National Continence Management Strategy - Innovative Grant

A Care Model for Management of Faecal Incontinence for Clients Receiving Care in their Home

Final Report

September 2001

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1. Executive Summary

The project ' A Care Model for Management of Faecal Incontinence for Clients Receiving Care in the Home' was funded under the Commonwealth National Continence Management Strategy Innovative Grants Program. The contract was signed in December 2000. Under the terms of the contract, RDNS was funded $20,300 to conduct the project between December 2000 and September 2001.

The project outcomes were as follows:

Completion of literature search
A total of 74 articles dated from 1992 to 2001 on bowel incontinence, bowel management and health care models were reviewed and a literature review paper was prepared.

Review RDNS policies and procedures on management of faecal incontinence
RDNS bowel care policies and procedures were reviewed to ensure they reflect current evidence-based best practices. This work was scheduled as a part of the ongoing policy review process undertaken within RDNS.

Develop policies and procedures on management of faecal incontinence and incorporate into RDNS client care manual
RDNS policies and procedures in the RDNS Staff Clinical Manual have been updated. Two new procedures: Manual Evacuation and Faecal Incontinence Management Policy have been developed and added to the Manual. A Bowel Assessment Form, Bowel Chart and Standardised Care Plan for Bowel Management have also been updated. These are now being used within RDNS.

Produce a Care Model and 1-page Protocol describing a process for assessment, care, service coordination and support for clients experiencing faecal incontinence
The Faecal Incontinence Management in the Community - Care Model was developed with the involvement of a sample of consumers, Aged Care Clinical Nurse Consultants, Continence Advisers and senior RDNS personnel. Feedback from consumers indicates the information and its presentation meets their needs. Input was also obtained from health professionals who may use the materials. For example Continence Advisers from other states in Australia have been contacted throughout the project for their input into developing the care model and flow diagram.

Incorporate Care Model into existing RDNS education program including in-service continuing education and external post-graduate education
A plan for launching the Care Model and Protocol and incorporating the resources into RDNS in-service and external post-graduate education for Registered Nurses has been developed and is currently being implemented. Under this plan the Aged Care Clinical Nurse Consultants will apply the Care Model and Protocol to client care in collaboration with Registered Nurses at RDNS centres across metropolitan Melbourne.

The Aged Care Consultants will involve a Health*links* Nurse Educator and a representative from the RDNS Institute for Community Health in developing teaching and communication strategies. The Institute will be reviewing the current RDNS Graduate Certificate in Advanced Clinical Nursing Practice – Continence Promotion. The Care Model will be incorporated into the curriculum.

The project was completed on schedule and has achieved the above objectives. The project materials are being promoted widely across the organisation and are accessible to health professionals involved in the provision of services to individuals with faecal incontinence.

2. Methodology

The project methodology included:

Contract and financial management
Establishing Reference Group
Literature research
Liaison with Independent Evaluator Agency
Review of RDNS practices and procedures
Input from RDNS Aged Care Team
Liaison with interstate nursing services
Input from medical personnel
Participation by consumer representatives
Evaluation of consumer involvement in the project
Project process evaluation

A detailed project workplan is attached as **Appendix 1**

Contract and financial management

In December 2000 Royal District Nursing Service (RDNS) was funded $20,300 from the Commonwealth Government's National Continence Management Strategy - Innovative Grants Program, to conduct a project for developing a care model for management of faecal incontinence in the community.

Following the approval of the RDNS Research and Ethics Committee for the project to proceed, Rosa Lam, Division 1 Registered Nurse, was seconded as the Project Coordinator. The project commenced on 12th February 2001.

On 2 March 2001 a letter was sent to the Commonwealth requesting an extension to the project timeframe. A letter was received 16 March advising RDNS of changes to the Schedule for Agreement for the project as requested. The revised project timeframe extended the completion date and presentation of final report to 17 September 2001.

To date RDNS has received the following monies from the Commonwealth Government:

2 February 2001	$3,300	($3000 + $300 GST)
12 April 2001	$16,500	($15,000 + $1500 GST)
An additional:	$2530	($2,300 + $230 GST)

is due on presentation of this report.

As required by the project Service Agreement an Interim Financial Report was submitted on 4 May 2001.

A final Project Financial Report is attached as **Appendix 2.**

Literature research

A total of 74 articles dated from 1992 to 2001 on bowel incontinence, bowel management, and health care models were reviewed.

A literature review paper is attached as **Appendix 3**.

Establishing Reference Group

The Project Steering Committee was formally established on 17 January 2001. The following RDNS staff were involved in the committee.

Rosa Lam, Aged Care Clinical Nurse Consultant
Gail Miles, Research and Development Officer
Jean Anderson, Manager- Health*links*
Paul Ryan, Centre Manager – Camberwell
Leanne Toby, Nurse Educator- Health*links*
Andrew Jones-Roberts, Manager – Business Development
Phillip de Rose, Aged Care Clinical Nurse Consultant

The Steering Committee met on five occasions during the project and has worked within the agreed Terms of Reference. The first two Steering Committee meetings were dedicated to obtaining approval from the RDNS Research and Ethics Committee for the project and appointment of the Project Coordinator. Subsequent meetings focused on project methodology, reviewing project progress including feedback on draft project materials, and providing direction for the Project Coordinator.

At the final Steering Committee Meeting on 4 September 2001, a plan was developed to announce the successful completion of the project and launch of the project materials. This is to provide the momentum necessary for agency-wide implementation of the care model and protocol.

Liaison with Independent Evaluation Agency (IEA)

Liaison with the Evaluators for the National Continence Management Strategy was established on 26 April 2001. Greta Mason was nominated as the contact person. The IEA were provided with a copy of the project proposal and its evaluation methodology. The feedback from the IEA was that the project evaluation was adequate. Copies of the Interim Report and this Final Project Report have been forwarded to the IEA.

Review of RDNS practices and procedures

The Project Coordinator met with Pat McPherson, RDNS Policy & Planning Officer on 7 March 2001 to discuss a strategy for reviewing and updating existing RDNS bowel care policies and procedures to ensure they reflect current evidence-based best practices. This work was already scheduled as a part of the ongoing policy review process undertaken within RDNS.

In addition to the review of existing procedures, new procedures for 'Manual removal of faeces' in long-term bowel management and 'Faecal incontinence management' were developed during this project.

