Bowel Management System Guideline

University Hospitals of Leicester NHS
NHS Trust

B45/2021

1. Introduction

Bowel management systems (BMS) are temporary containment devices, indicated for bedridden or immobilised incontinent patients, with little or no bowel control, who have a liquid or semi-liquid stool. They are also indicated for patients with severe burns to manage their bowel function, promote healing of genital, perineal or anal skin grafts and to maintain infection control following plastic surgery.

They are designed to safely and effectively divert faecal matter, protect patients' wounds from faecal contamination and to reduce both the risk of skin breakdown and spread of infection.

A BMS for the control of faecal incontinence should only be inserted once all other faecal incontinence management alternatives have been considered. The use of a BMS must be agreed with the medical team in charge of the patient's care following a holistic assessment of the patient which has taken into consideration: infection control, risk of device related skin breakdown, privacy and dignity, and contraindications for use. This agreement must be documented in the patient's records.

2. Scope

To be performed by Medical and Nursing staff that have been trained how to use the BMS.

Indications for the use of Bowel Management Systems (see appendix 1)
A BMS can be used for bed-bound or very limited mobility patients with intractable faecal incontinence or persistent diarrhoea, i.e. 4 or more episodes of faecal incontinence in 24 hours (liquid to semi-liquid stools type 6–7 as per Bristol stool chart).
They are used to reduce the risk of skin breakdown

- To reduce the risk of spread of infection
- To protect wounds, surgical sites and burns
- To improve patient comfort
- To promote patient dignity
- To assist with faecal management (burn injured patients).

Contraindications for the use of Bowel Management Systems
The BMS must not be inserted in the following circumstances, and the patient must be referred to the medical team if:

- The need for the insertion of the BMS has not been documented by the medical staff.
- The patient is under the age of 18. **NB** A BMS may be used in a burn injured patient between the ages of 16 and 18 'off label'; however the decision to use a BMS must be made

by the patient's consultant, based on the patient's weight and size. Any decision to insert a BMS, and the rationale for use, must be clearly documented.

- The patient has capacity and refuses the procedure.
- The patient has faecal loading/ impaction.
- The patient has rectal/anal conditions i.e. proctitis, Crohn's disease, stricture.
- The patient has a rectal or anal injury.
- The patient has severe haemorrhoids.
- The patient has a suspected or confirmed rectal/anal tumour.
- The patient has had anal or low rectal surgery within 6 weeks. Any surgery between 6 weeks and 1 year must be discussed with a colorectal surgeon.
- The patient has an established spinal cord lesion, above the level of the sixth thoracic vertebra, and is at risk of developing autonomic dysreflexia.
- The patient has an inflammatory bowel condition. A member of the medical team must determine the degree and location of inflammation within the colon/rectum prior to the use of this device.
- The patient has sensitivity or allergies to any of the materials used in the faecal management system (i.e. silicone).
- The patient is at risk of bleeding, has a low Hb or platelet count. Seek further advice from Consultant.
- Always seek further medical advice if needed.

3. Recommendations, Standards and Procedural Statements

Please note: there is more than one type of BMS available, and therefore the manufacturer's instructions relating to the insertion of the particular system, removal of the system, and maintenance of the system must be followed. More information can be found at:

http://www.bard.com

http://www.convatec.com

http://www.hollister.com

Bowel Management Systems should not be used:

- Single tubes for longer than 29 days.
- For patients with solid or semi-formed stools
- For patients who sit out in a chair for long periods of time.

NB If the clinician has judged it to be necessary, or clinically beneficial to sit the patient out of bed with a BMS in situ, the following must be adhered to:

- The sitting position should avoid compressing, kinking or obstructing the device.
- The sitting period must be the shortest possible (no more than 1 hour), and the duration must be documented.
- If there is a moisture lesion, or category 2 (or greater) pressure damage around or in close proximity to the anus, the patient should not sit out.
- Close surveillance of the device must be undertaken to avoid the risk of pressure damage to the anal/perianal region.
- The collection bag must be emptied prior to sitting the patient out of bed.
- Upon returning the patient to bed, the nursing staff must inspect the anal area and document the condition of the skin on a skin assessment chart. The tube must be positioned correctly and the collection bag supported at all times.

