| Document Type: | Policy | |
|---|---|---|
| Reference Number : **2463** | Version Number: **1** | Next Review Date: **22 June 2023** |
| Title: | **Bowel Care for Adults** | |
| Document Author: | Bladder & Bowel Care Specialist Nurse | |
| Applicability: | All patients as defined in policy | |

## Contents

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# 1. Purpose

**1.1.** This policy aims to identify the responsibilities and processes for providing bowel care to adults, ensuring that this care complies with evidence based best practice and legal responsibilities bowel care covered by this policy includes rectal interventions such as digital rectal examinations (DRE), digital rectal stimulation (DRS) and digital removal of faeces (DRF), management of constipation, faecal incontinence and promotion of normal bowel habit.

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

**1.2.** This policy does not apply to stoma care

**1.3.** (See Associated Documentation for links to Torbay and South Devon NHS Foundation Trust website sections.)

All care will be delivered according to the Trust Consent Policy, Infection Control Policy, Assessment and Maintenance of Clinical Competences Policy; and in accordance with relevant legislation and profession codes, including, amongst others The Mental Capacity Act (MCA) 2005 and Nursing and Midwifery Council (NMC) Code (2015).

**1.4.** The policy applies to all clinical staff employed by the Trust.

# 2. Introduction

Ensuring patients achieve and maintain a normal and regular bowel habit, free from incontinence, is a fundamental part of basic care. Many patients are unable to achieve this for a variety of reasons and require assessment, appropriate treatment and review to ensure their optimum health and independence are maintained. This policy is designed to support staff in achieving these goals for their patients in both acute and community settings.

# 3. Roles and Responsibilities

**3.1.** The **Chief Nurse** is responsible for the provision of safe nursing care, including access to relevant guidance and training for staff.

**3.2.** **Managers** are responsible for the implementation of this policy within their ward/department, including ensuring staff are aware of the policy; have access to relevant education and achieve competence.

**3.3.** **Each Healthcare Professional** is accountable for his/her own practice and will be aware of the legal and professional responsibilities relating to their competence and work within their job description and within the Code of Practice of their professional body.

**3.4.** When a **Registered Nurse** delegates bowel care to a non-registered healthcare worker or carer, the registered nurse will remain accountable for this decision (NMC The Code. *Professional standards of practice and behaviour for nurses and midwives*, 2015) including the appropriateness of the delegation, ensuring the person who does the work has the competence and understanding to follow your instructions, is able to achieve the required standard, and that adequate supervision and support is provided.

**The Bladder and Bowel Care Service** provide specialist guidance, support and education. The Service can be contacted at

Newton Abbot Hospital (for South Devon)
West Golds Road
Jetty Marsh
TQ12 2TS
Tel 01626 324685

Franklyn House (for Exeter, East and Mid Devon)
Franklyn Drive
St Thomas
Exeter EX2 9HS
Tel 01392 208478
ndht.bladderandbowel@nhs.net

Crown Yealm House (for North Devon)
Pathfields Business Park
South Molton
EX36 3LH
Tel 01392 675336

# 4. Main Body of the Document

**4.1.** The aims and objectives:

- To provide the knowledge, skills and understanding needed by staff to provide bowel care.
- How to assess and manage bowel problems and identify emergencies and complications.
- To provide specific advice for bowel care for patients with specific problems such as spinal injury, neurological disease, dementia and those receiving end of life care.
- To provide seamless bowel care for patients moving between hospital and community settings.

**4.2.** The document is for all health care professionals involved in providing bowel care for patients and covers normal bowel function, assessment and identification of bowel problems, how to treat them and promote regular bowel movements. The document also includes trouble shooting.

**4.3.** The document includes: Normal Bowel Habit, Constipation, Faecal Incontinence, Laxatives, rectal medication, Digital Rectal Examination (DRE), Digital Manual Removal of Faeces (DRF).

**4.4.** The document is based on NICE guidelines on faecal incontinence: management, RCN guidelines on management of lower bowel dysfunction and Spinal Injuries Association.

**4.5.** This document is relevant for hospital and community staff.

**4.6.** The document will help support staff in the provision of both basic and invasive bowel care to ensure patients continue to receive seamless care regardless of their location within the Trust.

**4.7.** This policy does not cover children, rectal examinations for the purpose of prostate assessment nor assessment of anorectal abnormalities.

**4.8.** Healthcare professionals involved in bowel care will be able to provide patients with assessment and care appropriate to their needs so that regular bowel habit is maintained. Risk to spinal injury patients will be minimized.

# Bowel assessment and management

## Elimination assessment in first/holistic assessment

Bowel care deals with an intimate and private area of the body and requires discretion and sensitivity in the assessment and care delivery process. Embarrassment may prevent patients from reporting a problem, so careful history taking and monitoring should be undertaken. Bowel dysfunction is very common yet under-reported and can severely impact on quality of life. Problems are often linked to ageing, underlying disease, medical conditions and medications.

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

Best practice includes completion of a **Bowel Signs and Symptoms Questionnaire** (Appendix 3) and **Bowel Diary** (Appendix 6) for all patients if only to establish normal. bowel pattern. If first assessment identifies bowel dysfunction, complete:

**Bowel Continence Care Pathway** (Appendix 1)

The above includes the need to identify red flag symptoms e.g. for suspected cancer (2015 NICE guidelines re suspected cancer referrals https://www.nice.org.uk/guidance/ng12) and bowel care emergencies and complications including faecal impaction, bowel obstruction (see Appendix 2), perforation, Autonomic Dysreflexia (AD), strangulated hernia, undiagnosed rectal bleeding and undiagnosed diarrhoea.

