Adult Bowel Care Policy

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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
Version 2	January 2021		3 year review - no changes to practice, only change is to show difference to constipation	January 2021

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	January 2021	Lesley Bradrick	Policy Steering Group, Clinical Executive Group	

SUMMARY OF POLICY

This document provides overarching guidance on bowel care for adult patients within Solent NHS Trust. It should be used in conjunction with the underlying standard operating procedures.

This policy outlines the types of bowel management that patients' may require assistance with and the procedures for carrying these out. The areas covered are:

- Constipation - diagnosis and management and use of laxatives
- Diarrhoea – ID and management
- Digital Rectal Examination – This may be delegated to HCSW however any staff undertaking this procedure must undertake Trust approved training and complete the competencies found in appendix H and attend 3 yearly updates.
- Digital Removal of Faeces – This may be delegated to HCSW however any staff undertaking this procedure must undertake Trust approved training and complete the competencies found in appendix H and attend 3 yearly updates.

- Management of bowels in spinal patients – How to identify, manage and treat Autonomic Dysreflexia
- Procedures for administering suppositories, enemas, use of anal plugs are found in Appendices B & C

Any medication administered by trust staff under this policy must be prescribed for the patient and in accordance with the Trust Medicines Management Policy or given under the Medication Administered at Nurses discretion list appearing in the Medicines Policy.

Assessment of bowel continence and function should form part of the holistic patient/client assessment.

Table of Contents

Adult Bowel Care Policy

1. INTRODUCTION & PURPOSE

1.1 This document provides overarching guidance on bowel care for adult patients within Solent NHS Trust. It should be used in conjunction with the underlying standard operating procedures.

1.2 The aims of effective bowel management are to "achieve regular, predictable emptying, at a socially acceptable time and place, avoiding constipation and unplanned evacuations" Coggrave et al (2009) (on behalf of Spinal Cord Injury Centre's of United Kingdom and Ireland). *Guidelines for Management of Neurogenic Bowel Dysfunction after Spinal Cord Injury*. Peterborough: Coloplast.

1.3 Due to the nature of these procedures privacy and dignity for the patient must be maintained at all times. Consideration must also be given for consent, capacity and safeguarding.

1.4 As many of the intervention made to manage patients' bowels require close personal contact, consideration must be given to the requirement for a chaperone as per the Trust's Chaperone policy.

2. SCOPE & DEFINITIONS

2.1 This policy applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 Any medication administered by trust staff under this policy must be prescribed for the patient and in accordance with the Trust Medicines Management Policy or given under the Medication Administered at Nurses discretion list appearing in the Medicines Policy.

2.4 Definitions:

- **Anal plug** - a foam, cup-shaped device that sits inside the rectum in order to prevent bowel leakage.

- **Autonomic dysreflexia** – Life threatening complication of a spinal injury at level T6 or above, where there is an abnormal response from the autonomic nervous system to a stimulus perceived below the level of the spinal cord injury.
- **Bowel care** – any intervention made to manage a patient's bowel function.

- **Bowel Obstruction** – passage of contents through the bowel lumen is inhibited, either by mechanical or non-mechanical causes.

- **Constipation** – persistently difficult, infrequent or incomplete defaecation, which may or may not be accompanied by hard, dry stools. It is a subjective disorder, being perceived differently by different people owing to the wide variety in patients' usual bowel habits, in general less than 3 bowel movements per week.

- **Diarrhoea** – the passage of three of more loose stools per day, or more frequently than is usual for the patient (World Health Organisation in Marsden Manual). Loose watery stools (RCN, 2012).

- **Digital Rectal Examination (DRE)** – an invasive procedure which involves inserting a lubricated, gloved finger into the rectum. This policy does not include DRE as part of a physical assessment other than for bowel care.

- **Digital Removal of Faeces (DRF) (also known as Manual Evacuation)** – an invasive procedure involving the removal of faeces from the rectum using a gloved finger. For some patients/clients such as those with spinal cord injury, cauda equina, spina bifida and multiple sclerosis the digital removal of faeces is an integral part of their routine bowel management.

- **Digital Stimulation – s**timulation of the anus or anal sphincter can aid some patients/clients with defecation.

- **Enema** – a substance administered in liquid form into the rectum, either to aid bowel evacuation or to administer medication.

- **Faecal incontinence** – the uncontrolled passage of solid or liquid faeces at socially inappropriate times and places.

- **Laxative** – substances that cause evacuation of the bowel. Also known as an aperient if mild acting and a purgative if strong effect.

- **Suppositories** – a solid or semi-solid, bullet shaped pellet that is prepared by mixing a medication with a wax-like substance that melts once inserted into the rectum.

2.5 **This policy does not include rectal examination for the purpose of prostate assessment, any rectal abnormality or stoma care.**

3. PROCESS/REQUIREMENTS

3.1 ASSESSMENT

3.1.1 Assessment of bowel continence and function should form part of the holistic patient/client assessment. Bowel assessment includes obtaining a history, particularly noting any changes in usual bowel activity and carrying out relevant clinical examinations ensuring valid consent is obtained and documented. It also

includes carrying out and interpreting relevant baseline physiological observations and tests

3.1.2 An assessment of the following can be helpful in determining bowel care issues and provide information to develop a treatment plan (many of these will already be considered as part of a general assessment):

- Diet or fluid intake including recent changes.
- Food intolerances and allergies.
- Exercise levels.
- Medication history – opiate analgesics.
- Patient bowel history including frequency, volume, consistency (using Bristol Stool Scale, Appendix A) and colour and any recent changes.
- Pain.
- Toileting factors – where are the facilities, what help does the patient require, what position do they adopt when defecating etc.
- Medical Conditions which may affect the bowel e.g. inflammatory bowel disease, irritable bowel syndrome, cancers, diabetes, neurological conditions such as multiple sclerosis or muscular dystrophy.
- Existing bowel management regimes.
- DRE.

3.2 CONSTIPATION

3.2.1 The identification of the underlying cause of any constipation is important in achieving successful treatment and management.