Limitations for the use of Bowel Management Systems
If the following occur whilst the BMS is in situ, the patient must be referred to the medical team for immediate review:

- Persistent rectal pain
- Rectal bleeding
- Abdominal distension
- Excessive leakage of stool around the device
- Loss of anal sphincter muscle tone (this could lead to temporary anal sphincter dysfunction)
- Pressure necrosis of rectal or anal mucosa
- Signs and symptoms of infection and inflammation of the anus
- Bowel obstruction
- The registered nurse is concerned about the patient's condition.

Further considerations:

- Prior to the insertion of a BMS, a digital rectal examination must be performed to rule out the possibility of faecal impaction. The device can be inserted once the faecal impaction is removed.
- A digital rectal examination may also confirm presence or absence of anal tone, as poor or absent tone may increase leakage around the device or may contribute to the inability to retain the device.
- If the BMS is being used to control diarrhoea, the device must be removed when the patient's bowel control, consistency and frequency of stool begin to return to normal.
- Close attention must be exercised with the use of the device in patients who have inflammatory bowel conditions (seek advice from colorectal nurses/clinicians).
- Caution must be exercised when considering use in patients with thrombocytopenia and/or clotting disorders and individuals taking anticoagulant medication (seek advice from consultant haematologist).
- To avoid injury to the patient, do not insert anything into the anal canal while the device is in place. Remove the device prior to insertion of anything into the anal canal (e.g. suppositories).
- There is no specific evidence to contraindicate use of the system in cancer and haematological oncology patients, but because of the higher risk of proctitis and clotting disorders, its use must be sanctioned by the patient's consultant and this must be documented.

Consent
The registered practitioner, obtaining consent or making the decision to insert the BMS, must ensure the patient and carers are aware of the potential risks associated with this procedure before the decision to insert the BMS is made, and that the primary reason to use the BMS is for the benefit of the patient and not for the convenience of the carers.

Who can undertake the Insertion of a Bowel Management System?
The bowel assessment, prior to the insertion of the BMS, must be carried out by an appropriate, competent, health professional trained in the skill of undertaking a digital rectal examination to determine the presence of faeces in the rectum.

The outcome of the bowel assessment must be documented in the patient's records. If faecal impaction is present, the device can be inserted once the faecal impaction is removed. The outcome of the bowel assessment must be documented in the patient's records.
A registered nurse who is competent and has undertaken education and training can perform the insertion of a BMS.

Pre-Insertion Checklist

Following the DRE, and before the Bowel Management System in inserted, the Pre-Insertion Checklist must be completed to ensure that there are no contra-indications **(see appendix 3).**

Procedure for Insertion of BMS: Refer to **Appendix 2:**

Maintenance of the Bowel Management System

Observe the device at least every 2 hours for obstructions which may be caused by kinks, solid faecal particles or external pressure. Change the position of the drainage tube, e.g. hang the bag on alternate sides of the bed or lie in the middle. Update the BMS maintenance checklist 2 hourly **(see Appendix 4).**

Ensure the anal area is clean and dry, and the skin is intact. Slight faecal seepage may occur occasionally. If faecal seepage does occur, the skin must be kept clean and protected with an appropriate barrier product (e.g. Clinicept wipes). Document the condition of the skin on a skin assessment chart.

Perform and document a full skin inspection at least every 12 hours. If there are any concerns about skin breakdown, the patient should be referred to the Tissue Viability Team for advice.

If stool samples are required ensure they are taken from the tubing of the system rather than the bag to ensure a recent sample is taken.

Record the faecal output at least every 2 hours on the fluid balance chart and BMS monitoring chart.

The collection bag must be emptied frequently and supported well to prevent dragging. It must be changed every seven days or earlier if required. Discard the used bag according to Trust policy and procedures for waste management.

Irrigation of the Bowel Management System

Flush the BMS daily using 50mls saline, using the irrigation port, to keep the silicone catheter perfuse and as and when needed to maintain the unobstructed flow of stool into the collection bag. Update the maintenance care plan after irrigating. Please follow the manufacturer's instructions.

Before proceeding with irrigation, check that the tubing is not kinked or obstructed by pressure from a piece of equipment or a body part (consider repositioning the patient). If no external causes of the obstruction have been detected irrigate the device. If irrigation does not alleviate the blockage, and no source of obstruction is detected, refer the patient to the medical team to determine whether the use of the BMS is still indicated or if it should be removed.

