CLINICAL GUIDELINE

Faecal Management System (FMS) Guidance for nursing staff

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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INTRODUCTION

This guideline outlines the requirements for nursing staff to be aware of, and be competent in the use of a faecal management system (FMS) for skin protection.

The consequences of skin damage associated with faecal incontinence are severe. Potentially avoidable moisture lesions or pressure ulcers to the sacral or perianal region, plus any wounds to the groins or lower abdomen, are at risk of becoming contaminated with faecal matter.

Patients, who develop skin damage to the sacral area, as a result of faecal incontinence, are unable to sit out in the chair for long periods, due to the pain and discomfort experienced, and the added risk of worsening the damage. Consequently, immobility can lead to other complications. Furthermore, both incontinence and skin damage to the sacral area can cause a great deal of distress and embarrassment for the patient, and may lead to depression, and a prolonged hospital stay.

Further benefits of bowel management systems include how they can contribute towards preventing the spread of infection. The prevention of infection is achieved by the containment of infected stools, resulting in the reduced contamination of bedding and the environment. The systems have other advantages, including accurate monitoring of fluid loss, and some collection bags containing deodorizing filters to reduce unpleasant odour. In addition to preventing the spread of infection, a bowel management system can potentially prevent faecal bacterial contamination of urinary, intravenous and arterial catheters located in the groin area, causing local and systemic infection.

It has been recognised that there is a group of patients within NHS Greater Glasgow & Clyde Acute Services, which can benefit from the use of a FMS.

FMS is designed to provide a safe, effective faecal diversion and containment system created with the goal to improve patient care.

SCOPE

This guideline applies to all staff within NHS Greater Glasgow and Clyde Acute Services. The guideline will provide clear instructions to support staff during the decision making process and use of the FMS; please refer to Faecal Management System flow chart (Appendix 1).

ROLES AND RESPONSIBILITIES

A registered nurse should complete the pre-insertion checklist to ensure that the patient is a suitable candidate for insertion of the FMS (Appendix 2).

If the patient is suitable for use of a FMS, the decision to proceed should be discussed and agreed with senior medical staff and consent documented / recorded within clinical notes.

Nursing staff must document that the patient has given consent. Patients may indicate consent verbally, non-verbally, or in writing. For the consent to be valid, the patient must:

- Have capacity to take the particular decision under discussion
- Have been fully informed with sufficient explanation and guidance to take that decision
- Not be acting under duress

Where patients cannot give consent, please refer to current Consent Policy on Healthcare Assessment, Care and Treatment NHSGGC 2017 and Adults with Incapacity (Scotland) Act 2000.

All registered staff must ensure that they have the necessary knowledge and competence to perform insertion of a FMS and undertake the procedure in a safe and skilled manner. Staff should complete education and training and the Competency Checklist (Appendix 3) under supervised practice before carrying out this procedure and a record of training retained in their file.

Nursing staff must ensure the use of a pre-insertion checklist for FMS is completed. All discussions with the patient should be documented within the patient's records with particular attention being paid to date of insertion being completed on the pre-insertion checklist form. Care of the patient and the device should then be incorporated into the person centred care plan.

INDICATIONS

The FMS is for bedbound patients with little or no bowel control, who are experiencing recurrent episodes of liquid or semi liquid stool (Bristol Stool Chart Type 6/7) resulting in moderate or severe excoriation. Please refer to excoriation and moisture damage pathway tools (Appendix 4). Some examples are:

- Infected diarrhoea
- Diarrhoea caused by medication
- Diarrhoea secondary to a disease process
- Diarrhoea secondary to enteral feeding
- To aid in palliative care

Benefits for use:

- Aid in the management of bedbound patients with acute faecal incontinence
- Reduce the risk of skin breakdown
- Reduce the risk of spread of infection
- Restore patient dignity
- Improve patient comfort
- Reduce risk of complications that can extend length of stay e.g. development of a moisture lesion
- Protect wounds, surgical sites and burns

CONTRAINDICATIONS AND EXCEPTIONS

Faecal Management System (FMS) should NOT be used on patients with the following conditions before first seeking Medical Consent. The rationale for the insertion of the FMS requires to be documented by the medical staff.

