Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: West Locality
Code: CC44
Issue number: 2

Guideline for Administration of Suppositories and Enemas

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Type of document	Guidance
Target audience	All clinical staff
Document purpose	This policy is intended to serve as an evidence based guide for community Registered Nurses employed by Cheshire and Wirral Partnership, in how to administer suppositories and enema's. Please note this guideline is intended for adult patients only.

Approving meeting	Neighbourhood-Based Care Group Meeting	Date 11-Sep-19
Implementation date	11-Sept-19	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
IC2	Hand decontamination policy and procedure
HS1	Waste management policy
IC3	Standard (universal) infection control precautions policy
CP3	Health records policy
CC43	Clinical guidelines for administration of suppositories and enemas
MP16	Non-medical prescribing policy
MP1	Medicine policy
CP70	Administration of laxative rectal suppositories by named carer
GR26	Policy for the safe manual handling of people

Document change history	
What is different?	Incorporated NHS Patient Safety Alert (NHS/PSA/RE/2018/005). Resources to support safer bowel care for patients at risk of autonomic dysreflexia.
Appendices / electronic forms	N/A
What is the impact of change?	Provide clinical staff with clear guidance on the administration of suppositories and enemas

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	via discussion board
Corporate services	Consultant Nurse, Head of Infection Prevention and Control
External agencies	Patient Safety Clinical Lead (NHS Improvement)

Financial resource implications	None

External references
1. Bradshaw A, Price L. Rectal suppository insertion: the reliability of the evidence as a basis for nursing practice. Journal of Clinical Nursing 2006,16, 98-103. 2. Coggrave M, (2008) Neurogenic continence. Part 3: bowel management strategies, British Journal of Nursing, 17 (15), pp.962-968. 3. Crown copyright. (2005). The Mental Capacity Act 2005 Code of Practice. Retrieved April 05, 2019, from https://www.legislation.gov.uk/ukpga/2005/9/contents 4. Dougherty L, Lister S. The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Wiley-Blackwell. Eight Edition, 2011. 5. Higgins D. How to administer an enema. Nursing Times. 2006, 102(20), 24-25. 6. HSU HJ, Wu MS. Extreme hyperphosphatemia and hypocalcemic coma associated with phosphate enema. Internal Medicine 2008. 47:643-646. 7. Kyle G. Bowel care part 4. Administering an enema. Nursing Times. November 2007, 103 (45), 26-27. 8. Kyle G. Why are nurses failing to undertake digital rectal examinations? Nursing Times. 2010, Feb. 9. Moppett, S. (2000) Which way is up for a suppository? Nursing Times, 96 (19 Suppl), 12–13. 10. NHS Improvement. Patient Safety Alert. resources to support safer bowel care for patients at risk of autonomic dysreflexia. NHS/PSA/RE/2018/005. 2018, July 10. Retrieved April 05, 2019, from https://improvement.nhs.uk/documents/3074/Patient_Safety_Alert_-_safer_care_for_patients_at_risk_of_AD.pdf 11. Nursing and Midwifery Council (NMC). The Code - Standards of conduct, performance and ethics for nurses and midwives. 2015. 12. Nursing and Midwifery Council (NMC). (2015). The code. Professional standards of practice and behaviour for nurses and midwives. Retrieved April 05, 2019, from https://www.nmc.org.uk/standards/code/ 13. Nursing and Midwifery Council (NMC). Standards for Medicines Management. April 2010. 14. Royal College of Nursing (RCN). Management of lower bowel dysfunction, including DRE and DRF. RCN guidance for nurses. London, 2012.

