constipation signs and symptoms checklist (Appendix 4). Assessment by all practitioners should include:

- Medical History
- Underlying disease
- Obstetric History
- Normal bowel habit for the patient
- Diet including fibre intake
- Medication, including over the counter medication

6.3 Assessment will identify the correct treatment pathway to follow. Prior to initiating any interventions or planning further investigations, such as abdominal x-rays, obtain the patients' medical practitioners' written consent.

7 Irritable Bowel Syndrome (IBS): IBS is one of the most common gastrointestinal disorders, with a prevalence estimated between 10% - 20% of the population presenting to primary care with a wide range of symptoms that require prompt referral to gastroenterology services. Key management is to establish a positive diagnosis, working with the patient for a long-term person centred partnership to manage their symptoms. This change in practice from a professional led service to patient involvement is a 'Strength Based' approach to care as defined in TSDFT Policy: *Delivering Strengths Based Approaches – Social Work in Torbay (2015)* and *NICE Guideline ng27 (2015)*

7.1 In patients who meet the diagnostic criteria for IBS, doctors will perform the following tests to rule out other diagnoses:

- Full blood count (FBC)
- Erythrocyte Sedimentation Rate (ESR) or plasma viscosity

- C-reactive protein (CSR)
- Antibody testing for celiac disease, endomysial antibodies (EMA) or tissue transglutaminase (TTG)

7.2 The following tests should not be done to confirm IBS:

- Ultrasound
- Rigid/flexible sigmoidoscopy
- Colonoscopy: barium enema
- Thyroid function test
- Faecal ova and parasite test
- Faecal occult blood
- Hydrogen breath test (for lactose intolerance and bacterial overgrowth)

6.3 **Exceptions:** Patients with pain on defecation or a change in bowel pattern who have blood and/or mucus in their stool or complain of any other abnormality of defecation e.g. incomplete emptying or tenesmus (painful and ineffectual straining) and those meeting the Bowel Assessment criteria for referral for suspected cancer, follow the process in Appendix 2. These patients should be referred to the Medical practitioner and discussed with the Bladder and Bowel Specialist Nurses.

7. Intervention and Treatment: Treatment is based on the outcome of the care pathway assessment and staff should follow the appropriate algorithm (Appendix 6)

7.1 Where the patient is unable to follow the care pathway as detailed in the variance column, then a referral should be made to the Bladder and Bowel team or to a Colorectal Surgeon.

7.2 The specialist nurses can assist with assessment of faecal incontinence and act as an advocate for further investigation and treatment.

7.3 Initial nursing intervention should include the following:

Intervention	Rationale
Encourage mobility	Helps simulate peristaltic action of the bowel
Education with regard to fluid intake	Good hydration prevents excess water reabsorption and hardened faeces in the colon
Dietary advice including fibre intake	Fibre increase stool bulk and gut transit time
Provision of toileting aids e.g. raised toilet seat, footstool for correct positioning. Assessment should be arranged as appropriate.	Correct positioning avoids straining and ensures patient is relaxed
Provision of incontinence pads following full assessment for eligibility of free NHS pad provision	To ensure containment of both odour and faeces
Encourage patients to attempt defecation within half an hour of eating breakfast	To take advantage of the gastrocolic reflux (a response to food/drink in the stomach enhancing muscular activity in the large bowel)
Information from: www.bladderandbowelfoundation.org	

8. Medications for constipation and faecal incontinence:

8.1 Patients with regular constipation should discuss treatment options with their General Practitioner (GP), Nurse Prescriber, Practice Nurse or bladder and bowel specialist nurses

8.2 Medications depending on symptoms, are recommended by the Bladder and Bowel Care Service, together with a list of medications associated with constipation (Appendix 5) and advice on laxative and enema use (Appendix 8)

8.3 These must be prescribed in line with the British National Formulary (BNF) and Local Formulary Guidelines.
8.4 Registered Nurses (RN's) should ensure that drug therapy for patients with regular constipation is documented in the individual's care plan.
8.5 Pharmacists and prescribing advisors will provide further advice on medications and regimes if required.

9. Containment:
9.1 It has been shown that provision of low cost alternative treatments, and cost-effective continence products, are offset against the cost of absorbent incontinence pads, surgery, and social care interventions. *All Party Parliamentary Group for Continence Care Report (2011)*
9.2 Product information for managing faecal incontinence can be obtained from Continence Products Catalogue, the Drugs Formulary and procurement.

