

**Guidelines for Digital Rectal Examination and Digital  
 Removal of Faeces in Adult Patients,  
 aged 16 years and Over**

**CONTROLLED DOCUMENT**

<b>CATEGORY:</b>	Procedural Document
<b>CLASSIFICATION:</b>	Clinical
<b>PURPOSE</b>	To provide practical guidance for the performance of digital rectal examination to determine presence of faeces in the rectum, and digital removal of faeces in patients (aged 16 years and over).
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<ul style="list-style-type: none"> <li>• <b>Essential Reading for:</b></li> </ul>	<b>All Nursing, Medical and Allied Health Care Professional staff involved in direct patient care which involves digital rectal examination to determine the presence of faeces in the rectum and digital removal of faeces</b>
<ul style="list-style-type: none"> <li>• <b>Information for:</b></li> </ul>	<b>All clinical staff</b>

**To be read in conjunction with the following document:**  
 CD ref 345: Bowel Care Guidelines for Adult Patients aged 16 years and over

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## 1.0 Introduction

Digital rectal examination (DRE) and digital removal of faeces from the rectum are invasive procedures which should only be performed when necessary and after individual assessment.

**For certain patients, such as those with spinal injuries, these procedures may be the only suitable bowel-emptying technique.**

For information regarding consent and chaperones, refer to CD ref 345: Bowel Care Guidelines for Adult Patients aged 16 years and over.

If the practitioner caring for the patient is concerned about the patient's condition they must refer the patient to the appropriate medical practitioner for advice on any further action to be taken, and this must be recorded in the patient's records.

## 2.0 Digital Rectal Examination

(See [Appendix 1](#) for procedure)

Digital rectal examination can be used as part of a patient assessment, providing the registered practitioner has received suitable training and assessment to perform the procedure. Digital Rectal Examination should not be seen as a primary investigation in the assessment and treatment of constipation (RCN 2012).

Digital rectal examination can be used in the following circumstances:

- To establish the presence of faecal matter in the rectum; the amount and consistency
- To ascertain anal tone and the ability to initiate a voluntary contraction and to what degree
- To establish anal and rectal sensation
- To teach pelvic floor exercises
- To assess anal pathology for the presence of foreign objects
- Prior to giving any rectal medication to establish the state of the rectum
- To establish the need for, and effects of, rectal medication in certain circumstances
- To administer suppositories or enema prior to endoscopy
- To determine the need for digital removal of faeces or digital rectal stimulation and evaluating bowel emptiness
- To evaluate bowel emptiness in neurogenic bowel management: in other words after use of suppositories, enemas or transanal irrigation
- Prior to insertion of rectal catheters in patients following colorectal surgery. (RCN 2012)

### **3.0 Digital Removal of Faeces**

(See [Appendix 2](#) for procedure)

Digital removal of faeces may be performed by a competent registered practitioner in the following situations:

- When other bowel emptying techniques have failed or are inappropriate
- Faecal impaction or loading
- Incomplete defecation
- Inability to defecate
- Neurogenic bowel dysfunction
- In many patients with spinal cord injury who routinely manage their bowels in this way.

(RCN 2012)

#### **3.1 Digital Removal of Faeces in Patients with a Spinal Cord Injury.**

The National Patient Safety Agency (NPSA) in 2004 identified that patients with an established spinal cord lesion are at risk because their specific bowel care needs are not always met in acute trusts.

People with established spinal cord lesions experience loss of normal bowel function and control as a direct and permanent consequence of spinal cord nerve damage. Many are dependent on digital removal of faeces as their essential and routine method of bowel care.

Evidence shows that failing to support the bowel care of patients with an established spinal cord lesion, above the level of the sixth thoracic vertebra,

can place them at risk of developing a form of severe hypertension called **Autonomic Dysreflexia**. This is a medical emergency and is potentially a life-threatening condition that can develop suddenly. If not treated promptly and correctly, it may lead to seizures, stroke, and even death (Karlsson 1999).

One of the most common causes of autonomic dysreflexia, amongst people with established spinal cord lesion, is bowel distension due to constipation or impaction. Intervention, in the form of digital removal of faeces, is required immediately and urgently.

