The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bowel / Faecal Management Systems: Guidelines for use

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Ratified By:	Colorectal Services and Newcastle Specialist Continence Service

1. Introduction

This guideline is to ensure the appropriate use of the bowel / faecal management system within the Trust. The guideline outlines the requirements of registered nurses and qualified medical staff to be competent in the use of the bowel/faecal management system.

2. Guideline scope

It has been recognised that there are a group of patients who may benefit from the use of a bowel / faecal management system. The system is designed to provide a safe, effective faecal diversion and containment system designed to improve patient care.

3. Evidence review and evaluation

Bowel / faecal management systems have been developed to assist clinicians in the care and management of faecal incontinence and infection control, and the prevention of associated skin damage.

Extensive skin damage can be caused by prolonged contact with excessive moisture from urine or liquid stool incontinence. Faecal incontinence causes more irritation to the perianal skin than urinary incontinence because faeces contain bacteria and digestive enzymes that damage the skin.

Patients with incontinence are also at risk of developing moisture lesions and breaks in the skins integrity which increases susceptibility to pressure ulceration and secondary dermal infection. Patients with faecal incontinence, skin injury can occur within minutes of onset. This is also a potential problem in patients with infective bacteria present in their faeces, e.g. Escherichia coli, incontinence may add to the risk of cross-infection.

A bowel / faecal management system is a temporary containment device consisting of a soft, flexible, silicone catheter with a low-pressure balloon, which is filled with water or saline to aid retention, and which is easily inserted into the patients rectum. The catheter is attached to a closed-end collection bag. The device is suitable for the collection of liquid or semi-liquid stools and has a port to allow for the flushing of the system if required.

Bowel / faecal management systems have been designed to provide a closed system for the management of liquid or semi-liquid faecal incontinence and prevent faecal contamination of the environment.

4. Main body of the guideline

Clinical areas

Bowel / faecal management systems are to be used within general wards, intensive care units, high dependency units, specialist burns and plastics unit. When a bowel /faecal management system may be considered, ward staff should discuss and seek approval with the named consultant, specialist staff, including gastroenterologists, colorectal surgeons, colorectal nurse specialist, nurse consultant continence prior to using the system.

Indications for appropriate use

- Named consultant to give approval for using the bowel / faecal management system and document in patients medical notes
- The patient is over 18 years old
- The patient is incontinent with liquid or semi-liquid stool and has persistent diarrhoea. If persistent diarrhoea is evident this must be further investigated for example stool cultures
- The patient has confirmed infective diarrhoea e.g. Clostridium difficile positive or Salmonella
- The patient has diarrhoea colonised with vancomycin resistant enterococcus
- The patient has large amounts of persistent melaena due to bleeding oesophageal varices
- There is antibiotic resistant organisms in the GI tract
- The system is to be used for immobile patients only
- There is a risk of skin breakdown or invasive line contamination due to faecal incontinence
- To reduce the spread of infection
- Improve patient comfort and dignity
- To protect wounds, surgical sites, burns and skin
- To reduce the cost of managing faecal incontinence

Contraindications

Please note: Clinical contraindications should be assessed prior to use

Bowel / faecal management systems should not be used on patients with the following conditions:

- Paediatric patients
- Suspected or confirmed rectal mucosa impairment (i.e. proctitis, ischaemic proctitis, mucosal lacerations)
- Recent large bowel (colon) surgery or rectal surgery within the last year
- Patients who have had a restorative proctocolectomy (ileo-anal pouch)
- Sensitivity or allergies to any of the materials used in the device (i.e. silicone)
- Rectal or anal injury

- Severe rectal or anal stricture or stenosis (the distal rectum cannot accommodate the balloon)
- Confirmed rectal/anal tumour
- Severe haemorrhoids
- Faecal impaction
- Patients with poor rectal tone
- People with established spinal cord lesions experience loss of normal bowel function and control as a direct and permanent consequence of nerve damage. Autonomic dysreflexia usually occurs in people with a spinal cord lesion above the level of the sixth vertebra. If left unresolved autonomic dysreflexia could have damaging outcomes such as cerebral haemorrhage, seizures and cardiac arrest. Therefore a bowel / faecal management system is not suitable for spinal cord injury patients due to the high risk of Autonomic dysreflexia

The bowel / faecal management system is not intended for use:

- Beyond 29 days
- For patients under the age of 18

Precautions and observations

The use of the system is not indicated for solid or soft-formed stool. Patients with the device in situ who have inflammatory bowel disease should be closely monitored.

Close attention should be applied with the use of the device in patients who have inflammatory bowel disease. If a bowel / faecal management system is to be used in patients with inflammatory bowel disease this should be discussed with the patient's named consultant by the registered nurse or qualified medical staff.
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.

