Guideline for Digital Rectal Examination and/or Digital Removal of Faeces

Lead executive: Director of nursing, Therapies Patient Partnership
Authors details: Community Continence and Urology Service - 0151 488 8230

Type of document: Guidance
Target audience: All clinical staff

Document purpose: This policy is intended to serve as an evidence based guide for Community Registered Nurses employed by Cheshire and Wirral Partnership, in how to perform a digital rectal examination and digital removal of faeces. Please note this guideline is intended for adult patients only.

Approving meeting: Neighbourhood-Based Care Group Meeting Date: 11-Sep-19
Implementation date: 11-Sept-19

CWP documents to be read in conjunction with:
- HR6: Mandatory Employee Learning (MEL) policy
- IC2: Hand decontamination policy and procedure
- HS1: Waste management policy
- IC3: Standard (universal) infection control precautions policy
- CP3: Health records policy
- CC44: Clinical guidelines for administration of suppositories and enemas
- MP16: Non-medical prescribing policy
- GR26: Policy for the safe manual handling of people

Document change history
What is different?: Incorporated NHS Patient Safety Alert (NHS/PSA/RE/2018/005) to support safe bowel care for patients at risk of autonomic dysreflexia.

Appendices / electronic forms: N/A

What is the impact of change?: Provide clinical staff with clear guidance on Digital Rectal Examination and/or Digital Removal of Faeces

Training requirements: YES- Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation
Clinical Services: Consultant Nurse, Head of Infection Prevention and Control
Corporate services: via discussion board
External agencies: Patient Safety Clinical Lead (NHS Improvement)

Financial resource implications: None

External references: None

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<th>Equality Impact Assessment (EIA) - Initial assessment</th>
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Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.

If you have identified a potential discriminatory impact of this procedural document, please refer it to
### Equality Impact Assessment (EIA) - Initial assessment

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the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.

<table>
<thead>
<tr>
<th>Was a full impact assessment required?</th>
<th>No</th>
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<td>What is the level of impact?</td>
<td>Low</td>
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</table>
Quick reference flowchart for digital rectal examination (DRE)
For quick reference the guide below is a summary of actions required.

Complete bowel assessment
(see section 4)

Indication for digital rectal examination
(see section 1 and 5.1)

Yes

Contra-indications or precautions
(see section 5.2 and 5.3)

No

DRE procedure
(see section 8.1)

Yes

Refer to GP

Quick reference flowchart for digital removal of faeces (DRF)
For quick reference the guide below is a summary of actions required.

Complete bowel assessment
(see section 4)

Indication for digital removal of faeces (DRF)
(see section 1 and 6.1)

Yes

Contra-indications or precautions
(see section 6.2 and 6.3)

No

DRF procedure
(see section 8.2)

Yes

Refer to GP
1. Introduction
This guideline is intended to serve as evidence based guide for Community Registered Nurses employed by Cheshire and Wirral Partnership, in how to perform digital rectal examination and digital removal of faeces. Please note this guideline is intended for adult patients only.

Digital Rectal Examination (DRE) is an invasive procedure and should only be performed when necessary (Powel, 2000). Cultural, religious beliefs, dignity and privacy of the patients must be a priority and considered before performing this procedure (RCN, 2012).

Advances in oral laxatives, anal/rectal irrigation and surgical treatments have reduced the need for digital removal of faeces (DRF). Powell and Rigby (2000) suggest that digital removal of faeces is a last resort procedure and should only be practiced when all other methods of bowel evacuation have failed. However for some patients such as those with spinal cord injury, cauda equina, spina bifida and multiple sclerosis, digital removal of faeces can be an integral part of their routine bowel management (Kyle, 2008).

An assessment of the individual is required by a community registered nurse before any digital rectal examination or digital removal of faeces is contemplated. The aim of the assessment is to establish a symptom profile to plan individualised bowel care. In the assessment all the possible causes of bowel dysfunction need to be considered (NICE, 2007; Kyle, 2010).

These procedures must only be carried out by Registered Nurses who have received suitable training and have been assessed as competent to carry out the procedure.