(See [Appendix 3](#) for further information and treatment of **Autonomic Dysreflexia in patients with a spinal cord lesion**).

### 3.2 Digital Removal of Faeces as an Acute or Ongoing Intervention

When using digital removal of faeces as an acute intervention, or as part of a regular package of care, it is important to carry out an individualised risk assessment. While undertaking digital removal of faeces the following must be performed or observed for and documented in the patient's records:

- Blood pressure in spinal cord injury patients who are at risk of autonomic dysreflexia, prior to and at the end of the procedure. A baseline blood pressure is advised for comparison. For patients where this is a **routine** intervention, and tolerance is well established, the routine recording of blood pressure is not necessary
- Signs and symptoms of autonomic dysreflexia- headache, flushing, hypertension, sweating
- Distress, pain or discomfort
- Bleeding
- Collapse
- Stool consistency. (RCN 2012)

### 4.0 Exclusions and Contra-indications for Digital Rectal Examination and Digital Removal of Faeces.

Registered nurses must not undertake a digital rectal examination or digital removal of faeces when:

- The patient's doctor has given specific instructions that these procedures are not to take place (RCN 2012)

### 4.1 Circumstances where extra care and multidisciplinary discussion is required

The patient has:

- Active inflammation of the bowel including Crohn's disease, ulcerative colitis and diverticulitis
- Recent radiotherapy to the pelvic area
- Rectal or anal pain
- Undergone 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
- A spinal cord injury, with the injury at or above the sixth thoracic vertebra, due to the risk of autonomic dysreflexia
- A known history of allergies such as latex
- There is lack of consent from the patient, written, verbal or implied. If the patient is unable to give their consent, the registered practitioner must document in the patient's records why they believe the procedure to be in the patient's best interests, including any involvement from other health professionals, family or carers in reaching that decision (in accordance with the *Mental Capacity Act* (2005)).

(RCN 2012)

## 5.0 Who can Perform Digital Rectal Examination and Digital Removal of Faeces?

DRE and digital removal of faeces can be undertaken by competent registered practitioners, including registered nurses. To perform DRE to determine presence of faeces in the rectum, the registered nurse must undertake education and training, supervised practice and demonstrate competence in DRE ([Appendix 4](#)). If the registered nurse will be performing digital removal of faeces, then they must undertake additional education and training, supervised practice and assessment of competence in the performance of digital removal of faeces ([Appendix 5](#)).

The supervised practice and assessment of competence in DRE to determine presence of faeces in the rectum must be undertaken by a practitioner who is competent in the performance of DRE. The supervised practice and assessment of competence in digital removal of faeces must be undertaken by a practitioner who is competent in the performance of DRE and digital removal of faeces. The number of supervised practices required to achieve competence will be determined by the registered nurse and supervisor, taking into account the registered nurse's own learning needs.

Evidence of competence in DRE to determine presence of faeces in the rectum ([Appendix 4](#)) and digital removal of faeces ([Appendix 5](#)) must be provided and a copy kept in the registered nurse's personal file and in the ward or department where the skill is practised.

A registered nurse who can demonstrate competence in DRE to determine presence of faeces in the rectum and the digital removal of faeces can delegate these procedures to patients or carers as appropriate, ensuring their competence is assessed and reviewed as necessary. The registered nurse remains accountable for the appropriateness of the delegation (NMC 2008).

The registered nurse is responsible for informing his/her manager if s/he does not feel competent in these procedures and for identifying any training needs.

## 6.0 Training Requirements for Digital Rectal Examination to determine presence of faeces in the rectum and Digital Removal of Faeces.

