Abstract
Faecal incontinence is a condition that can develop as a result of age, injury or long-term conditions, and may be associated with significant stigma for those affected. Symptoms of faecal incontinence include leakage of flatus and faeces, and the condition can affect people of any age, although it is most prevalent in older people. Faecal incontinence is a subject that might not be openly discussed by patients and healthcare professionals; therefore, it is important for nurses to be aware of its signs, symptoms, causes and risk factors, so that they can identify patients at high risk. This article provides an overview of faecal incontinence, exploring its causes, psychological effects for patients, and conservative and specialised management measures, as well as the nurse’s role in providing treatment and support.

Nursing management of patients with faecal incontinence
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When an individual's bowel health is compromised as a result of age, long-term conditions or injury, they may develop faecal incontinence, also known as bowel incontinence. Faecal incontinence is a sign or a symptom, not a diagnosis. It has been defined as the involuntary passage of flatus, liquid or solid stool (Allison 2010).

While faecal incontinence is more common in older people and women (National Institute for Health and Care Excellence (NICE) 2007), it can affect patients of any age. Between 0.5% and 1% of adults in the UK regularly experience faecal incontinence that affects their quality of life (NICE 2007), while in Australia up to 20% of men and 13% of women have experienced faecal incontinence (Continence Foundation of Australia 2018). In a study by Dunivan et al (2010), faecal incontinence was self-reported by 36% of 1,707 patients in primary care settings.

The symptoms of faecal incontinence can be embarrassing and may result in patients feeling stigmatised and being reluctant to seek assistance and support from healthcare services (Royal College of Nursing (RCN) 2012). Therefore, it is important that nurses actively and sensitively enquire about the symptoms of faecal incontinence in patients who are in high-risk groups, such as older patients, those with neurological conditions such as Parkinson’s disease and multiple sclerosis, and women following childbirth. Dunivan et al (2010) noted that the condition has a significant effect on quality of life, with many patients experiencing embarrassment, social stigma, depression and anxiety.

Patients who report faecal incontinence should be managed by healthcare professionals, such as nurses, who have the relevant skills, training and experience. These healthcare professionals often work within an integrated continence service; however, non-specialist nurses with the relevant skills can undertake an initial assessment and offer conservative management measures in a sensitive manner. Community and practice nurses are well-placed to undertake these initial measures because faecal incontinence is often managed in the community setting. However, any nurse with the relevant skills can support patients with the condition.
Signs and symptoms of faecal incontinence

Many adults who experience faecal incontinence do so only during an occasional episode of diarrhoea. However, for others, faecal incontinence is a recurring or chronic condition. They may be unable to resist the urge to defecate, which occurs so suddenly that they cannot access a toilet in time. This is known as urge faecal incontinence (RCN 2012). Another type of faecal incontinence occurs in patients who are not aware of the leakage of liquid or solid stool, known as passive faecal incontinence (RCN 2012). Patients might also involuntarily defecate, for example when passing flatus (NHS Choices 2018a). Faecal incontinence may be accompanied by other bowel issues, such as diarrhoea, constipation, flatus and bloating.

Signs and symptoms should occur on a regular basis to be indicative of faecal incontinence, rather than as one-off incidents, and often significantly affect an individual’s quality of life. Many individuals with faecal incontinence experience a loss of dignity, which can also be associated with psychological factors such as embarrassment and shame (NICE 2007). Because of this, it is common for patients with faecal incontinence to attempt to disguise the condition or to avoid social contact. Furthermore, the skin around the anus is delicate and sensitive, so repeated contact with stool can lead to pain and itching, and potentially to ulcers in the perianal area (Norton and Chelvanayagam 2004).

NICE (2007) provides detailed guidance on the management of faecal incontinence and notes that there is no consensus on methods of classifying the symptoms and causes of faecal incontinence. The condition is most commonly classified according to: symptoms, for example urge faecal incontinence or passive faecal incontinence; character of the leakage, for example solid or liquid faeces; patient group, for example those with neurological conditions, frail older patients or women with obstetric injuries; or presumed primary underlying cause (NICE 2007).

