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**Bowel Management Policy**

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CONTENTS

[1. Introduction 3](#_Toc147931505)

[2. Policy Statement 3](#_Toc147931506)

[3. Scope 3](#_Toc147931507)

[4. Procedures 3](#_Toc147931508)

[5. Bowel Assessment 4](#_Toc147931509)

[6. Bowel Management 7](#_Toc147931510)

[7. Bowel Emptying Techniques 9](#_Toc147931511)

[8. Alternative Management Strategies 11](#_Toc147931512)

[9. Spinal/Neurogenic Conditions 11](#_Toc147931513)

[10. Prescribing and Administering Medications 12](#_Toc147931514)

[11. Autonomic Dysreflexia 13](#_Toc147931515)

[12. Lower Bowel Care Emergencies and Complications 13](#_Toc147931516)

[13. Infection Prevention and Control 14](#_Toc147931517)

[14. End of Life 14](#_Toc147931518)

[15. Documentation 15](#_Toc147931519)

[16. Monitoring 15](#_Toc147931520)

[17. Related Policies and Procedures 15](#_Toc147931521)

[18. Legislation and Guidance 16](#_Toc147931522)

[19. Summary of Review 17](#_Toc147931523)

# Introduction

Effective and appropriate bowel management is an essential component of high-quality client care that can significantly affect a client’s quality of life, as well as their clinical condition.

# Policy Statement

[Company Name] is committed to ensuring that all clients are routinely assessed and that appropriate bowel management strategies are put into place where indicated. Staff should only work within their competence and scope of practice and seek additional support from other professionals where required.

# Scope

This policy and the procedures apply to all staff involved in direct client care.

[Clinical Lead Name] is responsible for supporting staff in the appropriate assessment and management of client’s bowel management plans and for ensuring that the content of this policy remains current and in line with the standards for best practice.

# Procedures

**All procedures and assessments should only be carried out by trained and experienced persons. If you are in any doubt about your competence to carry out a given task, please seek advice from the registered manager.**

Staff are responsible for ensuring that they are competent and confident in overall bowel management, including bowel anatomy and physiology, assessment, interventions, complications, and emergencies.

All bowel management assessment and intervention procedures must be supported by fully informed consent while maintaining confidentiality and privacy and dignity, as well as offering chaperoning and ensuring the safeguarding of vulnerable clients. Any assessment and/or procedure must be documented accurately in the client’s care record, along with the results and any ongoing maintenance plans.

An ineffective bowel can be categorised as causing two main symptoms:

* Constipation - usually considered in two ways, clients with difficulty defecating but have normal bowel frequency and those with a transit abnormality. Constipation has numerous causes including:
  + primary or idiopathic and unrelated to any other complaint or pathological cause, but can be linked to immobility, poor diet, slow colonic transit, and pelvic floor abnormalities
  + secondary to another disorder
  + functional, which presents as a persistently (present for 3–6 months in at least 25% of defecations) difficult, infrequent, or incomplete defecation
  + obstructive defecation syndrome, which is a failure to relax the anal sphincter or pelvic floor muscles while trying to defecate
  + anismus, which is an inappropriate contraction rather than relaxation of the anal sphincter or puborectalis muscle during defecation
  + faecal impaction or loading where the rectum and/or lower colon is full of hard or soft stool that the client is unable to evacuate (easily misdiagnosed as diarrhoea due to overflow).
* Faecal incontinence – is commonly a symptom of an underlying cause and every attempt should be made to diagnose this before undertaking treatment. Common causes include:
  + faecal urgency (usually due to external anal sphincter weakness or defect)
  + passive soiling (usually caused by poor internal anal sphincter pressure)
  + diarrhoea (caused by increased gut motility)
  + inflammatory bowel disease (IBD)
  + irritable bowel syndrome (IBS)
  + anorectal pathology
  + neurological disease
  + lifestyle and environmental issues
  + functional (diagnosis should only be made based on a thorough history exclusion of somatic disease).