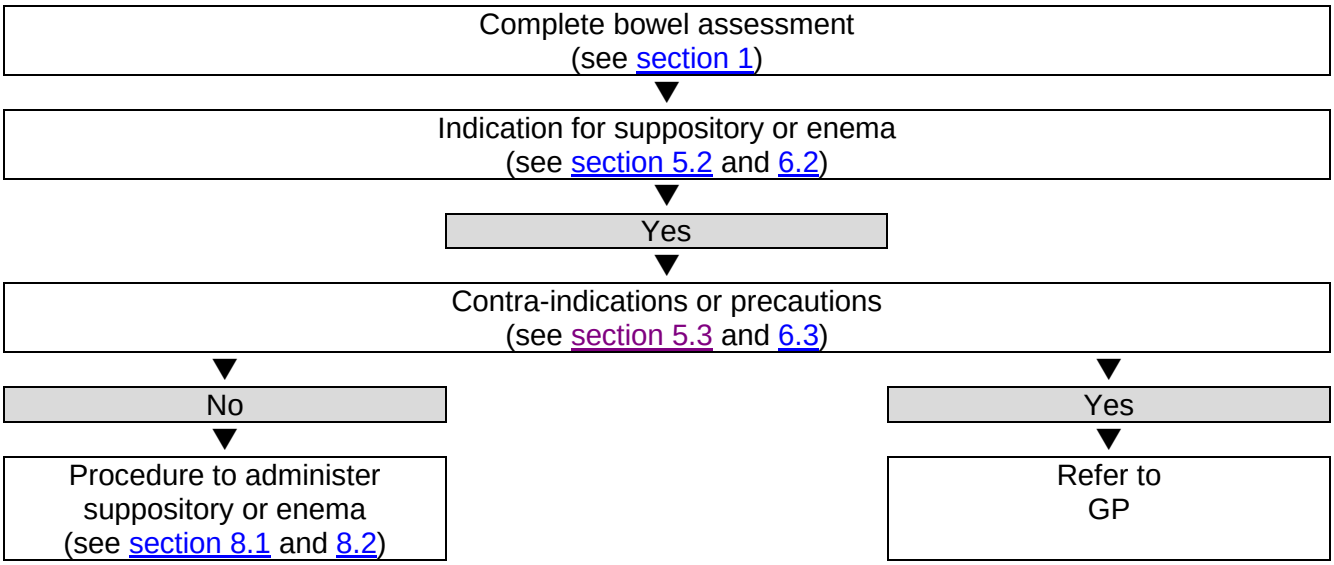
Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial		

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart

For quick reference the guide below is a summary of actions required.



1. Introduction

This guideline is intended to serve as an evidence based guide for Community Registered Nurses employed by Cheshire and Wirral Partnership, in how to administer suppositories and enemas. Please note this guideline is intended for adult patients only. This guideline needs to be read in conjunction with the digital rectal examination and/or digital removal of faeces guideline.

A full assessment of the individual's bowel dysfunction and implementation of less invasive interventions, i.e. oral laxatives, is required before the administration of suppositories or enemas is contemplated. For instance when lifestyle interventions or oral laxatives have not produced a bowel movement or when rapid relief from rectal loading is required, suppositories or an enema may be appropriate. For some patients suppositories or enemas may be given on a regular basis as part of their prescribed bowel management plan.

Valid, informed consent must be obtained from the patient and documented prior to administering suppositories or enemas. This consent can be withdrawn at any point throughout the procedure. If the patient is deemed not to have capacity to consent to this procedure, the Mental Capacity Act (2005) provides nurses with a statutory framework to empower and protect those patients who are unable to make their own decisions (Kyle, 2010).

This procedure must only be carried out by Registered Nurses who have received suitable training and have been assessed as competent to carry out the procedure (see section 3).

It is Registered Nurse's responsibility to review the clinical need for suppositories and/or enemas and to explore alternative options, i.e. oral medication, anal irrigation.

2. Definitions

To provide guidance for Registered Nurses in:

- The clinical decision to administer suppositories and/or enemas following the completing of a bowel assessment (see guideline for digital rectal examination and/or digital removal of faeces);
- Indications, contra-indications and precautions for the administration of suppositories and enemas;
- Procedure for the administration of suppositories and enemas;
- The delegation and supervision of administering suppositories and enemas to patients or carers.