10. Terminally ill patients: Constipation, faecal impaction and overflow, are common causes of faecal incontinence in palliative care due to reduced mobility, function and opioid drug regimes. Nurses need to use the integrated care pathway (Appendix 1) to ask sensitive questions and plan continence care before the terminal stage of illness is reached. The treatment and management of bowel care should have a multidisciplinary approach with close liaison with the palliative care team.

11. Abdominal X-Rays: Referral for an abdominal x-ray should only be requested following discussions with a medical practitioner. They should be performed if the patient has any of the following:
- Suspected obstruction
- Suspected perforation
- Suspected severe acute colitis
- Occasionally to differentiate between constipation and overflow diarrhoea, incontinence and diarrhoea and faecal incontinence due to other causes.

12. Digital Rectal Examination (DRE): This procedure can be performed by a suitably trained nurse to identify:
- The presence or absence of faeces in the rectum: The amount and consistency in order to assess for faecal overloading
- Anal tone, both resting and under voluntary contraction in those patients with bowel dysfunction associated with lax pelvic muscle tone or faecal incontinence
- A "gaping anus" being an obvious sign of a lax anal sphincter
- The presence of a rectal mass
- Nurses must have had training and successfully been assessed as competent to undertake DRE before undertaking rectal examinations without supervision (Appendix 6)
- The procedure and consent forms for DRE are attached to this policy (Appendices 7, 7a,7b))

13 Neurogenic Bowel Management:
13.1 **Digital Stimulation and abdominal massage, and Patient Specific Manual Digital Evacuation (DME) of Faeces** can cause autonomic dysreflexia due to stimulation of the vagus nerve, traumatic bleeding and perforation of the colon. These are specialist procedures and can only be undertaken with supervision by a bladder and bowel specialist nurse, or after attending their training and being assessed as competent using their criteria.

14 Anal irrigation: Staff and patient training and assessment must be provided by a professional specialist in this procedure.

14.1 **The trainee must:**
- Ensure they gain consent each time they perform the skill for a patient.

- Be able to list the contraindications and precautions for undertaking this skill.
- Recognise emergency signs such as anal or rectal bleeding, and severe autonomic dysreflexia.
- Know who to inform, and have the means to contact them in case of emergency.
- Understand the Bristol Stool Chart criteria
- Understand how to record the results of the irrigation.
- Know how to order equipment on behalf of the patient if necessary.

14.2 **Contraindications for anal irrigation:** Anal irrigation must **NOT** be used in the following situations:

- Known anal or colorectal stenosis.
- Colorectal cancer
- Acute inflammatory bowel disease.
- Within 3 months of anal or colorectal surgery
- Ischaemic colitis
- Individual patient factors must also be considered.

14.3 **Precautions:** The first patient use of any anal irrigation system must be undertaken or overseen by a specialist nurse or clinician. It is not appropriate for trainees or newly assessed staff to undertake this task.

15 Training and Supervision

15.1 **Manual Digital Evacuation (MDE) will not be taught by the Clinical Skills Facilitators due to the high risks to patient health when performing this intervention.**

15.2 The Bladder and Bowel Specialist Nurses will only undertake this procedure, or provide carer training for patients whose preferred bowel management is MDE, or it is their only method of bowel evacuation.

15.3 Where MDE is an established part of a patients bowel management programme, it should be maintained until reassessment and review has been undertaken by the specialist nurses or colorectal medical team.

15.4 Bowel management training must include assessment, suppository insertion, and the use of micro-enemas.

15.5 **Phosphate enemas are contraindicated** for a number of patients and conditions, and should only be used following thorough assessment and in absence of other methods of bowel evacuation. This should be a client specific intervention, not a first line of intervention, therefore patient specific training would be required with the bladder and bowel specialist nurses or experienced nurses undertaking this intervention regularly for named patients.

15.6 Training should be repeated every 3 years for Trust Staff, or earlier in response to changes in practice or clinical incidents.

