Digital rectal examination

Guidance for nurses working with children and young people
**Background**

Following the guidance document, *Digital rectal examination and manual removal of faeces*, first published by the Royal College of Nursing in 2000, (RCN, 2003a) it became clear that there was a need to develop specific guidance for nurses working with children and young people on these issues. As there is little published research or evidence about this practice, this document has been developed from a consensus of expert opinion.

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Introduction

Many nurses are concerned about the professional and legal aspects of digital rectal examination (DRE) and the manual removal of faeces. In children and young people, these invasive procedures usually do not form part of the routine assessment, treatment and management of bowel problems. However, for a limited number of children and young people, particularly those with spinal injuries, these procedures will form an important component of their bowel management routine.

Nurses may be faced with requests for inappropriate bowel care from many sources, including parents or medical colleagues. Clearly, issues of clinical judgement are involved and nurses must feel confident to challenge and, where necessary, refuse to carry out inappropriate interventions where safer alternatives are available. The onus is on health care professionals to identify their training needs and for employers to meet them.

As a matter of urgency, trusts should identify a strategy to ensure that children and young people receive care and treatment from nurses who have undertaken specific training (RCN, 2003b; DH, 2003). Non-registered children’s nurses who are currently providing care to children and young people must do so only under the direct supervision of a registered children’s nurse on part 8 or 15 of the Nursing and Midwifery Council’s register (NMC, 1997).

This guidance sets out the professional and legal background against which all nurses are required to act, giving some examples of legal issues that may arise in this procedure. Further, it looks in detail at the importance of listening to and involving the child or young person in obtaining informed consent. Finally, it answers some important questions about the procedures.
Consent

Consent is an important and necessary element of clinical practice. Striving to maintain trust and dignity between the nurse and patient, however young, is an accepted aspect of your professional role. Obtaining the child or young person's consent for care and treatment, whenever possible, affirms their right to self-determination.

Gaining consent should be seen as a continuous process and not just a one-off signature. It should be applied to all clinical procedures and examinations that involve touching. However, this does not necessarily mean obtaining more signed consent forms; rather it should be about increasing communication between the individual and the professional (DH, 2001a,b,c).

Consent is also the legal means by which the patient gives valid authorisation for their treatment and care. As a nurse, you have a duty not to carry out nursing care or treatment that involves physical contact with a patient’s body, unless consent has been given. If you do not have consent, then the touching of the child or young person’s body will not be lawful and the family could sue you or your employer for compensation, even if no harm occurred. For example, if you carried out a rectal examination on a child without appropriate consent, your action would not be lawful and you could face litigation, even though the outcome was beneficial to the health of the child.

Ensuring that consent is lawful

Case law on consent has established three requirements that must be satisfied before consent given by a patient is deemed lawful and these are:

1. Consent should be given by someone with the mental ability to do so
2. Sufficient information should be given to the patient
3. Consent must be given freely.

Now we will look in more detail at what these requirements mean in practice.

1 MENTAL ABILITY

Adolescents aged between 16 and 18 are presumed to be competent to consent to treatment as if they were adults, with their rights set out under the provisions of section 8 (1) Family Law Reform Act 1969. However, you should bear in mind that if they withhold their consent, their parents or the court may override their decision. Young adults aged 16 or more who do not have the mental ability to make their own choices will not be able to consent to treatment or care.

Children and young people who are less than 16 years old are not necessarily without the right of consent. The Gillick case examined the right to choose for people aged below 16. The House of Lords decided that it would be unrealistic to deny this group any legal ability to consent by reference to age alone. The judgment reflected the fact that many young people aged less than 16 have the intelligence and maturity to make clinical decisions on their own behalf. This ruling has been incorporated into the Children’s Act 1989 and into section 2 (4) of Age of Legal Capacity (Scotland) Act 1991.

The expert panel responsible for preparation of these guidelines recommends that no child aged under 18 should be forced to undergo DRE or manual evacuation of faeces, even if technically their legal guardian can override their refusal.

2 SUFFICIENT INFORMATION

The law says that if you are proposing to carry out treatment, you must provide the patient with information that includes the material risks, any alternatives, and the nature and likely consequences of the procedure.