3.2.2 An individual reporting two of the following can be diagnosed with constipation (Rome IV Criteria, 14/08/2020): in Royal Marsden manual

A patient must have experienced at least 2 of the following symptoms over the preceding 3 months

- Fewer than 3 spontaneous bowel movements per week.
- Straining for more than 25% of defaecation attempts
- Lumpy or hard stools for at least 25% of defaecation attempts

3.2.3 Management and treatment options include:

- Dietary advice, increasing fibre intake (caution should be taken in the older person and frail patients).
- Advice on appropriate fluid intake.
- Advice on lifestyle changes including increasing exercise.
- Regular toileting (maximising the gastro-colic reflex).
- Good seating position to defecate (raise knees higher than hips, lean forward and put elbows on knees, bulge out abdomen and straighten spine).
- Laxatives.
- Enema or suppositories.
- Digital removal of faeces.
- Specialist referral.

3.3 LAXATIVES

3.3.1 Laxatives may not be appropriate in all patients with constipation

3.3.2 Healthcare practitioners are reminded that they will normally administer or prescribe (if they are nurse prescribers) those laxatives that are recommended in the local prescribing formulary. All medicines should be used only according to their licensed indications. For further information please refer to the latest edition of the British National Formulary (BNF).

3.3.3 Although laxatives are not always necessary, they may be required in the short term to provide rapid initial relief of symptoms.

3.3.4 Laxatives alter the normal functioning of the alimentary tract and can be grouped in to four types according to their action:

- **Bulking agents** - hold on to water so that the stool remains large and soft and encourages gut movement but take a few days to work. They should be used with caution in patients with poor fluid intake and not used if intestinal obstruction is known or suspected, following recent bowel surgery, if there is faecal impaction or acute abdominal pain.

- **Stool softeners** – attract and retain water in the bowel, but not recommended in the treatment of constipation.

- **Osmotic agents** – increase stimulation of fluid secretion and movement in the bowel. Commonly used.

- **Stimulants** – causes water and electrolytes to accumulate in the bowel to stimulate the bowel to move. High usage can lead to electrolyte imbalance in frail elderly patients and loose stools.

3.4 SUPPOSITORIES

3.4.1 When oral laxatives have not produced a bowel movement, or when rapid relief from rectal loading is required or there is difficulty with emptying, a suppository may be appropriate.

3.4.2 There are two types of evacuant suppositories:

- **Lubricant** suppositories e.g. glycerine, should be inserted directly into the faeces and allowed to dissolve to enable softening of the faecal mass.
- **Stimulant** suppositories e.g. bisacodyl, CO_2 producing Lecicarbon, these must come into contact with the mucus membrane of the rectum to be effective. They should not be inserted into a faecal mass.

3.4.3 Indications for use of Suppositories**:**

- To relieve acute constipation or to empty the bowel when other treatments for constipation have failed.
- To empty the bowel before surgery.
- To introduce prescribed medication into the system.
- As part of a bowel management programme with someone who has a neurogenic bowel

3.4.4 Contraindications for use

- Colonic Obstruction.
- Paralytic ileus.
- Post- surgery bowel resection.
- Diverticular disease.
- Inflammatory bowel disease.

3.4.5 Please refer to Appendix B for procedure for administering suppositories

3.5 ENEMAS

3.5.1 When laxatives or suppositories have not produced a bowel movement or when rapid relief from rectal loading is required, an enema may be appropriate. Please see appendix C for the procedure for administering enemas

3.5.2 There are two types of enema: retention enemas and evacuant enemas:

- A retention enema is a solution introduced into the rectum or lower colon with the intention of being retained for a specified period of time.
- An evacuant enema is a solution introduced into the rectum or lower colon with the intention of its being expelled along with faecal matter. Phosphate enemas (large volume) and sodium citrate micro-enemas (small volume) come under this group.

3.5.3 Indications for use:

- Severe constipation or impaction of faeces, phosphate enemas can be used daily for up to 5 days where a stool ball has been identified.
- To administer prescribed medication into the system.
- Neurogenic bowel.
- Where large amounts of fluid into the colon may cause perforation or haemorrhage.

- Following gastrointestinal or gynaecological surgery where suture lines could be ruptured (unless medical consent has been given).

- In patients with a known cardiac condition where intervention could cause possible collapse.

3.6 TRANS-ANAL IRRIGATION

3.6.1 Rectal irrigation is being increasingly offered as a treatment for chronic constipation, particularly where biofeedback has not worked, as well as faecal incontinence. It involves instilling lukewarm water into the rectum using a rectal catheter with the aim of ensuring the rectum, sigmoid and descending colon is emptied of faeces.

3.6.2 Staff may be involved in supporting patients with this procedure however it is usual for the patient to have the dexterity to be independent with this procedure.

3.7 DIGITAL RECTAL EXAMINATION OF RECTUM (DRE) AND DIGITAL REMOVAL OF FAECES (DRF)

Delegation to HCSW (Health Care Support Worker)

3.7.1 The Healthcare Professional (HCP) may delegate DRE /DRF procedures as appropriate, ensuring their own competence has been assessed prior to assessing the competency of the patient/carer /support worker (RCN 2012). See Appendix E for the DRE and Appendix F for DRF.

3.7.2 Heath Care Support Workers (HCSW) should have received approved training and been assessed as competent in carrying out DRE/DRF before carrying out the procedure. If these conditions are met, the HCSW can be expected to carry out these procedures on patients who have been prescribed these bowel care interventions as part of their ongoing, pre-planned nursing care. It is not expected that HCSWs would carry out these procedures on patients that have not previously been assessed by a HCP.

3.7.3 DRE/DRF are both invasive procedures and should only be performed when necessary, after individual assessment and with patient consent or in the patient's best interest as per the Depravation of Liberty and Mental Capacity Act Policy.

3.7.4 Contra-indications to performing DRE and Digital Removal of Faeces:

- Absence of patient consent.

- Specific, documented instructions from the patient's consultant/GP/bladder and bowel nurse specialist that the procedure should not be undertaken.
- Recent rectal/anal surgery or trauma.

3.7.5 Digital Rectal Examination

3.7.5 (i) DRE can be used to establish:

- The presence of faecal matter in the rectum, the amount and consistency of stool.
- Anal tone and ability to initiate a voluntary contraction, and to what extent anal/rectal sensation is present.
- The need for digital removal of faeces and evaluating of rectal emptiness.
- The effectiveness of rectal/colonic washout/irrigation.
- Apply digital stimulation in order to trigger defaecation by stimulating the recto-anal reflex.

