Administering an enema: how to, care of, monitoring, reporting: at a glance

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| This article will: * Increase knowledge of constipation
* Provide clinical guidance on the assessment of constipation in adults
* Increase knowledge of rectal examination and prescribing enemas
* Increase knowledge on monitoring care of patients with constipation
* Provide an awareness of the complications of constipation
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**What is constipation?**

Constipation is a common problem which can occur at any age. The incidence rate is 2-3 times higher in women than in men and prevalence increases with age; however, it is important to note that this may be underestimated due to the high proportion of self-management and treatment (NICE, 2017). Constipation is more common in pregnancy and can be exacerbated by medication. Effective treatment of constipation relies on a thorough holistic assessment which identifies the cause.

Constipation is defined as unsatisfactory defecation due to the infrequent passing of stools (NICE, 2017). The Rome IV diagnostic criteria for diagnosing gastrointestinal disorders identifies constipation as two of the following criteria in the last month: a spontaneous bowel movement which occurs less than 3 times a week, painful or hard stools, presence of faecal matter in the rectum or a history of incomplete evacuation, (Drossman, 2016). Chronic constipation is defined as symptoms that persist for more than 12 weeks in 6 months (NICE, 2017). Constipation is a subjective disorder, patients are measured by their dissatisfaction with the frequency of defecation and the relevance of these symptoms to the individual (Woodward, 2012; Dougherty & Lister, 2015; Basilisco & Coletta, 2013). However, this can be erroneous depending on an individual’s perception of normal. Consequently, this has led to a lack of consensus around constipation definition (Kyle, 2011; Dougherty & Lister, 2015).

**Causes of Constipation**

There is no pathological cause for primary constipation (RCN, 2012, Dougherty & Lister, 2015). Factors that lead to the devolvement of primary constipation are extrinsic or related to lifestyle. These include inadequate fibre in the diet (a fibre-rich, well-balanced diet softens and increases the stool weight and accelerates transit time (Basilisco & Coletta, 2013)), a change in lifestyle, poor fluid intake and ignoring or delaying the urge to defecate (Dougherty & Lister, 2015). The causes of chronic constipation are multifactorial and relate to colonic motility and absorption, diet, sensory function, behavioural and psychological factors (Basilisco & Coletta, 2013). Secondary constipation is caused by either a metabolic, neurological or psychological disorder (Dougherty & Lister, 2015). These include colonic tumours, irritable bowel syndrome, anal fissures and other neurological, myopathic and structural conditions (Dougherty & Lister, 2015). Constipation can also be a direct side effect of some medications for example opioid analgesics (RCN, 2012; Woodward, 2012).

**Diagnosing constipation**

Risk factors for constipation should be considered from a physical, psychological and social perspective (NICE, 2017). Diagnosis of constipation should only be reached following a full assessment, a detailed structured evaluation and rectal examination (Basilisco & Coletta, 2013).

**Assessment**

1. Assess the person’s normal bowel habits (this may influence diagnosis) (NICE, 2017)
2. Ask the patient how long they have they been constipated and if this has occurred before? (Dougherty & Lister, 2015) Ask the patient what self-help methods have been previously tried and what was the outcome? Understanding a patient’s bowel history is key to an accurate diagnosis. Withholding bowel movements following previous experiences of pain or discomfort are known to cause functional constipation particularly in older people who are in hospitals or institutions (Basilisco & Coletta, 2013)
3. Record the volume, colour and consistency of stools for example; hard, small. Use the Bristol stool chart to assess this. Constipation would be classified as type’s 1 or 2 (separate hard lumps or lumpy and sausage like) on the Bristol Stool chart (Dougherty & Lister, 2015). Consider implementing a bowl diary to record the frequency of bowel evacuation, stool consistency, and to record any faecal incontinence (RCN, 2012). Ask the patient if they have any nocturnal symptoms (this may be an indication of impaction and overflow).