Removal of the Bowel Management System

The BMS must be removed if it is no longer indicated, or has been in situ for 29 days. Please follow the manufacturer's instructions for the removal of the device.

Transferring a patient with a BMS - Complete the BMS transfer form when transferring a patient with a BMS to another ward area. **(see Appendix 5)**

Patients Being Discharged

Patients should never be discharged from UHL into the community with a BMS. The BMS is not a generic or specialist nursing task supported in any community setting and should always be removed prior to a patients discharge.

Refer to the Adult Continence Team one week prior to discharge if a bowel management plan is required for managing diarrhoea post-BMS removal. Do not refer on day of discharge.

4. Education and Training

Only competent practitioners should insert bowel management systems independently. Staff with no previous experience of BMS insertion should be supervised by a practitioner competent in BMS insertion until deemed competent and signed off to do so.

Staff who have attended BMS training face to face and are signed off as competent, will complete refresher training annually (not including ITU nurses). The training will alternate each year between face to face and electronically via HELM, to maintain competency. Only staff trained and competent should provide the on-going care of patients with a BMS.

Criteria for Competency (see appendix 7)

Trouble Shooting and Out of Hours/In-hours Support

Refer to BMS Trouble Shooting Guide (see appendix 8) initially for guidance to manage any BMS issues. If further support is required, contact Medical Continence Team, Monday – Friday 8.30-4.30. For Out of Hours BMS support, refer to the Out of Hours BMS Pathway, and contact relevant CMG/site. If BMS issue cannot be resolved by out of hours support, and there are on-going concerns with continued use of BMS, medical team to decide whether to remove and consider referral to Adult Continence Team for review (see Appendix 8).

5. Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Review of clinical incidents	Datix	Quarterly	UHL continence team

6. Supporting Documents and Key References

There is more than one type of BMS available, and therefore the manufacturer's instructions relating to the insertion of the particular system, removal of the system, and maintenance of the system must be followed. More information can be found at:

http://www.bard.com

http://www.convatec.com

http://www.hollister.com

7. Key Words

"BMS" Bowel management system

Appendix 1

Adult Continence Service

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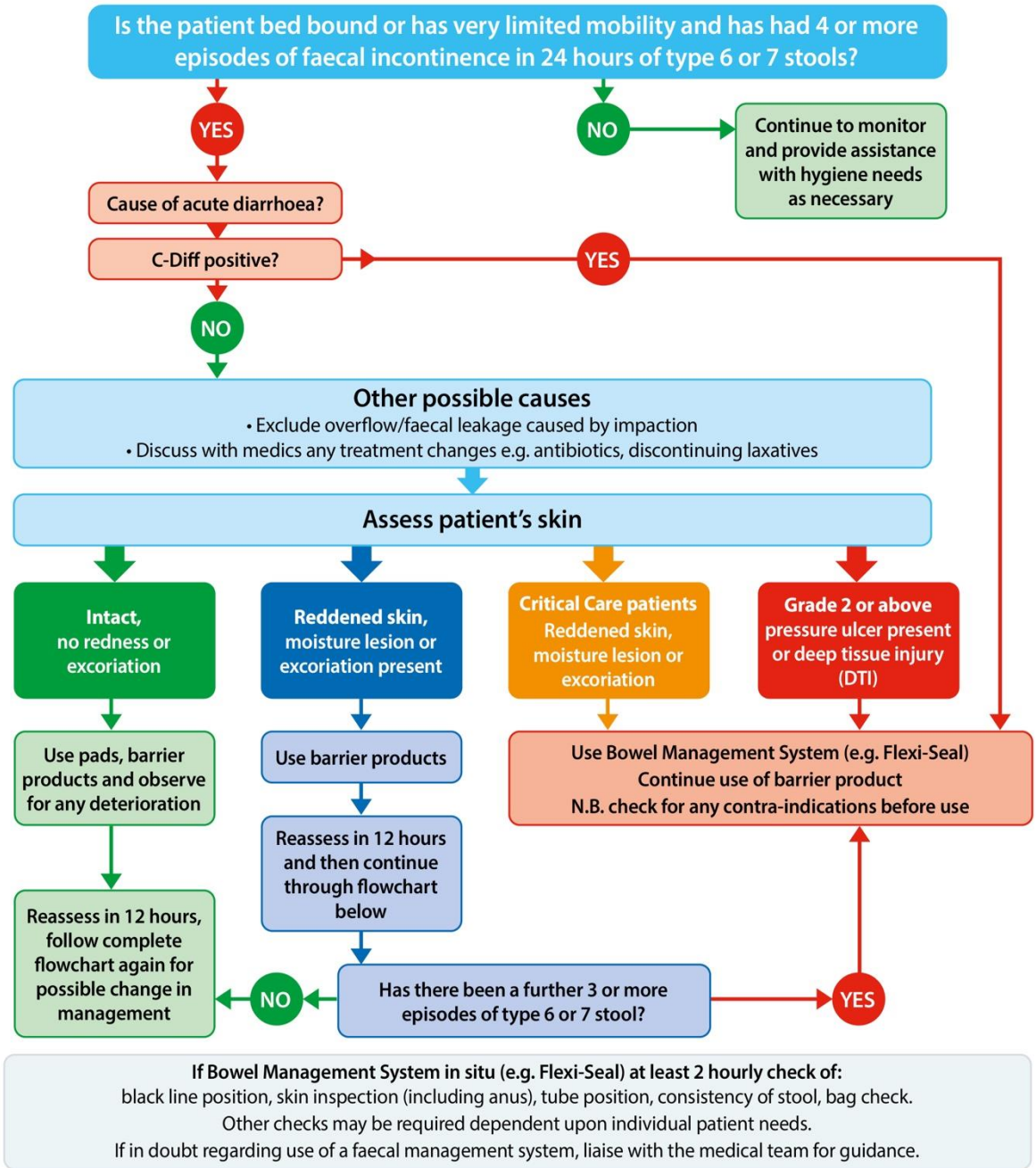
Management of Acute Diarrhoea causing Faecal Incontinence: Assessment for Bowel Management System e.g. Flexi-Seal



