Sandwell and West Birmingham Hospitals NHS
NHS Trust

CLINICAL GUIDELINES FOR DIGITAL RECTAL EXAMINATION DIGITAL RECTAL STIMULATION AND DIGITAL REMOVAL OF FAECES FOR ADULTS FOR USE BY NURSES

Policy author	Community Continence Service
Accountable Executive Lead	Chief Nurse
Approving body	Clinical Effectiveness Committee
Policy reference	SWBH/PtCare/050

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – All trained nurses

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – All trained nurses

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CLINICAL GUIDELINES FOR DIGITAL RECTAL EXAMINATION DIGITAL RECTAL STIMULATION AND Digital REMOVAL OF FAECES FOR ADULTS FOR USE BY NURSES

KEY POINTS

1. This guideline seeks to provide a standardised approach for the procedure of digital rectal examination and digital removal of faeces.

2. Principles of digital rectal examination

3. Principles of digital removal of faeces

4. Contraindications to digital rectal examination and digital removal of faeces

5. Identification and management of Autonomic Dysreflexia

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Clinical Guidelines for Digital Rectal Examination, Digital Rectal Stimulation and Digital Removal of Faeces for Adults For use by Nurses

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Introduction

There is confusion about the professional and legal aspects of digital rectal examination (DRE) and digital removal of faeces (DRF) because of the invasive nature of these procedures. There is uncertainty among nursing staff about whether or not these procedures should be undertaken and by whom.

However, not meeting this care need could be a breach of the Nursing and Midwifery Council Code of Conduct (NHS/PSA/RE/2018/005).

In order to reduce variations in practice and the risk of errors, it is the remit of Sandwell and West Birmingham NHS Trust (SWBH) to provide a standardised approach for the procedure of digital rectal examination (DRE) and digital removal of faeces (DRF) by nurses.

The Royal College of Nursing (RCN) has produced clear guidelines for nurses working with adults in their documentation, “Management of Lower Bowel Dysfunction, including DRE & DRF” (RCN, 2019). It should be noted that these national guidelines refer to adults only. Nurses working with children should refer to RCN guidance for children document (RCN, 2005).

DRE and DRF are invasive procedures and should only be performed when necessary and after an individual assessment (RCN 2019). DRE is often avoidable and should only be undertaken when clinically justified and performed by a nurse who can demonstrate clinical competence.

DRF should not be seen as a first line treatment of constipation. There is now a wide range of bowel emptying techniques available and consideration should be given to these. With these new treatments, the need for DRF has been reduced. However, for a small number of patients, such as those with spinal injuries DRF is the only suitable bowel emptying technique~~s~~.

1. Objectives

- To inform nurses of the professional and legal aspects of DRE and DRF.
- To clarify issues of consent.
- To illustrate criteria for use of DRE/DRF
- To identify and discuss special circumstances and care interventions
- To identify preventative measures and / or treatment for Autonomic Dysreflexia.

2. Scope

These guidelines apply to all trained nursing staff within the Trust.

3. Definitions

Definition of Digital Rectal Examination: DRE
DRE is the insertion of a lubricated, gloved finger into the rectum as part of a nursing assessment. (Trust adult assessment document appendix 8)

Definition of Digital removal of faeces: DRF
DRF is an invasive procedure; it involves the removal of rectal contents by the insertion of a lubricated, gloved finger into the rectum. It can only be performed following an individual assessment.

Digital Stimulation: DS
In patients with an upper motor neurone spinal cord lesion a reflex bowel should be present. Thus, stimulation of the anus or anal sphincter can aid some patients with defecation. The procedure may be performed by a nurse or the patient / carer can be taught to do it.
A patient using digital self-stimulation should be in a comfortable sitting position if possible.

4. Specific Responsibilities and Accountability

5.1 Chief Executive

- To ensure that staff have access to equipment that meets safety and maintenance requirements.
- Accountable for governance and risk management.
- Review and ensure the effective implementation of this policy

5.2 The Registered Nurse (RN)

The individual nurse is responsible and accountable for his / her own practice. The NMC's Code (2015) requires nurses to maintain the knowledge and skills required for safe and effective practice. Recognise and work within the limits of their competence and ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of the nurse's competence.

The RN must:

- Be aware of best practice recommendations with regard to bowel care and management and professional guidelines, i.e. RCN (2020).
- Practice within the scope of their professional competency, acknowledging their limitations and addressing these through education and training.
- Read and adhere to trust policy.

