Bowel Management Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care for bowel management throughout the WA Country Health Service (WACHS).

Information regarding bowel management for patients with a faecal stoma can be found in the WACHS Stoma Management Clinical Practice Standard.

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

Further information relating to specialty areas including Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WHNS) can be found via HealthPoint if not covered in this policy.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency.

3. Procedural Information

Where care requires specific procedures that may vary in practice across sites, staff are to seek senior clinician advice.

Procedural aspects of bowel management covered in this CPS are:

- Baseline bowl assessment
- Bristol Stool Chart
- Constipation
- Diarrhoea
- Faecal Incontinence
- Rectal Preparations
- Skin Care: Incontinence Associated Dermatitis (IAD)
- Bowel Management Products

4. Considerations

On admission all patients to have a baseline bowel assessment performed. All patients with bowel dysfunction must have a bladder assessment completed.

Liaise with Medical Officer and inform shift coordinator if any of the following symptoms are identified:

- Unexplained change in bowel habit
- Cramping
- Confusion
- Delirium
- Fever
- Pain, including abdominal or lower back pain that is new or worsening
- Rectal bleeding or pain
- Presence of mucous/blood in stool
- Urinary incontinence that is new or worsening
- Urinary tract symptoms, such as pain or decreased flow[1]
- Anaemia
- Weight loss
- Autonomic hyperreflexia (may occur if the constipation occurs in patient with a spinal injury / conditions such as Multiple Sclerosis
- Presence of interstitial worms in the stool
- Severe diarrhoea (may cause acute dehydration)

Caution: The above symptoms may be indicative of intestinal failure whereby the intestines cannot digest food and absorb the fluids, electrolytes and nutrients essential to live. If any of the symptoms are indicating intestinal failure seek specialist advice.

Do not perform: digital rectal examination or administer PR medication to:

- Neutropenic or thrombocytopenic patients (refer to WACHS Nursing Management of Neutropenic ADULT Haematology and Oncology Patient Procedure)
- Patients who have had recent colorectal surgery or trauma (Patients who have had a low resection may be at risk of perforation[2])
- Patients who are in the post-operative period following radical prostatectomy

Medical Officer may:

- Perform a digital rectal examination
- Organise an abdominal X-ray
- Initiate further investigation e.g. colonoscopy, sigmoidoscopy, barium enema, faecal specimen, blood tests

Ensure:

- The patient has received information relating to the intended procedure, and has given appropriate consent.
- Patient identification and procedure matching processes are undertaken.
- Patient privacy and dignity is maintained
- The presence of a chaperone where appropriate to patient and clinician requirements has been offered.
- To provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements. (See WA Health Language Services Policy.)

Infection Control Considerations

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

5. General Information

Relevant bowel management standards should be applied in accordance with the needs of the individual patient. Continence issues should be identified on admission and through the ongoing monitoring of patients by medical, nursing and allied health staff.

Conducting a bowel assessment in the first instance will identify specific symptoms and considerations which may require specialised assessment but will also provide information that can be used to formulate a bowel management plan. The clinical status of the patient should be reviewed following all interventions and disease processes and in accordance with medical instructions.

An individualised management plan is to be documented in the patient's health records as soon as practicable.

Healthy Bowel Function[29]

The small intestine absorbs food nutrients. The waste is pushed into the large bowel where water is removed. The resulting faeces are temporarily stored in the rectum before being expelled from the body via the anus.

Water makes up about three quarters of faecal content, while the rest is composed of solids, including undigested fibre, intestinal bacteria and dietary fats. Many illnesses and events can affect the colour and texture of faeces.

Characteristics of the normal, healthy bowel motion include:

- Bowel motions should be firm, moist and easy to pass
- Regularity differs from one person to the next – the range of 'normal' includes once per week to several times every day, depending on the individual
- The average adult produces between 100g and 180g of faeces every day
- Bowel motions are brown because they contain bile pigments (stercobilin)
- Bacteria use chemical reactions to break down the faeces. These chemical reactions produce smelly compounds like hydrogen sulphide, which account for the characteristic odour

Baseline Assessment

Determines current bowel function and assists in identifying if further assessment is required. It is essential to establish whether or not the patient has a bowel dysfunction on admission or if it is identified during their stay within the health care facility.

The gastrointestinal sections of the WACHS MR111 Nursing Admission, Screening and Assessment Tool (Adults) and the MR111P Paediatric Nursing Admission /Discharge Assessment Form are used to document the assessment. Information surplus to the forms can be documented in the inpatient notes.

Those in residential aged care can follow the Aged Care Accreditation Standard 2.12 Continence Management Flowchart.

Should any concerns about bladder function be identified refer to WACHS Bladder Management Continence Clinical Practice Standard. Refer also to the WACHS Stoma Management Clinical Practice Standard for patients with a faecal stoma.