2. Definitions
To provide guidance for Registered Nurses in:
- bowel assessment;
- Indications, contra-indications and precautions for digital rectal examinations and digital removal of faeces;
- Procedure for digital rectal examination (DRE) and digital removal of faeces (DRF);
- The delegation and supervision of any DRE and/or DRF procedures patients or carers.

3. Introduction
This guidance applies to all Community Registered Nurses, who are currently registered with the Nursing and Midwifery Council (NMC) and employed by Cheshire and Wirral Partnership.

Following completion of a face to face bowel management study session, the Registered Nurses need to complete a minimum of 2 supervised practices or until they feel confident and competent in digital rectal examination (Appendix 1) and/or digital removal of faeces (Appendix 2).

Following this it is the Registered Nurse’s personal responsibility to identify when they require a bowel management study session update.

The supervision of these practical procedures can only be undertaken by a Registered Nurse who has:
- Attended a bowel management study session;
- Has up to date knowledge and skills to perform these procedures;
- Is confident and experienced in carrying out digital rectal examinations and digital removal of faeces.
3.1. Delegation of procedure to patients and carers
A Registered Nurse, who can demonstrate competence in digital removal of faeces can delegate this procedure to patients and carers.

The Registered Nurse is accountable for the appropriateness of the delegation, for ensuring that the carer is competent and confident to perform the digital removal of faeces and has the knowledge and skills to report back any changes/incidents as necessary. The Registered Nurse also needs to provide supervision or support on a regular basis.

When the Registered Nurse is teaching a carer to carry out digital removal of faeces this should be on a named patient-named carer basis only (RCN, 2012). It is Registered Nurse’s responsibility to review the clinical need for digital removal of faeces and to explore alternative options, i.e. oral or rectal medication, anal irrigation.

4. Assessment and review
A bowel assessment of the individual and their needs is required before any digital rectal examination and/or digital removal of faeces is contemplated by a Registered Nurse.

Factors that need to be assessed in patients with a bowel dysfunction (RCN, 2012):
- Signs and symptoms to include frequency of passage of stools, consistency of stools, any rectal bleeding, unintentional weight loss, anaemia, pain before, during or after defecation, faecal leakage, and faecal urgency;
- Identify high risk individuals or factors such as bowel cancer, severe faecal impaction, Clostridium Difficile (NICE, 2007);
- Medical, surgical, obstetric, family, neurological history; allergies;
- Diet, fluids, smoking status, body mass index;
- Impact on quality of life;
- Home and social circumstances, functional capabilities, need for assistance with bowel care and carer availability.

Valid, informed consent must be obtained from the patient and documented prior to undertaking DRE or digital removal of faeces. This consent can be withdrawn at any point throughout the procedure. If the patient is deemed not to have capacity to consent to this procedure, the Mental Capacity Act (2005) provides nurses with a statutory framework to empower and protect those patients who are unable to make their own decisions (Kyle, 2010).

Discuss with the patient the findings of the DRE and/or DRF, also review the need for further investigations and treatment choices/recommendations (RCN, 2012).

5. Digital rectal examination (DRE)

5.1 Indications for digital rectal examination
Digital rectal examination can be used in the following circumstances
- Establish the presence of faecal matter in the rectum; the amount and consistency. Please note that a lack of faecal matter in the anus does not necessarily signify that a patient is not constipated. The patient might be constipated higher up in the sigmoid or colon (Fallon and O’Neill, 1997);
- Prior to giving any rectal medication to establish the state of the rectum;
- Ascertain anal tone and the ability to initiate a voluntary contraction and to what degree;
- Establish anal and rectal sensation;
• To establish the effects of rectal medication;
• Assess anal pathology for the presence of foreign objects (RCN, 2012).

A Specialist Nurse/Practitioner might use DRE for a variety of reasons during the following procedures:
• Teach pelvic floor exercises;
• The placement of a probe used for electrical stimulation of the pelvic floor muscles;
• The placement of rectal catheters used in the treatment of obstructive defecation and/or biofeedback;
• Prior to using trans anal irrigation;
• To assess prostate size, consistency, mobility and anatomical limits (RCN, 2012).

