Invasive Procedures Relating to Bowel Management

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Clinical Guidance for Bowel Care

Please Note: This Guidance is Only Relevant to Nurses Working with Adults. It Does Not Refer to Children

Summary of the purpose of the clinical guideline: The principles of hand-washing and disposable of waste (Clinical & Private Home) relate to this Guidance.

In relation to the administration of enemas and suppositories, this guidance supports:-

- the practice of registered nurses.
- the practice of health care assistants/carers who have been assessed, by Registered Nurses, as being competent and confident. Delegation of this procedure should be on a named patient/named carer basis only and each carer should be re-assessed every 3 months.

Enemas and suppositories can only be given by a registered nurse. However these procedures can be delegated to a carer on a one to one named patient/named carer basis, as part of their bowel management programme. All carers must receive the appropriate training and have completed a minimum of 3 supervised practices and be deemed competent (see Appendices 2 and 3).

In relation to digital rectal examination and manual evacuation of faeces, this guidance supports:-

- the practice of registered nurses who have been assessed by specialist continence nurses as being competent and confident.

Associated Policies (available on nww.cwpct.nhs.uk)

- GR3010 Clinical Guidance for Hand washing policy
- GR3021 Clinical Guidance for Sharps disposal
- GR3012 Clinical Guidance for Medical Devices Single Use
- GR3003 Disposal of Waste (Clinical & Private Home)
- GR3031 Clinical Guidance for the Use of Alcohol Gel in Hand Decontamination
- CWPCT Control of Infection Manual
- CWPCT Infection Control and Minor Surgery Guidance for Good Practice -General Medical Practices
**Assessment** of needs will be completed by a registered nurse, in conjunction with a continence advisor if appropriate.

**Following Assessment** a continence management plan will be completed by a registered nurse.

**Patient Monitoring and Review** will be completed by a registered nurse on a 6 monthly basis.

However the registered nurse should be contacted to reassess if the following problems are noted:

- Changes in the bowel habit e.g. diarrhoea or constipation;
- Changes in colour of stools or presence of blood, haemorrhoids (piles);
- Or any other concerns.
Clinical Guidance

For Digital Rectal Examination And Manual Evacuation Of Faeces

Nurses carrying out the above procedure need to be sure they are acting according to best practice, and within the right ethical and legal framework.

The above procedure can be carried out by a registered nurse who can demonstrate professional competence to the level determined by the Code of Professional Conduct NMC document (2000). I.e. Must have attended digital/rectal course and performed three under supervision.

A Registered nurse who can demonstrate competence to this professional level can delegate these procedures to relatives/carers (only on a named carer/named patient basis) or patients, if appropriate, ensuring competence is assessed and reviewed on a 3 monthly basis by the registered nurse involved in their care. (See appendices one, two and three).

Nursing Assessment

It is the nurse’s responsibility to be aware of the medical diagnosis of the patient, any contra indications that may exist and be aware of when extra care is required. Attention is drawn to Royal College of Nursing Digital Rectal Examination and Manual Removal of Faeces Guidance for Nurses, May 2000 (copy enclosed).

Permission / Consent

After an assessment a doctor’s opinion is required to provide a diagnosis and to decide jointly on appropriate intervention including manual evacuation of faeces.

The consent of the patient must be obtained and documented as per trust guidelines prior to the commencement of the treatment following a full explanation of the procedure, potential complications and alternative treatments if appropriate.

For consent to be valid. Patients need to have the mental ability to do so, sufficient information and to give consent freely.
Digital Rectal Examination

Definition

Digital rectal examination is the insertion of gloved and lubricated index finger into the rectum to establish the following:

• To assess if faecal matter is present, its amount and consistency;
• The need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex;
• The need for and effects of rectal medication in certain circumstances;
• The need for manual removal of faeces and evaluating bowel emptiness;
• The outcome of rectal / colonic washout / irrigation if appropriate;
• Anal tone and the ability to initiate a voluntary contraction and to what degree;
• Anal / rectal sensation.