Pathway assessment documents include:

Signs and Symptoms Questionnaire (Appendix 3), Bowel Diary (Appendix 6), Rome Constipation criteria (Appendix 4), Fibre scoring sheet (Appendix 5), Food diary (Appendix 8), medications affecting bowel checklist (Appendix 13)

Pathway bowel management documents Dietary/lifestyle management (Appendices 10, 11, 12)

For laxatives/suppositories/enema advice, consult the South and West Devon Formulary and Referral which can be accessed on ICON at: https://southwest.devonformularyguidance.nhs.uk/

Pathway bowel care interventions guidance DRE, DRS, DRF, (Appendices A, B and C)

## Rectal/trans-anal irrigation

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 tried after other less invasive methods of bowel management have been tried. It is important to carry out a full individualised assessment first, with checks for any contraindications.

## Bowel Care Emergencies/Complications

Bowel care emergencies and complications are very rare but it is important to be aware of these and to act quickly to reduce further complications.

**Bowel obstruction** can be associated with no bowel activity or lots of painful activity to try to bypass a mechanical obstruction, abdominal pain and distension, vomiting, possible dehydration and requires immediate medical attention. Main causes are colon cancer, adhesions, scarring from infection.

**Perforation** is a hole in the bowel which allows leakage of intestinal contents into the abdominal cavity. Perforation could cause peritonitis which if not treated can cause almost immediate death (Medline Plus, 2007). Causes of perforation include a diverticular or cancerous lesion, colonoscopy or sigmoidoscopy (very rare), ischemia of the bowel possibly caused by a strangulated hernia.

**Strangulated hernia** occurs when the blood supply to the bowel is cut off and may lead to ischemia, necrosis and gangrene. Main symptoms are nausea, vomiting and severe pain.

**Diarrhoea**.

There are many causes of diarrhoea. Beware mistaking faecal overflow for diarrhoea. If faecal overflow is a consideration a digital rectal examination and stool charts will be required for diagnosis. Where consent cannot be obtained medical advice should be sought. Any patient experiencing unexplained diarrhoea requires full assessment and diagnosis before treating. This assessment should consider 'red flag' symptoms of blood, mucous and pain and a medicines review as well as the possibility of the diarrhoea being infectious and contagious. Ensure dehydration is recognised and managed. The following Trust policies should be consulted:

Infection Control – Operational – Ref 0783

Clostridium Difficile Policy – Ref 0914

Waste
https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/Waste%20Management%20Policy.pdf

Long standing or sporadic diarrhoea that has been fully investigated and cannot be rectified may be managed with anti-motility medication given under medical or specialist supervision. Patients with mental capacity may also find anal plugs helpful in managing their symptoms.

**Undiagnosed rectal bleeding** can have a number of causes, including haemorrhoids, anal fissure, proctitis, diverticular disease, colitis, polyps, ulceration or a life threatening malignancy. The type of blood (fresh or dark) and where seen (on the toilet paper, on wiping, or on the faeces) needs to be ascertained. Recent change in bowel habit, unintentional weight loss, rectal bleeding, anaemia, increased mucus and wind not associated with any lifestyle changes may be due to malignancy, inflammation or ischemia (Steele, 2007). An individual with any of these symptoms should inform their GP, see NICE guidance on suspected cancer https://www.nice.org.uk/guidance/ng12

**Faecal impaction** is a complication of constipation, and if not treated can cause an obstruction of the bowel. Impaction may be accompanied by "overflow" diarrhoea where looser stool leaks round an unmoving faecal mass. Macrogol 3350 with electrolytes is licensed to treat faecal impaction and may need to be given, on prescription only, in combination with rectal stimulants such as an enema.

**Autonomic dysreflexia (AD)**
Refer to policy: Autonomic Dysreflexia, prevention or management of spinal injury patients with spinal injury at T6 or above.

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

See www.mascip.co.uk : for latest guidelines.

https://www.spinal.co.uk: for 2018 Statement on Spinal Cord Injury Bowel Management.

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.

Central neurological conditions include:

- Multiple sclerosis
- Parkinson's disease
- Stroke
- Cerebral palsy
- Cauda equina syndrome
- Spina bifida
- Spinal cord injury

Neurogenic bowel management aims to deliver planned interventions to pre-emptively achieve effective bowel evacuation at specific frequency to avoid faecal incontinence and constipation. Interventions are usually chosen following assessment of individual needs and will usually start with the most simple and least invasive options (defaecation routine and posture, diet and fluids, maximising mobility, teaching to use abdominal muscles, laxatives/constipating medication) and progress as necessary. Development of a care plan is likely to involve specialists, especially in the case of spinal cord injury, where neurogenic bowel care will be planned prior to discharge from the inpatient spinal cord injury centre. A high spinal cord injury (T12 and above) will result in a reflex bowel which may need less intervention, for example suppositories/mini enemas and/or digital rectal stimulation. A low spinal cord injury will result in a flaccid areflexic bowel and may require DRF.

Staff responsible for the bowel management of patients with a spinal cord lesion need to be familiar with the National Patient Safety Agency alert from July 2018 accessed via https://improvement.nhs.uk/news_alters/patients-at-tisk-of-autonomic-dysreflexia/

Once the individual bowel management programme is established, actual day-to-day bowel care may be delegated to other carers.

Abdominal massage may be helpful.

**Infection Control including**
**Clostridhttps://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G0914.pdfium difficile**

See Clostridium Difficile Policy on ICON – Ref 0914

**How to deal with the problem: Core guidance (HPA, 2009)**
It is important that when a patient presents with diarrhoea, the possibility that it may have an infectious cause is considered. Patients with suspected potentially infectious diarrhoea should be isolated.