Health history

History taken needs to include:

- Usual bowel activity including:
    - Frequency of bowel action
    - Stool consistency (refer to Appendix 1 Bristol Stool Chart)
    - Straining/presence of urge
    - Rectal/abdominal pain on passing stools
    - Blood on stools
    - Presence of fecal incontinence
    - Any recent changes to usual bowel activity
- Triggers/dietary management
- Level of activity (immobility is a risk factor for constipation)
- Any medications that may contribute to changes in bowel function[3]
- Use and frequency of use of laxatives or aperients
- History of bowel surgery
- Psychosocial and/or cultural factors that could impact on bowel function and compliance

Physical assessment

Physical assessment by a Medical Officer /skilled nurse, if indicated should include: inspection, auscultation, percussion and palpation of the abdomen[4].

- Visual check of the abdomen - look for scars, symmetry, abnormal movement (peristalsis)
- Abdominal distension
- Listening for bowel sounds – presence or absence of bowel sounds (indicates bowel motility)
- Palpation of the abdomen
- Hard faecal masses in the colon may be felt
- Observation and assessment of the perianal and perineal areas for anal fissure, haemorrhoids, rectal prolapse and skin condition
- Presence or absence of bowel sounds (indicates bowel motility)
- Pain related to haemorrhoids or anal fissures may contribute to constipation[5]

Discharge planning

To assist individuals to maintain good bowel habits on discharge, all patients discharged home with a bowel management plan to be educated on healthy bowel habits, lifestyle modifications and the need to commit to these modifications long term. A relative or carer is to be involved in education if assisting or caring for the patient at home[26].

The discharge plan should be holistic and individualised with the following considerations:

- Psychological responses to illness and disability. Liaise with Medical Officer as indicated
- Patient strengths and weaknesses
- Ethnic and cultural beliefs

On discharge:

- Advise the patient to contact GP if bowel function worsens
- All information is in patient's language and takes their cultural beliefs into consideration
- Advise the patient relating to preservation of dignity and independence
- Patient and/or carer given advice on skin care, continence products and information about product choice. The patient may be eligible for funding to assist in the cost of purchasing continence equipment.
- Referral to Continence Service as required for clinic appointments, if any concerns or advanced education required, information of any funding schemes available[15].

6. Clinical Communication

Clinical Handover

Information relating to bowel function and activity is to be provided at each handover opportunity. Documentation is to be checked at each shift bedside handover.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Documentation

Refer to the WACHS Documentation CPS.

Monitoring of food and fluid intake will provide relevant information on intake and enable monitoring of the current bowel pattern[6], and assist in decision making processes for management strategies. Early identification and intervention of constipation will assist in reducing the risk of faecal impaction and urinary retention during periods of illness.

Where indicated, commence an MR144 WACHS Fluid Balance Work Sheet (adults), MR144P WACHS Neonatal – Paediatric Fluid Balance Worksheet and MR144C WACHS Dietetics – Food Intake Chart.

The MR144E WACHS Bowel Chart is available for use as indicated. Where patients have not had bowels open during a shift, this is to be recorded in the inpatient notes and passed on during clinical handover.

The RC12 Bowel Chart – Bristol Stool Guide (Residential Aged Care) is used for residential aged care patients.

Patients who require further investigation/ management to be referred to specialist continence service (if available) or liaise with MO/Senior Clinician for an individualised management plan to be developed and implemented for inpatients and follow up as outpatient as required[7].

Referral to a continence service (if available) and/or MO/Senior Clinician the following:

- Patients with newly identified faecal incontinence
- Patients with existing faecal incontinence who request further support and advice
- Perineal dermatitis relating to incontinence
- Chronic constipation/faecal impaction

Refer to Related WACHS Documents and Forms sections for specific items.

Patient/Carer information

There are a number of ways patients and carers can obtain specific information relating to hospital admissions, transfers and discharge from hospital. Relevant documents can be located via:

- Procedure Specific Information Sheets (PSIS)
- Consumer medicine information – medicine finder
- Information leaflets for patients about medicines used in mental health
- Emergency Discharge Information Sheet, WA Health.

Refer to the discharge planning section for further information.

7. Equipment Required

- Specific equipment related to bowel management is referred to within the appendices section of this CPS.
- Equipment must be appropriate for the age/size of the patient.
- Specific sites may have pre-prepared equipment packs where contents may vary.
- Equipment must be checked, serviced and calibrated in accordance with manufacturer's recommendations to ensure reliability and accuracy.
- Staff must follow the manufacturer's operating instructions.

8. Compliance Monitoring

Evaluation, audit and feedback processes are to be in place regionally to monitor compliance.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

9. Relevant Legislation

(Accessible via: Western Australian Legislation or ComLaw) sites)

- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Mental Health Act 1996*
- *Occupational Safety and Health Act 1984*
- Occupational Safety and Health Regulations 1996
- *Privacy Act 1988*
- *State Records Act 2000*

10. Relevant Standards

National Safety and Quality Healthcare Standards (Second edition 2017)
5.10, 5.11, 5.12 and 5.13

Australian Aged Care Quality Agency Accreditation Standards
2.11 and 2.12.