In order to give rational consent, the child or young person needs information about what they will experience and how the intervention might help them. These requirements determine the minimum information the child or young person needs in order to give their informed consent. Initially, the nurse should:

✦ inform the child or young person what will happen if nothing is done
✦ describe the procedure or intervention
✦ explain how the proposed intervention will improve the situation.
From this the next natural step is to obtain consent. The child or young person is then asked whether they agree that the proposed intervention will produce a better outcome than doing nothing. Only now should the child or young person's consent to proceed be sought. (Foreman, 1999)

There is no duty imposed by law to inform the patient of every likely risk or advantage in the proposed treatment. The courts consider that the extent of what to tell a patient is within a nurse’s discretion. If questions are asked, they should be answered truthfully, but again the amount of information specified is the decision of the health professional. However, if you choose to withhold information, you must be able to justify your decision.

3 CONSENT MUST BE GIVEN FREELY

Documenting consent
Consent may be given verbally, in writing by the parent or legal guardian, or by implication through the child’s co-operation with the procedure. There should be documented evidence that informed consent has been obtained. Nurses should ensure that details about the process of gaining consent are recorded in the care plan of the child or young person. This should include who was present, what information was provided and whether it was given verbally, in writing or both.

Although a signed consent form does not necessarily prove that informed consent was obtained, it is usually considered to be good evidence that a discussion took place.

Emergencies
Generally speaking, consent is not required in an emergency situation where a patient is unable to give it, for example, if they are unconscious or mentally incompetent. However, if a patient previously, when competent, withheld their consent to a particular procedure, their decision should be respected, even if the condition poses a threat to their life. In the case of children and young people, the law allows the parents or the court to overrule their withholding of consent and they may be treated, even if they have previously said no. In practice, while significant treatment intervention – including DRE and manual evacuation – may take place in an emergency, these procedures are highly unlikely to be an issue.
Carrying out DRE and manual evacuation in children

This section answers some common questions about performing these procedures.

Who should perform these procedures?

Under no circumstances should either procedure be carried out in routine clinical practice. Instead, only specialist practitioners should perform them in exceptional circumstances. To be able to undertake these procedures, a qualified nurse or health professional should be able to demonstrate their professional skill, knowledge and competence to a level determined by their professional body. Where appropriate, they may delegate these procedures to either the parents or the child or young person themselves, ensuring their competence is assessed and reviewed as necessary.

You should be aware that if you fail to carry out your tasks competently or appropriately – for example, using undue restraint where a child or young person refuses consent – you may be forced to explain your actions. This may apply even if the child or young person concerned suffers no physical harm and legal negligence cannot be established.

Your contract of employment should state that you should competently perform the professional duties associated with your role, in accordance with the employer’s policies and procedures. In addition, your job description should ensure that your employer has specific policies and procedures in place for DRE and manual evacuation of faeces. It should also specify that you will receive any training necessary in order to be able to perform these procedures to the standard required.

What are the sensitivities surrounding these procedures?

Generally speaking, both DRE and manual evacuation are best avoided in children.

Research shows that very young children may perceive unexplained treatment as an assault. This may be more damaging than the disease the treatment is intended to treat (Alderson and Montgomery, 1996). There may also be physical trauma if the child is already experiencing painful defecation. Bearing in mind the potential risk of abuse, care should be taken to avoid conditioning the child to accepting rectal interventions as the norm.

Treatment, such as administering enemas, should not be carried out in collusion with the parent or carer, without the child’s prior knowledge. In some circumstances, conflict between the child or carers and nurse over the need for DRE and manual evacuation of faeces can create difficulties. In these circumstances, multidisciplinary consultation with your colleagues is advised.

We recommend that a nurse undertaking either procedure ensures that another adult is present, for example, the child’s parent or guardian. This is an important child protection safeguard and will help to support and comfort the child (RCN, 2003c).

Finally, you should take into account any cultural and religious beliefs before performing either procedure.

When should a nurse perform a DRE?

DRE is an invasive procedure and should only be used for infants and children as part of a medically prescribed treatment programme. Examples of where it might be necessary include: children with imperforate anus, anal stenosis, anal dilatation, ano rectal manometry, or as part of an investigation into medical problems, for instance, Hirschsprung’s disease.

Nurse specialists and nurse practitioners whose roles are expanding may participate in additional areas of
care that sometimes involve undertaking DRE. The procedure may be used for a variety of reasons, including:

✦ during anorectal physiology studies
✦ placing a rectal probe or sensor before undertaking a urodynamic study or to assess muscle strength, for example, a manometric device
✦ placing a probe to electrically stimulate the pelvic muscles
✦ placing catheters used in the treatment of anismus or constipation.

