University Hospitals Birmingham NHS
NHS Foundation Trust

CONTROLLED DOCUMENT

Bowel Care Guidelines for Adult Patients, aged 16 years and Over

CATEGORY:	**Procedural Document**
CLASSIFICATION:	**Clinical**
PURPOSE	**The purpose of these guidelines is to provide practical guidance for the provision of bowel care for adult patients (aged 16 years and over).**
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Controlled Document Lead:	**Clinical Nurse Specialist Functional Bowel Service**
Approved By:	**Executive Chief Nurse** **Executive Medical Director** **Chair of Medicines Management Advisory Group**
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Distribution: • **Essential Reading for:** • **Information for:**	**All Nursing, Medical and Allied Health Care Professional staff involved in direct patient care which involves bowel care** **All clinical staff**

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To be read in conjunction with the following documents:
CD ref TBC: Guidelines for Digital Rectal Examination and Digital Removal of Faeces in Adult Patients, aged 16 years and over
CD ref TBC: Guidelines for the Bowel Care of Patients with a Colostomy or Ileostomy
CD ref TBC: Guidelines for the use of Faecal Management Systems in Adult Patients, aged 16 years and over

Bowel Care Guidelines

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Part 1 – Introduction

1.0 Purpose of the Guidelines

These guidelines aim to provide practical guidance for the provision of bowel care for adults (aged 16 years and over).

2.0 General Guidance

These guidelines must be read in conjunction with the following policies, procedures and guidelines (current versions):

- Medicines Code Policy and Procedure
- Infection Prevention and Control Policy and Procedural Documents
- Consent to Examination or Treatment Policy and Procedure
- The Royal Marsden Hospital Manual of Clinical Nursing Procedures

2.1 Dignity and Respect

Bowel care involves subject matter/procedures of a sensitive nature. Every effort must be taken to ensure that individuals' personal and/or cultural requirements are met, whenever possible, in terms of privacy and dignity, the gender of the practitioner, and chaperoning arrangements. (Essence of Care benchmarks for Respect and Dignity; and Bladder, Bowel and Continence Care, DH 2010).

All aspects of bowel care should adhere to the 'Behind Closed Doors- using the toilet in private' standards outlined by the British Geriatrics Society (BGS) (2006) (Appendix 1). A decision making tool can be found on the BGS website.

2.2 Infection control

Safe infection control practices must be adhered to throughout any patient contact and/or procedures in accordance with the Trust's infection prevention and control policy and procedures (current versions). The appropriate Health and Safety risk assessments must have been completed for the clinical area.

2.3 Consent

Valid, informed consent must be obtained from the patient, wherever possible in accordance with the Trust's Consent to Examination or Treatment Policy and Procedure (current versions) and the *Mental Capacity Act* (2005).

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If the patient is unable to give their consent, the registered practitioner must document in the patient's records why they believe the procedure to be in the patient's best interests, including any involvement from other health professionals, family or carers in reaching that decision (in accordance with the *Mental Capacity Act* (2005)).

2.4 Documentation

All aspects of bowel care must be documented in the patient's records. A record of bowel movements or lack of movements must be made on the Prescribing Information and Communication System (PICS) at least daily.

In patients with cognitive impairment, the 'All about Me' document should be completed to help identify the cues which may indicate they need the toilet. If the patient has a 'Hospital Book' please refer to this.

2.5 Monitoring of the Guidelines

The controlled document lead will lead the audit of the guideline with support from the Practice Development Team. The audit will be undertaken in accordance with the review date and will include:

- Any untoward incidents related to bowel care
- Use of lactulose for constipation
- Correct pad usage for faecal incontinence
- Patient Experience Feedback (for example compliments and complaints)

All audits must be logged with the Risk and Compliance Unit.

References

British Geriatrics Society (2006) **Behind Closed Doors: 'Using the toilet in private'** http://www.bgs.org.uk/index.php?option=com_content&view=article&id=302:dignitytools&catid=60:dignity2006&Itemid=830 [accessed 15.07.14]

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University Hospitals Birmingham NHS Foundation Trust (current version) I**nfection prevention and control Policy** University Hospitals Birmingham NHS foundation Trust http://uhbpolicies/Microsites/Policies_Procedures/infection-prevention-and-control.htm [accessed 15.07.14]

University Hospitals Birmingham NHS Foundation Trust (current version) **Medicines Code,** University Hospital Birmingham NHS Foundation Trust http://uhbpolicies/Microsites/Policies_Procedures/medicines.htm [accessed 15.07.14]

University Hospitals Birmingham NHS Foundation Trust (current version) **Policy for consent to examination or treatment**, University Hospitals Birmingham NHS Foundation Trust http://uhbpolicies/Microsites/Policies_Procedures/consent-to-examination-or-treatment.htm [accessed 15.07.14]

University Hospitals Birmingham NHS Foundation Trust (current version) **Procedure for consent to examination or treatment**, University Hospitals Birmingham NHS Foundation Trust http://uhbpolicies/Microsites/Policies_Procedures/consent-to-examination-or-treatment.htm [accessed 15.07.14]

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Behind Closed Doors Standards

Access
All people, whatever their age and physical ability, should be able to choose and use the toilet in private.
There must be sufficient toilets and equipment available to achieve this.

Timeliness
People who need assistance to use the toilet should be able to request and receive timely and prompt help.
People should not be left on the commode or bed pan for longer than necessary.

Equipment for Transfers and Transit
Essential equipment to assist people to gain access to a toilet should be
- readily available.
- used for transfer onto a transit chair and on / off the toilet.
- used in a way that respects the persons dignity.
- used in a way that avoids unwanted exposure.

Safety
People who are unable to use a toilet alone safely should normally be offered use of a toilet with appropriate safety equipment in place and with supervision if required.

Choice
People's choice is paramount. Their views should be sought and respected.

Privacy
Privacy and dignity must be preserved. People who are bed bound require special attention.

Cleanliness
All toilets, commodes and bed pans must be clean.

