Essex Partnership University
NHS Foundation Trust

Clinical Guideline for intimate bowel care interventions for individuals with neurogenic bowel dysfunction due to Spinal Cord Injury

CLINICAL GUIDELINE REFERENCE NUMBER:	CG90
VERSION NUMBER:	V 1
REPLACES SEPT DOCUMENT	None
REPLACES NEP DOCUMENT	None
KEY CHANGES FROM PREVIOUS VERSION	N/A
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CONSULTATION GROUPS:	Operational Service Leads, Head of IPC, Clinical Governance and Quality Subcommittee.
IMPLEMENTATION DATE:	February 2019
AMENDMENT DATE(S):	N/A
LAST REVIEW DATE:	N/A
NEXT REVIEW DATE:	February 2022
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE:	20th February 2019
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CLINICAL GUIDELINE SUMMARY

The Patient Safety Alert on Bowel Care in July 2018 highlighted widespread patient safety concerns and requires all trust to have policies and procedures in place to safely manage SCI patients' bowel care needs. The alert calls on all providers to review both local clinical policy as well as guidance relating to bowel assessment and management, training and education provision by 25 January 2019 so that patients have access to staff confident and competent in providing safe bowel care. The following guidance has been adopted from the Spinal Injuries Association. Individual Spinal Units will have their own procedures in place when a patient is being transferred to EPUT Services. All staff must be familiar with local protocols (in both West Essex and South East Essex CHS) and ensure that they are competent to care for patients with spinal cord injury.

The Trust monitors the implementation of and compliance with this clinical procedure in the following ways;

Services	Applicable	Comments
Trustwide		
MH&LD		
CHS	✓	

The Executive Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse

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1.0 INTRODUCTION

1.1 Individuals with neurogenic bowel dysfunction due to spinal cord injury (SCI) may require intimate bowel care interventions to maintain continence, prevent constipation and associated complications. These interventions can include Digital Rectal Examination (DRE) prior to any further rectal interventions, Digital Rectal Stimulation (DRS) and/or Digital Removal of Faeces (DRF).

1.2 NHS Improvement (NHSI) issued a Patient Safety Alert stating that NHS and private organisations require a policy to support staff to undertake these procedures for individuals with neurogenic bowel dysfunction and ensure availability of suitable skilled staff twenty four hours per day, seven days a week. (NHSI 2018)

1.3 Failure to provide digital rectal procedures for SCI patients who require them may lead to perforation of the bowel and/or Autonomic Dysreflexia, medical emergencies leading to potential damaging outcomes such as haemorrhage, seizures and cardiac arrest. (Appendix 1)

1.4 Not meeting this care need could be a breach of the Nursing and Midwifery Council Code of Conduct (The Code 2015)

2.0 PURPOSE

2.1 The aim of bowel care interventions is to achieve a regular and predictable emptying pattern of the bowel at a socially acceptable time and place. Avoiding incontinence, constipation and associated complications.

3.0 SCOPE

3.1 This policy applies to individuals with a confirmed diagnosis of spinal cord injury, also diagnosed with neurogenic bowel dysfunction.

3.2 This policy applies to all organisations providing care to individuals with neurogenic bowel dysfunction due to SCI. This can be in the acute hospital, community setting or third sector organisations.

4.0 ROLES AND RESPONSIBILITIES

The Trust Board has overall responsibility for ensuring:

- That the principles of this guideline and other associated procedures are implemented across the organisation
- The availability for any necessary financial resources to ensure staff are appropriately trained and have access to appropriate pressure relieving equipment.

The Executive Nurse has lead responsibility to ensure:

- Clinical Guidelines are embedded into clinical practice and in ensuring these are updated regularly.
- That any clinical risk issues identified are addressed with relevant line managers

Directors and Senior Management are responsible for:

- Disseminating, implementing and monitoring this guideline within their services via clinical audit and supervision
- Ensuring that EPUT policies and procedures are followed

Clinical Leads have responsibility for ensuring:

- That the required structures and resources are in place to enable effective care for patients requiring DRE/DRS/DRF. Ensuring their staff are aware when it is appropriate to carry these out, and how to seek advice/guidance on the procedures from clinicians competent to carry out the interventions.

Individuals will ensure:

- Any difficulties relating to carrying out the care of patients are reported to their line manager;
- That they adhere to all EPUT policies and guidelines;
- That they are familiar with these guidelines and associated documents and know where to locate them i.e. on the Trust intranet (InPut).

5.0 DEFINITIONS

5.1 Digital Rectal Examination (DRE): an intimate care intervention that involves insertion of a lubricated gloved finger into the rectum to determine the presence of faecal matter and any abnormalities or contraindications to performing DRS, DRF or proceed with insertion of a chemical stimulant. Digital Rectal Stimulation (DRS): an intimate care intervention that involves insertion of a lubricated gloved finger into the rectum to stimulate the recto anal reflex, reduce outlet resistance and trigger defecation.

5.2 Digital Removal of Faeces (DRF): an intimate care procedure that involves the insertion of a lubricated gloved finger to remove faecal matter from the rectum.

5.3 Autonomic dysreflexia: A potentially fatal complication for SCI patients with an injury above T6 (sixth thoracic nerve) because of an abnormal sympathetic nervous system response to a noxious stimuli below the level of injury to the spinal cord. Symptoms include skin flushing on the upper trunk and face, goose bumps, profuse sweating, increase in blood pressure above normal base line

(note baseline blood pressure can be low in tetraplegia) and bradycardia. The individual themselves may complain of rapid onset severe headache, visual disturbances and acute distress.

