

HOW TO PERFORM A DIGITAL REMOVAL OF FAECES

For some patients, such as those with spinal cord injury, cauda equina, spina bifida and multiple sclerosis, the digital removal of faeces is an integral part of bowel management. However, the invasive nature of the procedure has led to confusion among healthcare workers concerning their professional responsibilities. This article examines the best practice for performing digital removal of faeces.

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The publication of *Digital Rectal Examination and Manual Removal of Faeces – Guidance for Nurses* by the RCN (2000) addressed many issues concerning the professional and legal aspects of the manual (digital) removal of faeces. However, the document did not give detailed guidance on how to actually carry out the procedure.

In most cases, the need for the digital removal of faeces is preventable by using a stepped approach to the management of constipation (Bayliss et al, 2000; Correa and Rotter, 2000; RCN, 2000) and Powell and Rigby (2000) suggest that digital removal of faeces is a last resort procedure and should only be practised when all other methods of bowel evacuation have failed.

However, for some patients, such as those with spinal cord injury, cauda equina, spina bifida and multiple sclerosis, the digital removal of faeces is

an integral part of their routine bowel management.

This essential routine can be interrupted when patients are admitted into a general hospital that does not specialise in treating spinal injuries (National Patient Safety Agency, 2004), as many healthcare workers lack sufficient knowledge and expertise to competently perform a digital removal of faeces.

'In most cases, the need for digital removal of faeces is preventable by using a stepped approach to the management of constipation.'

The invasive nature of this procedure together with fears of litigation and accusations of abuse has led to confusion among healthcare workers (especially nurses) concerning their professional and legal responsibilities. In fact, some nurses are actively refusing to undertake digital removal of faeces on spinal cord injury patients either because they have not been trained or, even more alarmingly, because they think they are not allowed to perform the procedure at all.

In their defence, such nurses are behaving in a responsible manner because the NMC (2002) states that to practise competently nurses must possess the skills and abilities to carry out a particular procedure. In the light of this legislation, nurses need to be sure they are giving evidence-based care, within the correct ethical and legal framework.

GUIDELINES

The guidelines for this procedure were developed in order that healthcare workers practising digital removal of faeces do so within the remit of their professional and legal responsibilities and to ensure patients receive the most effective evidenced-based care (Kyle et al, 2005).

Therefore, advice from significant publications such as the NMC *Code of Conduct* (NMC, 2001), *Good Practice in Continence Services* (Department of Health [DoH], 2000), *Reference Guide to Consent for Examination or Treatment* (DoH, 2001a), *National Framework for Older People* (DoH, 2001b) and *Reference Guide to Consent for Examination or Treatment* (DoH,

2001a) have been used to inform the procedure.

It was decided at the initial conception of these guidelines to emphasise the use of faecal evacuation using a single finger, in line with digital examination (RCN, 2000), rather use the term manual removal of faeces.

The guidelines contained in this article explain the procedure for digital removal of faeces and should be referred to by all healthcare workers. The RCN *Digital Rectal Examination and Manual Removal of Faeces, Guidance for Nurses* (RCN, 2000) (particularly sections eight and nine) should be adhered to and used concurrently with these guidelines.

It is recommended that only competent practitioners should carry out this procedure. To ensure this is the case, any healthcare worker wanting to perform the procedure should have successfully completed a digital rectal examination course based on the RCN (2000) publication. In addition, healthcare workers should familiarise themselves with Trust/organisational policies and protocols before undertaking this procedure.

PRACTICAL GUIDE TO THE DIGITAL REMOVAL OF FAECES

There are some basic rules that should be adhered to when planning to perform a digital removal of faeces. These are known as the 'Do's' and 'Don'ts' and the 'Think twice'. The 'Do's' include the following:

- ▶▶ Do complete a full bowel assessment (Bayliss et al, 2000)

- ▶▶ Do consider treatment options with the multidisciplinary team (Powell and Rigby, 2000; NMC, 2002)
- ▶▶ Do inform the patient of the treatment options and risks involved (NMC, 2002)
- ▶▶ Do gain valid consent (written, verbal or implied) from the patient (Wiliis, 2000; DoH, 2001a; NMC, 2002).