If Bowel Management System in situ (e.g. Flexi-Seal) at least 2 hourly check of:
black line position, skin inspection (including anus), tube position, consistency of stool, bag check.
Other checks may be required dependent upon individual patient needs.
If in doubt regarding use of a faecal management system, liaise with the medical team for guidance.

NB: Paper copies of this document may not be the most recent version. The definitive version is held on UHL Connect in the Policies and Guidelines Library.

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Appendix 2

Procedure for the Insertion of a Bowel Management System (BMS) (e.g Flexi seal)

NB- there is more than one type of BMS available and therefore the manufacturers' instructions must be followed.

Equipment

- Dressing trolley (cleaned with soap and water followed by a Sani-Cloth 70% alcohol wipe and allowed to air dry).
- Bowel management system (BMS)
- Water soluble lubricating gel
- 50 ml syringe
- Non-sterile jug (for single patient use)
- Tepid water
- Disposable non-sterile gloves
- Disposable apron
- Face protection (full face visor)
- Procedure pad
- Clinisept wipes (intact skin) or Medi-derm stick (broken skin)
- Hand washing/ decontamination facilities

No.	Action	Rationale
1.	• Explain procedure to the patient to gain co-operation and verbal consent (where possible) • Document that consent has been given • Document if patient is unable to give valid consent utilising the minimum requirements for assessment of capacity and best interests, as set out in section 4 of the Mental Capacity Act 2005 and in the Code of Practice, section 5.13	• Patient information may reduce anxiety • To ensure that the patient understands the procedure and gives his/her valid consent • If the patient has lost the capacity to consent or to refuse the procedure due to, e.g. unconsciousness, sedation or a confusional state. It is vital to document why the procedure is in the patient's best interest
2.	Screen the bed	To ensure privacy for the patient
3.	Decontaminate hands with soap and water and apply alcohol gel rubbing until dry	To decontaminate hands prior to patient contact