- Suspected or confirmed rectal mucosa impairment (i.e. proctitis, ischaemic proctitis, mucosal lacerations)
- Large bowel (colon) surgery or rectal surgery within the last year
- Sensitivity or allergies to any of the materials used in this device (i.e., silicone)
- Rectal or anal injury
- Severe rectal or anal stricture or stenosis (distal rectum cannot accommodate the balloon)
- Confirmed rectal/anal tumour
- Severe haemorrhoids
- Rectal varices
- The patient has an established spinal cord lesion, above the level of the sixth thoracic vertebra, and is at risk of developing autonomic dysreflexia
- For patients under the age of 18

Faecal Management Systems should not be used:

- for longer than 29 days (single tubes); if a FMS is needed for longer than 29 days the tube must be changed
- For patients with solid or semi-formed stools (Bristol Stool Chart Types 1 – 5)
- For patients who sit out in a chair for long periods of time

PRECAUTIONS

Close attention must be exercised with the use of the device in patients who have inflammatory bowel conditions (seek advice from colorectal 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).

There is no specific evidence to contraindicate use of the system in cancer and haemato-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.

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 of bed for any longer than one hour in every four on a pressure redistributing cushion.
- 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.

CLINICAL ISSUES

Prior to the insertion of a FMS, a digital rectal examination must be performed to rule out the possibility of faecal impaction.

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.

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 at the bedside with room temperature tap water and reinsert. **An expelled device should never be stored and used at a later date**.

As with the use of any rectal device, the following adverse events could occur:

- Excessive leakage of stool around the device
- Loss of anal sphincter muscle tone could lead to temporary anal sphincter dysfunction
- Pressure necrosis of rectal or anal mucosa (Please ensure any new device related pressure damage is referred to relevant specialist)
- Infection
- Bowel obstruction
- Perforation of the bowel

Notify medical staff if any of the following occur:

- Persistent rectal pain
- Rectal bleeding
- Abdominal distension

DIRECTIONS FOR USE

Please refer to the manufacturer's guidance for use accessible here, then select 'Additional Resources'.

Procedure: Digital Rectal Examination and insertion of a Faecal Management System NB: Standard Infection Control Precautions must be followed		
No.	**Action**	**Rationale**
1.	Explain the procedure to the patient	To obtain patient consent and co-operation
2.	Create privacy	This will help the patient to relax. To maintain privacy and dignity
3.	The patient is positioned, if possible, in the left lateral position with knees flexed.	To expose the anus and allow easy insertion of a finger for examination
4.	Wash hands and put on disposable apron and gloves	To minimize cross infection and protect hands for examination purposes
5.	Place protective covering sheet under the patient's bottom	To prevent contamination and reduce patient's embarrassment
6.	Examine the perianal area	To observe for skin damage, haemorrhoids etc.
7.	Lubricate your gloved index finger with single use sachet of a water-based lubricant	To facilitate easier insertion and minimise patient discomfort. Reduce mucosal trauma
8.	Advise patient when you are ready to insert your finger and ask them to relax (separate patient's buttocks gently if necessary)	To ensure patient is ready and relaxed To prevent natal cleft splits, and easy identification of orifice
9.	Insert gloved index finger slowly into the patient's rectum, to undertake digital examination	To assess rectal content for hard/formed impacted stools
10.	Slowly withdraw finger from patient's rectum when finished	To minimise patient discomfort Reduce inconvenience to patient

