Harrogate and District NHS Foundation Trust

Policy for Bowel Care Management in Adult Patients

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	16/1/2019	New guideline	16/1/2022

Status	Open	
Publication Scheme	HDFT intranet	
FOI Classification	Release without reference to author	
Function/Activity	Clinical Guideline	
Record Type	Clinical Guideline	
Project Name	Bowel care management	
Key Words	Bowel care, digital rectal examination, digital rectal stimulation, digital removal of faeces, manual evacuation of faeces	
Standard	Management of lower bowel dysfunction RCN 2012; Management of neurogenic bowel dysfunction in individuals with central neurological conditions, MASC 2012.	
Author	Kate Sansam	**Date/s**
Approval and/or Ratification Body	Improving Fundamental Care Steering Group	15/1/19

CONTENTS

Table of Contents

INTRODUCTION

"*Bowel care is a fundamental area of patient care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients, many of whom are hesitant to admit to bowel problems or to discuss such issues."*

(RCN 2012)

Bowel care may include invasive rectal interventions and should only be carried out when there is a specific clinical indication, by clinicians competent to perform these.

Non-adherence to a patient's regular bowel care regime can not only result in impaction, overflow and patient distress, but may lead to the potentially life-threatening condition of Autonomic Dysreflexia in patients with spinal cord injury and other neurological conditions. (RCN 2012, NPSA 2018, MASCIP 2012)

1.1. Purpose

To ensure a high standard of bowel care, including assessment, treatment and rectal interventions across adult services provided by Harrogate & District NHS Foundation Trust.

To ensure safe, competent practice by all clinicians undertaking bowel care and reduce the risk of associated complications such as Autonomic Dysreflexia due to a patient's routine bowel care not been provided.

To ensure that all practice is evidence-based, relevant and appropriate.

1.2. Scope

The policy will apply to all staff undertaking bowel care for adults, with the exception of stoma care.

In order to carry out invasive bowel care all staff should attend relevant training, achieve competency, and be working within their job description.

1.3. Definitions

Digital Rectal Examination (DRE) – Examination of the rectum by inserting a gloved, lubricated finger into the rectum.

Digital Rectal Stimulation (DRS) – The insertion of a gloved, lubricated finger through the anus into the rectum followed by a gentle circular motion of the finger for 20-30 seconds to stimulate reflex evacuation of stool.

Digital Removal of Faeces (DRF) – The removal of stool from the rectum using a gloved, lubricated finger.

Bristol Stool Scale – A diagnostic tool used to classify the consistency of faeces into 7 types. See Appendix 3.

Autonomic Dysreflexia (AD) – A potentially dangerous complication of neurological conditions, most commonly spinal cord injury, which results in acute, uncontrolled hypertension. Acute AD is a reaction of the autonomic nervous system to overstimulation.

2. GUIDELINE

2.1. Bowel Assessment

Assessment of bowel continence and function should form part of the holistic patient assessment and includes obtaining a history and carrying out relevant clinical examinations. It may also involve carrying out and interpreting relevant baseline physiological observations and tests.

In some circumstances patients will have regular administration of either enemas or suppositories to ensure regular bowel evacuation. This is more common in people with long term neurological conditions such as spinal cord pathology. It will be performed under the guidance of the prescriber and should be incorporated into the individual patient's care plan.

If a patient with an established bowel care regime is admitted to hospital this regime should be continued unless there are definite contraindications identified. If a patient's regular bowel care programme needs to be altered, consider obtaining further advice from their treating specialist, particularly in the case of patients with spinal cord injuries who will usually be under life-long follow up with their regional spinal injuries centre.

2.2. Digital Rectal Examination

Digital Rectal Examination involves visually inspecting the perianal area and inserting a lubricated gloved finger into a patient's rectum. It may be used to assess for the presence of masses; perianal/rectal sensation; anal tone and power; the presence, amount and consistency of faeces within the rectum and as part of administering rectal medications. It is an invasive procedure and should only be performed when necessary after assessment of the individual.

DRE is contraindicated if:

- Patient refuses consent (procedure can be undertaken if patient lacks capacity to consent and it is deemed to be in their best interest)
- Recent recent/anal surgery or trauma
- There is specific, documented instructions from the patient's doctor/specialist nurse that the procedure should not be undertaken

- The clinician is not competent to perform the procedure (in which case they should seek the assistance of a colleague with this competency)

Additional assessment and care is required if:

- There is active inflammation of the bowel, including Crohn's disease, Ulcerative Colitis and Diverticulitis
- Recent radiotherapy to the pelvic area
- Rectal/anal pain
- Previous rectal or anal surgery/trauma
- Known allergies eg to Latex
- Patients at risk of autonomic dysreflexia eg those with previous spinal injury
- Known history of sexual abuse
- Fresh, rectal bleeding and anticoagulation medication
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment

Equipment needed:

- plastic-backed absorbent sheet
- non-latex disposable gloves
- clinical swabs/wipes
- lubricating jelly
- access to commode/toilet as procedure may stimulate bowel evacuation

See Appendix 4 for DRE procedure.

2.3. Digital Rectal Stimulation

Digital Rectal Stimulation (DRS) can be used to aid defecation in some patients, by helping to relax the sphincter and stimulate the rectum to contract. It involves inserting a lubricated gloved finger into the anus and slowly rotating the finger in circular movements, maintaining contact with the rectal mucosa and gently stretching the anal canal. This procedure may be more effective when used together with other techniques to enhance defecation such as adopting the correct position on the lavatory and taking hot drinks/food 20-30 minutes prior to instigating bowel care, to take advantage of the gastric colic reflex which is strongest after the first meal of the day. It can also be used at other times of the day. This technique may be particularly useful in patients with previous spinal cord pathology. In some patients the stimulated reflex may be sufficient to completely empty the bowel, but others may require digital removal of faeces in addition.

Equipment needed:

- plastic-backed absorbent sheet
- non-latex disposable gloves
- clinical swabs/wipes
- lubricating jelly

See Appendix 4 for DRS procedure.

2.4. Digital Removal of Faeces

Digital Removal of Faeces (DRF) involves the insertion of a single lubricated gloved finger into a patient's rectum to break up or remove faeces. For most patients with constipation the need for the digital removal of faeces can be prevented by using alternative interventions. However for some patients, particular those with spinal cord or cauda equina pathology, DRF is an essential part of their routine bowel management. It may be used for removal of faeces prior to placing suppositories in individual's with reflex bowel emptying (often seen after spinal cord injury) or to complete evacuation where reflex activity alone in insufficient to empty the bowel.

Equipment needed:

- plastic-backed absorbent sheet
- non-latex disposable gloves
- clinical swabs/wipes
- lubricating jelly (ensure adequate amount)
- clinical waste bag or other suitable receptacle for disposal of faeces and soiled swabs/wipes

See Appendix 4 for DRF procedure.

