Airedale NHS Foundation Trust

Bowel Care in Critical Care

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Target Audience:	Explicitly note if this does/does not apply to AGH Solutions Staff.	**Equality Impact Analysis:**	
People Authorised To Use This Guideline:	Critical Care Staff	**Training Requirement To Use This Guideline:**	RGN

GUIDELINE CHECKED FOR:	**Yes/No**
Corporate Issues:	**yes**
Clinical Governance Issues:	**yes**
People Governance Issues:	**yes**
Risks Identified With Using This Guideline:	Nurse not familiar with bowel protocol
Risk Counter Measures:	Nurse can demonstrate competence

GUIDELINE REVIEW HISTORY

Version No:	Review Date:	Reviewer:	Changes Made:
2	March 2018	Vincy E Ommen Thadathil Linda Brennand	Updated with NICE guidelines

If printed, this Guideline is **valid on the day of printing only**. Please ensure that you check AireShare to ensure you are using the current version

Contents

1. Introduction

Airedale NHS Foundation Trust fully recognises that the obligation to implement guidance should not override any individual clinician to practice in a particular way if that variation can be fully justified in accordance with Bolam Principles. Such variation in clinical practice might be both reasonable and justified at an individual patient level in line with best professional judgement. In this context, clinical guidelines do not have the force of law. However, the Trust will expect clear documentation of the reasons for such a decision and for this variation. In addition, any decision by an individual patient to refuse treatment in line with best practice must be respected, escalated to the consultant and fully documented in the appropriate records of care/treatment

Bowel Care in Critical Care

Bowel care is a fundamental area of patient care that is frequently overlooked yet it is of paramount importance for the quality of life of service users, many of whom may be reluctant to admit to bowel problems or to discuss such issues (Royal College of Nursing (RCN) 2012). Robert Francis referred to continence as 'this most basic of needs', his report highlighting significant concerns in this area of care (Department of Health, 2010).

The aim of the guideline is to promote and maintain normal bowel function, with early recognition and treatment of bowel dysfunction.
The guideline is intended to be followed by nursing staff caring for critically ill patients on the critical care unit, taking into account the following criteria:

1. All nursing staff will have had education in the principles of bowel management for the prevention or resolution of constipation and diarrhoea during their induction period.

2. All nursing staff will have been instructed in the safe and effective administration of all bowel care interventions whilst respecting the patient's right to privacy.

3. All relevant protocols and flowcharts will be available on the Critical Care Unit.

4. All necessary equipment and medication will be available on the Critical Care Unit.

5. Medical staff will be involved throughout the process.

Statement of intent

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. It is advised however that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

2. Management

The recommended process criteria are:

A) The nurses will assess the patient's bowel function status on admission from previous and /or present medical/nursing history and information. This assessment will be documented in the nursing care plan.

B) All nursing staff will adhere to the established protocol for the management of bowel function and be competent to follow this protocol in order to promote and maintain normal bowel function.

C) The effectiveness of interventions to promote normal bowel function will be evaluated using the bowel management protocol.

The outcome criteria are:

A) The patient's bowel function status will be assessed on admission.

B) The assessment will be documented in the nursing care plan.

C) The patient's bowel function status will be assessed and documented each shift.

D) All staff will be aware of the effective administration of bowel care interventions.

E) All nursing staff will perform bowel care interventions in a safe, effective manner whilst respecting the patient's right to privacy and dignity.

Clinicians/ Staff responsibilities

- Registered healthcare professionals are accountable for their own practice and will be aware of their legal and professional responsibilities and work within the code of practice of their professional body.
- Maintaining clinical competency as per competency framework
- Attending relevant training provided by the Trust and put it into practice
- Ensuring they are familiar with relevant policies and procedures in their area of practice.
- All staff that carries out bowel care must be trained and assessed as competent prior to undertaking that skill.

Consent

Consent is a service user's agreement for a health professional to provide care. Before health care professionals examine, treat or care for any person they must obtain their valid consent. There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way. When service users do not have the ability to consent for themselves the health care professionals should undertake an assessment of mental capacity and make the decision in the service user's best interests in line with the Mental Capacity Act 2005 and trust policies. This must be documented in the service user's notes.

Privacy, Dignity and Respect

In all examinations, procedures and interventions the Privacy, Dignity & Respect Policy (AGH Policy) must be followed. Prior to any such examinations, procedures or interventions service users will be offered a chaperone according to the Chaperone Policy (AGH Policy).

