University Hospitals Birmingham NHS
NHS Foundation Trust

CONTROLLED DOCUMENT

# Guidelines for the use of Faecal Management Systems in Adult Patients, aged 16 years and over

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|---|---|
| **CATEGORY:** | **Procedural Document** |
| **CLASSIFICATION:** | **Clinical** |
| **PURPOSE** | **The purpose of these guidelines is to provide practical guidance for the use of Faecal Management Systems in 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**<br>**Executive Medical Director**<br>**Chair of Medicines Management Advisory Group** |
| **On:** | |
| **Review Date:** | |
| **Distribution:**<br>• **Essential Reading for:**<br>• **Information for:** | **All Nursing, Medical and Allied Health Care Professional staff involved in direct patient care which involves insertion, removal and ongoing care of faecal management systems.**<br>**All clinical staff** |



**To be read in conjunction with the current versions of the following documents:**
CG ref 345: Bowel Care Guidelines for Adult Patients aged 16 years and over
CG ref TBC: Guidelines for Digital Rectal Examination and Digital Removal of Faeces in Adult Patients, aged 16 years and over

## Faecal Management Systems


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### 1.0 Introduction

Faecal management systems (FMS) are temporary containment devices, indicated for bedridden or immobilised incontinent patients, with little or no bowel control, who have a liquid or semi-liquid stool. They are also indicated for patients with severe burns to manage their bowel function, promote healing of genital, perineal or anal skin grafts and to maintain infection control following plastic surgery.

They are designed to safely and effectively divert faecal matter, protect patients' wounds from faecal contamination and to reduce both the risk of skin breakdown and spread of infection.

A FMS for the control of faecal incontinence should only be inserted once all other faecal incontinence management alternatives have been considered. (Refer to CG ref 345: Bowel Care Guidelines for Adult Patients aged 16 years and over, current version).

The use of a FMS must be agreed with the medical team in charge of the patient's care following a holistic assessment of the patient which has taken into consideration: infection control, risk of device related skin breakdown, privacy and dignity, and contraindications for use. This agreement must be documented in the patient's records.

**Please note:** there is more than one type of FMS available, and therefore the manufacturer's instructions relating to the insertion of the particular system, removal of the system, and maintenance of the system must be followed. More information can be found at:
http://www.bard.com
http://www.convatec.com
http://www.hollister.com
http:// www.secco-fms.com

## 2.0 Indications for the use of Faecal Management Systems

A FMS can be used for bed-bound or very limited mobility patients with intractable faecal incontinence or persistent diarrhoea, i.e. 4 or more episodes of faecal incontinence in 24 hours (liquid to semi-liquid stools type 6–7 as per Bristol stool chart).
They are used (see Appendix 1 for assessment flow chart):

- To reduce the risk of skin breakdown
- To reduce the risk of spread of infection
- To protect wounds, surgical sites and burns
- To improve patient comfort
- To promote patient dignity
- To assist with faecal management (burn injured patients).

## 3.0 Contraindications for the use of Faecal Management Systems

The FMS must not be inserted in the following circumstances, and the patient must be referred to the medical team if:

- The need for the insertion of the FMS has not been documented by the medical staff.
- The patient is under the age of 18.
  **NB** A FMS may be used in a burn injured patient between the ages of 16 and 18 'off label'; however the decision to use a FMS must be made by the patient's consultant, based on the patient's weight and size. Any decision to insert a FMS, and the rationale for use, must be clearly documented.
- The patient has capacity and refuses the procedure.
- The patient has faecal loading/ impaction.
- The patient has rectal/anal conditions i.e. proctitis, Crohn's disease, stricture.
- The patient has a rectal or anal injury.
- The patient has severe haemorrhoids.
- The patient has a suspected or confirmed rectal/anal tumour.
- The patient has had anal or low rectal surgery within 6 weeks. Any surgery between 6 weeks and 1 year must be discussed with a colorectal surgeon.
- The patient has an established spinal cord lesion, above the level of the sixth thoracic vertebra, and is at risk of developing autonomic dysreflexia.