The 'Don'ts' include:

- ▶▶ Don't proceed if there is a lack of consent (written, verbal or implied) or if the patient actually refuses
- ▶▶ Don't proceed if the patient's doctor has given specific instructions that the procedure should not be performed
- ▶▶ Don't proceed if the patient has recently undergone rectal/anal surgery or trauma
- ▶▶ Don't proceed if you feel you are not competent to perform the procedure (NMC, 2002).

The 'Think twice' rule comes into effect if the patient has any of the following diseases or conditions:

- ▶▶ Active inflammatory bowel disease
- ▶▶ Rectal pain
- ▶▶ Obvious rectal bleeding
- ▶▶ If the patient is taking anti-clotting medication (new spinal cord injury patients may be taking anticoagulatory medication, but still require digital removal of faeces)
- ▶▶ Spinal injury at thoracic T6 or above. Remember that allowing constipation to occur leads to a greater risk of autonomic dysreflexia developing.

The full guidance for performing digital removal of faeces is contained in *Table 1*.

DIGITAL STIMULATION

Patients may be taught to carry out this simple procedure for themselves as stimulation of the anus or anal sphincter can aid some patients with defecation.

Watson (1997) suggests that this procedure alone can be effective when used together with techniques designed to enhance defecation, such as adopting the correct position on the lavatory and taking hot drinks and food 20–30 minutes before instigating bowel care. This takes advantage of gastric colonic reflex, which is strongest after the first meal of the day but can be stimulated at other times as well.

In spinal injury patients with a lesion above the cauda equina, it is usually possible to stimulate a defecation reflex voluntarily using digital stimulation (Powell and Rigby, 2000). This stimulated reflex may be insufficient to completely empty the bowel and a digital removal of faeces may still be required. Guidance on the correct technique for digital stimulation is contained in *Table 2* (p130).

CONCLUSION

Digital removal of faeces is a procedure that many healthcare workers are not confident about performing. However, in some patients it is a necessary part of their routine bowel care.

This article provides healthcare workers with best practice for performing this procedure, which after all, is necessary for the health and wellbeing of many patients. **CE**