Hygiene
All people in all settings must be enabled to leave the toilet with a clean bottom and washed hands.

Respectful Language
Discussions with people must be respectful and courteous especially in regards to episodes of incontinence.

Environmental Audit
All organisations should encourage a lay person to undertake an environmental audit to assess the toilet facilities

British Geriatrics Society (2006)

Part 2 Normal Bowel Function and Patient Assessment

1.0 Normal Bowel Function

There is a very wide range of 'normal' bowel function between different people. As long as stools are passed without excessive *urgency* (needing to rush to the toilet), with minimal effort and no straining, and without the use of laxatives, bowel function may be regarded as normal (Norton 2004).

2.0 Patient Assessment

Assessment of a patient's 'normal' bowel function is the first step in determining bowel dysfunction and planning a treatment regime. Ascertain if there are any changes in the patient's bowel activity. How long have these changes been present and have they been present before?

Establish the following, and document in the patient's records and on the 'other obs' section of the Prescribing Information and Communication System (PICS):

- Frequency of bowel action (PICS).
- Volume, consistency and colour of the stool. For identification of stool type refer to The Bristol Stool Form Scale on PICS (appendix 1).
- Presence of mucus, blood, undigested food or offensive odour.
- Presence of pain or discomfort on defecation.
- Previous and current use of medication to stimulate defecation and its effectiveness.

(Dougherty and Lister 2011)

If the practitioner undertaking the assessment is concerned about the patient's condition they must refer the patient to the appropriate medical practitioner for advice on any further action to be taken, and this must be recorded in the patient's records.

References

Dougherty, L. Lister, S (Eds) (2011) **The Royal Marsden Hospital Manual of Clinical Procedures** (8th Edition). Blackwell Publishing, Oxford. http://uhbhome/Policies/R/RoyalMarsden.html [accessed 15.07.14]

Norton C. *The Development of Bowel Control* in Norton C and Chelvanayagam S (2004) (eds*)* **Bowel Continence Nursing.** Buckinghamshire: Beaconsfield Publishers.

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The Bristol Stool Form Scale
(To be documented on PICS)

Type 1		**Separate hard lumps (like nuts) hard to pass**
Type 2		**Sausage shaped but lumpy**
Type 3		**Like a sausage but with cracks on its surface**
Type 4		**Like a sausage or snake, smooth and soft**
Type 5		**Soft blobs with clear-cut edges (passed easily)**
Type 6		**Fluffy pieces with ragged edges, a mushy stool**
Type 7		**Watery, no solid pieces ENTIRELY LIQUID**

Adapted from Heaton et al (1992)

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Part 3 Constipation

1.0 Definition of Constipation

Constipation results when there is a delayed movement of intestinal content through the bowel (Walsh 1997). It is characterised by infrequent hard, dry stools which may be difficult to pass (Norton 1996, Winney 1998). Constipation occurs when there is a failure of colonic propulsion (slow transit) or a failure to evacuate the rectum, or a combination of these problems (Norton 1996). The management of constipation is dependent on the cause.

2.0 Management of Constipation

A stepped-care approach to management should be followed where possible. The guidelines contained in appendices 1 and 2 should be followed.

Step 1: Identify possible causes of constipation (Appendix 1)
Step 2: Educate the patient (Appendix 1)
Step 3: Drug treatment (Appendix 2)

Use the Bristol Stool Form Chart to aid identification of stool type (see **Part 2** Appendix 1 and PICS).

Patient information about constipation is available from the Bladder and Bowel Foundation
http://www.bladderandbowelfoundation.org/bowel/bowel-problems/constipation.asp

Please refer to 'The Royal Marsden Hospital Manual of Clinical Nursing Procedures' for procedure guidelines for the administration of suppositories and enemas (current version available on the intranet).

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Once constipation is confirmed, and any secondary causes have been addressed, most adults with mild or acute functional (idiopathic) constipation can be managed by dietary and lifestyle changes (Appendix 1).

If the practitioner caring for the patient is concerned about the patient's condition they must refer the patient to the appropriate medical practitioner for advice on any further action to be taken, and this must be recorded in the patient's records.

2.1 Drug Treatment.

Advice regarding medication for the treatment of constipation can be sought from the ward pharmacist

Laxatives are recommended when:

- Dietary and lifestyle changes are insufficient, or whilst waiting for them to take effect
- For people taking constipating medication that cannot be stopped
- For people with secondary causes of constipation

Management with laxatives

- In adults, laxatives should be reserved for cases where simple interventions have failed, or where rapid relief of symptoms is required.
- Prolonged treatment is seldom necessary, except occasionally in the elderly, in patients on constipating medication which cannot be stopped, in palliative care, or to prevent recurrence in children.
- With the exception of relatively recent evidence comparing efficacy of macrogols with lactulose, there is limited clinical evidence on which to judge the comparative efficacy of individual laxatives. Therefore, prescribing choice mainly depends on the presenting symptoms, patient acceptability and cost.
- Prucalopride and Methylnaltrexone are available via chairman's action for specialist indications and are consultant-initiated only. Contact your ward pharmacist for further advice.
- Laxatives are contraindicated in patients with *Clostridium difficile* associated diarrhoea.
- Please refer to Appendix 2 for laxative treatment guidelines for patients aged 16 years and over.

Aims of Treatment with Laxatives

- Set realistic expectations with the patient for the results of treatment.
- The dose of laxatives should be gradually titrated upwards or downwards in a stepwise approach to produce one or two soft formed stools (or whatever the patient feels is normal for them) per day.
- Adjust choice, dose and combination of laxative according to the patient's symptoms, speed with which relief is required, response to treatment and patient preference.

Stopping Laxatives

- Laxatives should be gradually withdrawn once regular bowel movements occur without difficulty (2-4 weeks after defecation has

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become comfortable and a regular bowel habit has become established).
- It can take several months to be completely weaned off laxatives.
- If a combination of laxatives has been used, reduce and stop one laxative at a time (preferably stimulants first).
- Relapses are common and should be treated early with laxatives.

