GUIDELINE DOCUMENT CONTROL SHEET

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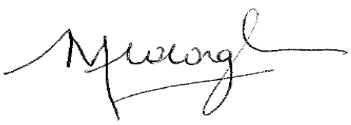
Signature of Executive Sponsor of Ratifying Body	
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TABLE OF REVISIONS

Date	Section	Revision	Author
2013	All	New Document	Sarah Aungiers / Michelle Henderson

CONTENTS

1 INTRODUCTION

There is much confusion and concerns within the nursing profession about the professional and legal aspects of digital rectal examination (DRE) and digital removal of faeces (DRF). It is vital that there are clear guidelines to support staff in this situation.

2 PURPOSE

This document provides a framework which clearly identifies the roles, responsibilities and competencies required for undertaking digital rectal examination (DRE) and digital removal of faeces (DRF). In order to reduce variations in practice and the risk of errors, it is the remit of County Durham and Darlington NHS Foundation Trust to provide a standardised approach for these procedures. This guideline will:

- Inform nurses of the professional and legal aspects of DRE and DRF.
- Enable nurses to understand issues of consent.
- Enable nurses to decide which group of patients are suitable for this type of bowel management.
- Enable nurses to understand the circumstances where extra care is required.
- Enable nurses to be able to instigate preventative measures and / or treatment for Autonomic Dysreflexia.

3 DUTIES

This guideline applies to Registered General Nurses who can demonstrate professional competence to the level determined by the *Nursing and Midwifery Council (NMC) Code of Professional Conduct (NMC 2008).*

The Royal College of Nursing (RCN) has produced clear guidelines for nurses to support nurses in the management of bowel dysfunction (Management of lower bowel dysfunction, including DRE and DRF, RCN 2012). It should be noted that these national guidelines refer to adults only. Nurses working with children should refer to RCN guidance for children document (RCN, 2003).

DRE and DRF are invasive procedures and will only be performed when necessary and after an individual assessment (RCN 2012). DRE is often avoidable and will only be undertaken when clinically justified and performed by a nurse who can demonstrate clinical competence. DRE and DRF will not be seen as a first line investigation in the assessment and treatment of constipation. There is now a wide range of bowel emptying techniques available and consideration will be given to these. With these new treatments, the need for DRE and particularly DRF has been reduced. However, for a small number of patients, such as those with spinal injuries, DRF is the only suitable bowel emptying technique.

Within this Trust, DRE and DRF are regarded as clinical practices which may only be undertaken by qualified nursing staff who have undertaken specific training in this procedure. Student nurses and Health Care Assistants are not permitted to perform these procedures.

Student nurses may observe as part of a learning process. Registered Nurses and Midwives who accept accountability for their actions and feel capable to undertake the procedure may do so.

4 WHEN TO UNDERTAKE DRE/DRF

Before carrying out a DRE, the perineal area should be observed for any abnormalities which need to be documented and reported as necessary:

1. Rectal prolapse – grade, ulceration
2. Haemorrhoids – grade, internal or external
3. Anal fissure
4. Anal skin tags
5. Anal lesions possible malignancy
6. Anal fistula/induration
7. Anal tone absent / reduced
8. Increased skin conditions (such as psoriasis or eczema)
9. Broken areas or sore/red skin
10. Pressure sore – grade
11. Blood – colour
12. Faecal matter
13. Scarring – possible previous surgery or damage through childbirth
14. Infestation
15. Foreign bodies

DRE may be used as part of a nursing assessment in conjunction with the assessment process. DRE can be used in the following circumstances to:

- Establish the presence of faecal matter in the rectum; the amount and consistency Establish sensation – anal / rectal
- Ascertain anal tone and the ability to initiate a voluntary contraction and to what degree.
- Teach pelvic floor exercises
- Assess anal pathology for the presence of foreign objects
- Prior to giving any rectal medication to establish the state of the rectum
- Establish the effects of rectal medications
- Assess the need for and effects of rectal medication in certain circumstances
- Administer suppositories or enema prior to endoscopy
- Determine the need for digital removal of faeces (DRF) or digital stimulation and evaluate bowel emptiness
- Evaluate bowel emptiness in neurogenic bowel management, after suppositories, enemas or transanal irrigation

DRF may be undertaken in the following circumstances:

- When other methods of bowel emptying fail or are inappropriate
- When there is faecal loading and impaction
- For incomplete defecation
- If there is inability to defecate
- If neurogenic bowel dysfunction is present
- In many patients with spinal cord injury