Before undertaking DRE and/or digital removal of faeces, registered nurses must ensure they are competent in the following areas:

- Understanding of the anatomy and physiology of the lower gastro-intestinal tract.
- Identification of possible causes of constipation
- The various treatment options for constipation
- Planning nursing care to prevent and treat constipation
- Indications for DRE and digital removal of faeces
- Exclusions and contraindications for DRE and digital removal of faeces
- Issues of consent
- Understanding and awareness of the signs, symptoms and treatment of autonomic dysreflexia ([appendix 3](#))

Assessment of competency for carers or patients must include an understanding of the anatomy of the lower gastro-intestinal tract, the indications, exclusions and contraindications for DRE and digital removal of faeces

## 7.0 Monitoring of the Guidelines

The controlled document lead will lead the audit of the guideline with support from the Practice Development Team. The audit will be undertaken in accordance with the review date and will include:

- Any untoward incidents related to DRE and /or digital removal of faeces
- Number of staff trained and as assessed as competent in the procedure of DRE and/or digital removal of faeces

All audits must be logged with the Risk and Compliance Unit.

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[http://uhbpolicies/Microsites/Policies\\_Procedures/consent-to-examination-or-treatment.htm](http://uhbpolicies/Microsites/Policies_Procedures/consent-to-examination-or-treatment.htm) [accessed 15.07.14]

## Procedure for Digital Rectal Examination (DRE)

<b>Equipment:</b>		
<ul style="list-style-type: none"> <li>• Disposable non sterile gloves</li> <li>• Disposable apron</li> <li>• Water soluble lubricating gel</li> <li>• Procedure pad</li> <li>• Tissues/ wipes</li> <li>• Waste bag</li> <li>• Hand washing/ decontamination facilities</li> <li>• Access to toilet/ commode/ bedpan</li> </ul>		
No	Action	Rationale
1.	Introduce yourself as a staff member and any colleagues involved at the contact	To promote mutual respect and put patient at their ease
2.	Verbally confirm the identity of the patient in accordance with the Trust Patient Identification Policy (current version)	To avoid misidentification of patient
3.	<ul style="list-style-type: none"> <li>• Explain procedure to the patient to gain co-operation and verbal consent (where possible)</li> <li>• Document that consent has been given</li> <li>• Document if patient is unable to give valid consent</li> </ul>	<ul style="list-style-type: none"> <li>• Patient information may reduce anxiety</li> <li>• To ensure that the patient understands the procedure and gives his/her valid consent</li> <li>• If the patient has lost the capacity to consent or to refuse the procedure due to, e.g. unconsciousness, sedation or a confusional state. It is vital to document why the procedure is in the patient's best interest</li> </ul>
4.	Establish that the patient has no known allergies, check in patient's health records and also ask patient/family of known allergies	To reduce risk of allergic reactions to any of the equipment used
5.	Ask the patient if they wish to use the toilet prior to undertaking the procedure (where possible)	To support patient comfort
6.	<ul style="list-style-type: none"> <li>• Ensure privacy at all times.</li> <li>• Offer assistance with undressing/ positioning</li> </ul>	To avoid unnecessary embarrassment to the patient
7.	Ensure that a bedpan, commode or toilet is readily available	DRE can stimulate the need for bowel movement
8.	Decontaminate hands prior to procedure	To reduce the risk of transfer of transient micro-organisms on the healthcare worker's hands
9.	Where possible, assist the patient to lie in the left lateral position with knees flexed, the upper knee higher than the lower knee, with the buttocks towards the edge of the bed	This allows ease of digital examination into the rectum, by following the natural anatomy of the colon. Flexing the knees reduces discomfort as the examining finger passes the anal sphincter
10.	Place a procedure pad beneath the patient's hips and buttocks	To reduce potential infection caused by soiled linen. To avoid embarrassing the patient if faecal staining occurs during or after the procedure