3.0 Digital Rectal Examination and Digital Removal of Faeces.

Digital rectal examination (DRE) and digital removal of faeces from the rectum is an invasive procedure which should only be performed when necessary and after individual assessment. For certain patients, such as those with spinal injuries, this procedure may be the only suitable bowel-emptying technique.

For more information, procedure and competencies see **CD ref** TBC: Guidelines for digital rectal examination and digital removal of faeces in adult patients, aged 16 years and over.

3.1 Digital Rectal Examination

Digital Rectal examination can be used as part of a patient assessment, providing the registered practitioner has received suitable training and assessment to perform the procedure.
Digital Rectal Examination should not be seen as a primary investigation in the assessment and treatment of constipation (RCN 2012).

3.2 Digital Removal of Faeces

Digital removal of faeces may be performed by a competent registered practitioner in the following situations:
- When other bowel emptying techniques have failed or are inappropriate
- Faecal impaction or loading
- Incomplete defecation
- Inability to defecate
- Neurogenic bowel dysfunction
- **In patients with spinal cord injury who routinely manage their bowels in this way** (RCN 2012).

3.3 Digital Removal of Faeces in Patients with a Spinal Cord Lesion.

The National Patient Safety Agency (NPSA) in 2004 identified that patients with an established spinal cord lesion are at risk because their specific bowel care needs are not always met in acute hospital trusts.

People with established spinal cord lesions experience loss of normal bowel function and control as a direct and permanent consequence of spinal cord nerve damage. Many are dependent on digital removal of faeces as their essential and routine method of bowel care.

Evidence shows that failing to support the bowel care of patients with established spinal cord lesion, above the level of the sixth thoracic vertebra, can place them at risk of developing a form of severe hypertension called **Autonomic Dysreflexia.** This is a medical emergency and is potentially a life-threatening condition that can

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develop suddenly. If not treated promptly and correctly, it may lead to seizures, stroke, and even death (Karlsson 1999).

One of the most common causes of autonomic dysreflexia, amongst people with established spinal cord lesion, is bowel distension due to constipation or impaction. Intervention, in the form of digital removal of faeces, is required immediately and urgently.

(See Appendix 3 for further information and treatment of Autonomic Dysreflexia in patients with a spinal cord lesion).

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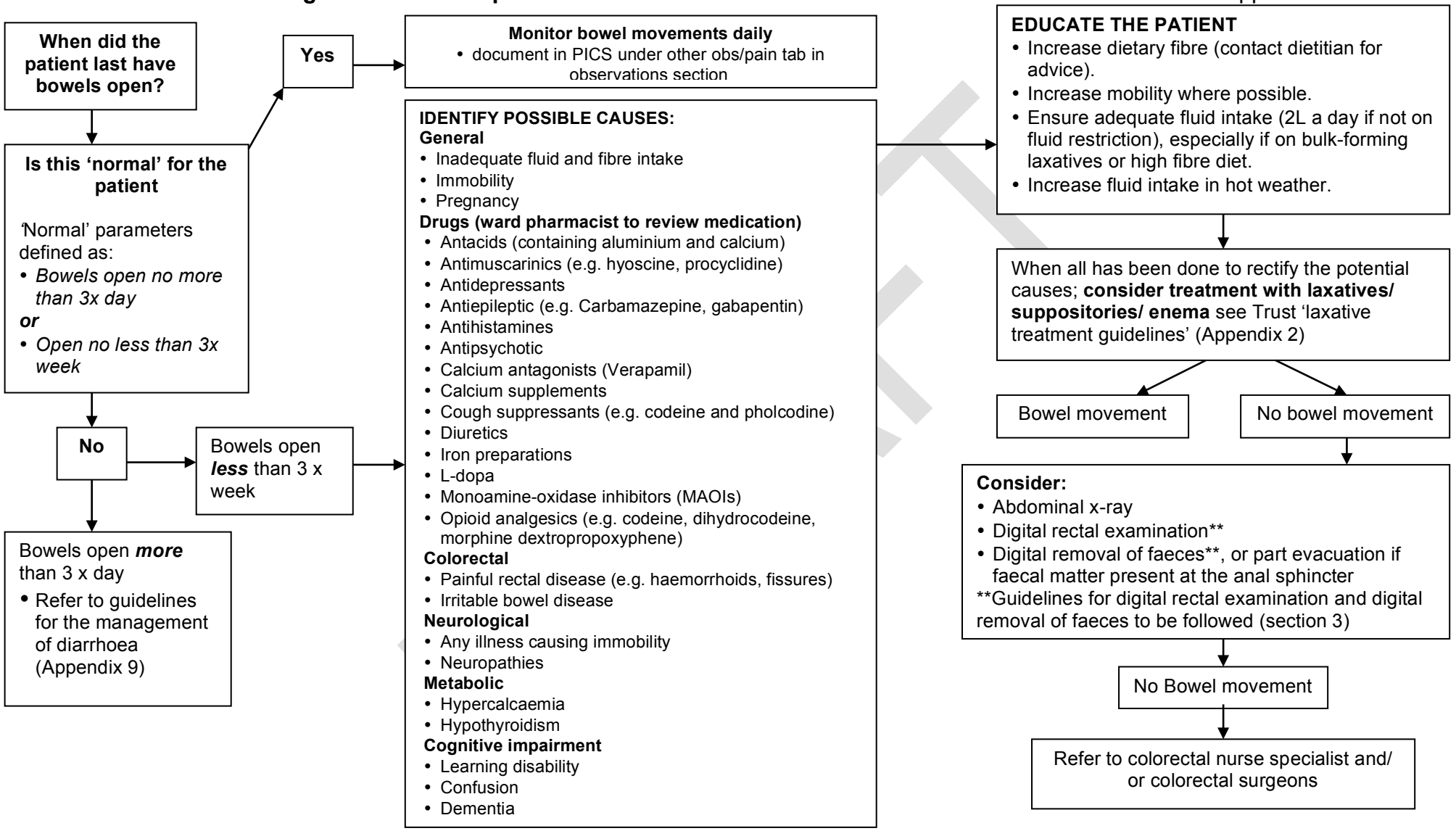
Guidelines for the Management of Constipation