15.7: Following training, staff should be assessed using the Bowel Care Practical Procedures Summative Assessment Book – available on the Trust intranet

16. Clinical Advice and Support:

- Patient's hospital medical practitioner/General Practitioner (GP)
- Bladder and Bowel Specialist Nurses 01626 324685
- Trust Policies

17. Patient Advice and Support:

- NHS Continence Advice Service
- Bladder and Bowel Foundation Charity www.bladderandbowelfoundation.org

Telephone; 0845 345 0165 they have a 24 hour helpline, and confidential helpline form 9am – 5pm Monday to Friday plus a Councillor Helpline 0870 770 3246
Address:
Bladder and Bowel Foundation
SATRA Innovation park
Rockingham Road
Kettering
Northants
NN16 9JH

18. Monitoring and Auditing

18.1 Monitoring of standards or audits undertaken to monitor compliance will be undertaken by the Bladder and Bowel Specialist Nurse Team and Colorectal Specialists

19. References:

- **The Royal Marsden Hospital Manual of Clinical Nursing Procedures** (8th Edition) Dougherty and Lister (2011) Wiley-Blackwell pubs

- **.NHS England Excellence in Continence Care:** *Practical Guide for Commissioners, providers, health and social care staff and information for the public* November 2015

- **Cost- Effective Commissioning for Continence Care:** *All Party Parliamentary Group For Continence Care Report* (2011)

- **Delivering Strengths Based Approaches – Social Work in Torbay.** Community Divisional Board. J.Williams, AD Social Care. (30/10/2015)

- **Rectal Drug Administration in Adults: how, when, why?** Nursing Times 24.02.16/vol112 No.8/www.nursingtimes.net

- **Mental Capacity Act (2005).** *Statutory Code of Practice/Policy/Practice Guidance/IMCA Referral Forms and Guidance.* Accessed Jan 2016 at: http://icare/operations/mental capacity act/Pages/default.aspx

20. Equality and Diversity

This document complies with Torbay and South Devon Healthcare Foundation Trust (TSDFT) Equality and Diversity statements.

21. Further Information:

This policy has been reviewed by Debbie Yarde, as the Acting Professional Lead Bladder & Bowel Care Department, North Devon Partnership Trust, Exeter, because the Bladder and Bowel Specialist Team work across North and South Devon.

22. Links to policies:

- Guidelines for Neurogenic Bowel Management (MASCIP) 2014
- TSDFT Consent Policy
- TSDFT Supervision, Accountability and Delegation of Activities to Skilled Not Registered Staff: *A guideline for Registered Practitioners and Support Workers* (August 2015)
- TSDFT Delegation of Level 3 Tasks to Skilled Not Registered (SNR) workers, not employed by Torbay and South Devon Foundation Trust Policy

23. Best Practice Information:

This document is linked to the TSDFT Bowel care Practical Procedures Summative Assessment Book for competency.

24. Appendices;

1. Bowel Continence Care Pathway Assessment
2. Referral Guidelines for suspected cancer
3 Rome Criteria and Bristol Stool Chart
4. Constipation signs and symptoms
5. Medicines associated with constipation
6. Adult Constipation Algorythm
7. Procedure and consent forms for Digital Rectal Examination
8. Laxative and enema use advice

APPENDIX 1

BOWEL CONTINENCE CARE PATHWAY ASSESSMENT

Patient Name: **Date of Birth:**		**NHS No:** **Clinic Base/Ward:**	**Date of Assessment:**
Patient Address:			
GP/Consultant: **GP Address:**			
PREVIOUS MEDICAL HISTORY (Tick appropriate box/s)			
Diabetes	Dementia	Urological	Gynaecological
Neurological	Cardiovascular	Learning Disability	Mental Health
Physical Disability	Neoplasm	Back Problems	Arthritis
Allergies/Sensitivities:			
Current Medication:			
Other (State)			
Urinary Problems (If Yes Please State then go to Urinary Care Pathway) YES/NO			
Recent Surgery YES/NO (State)		Has the patient had a catheter YES/NO	

WHAT HAS BEEN THE EFFECT ON THE PATIENT'S LIFE?

How much does your bowel problem bother you?

Not at all **a little** **moderately** **a lot** *(circle the choice)*

What has been the effect on your life of your bowel problem?

	COMMENTS REGARDING PATIENT CARE
If patient has any signs of undiagnosed bleeding, or black tarry stool and is not taking ferrous sulphate, stop pathway and refer to doctor immediately.	
Using obstruction checklist (Appendix 11), observe	

patient for any signs of obstruction. If present, stop pathway and refer to doctor immediately.	
Establish patient's bowel activity using Bristol Stool Chart (Appendix 5). SCORE:	
Patient drinks ..... amount of fluid per day.	