3.7.5 (ii) Circumstances when additional assessment and care is required:

- Active inflammation of the bowel, including Crohn's disease, Ulcerative Colitis and Diverticulitis.
- Recent radiotherapy to the pelvic area.
- Rectal/anal pain.
- Rectal surgery/ trauma to the anal/rectal area.
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment.
- Fresh, rectal bleeding and evidence of anticoagulation medication.
- If the patient has a known or suspected history of sexual abuse.
- Spinal Injury patients due to autonomic dysreflexia.

3.7.6 Digital Removal of Faeces

3.7.6 (i) DRF should be avoided if possible and should only be performed if other methods of relieving constipation have failed, with the exception of patients with spinal injuries or conditions where DRF has been assessed as the best bowel management regime.

3.7.6 (ii) DRF can be performed when there is:

- Faecal impaction/loading.
- Incomplete defaecation.
- Inability to defecate.

3.7.6 (iii) Contra-indications to carrying out Digital Removal of Faeces

- The patient is experiencing severe abdominal/rectal/anal/pain
- Acute inflammation of the bowel
- Recent radiotherapy to the pelvic area
- If patient has a known or suspected history of sexual abuse

3.8 BOWEL MANAGEMENT IN PATIENTS WITH SPINAL CORD INJURY

3.8.1 After a spinal cord injury the connection between brain and bowel is lost and the effects on Bowel Function can be as follows, but will depend on the level at which the damage has occurred and whether the damage is complete or incomplete:

- The brain does not transmit messages to the bowel which prevents the patient from being aware of the urge to defecate or ability to control the anal sphincter.
- The ability to coordinate what is under voluntary control and influence reflex activity in the bowel is lost.
- The enteric nervous system in the bowel continues to produce peristalsis but because the brain cannot coordinate it this is less effective. As a result the stool takes longer to pass through the bowel.
- Slower transit time through the colon may result in greater absorption of water resulting in harder, more constipated stools.
- Constipation causes stretching of the colon, which makes peristalsis less effective.
- The remaining bowel function is described as either reflex or flaccid but maybe a mixture of the two in incomplete lesions.

3.8.2 A bowel management plan must be developed and agreed between the appropriate healthcare professionals, the patient and patient carers to facilitate compliance and ensure maximum independence.

3.8.3 The bowel management plan will aim to:

- Facilitate the patient to empty the rectum on a regular predictable basis taking into consideration individual timings and lifestyle.
- Avoid constipation, faecal incontinence and soiling.
- Avoid Autonomic Dysreflexia.
- All patients at risk of Autonomic Dysreflexia should have a base line recording blood pressure taken when a bowel management plan is set up and must be checked prior to bowel care.

3.8.4 Signs and symptoms of Autonomic Dysreflexia

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

3.8.5 If autonomic Dysreflexia is suspected:

- Identify and remove the trigger by performing a manual evacuation of faeces or ensuring bladder is emptying and removing any other triggers, change the catheter, do not instil further fluid.

- Sit patient upright as soon as possible.
- Give Glyceryl Trinitrate (GTN) OR Nifedipine as prescribed.
- Record in patient record and report as a clinical incident, also completing the medical incident form.

3.9 DIARRHOEA

3.9.1 There can be many causes for diarrhoea some of which may be due to infectious agents which pose a risk of onward transmission to other service users, staff or visitors.

All cases of unexpected diarrhoea should be treated as potentially infectious until an alternative cause has been identified.
Consider calprotectin test to identify any inflammation.

It is important to recognise individuals may experience an infective episode in addition to pre-existing non-infectious conditions.

3.9.2 Two or more patients reporting unexplained diarrhoea who are linked in time and place maybe part of an infective outbreak. If an infective outbreak is suspected, the Policy on Diarrhoea and Vomiting must be followed and the policy for the prevention and control of Clostridium Difficile.

3.9.3 Factors which may cause diarrhoea include:

- Diet or fluid intake including eating too much fruit, excessive alcohol intake.
- Food intolerances and allergies.
- Infections: travel associated, viral, bacterial, antibiotic related particularly Clostridium Difficile.
- Use of drugs e.g. overuse of laxatives, antibiotics.
- Over flow – DRE to identify.

3.9.4 Chronic diarrhoea lasts more than 2-4 weeks and may have more complex causes.

3.9.5 The cause of any diarrhoea needs to be identified before treatment can be instigated. This might include clinical investigations such as stool cultures.

3.9.6 The effects on the patient can include dehydration, malnutrition, electrolyte disturbance, pain and skin breakdown, as well as psychological effects. Dehydration and electrolyte disturbance would indicate need for admission.

3.9.7 Drug support

3.9.7.1 Antimotility drugs reduce gastrointestinal motility, but must not be used in cases of infective diarrhoea.

3.9.7.2 Antibiotics recommended only in very severe cases where there is systemic involvement.

3.9.7.3 Fluid replacement must be offered and may need to be intravenous or sub cutaneous if the patient is unable to tolerate oral fluids. A patient will need an additional 200ml per each loose stool in addition to normal requirements.

3.9.8 Non pharmacological support

3.9.8.1 Maintaining dignity, hygiene and skin care are priorities for care of a patient with diarrhoea. Soap should be avoided and emollients and barrier products used as per local wound care formulary. Skin should be patted dry rather than rubbing.

3.9.8.2 Consideration should be given to the use of a faecal management system for patients who are being nursed in bed. They are not suitable for mobile patients due to the risk of leakage.

3.9.8.3 Dietary advice should include limiting fibre, spices and chilli, artificial sweetener, beer, stout and high doses of vitamins and minerals.

3.10 FAECAL INCONTINENCE

3.10.1 Factors that can contribute to the development of faecal incontinence include:

- Damage or weak anal sphincter
- Severe diarrhoea
- Faecal loading (impaction)
- Neurological conditions
- Cognitive deficits
- Post-partum
- Obstetrics

3.11 ANAL PLUGS

3.11.1 Anal plugs are foam, cup-shaped devices that sit inside the rectum in order to prevent bowel leakage which may offer some comfort and dignity to people where faecal leakage is passive.

