Assessing patients with bowel dysfunction presents many challenges. Health professionals not only have to overcome communication barriers associated with bowel habits as well as the embarrassment that is associated with an intimate rectal examination, but must also be aware that bowel dysfunction may not result from a single, straightforward cause.

Considering causes
Assessment is based on considering all the possible causes of bowel dysfunction, checking in particular that it is not because of an underlying undiagnosed medical condition.

Evidence-based guidelines (National Institute for Health and Clinical Excellence, 2007) suggest a structured approach is needed when assessing patients with bowel dysfunction. All symptoms should be considered in the context of relevant medical history. The aim of assessment is to establish a symptom profile to plan individualised bowel care.

NICE (2007) identified the procedure of digital rectal examination (DRE) as an essential component of bowel assessment. However, recent results of the National Audit of Continence Care highlighted a lack of DRE being carried out in bowel assessment (Wagg et al, 2010). It was performed on less than a third of the patients in primary care (29%), falling to 15% of residents in care homes. Only in acute care were more than half the patients examined rectally (53%). These rates are clearly unsatisfactory.

Need for consent
DRE is an intimate and invasive procedure, so valid consent must be obtained before it is performed. Consent is the legal means by which a patient gives valid authorisation for any treatment or care. Obtaining consent is a necessary part of good professional practice, ensuring trust between nurse and patient (Department of Health, 2009).

In the past, the intimate nature of DRE, together with fears of litigation and accusation of abuse, has led to confusion among nurses about their professional and legal responsibilities. Perhaps more alarmingly, some nurses believe they are not allowed to perform a DRE, thinking it part of a medical examination. These fears and anxieties are further compounded if a patient lacks the capacity to make a decision about this intimate procedure. However, the Mental Capacity Act 2007 gives nurses a statutory framework to empower and protect patients who are unable to make their own decisions.

Training
Chronic constipation is one of the most common lower gastrointestinal disorders affecting people in the western world (Müller-Lissner et al, 2005) and it is estimated that 1-10% of adults are affected with faecal incontinence (NICE, 2007). These facts highlight the importance of nurses possessing the skills and knowledge to assess bowel dysfunction competently to make a clear nursing diagnosis.

Fitness to practise means having the required skills, knowledge and competency...
to provide a high standard of practice and care at all times. A failure to undertake a DRE during a bowel assessment may result in a patient receiving inappropriate or ill-timed bowel intervention.

Bowel Care, including Digital Rectal Examination and Manual Removal of Faeces (Royal College of Nursing, 2008) addressed many of the issues pertaining to the professional and legal aspects of DRE. The document identified Skills for Health bowel care competencies (SFH, 2008) and emphasised the importance of appropriate training in order to undertake this procedure competently. Most continence services organise DRE training, which is available throughout the UK. The courses aim to improve knowledge and increase skills in the management of bowel dysfunction.

Rectal examination should always be performed as part of the bowel assessment process and never as a standalone investigation (SFH, 2008). Nurses who lack the necessary knowledge and expertise to perform a DRE competently must acknowledge the limits of their professional competence (Nursing and Midwifery Council, 2008).

It is important that all nurses access their local DRE courses so they are able to perform this important procedure. Effective bowel assessment, including a DRE, gives nurses the information they need in order to plan advice and interventions, measure outcomes and evaluate care.

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References

BOX 3. CAUTIONS
Take special care when undertaking a digital rectal examination if the patient:

- Has active inflammatory bowel disease, such as Crohn’s disease, ulcerative colitis and diverticulitis
- Has had recent radiotherapy to the pelvic area
- Has rectal or anal pain
- Has obvious rectal bleeding
- Has had recent rectal or anal surgery
- Has spinal cord injury to T6 or above because of autonomic dysreflexia
- Has a history of abuse
- Gains sexual pleasure from the procedure
Any concerns should be addressed with the patient’s doctor

BOX 4. ASSESSMENT USING DIGITAL RECTAL EXAMINATION
Consult local policies and procedures before undertaking a DRE

Stage 1
Observe the perineal perianal area (SFH, 2008) for any abnormalities or signs of:

- Rectal prolapse: (protrusion of rectal tissue through the anus to the exterior of the body occurs when the internal anal sphincter is incompetent and/or pelvic floor muscles are weak) observe the degree of protrusion, colour, swelling and signs of any ulceration
- Haemorrhoids: note number, size and check for signs of bleeding
- Anal skin tags: note number, position and condition
- Anal lesions or swelling: could indicate anal/rectal malignancy
- Gaping anus: may indicate poor sphincter tone; if faecal matter is observed this can indicate faecal impaction
- Skin condition, broken areas, pressure ulcers: excoriation or pruritus indicates possible signs of faecal incontinence
- Soiling: may indicate faecal incontinence or inability to maintain personal hygiene
- Bleeding or mucus discharge: may indicate inflammatory bowel disease or malignancy
- Infestations: including anal warts caused by a virus, or threadworms
- Foreign bodies: any of these abnormalities should be documented and reported to the healthcare team. Observation of any perineal movement and anal sphincter squeeze is useful, as poor muscle coordination may indicate problems with obstructive defaecation

Stage 2
Following local procedures for DRE, insert a lubricated, gloved finger into the patient’s rectum to:

- Establish the presence of faecal matter in the bowel (SFH, 2008)
- Assess the amount and consistency of faecal matter (SFH, 2008)
- Assess the need for rectal medication or the need for digital removal of faeces in extreme cases of faecal impaction (SFH, 2008)
- Assess anal sphincter function and tone (SFH, 2008)
- Assess rectal sensation (SFH, 2008)
- Assess size, consistency of the prostate gland (usually part of specialist nurse practitioner’s role).

The rectum is normally empty so a lack of faecal matter on DRE does not necessarily signify the absence of constipation. Constipation of the sigmoid colon has been found in 30% of patients with an empty rectum (Smith and Lewis, 1990)