Faecal incontinence management and' Manual removal of faeces' in long-term bowel management
An RDNS Aged Care Team subcommittee was established to review the practice of manual evacuation in long-term bowel management. The subcommittee considered information obtained through the literature research and current best practices. Recommendations for future RDNS policy were forwarded to the Clinical Practice Advisory Committee for consideration. At the Clinical Practice Advisory Committee meeting in July 2001 new procedures for 'Manual removal of faeces' and 'Faecal incontinence management' were approved for incorporation into the RDNS Staff Clinical Manual.

Bowel Assessment form, Bowel charts and Standardised Nursing Care Plan for Bowel Management
To ensure that the RDNS Bowel Assessment form, Bowel charts and Standardised Nursing Care Plan for Bowel Management reflect current evidence-based best practices in managing clients with bowel incontinence, constipation or diarrhoea, the Project Steering Committee identified that these documents

also needed to be updated. The RDNS Aged Care Team reviewed and updated these documents. The new Bowel Assessment Form and Bowel Chart have been in use by the Aged Care Team on a trial basis since 5 September 2001. Following this trial the resources will be used across RDNS. The revised Standardised Nursing Care Plan has been approved for use.

Input from RDNS Aged Care Team

The RDNS Aged Care Team has been consulted in the process of updating RDNS policies and procedures and other documentation used in bowel care. The Team was involved in the drafting and refining of the Faecal Incontinence Management in the Community - Care Model and the Faecal Incontinence Management in the Community - Protocol.

Feedback from two Aged Care Consultants on the early drafts were that they found the draft care model:

> ‘visually disturbing’
> ‘too much information on it’.

The care model was refined further. The following is a list of positive comments from RDNS Aged Care Consultants on the later versions of the care model:

> ‘look quite impressive’,
> ‘like the presentation with the client as the focus and everything circling the client’
> ‘what is there is good’
> ‘the information under each heading is very comprehensive’
> ‘lots of useful information’
> ‘as it stands at the moment, I have no changes’
> ‘it seems very comprehensive’
> ‘looking good’
> ‘there is a lot of information contained in the model’
> ‘think it's excellent and will certainly raise the standard of bowel management in the agency and potentially elsewhere’

Liaison with interstate nursing services

Drafting the Care model
Between 23 April 2001 and 7 May 2001, contact was established with Continence Nurse Advisers in Queensland, New South Wales, the Northern Territory, South Australia and Western Australia to obtain their input on development of the draft care model. The response was very enthusiastic. A teleconference was conducted on 7 May with the group of Continence Advisers at RDNS, South Australia to discuss development of the draft care model.

Staff at the Sir Charles Gairdner Hospital in Western Australia had previously developed a protocol for bowel and urinary incontinence. The Continence Adviser made this protocol available to the Project Coordinator.

Feedback on the draft Faecal Incontinence Management in the Community - Care Model and Faecal Incontinence Management in the Community - Protocol
To obtain feedback and input on the draft care model and protocol, they were faxed to the Continence Advisers in Queensland, New South Wales, the Northern Territory, South Australia, Western Australia and Victoria on 25th and 26th June. Enthusiastic responses were received between 27 June to 4 July.

The words they used when describing the care model and protocol were:

‘comprehensive’
‘practical’
‘workable’
‘concise’
‘easy to read’
‘impressive’
ranged from ‘looks okay’ to ‘really good’ and ‘looked very good’

The Continence Adviser in Western Australia approached a group of graduate nurses on secondment for their input. Their response was:

‘they liked it’

and found the care model and protocol:

‘easy to understand’

Feedback received on further refining the care model and protocol was also used when updating the Bowel Assessment Form.

Input from medical personnel

At the suggestion of one of the interstate Continence Advisers, the Project Coordinator contacted two General Practitioners (who were referees for the project), and a Geriatrician for their input into refining the draft Faecal Incontinence Management in the Community - Care Model and Faecal Incontinence Management in the Community - Protocol. The response was encouraging and feedback received was used to further refine the care model and protocol. Their general comments were:

‘good’
‘interesting’

Participation by consumer representatives

The project made a commitment to engage consumers in the development of the care model through the involvement of a minimum of 9 and a maximum of 12 consumer representatives in the project.

The Project Coordinator worked with staff from the RDNS Centres at Box Hill, Camberwell, Altona and Heidelberg to recruit consumers. Five presentation-and-question sessions were held involving the RDNS Aged Care Team, Centre Managers and Primary Nurses at each of the nominated centres. At the presentation sessions information leaflets about the project were made available for distribution to potential consumer representatives. Nurses were also given written instructions regarding recruitment of consumer representatives.

The timeline for recruiting consumer representatives was extended. The reason being that although there were many clients with faecal incontinence, most of them did not wish to talk about it or be involved in the project.

On 3 May 2001, a total of 9 consumer representatives had been recruited to participate from the following groups: 4 older adults, 2 younger adults, and 3 adults with disabilities.

Conducting first interview with consumer representatives
Despite the delay in recruitment, the series of first interviews progressed well. The Project Coordinator was able to establish a relationship and rapport with the 9 consumer representatives. This enabled the commencement of the qualitative research aspect of the project. This project benefited from this opportunity to incorporate a consumer perspective of the impact of faecal incontinence.

From the feedback obtained, it was noted that most of the consumer representatives received information about their bowel management while they were in hospitals. Once they are in the community, most clients rely on the GP, RDNS or the Spinal Visiting Nurses for ongoing management and review.

The main concerns expressed were about the limitations faecal incontinence places on their activities. One consumer representative wished for 'firmer stool'. Another looked forward to 'not having to toilet every 2 hours in the evening', and being able to 'differentiate between passing wind or bowel'. One consumer representative just wished 'to be able to eat stone fruit' without fear of adverse consequences related to faecal incontinence.

All 9 consumer representatives expressed interest in the second series of interviews.

Conducting second interview with consumer representatives
The second interview was carried out between 25 June and 10 July. The consumer representatives were presented with the draft Faecal Incontinence Management in the Community - Care Model and Faecal Incontinence Management in the Community - Protocol. They expressed strong interest in the documents and provided positive feedback to the Project Coordinator.