Procedure: Digital Rectal Examination and insertion of a Faecal Management System NB: Standard Infection Control Precautions must be followed		
11.	If hard impacted or formed stool present, inform medical staff for further assessment and advice Administer prescribed medication and do not proceed with insertion of FMS	To ensure appropriate use of FMS To treat constipation
12.	If liquid/semi-liquid stools present or rectum is empty, proceed with insertion of the FMS	See background and rationale as per guidelines
13.	Remove soiled gloves and apron, dispose of in clinical waste and wash hands	To prevent cross-infection
14.	Read manufacturer's Directions for Use within the FMS product pack	Familiarity with product and clinical considerations/instructions
15.	Explain and discuss the procedure with the patient.	To obtain patient consent and co-operation.
16.	Assemble equipment, including gloves and apron, water soluble lubricants and 45mls of tap water in a clean container. Wash hands Open kit, fill syringe with 45mls of tap water at room temperature and attach the syringe to the inflation port Securely snap the collection bag to the connector at the end of the catheter Unfold the length of the catheter to lay flat on the bed, extending the collection bag towards the foot of the bed Insert a lubricated, gloved index finger into the blue finger pocket (located above the position indicator line) Coat the balloon end of the catheter in lubricating jelly	To reduce inconvenience to patient and save time. To prepare correctly for procedure To aid digital guidance during device insertion To ensure correct and appropriate insertion of a FMS
17.	Gently insert the balloon end through the anal sphincter until the balloon is beyond the external orifice and well inside the rectum The finger may be removed or remain in place in the rectum during inflation. Use 45mls of water to inflate balloon by slowly depressing the syringe plunger. DO NOT USE MORE THAN 45mls of water to inflate balloon. Remove the syringe from the inflation port, and gently pull on the soft silicone catheter to check that the balloon is securely in the rectum and that it is positioned against the rectal floor.	The oval inflation indication chamber on the inflation port will expand as fluid is injected. This normal expansion should subside once the plunger stops. If the inflation indication chamber remains excessively expanded after the plunger stops, the balloon is not properly inflating. This is likely the result of improper balloon positioning in the rectum. In this case, use the syringe to withdraw the fluid from the balloon, reposition the balloon in the rectum and re-inflate the balloon. Take note of the position indicator line relative to the patient's anus. Observe changes in the location indicator line as a means to determine movement of the retention balloon in the patient's rectum. This may indicate the need for the balloon or device to be repositioned.

Procedure: Digital Rectal Examination and insertion of a Faecal Management System NB: Standard Infection Control Precautions must be followed		
18.	Remove gloves and apron, then discard in clinical waste and wash hands	To prevent cross infection
19.	Position the length of the flexible silicone catheter along patient's leg avoiding kinks and obstruction; reduce knee bend on profiling bed to avoid back flow; Hang the bag by the strap at a convenient location on the bedside	To maintain patient comfort To encourage and allow faecal flow from the rectum into the collection bag
20.	Record in the appropriate documents (nursing care plan and fluid balance chart) that the FMS has been inserted and record all output	To monitor the patients bowel function
21.	Inform patient of outcome and ensure they are left comfortable	Reduce anxiety and increase ownership of care

MAINTENANCE OF DEVICE

Change the collection bag as needed or at least daily. Snap the cap onto each used bag and discard according to Waste Management Policy. Standard Infection Control Precautions within the National Infection Prevention and Control Manual must be followed.

Record output on fluid balance chart.

Observe the device frequently for obstructions from kinks, solid faecal particles or external pressure.

Ensure regular hygiene is maintained around anal region as there may be occasional slight faecal seepage.

Manufacturer recommends 2 hourly recording of care for patients with a FMS insitu, and should be included as part of the care rounding process.

IRRIGATION OF DEVICE

If the silicone catheter becomes blocked with solid particles, it can be rinsed by filling the syringe with tap water, attaching the syringe to the irrigation port and depressing the plunger. Repeat the procedure as often as necessary to maintain proper functioning of the device. (Flushing the device as described above is an optional procedure for use only when needed to maintain the unobstructed flow of stool into the collection bag).

If repeated flushing with water does not return the flow of the stool through the catheter, the device should be inspected for kinks, patency (flow) and obstruction to ascertain that there is no external obstruction (i.e. pressure from a piece of equipment

or a body part if so consider repositioning the patient). If no source of obstruction of the device is detected, use of the device should be discontinued.

REMOVAL OF DEVICE

Indications for removal:

- Stool becomes semi-formed
- Diarrhoea ceases
- Patient unable to tolerate system
- Patient no longer bed bound or condition changes
- Adverse reaction to system

If diarrhoea persists beyond 29 days device must be removed as per manufacturer's instructions.

Process for removal:

Standard Infection Control Precautions must be followed.