2.5. Rectal Stimulant Medication

Rectal Stimulant Medication include suppositories and enemas. A suppository is a medicated solid formulation prepared for insertion into the rectum. Once inserted the temperature of the body will melt the suppository from its solid form to a liquid. Some suppositories (eg Bisacodyl) contain medication to stimulate colonic contraction, others (eg Glycerol) act mainly through their physical presence stimulating the rectum and by providing additional lubrication to facilitate evacuation of faeces. An enema is a liquid preparation that is introduced via the rectum for the purpose of producing a bowel movement or administering medication.

Suppositories and enemas may be used to treat faecal impaction/constipation, as part of a bowel management programme for someone with neurogenic bowel dysfunction, stimulate bowel clearance before bowel investigations/surgery or to introduce prescribed medication eg to treat Inflammatory Bowel Disease. For some patients, rectal medication is a regular part of lower bowel care, used to trigger evacuation as part of their routine bowel management programme.

In the case of suspected rectal loading, Digital Rectal Examination should be performed prior to administration to assess the need for rectal medication. Suppositories and enemas should be administered at room temperature with the patient lying in the left lateral position.

Suppositories and enemas are contraindicated in:

- Colonic obstruction
- Paralytic ileus
- Following gastrointestinal or gynaecological surgery where suture lines could be ruptured (unless otherwise directed by the surgeon)

2.6. Rectal Irrigation

Rectal Irrigation, also known as trans-anal irrigation, involves using warm water irrigation to facilitate evacuation of stool from the descending colon and rectum. It may be used to treat chronic constipation, faecal incontinence and neurogenic bowel dysfunction. It should only be used if other, less invasive, methods of bowel management have failed to adequately control symptoms. It is a specialist procedure and should only be commenced by trained individuals following consultation with the Continence or Colorectal Services.

2.7. Autonomic Dysreflexia

Autonomic Dysreflexia is a condition characterised by uncontrolled elevation of blood pressure associated with bradycardia which can result in intracranial haemorrhage, seizures and death if not promptly managed. It is most commonly seen in patients with previous spinal cord injury, usually at or above the level of T6 (although has been reported as low as T10 rarely). A small number of patients who have had a severe stroke or who have severe forms of Parkinson's Disease, multiple sclerosis, cerebral palsy, or spina bifida may also be susceptible to autonomic dysreflexia, but this is very rare.

Autonomic Dysreflexia is usually triggered by any noxious stimuli below the level of the spinal cord lesion, even if the individual has no perception of pain in that area. Common triggers include constipation/full rectum and urinary retention. Treatment must be instituted promptly and any precipitators should be removed – ie bowel care if needed, insertion of catheter etc. If the cause is not known or cannot be reversed the patient should be sat upright and sublingual GTN spray given. Further advice can be obtained from the Yorkshire Regional Spinal Injuries Centre based at Pinderfields Hospital.

For further information see: www.rnoh.nhs.uk/our-services/spinal-cord-injury-centre/medical-management-advice/autonomic-dysreflexia

2.8. Consent

DRE, DRS and DRF are invasive procedures and should only be performed when necessary and after individual assessment. Prior to each intervention the procedure should be explained to the patient and their consent should be obtained or a decision

made that the procedure is in their best interest if they lack capacity to make this decision.

All patients should be offered a chaperone when undergoing any procedure, examination or treatment. If a chaperone cannot be provided the patient must be informed and asked if they wish to continue with the procedure and their decision should be documented in the patient records.

Please refer to the Trust's Policies for Consent, Chaperones and Mental Capacity Act for further information.

3. ROLES AND RESPONSIBILITIES

All staff working with patients where bowel care may be needed, including all adult inpatient wards and community nursing teams, should be familiar with the procedures detailed in this document and other related policies. Clinical managers of these areas are responsible for ensuring staff competent to perform bowel care are available at all times should this be required.

Each registered healthcare professional is accountable for their own practice, will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body. Registered healthcare professionals are responsible for maintaining their competencies and seeking appropriate education and training.

All staff that carry out bowel care must be trained and assessed as competent prior to undertaking that skill – see Appendix 4. Competency should be reassessed every three years by a suitable person, who has themselves been assessed as competent, such as clinical skills trainers or other senior clinicians within a department, as appropriate.

Line managers are responsible for ensuring all staff providing bowel care are familiar with this policy and related policies and must support staff in providing them with the time to attend relevant training and to access professional supervision.

The Continence Service offers training on assessment and management of constipation and faecal incontinence that may be booked through Learning and Development.

4. POLICY DEVELOPMENT AND EQUALITY

This policy has undergone Stage 1 Equality Impact Assessment screening. This guideline does not discriminate on the grounds of race, disability, age, gender, sexuality, faith or language.

5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The policy was circulated to those identified in Appendix 1 for comment during development. The policy will be approved and ratified by the Fundamental Cares Group.

6. DOCUMENT CONTROL

The policy will be published on the Trust intranet. Previous versions will be archived. Paper copies will only be valid on the date of printing.

7. DISSEMINATION AND IMPLEMENTATION

The guideline will be published in the Trust electronic document library. The publication on the intranet will be highlighted to all staff via Staff Bulletin.
It will also be highlighted to staff during Bowel Care training and competency assessments.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1. Standards / Key Performance Indicators

See Appendix 2 for Standards and Key Performance Indicators

8.2. Process for Monitoring Compliance

Deviations from the guideline will be reported via a Datix form. The care in each case reported will be reviewed by a member of the continence service and where deficiencies have arisen this will be fed back to the appropriate staff.

Where incidents indicate any deficiencies in practice, a more thorough one off audit may be instigated with assistance from the Clinical Effectiveness Department.

9. REFERENCE DOCUMENTS

Royal College of Nursing 2012 Management of lower bowel dysfunction, including digital rectal examination and digital removal of faeces.
www.rcn.org.uk/professional-development/publications/pub-003226

National Patient Safety Agency 2018 Patient safety alert “Resources to support safer bowel care for patients at risk of autonomic dysreflexia”
improvement.nhs.uk/news-alerts/patients-at-risk-of-autonomic-dysreflexia/

Guidelines for management of neurogenic bowel dysfunction in individuals with central neurological conditions 2012. MASCIP.
www.mascip.co.uk/wp-content/uploads/2015/02/CV653N-Neurogenic-Guidelines-Sept-2012.pdf

The Royal Marsden Clinical Procedures (9th edition)
www.rmmonline.co.uk

Skills for Health 2010, National Occupational Standards CC01 - Assess bladder and bowel dysfunction
tools.skillsforhealth.org.uk/competence/show/html/code/CC01/

Skills for Health 2010, National Occupational Standards CC09 - Enable individuals to effectively evacuate their bowels
tools.skillsforhealth.org.uk/competence/show/html/id/760/

National Institute for Heath and Care Excellence 2017, Clinical Knowledge Summary on constipation
cks.nice.org.uk/constipation

10. ASSOCIATED DOCUMENTATION

HDFT Mental Capacity Act Policy and Procedures
HDFT Consent to Treatment or Examination
HDFT Chaperone Policy

11. APPENDICES

Appendix 1: Consultation Summary
Appendix 2: Monitoring, audit and feedback summary
Appendix 3: Bristol Stool Scale
Appendix 4: Combined Bowel Care Competencies