BOWEL CARE MEDICATIONS

All bowel care medications referred to in this policy must be prescribed by medical staff or administered by nurses trained to do so under Patient Group Directives.

PROCEDURE FOR THE ASSESSMENT AND EVALUATION OF BOWEL FUNCTION.

To be used in conjunction with the Bowel management flow chart.

Nursing Action	Rationale
1. Assessment of bowel function should be made on admission, using pre-admission history if available.	To establish the patient's present bowel status and any previous known complications or treatment.
2. If the last bowel movement was diarrhoea follow the flowchart for diarrhoea and take appropriate action.	Diarrhoea reflects abnormal bowel function: its presence should be confirmed and treated without delay
3. If the last bowel movement was rock like faeces, follow the constipation flow chart and take appropriate action.	Faeces should be soft and easily passed. Rock like stools also reflect abnormal bowel function and should be treated without delay.
4. If bowels have been opened normally within the last 48 hours continue to reassess every shift and document.	Normal bowel function, no intervention other than regular assessment as per protocol necessary.

DIARRHOEA

Nursing staff must be aware that liquid stool may be excreted around an impaction. For this reason the patient must be assessed for constipation first and this excluded before following the flowchart for diarrhoea.

The cause of the diarrhoea should also be identified if possible, e.g. antibiotic usage, infection or contamination of enteral feed.

Nursing Action	Rationale
1. Perform a per rectum (PR) examination, according to Royal College of Nursing (RCN) Guidelines.	To assess for overflow or impaction.
2. If impaction is evident follow the flowchart for constipation.	To promote a bowel action and prevent further overflow.
3. If the patient has diarrhoea, the continued administration of laxative agents may be contraindicated. (Lactulose is sometimes used in the treatment of hepatic encephalopathy).	Laxative therapy will increase diarrhoea
4. Consult the dietician as to whether a high fibre enteral feed should be considered if it is not already being used.	Fibre adds bulk and softens stool, helping to promote and maintain a normal bowel pattern.
5. If 2 or more loose bowel actions appear in 24 hours send a sample to microbiology and record in the nursing documentation.	To assess for the presence of infection, particularly clostridium difficile (C-Diff).
6. Report findings. If C-Diff is isolated follow the trust infection control guidelines.	To enable commencement of treatment and prevention of cross infection.
7. Loperamide is not indicated in the treatment of C-Diff.	It is not beneficial to slow diarrhoea caused by C-Diff.
8. If C-Diff is not present consider the use of loperamide as per flow chart (This must be prescribed).	To slow the motility of the bowel and ease the amount of diarrhoea.
9. Continue to assess the bowel function as per flowchart.	To establish normal bowel function.

Nursing Action	Rationale
10. The skin should be kept clean and dry as much as possible. An appropriate protective agent should be used on the perianal area to protect the skin. If the skin is broken follow wound care guidelines	To protect and promote skin integrity.

CONSTIPATION

Constipation may be described as the passage of hard stools, usually less frequent than the patient's normal pattern (Nazarko 1996). Risk factors include a low dietary fibre intake, poor liquid intake, poor mobility and certain medications. The use of laxative preparations may be considered after the above factors have been taken into account.

Special considerations are necessary for patients with spinal cord lesions. Please see additional information and Airedale NHS Foundation Trust clinical guideline number18.

The possibility of intestinal obstruction should be excluded. Medical advice should be sought if intestinal obstruction is known or suspected.

Nursing Action	Rationale
1. A PR examination should always be performed first.	To establish the patient's bowel status.
2. If no faeces are felt lactulose should administered.	Lactulose is an osmotic laxative that may promote peristalsis and aid bowel movement.
3. If the bowels are successfully opened within 2 days continue with the lactulose and reassess each shift.	As per flow chart.
4. If the bowels have not been opened within 2 days of lactulose therapy repeat a PR examination.	To reassess bowel status.
5. If the rectum is still empty administer senokot 2 tablets or 10 ml once daily as per flow chart. **Note: Any patient having undergone abdominal surgery should be referred to the surgical team before prescribing stimulant laxatives.**	Senokot is a gentle bowel stimulant.