5.3 The Manager

Managers must ensure that staff are aware of and have access to policy documents and the necessary education and supervision to ensure safe practice. This will include education for new staff. Training needs must be highlighted and addressed through the appraisal process and a record kept for audit and development purposes.

5. Indications for Digital Rectal Examination

DRE is indicated to establish the following:

- Sensation/pain/discomfort/spasm – anal / rectal
- Anal tone and the ability to initiate a voluntary contraction and to what degree.
- Outcome of rectal / colonic washout / irrigation.
- Need for medication.
- Presence of faecal matter in the rectum, amount and consistency.
- Effects of rectal medication in certain circumstances.
- Need for manual removal of faeces and evaluating bowel emptiness.
- Need for using digital stimulation to trigger defecation of recto-anal reflex.

6. Indications for digital rectal removal of faeces under medical supervision

- Failure of other bowel emptying techniques.
- Loading and impaction.
- Incomplete bowel emptying.
- Inability to defecate.
- Neurological causes.
- Spinal causes.

7. Contra-indications to DRE, DS and DRF

Under **NO** circumstance should a nurse undertake a digital rectal examination or manual removal of faeces unless competent to do so.

- Nurses should not undertake DRE, DS or DRF when: -
- There is no consent from the patient – written, verbal or implied.
- The patient has recently undergone rectal / anal surgery or trauma.
- Abnormalities of the perineal and perianal area are present.
- Undiagnosed abnormalities of the perineum and perianal area are observed.
- The Patient gains sexual satisfaction from these procedures. Consultation with the patient's medical team should be sought and a risk assessment carried out by the nurse.
- The patient's medical team has not prescribed this intervention.
- Allergies including latex, soap, (lanolin), phosphate and peanut (in arachis oil enemas) exist.

Before performing DRE, DS or DRF, check for abnormalities of the perineal and perianal area and document and report. Check for the following:

- Rectal Prolapse – degree, ulceration.
- Haemorrhoids – number, position, grade and prolapse.
- Anal skin tags – number, position and condition.
- Wounds, dressings and discharge.
- Anal lesions (malignancy)
- Gaping anus
- Skin condition, broken areas, scarring and pressure ulcers of all grades.
- Bleeding and colour of the blood
- Faecal matter
- Infestation
- Foreign bodies
- Blood-colour
- Anal fissure
- Anal tone absent/reduced

Advice may need to be sought from the clinical nurse specialist or a medical practitioner in the presence of any of these abnormalities before undertaking a DRE, DS or DRF. However, if the nurse feels confident and is competent then the procedure may be carried out.

When to refer to a Medical Practitioner

- Accompanying abdominal pain or vomiting
- Blood and / or slime in the stool
- Change in normal bowel habit
- Diarrhoea alternates with constipation
- If any abnormality is felt upon digital rectal examination

Autonomic Dysreflexia in Spinal Cord Injury

Autonomic dysreflexia is a condition that develops after spinal cord injury in which potential life threatening episodic hypertension is triggered by stimulation of the sensory nerves below the site of the injury. AD can occur in patients with an injury usually above T-6. For treatment see appendix 4 and 5.

8. Special considerations

Ensure extra care / observations are under taken when performing DRE, Digital stimulation or digital removal of faeces on patients who have the following diseases or medical conditions:-

- Active inflammation of the bowel including Crohns disease, ulcerative colitis and diverticulitis
- Recent radiotherapy to the pelvic region
- Rectal / anal pain
- Recent surgery / trauma to the anal or rectal area
- Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment

- Obvious rectal bleeding
- If a patient has a known history of abuse
- In spinal injured patients because of autonomic dysreflexia (see risk management section)
- If patients have known allergies (see risk management section)
- If the patient is unconscious
- If the patient gains sexual gratification from the procedure

9.1 Consent

Consent is an important part of good clinical practice and is the legal means by which the patient gives a valid authorisation for treatment or care. Consent must be obtained from the patient before DRE and / or DRF is performed in accordance with local and national guidelines for consent including any issues relating to the patient's capacity to consent. (See Consent Policy).

Consent may be verbal, written or implied and should be recorded in the patient's records. Where digital rectal examination and / or digital removal are an ongoing package of care the patient must consent to the package of care and verbal consent gained and documented on each occasion in the patient's notes.
In the absence of informed consent, the procedure must not be carried out. If the patient changes their mind or becomes upset during the intervention, the procedure must be stopped. Without consent DRE, DS and DRF are unlawful.