Their opinion of the draft care model and protocol ranged from:

> 'good', 'alright' to 'very good' and 'comprehensive'

One consumer representative stated that the drafts:

> 'cover all aspects that are necessary'

Another said that the drafts:

> made it 'easier to absorb more information'
> 'good presentation and information'

One consumer representative said the drafts:

> 'tell you what will happen, what you have to do. What the nurse can do for you. That something can be done for faecal incontinence - don't have to stay incontinent'

Some comments were complimentary:

> 'well done'
> 'compliment you on the effort and work that went into it'

7 out of 9 consumer representatives said the drafts were clear on where and how to get information and available services. All 9 consumers stated that the drafts address the issues that are important to them, and that they would feel confident if their care were provided based on the protocol.

All consumer representatives were keen to receive a copy of the finalised documents. One representative expressed a strong desire to share the information immediately with a friend who was having difficulty looking after someone with faecal incontinence.

Conducting third interview with consumer representatives
At the final interview the consumer representatives were presented with the refined drafts for final comments. The feedback ranged from:

> 'all right'
> 'happy with it'
> 'very good'
> 'excellent'

One consumer representative described the drafts as:

> 'easy to interpret, well set out, can see everything you need at a quick glance' and
> 'you don't have to read a book to get the answers'

Another found the protocol

> 'good, clear with lines of investigation clearly mapped out' but is
> 'less impressed' with the care model because
> 'it is designed to suit the interests of too many people and is too cluttered'

Another consumer representative found the protocol:

> 'thoughtful and sensitive enough to our needs'

Another consumer representative stated that the care model:

> 'addresses a need for clear care models of action of the people involved, to know who to turn to for advice or action'

Evaluation of Consumer Involvement in the Project.

An evaluation questionnaire in a stamped-and-addressed envelope was provided for each consumer representative to complete and return to RDNS. Eight of the nine participants returned the survey.

Results of the Evaluation questionnaires from consumer representatives

Question 1 asked: Was sufficient information provided about the project to help you decide whether to participate?

All eight respondents replied yes.

Question 2 asked: Was sufficient time allowed at the interview for you to present your views?

All eight respondents replied yes.

Question 3 asked: Would you participate in future RDNS research project?

All eight respondents replied yes.

Comments were sought to support their response to question 3.

The following replies were forthcoming:

> ‘The information is helpful’
> ‘The research project highlighted for me the care that is being taken by the RDNS staff that I have been associated with in my bowel program.’
> ‘The more the patients are part of ‘the team’ the better – we all learn from each other’
> ‘We found it necessary to be informed of the outcome and have our questions answered’
> ‘An interesting project to get my teeth into’
> ‘I would be quite willing to help in any way I can. I cannot thank all the people enough who have helped me.’

Question 4 asked: Is there anything you would like to change or improve on that would enhance your participation in the research project?

The following replies were forthcoming:

> 3 answered ‘No’
> ‘The outcome of the care model was from my perspective cluttered with too many players with conflicting interests – the process was very capably done. I will be pleased to participate in any similar projects.’
> ‘Contact telephone number required on patient information sheet’
> ‘No improvement needed, as we were fully satisfied upon leaving’
> ‘Not really – all covered in a reasonable fashion’
> ‘I cannot think of any way to improve or change things as they are.’

Project process evaluation

Progress towards achieving project outcomes was regularly reviewed at Steering Committee meetings. A series of fish-bone charts were developed to illustrate the processes required to coordinate and progress the project while integrating it with the relevant RDNS committees and functional divisions. Although this is a relatively small project, its complexity was such that it involved various departments of the agency in its implementation.

The successful completion of the project has relied on a contribution from many staff within RDNS who have ensured painstaking attention to details of clinical practices. Timely liaison has been required with the following functional departments within RDNS:

> Manager - Business Development and Business Development Support Assistant
> Head of Department - Health*links,* her assistant, and Nurse educators
> Research and Ethics Committee
> Clinical Nurse Consultants who make up the Aged Care Team
> Clinical Practice Advisory Committee
> RDNS Policy Officer and Technical Writer/Complaints Officer
> General Managers/Director of Nursing
> RDNS Centre Managers

The implementation process will require further involvement of the General Manager - Director of Nursing, RDNS Centre Managers and Aged Care Clinical Nurse Consultants in the 18 RDNS centres. As detailed in the following section of the report, the project has achieved all outcomes in accordance with the project timeline.

The project has highlighted the wide range of expertise within RDNS and its potential to undertake projects of high complexity.

A detailed project workplan is attached in **Appendix 1**

3. Project Outcomes

The project outcomes were:

Outcome #1	Completion of Literature search
Outcome #2	Review of RDNS practices and procedures on management of faecal incontinence
Outcome #3	Update existing procedures and policies as required
Outcome #4	Development of an approved Care Model
Outcome #5	Production of 1-page flow diagram of Care Model
Outcome #6	Incorporate Care Model into existing RDNS in-service and post graduate education

Outcome #1 Completion of literature search

A total of 74 articles dated from 1992 to 2001 on bowel incontinence, bowel management, and health care models were reviewed.

The 'Literature Review – Management of the client with faecal incontinence in the community' is attached as **Appendix 3**.

Outcome #2 Review of RDNS practices and procedures on management of faecal incontinence

The following clinical procedures for bowel management were reviewed by RDNS.

CP-K01 Bowel procedures-general principles
CP-K02 Digital (anal) stimulation
CP-K03 Bowel management in children
CP-K04 Colostomy management
CP-K05 Enema-low volume (eg. Microlax)
CP-K06 Enema-high volume (eg. 200-300mls)
CP-K07 Enema-retention
CP-K08 Ileostomy management
CP-K09 Suppository administration

Two new clinical procedures were developed during the project:

CP-K10 Manual removal of faeces
CP-K11 Faecal Incontinence Management

The RDNS Policy & Planning Officer, members of the RDNS Aged Care Team and the Clinical Practice Advisory Committee were responsible for this process.

Outcome #3 Update existing procedures and policies as required

The updated policies and procedures have been incorporated into the RDNS Client Care Staff Manual.

The Bowel Assessment Form, Bowel Chart and Standardised Nursing Care Plan for Bowel Management used by RDNS were reviewed. The RDNS Aged Care Team updated these documents. Please note: within the constraints of the Copyright Act (1968) under which these documents are registered, these documents may not be adapted or passed on to any third party organisation without the written authority of the Royal District Nursing Service.