Nursing Action	Rationale
6. If the patient is impacted an Arachis oil enema should be administered.	Softens and lubricates stools. **NOT FOR USE IF THE PATIENT AS A NUT ALLERGY.**
7. If there is a positive response to the Arachis oil enema continue with lactulose and reassess each shift.	To continue to promote peristalsis.
8. If faeces are present in the rectum but not impacted, 2 glycerine suppositories should be prescribed. If successful continue as per flow chart.	Glycerine acts as a lubricant and softens faecal mass, aiding its passage.
9. If glycerine suppositories are unsuccessful, then a docusate sodium enema should be prescribed. If this is successful then continue Lactulose, monitor and review as per flow chart.	Docusate sodium acts as osmotic agent to promote peristalsis.
10. If 'docusate sodium is unsuccessful, a phosphate enema should be prescribed. If this is successful continue with lactulose and reassess as per flow chart.	Phosphate enemas also act as an osmotic agent to promote peristalsis.
11. If this is still unsuccessful, senokot should be prescribed, with or without suppositories depending on PR examination.	To continue to attempt to stimulate peristalsis.
12. **Medical staff should be informed of bowel dysfunction at all times.**	To consider further treatment and exclude anatomical problems.
13. It is important to ensure that the patient's right to privacy and dignity is preserved at all times when assessing bowel function and administering medications. Where possible, informed consent should always be obtained before commencement of these interventions.	To avoid unnecessary embarrassment to the patient and others on the unit.

Additional Information

Diarrhoea

Although the strict definition is a liquid stool greater than 200ml per day or more than 3 soft stools per day (Levinson and Bryce 1993), it would be more practical to accept the definition proposed by Jamie Basset al (1993) that diarrhoea is any alteration of bowel action associated with the passage of loose or liquid stool sufficient to be noticed by the patient or nursing staff. These observations would then be documented in the care plan and action instigated to resolve the diarrhoea.

Between 25% and 40% of critically ill patients develop diarrhoea (Adams 1994). The patient's general condition is most likely to be an indicator of the likelihood of diarrhoea. It is thought that this form of gastrointestinal dysfunction may be another manifestation of multiple organ dysfunctions.
Previous studies conflict in whether or not enteral feeding is a cause of diarrhoea (Smith et al 1998; Levinson and Bryce 1993). It should be acknowledged that enteral feeding might exacerbate diarrhoea if the problem is already present. The most important intervention would be to identify and if possible treat the original cause. It is also important to recognise that drugs, such as antibiotics and electrolyte replacements, can cause diarrhoea. AGH adapted Bristol Stool Chart for stool assessment.

Clostridium Difficile (C-diff)

Clostridium difficile is a bacterium that releases endotoxins. Guenter et al (1991) carried out a study that showed that of those patients who had diarrhoea, 50% had C-diff toxin present, a recognised complication of antibiotic therapy in the critically ill and a potent cause of diarrhoea.

Antidiarrheal, such as loperamide, is not recommended for use when the patient has C-diff, as the endotoxins would be retained in the gut. The patient is usually treated with appropriate antibiotics.

Constipation

Constipation is defined as when defaecation is infrequent and stools are hard and difficult to evacuate (Nazarko 1996). Usually critically ill patients suffer from secondary causes of constipation, such as metabolic disorders, system illness or drug therapy.

The movement of faeces through the colon towards the anus is by peristaltic action. The colon absorbs about 2 litres of water in 24 hours (Smith 1990, Moriarty and Irving 1992). If faeces are not expelled they will become hard due to dehydration and will be difficult to expel. Eventually colonic stasis will occur, leading to impaction of faeces.

Laxatives

A laxative with a mild effect is known as an aperient and one with a strong effect is known as a purgative. The nurse should always perform a rectal examination first to establish whether the patient is constipated and to what degree. Laxatives are agents used in the treatment of constipation to aid defaecation and can be classified as bulk forming agents, osmotic laxatives, stimulant laxatives and stool softening preparations (Bouchier et al). The exact mode of action is however, poorly understood. The overall effect of these agents is a complex combination of an increase of faecal water content, an acceleration of intestinal transit and alterations in intestinal motility (Bouchier et al).

- Bulk- forming laxatives (containing soluble fibre) act by retaining fluid within the stool and increasing faecal mass, stimulating peristalsis: also have stool – softening properties.
  a. Ispaghula husk.
  b. Methylcellulose.
  c. Sterculia.
- Osmotic laxatives act by increasing the amount of fluid in the large bowel producing distension, which leads to stimulation of peristalsis: lactulose and macrogols also have stool softening properties.
  a. Lactulose
  b. Macrogols (polyethylene glycols).
  c. Phosphate and sodium citrate enemas.