**When should a manual evacuation be undertaken?**

In usual circumstances, this should only be performed when all other measures have failed and under a general anaesthetic. With a wider range of bowel emptying techniques now available, the need to use manual evacuation of faeces is sometimes questioned. However, for a rare number of children, including those with spinal injuries, this may be the only suitable technique. These patients are used to managing their bowels in this way and this is a necessary procedure for nurses who care for them.

**In what circumstances should a nurse not carry out these procedures?**

There are several situations in which nurses should not carry out these procedures, for example:

✦ when the patient’s doctor has given specific instructions that these procedures are not to take place
✦ if the patient has recently undergone rectal or anal surgery or trauma
✦ if the patient gains sexual satisfaction from these procedures and the nurse performing them finds this embarrassing. In this case, consultation with a doctor is advised, involving the patient. You may wish to consider the need for a chaperone.

In incidences where there is a lack of consent from the patient – whether written, verbal or implied – issues of restraint need to be considered (RCN, 2003d). If a child has to be held during the procedure, then you should ensure that local policies are followed.

Finally, it is vital to check for allergies, including those to latex, soap, lanolin, phosphate and peanuts – present in an arachas oil enema – before going ahead with either procedure.

**How should the procedures be performed?**

To keep discomfort to a minimum, if circumstances allow, ask the child to lie on their left side. Use play or distraction techniques to divert the child’s attention. Depending on the age and size of the child, the nurse should use only their lubricated little finger.

**What should a nurse look for?**

In terms of child protection, observation of the perineal and perianal area could form part of a child’s initial assessment, where appropriate. You may wish to check for evidence of the following:

✦ anal fissure
✦ worm infestation
✦ inflammation or excoriation
✦ infection
✦ rectal prolapse, for example, the degree and any ulceration
✦ haemorrhoids, including their number, position, grade and any prolapse
✦ anal skin tags and their number, position and condition
✦ wounds, dressings and any discharge
✦ anal lesions, for example, Crohn’s disease
✦ gaping anus
✦ skin conditions, broken areas and pressure sores of all grades
✦ any bleeding and the colour of the blood
✦ faecal matter
✦ foreign bodies.
Further, in the unusual circumstances where manual evacuation of faeces is performed as an intervention, nurses should be careful to observe:

✦ the patient’s pulse at rest prior to the procedure and during
✦ any distress, pain or discomfort
✦ any bleeding
✦ the stool consistency
✦ any collapse.

**In what circumstances is extra care required?**

You should exercise particular caution when performing DRE, manual evacuation or the administration of medication with patients who have the following diseases and conditions:

✦ active inflammation of the bowel, including Crohn’s disease, ulcerative colitis and diverticulitis
✦ recent radiotherapy to the pelvic area
✦ rectal or anal pain
✦ rectal surgery or trauma to the anal or rectal area
✦ tissue fragility due to radiation, loss of muscle tone in neurological diseases or malnourishment
✦ obvious rectal bleeding
✦ a known history of abuse
✦ spinal injury through autonomic dysreflexia
✦ a known history of allergies
✦ learning disabilities or other vulnerabilities.

**What kind of medications can a nurse prescribe?**

Some health visitors, district nurses and community children's nurses are now registered with the NMC as eligible to prescribe independently from a nurse formulary. This includes a limited range of products to alleviate constipation. Additionally, medication that is administered rectally by a nurse or carer may be prescribed. This may include drugs used in the treatment of epilepsy and asthma, and painkillers.

The introduction of group protocols allows the supply and administration of prescription-only medicines by nurses, without the need for a prescription from a medical practitioner (RCN, 2002). However, before a laxative is prescribed for a child or young person under the age of 16, the formulary states that the prescribing nurse should discuss the issue with a doctor. In addition, the child’s parents should be consulted.

When assessing a patient for the first time, you should discuss your findings with the child’s doctor to inform the diagnosis and agree on the necessary medication. You can then prescribe, obtain and administer the medication. Once a medical diagnosis has been established and a nursing assessment taken place, including a review of the need for intervention, you may prescribe, obtain and administer a further supply of the rectal medication if required.

An enema or suppository to help manage constipation should only be administered in exceptional circumstances or if the oral route has failed to facilitate evacuation. Where possible, consent from the child or young person should be obtained (see section on consent for more information).

Finally, even if you are not currently able to prescribe, the RCN believes all nurses administering medicines as part of their practice should understand the drugs they use.
References and further reading


The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

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