- The patient has an inflammatory bowel condition. A member of the medical team must determine the degree and location of inflammation within the colon/rectum prior to the use of this device.
- The patient has sensitivity or allergies to any of the materials used in the faecal management system (i.e. silicone).

**Faecal Management Systems should not be used:**

- Single tubes for longer than 29 days. If a FMS is needed for longer than 29 days the tube must be changed.
- For patients with solid or semi-formed stools
- For patients who sit out in a chair for long periods of time.

**NB** If the clinician has judged it to be necessary, or clinically beneficial to sit the patient out of bed with a FMS in situ, the following must be adhered to:

- The sitting position should avoid compressing, kinking or obstructing the device.
- The sitting period must be the shortest possible (no more than 1 hour), and the duration must be documented.
- If there is a moisture lesion, or grade 2 (or greater) pressure damage around or in close proximity to the anus, the patient should not sit out.
- Close surveillance of the device must be undertaken to avoid the risk of pressure damage to the anal/perianal region.
- The collection bag must be emptied prior to sitting the patient out of bed.
- Upon returning the patient to bed, the nursing staff must inspect the anal area and document the condition of the skin on a skin assessment chart. The tube must be positioned correctly and the collection bag supported at all times.

## 4.0 Limitations for the use of Faecal Management Systems

If the following occur whilst the FMS is in situ, the patient must be referred to the medical team for immediate review:

- Persistent rectal pain
- Rectal bleeding
- Abdominal distension
- Excessive leakage of stool around the device
- Loss of anal sphincter muscle tone (this could lead to temporary anal sphincter dysfunction)
- Pressure necrosis of rectal or anal mucosa
- Signs and symptoms of infection and inflammation of the anus
- Bowel obstruction
- The registered nurse is concerned about the patient's condition.

**Further considerations:**

- Prior to the insertion of a FMS, a digital rectal examination must be performed to rule out the possibility of faecal impaction. The device can be inserted once the faecal impaction is removed.
- A digital rectal examination may also confirm presence or absence of anal tone, as poor or absent tone may increase leakage around the device or may contribute to the inability to retain the device.

- If the FMS is being used to control diarrhoea, the device must be removed when the patient's bowel control, consistency and frequency of stool begin to return to normal.
- Close attention must be exercised with the use of the device in patients who have inflammatory bowel conditions (seek advice from colorectal nurses/clinicians).
- Caution must be exercised when considering use in patients with thrombocytopenia and/or clotting disorders and individuals taking anticoagulant medication (seek advice from consultant haematologist).
- To avoid injury to the patient, do not insert anything into the anal canal while the device is in place. Remove the device prior to insertion of anything into the anal canal (e.g. suppositories).
- There is no specific evidence to contraindicate use of the system in cancer and haematological oncology patients, but because of the higher risk of proctitis and clotting disorders, its use must be sanctioned by the patient's consultant and this must be documented (All Wales Guidelines for Faecal Management Systems 2010).

## 5.0 Consent

The registered practitioner, obtaining consent or making the decision to insert the FMS, must ensure the patient and carers are aware of the potential risks associated with this procedure before the decision to insert the FMS is made, and that the primary reason to use the FMS is for the benefit of the patient and not for the convenience of the carers.

## 6.0 Who can undertake the Insertion of a Faecal Management System?

The bowel assessment, prior to the insertion of the FMS, must be carried out by an appropriate, competent, health professional trained in the skill of undertaking a digital rectal examination to determine the presence of faeces in the rectum. Please refer to CG ref: TBC Trust Guidelines for Digital Rectal Examination and Digital Removal of Faeces in Adult Patients, aged 16 years and over (current version).

The outcome of the bowel assessment must be documented in the patient's records. If faecal impaction is present, the device can be inserted once the faecal impaction is removed. The outcome of the bowel assessment must be documented in the patient's records.