9.2 Risk Management

- In some circumstances, conflict between the patient or carer and nurse over the need for manual evacuation of faeces can create difficulties. Early consultation with the multidisciplinary team with the inclusion of the patient or carer is advised.

- If performed inappropriately DRE, DS and DRF can cause damage to the anal and rectal mucosa, while poor technique may cause stretching of the anal sphincter, potentially resulting in faecal incontinence.

- The risks involved in the use of latex based products must be recognised and steps taken to eradicate risk.

- Be aware of the contra-indications to the use of Instillagel. Nurses should read the warning and undesirable effects detailed in the manufacturers literature before using Instillagel for DRE or DRF.

- Autonomic dysreflexia (AD) is a syndrome unique to people with spinal cord injury (SCI). Never change patients who have been discharged from spinal injury unit's bowel care regime without first consulting the individual's spinal injury unit to ensure that other methods of evacuation are suitable.

9.3 Untoward Incidents

Report any untoward incident, which arises during DRE or DRF, on the Trust's incident reporting system, which should then be forwarded to the line manager.

Line managers will ensure that remedial action is taken and that learning points and opportunities are fed back to staff.

10. Equality

The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality initial screening toolkit, the results of which are monitored centrally.

11.Education and Training

Ensure training and competence has been gained prior to undertaking DRE or digital removal of faeces. It is the nurse's responsibility to inform their manager if they are not competent to carry out the procedure.

Before undertaking DRE, DS or DRF nurses require suitable training and instruction in the following areas: -

- Understanding of the anatomy of the rectum, anus, sigmoid colon, perianal skin and lower pelvic muscles associated with defecation.
- Physiology of defecation and ability to identify different stool types.
- Recognition of perianal conditions e.g. haemorrhoids, anal skin tags, fissures, fistula and perianal Crohns disease.
- Identification and common causes of constipation, irritable bowel syndrome, diverticulitis, Crohns disease and ulcerative colitis.
- Various treatment options for constipation.
- Planning nursing care to prevent and treat constipation.
- Indications for DRE and digital removal of faeces.
- Exclusions and contra indications for DRE and manual evacuation of faeces.
- Issues of consent.
- Symptoms and management principles of autonomic dysreflexia.

A period of consolidation of practice will be necessary following attendance at the training course. A senior nurse who is competent in the procedure should witness nurses who are performing the procedure on at least three occasions whilst undergoing their period of consolidation following DRE, DS and DRF training. Failure of a nurse to achieve the required competency should be highlighted to the team leader so that further support can be given. (Competencies and training programme outlined in Appendix 7)

Registered staff who are new to the Trust and have been performing the skill elsewhere must familiarise themselves with the Trust's policy and standards of care.

Evidence of previous education and training will be required.

12. Advice to Patients and Carers

An understanding of health education issues regarding bowel function is necessary to enable the skilled nurse to provide accurate and relevant health education to patients and carers.

Patients and carers may need a great deal of support and educational input in the early days to enhance their independence and self-care. If this technique is required as part of a holistic package of care and a carer is required to carry out the technique with the consent of the patient then the named nurse takes on full responsibility and onus for that training.

To be included:

- A planned teaching programme with written competencies and material, which can be referred to at home, with regular evaluation of that care package from the named nurse, reviewing and addressing any competencies.

- In order to reduce anxiety and promote acceptance of any bowel care regime, careful explanation needs to be given to the patient / carer. Ensure this is documented in the patient's notes.

- Explain to the patient the procedure and why it is necessary, in addition to an explanation of what to expect during and after the procedure.

- Ensure the patient is given health promotional advice with regard to preventing constipation. This relies on a simple strategy of eating a well-balanced, high fibre diet, a high fluid intake and by encouraging physical activity, as able.

13. References

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15. Appendices

Appendix 1

DRE Procedure

Equipment Used
Water-soluble lubricant
Commode or bedpan if required
Tissues
Disposable gloves
Disposable apron
Protective sheet
Waste receptacle (for Trust premises orange clinical waste bag if no clinical bin available)