No	Action	Rationale
11.	Wash hands with soap and water or decontaminate with alcohol hand rub and put on disposable gloves and fresh apron	To reduce the risk of cross infection
12.	Place some lubricating gel on a swab and gloved index finger	Lubricating gel minimises discomfort and minimises possible anal mucosal trauma
13.	Inform patient that the procedure is about to start	Assists with patient co-operation with the procedure
14.	<ul style="list-style-type: none"> <li>Observe anal area prior to the insertion of the finger into the anus for evidence of skin soreness, excoriation, swelling, haemorrhoids, rectal prolapse and infestation</li> <li>Proceed to insert finger into the anus/rectum</li> </ul>	May indicate incontinence or pruritus. Swelling may be indicative of possible mass or abscess. Abnormalities such as bleeding, discharge or prolapse should be reported to medical staff before any examination is undertaken (RCN 2006)
15.	On insertion of finger assess anal sphincter control; resistance should be felt	Digital insertion with resistance indicates good internal sphincter tone, poor resistance may indicate the opposite
16.	Complete digital examination, faecal matter may be felt within the rectum; note consistency of any faecal matter	May establish loaded rectum and indicate constipation and the need for rectal medication
17.	Clean anal area after the procedure	To prevent irritation and soreness occurring. Preserves patient dignity and personal hygiene
18.	Dispose of equipment in appropriate clinical waste bin and remove gloves. Decontaminate hands with alcohol gel	To minimize the risk of cross-infection
19.	Assist patient into a comfortable position and offer toilet facilities as appropriate	To promote comfort
20.	On completion of procedure remove and dispose of apron	To prevent cross infection and environmental contamination
21.	Decontaminate hands following removal of personal protective equipment (PPE)	To remove any accumulation of transient and resident skin flora that may have built up under gloves and possible contamination following removal of PPE
22.	Document findings and report to medical team	To ensure continuity of care and assist in nursing diagnosis so appropriate corrective action may be initiated

Taken from: The Royal Marsden Hospital Manual of Clinical Nursing Procedures, (8<sup>th</sup> ed) 2011.

## Procedure for the Digital Removal of Faeces

<b>Equipment:</b>		
<ul style="list-style-type: none"> <li>• Disposable non sterile gloves x2 pairs</li> <li>• Disposable apron</li> <li>• Water soluble lubricating gel/ lidocaine gel</li> <li>• Procedure pad</li> <li>• Glycerine suppositories if required and prescribed</li> <li>• Tissues/ wipes</li> <li>• Receptacle for faecal matter</li> <li>• Waste bag</li> <li>• Hand washing/ decontamination facilities</li> <li>• Access to toilet/ commode/ bedpan</li> </ul>		
No	Action	Rationale
1.	If the patient has an established digital removal of faeces regime, 1-2 glycerine suppositories may need to be administered 2 hours before the procedure. Check with the patient and prescription for their usual regime	To maintain the patients established routine
2.	<ul style="list-style-type: none"> <li>• Explain procedure to the patient to gain co-operation and verbal consent (where possible)</li> <li>• Document that consent has been given</li> <li>• Document if patient is unable to give valid consent</li> </ul>	<ul style="list-style-type: none"> <li>• Patient information may reduce anxiety</li> <li>• To ensure that the patient understands the procedure and gives his/her valid consent</li> <li>• If the patient has lost the capacity to consent or to refuse the procedure due to, e.g. unconsciousness, sedation or a confusional state. It is vital to document why the procedure is in the patient's best interest</li> </ul>
3.	<ul style="list-style-type: none"> <li>• Ensure privacy at all times.</li> <li>• Offer assistance with undressing/ positioning</li> </ul>	To avoid unnecessary embarrassment to the patient
4.	Take the patient's pulse. In spinal injury patients a blood pressure reading should also be taken (RCN 2006)	Provides a baseline measurement. Stimulation of the vagus nerve in the rectal wall can lead to a reduction in pulse rate (Powell and Rigby 2000). In spinal cord injury, stimulus below the level of injury may result in symptoms of autonomic dysreflexia including hypertension (Kyle <i>et al.</i> 2005)
5.	Assist the patient to lie (if possible) in the left lateral position with knees flexed, the upper knee higher than the lower knee, with the buttocks towards the edge of the bed	To expose the anus and allow easy insertion of the finger
6.	Place a disposable under pad beneath the patient's hips and buttocks	To reduce potential infection caused by soiled linen. To avoid embarrassing the patient if undue soiling of linen occurs during or after the procedure

