Internal Fecal Management Systems (FMS) Guideline for Adults

Site Applicability

VCH:

- Vancouver General Hospital (VGH) Intensive Care (ICU), Cardiac Surgical Intensive Care Unit CSICU, Burns Trauma High Acuity Unit (BTHA)
- Lions Gate Hospital (LGH) ICU/HAU
- Richmond Hospital (RH) ICU/HAU

PHC:

- Critical Care units

Practice Level

Profession	Basic Skill	Specialized Skills and Associated Competency Requirements
Registered Nurse (RN)	Assessment and management	Initial assessment, insertion, and removal: Basic skill with **additional education***

*with critical care and/or high acuity specialty training and/or equivalent

Requirements

1. Use of Fecal Management System (FMS) requires assessment and an order by a provider: physician or NP.
2. Provider assessment includes review of the indications, precautions, and contraindications to the use of an FMS.
3. **VCH ONLY**- Provider must order abdominal x-ray to rule out constipation or impaction.
4. The FMS cannot be used for more than 29 consecutive days. A provider must re-order the re-insertion of a new FMS after 29 consecutive days if there is a persistent need and if the benefit of continued use outweighs potential risks.
5. Do not insert rectal devices or rectal medications that cannot be administered through the irrigation port while the FMS is in situ.
6. Requires routine monitoring and daily reassessment for continued use**.** See Procedure and Documentation.
7. The clinician is required to obtain verbal consent prior to inserting, repositioning and removing the FMS

a. If the patient does not consent to the FMS insertion or use, discuss alternative fecal management approaches with the most responsible physician

8. Provide a culturally competent and trauma-informed explanation of the procedure, understanding that this intervention involves patient vulnerability. The patient may request further discussion and understanding of the purpose, procedure, and side effects. Refer to the Related Documents for health authority specific decision support tools for guidance.
9. Maintain patient dignity whenever possible by:
    - Keeping the patient draped and covered throughout the procedure
    - Asking visitors to step out for the duration of the procedure
    - Checking in frequently throughout the procedure to ensure comfort
    - Drawing the curtains and maintaining privacy
    - Retrieving consent prior to procedure

Need to Know

- FMS is an internal fecal management system that is a temporary collection device comprised of a soft silicone catheter tube with a sterile water-filled retention balloon that is inserted into the rectum. The catheter tube ends with a detachable collection device that can be hung off the bed.
- FMS should only be used in the presence of loose or liquid stool.
- Prior to inserting the FMS, RN assesses for constipation, sphincter tone or strictures by performing a digital rectal exam. Discuss with provider if any of the following were noted, as they are contraindications to the insertion of FMS:
    - Palpation of stool in the rectal vault
    - Obstruction or narrowing of the rectum
    - Difficulty performing rectal exam for any reason (e.g. pain, difficulty inserting digit, etc.)
    - Rectal sphincter tone is decreased as demonstrated by low to minimal squeeze pressure allowing for leakage of stool. Tone must be sufficient to retain FMS balloon within rectum.
- **VCH:** If patient desires, make a referral to Indigenous Patient Experience and or Spiritual Care and Multifaith Services.
- **PHC**: Consult Indigenous Wellness or appropriate Spiritual Health team using Cerner.

Indications

- To **CONTAIN** infectious stool (e.g. Clostridiodes difficile [C. diff]) within a closed drainage system in order to minimize the risk of spread of infection.
- To **PREVENT** occurrence of or exacerbation of denuded skin in the presence of ongoing diarrhea.
- To **PROTECT** any wounds (e.g. burns, grafts, stage 3 or 4 pressure injuries) that are likely to be threatened by contamination with stool.
- Should be considered when:

- There is greater than 300 mL of liquid stool (or 4 to 5 loose bowel movements) in a 12-hour period when constipation or impaction have been ruled out.
- For consideration of use when other external fecal collection devices have failed.