- Stimulant laxatives cause peristalsis by stimulating colonic nerves (Senna) or colonic and rectal nerves (bisacodyl), sodium picosulfate).
  a. Senna- hydrolysed to the active metabolite by bacterial enzymes in the large bowel

Stool softeners lower the surface tension of faeces and allow penetration by water. They usually act within 24-48hours.
Osmotic agents retain water in the small bowel and increase the flow of fluid into the colon. This increased volume will cause peristalsis and consequently expulsion of faeces. They usually act within 3-6 hours.

Enemas

An enema is the introduction into the rectum or lower colon of a stream of fluid for the purpose of producing a bowel action or instilling a medication. The enema should be warmed by immersion in a jug of warm water prior to administration. The privacy of the patient should be respected.
Evacuant enemas such as phosphate enemas are administered with the intention of being expelled along with faecal matter and flatus within a few minutes. Retention enemas, such as Arachis oil are administered with the intention of trying to be retained for a period of time before being expelled.

Suppositories

A suppository is a solid or semi solid pellet introduced into the anal canal in order to relieve acute constipation. **The privacy of the patient should be respected when administering suppositories.** Suppositories should be administered blunt end first to enhance adhesion to any impacted faecal mass (Abd-El-Maeboud et al, 1991).

Glycerine suppositories lubricate and soften faecal mass.
Biscodyl suppositories act as a stimulant when they come into contact with the mucous membrane of the rectum.

Enemas and Suppositories

The administration of enemas and suppositories is an invasive intimate intervention and can only be performed by a Registered Nurse who can demonstrate competence to an appropriate level in accordance with the Nursing and Midwifery Council (NMC) The Code: Professional standards of practice and behaviour (NMC, 2015).

Contraindications of suppositories and enemas

Paralytic ileus
Colonic obstruction
Administration following gastrointestinal or gynaecological surgery
Please refer to THE ROYAL MARSDEN MANUAL OF CLINICAL NURSING PROCEDURES for further information regarding the administration of suppositories and enemas.

Patients with established spinal cord lesions

Some people with established spinal cord lesions are dependant on manual evacuation of faeces as their routine method of bowel care. This method will have been established as part of their ongoing care by their specialist neurological unit. These patients may well be admitted to other NHS acute trusts for reasons not directly related to their existing spinal cord lesion.
Failure to provide manual evacuation can place individuals with spinal cord lesions at risk of developing autonomic dysreflexia, a condition unique to this patient group.

Complications of autonomic dysreflexia may include cerebral haemorrhage, seizures or cardiac arrest. For these reasons autonomic dysreflexia is considered a medical emergency. The National Patient Safety Agency has identified failure to provide this patient group with the care that they need as a possible breach of the NMC code of conduct. Airedale NHS Foundation Trust has a clinical guideline (clinical guideline 18) to meet this need.

It is included as an appendix to this protocol and is also available on the Airedale NHS Foundation Trust Aireshare.

3. Implementation & audit

Local Implementation

Implementation of national clinical guidelines is the responsibility of local NHS organisations and is an essential part of clinical governance.it is acknowledged that not every guideline can be implemented immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement them national guideline in individual hospitals, units and practices, and to monitor compliance.

This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

This guideline is based on best available evidence and will be reviewed in the light of new evidence or guidelines.