No	Action	Rationale
7.	Wash hands with soap and water or decontaminate hands with alcohol hand rub and put on disposable gloves (double glove)	To reduce the risk of cross infection and to protect hands
8.	Warn patient you are ready to proceed	To ensure patient is ready and relaxed
9.	Examine perianal area prior to the insertion of the finger into the anus	To observe for evidence of skin soreness, excoriation, swelling, haemorrhoids, rectal prolapse and infestation
10.	For patients undergoing this procedure on a regular basis, place water-based lubricating gel on gloved index finger	To facilitate easier insertion of index finger
11.	For an acute procedure a local anaesthetic gel can be applied topically. This must be prescribed. Do not apply if there is evidence of anal damage or bleeding	To reduce sensation and discomfort for the patient. Lidocaine is absorbed via the anal mucous membrane and may cause anaphylaxis, hypotension, bradycardia or convulsions if applied to a damaged mucosa
12.	<ul style="list-style-type: none"> <li>Gently insert one finger 2-4 cm into the rectum.</li> <li>Proceed with caution in those patients with spinal cord injury</li> </ul>	<ul style="list-style-type: none"> <li>To avoid trauma to the anal mucosa and prevent forced over dilation of the anal sphincter.</li> <li>The majority of spinal cord injury patients will not experience any pain</li> </ul>
13.	If the stool is soft, continuous gentle circling of the finger may be used to remove the stool	To minimise discomfort and facilitate easier removal of stool
14.	If separate hard lumps like nuts (Type 1 Bristol stool scale) are felt, remove a lump at a time until the rectum is empty	To minimise discomfort and facilitate easier removal of stool
15.	<ul style="list-style-type: none"> <li>If a solid faecal mass is felt, split it and remove <b>small</b> sections at a time with a hooked finger until no more faecal matter can be felt</li> <li>If the faecal mass is too hard to break up, or more than 4 cm across, stop the procedure and discuss with the multidisciplinary team. The patient may require the procedure to be carried out under anaesthetic (Kyle et al. 2005)</li> </ul>	<ul style="list-style-type: none"> <li>To minimise discomfort and facilitate easier removal of stool</li> <li>Using a hooked finger to remove <b>large</b> pieces of hard stool may over-stretch the sphincters and may also graze the rectal mucosa</li> </ul>
16.	Check the patient's pulse at least once during the procedure. In spinal injury patients a blood pressure reading must also be taken at least	Stimulation of the vagus nerve in the rectal wall can lead to a reduction in pulse rate (Powell and Rigby 2000). In spinal cord injury, stimulus below the

No	Action	Rationale
<b>16 cont.</b>	once during the procedure or at any sign of distress (RCN 2006). If the patient is displaying a reduction in pulse rate or change in rhythm, or in the spinal cord injury patient, a raised blood pressure, STOP the procedure and if possible sit the patient up and administer appropriate medications as prescribed (Kyle et al. 2005)	level of injury may result in symptoms of autonomic dysreflexia, including hypertension (Kyle et al. 2005)
<b>17.</b>	Place faecal matter in an appropriate receptacle as it is removed	To facilitate appropriate disposal of faecal matter at the end of the procedure
<b>18.</b>	When the rectum is empty, remove top glove and clean the patient's perianal area. Use a dry cloth such as TENA Soft Wipe and apply 10ml (10 pence piece sized blob) of TENA Wash Cream and gently work the product into the skin. There is no need to rinse	To reduce risk of cross infection and to leave the patient feeling comfortable
<b>19.</b>	Remove gloves and dispose of waste in a clinical waste bag. Decontaminate hands	To minimise cross infection
<b>20.</b>	Inform the patient of the outcome and ensure the procedure and outcomes are documented	To assist in continuity of care and to ensure the patient understands the results of the procedure

## Autonomic Dysreflexia in Patients with a Spinal Cord Lesion.

Autonomic dysreflexia is a medical emergency. It is potentially a life-threatening condition that can develop suddenly. It is characterised by a rapid rise in the blood pressure, and if not treated promptly and correctly, it can lead to cerebral haemorrhage, seizures and cardiac arrest.

Autonomic dysreflexia, also known as hyperreflexia, 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 (RCN 2012) Anything that would have been painful, uncomfortable or physically irritating before the injury may cause autonomic dysreflexia (Glickman and Kamm 1996).