Contraindications

- C. diff positive **AND** at risk for perforation or toxic megacolon
- Toxic megacolon
- Coagulopathies:
  - Platelets less than 50 x 10^9/L
  - INR greater than 1.5
  - PTT greater than 2 times the control value
- Neutropenia (neutrophils less than 1 x 10^9/L)
- Suspected or confirmed fecal impaction
- Absent or inadequate anal sphincter muscle tone to retain the device
- Stool is soft, pasty, hard or formed
- Suspected or confirmed rectal or anal tumour
- Severe hemorrhoids
- Suspected or confirmed rectal mucosa impairment (i.e., severe proctitis, ischemic proctitis, or mucosal ulcerations)
- Suspected or confirmed bowel obstructions or bowel perforation
- Indwelling rectal or anal devices present
- Anal or rectal strictures, stenosis and/or injury
- Large bowel or rectal surgery within the last year
- Sensitivity or previous allergic reaction to product components (e.g. silicone)

Precautions

- Patients with an inflammatory bowel condition or who have had any previous rectal surgery.
- Patients who have a tendency to bleed (anticoagulant or antiplatelet therapy, coagulation disorder, or diseases where bleeding is common). If any signs of rectal bleeding, rectal pain, abdominal distention or pain, remove device immediately and notify provider.
- Patients with spinal cord injury due to the possibility of the development of autonomic dysreflexia.
- Patients may be positioned upright for a maximum of 30 minutes. A longer duration may cause obstruction of stool and/or a medical device related pressure injury. Tolerance for critically ill patients must be assessed individually and in accordance with the prescriber's order. See Mobilization for full details.

Potential Adverse Effects include:

- Leakage of stool around the device
- Rectal or anal bleeding due to pressure necrosis or ulceration of the anal or rectal mucosa
- Peri-anal skin breakdown
- Infection
- Loss of anal sphincter muscle tone could lead to temporary anal sphincter dysfunction
- Bowel obstruction
- Bowel perforation

Notify Provider with any of the following:

- Persistent rectal pain
- Rectal bleeding
- Abdominal distention or pain
- Decreased or absent anal tone (could be identified by balloon needing regular increase in fluid or inability to maintain the system in the rectal vault)
- Stool is soft, semi-formed or solid

Procedure

See device specific Product Information Sheets for the following:

- Insertion
- Changing of the FMS
- Sampling
- Irrigation
- Removal procedures
- Troubleshooting
    - If the FMS becomes dislodged from the patient and is still indicated, it can be reinserted. Before reinserting the FMS, the provider ensures that there are no kinks, tubing twists, blockages, hard stool or leaks in the device itself and that rectal tone is present (there could have been a change).

Ongoing Assessment & Management

- Assessment at least every 24 hours for appropriateness of ongoing use. See Discontinue FMS for criteria. If the patient no longer meets the indications, notify the provider for an order to remove the FMS.
- Assess FMS at least every 6 hours, with every patient reposition, and PRN for:
    - Correct positioning of FMS by following instructions in Product Information Sheets. If a change in the position of the FMS is identified, this may indicate that the balloon or device requires repositioning.
    - Obstruction (e.g. kinks, twists or presence of solid fecal particles) or external pressure (e.g. patient laying on catheter or collection bag is full). Tubing may require repositioning or need "milking" to promote drainage.

- Ensure that tubing is not a potential falls risk during mobilization.
- Patient tolerance of the device and new or worsening rectal or abdominal pain.
- Signs and symptoms of toxic megacolon:
  - Fever and malaise
  - Abdominal pain
  - Abdominal distention
  - Hematochezia

- Measure stool output as per unit routines or as indicated by provider.
  - Minimum every 6 hours
- Monitor and Screen for spiritual distress
  - **VCH:** Contact Spiritual Care and Multifaith Services to offer an initial Spiritual Health assessment. If the patient comes from an Indigenous background and is wanting a Navigator to join them please involve Indigenous Patient Experience to assist with proper ceremonies and support.
  - **PHC:** Contact Indigenous Wellness for support.

For patients with FMS for wound protection

- Follow prescriber's orders to maintain a stool output of greater than 300 mL every 12 hours.
- Bowel preparation and post-insertion bowel protocol may be ordered to assure stool consistency and volume is within recommended guidelines.
- Notify provider if unable to maintain minimum stool output.
  - **For VGH**- Follow the PowerPlan: Wound Protection for Patients with Burn-Injuries in ICU and BTHA using FMS
- Monitor patient for increased gastric residual volumes, emesis, abdominal distention or pain.

Discontinue FMS

Refer to the patient-specific PowerPlan for discontinuation instructions. If there is no indication of discontinuation guidelines, reach out to provider for an order prior to removal. Indications for removal of FMS:

- When output is soft, semi-formed or solid.
- When output is less than 300 mL in 12 hours.
- If wound protection is deemed no longer required by care team.
- If FMS has been in situ for 29 days. If FMS is still indicated after 29 days, a new provider's order is required to remove and reinsert a new FMS device.

Skin Care

- Small amounts of moisture or seepage around the catheter may occur.
- Ensure perianal skin is clean and dry.
- Provide skin care as per the Health Authority policy. See Related Documents for resources.

Mobilization

1. Head of bed no greater than 30 degrees when in bed.
2. Patients with FMS may mobilize as ordered by a provider if:
   - The patient may stand and ambulate.

- The correct positioning of the FMS must be checked prior to and immediately after mobilization. See Product Information Sheet.
- When ambulating, ensure FMS tubing remains securely attached and is visible and away from patient to decrease risk of falls.

- The patient may sit in a chair or at the bedside for up to 30 minutes.
  - Tolerance may vary between patients therefore sitting in chair is assessed on a case–by-case basis.
  - During this sitting period, regular monitoring is required to ensure the tubing is not blocked or kinked.
  - After sitting period assess for pressure injury to the anal or perianal region.

Documentation

Document the following in the patient's health record:

Insertion Procedure

- Date of provider's order and assessment
- Date and time of insertion of FMS and by whom
- Patient's tolerance of procedure

Ongoing Management

- A reassessment is needed at least every 24 hours to determine if FMS continues to meet indications for use
- Monitor every 6 hours with the following parameters:
  - FMS position check
  - Patency of FMS
  - Site condition (perianal skin condition)
  - Patient's response to FMS placement
  - Worsening or new onset of rectum, insertion site, or abdomen pain

At least once per shift:

- Stool volume, colour and description
- Gastrointestinal assessment
- Skin care protocol in use to prevent or treat perianal skin damage

After mobilization

- FMS position check
- Patency of FMS
- Patient status
- Notify provider **immediately** if abdominal/rectal pain is reported

After Removal

- Rationale for removal
- Status of tube (i.e., intact, balloon deflated, and/or evidence of a blockage or blood)
- Patient response

When needed:

- Troubleshooting procedures, such as irrigation
- Unexpected events
- Wound measurements and concern related to depth and if wound starts to connect/erode to the rectal vault

Documentation in Cerner:

- Add a dynamic group under **Devices**
    - Under Gastrointestinal Tubes add a dynamic group specific to the FMS system (see Appendix A)
- Document activity, insertion, ongoing management, stool volume and description, FMS position checks, patency, and patient response in iView under the added dynamic group (see Appendix B, Appendix C)

Patient and Family Education

- Explain the indication of the device to patient and family as required.
- Explain mobilization restrictions.
- Describe contraindications and precautions of the FMS.
- To prevent skin breakdown and tube migration, encourage patients to communicate tube discomfort and pain when possible. This may require clinician inspection.
- Flexi-seal Information Fact Sheet
- For more information, provide patients and families with the Convatec Product Information Website.
- Inform patients and families of Indigenous Patient Experience and or Spiritual Care and Multifaith Services are available if the patient would like to discuss the content and the meaning of their experience

Related Documents

- Provincial Adult Skin Care Protocol
- Connecting Learners with Knowledge (CLWK) Flexi-Seal Protect Product Information Sheet
- Elsevier Insertion Guide
- Guidelines Flexi-Seal Signal
- Flexi-Seal Information Fact Sheet
- Flexi-Seal Protect Plus Directions for use Enfit Connection or Flexi-Seal Protect Plus Directions for use Luer Connection
- Convatec acute Fecal incontinence in ICU algorithm
- Algorithm for Acute Fecal Incontinence with diarrhea risk assessment and Management in the ICU
- Indigenous Cultural Safety

- Cultural Competency and Responsiveness

PHC Only Related Documents:

- Site/ Unit Specific Adult Skin Care Protocols
- Indigenous Cultural Safety Policy

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Definitions

Cultural Competency: means developing cultural knowledge, skills in understanding cross- cultural interactions, and an awareness and acceptance of the dynamic variety of people and populations we work with. Cultural competency is not a discrete end point but rather it is a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves. Organizational cultural competency requires multi-level interventions and supports to foster a culture of openness and respect.