- To remove the catheter from the rectum, the retention balloon must be deflated. Attach the syringe to the inflation port and slowly withdraw all the water from the retention balloon. Disconnect the syringe and discard.
- Grasp the catheter as close to the patient as possible, ask the patient to bear down and slowly slide it out of the anus.
- Dispose of the device in accordance with infection control procedures for disposal of medical waste.
- Check and cleanse area, if required.

REVIEW

This guideline will be reviewed every three years.

REFERENCES

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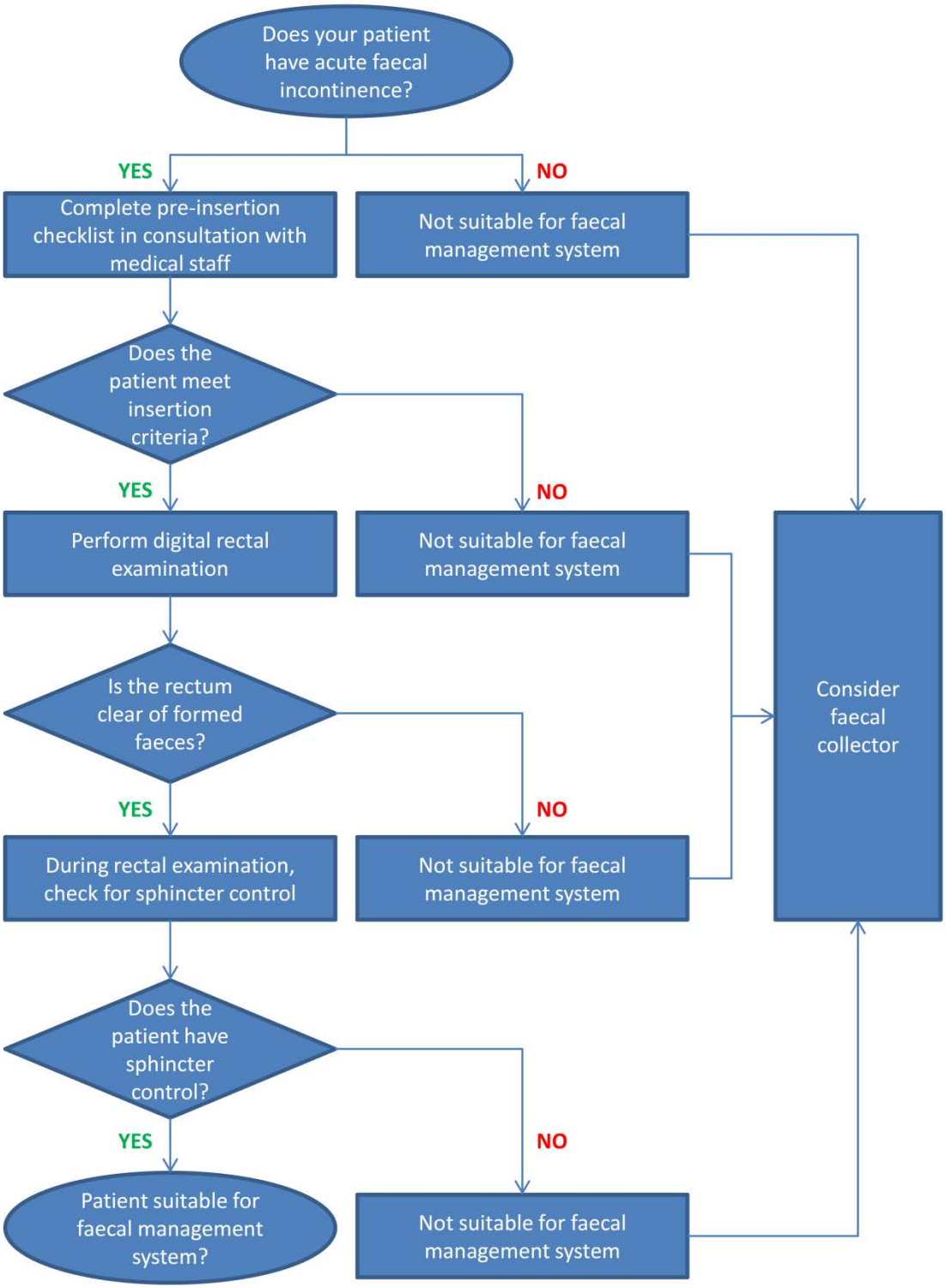
APPENDIX 1 Suitability Flow Chart