4. Development

Methodology

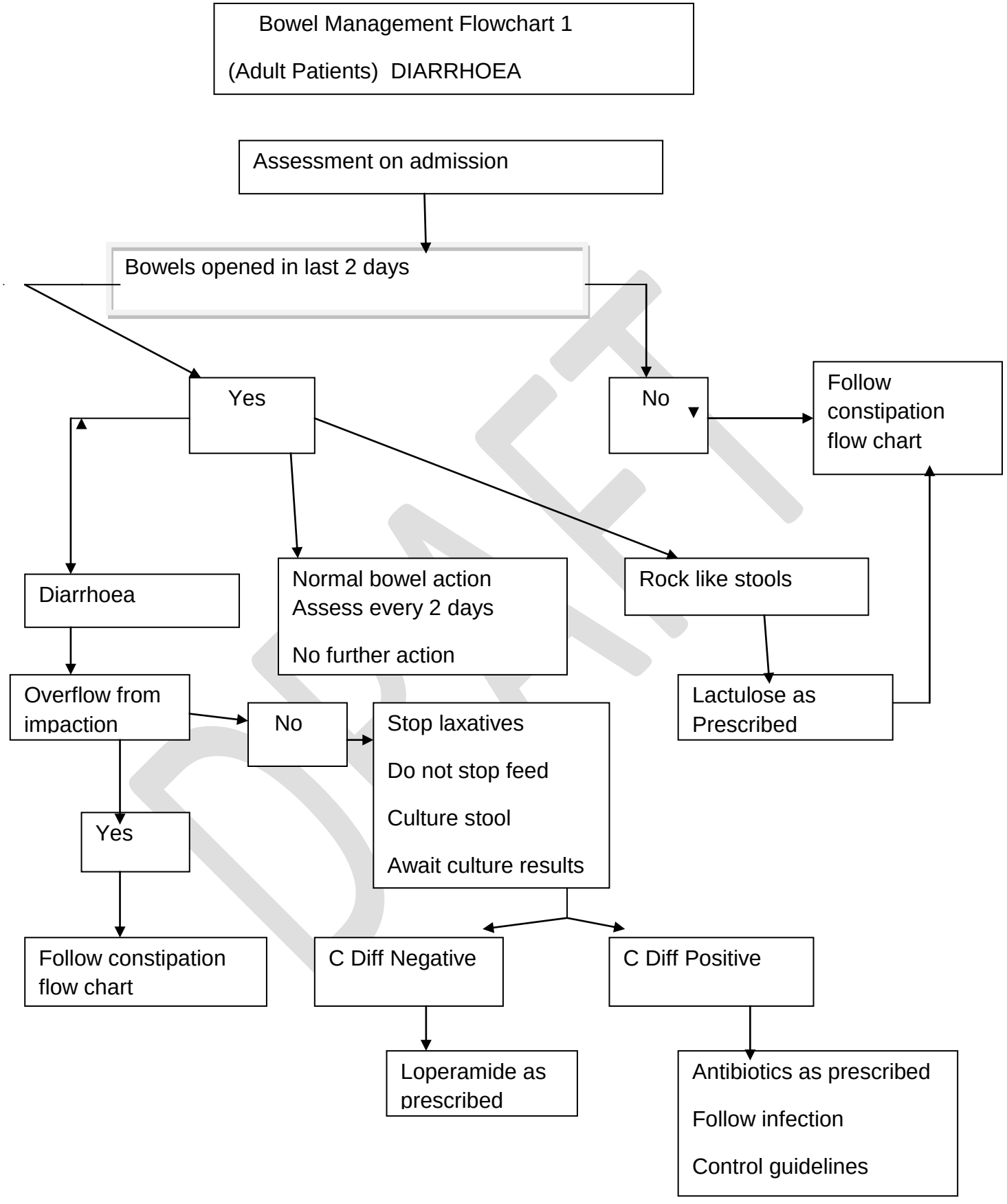
This guideline is based on currently accepted practise, best available evidence and will be reviewed in the light of new evidence or guidelines.

