The development of an accredited bowel-management course

Courses are free to the organisation’s staff. The CCHCS has proven successful in ensuring that clinical education can be developed and provided swiftly once a service-led learning need has been identified.

All the units (courses) it develops are taught in Chichester and these become part of the PIMHS undergraduate framework. If they wish, staff can register with the university and use CCHCS courses to accumulate academic credits that they can put towards either a diploma or degree.

The philosophy of the course Its philosophy is that the patient is central to practice, and the title of the course, Patient-Centred Bowel Management, reflects this ethos. For each course a patient with a neurological disease is invited to speak about his or her experiences of bowel management. This part of the course is always extremely well evaluated and links the theory directly to the experiences of the patient on the receiving end of health professionals’ care. Although this course is predominantly accessed by community staff, and hospital and hospice nurses, it is able to cater for non-nursing health professionals. Recently, a radiographer successfully completed the course.

The structure of the course The course management team decided that the bowel course should be short to alleviate the problems of staff having to be released from practice to study. The course comprises two days of classroom-based learning (Table 2). There is a break of one month between the last day of the course and the day of the exam. This allows students to broaden their knowledge of bowel management and consolidate what they have learned in a practice setting.

Course evaluation and the impact on practice The course was validated and approved by the University of Portsmouth in July 2002. Since then five courses have been run. Currently, from the four courses that have ended, 45 students have completed them and 39 have passed the examination – an 87 per cent pass rate. Five of the six who did not pass chose not to complete the exam, while one failed. This adjusts the pass rate to 97 per cent.

The pie chart in Fig 1 provides a breakdown of numbers of students by employer who have attended the course. Most nurses who have attended are either from the local PCT or from neighbouring ones. The reasons why community nurses are keen to attend the course may be that bowel care forms a large part of their role and that they work and make decisions in isolation.

Three nurses stated in their course evaluation that bowel training should be mandatory before nurses are competent, staff are required to update their knowledge and competence is checked through annual peer reviews.

It was envisaged that the bowel course would be available not only to The Royal West Sussex NHS Trust staff, but also to staff in the local primary care trust and hospice. This raised dilemmas about assessing competence, as the quality assurance structures and policies within each of these organisations are different. This begged the question of how to ensure that competence could be equitably monitored for validity and reliability across the whole local health economy.

An accredited course was developed that tested competence by examination (Table 1). The examination is designed to test:

- Knowledge of relevant anatomy and physiology;
- Pharmacological knowledge;
- History taking;
- Assessment;
- Decision making;
- Patient management;
- Clinical intervention skills.

Designing and accrediting the course Designing and accrediting service-led education locally was remarkably easy due to a tripartite organisation, the CCHCS, already mentioned, which comprises The Royal West Sussex NHS Trust, Western Sussex Primary Care Trust and St Wilfrid’s Hospice in Sussex. The CCHCS is an accredited Centre of the Postgraduate Institute of Medicine Health and Social Care (PIMHS), which is a faculty of the University of Portsmouth. All CCHCS
Bowel management – particularly digital rectal examination (DRE) and the manual removal of faeces – has been a contentious issue for some time. In the past few years this has been brought to the fore by a number of cases of professional misconduct by nurses.

One such incident involved a patient who had a phosphate enema administered without his consent while he was asleep (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1992). Willis (2000) discusses a case heard by the UKCC Professional Conduct Committee in 1998 that involved a nurse performing manual evacuations on vulnerable patients without their prior consent. Another case involved a nurse who inserted a soiled gloved finger into a patient’s vagina while performing a manual evacuation. As well as this, she was also found to have inserted an enema into another patient’s vagina and performed manual evacuations on patients while they were standing (UKCC, 2001). These nurses were removed from the register, but the cases sent reverberations throughout NHS trusts and in some instances nurses were informed that they were no longer allowed to perform manual evacuations of faeces (Willis, 2000).

The need for bowel-management training

Manual evacuation is the only practicable solution for bowel management for some patients. It may also sometimes be patients’ preferred method of bowel management. In light of these high-profile professional conduct cases, and the resultant implications for some patients’ bowel care, the RCN was prompted to produce guidance for nurses who carry out DRE and the manual removal of faeces (RCN, 2000). The guidance states that employers should ensure nurses are adequately trained in these procedures so they are confident and competent to provide appropriate bowel care.