3. Qualification and training

This guidance applies to all Community Registered Nurses, who are currently registered with the Nursing and Midwifery Council (NMC) and employed by Cheshire and Wirral Partnership.

The Registered Nurse should have attended a bowel management study session and should have completed a minimum of 2 supervised practices till they feel confident and competent in digital rectal examination and the administration of suppositories and enemas (see Appendix 1).

Following this it is the Registered Nurse's personal responsibility to identify when they require a bowel management study session.

The supervision of these practical procedures can only be undertaken by a Registered Nurse who:

- Is confident and experienced in carrying out digital rectal examinations and the administration of suppositories and enemas;
- Has up to date knowledge and skills to perform these procedures.

4. Delegation procedure to patient or carers

A Registered Nurse, who can demonstrate competence in digital rectal examination and the administration of suppositories and enemas, can delegate the procedure to administer suppositories or enemas to a patient/carer.

The Registered Nurse is accountable for the appropriateness of the delegation, for ensuring that the patient/carer is competent and confident to perform the administration of suppositories and/or enemas (see CP70) and has the knowledge and skills to report back any changes/incidents as necessary. The Registered Nurse also needs to provide supervision and support on a regular basis.

When the Registered Nurse is teaching a carer to carry out digital rectal examination and administration of suppositories and enemas, this should be on a named patient-named carer basis only (RCN, 2012). Prior to teaching the administration of suppositories or enemas, the Registered Nurse needs to check if the professional carer is covered for vicarious liability by his/her employer (see CP70 “Administration of laxative rectal suppositories by named carer”).

5. Suppositories

5.1. Types of suppositories

There are two main groups of suppositories available, retention and evacuant suppositories (Dougherty et al, 2011).

Retention *suppositories* are designed to deliver drug therapy, for example analgesia, antibiotic, non-steroidal anti-inflammatory drug (NSAID). The suppository must come into contact with the mucous membrane of the rectum if they are to be effective.

Evacuant *suppositories* are designed to stimulate bowel evacuation. Dependent on their active ingredients, they can act as a lubricant or a stimulant.

- Lubricant suppositories, for example glycerine, should be inserted directly into the faeces and allowed to dissolve. They have a mild irritant action on the rectum and also act as faecal softeners;
- Stimulant suppositories, for example bisacodyl, must come into contact with the mucous membrane of the rectum if they are to be effective as they release carbon dioxide, causing rectal distension and thus evacuation.

5.2. Indications to administer suppositories

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

5.3. Contra-indications to administer suppositories

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

- Paralytic ileus;
- Colonic obstruction;

- Malignancy of the perianal region;
- Following gastrointestinal or gynaecological surgery where suture lines may be ruptured (unless medical consent has been given).

6. Enema

6.1. Types of enemas

There are two types of enemas, evacuant and retention enemas.

An ***evacuant*** *enema* is a solution introduced into the rectum or lower colon with the intention of it being expelled, along with faecal matter and flatus, within a few minutes. The osmotic activity increases the water content of the stool so that rectal distension follows and induces defecation by stimulating rectal motility (Dougherty et al, 2011). Examples of an evacuant enema are phosphate enemas (Fleet®), sodium citrate (Micralax®).

A ***retention*** *enema* is a solution introduced into the rectum or lower colon with the intention of being retained for a specified period of time. An example of a retention enema is Arachis oil (Kyle, 2007), Prednisolone (Predsol®).

6.2. Indications to administer enemas

Enemas may be prescribed for the following reasons (Dougherty et al, 2011)

- To clean the lower bowel before surgery, x-ray examination of the bowel using contrast medium, before endoscopy examination;
- To treat severe constipation;
- To soothe and treat irritated bowel mucosa;
- To stop local haemorrhage.