*Attach picture of the Bristol Stool Chart*

1. Assess for any associated symptoms such as excessive straining, rectal discomfort or bleeding, feeling of incomplete evacuation, abdominal pain or distension. Ask the patient if they have any pain or discomfort on defaecation (Dougherty & Lister, 2015).
2. Assess for any symptoms of fever, vomiting, nausea, loss of appetite or weight loss. Use a validated tool to assess that patient’s nutritional status.
3. Ask the patient if they have any urinary symptoms such as incontinence, retention or dyspareunia? Large amounts of stool in the colon can put pressure on the bladder causing the bladder not to fill or contract as it should (Basilisco & Coletta, 2013).
4. Assess the patients diet particularly fibre and fluid intake. A person’s fibre intake should be approximately 30g per day (NICE, 2017). The person’s diet should contain whole grains, fruits (including their juices) and have a high sorbitol (sugar) content such as apples, apricots, strawberries, pears, plums etc. (NICE, 2017). Consider not only insufficient fibre intake but also excessive fibre in the diet which can cause bloating and abdominal pain particularly in patients who have a delayed colonic transit (Basilisco & Coletta, 2013). Use the public Health England Eatwell Guide to provide patient information (GOV.UK, 2016). Fibre intake must be increased slowly to minimise bloating and flatulence (NICE, 2017). Adults including older people are recommended to drink between 1600ml to 2000ml of water a day (Bda.uk.com, 2017). Ask the patient to use a food and fluid diary to monitor intake and refer to a dietitian if any concerns.
5. Assess for a family history of inflammatory bowel disease or colorectal cancer. If any red flag symptoms are detected such as hematochezia (fresh blood in the stool or anus), anaemia or a change in bowel habits refer the patient for further investigation (NICE, 2017)
6. Assess the patient for the impact of constipation on quality of life and daily functioning. Does the patient have any mechanical aspects of faecal incontinence such as regularly soiled underwear, loose stools (NICE, 2017)?
7. Check the patient’s position on the toilet seat. This should be a squatting position for defecation (NICE, 2017). Assess their toilet habits. Do they feel hurried or withhold the urge to defecate, what toilet access do they have and to what level of privacy? Consider current lifestyle and habits and ask the patient if they allow sufficient time for defecation (NICE, 2017)?

*Insert image of correct toilet positioning*

1. Ask the patient if there have been any changes in the patient’s mobility or reduction in exercise (Dougherty & Lister, 2015)
2. Assess for any psychological conditions including any adverse life events, depression, anxiety, eating disorders, somatization disorders or a history of abuse (Basilisco & Coletta, 2013, NICE, 2017).
3. Review the patient’s current medication and treatment with underlying contraindications of constipation.
4. Complete an abdominal examination to assess for any pain, distension, mass or palpable colon (which would indicate retained faecal masses) (Dougherty & Lister, 2015).
5. Assess the patient for secondary causes of constipation. The underlying and secondary cause of constipation needs to be managed as part of the treatment to prevent recurrence (NICE, 2017).
6. Complete baseline observations to support the bowel assessment and aid differential diagnosis (RCN, 2012).

**Digital rectal examination**

A digital rectal examination (DRE) should only be performed by nurses who have received suitable training and who have demonstrated a level of competence determined by the NMC (Dougherty & Lister, 2015; NMC 2015). All patients with chronic constipation should undergo a DRE to look for causes of anal pain that may precipice secondary constipation (Basilisco & Coletta, 2013). Before undertaking a DRE nurses must observe the perineal areas for any abnormalities such as:

* Rectal prolapse (this should be graded) (RCN, 2012)
* Anal fissure (can cause anal pain) or anal skin tags (Basilisco & Coletta, 2013)
* Thrombosed haemorrhoids (grade and note if they are internal or external, may be a cause of anal pain) (Basilisco & Coletta, 2013)
* Any wounds, areas of broken red or sore skin, lesions, fistulas or foreign bodies (RCN, 2012)
* Pressure ulcers (This should be graded using the NUPAP, 2014 grading system)
* If the anal tone is reduced (RCN, 2012)
* Any blood or faecal matter (RCN, 2012)
* Any signs of infestation (RCN, 2012)

Watching the patient while they strain may identify stool leakage, a gaping anus or a prolapse of internal haemorrhoids (Rao, 2010).

DRE is contraindicated when there is a lack of informed consent from the patient written, verbal or implied (RCN, 2012) or there is instruction from a doctor or senior physician that this procedure should not take place. Nurses should use caution if patients have acute inflammation of the bowel including diverticulitis, Crohn’s disease or ulcerative colitis. If a patient has recently undergone radiotherapy on the pelvic area. If the patient has had rectal surgery or experienced a trauma to the anal or rectal area in the last 6 weeks (RCN, 2012). If the patient is complaining of rectal or anal pain or there are obvious signs of rectal bleeding. If a patient has a known allergy to latex, a known history of abuse or for any patient who has an injury above the sixth thoracic vertebra as this increases the risk of autonomic dysreflexia (RCN, 2012).