Exclusions and contra-indications for undertaking a DRE:

Nurses should not undertake a DRE or DRF when:

- They are not competent to do so
- There is a lack of consent from the patient – written, verbal or implied
- The patients doctor has given specific instructions that these procedures are not to take place

Circumstances when extra care and multi-disciplinary discussion is required:

Nurses should exercise particular caution when performing DRE or DRF with patients who have the following –

- Active inflammation of the bowel including Crohn's disease, ulcerative colitis and diverticulitis
- Recent radiotherapy to the pelvic region
- 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- consider possible causes for this
- A known history of abuse
- Spinal cord injured patients with an injury at or above the sixth thoracic vertebra due to the risk of autonomic dysreflexia
- If patients have known history of allergies such as latex

Procedures for undertaking Digital Rectal Examination, Digital Removal of faeces and Digital Rectal Stimulation are included in Appendices A to C. Advise on Autonomic Dysreflexia is included in Appendix D.

5 CONSENT

Obtaining consent is essential before carrying out nursing care, treatment or procedures involving physical contact with the patient. Without consent, the care or treatment may be considered to be unlawful. Your employer – or you personally – could be sued for compensation by the patient if you have not obtained consent, even if your care or treatment was to the patients benefit.

Consent may be verbal, written or implied. In all instances, you must record the type of consent obtained in the patients nursing record. For full details refer to Trust policy on Consent to Examination and Treatment.

6 COMPETENCY

A DRE can be undertaken by a qualified / registered nurse who can demonstrate professional competence to the level determined by the Nursing and Midwifery Council (NMC) in its Code of professional conduct (NMC 2008). Please refer to the CDDFT Clinical Skills Policy.

7 MONITORING

7.1 Key Performance Indicators

Monitoring Criterion	Response
Who will perform the monitoring?	Continence Service
What are you monitoring?	Deviation from guideline
When will the monitoring be performed?	Case by case basis
How are you going to monitor?	Notification of cases & investigation of any near misses
What will happen if any shortfalls are identified?	Action Plan will be developed
Where will the results of the monitoring be reported?	CCTH Patient Safety Meeting
How will the resulting action plan be progressed and monitored?	An action plan will be developed to address areas of deviation from guideline. Specialist Continence Nurses will monitor implementation of the action plan.
How will learning take place?	Dissemination of audit results & completion of actions plans

Attendance at essential training is recorded by People & Organizational Development and entered onto the Trust Training Management System, OLM. Monitoring of non-attendance will be in line with the Training Needs analysis, Monitoring and Evaluation Policy and carried out by People & Organizational Development. Please refer to this policy for detailed information.

8 REFERENCES

- BNF (2008) Latest edition available from www.bnf.org
- Coggrave M et al (2008) Neurogenic continence. Part 3: bowel management strategies. *British Journal of Nursing* , 17 (15), pp.962-968

- Department of Health (2001) *Reference guide to consent for examination or treatment,* London:DH
- Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice.* London:DHosman B C and Vu T T (2005) Lidocaine anal block limits autonomic dysreflexia during anorectal procedures in spinal cord injury: a randomised, double-blind, placebo-controlled trial. *Diseases of the Colon & Rectum, 48 (8) pp.1556-1561*
- Furusawa K et al (2009) Topical anaesthesia blunts the pressor response induced by bowel manipulation in subjects with cervical spinal cord injury. *Spinal Cord, 47 (2) pp. 144-148*
- Heaton K W et al (1992) Defecation frequency and timing, and stool form in the general population: a prospective study. *Gut* 33, pp.818-824
- Kavchak-Keyes M (2000) Autonomic hyperflexia, *Rehabilitation Nurse,* 25 (1), pp.31-35
- Multidisciplinary Association of Spinal Cord Injury Professionals (2009) *Guidelines for management of neurogenic bowel after spinal cord injury.* Stanmore: MASCIP, available from www.mascip.co.uk
- Nursing and Midwifery Council (2008): The code: standards of conduct performance and ethics for nurses and midwives. London. NMC
- Royal College of Nursing (2003) Digital rectal examination. Guidance for nurses working with children and young people. RCN, London
- Royal College of Nursing (2012): Management of lower bowel dysfunction, including DRE and DRF. RCN guidance for nurses. RCN, London

9 ASSOCIATED DOCUMENTATION

This Guideline should be read in conjunction with the following CDDFT Trust policies and procedures:

- Clinical Records Policy
- Infection control Policies
- Consent to Examination or Treatment Policy
- Privacy and Dignity Policy
- Clinical Skills Policy

10 APPENDICES

10.1 Appendix A: Procedure for digital rectal examination (DRE) (RCN, 2012)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop
- The patient should be asked if they wish to have a chaperone present
- Give the patient the opportunity to empty their bladder
- Ensure privacy and dignity is maintained at all times
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia
- Wash hands and put on disposable apron and gloves

- Ask / assist patient to lower any clothing to knees and ask the patient to ideally lie in the left lateral position with knees flexed so that the perianal area can be easily visualised. The left side is preferred as it allows DRE to follow the natural anatomy of the bowel but it is not essential
- Place protective pad under the patient, and cover the legs/area not to be exposed
- Inform the patient that you are to begin and that you will be looking and examining the outer and internal area
- Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula, tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood
- Next palpate the perianal area by starting at the 12 o'clock position moving clockwise to 6 o'clock and then returning to 12 o'clock and moving to 6 o'clock anticlockwise, feeling for irregularities, indurations, tenderness or abscess
- Lubricate a gloved index finger, part the buttocks and gently insert into the anus to avoid trauma to anal mucosa, noting tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient feels any pain ensure that they are happy for you to continue with the procedure. It may be easier to ask the patient to talk or breathe out to prevent spasm or difficulty on insertion. Also work with the anal reflex by putting your finger on the anus gently and wait a few seconds this will allow the anus to contract and then relax
- Sweep clockwise and then anticlockwise, palpate for irregularities internally. Noticing the presence of any tenderness, presence and consistency of faecal matter (an assessment of its consistency according to the Bristol Stool Form chart) and any lesions
- You also assess the external sphincter tone by asking the patient to squeeze and hold. Also ask the patient to push down to assess for relaxation on straining
- Prostate and advance pelvic floor assessment may also take place at this point if competent to do so
- Remove finger, clean perianal area of any gel/faecal matter. Remove gloves and apron disposing of them appropriately then wash your hands
- Ensure patient's privacy, dignity and comfort at all times
- Wash hands and allow the patient to dress in private, unless they need assistance
- Explain your findings and plan
- Document all observations, findings and actions. Consider onward referral to another health care professional if there were any concerns on examination.

10.2 Appendix B: Procedure for digital removal of faeces (DRF) (MASCIP, 2009)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop
- The patient should be asked if they wish to have a chaperone present
- Ensure a private environment
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily visualised
- Place protective pad under the patient if appropriate
- Wash hands, put on two pairs of disposable gloves and an apron
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Fuurasawa, 2008; Cosman 2005). It should be considered if this is undertaken as an acute intervention. This requires five-ten minutes to take effect and

lasts up to 90 minutes. Note that long-term use should be avoided due to systemic effects (BNF, 2008)
- Lubricate gloved finger with water soluble gel
- Inform patient you are about to begin
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum
- If stool is a solid mass, push finger into centre, split it and remove small sections until none remain. If stool is in small separate hard lumps remove a lump at a time. Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – in other words 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
- Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces. If the rectum is full of soft stool continuous gentle circling of the finger may be used to remove stool; this is still digital removal of faeces
- During the procedure the person delivering the care may carry out abdominal massage
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that the evacuation is complete
- Place faecal matter in an appropriate receptacle as it is removed, and dispose of it and any other waste in a suitable clinical waste bag
- When the procedure is completed, wash and dry the patients buttocks and anal area and position comfortably before leaving
- Remove gloves and apron and wash hands
- Record outcomes using Bristol Scale (Heaton 1993)
- Record and report abnormalities

10.3 Appendix C: Procedure for digital rectal stimulation (DRS) (MASCIP, 2009)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop
- The patient should be asked if they wish to have a chaperone present
- Ensure a private environment
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily visualised
- Place protective pad under the patient if appropriate
- Wash hands, put on two pairs of disposable gloves and an apron
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Fuurasawa, 2008; Cosman 2005). It should be considered if this is undertaken as an acute intervention. This requires five-ten minutes to take effect and lasts up to 90 minutes. Note that long-term use should be avoided due to systemic effects (BNF, 2008)
- Lubricate gloved finger with water soluble gel
- Inform patient you are about to begin
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum
- Turn the finger so that the padded inferior surface is in contact with the bowel wall
- Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout
- Withdraw the finger and await reflex evacuation

- Repeat every five-ten minutes until rectum is empty or reflex activity ceases
- Remove soiled glove and replace, relubricating as necessary between insertions
- If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum
- Once the rectum is empty on examination , conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete
- Place faecal matter in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag
- When the procedure is completed, wash and dry the patients' buttocks and anal area and position comfortably before leaving
- Remove gloves and apron and wash hands
- Record outcomes using Bristol Scale (Heaton 1993)
- Record and report abnormalities

10.4 Appendix D: Autonomic Dysreflexia (AD) (RCN 2012)

Is an abnormal sympathetic nervous system response to a noxious stimulus below the level of injury which can occur only in people with a spinal cord injury at level sixth thoracic vertebrae (T6) or above.