A copy of clinical procedures for bowel management are attached at **Appendix 4**

A copy of the Bowel Assessment Form, Bowel Chart and Standardised Nursing Care Plan for Bowel Management are attached as **Appendix 5**

Outcome #4 Development of an approved Care Model

The feedback from consumer representatives, interstate Continence Advisers and medical practitioners was incorporated into the draft project materials:

Faecal Incontinence Management in the Community - Care Model
Faecal Incontinence Management in the Community - Protocol.

These documents were further refined with input from the Project Steering Committee, Pat McPherson, RDNS Policy & Planning Officer and the RDNS Aged Care Team. The finalised documents were approved by the RDNS Clinical Practice Advisory Committee. An external graphics agency and printing company was contracted to professionally finish and print the care model.

The Care Model is designed to reflect the client's needs, the health professionals who may be involved at each stage of the client's bowel management, and the strengths they bring with them based on their areas of expertise. The Care Model also reflects the relationships between health professionals in their professional capacities, and the close communication links that have to exist between them to enable a coordinated approach and a desirable outcome for the client.

The proposed Care Model for Bowel Management consists of 3 main interacting components.

The client
The care model places the client as the central focus around which the other components of the model revolve. The client is made up of a personal environment governed by individual needs, circumstances, feelings and interests in life, and desired outcomes from the bowel management plan. This client-focused model emphasises the need to involve the clients in decision-making regarding their care and using their desired outcomes as criteria for evaluation.

The relationship between the client, their carer and health professionals
Surrounding the client is a circle of double-headed arrows which represents the interaction between the carer, the multidisciplinary health team of Nurses, GPs, Specialists, Allied Health personnel and the supporting team of medical products suppliers. Each has their defined roles and areas of expertise to offer. Each forms a partnership with the client and plays an essential important role in facilitating the client achieve a desirable outcome.

The carer represents the person taking on the caring role and providing the main support for the client, taking an active role regarding the client's general well-being or physical needs. The carer can be a member of the family, a spouse, partner, friend, or paid personnel assigned on a daily basis to look after the client.

The Care Model presents the client's family, partners, and friends as an essential component giving support and meaning to the client's life, making it possible for the client to be maintained at home, and connecting the client to the wider community in the social environment.

Health professionals frequently need to involve the client's family and significant others in client care planning, bowel care activities and evaluation of outcomes. Education and support of carers can enhance the process and effectiveness of the management plan.

Maintaining close communication links with everyone involved in the client's care is critical in achieving a satisfactory client outcome.

The Community
The community makes up the client's external social environment. It is an all-encompassing and dynamic component where all the client's social interactions take place.

Health professionals often interact with the client in the context of this external environment and work within the constraints of time and available resources eg. client's social commitments, work/school schedules, client's support system and carer availability.

A copy of the completed Faecal Incontinence Management in the Community - Care Model is attached as **Appendix 6.**

Outcome #5 Production of 1-page flow diagram of Care Model

The Project Coordinator developed the Faecal Incontinence Management in the Community – Protocol with input from those involved in the development of the Care Model.

The format and content of the Protocol was edited and formatted by Sharon McNeil, RDNS Technical Writer & Complaints Officer.

The Protocol is built on the RDNS Aged Care Team consultancy model in which Registered Nurses refer clients with specific health needs to Clinical Nurse Consultants with skills in those areas. The Clinical Nurse Consultant in partnership with the client, carer and the Registered Nurse carries out a detailed assessment of the client, forms a nursing diagnosis, makes recommendations regarding the client's care, and adopts the client's desired outcomes as criteria for evaluating progress. In the Protocol the role of the Clinical Nurse Consultant is described as Continence Adviser.

The purpose of the Protocol is to lay out the process and management strategies for Registered Nurses who have identified that their client has faecal incontinence. It is intended to be used together with the Faecal Incontinence Management in the Community - Care Model where the relationship between the client and other health professionals and their defined roles and areas of expertise are represented in more detail. The Protocol is to be kept in client records and used with the client's bowel management care plan.

The Protocol places the client with faecal incontinence at the start of the diagram and ends with the outcome - a continent and socially integrated client. Faecal incontinence reduces a person's self-confidence frequently resulting in the person withdrawing from social interactions. By helping the person achieve continence, this may facilitate that individual's social integration.

The Registered Nurse plays an important role in identifying and approaching the client with faecal incontinence. The Registered Nurse has developed a good rapport with their client, but may not necessarily have all the skills to address the condition. However, the Registered Nurse is often in a good position to act as an advocate for the client to seek help and to inform them about the range of

help available in faecal incontinence management. The Registered Nurse initiates bowel assessments and makes referrals to the health professional who is most appropriate for the client's condition.

The Continence Adviser works within the confines of their profession and liaises with the General Practitioner regarding the nursing assessments and recommendations on the client's care. Ongoing liaison will occur as indicated by the client's progress and needs.

The Continence Adviser develops the management plan in partnership with the client and Registered Nurse who then implements the care and monitors the client's progress. The Continence Adviser and the Registered Nurse maintain a close liaison regarding the client's progress. Reviews by the Continence Adviser are arranged as indicated by the client's needs.

The Protocol also highlights some of the health conditions that are associated with faecal incontinence. These are the upper and lower spinal cord injuries, conditions that involve the central nervous system and dementia. The protocol seeks to raise awareness of the specific needs related to each health condition and the different effects they have on the normal physiology and processes of defaecation.

The Protocol is designed to facilitate the development of individualised bowel management plans using current best practices. For best results, the components of the management plan should be implemented as an integrated strategy, rather than in isolation to each other or as an ad hoc measure for symptomatic control.

In some instances, bowel incontinence may not be satisfactorily managed by nursing strategies, lifestyle changes, and the use of aperients. The client may need to be referred to a Continence Clinic, Bowel Specialist or a Colorectal Surgeon for specific investigations and further management. It is important to inform clients about this option and to support clients in their decisions by providing them with the necessary information.

A copy of the 1-page flow diagram of the care model titled the Faecal Incontinence Management in the Community – Protocol is attached as **Appendix 7.**

Outcome #6 Incorporate Care Model into existing RDNS in-service and post graduate education

A three-tier plan for launching the Faecal Incontinence Management in the Community - Care Model and Faecal Incontinence Management in the Community – Protocol within RDNS has been developed for implementation commencing the last week in September 2001. This will provide the momentum necessary for agency-wide adoption of the project materials.