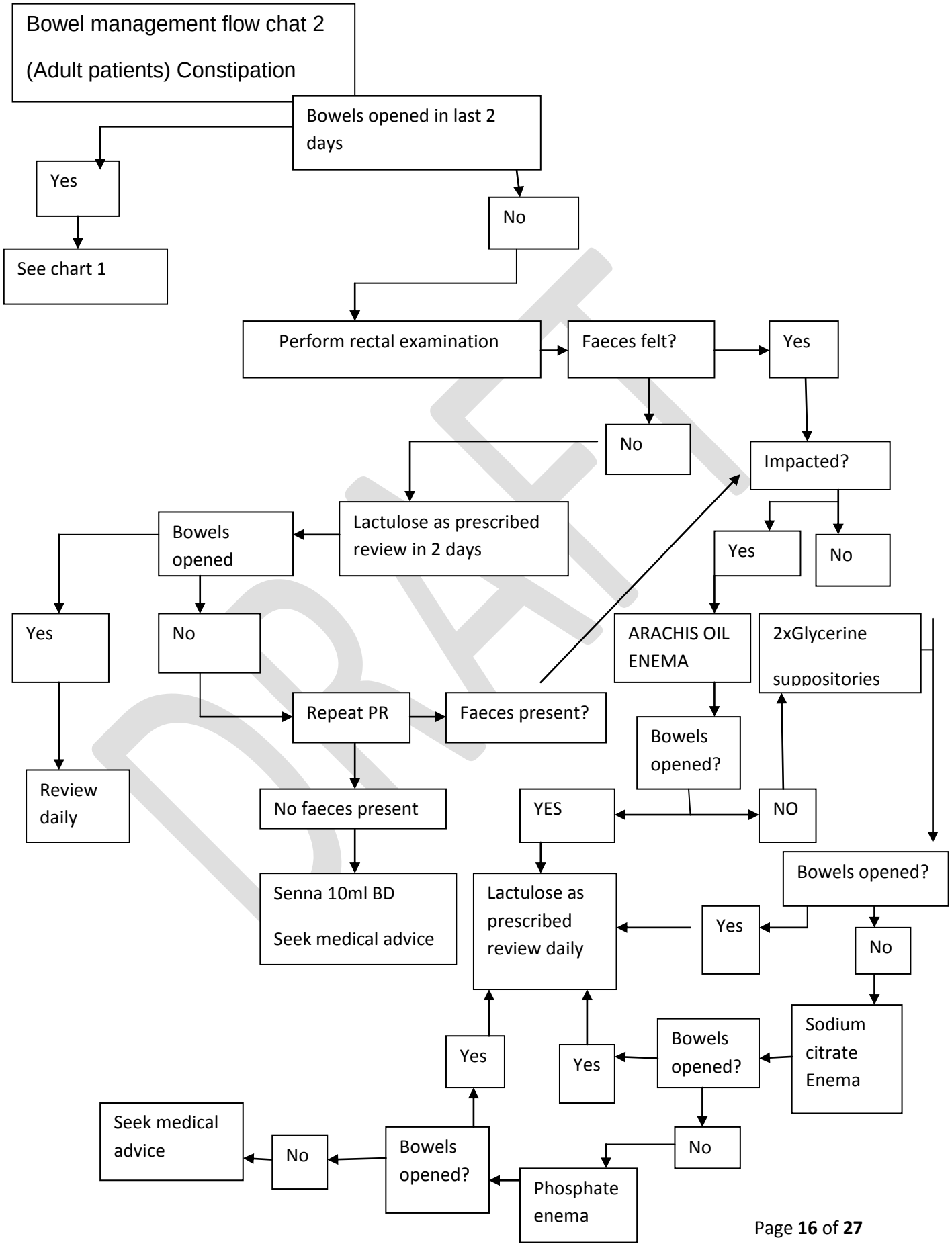
Evidence will be gathered using literature reviews and participation by members of the Critical Care Forum in the West Yorkshire Critical Care Network, Intensive Care Society, Critical Care Forum of the RCN and regional benchmarking groups.

5. Glossary of terms

RCN - Royal College of Nursing

NMC - Nursing and Midwifery Council


Bowel Management Flowchart 1
(Adult Patients) DIARRHOEA
Assessment on admission
Bowels opened in last 2 days
Yes
No
Follow constipation flow chart
Diarrhoea
Normal bowel action
Assess every 2 days
No further action
Rock like stools
Overflow from impaction
No
Stop laxatives
Do not stop feed
Culture stool
Await culture results
Lactulose as Prescribed
Yes
Follow constipation flow chart
C Diff Negative
C Diff Positive
Loperamide as prescribed
Antibiotics as prescribed
Follow infection
Control guidelines


Bowel management flow chat 2
(Adult patients) Constipation
Bowels opened in last 2 days
Yes
See chart 1
No
Perform rectal examination
Faeces felt?
Yes
No
Impacted?
Yes
No
ARACHIS OIL ENEMA
2xGlycerine suppositories
Bowels opened?
YES
NO
Lactulose as prescribed review in 2 days
Bowels opened
Yes
No
Review daily
Repeat PR
Faeces present?
No faeces present
Senna 10ml BD
Seek medical advice
Lactulose as prescribed review daily
Yes
Bowels opened?
No
Sodium citrate Enema
Bowels opened?
Yes
Yes
Yes
No
Phosphate enema
Bowels opened?
No
Seek medical advice