## Bowel care for people who may lack mental capacity

Care will be delivered in line with the Trust's Mental Capacity Act Policy

http://nww.torbaycaretrust.nhs.uk/Operations/mental_capacity_act

**Advice specific to Dementia:** difficulties with using the toilet, accidents and incontinence can all be problems for people with dementia, particularly as the condition progresses. However, incontinence is not an inevitable consequence of dementia. Someone with dementia is more likely to have accidents, problems with the toilet or incontinence than a person of the same age without dementia.
There are many reasons including:

- not being able to react quickly enough to the sensation of needing to use the toilet and failure to get to the toilet in time, sometimes due to mobility problems caused by other conditions
- not being able to communicate the need to go to the toilet; inability to find, recognise, or use the toilet
- not understanding a prompt from someone to use the toilet
- not managing the personal activities of toileting, such as undoing clothing and personal hygiene
- not letting others help with toileting – perhaps because of embarrassment or not understanding the offer of help
- not making any attempt to find the toilet – this could be due to lack of motivation or depression, or because the person is distracted
  embarrassment after an accident, which the person unsuccessfully tries to deal with. Wet or soiled clothes or faeces may be put out of sight (for example, wrapped up and put at the back of a drawer) to be dealt with later, but then forgotten.

In addition to help with fluid intake, diet and maximising mobility to manage bowel problems, the following ideas may help someone to find, recognise and use the toilet more easily:

- Help the person identify where the toilet is. A sign on the door, including both words and a picture, may help. It will need to be clearly visible, so place it within the person's line of vision and make sure the sign is bright so it's easy to see. Help the person know when the toilet is vacant; leaving the toilet door open when not in use makes this obvious. Check the placement of mirrors in the bathroom. The person with dementia may confuse their reflection for someone else already in the room, and not go because they believe the toilet is occupied.
- Help the person make their way easily to the toilet. Move any awkwardly placed furniture or prop ajar any doors that are hard to open. The room and the route to the toilet should be well lit, especially at night. Movement sensor lights in the bedroom and bathroom can help at night.
- Make using the toilet easier for people with mobility problems. Aids such as handrails and a raised toilet seat may help.
- Help the person identify and use the toilet. A contrasting colour (eg black seat on a white base) can make it easier to see.

- Help the person undo, remove and replace clothing easily. Trousers with an elasticated waist (eg tracksuit bottoms) are often easier than zips. Some people find Velcro™ fastenings easier to use than zips or buttons.
- If getting to the toilet becomes too difficult because of mobility problems, an aid such as a commode may be useful. Using this will require the person to recognise the commode, be willing to use it, and find it an acceptable piece of furniture
- The person should have privacy in the toilet, but make sure they don't have difficulty managing locks. Some people with dementia struggle with this. To avoid the person locking themselves in, disable locks or ensure you can open them quickly from the outside.

## Bowel Care at End of Life

www.rcnendoflife.org.uk covers the fundamentals of nursing care at the end of life and includes advice on constipation. Specialist palliative care professionals will also provide guidance.

**Constipation** at end of life is very common and can have serious effects on quality of life and worsen other symptoms, especially pain. Patients taking opiate medication are likely to need regular laxatives. Opioid induced constipation needs a regime including osmotic and stimulant laxatives and bulk forming laxatives should be avoided. Co-danthramer is indicated for constipation at end of life (only) as per the South and west Devon Formulary and Referral which can be accessed on ICON at:

https://southwest.devonformularyguidance.nhs.uk/search-results?q=co-danthramer

Assessment needs to include bowel routines, access to toilet or commode, pain when the using toilet, difficulty eating and drinking (including mouth ulcers or thrush). Laxatives may help, together with increased fluid intake, offering fluids little and often if necessary, encourage mobility if an option, dietary fibre or purees and fruit juices.

**Diarrhoea** at end of life may occur due to malabsorption, medications, constipation with overflow, poor appetite, gastrointestinal bleeding. Quality of life considerations are essential. When dietary or pharmacological options are ineffective or not possible, containment in the form of anal plugs (for slight incontinence), pads or faecal collection systems (especially if immobile or unconscious)

### Knowledge, skills and understanding needed for bowel care

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, including (from RCN guidance for nurses *Management of lower bowel dysfunction, including DRE and DRF.* Sept 2012 3rd ed.):

- consent, privacy, dignity (which may include consideration of best interest decisions in line with the Mental Capacity Act (MCA) 2005)

- anatomy and physiology of the lower gastrointestinal tract
- definitions and causes of bowel dysfunction
- assessment, investigations (including DRE) diagnosis and prognosis
- interventions to improve and maintain bowel function (including DRF)
- pharmacology and prescribing
- bowel emergencies and complications
- risk assessment
- infection control

## Suggested sources of learning

Recommended resources include the following, it is important to ensure the most up-to-date versions are accessed. The best way to do this is online:

- www.rcn.org.uk :

  RCN guidance for nurses *Management of lower bowel dysfunction, including DRE and DRF.* Sept 2012 3rd ed.
  RCN guidance for nurses *The management of diarrhoea in adults* 2013

- https://www.mascip.co.uk:

  *Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. Initiated by the Multidisciplinary Association of Spinal Cord Injured Professionals*. Sept 2012.

- Management of Constipation, via ICON South and West Devon Formulary and Referral Site.
  https://southwest.devonformularyguidance.nhs.uk/formulary/chapters/1.-gastrointestinal

- www.nice.org.uk has pathways, guidance, standards on faecal incontinence.
  NICE Guideline CG49 Faecal incontinence in adults; management
  NICE Guideline CG61 Irritable bowel syndrome in adults: diagnosis and management

- Public Health England have guidance on the reduction of Gram-negative bacteraemias including those caused by E-Coli
  - https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/

- **Alzheimers Society** for dementia resources for continence care

- St Marks Hospital in Harrow, Middlesex, a tertiary bowel hospital www.stmarkshospital.nhs.uk has a comprehensive range of patient information leaflets, e.g. on constipation / diverticular disease in the website Patients and Visitors section.

## 5. Training and Supervision

Basic bowel care training is provided by the Education and Development team. See Appendix 14. Training on Trans anal Irrigation and Digital Removal of Faeces can be provided by the Bladder & Bowel Care Service. Registered healthcare professionals who are already competent to perform these tasks can support colleagues and sign off competencies. Once training has been undertaken it is the responsibility of the individual to remain competent.

