Faecal Incontinence - Full Clinical Guideline

Reference no.: CG-T/2011/093

1. Introduction

Faecal Incontinence can be a cause of extreme distress for the sufferer and also compromise tissue viability.

2. Aim and Purpose

The purpose of this resource pack is to provide registered and non-registered practitioners with an evidence based clinical direction in order to assess and manage adult patients who present with faecal incontinence within the acute trust.

The guidelines:-

- Are applicable to all adults who present with clinical symptoms and/or history of faecal incontinence.
- Indicate predisposing factors to faecal incontinence, assessment of the type of faecal incontinence and on identification provides guidelines on the implementation of a care plan.

3. Definitions

Faecal Incontinence occurs "when a person loses control of the bowel and is unable to retain faeces in their rectum"[i]

Faecal Incontinence/Faecal Leakage/Faecal Seepage, these terms are often used interchangeably with anal incontinence- any involuntary loss of faecal material and/or flatus2

4. Assessment and Management

In all cases the cause of the faecal incontinence and the possibility of symptoms indicating a more serious problem such as malignancy should be investigated by medical staff. Non malignant causes such as inflammatory bowel disease also need to be ruled out.
Undertaking a detailed bowel assessment will enable the healthcare practitioner to identify the level of faecal incontinence, duration of symptoms and plan the treatment accordingly. Assessing a patient's diet and fluid intake, as well as t h e i r lifestyle, routine and habit should be the first step in treating faecal incontinence, and may be enough to alleviate the condition. Reviewing medication must also be part of the initial approach.
If the basic measures prove ineffective then consideration may be given to referral to the continence team.

Diarrhoea

There are many causes for patient's to suffer from diarrhoea. Always refer to the infection control guidelines.

Lifestyle Advice

People of all ages can experience faecal incontinence; therefore everyone should receive lifestyle advice as appropriate that includes:-

Diet and fluids

Possible dietary causes of diarrhoea and/or faecal incontinence

Sorbitol found in products such as elixirs3, sugar free gum, pears, prunes, peaches and orange juice.

Fructose found in products such as soft drinks, apples, honey, pears, cherries, dried dates, dried figs, grapes and prunes.

Mannitol found in products such as sugar free products and mints.

Bran and other fibre supplements when used in excessive amounts or used inapprop

Caffeine found in products such as tea, coffee, cola, Red Bull, Iron Bru stimulates the gastrointestinal motility.

Alcohol

Lactose and gluten intolerance. (investigated by an appropriate diagnostic tool).

Eating a Low Fibre Diet in Hospital.

If diarrhoea – stool type 6-7 causes faecal incontinence it may be useful to reduce fibre intake. Refer to dietician for advice.

Foods to encourage from the hospital menu include:

- Breads ,Cereals White Bread Potatoes Rice Krispies
  Cornflakes
  Boiled/Mashed/Roast
  Potatoes White rice dishes
  Creamed crackers, rice cakes
- Fruit and Veg: Fruit (fresh, tinned or in puddings) but remove skin, pips Vegetables but remove any skins, stalks, seeds
- Protein Foods Meat, poultry, fish, eggs
- Milk and Diary yoghurts,cheese. Milk, cream, plain and fruit

Medication

Both prescription and over the counter medications are common causes of diarrhoea and faecal incontinence. A careful drug history is mandatory, including specific questions relating to medicines brought from the chemist.

The classes of drug most commonly implicated include antacids, antibiotics, laxatives and non-steroidal anti-inflammatory drugs (NSAIDS), anti hypertensives and potassium supplements.
This list is not exhaustive , review using the BNF or discussion with pharmacist is advised.

Pelvic Floor Exercises

Sphincter exercises can help improve bowel control4. When performed correctly, these exercises can build up and strengthen the external anal sphincter to help hold both gas and stool in the back passage. However, these exercises are unlikely to be helpful if there is an actual break in the muscle, or if the leakage is from a cause other than weak muscles.

Performing the exercises (see trust patient information leaflet)

1. Sit, stand or lie with your knees slightly apart, and imagine you are trying to stop yourself from passing wind. Squeeze and lift the muscle around the back passage tightening and lifting, aim to hold for **5 seconds,** and then relax **for 5 seconds.** Repeat **5 times.** These are called **slow pull ups.**

2. Now try to pull the muscles quickly and tightly and relax straight away. Repeat **5 times.** These are called **fast pull ups.**

Both slow and fast pull ups should be undertaken to ensure an effective workout. They should be performed x6 daily if possible

Bowel Retraining[5]

Most patients find that their emotions have an influence on their bowels. If they are worried or anxious it leads to more frequent, more urgent, and looser bowel actions. It is known that worry stimulates the bowels to work more often and with greater urgency. If a patient panics when the bowel is full, this can cause the sense of urgency to become even stronger - the more they panic the more they need to go.