3.11.2 They are covered in a dissolvable film which keeps the plug in a size and shape similar to a suppository or small tampon for easy insertion. Once in the rectum, moisture from the lining of the rectum dissolves the film and the anal plug expands to a cup or mushroom shape. They can stay in place for a maximum of 12 hours but must be removed in order to pass stool. Please see Appendix F for the procedure for using anal plugs.

3.11.3 Anal plugs should not be used in patients with the following conditions:-

- Disease of the bowel or rectum
- Spinal cord injury – patients are at risk from autonomic dysreflexia

- Unable to consent unless Mental Capacity Act Best Interests Assessment has been completed.

3.12 Interventions that may be used to manage a flaccid or Lower Motor Neurone Bowel

3.12.1 Spinal cord injury at or below L1 will give rise to lower motor neurone or flaccid bowel function. The aim is to produce a firmly formed stool that can be removed digitally.

It would usually consist of these types of interventions:

- Stimulate gastro-colic reflex by having a warm drink or something to eat 20-30 minutes before starting the routine.
- Abdominal massage or use of posture to raise intra-abdominal pressure.
- Use of gentle digital evacuation to remove stool from rectum by a competent healthcare professional.

4. ROLES & RESPONSIBILITIES

4.1 Clinical service managers have responsibility to ensure that their staffs are trained and have the competencies needed to undertake all elements of bowel management which they are required to undertake as part of their role.

4.2 Staff members have responsibility for ensuring they only carry out bowel management procedures for which they have received training and have been deemed competent unless it is being carried out as part of that training or competency assessment, in which case they must be accompanied by a competent colleague.

4.3 Students in practice may undertake certain elements of bowel management provided they are accompanied by a competent member of staff at all times. They must **NOT** perform DRE or DRF.

4.4 Staff delegating any aspect of bowel management to non -registered staff must ensure they have been trained and deemed competent to do so.

5. TRAINING

5.1 Healthcare staff performing bowel care assessment and management (including Digital Rectal Examination and Digital Removal of Faeces) is required to complete the Trust's Bowel Care and DRE training, available via Learning and Development prospectus. This should be undertaken once every 3 years. The Trust's Bowel Management training programme is provided and delivered by the Bladder and Bowel Service, but staff may attend specific bowel management training delivered as

part of a Spinal Injuries Care course at the Spinal Treatment Centre at Salisbury District Hospital.

5.2 Staff must complete elements of the competency tool which are appropriate to their role. Appendix G. Sign off must be completed by a registered practitioner who has attended training as in 5.1 above and has already been deemed competent in the sections they are signing off.

5.3 Health care support workers may carry out bowel care as delegated by a registered nurse (RCN, 2012), as long as they have completed approved training as in 5.1 above, completed the bowel care competency tool and been observed and signed off as competent in giving the care specified in the patient care plan on a named patient basis. The support worker should be named on the care plan as able to perform the planned activity.

5.4 If a member of staff joining the Trust has completed up to date, appropriate training elsewhere and is able to offer proof of that training, they may complete the competency tool as described in 5.2.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 An equality impact assessment was carried out as part of the development of this policy. The outcome was no negative impact. (See Appendix G).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Incidents reported regarding bowel care will be monitored by the governance processes within each Service Line.

7.2 Records of staff training and competencies will be kept and reviewed by clinical managers in each team where staff perform bowel care procedures

7.3 Any non-compliance with this policy must be reported using the Trusts incident reporting system

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 East Cheshire NHS Trust 2016, *Integrated Trust Policy for Bowel care Management in Adult Patients.*

NICE 2007, *Faecal incontinence in adults: management* Clinical guideline 49 nice.org.uk/guidance/cg49.
RCN 2012, *Management of lower bowel dysfunction, including DRE and DRF*, https://www2.rcn.org.uk/__data/assets/pdf_file/0007/157363/003226.pdf Accessed 30th May 2017.

Royal Marsden Manual of Clinical Procedures Online, chapter 5, Elimination www.rmmonline.co.uk , accessed 22nd March 2017.

Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour, London NMC.

Blackmore Press, cited in Fearon, M. (1998) Assessment and measurement of competence in Practice, *Nursing Standard* 12(22), pp43-47.

9.2 Reporting of Adverse Events Policy
Chaperone Policy
Consent to Examination and Treatment Policy
Deprivation of Liberty Standards Mental Capacity Act Policy
Medicines Policy
Hand hygiene policy
Standard precautions policy

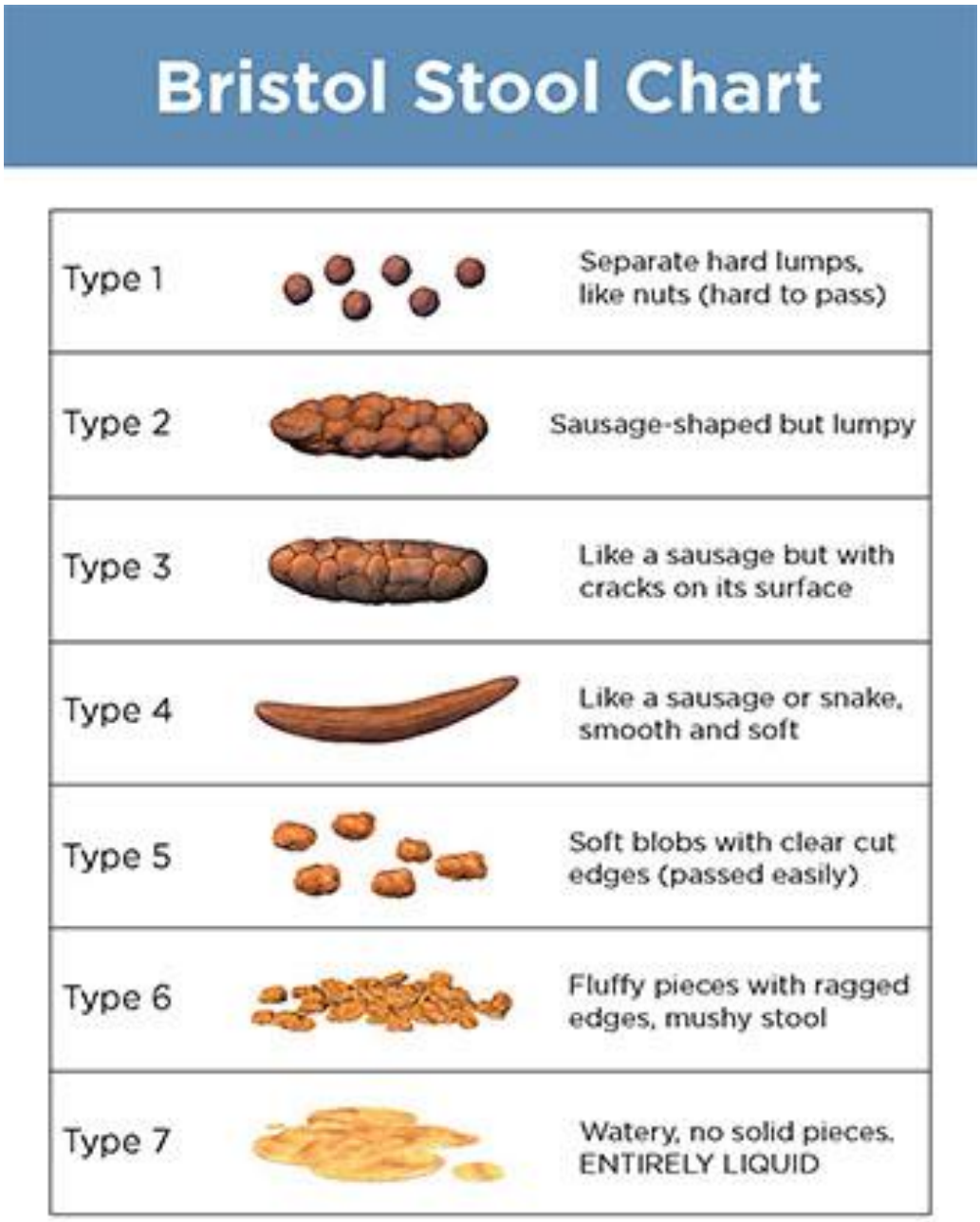
Policy on Diarrhoea and Vomiting
Policy on prevention and control of Clostridium Difficile
Waste Management Policy
Wound Formulary

