Digital rectal examination: why, who, how?

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Rectal interventions are a fundamental part of nursing care across all settings aimed at establishing whether effective bowel emptying is taking place. Functional bowel disorders, including constipation, are common conditions affecting many of the general population and often go undetected by both patients, who perceive it as their normal, and healthcare professionals, who may not include a thorough bowel assessment at every clinical contact due to time restraints, lack of knowledge, or fear of intimate procedures causing harm or embarrassment. An inaccurate or complete lack of appropriate bowel assessment can increase risk of harm or ill health for many patients and therefore should be an intrinsic part of everyday clinical contact. The Royal College of Nursing (RCN) recently reviewed its bowel care guidance (Fenton et al, 2019) to address some of the concerns around bowel assessment and management. With an ever changing workforce, multiple grades of registered and non-registered staff taking on additional tasks, it is prudent for all clinicians to review their current knowledge and practice to ensure that they are following the latest evidence-based guidance for safe and effective practice.

KEYWORDS:
- Bowel management
- Bowel assessment
- Knowledge

Functional bowel conditions, including faecal incontinence and constipation are some of the commonest gastrointestinal conditions affecting up to a quarter of all the population, with a particular prevalence in children and older people (Belsey, 2010; Tack et al, 2011; Holroyd, 2015). It is a widely cited statistic that around one in 10 of the population will suffer with a bowel incontinence problem during their lifetime (Bladder and Bowel Community, 2020; BBUK, 2020), but due to social embarrassment many people try to self-manage and do not seek appropriate help (Bedoya-Ronga and Currie, 2014).

Isolation, anxiety, depression and embarrassment are commonly reported by people who have a bowel issue (Wan and Wang, 2014). Based on this evidence, bowel management should be an essential part of health and social care, yet in the author’s opinion, it does not receive the attention it deserves. Bowel care is often overlooked in some healthcare settings in favour of more perceived important factors, such as the more obvious presenting complaint/condition (Ness, 2013; National Institute for Health and Care Excellence [NICE], 2018).

Digital rectal examination (DRE) and digital removal of faeces (DRF) are intimate interventions, which have been carried out by nursing and medical professionals for decades — with DRE being an essential component of holistic bowel assessment. The intimate nature of the procedures has caused concern among some healthcare professionals, with fears of litigation or accusations of abuse cited as the reason for reluctance to carry out the procedures (Kyle, 2010; Royal College of Physicians, 2010; Ness, 2013). In the author’s experience, there is a widespread reluctance and at times an outright refusal by staff to carry out rectal examination or manual evacuation techniques in practice today. This can lead to increased risk for patients who rely on digital rectal procedures to maintain an effective bowel emptying programme.

The Nursing and Midwifery Council’s (NMC) standards of proficiency for registered nurses (2018) is clear in its instruction that nurses must: ‘demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people’s needs related to nutrition, hydration and bladder and bowel health’. There are specific nursing procedures that all registered nurses should be competent at to achieve entry to the register. These are clearly identified in the annex of the document — 6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention; 6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate. Interpretation of these documents therefore suggests that a registered professional cannot refuse to perform a DRE/DRF if there is a clear clinical need for the procedure.

Healthcare provision has altered over the past few years with many non-registered grades of staff providing essential care and support...
across acute and community settings. The Royal College of Nursing (RCN) (Fenton et al, 2019) recently revised its evidence-based guidelines on bowel care. The new guidance clarifies the current evidence-based practice and offers all staff involved in bowel management guidance that reflects changing practice and healthcare provision. There are situations where a non-registered staff member may be considered competent to carry out intimate rectal procedures, including DRE, DRS, digital rectal stimulation (DRS) and administration of medication. These healthcare professionals should demonstrate competence in the practical procedures and also an underpinning theoretical knowledge and understanding of the risks and benefits of the procedure, as well as awareness of the relevant anatomy and physiology. The ability and authority to carry out rectal interventions by a non-registered healthcare professional must be determined on an individual named patient and covered by local policy (Fenton et al, 2019).

With this in mind, it is pertinent for all healthcare professionals to revisit their practice in relation to bowel assessment and, more importantly, the DRE procedure—what does it actually mean, who can do it, and how should it be carried out safely and appropriately?

**BOWEL ASSESSMENT**

To complete a meaningful bowel assessment, healthcare professionals should have knowledge and understanding of the anatomy and physiology of the gastrointestinal tract. This knowledge must be applied to the individual patient to understand their normal and to start to identify the abnormal. The National Institute for Health and Care Excellence (NICE, 2007) produced evidence-based guidelines several years ago detailing the benefits of a structured approach to assessing any form of bowel dysfunction using appropriate tools, including the Bristol Stool Chart, bowel habit diaries to record the type, consistency and frequency of stool, as well as any evidence of straining, and Rome III classification (Rome, 2006).

