How to perform digital removal of faeces

Date of submission: March 3 2016; date of acceptance: April 14 2016.

Rationale and key points

This article provides practitioners with information about how to perform digital removal of faeces in a safe, effective and patient-centred manner, promoting privacy and dignity. Passing faecal matter is essential to enable the elimination of waste. For some people, however, defecation is not possible without some form of intervention; this could be the administration of oral medication or an enema, insertion of suppositories or digital removal of faeces.

- Bowel care is a fundamental aspect of patient care.
- Digital removal of faeces should be performed by a practitioner competent in this skill.
- Digital removal of faeces is an invasive procedure and should only be carried out when necessary following holistic patient assessment.

Preparation and equipment

- The practitioner should have an understanding of the anatomy and physiology of the lower gastrointestinal tract before undertaking digital removal of faeces.
- The practitioner should ensure the necessary equipment is available, including:
  - Protective bed cover.
  - Non-latex gloves and an apron.
  - Lubricating gel.
  - Local anaesthetic gel, if prescribed.
  - Towel and wipes.
  - Hand-hot water in a washing bowl.
  - Suitable receiver for collecting faeces.
  - Clinical waste bags.
- The patient’s care plan should be available.
- There should be a good source of light.
- The practitioner should not undertake digital removal of faeces if the patient has recently undergone rectal surgery, or there is trauma to the anal or rectal area.

Procedure

1. Confirm the patient’s identity. Explain the procedure, treatment options and potential risks, and obtain consent. If the patient lacks capacity, the practitioner must act in their best interests in accordance with the requirements of the Mental Capacity Act 2005.
2. Assess the patient’s needs, ascertaining if there are specific requirements that require attention. The patient should be offered a chaperone.
3. Take the patient’s pulse as a baseline measurement.
4. Assess the risk of autonomic dysreflexia in patients with spinal cord injury at T6 or above. If the patient has an injury of this nature, obtain and record a baseline blood pressure.
5. Gather the necessary equipment.
6. Ensure privacy and dignity: screen the bed or close the door.
7. Remove the patient’s clothing from the waist down, or if the patient is able to do this themselves ask them to do so, ensuring that they are not unnecessarily exposed.

Reflective activity

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1. How you think this article will improve your practice.
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Keywords

bowel care, bowel dysfunction, clinical procedures, clinical skills, gastrointestinal nursing, invasive procedure

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if pain persists or if the patient asks you to stop, you must discontinue the procedure and inform a senior clinician.

21. Monitor the patient’s pulse. This can be done manually or electronically, depending on the setting and circumstances. If the heart rate drops or the rhythm changes, cease digital removal of faeces.

22. If there are any signs of autonomic dysreflexia, if pain persists or if the patient asks you to stop, you must discontinue the procedure and inform a senior clinician.

8. Undertake a bowel assessment to determine the need for digital removal of faeces (Figure 1).

9. Assist the patient if there are no contraindications, such as the presence of any musculoskeletal disorders to assume the left lateral position with the knees drawn up towards the chest (Figure 2).

10. Place a protective bed cover beneath the patient’s hips and buttocks.

11. Wash and dry your hands. Put on the apron and non-latex gloves.

12. Observe the perianal area. Check for rectal prolapse, haemorrhoids, anal skin tags, wounds, discharge, anal lesions, bleeding, infestation and foreign bodies. Document and record any irregularities. In the presence of any of these irregularities, do not continue with the procedure. Document any findings and seek appropriate advice.

13. Lubricate your gloved index finger with lubricating gel.

14. If an anaesthetic gel has been prescribed, apply this topically to the anal area. Do not use the gel if there is documented evidence of anal trauma or bleeding.

15. Explain the procedure to the patient as you perform each action.

16. Gently and slowly insert your gloved, lubricated index finger into the rectum (Figure 3). Determine the type of faeces in the rectum using the Bristol Stool Chart (Lewis and Heaton 1997).

17. If the stool is type 1 (scybala – faecal pellets), slowly and gently remove one lump at a time until no more faecal matter is felt, placing it in a suitable receiver. If a solid faecal mass is felt, gently push the gloved finger into the middle of the mass, split it and remove pieces using a hooked finger until no faecal matter is felt, placing it in a suitable receiver. Care is required to avoid causing trauma.

18. On examination, if the faecal mass is more than 4cm across and it is difficult to break it up, discontinue the procedure. Refer the patient to the medical team who may consider digital removal of faeces under general anaesthesia.

