Performing manual/digital removal of faeces

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| This article will:   * Increase knowledge of bowel management * Provide clinical guidance on bowel the assessment in adults * Increase knowledge of manual/digital removal of faeces * Increase knowledge on monitoring care of patients who are unable to defecate * Provide an awareness of the complications of digital removal of faeces |

**Defecation**

In a healthy person, normal stool output is estimated at approximately 150g-200g per day (RCN, 2012). Bowel frequency occurs between three times a day to three times a week and consistency can vary depending on gender, health and diet (for stool classification see the Bristol Stool Chart) (RCN, 2012). The process for rectal emptying is a voluntary action. Faeces moves into the rectum which causes rectal distension and evokes the desire to defecate (RCN, 2012). This term is known as the ‘call-to-stool’ (RCN, 2012). Under normal circumstances, an individual adopts a sitting or squatting position allowing for straightening of the anorectal angle and the relaxation of the external anal sphincter and puborectalis muscle. There is a rise in abdominal pressure and the muscles of the anterior abdominal wall become tense to direct pressure down into the pelvis (RCN, 2012). Stool enters the lower rectum, which initiates a spontaneous recto-sigmoid contraction and it is pushed through the anal canal (RCN, 2012). This sequence of events is repeated until the rectum is empty and the person no longer has an urge to defecate (RCN, 2012). Once defecation is complete the closing reflex of the external sphincter is stimulated which ensures continence is maintained (RCN, 2012).

Nurses need to be aware of interventions which can improve and maintain the patient’s normal bowel function. These include lifestyle advice for example weight management, advice around fluids and diet, smoking cessation and exercise. As part of a holistic assessment nurses should give patients dietary advice to promote the ideal stool consistency as well as general health needs. An assessment should include:

* The patients’ existing therapeutic diets (RCN, 2012) and their whether nutritional intake is balanced.
* Recommend to patients that they use a food and fluid diary to record intake and help establish a baseline. According to the British Dietetic Association (2006), a general adult should drink between 1.5l and 2.5l per day.
* Assess the patients’ urine for colour and consistency to ensure that they are adequately hydrated (Coggrave, 2008).
* Suggest to patients that they modify one food at a time to eradicate contributory factors.
* Consider screening for malnutrition and risk factors for malnutrition.
* Take into account the patients religious and cultural beliefs.
* Consider onward referral to a dietitian if required.

**Digital removal of faeces**

The digital removal of faeces (DRF) is defined as an invasive procedure which involves the manual removal of faeces from the rectum using a gloved finger (Dougherty & Lister, 2015). This should only be performed following a complete bowel assessment to understand the patient’s normal bowel habits (NICE, 2017), bowel history including constipation, complications, current medication and medical history. DRF should only be performed by a nurse deemed competent with the correct knowledge, skills and ability required for safe practice (NMC, 2015). Competent nurses should have successfully completed bowel-dysfunction training which includes the practical and theoretical aspects of DRF and follow local protocols and policies.

Digital removal of faeces is often carried out for patients with spinal injuries, spina bifida and multiple sclerosis as part of their routine bowel management (Dougherty & Lister, 2015) in conjunction with a fibre rich diet, digital stimulation, suppositories, enemas, abdominal massage and stool softeners (Dougherty & Lister, 2015). Digital stimulation is a method which initiates the defecation reflex by dilating the anus either using a finger or an anal dilator (Dougherty & Lister, 2015). It is important to note that this procedure is only useful if the rectum is full (Dougherty & Lister, 2015). Advances in oral medications and rectal and surgical treatments and reduced the need for the digital removal of faeces in patients (Dougherty & Lister, 2015).

Autonomic dysreflexia Is an abnormal response from the autonomic nervous system to a painful stimulus unique to patients with a spinal cord injury at the sixth thoracic vertebrae or above (RCN, 2012). A distended bowel caused by constipation can lead to autonomic dysreflexia (AD). Nurses should be aware that acute AD can be a response to digital inventions and must assess for the signs and symptoms throughout the procedure. These include headache, hypertension, brachycardia, sweating, flushes, nasal obstruction, pallor below the level of spinal injury and hypertension (RCN, 2012; Dougherty & Lister, 2015). Severe hypertension may lead to life threatening complications such as intracranial bleeding, seizure or retinal detachment. Note, the most significant symptom is the rapid onset of a severe headache if this occurs the invention should be stopped immediately (Dougherty & Lister, 2015).

The digital removal of faeces can be a distressing, painful and dangerous procedure. Nurses must ensure that they follow best practice guidelines and local policies when performing this role. Caution should be taken to avoid damage to the vagus nerve in the rectal wall as this can slow the patient’s heart rate, take care to minimise the risk to bowel perforation, bleeding or rectal trauma (Dougherty & Lister, 2015). Digital removal of faeces should only be performed following a complete bowel assessment and for the following indications:

* Faecal impaction/loading
* The patient is experiencing incomplete defecation
* An inability to defecate
* When other methods of bowel emptying have failed, or are deemed inappropriate
* If a patient has a neurogenic bowel dysfunction
* For patients with a spinal cord injury

During the procedure, the nurse should observe the patient at all times for signs of distress which could include pain or discomfort, bleeding, symptoms of autonomic dysreflexia or collapse (RCN, 2012; Dougherty & Lister, 2015). Nurses should not perform digital removal of faeces if the patient has recently undergone rectal surgery or if there is any indication of trauma to the anal or rectal area (Peate, 2016).