4.	Wearing non-sterile gloves and apron, place the procedure pad under the patient's bottom. Assist the patient to lie in the left lateral position with knees flexed. Cover the patient's bottom half with a sheet (assistance may be required dependant on the independence of the patient (follow Manual Handling Procedure)) Remove and dispose of gloves and apron, and wash hands as per Trust policy and apply alcohol gel, Rub until dry	To protect bedding from soiling and to maintain the patient's dignity. To ensure the patient is in the correct position for the procedure
5.	Put on clean disposable plastic apron. Prepare the trolley, placing all equipment required on the bottom shelf and take to the patient's bedside	To reduce risk of cross-infection from or to uniform. To reserve the top shelf for the preparation of the equipment
6.	Ensure curtains are fully closed and apply alcohol gel to hands Put on non-sterile gloves	To ensure the patient's privacy and dignity To allow dust and airborne organisms to settle before starting the procedure
7.	Examine the perianal area	To observe for skin damage, and external haemorrhoids
8.	Lubricate the gloved index finger	To facilitate easier insertion of the finger and minimise patient discomfort. To reduce mucosal trauma
9.	Perform a digital rectal examination. Assess the rectum for haemorrhoids, presence of stool and possible faecal impaction	The BMS is contraindicated for faecal impaction and severe haemorrhoids. If either detected, refer the patient to the medical staff
10.	Ensure the area is cleaned and dried and protective barrier cream (intact skin) or barrier film (broken skin) is applied	To protect the skin
11.	Remove and dispose of gloves, and apply alcohol gel, rub until dry	To decontaminate hands
12.	If liquid/semi-liquid stools are present or the rectum is empty, and haemorrhoids have not been detected, prepare the BMS	The BMSs are expensive and, by assessing the patient before opening the packaging, unnecessary waste will be avoided
13.	Refer to the manufacturer's instructions for preparation of the equipment	More than one type of BMS is available

14.	Wear apron and double glove hand inserting BMS with non-sterile gloves	To maintain PPE when inserting BMS
15.	Insert the BMS in accordance with the manufacturer's instructions.	More than one type of BMS is available
16.	Dispose of outer glove used to insert BMS	To reduce the risk of cross infection
17.	Position the length of the flexible tubing along the patient's leg avoiding kinks and obstruction Hang the drainage bag by the strap at a convenient location on the bedside. Ensure the drainage bag is well supported and is not pulling	To maintain patient comfort To encourage and allow faecal flow from the rectum into the collection bag
18.	Dispose of equipment in accordance with Trust policy and procedures for waste management	To reduce the risk of cross infection
19.	Remove gloves and apron and decontaminate hands with soap and water. Apply alcohol gel and rub until dry	To reduce the risk of cross infection
20.	Document procedure and outcome in the patient's notes and on any other relevant bedside documentation (e.g. stool record chart, c. diff care plan/ diarrhea care pan/ skin assessment chart)	To ensure communication between the multidisciplinary team and a record of care given

Appendix 3

Patient ID Label *or write name and number*
Hospital No.:
Name:
Address:
D.O.B.: Sex:
Telephone No. 1:
Telephone No. 2:

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Inserted by: Role:
Date of Insertion: Date to be removed by: *(29 days from insertion)*

Ward:

CONTINENCE TEAM

Pre-insertion Bowel Management Checklist

Reason for Insertion:

You need to be able to answer TRUE to ALL the questions below in order to use Flexi-Seal® Faecal Management System	**True**	**False**
The patient is incontinent with liquid or semi-liquid stool		
The patient is over 18		
The patient is not sensitive or known to have had allergic reactions to any component within the kit		
The patient has not had lower large bowel or rectal surgery within the last year		
The patient does not have suspected or confirmed rectal mucosal impairment		
The patient does not have any rectal or anal injury		
The patient does not have a confirmed rectal/anal tumour, stricture or stenosis		
The patient does not have haemorrhoids of significant size and/or symptoms		
The patient does not have a faecal impaction		
The patient does not have any in-dwelling or anal device (e.g. thermometer) or delivery mechanism (e.g. suppositories or enemas in place)		
Skin category in sacral area. *Rate skin from Category 1 (excoriation) to Category 4 (deep tissue damage):*		

Date inserted:			
Lot number:			
Quantity of fluid inserted into balloon:		ml	*(do not put more than 45 mls)*
Confirm black line on the tube is visible directly outside patient's anus	Yes ☐	No ☐	
Mental capacity	Yes ☐	No ☐	
Consent	Yes ☐	No ☐	*(please explain in patient notes)*

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Appendix 4

Patient ID Label *or write name and number*
Hospital No.:
Name:
Address:
D.O.B.: Sex:
Telephone No. 1:
Telephone No. 2:

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Lot Number:

CONTINENCE TEAM

Maintenance Checklist for the Bowel Management System Care Plan

Clinical Area:

Date	Black Line Position Checked	Bristol Stool Score *12 hrly*	**BESTSHOT** Sacral Code	Perianal skin clean/ dry	Patient pain-free and comfortable	Patient re-positioned	Tube Position Correct	No Kinks or Blocks in System	Retention Cuff inflated *(weekly volume check)*	Irrigation *(50mls once daily or as required)*	Actions Taken/ Comments	Initials
02:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
04:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
06:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
08:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
10:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
12:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
14:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
16:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
18:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
20:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
22:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
24:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		

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CONTINENCE TEAM

Maintenance Checklist for the Bowel Management System Care Plan

Clinical Area:

Date	Black Line Position Checked	Bristol Stool Score *12 hrly*	**BESTSHOT** Sacral Code	Perianal skin clean/ dry	Patient pain-free and comfortable	Patient re-positioned	Tube Position Correct	No Kinks or Blocks in System	Retention Cuff inflated *(weekly volume check)*	Irrigation *(50mls once daily or as required)*	Actions Taken/ Comments	Initials
02:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
04:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
06:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
08:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
10:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
12:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
14:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
16:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
18:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
20:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
22:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		
24:00	Y / N			Y / N		Y / N	Y / N	Y / N		Y / N Vol used:		

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Appendix 5

BMS Transfer Plan

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Patient's addressograph

Transferred from Ward, Site .....

Date of transfer .....

Date of first insertion	Reason for insertion
Quantity of fluid into balloon	..... ml **Note: never inflate more than 45ml**
Skin integrity in the sacral area *e.g. intact, reddened etc.*	
Black indicator line position (visible directly outside of patient's anus)	☐ Yes ☐ No
Consistency of stool	☐ Solid ☐ Semi-solid ☐ Semi-liquid ☐ Liquid
Output colour of stool	Refer to patient's notes for outport volume. Bag should be changed as needed.
Device expelled during use	☐ Yes ☐ No If yes, how many times .....
Irrigation / Flush (times per day)	☐ 4 ☐ 3 ☐ 2 ☐ Irrigation ..... ml
Mobilization	☐ Yes ☐ No Per rectum medication (via irrigation port) ☐ Yes ☐ No

Notes

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Appendix 6

Troubleshooting

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Bowel Management System (BMS)

A Causes of Excessive leakage

(assuming patient has adequate tone, and the balloon is filled to the correct amount for each patient e.g. 45mls or less)

1 Black Line on tubing is not visible outside anus

The line should be just visible outside the anus. If it is not visible, it is possible it has migrated further up the anal canal and the seal that the inflated balloon has made on the floor of the rectum may be dislodged. This can increase the chance of leakage. This can be remedied by ***very gently*** pulling the catheter down to re-seat the balloon and re-make the seal.

**Check positioning minimum 2 hourly.*

2 Is the catheter occluded?

The clear flow of the catheter could be impeded by the patient lying across the catheter and blocking it, or by the catheter being folded or twisted and blocking it. Check the catheter and ensure no kinks or twists are in the tubing and the bag is hung securely, not laying on the floor and draining downwards.

3 Check the position of the patient and tubing

The patients needs to be positioned appropriately to facilitate a clear path. The tubing and drainage bag should be placed on the opposite side of the bed to which the patient is laying. If this is not possible, then a pillow may be placed between the patients' knees to provide a clear path for the tubing. Make sure the valves are well away from the patient's skin.

4 Is the catheter blocked on the inside?

As the patients' stool returns to a more normal consistency the catheter could be blocked by solid stool matter. Try irrigating the tube using the irrigation port (blue) to introduce fluid into rectum to help soften stool and release blockage. Alternatively, milk any semi solid stool down the tube to release blockage. Always check you are using the correct port.

(NB: if you suspect the patients' stools may be returning to a more normal consistency it may be time to remove the BMS).

Empty the balloon and withdraw the catheter to ensure that it is not twisted. Wash the BMS kit and re-insert as per protocol.

5 The catheter balloon has not made a good seal on the floor of the rectum

Everyone has slightly different size and shape anatomy. Some patients may need less than the recommended maximum of 45mls of water in the balloon for it to sit correctly on the rectal floor. Firstly, withdraw all the water from the balloon and then re-inflate only until the little white bubble indicator 'pops' out. If this hasn't worked, then try reducing the amount of water in the balloon by 2 – 5ml.