Causes of faecal incontinence

For many patients, the condition is the result of a complex interplay of causes and contributing factors, many of which can co-exist. Examples of the potential causes of faecal incontinence are listed in Box 1.

Faecal incontinence is a symptom of an underlying issue or medical condition, and is often caused by diarrhoea, constipation or weakening of the muscle that controls the opening of the anus (NICE 2007). It can also be caused by long-term conditions such as Parkinson’s disease, diabetes mellitus, spinal cord injury, multiple sclerosis and dementia (Norton and Chelvanayagam 2004, NICE 2007, RCN 2012). Anal sphincter muscle damage is associated with causes such as injury during childbirth (Lunniss et al 2004, Allison 2010).

Injury to the parasympathetic nerves that sense stool in the rectum, or those that control the anal sphincter, can lead to faecal incontinence. Nerve damage can be caused by childbirth, constant straining during bowel movements, spinal cord injury or stroke. Some conditions, such as diabetes and multiple sclerosis, can also affect these nerves and cause damage that leads to faecal incontinence (Norton and Chelvanayagam 2004).

Solid stool is easier to retain in the rectum than loose stool; therefore, the loose stools experienced in diarrhoea can cause or worsen faecal incontinence. Normally, the rectum stretches to accommodate stool. If the rectum is scarred or the rectal walls have stiffened from surgery, radiation treatment or inflammatory bowel disease, the rectum cannot stretch and retract as much as required, and excess stool can leak (Cancer Research UK 2016). Surgery to treat enlarged veins in the rectum or anus (haemorrhoids), as well as more complex operations involving the rectum and anus such as those undertaken to correct an anal fissure, can cause muscle and nerve damage that leads to faecal incontinence (Oxford University Hospitals NHS Trust 2015). Faecal incontinence can result from the rectum collapsing into the anus (rectal prolapse), and in women faecal incontinence can occur if the rectum protrudes through the vagina (rectocele) (Norton and Chelvanayagam 2004).

High-risk groups

Box 2 lists the groups of people who are at high risk of faecal incontinence. Faecal incontinence can occur at any age, but is more common in frail older adults (Allison 2010, Ness 2012). While it is more common in women (Continence Foundation of Australia 2018), potentially as a complication of childbirth, most women with faecal incontinence develop the condition when they are over 40 years old (Perry et al 2002); therefore, its association with pelvic floor injury during childbirth is unclear. However, it is possible that some injuries sustained during childbirth do not cause symptoms immediately (Perry et al 2002). For some groups, such as women who have recently given birth, there appears to be some spontaneous resolution of symptoms (NICE 2007). Nurses should actively yet sensitively enquire about symptoms of faecal incontinence with individuals in high-risk groups.

Assessment

Nurses should undertake an initial assessment of any patient suspected of experiencing faecal incontinence to...
identify the causes and contributory factors. This assessment should include the patient's medical history, cognitive assessment and, if appropriate, anorectal examination, for example if it is necessary to assess the patient’s anal sphincter function. It is also important to undertake a cognitive assessment in people suspected of experiencing faecal incontinence (NICE 2007), since continence requires the patient to recognise the need to pass urine or faeces, as well as to identify and reach the correct location to pass urine or faeces, such as the toilet or commode. Cognitive impairment can affect the patient’s ability to undertake these functions.

During the assessment, the nurse may identify signs of the following conditions, which should be addressed before instigating treatment for faecal incontinence (NICE 2007):

» Faecal loading (faeces becomes impacted in the bowel, leading to constipation).

» Potentially treatable causes of diarrhoea, such as irritable bowel syndrome.

» Lower gastrointestinal cancer.

» Rectal prolapse.

» Third-degree haemorrhoids.

» Acute anal sphincter injury.

» Acute disc prolapse or cauda equina syndrome.

It is possible that nurses might assume that a patient’s faecal incontinence has resulted from a pre-existing condition – for example, multiple sclerosis or the cognitive impairment associated with dementia – without having undertaken a comprehensive assessment (NICE 2014). NICE (2014) guidelines recommend that nurses undertake a baseline assessment of the individual, rather than assuming that any faecal incontinence is related to a pre-existing condition.