Notify medical staff if any of the following occur:

- Persistent rectal pain
- Rectal bleeding
- Abdominal distension
- Abdominal pain
- Decrease in urinary output

As with the use of any rectal system, the following adverse events can occur:

- Excessive leakage of stool around the system
- Loss of anal sphincter muscle tone could lead to temporary anal sphincter dysfunction
- Pressure necrosis of rectal or anal mucosa
- Infection
- Bowel obstruction
- Perforation of the bowel

Assessment
Prior to introducing the system a full bowel assessment should be carried out by a registered nurse or qualified medical staff to determine the patient's individual bowel regime. All patients should have their bowel care needs assessed and documented within their normal care plan. All documentation must be updated as required depending on the patient's symptoms and individual needs.

The insertion of a Bowel / faecal management system should be carried out by a qualified health care practitioner who has undertaken the "Assessment of competencies – performance criteria".

Assessment in Adult Critical Care
Adult patients in critical care should have their needs for a BMS assessed *on admission* and every 12 hours using a critical care bowel management assessment tool (appendix 1). This bowel management assessment will supplement the required general bowel assessment. The score and actions should be recorded within the existing nursing records.

Consent
It is imperative that the patient gives consent prior to this device being used. The Department of Health (2009) issued guidelines in respect of legal consent as follows:

- The patient must have the mental capability to consent
- The patient must be given sufficient information to make an informed choice
- The patient must give consent freely

Registered nursing staff (NMC, 2015) or qualified medical staff must document that the patient has given consent and in any case where the patient is not deemed to be competent to give consent, the procedure must be discussed with the Consultant in charge of the patient and reference should be made to the Department of Health document (2009) Reference guide to consent for examination or treatment.

Directions for use
It is imperative that the registered nurse and qualified medical staff follow the manufactures instructions relating to the administration, irrigation of the system, removal of the system and maintenance of a bowel / faecal management system.

There may be certain clinical situations when a bowel / faecal management system would be of benefit to the patient this should be discussed with the named Consultant.

5. Training, implementation, resource implications

Registered nurses and qualified medical staff are responsible for ensuring that they have achieved competence prior to using the bowel / faecal management systems.

Using the systems should only be carried out by registered nursing staff and qualified medical staff who can demonstrate that they have received suitable training or instruction to a level where they are deemed competent and under the NMC Code (NMC, 2015*)* and General Medical Council (GMC, 2013). Staff must demonstrate

that they have kept their knowledge and skills up to date and acknowledge their own limitations and seek expert supervision if required.

The Trust will provide training for registered nursing staff and qualified medical staff who may be exposed to using these systems. This can be achieved as follows:

- By contacting the Clinical Nurse Specialist - Colorectal Nurses and the Nurse Consultant Continence Care
- By providing formal teaching programmes, using teaching models in the skills lab to develop practical skills. Support and training will be provided by the bowel/ faecal management system manufacturer
- Within clinical areas where registered nursing staff and qualified medical staff who are competent in this procedure and who are caring for patients using this system
- It is expected that staff are deemed competent with using the bowel / faecal management system

There may be certain clinical situations where a bowel / faecal management system is contraindicated but the registered nurse or qualified medical staff feel that the device would benefit the patient by improving the quality of care. In this situation staff must discuss this concern with the named Consultant.

6. Monitoring

Compliance with this guideline will be monitored by periodic audit. The audit data will be reported to the appropriate groups, which will review the report, identify any actions required to improve compliance and monitor these actions through to completion.
Audit results will be disseminated to the appropriate forums.

7. References

- Department of Health (2009) Reference guide to consent for examination or treatment. DOH, London
- NPSA Patient Safety Agency (2004) Patient Safety information http://www.mascip.co.uk/pdfs/PSI_Final_2.pdf
- Nursing and Midwifery Council (2015) Code, Nursing and Midwifery Council, London
- General Medical Council (2013)

Appendix 1

CRITICAL CARE BOWEL MANAGEMENT ASSESSMENT TOOL

Bowels Opened? If YES

Faecal overflow from constipation needs to be excluded by rectal examination carried out by qualified competent nurse/medical staff

If constipation identified this should be managed through the Trust 'Guidelines for the Management of Constipation in Adult Critical Care'

Overall Risk

Assess three categories and record overall risk on admission and at least every 12 hours

Tissue Integrity to Perineal Area

Intact Healthy Skin	= 0
Clammy moist Skin	= 2
Redness and/or excoriation	= 3
Pressure Ulcer (grade 1 or above) or moisture lesion	= 4
Burns Trauma	= 4

Continence

Continent	= 0
Urinary Incontinence	= 1
Faecal Incontinence (2-5 on Bristol Stool Chart)	= 3
Acute Diarrhoea (6/7 on Bristol Stool Chart)> 3 times/24 hours	= 4

Mobility

Limited Mobility (able to move self and/or up in chair)	= 1
Immobile (unable to move without assistance)	= 2
Unstable unable to be turned	=3

Add scores together to calculate overall risk (utilising clinical judgement) and record on grid below. Actions should be recorded in the nursing care plan.