Special Precautions

You should exercise particular caution when performing these procedures with patients who have the following diseases and conditions:

• Active inflammation of the bowel including Crohns Disease, ulcerative colitis and diverticulitis;
• Recent radiotherapy to the pelvic area;
• Rectal/anal pain;
• Rectal surgery/trauma to the anal/rectal area;
• Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment;
• Obvious rectal bleeding;
• If patient has a known history of abuse;
• Patients with spinal injuries because of autonomic dysreflexia;
• If patient has a known history of allergies e.g. to latex, soap (lanolin), phosphate and peanut (present in arachas oil enema).
Digital Rectal Examination

Exclusions and Contraindications

Nurses should not undertake a Digital Rectal Examination or Manual Evacuation of Faeces when:

- There is a lack of consent from the patient – either written or verbal;
- The patient’s doctor has given specific instructions that these procedures are not to take place;
- The patient has recently undergone rectal/anal surgery or trauma;
- The patient gains sexual satisfaction from these procedures and the nurse performing them finds this embarrassing. In this case, consultation with a doctor is advised, involving the patient in that consultation. You might consider whether there is a need for a chaperone in some circumstances.

Equipment

- Nursing Procedure Sheet
- Non-sterile disposable gloves
- Lubricating gel
**Digital Rectal Examination**

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient including risks and benefits. Document in patient’s records that they have agreed to procedure.</td>
<td>1. To gain co-operation and informed consent. Consent must be recorded in patient’s record prior to carrying out the procedure. <strong>For consent to be valid. Patients need to have the mental ability to do so, sufficient information and to give consent freely.</strong></td>
</tr>
<tr>
<td>2. Ensure privacy.</td>
<td>2. To maintain patient’s privacy and dignity.</td>
</tr>
<tr>
<td>3. Where possible assist the patient to lie in the required position i.e. on the left side with knees well flexed, the upper thigh higher than the lower one and the buttocks near the edge of the bed.</td>
<td>3. This allows ease of passage into the rectum.</td>
</tr>
<tr>
<td>4. Place a disposable nursing procedure sheet below the patient's hips and buttocks.</td>
<td>4. To reduce potential infection caused by soiled linen.</td>
</tr>
<tr>
<td>5. Wash hands, put on apron and non-sterile gloves.</td>
<td>5. To reduce cross infection.</td>
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</tr>
<tr>
<td><strong>6.</strong></td>
<td><strong>6.</strong> If any abnormalities of perineal or perianal area are observed, document and report before carrying out procedure.</td>
</tr>
<tr>
<td>Observe the perineal and perianal area for:</td>
<td></td>
</tr>
<tr>
<td>• Rectal prolapse;</td>
<td></td>
</tr>
<tr>
<td>• Haemorrhoids;</td>
<td></td>
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<tr>
<td>• Anal skin tags;</td>
<td></td>
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<tr>
<td>• Wounds;</td>
<td></td>
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<tr>
<td>• Anal Lesions;</td>
<td></td>
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<tr>
<td>• Gaping Anus;</td>
<td></td>
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<tr>
<td>• Skin Conditions;</td>
<td></td>
</tr>
<tr>
<td>• Bleeding;</td>
<td></td>
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<tr>
<td>• Faecal matter;</td>
<td></td>
</tr>
<tr>
<td>• Infestation;</td>
<td></td>
</tr>
<tr>
<td>• Foreign Bodies.</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td><strong>7.</strong> Lubricating reduces surface friction, eases insertion, and avoids anal mucosa damage.</td>
</tr>
<tr>
<td>Lubricate the gloved index finger</td>
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</tbody>
</table>
# Digital Rectal Examination

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
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</thead>
</table>
| 8. Separate the patient’s buttocks and insert lubricated finger. | 8. To determine the following:  
- Faecal matter in rectum, type and consistency;  
- Anal tone;  
- Anal rectal sensation;  
- Need for rectal medication;  
- Need for manual removal of faeces;  
- The outcome of rectal/colonic washout/irrigation;  
- The need and outcome of using digital stimulation. |
| 9. Remove finger, wipe residual lubricating gel from the anal area. | 9. To ensure prevention of irritation and soreness. |
| 10. Remove and dispose of gloves and apron and wash hands. | 10. To avoid cross infection. |
| 11. Return patient to comfortable position and ensure toileting facilities are available if needed. | 11. To ensure patients comfort and dignity. |
| 12. Record results of Digital Rectal Examination in patient’s record. | 12. To enable implementation of effective treatment programme and to comply with Trust Record Keeping Policy. |
Manual Evacuation

It should only be performed by a nurse who has been properly trained in the procedure (Norton 1996a)

Manual Evacuation of faeces should only be performed if all other methods of relieving constipation have failed.