There is no single tool used in continence assessment, but local integrated continence care pathways should be available for use in healthcare organisations (NICE 2014, Croydon Health Services NHS Trust 2017).

**Conservative management**

Conservative management measures are any non-surgical, non-invasive interventions aimed at improving faecal incontinence or preventing further deterioration, and are the first-line treatment for the condition. NICE (2014) guidelines state that nurses should develop an initial management plan for patients with faecal incontinence. This should detail any specific conditions that are contributing to the faecal incontinence, as well as any planned diet, bowel habit, toilet access and medicines interventions.

Several conservative management measures are available, including regulation of the patient’s diet, fluid intake and bowel habits, bulking agents (substances that increase stool consistency), and psychological support.

**Diet, fluid intake and bowel habits**

The initial treatment approach in patients with faecal incontinence usually involves regulating their diet, fluid intake and bowel habits. Patients should be advised to avoid food or drinks that can result in loose stools and frequent bowel movements, for example alcoholic beverages, foods and drinks containing caffeine, high-fat foods, spicy foods, and dairy products such as milk, cheese and ice cream (Whitehead 2017). Some patients find that sweeteners such as sorbitol, which is found in many low-calorie foods, drinks and chewing gums, can result in looser stools (Chelvanayagam and Norton 2004). However, it can be challenging for nurses to provide definitive advice on diet since the influence of food on faecal incontinence varies between individuals and there is limited research on which foods improve or worsen symptoms (Chelvanayagam and Norton 2004).

Monitoring a patient’s caffeine intake may be effective in reducing the symptoms of faecal incontinence because some patients’ gastrointestinal tracts are sensitive to the caffeine present in coffee, tea, cola drinks and some types of chocolate (Chelvanayagam and Norton 2004). Studies have demonstrated that decaffeinated coffee has a similar stimulant effect on the gastrointestinal tract to caffeinated coffee (Boekema et al. 1999). According to Chelvanayagam and Norton (2004), patients experiencing urge faecal incontinence, frequency or looseness could benefit from trialling a caffeine-free diet for at least one week, to determine if their symptoms improve.

Patients experiencing hard stools should be encouraged to consume at least 1.5 litres of fluid per day, unless contraindicated (NICE 2007). Nurses should encourage patients to empty their bowels at around 30 minutes following a meal to benefit from the gastrocolic reflex (Ness 2012).

When assessing a patient’s diet, nurses should consider any existing conditions that may affect their ability to consume the diet, fluid intake and bowel habits recommended by NICE (2014). Patients should be advised to avoid food or drinks that can result in loose stools and frequent bowel movements, for example alcoholic beverages, foods and drinks containing caffeine, high-fat foods, spicy foods, and dairy products such as milk, cheese and ice cream (Whitehead 2017).

**Key points**

- Faecal incontinence is a sign or a symptom, not a diagnosis. It has been defined as the involuntary passage of flatus, liquid or solid stool (Allison 2010)

- Between 0.5% and 1% of adults in the UK regularly experience faecal incontinence that affects their quality of life (National Institute for Health and Care Excellence (NICE) 2007)

- The initial treatment approach in patients with faecal incontinence usually involves regulating their diet, fluid intake and bowel habits. Patients should be advised to avoid food or drinks that can result in loose stools and frequent bowel movements, for example alcoholic beverages, foods and drinks containing caffeine, high-fat foods, spicy foods, and dairy products such as milk, cheese and ice cream (Whitehead 2017)

- Nurses should advise patients with faecal incontinence about where to access psychological support in their local area, including counselling or psychological therapy (NICE 2007)

**Box 2. High-risk groups for faecal incontinence**

- Frail older adults
- Women following childbirth
- People with neurological conditions or spinal injury
- People with severe cognitive impairment
- Individuals with urinary incontinence
- Individuals with pelvic organ prolapse and/or rectal prolapse
- People who have had colorectal resection or anal surgery
- People who have undergone pelvic radiotherapy
- Individuals with learning disabilities
- Individuals with loose stools or diarrhoea
- People with perianal soreness, itching or pain

(National Institute for Health and Care Excellence 2007)
therapeutic diets that the patient may be following, such as a diet low in saturated fats aimed at reducing cholesterol, to ensure that their overall nutrient intake is balanced. Nurses should consider screening any patient with faecal incontinence who may be at risk of malnutrition using a standardised tool such as the Malnutrition Universal Screening Tool (British Association for Parenteral and Enteral Nutrition 2018).