5.2 Contra-indications for digital rectal examination
Nurses should not undertake digital rectal examination when:-
• There is a lack of consent from the patient –either written or verbal;
• The patient’s doctor has given specific instructions that these procedures are not to take place (RCN, 2012);
• The patient has recently undergone rectal/anal surgery or trauma.

5.3 Precautions for digital rectal examination
You should exercise particular caution with patients who have the following diseases and conditions (RCN, 2012):
• Active inflammation of the bowel including Crohn’s disease, ulcerative colitis and diverticulitis;
• Recent radiotherapy to the pelvic area;
• Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment;
• Rectal surgery or trauma to the anal or rectal area in the last 6 weeks;
• Rectal or anal pain;
• Obvious rectal bleeding;
• Patients with spinal cord injuries (T6 and above), severe stroke, severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida due to risk of autonomic dysreflexia;
• If patient has a known history of allergies e.g. to latex;
• Patients with history of abuse.

If any abnormalities of perineal or perianal area are observed, a DRE should not be carried out until advice is taken from a medical practitioner (Dougherty et al, 2011).

6. Digital removal of faeces (DRF)
Prior to digital removal of faeces, a digital rectal examination should be carried out as set out in this policy.

6.1 Indications for digital removal of faeces
Digital removal of faeces may be undertaken for the following:-
• Incomplete defecation;
• Faecal impaction/loading;
• Inability to defecate;
• When other bowel emptying techniques have failed.
6.2 Contra-indications for digital removal of faeces
Nurses should not undertake digital rectal examination or digital removal of faeces when: (Kyle, 2008)

- There is a lack of consent from the patient – either written or verbal;
- The patient’s doctor has given specific instructions that these procedures are not to take place;
- The patient has recently undergone rectal/anal surgery or trauma;
- The nurse does not feel competent.

6.3 Precautions for digital removal of faeces
You should exercise particular caution with patients who have the following diseases and conditions Kyle, 2008; RCN, 2012):

- Active inflammation of the bowel including Crohn’s disease, ulcerative colitis and diverticulitis;
- Recent radiotherapy to the pelvic area;
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment;
- Obvious rectal bleeding;
- Patient taking anticoagulant medication;
- Rectal or anal pain;
- Patient has a known history of allergies e.g. to latex;
- Rectal surgery or trauma to the anal or rectal area in the last 6 weeks;
- Patients with history of abuse;
- Patients with spinal cord injuries (T6 and above), severe stroke, severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy oe Spina Bifida due to risk of autonomic dysreflexia.

7. Information on Autonomic Dysreflexia
Patients with spinal cord injuries at T6 and above are particularly susceptible to autonomic dysreflexia. Spinal injury patients are usually aware of this condition and have experienced it prior to hospital discharge. However health care professionals need to be aware that a small proportion of patients who have severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke may also develop autonomic dysreflexia (NHS, 2018).

Autonomic Dysreflexia is a sudden and potentially lethal surge of blood pressure often triggered without warning by acute pain or a harmful stimulus. This occurs because the body is unable to lower the blood pressure therefore the blood pressure will continue to rise until the offending stimulus is removed.

Digital rectal examination and digital removal of faeces are some of the factors that may trigger Autonomic Dysreflexia.

Symptoms of Autonomic Dysreflexia may be mild or severe. Patients can present with one or more of the following:

- Cool, clammy skin;
- Flushed face;
- Blotchiness;
- Sweating above level of injury;
- Pounding headache;
- Seeing spots or blurred vision;
- Nausea;
- Feeling Anxious;
• Increased blood pressure.

Treatment for Autonomic Dysreflexia:
• Sit the patient up;
• Identify and remove irritation;
• Give prescribed medication for Autonomic Dysreflexia;
• Monitor blood pressure;
• Contact 999 if the cause cannot be identified or the hypertension cannot be controlled.

If you suspect the symptoms of autonomic dysreflexia in a patient who has not been diagnosed with it previously, i.e. patients who have severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke:-
• Contact 999;
• Sit the patient up;
• Identify and remove the irritation;
• Monitor blood pressure.