10. GLOSSARY

10.1 AD – Autonomic Dysreflexia.
DRE – Digital Rectal Examination.
DRF – Digital Removal of Faeces.
RCN – Royal College of Nursing.
PRN – To describe a medication that is prescribed for use on an "as and when required basis".

APPENDIX A

BRISTOL STOOL SCALE CHART



APPENDIX B
Procedure for administering suppositories

Prior to the administration of suppositories healthcare practitioners should undertake appropriate assessment and adhere to the guidance below:-

- Follow infection prevention policies relating to hand hygiene and the use of personal protective equipment(PPE)
- In cases of suspected rectal loading, the healthcare practitioner must perform a DRE (digital rectal examination) to determine the presence of faeces in the rectum
- Medicated suppositories should be inserted with the blunt end first to aid absorbency
- Do not insert a medicated suppository into a faecal mass as its effect will be minimal
- Lubricant suppositories should be inserted pointed end first although they may also be inserted blunt end first if the suppository is not easily retained
- Glycerine suppositories can be moistened with water before insertion. All other types of suppository require the use of a lubricating agent e.g. KY – Jelly This must be single use sachets to prevent cross contamination

Procedure

- Explain and discuss the procedure with the patient. Obtain consent and ensure privacy.
- Ensure that a bedpan, commode or toilet is readily available
- Assist the patient to lie on their left side with their knees flexed, the upper knee higher than the lower one and the buttocks near the edge of the bed
- Place a disposable incontinence pad beneath the patients hips and buttocks
- Wash hands and put on apron and gloves
- Place some lubricating jelly on gauze square and lubricate the end of the blunt end suppository. Separate the patients buttocks and insert the suppository as per manufacturing guidance
- Once the suppository has been inserted clean any excess lubricating jelly from the patients perineal area using gauze squares
- Encourage the patient to retain the suppository for 20minutes or until they are no longer able to do so. If a medicated suppository is given advise the patient that the aim is not to stimulate evacuation and retention is required for effectiveness

Post procedure

- Ensure all bedpans/commodes are cleaned as per local decontamination policy.
- Remove and dispose of PPE equipment. Wash hands
- Record that the suppository has been given, the effect on the patient and the result (amount, colour, consistency and content, using the Bristol Stool Chart, Appendix B, if appropriate, in the relevant documents.
- Observe patient for any adverse reactions

APPENDIX C
Administration of Enemas

Procedure

- Explain and discuss the procedure with the patient and ensure privacy,
- Wash hands, PPE as above.
- Ensure that a bedpan, commode or toilet is readily available.
- Warm the enema to room temperature by immersing in a jug of hot water.
- Assist the patient to lay on the left side, with knees well flexed, the upper knee higher than the lower one, and with the buttocks near the edge of the bed.
- Place a disposable incontinence pad beneath the patient's hips and buttocks.
- Place some lubricating gel on gauze square and lubricate the nozzle of the enema or the rectal tube.
- Expel excessive air from the enema and introduce the nozzle or tube slowly into the anal canal while separating the buttocks. (A small amount of air may be introduced if bowel evacuation is desired.)
- Slowly introduce the tube or nozzle to a depth of 10.0–12.5 cm.
- If a retention enema is used, introduce the fluid slowly and leave the patient in bed with the foot of the bed elevated by 45° for as long as prescribed.
- If an evacuant enema is used, introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is completely finished.
- Clamp the tubing before all the fluid has run in.
- Slowly withdraw the tube or nozzle.
- Dry the patient's perineal area using gauze squares.
- Ask the patient to retain the enema for 10–15 minutes before evacuating the bowel.
- Ensure that the patient has access to the nurse call system, is near to the bedpan, commode or toilet, and has adequate toilet paper.

Post-procedure

- Remove and dispose of equipment, gloves and apron.
- Wash hands with soap and water.
- Record in the appropriate documents that the enema has been given, its effects on the patient and its results (colour, consistency, content and amount of faeces produced), using the Bristol Stool Chart, Appendix B.
- Observe patient for any adverse reactions.