Definition

The manual removal of faeces from the rectum. This can be performed for an acute or regular intervention.

Acute Intervention – Observations and Complications

While undertaking a manual evacuation of faeces as an acute intervention, you should be careful to observe:

- Pulse at rest prior to the procedure;
- Pulse during the procedure;
- Blood pressure in spinal injuries prior to, during and at the end of the procedure. A baseline blood pressure is advised for comparison;
- Signs and symptoms of autonomic dysreflexia – headache, flushing, sweating, hypertension;
- Distress, pain, discomfort;
- Bleeding;
- Collapse;
- Stool consistency.
Manual Evacuation

Regular Intervention – Observations and Complications

These include:
- Distress, pain, discomfort;
- Bleeding;
- Signs and symptoms of autonomic dysreflexia – headache, flushing, sweating, hypertension;
- Collapse;
- Stool consistency.

Equipment

- Plastic Apron
- Non sterile gloves
- Lubricating gel
- Disposable Nursing Procedure Sheet
- Swabs or tissues
## Manual Evacuation

<table>
<thead>
<tr>
<th>Action</th>
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</tr>
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<tbody>
<tr>
<td>1. Explain procedure to the patient, including risks and benefits.</td>
<td>1. To gain co-operation and informed consent. Consent must be recorded in patient’s record prior to carrying out procedure.</td>
</tr>
<tr>
<td>Document in patient’s record that they have agreed to procedure.</td>
<td>For consent to be valid. Patients need to have the mental ability to do so, sufficient information and to give consent freely.</td>
</tr>
<tr>
<td>2. Ensure privacy</td>
<td>2. To maintain patients privacy and dignity.</td>
</tr>
<tr>
<td>3. Where possible assist the patient to lie in the required position,</td>
<td>3. This allows ease of passage into the rectum.</td>
</tr>
<tr>
<td>i.e., on the left side with knees well flexed, the upper higher than</td>
<td></td>
</tr>
<tr>
<td>the lower one and the buttocks near the edge of the bed.</td>
<td></td>
</tr>
<tr>
<td>4. Place a disposable nursing procedure sheet below the patient’s hips</td>
<td>4. To reduce potential infection caused by soiled linen.</td>
</tr>
<tr>
<td>and buttocks.</td>
<td></td>
</tr>
</tbody>
</table>
5. Wash hands, put on apron and non-sterile gloves.  

5. To reduce cross infection.

6. Observe the perineal and perianal area for:
   - Rectal prolapse;
   - Haemorrhoids;
   - Anal skin tags;
   - Wounds;
   - Anal Lesions;
   - Gaping Anus;
   - Skin Conditions;
   - Bleeding;
   - Faecal matter;
   - Infestation;
   - Foreign Bodies.

6. If any abnormalities of perineal or perianal area are observed, document and report before carrying out procedure.

7. Lubricate the gloved index finger.

7. Lubricating reduces surface friction, eases insertion, and avoids anal mucosa damage.
## Manual Evacuation

<table>
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<td>8. Separate the patient’s buttocks and insert lubricated finger.</td>
<td>8. To determine the following:</td>
</tr>
<tr>
<td></td>
<td>• Faecal matter in rectum, type and consistency;</td>
</tr>
<tr>
<td></td>
<td>• Anal tone;</td>
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<td></td>
<td>• Anal rectal sensation;</td>
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<td></td>
<td>• Need for rectal medication;</td>
</tr>
<tr>
<td></td>
<td>• Need for manual removal of faeces;</td>
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<tr>
<td></td>
<td>• The outcome of rectal/colonic washout/irrigation;</td>
</tr>
<tr>
<td></td>
<td>• The need and outcome of using digital stimulation.</td>
</tr>
<tr>
<td>9. Break up the impacted stool in the rectum if a solid mass.</td>
<td>9. Enables ease of removal.</td>
</tr>
<tr>
<td>10. Slowly and gently continue to remove faecal matter.</td>
<td>10. To empty rectum.</td>
</tr>
<tr>
<td>11. Observe patient throughout the procedure for any of above mentioned complications. Should they occur, stop procedure immediately and inform a doctor.</td>
<td>11. To prevent any further adverse reaction.</td>
</tr>
<tr>
<td>12. Once the procedure is complete, clean any excess lubricating jelly from the patient’s perineal area.</td>
<td>12. To ensure the patient’s comfort and avoid anal excoriation that may lead to infection.</td>
</tr>
<tr>
<td>13. Record in appropriate documents that the procedure has been carried out, its effects on the patient and to include its results, colour consistency, content and amount of faeces removed i.e., as per Bristol Stool Chart.</td>
<td>13. To monitor the patient’s bowel function. To adhere to Trust Record Keeping Policy.</td>
</tr>
</tbody>
</table>
Administration Of Enemas

Definition

An enema is the introduction into the rectum or lower colon of a stream of fluid for the purpose of producing a bowel action or instilling medication.

