Brighton and Sussex NHS
University Hospitals
NHS Trust

*Affix patient label or enter details:*

Trust ID No.:

Surname (BLOCK LETTERS):

First name:

D.O.B.:

**CORE CARE PLAN:**
REFLEX BOWEL MANAGEMENT

**Date care plan generated:**

**PROBLEM:** ..... has sustained a Spinal Cord Injury at level.....resulting in a Reflex bowel And requires an individualised reflex bowel management programme.

Injuries to the twelfth thoracic vertebra (T12) and above result in what is known as a 'reflex bowel'. Injuries at this level result in damage to upper motor neurons (lying within the spinal cord) leaving the reflex arc from the cord to the colon and ano-rectum intact therefore the patient will have a positive anal reflex 'anal wink', positive bulbo-anal reflex

They may have a loss of sensation and control over defecation. They have a potential to develop constipation, diarrhoea, autonomic dysreflexia (only for injuries T6 and above, and rarely extending to T12), incontinence and skin damage.

If the patient is suspected to have or is confirmed to have Autonomic dysreflexia please generate the autonomic dysreflexia care plan.

**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 4 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.<br>Discuss with patient and medical team regarding the necessary frequency of bowel care, either daily or alternate days.<br>**Please circle**: Daily / Alternate Days<br>Date Bowel regime commenced:..... | |
| 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 Bristol stool scale type 4 consistency.<br>Please document prescribed Medications, frequency and dose within the SCI bowel management daily assessment form. | |
| Administer stimulant laxatives 8-12 hours before planned bowel care (Administering laxatives any other time is likely to result in faecal leakage).<br>Agreed time of Planned bowel Care..... (Ensure same time each day).<br>Trial making the most of gastrocolic reflex which is at its strongest 15 -30mins minutes after eating breakfast normally and may be retained post injury, but can be triggered at any time of day following eating and drinking.<br>Agreed time to deliver stimulant Laxatives..... | |
| Offer the patient hot drink and/or food 20-30 minutes prior to performing bowel care (In order to trigger gastrocolic reflex (Harari 2004). | |
| The patient should be provided the option with where they would like to open their bowels. Seated on a toilet or commode is optimal. If this is not suitable the patient should be lying in a left lateral position where possible. | |
| Gain informed consent from patient prior to carrying out the procedure. | |
| Prepare patient for procedure ensuring appropriate equipment available. | |
| If it is the first time the procedure has been performed and the patient suffers local discomfort or 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.

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.
- If the rectum has faeces present suppository/ enema use is required, withdraw finger.

**Give suppositories if indicated**:

- Insert rectal stimulant: Suppositories / enema (Please circle)
- Allow at least 20 minutes for the rectal stimulant to work.
- Carry out abdominal massage with back or heel of hand during procedure to encourage peristalsis.

**If no bowel action observed digital rectal stimulation is required.**

**Procedure for Digital Rectal Stimulation:**

- Lubricate double gloved finger with water soluble gel and insert a single finger gently into the rectum.
- Turn the finger so that the padded surface is in contact with the rectal wall.
- Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the rectal wall throughout until relaxation of the external sphincter is felt, flatus or stool passed or the internal sphincter contracts ( indicative of colonic activity
- Withdraw finger and await reflex evacuation)
- Repeat every five to ten minutes until rectum is empty or reflex activity ceases.

**If no activity occurs, repeat up to but no more than 3 times.** Replace soiled glove between insertions.

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.

**Upon inspection of rectum:**

**Hard Stool**: If stool is hard & impacted further aperients may be required in combination with digital removal of faeces/manual evacuation.

**Soft stool:** 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.

Review oral aperients to achieve Bristol Scale 4

Record and report any abnormalities and number of rectal stimulations required. Undertake procedure at **same time every day.**

Daily Documentation must include:

- If care plan adhered to.
- Aperients administered.
- Interventions
- Fluid & Nutrition status
- Please use bowel assessment chart.

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

| **Signature of Nurse generating care plan:** | **Date:** |
|---|---|
| **Signature of Nurse reviewing the care plan:** | **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.