## 6. Monitoring and Auditing

### 6.1. Monitoring Compliance with and the Effectiveness of the Policy Standards/Key Performance Indicators

Key performance indicators comprise

- Documentation Audits
- Complaints and incident reports

### Process for Implementation and Monitoring Compliance and Effectiveness

Implementation and monitoring compliance with this policy will be the responsibility of the Service/Clinical Lead for each service/speciality

Bowel care pathways and care plans will be included in the Trust's nursing documentation audit processes (including consent processes and documentation).

Trust wide patient surveys will include information and feedback on the patient experience, including how well patients were informed about their condition and care plan, procedures and treatments.

Where non-compliance is identified, education, support and advice will be made available (if appropriate) by managers within the framework of an action plan to improve compliance.

## 7. References and links to policies

The following polices are all available on ICON via https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Pages/clinical-effectiveness.aspx

Infection Control – Operational Ref: 0783

Clostridium Difficile Policy Ref: 0914

Prevention or Management of Autonomic Dysreflexia in patients with a spinal cord injury at T6 and above. Ref 0901

Waste Policy

https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/Waste%20Management%20Policy.pdf

Mental Capacity Act Policy

https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G1915.pdf

## 8. Equality and Diversity

**8.1.** This document complies with Torbay and South Devon NHS Foundation Trust's Equality and Diversity statement.

## 9. Further information

Links to policies.

See Section 7.

**9.1.** Best Practice Information
Best practice dictates that a patient has their bowel requirements assessed and documented as soon as possible after hospital admission or being placed on a community nursing caseload. Where intervention or a treatment programme is required this will be provided in consultation with the patient. Established treatment programmes should continue for the patient regardless of care setting unless there is clear evidence that it needs to be reviewed. Spinal injury patients should not be put at risk through failure to receive established bowel management.

**9.2.** Forms/Recording Documentation

See Appendices

## 10. Appendices

**Appendix 1 – Bowel Continence Care Pathway**
**Appendix 2 – Symptoms and Causes of Obstruction**
**Appendix 3 – Signs and Symptoms Questionnaire (Bowels)**
**Appendix 4 – Rome Criteria II for Constipation**
**Appendix 5 – Fibre Scoring Sheet**
**Appendix 6 – Bowel Diary**
**Appendix 7 – Bristol Stool Chart**
**Appendix 8 – Food Diary**
**Appendix 9 – Fibre Content of Everyday Foods**
**Appendix 10 – Sitting Position for Opening Bowels**
**Appendix 11 – Looking After Your Bowels**
**Appendix 12 – The Management of Constipation**
**Appendix 13 – Medicines Associated with Constipation**
**Appendix 14 – Clinical Skills Assessment for Bowel Management**
**Appendix 15 – Competencies for the Assessment of Patients Requiring Bowel Care (including Digital Rectal Examination, Digital Rectal Stimulation and Digital Removal of Faeces)**

**Appendix A – Standard Operating Procedures – Procedure for digital rectal examination (DRE) (MASCIP, 2012)**

**Appendix B - Standard Operating Procedures – Procedure for digital rectal stimulation (DRS) (adapted from MASCIP, 2012)**

**Appendix C - Standard Operating Procedures – Procedure for digital removal of faeces (DRF) (adapted from MASCIP, 2012)**

**Appendix 1**

# Bowel Continence Care Pathway

| **Patient's Name**<br><br>**Date of Birth:** | **NHS No:**<br><br>**Clinic Base / Ward:** | **Date of Assessment:** |
|---|---|---|
| **Patient Address:** | | |
| **GP/Consultant:**<br><br>**GP Address:** | | |

| **1. 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 problems?

| | **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 2), observe patient for any signs of obstruction. If present, stop pathway and refer to doctor immediately. | |
| Establish patient's bowel activity using Signs & Symptoms Questionnaire (Appendix 3) | |

| | | |
|---|---|---|
| Meets Rome Criteria Questionnaire Constipation? (Appendix 4) | YES / NO | |
| Fibre Score (Appendix 5)<br>If <13 advise on dietary fibre | | |
| Provide / Review Bowel Diary (inc Bristol Stool Chart) (Appendix 6 & 7) | | |
| **Patient's Name**<br><br>**Date of Birth:** | **NHS No:**<br><br>**Clinic Base / Ward:** | **Date of Assessment:** |
| | **COMMENTS REGARDING PATIENT CARE** | |
| Establish constipation using signs and symptoms chart and record findings. If constipated as defined by Rome criteria, refer to 5 step management of constipation (Appendix 12). | | |
| Obtain consent to any invasive procedure (e.g. PR or manual evacuation) in line with Trust Policy | | |
| Use Fibre Scoring Chart (Appendix 5) to establish fibre levels. If 12 or less give information sheet and advice on increasing fibre in diet (Appendix 9) | | |
| If patient unable or unwilling to comply, consider fibre supplements. | | |
| If patient is in discomfort consider abdominal massage technique. | | |
| Give patient 'Looking after your bowels' Leaflet (Appendix 11) | ☐ (Tick box) | |
| Review in 2-4 weeks and record any further care in patient's note. | | |
| If any queries or concerns about further care and if no improvement following use of this Care Pathway discuss with Bladder and Bowel Care Team | | |