Appendix 1



NB if the patient develops acute symptoms at any point; e.g. vomiting, abdominal pain/ distension, the patient **MUST** be referred to the colorectal team **without delay**

Appendix 2

Laxative Treatment Guidelines for Patients Aged 16 Years And Over

STEP 1: identify possible causes: adjust constipating medication; ward pharmacist to review and advise				
STEP 2: Educate the Patient: where possible, increase fluid, increase fibre intake and increase mobility				
STEP 3: Treatment	**Laxative**	**Adult Dose**	**Onset**	**Notes**
Acute Constipation Short-term use	**First-line:** ISPAGHULA HUSK (Fybogel®/ Isogel®) (BULK FORMING LAXATIVE)	1 sachet orally (po) TWICE a day	24 – 48 hrs	**Ensure adequate fluid intake.** SHOULD NOT be taken straight before bedtime Avoid in intestinal obstruction, colonic atony or faecal impaction
	Second Line: MACROGOLS (Laxido®) (OSMOTIC LAXATIVE)	1 – 3 sachets po per day (in divided doses)	24 – 48 hrs	**Ensure adequate fluid intake.** Avoid in intestinal obstruction or perforation Contain electrolytes – sodium and potassium
	Third line or where adequate fluid intake is difficult: SENNA (STIMULANT LAXATIVE)	2 tablets po ONCE or TWICE daily 10ml liquid po ONCE or TWICE daily	8 -12 hrs	Do not use in intestinal obstruction. Prolonged use can precipitate the onset of atonic non-functioning colon and hypokalaemia. The liquid is unpalatable Useful for soft stools that are difficult to pass
	Or Third line or where adequate fluid intake is difficult: DOCUSATE SODIUM (SOFTNER and STIMULANT)	100- 200 mg po b.d. (Maximum 500mg / 24 hours)	24- 48 hrs	Do not use in intestinal obstruction. Capsules and liquid available
LAXATIVES can be stopped once stools are soft and easily passed				
Acute Constipation Rapid Relief	GLYCERIN SUPPS. 4G	One per rectum (pr) when required	15- 30 mins	**Review daily.** If no result after 5-7 days, treat as chronic constipation Phosphate enemas can cause hypocalcaemia & hyperphosphatemia in ill patients and renal impairment
	Second-line treatment SODIUM CITRATE (Micro enema) 5ml	One pr when required	5- 30 mins	
	Third-line treatment PHOSPHATE ENEMA	One pr when required	5–15 mins.	
Chronic Constipation Long-term use	• Relieve faecal loading / impaction – (see below) • EXCLUDE underlying causes • Laxatives should be used as in acute constipation • Adjust doses, choice and combination of laxative to produce comfortable defecation with soft, formed stools ONCE or TWICE a day • Regular use maybe needed to maintain comfortable defecation			
LAXATIVES should be slowly withdrawn once regular bowel movements occur without difficulty (2-4 weeks after a regular pattern has been established)				

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Treatment	Laxative	Adult Dose	Onset	Notes
Impaction	**Soft Stool:** SENNA	2 tablets po ONCE or TWICE daily 10ml liquid po ONCE or TWICE daily	8 -12 hrs	Do not use in intestinal obstruction. Prolonged use can precipitate the onset of atonic non-functioning colon and hypokalaemia The liquid is unpalatable
	Hard stools: MACROGOLS (Laxido®)	8 sachets daily dissolved in 1 litre water and drunk within 6 hours. Maximum 3 days. Review daily.	< 24 hrs	**Ensure adequate fluid intake.** Avoid in intestinal obstruction or perforation Contain electrolytes – sodium and potassium On resolution start Laxido (macrogol) maintenance, 1–2 sachets daily
Impaction Rapid Relief	**First-line treatment** MICRO-ENEMA 5ml	One pr when required	5–30 mins.	On resolution start Laxido (macrogol) maintenance, 1–2 sachets daily
	Second-line treatment: PHOSPHATE ENEMA	One pr when required	5–15 mins	On resolution start Laxido (macrogol) maintenance, 1–2 sachets daily
Opiate Induced Constipation (agents can be used in combination)	SENNA	2 tablets po ONCE or TWICE daily 10ml liquid po ONCE or TWICE daily	8– 12 hrs	Chronic opiate intake almost inevitably causes constipation. Anticipatory laxative use is helpful. Both are available as liquid (however senna liquid is unpalatable)
	DOCUSATE SODIUM	100- 200 mg po b.d. (Maximum 500mg / 24 hours)	24- 48 hrs	
For Terminally ill Patients	**First-line treatment** CO-DANTHRAMER	1-2 capsules po at night or 5 – 10ml suspension po at night.	6-12 hrs	NOT TO BE USED WHERE PATIENT IS INCONTINENT *(Urinary **and/or** faecal)* May colour the urine red **NB** If skin irritation occurs follow the guidelines above for rectal interventions
	Or **First-line treatment** CO-DANTHRUSATE	1-3 capsules po at night or 5–15ml suspension po at night	6-12 hrs	

NB: The guidelines provide limited information on the common use of laxatives. They are not intended to cover all indications for which a laxative may be required. For full prescribing information please consult the BNF and the manufacturer's data sheets. For additional information please contact your WARD PHARMACIST or MEDICINES INFORMATION.

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Appendix 3

Autonomic Dysreflexia in Patients with a Spinal Cord Lesion.

Autonomic dysreflexia is a medical emergency. It is potentially a life-threatening condition that can develop suddenly. If not treated promptly and correctly, it can lead to cerebral haemorrhage, seizures and cardiac arrest.