B Experiencing odour

1 Large amounts of stool in the tubing

Flush the catheter with water via the Flush/Sample port (blue). This will wash away faecal residue remaining in the catheter and help reduce odour from the tube.

2 The drainage bag is full (ideally empty when ¾ full due to traction)

Change the bag immediately. Ensure the collection bag is positioned correctly below the height of the patient at the foot of the bed and not lying on the bed.

C The patient reports discomfort

1 Check volume of water in the balloon

This is to ensure that it has not been inadvertently over-filled. Under no circumstances should more than 45ml of water be used. Withdraw water via the 'white' inflation port until completely empty, remove, wash and re-insert until the bubble on valve pops up.

2 The catheter has become twisted within the anal canal

Withdraw water via the 'white' inflation port until completely empty, remove and observe for any abnormalities, then clean, and re-insert to the correct fill.

(NB: if a patient is reporting ongoing discomfort, it may be that the BMS could be causing tissue damage inside the rectum. If this is suspected remove the device and don't reinsert until reviewed by the medical team.)

D Difficulty withdrawing water from the balloon

1 Ensure that the syringe is screwed tightly onto the white Luer-lock connector

This releases the internal valve. Pull slow and steadily on the syringe removing the water (not harshly).

**Check that the catheter and valve is not twisted between the white connector and the patient's anus.*

Please ensure the correct ports on the catheter are used

***Blue port** for irrigation of the tubing and bowel

***White port** for inserting and aspirating water to inflate and deflate the balloon.

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IF IN ANY DOUBT, CONSULT A SENIOR MEMBER OF STAFF
Also refer to the manufacturers box instructions for full details of indications/contra-indications and guidelines for use

Troubleshooting

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Expelled Bowel Management Systems

Expelled Inflated BMS

- Medical Team to do DRE/PR to check no rectal trauma, patient not constipated.
- If BMS clinically indicated, and patient not confused (and pulled BMS out), staff trained and competent, to re-insert BMS.
- If patient confused and pulled out BMS, rectal trauma present, or formed stool in rectum, do not re-insert BMS.
- Datix if needed.

Expelled Deflated BMS

- Medical Team to do DRE/PR to check no rectal trauma.
- Was BMS over-inflated using water via irrigation port and burst? If yes, Datix.
- Check the expelled BMS for damage, by re-inflating balloon with 45mls water using white inflation port. Assess for balloon leakage. If yes, datix and send to manufacturer, if manufacturing fault.
- If BMS clinically indicated, staff trained and competent, to re-insert new BMS.

If the BMS expels for more than three episodes, discontinue using.

Do not re-use BMS

Refer to Continence Team via ICE for further support with BMS if required

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IF IN ANY DOUBT, CONSULT A SENIOR MEMBER OF STAFF
Also refer to the manufacturers box instructions for full details of indications/contra-indications and guidelines for use

Appendix 7

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CRITERIA FOR COMPETENCE

END COMPETENCE: Insertion and removal of a bowel management system (BMS) and ongoing patient care

Date(s) of Education and assessed practice: ……..

Name of Registered Nurse (print): ……..

Name of Assessor (print): …….. Designation: ……

The elements of competence related to ongoing care must be completed by all registered nurses providing care to patients with a BMS in situ. The elements of competence related to insertion and removal may be completed at a later date.

Element of Competence To Be Achieved - Knowledge	Date Achieved	Registered Nurse	Assessor Sign
Discuss and identify • indications • contraindications • limitations • further considerations For insertion of a BMS			
Demonstrate knowledge of relevant anatomy			
Demonstrate knowledge and understanding of why it is essential to follow the manufacturer's instructions for the specific device			
Demonstrate a working knowledge of the Trust's policy for consent to examination or treatment			
Demonstrate a working knowledge of the *Mental Capacity Act*			
Demonstrate accurate provision of information pre and post the procedure in a way that the patient understands			
Demonstrate maintenance of the patient's privacy and dignity throughout the procedure			