APPENDIX 2

Faecal Management System Pre-Insertion Checklist
You MUST answer YES to ALL questions unless used under medical advice and with patient consent

NHS Greater Glasgow and Clyde

If you have answered 'Yes' to all the following, please refer to Product Guidelines before insertion of Flexi-Seal® FMS. Consult with a doctor if in ANY doubt about the use of the Flexi Seal Mechanism and the suitability of your patient	**YES**	**NO**	**Reason for insertion:**	**Assess consistency of stool (circle) – see Bristol Stool Chart (Appendix 5)**	**Date Inserted:** / /	**Patient Name:** **CHI:**
The patient is incontinent with liquid or semi-liquid stool					**Lot Number:**	
The Patient is over 18 and the patient/carer/family has given consent Refer to Adults with Incapacity Policy if required.				**1**		**Inserted by:**
The patient is not sensitive or known to have had allergic reactions to any component within the kit				**2**	**Quantity of fluid inserted into balloon:**	**Designation:**
The patient has not had lower large bowel or rectal surgery within the last year.				**3**		**Doctor's Name:**
The patient does not have suspected or confirmed rectal mucosal impairment			**Integrity of patient's sacral areas**	**4**	**ml**	(if used under medical supervision)
The patient does not have any rectal or anal injury				**5**		
The patient does not have a confirmed rectal/anal tumour, stricture or stenosis				**6**	**Confirm the black line on the tube is visible directly outside patient's anus:**	**Comments:**
The patient does not have haemorrhoids of significant size and/or symptoms						
The patient does not have any in-dwelling or anal device (e.g. thermometer) or delivery mechanism (e.g. suppository or enema) in place				**7**	**YES / NO**	
Where contraindicated the procedure is being carried out under medical advice/supervision						

APPENDIX 3

Faecal Management System

Staff Competency Checklist

NHS Greater Glasgow and Clyde

	Critical Competencies	Met	Not Met	Comments	Sign
1. Patient Selection – Discuss/Demonstrate					
1.1	Relevant anatomy and physiology				
1.2	Explain the procedure to the patient, obtaining consent to treatment as per Board policy				
1.3	Guidance on the Adults with Incapacity (Scotland) Act (2000)				
1.4	Indications: • Identify appropriate patient selection • Perform accurate digital rectal exam. to determine presence of faeces in rectum • Make an assessment of sphincter tone				
1.5	Contraindications				
1.6	Precautions				
2. Insertion of Device – Discuss/Demonstrate					
2.1	Preparation of patient				
2.2	Assemble appropriate equipment: NB: Balloon fill volume and indicator function				
2.3	Correctly position patient				
2.4	Demonstrate insertion technique and correctly position balloon				
2.5	Identify what to do in the event of improper balloon inflation				
2.6	Identify the importance of accurate recording in the patient's health record: • The position of the black indicator line • Total inflation volume • Date of insertion • Lot number				
2.7	Demonstrate correct positioning of the collection bag				
3. Maintenance of Device					
3.1	Demonstrate correctly how to irrigate device				
3.2	Demonstrate procedure for stool sampling				
3.3	Understand how to maintain device patency				
3.4	Discuss importance of maintaining: • Accurate fluid balance • Record of stool consistency • Tube position • Frequency of irrigation				
3.5	Demonstrate appropriate changes of collection bag				
3.6	Demonstrate requirements for ongoing patient care: • Changing of position of tube • Maintaining skin hygiene • Observe and maintain skin integrity				
3.7	Knowledge of maximum length of time that a patient can sit out of bed				

	Critical Competencies	Met	Not Met	Comments	Sign
4. Removal of Device					
4.1	Identify maximum length of time the faecal management system can be used				
4.2	Identifies indicators for removal				
4.3	Demonstrate how to deflate balloon before removal				
4.4	Demonstrate correct removal of device				
4.5	Demonstrate correct disposal of device				
5. Adverse Events					
5.1	Identify potential adverse effects on insertion and during use of a faecal management system				

Notes:

Competency self assessment statement:

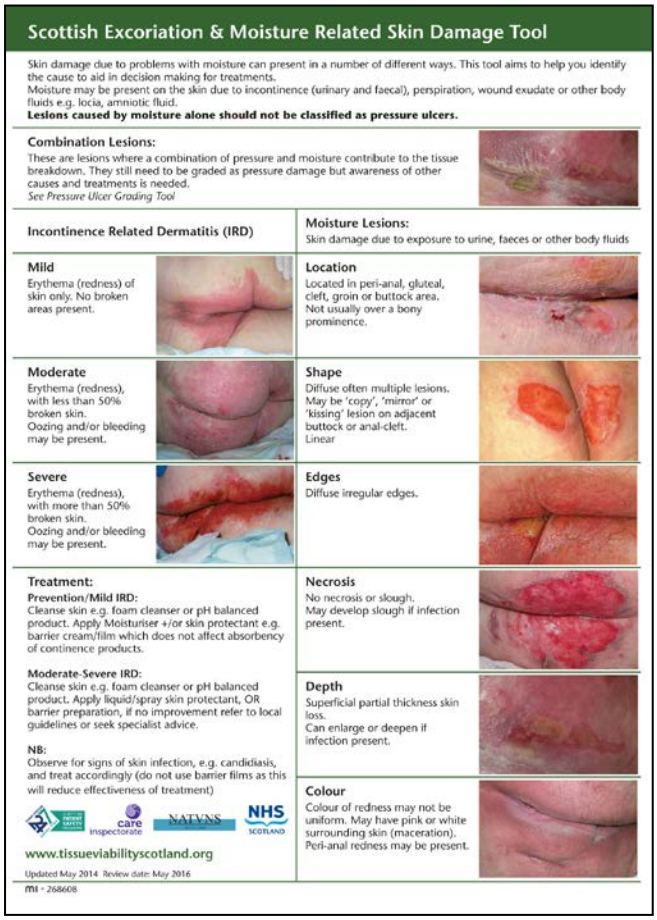
I have read the clinical guideline for nursing staff on the use of a Faecal Management System (FMS) and have demonstrated that I am competent to use the FMS appropriately and in accordance with the NHSGGC Guideline.

Staff Member		**Manager**	
Sign:		Sign:	
Name:		Name:	
Designation:		Designation:	
Date:		Date:	
Ward/Dept.		Ward/Dept.	

This copy should be retained in staff member's employment records.

Further copy should be retained by staff member for professional portfolio.

APPENDIX 4



Scottish Excoriation & Moisture Related Skin Damage Tool

Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in decision making for treatments.
Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. locia, amniotic fluid.
Lesions caused by moisture alone should not be classified as pressure ulcers.

Combination Lesions:
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed.
See Pressure Ulcer Grading Tool

Incontinence Related Dermatitis (IRD)

Mild
Erythema (redness) of skin only. No broken areas present.

Moderate
Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.

Severe
Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.

Treatment:
Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

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Updated May 2014 Review date: May 2016

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Moisture Lesions:
Skin damage due to exposure to urine, faeces or other body fluids

Location
Located in peri-anal, gluteal, cleft, groin or buttock area. Not usually over a bony prominence.

Shape
Diffuse often multiple lesions. May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft. Linear

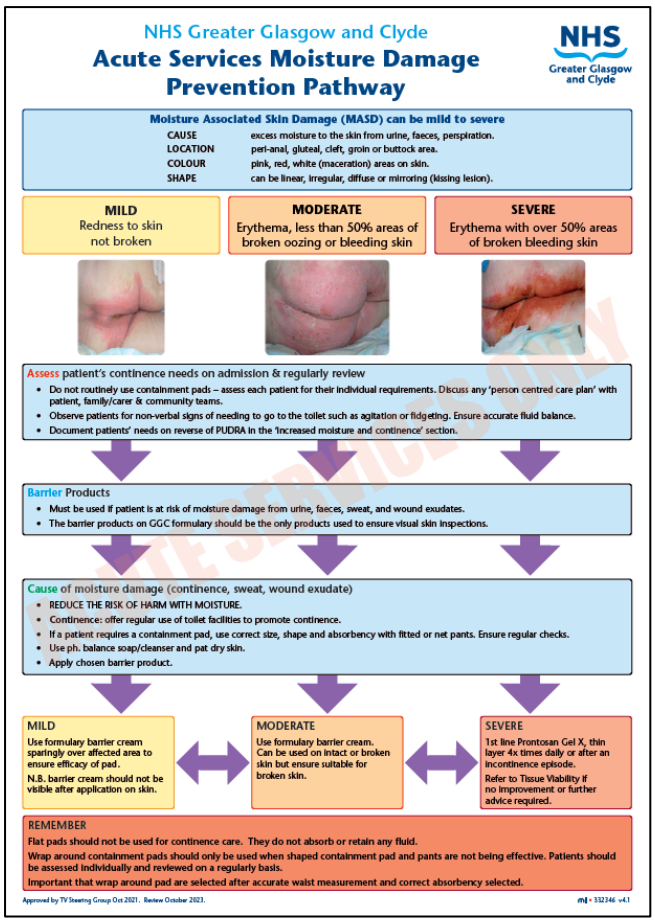
Edges
Diffuse irregular edges.