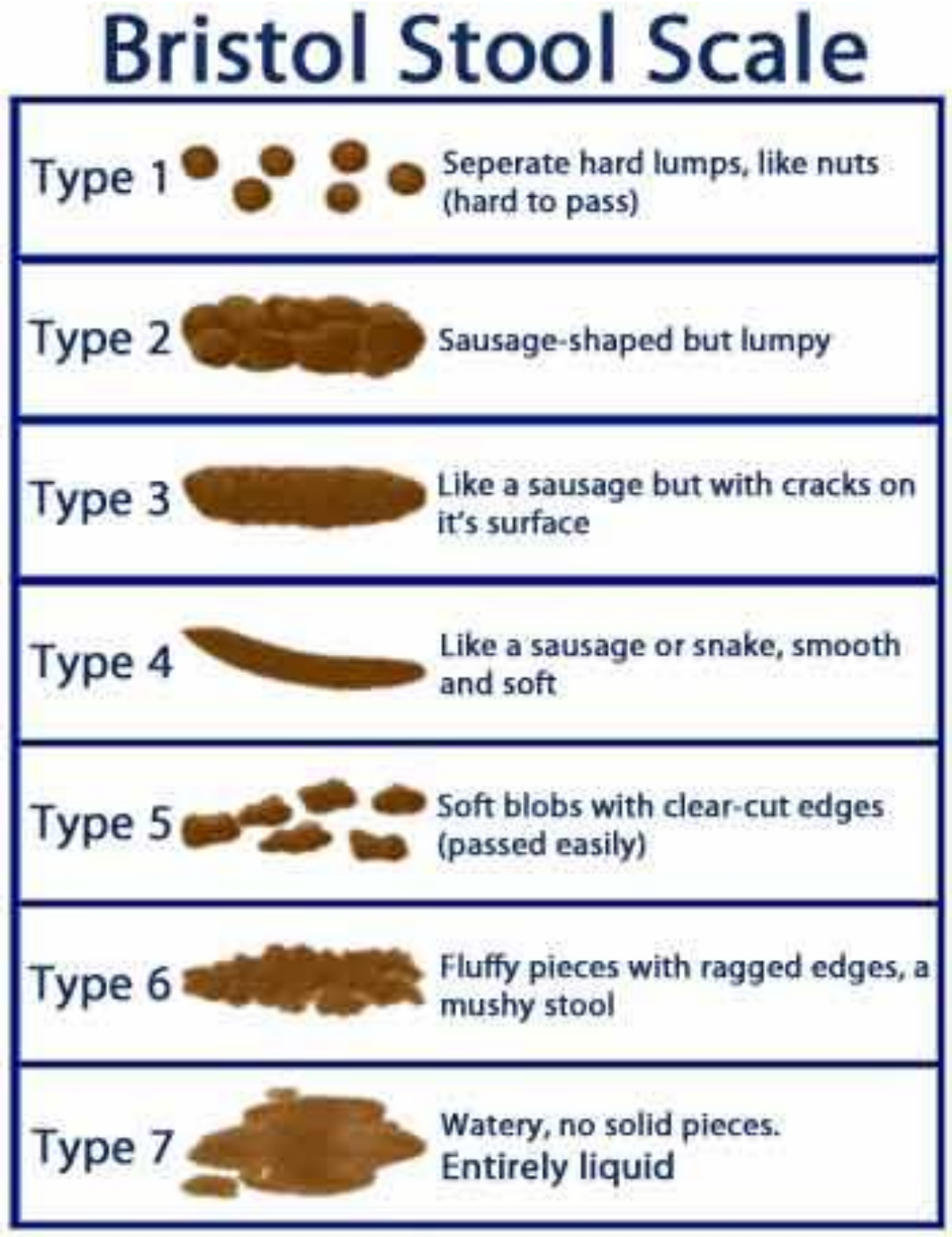
11.1. Appendix 1: Consultation Summary

Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	**List Groups and/or Individuals Consulted**
	Chief Nurse
	Heads of Nursing
	Matrons
	Specialist Continence Service
	Colorectal Specialist Nurses
	Dr Sivaji, Consultant Gastroenterologist
	Mr Mahon, Consultant Surgeon
	Jo Prosper, Specialist Physio

11.2. Appendix 2: Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reported to	Concerns with results escalated to
Review of all incident reports relating to this clinical guideline	Was the relevant guideline followed?	Specialist Continence Service	Following each incident	Risk Management Group Staff meetings	CORM
Review of guidelines when any new evidence/ guidance resulting in change of practice is published	Do these guidelines reflect current evidence and recommendations	Specialist Continence Service & Dr Sansam	When new information published or new evidence comes to light.	Improving Fundamental Care Steering group	CORM

11.3. Appendix 3: Bristol Stool Scale



(Heaton et al 1992)

11.4. Appendix 4: Combined Bowel Care Competencies

Combined Bowel Care Competencies

This tool is in 2 sections:

Section 1: Underpinning knowledge required to meet the competency. The candidate will be required to provide evidence to demonstrate they understand the principles of undertaking the clinical activity. Examples of evidence can include questioning and observing, attendance at training, testimonies of colleagues, completion of workbooks, reading policy /protocols etc. A separate crib sheet is available to guide assessors with meeting the theoretical knowledge. To achieve more than one Bowel Care Competency section 1. does not have to be repeated.

Section 2: Demonstrate competency in carrying out the procedure/skill. The WASP assessment tool is to be used for assessment of clinical skills at Harrogate and District NHS Foundation Trust. All elements of the tool must be completed and signed off by a registered health care professional who is themselves, deemed competent. To achieve competency, the practitioner must be assessed as competent in both knowledge and practice. For some roles it may not be appropriate or necessary to complete all of the bowel competencies.

When the practitioner is consistently proficient in all elements each competency, they can be signed off. The practitioner can then be delegated this task to undertake without supervision. Continued adherence to delegation guidelines, competency renewal and recognition of scope of practice must always be applied.

Procedures

1. Digital Rectal Examination
2. Digital Removal of Faeces
3. Digital Rectal Stimulation
4. Administration of Rectal Suppositories
5. Administration of Enemas

Name of Practitioner:…….. **Name of final sign off assessor:…….....**	**Examples of evidence:** Testimonies from colleagues, attendance at training, completion of workbooks, reading policy /protocols, leading on practice initiatives, questioning and observing, completed documentation etc.

