Faecal management systems help prevent cross infection and preserve skin integrity. Nurses in Wales developed guidelines to ensure these systems are used appropriately.

Faecal incontinence: a joint approach to guideline development

In this article...
- The prevalence and effects of faecal incontinence
- Indications and contraindications of management systems
- Developing guidelines for use of faecal management systems

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Faecal incontinence is an embarrassing symptom that should be assessed. Faecal management systems (FMS) collect and contain liquid or semi-liquid stool, helping to preserve skin integrity and prevent environmental contamination. Nurses from three health boards across Wales joined together to produce guidance for using FMS in practice. Backed by national organisations and the chief nursing officer for Wales, this was published in March 2011.

Faecal incontinence is an embarrassing condition. It can have a detrimental effect on psychological, social and physical functioning, significantly reducing quality of life (Wishin et al, 2008). The National Institute for Health and Clinical Excellence (2007) says all staff working with people who have faecal incontinence should be aware of its physical and emotional impact. Health professionals should ensure all patients who report faecal incontinence are offered a focused baseline assessment, including relevant medical history, an anorectal examination and a cognitive assessment if appropriate.

In some cases, containment measures may also be needed. Most management and containment of faecal incontinence, especially in acute settings, focuses on meeting patients’ hygiene needs, changing bedlinen and using incontinence pads. However, severe uncontrolled diarrhoea is a threat to skin integrity, and nurses should consider using a faecal collection device (NICE, 2007). Uncontrolled diarrhoea also increases the risk of cross contamination and infection from pathogens such as C. difficile.

Background Studies have shown that 1–10% of adults are affected by faecal incontinence (NICE, 2007). It has been suggested that the different definitions of the condition make it difficult to determine its exact prevalence (Ousey et al, 2010) but it is common in hospital patients (Wishin et al, 2008).

A UK study by Ousey and Gillibrand (2010) found a high prevalence of faecal incontinence in patients in intensive care. A study of 1,106 patients also found that more than a third were continent of urine, faeces or both. Of the 125 patients considered at very high risk of pressure damage, 78% were continent (Evans, 2010).

Three nursing groups in Wales – continence, infection control and tissue viability – had all considered producing guidelines on the use of faecal management systems (FMS). Acknowledging that all relevant disciplines would need to be involved in producing guidelines if they were to be fit for purpose, we convened a group to produce the All Wales Guidelines for Faecal Management Systems (www.welshwoundnetwork.org).

The purpose of the guideline is to ensure the appropriate use of FMS within Welsh health boards and independent sector organisations, and to give staff guidance on the most appropriate systems for patients. It is based on expert consensus that, along with audit, is suggested as a positive method of directing care (Ousey et al, 2010).

High-risk groups Groups at high risk of faecal incontinence include frail older people, women after childbirth, and people with neurological or spinal disease (Box 1). Before using any device or treatment to manage faecal incontinence, a full assessment should be undertaken by a health professional with the relevant skills, training and experience in bowel dysfunction (NICE, 2007).

Effects of faecal incontinence Faecal incontinence can have a detrimental effect on psychological, social and physical functioning, and the stigma associated with the condition can result in significant psychological trauma (Wishin et al, 2008). Faecal incontinence is seen as undignified, and the subsequent care as an invasion of personal space. The associated odour is a further source of embarrassment and humiliation (Wishin et al, 2008). It causes distress, anxiety, and a loss of personal control and dignity, is inconvenient and threatens self-esteem and self-confidence.

People with faecal incontinence can feel stigmatised, as if they no longer fit societal...
“norms”. An extensive study of teenagers living with it found they faced exclusion, humiliation, ignorance and ridicule (Cavet, 1998). Maintaining privacy and dignity should therefore be paramount when caring for people with faecal incontinence.

Physical symptoms include abdominal discomfort, pain or bloating, and bowel urgency and frequency. This can lead to dehydration, skin problems, and urea and electrolyte imbalance if not treated or managed effectively (Box 2).

**C. difficile**

Patients with *C. difficile*-associated diarrhoea can experience faecal incontinence, which has direct implications for environmental contamination and cross infection (Starr, 2005). As such the Welsh Assembly Government introduced mandatory surveillance of *C. difficile* in hospital patients aged 65 and over in 2005. In 2008-09, a total of 2,744 *C. difficile* cases were reported in Wales, representing 15.46 per 1,000 hospital admissions (Welsh Healthcare Associated Infection Programme, 2009). Health boards throughout Wales are required to reduce healthcare-associated *C. difficile* infections by at least 20% year on year (WHAIP, 2009).

**Faecal management systems**

FMS are fully closed systems that collect and contain liquid or semi-liquid stools, helping to prevent faecal contamination of the environment (Johnston, 2005). A clinical evaluation of a flexible faecal incontinence system found it also improved skin condition (Padmanabhan et al, 2007).