The plan is as follows:

The Project Coordinator will develop material to be used for presentation of the Care Model and Protocol at the launch.

The General Manager / Director of Nursing will issue a memo to all Centre Managers informing them of the launch and related details.

The launch will be Centre-based, with the Centre Manager and Clinical Nurse Consultant at each Centre taking the leading role. Each Clinical Nurse Consultant will conduct a presentation session to introduce the Care Model and Protocol, using the materials provided by the Project Coordinator.

To support the launch, the Project Coordinator will prepare an article for publication in the RDNS Newsletter.

The Aged Care Clinical Nurse Consultants will use the Care Model and Protocol to guide client care provided by themselves and Registered Nurses at RDNS Centres. Implementation issues and education needs will be identified and discussed at the Aged Care Team meetings.

The Aged Care Clinical Nurse Consultants will involve a Healthlinks Nurse Educator and RDNS Institute of Community Health representative, to develop teaching and communication strategies. Centre-based in-service education sessions will be provided using the Care Model and Protocol.

The RDNS Institute of Community Health is committed to reviewing the current RDNS Graduate Certificate in Advanced Clinical Nursing Practice – Continence Promotion, and incorporating the Care Model into the curriculum.

A copy of RDNS Education and Training Initiatives for 2002 and associated implementation timeline is included as **Appendix 8**.

4. Conclusion

The project was completed on schedule and within budget and has achieved its stated objectives.

The project has been implemented in accordance with the project proposal methodology. This has included a literature search, identification of best practices and input from consumer representatives and clinical experts in the field.

Feedback has been extensively sought and incorporated into the development and refinement of the documents. Through the involvement of consumers throughout the process of development and refining of the project materials, the project has ensured the information and its presentation is appropriate to meet their needs. Consumers who participated in the project have provided positive feedback regarding the project materials that have been developed. The consumer representatives have described the experience of participating in the project as a positive experience and most have expressed a desire to participate in future RDNS research projects.

RDNS policies and procedures have been updated as part of the project and have been incorporated into the RDNS Staff Clinical Manual. Two new procedures - CP-K10 Manual Removal of Faeces and CP-K11 Faecal Incontinence Management - were also developed as part of the project and added to the Manual. A Bowel Assessment Form, Bowel Chart and Standardised Care Plan for Bowel Management have also been updated and are being used within RDNS.

The project has achieved its objective of developing a Faecal Incontinence Management in the Community –Care Model and Faecal Incontinence Management in the Community – Protocol. The information is presented in a user-friendly format for both the client and health professionals who will be making use of the materials. These project materials encourage a multi-disciplinary and client-focused approach, taking into consideration the client's individual social circumstances. The Care Model and Protocol are also based on life-style changes, client and carer education and support, and close liaison with the carer, GP and other health professionals.

The project materials will be widely accessible to health professionals by incorporating them into RDNS education for Registered Nurses both as in-service and external post-graduate courses under the RDNS Education and Training Initiatives for 2002.

5. Acknowledgments

RDNS thanks the Commonwealth Government for this opportunity to participate in the National Continence Management Strategy under the Innovative Grants Program.

The funding of the project ' A Care Model for Management of Faecal Incontinence for Clients Receiving Care in their Home' has enabled the Royal District Nursing Service to fast-track the organisation's plans to evaluate existing clinical practices in faecal incontinence management. The project enabled the Royal District Nursing Service to develop a comprehensive model for providing client care and nursing education and development in this area.

Royal District Nursing Service acknowledges the involvement of consumer representatives, General Practitioners, and Continence Advisers around Australia in the project.

Thankyou to all the individuals in RDNS and other organisations who have contributed generously to the project.

RDNS Aged Care Team

Janeen Rees – Facilitator
Anne Marie Mahoney – Nurse Educator
Alison Kairns, CNC – Aged Care
Elaine Scanlon, CNC – Aged Care
Sue Abbott, CNC – Aged Care
Anne Marie Fabri, CNC – Aged Care
Jo Hosking, CNC – Aged Care
Ailsa Sutherland, CNC – Aged Care
Jan Birch, CNC – Aged Care
Katherine Sheridan, CNC – Aged Care
Gail Allingham, CNC – Aged Care
Sue Nuske, CNC – Aged Care
Michael Dodd, CNC – Aged Care
Debbie Elks, CNC – Aged Care

Interstate Continence Advisers

South Australia: Lesley Seymour, Anne Schofield
West Australia: Mary King and Graduate nurses, Debra Gordon, Barbara Dickson
Northern Territory: Gail McBean
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6. List of Appendices

Appendix 1: Detailed project workplan

Appendix 2: Final Project Financial Report

Appendix 3: Literature review paper

Appendix 4: A copy of clinical procedures for bowel management

Appendix 5: A copy of the Bowel Assessment Form, Bowel Chart and Standardised Nursing Care Plan for Bowel Management

Appendix 6: Faecal Incontinence Management in the Community - Care Model

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Literature Review - Management of the Client with Faecal Incontinence in the Community

Prepared by Rosa Lam, Project Coordinator, Royal District Nursing Service

Background

Faecal incontinence is very much a hidden problem. An American community-based study in 1996 has found that faecal incontinence affected 2.6% of the general population. It has been estimated to be as high as 30-40% among the elderly. Faecal incontinence is also one of the most common causes for nursing home admissions. (Nelson et. al., 1996)
In Australia, faecal incontinence is noted in more than 10% of elderly people in hospitals and nursing homes. (Wishaw, 1995) However, true prevalence is unknown.

A purely pharmacological or surgical approach to managing faecal incontinence offers limited benefits. A multi-facet care model approach is indicated, as the cause of faecal incontinence is often multi-factorial.

RDNS has had good results managing clients with bowel incontinence based on the RDNS Aged Care Team nursing consultancy model. Under this model, Registered Nurses identify clients with bowel problems and refer them to the Clinical Nurse Consultant -Aged Care/Continence for detailed assessments, and the development of bowel management care plans. These care plans are based on lifestyle changes (especially in ensuring adequate dietary fibre and fluid intake), physiology of defaecation and the gastro-colic reflex, establishment of bowel routines which reinforce this reflex, and liaison with GPs regarding review of all medications, use of aperients and on-going progress and management.