Food diary
One method of managing faecal incontinence is to eliminate any food and drinks from the diet that may be contributing to a patient’s symptoms. This can be achieved by maintaining a food diary to monitor the food and drink the patient consumes (Whitehead 2017). The aim is to achieve ideal stool consistency and satisfactory bowel emptying at a predictable time. The diary should also monitor the size and consistency of the patient's stools, for example loose, hard or liquid, and any symptoms such as stomach cramping or excess flatus. The nurse and patient can review the diary to assess whether any patterns have emerged, for example the diary may assist the nurse and patient in isolating foods or drinks that trigger loose bowel movements. Those foods or drinks should be eliminated from the diet, one at a time, while the patient continues to maintain the diary, to assess whether the symptoms resolve. The suspect food or drink can then be reintroduced to assess whether they trigger further bowel symptoms. If so, these items can be eliminated from the patient’s diet completely (Whitehead 2017).

Bulking agents
It has been demonstrated that fibre and bulking agents such as psyllium, methylcellulose or synthetic polycarbophil are effective in treating faecal incontinence (Bliss et al 2001, Sze and Hobbs 2009). Supplementing the diet with dietary fibre from psyllium has been associated with a decrease in the quantity of loose stools and improvements in stool consistency (Wilson 2007). Nurses should ensure that patients are aware of the general health benefits of adding fibre to the diet. For example, foods such as biscuits with added arrowroot, flour substitutes that can be added to sauces and soups, and ripe bananas, all contribute to firmer stools, which can assist some patients to control the symptoms of faecal incontinence (Chelvanayagam and Norton 2004).

Continent products
NICE (2014) guidelines state that all patients should be offered appropriate continence products to assist them in the management of their symptoms for as long as they experience episodes of faecal incontinence. Nurses should be aware of the various products available for the management of faecal incontinence such as continence pads and anal plugs. However, despite the availability of these products, nurses may find it challenging to find one that can reliably disguise bowel leakage and odour. For example, most continence pads are designed for urinary rather than faecal incontinence (Ness 2012).

Continent pads
Several types of continence pads are available for use in faecal incontinence, many of which fit inside the patient’s underwear and have a hydrophobic layer that draws urine and faecal fluid away from the surface of the pad, so that the patient’s skin remains dry (NHS Choices 2017). However, patients may find that many continence pads are too thick, bulky and not the right shape or length to adequately contain faeces. According to NICE (2007) guidelines, people with faecal incontinence should be offered disposable body-worn pads and bed pads, as required. Nurses should provide sufficient quantities of continence pads to meet the individual’s needs, and not limit the number of pads supplied.

The use of reusable absorbent products in the management of faecal incontinence is not generally recommended because it is challenging to ensure they remain clean (NICE 2007).

Anal plugs
An anal plug is a useful device for those who experience passive faecal incontinence. Anal plugs can be used daily, or when the individual takes part in activities such as sports and swimming. Manufactured anal plugs are inserted like a suppository and some can be used for up to 12 hours (Herbert 2008). Manufactured anal plugs are often covered with a water-soluble film, which dissolves once inside the rectum, when the plug expands into a cup shape with a string for removal. Anal plugs should be lubricated to aid insertion, according to the manufacturer’s instructions. NICE (2007) guidelines state that anal plugs should be offered to patients with faecal incontinence who can tolerate their use.

Medicines
The nurse should review the patient’s medicines and consider alternatives to drugs that might be contributing to their faecal incontinence (NICE 2007). For example, many drugs can cause or exacerbate diarrhoea, such as non-steroidal anti-inflammatory drugs and antibiotics (NHS Scotland 2014).