ACTION	RATIONALE
Explain and discuss the procedure with the client	To gain the clients consent and co-operation. The client must have been given sufficient information about any risk involved to either consent or refuse. Check for allergies including latex, phosphate and peanut before continuing.
Document consent has been given. Discontinue procedure If consent is not given.	To show evidence that discussion has taken place. Consent must be given freely and voluntarily without coercion or manipulation.
Wash hands and put on apron	Refer to Infection Prevention Policy & Procedure. To minimize the risk of cross infection.
Allow the client to empty their bladder if necessary	To minimise discomfort during the procedure
Create a private environment	To ensure the clients dignity and help them to relax
Place a protective pad under the client and ensure all equipment is to hand	Protect patient's bed linen
Assist the client to a lying position (left lateral with knees perineal flexed, the upper slightly higher than the lower)	To obtain maximum view of the area and expose the anus
Observe perineal and perianal area. Document and report	Observe surrounding skin for any lesions, prolapse, infestation, gaping abnormalities anus, skin tags, haemorrhoids or foreign bodies
Put on a pair of non-sterile gloves, place water based lubricant on gloved index finger. Warn the client you are about to commence the procedure and ask them to relax	To facilitate easier insertion of index finger. To ensure the client is ready and relaxed
Insert a gloved lubricated index finger slowly and gently into the rectum, whilst encouraging the client to remain relaxed	To avoid trauma to anal mucosa and prevent forced over dilation of the anal sphincter
Carry out DRE	To assess for anal tone, faecal

	matter and the need for medication
After DRE remove excess lubricating jelly from the perineal area	To prevent soreness and irritation contamination
Ensure client is comfortable and offer toilet or commode	To ensure client is comfortable as DRE may stimulate a bowel action
Remove gloves and apron and dispose into appropriate waste receptacle. Wash hands.	To facilitate the appropriate disposal of waste. To minimise the risk of cross infection.
Record the finding in the notes	A legal requirement
Identify an action plan based on the findings. This should include: - What did you observe? What did you feel? Presence of Faecal matter. Anal tone. Nursing intervention as appropriate.	

RCN (2019)

Appendix 2

Digital removal of faeces (DRF)

DRF as an acute intervention

The procedure differs when used as part of a regular package of care. Two healthcare professionals are required to carry out this procedure due to the specific requirements of monitoring vital signs e.g. blood pressure and pulse both pre and during the procedure. Care assistants who are competent in the procedure of monitoring vital signs may be one of the healthcare personnel.

When undertaking DRF as an acute intervention, observe: -

- Pulse pre procedure
- Pulse during procedure
- Blood pressure in spinal injuries prior to, during, and at the end of the procedure
- Signs and symptoms of autonomic dysreflexia (AD), headache, flushing, and hypertension
- Distress, pain, discomfort
- Bleeding
- Collapse
- Stool consistency

Digital Removal of Faeces Procedure

Equipment

- Disposable gloves
- Water-soluble lubricant
- Disposable apron
- Commode or bedpan if required
- Protective sheet
- Tissues
- Blood pressure monitoring machine

- Waste receptacle (for Trust premises orange clinical waste bag if no clinical bin available)

ACTION	RATIONALE
Explain and discuss the procedure with the client. The patient should be invited to have an escort present if they wish. Explain that the nurse has to monitor the pulse and Blood pressure	To gain the clients consent and co- operation. The client must have been given sufficient information about any risk involved to either consent or refuse. Check for allergies including latex, phosphate and peanut before continuing. There is a risk of autonomic dysreflexia that needs to be monitored effectively.
Document consent has been given. Discontinue procedure If consent is not given.	To show evidence that discussion has taken place. Consent must be given freely and voluntarily without coercion or manipulation.
Wash hands and put on apron	Refer to Infection Prevention Policy & Procedure. To minimise the risk of cross infection.
Allow the client to empty their bladder if necessary	To minimise discomfort during the procedure
Create a private environment	To ensure the clients dignity and help them to relax
Place a protective pad under the client and ensure all equipment is to hand	Protect patient's bed linen
Take the patient's pulse at rest prior to the procedure	To obtain a baseline of the patient's condition prior to the procedure as vagal stimulation can slow the heart rate.
Take baseline blood pressure in ALL spinal injury patients	To observe for potential signs of autonomic dysreflexia
Assist the client to a lying position (left lateral with knees perineal flexed, the upper slightly higher than the lower)	To obtain maximum view of the area and expose the anus
Observe perineal and perianal area. Document and report any abnormalities	Observe surrounding skin for any lesions, prolapse, infestation, gaping abnormalities anus, skin tags, haemorrhoids or foreign bodies
Put on a pair of non-sterile gloves. Place water based lubricant on gloved index finger. Warn the client you are about to commence the procedure and ask them to relax	To facilitate easier insertion of index finger. To ensure the client is ready and relaxed
Insert a gloved lubricated index finger slowly and gently into the rectum, whilst encouraging the client to remain relaxed. Use one finger only	To avoid trauma to anal mucosa and prevent forced over dilation of the anal sphincter
Carry out DRE	To assess for anal tone, faecal matter and the need for medication
In scybala type stool (Bristol stool scale type 1) (Appendix 6) remove one lump at a time until no more faecal matter can be felt	To relieve patient's discomfort
In a solid faecal mass, push finger into the middle of the mass, split it and remove small pieces with hooked finger until no more faecal matter can be felt. If faecal mass is too hard or larger than 4 cm across and you are unable to break it up STOP and refer to medical team for digital removal of faeces under general anaesthetic	To relieve patient's discomfort To avoid considerable pain and trauma (anal sphincter damage) to the patient
Every 3-5 minutes, take the client's blood	To observe a possible rise in blood pressure

