Brighton and Sussex University Hospitals NHS Trust

Affix patient label or enter details:

Trust ID No.:

Surname (BLOCK LETTERS):

First name:

D.O.B.:

CORE CARE PLAN:
AREFLEXIC (FLACCID) BOWEL REGIME

PROBLEM: ..... has sustained a Spinal Cord Injury at level_____ resulting in a flaccid (Areflexic) bowel and requires an individualised flaccid bowel management programme.

Injuries to the first lumbar vertebra (LI) and below result in a flaccid bowel with a lax anal sphincter and pelvic floor. They will have a loss of sensation and control over defecation. They have a potential to develop constipation, diarrhoea, autonomic dysreflexia, incontinence and skin damage.

GOAL: To achieve regular and predictable emptying of the bowel:

- To prevent autonomic dysreflexia
- Minimise incontinence and constipation
- Maintain skin integrity
- Promote dignity and independence.
- Achieve regular and predictable emptying of the bowel at an acceptable time and place
- **To aim for Bristol Stool scale 3 stool.**

ACTIONS (Circle appropriate actions)	AMENDMENTS (Date/Signature)
Nurses performing bowel care will have completed the Neurogenic Bowel competency and or had relevant training. If the competency has yet to be completed a nurse can be assessed by a senior nurse to ensure competency at point of care. Discuss with patient and medical team regarding the necessary frequency of bowel care, either daily or twice daily at a regular time: ➢ Date Bowel regime commenced: ..... ➢ Once Daily/ Twice Daily (Please circle) ➢ Time..... Please fill out Bumble Bee sign to express agreed time of care.	
Review fluid balance chart and Nutritional Intake Chart prior to intervention.	
Explain the procedure to the patient and obtain consent. Ask the patient if they would like a chaperone. Maintain patient's privacy and dignity at all times.	
Ensure regular oral aperients are prescribed for a **Bristol stool scale 3 consistency.**	
Administer stimulant laxatives 8-12 hours before planned bowel care. ➢ Agreed time to deliver stimulant Laxatives.....	
Offer the patient hot drink and/or food 20-30 minutes prior to performing bowel care to support gastrocolic reflex.	
Gain informed consent from patient prior to carrying out the procedure. Prepare patient for procedure ensuring appropriate equipment available and to hand.	
The patient should be provided the option with where they would like to open their bowels. Seated on a commode is optimal. If this is not suitable the patient should be lying in a left lateral position where possible.	
If it is the first time the procedure has been performed and the patient suffers symptoms of autonomic dysreflexia then local anaesthetic gel can be instilled in the rectum before beginning the procedure-this takes 5-10mins to take effect (Long term use should be avoided).	
Observe the patient throughout the procedure for signs of autonomic dysreflexia including headache, flushing, sweating, nasal obstruction, blotchiness above the lesion and hypertension. Cease care if these symptoms are observed and perform full set of observations, contact Doctor and commence Autonomic Dysreflexia care plan.	

If patient develops a rapid onset of severe headache then procedure should be stopped, medical assessment undertaken and should be treated promptly

Procedure

Explain to Patient what is happening throughout procedure.

Lubricate a double gloved finger with water soluble gel and insert a single finger gently into the rectum and assess contents.

Turn the finger so that the padded surface is in contact with the bowel wall.

Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.

Use digital removal of faeces/manual evacuation if stool is present in the rectum:

- If stool is a solid mass, push finger into centre, split it and remove in small sections until no stool remains.
- If stool is in small separate lumps remove a lump at a time. Do **not** overstretch the sphincters by using a hooked finger.

If the stool is hard & impacted further aperients may be required in combination with digital removal of faeces/manual evacuation. Please speak with the appropriate Doctor.

If the stool is soft then continuous gentle circling of the finger may be used to remove stool.

Once rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure evacuation is complete.

Record and report any abnormalities.

Undertake procedure at **same time every day.**

Daily Documentation must include:

- If care plan adhered to.
- Aperients administered.
- Interventions
- Fluid & Nutrition status

Please refer to the bowel management and on-going assessment care plan.

Name of Nurse generating Care plan:	**Date:**
Name of Nurse reviewing care plan (normally between 7-10 days):	**Date:**

Evidence: Management of lower bowel dysfunction, including DRE and DRF. *RCN guidance for nurses.*2012
Spinal Injury Association-online
Evaluation of a Bowel and Bladder Health Management Program for Individuals With Spinal Cord Injury (SCI) Meade MA ClinicalTrials.gov 2016;:NCT01920243.

Please document any changes to the care plan and provide rationale: