MVH - PROCEDURE

ORIGINAL DATE: 05/18
REVISED:

SUBJECT: MEDICATION ROUTE: RECTAL & VAGINAL

PURPOSE: To outline care objectives and procedures for the clinical management of medication administered rectally or vaginally.

PROCEDURE:

1. MVH has adopted the VNAA recommended Hospice and Palliative Care approach as outlined in Section: 12.13. (See attached)

Nature of Change	N/A - New
CCO Signature:	Julie Conway 5/24/18 Date
CEO Signature:	10/12 (DB) Date

KEY POINTS

1. Medications administered vaginally or rectally are usually suppositories.
   a. Store suppository in refrigerator.
   b. Suppositories are easier to insert the more firm they are. Keep refrigerated until ready to insert.
2. Vaginally administered medications are usually given for vaginal infections.
   a. Medication can be a suppository or cream/foam/jelly administered with an applicator.
   b. Since vagina has little sphincter control, patient should remain supine for at least 10 minutes post insertion so medication has a chance to dissolve and coat the vagina.
   c. If goal is self-administration, assess patient's ability to manipulate suppository or any applicators.
   d. Insert a suppository about 3 – 4 inches (7.5 – 10 cm) into the vagina, about the full length of a finger.
3. Rectally administered medications are usually given as an alternative to oral route.
   a. Although rectal mucosa can absorb medications well, it is not as reliable as the oral route.
   b. Do not administer medication into a fecal mass; it will not be effective.
   c. If patient has diarrhea or rectal bleeding, the suppository may not be appropriate.
   d. Suppositories may be contraindicated in immunocompromised patient or patients with bleeding disorders.
   e. Insertion of suppository
      1) Infants & small children: 2 inches (5 cm)
      2) Adults: 4 inches (10 cm)
   f. Medication must be inserted beyond the internal sphincter, or it will likely be expelled prematurely. The pressure of sphincter contracting will be felt on your finger during insertion.
   g. For infants and small children, it may be necessary to hold buttocks together after insertion for a couple of minutes, until suppository has a chance to dissolve.

EQUIPMENT

Gloves
Medication
- Suppository, kept cold & firm until ready for use
- Vaginal cream/foam/jelly/tablet and applicator
- Vaginal irrigation:
  - Vaginal irrigating solution
  - Irrigation bag and tubing
  - Bedpan

Water-soluble lubricant
Perineal pad, post vaginal administration

PROCEDURE

1. Check order for medication, dose, frequency, route, and amount.
2. Identify patient using two identifiers. Adhere to Standard precautions. Assemble equipment.
3. Ask patient to void.
4. Perform hand hygiene. Don gloves.
5. Maintain patient's privacy.
6. Assist patient into position.

Vaginal suppository

1. Assist patient to side-lying position with knees bent or in supine position with legs abducted.
2. Inspect external genitalia and identify vaginal opening. Cleanse perineal area if needed.
3. Open suppository wrapper, exposing front rounded end of suppository.
4. Apply lubricant to rounded end of suppository and to 3rd finger of gloved dominant hand.
5. With non-dominant hand, separate labial folds front-to-back direction.
6. Insert rounded end of suppository along posterior wall of canal entire length of finger 7.5 to 10 cm (3 - 4 inches).
7. Withdraw finger and wipe away remaining lubricant from around orifice and labia with tissue.
8. Provide patient with a perineal pad.

Vaginal cream/foam/jelly/tablet with applicator

1. Assist patient to side-lying position with knees bent or in supine position with legs abducted.
2. Inspect external genitalia and identify vaginal opening. Cleanse perineal area if needed.
3. Fill applicator by following package directions.
4. With non-dominant hand, separate labial folds.
5. With dominant hand, insert applicator approximately 5 to 7.5 cm (2 - 3 inches).
6. Push plunger to deposit medication into vagina.
7. Withdraw applicator and place on tissue.
8. Wipe off residual cream/foam from labia or vaginal orifice with another tissue.
9. Provide patient with a perineal pad.
10. If applicator will be reused, wash with soap and water. Rinse and store.

Vaginal irrigation

1. Inspect external genitalia and identify vaginal opening. Cleanse perineal area if needed.
2. Place patient on bed pan with pad underneath.
3. Make sure irrigating solution is at body temperature, prime tubing.
4. With non-dominant hand, separate labial folds.

5. Direct nozzle toward sacrum, following the floor of the vagina. Insert nozzle 7 - 10 cm (3 - 4 inches).
6. Raise container approximately 30 - 50 cm (12 - 20 inches) above level of vagina.
7. Unclamp to allow solution to flow while rotating nozzle.
8. Administer all the solution, as ordered.
9. Withdraw nozzle.
10. Assist patient to comfortable sitting position.
11. Allow additional time on bed pan to facilitate vaginal drainage, usually few minutes.
12. Remove bedpan.
13. Dry perineum.
14. Provide patient with perineal pad.

Rectal suppository

1. Assist patient into left side-lying (Sims') position with upper leg flexed upward.
2. Examine condition of anus externally.
3. Open suppository wrapper, exposing front rounded end of suppository.
4. Apply lubricant to rounded front- end of suppository and to 3rd finger of gloved dominant hand. Apply liberally for patient with hemorrhoids.
5. Lubricate gloved finger of dominant hand with water-soluble lubricant. Apply liberal amount, if patient has hemorrhoids.
6. Retract patient's buttocks with non-dominant hand.
7. Ask patient to breathe deeply to relax anal sphincter.
8. With gloved finger, insert suppository gently through anus, past internal sphincter, and against rectal wall:
   a. 10 cm (4 Inches) in adults
   b. 5 cm (2 inches) in infants and children
9. Withdraw finger.
10. Clean anal area with tissue.
11. Ask patient to remain in supine position for 5 minutes, if able.

Post procedure

1. Remove gloves.
2. Perform hand hygiene.

AFTER CARE

1. Teach patient/caregiver:
   a. How to do procedure with return demonstration, if patient needs medication regularly
   b. Importance and technique for regular perineal hygiene
   c. To call home health agency if any post-procedure issues or problems
2. Document in patient record:
   a. Medication name, dose, time, route, form, and amount of solution used
   b. Response, including effectiveness or any adverse reaction
   c. Instructions given to patient/caregiver; comprehension
   d. Communication with primary care provider as indicated based on patient condition

REFERENCES

Barstow, N. & Perry, A.G. (2014). Oral and topical medications. In A. G. Perry & P. A. Potter (Eds.), *Nursing skills and techniques* (8th ed.) (pp.492-537). St. Louis, MO: Mosby.

Harrison, R. L. (2014). Safe medication preparation. In A.G. Perry & P. A. Potter (Eds.), *Nursing skills and techniques* (8th ed.) (pp.472-491). St. Louis, MO: Mosby.