Knowledge	Date Achieved	Registered Nurse	Assessor Sign
Demonstrate safe infection control practices throughout the procedure. To include: • Standard precautions • Isolation procedures			
Demonstrate accurate record keeping			
Discuss any health and safety issues in relation to this procedure			
Demonstrate an understanding of the incident reporting process			
Demonstrate a working knowledge of the NMC Code: Standards of conduct, performance and ethics for nurses and midwives (2008)			
Ongoing Care of a BMS	***Date Achieved***	***Registered Nurse***	***Assessor Sign***
Demonstrate maintenance of the BMS to include:			
• Checking the position of the black line (dependent on the type of system used)			
• Knowledge and understanding of the importance of changing the tube's position			
• Knowledge and understanding of when to change the collection bag			
• Procedure for changing the collection bag			
• Recording faecal output, to include stool amount, type and significance of change to the stool type			
• Observing the device for obstruction			
• Irrigating the device			
• Maintaining skin hygiene around anal area			
• Observing and maintaining skin integrity			
• Knowledge and understanding of the barrier creams and skin wash creams available to help maintain skin integrity			
• Knowledge and understanding of maximum length of time that the patient can sit out of bed			
• *Obtaining stool samples*			

Element of Competence To Be Achieved	Date Achieved	Registered Nurse	Assessor Sign
Insertion of a BMS			
Demonstrate evidence of competence in accurate digital rectal examination to determine presence of faeces in the rectum			
Discuss and demonstrate the procedure for the insertion of a BMS to include:			
• Preparation of the patient			
• Positioning of the patient			
• Preparation of equipment			
• Insertion of the tube			
• Positioning of the balloon			
• Inflation of the balloon and what to do in the event of improper balloon inflation			
Discuss and identify potential adverse events during insertion and use of a BMS			
Removal of a BMS			
Demonstrate removal of the BMS to include: • Deflating the balloon • *Correct disposal of waste in accordance with Trust Waste Policy and associated procedural documents (current versions)*			

I declare that I have expanded my knowledge and skills and undertake to practice with accountability for my decisions and actions. I have read and understood the guidelines for the ***insertion of faecal management systems and on-going care***

Signature of Registered Nurse: …… Date:…….

I declare that I have supervised this registered nurse and found her/him to be competent as judged by the above criteria.

Signature of Assessor: …… Date: ……..

Appendix 8

NHS
University Hospitals of Leicester
NHS Trust

Adult Continence Service

Bowel Management System (BMS) Out of Hours Support Guide

Refer to Troubleshooting Guide for advice (BMS Policy, appendix 6)
If issue not resolved, or help with insertion/ removal needed

Contact your CMG

Glenfield Hospital (GH)		Leicester Royal Infirmary (LRI)		Leicester General Hospital (LGH)	
RRCV:	Ward 23, SECU, Ward 30 and Ward 27	**EM:**	ACB/AMU	**CHUGGS:**	Ward 28
		SM:	Ward 34		
		CHUGGS:	Ward 22		
		ITAPS:	ITU		
		MSS:	Kinmonth Unit		

Wards requesting BMS support may be asked to swap a Registered Nurse with the ward providing out of hours provision, to provide cover during this time.

For in-hours BMS support contact:
Continence Team, ext 15384 or refer via ICE to Medical Continence Team.

This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	Sarah Coombes	**Job Title:** Continence Nurse Specialist
Reviewed by:	Sarah Coombes	
Approved by:	Elinor Howcroft	**Date Approved:** 11/2/2025

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
09/10/2023	2	Sarah Coombes	Addition of appendix 3 (pre insertion checklist), appendix 4 (maintenance checklist) and appendix 5 (troubleshooting guide). Section 4 (education and training) and section 5 (monitoring and audit) updated.
11/12/2023	3	Sarah Coombes	Addition of appendix 6 (BMS competency).
30/9/2024	4	Sarah Coombes	Appendix 1 Management of BMS updated Appendix 4 Maintenance Care Plan updated. Appendix 5 Transfer Form added Appendix 7 Criteria for Competency renamed from Appendix 6 Appendix 8 added: Out of Hours/In-hours Support added Section 2 Contra-indications updated. Section 4 Education and Training updated. Section 4 Troubleshooting and Out of Hours updated Section 5 Monitoring and Auditing updated
30/10/2024	5	Sarah Coombes	Section 3: Added Pre-insertion Checklist paragraph
12/2/2025	6	Sarah Coombes	Section 3 Patient Being Discharged added. Section 4: Training and Education updated.

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**