In some instances, faecal incontinence may not be satisfactorily managed by nursing strategies, lifestyle changes, and the use of aperients. The client may need to be referred to a Continence Clinic, Bowel Specialist or Colorectal Surgeon or other specialists for specific investigations and further management.

By setting up a coordinated care model, a mechanism is provided to support the health professionals and carers looking after a person with faecal incontinence. It would facilitate and improve the management of faecal incontinence, and reduce premature admission and readmission of older Australians to residential facilities.

Literature review

Definition
The term faecal incontinence is used to define the involuntary or inappropriate passing of liquid or solid stool. (The Royal College of Physicians, 1995; Brocklehurst J. C., Fillit H. M. and Tallis, R. C. 1998; Katz et. al., 1998). Anal incontinence has been used to describe any involuntary leakage of flatus, solid or liquid material from the anus. (Whitehead et. al., 1998)

Impact of faecal incontinence
The severe impact of faecal incontinence on the whole person, his/her family and friends is well documented. The loss of bowel control is frequently interpreted as a more general loss of control and can be a cause of embarrassment and humiliation. Professor Paul O' Brien rates being incontinent of faeces in public near the top of the list for the most embarrassing situations that could possibly occur. He captures its essence when he describes faecal incontinence as

> …socially devastating, and pushes otherwise competent and confident people into a life of isolation, shame and fear of embarrassment. Many regard faecal incontinence as a 'weakness' or 'failing' on their part rather than a medical disease for which help can be obtained.… (Professor Paul O'Brien, p. 109, 1998)

Faecal incontinence is very much a hidden problem. O'Brien (1998) has found that people with faecal incontinence often do not seek professional help because of its perceived social unacceptability, and will admit to the problem only if asked directly. Mitchell Beddar (1997) identifies feelings of shame and embarrassment, and the general lack of knowledge regarding what can be done, as a barrier to seeking help.

Norton (1997) and Salcido (2000) have found that clients with faecal incontinence have low confidence and poor self-image and their needs are best addressed in supportive and non-judgemental relationships with health professionals that are built

on trust. This trust is critical for clients to openly discuss their problems and provide accurate information to the health professional about their condition and needs.

Causes

Damage to the anal sphincter is the most common cause of faecal incontinence in the absence of bowel disease. Other causes of faecal incontinence in adults are severe diarrhoea, chronic faecal loading, and neurological conditions. (Norton,1997, pp.53-54) Barrett (1992) defines neurological conditions as dementia, impaired consciousness and behavioural disturbances. Salcido (2000) narrows the definition to include those conditions that directly affect bowel function – spinal cord injuries, Diabetes Mellitus and associated neuropathy, Multiple Sclerosis, and Parkinson's disease.

Impaired sphincters and faecal incontinence

Fynes (1999) identifies that vaginal delivery during childbirth is the most important risk factor for anal-sphincter injury and for development of faecal incontinence in women. This can be related to direct disruption of the anal-sphincter muscles, or from traction of the pudendal nerves. The risk of of anal-sphincter disruption is greatest during first vaginal delivery, but damage to the pudendal nerves is cumulative with successive vaginal deliveries. Cumulative anal-sphincter injury or pudendal nerve damage may result in faecal incontinence either post-delivery or at menopause. (Fynnes et.al. 1999, p.983) Chevalnayagam et. al. (1999) have noted that faecal incontinence can be related to surgery involving the anal sphincter eg. haemorrhoidectomy, or as a result of rectal prolapse and recto-vaginal fistula.

Neurological conditions and faecal incontinence

Spinal cord injury causes faecal incontinence by affecting the anal sphincter muscle tone and control. The effect depends on the level of injury. In spinal cord injuries above T12, the anal sphincter becomes spastic with no voluntary control, but the reflexes (gastro-colic and defaecation reflexes) are intact. This may result in involuntary bowel emptying every 2-3 days. (Chen et. al., 2000, pp.48-49; Edwards-Beckett, 1996, p.296)

In spinal cord injuries below T12, the anal sphincter becomes flaccid with some voluntary control, but the reflexes are absent. As there is no reflex emptying, the rectum is able to store large amounts of faeces, and constipation can be a chronic problem. (Chen et. al., 2000, pp.48-49; Edwards-Beckett, 1996, p.296) Bryant (2000) identifies that a person with a neurogenic bowel condition is at risk of bowel obstruction, colorectal distension, bleeding haemorrhoids, and diverticulosis.

A person with Multiple Sclerosis is at risk of both constipation and faecal incontinence. Nordenbo (1996) identifies that a person with Multiple Sclerosis has prolonged bowel transit time, and delayed defaecation reflex and reduced ano-rectal inhibition, which predisposes them to constipation. Multiple Sclerosis also reduces resting tone of the anal sphincter, impairs rectal sensation, causes abnormal rectal contractions, and reduces storage capacity of the rectum, predisposing the person to faecal incontinence. Weisel et. al. (2000) point out that reduced coordination of pelvic floor muscles is a possible cause of constipation in Multiple Sclerosis.

Constipation, diarrhoea and faecal incontinence

Salcido (2000) notes that constipation and faecal incontinence often co-exist. Norton (1997) has found that faecal incontinence can be secondary to chronic bowel loading. Weisel et. al. (2000) have found this co-existence to be especially common among people with neurological conditions.

A study by Chassagne et. al. in 1998 has found faecal impaction to be a major cause of faecal incontinence in the elderly in institutions. Among the 206 patients aged 65 years and above in the five long-term units where the study has been carried out, the prevalence of faecal impaction is about 30%. As a result of the faecal impaction there is reduced tolerance for rectal distension, leading to overflow faecal incontinence. (Chassagne et. al., 2000, pp. 159, 163)

It is reported that 70% of people with Multiple Sclerosis (Hinds 1990; Chia, 1995), 30% of people with spinal cord injury (Glickman 1996; Krogh 1997; Menter 1997) and 23% of people with CVA have faecal incontinence (Brocklehurst 1985; Nakayama 1997).

Constipation is noted in up to 70% of people with Multiple Sclerosis (Hinds 1990; Chia, 1995), 80% of people with spinal cord injury (Glickman 1996; Krogh 1997; Menter 1997) and 10% of people with Parkinson's Disease (Quigley 1996).