6.3 Contra-indications for the use of enemas

Enemas are contra-indicated for the following conditions (Dougherty et al, 2011)

- Paralytic ileus;
- Colonic obstruction;
- Allergy to latex, phosphate, soap (lanolin) and peanut (arachis oil enema);
- 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;
- Where the administration of large amounts of fluid high into the colon may cause perforation and haemorrhage;
- Following gastrointestinal or gynaecological surgery where suture lines may be ruptured (unless medical consent has been given);
- The use of micro-enemas and hypertonic saline enemas in patients with inflammatory or ulcerative conditions of the large colon.

6.4. Precautions

A phosphate enema may have more associated complications in certain patients such as the frail elderly, people with impaired renal function, impaired bowel motility and small intestinal disorders (Hsu, 2008).

7. Autonomic Dysreflexia

Patients with spinal cord injuries at T6 and above are particularly susceptible to autonomic dysreflexia. Spinal injury patients are usually aware of this condition and have experienced it prior to hospital discharge. However health care professionals need to be aware that a small proportion of patients who have severe forms of Parkinson's Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke may also develop autonomic dysreflexia (NHS, 2018).

Autonomic Dysreflexia is a sudden and potentially lethal surge of blood pressure often triggered without warning by acute pain or a harmful stimulus. This occurs because the body is unable to lower the blood pressure therefore the blood pressure will continue to rise until the offending stimulus is removed.

Digital rectal examination and the administration of enemas or suppositories are some of the factors that may trigger Autonomic Dysreflexia.

Symptoms of Autonomic Dysreflexia may be mild or severe. Patients can present with one or more of the following:

- Cool, clammy skin;
- Flushed face;
- Blotchiness;
- Sweating above level of injury;
- Pounding headache;
- Seeing spots or blurred vision;
- Nausea;
- Feeling Anxious;
- Increased blood pressure.

Treatment for Autonomic Dysreflexia:

- Sit the patient up;
- Identify and remove irritation;
- Give prescribed medication for Autonomic Dysreflexia;
- Monitor blood pressure;
- Contact 999 if the cause cannot be identified or the hypertension cannot be controlled.

If you suspect the symptoms of autonomic dysreflexia in a patient who has not been diagnosed with it previously, i.e. patients who have severe forms of Parkinson's Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke:-

- Contact 999;
- Sit the patient up;
- Identify and remove the irritation;
- Monitor blood pressure.

8. Procedure

8.1. Procedure: administration of suppositories

Equipment		
• Disposable non-sterile, latex-free gloves; • Disposable plastic apron; • A single sachet of lubricant, i.e. Aqua gel or Sutherland lubricating Jelly 5g sachet if required; • Suppository(ies) as prescribed; • 1 Nursing procedure sheets or 1 towel; • Wipes or tissue paper.		
No.	**Action**	**Rationale**
1	Explain the procedure to the patient. Obtain consent and document on care plan. If patient is unable to consent due to lack of capacity, follow the framework as set out in the Mental Capacity Act (2005) and document on the care plan.	To ensure that the patient understands the procedure and gives his/her valid consent (NMC, 2015). To ensure that the procedure is carried out in the best interest of the patient.
2	Check if the prescription is correct (NMC, 2010) and appropriate for the patient.	To prevent adverse reaction.
3	If administering a retention suppository, it is best to do so after the patient has emptied his/her bowels.	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.
4	Assess if the patient is able to get to the toilet. If not a commode or bedpan maybe required.	In case of premature ejection of the suppository or rapid bowel evacuation following their administration.
5	Wash and dry hand as per infection, prevention and control policy. Put on apron and gloves.	To reduce cross infection.
6	Patients who are at increased risk of autonomic dysreflexia, should have their blood pressure taken prior to and at the end of the procedure. During the procedure the nurse should observe for signs and symptoms of autonomic dysreflexia in patients with spinal cord injury T6 and above, or patients who have severe forms of Parkinson's Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke	A record of baseline blood pressure is advised for *all* patients for *future* comparison. *This should be recorded at least once a year.* For those spinal cord injury patients where routine and tolerance is well established, recording of blood pressure on each intervention is not necessary (RCN, 2012).
7	Remove any clothing below the waist. Cover	To maintain the patients dignity.