19. Provide a rest period for the patient, if needed. If appropriate, ask the patient to perform the Valsalva manoeuvre – the patient is asked to breathe in and then try to force air out with the mouth and nose closed – this can assist with the passage of faeces into the rectum.

20. Observe the patient during the procedure, noting signs of pain, distress, bleeding or general discomfort. If the anal area bleeds,
discontinue the procedure. Take the patient’s blood pressure and compare with the baseline blood pressure recording. Sit the patient up if possible, administer prescribed medication for autonomic dysreflexia and explain your actions to the patient. It may be necessary to refer the patient to a local spinal cord injury centre.

23. Dispose of any equipment and waste, adhering to local policy and procedures.
24. Wash and dry the patient’s buttocks and anal area using hand-hot water, wipes and a towel.
25. Remove gloves and apron and dispose of as per local policy. Wash and dry your hands and offer the patient the opportunity to do the same.

Evidence base
Practitioners should adopt a structured approach to the assessment of patients with bowel dysfunction, in accordance with evidence-based guidance (National Institute for Health and Care Excellence 2007).

Bowel care is an important aspect of holistic patient care. Performing digital removal of faeces can be embarrassing and uncomfortable for the patient, and not without risk (Association for Continence Advice 2011, Royal College of Nursing (RCN) 2012, Ness 2013). Practitioners should ensure they respect the patient’s privacy and dignity, and demonstrate compassion and sensitivity (NHS Commissioning Board and Department of Health 2012).

In some individuals, such as those with neurological conditions, defecation is not possible without intervention. Defecation is essential for the elimination of waste (Waugh and Grant 2014). Assistance with defecation may include the use of oral medication, for example, laxatives to make the stool softer enabling faeces to move around the colon. Mechanical approaches include transanal irrigation, digital rectal stimulation or digital removal of faeces (Wiesel and Bell 2004, RCN 2012).

Practitioners are accountable for their actions or omissions (Nursing and Midwifery Council 2015) and the practitioner undertaking digital removal of faeces should be skilled and competent to do so (RCN 2012). Practitioners must act in the patient’s best interests and adhere to policy and guidelines.

Practitioners need to perform a risk assessment of the patient before and during digital removal of faeces. The practitioner should check blood pressure in patients with a spinal cord injury who are at risk of autonomic dysreflexia, before and at the end of the procedure. A baseline blood pressure is used to provide a benchmark value for comparison (RCN 2012). Ness (2013) suggested that for those with spinal cord injury where digital removal of faeces is routine, and they have been able to demonstrate tolerance to the procedure, routine recording of blood pressure is not required.

During digital removal of faeces, the patient should be observed for signs of distress, pain, discomfort, bleeding and collapse, and the consistency of stool should be noted (RCN 2012). The Rome III diagnostic criteria (Mostafa 2008) can be used to identify and classify functional constipation. The Bristol Stool Chart (Lewis and Heaton 1997) can be used to identify the type of stool passed.

Autonomic dysreflexia is a sudden, abnormal and exaggerated autonomic response to an unpleasant stimulus, such as a full rectum, constipation or digital stimulation of the rectum that occurs during bowel evacuation (Kyle et al 2005, RCN 2012, Ness 2013). The condition occurs in people with spinal injuries at T6 or above. In an acute episode, the patient presents with marked hypertension and headache. Since autonomic dysreflexia may occur in response to digital interventions such as digital removal of faeces, the patient should be observed for symptoms such as flushing, sweating, chills, nasal congestion, blurred vision and headache (Coggrave 2008, Ness 2013). If autonomic dysreflexia occurs during digital removal, the procedure should be stopped, medical assistance sought and treatment instigated promptly.

Effective bowel care is a vital component of holistic patient care and failure to provide such care could be fatal for some patients NS.

Disclaimer: please note that the information provided by Nursing Standard is not sufficient to make the reader competent to perform the task. All clinical skills should be formally assessed at the bedside by a nurse educator or mentor. It is the nurse’s responsibility to ensure their practice remains up to date and reflects the latest evidence.

USEFUL RESOURCES

- Bladder and Bowel Foundation www.bladderandbowelfoundation.org (Last accessed: May 3 2016.)
- Spinal Injuries Association www.spinal.co.uk (Last accessed: May 3 2016.)
References

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


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