Considerations regarding Bowel Assessment

Management of faecal incontinence starts with a comprehensive assessment. This is best carried out either by the GP, bowel specialist or a registered nurse experienced and appropriately trained in bowel incontinence management.

The assessment should provide sufficient information to help determine whether the patient is actually incontinent. If diarrhoea or constipation with overflow incontinence is present, it will need to be corrected before faecal incontinence can be properly assessed and managed. The assessment should also identify underlying causes affecting bowel function and faecal incontinence to provide a basis for an effective management plan, as well as identify clients who may require referral to further investigation and treatment. (Mitchell Beddar, SA., et. al. 1997, p.31)

Considerations regarding Bowel Management
A management plan is then set up to address the individual situation, taking into consideration the client's health needs, social activities, lifestyle and environmental constraints and any required adaptations, and the individual's desired outcomes regarding bowel management. A multidisciplinary approach is recommended to address the complexities and needs of the client.(O'Brien, 2000, p.50; Norton, 1997, pp.54-57)

Manual evacuation has been mentioned as a means of bowel management, especially for clients with spinal cord injuries. However, there is no evidence-based research available to demonstrate this invasive procedure as an effective or satisfactory means of regular bowel evacuation. In fact, the risks to clients are many and well documented. One of the major risks is the possibility of precipitating an attack of autonomic dysreflexia in spinal patients as a result of noxious stimulation. This is an abnormal response where the patient experiences palpitations, sweating, headaches and severe hypertension. Other risks include rectal bleeding, damage to rectal mucosa or anal sphincter, perforation of the bowel, and bradycardia caused by stimulation of the vagus nerve in the rectal wall during the procedure. It also causes pain and discomfort and can be distressing to patients receiving the procedure.

Other strategies need to be considered and implemented for ongoing prevention of impaction and to achieve effective bowel evacuation. In situations where manual evacuation is indicated (usually as a last resort for disimpaction), a rectal examination by a doctor is required prior to the procedure. The health professional performing the manual evacuation has to be trained in the procedure – both in theory and clinical practice. (Addison, 1996, pp. 18-20; Willis, 2000, pp.7-8; Powell, 2000, pp 47-51)

James A. Barrett (1992) has described a management plan for faecal incontinence in clients with dementia where planned defaecation is achieved by use of an enema or potent laxative such as Picolax given one to three times a week. To prevent faecal soiling in between these planned bowel days, a constipating medication is prescribed eg. Loperamide or codeine phosphate. No evidence-based research is available to demonstrate effect of this management plan, nor support for this practice. In fact, Weisel et. al. (2000) and Chassagne et. al. (2000) have pointed out that constipation may result in impaction with 'overflow diarrhoea' and cause faecal incontinence.

An effective bowel management plan is important because of the tendency to develop megacolon in some situations. Abyad (1998) reported that in some patients, megacolon can be associated with constipation, diarrhoea and faecal incontinence.

A study by Harari et. al. on megacolon in spinal patients, shows that 74% of subjects have megacolon in at least one segment of their lower bowel in the absence of constipation. The prevalence is greater in the right side of the colon (62.5%) compared to 46.1% in the descending or sigmoid colon. 39% of the subjects also have small bowel dilatation resulting from faecal retention and backpressure in the ascending colon. 79% of subjects have megarectum, but stool retention is least apparent in the rectosigmoid because of regular bowel care. (Harari, et. al., 2000, pp.331-339)

Doughty (1996) has highlighted the need for bowel management plans to be based on detailed knowledge of the anatomy and physiology involved in the processes of normal defaecation. Mitchell Beddar (1997) further emphasises that to encourage these normal processes, the client's premorbid bowel patterns should be adopted and reinforced wherever possible. Demata (2000) and Hinrichs (2001) in elaborating on the principles of bowel training, recommend the establishment of a routine toileting pattern making use of the gastrocolic reflex.

Bowel management plans also need to be based on a good understanding of pharmacology. Any aperients prescribed should supplement the actions of the other components in the management plan. Hinrichs et. al.(2001) found that chronic laxative use is strongly associated with reduced bowel transit time and can contribute to constipation. It is recommended that laxatives be used only when needed. eg. if there were no bowel actions for more than 3 days.

An effective bowel management plan
Constipation and impaction can easily develop in spite of a well thought out bowel management plan if a client's bowel evacuation is delayed by more than 3 days. (Mitchell Beddar, SA., et. al. 1997, p.35)

Effective bowel management of bowel incontinence should, therefore, include relief and prevention of constipation, impaction or diarrhoea. Abyad (1998) describes a phased-in approach to treatment of constipation for the elderly beginning with lifestyle

interventions such as bowel retraining, exercise, and dietary adjustments. Laxatives are only used when lifestyle changes fail or do not produce significant improvement in symptoms.

Salcido (2000) recommends a bowel program based on increased dietary fibre, establishment of regular bowel routine making use of the gastro-colic reflex, supplemented by use of aperients. The program started with bulking agents, and progressing to stool softeners, osmotic laxatives, stimulant suppositories, or regular enemas to prevent impaction.

Hinrichs et.al. (2001) advocates a prevention approach focusing on fluids and dietary fibre intake, exercise program tailored to individual physical and health condition, and a regular toileting regime
making use of the gastro-colic reflex. Laxatives are only used when needed eg. when bowel has not been opened for more than 3 days.

The components of an effective bowel management plan should consist of:

- Liaison with GP to relieve client of constipation or impaction during acute episode
- Liaison with GP regarding nursing assessment findings, medication review and adjustments, proposed bowel management plan and on-going progress
- Client and carer education regarding bowel incontinence, its causes and management strategies
- Support to client and carer during initial implementation of bowel management plan as well as when making further adjustments at reviews
- Lifestyle adjustments - especially in dietary fibre and fluid intake to achieve soft formed stool consistency
- Establishment of regular bowel routines making use of intact reflexes
- Means of achieving effective evacuation – such as environmental adjustments, effective use of aperients (oral and rectal), abdominal exercises/massage, and correct positioning
- Liaison with GP for referral to specialists regarding further management where indicated

(Mitchell Beddar, SA., et. al. 1997, p.35; Demata, 2000, pp. 13-15; Hinrichs, et. al., 2001, pp. 21-23; Bryant, 2000, pp. 28-31)

For best results, the components in the management plan should be implemented as an integrated strategy, rather than in isolation to each other or as an ad hoc measure for symptomatic control.