A registered nurse who has undertaken education and training and can provide evidence of competence and supervised practice can perform the insertion of a FMS (Appendix 2).

The supervised practice and assessment of competence will be undertaken by a practitioner (supervisor) who is competent in the insertion and management of a FMS. The number of supervised practices required to achieve competence will be determined by the registered nurse and supervisor, taking into account the registered nurse's own learning needs.

Evidence of competence must be provided and a copy kept in the registered nurse's personal file and in the ward or department where the skill is practised.

In accordance with codes of professional practice, the registered nurse has a responsibility to recognise, and to work within, the limits of their competence. In addition, the registered nurse has a responsibility to practise within the boundaries of the current evidence based practice and in line with up to date Trust and national policies and procedural documents. Evidence of continuing professional development and maintenance of skill level will be required and confirmed at the registered nurse's annual appraisal by the registered nurse's line manager.

## 7.0 Insertion of a Faecal Management System

See Appendix 3 for the insertion procedure. Please refer to the manufacturer's instructions for the specific device used.

## 8.0 Maintenance of the Faecal Management System

Observe the device at least every 2 hours for obstructions which may be caused by kinks, solid faecal particles or external pressure. Change the position of the drainage tube, e.g. hang the bag on alternate sides of the bed or lie in the middle. Complete the FMS maintenance checklist (Appendix 4).

Ensure the anal area is clean and dry, and the skin is intact. Slight faecal seepage may occur occasionally. If faecal seepage does occur, the skin must be kept clean and protected with a pH balanced cleanser e.g. Tena cream wash or Cavilon. Document the condition of the skin on a skin assessment chart.

Perform and document a full skin inspection at least every 12 hours. If there are any concerns about skin breakdown, the patient should be referred to the Tissue Viability Team for advice.

If stool samples are required ensure they are taken from the tubing of the system rather than the bag to ensure a recent sample is taken.

Record the faecal output at least every 2 hours on the Prescribing Information and Communication System (PICS).

The collection bag must be emptied frequently and supported well to prevent dragging. It must be changed every seven days or earlier if required. Discard the used bag according to Trust policy and procedures for waste management.

## 8.1 Irrigation of the Faecal Management System

If the silicone catheter becomes obstructed with solid particles, it can be irrigated with tepid tap water. Only flush the device when needed to maintain the unobstructed flow of stool into the collection bag. Please follow the manufacturer's instructions.

Before proceeding with irrigation, check that the tubing is not kinked or obstructed by pressure from a piece of equipment or a body part (consider repositioning the patient). If no external causes of the obstruction have been detected irrigate the device. If irrigation does not alleviate the blockage, and no source of obstruction is detected, refer the patient to the medical team to determine whether the use of the FMS is still indicated or if it should be removed.

## 8.2 Removal of the Faecal Management System

The FMS must be removed if it is no longer indicated, or has been in situ for 29 days. Please follow the manufacturer's instructions for the removal of the device.

## 9.0 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 FMS, to include incidence of pressure ulcers associated with use of a FMS
- Number of staff trained and as assessed as competent in the insertion and removal of a FMS, and the number of staff trained and assessed as competent in the ongoing care of a FMS

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

## References


Evans et al (2010) **All Wales Guidelines for Faecal Management Systems. Guidelines for Best Practice**. MA Healthcare Ltd, London

National Institute for Health and Clinical Excellence (2007**) Faecal Incontinence: The Management of faecal incontinence in Adults**. http://publications.nice.org.uk/faecal-incontinence-cg49/introduction [accessed 10.09.14]