Diarrhea: greater than three (3) loose or liquid stools or 300 mL over the past 12 hours that persists for greater than 48 hours (despite full evaluation into etiology and 24 hour trial of anti-diarrhea agent, unless contraindicated).

Hematochezia: refers to the presence of fresh blood in the stool.

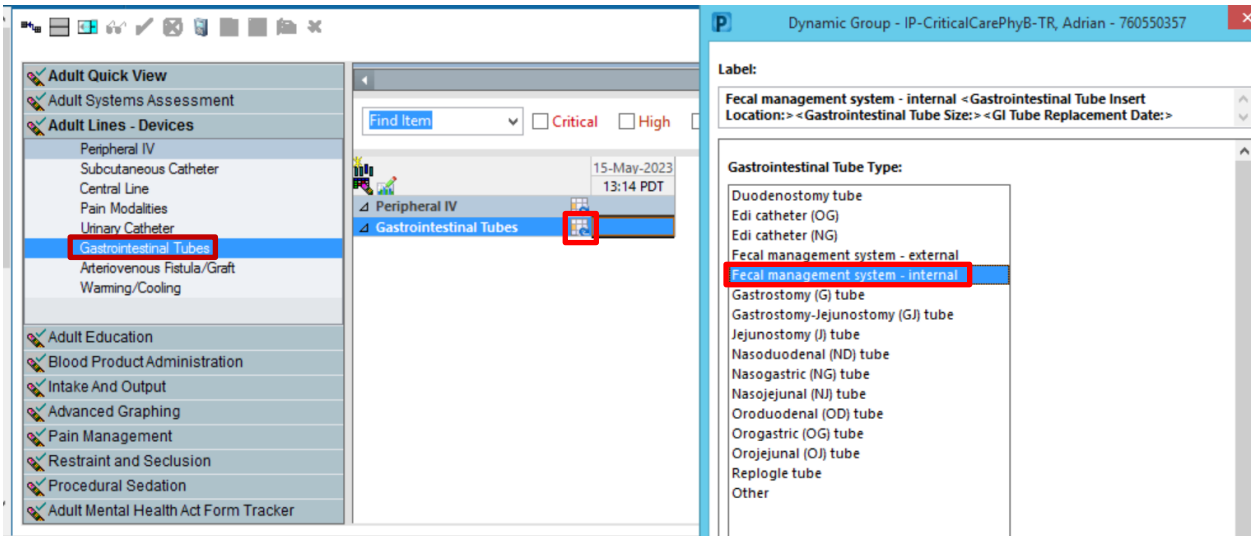
Milking: refers to the procedure used to express the contents of a tube, prevent clogging or restore flow.

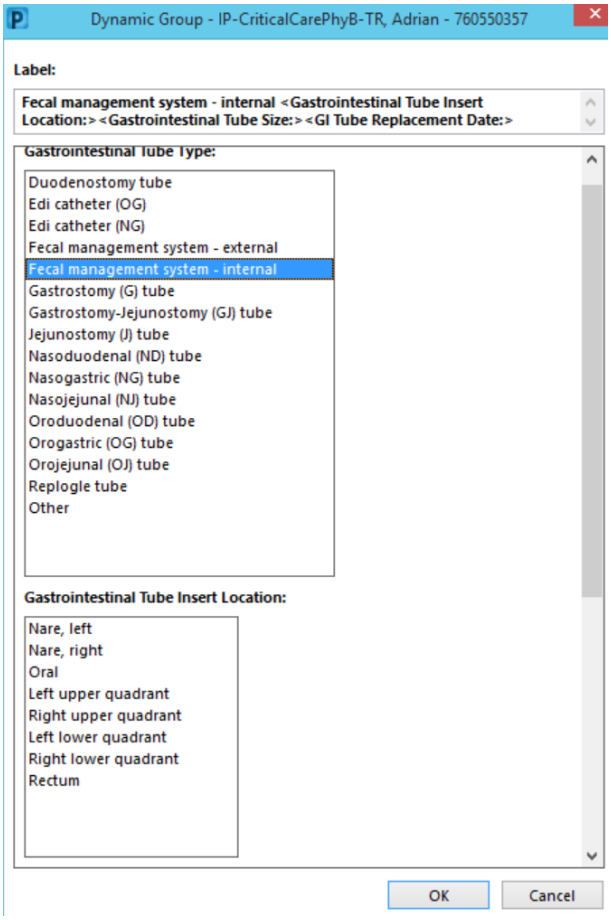
Patient: refers to an individual receiving health care within Vancouver Coastal Health or Providence Health Care, interchangeable with client or resident.