11. Related WA Health Policies

- WA Clinical Alert (Med Alert) Policy
- Clinical Handover Policy
- Clinical and Related Waste Management Policy
- Clinical Incident Management Policy
- Correct Patient, Correct Site and Correct Procedure Policy and Guideline for WA Health Services (2nd Edition)
- Falls Risk Assessment and Management Plan (FRAMP)
- Recognising and Responding to Acute Deterioration Policy
- WA Health Consent to Treatment Policy
- National Hand Hygiene Initiative in Western Australian Healthcare Facilities
- Western Australian Patient Identification Policy 2014

12. Relevant WACHS Documents

- Acute Spinal Injury Clinical Practice Standard
- Aged Care Accreditation Standard 2.12 Continence Management Flowchart
- Chaperone Policy
- Documentation Clinical Practice Standard
- Medication Administration Policy
- Stoma Management Clinical Practice Standard

13. Related WACHS Forms

- MR111 Nursing Admission, Screening and Assessment Tool (Adults)
- MR111P Paediatric Nursing Admission /Discharge Assessment Form
- MR144 Fluid Balance Work Sheet
- MR144P WACHS Neonatal – Paediatric Fluid Balance Worksheet
- MR144C WACHS Dietetics – Food Intake Chart
- MR30AA Patient Consent to a Chaperone Form
- RC12 Bowel Chart – Bristol Stool Guide (Residential Aged Care)
- MR144E WACHS Bowel Chart

14. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

15. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Bowel Management Clinical Practice Standard.

16. References

1. IMPACT. A guide to the management of constipation and faecal impaction in the older person NSW, Australia: IMPACT; 2010. Accessed 20 November 2013.
2. Paris G, Gourcerol G, Leroi AM. Management of neurogenic bowel dysfunction. *European journal of physical and rehabilitation medicine.* Dec 2011;47(4):661-676.
3. Dougherty LLS. *The Royal Marsden Hospital manual of clinical nursing procedures.* 8th revised ed. UK: Wiley Blackwell; 2011.
4. Munn Z. Management of constipation for older adults. Adelaide, SA: The Joanna Briggs Institute,; 2010. Accessed 8 November 2013.
5. Weber JRK, J. H. *Health assessment in nursing.* 4th ed. New York, NY: Lippincott Williams & Wilkins; 2011
6. Hawley P, Barwich D, Kirk L. Implementation of the victoria bowel performance scale. *Journal of pain and symptom management.* Dec 2011;42(6):946-953.
7. National Collaborating Centre for Acute Care. Faecal incontinence: The management of faecal incontinence in adults. London, UK: Commissioned by the National Institute for Health and Clinical Excellence; 2007. Accessed 8 November 2013.
8. Su Fee L, Childs C. A systematic review of the effectiveness of bowel management strategies for constipation in adults with stroke. *International Journal of Nursing Studies.* 2013;50(7):1004-1010.
9. Crisp JT, C.; Douglas, C.; Rebeiro, G. Bowel elimination. In: Potter PAP, A.G.; Stockert, P.A.; Hall, A.M., ed. *Potter and Perry's fundamentals of nursing*. 4th ed. Chatswood, NSW: Elsevier Australia; 2013:1113-1149.
10. Rao SSC. Constipation in the older adult. *UpToDate*. Waltham, MA: UpToDate; 2013.
11. Emmanuel A. Review of the efficacy and safety of transanal irrigation for neurogenic bowel dysfunction. *Spinal cord.* Sep 2010;48(9):664-673.
12. Schiller LR. Definitions, pathophysiology, and evaluation of chronic diarrhoea. *Best practice & research. Clinical gastroenterology.* Oct 2012;26(5):551-562.
13. Wald A. Factitious diarrhea. *UpToDate*. Waltham, MA: UpToDate; 2013.
14. Li Z, Vaziri H. Treatment of chronic diarrhoea. *Best practice & research. Clinical gastroenterology.* Oct 2012;26(5):677-687.