### Commonest Causes of Autonomic Dysreflexia

- Any painful or noxious stimuli below the level of the lesion
- Distended bladder (usually due to a blocked catheter or other outflow obstruction)
- Distended bowel due to a full rectum, constipation or impaction
- Ingrown toe nail
- Fracture below the level of the lesion
- Labour/ childbirth
- Ejaculation

### Other causes

- Pressure sores
- Deep Vein Thrombosis
- Appendicitis
- Ulcers
- Surgery
- Burns
- Severe anxiety or emotional distress

### Signs and Symptoms of Autonomic Dysreflexia

The commonest presenting symptoms are:

- Severe hypertension
- Bradycardia
- 'Pounding' headache
- Flushed or blotchy skin above the level of the lesion
- Pallor below the level of the lesion
- Profuse sweating above the level of the lesion
- Nasal congestion

### Treatment of Autonomic Dysreflexia

Treatment must be initiated quickly and the blood pressure closely monitored:

- The first step of treatment, regardless of the cause, is to sit the patient upright, to induce an element of postural hypotension. If bladder problems are suspected,

only sit patient to 45 degrees. Sitting at 90 degrees may cause increased pressure on the full bladder.

- Identify the source of the noxious stimulus (removing the stimulus will cause the symptoms to settle).
- Restrictive clothing such as tight belts must be removed.
- High blood pressure should be treated until the cause is found and eliminated. Administer a proprietary vasodilator as prescribed e.g. GTN tablets sublingually, or oral nifedipine capsules (capsule to be pierced and the contents put in the patient's mouth)
- Check the bladder
- If patient is not catheterised and the bladder appears full, catheterise immediately and leave on free drainage. The catheter must be lubricated with an anaesthetic gel prior to insertion.
- If catheterised, empty the bag and untwist any kinked tubing. If the catheter appears blocked, change the catheter immediately. **DO NOT ATTEMPT A BLADDER WASHOUT**; this will only distend the bladder further with potentially fatal consequence.
- If the above steps do not resolve the issue; and the patient remains hypertensive and symptomatic, then the rectum should be examined and emptied by gentle insertion of a gloved finger, lubricated in anaesthetic gel.

(Bycroft et al (2005), NHS Quality Improvement Scotland (2004))

DRAFT

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**  
**CRITERIA FOR COMPETENCE**

**END COMPETENCE: Digital rectal examination to determine presence of faeces in the rectum.**

**Date(s) of Education and supervised practice:** .....

**Name of registered nurse (print):** .....

**Name of Supervisor (print):** ..... **Designation:**.....

Element of Competence To Be Achieved	Date Achieved	Registered Nurse Sign	Supervisor Sign
Discuss and identify <ul style="list-style-type: none"> <li>• indications</li> <li>• contra-indications</li> </ul> For digital rectal examination			
Discuss and identify potential risks of digital rectal examination			
Demonstrate knowledge and understanding of the anatomy and physiology of the lower gastro- intestinal tract			
Discuss and demonstrate the procedure for digital rectal examination to include: <ul style="list-style-type: none"> <li>• Preparation of the patient</li> <li>• Positioning of the patient</li> <li>• Preparation of equipment</li> <li>• The procedure to determine presence of faeces in the rectum.</li> </ul>			
Demonstrate a working knowledge of the Trust's policy for consent to examination or treatment.			
Demonstrate a working knowledge of the <i>Mental Capacity Act</i> .			

Element of Competence To Be Achieved	Date Achieved	Registered Nurse Sign	Supervisor Sign
Demonstrate accurate provision of information pre and post the procedure in a way that the patient understands.			
Demonstrate maintenance of the patient's privacy and dignity throughout the procedure.			
Demonstrate safe infection control practices throughout the procedure. To include: • Standard precautions • Isolation procedures			
Demonstrate knowledge and understanding of when to refer the patient to an appropriate medical practitioner			
Demonstrate accurate record keeping.			
Discuss any health and safety issues in relation to this expanded practice			
Demonstrate an understanding of the incident reporting process.			
Demonstrate a working knowledge of the NMC Code: Standards of conduct, performance and ethics for nurses and midwives (2008).			