# Bowel Assessment

Staff must ensure that all clients receive a bowel assessment to determine whether any interventions are needed. This should be approached with sensitivity to facilitate an open and honest conversation while minimising any embarrassment for the client.

For clients that are independent and report no bowel related issues or concerns, further input and/or assessment is unlikely to be required as long as the client is aware that they should report any changes or concerns if they occur.

For clients where bowel management is a potential concern, an accurate clinical history and bowel movement history should be obtained.

To classify the type of stool passed see [bristol-stool-chart-pdf-245459773 (nice.org.uk)](https://www.nice.org.uk/guidance/cg99/resources/bristol-stool-chart-pdf-245459773), [BBC002\_Bristol-Stool-Chart-Jan-2016.pdf (bladderandbowel.org)](https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002_Bristol-Stool-Chart-Jan-2016.pdf) for Bristol Stool Chart Scoring.

Clients with the following would be considered at higher risk of developing bowel dysfunction or complications:

* bowel cancer
* severe faecal impaction
* an obstruction
* clostridium difficile
* central neurological disease or a trauma
* end of life care needs
* cognitive impairment or behavioural issues
* acute disc prolapse
* acquired brain injury
* history of abuse
* mobility issues
* prostatic obstruction/hypertrophy
* nutritional issues
* alcohol and drug dependency issues
* frail older clients
* perinatal/pregnant or post-childbirth women
* postoperative clients
* critically ill clients.

Additionally, clients who report any of the following symptoms may have an underlying pathology:

* rectal bleeding
* change of bowel habit for six weeks
* unintentional weight loss
* pain before, during or after defecation
* faecal leakage
* faecal urgency.

For clients with bowel symptoms, a bowel diary should be implemented to monitor:

* frequency
* consistency
* effort/ease of passage/urgency
* amount
* colour
* incontinence and time of episode(s)
* whether the client can use/sit on the toilet with or without assistance.

Assessments should also include details of the following:

* surgical, medical, obstetric, sexual, family, neurological and psychological history
* functional capabilities
* current medications
* allergies
* diet and fluid intake
* body mass index (BMI)
* lifestyle issues, including smoking status
* home and social circumstances (if relevant).

Referrals must be made to the clients GP if there are red flag signs of bowel cancer as per NICE [Gastrointestinal tract (lower) cancers - recognition and referral | Health topics A to Z | CKS | NICE](https://cks.nice.org.uk/topics/gastrointestinal-tract-lower-cancers-recognition-referral/) or if abnormalities/concerns are found.

**Clinical examination**

A digital rectal examination (DRE) can be performed in addition to obtaining a clinical history for the following indications:

* to establish the presence, amount, and consistency of any faecal matter in the rectum
* to assess anal tone and sensation
* to assess the general status of the anal and rectal area prior to rectal interventions
* to assess the need for and effects of rectal medication
* to assess for anal pathology and/or the presence of foreign objects
* prior to investigative procedures.

When performing a DRE, monitor for and document the presence of any of the following:

* blood
* faecal matter
* rectal prolapse
* haemorrhoids
* anal fissure
* anal skin tags
* anal lesions
* anal fistula/induration
* anal tone absent/reduced
* anal reflex present or not
* broken areas or sore/red skin
* pressure sore
* wounds
* increased skin conditions
* scarring
* infestation
* foreign bodies.

Advice should be sought from a medical professional before performing a DRE in clients with the following:

* inflammatory bowel disease
* recent radiotherapy to the pelvic area
* rectal or anal pain
* rectal surgery or trauma to the anal or rectal area (in the last six weeks)
* tissue fragility due to age, radiation, or malnourishment
* obvious rectal bleeding
* known history of abuse
* spinal cord injury at, or above, T6
* a known history of allergies (such as latex)
* is unconscious
* gain’s sexual gratification from the procedure.