15. Ahmad M, McCallum IJ, Mercer-Jones M. Management of faecal incontinence in adults. *BMJ (Clinical research ed.).* 2010;340:c2964.
16. Ness W. Faecal incontinence: causes, assessment and management. *Nursing standard (Royal College of Nursing (Great Britain) : 1987).* Jun 20-26 2012;26(42):52-54, 56, 58-60.
17. Kunde L. Incontinence (faecal) management. Adelaide, SA: The Joanna Briggs Institute,; 2012. Accessed 8 November 2013.
18. Allison M. Conservative management of faecal incontinence in adults. *Nursing standard (Royal College of Nursing (Great Britain) : 1987).* Mar 3-9 2010;24(26):49-56; quiz 58, 60.
19. Price RO, Bradley R. Assessing and treating faecal incontinence. *Nursing older people.* Sep 2013;25(7):16-23.
20. Selby WC, C. Managing constipation in adults. *Australian Prescriber.* 2010;33(4):116-119.
21. Wald A. Management of chronic constipation in adults. *UpToDate*. Waltham, MA: UpToDate; 2013.
22. Pamaiahgari P. Enema: Administration. Adelaide, SA: The Joanna Briggs Institute; 2011. Accessed 8 November 2013.
23. Bardsley A. Prevention and management of incontinence-associated dermatitis. *Nursing standard (Royal College of Nursing (Great Britain) : 1987).* Jul 3-9 2013;27(44):41-46.
24. Smith B. Faecal incontinence in older people: delivering effective, dignified care. *British journal of community nursing.* Aug 2010;15(8):370, 372, 374.
25. Deutekom M, Dobben AC. Plugs for containing faecal incontinence. *Cochrane Database of Systematic Reviews.* 2012(4).
26. National Institute for Health and Clinical Excellence. Faecal incontinence: The management of faecal incontinence in adults. London, UK: NICE; 2007: http://www.nice.org.uk/Search.do?searchText=CG49&newsearch=true&x=10&y=8. Accessed 20 November 2013.
27. National Health Service England. 2013/14 NHS standard contract for intestinal failure (adult). London, UK: NHS; 2013. Accessed 7 March 2014.
28. Australian Medicines Handbook Pty Ltd. https://amhonline-amh-net-au.wachslibresources.health.wa.gov.au/. Accessed 18 October 2018
29. Betterhealth Victoria Conditions and Treatments – Bowel Motions [Accessed via internet: 18 January 2019]
30. HMRC. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Australian Government [Internet] 2010 [Accessed: 18 January 2019

17. Definitions

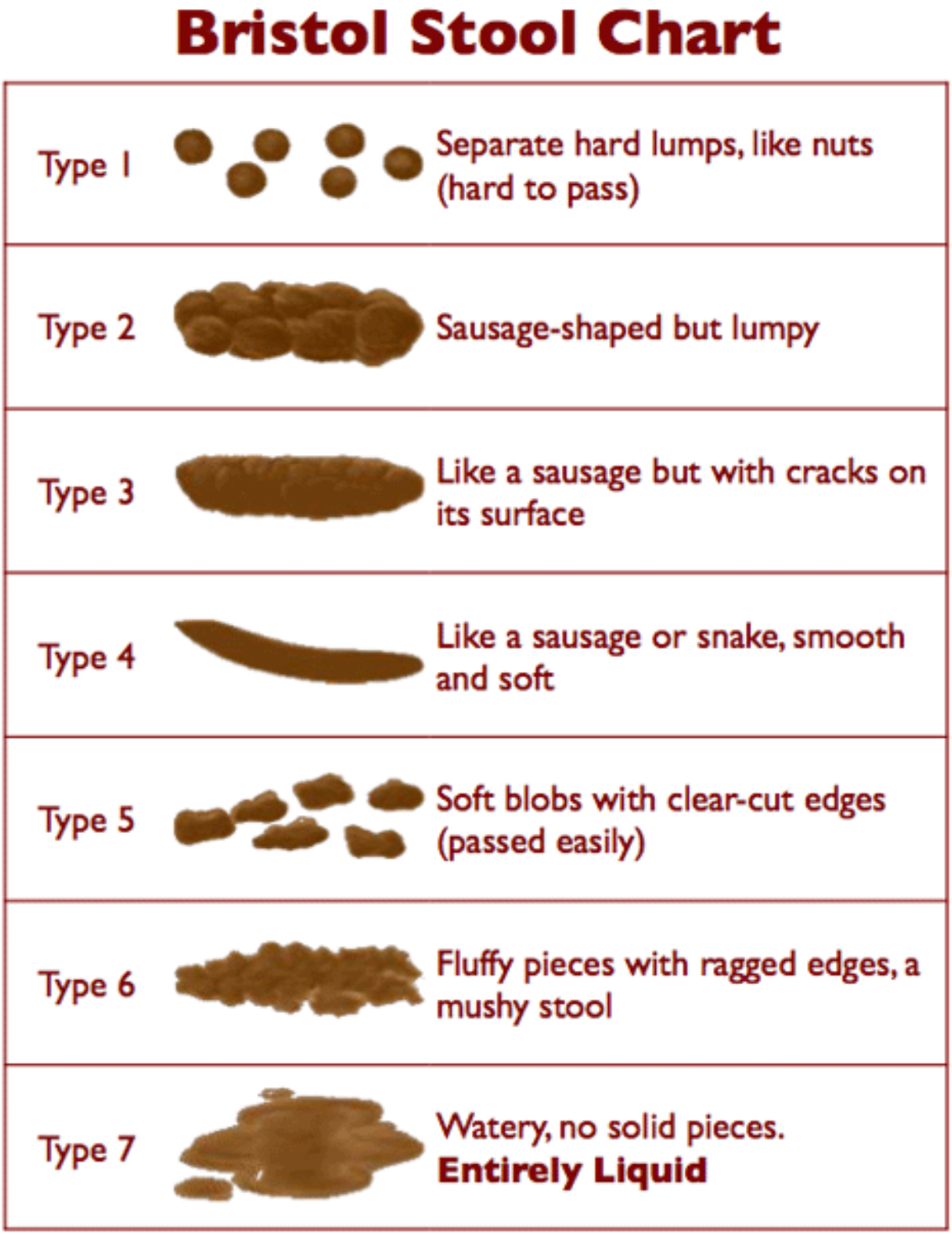
Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged
Patient	A person who is receiving care in a health service organisation