	the genital area with a blanket. Place a nursing procedure sheet or towel beneath the patient's hips and buttocks.	To reduce potential infection caused by soiled linen.
8	Ask the patient to lay on their left side with their knees up towards their chest (right knee slightly higher than the left) and the buttocks near the edge of the bed.	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 (Dougherty et al, 2011).
9	If appropriate, perform a digital rectal examination (see guideline for digital rectal examination and/or digital removal of faeces) before inserting a suppository.	To check if rectum is loaded.
10	Lubricate the end of the suppository as per manufacturer's guideline.	Lubrication reduces surface friction, eases insertion of the suppository and avoids anal mucosal trauma.
11	Separate the patient's buttocks and insert the suppository into the rectum as per manufacturer's guideline, advancing it for about 2 – 4 cm (Bradshaw et al, 2006). *Repeat this procedure if a second suppository is to be inserted.*	The anal canal is approximately 2 - 4 cm long. Inserting the suppository beyond this ensures that it will be retained.
12	Once the suppository has been inserted, clean any excess lubrication jelly from the patient's perianal area.	To ensure the patient's comfort and avoid anal excoriation that may lead to infection.
13	Ask the patient to retain the suppository for 20 minutes or until he/she is no longer able to do so. Following this, assist the patient onto the toilet/bedpan/commode if required.	This will allow suppositories to melt and release active ingredients. Inform patient that there may be some discharge as the medication melts in the rectum (Dougherty et al, 2011).
14	Remove and dispose of equipment. Wash and dry hands as per policy.	To reduce risk of infection.
15	Observe the patient for any adverse reactions.	To monitor any complications (Dougherty et al, 2011).
16	Record in the patient's care plan the outcome of the digital rectal examination if it was performed and the details of the suppository that has been given. If a suppository is given to evacuate the bowel, record the effect on the patient and the result (amount, colour, consistency and content of faeces as per Bristol Stool Chart).	To monitor the patient's bowel function To adhere to NMC guidance on record keeping (2015) and CWP CP3.

8.2. Procedure: administration of enemas

Equipment		
• Disposable non-sterile latex-free gloves (1 pair); • Disposable plastic apron; • A single sachet of lubricant, i.e. Aqua gel or Sutherland lubricating Jelly 5g sachet; • 1 nursing procedure sheets or 1 towels; • Wipes or tissue paper; • Prescribed enema.		
No.	**Action**	**Rationale**
1	Explain the procedure to the patient Obtain consent and document on care plan (NMC, 2015). If patient is unable to consent due to lack of capacity, follow the framework as set out in the Mental Capacity Act (2005) and document on care plan.	To ensure that the patient understands the procedure and gives informed consent. To ensure that the procedure is carried out in the best interest of the patient.
2	Check the prescription is correct and appropriate for the patient (NMC, 2010).	To prevent adverse reaction.
3	Assess if the patient is able to get to the toilet. If not a commode or bedpan maybe required.	In case of premature expelling the enema or a rapid bowel evacuation following the administration.
4	Wash hands as per policy and put on a disposable plastic apron.	To minimise risk of cross infection.
5	Allow patient to empty bladder first if necessary.	A full bladder may cause discomfort during procedure (Higgins, 2006).
6	Patients who are at increased risk of autonomic dysreflexia, should have their blood pressure taken prior to and at the end of the procedure. During the procedure the nurse should observe for signs and symptoms of autonomic dysreflexia in patients with spinal cord injury T6 and above, or patients who have severe forms of Parkinson's Disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke.	A record of baseline blood pressure is advised for *all* patients for *future* comparison. *This should be recorded at least once a year.* For those spinal cord injury patients where routine and tolerance is well established, recording of blood pressure on each intervention is not necessary (RCN, 2012).
7	If required warm the enema to the required temperature, as per manufacturer's instructions.	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 (Higgins, 2006).
8	If appropriate, perform a digital rectal examination (see guideline for digital rectal examination and/or digital removal of faeces) before administering the enema .	To check if rectum is loaded.
9	Ask the patient to lay on their left side with	This allows ease of passage into rectum by