In 2007, FMS was awarded rapid review panel recommendation 1 by the Department of Health’s HCAI Technology Innovation Programme. This identifies and supports the development of new initiatives for tackling HCAIs, and found the system to be clinically and cost effective. It recommended decisions on its implementation be made at local level (HCAI Technology Innovation Programme, 2009).

**FMS guidance**

Members of the group (Julie Evans, tissue viability nurse; Joanna Price, infection control nurse; Trudie Young, lecturer in tissue viability; and Ann Yates, director of continence services) convened to produce the guidance work for a range of health boards across Wales.

We met in March 2010 to set the project’s aims and objectives. We reviewed the available literature and existing faecal management policies and undertook a scoping exercise to define the development process and individual roles. The first draft of the document was produced and reviewed by May 2010. After further amendments it was reviewed by local and nationally recognised organisations and returned by September 2010. Our final group meeting took place in October 2010, when we reviewed all comments and feedback and integrated them into the document as appropriate.

The guideline includes the background to faecal incontinence, the extent of the problem, individuals at risk and advice on carrying out assessments. It also includes:

- Guidance on skin care and use of FMS;
- Alternatives to the use of FMS;
- Consent;
The group received an unrestricted educational grant from ConvaTec for the development, production and dissemination of the guidance.

To access, All Wales Guidelines for Faecal Management Systems, go to www.welshwoundnetwork.org

References


Welsh Healthcare Associated Infection Programme (2009) All Wales Mandatory Clostridium difficile Surveillance. tinyurl.com/C-diff-surveillance


» Indications/contraindications for using FMS, and possible adverse events (Box 3):
» Directions for use;
» Resources, training and organisational issues;
» A quick reference guide (Fig 1).

Its foreword was written by Professor Jean White, chief nursing officer for Wales, and it has been endorsed by local (Welsh Wounds Network) and national organisations (Association for Continence Advice, Infection Prevention Society, Wound Care Alliance UK). We are happy to share it with all health professionals, and will continue to work on other aspects of the guidance, such as implementation and education.

Conclusion

The underlying philosophy behind the guideline is recognition that people with faecal incontinence have complex needs that require an interdisciplinary approach. This project has shown effective working between nursing groups in Wales, resulting in clear guidance for practice in the absence of definitive research on FMS use.

The document has attracted interest from nurses in Scotland and England, who may adopt it to form part of national guidance on the use of FMS and good practice in containing faecal incontinence if appropriate for that individual.

BOX 1. FAECAL INCONTINENCE: HIGH-RISK GROUPS

People at risk of developing faecal incontinence include:
- Frail older people
- Women following child birth (especially following third and fourth degree obstetric injury)
- or people who have:
- Loose stools or diarrhoea from any cause
- Neurological or spinal disease (for example spina bifida, stroke, multiple sclerosis or spinal cord injury)
- Severe cognitive impairment
- Urinary incontinence
- Pelvic organ prolapse and/or rectal prolapse
- Perianal soreness, itching or pain
- Learning disabilities
- Undergone colonic resection or anal surgery
- Had pelvic radiotherapy

Source: NICE (2007)

BOX 2. EFFECTS OF FAECAL INCONTINENCE

- Faecal contamination can increase the risk of post-surgical wound breakdown in susceptible areas, such as the groin and perineal regions (Estrada et al, 2009)
- Alkaline faeces can change the slightly acidic pH of skin, causing skin irritation (Beldon, 2008)
- Increased moisture from episodes of incontinence, combined with bacterial and enzymatic activity, can cause skin breakdown
- Dehydration due to faecal incontinence can cause skin changes, such as dryness and turgor
- Cross-contamination can occur if patients have infected diarrhoea
- Financial costs include containment products, laundry, nursing time, drug therapies and extra bed days make faecal incontinence expensive

BOX 3. INDICATIONS AND CONTRA-INDICATIONS FOR USING FACIAL MANAGEMENT SYSTEMS AND POSSIBLE ADVERSE EVENTS

Indications:
- Patient has liquid to semi-liquid stool (type 6-7 on the Bristol Stool Chart)
- Patient is bed bound
- Confirmed diagnosis of C. difficile infection

Contraindications:
- Large bowel surgery or rectal surgery within the past year
- Sensitivity or allergy to any of the materials used in FMS
- Possible adverse events:
- Loss of anal tone
- Pressure necrosis of rectal or anal mucosa
- Infection
- Bowel obstruction
- Perforation of the bowel
- Persistent rectal pain
- Abdominal distension
- Unable to open bowels for more than 48 hours

Discussion

“Learning how to use and receive criticism will result in positive outcomes”

Susan Hodgetts p41

-induced pain.

Journal; 35: 1, 104-110.


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