6. References

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7. Appendix

Appendix A

Procedure for Administering Suppositories and Enemas

Action	**Rationale**
Obtain careful history from patient prior to examination, including establishing whether patient has any known allergies.	To assess symptoms, and reduce the risk of allergic reaction.
Establish indications for use and eliminate any contra-indications or allergies prior to proceeding.	To ensure appropriateness, suitability and safety of administration.
Ensure patient is introduced to staff involved in the procedure.	Helps reduce anxiety by improving communication.
Explain each step of the procedure to the patient, including potential risks and complications, and also the benefits.	To ensure patient is informed and understands the procedure. Patient information can help to reduce anxiety.
Obtain valid and informed consent and document in patient's health records. If necessary refer to the Mental Capacity Act 2005, and consider if the examination is in patient's best interest. Follow the AGH consent for examination or treatment policy.	To ensure patient is happy for the procedure to take place.
Identify patient by surname, first name and date of birth using open questions checking against NHS number	To ensure correct identification of the patient.

Action	Rationale
Establish that the patient has no known allergies.	To reduce the risk of allergic reactions.
Clarify if the patient requires a formal chaperone. Follow AGH Chaperone policy.	It is the patient's choice to have a chaperone if required. Refer to Chaperone policy.
Check Suppository/Enema to be administered against Medicines Administration chart or, if at nurses' discretion according to policy, document the administration appropriately.	To protect patient from harm and ensure effective record keeping.
Ensure Medicines Administration chart specifies: • Patient's full name • Patient's date of birth • Prescriber's signature and date prescribed • Name of Suppository/Enema to be administered • Dose to be administered • Route of administration • Patients allergy status	To maintain patient safety.
Read manufacturer's instructions for use.	To ensure the enema or suppository is prepared and administered in accordance with manufacturer's instructions.

Action	Rationale
Allow patient to empty bladder first if required.	To reduce the feeling of discomfort during the procedure (Higgins 2006).
Ensure a bedpan, commode or toilet is readily available.	In case the patient feels the need to expel the enema or suppository before the procedure is completed.
Decontaminate hands as per AGH Hand Hygiene Procedure, and apply gloves and apron (single use non sterile disposable)	To reduce the risk of infection, and to protect clothing or uniform from contamination and potential transfer of micro-organisms.
Administration of Enemas: Prepare the enema by warming to body temperature in accordance with manufacturer's instructions.	Warming the enema solution to body temperature may be beneficial as heat is an effective stimulant to the intestinal mucosa. Cold solutions should be avoided as they may cause cramping. (Higgins 2006) If water is used to warm the enema, care must be taken not to overwarm.
Assist the patient to lie on the left side, with knees drawn to the abdomen, and buttocks near the edge of the bed.	To allow ease of passage and flow of fluid into rectum. The anatomical structure of the sigmoid colon assists enema distribution and retention
Place some lubricating gel on nozzle of enema	To prevent trauma to the anal and rectal mucosa, reducing surface friction (Higgins 2006)
Expel excessive air from enema prior to administration	Excessive air may cause abdominal discomfort or pain (Kyle 2007)
Inform the patient that you are about to commence the procedure, slowly introduce the nozzle to the depth recommended by the manufacturer	To ensure the nozzle is in the rectum
Introduce the fluid slowly as recommended by the manufacturer	To promote comfort

Action	Rationale
Once instilled, slowly withdraw the nozzle	To avoid reflex emptying of the rectum
Ask the patient to retain the enema for 10-15 minutes before evacuating the bowel	To enhance the evacuant effect
Administration of Suppository: Open the packet/ suppository and lubricate the suppository with lubricating gel or water according to the manufacturer's instructions	Lubrication reduces surface friction, avoiding anal mucosa trauma. Aids ease of suppository insertion.
Insert the suppository into the rectum, ensuring that it is placed against the bowel wall.	Suppositories need body heat in order to dissolve and become effective. If they are placed in faecal matter they will remain intact and be ineffective.(Kyle 2009) There is inconclusive evidence regarding whether suppositories should be inserted blunt end first (Higgins 2007). Please refer to individual manufacturer's instructions for use.
Observe the patient throughout the procedure: **STOP** • **If anal area is bleeding** • **If the patient asks you to** • **If patient is showing signs of Autonomic Dysreflexia**	To note signs of distress, pain, bleeding and general discomfort. Or Autonomic Dysreflexia
When completed procedure, clean residual lubricating gel from the perineal area.	To prevent skin excoriation and promote comfort.