18. Appendices

This document can be made available in alternative formats on request for a person with a disability

Contact:	WACHS Project Officer Clinical Practice Standards (R. Phillips)		
Directorate:	Medical Services	**EDRMS Record #**	ED-CO-15-92747
Version:	2.00	**Date Published:**	9 April 2019

Appendix 1: Bristol Stool Chart



Source: Continence Foundation of Australia [Accessed 30 August 2018]

Appendix 2: Constipation

Constipation is determined following a bowel assessment and can be characterised by straining on defecation, reduced or infrequent defecation (<3 per week) or a feeling of incomplete emptying of the rectum.

Faecal impaction: is a state in which the person becomes so severely constipated that they are unlikely to be able to pass faeces of their own accord. It is usually but not necessarily, associated with hardened stools and patient discomfort. It is a major cause of faecal incontinence[9]. Often presents as faecal incontinence or overflow diarrhoea. Management includes[28]:

- High-dose oral macrogol laxatives
- Suppositories and enemas
- Manual disimpaction

Other special cases where constipation may be an issue are in palliative care, pregnancy and with opioid analgesia. Refer to Australian Medicines Handbook – gastrointestinal drugs – constipation section for more information.

Use of aperients should be considered early for inpatients whose mobility is decreased/or anticipated to decrease following intervention(s) and those receiving opioid analgesia.

Assessment / Management

- Establish when usual bowel activity last occurred and document on bowel chart[6]. Refer to documentation section for appropriate form(s)
- Refer to fluid balance work sheet to evaluate if fluid intake adequate. Promote 2L per day as clinically appropriate.
- Promote well balanced diet and monitor dietary intake as appropriate. Liaise with Dietitian as indicated.
- Promote physical activity/ exercise as able[10]. Consider referral to Physiotherapy especially if immobile.

The management of constipation depends on the cause, with many patients being affected by more than one causative factor. Consider referring to Continence Service, where available.

Faecal impaction should be confirmed following assessment by the MO.

Dietary and lifestyle changes are usually the first steps in treatment. They should be encouraged and continued, recognising the individual's limitations, even if laxatives are used. Changes include:

- adequate dietary fibre intake (18–30 g daily is recommended for adults; increase intake gradually to avoid bloating and flatulence; may be less beneficial in slow transit constipation),
- adequate fluid intake,

- increasing activity/exercise,
- immediately responding to the urge to defecate and using the toilet after meals because gastrocolic reflex is maximal.

Oral preparations should be considered first and may be used in conjunction with rectal preparations. Consider the WACHS Chaperone Policy when rectal administration of medications is needed.

Refer to WACHS Medication Administration Policy and the Australian Medicines Handbook – gastrointestinal drugs – constipation section. This section provides current guidance on the following drug choices in managing constipation, including product information[28]:

- Bulk-forming laxatives
- Osmotic laxatives
- Stool softeners
- Stimulant laxatives
- Suppositories and enemas
- Opioid antagonists
- Other laxatives

Do not administer: rectal medication to patients with:

- Neutropaenia
- Thrombocytopaenia
- A history of recent colorectal surgery[11].

Long-term laxative use is not necessary unless constipation or faecal impaction is likely to recur, e.g. opioid-induced constipation, progressive neurological conditions, immobility due to old age or illness, and in some children to prevent relapse.

Do not stop laxatives abruptly when treating chronic constipation - withdraw gradually 2–4 weeks after regular pattern established.

Manual Evacuation

If medical therapies are unsuccessful, manual evacuation may be appropriate and should only be performed following liaison with the MO/Senior Clinician, by a person experienced in this procedure, in the presence of a chaperone and with informed patient consent.

If manual evacuation is recommend by the MO, contact Continence Services as required.

For information relating to manual evacuation in the patient with a spinal injury refer to WACHS Acute Spinal Injury Clinical Practice Standard.