Patients with frequency or loose stools may be offered antidiarrhoeal medicines once other potential causes, such as excessive laxative use, dietary factors and concomitant medicines, have been excluded. NICE (2007) guidelines recommend loperamide hydrochloride as the first-choice antidiarrhoeal drug. Loperamide should be introduced at a low dose and escalated, as tolerated, until the desired stool consistency is achieved. Patients should be advised that they can adjust the dose and frequency up or down according to their stool consistency. However, loperamide is contraindicated for those who have hard or infrequent stools, acute diarrhoea without a diagnosed cause and acute flare-ups of ulcerative colitis. Codeine phosphate or co-phenotrope should be offered to patients who cannot tolerate loperamide (NICE 2007).

Chelvanayagam and Norton (2004) emphasised the importance of timing of medicines administration, since taking some medicines before meals can assist in slowing the gastrocolic reflex (this reflex stimulates contractions in the intestine following eating, which control peristalsis...
or gut motility). Therefore, nurses should advise patients on adjusting the timing and dose of any medicines, within the range prescribed, to maximise their effectiveness.

**Psychological support**

The benefits of psychological support for patients experiencing faecal incontinence are challenging to quantify and evaluate. Chelvanayagam and Norton (2000) found that patients experiencing faecal incontinence expressed feelings of guilt, embarrassment and unattractiveness; patients also reported feeling under pressure to disguise their faecal incontinence from others. Chelvanayagam and Norton (2004) noted that patients expressed gratitude when offered the opportunity to discuss faecal incontinence with a knowledgeable healthcare professional, because this made them feel less isolated. Patients also appreciated being informed that other people may experience faecal incontinence and that there was assistance and support available.

**Specialised management**

NICE (2014) guidelines recommend that patients who continue to experience episodes of faecal incontinence following an initial period of conservative management should be considered for specialised management, which may involve referral to a specialist continence service. Specialist continence services comprise clinics run by continence clinical nurse specialists and/or a physiotherapist, which can provide targeted interventions such as bowel retraining, pelvic floor exercise programmes, biofeedback and percutaneous tibial nerve stimulation, as well as specialist dietary assessment and management.

The patient’s symptoms should be reviewed after each intervention undertaken. To assist in this, it may be useful to ask the patient to complete a bowel diary, which will demonstrate whether there has been an increase or decrease in episodes of faecal incontinence (NICE 2007).

**Bowel retraining**

Bowel retraining comprises a range of measures designed to assist the patient with faecal incontinence to gain control over their bowel movements, including (NHS Choices 2018b):

- Altering the patient’s diet to reduce constipation or diarrhoea.
- Assisting the patient to adopt a regular toileting routine, for example opening their bowels following a meal.
- Providing advice on methods that patients can use to improve bowel emptying, for example adopting a different position when sitting on the toilet.

**Pelvic floor exercises**

The pelvic floor muscles support the rectum and the bladder and have an important role in maintaining faecal continence. Pelvic floor exercises involve the repeated tensing and releasing of the pelvic floor muscles and those surrounding the anal sphincter, and should be undertaken as a regular programme. The aim is to strengthen these muscles to promote sphincter control and prevent leakage. Since sphincter disruption and pelvic floor damage may occur in childbirth, NICE (2007) guidelines suggest that it may be beneficial to undertake these exercises before and immediately after childbirth. However, there is no standardised method for undertaking pelvic floor exercises (NICE 2007). The progress of a pelvic floor exercise programme should be monitored by digital rectal or vaginal assessment undertaken by an appropriately trained healthcare professional (NICE 2007).

**Biofeedback**

Biofeedback is an instrument-based intervention in which intra-anal, intra-vaginal or skin sensors attached to a computer monitor provide visual or auditory information regarding the patient’s anorectal muscle function. Anorectal biofeedback uses neuromuscular conditioning of rectal sensation and rectoanal coordination to treat patients with faecal incontinence. Biofeedback can enhance the effectiveness of anal sphincter and pelvic floor exercises by providing feedback that they are being performed correctly (Allison 2010, Ness 2012).