Table 1

Guidelines for performing digital removal of faeces

Action	Rationale
Complete bowel assessment with the patient (Bayliss et al, 2000)	To ascertain the need for digital removal of faeces ensure: <ul style="list-style-type: none"> • All other bowel emptying techniques have failed • The presence of faecal impaction/loading • The presence of incomplete defaecation • An inability to defecate, • The presence of neurogenic bowel dysfunction, e.g. in multiple sclerosis
Check the DOs, DON'Ts and THINK TWICE section at the beginning of this article	To identify exclusions and contra-indications or circumstances when extra caution is required (RCN, 2000)
Discuss treatment with patient and the team JUSTIFY THE NEED FOR THIS PROCEDURE AND DOCUMENT	To allow patient choice and to ensure optimum treatment option (NMC, 2002)
Explain procedure	To gain the patient's consent and co-operation, the healthcare worker must ensure that the patient has the mental ability to give consent and that the patient has been given sufficient information about the risks involved (NMC, 2002) to either consent or refuse (NMC, 2002). Digital removal of faeces entails a possible risk of damage to anal and rectal mucosa and of stretching the anal sphincter (Getliffe, 1996). The patient needs to consent freely and voluntarily without coercion or manipulation (DoH, 2001)
Explain potential risks to the patient	
Document consent given	
Document if patient is unable to give valid consent, i.e. if the patient has lost the capacity to consent or to refuse the procedure due to, e.g. unconsciousness, sedation or a confusional state. IT IS VITAL TO DOCUMENT why the procedure is in the patient's best interest	This is an invasive procedure and may be harmful in certain circumstances, therefore, the healthcare worker must ensure his or her professional accountability is maintained (NMC, 2002)
Ensure privacy	To help the patient relax and minimise embarrassment (NMC, 2002)
Take the patient's pulse at rest before the procedure	To obtain a baseline of the patient's condition before the procedure, as vagal stimulation can slow the heart rate
Assess the risk of autonomic dysreflexia of those spinal injury patients with injury at T6 or above	Autonomic dysreflexia is a sudden and exaggerated autonomic response to an unpleasant stimulus, e.g. a full rectum or digital stimulation of the rectum during bowel evacuation. It occurs in spinal injuries at T6 or above (Ahrens and Prentice, 1998). Patients present with marked hypertension and complain of headaches
Record blood pressure if patient has a spinal cord injury at T6 or above	To obtain a baseline blood pressure
Find out whether the patient has recently had an autonomic episode Find out if the patient is constipated	YES to either of these questions signifies a risk of autonomic dysreflexia, but this risk must be balanced against the risk of constipation leading to dysreflexia
Place a protective pad under the patient and ensure a suitable receptacle is to hand	To protect bedding from faecal matter
Assist the patient to adopt, if possible, the left lateral position with knees flexed	To expose anus and allow easy insertion of finger
A sitting position should be avoided	To prevent overstretching of the anal sphincter and discomfort to the patient
Individual assessment of each patient's digital removal of faeces regime is required	For example, independent spinal cord injury patients may prefer to conduct digital removal of faeces over a toilet
Observe the perineal and perianal area. Document and report any abnormalities	To check for rectal prolapse, haemorrhoids, anal skin tags, wounds, discharge, anal lesions, gaping anus, bleeding, infestation or foreign bodies
Wash hands and put on a disposable apron and non-latex gloves of a suitable thickness	To minimise cross infection and to protect the hands
For patients receiving this procedure on a REGULAR basis, place water-based lubricating gel on gloved index finger	To facilitate easier insertion of index finger