Indications

Enemas may be prescribed for the following reasons:

• To clean the lower bowel before surgery, x-ray examination of the bowel using contrast medium, before endoscopy examination or in cases of severe constipation;
• To introduce medication into the system;
• To soothe and treat irritated bowel mucosa;
• To decrease body temperature (due to contact with the proximal vascular system);
• To stop local haemorrhage;
• To reduce hyperkalaemia (calcium resonium);
• To reduce portal systemic encephalopathy (phosphate enema).

Contraindications

1. In paralytic ileus.
2. In colonic obstruction.
3. Where the administration of tap water or soap and water enemas may cause circulatory overload, water intoxication, mucosal damage and necrosis, hyperkalemia and cardiac arrhythmias.
4. Where the administration of large amounts of fluid high into the colon may cause perforation and haemorrhage.
5. Following gastrointestinal or gynaecological surgery where suture lines may be ruptured (unless medical consent has been given).
6. The use of micro-enemas and hypertonic saline enemas in patients with inflammatory or ulcerative conditions of the large colon.
Administration Of Enemas

Equipment

- Nursing Procedure Sheet
- Disposable non sterile gloves
- Lubricating jelly
- Swabs or tissues
- Enema as required
**Administration Of Enemas**

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
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</thead>
<tbody>
<tr>
<td>1. Check the prescription is correct and appropriate for the patient.</td>
<td>1. To prevent adverse reaction.</td>
</tr>
<tr>
<td>2. Explain and discuss the procedure with the patient and obtain patient’s consent.</td>
<td>2. To ensure that the patient understands the procedure and gives his/her valid consent. For consent to be valid the patient needs the mental ability to do so, have sufficient information and give consent freely.</td>
</tr>
<tr>
<td>3. Ensure privacy.</td>
<td>3. To maintain patient’s privacy and dignity.</td>
</tr>
<tr>
<td>4. Allow patient to empty bladder first if necessary.</td>
<td>4. A full bladder may cause discomfort during the procedure.</td>
</tr>
<tr>
<td>5. Ensure that bedpan, commode or toilet is readily available.</td>
<td>5. In case patient feels the need to expel the enema before the procedure is completed.</td>
</tr>
<tr>
<td>6. Warm the enema to the required temperature, as per manufacturers instructions.</td>
<td>6. Heat is an effective stimulant of the nerve plexi in the intestinal mucosa. An enema temperature the same as body temperature, or just above, will not damage the intestinal mucosa.</td>
</tr>
<tr>
<td>7. Where possible assist the patient to lie in the required position i.e. on the left side, with knees well flexed, the upper thigh higher than the lower one and with the buttocks near the edge of the bed.</td>
<td>7. This allows ease of passage into the rectum by following the natural anatomy of the colon. In this position gravity will aid the flow of the solution into the colon. Flexing the knees ensures a more comfortable passage of the enema nozzle or rectal tube. Be sure that throughout the procedure the patient is made aware of what is being done, as they are facing away from you.</td>
</tr>
</tbody>
</table>
## Administration Of Enemas