Review and Evaluation

Salcido lays down the principles of management of faecal incontinence very succintly by stating that

> …practitioners need basic understanding of normal physiology of bowel function, and keen awareness of bowel abnormalities and treatment options…(Salcido, 2000, p. 92)

Salcido (2000) further emphasises that health professionals must recognize that the cornerstone of treatment of faecal incontinence is prevention and the implementation of a well thought out bowel program. Patients who do not respond to these conservative measures should be referred to an appropriate specialist for further management.

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Faecal Incontinence Management in the Community - Care Model

Registered Nurse (CHS, District Nurse)
- Facilitate discussion of faecal incontinence with client/carer
- Refer to GP or Continence Adviser as appropriate
- Administer bowel therapy as prescribed
- Support client/carer in carrying out care plan
- Monitor progress

Continence Adviser (Hosp, Clinic, District Nurse)
- Assess client in liaison with RN
- Refer to GP if bowel abnormalities present
- Develop individualised care plan in liaison with GP and RN
- Educate and support RN/client/carer re: faecal incontinence
- Advise re: continence aids and funding programs
- Evaluate progress with RN and client/carer using client desired outcomes as criteria

Stomal Therapist (Hosp, Clinic, District Nurse)
- Educate and support client/carer considering colostomy as treatment option

GP, Geriatrician
(Hosp, Clinic)
- Discuss faecal incontinence with client
- Arrange preliminary investigations
- Review and adjust client's medications
- Prescribe treatment
- Refer to RN for ongoing management and specific bowel therapies eg. enemas
- Refer client to Specialists

Specialists (Hosp, Clinic)
- Discuss treatment options with client/carer

Colorectal Surgeon
- Organise specific investigations eg. anal ultrasound or manometry
- Carry out sphincter repairs or bowel/rectal surgery

Gastro-enterologist
- Prescribe treatment for bowel conditions eg. Chron's Disease, Irritable Bowel Syndrome, Diverticulitis

Neurosurgeon
- Perform surgery to correct spinal cord lesions

NURSE — CLIENT — DOCTOR

Personal environment
- Life goals and interests
- Self expression
- Independence
- Dignity and control
- Cultural beliefs

Desired outcomes
- Bowel continence
- Bowel predictability
- Reduction of constipation and diarrhoea

ALLIED HEALTH — CARER — MEDICAL SUPPLIERS

Physiotherapist (Hosp, Clinic, CHS)
- Teach pelvic floor exercises, breathing and bracing exercise
- Carry out biofeedback and anal electro-stimulation

Dietitian (Hosp, CHS)
- Advise on dietary fibre intake: soluble and non-soluble
- Advise on specific diets for bowel conditions

Occupational Therapist (Hosp, CHS)
- Carry out environmental assessment and adaptations

Continence Resource Centre
- Advise on continence services and products

Pharmacist
- Advise on medications and continence aids

Wholesaler
- Advise on continence aids and provide in bulk

Manufacturer and Sales Representative
- Advise on continence aids and provide in bulk or samples if required

Family, Spouse, Partner, Friend
Formal support worker
(Person taking on caring role)
- Assist client with ongoing bowel care with education and support from RN
- Assist client with lifestyle changes
- Monitor progress and effect of care plan with client
- Participate with client in review by GP and RN

C O M M U N I T Y

(ABN 49 052 188 717)

GP: General Practitioner
RN: Registered Nurse
Hosp: Hospital
CHS: Community Health Service

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for review 8/2002

401113

This project is supported by funding from the Innovative Grants Program under the Commonwealth Government's National Continence Management Strategy.

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ABN 49 052 188 717

Faecal Incontinence Management in the Community—Protocol

ASSESSMENT

Client has faecal incontinence

Refer to Continence Adviser for:
- comprehensive assessment in liaison with RN
- identification of underlying causes
- development of individualised care plan in liaison with GP and RN.

Registered Nurse:
- adopt supportive manner
- commence bowel assessment
- show client/carer how to keep bowel chart.

Refer to GP if client has:
- constipation or impaction with overflow incontinence
- abnormalities in stool (eg. blood, mucus or changes in stool formation).

Underlying causes/related factors

Spinal cord injury C1 to T12	Spinal cord injury below T12	CNS and peripheral nervous system	Impaired cognition	Impaired sphincter	Known bowel conditions

CARE PLAN DEVELOPMENT and IMPLEMENTATION

Best practice management strategies to address specific needs

Spinal cord injury C1 to T12

Specific needs:
- digital stimulation to relax spastic sphincter and activate reflex for defecation

Spinal cord injury belowT12

Specific needs:
- soft formed stool consistency to reduce faecal soiling from flaccid sphincter

CNS and peripheral nervous system

Specific needs:
- reduction in bowel transit time
- increased awareness to defecate by pelvic floor exercises and biofeedback

Impaired cognition

Specific needs:
- increased awareness to defecate by prompted or assisted toileting

Impaired sphincter

Specific needs:
- specific tests to determine extent of trauma/ treatment
- pelvic floor exercises
- anal electro-stimulation

Known bowel conditions

Specific needs:
- avoidance of dietary irritants or lifestyle stresses
- bowel regularity

Keep stool at soft formed consistency by:
- drinking at least 2 litres of fluid/day, unless contraindicated
- adjusting fibre intake
- using stool softeners.

Establish bowel regularity by:
- making use of the gastro-colic reflex (toileting within ½ hour after a meal, repeat at same time daily)
- taking oral aperients in PM to achieve AM bowel regime
- reducing bowel transit time with appropriate aperients.

Facilitate bowel evacuation by:
- using prescribed bowel therapies (eg. suppositories/enemas)
- performing abdominal exercises or abdominal massage
- adopting upright position over toileting facilities, leaning forward and, if possible, with knees higher than hips.

Review aperients and other medicines with GP.

Educate and support client/carer in carrying out care plan.

Monitor effectiveness of care plan and review as needed.

EVALUATION

Outcome of faecal incontinence management plan and other options

Client's desired outcomes achieved:
- bowel continence
- bowel predictability
- elimination of complications (constipation and diarrhoea)

Yes → Continent, socially integrated client

No → **Desired outcomes not achieved:**
- persistent incontinence requiring further medical evaluation and treatment
- the client may benefit from surgical treatment

→ Continent, socially integrated client

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