Autonomic dysreflexia, also known as hyperreflexia, is a state that is unique to patients after spinal cord injury and usually occurs in people with a spinal cord lesion above the level of the sixth thoracic vertebra.

Autonomic dysreflexia means an over-activity of the sympathetic nervous system. It is characterised by a rapid rise in the blood pressure. Anything that would have been painful, uncomfortable or physically irritating before the injury may cause autonomic dysreflexia (Glickman and Kamm 1996).

Commonest Causes of Autonomic Dysreflexia

- Any painful or noxious stimuli below the level of the lesion
- Distended bladder (usually due to a blocked catheter or other outflow obstruction)
- Distended bowel due to a full rectum, constipation or impaction
- Ingrown toe nail
- Fracture below the level of the lesion
- Labour/ childbirth
- Ejaculation

Other causes

- Pressure sores
- Deep Vein Thrombosis
- Appendicitis
- Ulcers
- Surgery
- Burns
- Severe anxiety or emotional distress

Signs and Symptoms of Autonomic Dysreflexia

The commonest presenting symptoms are:

- Severe hypertension
- Bradycardia
- ‘Pounding’ headache
- Flushed or blotchy skin above the level of the lesion
- Pallor below the level of the lesion
- Profuse sweating above the level of the lesion
- Nasal congestion

Treatment of Autonomic Dysreflexia

Treatment must be initiated quickly and the blood pressure closely monitored:

- The first step of treatment, regardless of the cause, is to sit the patient upright, to induce an element of postural hypotension. If bladder problems are

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suspected, only sit patient to 45 degrees. Sitting at 90 degrees may cause increased pressure on the full bladder.

- Identify the source of the noxious stimulus (removing the stimulus will cause the symptoms to settle).
- Restrictive clothing such as tight belts must be removed.
- High blood pressure should be treated until the cause is found and eliminated. Administer a proprietary vasodilator as prescribed e.g. GTN tablets sublingually, or oral nifedipine capsules (capsule to be pierced and the contents put in the patient's mouth).
- Check the bladder.
- If patient is not catheterised and the bladder appears full, catheterise immediately and leave on free drainage. The catheter must be lubricated with an anaesthetic gel prior to insertion.
- If catheterised, empty the bag and untwist any kinked tubing. If the catheter appears blocked, change the catheter immediately. **DO NOT ATTEMPT A BLADDER WASHOUT**; this will only distend the bladder further with potentially fatal consequence.
- If the above steps do no resolve the issue; and the patient remains hypertensive and symptomatic, then the rectum should be examined and emptied by gentle insertion of a gloved finger, lubricated in anaesthetic gel.

Bycroft et al (2005), NHS Quality Improvement Scotland (2004)

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Part 4 Diarrhoea

1.0 Diarrhoea

Definition of Diarrhoea

Diarrhoea results when the balance among absorption, secretion and intestinal motility is disturbed (Hogan 1998). It has been defined as an 'abnormal increase in the quantity, frequency and fluid content of stool and associated with urgency, perianal discomfort and incontinence' (Basch 1987). The Bristol Stool Form Scale can be used to aid identification of stool type.

1.1 Acute Diarrhoea (sudden onset)

This is very common; it is usually self-limiting and lasts less than 2 weeks. It often requires no investigation or treatment. For inpatients with diarrhoea, see Appendix 1 and refer to the Trust's current Infection prevention and control policy and associated procedures:

- Procedure for the Management of Outbreaks of Diarrhoea with or without Vomiting (CD ref: 392, current version) http://uhbpolicies/assets/DiarrhoeaOutbreakProcedure.pdf
- Procedure for *Clostridium Difficile* infection (CD ref: 819, current version) http://uhbpolicies/assets/ClostridiumDifficileProcedure.pdf

Causes of acute diarrhoea include:

- Infective:
  - (a) Travel associated
  - (b) Viral
  - (c) Bacterial (usually associated with food)
  - (d) Antibiotic related
- Contrast media used for screening purposes
- Dietary indiscretion (eating too much fruit, alcohol misuse)
- Allergy to food constituents

Dougherty and Lister 2011

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1.2 Chronic Diarrhoea

In adults, this is defined as the passage of unformed stool (more than three times per day) for one month or more (Tally and Martin, 1996).

1.3 Overflow Diarrhoea (spurious diarrhoea)

This can occur in people who are constipated for a prolonged period of time and may cause faecal incontinence. In this condition, faeces obstructs most of the width of the bowel lumen, but some fluid faeces may seep past the impacted mass, leading to a loose unformed stool which is produced in relatively small amounts.

Overflow diarrhoea ***should not*** be treated as diarrhoea because it will only lead to worsening constipation. The performance of a rectal examination may confirm the presence of impacted stool; however an empty rectum may not exclude faecal impaction. The patient should be referred to the medical staff or to a colorectal nurse specialist for advice. A rigid sigmoidoscope or an abdominal X-ray may be needed to confirm faecal impaction and overflow where the presentation is diarrhoea.

2.0 Management of Diarrhoea

Once the cause of diarrhoea has been established, management should be focused on resolving the cause and providing physical and psychological support for the patient.

2.1 Stool Sampling

For guidance regarding stool sampling refer to Appendix 1 and the Trust's Infection Prevention and Control Policy and associated Procedures (current versions)

2.2 Nursing Assessment

Assess, and document in the patient's records and on PICS:

- Date of onset, frequency and duration of diarrhoea
- Stool consistency (Bristol Stool Form Scale on PICS), and the colour of stool: presence of blood, fat, mucus
- Symptoms e.g. pain, nausea, vomiting, fatigue, weight loss, fever
- Recent lifestyle changes, emotional disturbances, or travel abroad
- Fluid intake and dietary history, explore any cause and effect relationships between food consumption and bowel action
- Normal medication including recent antibiotics, laxatives or chemotherapy
- Significant past medical history, e.g. bowel resection, pancreatitis, pelvic radiotherapy
- Hydration status; evaluation of mucous membranes and skin turgor
- Perianal or peristomal skin integrity
- In non-infective diarrhoea, assess effectiveness of antidiarrhoeal medication (dose and frequency)
- Faecal impaction can give rise to 'overflow diarrhoea' and must be excluded before antidiarrhoeal medication is started.

