Key Competency 2: Neurogenic Bowel Management

Through discussion, demonstration and observation, workbook completion and Q&A, the healthcare professional must demonstrate;

1.0 Knowledge and understanding of the Anatomy and Physiology of the digestive system

1.1 Demonstrate knowledge and understanding of gross structure and functions of the digestive system, including:

- 1.1.1 Mouth
- 1.1.2 Salivary Glands
- 1.1.3 Oesophagus
- 1.14 Stomach
- 1.1.5 Small intestine
- 1.1.6 Large intestine
- 1.1.7 Rectum
- 1.1.8 Ano-Rectal sphincter

1.2 Describe the mechanisms of the normal bowel function:

- 1.2.1 Peristalsis
- 1.2.2 Gastro-colic reflex
- 1.2.3 Ano-rectal sphincter

1.3 Describe and discuss how Spinal Cord Injury (including cauda equina syndrome (CES) and metastatic spinal cord compression (MSCC)) can affect the bowel:

- 1.3.1 The difference between Reflex bowel and Areflexic/Flaccid bowel
- 1.3.2 Autonomic dysreflexia related to bowel
- 1.3.3 Describe the content of the Patient Safety Alert (NHS/PSA/RE/2018/005) and explain implications for patient safety

2.0 Bowel Assessment of the Spinal Cord Injured patient

2.1 Demonstrate knowledge and understanding through discussion, with reference to the evidence base of:

- 2.1.1 The effects of spinal shock on the bowel
  - Areflexic/ Flaccid bowel
  - Paralytic Ileus
- 2.1.2 The frequency required for digital rectal examination(DRE), digital removal of faeces (DRF) and/or digital rectal stimulation (DRS)
- 2.1.3 When to discontinue DRE, DRF or DRS and when to escalate care to medics/ SCI Link or SCI Outreach Nurse

2.2 Undertake the following procedures in a safe manner and provide an evidence-based rationale for:

Digital Rectal Examination (DRE): Observed practical assessment to include undertaking the following in a safe and professional manner.

- 2.2.1 Gain appropriate consent
- 2.2.2 Provide explanation of the procedure to the patient using layperson terminology
- 2.2.3 Understand any contra-indications
- 2.2.4 Prepare required materials
- 2.2.5 Maintain dignity and privacy (including use of chaperone if required) throughout the procedure
- 2.2.6 Note baseline physiological observations and acknowledge potential changes and warning signs
- 2.2.7 Good hand hygiene and correct PPE
- 2.2.8 Position patient in correct position for procedure
- 2.2.9 Note any physical abnormalities of anus or rectum on visual inspection or examination
- 2.2.10 Note ano-rectal sensation
- 2.2.11 Note any gas or faeces present
- 2.2.12 Note if anal tone is present or absent
- 2.2.13 Note if voluntary anal contraction is present or absent
- 2.2.14 Appropriately dispose of equipment and waste
- 2.2.15 Repeat physiological observations post-procedure
- 2.2.16 Accurately document findings (including stool type, using Bristol Stool Chart)

3.0 Bowel Care of the Spinal Cord Injured Patients

3.1 Demonstrate knowledge and understanding of possible complications of inappropriate bowel care:

- 3.1.1 Constipation and faecal impaction
- 3.1.2 Faecal incontinence
- 3.1.3 Megacolon
- 3.1.4 Haemorrhoids
- 3.1.5 Anal fissure
- 3.1.6 Rectal prolapse
- 3.1.7 Perforated bowel
- 3.1.8 Autonomic dysreflexia – potential causes, pathophysiology and treatment
- 3.1.9 Abdominal pain/spasm

3.2 Digital Removal of Faeces (DRF): Observed practical assessment to include undertaking the following in a safe and professional manner.

- 3.2.1 Gain appropriate consent
- 3.2.2 Provide explanation to patient (as above)
- 3.2.3 Understand any contra-indications
- 3.2.4 Prepare required materials
- 3.2.5 Maintain dignity and privacy (including use of chaperone if required)
- 3.2.6 Note baseline physiological observations
- 3.2.7 Good hand hygiene and correct PPE
- 3.2.8 Position patient in correct position for procedure
- 3.2.9 Carry out DRE as above
- 3.2.10 Identify stool type and if suppositories or enemas are required
- 3.2.11 Removal of faeces using correct technique
- 3.2.12 Repeat DRE to ensure rectum is empty of stool
- 3.2.13 Appropriately dispose of equipment and waste
- 3.2.14 Repeat physiological observations post-procedure
- 3.2.15 Accurately document findings (including stool type, using Bristol Stool Chart)

3.3 Digital Rectal Stimulation (DRS) – observed practical assessment to include undertaking the following in a safe and professional manner

- 3.3.1 Gain appropriate consent – and explanation to patient as above
- 3.3.2 Understand any contra-indications
- 3.3.3 Prepare required materials
- 3.3.4 Maintain dignity and privacy (including use of chaperone if required)
- 3.3.5 Note baseline physiological observations
- 3.3.6 Good hand hygiene and correct PPE
- 3.3.7 Position patient in correct position for procedure
- 3.3.8 Carry out DRE as above

- 3.3.9 Identify if stool is present and remove using DRF as above
- 3.3.10 Insert rectal stimulant (Enema or suppository, as prescribed)
- 3.3.11 Wait for result of rectal stimulant
- 3.3.12 Repeat DRE.
- 3.3.13 If faeces present, carry out DRS using correct technique
- 3.3.14 Await reflex bowel opening
- 3.3.15 Repeat DRE/DRS until rectum empty
- 3.3.16 Appropriately dispose of equipment and waste
- 3.3.17 Repeat physiological observations post-procedure
- 3.3.18 Accurately document findings (including stool type, using Bristol Stool Chart)

4.0 Pharmacological Management

4.1 You must be able to demonstrate through discussion essential knowledge of (and its application to practice):

- 4.1.1 Lubricating gel (water based)
- 4.1.2 2% Lidocaine gel
- 4.1.3 Microlax enema
- 4.1.4 Movicol/ Macrogol (PO)
- 4.1.5 Senna (PO)
- 4.1.6 Sodium Docusate Enema
- 4.1.7 Sodium Docusate (PO)
- 4.1.8 Large volume enemas (e.g. phosphate – and why to avoid)

Appendix 1. Recommended Reading

1) East Midlands Spinal Network – Bowel Management Pathway

2) Royal College of Nursing – Bowel Care (2019). Management of Lower Bowel Dysfunction including Digital Rectal Examination and Digital Removal of Faeces. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/september/007-522.pdf

3) Krassioukov, A., Eng, J.J., Claxton, G., Shakakibara, B.M. and Shum, S. (2018) Neurogenic bowel management after spinal cord injury: A systematic review of the evidence. Available at: https://www.nature.com/articles/sc201014

4) NICE CG75 – Metastatic spinal cord compression in adults: risk assessment, diagnosis and management.

5) NICE CG49 – Faecal incontinence in adults: management.

6) British Association of Spinal Cord Injury Specialists (BASCIS), Multi-disciplinary Association of Spinal Cord Injury Professionals (MASCIP) and Spinal Injuries Association (SIA) joint statement on Autonomic Dysreflexia (2017) https://www.mascip.co.uk/wp-content/uploads/2019/01/Statement-on-Autonomic-Dysreflexia-2017.pdf

7) NHS Improvement – Patient Safety Alert (2018) Resources to support safer bowel care for patients at risk of autonomic dysreflexia https://improvement.nhs.uk/documents/3074/Patient_Safety_Alert_-_safer_care_for_patients_at_risk_of_AD.pdf