BOWEL CONTINENCE CARE PATHWAY ASSESSMENT CONTINUED

Patient Name: **Date of Birth:**	**NHS No:** **Clinic Base/Ward:**	**Date of Assessment:**

	COMMENTS REGARDING PATIENT CARE
Obtain written consent to any invasive procedure e.g. PR or manual evacuation.	
If patient has a neurogenic bowel problem read information sheet and refer to Bladder and Bowel Care Nurse Specialists.	
Establish constipation using signs and symptoms chart and record findings. If constipated as defined by Rome criteria, follow algorithms 1 & 2 and refer to 5 step management of constipation.	
Report any abnormal changes in bowel habit.	
If faecal incontinence follow algorithm 3.	
Use fibre scoring chart to establish fibre levels. If 12 or less give information sheet and advice on increasing fibre in diet.	
If patient unable or unwilling to comply, consider fibre supplements.	
If patient is in discomfort consider abdominal massage technique.	
Administer and record appropriate treatment.	
Review in 2-4 weeks and record any further care in patient's notes.	
If any queries or concerns about further care and if no improvement following use of this care pathway refer to Continence Nurse Specialist on 020 7530	

3310.	

FULL NAME (Print)	DESIGNATION	SIGNATURE	DATE

Appendix 2

Referral Guidelines for Suspected Cancer

Lower Gastrointestinal Cancer

Refer a patient who presents with symptoms suggestive of colorectal or anal cancer to a team specialising in the management of lower gastrointestinal cancer, depending on local arrangements e.g. Torbay, Plymouth, RD&E Hospitals

Urgent referral

Refer urgently patients:

- Aged 40 years and older, reporting rectal bleeding with a change in bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more
- Aged 60 years and older, with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms
- Aged 60 years and older, with a change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding
- Of any age with a right lower abdominal mass consistent with involvement of the large bowel
- Of any age with a palpable rectal mass (intraluminal and not pelvic; a pelvic mass outside the bowel would warrant an urgent referral to a urologist or gynaecologist)
- Who are men of any age with unexplained iron deficiency anaemia and a haemoglobin of 11g/100 ml or below
- Who are non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin of 10g/100ml or below