<table>
<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>8. Place a disposable nursing procedure sheet beneath the patient’s hips and buttocks.</td>
<td>8. To reduce potential infection by soiled linen. To avoid embarrassing the patient, if the fluid is ejected prematurely following administration.</td>
</tr>
<tr>
<td>9. Wash hands and put on apron and non sterile gloves.</td>
<td>9. To reduce cross infection.</td>
</tr>
<tr>
<td>10. Be sure the end of the enema tube is well lubricated.</td>
<td>10. To prevent trauma to the anal and rectal mucosa by reducing surface friction.</td>
</tr>
<tr>
<td>11. Expel excessive air and introduce the nozzle or tube slowly into the anal canal while separating the buttocks. (A small amount of air may be introduced if bowel evacuation is desired).</td>
<td>11. The introduction of air into the colon causes distension of its walls, resulting in unnecessary discomfort to the patient and it increases peristalsis. The slow introduction of the lubricated tube will minimise spasm of the intestinal wall. (Evacuation will be more effectively induced due to increased peristalsis).</td>
</tr>
<tr>
<td>12. Slowly introduce the tube or nozzle to a depth of 10 – 12.5 cm (4 – 5 inches).</td>
<td>12. This will bypass the anal canal (2.5 – 4 cm) in length and ensure that the tube or nozzle is in the rectum.</td>
</tr>
<tr>
<td>13. If retention enema is used, introduce the fluid slowly and leave the patient in bed with the foot of the bed elevated by 45° for as long as prescribed.</td>
<td>13. To avoid increasing peristalsis, the slower the rate at which the fluid is introduced the less pressure is exerted on the intestinal wall. Elevating the floor of the bed aids in retention of the enema by force of gravity.</td>
</tr>
<tr>
<td>14. If an evacuant enema is used, introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is completely finished.</td>
<td>14. The faster the rate of flow of the fluid the greater the pressure on the rectal walls. Distension and irritation of the bowel wall will provide strong peristalsis, which is sufficient to empty the lower bowel.</td>
</tr>
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### Administration Of Enemas

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<tr>
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<th>Rationale</th>
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</thead>
<tbody>
<tr>
<td>15. If using a funnel and rectal tube, adjust the height of the funnel according to the rate of flow desired.</td>
<td>15. The forces of gravity will cause the solution to flow from the funnel into the rectum. The greater elevation of the funnel the faster the flow of fluid.</td>
</tr>
<tr>
<td>16. Clamp the tubing before all the fluid has run in.</td>
<td>16. To avoid air entering the rectum and causing further discomfort.</td>
</tr>
<tr>
<td>17. Slowly withdraw the tube or nozzle.</td>
<td>17. To avoid reflex emptying of the rectum.</td>
</tr>
<tr>
<td>18. Dry the patient’s perineal area with a gauze swab.</td>
<td>18. To promote patient comfort and avoid excoriation and infection.</td>
</tr>
<tr>
<td>19. Ask the patient to retain the enema for 10 – 15 minutes before evacuating the bowel.</td>
<td>19. To enhance the evacuant effect.</td>
</tr>
<tr>
<td>20. Ensure that the patient has access to the nurse call system, is near to the bedpan, commode or toilet and has adequate toilet paper.</td>
<td>20. To enhance patient’s comfort and safety. To minimise the patient’s embarrassment.</td>
</tr>
<tr>
<td>21. Remove and dispose of equipment.</td>
<td>21. To avoid infection.</td>
</tr>
<tr>
<td>22. Wash and dry hands.</td>
<td>22. To reduce the risk of cross infection.</td>
</tr>
<tr>
<td>23. Following enema observe for any complications such as pain, bleeding, shock or fainting.</td>
<td>23. To ensure patient’s safety and comfort at all times.</td>
</tr>
</tbody>
</table>
### Administration Of Enemas

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Record in the appropriate documents that the enema has been given, its effects on the patient, including its results, colour, consistency, content and amount of faeces produced i.e. as per Bristol Stool Chart.</td>
<td>24. To monitor the patient's bowel function. To adhere to Trust Record Keeping Policy.</td>
</tr>
</tbody>
</table>
Administration Of Suppositories

Definition

A suppository is a solid or semi-solid pellet introduced into the anal canal for medicinal purposes. This procedure can be delegated to a nursing auxiliary providing they have received training from a member of the continence team and have been assessed as competent in practice by a Registered Nurse (a named patient, named carer basis only). The procedure must be part of a planned programme of care that has been assessed, monitored and reviewed by a Registered Nurse.

Indications

- To empty the bowel before certain types of surgery
- To empty the bowel to relieve acute constipation or when other treatments for constipation have failed
- To empty the bowel before endoscopic examination
- To introduce medication into the system
- To soothe and treat haemorrhoids or anal pruritus.