Problem Solving

Problem	Cause	Prevention	Action
Unable to insert the nozzle of the enema pack or rectal tube into the anal canal. Unable to advance the tube or nozzle into the anal canal. Unable to advance the tube or nozzle into the rectum. Patient complains of cramping or the desire to evacuate the enema before the end of the procedure. Patient unable to open bowels after an evacuant enema.	Tube not adequately lubricated. Patient in an incorrect position. Patient unable to relax anal sphincter. Patient apprehensive and embarrassed about the situation. Spasm of the canal walls. Blockage by faeces. Blockage by tumour. Distension and irritation of the intestinal wall produces strong peristalsis sufficient to empty the lower bowel. Reduced neuromuscular response in the bowel wall.	Ensure patient is relaxed and in the correct position. Ask the patient to take slow deep breaths to help them relax. Encourage the patient to retain the enema. Inform the doctor that the enema was unsuccessful and reassure the patient	Apply more lubricating jelly. Ask the patient to draw knees up further towards the chest. To ensure the patient is relaxed before inserting the nozzle or rectal tube. Ask the patient to take deep breaths and 'bear down' as if defecating. Wait until spasm has passed before inserting the tube or nozzle more slowly, thus minimizing spasm. Ensure adequate privacy and give frequent explanations to the patient about the procedure. Withdraw tubing slightly and allow a little solution to flow and then insert the tube further. If resistance is still met, stop the procedure and inform a doctor. Stop instilling the enema fluid and wait with the patient until the discomfort has subsided.

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APPENDIX D

Digital Rectal Examination

Procedure

- Explain and discuss procedure with patient, obtain consent and ensure privacy.
- 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.
- Clean hands and put on disposable gloves and apron.
- 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.
-
- Place some lubricating gel on gauze square and gloved index finger. Inform the patient you are about to proceed. Prior to insertion, encourage the patient to breathe out or talk and/or place gloved index finger on the anus for a few seconds prior to insertion.
- On insertion of finger, assess anal sphincter control; resistance should be felt.
- With finger inserted in the anus, sweep clockwise then anticlockwise, noting any irregularities.
- Digital examination may feel faecal matter within the rectum; note consistency of any faecal matter.
- Clean anal area after the procedure.

Post-procedure

- Remove gloves and apron and dispose of equipment in appropriate clinical waste bin. Wash hands with soap and water.
- Assist patient into a comfortable position and offer bedpan, commode or toilet facilities as appropriate.
- Document findings and report to appropriate members of the multidisciplinary team.

APPENDIX E

Digital Evacuation of Faeces

1. If this procedure is used as an acute intervention, the patient's pulse rate should be recorded before and during the process.

2. Patients with a spinal cord injury should also have their blood pressure measured before, during and after the procedure. A baseline blood pressure measurement should be available for comparison.

3. Every time the procedure is performed, the consistency of the stool should be noted before continuing. If the stool is hard and dry, lubricant suppositories should be inserted and left for 30 minutes before commencing. If the stool is too soft to remove effectively, consider delaying the procedure for 24 hours to allow further water reabsorption to occur.

During the procedure the nurse should observe the patient for signs of:

- Distress, pain or discomfort.
- Bleeding.
- If a patient with spinal injury - Autonomic Dysreflexia: hypertension, bradycardia, headache, flushing above the level of the spinal injury, sweating, pallor below the level of spinal injury, nasal congestion.
- Collapse.

Procedure

- Explain and discuss procedure with the patient, obtain consent and ensure privacy.
- In spinal cord injury patients who are at risk of Autonomic Dysreflexia, a blood pressure reading should be taken prior to the procedure. A baseline blood pressure reading should be available for comparison. For such patients where this procedure is routine and tolerance is well established, this is not required.

Procedure

- 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 Place a disposable incontinence pad beneath the patient's hips and buttocks.
- Clean hands and put on disposable apron and gloves. Place some lubricating gel on gauze square and gloved index finger.
- Inform the patient you are about to proceed.
- In spinal cord injury patients, observe for signs of AD throughout the procedure
- Observe anal area prior to the insertion of the finger into the anus for evidence of skin soreness, excoriation, swelling, haemorrhoids or rectal prolapse.
- Proceed to insert finger into the anus/rectum. Proceed with caution in those patients with spinal cord injury.
- If the stool is type 1 as per Bristol stool scale, Appendix B, remove one lump at a time until no more faecal matter is felt.
- If a solid faecal mass is felt, split it and remove small pieces until no more faecal matter is felt. Avoid using a hooked finger to remove faeces.
- If faecal mass is too hard to break up, or more than 4 cm across, stop the procedure and discuss with the multidisciplinary team

- Once faeces are removed, it should be placed in an appropriate receiver.
- Encourage patients who receive this procedure on a regular basis to have a period of rest or, if appropriate, to assist using the Valsalva manoeuvre.
- Wash and dry the patient's anal area and buttocks.

Post-procedure

- Remove gloves and apron and dispose of equipment as per Trust policy. Wash hands with soap and water.
- Assist patient into a comfortable position.
- In spinal cord injury patients, take a blood pressure reading.
- Document findings and report to appropriate members of the multidisciplinary team

APPENDIX F

Use of anal plugs

Procedure

- Explain and discuss procedure with the patient, obtain consent and ensure privacy.
- Clean hands and apply gloves and apron.
- Anal plugs are available in different sizes, try the smallest size first if the first use, or the size usually used by the patient.
- Apply lubricant gel and insert like a suppository. Once in place, moisture from the lining of the rectum dissolves the film and the plug opens out into its cup or mushroom shape.
- Correct insertion is very important; they must be inserted into the anal canal and not allowed to inflate near the entrance or lower end of the anal canal.
- To remove, pull gently on the string.
- Alternatively they can be expelled by raising intra-abdominal pressure and pushing as during normal bowel movements (defecation) if the patient is able to do this.
- Dispose of used plugs as per Trust policy. They are not biodegradable and must not be flushed down the toilet.