SECTION 1 UNDERPINNING KNOWLEDGE FOR BOWEL CARE COMPETENCIES:

1. **Digital Rectal Examination**
2. **Digital Removal of Faeces**
3. **Digital Rectal Stimulation**
4. **Administration of Rectal Suppositories**
5. **Administration of Enemas**

Indicators	Evidence	Assessor Sign/date
1.0 Humanistic elements (examples - communication/privacy/choices/family/carers/culture/beliefs/self-care)		
1.1 Describe and demonstrate respect for an individual's privacy, dignity and choice.		
1.2 Awareness and understanding of • HDFT Chaperone Policy • HDFT Consent Policy		
2.0 Safe practice (examples - Policy/ protocol/ infection prevention/ patient condition/ training/ safe use of equipment)		
2.1 Explain the meaning of working within your sphere of competence and when to seek advice		
3.0 Record keeping and documentation		
3.1 Describe the importance of documentation and the consequences of poor recording		
4.0 Knowledge		
4.1 Name three possible signs of bowel cancer or inflammatory bowel disease and what actions to take.		
4.2 Describe the anatomy of the lower bowel including normal appearance of the anus and skin		
4.3 Explain the normal range of bowel frequency and how to classify stool types by use of the Bristol Stool Chart		

4.4 Explain four causes of constipation. Describe four signs and symptoms		
4.5 Describe 3 risks or complications associated with constipation.		
4.6 Demonstrates understanding of Autonomic Dysreflexia and who is at risk. List 3 signs and symptoms.		
4.7 Describe the best position for defecation and how it could improve obstructed defecation.		
4.8 Demonstrate understanding of the importance of fluid intake and its role in avoiding constipation		
4.9 Describe the impact constipation can have in relation to urinary retention		
4.10 **(Registered staff only)** Demonstrate 3 different types of oral and/or rectal medication and how they work to treat constipation		
4.11 **(Registered staff only)** In what circumstances should Phosphate Enemas be considered. Name 2 contraindications. List 2 potential risks		
4.12 Explain how to establish if a treatment has been effective and what to do if it is not effective.		

COMPETENCY	DIGITAL RECTAL EXAMINATION	
Staff group	**Registered Practitioners and Healthcare Support Workers (HCSW) Band 3 and above**	
Delegation guidance	HCSWs may undertake DRE following assessment by a qualified competent clinician, if the HCSW: • has been deemed competent in the particular lower bowel care task • has been delegated the task by a registered clinician • obtains patient consent (RCN, 2012) • Suitable for a HCSW: • Patients assessed by a registered practitioner as needing repeat suppositories, where the procedure is expected to be non-complex and routine. DRE should precede each administration.	Unsuitable for non-registered clinical staff: • New patients • Patients who require complex assessment • Patients requiring reassessment. • Where routine suppository use has not been well established. • Patients who do not give their consent. • This list is not definitive and the registered practitioner should exercise clinical judgement on the suitability of patients according to the needs of the patient and the competencies of the HCSW.
Sources /evidence	The Royal Marsden Clinical Procedures (9th edition). http://www.rmmonline.co.uk Skills for Health NOS CC01 - Assess bladder and bowel dysfunction Skills for Health NOS CC09 Enable individuals to effectively evacuate their bowels https://cks.nice.org.uk/constipation RCN management of Lower Bowel Dysfunction including DRE and DRF. RCN Guidance for nurses, 2017	
Relevant policy / protocol and further reading	HDFT Chaperone Policy, HDFT Consent Policy	
Pre –requisites: • **Training requirement** • **Completed competencies**	Chaperone Competency,	
Frequency of assessment	3 yearly	
Author /designation	Rachel Kerr, Joanne Burnside and Wendy McCulloch. Specialist Continence Service	
Date produced	January 2018	
Date to be reviewed	January 2021	

Name of Practitioner: ……..……			
	W	**WITNESSED**	Observe the skill being carried out – staff should have had the opportunity to observe the procedure prior to being supervised and has undergone the relevant training. A period of supervised practice should be agreed with the practitioner and assessor
	A	**ASSIMILATED**	Understands the underpinning knowledge and reasoning and how to perform the skill/activity to support safe delivery of the skill.
	S	**SUPERVISED**	Practice under supervision **(further guidance on scoring on assessors answer sheet)** 1– Needs practice and direct supervision 2 – Needs further practice and supervision 3 – Proficient and can work independently
	P	**PROFICIENT**	Competent in both knowledge and skill elements of the competency

SECTION 2 PROCEDURE/SKILL DIGITAL RECTAL EXAMINATION

	Action	Rationale	W	A and S					
			Yes/No	Score	Score	Score	Score	Score	
1	Explain the procedure to the patient and gain verbal consent. Offer a chaperone as per HDFT policy.	To ensure the patient understands the procedure and gives valid consent. To ensure local policy and procedure are followed.							
2	If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia	Stimulus below the level of their injury may induce a potentially life threatening increase in blood pressure.							
3	If required, ask patient if they would prefer members of family/carers/friends to leave the room. Close curtains and doors as appropriate.	To ensure patients privacy and dignity at all times.							

4	Collect necessary equipment, wash hands and put on protective apron.	To ensure all equipment is available before commencing the procedure and reduce transmitting of infection							
5	Ensure bedpan/ commode or toilet is readily available.	DRE can stimulate the need for bowel movement							
6	Assist the patient to lie in the left lateral position, if possible, with knees flexed, the upper knee higher than the lower knee, with the buttocks towards the edge of the bed.	Allows ease of passage into the rectum by following the natural anatomy of the colon. Flexing the knees will reduce discomfort at the anal sphincter and allow observation of the anus							
7	Place a disposable protective sheet beneath the patient's buttocks and cover the legs/area not to be exposed.	To reduce potential infection caused by soiling and to avoid embarrassing the patient.							
8	Wash hands with soap and warm water or use alcohol hand rub put on non-sterile gloves	For infection prevention and control							
9	Inform the patient you are about to proceed.	Informing the patient assists with co - operation with the procedure and may reduce distress.							
10	Observe anal area prior to the insertion of the finger into the anus for evidence of skin soreness, soiling excoriation, swelling, haemorrhoids, rectal prolapse and infestation.	May indicate incontinence or pruritus. Swelling may be indicative of possible mass or abscess. Abnormalities such as bleeding, discharge or prolapse should be reported to medical staff before any examination is undertaken							
11	Palpate the perianal area starting at 12 o'clock, clockwise to 6 o'clock and then from 12 anticlockwise to 6 o'clock.	To assess for any irregularities, swelling, indurations, tenderness or abscess in the perianal area							
12	Place some lubricating gel on a gauze square and gloved index finger.	To minimize discomfort, as lubrication reduces friction and, to ease insertion of the finger into the anus/rectum. Lubrication also helps minimize anal mucosal trauma.							
13	Prior to insertion, encourage the patient to breathe out or talk and/or place	To prevent spasm of the anal sphincter on insertion. Gently placing a finger on the anus							

	gloved index finger on the anus for a few seconds prior to insertion. On insertion of finger, assess anal sphincter control; resistance should be felt.	initiates the anal reflex, causing the anus to contract and then relax. Digital insertion with resistance indicates good internal sphincter tone, poor resistance may indicate the opposite							
14	With finger inserted in the anus, sweep clockwise then anticlockwise, noting any irregularities.	Palpating around 360° enables the assessor to establish if there is any swelling or tenderness within the rectum							
15	Digital examination may feel faecal matter within the rectum; note consistency of any faecal matter using Bristol Stool Chart.	May establish loaded rectum and indicate constipation and the need for rectal medication							
16	Wipe the patient's perineal area to remove excess lubrication gel.	To promote patient comfort and avoid excoriation of the skin.							
17	Remove apron and wash hands.	For infection prevention and control							
18	Allow the patient to dress in private, unless they need assistance. Offer bedpan, commode or toilet facilities as appropriate.	To maintain patient dignity							
19	Document all observations, findings and actions. Consider onward referral to another health care professional if there were any concerns on examination.	To evaluate the success of the intervention and monitor bowel function. To aid communication and to maintain accurate, professional and legal records.							
Signature and date									

