Guideline

Guideline Title: Faecal Management System for ICU patients

Summary: All ICU patients will receive ongoing assessment and management of their bowels. In the presence of faecal incontinence, a faecal management system will be utilised to prevent pressure area complications and promote patient comfort.

Approved by: ICU Medical Director

Publication (Issue) Date: December 2015

Next Review Date: December 2018

Replaces Existing Guideline: Faecal Management System for Intensive Care Patients


1. Introduction:
The faecal management system provides containment and diversion of stool, which is of liquid or semi liquid consistency. When used in patients with faecal incontinence, it helps to keep the skin clean and dry and free from contaminants and moisture that contribute to skin breakdown. It minimises spread of infection by keeping infectious body waste contained in a closed system. It aids in the prevention and protection of perianal and sacral pressure areas. It can also serve to increases patient comfort.

The risk addressed by this policy:

Patient Safety and Patient Comfort

The Aims / Expected Outcome of this policy:

- Staff will appropriately identify patients requiring faecal management systems
- Faecal management systems will be inserted and managed safely by ICU staff

Related Standards or Legislation

NSQHS Standard 1 Governance

Related Policies

ICU2014_Clinical_Guideline: Bowel Management
2. **Policy Statement:**

- All care delivered in the Intensive Care Unit will abide by Occupational Health and Safety guidelines, minimisation and management of aggression principles, standard precautions for infection control and current legislation.
- Bowel assessment must be attended with ICU physical assessment and documented daily on the ICU flowchart.
- The need for use of faecal management system needs to be prescribed by a medical officer and documented as part of the medical care plan.
- The faecal management system is only to be used for patients who are incontinent and bedridden with liquid or semi-liquid stool.

3. **Principles / Guidelines**

**Indications**
- Patients who are bedridden, with incontinent liquid or semi-liquid stool, in whom use of a faecal incontinence pouch has failed. When stool begins to become solid this device should be removed.
- Patients with persistent incontinence who at risk of perianal and sacral skin breakdown and pressure ulcers.
- Patients requiring faecal diversion for the protection of wounds, burns, flaps or grafts.
- For the containment of infectious liquid or semi-liquid stools

N.B: If Patient has diarrhoea, do not use BMS as treatment of diarrhoea but look for and treat the cause of diarrhoea.

**Contraindications**
- Colon or rectal surgery within the last 12 months
- Rectal or anal injury
- Severe rectal or anal stricture or stenosis (distal rectum cannot accommodate the balloon).
- Suspected or confirmed rectal mucosa impairment (eg: severe proctitis, ischemic proctitis, mucosal lacerations).
- Rectal or anal tumour
- Severe haemorrhoids
- Faecal impaction
- Sensitivity or allergy to any of the material in the faecal incontinence device.

**Precautions**
- The faecal management system is not indicated for solid or soft formed stool.
- If the patient develops rectal bleeding, assess for pressure necrosis from the catheter then discontinue use.
- To avoid injury do not insert anything into the anal canal while the device is in place (eg: temperature probe, suppositories).
- Patients with weak sphincter function may expel the catheter or have increased leakage of stool.
- Use with caution in patients with spinal cord injury because of the risk of autonomic dysreflexia
- Do not use ointments with petroleum as contact with the catheter may cause damage.
- Only use water to inflate the retention cuff. Do not use saline solution, which may adversely affect valve function.

**Equipment**
- Faecal management system- Flexi Seal Bowel Catheter system. Kit contains silicone catheter, inflation syringe and collection bags.
- Water soluble lubricant
- Water for injection 10ml amps x 5 (need 45ml)
- Gloves, gown, goggles
- Dressing pack

**Procedure**

**Catheter Insertion:**
1. Put on appropriate PPE
2. Explain the procedure to the patient if they are alert and orientated.
3. Place the patient in a left lateral knee-chest position, if not contraindicated.
4. Examine the rectum for faecal impaction and clear any stool present. Feel for any mass, lesion or stricture which may preclude the use of the device.
5. Connect catheter to collection bag.
6. Use provided luer lock syringe to withdraw all air from cuff via “white” connector

7. Squeeze cuff flat and fold in half

8. Generously lubricate catheter end

9. Insert cuff into distal rectum
10. Fill cuff with 45mL water via “white” connector

11. Gently tug and release to seat the cuff

Catheter Removal
1. Put on appropriate PPE
2. Lubricate catheter and around anal canal with water soluble lubricant
3. Fully deflate cuff via “white” connector
4. Hold catheter near anus and use an absorbent pad/ bluey to cover catheter during removal to protect against splatter
5. Ask patient to bear down and slide catheter out
6. Dispose of catheter and bag in contaminated waste bin

Clinical Issues
- Ensure the device is correctly inserted and maintained in position.
- Obtain verbal consent from patient / or person responsible if patient unable to consent.
- Check frequently to ensure that the catheter and tubing is not twisted or kinked or externally compressed.
- Position drainage bag to allow drainage by gravity.
- Check that the stool is not accumulating in the drainage tubing. This may require milking of the tubing to aid drainage.
- If prescribed follow the stool modification plan to maintain optimal stool consistency for drainage.
- Flush catheter with 50mL lukewarm water via “blue” connector twice daily to prevent stool accumulation and catheter obstruction. Record volumes on fluid balance chart. Replace cap on irrigation port to prevent leakages
• If leakage or lack of drainage occurs, check tubing to ensure no kinks or working against gravity. Check retention cuff for inward migration, apply gentle traction to ‘seat’ cuff on rectal floor, so approximately 1cm of blue Low Impact Zone extends from the anus. Check retention cuff inflated with 45ml water. Ensure stool consistency is loose. Irrigate with lukewarm water via “blue” connection port

• The faecal management system cannot remain insitu for anymore than 29 days. Verify the retention cuff volume atleast every 7 days.

• Catheter expulsion may occur if sphincter control is inadequate. If catheter is expelled, verify no stool is present in the distal rectum, ensure the catheter is not under excessive traction, rinse catheter and reinsert.

• Assess the patient for the following potential adverse effects:
  ➢ Infection
  ➢ Leakage of faecal content
  ➢ Perforation
  ➢ Pressure necrosis
  ➢ Obstruction or loss of sphincter tone

• Notify the medical team if the following should occur:
  ➢ Persistent rectal pain
  ➢ Rectal bleeding
  ➢ Abdominal distension

4. Performance Measures
All incidents are documented using the hospital electronic reporting system: IIMS and managed appropriately by the NUM and staff as directed.

5. References / Links


Author: CNC – ICU (S. Shunker), NUM – ICU (T. Hockey)
Reviewers: ICU – CNC, CNE, NM, NUM, Staff Specialists, CNS ‘s
Endorsed by: Prof M. Parr, Director ICU.