8. Procedures

8.1 Digital rectal examination

<table>
<thead>
<tr>
<th>No.</th>
<th>Action</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1.</td>
<td>Explain the procedure, rational and risks to the patient. Obtain consent and document on care plan.</td>
<td>To ensure that the patient understands the procedure and gives informed consent (NMC, 2015). However the patient may change his/her mind at any time throughout the procedure. To ensure that the procedure is carried out in the best interest of the patient.</td>
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<td></td>
<td>If patient is unable to consent due to lack of capacity, follow the framework as set out in the Mental Capacity Act (2005).</td>
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<td>2.</td>
<td>Assess if the patient is able to get to the toilet. If not a commode or bedpan maybe required.</td>
<td>Performing a digital rectal examination could stimulate defaecation (Dougherty et al, 2011).</td>
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<tr>
<td>3.</td>
<td>Wash hands as per Trust policy. Put on a disposable plastic apron and non-sterile gloves.</td>
<td>To minimise risk of cross infection.</td>
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<tr>
<td>4.</td>
<td>Patients who are at increased risk of autonomic dysreflexia, should have their blood pressure taken prior to and at the end of the procedure.</td>
<td>A record of baseline blood pressure is advised for all patients for future comparison. This should be recorded at least once a year. For those spinal cord injury patients with</td>
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| 5. | Remove any clothing below the waist. Cover the genital area with a blanket.  
Place a nursing procedure sheet or towel on the bed.  
Ask the patient to lay on their left side with their knees up towards their chest (right knee slightly higher than the left) and the buttocks near the edge of the bed. | To maintain the patient's dignity.  
To obtain maximum view of the perineal area and expose the anus. |
| 6. | Observe the perineal and perianal area for: (Kyle, 2007; RCN, 2012))  
• Rectal prolapse;  
• Haemorrhoids;  
• Anal skin tags;  
• Wounds (i.e. pressure sore, etc.);  
• Anal lesions, fissures, fistula’s or scaring;  
• Anal tone;  
• Skin conditions (i.e. psoriasis, eczema, etc);  
• Bleeding;  
• Faecal matter;  
• Infestation;  
• Foreign bodies. | If any abnormalities of perineal or perianal area are observed, document and if any concerns take advice from a medical practitioner before carrying out procedure (RCN, 2012). |
| 7. | Lubricate the gloved index finger | Avoids trauma to anal mucosa damage |
| 8. | Separate the patient's buttocks and insert lubricated finger. | To determine the following:  
• Faecal matter in rectum, type and consistency;  
• If required establish anal and rectal sensation and anal tone;  
• Need for rectal medication;  
• Need for manual removal of faeces;  
• The outcome of rectal/colonic washout/irrigation;  
• The need and outcome of using digital stimulation. |
| 9. | During the procedure the nurse should also observe the patient for signs of: (Dougherty, 2011; RCN 2012)  
• Distress, pain, discomfort;  
• Bleeding;  
• Collapse;  
• Bradycardia due to the stimulation of autonomic dysreflexia, where routine and tolerance is well established, recording of blood pressure on each intervention is not necessary (RCN, 2012). | To prevent any further adverse reaction. |
the vagus nerve in the rectal wall;  
- Signs and symptoms of autonomic dysreflexia in patients with spinal cord injury T6 and above or patients who have severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke.

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<tr>
<td>10. Remove finger. Wipe residual lubricating gel from the anal area</td>
<td>To ensure prevention of irritation and soreness</td>
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<tr>
<td>11. If the patient requires enemas, suppositories or digital removal of faeces refer to the guidelines for these procedures.</td>
<td>To ensure safe practice.</td>
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<tr>
<td>12. Remove and dispose of gloves and apron and wash hands according to Trust policies IC2 and HS1.</td>
<td>To avoid cross infection.</td>
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<tr>
<td>13. Return patient to comfortable position and assist the patient to the toilet if required.</td>
<td>To ensure patients comfort and dignity.</td>
</tr>
<tr>
<td>14. Discuss with the patient the findings of the DRE</td>
<td>To inform the patient and to review the need for further investigations and treatment choices/recommendations.</td>
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</table>
| 15. Record information in care plan, to include:  
- Consent;  
- Rational for performing Digital Rectal Examination;  
- Observations of perineal and perianal area;  
- Presence and consistency of faecal matter within rectum;  
- Anal and rectal sensation and anal tone if assessed;  
- Treatment plan. | To provide a point of reference to ensure accurate record keeping. |