**Percutaneous tibial nerve stimulation**

Percutaneous tibial nerve stimulation is a minimally invasive nurse-led procedure that involves electrical stimulation of the sacral nerve plexus, which is responsible for regulating bladder and bowel function. During the procedure, a needle is inserted through the skin adjacent to the posterior tibial nerve at the patient’s ankle (Boyle et al 2009, Allison 2010, NICE 2011). The tibial nerve also serves the pelvic floor, bladder and rectum; therefore, the rectum and the anal sphincters can be stimulated to assist the patient in deferring defecation. Research has indicated that up to 70% of patients may benefit from this treatment (Govaert et al 2010).

**Rectal irrigation**

Rectal irrigation is a technique used to completely empty the rectum. The equipment used includes a self-retaining rectal balloon catheter that is inserted into the rectum allowing water to be inserted, which encourages bowel evacuation. The procedure can take up to 45 minutes and can provide relief for patients who are concerned about faecal incontinence since, following the procedure, they will know that their bowel is empty (Allison 2010).

**Patient education, advice and support**

Ness (2012) stated that patients should be educated on appropriate toileting position to ensure complete emptying of the bowel, thus reducing the risk of passive faecal incontinence. The patient’s feet should be elevated using a stool so that their knees are positioned above their hips, and the patient should lean forward between their knees, with a straight back and their lower abdomen extended (Ness 2012).

When seeking to enable efficient toilet access in a patient’s home or the hospital setting, nurses should ensure that the toilet’s location is clearly indicated and that any equipment required to assist the patient to access the toilet is provided, for example patients may require the use of a walking frame to mobilise from a chair to the toilet (NICE 2007, Allison 2010). Nurses can also provide practical advice on easy-to-remove clothing that will minimise the time required to use the toilet (NICE 2007). Where rapid access to the toilet is required, nurses
can refer patients for assessment of their home for ease of mobility, for example the location of doors or furniture can be a barrier to toilet access.

Nurses should advise patients to wipe the anus and perianal area gently with soft toilet paper following a bowel movement and discard each piece of toilet paper after a single wipe to reduce the risk of infection (Chelvanayagam and Norton 2004). To minimise trauma to the skin, where possible patients should gently wash around the anus after a bowel movement with a soft disposable cloth and tap water and/or non-perfumed soap, patting the skin dry afterwards with a towel. Flannels and sponges should not be used to wash the perianal area because this can be abrasive on the skin and challenging to keep clean.

Nurses can also recommend lifestyle modifications to assist patients in managing faecal incontinence. For example, nicotine use is reported to induce bowel movements and nurses should consider providing smoking cessation advice to patients with urge faecal incontinence (Sloots et al 2005).

Information about the management of faecal incontinence should be offered to patients in a range of languages and formats, including face-to-face and telephone discussions, web-based resources and leaflets. Providing such information alone is not always sufficient and patients should also be offered one-to-one support from a community, practice or continence nurse to ensure that they understand any information given. Where possible, carers and relatives should have the opportunity to be involved in decisions about the patient’s treatment; however, because of the sensitive nature of the condition, the patient must consent to this.

Nurses should advise patients with faecal incontinence about where to access psychological support in their local area, including counselling or psychological therapy (NICE 2007). Practical and psychological support is also available from organisations such as Bladder and Bowel UK (www.bladderandboweluk.co.uk) and the Continence Foundation of Australia (www.continence.org.au), which provide resources aimed at assisting patients with faecal incontinence to manage their symptoms. In the UK, another useful resource is the national Radar key scheme, which facilitates access to public toilets (Ness 2012).

**Conclusion**

Faecal incontinence can be a distressing, socially restricting and stigmatising condition for patients. Nurses should be able to assess the underlying causes of faecal incontinence, initiate conservative management measures and provide practical advice on reducing the effects of the condition on patients’ quality of life. Many of the interventions required in the initial management of faecal incontinence, such as dietary advice, can be provided by non-specialist nurses with the relevant knowledge and skills. Specialist continence services and continence clinical nurse specialists are available to provide specialist interventions if initial treatments are unsuccessful, while continence charities and societies can offer additional practical and psychological support.

**References**