# Bowel Management

**Nutrition**

Balanced nutrition and hydration are essential to good bowel management and adults are recommended to consume 30g of fibre per day. Any current therapeutic diets should be taken into consideration and reviewed as to whether they remain appropriate. The following therapeutic diets and/or options can be considered depending upon the presenting complaint:

* a low residue diet could reduce fibre intake and decrease motility of the gut, making the stool firmer
* excluding wheat or dairy in clients with food intolerance could reduce loose stools and bloating
* exclusion diets to establish trigger foods that could be causing dysfunction
* bulking agents may increase the stool, soften hard stool, or firm loose stool
* improve fibre intake
* referral to a dietician/nutrition team where more specialised knowledge is required
* fibre supplements for loose stools and faecal incontinence (this could worsen the problem in clients with certain intolerances)
* a low fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAP) diet and the British Dietetic Association irritable bowel syndrome diet
* probiotics and prebiotics can improve the balance of bacteria within the bowel
* eating small regular meals rather than one large one.

Clients should avoid foods that may exacerbate bowel dysfunction, including:

* spicy foods
* soluble fibre
* supplementary feeds.

Adult fluid intake should be between 1.5–2L each day, depending on level of activity and weather conditions. The following fluids should be reviewed as contributors to any bowel dysfunction:

* milk as a common intolerance
* coffee and caffeine, which increase motility of the bowel
* diet drinks that contain sorbitol and act as a laxative
* herbal teas aid digestion
* alcohol in excessive quantities increases bowel motility
* fizzy carbonated drinks increase abdominal bloating.

**Skin care**

For clients with faecal incontinence and at an increased risk of pressure sores, skin care and pressure ulcer prevention should be performed in line with the Pressure Ulcer Prevention Policy.

**Containment**

Some clients with faecal incontinence may benefit from a containment device to promote dignity, these include:

* anal plugs made of soft slightly absorbent foam that are inserted into the rectum to open up like a cup shape and reduce faecal leakage
* anal inserts made of soft silicone that are inserted into the rectum to manage accidental bowel leakage
* pads (ensure that the pad is appropriately sized and suitable for faecal leakage, take care in clients with reduced sensation and an increased risk of pressure ulcers)
* faecal collectors are only usually effective in bed bound clients with liquid faeces
* bowel management systems, a tube-like device placed into the rectum to contain diarrhoea, should be used with extreme caution, when used incorrectly can cause internal injuries. Indicated in bed bound clients with liquid, continuous diarrhoea (e.g., C-difficile).

# Bowel Emptying Techniques

For clients unable to empty their bowel effectively or completely, there are several bowel emptying techniques that can be employed. As with any procedure, prior to commencement the procedure should be fully explained to the client along with the expected result for consent to be obtained. Ensure that the chosen technique is safe and appropriate for the client and their situation

* Positioning – where possible, ideal positioning has the client’s feet elevated to ensure that knees are above hips, while allowing them to lean forward in between their knees with a straight back and lower abdomen bulged.
* Dynamics of defecation – brace the abdominal wall to stop anterior movement, adopt a brace and pump technique (use the diaphragm to increase intra-abdominal pressure from above with simultaneous relaxation of the external anal sphincter and puborectalis).
* Perineal support – support the skin between the anus and vagina with two fingers while performing the above manoeuvres.
* Vaginal digitation – (for posterior vaginal wall prolapse) put the thumb or first finger into the vagina and push backwards.
* Digital stimulation of the rectum (DSR) – insert a gloved lubricated finger into the anus and slowly rotate the finger in circular movements, maintaining contact with the rectal mucosa and gently stretching the anal canal. This helps to relax the sphincter and stimulates the rectum to contract.
* Rectal stimulant medication – includes suppositories and enemas.
* Transanal bowel irrigation (TAI) – the instillation of warm water, either via a cone or rectal catheter, into the descending colon and rectum to facilitate evacuation of stools. Contraindicated in the following:
  + pregnant or planning pregnancy
  + active perianal sepsis
  + diarrhoea
  + anal fissure
  + large haemorrhoids that bleed easily
  + faecal impaction
  + past pelvic radiotherapy causing bowel symptoms
  + known diverticular disease
  + where using rectal medications for other diseases
  + congestive cardiac failure
  + anal surgery within the past six months
  + acute active inflammatory bowel disease
  + known obstructing rectal or colonic mass
  + rectal or colonic surgical anastomosis within the last six months
  + severe cognitive impairment.
* Digital removal of faeces (DRF) – is an intimate procedure that should only be considered when clinically indicated, as follows:
  + other methods of bowel emptying have failed or are inappropriate
  + there is faecal impaction or loading
  + there is incomplete defecation
  + there is an inability to defecate
  + there is a neurogenic bowel dysfunction
  + the client has a spinal cord injury.