Acute episodes may result in rapidly rising blood pressure with accompanying risk of brain hemorrhage and possible death (Kavchak-Keyes, 2000).

Among susceptible individuals 36% report dysreflexic symptoms occasionally and 9% always when they conduct bowel management (Coggrave, 2008).

The patient should be observed for symptoms of AD which may include flushing, sweating. Chills, nasal congestion and headache while bowel care is being carried out, as acute AD may occur in response to digital interventions; however it is most likely to occur in response to ineffective bowel care due to withholding of essential interventions (Coggrave, 2008).

Therefore it is important that all nurses in whatever care setting are aware of this condition and are aware of how it can be treated to reduce the risk of the above complications occurring.

The signs and symptoms of AD are headache, flushing, sweating, nasal obstruction, blotchiness above the lesion and hypertension. The cardinal signs of acute AD is a rapidly developing severe headache. If this occurs DRF should be stopped, medical assessment undertaken and should be treated promptly (Coggrave, 2008).

10.5 APPENDIX E: Digital rectal examination / digital removal of faeces and digital rectal stimulation Competency WASP Framework

W	WITNESSED	Observe or witness the competency – it is considered good practice that the practitioner will have had the opportunity to observe the procedure prior to being supervised.
A	ASSIMILATED	Understand the elements of the competency
S	SUPERVISED	Practice under supervision to demonstrate understanding: score as follows: 1 = NEEDS FURTHER PRACTICE 2 = SHOWS APTITUDE 3 = PROFICIENT
P	PROFICIENT	Competent in both knowledge and skill elements of the Competency.

Digital Rectal Examination

ACTION:		**W Score**	**A Score**	**S Score**	**P Score**
Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop					
The patient should be asked if they wish to have a chaperone present					
Give the patient the opportunity to empty their bladder					
Ensure privacy and dignity is maintained at all times					
If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia					
Wash hands and put on disposable apron and gloves					
Ask / assist patient to lower any clothing to knees and ask the patient to ideally lye in the left lateral position with					

knees flexed so that the perianal area can be easily visualised.					
Place protective pad under the patient, and cover the legs/are not to be exposed					
Inform the patient that you are to begin and that you will be looking and examining the outer and internal area					
Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood					
Next palpate the perianal area by starting at the 12 o'clock position moving clockwise to 6 o'clock and then returning to 12 o'clock and moving to 6 o'clock anticlockwise, feeling for irregularities, indurations, tenderness or abscess					
Lubricate a gloved index finger, part the buttocks and gently insert into the anus to avoid trauma to anal mucosa, noting tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient feels any pain ensure that they are happy for you to continue with the procedure. It may be easier to ask the patient to talk or breathe out to prevent spasm or difficulty on insertion. Also work with the anal reflex by putting your finger on the anus gently and wait a few seconds this will allow the anus to contract and then relax					
Sweep clockwise and then anticlockwise, palpate for irregularities internally. Noticing the presence of any tenderness, presence and consistency of faecal matter					

(an assessment of its consistency according to the Bristol Stool Form Chart) and any lesions					
You also assess the external sphincter tone by asking the patient to squeeze and hold. Also ask the patient to push down to assess for relaxation on straining					
Remove finger, clean perianal area of any gel/faecal matter. Remove gloves and apron disposing of them appropriately then wash your hands					
Wash hands and allow the patient to dress in private, unless they need assistance					
Explain your findings and plan					
Document all observations, findings and actions. Consider onward referral to another health care professional if there were any concerns on examination.					
	DATE				
	RN ASSESSOR SIGNATURE				
	HCA SIGNATURE				
Digital removal of Faeces					
ACTION:		**W Score**	**A Score**	**S Score**	**P Score**
Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop					
The patient should be asked if they wish to have a chaperone present					
Ensure a private environment					
If the patient has a spinal injury (SCI) above T6 observe					