Manual evacuation should not be performed if the patient has:

- Had recent anal/ rectal surgery[11]
- Rectal/ anal trauma
- Neutropaenia
- Thrombocytopaenia

Extra caution should be observed with patients who have:

- Rectal/ anal pain
- Obvious rectal bleeding
- Anticoagulant medication
- Active inflammatory bowel disease
- Spinal injury at or above T6
- Recent radiation treatment to the pelvic area
- History of sexual abuse[3]

Appendix 3: Diarrhoea

Diarrhoea can be characterised by decreased stool consistency, increased frequency, urgency, volume or weight may also be indicative of diarrhoea. Diarrhoea is a symptom and the underlying cause should be identified and treated if possible. Assessment and correction of dehydration and electrolyte disturbances is a priority in treatment. Exclusion of diarrhoea secondary to faecal impaction is important[28].

Acute diarrhoea: is a rapid onset and present for less than 2 weeks. Episodes of acute diarrhoea should be considered potentially infectious until otherwise proven. Consult local infection control consultant/nurse if indicated.

Chronic diarrhoea: is persistent and has been present for more than 2 weeks[3,12]. Symptoms can range from abdominal cramping to severe abdominal pain and there may be burning and/ or itching around the perianal area[13]. Refer to Skin Care: Incontinence Associated Dermatitis (IAD) .

Risk Factors

Severe or extended diarrhoea may result in dehydration, electrolyte imbalance and malnutrition, anxiety, stress, and depression[3].

Risk factors that may predispose diarrhoea include:

- Recent overseas travel
- Surgery e.g. abdominal and colorectal
- Infection
- Gastrointestinal tract disorders
- Mal absorption syndromes
- Lifestyle e.g. excessive alcohol intake
- Psychological factors /psychiatric history
- Medications including over the counter and/or complementary therapies
- Food allergies and intolerance
- Graft versus host disease (GVHD)

Medications which may cause diarrhoea include, but are not limited to:

- Antibiotics
- Non-steroidal anti-inflammatories
- Laxatives
- Antihypertensives
- Antiarrythmics
- Bronchodilators
- Antineoplastics
- Chemotherapy
- Metformin

Assessment / Management

Assess when normal bowel activity last occurred and document appropriately.

Refer to Bristol Stool Chart to determine stool assessment including:

- Frequency
- Consistency
- Colour
- Volume, mucous, blood, pus, excessive fats, undigested food or tablets and offensive odour[12].

Commence monitoring and document intake and output to identify problems such as dehydration[14]. Refer to documentation section for appropriate form(s)

Consider single room with ensuite for patients who have two or more unexplained loose bowel actions and send a stool specimen. Implement transmission-based precautions in patients where the suspected or confirmed infectious agent represents an increased risk of transmission[30]. Consult with Infection Control Nurse.

Assess and record episode of:

- Pain or discomfort
- Vomiting
- Generalised weakness
- Assess perianal area for signs of impaired skin integrity

Treatable factors of diarrhoea or faecal incontinence should be addressed prior to initiation of a bowel management plan[3].

Initiate review by MO who may consider:

- Analgesia
- Anti-motility medications (refer to Australian Medicines Handbook – gastrointestinal drugs – drugs for diarrhoea section for more information)
- Anti-emetics
- Intravenous (IV) therapy/ electrolyte replacement
- Stool specimen collection for microbiology, culture and sensitivity (if not already undertaken)
- Digital rectal examination
- Abdominal X-ray

Liaise with Continence Service for further advice. Consider the use of products such as faecal collection bags, skin care products.

Consider Dietitian review in liaison with MO for:

- Review of nutritional status e.g. dietary intake[7]
- Review of causative factors e.g. food allergies and intolerance
- Review to ensure safe route for nutrition is considered

Appendix 4: Faecal Incontinence

Faecal incontinence can be defined as the involuntary passage of solid or liquid faeces and/or flatus.

Causes

- Faecal impaction with overflow
- Anal sphincter/pelvic floor damage
- Degenerative neurological disease i.e.: Alzheimer's dementia
- Ano-rectal pathology such as rectal prolapse
- Gut motility/stool consistency i.e.: infection, pelvic irradiation, irritable bowel syndrome, inflammatory bowel disease, dietary intake
- Environmental/ lifestyle, e.g. poor toileting facilities, physical/mental impairment
- Idiopathic[15,16]

Damage to the anal sphincter or pelvic floor may be caused by:

- Obstetric trauma[16]
- Anal trauma or surgery
- Neurological disease (Multiple Sclerosis, spinal cord injury, cerebrovascular accident)

Risk factors[16]

- Age
- Gender
- Constipation/faecal impaction
- Diarrhoea
- Cognitive impairment

Assessment / Management

Assess when normal bowel activity last occurred and document appropriately.

For faecally incontinent patients, a single room with en-suite is desirable. Refer to Australian Guideline for the Prevention and Control of Infection in Healthcare (2010) for type and duration of precautions for specific infections and conditions.