When performing DRF healthcare professionals / assistants should monitor for:

* distress, pain, or discomfort
* bleeding
* collapse
* stool consistency
* pre and post procedure pulse and blood pressure in clients with spinal cord injury at, or above, T6.

# Alternative Management Strategies

Clients with faecal incontinence may benefit from alternative strategies if initial treatments have been unsuccessful, these include:

* Pelvic floor muscle re-education (PFME) – a progressive and intensive programme intended to strengthen and improve the coordination, endurance, and speed of pelvic floor muscle response.
* Biofeedback - a technique aimed at transforming aspects of physiological behaviour into a visual or auditory signal to establish a change in behaviour and help manage a client’s bowel dysfunction.
* Neuromuscular electrical muscle stimulation (NMES) – where electrical stimulus is delivered to the external sphincter and pelvic floor muscle and indicated when anorectal assessment identifies extremely weak muscles with poor endurance.
* Percutaneous posterior tibial nerve stimulation (PTNS) - delivers an electrical current through a needle inserted into the posterior tibial nerve. It should only be delivered in specialist units after unsuccessful PFME and biofeedback interventions.

# Spinal/Neurogenic Conditions

Neurogenic bowel management aims to deliver planned interventions to achieve effective bowel evacuation at specific times to avoid faecal incontinence and constipation.

Clients with spinal or Neurogenic conditions must have a specialist care plan in place.

In the case of spinal cord injury, bowel care for spinal clients will be planned prior to discharge from the inpatient spinal cord injury centre.

Abdominal massage may be helpful.

# Prescribing and Administering Medications

All medications must be prescribed by a registered prescriber before administering by trained staff.

Any medication prescribed as part of a bowel management plan should be done so in line with the prescriber’s limitations of practice and the British National Formulary (BNF). The following indications and risk factors should be considered when prescribing and administering any bowel management medications to ensure that they are appropriate to the client and their condition:

* type(s) of bowel dysfunction
* choice of route
* administration times
* duration of treatment
* interactions and expected outcomes
* cautions, contraindications, and side effects
* licensed usage
* local formularies.

When prescribing medications aimed at treating other conditions, prescribers should consider their potential effects on a client’s bowel function and address or reassess these appropriately. Medications that are known to have bowel altering side effects include:

* opioids
* broad-spectrum antibiotics
* laxatives
* diabetic medications
* obesity medications
* anti-diarrhoeal
* antidepressants
* antihistamines
* antimuscarinics
* antacids
* iron preparations
* polypharmacy.

All medications will be administered as per the prescription in accordance with the medicines management policy.

# Autonomic Dysreflexia

This is a medical emergency that unresolved may give rise to serious consequences such as cerebral haemorrhage, seizures, or cardiac arrest. This occurs mostly in lesions above T6. One of the main causes for this is an overloaded bowel

The reflex causes Vaso-constriction below the level of the lesion causing a pathological rise in blood pressure that can be life threatening if allowed to continue unchecked.

Symptoms include:

* Sweating and goose pimples
* Peripheral cyanosis
* Pounding headache
* Blurred vision and dizziness
* Shortness of breath
* Slow pulse.