pressure whilst performing DRF	which may be a sign of autonomic dysreflexia
Encourage patients who receive this procedure on a REGULAR basis to have a period of rest to assist, if appropriate, with Valsalva manoeuvre. Patient and nurse education is required to safely use this manoeuvre. Extra lubrication may be required.	To allow further faecal matter to descend into the rectum. Correct breathing technique will prevent raised intra-cranial pressure. Use of the Valsalva manoeuvre in an upright position may result in increased hydrostatic pressure in perirectal blood vessels, thereby increasing the likelihood of haemorrhoids **NB** For some client's with spinal cord injury raising intra- abdominal pressure does not result in relaxation of the sphincter or excessive pressures may be required. Therefore the valsalva manoeuvre should be used with caution, and Its effects evaluated for each patient. Patients with injuries to the Cauda Equina have an absence of the reflex constricting response of the internal sphincter to the Valsalva manoeuvre and therefore unable to assist in this manoeuvre.
Observe the patient throughout the procedure: **STOP if anal area bleeding.** **STOP if client asks you to.** **STOP if there are signs of Autonomic dysreflexia** i.e. hypertension, pounding headache, sweating above level of injury, apprehension or anxiety, skin flushing above level of injury, blurred vision, bronchospasm, chills without fever. A typical resting blood pressure for quadriplegic clients is 90/60; even a BP of 120/80 could suggest dysreflexia	To note signs of distress, pain, bleeding and general discomfort.
Remove trigger factor, i.e. bowel procedure, sit the Client up, lower the legs If possible.	May allow a pooling of blood in the lower extremities and may reduce the blood pressure.
Check patients pulse **STOP if heart rate drops or rhythm changes significantly**	Vagal stimulation can slow heart rate and alter heart rhythm
After procedure remove excess lubricating jelly from the perineal area	To prevent soreness and irritation contamination
After the DRF procedure, record the blood pressure and pulse, and make the client comfortable	To record that the client's condition is stable before you leave them.
Remove gloves and apron and dispose into waste receptacle. Wash hands.	To facilitate the appropriate disposal of waste. To minimise the risk of cross infection.
NB As an ACUTE procedure, a local anaesthetic gel may be applied topically to the anal area. Read contra-indications, interactions of anesthetic gel you propose to use. **DO NOT apply if you have documented evidence of anal damage or bleeding**	To reduce sensation and discomfort for the patient, Lignocaine is the drug found in topical local anesthesia and is absorbed via the anal mucous Membrane. Lignocaine may cause anaphylaxis, hypotension, bradycardia or convulsions if applied to a damaged mucosa.
Document procedure & outcome	A legal requirement

RCN (2019)

Appendix 3

Digital Stimulation Procedure

Equipment

- Latex free disposable gloves
- Water-soluble lubricant
- Disposable apron
- Commode or bedpan if required
- Protective sheet
- Tissues
- Waste receptacle (for Trust premises orange clinical waste bag if no clinical bin available)

ACTION	RATIONALE
Explain and discuss the procedure with the client. The patient should be invited to have an escort present if they wish.	To gain the clients consent and co-operation. The client must have been given sufficient information about any risk involved to either consent or refuse. Check for allergies including latex, phosphate and peanut before continuing.
Document consent has been given. Discontinue procedure If consent is not given.	To show evidence that discussion has taken place. Consent must be given freely and voluntarily without coercion or manipulation.
Wash hands and put on apron	Refer to Infection Prevention Policy & Procedure. To minimise the risk of cross infection.
Allow the client to empty their bladder if necessary	To minimise discomfort during the procedure
Create a private environment	To ensure the clients dignity and help them to relax
Place a protective pad under the client and ensure all equipment is to hand	Protect patient's bed linen
Assist the client to a lying position (left lateral with knees perineal flexed, the upper slightly higher than the lower)	To obtain maximum view of the area and expose the anus
Observe perineal and perianal area. Document and report any abnormalities.	Observe surrounding skin for any lesions, prolapse, infestation, gaping abnormalities anus, skin tags, haemorrhoids or foreign bodies
Put on a pair of non-sterile gloves. Place water based lubricant on gloved index finger. Warn the client you are about to commence the procedure and ask them to relax	To facilitate easier insertion of index finger. To ensure the client is ready and relaxed
Gently insert the gloved lubricated index finger slowly and gently into the rectum, to second joint of finger only	To avoid trauma to anal mucosa and prevent forced over dilation of the anal sphincter
Slowly rotate the finger, maintaining contact with the rectal wall at all times	To stimulate the anal-sigmoid reflex
Rotate for one minute and remove finger. In	To prevent trauma / allow faeces to descend into