5.4 Spinal Cord Injury (SCI): damage to the spinal cord caused by trauma, illness or disease that maybe either incomplete or complete.

5.5 Bulbocavernosus reflex is a well-known somatic reflex that is useful for gaining information about the state of the sacral spinal cord segments. When present, it is indicative of intact spinal reflex arcs (S2–S4 spinal segments) with afferent and efferent nerves through the pudendal nerve.

5.6 Reflex neurogenic bowel dysfunction (Reflex bowel): usually present in individuals with a spinal cord injury in the cervical or thoracic region; determined by positive involuntary anal wink and bulbocavernosus reflex. This reflex activity is often utilised in bowel care interventions. Without appropriate interventions, the SCI individual will experience constipation and incontinence.

5.7 Areflexic neurogenic bowel dysfunction (Flaccid bowel): Usually present in individuals with SCI in lumbar and sacral regions. Damage to conus medullaris or cauda equina (at or below the first lumbar vertebra) results in no involuntary anal tone or bulbocavernosus reflex. Therefore requiring DRF without which the outcome is a high risk of faecal incontinence through the lax sphincter, as well as constipation.

5.8 Chemical rectal stimulant: a prescribed medication inserted into the rectum to stimulate recto-anal reflex in individuals with reflex neurogenic bowel function.

6.0 GUIDELINE STATEMENTS

6.1 Acute onset neurogenic dysfunction (For example, spinal cord injury, cauda equina or spinal stroke):

- Patients with an acute spinal cord injury presenting with a loss of sensation, movement and reflex activity (spinal shock) below the level of injury. The rectum and anus may be areflexic and peristalsis will be absent resulting in a paralytic ileus.
- Bowel care interventions must start on the day of admission with a digital check per rectum as part of the initial neurological examination by medical staff. If faeces present in rectum, DRF is required with ample lubrication so as not to damage sensitive nerve and muscle fibres within the ano-rectal sphincters.
- During the period of spinal shock, daily glycerine suppositories and gentle digital removal of faeces is required DRE should be carried out on a daily basis by nursing staff after the initial medical examination. This will allow assessment of any change and establish the underlying function of the bowel.
- Once spinal shock has resolved and the function of the bowel has been identified as areflexic (flaccid) or reflexic, an individual management plan can be drawn up for each patient.

6.2 Chronic neurogenic dysfunction: patients with established spinal cord injury will usually have established bowel management interventions that must be continued.

These may include regular DRE, DRS and/or DRF. During an acute hospital admission for patients with established spinal cord injury medical staff should confirm that the care routine established at home could be maintained as the patient's current medical/surgical reason for admission may have compromised this.

6.3 Further information/guidance on bowel management programmes for SCI patients can be found in 'Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions' Multidisciplinary Association of Spinal Cord Injured Professionals (MASCIP 2016).

Digital rectal examination (DRE)

6.4 May be performed in the following circumstances:

- To establish the presence/amount/consistency of faecal matter in the rectum prior to DRF in the patient groups specified above.
- To ascertain anal tone and the ability to initiate a voluntary contraction and to what degree (neurogenic bowel)
- To establish anal and rectal sensation (neurogenic bowel)
- Prior any further rectal interventions i.e. administration of PR medications, DRS or DRF
- Evaluate effectiveness of bowel emptying in neurogenic bowel management e.g. after the use of suppositories, enemas or DRS.

6.5 Nurses should not undertake DRE when:

- There is a lack of consent from the patient – written, verbal or implied. NB in a patient lacking ability to give consent a 'best practice decision' will be required.
- The patient's doctor has given specific instructions it should not take place.

6.6 Nurses should exercise particular caution with patients who have the following:

- Active inflammation of the bowel, including Crohn's disease, ulcerative colitis and diverticulitis.
- Recent radiotherapy to the pelvic area.
- Rectal or anal pain.
- Rectal surgery or trauma to the anal or rectal area (in last 6 weeks).
- Tissue fragility due to age, radiation or malnourishment.
- Obvious rectal bleeding – consider possible causes.
- History of allergies such as latex (non-latex gloves should be used).

6.7 Procedure for DRE: (See Appendix 2.)

Digital rectal stimulation (DRS)

6.8 An intervention to stimulate the movement of stool into the rectum and to initiate predictable defaecation; therefore avoiding constipation and incontinence. It is only appropriate in individuals with reflex bowel dysfunction.

6.9 The precautions outlined in 6.5 and 6.6 also apply to DRS

6.10 Procedure for DRS: (See Appendix 3)

Digital removal of faeces (DRF)

6.11 DRF is an appropriate intervention in the following circumstances:

- Following a diagnosis of areflex neurogenic bowel dysfunction
- As part of established bowel care for specific SCI patients
- Incomplete defaecation for those with reflex neurogenic bowel dysfunction

6.12 The precautions outlined in 6.5 and 6.6 also apply to DRF

6.13 Procedure for DRF: (Appendix 4)

7.0 RELATED LEGISLATION AND DOCUMENTS

Multidisciplinary Association of Spinal Cord Injured Professionals (2016) Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions. London: MASCIP

Royal College of Nursing (2012) Management of lower bowel dysfunction, including DRE and DRF. London: Royal College of Nursing

National Patient Improvement Alert reference NHS/PSA/RE/2018/005 Nursing and

Midwifery Council Code of Conduct 2105

8.0 EDUCATION AND TRAINING

Education and training is available from:

- Spinal Cord Injury Centres (Appendix 5)
- SIA Academy (Appendix 6)
- Specialist Care Agencies

END