**Procedure**

1. Confirm the patient’s identity, explain and discuss the full procedure.
2. Assess the patients’ specific requirements and the reason for intervention. If the patient is constipated a full physical, psychological and social assessment should be completed (NICE, 2017).
3. Check for any allergies such as latex (NMC, 2010, RCN 2012).
4. Wash hands and put on apron and gloves. This is to ensure that hygiene and infection control measures are maintained (Dougherty & Lister, 2015).
5. Close the door or draw the curtains to maintain privacy and dignity (NMC, 2015).
6. Encourage the patient to empty their bladder first. A full bladder can create discomfort during the procedure (Peate, 2015).
7. Place the waterproof pad underneath the patient (Pegram, Bloomfield & Jones 2008; Dougherty & Lister, 2015).
8. Remove the patients clothing from the waist down if they are unable to do this themselves.
9. The patient should lie on their left side, knees flexed with the upper knee higher than the lower knee and buttocks near the edge of the bed (Dougherty & Lister, 2015). This supports the easy passage of the finger into the rectum (Dougherty & Lister, 2015). Note that patients with musculoskeletal conditions may not be able to lie in this position. Ensure you have adequate lighting and that the patient is not at risk of falling (Pokorny, 2017).

*Insert picture of lateral positioning*

1. Change gloves. Place lubricating jelly on the gauze and lubricate the index finger. Lubrication reduces friction, aids insertion and reduces anal mucosal trauma (Dougherty & Lister, 2015). Separate the buttocks and observe the perineal and perianal areas. Document any abnormalities for anything that may make assessment difficult for example haemorrhoids, rash, discharge or bleeding (Pegram, Bloomfield & Jones, 2008; Peate, 2015).
2. Gently advance lubricated index finger into the patients’ rectum (Rao, 2011). Assess the anal sphincter and tone. This can be achieved by asking the patient to squeeze the examining finger or push and bear down as if to defecate (Rao, 2011; Pokorny, 2017). The external anal sphincter is responsible for voluntary contraction of the sphincter. Weakening or disruption of the anal sphincter by trauma can result in faecal incontinence (RCN, 2012). At the same time explain to the patient what is happening and encourage the patient to relax if possible by taking deep breaths (Pegram, Bloomfield & Jones, 2008).
3. Establish the content of the rectum and the amount and consistency of faecal matter (use the Bristol Stool Chart). Assess anal and rectal sensation, assess for the presence of any foreign bodies and review the rectum for any conditions which may cause discomfort (RCN, 2012). Insert 360-degree palpation of the rectal wall to identify for any polyps or masses (Rao, 2011). Determine if there is a need for digital removal of faeces, prior to the administration of suppositories or an enema.
4. Discontinue the procedure if the patient is complaining of pain or abdominal cramps. DRE may be uncomfortable but the procedure should not be painful (Pokorny, 2017).
5. Slowly remove index finger. Examine the glove for any signs of blood, faecal consistency and colour (e.g pale or melaena) (Pokorny, 2017). Dry the perineal area to any prevent discomfort or excoriation.
6. Remove and dispose of all equipment according to local policy. Wash hands.
7. Document treatment. If an enema or suppositories are required ensure these are prescribed for the patient prior to administration. Document colour, consistency and amount using the Bristol Stool Chart. Avoid subjective descriptions such as copious amounts or +++.

**Prescribing**

There are several different options for the treatment of constipation but their role in the therapeutic approach needs to optimised (Basilisco & Coletta, 2013). If the patients’ response to oral laxatives is inadequate or does not achieve the desired results consider using a mini-enema (docusate) which is a softener and weak stimulant or a sodium citrate enema which is osmotic (NICE, 2017). Enemas should be used with caution and observed for contraindications, for example, gastrointestinal obstructions or inflammatory bowel disease (NICE, 2017). Caution should be used in patients with ascites, congestive heart failure, older people or debilitated patients, patients with electrolyte disturbances (a side effect of some enemas can be electrolyte disturbances) or uncontrolled hypertension (NICE, 2017). Other side effects can include a local irritation. Nurses should advise patients and carers about adequate hydration particularly with osmotic enemas (osmotic enemas absorb fluids in the stool and soften the faeces to make defecation easier) (NICE, 2017). Nurses should ensure that the patients are warned about the potential for faecal overflow and diarrhoea during disimpaction (NICE, 2017).

Consider the use of a Sodium Phosphate enema or Arachis oil retention enema if the rectum is empty but the colon is full. These enemas should be inserted into the rectum to the depth of 10-12.5cm (Dougherty & Lister, 2015). The anal canal is between 2.5 and 4cm in length. Insertion beyond this ensures that the anal canal is bypassed and that the nozzle of the enema is in the rectum (Dougherty & Lister, 2015). For hard stools, an Arachis oil enema could be given overnight and a sodium phosphate or sodium citrate can be given the next day. It may be necessary to repeat the enema several times to remove hard, impacted faeces (NICE, 2017). Following treatment, regular laxatives should be considered to maintain bowel movements and the patient should be reviewed regularly to monitor their response to the treatment (Dougherty & Lister, 2015). If constipation fails to improve it is recommended that patients are referred to a specialist for further investigations (Basilisco & Coletta, 2013).

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