APPENDIX 3

Rome Criteria II

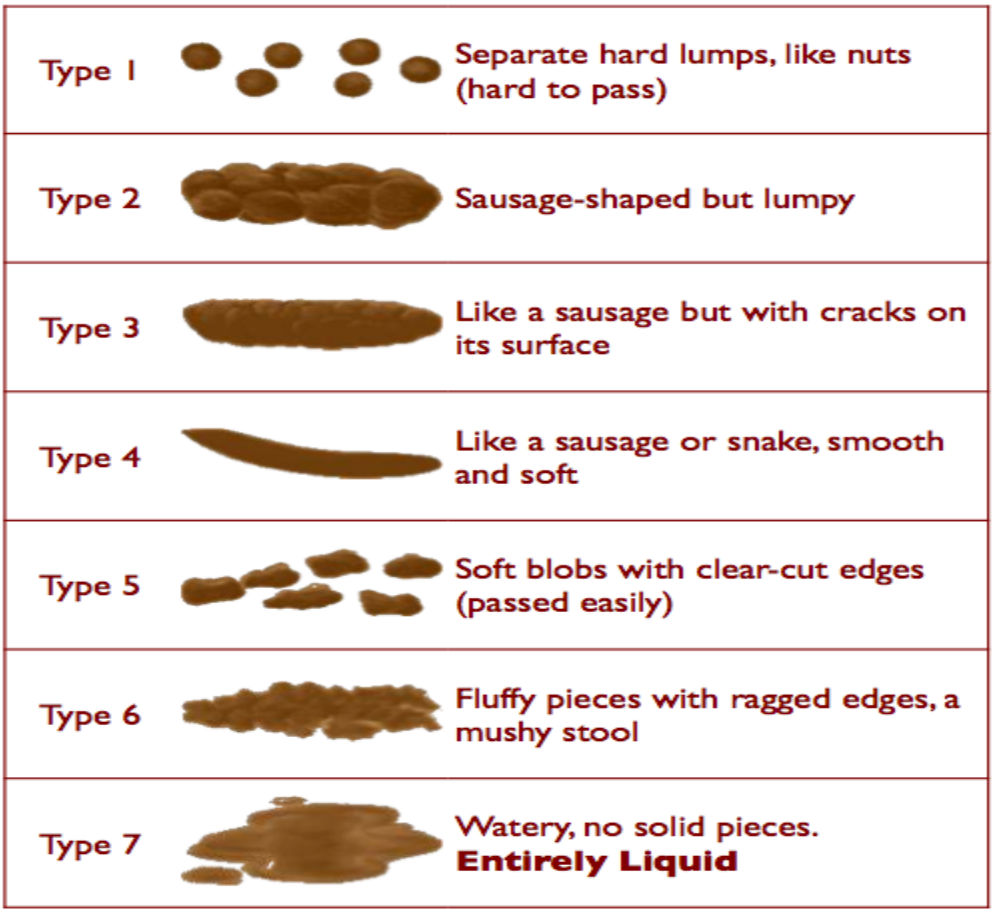
< 2 or fewer bowel movements per week

Or

> 2 or more of the following symptoms:

I. Straining on 1 in 4 occasions
II. Hard stools on 1 in 4 occasions
III. Feeling of incomplete evacuation on 1 in 4 occasions

Bristol Stool Chart



Appendix 4

CONSTIPATION SIGNS AND SYMPTOMS

FOLLOW UP CHECK LIST

Patient Name: **Date of Birth:**	**NHS No:** **Clinic Base/Ward:**	**Date of Assessment:**

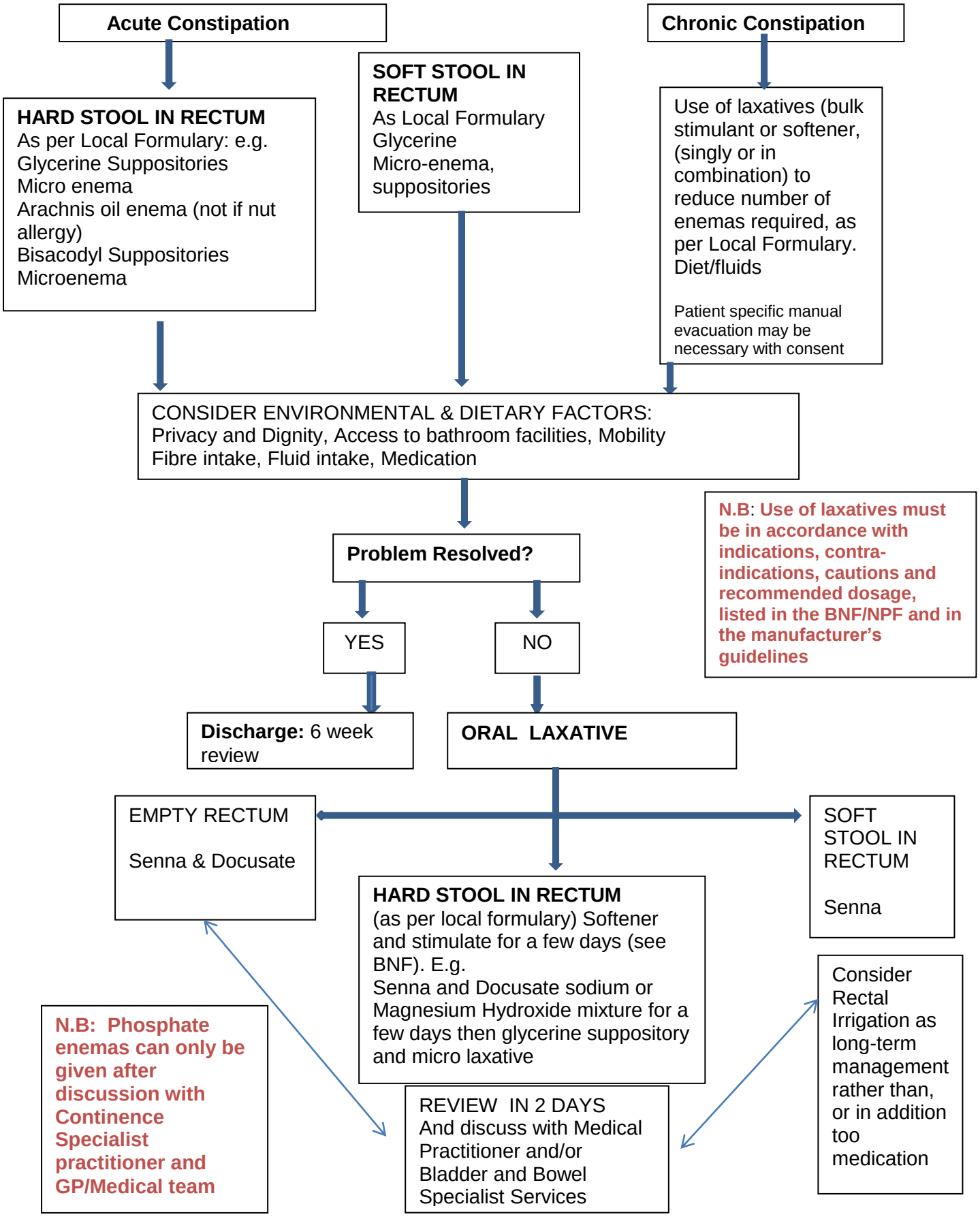
SYMPTOM	VISIT 1	VISIT 2	VISIT 3
Have your bowel habits recently changed? If yes, when did it start?			
Do you have to make an effort and strain to pass bowel motion?			