Action	Rationale
If this is an ACUTE procedure, a local anaesthetic gel may be applied topically to the anal area	To reduce sensation and discomfort for the patient
Read the contra-indications, warnings, precautions and interactions of the anaesthetic gel to be used	Lignocaine is a topical local anaesthesia and it is absorbed via the anal mucous membrane
DO NOT apply if you have documented evidence of anal damage or bleeding	Lignocaine may cause anaphylaxis, hypotension, bradycardia or convulsions if applied to a damaged mucosa
Inform patient of imminent examination	To ensure the patient is ready and relaxed
Insert non-latex gloved, lubricated index finger slowly and gently, encouraging the patient to relax. Use one finger only	To avoid trauma to the anal mucosa and prevent forced over-dilation of the anal sphincter
If scybala type stool is present (Bristol stool scale type-1) remove one lump at a time until no more faecal matter can be felt	To relieve the patient's discomfort
In the case of a solid faecal mass, push the finger into the middle of the mass, split it and remove small pieces with hooked finger until no more faecal matter can be felt.	To relieve the patient's discomfort
If the faecal mass is too hard, larger than 4cm across and is impossible to break up, STOP and refer to the medical team for a possible digital removal of faeces under general anaesthetic.	To avoid considerable pain and trauma (anal sphincter damage) to the patient
Proceed with caution with spinal cord injury patients – those patients with a reflex bowel may require a further rectal stimulant	Most spinal cord injury patients will not experience any pain
As faecal matter is removed it should be placed in a suitable receptacle	To facilitate appropriate disposal of faecal matter
Encourage patients who receive this procedure on a REGULAR basis to have a period of rest or to assist, if appropriate, by using the Valsalva manoeuvre. Patient and healthcare worker education is required to safely use this manoeuvre.	To allow further faecal matter to descend into the rectum. Correct breathing technique will also prevent raised intra-cranial pressure Use of the Valsalva manoeuvre in an upright position may result in increased hydrostatic pressure in peri-rectal blood vessels, thereby increasing likelihood of haemorrhoids (Menter et al, 1997). Spinal cord injury patients may assist with evacuation by using the Valsalva manoeuvre – however excessive straining should be discouraged for the reasons stated above For some spinal cord injury patients, raising intra-abdominal pressure does not result in relaxation of the sphincter or excessive pressures may be required, therefore, the Valsalva manoeuvre should be used with caution and its effects evaluated for each patient. Valsalva is not recommended to be used by patients with intrathecal baclofen pumps
Extra lubrication may be required	
Observe the patient throughout the procedure STOP if there is anal area bleeding STOP if pain persists STOP if the patient asks you to	To note signs of distress, pain, bleeding and general discomfort
Check patient's pulse STOP if heart rate drops or rhythm changes	Vagal stimulation can slow heart rate and alter heart rhythm
STOP at first sign of autonomic dysreflexia	Symptoms include headache, blurred vision, nausea, sweating, bradycardia, respiratory distress, pupil constriction and flushing above the lesion with pallor below (Walker, 2002)
Healthcare workers must respond immediately to any signs of autonomic dysreflexia (take blood pressure if a spinal cord injury patient becomes distressed or feels the onset of an autonomic episode – compare with baseline blood pressure)	Blood pressure is always raised during an autonomic episode.
If possible sit the patient up, administer the patient's prescribed medication for autonomic dysreflexia and reassure him or her. If you are still concerned, contact the local spinal cord injury centre	To reduce hypertension and the patient's apprehension. If it is inadequately treated, the patient can become sensitised and then develop autonomic dysreflexia with the minimum of stimulus (Grundy and Swain, 1996)
When the procedure is complete, wash and dry the patient's buttocks and anal area	To leave the patient comfortable and clean
Inform the patient of the outcome and ensure that the procedure and outcome are documented	Documentation should provide clear evidence of the care planned, the decisions made and the care delivered (NMC, 2002)

Remember, bowel management strategies must be constantly reviewed and assessed and healthcare workers should be proactive not reactive. Effective bowel management for patients with a spinal cord injury at all levels is extremely important and at T6 or above is the best measure for preventing autonomic dysreflexia.

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Free copies of the digital removal of faeces procedure can be obtained from Norgine Ltd who kindly sponsored its publication. Please send your name and address to: Norgine Ltd (DRF), FREEPOST (HA4696), Uxbridge, Middlesex UB9 6BR. Alternatively, email your details to mss@norgine.com

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Table 2

Technique for digital stimulation

Action	Rationale
A patient using digital self-stimulation should be in a comfortable sitting position	Gravity will aid evacuation (Banwell et al, 1993)
Individual assessment required, as to the optimum position of the patient	Some spinal cord injury patients who need assistance with digital stimulation may find a sitting position more effective and quicker than lying down
Assist the patient to adopt the left lateral position with knees flexed.	To expose the anus and to avoid damage to the anal canal
Insert a gloved (non-latex) lubricated index finger through the anal sphincter to second joint of finger only	To facilitate easier insertion and rotation of the finger and also to prevent trauma to the anal and rectal mucosa
Gently rotate the finger 6–8 times in a clockwise motion and withdraw	To minimise discomfort and to stimulate the ano-rectal reflex (Spinal Injuries Unit, 1999)
This may be repeated up to three times allowing 5–10 minutes between each stimulation	
Results should be noted and documented	To establish the effectiveness of the procedure

Women may be taught to apply perineal support or pressure to the posterior wall of the vagina in conditions arising from posterior vaginal wall collapse (Govan et al, 1993; Getliffe, 1996), to aid defaecation. This is **not recommended** as a nursing procedure.

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