**Equipment**

Disposable apron and Gloves

Lubricating Gel

Swabs

Commode or bedpan

Specimen pot (If required)

Yellow bag

Disposable incontinence pad

Local anasthetic gel (if prescribed)

**Procedure**

1. Confirm the patient’s identity, explain and discuss the full procedure.
2. Obtain consent either verbal, written or implied. Ask the patient if they would like to have a chaperone present (RCN, 2012). The procedure must be stopped at any time if the patient requests this (RCN, 2012). If the patient lacks capacity practitioners must act in accordance with the Mental Capacity Act (2005) (Peate, 2016).
3. Assess the patients’ specific requirements and the reason for intervention. If the patient is constipated a full physical, psychological and social assessment should be completed (NICE, 2017).
4. Check for any allergies such as latex (NMC, 2010, RCN 2012).
5. Wash hands and put on an apron and non-latex gloves (Peate, 2016). This is to ensure that hygiene and infection control measures are maintained (Dougherty & Lister, 2015).
6. Close the door or draw the curtains to maintain privacy and dignity (NMC, 2015).
7. Record the patients’ pulse rate before and during the procedure if this is used as an acute intervention (Dougherty & Lister, 2015).
8. Record the patients’ blood pressure before and during the procedure if the patient has a spinal cord injury (Dougherty & Lister, 2015). A baseline blood pressure should be recorded for comparison. For patients where this procedure is part of a well-established bowel routine, this is not required.
9. Encourage the patient to empty their bladder first. A full bladder can create discomfort during the procedure (Peate, 2015).
10. Place the waterproof pad underneath the patient (Pegram, Bloomfield & Jones 2008; Dougherty & Lister, 2015).
11. Remove the patients clothing from the waist down if they are unable to do this themselves.
12. The patient should lie on their left side, knees flexed with the upper knee higher than the lower knee and buttocks near the edge of the bed (Dougherty & Lister, 2015). This supports the easy passage of the finger into the rectum (Dougherty & Lister, 2015). Note that patients with musculoskeletal conditions may not be able to lie in this position. Ensure you have adequate lighting and that the patient is not at risk of falling (Pokorny, 2017).

*Insert picture of lateral positioning*

1. Observe the anal area for evidence of skin soreness, swelling, excoriation, haemorrhoids, anal skin tags, infestation, foreign bodies or a rectal prolapse (Dougherty & Lister, 2015, Peate, 2016). Swelling may be indicative of a mass or abscess. Report any abnormalities such as bleeding, discharge or prolapse and do not continue the procedure but seek additional advice (Dougherty & Lister, 2015, Peate, 2016).
2. If the patient has a spinal injury observe for signs of AD throughout the procedure (Dougherty & Lister, 2015).
3. Wash hands, put on two pairs of gloves (RCN, 2012).
4. Place lubricating gel on a gloved finger
5. Inform the patient that the procedure is about to begin (RCN, 2012)
6. Proceed with caution. Gently insert the lubricated finger in the anus and slowly to the rectum (Dougherty & Lister, 2015).
7. For digital rectal stimulation Insert lubricated gloved finger into the anus and slowly rotate the finger in circular movements (RCN, 2012). Note that contact should be maintained with the rectal mucosa. Gently stretch the anal canal, this helps the sphincter to relax and the rectum contract (RCN, 2012).
8. Check the stool type. If it is type 1 on the Bristol stool chart, remove one lump at a time until no more faecal matter can be felt (Dougherty & Lister, 2015). This will relieve patient discomfort (Dougherty & Lister, 2015). If the stool is soft gently circle the finger continuously to remove faeces.
9. If the matter is solid, use the index finger to split it and remove individual pieces at a time take care not to cause rectal trauma (Peate, 2016). Avoid using a hooked finger to remove faeces, this may cause damage to the rectal mucosa and anal sphincter (RCN, 2012). Using a hooked finger can cause scratching or scoring of the mucosa.
10. During the procedure carry out abdominal massage (RCN, 2012).
11. If the faecal matter is more than 4cm across and is too hard and solid to break up discontinue the procedure to avoid any pain or damage to the anal sphincter and discuss other approaches with the multidisciplinary team (Dougherty & Lister, 2015; Peate, 2016). It may be necessary for the procedure to be carried out under anasthetic (Dougherty & Lister, 2015).
12. Place the faeces in an appropriate receiver for disposal as it is removed to reduce contamination and cross infection (Dougherty & Lister, 2015).
13. Give the patient a rest if needed. If appropriate ask the patient to breathe in and force air out of the mouth with the nose closed. This is the Valsalva manoeuvre and can assist with the passage of faeces into the rectum (Peate, 2016).
14. Observe the patient throughout for any signs of distress and stop if the patient complains of pain or asks you to stop (Peate, 2016). If there are any signs of autonomic dysreflexia discontinue immediately, It may be necessary to refer the patient to the local spinal unit (Peate, 2016).
15. Once the rectum is empty carry out a final digital check after five minutes to ensure evacuation is complete (RCN, 2012).
16. Wash and dry the buttocks and anal area (Dougherty & Lister, 2015).
17. Remove gloves and apron and dispose of appropriately in clinical waste. Wash hands (Dougherty & Lister, 2015).
18. Assist the patient in a comfortable position.
19. For spinal injury, patients record blood pressure (Dougherty & Lister, 2015).
20. Document colour, consistency and amount using the Bristol Stool Chart.
21. Document any abnormalities and report any findings to the multidisciplinary team if necessary.

Bowel management is an important aspect of holistic care and failure to provide this can be fatal for some patients. Performing digital removal of faeces can be an uncomfortable and embarrassing procedure for patients and must only be carried out by a competent practitioner who has completed a risk assessment. Alternative assistance with defecation such as laxatives and digital rectal stimulation should be considered for long-term management.

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