## Bibliography

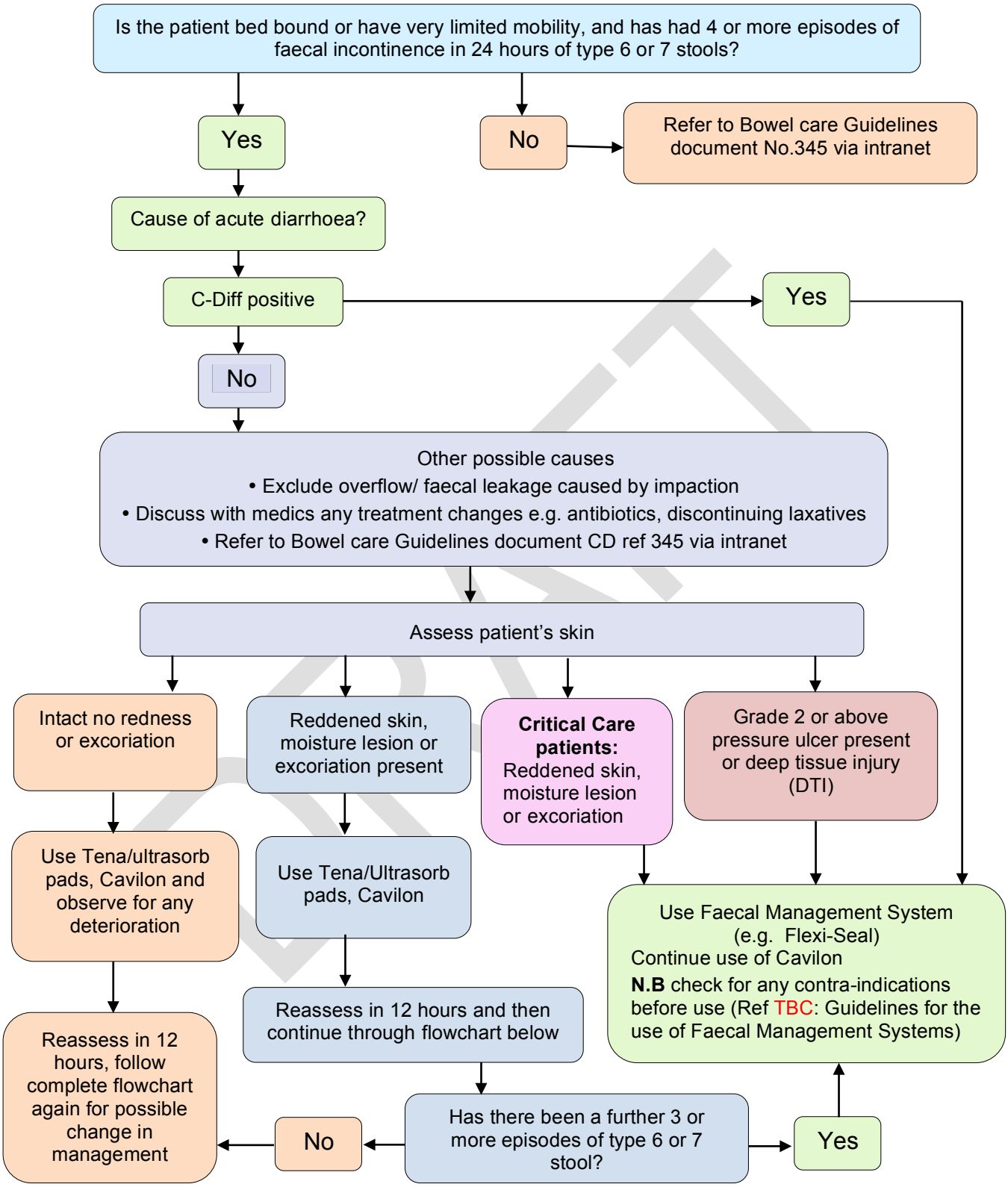

Bard: DIGNISHIELD® **stool management system guidance** http://www.bard.com [accessed 09.09.14]

Convatec: Flexi-seal ® **faecal management system guidance** www.convatec.co.uk/ [accessed 09.09.14]