< 6 Low Risk Observation

Use Trust Guidelines for Skin Care

Re-assess at least every 12 hours

≥ 6 High Risk Consider the use of a Bowel Management System for Stool

Refer to Trust Bowel Management System guidelines

Consider using a Bowel/Faecal Management System

If stool type 6-7 consider the use of a Secco Bowel Management System to divert and contain liquid stool

If stool type 2-5, a stool modification programme is usually required

Bristol Stool Form Scale

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

Maintenance plan of the Bowel/Faecal Management System

Maintenance and routine patient care

1. Observe at least 2 hourly that stool is flowing into the tubing and the collection bag, if not irrigate the system (refer to manufacturer guideline)
2. Observe at least 2 hourly that the system and collection bag are positioned so that the tubing is not twisted, kinked or externally compressed
3. Observe at least 2 hourly that waste is not accumulating in the draining tube, if this occurs, milk the tubing
4. Ensure at least 2 hourly that the patient is not lying on the tubing or connectors
5. Document the amount (mls) colour and type (Refer Bristol Stool Chart) at least 2 hourly
6. Flush the inside of the tubing through the blue irrigation port at least twice daily and document on care plan
7. Each week, fully deflate the white retention cuff using the white port and re-inflate with 45 mls maximum of water to ensure cuff patency
8. Check the retention cuff volume at least every 7 days
9. A patient can be sat out of bed for 15-30 minutes maximum. This should be decided by senior staff on an individual patient basis

How to irrigate

1. Fill a Luer lock syringe with water
2. Connect syringe to blue irrigation port labelled ‘Irrig’
3. Slowly depress the plunge

Note: Care should be taken when disconnecting the syringe from the blue irrigation port as fluids may drain or splatter from the connector when it is disconnected.

Removal of the system

1. Remove the water from the retention cuff by connecting the syringe to the white connector and withdrawing all the water (45mls)
2. Disconnect syringe
3. Check the retention cuff is deflated by observing and ensuring the pilot balloon is collapsed
4. Apply water-soluble lubricant to the anal canal
5. Hold the catheter as close to the anus as possible
6. Ask the patient to bear down (if capable), and apply steady traction to slide the catheter out of the anus
7. Place in clinical waste bag and dispose according to Trust policy

Note: Care should be taken when removing the system as it may splatter. Wear appropriate protective clothing e.g. apron, gloves, visor or goggles.

Bowel Management System

Named Nurse: _____ **Department/Unit:** _____

Maintenance checklist: Date of insertion: _____ **Cuff volume:** _____

Flush volume: _____ **Batch Number:** _____

Blank = Initial when task is performed

Day	1	2			3			4			5			6			7			8		
Date																						
Shift		am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n
Irrigation (blue port)																						
Milk tube																						
Catheter position																						
Bag change																						
BMS Score/Critical Care only																						
Cuff Refill (white port)																						

Day	9			10			11			12			13			14			15			16		
Date																								
Shift	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n
Irrigation (blue port)																								
Milk tube																								
Catheter position																								
Bag change																								
BMS Score/Critical Care only																								
Cuff Refill (white port)																								

Day	17			18			19			20			21			22			23			24		
Date																								
Shift	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n
Irrigation (blue port)																								
Milk tube																								
Catheter position																								
Bag change																								
BMS Score/Critical Care only																								
Cuff Refill (white port)																								

Day	25			26			27			28			29		
Date															
Shift	am	pm	n	am	pm	n	am	pm	n	am	pm	n	am	pm	n
Irrigation (blue port)															
Milk tube															
Catheter position															
Bag change															
BMS Score/Critical Care only															

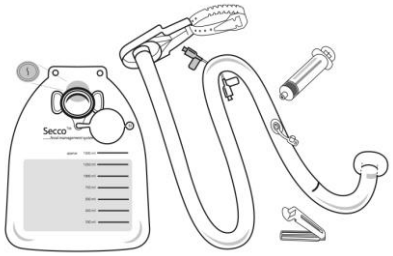
Management System should be removed/changed after 29 days

Bowel Management Systems for Acute (January 2015 – Review January 2017)

Type of system

Faecal Collectors

Item codes:
Hollister 25cm – 9822
Hollister 30cm – 9821
Secco 30cm connector – SEC600 CT
Secco 30cm fold-up tail – SEC600 FT



Secco Bowel Management System

Item codes:
Full kit – SEC100
Spare bags – SEC200
Dignity covers – SEC400
Peri – catheter absorbent pads – SEC500

Documentation

- Refer to guidelines for using a Bowel Management System
- All registered practitioners must be competent in using the system
- Ensure appropriate care plan is used

Management

Faecal Collector
•Assess patient
•Skin must be intact
•If Bristol stool Type 6-7 (less than three times in 24 hours) and if patient is immobile
•Reapply the collector every 24hours
•Maintain patient observation

Secco Bowel Management System
•Assessment – consider this system to divert & contain liquid stool
•If Bristol stool Type 6-7 (more than three episodes) if appropriate
•Faecal incontinence associated with diarrhoea
•Maintain patient observation

Reassessment

Ask yourself the following questions: is the patient's condition improving or deteriorating? If it continues to deteriorate despite following the above care, contact Colorectal Nurse Specialist, Continence Service

Do not flush the patients BMS without first checking you are using the correct port.
You must only irrigate through the blue port. If in doubt, check with Senior Nurse.