

*Blue Ridge HealthCare System
Patient Care
Wound Care Center*

Stool Management System: Insertion and Management

Origination Date: 10/10

Review/Revised Date: 12/14/2015

APPLICABILITY:

Carolinas HealthCare System Blue Ridge

POLICY:

Stool Management systems will be inserted and maintained in accordance to evidence-based guidelines, manufacturer's recommendations, and by provider order.

PURPOSE:

A Stool Management System is used to contain and divert liquid or semi-liquid stool in patients with little or no bowel control in order to protect the patient's skin and minimize exposure to infectious microorganisms.

NOTE:

- A. A provider's order is required.
- B. A Stool Management System is indicated only after the patient has been determined as an inappropriate candidate for the rectal pouch.
- C. **Different Stool Management Systems exist, therefore, manufacturer instruction guidelines must be followed to prepare the system, insert the device, and maintain device.**
- D. A Stool Management System is not intended for use for more than **29** days.
- E. Patients with very weak sphincter muscles may not be able to hold the device in place and may experience increased leakage of stool.
- F. **A Stool Management System should NOT be used on individuals who:**
 - a. Have had lower large bowel or rectal surgery within the last year.
 - b. Have any rectal or anal injury.
 - c. Have a severe rectal or anal stricture or stenosis (distal rectum cannot accommodate the balloon when inflated).
 - d. Have suspected or confirmed rectal mucosa impairment, eg. Severe proctitis, ischemic proctitis or mucosal ulcerations.

- e. Have a confirmed rectal / anal tumor.
 - f. Have severe hemorrhoids.
 - g. Have a fecal impaction.
 - h. Have indwelling rectal or anal device (thermometer / enema).
 - i. Are known to be sensitive or allergic to any components of the system.
 - j. Close attention should be exercised with patients who have inflammatory bowel conditions.
- G. A Stool Management System is **indicated** in the following patient situations:
- a. Rectal pouching has been unsuccessful.
 - b. Expectation is that the diarrhea will not be resolved within 48 hours or anti-diarrheal agents have been unsuccessful / inappropriate.
 - c. Uncontrolled diarrhea.
 - d. Wound / graft that is likely to become contaminated by incontinent stool.
 - e. Too hemodynamically unstable to move for frequent cleansing.
 - f. Patient size demands three or more staff members for turning and assistance to cleanse.

EQUIPMENT:

- A. Clean gloves
- B. Stool Management System
- C. 60 ml syringe
- D. Water-soluble lubricant
- E. Graduated cylinder for water

PROCESS:

- A. Identify the patient using two approved forms of identification.
- B. Review the patient's history to determine there is not a contraindication for Stool Management System insertion.
- C. Perform hand hygiene before and after patient contact.
- D. Use appropriate Personnel Protective Equipment (PPE's).
- E. Check Stool Management System for appropriate functioning:
 - a. Using a 60ml syringe, inflate retention cuff and / or intraluminal balloon according to manufacturer's instruction guide with required amount of water and / or air.
 - b. Inspect cuff / balloon for leaks or flaws.
 - c. After verifying proper function, use syringe to slowly and completely aspirate all fluid and air from the retention cuff and / or balloon. Disconnect syringe.
 - d. Inject water through the irrigation lumen to confirm lumen patency.
 - e. Connect end of catheter drain tube to collection bag following manufacturer's instructions.
- F. Position patient in left lateral, knee chest position unless the patient's clinical situation dictates the use of an alternate position. The goal of patient positioning is to maximize sphincter relaxation to ease catheter insertion.

G. Perform a digital rectal exam to assess rectum and anal canal for pathology, size, stool, and fecal impaction. If fecal impaction is present, rectum must be cleared of stool before inserting the rectal catheter.

H. Insertion of device:

- a. Unfold the length of catheter to lay flat on the bed, extending the collection bag towards the foot of the bed.
- b. Attach the 60 ml syringe with the required amount of water (according to manufacturer's direction) to the inflation port, but do not inflate.
- c. Ensure that the retention cuff is free from any air or fluid.
- d. Apply water-soluble lubricant generously over retention cuff before insertion.
- e. Gently insert the cuff end according to manufacturer's instruction guide through the anal sphincter until the cuff is beyond the external orifice and well inside the rectal vault.
- f. Inflate the retention cuff with the required amount of water by slowly depressing the syringe plunger. Follow manufacturer's instruction guide to determine proper cuff inflation.
- g. Remove the syringe from the inflation port and gently pull on the catheter to ensure that the cuff is securely in the rectum and positioned against the rectal floor.
- h. Position the length of the flexible catheter along the patient's leg; hang the bag by the hanger preferably below the patient's rectum avoiding kinks and obstruction.
Note: Observe the location of the position indicator line relative to the patient's anus. Observe for any changes in the location of the position indicator line as a means to determine movement of the retention cuff in the patient's rectum. A change in location may indicate the need for the device to be re-positioned at the cuff.

I. Maintenance of Device:

- a. Check the Stool Management System q2hr to ensure the device is positioned properly against the rectal floor and that is not obstructed. To ensure unobstructed flow of fecal matter from the drainage tube to the collection bag, verify that the catheter and collection bag are positioned so that the catheter is not twisted, kinked or externally compressed. Verify that waste is not accumulating in the catheter drain tube; if waste accumulates, irrigate as needed following manufacturer's instruction.
- b. Change the collection bag as needed according to manufacturer's instruction guide. Secure the plug onto each used bag and discard, maintaining appropriate precautions.
- c. Irrigate / Flush the catheter according to manufacturer's instruction guide and / or as needed.
Note: If repeated irrigation or flushing with water does not return the flow of stool through the catheter, inspect the device for any external obstruction (pressure from a body part or piece of equipment). If no source of obstruction of the device is detected, use of the device should be discontinued.

J. Removal of Device:

- a. To remove the catheter from the rectum, the retention cuff and / or balloon must be deflated.

- b. Withdraw all water and / or air from retention cuff and / or balloon.
- c. Grasp catheter as close to the patient as possible, ask patient to bear down and slowly slide it out of the anus.
- d. Maintain appropriate precautions, place in biohazard bag and place in biohazard container.

DOCUMENTATION:

- A. Document patient assessment
- B. Document goals and interventions on the Interdisciplinary Plan of Care
- C. Document patient and family education on the Educational Teaching Record
- D. Stool Management System type and purpose
- E. Date and time stool management system inserted
- F. Amount, color and consistency of feces collected
- G. Patient response

REFERENCES:

Echols, J., Friedman, B.C., Mullins, R.F., Hassan, Z., Shaver, J. R., Brandigi, C., Wilson, J., & Cox, L. (2007). Clinical utility and economic impact of introducing a bowel management system. *Journal of Wound, Ostomy Continence Nursing*, 34(6), 664-670.

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