Contraindications

The use of suppositories is contra-indicated when one or more of the following pertain:

- Chronic constipation which would require repetitive use;
- Paralytic ileus;
- Colonic obstruction;
- Following gastrointestinal or gynaecological surgery where suture lines may be ruptured (unless medical consent has been given).
Administration Of Suppositories

Equipment

- Nursing Procedure Sheet
- Disposable non sterile gloves
- Lubricating jelly
- Swabs or tissues
- Suppository (ies) as required (check prescription before administering a medicinal suppository, e.g. aminophylline)
## Administration Of Suppositories

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient. If administering a medicated suppository, it is best to do so after the patient has emptied his/her bowels.</td>
<td>1. To ensure that the patient understands the procedure and gives his/her valid consent. To ensure that the active ingredients are not impeded from being absorbed by the rectal mucosa or that the suppository is not expelled before its active ingredients have been released. <strong>For consent to be valid. Patients need to have the mental ability to do so, sufficient information and to give consent freely.</strong></td>
</tr>
<tr>
<td>2. Ensure privacy.</td>
<td>2. To avoid unnecessary embarrassment to the patient.</td>
</tr>
<tr>
<td>3. Ensure the patient has easy access to toilet, commode, and bedpan.</td>
<td>3. In case of premature ejection of the suppositories or rapid bowel evacuation following their administration.</td>
</tr>
<tr>
<td>4. Where possible assist the patient to lie in the required position i.e. left side with the knees flexed, the upper higher than the lower one, with buttocks near the edge of the bed.</td>
<td>4. This allows ease of passage of the suppositories into the rectum by following the natural anatomy of the colon. Flexing the knees will reduce discomfort as the suppository is passed through the anal sphincter.</td>
</tr>
<tr>
<td>5. Place a disposable nursing procedure sheet beneath the patient's hips and buttocks.</td>
<td>5. To avoid unnecessary soiling of linen and reduce infection. To avoid embarrassing the patient if the suppositories are ejected prematurely or if there is rapid bowel evacuation following their administration.</td>
</tr>
<tr>
<td>6. Wash and dry hands, and put on non-sterile gloves.</td>
<td>6. To reduce cross infection.</td>
</tr>
</tbody>
</table>
## Administration Of Suppositories

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Lubricate the blunt end of the suppositories with the appropriate gel, if it is being used to obtain systemic action.</td>
<td>7. Lubricating reduces surface friction, eases insertion of the suppository and avoids anal mucosal trauma. Research has shown that the suppository is more readily retained if inserted blunt end first. (Abo El-Maeboud et al, 1991).</td>
</tr>
<tr>
<td>8. Separate the patient’s buttocks and insert the suppositories blunt end first advancing it for about 2 – 4 cm. Repeat this procedure if a second suppository is to be inserted.</td>
<td>8. The anal canal is approximately 2 – 4 cm long. Inserting the suppository beyond this ensures that it will be retained.</td>
</tr>
<tr>
<td>9. Once suppository has been inserted clean any excess lubricating jelly from the patient’s perineal area.</td>
<td>9. To ensure the patients comfort and avoid anal excoriation that may lead to infection.</td>
</tr>
<tr>
<td>10. Ask the patient to retain the suppository if it is of an evacuant type. If it is medicated ask the patient to retain the suppository for 20 minutes or until he/she is no longer able to do so.</td>
<td>10. This will allow suppositories to melt and release active ingredients.</td>
</tr>
<tr>
<td>11. Remove and dispose of equipment. Wash and dry hands.</td>
<td>11. To reduce risk of infection.</td>
</tr>
<tr>
<td>12. Record in the patient’s care plan that the suppository has been given, the effect on the patient and the result amount, colour, consistency and content of faeces as per Bristol Stool Chart.</td>
<td>12. To monitor the patient’s bowel function. To adhere to Trust Record Keeping Policy.</td>
</tr>
</tbody>
</table>
References:

Department Of Health – Consent Policy
Mallett, J., Dougherty L., Manual Of Clinical Nursing Procedures (Fifth Edition), The Royal Marsden Hospital
Norton (1996a), Nursing For Continence (Second Edition), Beaconsfield Publication
Trust Consent Policy
United Kingdom Central Council For Nursing, Midwifery & Health Visiting (1992), Scope Of Professional Practice, London: UKCC
United Kingdom Central Council For Nursing, Midwifery & Health Visiting (1996), Guidelines For Professional Practice, London: UKCC
Appendix One

**Education Standard: Administration of Enemas and/or Suppositories**

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| • To attend a two-hour training session on the administration of enemas and or suppositories.  
• One-to-one supervision by a Registered Nurse until three procedures are performed competently. | • To give carers the underpinning knowledge to administer enemas and or suppositories.  
• To safely administer enemas and or suppositories and monitor the outcome and evaluate their effectiveness. |
Appendix Two

ON COMPLETION OF THIS COMPETENCY BOOKLET, PLEASE RETURN TO:

CONTINENCE ADVISORY SERVICE
MOSTON LODGE
COUNTESS OF CHESTER HEALTH PARK
LIVERPOOL ROAD
CHESTER
CH2 1UL

A CERTIFICATE WILL THEN BE FORWARDED TO YOU.