Hollister: **ActiFlo Indwelling Bowel Catheter System, InstaFlo Bowel Catheter System** www.hollister.com [accessed 09.09.14]

Secco **faecal management system guidance** www.secco-fms.com [accessed 09.09.14]

# Management of Acute Diarrhoea causing Faecal Incontinence: Assessment for Faecal Management System e.g. Flexi-Seal




If faecal management system in situ (e.g. Flexi-Seal) at least 2 hourly check of: black line position, skin inspection (including anus), tube position, consistency of stool, bag check. Other checks may be required dependent upon individual patient needs. If in doubt regarding use of a faecal management system, liaise with the colorectal nurses for guidance.

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**

CRITERIA FOR COMPETENCE

**END COMPETENCE: Insertion and removal of a faecal management system (FMS) and ongoing patient care**

**Date(s) of Education and supervised practice: ……..**

**Name of Registered Nurse (print): ……..**

**Name of Supervisor (print): …….. Designation:……**

The elements of competence related to ongoing care must be completed by all registered nurses providing care to patients with a FMS in situ. The elements of competence related to insertion and removal may be completed at a later date.

| Element of Competence To Be Achieved | Date Achieved | Registered Nurse Sign | Supervisor Sign |
|---|---|---|---|
| Discuss and identify<br>• indications<br>• contraindications<br>• limitations<br>• further considerations<br>For insertion of a FMS | | | |
| Demonstrate knowledge of relevant anatomy | | | |
| Demonstrate knowledge and understanding of why it is essential to follow the manufacturer's instructions for the specific device | | | |
| Demonstrate a working knowledge of the Trust's policy for consent to examination or treatment | | | |
| Demonstrate a working knowledge of the *Mental Capacity Act* | | | |
| Demonstrate accurate provision of information pre and post the procedure in a way that the patient understands | | | |
| Demonstrate maintenance of the patient's privacy and dignity throughout the procedure | | | |

| Element of Competence To Be Achieved | Date Achieved | Registered Nurse Sign | Supervisor Sign |
|---|---|---|---|
| Demonstrate safe infection control practices throughout the procedure. To include:<br>• Standard precautions<br>• Isolation procedures | | | |
| Demonstrate accurate record keeping | | | |
| Discuss any health and safety issues in relation to this procedure | | | |
| Demonstrate an understanding of the incident reporting process | | | |
| Demonstrate a working knowledge of the NMC Code: Standards of conduct, performance and ethics for nurses and midwives (2008) | | | |
| **Elements of Competence to be Achieved for Ongoing Care of a FMS** | | | |
| Demonstrate maintenance of the FMS to include: | | | |
| • Checking the position of the black line (dependent on the type of system used) | | | |
| • Knowledge and understanding of the importance of changing the tube's position | | | |
| • Knowledge and understanding of when to change the collection bag | | | |
| • Procedure for changing the collection bag | | | |
| • Recording faecal output, to include stool amount, type and significance of change to the stool type | | | |
| • Observing the device for obstruction | | | |
| • Irrigating the device | | | |
| • Maintaining skin hygiene around anal area | | | |
| • Observing and maintaining skin integrity | | | |
| • Knowledge and understanding of the barrier creams and skin wash creams available to help maintain skin integrity | | | |
| • Knowledge and understanding of maximum length of time that the patient can sit out of bed | | | |

| Element of Competence To Be Achieved | Date Achieved | Registered Nurse Sign | Supervisor Sign |
|---|---|---|---|
| • Obtaining stool samples | | | |
| **Elements of Competence to be Achieved for Insertion of a FMS** | | | |
| Demonstrate evidence of competence in accurate digital rectal examination to determine presence of faeces in the rectum | | | |
| Discuss and demonstrate the procedure for the insertion of a FMS to include: | | | |
| • Preparation of the patient | | | |
| • Positioning of the patient | | | |
| • Preparation of equipment | | | |
| • Insertion of the tube | | | |
| • Positioning of the balloon | | | |
| • Inflation of the balloon and what to do in the event of improper balloon inflation | | | |
| Discuss and identify potential adverse events during insertion and use of a FMS | | | |
| **Elements of Competence to be Achieved for Removal of a FMS** | | | |
| Demonstrate removal of the FMS to include:<br>• Deflating the balloon<br>• Correct disposal of waste in accordance with Trust Waste Policy and associated procedural documents (current versions) | | | |