APPENDIX G

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Adults Southampton/Trust Wide	
Title of Change:	Updated Bowel Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Tri-annual update of policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	Solent Staff and specialist nurses, other organisation policies Consultant at acute trust
Have you taken into consideration any regulations, professional standards?	Yes	Professional and trust policies NICE guidelines

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	Lesley Bradrick	*Date:*	*01/02/2021*

Appendix H: Competencies

Bowel Care: Digital Rectal Examination, Digital Removal of Faeces and Digital Rectal Stimulation Clinical Competencies

Name:	**Role:**
Base:	**Date Initial training completed*:***

Competency Statement

The participant demonstrates clinical knowledge and skill in assessment without assistance and/or direct supervision (level 3 – see level descriptors). Assessment in practice must be by a Registered Health Care Professional who can demonstrate competence at level 4 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self-assessed
The Participant will be able to:				
1. Demonstrate the knowledge and skill in digital rectal examination (DRE)				
a) Demonstrate an awareness of professional accountability and guidelines (e.g. RCN).	Questioning			
b) Discuss the rationale for DRE.	Questioning			
c) Demonstrate an understanding of the relevant anatomy and physiology of the gastro-intestinal tract.	Questioning			
d) Discuss the care of a patient with altered bowel function.	Questioning			
e) Identify when it would be appropriate to carry out DRE.	Questioning			
f) Identify when it would be necessary to stop procedure and what action to take.	Questioning			
g) Discuss the use of appropriate medication e.g. Laxatives, suppositories, enemas.	Questioning			
h) Demonstrate knowledge of appropriate use of equipment.	Observation			
i) Demonstrate preparation of the patient and gain informed consent.	Observation			

j) Demonstrate the correct procedure to perform DRE.	Observation			
k) Demonstrate safe disposal of equipment and waste.	Observation			
l) Complete documentation and any recommendations for treatment/follow-up.	Observation			
m) Recognise symptoms of autonomic dysreflexia in the paralysed patient and take appropriate action.	Observation/ Questioning			
Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self-assessed
2. Demonstrate the knowledge and skill in digital removal of faeces (DRF)				
a) Demonstrate an awareness of professional accountability and guidelines (e.g. RCN).	Questioning			
b) Identify the indications for digital removal of faeces.	Questioning			
c) Demonstrate an understanding of the relevant anatomy and physiology of the gastro-intestinal tract.	Questioning			
d) Discuss the care of a patient with altered bowel function.	Questioning			
e) Identify the conditions which contra-indicate digital removal of faeces.	Questioning			
f) Discuss the potential side-effects of procedure including stimulation of vagus nerve.	Questioning			
g) Identify when it would be necessary to stop procedure and what action to take.	Questioning			
h) Discuss the use of appropriate medication e.g. Laxatives, suppositories, enema.	Questioning			
i) Demonstrate preparation of the patient and gain informed consent.	Observation			

j) Demonstrate the correct procedure to perform removal of faeces.	Observation			
k) Demonstrate safe disposal of equipment and waste.	Observation			
l) Complete documentation and any recommendations for treatment/follow up.	Observation/ questioning			
m) Recognise symptoms of Autonomic Dysreflexia in the paralysed patient and take appropriate action.	Observation/ questioning			
Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self-assessed
3. Demonstrate the knowledge and skill in Digital Rectal Stimulation (DRS)				
a) Demonstrate an awareness of professional accountability and guidelines (e.g. RCN).	Questioning			
b) Discuss the rationale for DRS.	Questioning			
c) Demonstrate an understanding of the relevant anatomy and physiology of the gastro-intestinal tract.	Questioning			
d) Discuss the care of a patient with altered bowel function.	Questioning			
e) Identify when it would be appropriate to carry out DRS.	Questioning			
f) Identify when it would be necessary to stop procedure and what action to take.	Questioning			
g) Discuss the use of appropriate medication, e.g. Laxatives, suppositories, enemas.	Questioning			
h) Demonstrate knowledge of appropriate use of equipment.	Observation			
i) Demonstrate preparation of the patient and gain informed consent.	Observation			
j) Demonstrate the correct procedure to perform DRS.	Observation			
k) Demonstrate safe disposal of equipment and waste.	Observation			

l) Complete documentation and any recommendations for treatment / follow-up.	Observation			

m) Recognise symptoms of Autonomic Dysreflexia in the paralysed patient and take appropriate action.	Observation/Question			

Source: RCN Neurogenic Bowel Dysfunction in individuals with Central Neurological Conditions 2012.

Date all elements of Competency Tool completed to level 3 _____

Name _____ Signature _____ Status _____ Date _____

I confirm that I have assessed the above named member of staff and can verify that he/she demonstrates competency in patient/client assessment.

Assessor _____ Signature _____ Status _____ Date _____

Review Dates:	Competent Yes/No	Health Care Professional/ Assessor Signature	Verifier Signature	Comments

Competency rating scale

Levels of competency Rating Scale

	Level of achievement	Level
Novice	Awareness through observation of the performance indicator, but not active participant.	0
↓	Performing with assistance. At the stage of learning the activity but requires constant supervision and support to complete to level required.	1
↓	Performing activity with a basic understanding of theory and practice principles, but requires supervision and oversight of more senior colleague.	2
Competent Practitioner	Performing independently and at required level of competence.	3
↓	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice At this level competence will have been maintained for at least 6 months and/or is used frequently (2-3 times /week) The practitioner will demonstrate confidence and proficiency and show fluency and dexterity in practice **This is the minimum level required to be able to assess practitioners as competent**	4
↓	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. At this level the practitioner will be able to adapt knowledge and skill to special/ novel situations where there may be increased levels of complexity and/or risk	5
Expert	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. Demonstrate initiative and adaptability to special problem situations, and can lead others in performing this activity. Relates to Health Education Wessex Proposed Domains of Advanced Practice: Leadership, Research, Advanced Clinical Skills, Facilitating Learning. At this level the practitioner is able to co-ordinate, lead and assess others who are assessing competence. Ideally they will have a teaching and /or mentor qualification	6

Appendix I: Managing Constipation in Adults

Adapted from: Herman GD, Kenyon RJ (1987) Competency-Based Vocational Education. A Case Study, Shaftsbury, FEU, Blackmore Press, cited in Fearon, M. (1998) Assessment and measurement of competence in practice, *Nursing Standard* 12(22), pp43-47.
Appendix I

Management of Constipation and Faecal Impaction in Adult & Elderly Patients

Drug Therapy Guideline No: 177.00 **Issued: 20.01.2017**

Treatment Options

Please see below for all treatment options mentioned above. Aside from rarely used medication these are listed in order of cost; please take this into account when prescribing.

PRN is an abbreviation used on a drug chart/prescription for medication to be given when necessary.

Ensure only one of each type of laxative is prescribed. Combining laxatives of the same type will have no additional benefit.