| FULL NAME (Print) | DESIGNATION | SIGNATURE | DATE |
|---|---|---|---|
| | | | |
| | | | |

**Appendix 2**

# Symptoms and Causes of Obstruction

| SYMPTOMS AND CAUSES OF OBSTRUCTION | | | | |
|---|---|---|---|---|
| | SMALL BOWEL | LARGE BOWEL | PARALYTIC ILEUS | STRANGULATED OBSTRUCTION |
| HISTORY: | | | | |
| SURGICAL: | Adhesions from previous abdominal surgery | Adhesions from previous abdominal surgery | Recent abdominal surgery | Previous surgery or adhesions |
| MEDICAL: | Hernia, shock, occlusion of mesenteric arteries, radiation, gallstone migration | Tumour, diverticulitis, volvulus, intussusception, ulcerative colitis, mesenteric occlusion, faecal impaction, radiation | Pneumonia, pancreatitis, kidney infection, spinal cord injury, diabetic ketoacidosis, hypokalaemia, bile irritation | Any type of obstruction can progress to the point where the bowel contorts and cuts off blood suppl. |
| DRUGS: | Opiates, anticholinergics, tricyclic antidepressants | Opiates, anticholinergics, tricyclic antidepressants | Opiates, anticholinergics, tricyclic antidepressants | Opiates, anticholinergics, tricyclic antidepressants |
| SYMPTOMS: | | | | |
| ONSET: | Rapid | Insidious | As early as 1-2 days post-operatively or as late as 6 weeks post-op. | Rapid |
| VOMITING: | Early and frequent if high up, with lower blockage later and may contain faeces | Secondary to distension of small intestine; late onset may contain faeces | Usually not prominent, may only follow eating | Early: infrequent<br>Late: persistent |
| PAIN: | Cramping in mid to upper abdomen , episodic increases after meals; can be severe | Moderate cramping in suprapubic area | Dull, diffuse, continuous | Severe cramping in epigastric / periumbilical area |
| SIGNS: | | | | |
| ABDOMEN: | Non-tender, distension occurs in later stages | Distension in later stages | Distension; tense shiny skin | Distension, rigidity |
| BOWEL SOUNDS: | Early: high pitched tinkling, intermittent<br>Later: decreased or absent | Early: high pitched tinkling, intermittent<br>Later: decreased or absent | Infrequent or absent | Infrequent or absent |

**Appendix 3**

# Signs & Symptoms Questionnaire (Bowels)

| **Patient Name:**<br><br>**Date of Birth:** | **NHS No:**<br><br>**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? (If too loose and/or more frequent stools for 6 weeks or more you need to inform your doctor) | | | |
| Do you have an urgent need to open your bowels? | | | |
| 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 leak stool / soil yourself before reaching the toilet? | | | |
| Do you have any difficulty passing faeces / stool? | | | |
| Do you have the feeling that your bowel is not empty or you need to go again quickly? | | | |
| Do you drink at least 8 drinks per day? | | | |
| Fibre Score (Appendix 5) | | | |

**Appendix 4**

## Rome Criteria II For Constipation

< 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

**Appendix 5**

# Fibre Scoring Sheet

**Rate for your diet for fibre**
**Pick the foods you eat at home and find your score:**

| SCORE / FOOD | 1 | 2 | 3 | Write your score here |
|---|---|---|---|---|
| **BREAD** | White | Brown | Wholemeal / Granary | |
| **BREAKFAST CEREAL 3 times per week or more** | Rarely or never eat or eat sugar coated cereal e.g. Frosties | Corn Flakes Rice Crispies Cheerios Special K | Bran Flakes Weetabix Shredded Wheat Muesli Shreddies | |
| **POTATOES PASTA RICE** | Rarely or never eat | Eat potatoes, white rice or pasta most days | Eat potatoes in jackets, brown rice or pasta most days | |
| **PULSES BEANS NUTS** | Rarely or never eat | Once a week or less | Three times a week or more | |
| **VEGETABLES All kinds other than pulses, potatoes and beans** | Less than once a week | 1-3 times per week | Daily | |
| **FRUITS All kinds** | Less than once a week | 1-3 times per week | Daily | |

| | | | |
|---|---|---|---|
| **SCORE GUIDE:**<br>**0-12: Increase your fibre**<br>**13-17: Good** | | **YOUR TOTAL SCORE:** | |

**Appendix 6**

# Bowel Diary

NAME: NHS NO:

***PLEASE FILL IN FOR AS MANY DAYS AS POSSIBLE OR FOR UP TO 14 DAYS***

**PLEASE TICK THE RELEVANT BOX**

| DAY/DATE | TIME | BRISTOL STOOL TYPE | ACCIDENT | DID YOU WANT TO GO? | | SOILING | ANY OTHER COMMENTS e.g. laxatives, etc |
|---|---|---|---|---|---|---|---|
| | | | | YES | NO | | |
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**Appendix 7**

# The Bristol Stool Chart

## Linked to:

https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002_Bristol-Stool-Chart-Jan-2016.pdf

**Appendix 8**

# Food Diary

NAME: _____NHS NO: _____
Please list everything that you eat and drink and whether a small, medium or large amount

| DAY | BREAKFAST | MID-MORNING | LUNCH | TEA | DINNER | ANY SNACKS |
|---|---|---|---|---|---|---|
| MONDAY | | | | | | |
| TUESDAY | | | | | | |
| WEDNESDAY | | | | | | |
| THURSDAY | | | | | | |
| FRIDAY | | | | | | |
| SATURDAY | | | | | | |
| SUNDAY | | | | | | |