mobile patients, assist onto commode/ Toilet.	the rectum. To aid rectal emptying.
If necessary, repeat every 3-5 minutes for one minute each time.	To reassess / re-stimulate the anal / sigmoid reflex
Do not repeat more 5 times	To prevent trauma to the anal sphincter and rectal mucosa
Each time the finger is inserted into the rectum remove any stool that may be present by manual evacuation.	To allow further rectal filling.
Remove gloves and apron and dispose into an appropriate waste receptacle. Wash hands.	To facilitate the disposal of waste. To minimise the risk of cross infection.
Document procedure and outcome	A legal requirement

RCN (2019)

Appendix 4

Autonomic Dysreflexia

Definition

Autonomic Dysreflexia is a syndrome characterised by abrupt onset of excessively high blood pressure caused by uncontrolled sympathetic nervous system discharge in persons with spinal cord injury (SCI). Persons at risk of this syndrome generally have injury levels above T-6 (or rarely a low as T-8).
In other words, it can occur in all quadriplegics and in paraplegics who have loss of sensation at or above the lower rib cage.

When Does Dysreflexia Begin

The first episode of dysreflexia usually occurs four to six months after SCI, but may be as early as two months or as late as 10-12 years. Unfortunately, with the short hospital stays these days, many individuals will be discharged from hospital before the first episode. Even if they were told about dysreflexia in the hospital, they may not remember what they were told and do not recognise the symptoms.

How Often Does Dysreflexia Occur

The frequency varies, from several times a day to once in several years.
Some individuals seem to be very sensitive and every minor stimulus triggers dysreflexia. Others may only have dysreflexia with major stimulus such as a markedly over filled bladder. Since the first episode can occur many years after the onset of SCI, everyone with an injury at or above T-6 must be considered at risk, even if they have not yet had dysreflexia.

Symptoms

Symptoms may vary from one individual to another. The symptoms may start mild and gradually become more intense, or they may become very severe within the first one or two minutes.

Mild Dysreflexia:

- Sweating: The first sign is usually profuse sweating on the face and neck (that is, above the level of the injury.
- Mild Increase in Blood Pressure: (Up to 140/90). Since the typical resting blood pressure (BP) for quadriplegic clients is 90/60 (which is low normal);

even a BP of 120/80 could suggest Dysreflexia. Until the blood pressure reaches higher levels, the situation is not urgent, but it is important to try to identify and eliminate the cause before this happens.

Severe Dysreflexia – A Medical Emergency

- **Hypertension**. When the BP reaches 200/100 or higher, it should be considered. An emergency because the sudden change from low to very high blood pressure can lead to convulsions, stoke, haemorrhage, or even death. The BP can rise quickly during an episode of dysreflexia, so it is important to check the BP frequently, at least every 5-10 minutes until the cause has been found and eliminated.
- **Pounding Headache**. The headache is due to the sudden elevation of blood pressure; however, the severity of the headache is not necessarily related to the severity of the hypertension. A headache associated with normal blood pressure is not due to dysreflexia.
- **Heart Rate Changes**. The heart rate can either be very slow (bradycardia) or very fast (tachycardia) during episodes, so heart rate alone does not help to make a diagnosis.
- **Flushing of the Face and Neck**. (Above the level of SCI) associated with pale, cold skin on the trunk and extremities (below the SCI).
- **Less common symptoms** include nasal congestion, anxiety, nausea, blurred vision, difficulty breathing, increased spasticity, chest pain and piloerection (goose bumps). However, these symptoms alone do not suggest dysreflexia.