I declare that I have expanded my knowledge and skills and undertake to practice with accountability for my decisions and actions.
I have read and understood the guidelines for the **insertion of faecal management systems and ongoing care**

**Signature of Registered Nurse: ……**

**Date: ……**

I declare that I have supervised this registered nurse and found her/him to be competent as judged by the above criteria.

**Signature of Supervisor: ……**

**Date: ……**

A copy of this record must be placed in the registered nurse's personal file, a copy must be stored in the clinical area by the line manager and a copy can be retained by the individual for their Professional Portfolio.

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## EVIDENCE OF SUPERVISED PRACTICE

To become a competent practitioner, it is the responsibility of each registered nurse to undertake supervised practice in order to perform **insertion of faecal management systems and ongoing care** in a safe and skilled manner.

Name of Registered Nurse ……

| DATE | DETAILS OF PROCEDURE | SATISFACTORY STANDARD MET | COMMENTS | PRINT NAME, SIGNATURE & DESIGNATION |
|---|---|---|---|---|
| | | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |

## Procedure for the Insertion of a Faecal Management System (FMS) (e.g Flexi seal, Actiflo or other device)

**NB-** there is more than one type of FMS available and therefore the manufacturers' instructions must be followed.

**Equipment**

- Dressing trolley (cleaned with soap and water followed by a Sani-Cloth 70% alcohol wipe and allowed to air dry).
- Faecal management system (FMS) (type of tube dependent on reason for use)
- Water soluble lubricating gel
- 20 ml syringe
- Non-sterile jug (for single patient use)
- Tepid water
- Disposable non-sterile gloves
- Disposable apron
- Face protection (full face visor)
- Procedure pad
- Cavilon Barrier cream (intact skin) or Cavilon Barrier film (broken skin)
- Hand washing/ decontamination facilities

| No. | Action | Rationale |
|---|---|---|
| **1.** | • Explain procedure to the patient to gain co-operation and verbal consent (where possible)<br>• Document that consent has been given<br>• Document if patient is unable to give valid consent | • Patient information may reduce anxiety<br>• To ensure that the patient understands the procedure and gives his/her valid consent<br>• If the patient has lost the capacity to consent or to refuse the procedure due to, e.g. unconsciousness, sedation or a confusional state. It is vital to document why the procedure is in the patient's best interest |
| **2.** | Screen the bed | To ensure privacy for the patient |
| **3.** | Decontaminate hands with soap and water and apply alcohol gel rubbing until dry | To decontaminate hands prior to patient contact |
| **4.** | Wearing non-sterile gloves and apron, place the procedure pad under the patient's bottom. Assist the patient to lie in the left lateral position with knees flexed. Cover the patient's bottom half with a sheet (assistance may be required dependant on the independence of the patient (follow Manual Handling Procedure)) Remove and dispose of gloves and apron, and | To protect bedding from soiling and to maintain the patient's dignity.<br>To ensure the patient is in the correct position for the procedure |