Appendix 9

# Fibre Content of Everyday Foods

| Serving size (grams) | Fibre content (grams) | | Serving size (grams) | Fibre content (grams) | |
|---|---|---|---|---|---|
| **BREAD** | | | **BREAKFAST CEREALS** | | |
| 25 | 1.5 | Wholemeal | 40 | 9.6 | All-bran |
| 25 | 0.9 | Brown | 40 | 8.8 | Bran buds |
| 25 | 0.8 | Hovis | 30 | 3.9 | Bran flakes |
| 25 | 0.4 | White | 30 | 3.0 | Sultana bran |
| | | | 30 | 2.1 | Fruit 'n fibre |
| **FLOUR** | | | 30 | 1.8 | Country store |
| 25 | 2.3 | Wholemeal | 30 | 2.7 | Raisin splitz |
| 25 | 1.6 | Brown Flour | 30 | 0.3 | Corn flakes |
| 25 | 0.8 | White Flour | 40 | 2.6 | Muesli |
| 25 | 0.8 | Oatmeal – raw | | | |
| 25 | 0.5 | Rice – brown | **BISCUITS & PASTRY** | | |
| | | | 25 | 2.9 | Crispbread – rye |
| **NUTS** | | | 12 | 0.3 | Digestive |
| 25 | 1.9 | Almonds | 12 | 0.2 | Gingernuts |
| 25 | 1.1 | Brazils | 25 | 1.5 | Oatcakes |
| 25 | 1.1 | Chestnuts | 25 | 0.5 | Shortbread |
| 25 | 1.6 | Hazelnuts | 50 | 1.1 | Short pastry |
| 25 | 1.8 | Coconut | | | |
| 25 | 1.6 | Peanuts | **RICE** | | |
| 25 | 1.4 | Peanut butter | 150 | 1.2 | Brown |
| 25 | 0.9 | Walnuts | | | |
| | | **VEGETABLES** | | | **FRUIT (raw)** |
| 75 | 1.9 | Carrots | 100 | 1.8 | Eating apples |
| 75 | 1.9 | Beetroot | 75 | 2.6 | Avocado pear |
| 75 | 2.6 | Swedes | 100 | 1.1 | Banana |
| 100 | 1.4 | Potatoes – jacket | 100 | 3.1 | Blackberries |
| 100 | 1.1 | Potatoes – new | 100 | 0.9 | Cherries |
| 100 | 1.2 | Potatoes – peeled & boiled | 15 | 0.5 | Dates – dried |
| 100 | 1.6 | Spinach | 20 | 1.5 | Figs – dried |
| 100 | 3.0 | Broccoli tops | 100 | 0.7 | Black grapes |

| | | | | | |
|---|---|---|---|---|---|
| 100 | 3.6 | Spring greens | 80 | 1.0 | Grapefruit |
| 100 | 4.8 | Sprouts | 150 | 1.5 | Melon |
| 90 | 1.6 | Cabbage | 160 | 2.7 | Orange |
| 90 | 2.2 | Cabbage – raw | 110 | 1.7 | Peach |
| 90 | 1.4 | Cauliflower | 170 | 3.7 | Pear |
| 0 | 0.3 | Celery – raw | 24 | 0.5 | Raisins |
| 80 | 1.4 | Leeks | 60 | 1.5 | Raspberries |
| 30 | 0.3 | Lettuce | 100 | 1.1 | Strawberries |
| 65 | 3.3 | Peas – frozen | 24 | 0.5 | Sultanas |
| 85 | 4.1 | Peas – canned | 80 | 1.0 | Pineapple |
| 65 | 2.9 | Peas – fresh | | | |
| 120 | 7.8 | Broad beans | | | **FRUIT (cooked with sugar**) |
| 60 | 2.8 | Butter beans | 140 | 3.9 | Blackcurrants |
| 135 | 5.0 | Baked beans | 140 | 2.7 | Gooseberries |
| 90 | 1.7 | Runner beans | 140 | 1.7 | Plums |
| 90 | 3.7 | French beans | 24 | 0.6 | Prunes |
| 120 | 2.3 | Lentils – split | 140 | 1.7 | Rhubarb |
| 125 | 1.6 | Corn-on-the-cob | | | |
| 60 | 0.8 | Sweetcorn – can | | | |
| 85 | 0.9 | Tomatoes – raw | | | |
| 60 | 1.0 | Onions | | | |

**Appendix 10**

# Sitting Position for Opening Bowels

**Linked to:**
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/L56%20bowel%20opening%20position.pdf

Appendix 11

# Looking After Your Bowels

## DID YOU KNOW?

1. Drinking the correct amount of fluid for your body weight can help constipation. The job of the last part of the gut is to absorb fluid back into the body. It will do this even if you are drinking very little. If you are not drinking enough, this makes the waste hard and makes it difficult for you to get rid of waste. Fluid helps the waste to remain slippery and therefore easier to pass.

**I need to drink..... Cups/Mugs per day**

2. It is important to make sure that your diet has adequate fibre in it. The best advice is to eat 5 portions of fruit and vegetables a day for health. Your nurse has a useful fibre-scoring sheet for you to see how much you really are eating.

**Fibre Score.....**

**I need to consider this advice to improve my fibre .....**

3. Limber up!! Regular exercise, within your limitations, can stimulate the bowel to work regularly.

4. It is important to be in a good position to have your bowels open so… Are you sitting comfortably? Which means being well supported and feeling safe, not slipping or sliding or having trouble getting on and off the toilet.

**Your nurse can help you access aids and adaptations to help**

5. Bowels benefit from routine. Allow yourself time and privacy to empty your bowels. This can be difficult if you require help and assistance in the toilet, but discuss this with your nurse, they may have some ideas to help.

**Appendix 12**

# The Management of Constipation

## The Management of Constipation

This bulletin describes five steps to managing a constipated patient and provides prescribing information on chosen laxative agents.

### STEP 1 Diagnosis

There is considerable variation in the frequency of "normal" bowel movements for individuals, (e.g. from three movements per day to three per week), and it is any deviation from this norm that is important for the diagnosis of constipation. Constipation may also be used to describe the passing of hard, painful faeces or when full evacuation is achieved with difficulty.

### STEP 2 Identify a possible cause

2.1 Underlying disease, e.g. endocrine, metabolic or neurological disturbances
2.2 Immobility
2.3 Dietary change
2.4 Dehydration
2.5 Drug treatment, e.g. antacids containing aluminium, anticholinergics, iron salts, opioid analgesics, phenothiazines, tricyclic antidepressants, anti-psychotics, Verapamil. A full list of drugs causing constipation can be found in appendix 13.
2.6 Mechanical obstruction, e.g. tumour, haemorrhoids
2.7 Pregnancy

### STEP 3 Educate the patient

3.1 Encourage the patient to "answer the call of a stool"
3.2 Give dietary advice, e.g. a diet which includes fresh fruits and vegetables, wholegrain bread and cereals –supplemented by coarse bran may prevent constipation.
3.3 Encourage mobility where possible
3.4 Encourage an adequate fluid intake i.e. 2 litres a day

### STEP 4 Prescribe a laxative

All laxatives MUST be prescribed on the patient's drug chart (if relevant) and recorded when administered: This includes suppositories and enemas. The patient must be reviewed following the administration of a laxative and when the laxative has been ineffective further, medical review should be sought.

https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/ClinicalEffectiveness/G1927.pdf

### STEP 5 Monitor the patient

Bowel diaries should be kept. A fluid intake chart is also helpful.