Do you feel that your bowel motions are not frequent/ regular enough? How often do you go and how often would you like to go?			
Do you have any pain or discomfort; state where, when and how much.			
Do you have the feeling that your bowel is not empty or you need to go again quickly?			
Bristol Stool Chart score:			
Any other comments:			

APPENDIX 5 Medicines Associated with Constipation

Aluminium Antacids Aluminium hydroxide *Anticholinergics* **Atropine** Hyoscine Oxybutynin Tolterodine Propiverine Ipratropium bromide Oxitropium bromide *Antiepileptics* Carbamazepine *Antidepressants* Amitriptyline Clomipramine Dothiepin Imipramine Lofepramine Venlafaxine Nortriptyline Trimipramine Tranylcypromine Moclobemide Phenelzine	**Antiparkinson** Orphenadrine* Benzhexol* Benztropine Procyclidine **Antipsychotics** Chlorpromazine Flupenthixol Haloperidol Perphenazine Prochlorperzine Promazine Thioridazine Trifluoperazine Risperidone Sulpiride Clozapine **Calcium supplements** Calcium gluconate Calcium lactate Calcium carbonate	**Diuretics** Bendrofluazide Chlorothiazide Indapamide Frusemide Bumetanide Amiloride Spironalactone Co-amilozide **Gastrointestinal cytoprotectant** Sucralfate **Iron tablets** Ferrous sulphate Ferrous fumarate Ferrous gluconate **Opiates** Morphine Buprenorphine Codeine Dextropropoxphene Dihydrocodeine Fentanyl Methadone Pentazocine Pethidine Tramadol

APPENDIX 6: Adult Constipation Algorythm


Acute Constipation
Chronic Constipation
HARD STOOL IN RECTUM
As per Local Formulary: e.g.
Glycerine Suppositories
Micro enema
Arachnis oil enema (not if nut allergy)
Bisacodyl Suppositories
Microenema
SOFT STOOL IN RECTUM
As Local Formulary
Glycerine
Micro-enema, suppositories
Use of laxatives (bulk stimulant or softener, (singly or in combination) to reduce number of enemas required, as per Local Formulary.
Diet/fluids
Patient specific manual evacuation may be necessary with consent
CONSIDER ENVIRONMENTAL & DIETARY FACTORS:
Privacy and Dignity, Access to bathroom facilities, Mobility
Fibre intake, Fluid intake, Medication
Problem Resolved?
YES
NO
N.B: Use of laxatives must be in accordance with indications, contra-indications, cautions and recommended dosage, listed in the BNF/NPF and in the manufacturer's guidelines
Discharge: 6 week review
ORAL LAXATIVE
EMPTY RECTUM
Senna & Docusate
SOFT STOOL IN RECTUM
Senna
HARD STOOL IN RECTUM
(as per local formulary) Softener and stimulate for a few days (see BNF). E.g.
Senna and Docusate sodium or Magnesium Hydroxide mixture for a few days then glycerine suppository and micro laxative
N.B: Phosphate enemas can only be given after discussion with Continence Specialist practitioner and GP/Medical team
REVIEW IN 2 DAYS
And discuss with Medical Practitioner and/or Bladder and Bowel Specialist Services
Consider Rectal Irrigation as long-term management rather than, or in addition too medication

APPENDIX 7

PROCEDURE & CONSENT FORM FOR DIGITAL EXAMINATION OF THE RECTUM

N.B This document does not contain The Manual Evacuation of Faeces procedure, and Neurogenic Bowel Procedures, which must only be undertaken by Registered Nurses who have attended specialist training by the Bladder and Bowel Care Team, and meet their competency criteria.

