**Front Sheet for at a Glance Series**

Suppositories (Adults): *at a Glance*

1385 words

*By Aby Mitchell*

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

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| This article will: * Provide clinical guidance on the administration of suppositories in adults
* Increase knowledge on monitoring care of patients with constipation
* Provide an awareness of the complications of constipation
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**Suppositories**

A suppository is a ‘solid or semi-solid, bullet-shaped pellet’ (Dougherty & Lister, 2015) which is a mix of medication and a ‘wax-like’ substance that melts following insertion into the rectum (Galbraith, 2007). Suppositories are used for a local or systemic effect to empty the bowel prior to surgery, investigations or examinations, to administer medications, to soothe and treat haemorrhoids or anal pruritus (Dougherty & Lister, 2015). Suppositories may also be considered when oral medications cannot be used, in palliative care, if a patient has swallowing difficulties or has severe nausea and cannot retain oral medication. For the complete list of medicines available for rectal administration as suppositories refer to the BNF NICE guidelines (bnf.nice.org.uk, 2018).

Most commonly suppositories are used to empty the bowel to relieve constipation when other less invasive treatments have failed. Constipation is defined by NICE (2017) as a symptomatic disorder which describes unsatisfactory defecation due to infrequency or difficulty in passing stools which is less frequent than the individuals’ normal bowel pattern. Chronic constipation is defined as symptoms that present for at least 12 weeks in the last six months (NICE, 2017). Complications of constipation include faecal loading or impaction, haemorrhoids, anal fissure, faecal retention, rectal distension and loss of sensory and motor function (NICE, 2017). Early assessment and treatment of constipation are necessary to prevent long-term implications. Individuals with constipation often experience a reduction in their quality of life compared to the general population (Norton, 2006). In the short-term individuals can experience pain, discomfort and bloating. The long-term effects of constipation can lead to diverticular disease, chronic back pain, hernia or recurrent UTI’s.

**Types of suppositories**

There are various types of suppositories used for constipation. Nurses must be aware of any potential harm associated with their practice and reduce this whenever possible (NMC, 2015). Nurses should understand how each type of suppository works, the anatomy of the rectum and only administer medicines within their training and competence (Peate, 2015; NMC, 2015). There is currently no conclusive evidence to support the most effective way to insert a suppository. Abd-el-Maeboud et al (1991) suggested that the blunt end should be inserted first to prevent anal irritation and rejection of the suppository. However, this is a very small piece of research and other studies have subsequently challenged this work. Due to the lack of conclusive evidence, it is important that nurses always follow manufacturer’s instructions and local policies.

Glycerine suppositories work as a lubricator, softener and a weak stimulant by lowering the surface tension of faeces, allowing water to penetrate and soften the stool ((Dougherty & Lister, 2015; NICE, 2017). They can be used for both hard and soft stools and are licensed for occasional use only (NICE, 2017). Glycerine suppositories should be moistened before used to aid insertion and must be placed along the bowel wall (NICE, 2017). Heat from the body causes them to dissolve and distribute around the rectum (NICE, 2017). This technique requires accuracy and therefore insertion of the suppository apex first may be better (Kyle, 2009). Suppositories for systemic use are best absorbed by the lower rectum. Venous drainage avoids the portal circulation and moves quickly to the inferior vena cava, resulting in a more rapid therapeutic effect (Dougherty & Lister, 2015).

Bisacodyl suppositories act as a stimulant. They are often used for bowel clearance before radiological procedures and surgery (NICE, 2017). Bisacodyl suppositories have no softening effect and should be used only for soft stools, avoid administration into large, hard stools. Sodium phosphate and sodium bicarbonate suppositories are used for bowel clearance and work by an effervescent action (NICE, 2017). The chemical reaction leads to a liberation of carbon dioxide, which causes an evacuation of the bowel within 30 minutes. All suppositories must be prescribed for each individual prior to administration.

Suppositories are contraindicated if the patient is suffering from chronic constipation which would require repeated use, a chronic obstruction or malignancy, a paralytic ileus, low platelets or following any gastrointestinal or gynaecological operations unless prescribed by the surgeon/doctor (Dougherty & Lister, 2015). Glycerine suppositories should not be administered if an individual is allergic (hypersensitive) to Glycerol or any of the other ingredients in the suppositories (NICE, 2017). There are some instances when a suppository may be prescribed for administration via a stoma. Nurses should seek additional advice before undertaking this procedure (Peate, 2015).

Elimination is a sensitive issue and must be handled respectfully at all times by the nursing team. The privacy and dignity if the patient must be respected and it is essential that the procedure is clearly explained to ensure informed consent is granted (NMC, 2015). Nurses should ensure that a moving and handling risk assessment is completed prior to treatment to establish if additional equipment such as hoists are required.

Before administration of suppositories, it is essential to correctly assemble all the necessary equipment. This should include:

* A prescription written for the patient
* The suppository (correct dose should be calculated)
* Gloves and apron
* A protective cover (Incontinence sheet)
* Lubrication
* Care plan
* Commode or bedpan in case of premature ejection of the suppositories (Peate, 2015)

**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. If a medication suppository is administered, it is best to do this after the bowels have been emptied to enable absorption by the rectal mucosa and prevent premature expulsion of the suppository (Dougherty & Lister, 2015).
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. Remove the patients clothing from the waist down if they are unable to do this themselves.
7. 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 easy passage of the suppository into the rectum and follows the anatomy of the colon. Flexion of the knees assists in reducing discomfort as the suppository is passed through the anal sphincter (Dougherty & Lister, 2015). Note that patients with musculoskeletal conditions may not be able to lie in this position.

*Insert picture of lateral positioning*

1. Ensure that the disposable incontinence sheet is underneath the patients’ buttocks and hips. Not only does this avoid unnecessary soiling but reduces the risk of cross infection and preserves the patients’ dignity if a premature or rapid evacuation occurs (Dougherty & Lister, 2015).
2. Change gloves and place lubricating jelly on the gauze and blunt end of the suppository. Lubrication reduces friction, aids insertion and reduces anal mucosal trauma (Dougherty & Lister, 2015).
3. Separate the buttocks and observe the perineal and perianal areas. Document any abnormalities for example haemorrhoids, prolapse, rash, discharge or bleeding (Peate, 2015).
4. Lubricate index finger and gently insert into the rectum to ascertain if it is empty or full. If the suppository is to relieve constipation it should not be given if the rectum is empty (Peate, 2015).
5. Insert the suppository approximately the full length of the index finger. The anal canal is about 2-4cm long and insertion of the suppository beyond this ensures that it will be retained (Pegram et al, 2008). Repeat procedure if there is a second suppository.
6. Following insertion of the suppository clean away any excess lubricating jelly using the gauze this is to ensure comfort and avoid excoriation (Dougherty & Lister, 2015).
7. Advise the patient to retain the suppository for 20 minutes or for as long as they are able to. If the suppository is medicated remind the patient that the aim is to retain the suppository until full absorption (Dougherty & Lister, 2015). Inform the patient that they may have some discharge as the medication melts.
8. Remove and dispose of all equipment according to local policy. Wash hands.
9. Document treatment. If the suppository has been given for constipation record the result using the Bristol Stool Chart. Document colour, consistency and amount. Avoid subjective descriptions such as copious amounts or +++.

*Insert picture of Bristol Stool Chart*

1. Monitor the patient for any adverse reactions.
2. Reassess if symptoms persist.

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Medical device related

pressure ulcers in

hospitalized patients

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