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2.3 Nursing Care for Patients with Diarrhoea of all Causes

- Prevent and/or correct dehydration. Administer prescribed fluids/ encourage oral fluids. Maintain accurate fluid balance record
- Ensure easy access to clean toilet and washing facilities
- Ensure patient and family are aware of the need to wash hands after using the toilet
- Preserve the patient's privacy and dignity
- Observe, monitor and document all bowel actions, temp, blood pressure, pulse, general wellness, appetite and skin integrity
- Administer antimotility drugs as prescribed
- If the patient is on laxatives, the patient's doctor or pharmacist must review the medication.

For information about skin care for patients with faecal incontinence, please refer to Part 5 section 4.2

If the practitioner caring for the patient is concerned about the patient's condition they must refer the patient to the appropriate medical practitioner for advice on any further action to be taken, and this must be recorded in the patient's records.

Patient information about diarrhoea is available from the Bladder and Bowel Foundation: http://www.bladderandbowelfoundation.org/bowel/bowel-problems/diarrhoea.asp

References

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University Hospitals Birmingham NHS Foundation Trust (current version) **Procedure for *Clostridium Difficile* infection (CD ref 819)** University Hospitals Birmingham NHS foundation Trust http://uhbpolicies/assets/ClostridiumDifficileProcedure.pdf [accessed 15.07.14]

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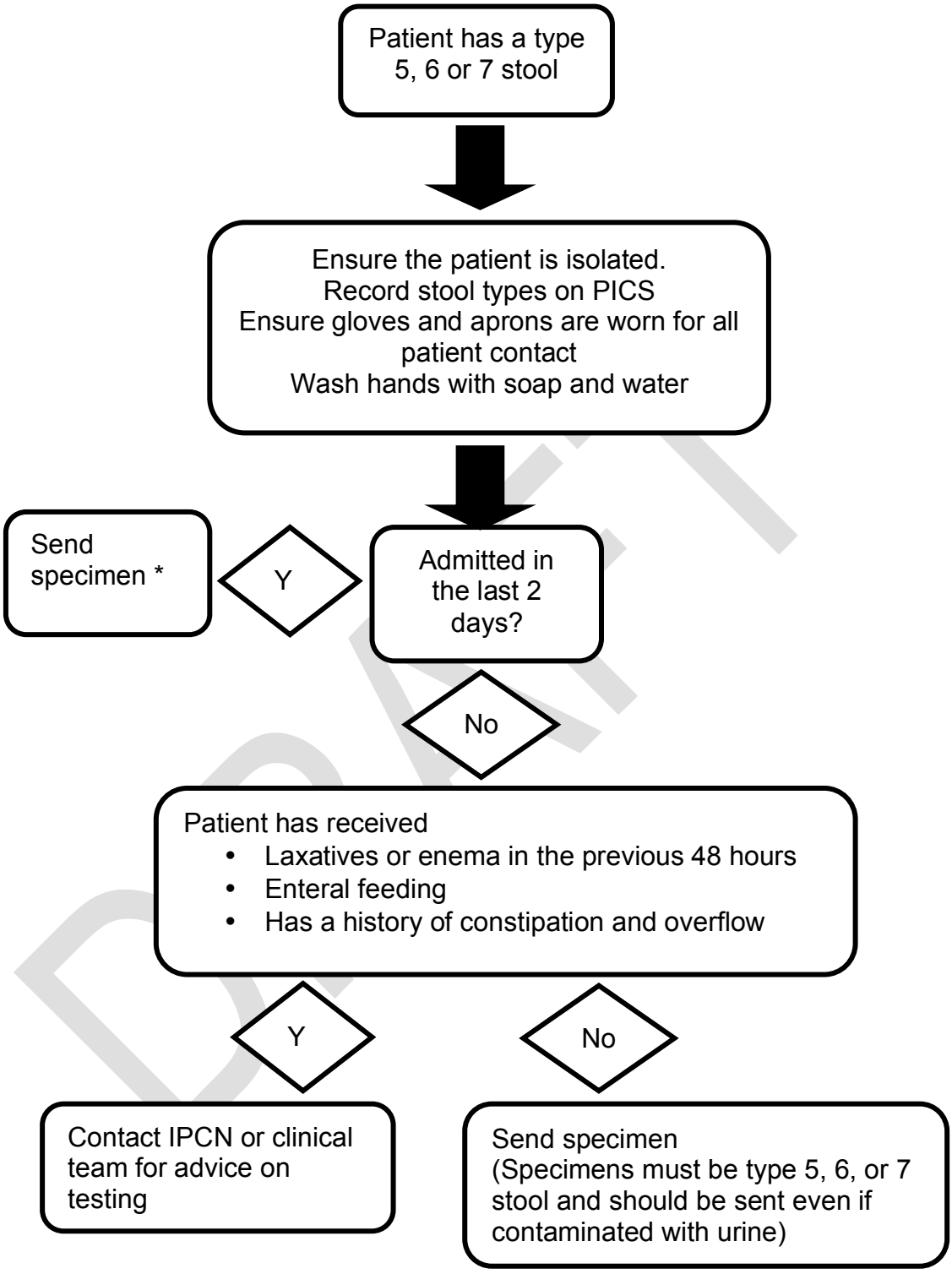
Guidance regarding stool testing



*Specimens must be type 5, 6, or 7 stool and should be sent even if contaminated with urine

Taken from:
Procedure for *Clostridium Difficile* infection (CD ref 819, current version)
http://uhbpolicies/assets/ClostridiumDifficileProcedure.pdf

Part 5 Faecal Incontinence

1.0 Faecal Incontinence

Definition of Faecal Incontinence

Faecal incontinence can be defined as 'involuntary leakage, whether of solid, liquid or gas'. (Norton 1996)

