Bowel Management System Guideline

University Hospitals of Leicester NHS
NHS Trust

Trust Ref: 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 Registered Nursing staff only, 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).

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

http:// www.secco-fms.com

Bowel Management Systems should not be used:

- Single tubes for longer than 29 days. If a BMS is needed for longer than 29 days the tube must be changed.
- For patients with solid or semi-formed stools
- For patients who sit out in a chair for long periods of time.

NB If the Medical or Registered Nursing staff 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 grade 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 medical team, 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 has undertaken education and training can perform the insertion of a BMS

Insertion of a Bowel Management System (see 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. Complete the BMS maintenance checklist.

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 flexiseal 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
If the silicone catheter becomes obstructed with solid particles, it can be irrigated with tepid tap water. Only flush the device when needed to maintain the unobstructed flow of stool into the collection bag. 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.

4. Education and Training

If training is being considered as 'mandatory' this must be taken through the Training, Education and Development (TED) group before the policy is approved.

5. Monitoring and Audit Criteria

All guidelines should include key performance indicators or audit criteria for auditing compliance,

if this template is being used for associated documents (such as procedures or processes) that support a Policy then this section is not required as all audit and monitoring arrangements will be documented in section 8 of the Policy.

Key Performance Indicator	Method of Assessment	Frequency	Lead
None required			

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

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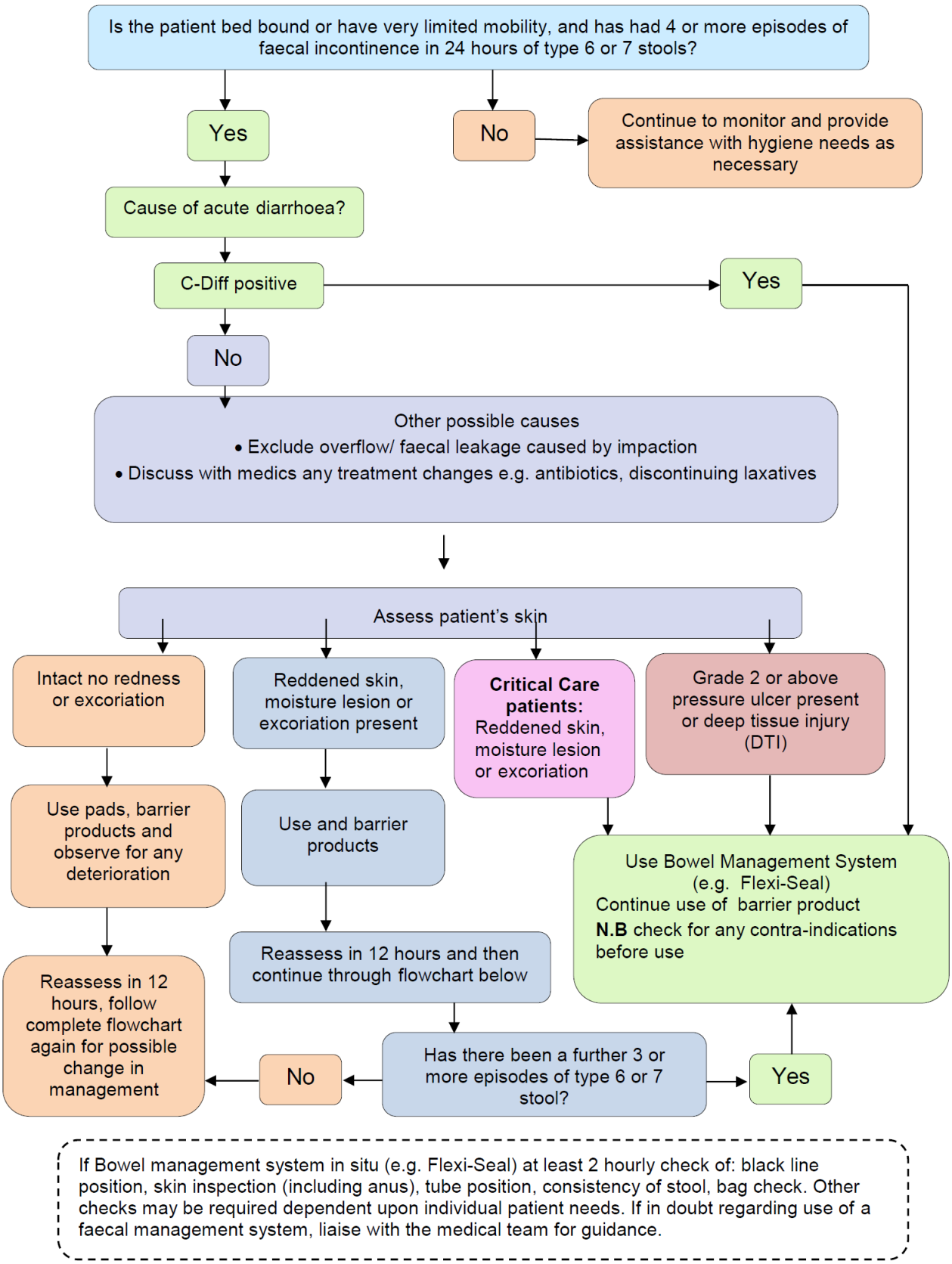
7. Key Words

"BMS" Bowel management system

Appendix 1

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.

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.

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

Equipment

- Dressing trolley (cleaned with soap and water followed by a Sani-Cloth 70% alcohol wipe and allowed to air dry).
- Bowell 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	• 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	To protect bedding from soiling and to maintain the patient's dignity. To ensure the patient is in the

	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	correct position for the procedure
No.	**Action**	**Rationale**
4. cont.	wash hands as per Trust policy and apply alcohol gel, Rub until dry	
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.	Insert the BMS in accordance with the manufacturer's instructions	More than one type of BMS is available

15.	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

No.	Action	Rationale
16.	Dispose of equipment in accordance with Trust policy and procedures for waste management	To reduce the risk of cross infection
17.	Remove gloves apron and decontaminate hands with soap and water. Apply alcohol gel and rub until dry	To reduce the risk of cross infection
18.	Put on clean apron and gloves and reposition the patient	To ensure patient comfort
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/ diarrhoea care pan/ skin assessment chart)	To ensure communication between the multidisciplinary team and a record of care given

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

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