Proficient - Final sign off (assessor name and designation)……..... Date:……

COMMENTS / PROGRESS **COMPETENCY:…… Name of Practitioner:……..**		
Date	**Comments /Progress**	**Assessor signature**

COMPETENCY	Digital Removal of Faeces (DRF)	
Staff group	Registered Practitioners and Healthcare Support Workers (HCSW Band 3 or above)	
Delegation guidance	HCSWs may undertake DRF following assessment by a qualified competent nurse, if the HCSW: • has been deemed competent in the particular lower bowel care task • the qualified nurse agrees to delegate that lower bowel care task to that particular HCSW • and that the patient consents (RCN, 2012) • • Suitable for non-registered clinical staff: • Patients assessed by a registered practitioner to need repeat digital removal of faeces. To be non-complex and routine.	Unsuitable for non-registered clinical staff: • Spinal cord injury patients who have an injury at T6 or above and are at risk of autonomic dysreflexia • Patients who have an acute need for bowel interventions. • Patients who require complex assessment or review. • Patients who do not give their consent. This list is not definitive and the registered practitioner should exercise clinical judgement on the suitability of patients according to the needs of the patient and the competencies of the HCSW.
Sources /evidence	The Royal Marsden Clinical Procedures (9th edition). http://www.rmmonline.co.uk Skills for Health NOS CC01 - Assess bladder and bowel dysfunction Skills for Health NOS CC09 Enable individuals to effectively evacuate their bowels https://cks.nice.org.uk/constipation RCN management of Lower Bowel Dysfunction including DRE and DRF. RCN Guidance for nurses, 2017	
Relevant policy / protocol and further reading	HDFT Chaperone Policy, HDFT Consent Policy	
Pre –requisites: • **Training requirement** • **Completed competencies**	Chaperone Competency,	
Frequency of assessment	3 yearly	
Author /designation	Rachel Kerr, Joanne Burnside and Wendy McCulloch. Specialist Continence Service	
Date produced	January 2018	
Date to be reviewed	January 2021	

Name of Practitioner:……			
	W	**WITNESSED**	Observe the skill being carried out – staff should have had the opportunity to observe the procedure prior to being supervised and has undergone the relevant training. A period of supervised practice should be agreed with the practitioner and assessor
	A	**ASSIMILATED**	Understands the underpinning knowledge and reasoning and how to perform the skill/activity to support safe delivery of the skill.
	S	**SUPERVISED**	Practice under supervision **(further guidance on scoring on assessors answer sheet)** 1– Needs practice and direct supervision 2 – Needs further practice and supervision 3 – Proficient and can work independently
	P	**PROFICIENT**	Competent in both knowledge and skill elements of the competency

SECTION 2 PROCEEDURE/SKILL DIGITAL REMOVAL OF FAECES (DRF)

	Action	**Rationale**	**W**	**A and S**					
			Yes/No	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
1	Explain the procedure to the patient and gain verbal consent to perform the procedure. Offer a chaperone as per HDFT policy.	To ensure the patient understands the procedure and gives valid consent. To ensure local policy and procedure are followed.							
2	In patients who have a spinal cord injury at or above T6, take their blood pressure prior to DRF to obtain a baseline BP. Observe the patient for signs of autonomic dysreflexia throughout	Stimulus below the level of their injury may induce a potentially life threatening increase in blood pressure. For patients where the procedure is routine and is well established, routine BP monitoring is not required							
3	Draw curtains and close doors and ask the patient if they would prefer family/carers/friends to leave the room	To ensure patients' privacy and dignity at all times.							
4	Assist the patient to lie in the left lateral position with knees flexed, if possible, the upper knee higher than the lower knee, with the buttocks towards the edge of the bed.	This allows ease of digital insertion into the rectum, by following the natural anatomy of the colon. Flexing the knees reduces discomfort as the finger passes the anal sphincter.							
5	Place a disposable incontinence pad	To reduce potential infection caused by							

	beneath the patient's buttocks and cover the legs and genital area	soiling and to promote patient dignity at all times.							
6	Wash hands with soap and water or bactericidal alcohol hand-rub and put on disposable apron and gloves	For infection prevention and control Assists with patient co-operation with the procedure							
7	Place some lubricating gel on a gauze square and gloved index finger.	To minimize discomfort and trauma as lubrication reduces friction and to ease insertion of the finger into the anus/rectum.							
8	Inform the patient you are about to proceed.	Facilitates patient co-operation with the procedure							
9	Observe anal area prior to the insertion of the finger into the anus for evidence of skin soreness, soiling, excoriation, swelling, haemorrhoids or rectal prolapse.	May indicate incontinence or pruritus. Swelling may be indicative of possible mass or abscess. Abnormalities such as bleeding, discharge or prolapse should be reported to medical staff before any examination is undertaken.							
10	Gently perform digital rectal examination with a lubricated, gloved finger (in accordance with DRE competency).	To assess risk prior to performing DRF and the need to proceed with DRF.							
11	If the stool is type 1 (see Bristol Stool chart), remove one lump at a time until no more faecal matter is felt.	To relieve patient discomfort.							
12	If a solid faecal mass is felt, split it and remove small pieces until no more faecal matter is felt. Avoid using a hooked finger to remove faeces.	To relieve patient discomfort. Use of a hooked finger may cause damage to the rectal mucosa and anal sphincter.							
13	If faecal mass is too hard to break up, or more than 4 cm across, stop the procedure and discuss with the multidisciplinary team.	To avoid unnecessary pain and damage to the anal sphincter. The patient may require the procedure to be carried out under anaesthetic.							
14	As faeces is removed, it should be placed in an appropriate receiver.	To assist in appropriate disposal and reduce contamination or cross-infection risk							
15	Encourage patients who receive this procedure on a regular basis to have a period of rest or, if appropriate, to assist	Patient and nurse education is required to use this technique safely and so further guidance should be sought before							

	using the Valsalva manoeuvre.	introducing this manoeuvre as it may lead to complications such as haemorrhoids							
16	Assist patient to toilet/commode/ bedpan if required and they are able.	To enhance patient comfort, dignity and aid a good bowel movement.							
17	Wash and dry the patient's anal area and buttocks	To ensure patient feels comfortable and clean							
18	Remove gloves and apron and dispose of equipment in appropriate clinical waste bin. Wash hands.	For prevention and control of infection							
19	Assist patient into a comfortable position. Allow the patient to dress in private, unless they need assistance. Offer bedpan, commode or toilet facilities as appropriate.	To promote comfort and dignity.							
20	In spinal cord injury patients, at risk of autonomic dysreflexia, repeat blood pressure reading.	In spinal cord injury, stimulus below the level of injury may result in symptoms of autonomic dysreflexia requiring immediate medical intervention							
21	Document findings including the effect DRF has had on the patient and the result (amount, colour, consistency using the Bristol stool chart) Report to appropriate members of the multidisciplinary team.	To ensure continuity of care and enable appropriate actions to be initiated							
Signature and date									