Necrosis
No necrosis or slough. May develop slough if infection present.

Depth
Superficial partial thickness skin loss. Can enlarge or deepen if infection present.

Colour
Colour of redness may not be uniform. May have pink or white surrounding skin (maceration). Peri-anal redness may be present.

Medical Illustration
Order Number:
268608



NHS Greater Glasgow and Clyde

Acute Services Moisture Damage Prevention Pathway

NHS Greater Glasgow and Clyde

Moisture Associated Skin Damage (MASD) can be mild to severe

CAUSE	excess moisture to the skin from urine, faeces, perspiration.
LOCATION	peri-anal, gluteal, cleft, groin or buttock area.
COLOUR	pink, red, white (maceration) areas on skin.
SHAPE	can be linear, irregular, diffuse or mirroring (kissing lesion).

MILD	MODERATE	SEVERE
Redness to skin not broken	Erythema, less than 50% areas of broken oozing or bleeding skin	Erythema with over 50% areas of broken bleeding skin

Assess patient's continence needs on admission & regularly review
- Do not routinely use containment pads – assess each patient for their individual requirements. Discuss any 'person centred care plan' with patient, family/carer & community teams.
- Observe patients for non-verbal signs of needing to go to the toilet such as agitation or fidgeting. Ensure accurate fluid balance.
- Document patients' needs on reverse of PUDRA in the 'increased moisture and continence' section.

Barrier Products
- Must be used if patient is at risk of moisture damage from urine, faeces, sweat, and wound exudates.
- The barrier products on GGC formulary should be the only products used to ensure visual skin inspections.

Cause of moisture damage (continence, sweat, wound exudate)
- REDUCE THE RISK OF HARM WITH MOISTURE.
- Continence: offer regular use of toilet facilities to promote continence.
- If a patient requires a containment pad, use correct size, shape and absorbency with fitted or net pants. Ensure regular checks.
- Use ph. balance soap/cleanser and pat dry skin.
- Apply chosen barrier product.

MILD	MODERATE	SEVERE
Use formulary barrier cream sparingly over affected area to ensure efficacy of pad. N.B. barrier cream should not be visible after application on skin.	Use formulary barrier cream. Can be used on intact or broken skin but ensure suitable for broken skin.	1st line Prontosan Gel X, thin layer 4x times daily or after an incontinence episode. Refer to Tissue Viability if no improvement or further advice required.

REMEMBER
Flat pads should not be used for continence care. They do not absorb or retain any fluid.
Wrap around containment pads should only be used when shaped containment pad and pants are not being effective. Patients should be assessed individually and reviewed on a regularly basis.
Important that wrap around pad are selected after accurate waist measurement and correct absorbency selected.

Approved by TV Steering Group Oct 2021. Review October 2023. mi • 332346 v4.1

Medical Illustration
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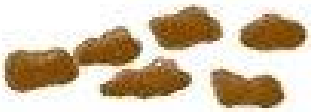
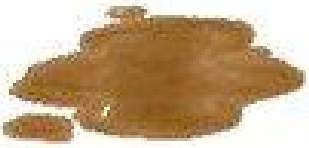
APPENDIX 5

Bristol Stool Chart

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**