Review laxative therapy regularly and stop or reduce when no longer required

**Appendix 13**

## Drugs that cause bowel dysfunction

Many prescribed drugs may have possible side effects on gut motility and stool consistency, causing loose stool or constipation. The main groups are:

- opioids
- broad-spectrum antibiotics
- laxatives
- diabetic medication
- obesity medication
- antidiarrhoeal
- antidepressants
- antihistamines
- antimuscarinics
- antacids
- iron preparations
- polypharmacy.

Reviewing medications to change or modify the regimen may help to improve bowel dysfunction. Polypharmacy refers to the use of multiple medications by a patient (Nishtala and Salahudeen, 2015).
Every medication has potential side effects and with every drug added, there is an increase in possible side effects.

**This list is not exhaustive, for up to date information check BNF or refer to your pharmacist.** Alternatively, North and East Devon Formulary and Referral which can be accessed on BOB at:
https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/favicon.ico

**Appendix 14**

# Competencies for the Assessment of Patients Requiring Bowel Care (including Digital Rectal Examination, Digital Rectal Stimulation and Digital Removal of Faeces)

| | Competence demonstrated (YES/NO) | Comments eg action required/how competence is demonstrated | Signature and role of Assessor | Signature and role of Health Practitioner | Date |
|---|---|---|---|---|---|
| 1. To have knowledge of national guidelines, organizational policies and protocols in accordance with clinical/corporate governance which affect the assessment of bowel dysfunction<br>2. An understanding of the specific health conditions which have an impact on bowel function and of the different types of bowel dysfunction. An understanding of how medications, lifestyle, diet and fluids affect bowel function.<br>3. An understanding of the anatomy and physiology of the male and female lower gastro intestinal tract in relation to lower bowel function and continence status. An understanding of the causes of poor bowel emptying and types of constipation | | | | | |

| | Competence demonstrated (YES/NO) | Comments eg action required/how competence is demonstrated | Signature and role of Assessor | Signature and role of health practitioner | Date |
|---|---|---|---|---|---|
| 4. Knowledge and understanding of the assessment process and documents and an understanding of how to adapt continence assessment to the health status of the individual for example, in end of life care, chronic long term conditions, dementia, post childbirth, infective diarrhoea, disability.<br><br>5. An understanding and knowledge of interventions to improve or maintain bowel function including lifestyle, the correct position for defaecation, bowel emptying programmes, pelvic floor exercises, abdominal massage, oral medications (laxatives, anti-diarrhoeal, bulking agents), rectal medications (suppositories, enema).<br><br>6. An understanding and knowledge of the procedure for digital rectal examination and insertion of rectal medication.<br><br>7. (For relevant staff only) An understanding and knowledge of the procedure for digital rectal stimulation and digital removal of faeces. | | | | | |

**Appendix A**

## Standard Operating Procedures

### Procedure for digital rectal examination (DRE) (MASCIP 2012)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone present.
- Give the patient the opportunity to empty their bladder.
- Ensure privacy and dignity is maintained at all times.
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia (described earlier in the document).
- Wash hands and put on disposable apron and gloves.
- Ask/assist patient to lower any clothing to knees and ask the patient to ideally lie in the left lateral position with knees flexed so that the perianal area can be easily visualised. The left side is preferred as it allows DRE to follow the natural anatomy of the bowel but it is not essential.
- Place protective pad under the patient, and cover the legs/area not to be exposed.
- Inform the patient that you are to begin and that you will be looking and examining the outer and internal area.
- Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood.
- Next palpate the perianal area by starting at the 12 o'clock position moving clockwise to 6 o'clock and then returning to 12 o'clock and moving to 6 o'clock anticlockwise, feeling for irregularities, indurations, tenderness or abscess.
- Lubricate a gloved index finger, part the buttocks and gently insert into the anus to avoid trauma to the anal mucosa, noting tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient feels any pain ensure that they are happy for you to continue with the procedure. It may be easier to ask the Patient to talk or breathe out to prevent spasm or difficulty on insertion. Also work with the anal reflex by putting your finger on the anus gently and wait a few second this will allow the anus to contract and then relax.
- Sweep clockwise and then anticlockwise, palpate for irregularities internally. Noticing the presence of any tenderness, presence and consistency of faecal matter (an assessment of its consistency according the Bristol Stool Form Chart) and any lesions.
- You also assess the external sphincter tone by asking the patient to squeeze and hold. Also ask the patient to push down to assess for relaxation on straining.
- Prostate and advance pelvic floor assessment may also take place at this point if competent to do so.
- Remove finger, clean perianal area of any gel/ faecal matter. Remove gloves and apron disposing of them appropriately then wash your hands.

- Ensure patient's privacy, dignity and comfort at all times.
- Wash hands and allow the patient to dress in private, unless they need assistance.
- Explain your findings and plan.
- Document all observations, findings and actions.
- Consider onward referral to another health care professional if there were any concerns on examination.

**Appendix B**

# Standard Operating Procedures

**Procedure for digital rectal stimulation (DRS) (adapted from MASCIP, 2012)**

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should
- ideally be lying in a lateral position, usually on the left, so that the anal area can easily viewed.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel (on prescription only and with caution in long term use due to systemic effects, BNF 2016) may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). Anaesthetic gel is contraindicated with inflamed or broken skin. Adrenaline should be available in case of an allergic reaction to the local anaesthetic gel.
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- Turn the finger so that the padded inferior surface is in contact with the bowel wall. Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.
- Withdraw the finger and await reflex evacuation.
- Repeat every five-ten minutes until rectum is empty or reflex activity ceases.
- Remove soiled glove and replace, re-lubricating as necessary between insertions.
- If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matters in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Stool Scale (Heaton, 1993).
- Record and report abnormalities.