Irwin (2002) stipulates that nurses should question their knowledge of anatomy and physiology of the lower gastrointestinal tract, as well as the underlying principles of defecation, because without this knowledge it is not possible for nurses to differentiate between normal and abnormal anatomy and physiology.

Addison (2002) argues that there is a need for ‘nurses to improve the evidence base for bowel care to support practice. Contingency assessment forms need to address bladder and bowel problems equally. We need to develop training for bowel care to ensure that competent practitioners are available’.

The skills required to perform DRE, the administration of enemas and suppositories, and, in certain circumstances, the manual evacuation of faeces, have historically been learned informally in practice (Willis, 2000). Willis argues that this approach to bowel management fosters attitudes of complacency that can lead to vulnerable patients being unintentionally abused.

Koch and Hudson (2000) undertook a limited pilot case study into laxative use among older people. Their literature review revealed concerns about the quality of patient assessment that has led, in their view, to over-prescription and reliance on laxatives. Koch and Hudson (2000) suggest that part of the problem rests with poor nursing assessment and management of patients with bowel dysfunction or altered bowel habit.

Assessing competence

In light of the problems surrounding DRE and the manual removal of faeces, discussion between the education leads for the local

### TABLE 1. EXAMINATION COMPONENTS AND THE KNOWLEDGE AND SKILLS TESTED

<table>
<thead>
<tr>
<th>Objective clinical structured exam</th>
<th>tests the students ability to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conduct a patient-centred assessment;</td>
<td></td>
</tr>
<tr>
<td>• Recognise altered pathology;</td>
<td></td>
</tr>
<tr>
<td>• Conduct a clinical examination;</td>
<td></td>
</tr>
<tr>
<td>• Communicate sensitively and effectively.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple-choice questions and unseen written exam</th>
<th>test the students knowledge and application of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient assessment;</td>
<td></td>
</tr>
<tr>
<td>• Pharmacology;</td>
<td></td>
</tr>
<tr>
<td>• Anatomy and physiology;</td>
<td></td>
</tr>
<tr>
<td>• Risk assessment;</td>
<td></td>
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<tr>
<td>• Professional and legal issues.</td>
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### TABLE 2. BROAD SUBJECTS TAUGHT ON THE BOWEL MANAGEMENT COURSE

- Legal implications, scope of professional practice and consent
- Anatomy and physiology of the lower rectal tract
- Anorectal disorders
- Pharmaceutical options in bowel management
- Healthy eating
- Bowel dysfunction in children and young adults
- Classification of constipation
- Patients’ perspective
- Neurological management and autonomic dysreflexia
- Digital rectal examination / insertion of suppositories / enemas / manual evacuation of faeces

It was unanimously agreed that the course must fit into the trust’s policy regarding The Scope of Professional Practice (UKCC, 1992), which is an integral part of its clinical governance framework. The trust’s

### REFERENCES


allowed to assess and manage patients with bowel problems. This is a contentious issue as trusts have a multitude of training demands and priorities that span all employees, both professional and non-professional.

Without this guidance there would not have been the necessary leverage to provide this clinically focused education. This learning is tailored to fit The Royal West Sussex NHS Trust’s clinical governance framework. It ensures competence in other organisations’ employees through examination to test their knowledge alongside clinical assessment and bowel-management skills. This approach ensures that health care professionals are competent and confident before engaging in an advanced practice role.

**Conclusion**

It is vital for nurses to develop their bowel-management knowledge, and assessment and intervention skills, in order to provide competent person-centred care to patients. The initial driver for the development of this Patient-Centred Bowel Management Course came directly from the RCN guidelines for DRE and the manual removal of faeces (RCN, 2000).

Currently there is only anecdotal evidence on how practice has been improved and the benefit this learning has had on patient care.

The CCHCS aims to evaluate the impact learning has had on practice by sending out impact-evaluation forms three months after completion of the course. However, out of the 39 impact-evaluation forms distributed, only one form has currently been completed and returned.

The course management team is currently considering how the return rate for these forms can be improved as this information is invaluable in developing the existing course and will hopefully validate the learning that students have been engaged in.