Manual evacuation of faeces

Controversy surrounds the manual evacuation of faeces by nurses, and many are confused about their professional and legal responsibilities when asked to undertake this procedure. The argument that it is a well-established and successful procedure is supported by many professionals, but there is very little documented evidence of its effectiveness as a method of bowel management.

There is also confusion about who should perform manual removal. In a survey in 1995 (Addison, 1995), 99 respondents — 57 nurses and 42 doctors — were asked who should carry out the procedure: 75% of the doctors said nurses should and 65% of the nurses said doctors should. RCN guidelines (2000) suggest that nurses should receive formal teaching before carrying out a manual evacuation, but at present it is considered to be outside the remit of undergraduate nurse education.

Several years ago a local nursing home approached me to advise on bowel management for a group of clients. The problems were based on their complex medical, nursing and personal needs. It had been an accepted culture of the home to perform manual evacuation of faeces, and for many of the patients it was an acceptable part of their routine. A new nurse manager expressed concerns about nurses performing the procedure and felt it was important to reassess the need to continue it.

With the support of the local consultant who was involved in our bowel dysfunction clinic and an invitation from the local GP we visited the clients to assess, examine and advise on management options. We were initially asked to see four clients who were having problems with faecal incontinence; three had regularly used the technique of manual evacuation. They all had complex bladder problems managed with a combination of intermittent self-catheterisation, urostomy and a suprapubic catheter.

Following detailed history, examination and assessment, management strategies including a combination of apperients, laxatives and enemas were suggested to replace manual evacuation.

Although the residents were given the choice of a balanced diet, many preferred the option of a low-fibre foods, in particular chips. Despite this we offered advice on changes that could be made to dietary intake to improve bowel management.

It also became apparent that many of the residents, because of their disabilities, were not given the opportunity to sit on a toilet or commode, as this was uncomfortable and impractical without modification to seating. We approached the community occupational therapist to carry out an assessment and to try and improve the position for defecation.

Despite these interventions I received a request from the clients when I visited the home to allow them to have their manual evacuations back. I had also received a copy of a letter from a GP expressing his concern that the clients where showing great distress from having their bowel management changed. He noted that ‘manual evacuation is a technique that has been practised for decades by patients, their carers and, of course, trained nurses’.

In response to the clients, staff and GP I needed to explore again the research, professional views and seek an evidence-based solution to what was becoming an emotive issue in the home.

Watson (1997) suggested that digital stimulation alone is effective, along with techniques known to enhance defecation, warm drinks, position and promoting a reflex action.

Manual evacuation of faeces is seen as a last resort in cases where all other methods of bowel evacuation have failed, and for a small number of patients with defecation difficulties manual evacuation can be the most effective option (Addison, 1996). Fader (1997) suggested that in neurologically impaired patients manual evacuation may be the only viable method of evacuation of the bowel.

Following discussion with the spinal injury units, the RCN, local bowel dysfunction clinic and the clients, carers and relatives, the clients’ bowel problems have now been reassessed, using a recognised bowel assessment tool. To date three clients continue to be managed successfully with faecal softeners, suppositories and regular enemas.

We have suggested changes in bowel regime that are acceptable to the clients; for example, one client claimed his suppositories, when given in the morning, often did not work until the evening. We have now changed the timing of the suppositories to the evening. One patient is currently having a trial with Movicol, but compliance can be an issue. It is anticipated that we will restart manual evacuation with his and his family’s consent.

The priority in this case study had been to discontinue manual evacuation and find acceptable nursing alternatives, the clients needs were constantly assessed and as an outcome one patient has since returned to manual evacuation. There remains no clear published evidence to support manual evacuation, but there is a consensus of opinion that it is the last resort and can be avoidable.