Refer to Bristol Stool Chart to determine stool assessment including:

- Frequency
- Consistency
- Colour

Special management is required for those individuals:

- Who are severely or terminally ill
- With spinal cord injury
- With intellectual disability

Liaise with MO to:

- Treat any potentially reversible causes such as:
  - Faecal loading
  - Treatable causes of diarrhoea e.g.: infective, inflammatory bowel disease
  - Rectal prolapse[17]
  - Acute anal injury
  - Acute injury such as disc prolapse[15,18]
- Consider alternatives to medications that may be contributing to faecal incontinence.
- Refer to Continence Service as required.
- Refer to Bowel Management Products section

Promote regular time for defecation:

- As per patients usual time or 30 minutes after meals
- Encourage the patient to respond immediately to defecate[3]
- Encourage patient to adopt correct sitting position on the toilet and to avoid straining
- Ensure appropriate dietary intake to promote ideal stool consistency[19]
- Consult with Dietitian as appropriate[18]

Appendix 5: Rectal Preparations

Refer to WACHS Medication Administration Policy

Suppository

A suppository is a medicated solid formulation prepared for insertion into the rectum to evacuate faeces in the following circumstances:

- Relief of constipation
- Preparation for procedures such as sigmoidoscopy

They are used when oral laxatives are not effective, unsuitable or rapid relief is required[28]. They are suitable for occasional use[28] and can be very effective.

Ensure correct administration to minimise damage to the rectal mucosa; best avoided if anal fissure present[28].

After insertion, body temperature dissolves the suppository from its solid form to a liquid.

Due to an increased risk of bleeding/ infection and increased risk of perforation[21], use of a suppository is contraindicated in patients with:

- Neutropenia or thrombocytopenia
- Intestinal obstruction, recent colorectal or gynaecological surgery and radiation treatment to pelvic area
- Recent anal or rectal trauma
- Undiagnosed abdominal pain

Enema

Enemas should only be used for constipation if all other management strategies have not worked.

An enema is used to administer substances in a liquid form into the rectum for evacuation of faeces in the following situations:

- Relief of constipation
- Faecal incontinence
- Preparation for procedures e.g. flexible sigmoidoscopy [22]

Due to increased risks of perforation[1] with the administration of an enema it is contraindicated in patients with:

- Neutropenia or thrombocytopenia due to increased risk of bleeding/infection
- Recent colorectal or gynaecological surgery
- Paralytic ileus or intestinal obstruction - due to decreased/absent peristaltic movements there is a potential risk that absorption of the enema fluid may occur which may contribute to electrolyte imbalance[3,5].
- Recent anal or rectal trauma[22]
- Severe colitis
- Toxic mega-colon

- Undiagnosed abdominal pain
- Diarrhoea
- Recent radiation therapy to pelvic area.

Saline Laxative Enema

(e.g. Sodium citrate – Microlax® (first choice of enema)

- Saline enemas contain ions such as magnesium, phosphate, sulphate and citrate which are poorly absorbed. As a result of the effect of osmosis, fluid is retained in the colon which results in the stimulation of peristalsis[22]. Risk of elevation in serum sodium levels and consequent dehydration[3,5].
- Prolonged retention of the enema solution should be avoided, particularly following administration of a phosphate enema. Sodium salts may contribute to or worsen fluid and electrolyte disturbances. Using sodium phosphate may increase the risk of acute renal failure. Risk of electrolyte imbalance and dehydration. Risk of hyponatraemic dehydration[1].
- Small volume 5mL
- Sodium phosphate – Fleet®
- Large volume 133mL

Specific consideration should be given before commencing rectal saline laxatives in the following situations:

- Cardiovascular disease eg: heart failure
- Electrolyte disturbance
- Medications e.g. Diuretics, ACE inhibitors, NSAID's, Angiotensin II antagonists
- Elderly
- Congenital mega-colon/imperforate anus

Appendix 6: Incontinence Associated Dermatitis (IAD)

Refer to WACHS Impaired Skin Integrity Clinical Practice Standard

Incontinence associated dermatitis (IAD) is defined as inflammation of the skin that occurs when urine or stool comes into contact with sacral, perineal or peri-genital skin[23]. IAD is characterised by epidermal erosion and macerated appearance of the skin.

There are 4 factors that contribute to skin breakdown:

- Excessive moisture/perspiration
- High skin pH related to urinary and/or faecal incontinence
- Colonisation of skin micro organisms
- Friction[23]

Incontinence Associated Dermatitis may present as:

- Tingling, itching, burning
- Pain
- Erythema
- Crusting and/or scalding
- Swelling or ooze[23]
- Vesicles
- Sacral Dermatitis

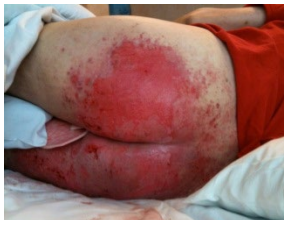


Figure 1: Example of sacral dermatitis

Assessment

Assess for signs of moisture, impaired skin integrity, rash/ dryness of the skin.

