Addressograph

Cardiff Critical Care Faecal Management System Protocol

Lot number……

Patient Assessment:

The following protocol must be completed and filed in the medical notes prior to FMS use; deviation from the protocol must be documented and addressed by a senior clinician.
All variables must have been addressed before an FMS is considered:

Patient risk assessment Parameters	Indicate
C. Diff / MC&S - as medically advised - **samples sent indicate**	**Yes / No**
Laxatives have been stopped / pro kinetics reviewed ≥ 12hrs	**Yes / No**
Sando - K / Phosphate meds containing Sorbitol are not being administered	**Yes / No**
No continuous NG water is being administered use IV or NG bolus	**Yes / No**
Feed prep is appropriate and containing fibre (special requirements - consult dietician)	**Yes / No**
Faecal drainage bag has failed and or is inappropriate **indicate**	**Yes / No**
Culture negative samples / C. Diff X 1 negative sample Consider a prescription for loperamide - initially 2mg tds ≥ 12 hrs	**Yes / No**

All parameters have been addressed and have failed to control the diarrhoea, the patient is deemed at risk, if you have answered No to any of the above seek advice – indicate

……

Device Placement:

- **Patient is > 18yrs and is bed bound**
- **Has diarrhoea type 6 -7 on Bristol Stool chart and**
- **Has had > 3 episodes in 24hrs**

There are no contraindications to FMS placement - you must answer No to all questions below

Placement risk assessment Parameters	Indicate
Is the patient **allergic** to any components of the kit / Silicone?	**No**
Has the patient had **lower bowel / rectal surgery** within 12 months?	**No**
Does the patient have **suspected / confirmed rectal mucosal impairment**?	**No**
Patient has **rectal or anal injury**?	**No**
Patient has a **confirmed rectal / anal tumour, stenosis or stricture**?	**No**
Does the patient have **haemorrhoids of significant size / symptoms**?	**No**
Does the patient have any **in-dwelling or anal device i.e. Thermometer or delivery mechanism e.g. suppositories in place**?	**No**

Digital Rectal examination	Indicate
Poor or lacking **anal tone / rectal / anal injury, stenosis, stricture, tumour**?	**No**
Faecal impaction? - **if yes do not use FMS, treat condition**	**No**

If you have answered Yes to any of the above seek advice –specify actions:……...
……
……

If there are relative contraindications seek senior or specialist medical advice

Patient consent / Best interests decision (MCA 2005) – indicate reasoning:
……..
……

FMS inserted to black marker and …… mls water inserted via inflation portal
(Please document fluid inserted and date by applying label on device also)

Protocol followed - Signed …… Date…../……/……. PTO

12/12/2013 P D Clark

Care of Faecal Management System

Patient Care Plan:

It is essential that the following are checked whenever rolling patient, or as indicated:

- Universal infection control procedures should be adhered to and PPE worn
- Monitor bowel output / record when emptied on daily fluid chart
- Check Black line is visibly in line with anus
- Consistency of stool is compatible with use of device (Type 6 / 7 Bristol Stool Chart)
- Flush (flush port) 12 hourly with 40mls warm sterile water and document in notes
- Check Skin Integrity, for soreness or pressure damage.
- Tube position correct i.e. between patients legs and not kinked
- Check Bag replace and dispose of in accordance with local policy when full
- Check device is draining freely, irrigate (irrigation port) with sterile water as necessary
- Observe patient for any pain, PR bleeding or soreness, abdominal distension and report if present
- Ordered samples sent: Date…… /Date……/Date……/Date……...

MAX time in situ 29 days - projected date for removal……

Care undertaken in accordance with management section – sign.

WEEK 1 Commence: Date……	Sign	WEEK 2 Commence: Date……	Sign	WEEK 3 Commence: Date……	Sign	WEEK 4 Commence: Date……	Sign
Day		Day		Day		Day	
Night		Night		Night		Night	
Day		Day		Day		Day	
Night		Night		Night		Night	
Day		Day		Day		Day	
Night		Night		Night		Night	
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Day		Day		Day		Day	
Night		Night		Night		Night	
Day		Day		Day		Day	
Night		Night		Night		Night	Remove

Diarrhoea has ceased >48hrs – Removal indicated?

……

Signed ……. Date…../…./……

Issues / Risks Identified – indicate Yes / No:

……

Reported to……Action taken:…….

……

Expand in patient care plan if necessary

Signed ……. Date…../…../…….

Deviation from process Yes / No

Indicate and document in patient notes

……

Signed ……. Date…../…./…….

Any adverse events should be documented utilising the clinical incident reporting process.

12/12/2013 P D Clark