Actions to take include:

* Recognise the signs and call for help/assistance
* Sit the client up
* Check blood pressure readings every 2-5 minutes
* Administer any prescribed anti-hypertensive medication (commonly GTN Sublingual spray or Nifedipine)
* Check bladder and bowel status/function
* Identify and treat the cause.

# Lower Bowel Care Emergencies and Complications

While complications are rare, healthcare professionals / assistants must be competent in identifying and responding to any potential complications or emergencies appropriately, including:

* Bowel obstruction – a potentially life-threatening condition if the bowel ruptures, it should be suspected where there is no bowel activity or lots of painful activity. Symptoms often include abdominal pain and distension, vomiting and possible dehydration.
* Perforation – potentially life-threatening if left untreated. A perforation is a hole in the bowel that allows the leakage of intestinal contents into the abdominal cavity. Symptoms include a high fever, nausea and severe abdominal pain that is worse on movement.
* Faecal impaction – resulting from constipation and can lead to a bowel obstruction.
* Undiagnosed diarrhoea – can have numerous causes and can lead to dehydration and an electrolyte imbalance.
* Undiagnosed rectal bleeding - can have numerous causes that is usually dependent upon the type of blood and location, along with any recent change in bowel habit, unintentional weight loss, rectal bleeding, anaemia, increased mucus, and wind not associated with any lifestyle changes.
* Strangulated hernia – is a potentially life-threatening surgical emergency that occurs when the blood supply to the bowel is cut off, leading to ischaemia, necrosis, and gangrene.

Where a potential complication or medical emergency is suspected, immediate referral should be made to either an attending or primary care medical professional or the emergency services (999), dependent upon the complication and severity of the client’s condition.

# Infection Prevention and Control

Infection prevention and control techniques should be applied as per the company Infection Control Policy and Infectious Diarrhoea and Vomiting Policy.

# End of Life

There are several functional bowel issues that can present at the end of life, and these should be managed promptly in an appropriate manner:

* constipation (common in advanced cancers and other terminal diseases)
* impaction and obstruction
* diarrhoea
* faecal incontinence.

It is important to continue to provide bowel management strategies as symptoms, such as nausea and vomiting, confusion, and abdominal pain, can severely impact on a client’s last days of life.

Clients should be assessed as per the assessment section of this policy and managed appropriately starting with the least invasive strategies to maintain bowel function.

Specialist palliative care input and guidance must be sought.

# Documentation

All assessments, reviews and care provided and omitted must be documented as per company policy.

The following details must always be documented:

* Consent
* Observations
* Findings on examination
* Outcome of any intervention
* If a referral on has been made.

# Monitoring

The effectiveness of this policy will be monitored through routine audit and the investigation of any adverse incidents and/or client complaints.

# Related Policies and Procedures

* Infection Prevention and Control Policy
* Infectious Diarrhoea and Vomiting Policy
* Pressure Ulcer Prevention Policy
* Consent (Adults) Policy
* Chaperone Policy
* Safeguarding (Adult) Policy
* Medicines Management Policy
* Information Governance and Record Keeping Policy
* Quality Assurance Policy

# Legislation and Guidance

**Guidance**

* Royal College of Nursing (2019): Bowel Care; Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of Faeces
* NICE [Overview | Irritable bowel syndrome in adults: diagnosis and management | Guidance | NICE](https://www.nice.org.uk/guidance/cg61)
* NICE [Overview | Faecal incontinence in adults: management | Guidance | NICE](https://www.nice.org.uk/guidance/cg49)
* Spinal Injuries Association [Microsoft Word - Autonomic Dysreflexia.docx (spinal.co.uk)](https://www.spinal.co.uk/wp-content/uploads/2017/05/Autonomic-Dysreflexia.pdf)
* NICE [Irritable bowel syndrome | Health topics A to Z | CKS | NICE](https://cks.nice.org.uk/topics/irritable-bowel-syndrome/)

# Summary of Review

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