Proficient - Final sign off (assessor name and designation):……Date:……

COMPETENCY	Digital Rectal Stimulation (DRS)

COMMENTS / PROGRESS COMPETENCY:…… Name of Practitioner:……..		
Date	**Comments /Progress**	**Assessor signature**

Staff group	**Registered Practitioners and Healthcare Support Workers (HCSW) Band 3 and above**	
Delegation guidance	HCSWs may undertake DRS following assessment by a qualified competent nurse, if the HCSW: • has been deemed competent in the particular lower bowel care task • the qualified nurse agrees to delegate that lower bowel care task to that particular HCSW • and that the patient consents (RCN, 2012) • • Suitable for non-registered clinical staff: • Patients assessed by a registered practitioner to need repeat DRS, where the procedure is expected to be non-complex and routine. DRE should precede each DRS	Unsuitable for non-registered clinical staff: • New patients • Patients who have an acute need for bowel interventions. • Patients who require complex assessment or review. • Where routine DRS has not been well established. • Patients who do not give their consent. This list is not definitive and the registered practitioner should exercise clinical judgement on the suitability of patients according to the needs of the patient and the competencies of the HCSW.
Sources /evidence	The Royal Marsden Clinical Procedures (9th edition). http://www.rmmonline.co.uk Skills for Health NOS CC01 - Assess bladder and bowel dysfunction Skills for Health NOS CC09 Enable individuals to effectively evacuate their bowels https://cks.nice.org.uk/constipation RCN management of Lower Bowel Dysfunction including DRE, DRS and DRF. RCN Guidance for nurses, 2017	
Relevant policy / protocol and further reading	HDFT Chaperone Policy, HDFT Consent Policy	
Pre –requisites: • **Training requirement** • **Completed competencies**	Chaperone Competency,	
Frequency of assessment	3 yearly	
Author /designation	Rachel Kerr, Joanne Burnside, Wendy McCulloch, Specialist Continence Service	
Date produced	January 2018	
Date to be reviewed	January 2021	

Name of Practitioner:……			
	W	**WITNESSED**	Observe the skill being carried out – staff should have had the opportunity to observe the procedure prior to being supervised and has undergone the relevant training. A period of supervised practice should be agreed with the practitioner and assessor
	A	**ASSIMILATED**	Understands the underpinning knowledge and reasoning and how to perform the skill/activity to support safe delivery of the skill.
	S	**SUPERVISED**	Practice under supervision **(further guidance on scoring on assessors answer sheet)** 1– Needs practice and direct supervision 2 – Needs further practice and supervision 3 – Proficient and can work independently
	P	**PROFICIENT**	Competent in both knowledge and skill elements of the competency

SECTION 2 PROCEEDURE/SKILL – DIGITAL RECTAL STIMULATION (DRS)

	Action	**Rationale**	**W**	**A and S**					
			Yes/No	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
1	Explain the procedure to the patient and gain verbal consent. Offer a chaperone as per HDFT policy.	To ensure the patient understands the procedure and gives valid consent. To ensure local policy and procedure are followed.							
2	In patients who have a spinal cord injury at or above T6, take their blood pressure prior to DRS to obtain a baseline BP. Observe the patient for signs of autonomic dysreflexia throughout.	Stimulus below the level of their injury may induce a potentially life threatening increase in blood pressure. For patients where the procedure is routine and is well established, routine BP monitoring is not required							
3	Ask the patient if they would prefer members of family/carers/friends to leave the room. Close curtains and doors.	To ensure patients privacy and dignity at all times.							
4	Collect necessary equipment, wash hands and put on a protective apron.	To ensure all equipment is available before commencing the procedure. To reduce transmitting of infection							

5	Ensure bedpan/ commode or toilet is readily available.	DRS can stimulate the need for bowel movement							
6	Assist the patient to lie in the left lateral position with knees flexed, the upper knee higher than the lower knee, with the buttocks towards the edge of the bed.	Allows ease of passage into the rectum by following the natural anatomy of the colon. Flexing the knees will reduce discomfort at the anal sphincter and allow observation of the anus							
7	Place a disposable protective sheet beneath the patient's buttocks and cover their genitals.	To reduce potential infection caused by soiling and to promote patient dignity at all times.							
8	Wash hands with soap and warm water or use alcohol hand rub. Put on 2 pairs of non-sterile gloves.	For infection prevention and control							
9	If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) local anaesthetic gel may be instilled into the rectum prior to the procedure This requires 5-10 minutes to take effect	To promote patient comfort and minimise the risk of autonomic dysreflexia.							
10	Inform the patient you are about to proceed.	Informing the patient assists with co-operation with the procedure and may reduce distress							
11	Gently perform digital rectal examination with a lubricated, gloved finger (in accordance with DRE competency).	To assess risk prior to performing DRS. To establish bowel contents and if digital removal of faeces is required.							
12	With finger still inserted, commence DRS. Slowly and gently rotate the finger so that the padded surface maintains contact with the bowel wall. Continue stimulation for 10 seconds	To stimulate peristalsis with minimal discomfort and trauma.							
13	Withdraw the finger and await reflex evacuation.	Peristalsis may not be immediate.							
14	Place faecal matter in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag.	For infection prevention and control							
15	Repeat every five-ten minutes until rectum is empty or reflex activity ceases.	Several attempts may be required to achieve complete bowel emptying.							

16	Remove soiled glove and replace, re-lubricating as necessary between insertions	For infection prevention and control							
17	If no bowel 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.	If no bowel movement has occurred after 3 stimulations it is unlikely to do so.							
18	Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes	To ensure evacuation is complete. Waiting allows any remaining stool to move into the rectum.							
19	When the procedure is completed, assist with cleansing the anal area. Remove gloves and apron and dispose of equipment in appropriate clinical waste bin. Wash hands.	For infection prevention and control and to promote good skin care.							
20	Allow the patient to dress in private, unless they need assistance. Offer bedpan, commode or toilet facilities as appropriate.	For patient comfort and dignity. Further bowel emptying may occur when in the correct position for defecation.							
21	Document findings including the effect DRS has had on the patient and the result (amount, colour, consistency using the Bristol stool chart). Record and report abnormalities. Discuss onward referral to another health care professional if there are any concerns.	To ensure continuity of care, aid communication and to maintain accurate, professional and legal records. To evaluate the success of the intervention and enable appropriate actions to be initiated.							
Signature and date									