Do not retain a paper version of this document, always view from the website www.cwp.nhs.uk to ensure it is the correct version
### 8.2 Digital removal of faeces

#### Equipment
- Disposable non-sterile gloves (2 pairs)
- Disposable plastic apron
- A single sachet of lubricant, i.e. Aqua gel or Sutherland lubricating Jelly 5g sachet.
- Protection for the bed, i.e. nursing procedure sheet
- Tissue paper, wipes or gauze swaps
- Plastic bag

<table>
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<tr>
<td>1.</td>
<td>Explain the procedure to the patient. Obtain consent and document on care plan. If patient is unable to consent due to lack of capacity, follow the framework as set out in the Mental Capacity Act (2005).</td>
<td>To ensure that the patient understands the procedure and gives informed consent (NMC, 2015). To ensure that the procedure is carried out in the best interest of the patient.</td>
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<td>2.</td>
<td>Assess if the patient is able to get to the toilet. If not a commode or bedpan maybe required.</td>
<td>Performing a digital rectal examination could stimulate defaecation (Dougherty, 2011).</td>
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<td>3.</td>
<td>Wash hands as per policy.</td>
<td>To minimise risk of cross infection.</td>
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<td>4.</td>
<td>Patients with a spinal cord injury, who are at risk of autonomic dysreflexia, should have their blood pressure taken prior to and at the end of the procedure (RCN, 2012). A record of baseline blood pressure is advised for all patients for future comparison. This should be recorded at least once a year. For those spinal cord injury patients where routine and tolerance is well established, recording of blood pressure on each intervention is not necessary (RCN, 2012).</td>
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<td>5.</td>
<td>Put on a disposable plastic apron and non-sterile gloves.</td>
<td>To reduce the risk of cross infection.</td>
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<td>6.</td>
<td>Remove any clothing below the waist. Cover the genital area with a blanket. Place a nursing procedure sheet on the bed. Ask the patient to lay on their left side with their knees up towards their chest (right knee slightly higher than the left) and the buttocks near the edge of the bed.</td>
<td>To maintain the patients dignity. To reduce potential infection caused by soiled linen. To obtain maximum view of the perineal area and expose the anus.</td>
</tr>
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<td>7.</td>
<td>Observe the perineal and perianal area for (Gayle, 2010): Rectal prolapse; Haemorrhoids; Anal skin tags; Wounds; Anal lesions; Gaping anus; Skin conditions; Bleeding; If any abnormalities of perineal or perianal area are observed, document and if any concerns take advice from a medical practitioner before carrying out procedure (RCN, 2012; Dougherty, 2011).</td>
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<tr>
<td>Step</td>
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<tr>
<td>8.</td>
<td>Lubricate the gloved index finger</td>
<td>Reducing surface friction, eases insertion and avoids anal mucosa damage (Kyle, 2008).</td>
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</tbody>
</table>
| 9.   | Separate the patient’s buttocks and insert lubricated finger. Use one finger only (Kyle, 2008). | To determine the following:  
- Faecal matter in rectum, type and consistency;  
- Need for rectal medication;  
- Need for manual removal of faeces. |
| 10.  | During the procedure the nurse should also observe the patient for signs of (Dougherty, 2011; RCN 2012):  
- Distress, pain, discomfort;  
- Bleeding;  
- Collapse;  
- Bradycardia due to the stimulation of the vagus nerve in the rectal wall;  
- Signs and symptoms of autonomic dysreflexia in patients with spinal cord injury T6 and above or patients who have severe forms of Parkinson’s Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke. | To prevent any further adverse reaction. |
| 11.  | If during the rectal examination the stool consistency is found to be the following:  
- small separate hard lumps → remove a lump at a time;  
- solid mass → push finger into centre, split it and remove small sections until none remain. Great care should be taken when removing large pieces of hard stool;  
- rectum is full of soft stool → continuous circling of the finger in a gentle manner may be used to remove stool (Kyle, 2008). | To avoid damage to the rectal mucosa and anal sphincters i.e. do not over-stretch the sphincters by using a hooked finger to remove large pieces of hard stool which may also graze the mucosa. Using a hooked finger can lead to scratching or scoring of the mucosa and should be avoided. |
<p>| 12.  | As faecal matter is removed it should be placed in a suitable receptacle (Kyle, 2008). | To facilitate appropriate disposal of faecal matter (Kyle, 2008). |
| 13.  | Remove finger. Wipe residual lubricating gel from the anal area. | To ensure prevention of irritation and soreness. |
| 14.  | If the patient requires enemas or suppositories refer to the guidelines for this procedure. | To ensure safe practice. |
| 15.  | Remove and dispose of gloves and apron and wash hands. | To avoid cross infection. |
| 16.  | Return patient to comfortable position and assist the patient to the toilet if required | To ensure patients comfort and dignity. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Discuss with the patient the findings of the DRF.</th>
<th>To inform the patient and to review the need for further treatment choices/recommendations.</th>
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<tr>
<td>17</td>
<td>Record information in care plan, to include:</td>
<td>To provide a point of reference to ensure accurate record keeping.</td>
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<tr>
<td></td>
<td>• Consent;</td>
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<td></td>
<td>• Rational for performing digital rectal</td>
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<td></td>
<td>examination and digital removal of faeces;</td>
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<td>• Observations of perineal and perianal area;</td>
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<td>• Presence and consistency of faecal matter</td>
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<td>within rectum;</td>
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<td>• Treatment plan.</td>
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Appendix 1 – Clinical competencies for Registered Nurses for digital rectal examination (DRE)