2.0 Causes of Faecal Incontinence

The following may be causes of faecal incontinence (Barrett 2004):

Loss of cognitive awareness:

- Impaired consciousness
- Dementia
- Poor vision

Disability:

- Patient related: poor mobility, poor dexterity, poor vision
- Carer related: availability, attitude, lack of timely toileting
- Related to suitability of toilet facilities/ toileting facilities

Damage to the anal sphincters:

- Childbirth
- Operations
- Injury
- Rectal prolapse

Loose stools:

- For more information about the causes of loose stools, refer to **Part 4** Diarrhoea

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Colorectal faecal loading/ impaction:

- For more information about the assessment and treatment of constipation refer to **Part 3** Constipation

Nerve injury or disease:

- Spinal injury
- Multiple sclerosis
- Stroke

For guidance regarding the digital removal of faeces in patients with a spinal cord lesion refer to **Part 3** section 3.3 **and CD ref:** TBC Guidelines for Digital Rectal Examination and Digital Removal of Faeces in Adult Patients, aged 16 years and over

3.0 Assessment of Patients with Faecal Incontinence

Review and document in the patient's records and on PICS:

- **Bowel actions:** stool consistency and stool type. Exclude faecal loading/faecal impaction. The Bristol Stool Form Scale can be used to aid identification of stool type. (See **Part 2**, Appendix 1)

- **Toilet habits:** routine, location, access, assistance required, mobility, signposting, lighting. In hospital, access to 'call bell'

- **Diet and fluid intake:** low fibre intake and poor fluid intake can contribute to constipation. Consider completing a food/fluid diary, which should be completed by the patient/carer for a minimum of 7 days

- **Medications:** consider side effects of drugs including 'over the counter preparations'. Ward pharmacist to review medication.

- **Use of continence aids/appliances:** what continence aids are being used? Are they suitable?

4.0 Management of Faecal Incontinence (Appendix 1)

4.1 Initial Management

The management of faecal incontinence should aim to ensure that the stool consistency is optimal and the bowels open at a predictable time (Barrett 2004)

For patients in whom the faecal incontinence has been exacerbated/ caused by inability to reach the toilet 'in time', ensure that they are positioned near to the toilet, have access to the call bell and receive assistance promptly.

For faecal incontinence caused by loose stools *(where constipation has been excluded)* medication such as loperamide or Ispaghula Husk (Fybogel®/ Isogel®) can be used to alter the stool's consistency. **NB** Loperamide must be used with caution as too much induces severe constipation.

Ensure the patient is wearing the appropriate pad and that it is correctly fitted. For information regarding the correct pads to use see Appendix 2.

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Faecally contaminated pads must be changed immediately without waiting for the wetness indicators to change.

If the patient is to be discharged home from hospital with pads, it is essential that they are discharged with 5 days' supply of pads. As part of the discharge process, the patient must be referred to the District Nurse for ongoing pad assessment and pad provision.

For faecal incontinence in patients who are bedridden or immobilised, with little or no bowel control, and who have a liquid or semi-liquid stool (type 6-7 on the Bristol Stool Form Scale), a faecal management system may be indicated (refer to: CD ref TBC: Guidelines for the use of faecal management systems in adult patients, aged 16 years and over)

For faecal incontinence caused by colorectal faecal loading/ impaction the aim is to relieve the loading/impaction (refer to **Part 3** Constipation) Constipation may be induced by reluctance to use the toilet facilities/ commodes in hospital. Nurses should be aware of personal preferences and ensure privacy good access to the toilet facilities (Royal College of Physicians 2002)

If the practitioner caring for the patient is concerned about the patient's condition they must refer the patient to the appropriate medical practitioner for advice on any further action to be taken, and this must be recorded in the patient's records.

4.2 Skin Care for patients with faecal incontinence

- After every episode of faecal incontinence, remove any wet or soiled undergarments and the pad (if worn)
- If required, gently remove large amounts of faecal matter with toilet tissue
- Using a dry cloth such as TENA Soft Wipe apply 10ml (10 pence piece sized blob) of TENA Wash Cream onto the wipe and gently work the product into the skin. There is no need to rinse with TENA Wash Cream, if the product has been applied correctly the skin should feel dry and soft
- Do not use soap.
- If the patient is female, ensure that the product is applied from front to back.
- Cavilon no sting barrier film can be used safely with pads following the use of the TENA wash cream if indicated. It is designed to protect intact, damaged or 'at-risk' skin from urine, faeces, other body fluids, adhesive trauma and friction http://uhbhome/Downloads/pdf/TissueViabilityMoistureLesionsPressureUlcers.pdf

4.3 Further Management:

If all the methods have been used as detailed above and faecal incontinence continues, further advice can be sought from the functional bowel clinical nurse specialist (CNS).

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Pelvic floor exercises can help to improve sphincter strength and can help to improve bowel control Advice can be sought from the functional bowel CNS.

Other interventions which may help with faecal leakage are available: e.g. anal plugs and washout systems. Advice should be sought from the functional bowel CNS as to the suitability of these for individuals.

Surgery may be appropriate for some causes of faecal incontinence. The need for surgery must be fully assessed by the colorectal surgeons.