Comprehensive bowel assessment should also include diet and fluid habits, relevant medical and pharmacology history, and a physical examination. Physical examination should also include abdominal palpation and rectal examination (NICE, 2007; Gray, 2011).

Visual assessment of the anal and perineal area will identify any obvious signs of prolapse, skin issues, and haemorrhoids. Palpation of the abdomen helps to determine areas of sluggish or absent activity, distension caused potentially by trapped wind or constipation; listening to bowel sounds with a stethoscope is a simple method of determining bowel activity.

DRE is a useful assessment to determine the rectal contents, type/consistency of stool, evidence of constipation, prostate size, anal tone and sensation. In practice, if you are administering rectal medications, a DRE should be performed first to determine the need for the medication, or its effect. However, it may not always be appropriate to perform more than one rectal intervention at the time, so how do you determine the need and balance this against patient compliance and legal implications of your actions or omissions?

Some pertinent questions to ask would be:

- Why do I need to do this procedure?
- What can I do instead?
- What are the implications if I don’t carry out a DRE?
- Is the patient safe—if I omit the procedure, will there be harm?

The ideal position for the patient undergoing a DRE is laying on the left lateral, as this enables easier observation of the anal area and follows the natural anatomical position of the anal canal. In the male patient, a supine position with knees flexed is a useful position to assess the prostate and male genitalia. The position for examination should be safe for both the practitioner and patient and take into account mobility restrictions and comfort.

DRE should only be undertaken with evidence of informed consent, considering the patient’s cognitive understanding of the procedure, and any cultural or religious issues.

Consideration should be given to a number of factors that may cause increased risk/harm when undertaking a DRE:

- Recent radiotherapy to the pelvic area
- Active inflammatory bowel disorders
- Rectal or anal bleeding or pain
- Tissue compromise caused by age or other medical conditions
- History of sexual/physical abuse
- Unconscious patient (Fenton et al, 2019).

Special attention should also be given when dealing with a patient who has a spinal cord injury as the risk of autonomic dysreflexia (AD) is high in some (Faaborg et al, 2014; Rodger, 2016). AD is a potentially life-threatening response seen in people who have a SCI at T6 or higher level of the spinal cord. The body is unable to react to certain stimuli below the level of injury (such as pain, constipation, full bladder). This results in a rapid and significant change in blood pressure and cardiac function, leading in some cases to seizures, brain haemorrhage and fatality. These patients should have a clear and detailed plan in place to manage their bladder and bowel function. There should be clear instructions on how to manage rectal interventions safely and effectively, and often these patients will use a pre-emptive medication such as sublingual glyceryl trinitrate (GTN) or nifedipine. The use of an appropriate anaesthetic lubricant to carry out the DRE procedure can also reduce the risk of AD episodes occurring (Faaborg et al, 2014; Rodger, 2016; Fenton et al, 2019).

It is advisable in this group of patients to record a baseline blood pressure (BP) before the rectal intervention and continue to monitor BP and cardiovascular status during the procedure. The rectal procedure should be stopped immediately if there are any sudden changes or signs of discomfort, pain or increased anxiety. However, it is not necessary to routinely monitor BP in
patients who rely on a regular rectal intervention to manage their function if there is evidence of an established tolerance to the procedure with no signs of AD (Ness, 2013).

COMPETENCE, KNOWLEDGE AND UNDERSTANDING OF RECTAL PROCEDURES

Pre-registration students will learn the clinical skill of rectal administration during their training. This should include an underpinning theoretical knowledge of anatomy and physiology of the gastrointestinal tract, reasons for bowel dysfunction, appropriate use of enemas and suppositories and a clinical demonstration of the correct procedure for effective DRE, DRF, and DRS. In the case of any non-registered staff undertaking rectal interventions, the same principles and learning must be applied. Practice of the clinical skill on a mannequin can improve confidence before supervised practice on a real patient. The updated RCN guidance (2019) offers a comprehensive supportive document to ensure training is evidence-based, relevant and consistent.

CONCLUSION

Rectal interventions are an essential component of patient care whether to assess current condition or maintain effective bowel action/emptying. Healthcare professionals have a duty of care to provide appropriate assistance to maintain safe and effective practice for those patients who may have an altered bowel function or need support in maintaining effective bowel function. It is important that all healthcare professionals reflect on their knowledge and practice, using national evidence-based guidelines to support their practice.

REFERENCES

Bladder and Bowel UK (2020) Available online: www.bbuk.org.uk/adults/adults-bowel/ accessed 11/05/2020

KEY POINTS

- Around one in 10 of the population will suffer with a bowel incontinence problem during their lifetime.
- Bowel care is often overlooked in some healthcare settings in favour of more perceived important factors.
- All healthcare professionals should reflect on their knowledge and practice, using national evidence-based guidelines to support their practice.