The competency documents will be provided by the Bladder & Bowel Specialist nurses following your training

You must access and follow the guidance below for any patient where there are concerns about mental capacity to inform their decision making

- **Mental Capacity Act** 2005 Statutory Code of Practice/Policy/Practice Guidance/ Assessment and Recording Tool and Guidance/ IMCA Referral Forms and Guidance accessed at:

  http://icare/Operations/mental_capacity_act/Pages/default.aspx

Appendix 7a Digital Examination of the Rectum

EQUIPMENT REQUIRED:
Non – latex disposable gloves, water-soluble lubricant, tissues, a small clinical waste bag, disposable bed pad, apron, a commode or bedpan may be needed for those patients unable to use a toilet.

STAGES	RATIONALE
1. Explain the procedure to the patient.	To ensure the patient understands the procedure and gives valid consent
2. Create privacy.	This will also help the patient to relax, and maintain dignity.
3. The patient is positioned on the disposable bedpad, in the left lateral position with knees flexed so as to expose the anus, where possible.##	To expose the anus and allow easy insertion of a finger for examination. ## Some patients may be unable to adopt this position
4. Wash hands and put on disposable gloves and apron.	To minimise cross-infection and protect hands for examination purposes.
5. Lubricate your gloved index finger.	To facilitate easier insertion and minimise patient discomfort
6. Warn patient when you are ready to insert your finger	To promote patient relaxation.
7. Examine the perianal area at this point for any abnormalities. See main text for aspects to consider.	. To inform management and treatment decisions.
8. Insert gloved finger slowly into the patient's rectum and undertake examination for: a) Presence of faecal matter. b) Presence of Non-faecal mass, bleeding, discharge or prolapse c) Anal tone at rest and with a voluntary contraction.	a)To ascertain presence and consistency of faecal matter as per Bristol Stool chart criteria b)To identify any abnormalities and report to medical staff to inform treatment To assess anal sphincter tone- internal and external.
9. Slowly withdraw finger from the patient's rectum when finished. **At this point, rectal medication can be administered if appropriate**. Clean anal area	To minimise patient discomfort. To relieve constipation To reduce infection risk and skin excoriation
10. Remove gloves and wash hands	To reduce risk of cross infection
11. Dispose of all clinical equipment used according to local policies.	To reduce inconvenience to patient and to save time.
12. Make patient comfortable and offer toileting facilities	Examination may stimulate the patient to defecate.
13. Record findings in nursing documentation and communicate finding with their doctor and the patient if appropriate.	To avoid duplication of care and promote effective multidisciplinary communication. To ensure the patient understands the results of the examination and associated care if appropriate

Ref: Royal Marsden Hospital Manual of Clinical Nursing Procedures (8th ***Edition)***

FORM **Appendix 7b**

DIGITAL RECTAL EXAMINATION

I ……

Of (Address)…….

……..

Hereby give my consent for the following procedures to be carried out:

	YES
EXAMINATION OF MY BOWEL……	
INSERTION OF SUPPOSITORIES……...	
GIVING OF AN ENEMA……	
MANUAL EVACUATION……..	
ABDOMINAL MASSAGE……..	
DIGITAL STIMULATION……..	

The nature and likely side effects of the above procedure/s has/have been explained to me.

I realise that I am free to withdraw my consent at any time and that this will not affect my future care.

SIGNATURE*…… **DATE……**

SIGNATURE OF NURSE…… **DATE……**

*** If the patient is unable to give informed consent then a direction from the responsible medical practitioner should be obtained.**

THIS CONSENT IS VALID FOR A 6 MONTH PERIOD

APPENDIX 8

Laxative and Enema Use

Laxative use is the most common treatment option for constipation (Petticrew et al, 1999). However, in a review undertaken by this team of researchers, little evidence was found of marked differences in effectiveness between laxatives and, in particular, there appeared to be no evidence to support the NHS trend towards prescribing the more expensive stimulant laxatives e.g. bisacodyl. If concerns about symptoms such as abdominal pain and stool consistency are paramount there is evidence that fibre and bulk laxatives are likely to be beneficial, providing that there is sufficient fluid intake and there are no contra-indications. The practitioner should consider the possible effects and side effects of the type of laxative prescribed, their mechanism and speed of onset of action. The length of time for which they are used may influence the risk of adverse effects of laxative.

a) There is inadequate evidence to establish whether fibre is superior to laxative or if one laxative is superior to another in treating constipation.

b) Laxatives should be used in accordance with the recommended indications, contra-indications, cautions and doses listed in the BNF/NPF and in the manufacturer's Summary of Product Characteristics (SPC).