Excessive moisture and alkalinity may promote excessive urea production, increasing risk of integument breakdown.

Skin may appear dry despite over hydration due to excessive cleaning with soap and water. Early detection minimises integument breakdown[23].

Management

Cleanse sacral and perineal skin daily and after each incontinence episode using a no rinse cleanser or warm water.

Soap is to be avoided due to its high pH which can compromise the natural barrier function of the skin.

The cleanser selected should be pH neutral and remove contaminants from the integument. Routine cleansing after incontinence promotes skin healing and resists further damage[23].

Skin Care

Moisturising agents and barrier creams are the preferred option to maintain skin integrity as they shield the skin from exposure to irritants and moisture[23].

For further advice and product supply contact Continence Service (if available), or MO/ Senior Clinician.

Ensure to Avoid:

- Use of talc based powders in skin care management
- Use of absorbent products
- Consider under pad
- Refer to Bowel Management Products section

Apply appropriate moisturiser and barrier products to the sacral, perineal/ perianal area if:

- The skin is dry or prone to breakdown
- Altered skin integrity present
- Commence wound management plan as required

Appendix 7: Bowel Management Products

The use of products may be indicated after an initial assessment of bowel function has been completed.

For further continence advice contact Continence Service/CNC within site or care facility.

The aim of appropriate product use is to promote:

- Isolation of faeces from clothing and bedding
- Dignity and comfort for the patient[24]

Products are not to be used as an alternative for toileting programs.

Assessment

When assessing for product use to manage bowel dysfunction consider:

- Functional ability of the patient
- Severity of bowel dysfunction
- Gender
- Failure with previous treatment
- Patient's preference and co-morbidity
- Skin condition in sacral and peri-genital area
- The long-term use of pads has financial implications for the individual

Types of Pads

- **Shaped pad/ 2 piece system:** waterproof backing, secured with adhesive strip. To be worn with firm fitting underwear
- **Self-adhesive water proof backing:** secured with an adhesive strip. To be worn with firm fitting underwear, can be used for small-moderate faecal loss
- **Insert booster pads:** to be used in addition with another pad, free from plastic backing, non-adhesive, extends the life of the outer pad, available from Continence Service (if available)
- **Non-adhesive waterproof backing:** use with firm fitting underwear or disposable pants. Used for large volume faecal loss, although good manual dexterity is required to manage these pads
- **Absorbent body worn/ self-contained pants:** use for mobile patients unable to manage 2-piece system. These pads are pulled on like underwear
- **Side fastening/ all-in-one style pads:** use for those who are bed/ chair bound with intractable incontinence and are unable to be managed by other means. These pads are secured with the aid of adhesive tabs
- **Under pad/ disposable absorbent sheet:** contraindicated for use with people with severe dermatitis. Use for those who are bed/ chair bound with skin excoriation. Check at 2 hourly intervals to minimise further skin irritation and maintain comfort.
  NB: Tissue bed protector sheets ('Blueys') are not a continence aid.

Faecal Collection Bags

- Consider use for immobilised bed bound patients with skin excoriation
- Allows for the healing of skin excoriation as loose faecal matter is contained within a collection bag
- Is available from the Continence Service onsite.

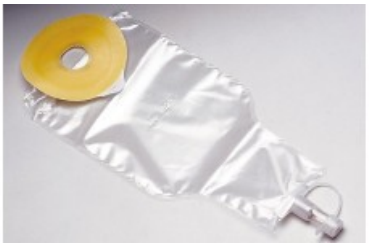


Figure 2: Example of faecal collection bag

Faecal Management Systems

- Used to collect liquid stool
- A digital rectal examination must be performed to ascertain adequate anal tone and absence of faeces in rectum
- Patient selection assessment checklist must be completed and patient must meet all specific manufacturer criteria
- Use for unconscious /immobilised bedbound patients
- Allows wound healing
- Maximum length of use 29 days

Figure 3: Example of faecal management system

Contact Continence Service/ MO/ Senior Clinician for further information

Anal Plug

- Used to contain faecal incontinence of soft stool i.e. not suitable for containment of loose stools
- Inserted into the rectum where it expands and conforms to the natural shape of the rectum so preventing leakage
- Can stay in situ for a maximum of 12 hours[25]

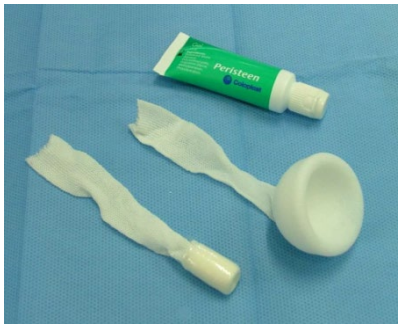


Figure 4: Example of anal plug

Contact Continence Service, for further information.