

breakdown can occur very rapidly. In this instance it is appropriate to consider the use of a faecal management system^[15].

In addition to cost savings described by Durnal et al^[18], one study found that, in patients with faecal incontinence and diarrhoea in a surgical intensive care unit, the use of faecal management systems reduced incidence of skin damage from 43% to 12.5%^[21].

Beldon^[22] identified that faecal management systems provide a 'closed system', which is useful if the patient has infective diarrhoea, containing infectious waste and helping to control infections like *C. difficile* from spreading^[23]. Closed systems also enable the monitoring of fluid balance, and help in maintaining skin integrity and preserving the patient's dignity.

Any FMS should be used in accordance with manufacturers' instructions to ensure proper use of the device and on appropriate patients.

The case study presented above demonstrates the effective use of a faecal management system in reducing skin damage.

CONCLUSION

Faecal incontinence can have a seriously deleterious affect on patients' wellbeing if not addressed, contributing to moisture lesions, pressure ulcers and combined lesions. If diarrhoea is caused by infectious bacteria such as *C. difficile*, the risk of cross infection may be high. Increased costs in terms of nursing time, consumables, and for some patients, increased length of stay may also be significant.

Prevention is paramount but if this is not possible, or if the patient is being seen at a late stage, adequate measures must be put in place to control faecal incontinence and minimise its effect on the skin of the patient.

AUTHOR DETAILS

Janice Bianchi is a Medical Education Specialist at JB Med Ed Ltd and Honorary Lecturer at University of Glasgow, Scotland

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Expert Commentary

Christine Berke, MSN APRN-NP CWOCN, The Nebraska Medical Center, Center for Wound Healing/Ostomy Clinic, Omaha, USA

In the past decade, incontinence-associated dermatitis (IAD) has become a 'buzzword' of sorts in the wound care arena. There has been an increased focus on identifying the true aetiology of wounds on or near the buttocks, for a variety of reasons, including the economic cost of care, financial reimbursement and not least, patient quality of life and comfort^[1-4]. Even though moisture has long been recognised as a risk factor for pressure ulcer development, the identification of IAD as a separate skin/wound phenomenon has only recently led to the development of treatment protocols and devices to specifically prevent the development of and/or treat IAD^[4]. As Bianchi discusses in this article, IAD may contribute to the development of pressure ulcers^[2,3]. The cost of care for patients with pressure ulcers in money, pain and suffering has been well-documented.

Frequent incontinence of loose or liquid stools and diminished cognition have been identified as independent risk factors for developing IAD in critically ill adults^[2]. Traditional management strategies for faecal incontinence in the critical care setting are themselves labour intensive and increase clinicians' exposure to potentially infectious biologic material. These risks to staff come from frequent changes of soiled incontinence briefs, reusable or disposable bed pads and bed linen, which may include rinsing the soiled pads, briefs and/or linen^[4]. This exposure to infectious material also places other patients at risk, as identified by the US Centers for Disease Control and Prevention^[5].

Segovia-Gómez's case study supports the intended use of an indwelling device designed for management of faecal incontinence, which can have a positive management outcome for patients, clinicians and hospitals. Before using these products, it is very important for clinicians to familiarise themselves with the manufacturer's recommendations for the product (save and read the packaging) and review the indications, contraindications, precautions and observations for use on the intended patient. Staff education before using the device and ongoing clinical support while the device is in use is necessary, especially if clinicians/carers are unfamiliar with the product. This will help identify and avoid complications^[4,6].

References

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