Rectal Laxatives

Many individuals, especially those with spinal cord injury or neurological problems, also require rectal medication although the use of suppositories and enemas, but this is not an essential part of bowel management for all spinal cord injured people. Suppositories should be administered blunt end first, however, the *Royal Marsden (2015)* has now added a caveat to this advice, for which there is little proof they are more effective if administered this way, and suggest insertion is patient specific depending on comfort and results. Manufacturers still advise tapered end insertion
Those listed below are commonly used:

- Glycerine suppository – irritates the colon wall, encouraging peristalsis and providing lubrication. Acts within 20-30 minutes. Most commonly used and mildest suppository
- Bisacodyl suppository (Dulcolax)- stimulates peristalsis. Acts within 30-60 minutes. Raises blood pressure slightly. May cause headache or abdominal cramps and 'accidents'
- Carbalax – Gives off carbon dioxide gas when wet in the rectum – this stimulates the rectum wall, stimulating peristaltic activity. Availability may be limited during summer months due to temperature/storage problems; this may lead to withdrawal of this product from the market in the future.
- Microlax enema – contains a stimulant laxative (Sodium Citrate). For treatment of acute constipation only. **NOT** recommended for routine maintenance
- Large volume enemas are not generally used after spinal cord injury as due to lack of sensation in the rectum there is a risk of damaging or perforating the bowel. They present a risk of autonomic dysreflexia, and many spinal cord injured patients cannot retain large volume enemas.

Phosphate Enemas Can cause:

- Trauma to the anal or rectal mucosa by the enema nozzle
- Local inflammation to tissue due to the phosphate
- Abnormal blood chemistry when there is local inflammation
- Problems with fluid shift in people with heart failure.

Phosphate enemas are contraindicated for patients with the following conditions:

- Colitis
- Proctitis
- Inflammatory bowel conditions
- Inflamed haemorrhoids
- Acute gastro-intestinal conditions
- Anal/rectal surgical wounds/trauma
- Haematological clotting disorders
- Those who have had radiotherapy to lower pelvic area
- Heart Failure
- Known electrolyte imbalance.

Practitioners/administrators should consider other options before phosphate enemas.

25. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	1900		
Document title:	**Assessment and treatment of Bowel Symptoms for Adults**		
Purpose of document:	To provide a framework for identifying procedures and pathways for effective bowel management		
Date of issue:	October 2013	**Next review date:**	March 2018
Version:	6	**Last review date:**	March 2016
Author:	Tina Mitchell		
Directorate:	Education and Professional Practice		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:			
Date approved:			
Links or overlaps with other policies:	All SDHCFT Trust Strategies, policies and procedure documents		

	Please select	
	Yes	*No*
Have you considered using Equality Impact Assessment?	☐	☒
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☒
Does this document have training implications? *If yes please state: Clinical Skills Training*	☒	☐
Does this document have financial implications? *If yes please state:*	☐	☒
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☒	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
17/11/11	1	Adapted from North Devon NHS Policy following merger with TCT	Care & Clinical Policies
16/12/11	2	Review following DN Lead consultation	Care & Clinical Policies
13/09/13	3	Review to include links for specialised bowel training and procedures	Care and Clinical Policies
25/10/2013	4	To include amendments to the Mental Capacity Act Policy	Care and Clinical Policies
26/10/2015	5	Merge to become Integrated Care organisation TSDFT. New logo and minor text changes	Care and Clinical Policies
07/03/2016	6	Changes in Practice, and reformatted into ICO policy template	Care and Clinical Policies.
13/04/2016	7	Amended following consultation	Care and Clinical Policies
29/04/16	7	Published on ICON	

26.

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

27.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? **NO**	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? **None**	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☒	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*	Developed with advice from Bladder and Bowel Specialist Nurses		