A digital rectal examination (DRE) should be performed before and, in some circumstances, after administering rectal medications; this is made clear in the recently updated bowel care guidance from the Royal College of Nursing (2019). However, from my experience of delivering training on safer bowel care training, it is apparent that there is a lack of awareness around when DRE is indicated and how to perform it competently.

Rationale for DRE

Benefits to the patient

Rectal medication can take various forms, including suppositories and enemas. They are used in many clinical situations, including for managing constipation, haemorrhoids, neurogenic bowel dysfunction, inflammatory bowel disorders and infection.

It is important that the medication is positioned correctly: for example, to manage constipation, placing a suppository against the bowel wall rather than inside a stool enables body heat to soften it (Fig 1). Stimulant suppositories, such as glycerol, must come into contact with the mucous membrane of the rectum because they act as a mild irritant and so stimulate evacuation (Bradshaw et al, 2009). Correctly positioning suppositories is not only necessary when managing constipation; Hagen et al (1991) found that when paracetamol suppositories were given to patients with a significant amount of stool in the rectum, peak plasma levels of the drug were reduced by 32%. The study may be old, but as no contradicting research has been published, it remains relevant.

Failing to assess the rectum before administering rectal medication may reduce its effectiveness.

Nurses might also perform DRE after administering a suppository or enema, to assess whether the medication has been successful in stimulating bowel evacuation or further action is needed to empty the bowel. It should be noted that there are situations in which DRE must be performed with caution (Box 1), and it should not be performed without the patient’s informed consent or if the patient’s doctor...
specifically prohibits it. If the patient does not have capacity to consent, the Nursing and Midwifery Council (2015) states that nurses should adhere to all relevant laws about mental capacity and ensure the patient’s rights and best interests are at the centre of the decision-making process.

**Benefits to the nurse**
The ability to undertake DRE is a fundamental nursing competency. The risks of failing to perform DRE before administering rectal medication may be significant. Although a doctor may already have performed one while assessing the patient, as nurses have a professional responsibility to ensure no harm comes to a patient as a result of an act or omission (Nursing and Midwifery Council, 2018a; Alexis and Caldwell, 2013), the administering nurse is personally accountable for ensuring there is no reason why rectal medication cannot be administered.

DRE can confirm there is no obstruction or stool preventing medications from being safely and effectively administered, and enables the nurse to ensure the patient’s comfort. Professional guidance on the administration of medicines highlights that registered health professionals who administer medicines, or delegate their administration when appropriate, remain accountable for their actions, and should exercise professionalism and professional judgement at all times; it also states that those administering medicines must be appropriately trained, assessed as competent, and meet relevant professional and regulatory standards and guidance (Royal Pharmaceutical Society and RCN, 2019).

In its standards for future nurses, the NMC (2018b) states that, when nurses complete pre-registration training, they must be able to administer enemas and suppositories and undertake rectal examination. This should mean that nurses qualifying after the standards were introduced will be able to administer enemas and suppositories appropriately trained, assessed as competent, and meet relevant professional and regulatory standards and guidance (Royal Pharmaceutical Society and RCN, 2019).

When asked whether they routinely perform DRE before administering rectal medication, 22% of respondents reported that they did not; interestingly, these respondents all worked in secondary care. A total of 100% of respondents working in community settings said they would perform DRE before rectal administration, while only 56% of hospital nurses said they would do so.

Survey responses highlighted many reasons for nurses’ reluctance to perform DRE before administering rectal medication – 38% of respondents said they had not received any formal DRE training. Box 3 gives an overview of the most common free-text responses to the question: “Why do you not perform a DRE before administering rectal medication?”

An NHS Improvement (2018) national patient safety alert highlighted a lack of awareness around autonomic dysreflexia and a lack of staff with the competence to perform DRE. The alert stated that “patients have made NHS Improvement aware of difficulties [in] ensuring their regular bowel care is provided when they come into hospital or mental health units”.

The results of my survey appear to confirm this, with certain responses implying that the recommended bowel care is not happening in practice.