| No. | Action | Rationale |
|---|---|---|
| **4. cont.** | wash hands as per Trust policy and apply alcohol gel, Rub until dry | |
| **5.** | Put on clean disposable plastic apron. Prepare the trolley, placing all equipment required on the bottom shelf and take to the patient's bedside | To reduce risk of cross-infection from or to uniform. To reserve the top shelf for the preparation of the equipment |
| **6.** | Ensure curtains are fully closed and apply alcohol gel to hands Put on non-sterile gloves | To ensure the patient's privacy and dignity To allow dust and airborne organisms to settle before starting the procedure |
| **7.** | Examine the perianal area | To observe for skin damage, and external haemorrhoids |
| **8.** | Lubricate the gloved index finger | To facilitate easier insertion of the finger and minimise patient discomfort. To reduce mucosal trauma |
| **9.** | Perform a digital rectal examination. Assess the rectum for haemorrhoids, presence of stool and possible faecal impaction | The FMS is contraindicated for faecal impaction and severe haemorrhoids. If either detected, refer the patient to the medical staff |
| **10.** | Ensure the area is cleaned and dried and protective barrier cream (intact skin) or barrier film (broken skin) is applied | To protect the skin |
| **11.** | Remove and dispose of gloves, and apply alcohol gel, rub until dry | To decontaminate hands |
| **12.** | If liquid/semi-liquid stools are present or the rectum is empty, and haemorrhoids have not been detected, prepare the FMS | The FMSs are expensive and, by assessing the patient before opening the packaging, unnecessary waste will be avoided |
| **13.** | Refer to the manufacturer's instructions for preparation of the equipment | More than one type of FMS is available |
| **14.** | Insert the FMS in accordance with the manufacturer's instructions | More than one type of FMS is available |
| **15.** | Position the length of the flexible tubing along the patient's leg avoiding kinks and obstruction Hang the drainage bag by the strap at a convenient location on the bedside. Ensure the drainage bag is well supported and is not pulling | To maintain patient comfort<br><br>To encourage and allow faecal flow from the rectum into the collection bag |

| No. | Action | Rationale |
|---|---|---|
| **16.** | Dispose of equipment in accordance with Trust policy and procedures for waste management | To reduce the risk of cross infection |
| **17.** | Remove gloves apron and decontaminate hands with soap and water. Apply alcohol gel and rub until dry | To reduce the risk of cross infection |
| **18.** | Put on clean apron and gloves and reposition the patient | To ensure patient comfort |
| **19.** | Remove gloves and apron and decontaminate hands with soap and water. Apply alcohol gel and rub until dry | To reduce the risk of cross infection |
| **20.** | Document procedure and outcome in the patient's notes and on any other relevant bedside documentation (e.g. stool record chart, *c. diff* care plan/ diarrhoea care pan/ skin assessment chart) | To ensure communication between the multidisciplinary team and a record of care given |

Name……

Reg. No……

Date of birth……
(Affix label)

## Faecal Management System Maintenance Checklist

**Appendix 4**

Date of insertion…../…./……
Number of days in situ: ……..

- Check system at least every 2 hours
- Record volume of drainage on PICS

| **Date:** …/…./…… | **Black line position checked** (✓) | **Consistency of stool** (Bristol stool score) | **Skin integrity** (e.g. intact, reddened etc) | **Patient position** (left/ right/ back/ sitting out) | **Tube position** (left / right/ centre) | **Check bag** (✓) | **Check drainage** (✓) | **Irrigation** (yes/no) **Volume used** (mls) | **Signature** | **Print name and designation** | **Comments** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 00.00-02.00 …….. | | | | | | | | | | | |
| 02.00-04.00 …….. | | | | | | | | | | | |
| 04.00-06.00 …….. | | | | | | | | | | | |
| 06.00-08.00 …….. | | | | | | | | | | | |
| 08.00-10.00 …….. | | | | | | | | | | | |
| 10.00-12.00 …….. | | | | | | | | | | | |
| 12.00-14.00 …….. | | | | | | | | | | | |
| 14.00-16.00 …….. | | | | | | | | | | | |
| 16.00-18.00 …….. | | | | | | | | | | | |
| 18.00-20.00 …….. | | | | | | | | | | | |
| 20.00-22.00 …….. | | | | | | | | | | | |
| 22.00-24.00 …….. | | | | | | | | | | | |