Patient information about faecal incontinence is available from the Bladder and Bowel Foundation:
http://www.bladderandbowelfoundation.org/bowel/bowel-problems/faecal-incontinence.asp

References

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Guidelines for the Management of Faecal Incontinence

FAECAL INCONTINENCE

The involuntary leakage of solid, liquid or gas

CONSIDER POSSIBLE CAUSES:

Damage to the anal sphincters:
- Childbirth
- Operations
- Injury
- Rectal prolapse

Diarrhoea:
- Infection
- Inflammatory bowel disease
- Irritable bowel syndrome
- Surgery to the colon

Constipation:
- Immobility or illness
- Some medications
- Some neurological conditions

Nerve injury or disease:
- Spinal injury
- Multiple sclerosis
- Stroke

MANAGEMENT OF FAECAL INCONTINENCE

1. **Exclude** faecal loading/faecal impaction.
2. **Inpatients:** review and document bowel movements (use Bristol Stool Form Scale for type)
3. **Review, address and document:**
   - **Diet** – (fibre intake) -is there a need to increase fluid and fibre intake?
   - **Fluid** intake -consider completing fluid/ food diary for 7 days
   - **Toilet**–consider: -what is their normal routine? (particularly for patients with spinal cord injury who rely on digital removal of faeces)
     -what is the ease of access, location and signposting of the toilet?
     -is the call bell within reach?
     -do they need assistance with mobility in order to reach toilet?
     -do they need assistance onto/off toilet?
   - **Medication**-consider: -side effects of drugs- medication to be reviewed by ward pharmacist
     -drugs to alter stool consistency (Fybogel®/ Isogel®) to bulk stool. Loperamide (to be used with caution)
   - **Continence aids** -inpatients: ensure the patient has the appropriate pads and they are correctly fitted.
     -outpatients: a referral to the district nurse must be made for ongoing pad assessment and pad provision
     NB pads should not be used as the first/only treatment option
   - **Infection-** consider: -does the patient have infective diarrhoea? Send stool specimens and treat in accordance with Trust Infection prevention and Control Policy and procedures

PERSISTENT FAECAL INCONTINENCE

ACUTE

1. **Treat causes** (e.g. constipation/ infection)
2. **Aim to prevent skin excoriation:**
   - Clean skin with TENA cream wash (no need to rinse)
   - Apply Cavilon durable barrier cream or Cavilon no sting barrier film
3. **If skin badly excoriated:**
   - Consider faecal management system

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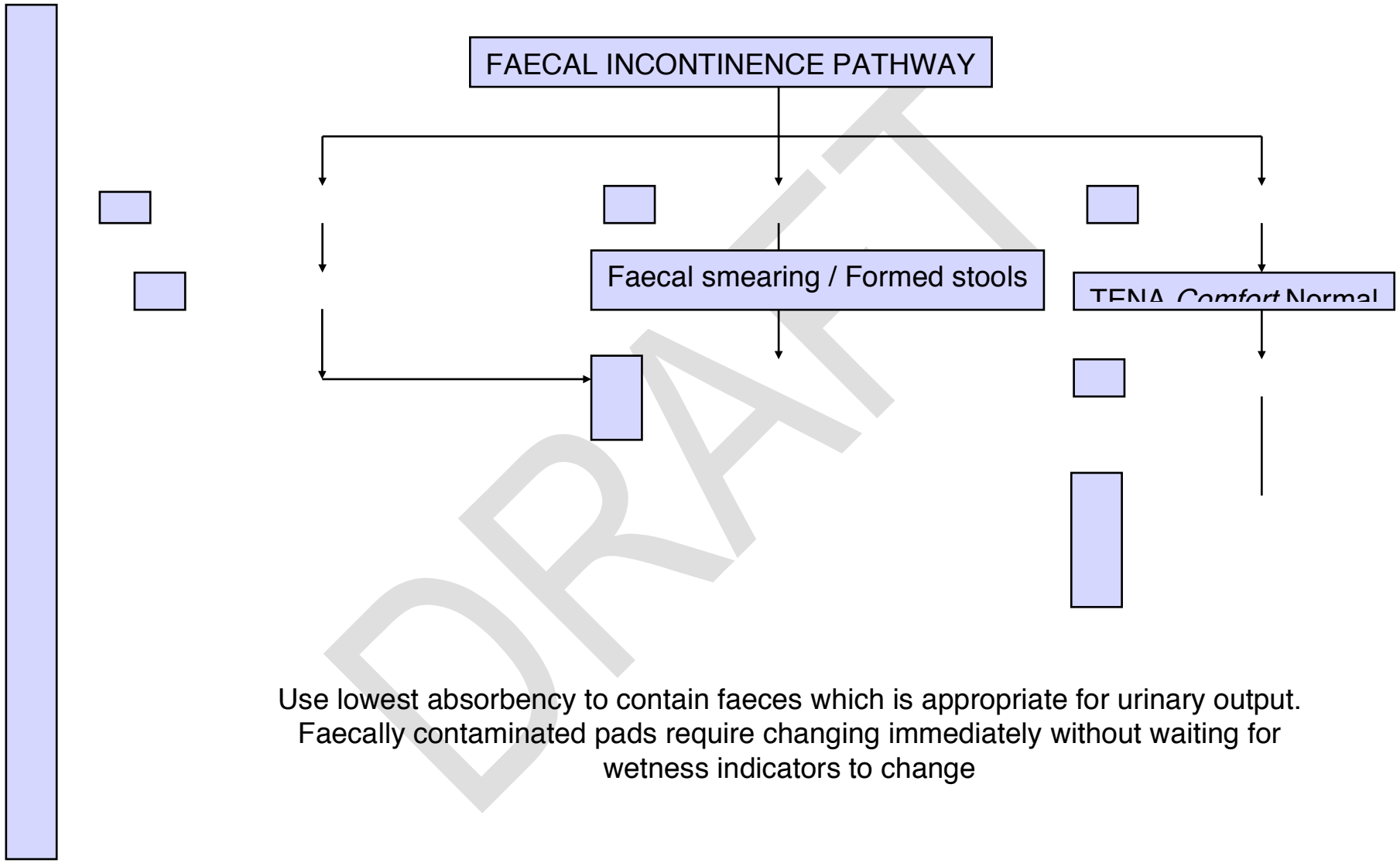
1. For discharge from hospital, the patient must be given 5 days' supply of pads and referred to the district nurse for ongoing pad assessment and provision.
2. Information for the patient can be obtained from the Bladder & Bowel Foundation www.bladderandbowelfoundation.org/



Use lowest absorbency to contain faeces which is appropriate for urinary output.
Faecally contaminated pads require changing immediately without waiting for wetness indicators to change

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