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**Box 1. When to perform a digital rectal examination**

Perform a digital rectal examination with caution if the patient:
- Has active inflammation of the bowel
- Has had recent radiotherapy to the pelvic area
- Has rectal or anal pain
- Has had recent surgery or trauma to the anal or rectal area
- Has tissue fragility due to age, radiation or malnourishment
- Has obvious rectal bleeding
- Has a known history of abuse
- Has a spinal cord injury at or above T6 (due to the potential risk of autonomic dysreflexia)
- Has a known history of allergies (for example latex)
- Is unconscious
- Gains sexual gratification from the procedure

Source: Royal College of Nursing (2019)
Clinical Practice
Innovation

“There is no training in our trust for this.”

“I didn’t think I was allowed to.”

Kyle (2010) indicated that some nurses believe they are prohibited from performing DRE – this belief clearly persists a decade later. However, this is not the case if:

● The DRE is indicated;
● Informed consent has been obtained
● The nurse is competent in the procedure (RCN, 2019).

The largest barrier to performing a skill is competence, which is defined as the “clinical and technical knowledge to deliver effective care and treatments based on research and evidence” (NHS Commissioning Board and Department of Health, 2012). Nurses can gain technical knowledge by attending teaching sessions on the use of DRE. As a result of the patient safety alert, all providers of NHS-funded inpatient and community healthcare are required to provide education and training provision for interventional bowel management (NHS Improvement, 2018). This means training should be available to all registered nurses employed in the NHS. Relevant charities and other organisations also offer training: for example, Bladder and Bowel UK – part of the charity, Disabled Living – offers a one-day course for nurses (Bit.ly/BBUKRectalExam).

Even when appropriate training is available, there can still be barriers preventing nurses achieving competence in DRE. For example, they need to be able to attend the training sessions and staffing levels in clinical areas can prohibit this; as such, the ward manager’s support is fundamental. Investing in staff training and development can only improve the skill mix in the clinical area.

Theoretical knowledge is the foundation for clinical competence, but attending training sessions and performing simulations on a manikin do not equate to competence in practice. To be assessed as competent practitioners, nurses are required to complete observed DRE practice on patients. This, in itself, can cause difficulties as, in some clinical areas, the opportunity to perform DRE arises infrequently. This not only makes it difficult for nurses to achieve competence, but also means there may be no nurses available with the required competence to observe DRE. In such situations, achieving this clinical competence may require some lateral thinking, for example:

● Finding patients requiring DRE in other clinical areas;
● Asking a doctor to sign off the competence;
● Asking a competent nurse in another area to observe your practice.

Conclusion

Nurses have a responsibility to provide evidence-based practice (NMC, 2018a), and evidence-based guidance is available for those delivering lower-bowel care as part of their role, including nurses administering rectal medication (RCN, 2019). Local policies vary and should always be consulted, but a common theme is the need to perform DRE to assess the rectum before, and sometimes after, administering rectal medication.

It is best practice to perform DRE before inserting rectal medication, both to identify the presence and consistency of any stool in the rectum and to ensure that medication will have the intended action. This also reduces the risk of perforating the bowel wall during administration. DRE may also be performed after administering rectal medication to assess the outcome of the intervention.

A survey carried out via social media demonstrated that there was a lack of awareness of the need for DRE, and a lack of competence in and a fear of performing the procedure. To ensure high-quality, evidence-based care is provided, employers have a responsibility to provide awareness, education and training opportunities in bowel management for their staff (NHS Improvement, 2018). This provision is particularly important in secondary care, as the survey highlighted a lack of training and awareness in this group. Nurses should reflect on their own practice and competence in this area, then access any necessary training and consolidate it through their clinical practice.

Box 3. Reasons nurses do not perform digital rectal examinations

Responses to the survey question: “Why do you not perform digital rectal examination before administering rectal medication?” included:

● “Not had the training and usually a doctor has done one”
● “Don’t feel competent”
● “Not trained to do it, but do it if I have any concerns”
● “Not aware it would be necessary in these circumstances”
● “Not taught to and never considered it”
● “There is no training in our trust for this”
● “Didn’t realise I had to”
● “DRE is an invasive procedure that I will only perform when absolutely necessary”
● “Didn’t think I was allowed to”
● “A doctor will have done one”
● “Doesn’t seem to be common practice”

Box 2. Survey questions

● Have you undergone formal training in digital rectal examination?
● Have you been signed off as competent in digital rectal examination?
● Do you perform digital rectal examination prior to administering rectal medication?
● If not, why do you not perform digital rectal examination before administering rectal medication?

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