the patient throughout the procedure for signs of autonomic dysreflexia					
When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily visualised					
Place protective pad under the patient if appropriate					
Wash hands, put on two pairs of disposable gloves and an apron					
If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Fuurasawa, 2008; Cosman 2005). It should be considered if this is undertaken as an acute intervention. This requires five-ten minutes to take effect and lasts up to 90 minutes. Note that long-term use should be avoided due to systemic effects (BNF, 2008)					
Lubricate gloved finger with water soluble gel					
Inform patient you are about to begin					
Insert a single, double-gloved, lubricated finger slowly and gently into rectum					
If stool is a solid mass, push finger into centre, split it and remove small sections until none remain. If stool is in small separate hard lumps remove a lump at a time. Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – in other words 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					
Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces. If the rectum is full of soft stool continuous gentle circling of the finger may be used to remove stool; this is still digital removal of faeces					
Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that the evacuation is complete					
Place faecal matter in an appropriate receptacle as it is removed, and dispose of it and any other waste in a suitable clinical waste bag					
When the procedure is completed, wash and dry the patients buttocks and anal area and position comfortably before leaving					
Remove gloves and apron and wash hands					
Record outcomes using Bristol Scale (Heaton 1993)					
Record and report abnormalities					
	DATE				
	RN ASSESSOR SIGNATURE				
	HCA SIGNATURE				

Digital rectal stimulation

ACTION:		**W Score**	**A Score**	**S Score**	**P Score**
Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you stop at any time, you must stop					
The patient should be asked if they wish to have a chaperone present					
Ensure a private environment					
If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia					
When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily visualised					
Place protective pad under the patient if appropriate					
Wash hands, put on two pairs of disposable gloves and an apron					
If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Fuurasawa, 2008; Cosman 2005). It should be considered if this is undertaken as an acute intervention. This requires five-ten minutes to take effect and lasts up to 90 minutes. Note that long-term use should be avoided due to systemic effects (BNF, 2008)					
Lubricate gloved finger with water soluble gel					

Inform patient you are about to begin					
Insert a single, double-gloved, lubricated finger slowly and gently into rectum					
Turn the finger so that the padded inferior surface is in contact with the bowel wall					
Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout					
Withdraw the finger and await reflex evacuation					
Repeat every five-ten minutes until rectum is empty or reflex activity ceases					
Remove soiled glove and replace, relubricating as necessary between insertions					
If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum					
Once the rectum is empty on examination , conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete					
Place faecal matter in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag					
When the procedure is completed, wash and dry the patients' buttocks and anal area and position comfortably before leaving					
Remove gloves and apron and wash hands					
Record outcomes using Bristol Scale (Heaton 1993)					

Record and report abnormalities					
	DATE				
	RN ASSESSOR SIGNATURE				
	HCA SIGNATURE				

Appendix F: Equality Impact Assessment

Equality Analysis / Impact Assessment

EAIA Assessment Form	v3/2013

Division/Department:	Continence Service, Care Closer to Home
Title of policy, procedure, decision, project, function or service:	Guideline for Digital rectal examination & manual removal of faeces
Lead person responsible:	Michelle Henderson
People involved with completing this:	Michelle Henderson Sarah Aungiers

Type of policy, procedure, decision, project, function or service:

Existing	☐
New/proposed	✓
Changed	☐

Date Completed:	2013

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To promote high quality interventions for Digital rectal examination & manual removal of faeces to those residents within County Durham and Darlington who require this intervention.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Adherence to this guideline will benefit people experiencing bladder bowel dysfunction. The principles of this guideline are considered to be best practice.

What barriers are there to achieving these outcomes?

- Lack of awareness about best practice requirements

How will you put your policy, procedure, project, decision, function or service into practice?

- The policy is available to staff on the internet
- Staff are expected to comply with the policy
- Training needs will be identified through appraisal process
- Continence Service provides training on Digital rectal examination & manual removal of faeces

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Step 2 – Collecting your information

What existing information / data do you have?

Staff request for evidence based guidelines

Who have you consulted with?

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

None

Sex/Gender

None

Age

None

Disability

None

Religion or Belief

None

Sexual Orientation

None

Marriage and Civil Partnership (applies to workforce issues only)

None

Pregnancy and Maternity

None

Gender Reassignment

None

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

None

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

No

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Guideline to be introduced following ratification

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Guideline will be updated / reviewed according to Organisation Policy

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk **and must be attached to any documentation to which it relates.**