I declare that I have expanded my knowledge and skills and undertake to practice with accountability for my decisions and actions. I have read and understood the guidelines for **digital rectal examination to determine presence of faeces in the rectum.**

**Signature of Registered Nurse:** .....

**Date:** .....

I declare that I have supervised this registered nurse and found her/him to be competent as judged by the above criteria.

**Signature of Supervisor:** .....

**Date:** .....

A copy of this record must be placed in the registered nurse's personal file, a copy must be stored in the clinical area by the line manager and a copy can be retained by the individual for their Professional Portfolio.



**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**  
**EVIDENCE OF SUPERVISED PRACTICE**

To become a competent practitioner, it is the responsibility of each registered nurse to undertake supervised practice in order to perform **digital rectal examination to determine presence of faeces in the rectum** in a safe and skilled manner.

Name of Registered Nurse .....

DATE	DETAILS OF PROCEDURE	SATISFACTORY STANDARD MET	COMMENTS	SUPERVISOR PRINT NAME, SIGNATURE & DESIGNATION
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**  
**CRITERIA FOR COMPETENCE**

**END COMPETENCE: Digital removal of faeces**

**Date(s) of Education and supervised practice:** .....

**Name of Registered Nurse Sign (print):** .....

**Name of Supervisor (print):** ..... **Designation:**.....

Element of Competence To Be Achieved	Date Achieved	Registered Nurse Sign	Supervisor Sign
Discuss and identify <ul style="list-style-type: none"> <li>• indications</li> <li>• contra-indications</li> </ul> for digital removal of faeces			
Discuss digital removal of faeces as an ACUTE intervention			
Discuss digital removal of faeces as an REGULAR intervention			
Identify and discuss potential risks of digitally removing faeces, to include: <ul style="list-style-type: none"> <li>• autonomic dysreflexia: signs, symptoms and treatment</li> </ul>			
Demonstrate knowledge and understanding of the anatomy and physiology of the lower gastro- intestinal tract			
Provide evidence of competency in digital rectal examination			
Discuss and demonstrate the procedure of digital removal of faeces to include: <ul style="list-style-type: none"> <li>• Preparation of the patient</li> <li>• Baseline observations and ongoing observations</li> <li>• Positioning of the patient</li> <li>• Preparation of equipment</li> <li>• The procedure of digital removal of faeces</li> </ul>			

Element of Competence To Be Achieved	Date Achieved	Registered Nurse Sign	Supervisor Sign
Demonstrate a working knowledge of the Trust's policy for consent to examination or treatment.			
Demonstrate a working knowledge of the <i>Mental Capacity Act</i> .			
Demonstrate accurate provision of information pre and post the procedure in a way that the patient understands.			
Demonstrate maintenance of the patient's privacy and dignity throughout the procedure.			
Demonstrate safe infection control practices throughout the procedure. To include: <ul style="list-style-type: none"> <li>• Standard precautions</li> <li>• Isolation procedures</li> </ul>			
Demonstrate knowledge and understanding of when to refer the patient to an appropriate medical practitioner			
Demonstrate accurate record keeping.			
Discuss any health and safety issues in relation to this expanded practice			
Demonstrate an understanding of the incident reporting process.			
Demonstrate a working knowledge of the NMC Code: Standards of conduct, performance and ethics for nurses and midwives (2008).			

I declare that I have expanded my knowledge and skills and undertake to practice with accountability for my decisions and actions. I have read and understood the guidelines for **Digital removal of faeces**

**Signature of Registered Nurse:** ..... **Date:** .....

I declare that I have supervised this registered nurse and found her/him to be competent as judged by the above criteria.

**Signature of Supervisor:** ..... **Date:** .....

A copy of this record must be placed in the registered nurse's personal file, a copy must be stored in the clinical area by the line manager and a copy can be retained by the individual for their Professional Portfolio.

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**  
**EVIDENCE OF SUPERVISED PRACTICE**

To become a competent practitioner, it is the responsibility of each registered nurse to undertake supervised practice in order to perform **digital removal of faeces** in a safe and skilled manner.

Name of Registered Nurse .....

DATE	DETAILS OF PROCEDURE	SATISFACTORY STANDARD MET	COMMENTS	SUPERVISOR PRINT NAME, SIGNATURE & DESIGNATION
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		