**Appendix C**

# Standard Operating Procedures

**Procedure for digital removal of faeces (DRF) (adapted from MASCIP, 2012)**

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can easily visualised.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel (on prescription only and with caution in long term use due to systemic effects, BNF 2016) may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). Anaesthetic gel is contraindicated with inflamed or broken skin. Adrenaline should be available in case of an allergic reaction to the local anaesthetic gel.
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- If stool is a solid mass, push finger into centre, split it and remove small sections until none remain. If stool is in small separate hard lumps remove a lump at a time. Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – in other words do not over-stretch the sphincters by using a hooked finger to remove large pieces of hard stool which may also graze the mucosa. Using a hooked finger can lead to scratching or scoring of the mucosa and should be avoided.
- Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces. If the rectum is full of soft stool continuous gentle circling of the finger may be used to remove stool: this is still digital removal of faeces.
- During the procedure the person delivering care may carry out abdominal massage.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matters in an appropriate receptacle as it is removed, and dispose of it and any other waste in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Scale (Heaton, 1993).
- Record and report abnormalities.

**Appendix 15**

Torbay and South Devon NHS Foundation Trust Assessment of Clinical Skills

(to add hyperlink here to assessment document once ratified and available in ICON)

## 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.*

*This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.*

| | | | |
|---|---|---|---|
| **Ref No:** | 2463 | | |
| **Document title:** | Bowel Care for Adults | | |
| **Purpose of document:** | This policy aims to identify the responsibilities and processes for providing bowel care to adults, ensuring that this care complies with evidence based best practice and legal responsibilities bowel care covered by this policy includes rectal interventions such as digital rectal examinations (DRE), digital rectal stimulation (DRS) and digital removal of faeces (DRF), management of constipation, faecal incontinence and promotion of normal bowel habit. | | |
| **Date of issue:** | 22 June 2020 | **Next review date:** | 22 June 2023 |
| **Version:** | 1 | **Last review date:** | |
| **Author:** | Bladder and Bowel Care Specialist Nurse | | |
| **Directorate:** | General Surgery and Urology | | |
| **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:** | Clinical Director of Pharmacy<br>Clinical Governance Lead for General Surgery and Urology | | |
| **Date approved:** | 16 June 2020 | | |
| **Links or overlaps with other policies:** | | | |

| **Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.** | Yes ☐ | |
|---|---|---|
| | *Please select*<br>*Yes* | *No* |
| **Does this document have implications regarding the Care Act?**<br>*If yes please state:* | ☐ | ☒ |
| | | |
| **Does this document have training implications?**<br>*If yes please state:* | ☐ | ☒ |
| | | |

| | | |
|---|---|---|
| **Does this document have financial implications?**<br>*If yes please state:* | ☐ | ☒ |
| | | |
| **Is this document a direct replacement for another?**<br>*If yes please state which documents are being replaced:*<br>Ref 1900 – Assessment and Treatmen of Bowel Symptoms in Adults | ☒ | ☐ |

**Document Amendment History**

| Date | Version no. | Amendment summary | Ratified by: |
|---|---|---|---|
| 22 June 2020 | 1 | New | Clinical Director of PharmacyClinical Director of General Surgery |

## 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.

NHS South Devon and Torbay Clinical Commissioning Group

NHS Torbay and South Devon NHS Foundation Trust

## Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

| | | | |
|---|---|---|---|
| Policy Title (and number) | D1902 Bowel Care for Adults Policy | Version and Date | Final October 2018 |
| Policy Author | Bladder and Bowel Care Specialist Nurse | | |

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

| | | |
|---|---|---|
| Patients/ Service Users ☒ | Staff ☒ | Other, please state… ☐ |

Could the policy treat people from protected groups less favourably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

| | | | | | |
|---|---|---|---|---|---|
| Age | Yes ☐ No☒ | Gender Reassignment | Yes ☐ No☒ | Sexual Orientation | Yes ☐ No☒ |
| Race | Yes ☐ No☒ | Disability | Yes ☐ No☒ | Religion/Belief (non) | Yes ☐ No☒ |
| Gender | Yes ☐ No☒ | Pregnancy/Maternity | Yes ☐ No☒ | Marriage/ Civil Partnership | Yes ☐ No☒ |
| Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees) | | | | | Yes ☐ No☒ |

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

| | |
|---|---|
| Is inclusive language[5] used throughout? | Yes ☒ No☐ NA ☐ |
| Are the services outlined in the policy fully accessible[6]? | Yes ☒ No☐ NA ☐ |
| Does the policy encourage individualised and person-centred care? | Yes ☒ No☐ NA ☐ |
| Could there be an adverse impact on an individual's independence or autonomy[7]? | Yes ☐ No☒ NA ☐ |

EXTERNAL FACTORS

| | |
|---|---|
| Is the policy a result of national legislation which cannot be modified in any way? | Yes ☐ No☒ |
| What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?) | |
| Policy review due | |

Who was consulted when drafting this policy?

| | | |
|---|---|---|
| Patients/ Service Users ☐ | Trade Unions ☐ | Protected Groups (including Trust Equality Groups) ☐ |
| Staff ☐ | General Public ☐ | Other, please state… ☐ |

What were the recommendations/suggestions?

| | |
|---|---|
| | |
| Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below | Yes ☐ No☒ |

ACTION PLAN: Please list all actions identified to address any impacts

| Action | Person responsible | Completion date |
|---|---|---|
| | | |
| | | |

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

| | | | |
|---|---|---|---|
| Name of person completing the form | | Signature | |
| Validated by (line manager) | | Signature | |

**Please contact the Equalities team for guidance:**
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
**This form should be published with the policy and a signed copy sent to your relevant organisation**

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

## Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.