Prior to completing this document the Registered Nurse must have read the Clinical Guideline “Guideline for digital rectal examination and/or removal of faeces”. In order to complete this document the practitioner will need to undertake a minimum of 2 supervised practices in digitally rectal examination or more until the practitioner feels confident and competent to carry out the procedure.

<table>
<thead>
<tr>
<th>Practitioner’s name</th>
<th>Base</th>
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<td>Designation</td>
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The Registered Nurse should be able to demonstrate competency in the following elements and work within CWP guidelines and policies:

- Assess and review the clinical indication for digital rectal examination.
- Check there is no contra-indication or precautions prior to performing digital rectal examination.
- Explain the procedure to the patient.
- Gain informed consent.
- Work within CWP's Infection Prevention & Control policies.
- Prepare patient equipment and environment before performing digital rectal examination.
- Perform a digital rectal examination as per CWP digital rectal examination guideline.
- Know when not to proceed or stop performing digital rectal examination.
- At all times maintain patient’s comfort and dignity.
- Dispose of clinical waste appropriately.
- Record outcome of procedure in patient’s records and leave contact details.
- Inform the relevant health professional if clinically indicated.

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Do not retain a paper version of this document, always view from the website www.cwp.nhs.uk to ensure it is the correct version.
Appendix 2 – Clinical competencies for Registered Nurses for digital removal of faeces (DRF)

Prior to completing this document the Registered Nurse must have read the Clinical Guideline “Guideline for digital rectal examination and/or digital removal of faeces”. In order to complete this document the practitioner will need to undertake a minimum of 2 supervised practices in digitally removal of faeces or more until the practitioner feels confident and competent to carry out the procedure.

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The Registered Nurse should be able to demonstrate competency in the following elements and work within CWP guidelines and policies

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- Assess and review the clinical indication for digital removal of faeces.
- Check there is no contra-indication or precautions prior to performing digital removal of faeces.
- Explain the procedure to the patient.
- Gain informed consent.
- Work within CWP’s Infection Prevention & Control policies.
- Prepare patient equipment and environment before performing digital rectal examination.
- Perform digital removal of faeces as per CWP guideline on digital rectal examination and/or digital removal of faeces.
- Know when not to proceed or stop performing digital removal of faeces.
- At all times maintain patient’s comfort and dignity.
- Dispose of clinical waste appropriately.
- Record outcome of procedure in patient’s records and leave contact details.
- Inform the relevant health professional if clinically indicated.