Proficient - Final sign off (assessor name and designation):…… Date:……

COMPETENCY	Procedure for Administration of Suppositories

COMMENTS / PROGRESS COMPETENCY:…… Name of Practitioner:……..		
Date	**Comments /Progress**	**Assessor signature**

<table>
<tr><td>Staff group</td><td colspan="2">Registered Practitioners and Healthcare Support Workers (HCSW) Band 3 and above</td></tr>
<tr><td>Delegation guidance</td><td>HCSWs may administer prescribed suppositories following assessment by a qualified competent nurse, if the HCSW:
has been deemed competent in the particular lower bowel care task
the qualified nurse agrees to delegate that lower bowel care task to that particular HCSW
and the patient consents.
Suitable for non-registered clinical staff:
Patients assessed by a registered practitioner to need repeat suppositories, where the procedure is expected to be non-complex and routine. DRE should precede
Regular review of need for suppositories is required and treatment plan agreed in partnership with the patient/carers, registered nurse and GP/medical team</td><td>The following categories are considered unsuitable for non-registered clinical staff:
Patients who have an acute need for bowel interventions.
Patients who require complex assessment or review.
Where routine suppository use has not been well established.
This list is not definitive and the registered practitioner should exercise clinical judgement on the suitability of patients according to the needs of the patient and the competencies of the HCSW.</td></tr>
<tr><td>Sources /evidence</td><td colspan="2">The Royal Marsden Clinical Procedures (9th edition). http://www.rmmonline.co.uk
Skills for Health NOS CC01 - Assess bladder and bowel dysfunction
Skills for Health NOS CC09 Enable individuals to effectively evacuate their bowels
https://cks.nice.org.uk/constipation
RCN management of Lower Bowel Dysfunction including DRE and DRF. RCN Guidance for nurses, 2017</td></tr>
<tr><td>Relevant policy / protocol and further reading</td><td colspan="2">HDFT Chaperone Policy, HDFT Consent Policy</td></tr>
<tr><td>Pre –requisites:
Training requirement
Completed competencies</td><td colspan="2">Chaperone Competency,</td></tr>
<tr><td>Frequency of assessment</td><td colspan="2">3 yearly</td></tr>
<tr><td>Author /designation</td><td colspan="2">Rachel Kerr, Joanne Burnside, Wendy McCulloch Specialist Continence Service</td></tr>
<tr><td>Date produced</td><td colspan="2">January 2018</td></tr>
<tr><td>Date to be reviewed</td><td colspan="2">January 2021</td></tr>
</table>

Name of Practitioner:……			
	W	**WITNESSED**	Observe the skill being carried out – staff should have had the opportunity to observe the procedure prior to being supervised and has undergone the relevant training. A period of supervised practice should be agreed with the practitioner and assessor
	A	**ASSIMILATED**	Understands the underpinning knowledge and reasoning and how to perform the skill/activity to support safe delivery of the skill.
	S	**SUPERVISED**	Practice under supervision **(further guidance on scoring on assessors answer sheet)** 1– Needs practice and direct supervision 2 – Needs further practice and supervision 3 – Proficient and can work independently
	P	**PROFICIENT**	Competent in both knowledge and skill elements of the competency

SECTION 2 PROCEEDURE/SKILL – SUPPOSITORY ADMINISTRATION

	Action	**Rationale**	**W**	**A and S**					
			Yes/No	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
1	Explain the procedure with the patient and gain verbal consent to perform the procedure. Offer a chaperone as per HDFT policy.	To ensure the patient understands the procedure and gives valid consent. To ensure local policy and procedure are followed.							
2	If you are administering a medicated suppository, it is best to do so after the patient has emptied their bowels.	To ensure that the active ingredients are not prevented from being absorbed by the rectal mucosa and that the suppository is not expelled before its active ingredients have been released							
3	Collect necessary equipment	To ensure all equipment is available before commencing the procedure and reduce transmitting of infection							
4	Check prescription for treatment against documentation and patient identity. Check expiry dates and allergies.	To ensure the correct care is delivered to the correct patient.							
5	Wash hands	For infection prevention and control							

6	Ask patient if they would prefer members of family/carers/friends to leave the room. Close curtains and doors.	To ensure patients privacy.							
7	Ensure bedpan/ commode or toilet is readily available.	In case the patient feels the need to expel the suppositories before the procedure is completed or have their bowels open.							
8	Assist the patient to lie on their left side, with knees flexed, the upper knee higher than the lower and with buttocks near the edge of the bed.	Allows ease of passage of the suppository into the rectum by following the natural anatomy of the colon. Flexing the knees will reduce discomfort and allow observation of the anus							
9	Place a disposable incontinence pad beneath the patient's buttocks. Cover the genital area	To reduce potential infection caused by soiling and to avoid embarrassing the patient if the suppositories are prematurely ejected or there is a rapid bowel evacuation following administration. To promote patient dignity at all times.							
10	Wash hands with soap and warm water or use alcohol hand rub put on gloves	To reduce risk of cross infection.							
11	With consent gently perform digital rectal examination (DRE) following trust competency, with a lubricated, gloved finger	To assess risk prior to administration of a rectal medication and rectal contents.							
12	Place lubricating jelly onto the blunt end of the suppositories and gently advance it 2-4 cm into the rectum touching the rectal mucosa.	Lubricating reduces surface friction and thus eases insertion of the suppository and avoids anal mucosal trauma. The suppository is more readily retained if inserted blunt end first. The anal canal is approximately 2–4 cm long. Inserting the suppository beyond this ensures that it will be retained							

13	Repeat process as above if second suppository is prescribed.	As above							
14	Wipe the patient's perineal area to remove excess lubrication gel.	To promote patient comfort and avoid excoriation of the skin.							
15	Ask the patient to retain the suppositories for 20 minutes or for as long as they are able. Inform patient that there may be some discharge as the medication melts in the rectum	This will allow the suppository to release the active ingredients.							
16	Remove gloves and wash hands	For infection prevention and control							
17	Assist patient to toilet/commode/ bedpan if appropriate.	To enhance patient comfort, dignity and aid a good bowel movement if treating constipation.							
18	Remove apron and wash hands	To reduce the risk of cross infection.							
19	Record suppository given, the effect on the patient and the result (amount, colour, consistency using the Bristol stool chart)	To evaluate the success of the intervention and monitor bowel function. To aid communication and to maintain accurate, professional and legal records.							
20	Observe patient for any adverse reactions	To monitor for complications.							
Signature and date									
Proficient - Final sign off (assessor name and designation):……..... Date:……									

COMPETENCY	Administration of Enemas

COMMENTS / PROGRESS COMPETENCY:…… Name of Practitioner:……..		
Date	**Comments /Progress**	**Assessor signature**