Precipitating Factors

In general, any noxious stimuli to areas of the body below the level of spinal injury. Things to consider include:

- Bladder (most common) – from overstretch or irritation of bladder wall
  - Urinary tract infection
  - Urinary retention
  - Blocked catheter
  - Overfilled collection bag
  - Non-compliance with intermittent catheterisation programme

- Bowel – over distension or irritation
  - Constipation / impaction
  - Distension during bowel programme (digital stimulation)
  - Haemorrhoids or anal fissures.
  - Infection or irritation (e.g. Appendicitis)

- Skin – related disorders
  - Any direct irritant below the level of the injury (e.g. prolonged pressure by object in shoe or chair, cut, bruise, abrasion.
  - Pressure sores
  - Ingrown toenails
  - Tight or restrictive clothing or pressure to skin from sitting on wrinkled clothing

- Sexual activity
    - Over stimulation during sexual activity (stimuli to the pelvic region which would ordinarily be painful if sensation were present.
    - Menstrual cramp

- Labour and delivery

- Other
    - Acute abdominal conditions (gastric ulcer, colitis, peritonitis)
    - Skeletal fractures

Responsibility

- Prior to discharge from the spinal unit, patients should be advised about the condition, symptoms, and self-management.

- The spinal unit should provide education information about the prevention and treatment of autonomic dysreflexia at the time of discharge that can be referred to in an emergency.

- During initial assessment the practitioner should assess the patient's knowledge regarding awareness / understanding of the condition and how to self-manage.

- Discuss autonomic dysreflexia during the individuals education programme, so that he or she will be able to minimise the risks known to precipitate AD, solve problems, recognise early onset, and obtain help as quickly as possible.

Treatment

- The overriding principle is to identify and remove the offending stimuli whenever possible. Often, this alone is successful in allowing the syndrome to subside without need for pharmacological intervention.

- Treatment of autonomic dysreflexia must be initiated quickly to prevent complications. If the precipitating cause of the autonomic dysreflexia episode is not determined call for an emergency assistance.

- If the patient is unable to self-manage, treat the hypertension whilst identifying
- the cause:

- Remove trigger factor e.g. stop bowel procedure.

- Check the individual's blood pressure a blood pressure elevation of 20 mm to 40 mm Hg above baseline may be a sign of autonomic dysreflexia.

- If blood pressure is elevated, immediately sit the person up if the individual is

in a supine position. Performing this manoeuvre may allow a pooling of the blood in the lower extremities and may reduce the blood pressure. If possible, in addition to sitting the person up, lower their legs as well.

- Loosen any clothing or constructive devices. Performing this manoeuvre may allow a pooling of blood in the abdomen and lower extremities and may reduce the blood pressure.

- Monitor the blood pressure and pulse frequently. Blood pressures have the potential of fluctuating quickly during an autonomic dysreflexia episode. Therefore, pressures need to be monitored every few minutes (every 2 to 5 minutes is commonly cited), until the individual is stabilised.

- Quickly survey the individual for the instigating causes, beginning with the urinary system. The most common cause of autonomic dysreflexia is bladder distension.

- If an indwelling urinary catheter is not in place, catheterise the individual.
- The most common cause of autonomic dysreflexia is bladder distension. Catheterisation can exacerbate autonomic dysreflexia therefore, it is vital to use Instilligel, which may decrease the sensory input and relax the sphincter to facilitate catheterisation.

- If the client has an indwelling urinary catheter, check the system along its entire length for kinks, folds, constriction, or obstruction and for correct placement. If a problem is found, correct it immediately.

- If the catheter is not draining and the blood pressure is elevated, remove and replace the catheter. Changing the catheter should be done as quickly as possible.

- In patients who tend to develop autonomic dysreflexia when catheter patency solution is instilled, catheter maintenance solutions are prohibited.

- Monitor the individual's blood pressure during bladder drainage. Sudden decompression of a large volume of urine would be expected to normalise blood pressure.

- If acute symptoms of autonomic dysreflexia persist, including a sustained elevated blood pressure, suspect faecal impaction. Faecal impaction is the second most common cause of autonomic dysreflexia.

- If faecal impaction is suspected and the elevated blood pressure is less than 150 mm Hg, check the rectum for stool. A rectal examination may exacerbate autonomic dysreflexia. Instillation of a local anaesthetic agent e.g. Instillagel, may decrease the occurrence of autonomic dysreflexia during the examination.

- Document the episode in the client's records, including:
  - Presenting signs and symptoms and their cause

- Treatment instituted.
- Recording of blood pressure and pulse.
- Response to treatment.