CONTINENCE ADVISORY SERVICE

ADMINISTRATION OF AN ENEMA
COMPETENCY BOOKLET FOR CARERS.
(On a one to one named patient named carer basis only)

HOW TO USE THIS BOOKLET
You will need to:

• Have attended a theoretical study session on the administration of enemas.
• Undertake a minimum of 3 supervised practices by a registered nurse, and be deemed competent in all areas.

Once you have been assessed as competent you can undertake the giving of enemas in accordance with Cheshire West clinical guidance on invasive procedures relating to bowel management.

To maintain your competency you will be required to be assessed on a 3 monthly basis by a registered nurse.
The carer should be able to demonstrate competency in the following elements:

- Procedure carried out as per Cheshire West PCT guidance on invasive procedures relating to bowel management (GR4021)
- Explain procedure to the patient and gain consent. Please document consent as per Cheshire West PCT Record Keeping Policy.
- Prepare equipment/area for administration of the enema as per Cheshire West PCT guidelines (GR4021)
- Check enema expiry date as per patient prescription.
- Administer enema as per Cheshire West PCT guidelines (GR4021)
- Dispose of clinical waste appropriately. Refer to Cheshire West PCT Disposable Clinical Waste Policy (GR3003)
- Record results of the enema in the patient’s care plan as per Cheshire West PCT Record Keeping Policy.
- Give advice and support to patient/carer as required.

Each carer must be assessed on administration of 3 enemas, or until they feel confident and competent to carry out the procedure.
Appendix Three

ON COMPLETION OF THIS COMPETENCY BOOKLET, PLEASE RETURN TO:

CONTINENCE ADVISORY SERVICE
MOSTON LODGE
COUNTESS OF CHESTER HEALTH PARK
LIVERPOOL ROAD
CHESTER
CH2 1UL

A CERTIFICATE WILL THEN BE FORWARDED TO YOU.

CONTINENCE ADVISORY SERVICE
ADMINISTRATION OF SUPPOSITORIES
COMPETENCY BOOKLET FOR CARERS.
(on a one to one named patient named carer basis only).

HOW TO USE THIS BOOKLET
You will need to:

- Have attended a theoretical study session on the administration of suppositories.
- Undertake a minimum of 3 supervised practices by a registered nurse, and be deemed competent in all areas.

Once you have been assessed as competent you can undertake the administration of suppositories in accordance with Cheshire West clinical guidance on invasive procedures relating to bowel management.

To maintain your competency you will be required to be assessed on a 3-monthly basis by a registered nurse.
The carer should be able to demonstrate competency in the following elements:

- Procedure carried out as per Cheshire West PCT guidance on invasive procedures relating to bowel management (GR4021)

- Explain procedure to the patient and gain consent. Please document consent as per Cheshire West PCT Record Keeping Policy.

- Prepare equipment/area for administration of the suppositories as per Cheshire West PCT guidelines (GR4021)

- Check suppository expiry date as per patient prescription.

- Administer suppositories as per Cheshire West PCT guidelines (GR4021)

- Dispose of clinical waste appropriately. Refer to Cheshire West PCT Disposable Clinical Waste Policy (GR3003)

- Record results of the suppositories in the patient’s care plan as per Cheshire West PCT Record Keeping Policy

- Give advice and support to patient/carer as required.

Each carer must be assessed on administration of suppositories on 3 separate occasions, or until they feel confident and competent to carry out the procedure.

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**Suppository administration: Supervised Practice**

Date:  
Signature of Supervisor:  
Date:  
Signature of Supervisor:  
Date:  
Signature of Supervisor:  
Date:  
Signature of Supervisor:  

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Invasive Procedures Relating to Bowel Management  
Pat O’Brien, Clinical Nurse Specialists (Continence)  
Cheshire West & EP & N PCT : 01244 364007  

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