Staff group	Registered Practitioners and Healthcare Support Workers Band 3 and above	
Delegation guidance	HCSWs may administer prescribed enemas following assessment by a qualified competent nurse, if the HCSW: • has been deemed competent in the particular lower bowel care task • the qualified nurse agrees to delegate that lower bowel care task to that particular HCSW • and that the patient consents (RCN, 2012) Considered suitable for delegation to HCSW: • Patients assessed by a registered practitioner as having a need for mini enema, where the procedure is expected to be non-complex and routine. Regular review of need for enemas is required and treatment plan agreed in partnership with the patient/carers, registered nurse and GP/medical team	The following categories are considered unsuitable for non-registered clinical staff: • Phosphate enemas • Patients who have an acute need for bowel interventions. • Patients who require complex assessment or review. • Where routine enema use has not been well established This list is not definitive and the registered practitioner should exercise clinical judgement on the suitability of patients according to the needs of the patient and the competencies of the HCSW.
Sources /evidence	The Royal Marsden Clinical Procedures (9th edition). http://www.rmmonline.co.uk Skills for Health NOS CC01 - Assess bladder and bowel dysfunction Skills for Health NOS CC09 Enable individuals to effectively evacuate their bowels https://cks.nice.org.uk/constipation RCN management of Lower Bowel Dysfunction including DRE and DRF. RCN Guidance for nurses, 2017	
Relevant policy / protocol and further reading	HDFT Chaperone Policy, HDFT Consent Policy	
Pre –requisites: • **Training requirement** • **Completed competencies**	Chaperone Competency,	
Frequency of assessment	3 yearly	
Author /designation	Rachel Kerr, Joanne Burnside, Wendy McCulloch Specialist Continence Service	
Date produced	January 2018	
Date to be reviewed	January 2021	

Name of Practitioner: **……..……**	**W**	**WITNESSED**	Observe the skill being carried out – staff should have had the opportunity to observe the procedure prior to being supervised and has undergone the relevant training. A period of supervised practice should be agreed with the practitioner and assessor
	A	**ASSIMILATED**	Understands the underpinning knowledge and reasoning and how to perform the skill/activity to support safe delivery of the skill.
	S	**SUPERVISED**	Practice under supervision **(further guidance on scoring on assessors answer sheet)** 1– Needs practice and direct supervision 2 – Needs further practice and supervision 3 – Proficient and can work independently
	P	**PROFICIENT**	Competent in both knowledge and skill elements of the competency

SECTION 2 PROCEEDURE/SKILL – ADMINISTRATION OF ENEMAS

	Action	Rationale	W	A and S					
			Yes/No	Score	Score	Score	Score	Score	Score
1	Explain the procedure to the patient and gain verbal consent to proceed. Offer a chaperone as per HDFT policy.	To ensure the patient understands the procedure and gives valid consent. To ensure local policy and procedure are followed.							
2	Check prescription for treatment against documentation and patient identity.	To ensure the correct care is delivered to the correct patient.							
3	Collect necessary equipment, wash hands and put on protective apron.	To ensure all equipment is available before commencing the procedure and reduce transmitting of infection							
4	Close curtains and the doors as appropriate. If required, ask patient if they would prefer members of family/carers/friends to leave the room.	To ensure patients privacy and dignity.							
5	Ensure bedpan/ commode or toilet is readily available.	In case the patient feels the need to expel the enemas before the procedure is completed or have their bowels open.							

6	Warm the enema to room temperature by immersing in a jug of hot water	Heat is an effective stimulant of the nerve plexi in the intestinal mucosa. An enema at room temperature or just above will not damage the intestinal mucosa. The temperature of the environment, the rate of fluid administration and the length of the tubing will all have an effect on the temperature of the fluid in the rectum.							
7	Assist the patient to lie in the required position, on the left side, with knees flexed, the upper knee higher than the lower and with buttocks near the edge of the bed. Cover the legs and genital area	Allows ease of passage of the enema into the rectum by following the natural anatomy of the colon- flexing the knees will reduce discomfort and allow observation of the anus. To promote patient dignity at all times.							
8	Place a disposable protective sheet beneath the patient's buttocks	To reduce potential infection caused by soiled linen and to avoid embarrassing the patient if the enema contents are prematurely ejected or there is a rapid bowel evacuation following administration.							
9	Wash hands with soap and warm water or use alcohol hand rub and put on non-sterile gloves and disposable apron	To reduce risk of cross infection.							
10	With consent gently perform digital rectal examination (DRE) with a lubricated, gloved finger (in accordance with DRE procedure)	To assess risk prior to administration of a rectal medication and rectal contents.							
11	Place some lubricating gel on a gauze square and lubricate the nozzle of the enema or the rectal tube.	To prevent trauma to the anal and rectal mucosa by reducing surface friction, increasing retention of the enema contents and to enhance efficacy of the medication							
12	Expel excessive air from the enema and introduce the nozzle or tube slowly into the anal canal while separating the	The introduction of air into the colon causes distension of its walls, resulting in unnecessary discomfort for the patient. The							

	buttocks. (A small amount of air may be introduced if bowel evacuation is desired.)	slow introduction of the lubricated tube will minimize spasm of the intestinal wall (evacuation will be more effectively induced due to the increased peristalsis).							
13	Slowly introduce the tube or nozzle to a depth of 10.0–12.5 cm	This will bypass the anal canal (2.5–4.0 cm in length) and ensure that the tube or nozzle is in the rectum.							
14	If a retention enema is used, introduce the fluid slowly and leave the patient in bed with the foot of the bed elevated by 45° for as long as prescribed	To avoid increasing peristalsis. The slower the rate at which the fluid is introduced, the less pressure is exerted on the intestinal wall. Elevating the foot of the bed aids retention of the enema by the force of gravity							
15	If an evacuant enema is used, introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is completely finished.	The faster the rate of flow of the fluid, the greater the pressure on the rectal walls. Distension and irritation of the bowel wall will produce strong peristalsis which is sufficient to empty the lower bowel							
16	If using a funnel and rectal tube, adjust the height of the funnel according to the rate of flow desired.	The forces of gravity will cause the solution to flow from the funnel into the rectum. The greater the elevation of the funnel, the faster the flow of fluid.							
17	Clamp the tubing before all the fluid has run in.	To avoid air entering the rectum and causing further discomfort.							
18	Slowly withdraw the tube or nozzle	To avoid reflex emptying of the rectum.							
19	Dry the patient's perineal area using gauze squares or paper towel to remove excess lubrication gel	To promote patient comfort and avoid excoriation							
20	Ask the patient to retain the enema for 10-15 minutes, if possible, before evacuating their bowels.	To enhance evacuant effect.							
21	Ensure that the patient is able to get	To enhance patient comfort and safety. To							

	assistance if required and/or is near to the bedpan, commode or toilet and has adequate toilet paper.	minimize the patient's embarrassment.							
22	Remove and dispose of equipment, gloves and apron and wash hands	To reduce the risk of cross infection.							
23	Document that the enema has been given, its effects on the patient and its results (colour, consistency and amount of faeces produced), using the Bristol Stool Chart.	To monitor the patient's bowel function.							
24	Observe patient for any adverse reactions	To monitor the patient for complications							
Signature and date									
Proficient - Final sign off (assessor name and designation):…… Date:……									

COMMENTS / PROGRESS **COMPETENCY:…… Name of Practitioner:……..**		
Date	**Comments /Progress**	**Assessor signature**