Digital removal of faeces

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Abstract Ness W (2013) Digital removal of faeces. Nursing Times; 109:17/18, 18-20. Defecation is essential to enable us to eliminate waste and keep our bowels functioning. In some individuals, defecation is not possible without an intervention. This might be oral medication, such as laxatives to soften the stool and propel the faeces round the colon, or digital removal of faeces (DRF) by a competent health professional on a regular basis. This article considers who needs DRF, who can carry it out, the ethical and legal implications, and the importance of appropriate bowel care being carried out in all care settings.

With newer bowel care techniques, such as transanal irrigation, digital removal of faeces (DRF) is not often needed. However, for a small group of patients – such as some who have sustained a spinal cord injury (SCI) or have a neurological condition such as multiple sclerosis – it is an essential part of their bowel-care routine (Box 1).

Aside from this, DRF may also be used as an acute intervention for patients who have impaction of stool that cannot be resolved with medication. Symptoms of impaction may include: absent or reduced evacuation of stool; abdominal bloating or distension; nausea; and pain. It may be accompanied by overflow or spurious diarrhoea, in which looser stools leak around an unmoving faecal mass, often associated with faecal soiling (Multidisciplinary Association of Spinal Cord Injury Professionals, 2012).

Who can carry out DRF?

DRF can be both uncomfortable and embarrassing for patients (Association for Continence Advice, 2011), so receiving well-informed and compassionate care for this is essential (Coggrave, 2010). It is recommended that only health professionals who can demonstrate competence to the level determined by the Nursing and Midwifery Council (2008) should carry out this procedure; however, a qualified nurse who can demonstrate competence to this professional level may be expected to delegate care delivery to others who are not registered, such as healthcare assistants or carers. Such delegation must not compromise existing care, but must be directed to meeting the needs and serving the interests of patients (Royal College of Nursing, 2012).

All nurses should have successfully completed bowel-dysfunction training that includes theoretical and practical aspects of digital rectal examination (DRE) and DRF. Ideally this training should be based on the RCN (2012) guidelines and Skills for Health’s National Occupational Standards on bowel dysfunction (Box 2).

Assessment and legal considerations

DRF is an invasive procedure and should only be performed when necessary, after individual assessment and taking religious and cultural beliefs into consideration (RCN, 2012). Before initiating any bowel-emptying technique, health professionals must explain to their patients what the intervention involves, including expected outcomes, side-effects and complications (Foxley, 2009). Valid consent must be obtained; this reflects patients’ right to determine what happens to their own body and is a fundamental part of good practice. Health professionals who do not respect this principle may be liable for legal action by the patient and by their professional body (Department of Health, 2009).

Blood pressure in patients with an SCI who are at risk of autonomic dysreflexia (AD), before and at the end of the procedure (Box 3) – a baseline blood pressure is advised for comparison. In patients for whom SCI is a routine intervention and tolerance is well established, the routine recording of blood pressure is not necessary; signs of distress, pain, discomfort;
As suggested earlier, patients may rely on other bowel-emptying techniques, such as digital rectal stimulation (DRS) or transanal irrigation, which reduces the need for DRE and (if appropriate) may be more acceptable options for the individual.

DRS triggers peristalsis of the left colon. It is performed by the patient or nurse/carer by gently inserting a gloved, lubricated finger into the rectum and slowly rotating the finger in a circular movement against the rectal mucosa. Rotation is continued until relaxation of the bowel wall is felt, flatus passes, stool passes or the internal anal sphincter contracts. It should be continued for 20 seconds then repeated every 5–10 minutes until stool evacuation is achieved (Wiesel and Bell, 2004).

Transanal irrigation with warm water is used to facilitate evacuation of stool from the descending colon and rectum. It can be used in a number of clinical scenarios, such as chronic constipation, faecal incontinence, and obstructive defecation secondary to, for example, a rectocele or neurogenic bowel dysfunction (RCN, 2012).

Conclusion

With a wide range of bowel-emptying techniques now available, the need for DRE is sometimes questioned; however it remains imperative in a small group of patients. These patients need seamless care, regardless of the setting. Failure to provide this could result in ineffective bowel management and could even be fatal if the patient experiences AD. Nurses need to acknowledge this important area of care, and understand that DRE, DRS and DRS are nursing roles. They must be able to access theoretical and practical bowel dysfunction training, including that for DRE and DRS, whether it is within their own trust or provided by an outside agency.

References

Association for Continence Advice (2011) Guidance for End of Life/Palliative Continence Care. Bathgate: ACA.