NB: All non-formulary drugs need a non-formulary drug form to be completed prior to supply

Bulk-forming Laxatives Increase faecal mass which stimulates peristalsis. Of particular benefit in patients with small hard stools in whom it is difficult to increase dietary fibre. **Not for use in faecal impaction**.	
Ispaghula Husk **Oral: 1 sachet BD**	• Each sachet should be dissolved in 150ml water • Ensure adequate fluid intake • May take days for full effect • Ideally to be taken after food
Methylcellulose: **Oral: 3-6 tablets BD**	• Ensure adequate fluid intake • May take days for full effect
Sterculia granules – Portsmouth formulary	•

Osmotic Laxatives Increase the amount of water in the large bowel to promote peristalsis.	
Lactulose: **Oral: 15mL BD, adjusted according to response**	• Takes up to 48 hours to work • Do not prescribe PRN (*PRN is used to describe a medication that is used on an as and when required basis*). • Can be used for hepatic encephalopathy – aim for 2-3 soft stools/day
Macrogol: **Oral: 1-6 sachets/day in divided doses**	• Each sachet should be dissolved in 125ml water • Cannot be thickened past stage 1 • Can be used PRN • Caution in cardiac failure • Can be used in faecal impaction (see above for dosing)
Magnesium hydroxide: **Oral: 10-20ml BD-TDS**	• Avoid in renal failure • Can be used PRN
Phosphate enema: **Rectal: One enema daily**	• Caution in elderly/frail patients as can cause dehydration and electrolyte disturbances • Can be used as a bowel-cleansing agent before procedures • Avoid giving oral medication within one hour of administering as absorption can be affected
Sodium citrate enema: **Rectal: 5-10mL (1-2 enemas) for one dose**	• Caution in debilitated patients • Avoid in inflammatory or ulcerative bowel disease
Liquid paraffin - Portsmouth Formulary	• Avoid use in the elderly
Magnesium Hydroxide – Portsmouth Formulary	• Avoid use in the elderly

Stimulant Laxatives Directly stimulate nerves in the large bowel to promote peristalsis. Likely to cause stomach cramps.	
Sennoside (Senna): **Oral: 2-4 tablets daily or** **10-20mL daily (liquid)**	• Dose normally given at night as onset time of 8-12 hours • Can be prescribed PRN
Bisacodyl: **Oral: 5-10mg OD increased to max 20mg/day** **Rectal: 10mg OD**	• Oral dose normally given at night as onset time of 10-12 hours • Available in suppositories that act in 20-40 minutes. PR dose to be given in the morning.
Glycerol: **Rectal: 4g as required**	• Moisten suppositories with water before insertion
Sodium picosulfate elixir – Portsmouth formulary	• **(secondary care initiated)**

Softeners Wet and soften faeces. Good option alone or in combination for patients with haemorrhoids.	
Docusate sodium: **Oral: up to 500mg/day in divided doses**	• Has stimulant and softener effects • Available in capsule and liquid form • Acts within 1-2 days
Arachis oil: **Rectal: 130mL enema as required**	• Use as a retention enema • **Not for use in those with peanut allergies** • Warm enema in warm water before use

Other/rarely used drugs for constipation **These are to be prescribed by specialist physicians only**	
Co-danthramer: **Oral: 1-2 capsules once daily at night or** **5-10ml once daily at night (liquid)**	• **For terminally ill patients only** • Stimulant and softener • Works in 12 hours • Comes in 'standard' and 'strong' capsules • Carcinogenic
Lecicarbon A suppositories: **(This is non formulary in Portsmouth)** **Rectal: 1 suppository when needed – can be repeated after 30-60 minutes** **Lecicarbon C is a half strength treatment** **(And is non formulary in Southampton and Portsmouth)**	• To be prescribed by gastroenterology or urogynaecology consultants **only**
Linaclotide: **Oral: 290mcg once daily**	• At least 30 minutes before meals • Review if no response after 4 weeks • Irritable bowel syndrome with constipation as recommended in NICE CG 61
Lubiprostone: **Oral: 24mcg twice daily**	• For 2-4 weeks • Review if no response after initial 2 weeks • Chronic idiopathic constipation after failure of standard laxatives • To be used in line with NICE TA 318
Methylnaltrexone injection: **Subcutaneous injection: dosing by weight on alternate days for a maximum of 4 months** **This is a non-formulary drug in Southampton**	• **Specialist palliative care recommendation only** • For opioid-induced constipation where there has been inadequate response to standard laxatives
Naloxegol: **Oral: 25mg once daily**	• Given in the morning • For opioid-induced constipation where there has been inadequate response to standard laxatives • To be used in line with NICE TA 345
Prucalopride: **Oral: 2mg once daily (adults)** **1mg once daily (elderly)**	• Review if no response at 4 weeks • Licensed for refractory constipation in **women only** • To be used in line with NICE TA 211

General Advice

- Provide patients with lifestyle advice:
  - Increase dietary fibre.
  - Increase fluid intake.
  - Never ignore the urge to go to the toilet – ensure call bell is within reach and patient knows how to use it if they are unable to mobilise to the toilet unaided.
  - Keeping mobile – consider patient-specific limitations e.g. falls risks.

- Ensure a PRN laxative is prescribed with every constipating medication prescribed, particularly opiates e.g. codeine

Chronic Constipation

The management of chronic constipation should be referred to and managed by specialist physicians.
Ensure you have obtained a thorough accurate history from the patient.

Investigations to consider include:

- Colonic imaging – CT faecal tagging
- SHAPES test (bowel transit study)
- Defecating proctogram
- Thyroid function tests

References

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2. Talley NJ, Fleming KC, Evans JM, O'Keefe EA, Weaver AL, Zinsmeister AR & Melton LJ. Constipation in an elderly community: a study of prevalence and potential risk factors.

3. Rome III Diagnostic Criteria for Functional GI Disorders. Am J Gastroenterol. 1996 Jan;91(1):19-25.

4. Bristol Stool Chart www.gutsense.org.uk Accessed 17/10/16.

5. NICE NG 12 Suspected cancer: recognition and referral 2015.

This guideline was written by Kerry Burrows (MOPRS Pharmacist) & Ecaterina Pascaru (Trust Doctor).

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Reviewed by Maria Nam Clinical Pharmacist Solent NHS Trust December 2017