- Evaluate the effectiveness of the treatment according to the level of outcome criteria reach:
  - Cause of the episode has been identified
  - Blood pressure has been restored to normal limits for the individual.
  - Pulse rate has been restored to normal limits.

The individual is comfortable, with no signs or symptoms of autonomic dysreflexia.

An education plan has been completed and included preventive and emergency management guidance.

Recommendations

Anyone who has a spinal cord injury at or above level T-6 should:

- Understand the signs, symptoms, causes, and treatment of dysreflexia.
- Have equipment for taking blood pressure available and know how to use it.
- Keep prescribed pharmacological agent on hand for emergencies, particularly if the patient is away from home.
- Keep a 'Medical Alert' bracelet / necklace with patient at all times, especially when away from home.
- Be sure that all of their regular physicians have information about dysreflexia.

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Appendix 5

Flow Chart for Professionals
Autonomic Dysreflexia

Autonomic dysreflexia is a potentially life-threatening condition that occurs in individuals with a spinal cord injury (SCI) at level T6 or above.

Common Signs and Symptoms:
Hypertention. Pounding headache. Bronchospasm. Blurred vision.
Chills without fever. Sweating above level of injury.
Apprehension or anxiety. Skin flushing above level of injury

Follow flow chart to eliminate any noxious stimuli below level of injury. A drop in blood pressure will occur with the removal of the stimuli

Sit patient up and take blood pressure in both arms (repeat blood pressure every 3 minutes and between steps.
Important note – Normal systolic BP for an individual with SCI above T6 can be in the 90-110mm Hg range.

Call for assistance

Look for Noxious Stimuli below level of injury

Check Bladder for Distention
Catheterise bladder using Instilagel. If indwelling catheter already in place, inspect for kinks, folds, constriction or obstruction. Replace catheter to insure patency.
Collect urine sample and send for C&S (irritation may be due to infection)

Check Bowel
Check for constipation. Remove constipated stool and recheck blood pressure.
Evaluate for high impaction.

Check Skin
Remove constricting clothing.

Gender specific
Males: Genitalia pinched – correct
Sheath too tight – remove
Females: Menstrual cramping – treat
Vaginitis - treat symptoms and infection

Appendix

THE BRISTOL STOOL FORM SCALE

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

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Appendix 7

Competence No 1: Digital Rectal Examination/Digital Removal Of Faeces (DRE/DRF)

				Practice Assessor
Outcome performance criteria	Evidence Methods	Practitioner Signature	Comments	Signature & date
Able to demonstrate proficiency in DRE /DRF in accordance with Trust policies and associated clinical guidelines. (Complete Trust Training Programme) To include:				
a.	Understanding of the issues surrounding DRE/DRF and implications for practice, including: 1 Accountability 2 Informed consent 3 Reasons for procedure 4 Documentation and communication			
b.	Identify and discuss reasons for DRE, including 1 Failed bowel techniques 2 Faecal impaction 3 Incomplete defaecation 4 Inability to defaecate 5 Neurogenic bowel dysfunction 6 Spinal injury			
c.	Demonstrate good knowledge of simple anatomy of the gastro-intestinal tract, including: 1 Structure and function 2 Common disorders 3 Mechanics of defaecation			
d.	Discuss significance of the gastro-colic reflex and normal bowel function			
e.	Demonstrate the skills to complete a bowel assessment			

f.	Recognise the symptoms associated with autonomic dysreflexia in patients with spinal injury and discuss the appropriate action			
g.	Demonstrate safe proficiency in the correct procedure for; 1 DRE 2 DRF (In accordance with Trust policy, clinical best practice guidelines and your own sphere of professional accountability)			
h.	Identify and discuss potential abnormalities that may be observed prior to DRE, including: 1 Rectal prolapse 2 Haemorrhoids/skin tags 3 Bleeding 4 Infestation 5 Gaping anus			
i.	Discuss circumstances when precautionary measures would be taken, including: 1 Bleeding 2 Abuse 3 Allergies 4 Spinal injury patients 5 Tissue fragility 6 Radiotherapy 7 Inflammation 8 Pain			
j.	Identify the appropriate use of medication, suppositories and enemas to support the procedure			
k.	Discuss the significance of stool assessment (relate to Bristol Stool Scoring Tool), including: 1 Frequency/amount 2 Consistency 3 Colour			

l.	Demonstrate safe proficiency in the correct procedure for digital stimulation in accordance with Trust policy and clinical guidelines			
m.	Competently complete appropriate documentation and communicate findings.			

Commenced……. Completed…….

Appendix 8

Adult Continence Assessment Tool.doc