Action	Rationale
Ensure patient is comfortable and ask them to retain the suppository for 20 minutes, or until they are no longer able to do so	To allow the suppository to melt and release the active ingredients.
Ensure patient has access to commode/ bedpan/toilet	To enable use
Dispose of all equipment and PPE as per AGH Handling and Disposal of waste policy, remove gloves and apron and decontaminate hands as per the AGH Hand Hygiene Procedure.	To prevent cross infection and environmental contamination and to ensure staff and patient safety.
Document the procedure carried out, and the outcome of the procedure in the patient's health records	To comply with NMC Code and AGH guidelines on documentation. To monitor effects and improve communication and enhance delivery of care.
If any abnormality is found ensure an appropriate referral is made in line with local policy	To promote continuity of care and patient safety.

Appendix B

Algorithm for Management of a Patient with Unexplained Diarrhoea Suspected *Clostridium difficile* infection (CDI)

If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is NOT clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) then it is necessary to determine if this is due to CDI. If in doubt please seek advice from the Infection Prevention Team

↓

Isolate patient in a single room

↓

Collect stool specimen and send to Microbiology. The stool sample must take on the shape of the container. The container should be at least ¼ filled.

↓

Refer to the following Trust guidance:

- **The SIGHT mnemonic (see bottom of page)**
- ***Clostridium difficile* Guideline**
- **Isolation Guideline**
- ***Clostridium difficile* Care Pathway**

S	Suspect that a case may be infective when there is no clear alternative cause for diarrhoea
I	Isolate patient
G	Gloves and aprons must be used for all contacts with the patient and their environment

H	**Hand washing with soap and water before and after each contact with the patient and the patient's environment**
T	**Test the stool by sending a specimen immediately**

Infection Prevention Team, April 2012, version 2, review August 2020

Appendix A Insert Text

Appendix B Insert Text

Appendix C Insert Text

PROCEDURAL DOCUMENT DEVELOPMENT CHECKLIST

Prior to submitting any document for initial ratification or following a review, the following checklist must be completed and appended by the author to the document. Please remember when writing a procedural document you need to be as specific as possible and not leave any area open for misinterpretation.

TITLE OF DOCUMENT:	✓or X	Comments
Front page – title, document reference table		
Is the title clear and unambiguous?	y	
Is it clear whether the document is a guideline, policy, or SOP?	y	
Has the correct document template been used?	y	
Is the document reference table completed?	y	
Is the review date identified?	y	
Is the frequency of review identified? If so, is it acceptable?	y	
Contents page and associated trust documents		
Are the contents page and page numbers accurate?	y	
Are all associated trust documents hyperlinked?	y	
Introduction		
Are the intention, purpose and scope of the document made clear?	y	
Are all relevant, supporting policies, local and national guidelines and SOPs listed?	y	
Has an equality impact assessment been completed?	N/A	
Definitions		
Are all terms clearly defined?	y	
Duties		
Are all roles and responsibilities made clear?	N/A	
Developing a new procedural document		
Have any training needs been identified?	y	
If so, have Education & Training / practice development been consulted?	y	

TITLE OF DOCUMENT:	✓ or X	Comments
Consultation, approval and ratification process		
Is the consultation / peer review process explicit?		
Has the patient and carer panel been consulted?	N/A	
Does the document identify which committee/group has approved it?	y	
Are there any fraud implications with this policy? If yes has the Local Counter Fraud Specialist been consulted?	N/A	
Is this document used to evidence CQC or NHSLA standards (if yes has the Assistant Director Healthcare Governance been consulted)	N/A	
Dissemination & Implementation		
Is there an outline/plan to identify how this will be done?	y	
Does the plan include the necessary training/support to ensure compliance?	y	
Have resources implications (including financial) been considered and documented?	y	
References		
Are all references properly listed?	y	
Is there a clear evidence base?	y	
Version control		
Does the document have a clear version number?	y	
Are minor amendments clearly documented on the version control page?		
Process for Monitoring compliance		
Are there measurable standards, KPIs or a defined audit tool to support monitoring compliance of the document?	N/A	
Is it clear which committee or group is responsible for monitoring compliance with the policy?	y	
Overall Responsibility for the Document		
Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	y	
Are there any other issues to be considered?	N	