ENEMA ADMINISTRATION

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM
   • To safely and effectively administer enema with the minimum of discomfort for the patient

2. PATIENT
   • Woman who has constipation and faecal loading
   • Woman being prepared for surgery or a procedure
   • Woman needing the removal of residual barium enema/meal

3. STAFF
   • Registered Nurse
   • Medical Officer
   • Registered Midwife

Microlax enema or Fleet (phosphate) enema

4. EQUIPMENT
   • Micralax enema or fleet (phosphate) enema
   • Lubricant (K-Y gel)
   • Non-sterile gloves
   • Blue under sheet
   • Apron
   • Protective eyewear (if at risk of splash)
   • +/- Bed pan as required

5. CLINICAL PRACTICE
   • Explain procedure and rationale to patient
   • Obtain required equipment
   • Ensure patient's privacy
   • Follow Medication Administration protocol
   • Put on apron and protective eyewear and don non-sterile gloves
   • Position patient in the left lateral position in knee-chest position if tolerated and place blue under sheet under their buttocks
   • Perform Hand hygiene (Moment 2) and put on non-sterile gloves
   • Remove cap and lubricate tip of enema tube
   • Instruct patient to relax and to breath normally
   • Slowly and gently insert tube approx 3 cm into the rectum
   • Ask the patient to take a deep breath in (relaxes the sphincter), if resistance is encountered at the internal sphincter
   • Squeeze the tube to instil all of the contents into the rectum, and keep the chamber compressed as you withdraw the tube (prevents suction of fluid back into the chamber)
   • Dispose of rubbish adhering to infection control policy
   • Instruct patient to remain lying in bed for as long as comfortable before opening bowels
   • Assist patient to mobilise to bathroom or onto bedpan as required
   • Perform hand hygiene (Moment 3)
   • Offer patient the opportunity to perform hand hygiene
ENEMA ADMINISTRATION  cont’d

**Olive Oil Retention Enema**

6. EQUIPMENT
   - Olive oil - 50 to 100 mls
   - Nelaton catheter
   - 50 ml irrigation syringe
   - Lubricant (K-Y gel)
   - Non-sterile gloves
   - Blue undersheet
   - +/- Bed pan as required
   - Apron
   - Protective eyewear

7. CLINICAL PRACTICE
   - Explain procedure and rationale to patient
   - Obtain required equipment
   - Ensure patient's privacy
   - Follow Medication Administration protocol
   - Put on apron
   - Put on protective eyewear
   - Position patient in the left lateral position in knee-chest position if tolerated and place blue under sheet under their buttocks
   - Perform hand hygiene (Moment 2) and put on non-sterile gloves
   - Remove Nelaton catheter from packaging and lubricate the tip.
   - Attach to syringe
   - Remove plunger from syringe
   - Instruct patient to relax and to breathe normally
   - Slowly and gently insert catheter into the rectum
   - Ask the patient to take a deep breath in (relaxes the sphincter), if resistance is encountered at the internal sphincter
   - Hold barrel of syringe upright and fill it with olive oil, with catheter in patient's rectum
   - Allow to flow into rectum by gravity
   - Refill syringe barrel and continue until all of the olive oil is used, or the patient is unable to tolerate any more fluid
   - Withdraw the catheter and dispose of, adhering to infection control policy
   - Instruct patient to retain the enema as long as possible before opening bowels
   - Assist patient to mobilise to bathroom or onto bedpan as required
   - Remove gloves and perform hand hygiene (Moment 3)
   - Offer patient opportunity to perform hand hygiene

8. DOCUMENTATION
   - Medication Chart
   - Clinical Care Pathway
   - Integrated clinical notes

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ENEMA ADMINISTRATION  cont’d

9. EDUCATIONAL NOTES

- **Do not force the catheter or use undue pressure.** If unable to proceed, withdraw the catheter, notify the prescribing medical officer and document in integrated clinical notes.
- Slow insertion of the catheter/nozzle decreases the incidence of internal anal sphincter spasm.
- Always instil fluid slowly, slow insertion of enema fluid decreases the incidence of intestinal spasm and premature expulsion of enema fluid.
- Allow volume administered to be dictated by patient tolerance.
- If patient complains of cramping pain, stop the instillation for a short period.
- For retention enemas, it may be helpful to tilt the foot of the bed, to encourage movement of the fluid beyond the rectum.

Enemas are not to be given to patients with the following conditions unless specifically ordered by the Medical Officer:

- Placenta praevia
- Ante-partum haemorrhage
- Threatened premature labour
- Ruptured membranes with high presenting part
- Any post-operative patient
- Pre-existing bowel conditions e.g. bowel cancer, mega colon, inflammatory bowel conditions.

Enemas are not to be given to patients with the following conditions:

- Ectopic pregnancy (known or suspected)
- Appendicitis (known or suspected)
- Acute abdomen - vomiting, diarrhoea, colic, or abdominal pain of unknown origin
- Undiagnosed rectal bleeding
- Intestinal obstruction
- Post-operative bowel surgery

10. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Hand Hygiene Policy
- Infection Control Policy
- Waste Management Guidelines
- Workplace Health and Safety Policy

11. REFERENCES

- Rosdahl C.B. & Kowalski M.T. 2008 Textbook of Basic Nursing, 9th edn, Lippincott Williams & Wilkins