	their knees up towards their chest (right knee slightly higher than the left) and the buttocks near the edge of the bed.	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.(Higgins, 2006). Be sure that throughout the procedure the patient is made aware of what is being done, as they are facing away from you.
10	Lubricate the nozzle of the enema as per manufacturer's instructions.	To prevent trauma to the anal and rectal mucosa by reducing surface friction (Higgins, 2006).
11	If required by manufacturer 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) (Dougherty, 2011).	The introduction of air into the colon causes distention of its walls, resulting in unnecessary discomfort to the patient and it increases peristalsis. The slow introduction of the lubricated tube will minimize spasm of the intestinal wall (evacuation will be more effectively induced due to increased peristalsis) (Dougherty, 2011).
12	Instill the enema into the rectum.	
13	Slowly withdraw the tube or nozzle.	To avoid premature ejection of the enema following the administration.
14	Dry the patient's perineal area with wipes or tissue paper.	To promote patient's comfort and avoid excoriation.
15	Ask the patient to retain the enema for 10- 15 minutes before evacuating the bowel according to manufacturer's instructions. Patients often find this easer lying down.	To enhance the effect.
16	Ensure that the patient is near to the bedpan, commode or toilet and has adequate toilet paper.	To enhance patient's comfort and safety. To minimize the patient's embarrassment.
17	Remove and dispose of gloves and apron (HS1) and wash hands.	To avoid cross infection.
18	Following enema observe for any complications, such as pain, bleeding, fainting.	To ensure patient's safety and comfort at all times.
19	Record in the patient's care plan the outcome of the digital rectal examination if it was performed and the details of the enema that has been administered. Record the effect on the patient and the result (amount, colour, consistency and content of faeces as per Bristol Stool Chart).	To monitor the patient's bowel function. (see RM) To adhere to Trust Record Keeping Policy (CP3).

Appendix 1 – Clinical competencies for Registered Nurses in the administration of suppositories or enemas

Prior to completing this document the Registered Nurse must have read the Clinical Guideline "Guideline for Administration of Suppositories & Enema's" and "Guideline for Digital Rectal Examination and/or Digital Removal of Faeces". In order to complete this document the practitioner will need to undertake a minimum of 2 supervised practices in administering suppositories or enemas *or* more until the practitioner feels confident and competent to carry out the procedure.

Practitioner's name		**Base**					
Designation							
The Registered Nurse should be able to demonstrate competency in the following elements and work within CWP guidelines and policies	**Date**	**Initial**	**Date**	**Initial**	**Date**	**Initial**
Assess and review the clinical indication for administering suppositories or enemas.						
Check there is no contra-indication or precautions prior to administering suppositories or enemas.						
Explain the procedure and potential adverse effects and symptoms to the patient						
Gain informed consent						
Work within CWP's Infection Prevention & Control policies						
Check prescription						
Prepare patient, equipment and environment for the administration of suppositories and enemas						
If appropriate perform a digital rectal examination and check anal area for any abnormalities						
Insert suppositories or enemas as per guideline						
Know when not to proceed or abandon this procedure and what actions to take						
At all times maintain patient's comfort and dignity						
Dispose of clinical waste appropriately						
Record outcome of procedure in patient's records and leave contact details						
Inform the relevant health professional if clinically indicated						