When the rectum fills, the internal sphincter opens. The patient needs to be able to contract the external sphincter hard enough and for long enough to allow this to close off again to prevent an accident. Rather than rushing to the toilet, it may do better to sit or stand still, breathe deeply and contract the anal sphincter, for long enough for that urge to wear off.

. Teach the patient that the next time they need to have their bowels open:

1) Sit on the toilet and hold on for as long as you can before opening your bowels. If you can only manage a few seconds, don't worry it will gradually get easier. Whatever you can manage now, you are aiming to double it, and then double it again. Gradually increase this to 5 minutes. Don't worry if you're not able to do this for the first few times but keep practicing.

2) When you have mastered this, repeat the above but hold on for 10 minutes before opening your bowels. It may be helpful to take something to read with you. This stage is harder but remember you're on the toilet and therefore "safe".

3) Once you are able to delay opening your bowels for 10 minutes sitting on the toilet now is the time to begin to move away from the toilet. Therefore the next stage is when you want to open your bowels to sit near the toilet either on the edge of the bath or on a chair inside or just outside the toilet area. Now hold on for 5 minutes. Once you are able to do this, repeat the exercise increasing to 10 minutes.

4) When you are able to delay opening your bowels for 10 minutes whilst off the toilet you should now gradually move further away, maybe sitting on the bed in your bedroom. As your muscles are now becoming stronger you should be able to hold on for 10 minutes and as you feel more confident, increase the distance between you and the toilet.

   Gradually you will find that you can increase the distance and the time away from the toilet. This may take some time to master but obviously the more practice you have at both your sphincter exercises and this programme the sooner improvements will be made.

Skin Care

Please refer to Skin Care Bundle as part of the Trust Prevention and Management of Pressure Ulcers Care Pathway – accessed via intranet- Flo for details on maintaining healthy skin in patients with faecal incontinence.

Disposable Products

Pads

Very few products have been designed specifically for faecal leakage. Most of the disposable pads used for urinary incontinence can be used for containment, but some people find them unnecessarily thick, bulky, and not exactly the correct shape at the back to contain the anal leakage.
The simplest sort of pad for minor leakage is a panty liner, available in supermarkets and chemists.
More major incontinence will require larger pads, which may be obtained following a comprehensive bowel assessment by a district nurse or continence advisor. If accidents are infrequent the patient may not meet the criteria for NHS pad provision.

Anal Plug

Please refer to Trust guidelines, accessed via Flo, regarding the suitability of an anal plug before use.

Faecal Collection Pouch

Occasionally people who are seriously ill and confined to bed and who have uncontrolled diarrhoea can benefit from wearing a collection bag over the anus. The faecal collector has a flexible foam backed skin barrier, which provides a leak proof fit and is comfortable to wear. The device also protects the perianal skin from irritation and maceration caused by contact with faecal discharge, which is collected in the pouch. It is available in two capacities, 1000ml and 500ml. Available on Drug Tariff.

5. References (including any links to NICE Guidance etc.)

1.Royal College of Surgeons (2014) Commisioning guide: Faecal Incontinence. London

2 ICS (2009) Recommendations of the International Scientific Committee: Evaluation and Treatment of Urinary Incontinenece, Pelvic Organ Prolapse and Faecal Incontinence. 4th International Consultation on Incontinence.

3 Getcliffe, K., and Dolman, M. (2007) Promoting Continence: A clinical and research resource. Third Edition. Bailliere Tindall, Elsevier.

4 de Oliveira Camargo, F., Rodrigues, A.M., Arruda, R.M., Sartori, M.G.F., Girao, M.J.B.C and Castro, R.A. (2009) Pelvic floor muscle training in female stress incontinence: comparison between group training and individual treatment using PERFECT assessment scheme. International Urogynaecological Association Journal 2009 20:1455-1462

5 National Collaborating Centre for Acute Care (2007) Faecal Incontinence: The management of faecal incontinence in adults. CG49 NICE London.

6. Documentation Controls

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