Trauma-informed Care: an approach to healthcare where healthcare organizations and care teams have a comprehensive understanding of the patients past and present experiences to provide knowledgeable care focused on holistic healing and sensitivity.

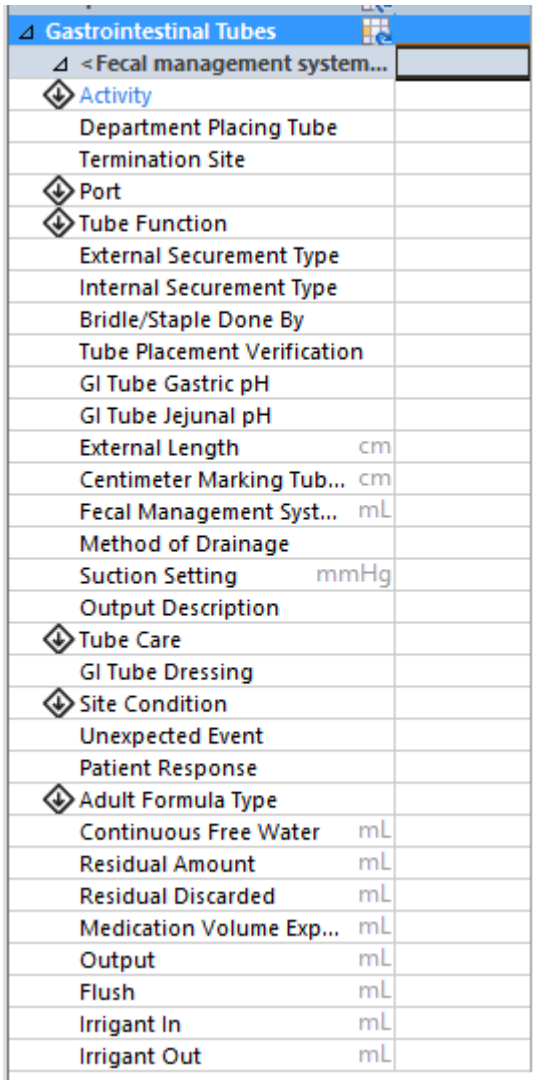
Appendices

Appendix A: Adding a Dynamic Group

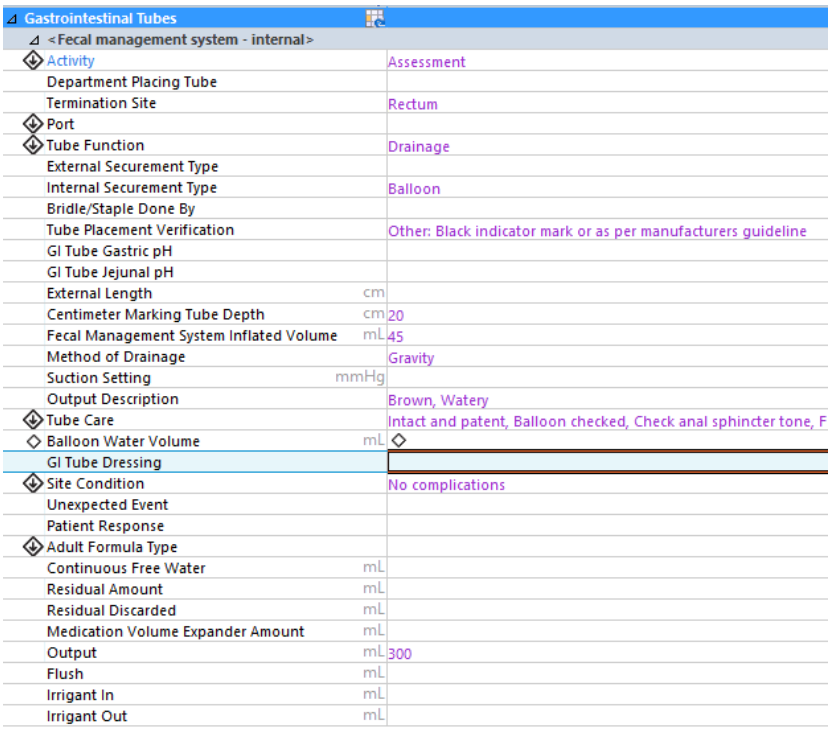




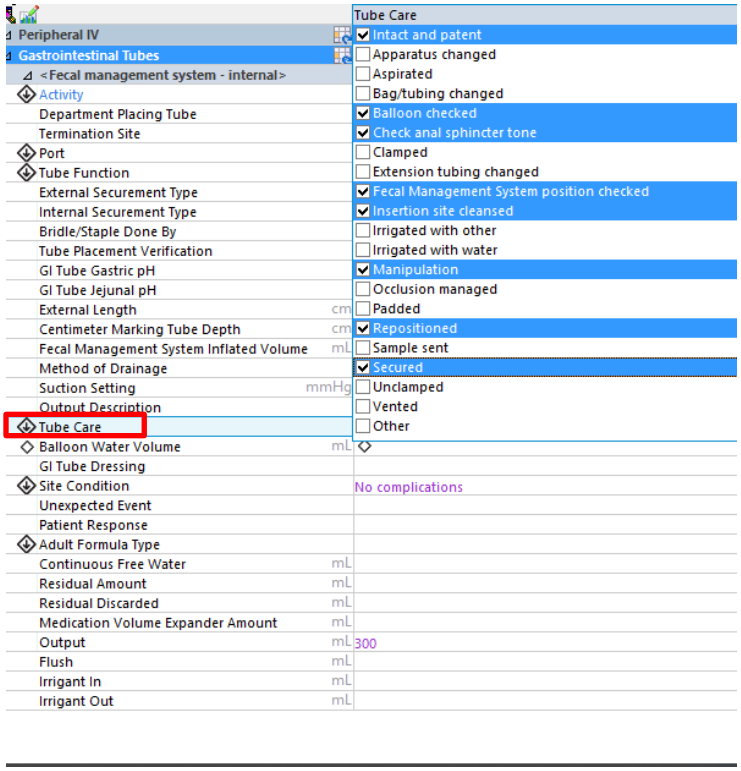
Appendix B: iView Fields for Internal Fecal Management System in Cerner



Appendix C: Cerner iView Field Charting Example for FMS charting



Gastrointestinal Tubes		
<Fecal management system - internal>		
Activity		Assessment
Department Placing Tube		
Termination Site		Rectum
Port		
Tube Function		Drainage
External Securement Type		
Internal Securement Type		Balloon
Bridle/Staple Done By		
Tube Placement Verification		Other: Black indicator mark or as per manufacturers guideline
GI Tube Gastric pH		
GI Tube Jejunal pH		
External Length	cm	
Centimeter Marking Tube Depth	cm	20
Fecal Management System Inflated Volume	mL	45
Method of Drainage		Gravity
Suction Setting	mmHg	
Output Description		Brown, Watery
Tube Care		Intact and patent, Balloon checked, Check anal sphincter tone, F
Balloon Water Volume	mL	
GI Tube Dressing		
Site Condition		No complications
Unexpected Event		
Patient Response		
Adult Formula Type		
Continuous Free Water	mL	
Residual Amount	mL	
Residual Discarded	mL	
Medication Volume Expander Amount	mL	
Output	mL	300
Flush	mL	
Irrigant In	mL	
Irrigant Out	mL	



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	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
	Practice Consultant, Professional Practice	Nursing Practice Initiatives Lead