CHECKLISTS FOR FINALS

1. **Performing Urinary Catheterization (Female)**
2. **Inserting a Nasogastric (NG) Tube**
3. **Administering Enema**

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Performing Urinary Catheterization (Female)

PURPOSES

- To relieve discomfort due to bladder distention or to provide
- Gradual decompression of a distended bladder
- To assess the amount of residual urine if the bladder empties incompletely
- To obtain a sterile urine specimen
- To empty the bladder completely prior to surgery Performing Urinary Catheterization
- To facilitate accurate measurement of urinary output for critically ill clients whose output needs to be monitored hourly
- To provide for intermittent or continuous bladder drainage and/ or irrigation
- To prevent urine from contacting an incision after perineal surgery

Equipment
• Sterile catheter of appropriate size
• For an indwelling catheter:
• Syringe prefilled with sterile water in amount specified by catheter manufacturer
• Collection bag and tubing
• 5–10 mL 2% Xylocaine gel or water-soluble lubricant for male
• Urethral injection (if agency permits)
• Clean gloves
• Supplies for performing perineal cleansing
• Bath blanket or sheet for draping the client
• Adequate lighting (Obtain a flashlight or lamp if necessary.)
• Catheterization kit or individual sterile items:
• Sterile gloves
• Waterproof drape(s)
• Antiseptic solution
• Cleansing balls
• Forceps
• Water-soluble lubricant
• Urine receptacle
• Specimen container

PROCEDURE	**RATIONALE**
1. Introduce self and verify the client's identity using agency protocol.	
2. Explain to the client what you are going to do, why it is necessary, and how he or she can participate.	

3. Perform hand hygiene and observe other appropriate infection prevention procedures.	
4. Provide for client privacy.	
5. Place the client in the supine position, with knees flexed, feet about 2 feet apart, and hips slightly externally rotated. Drape all except the perineum.	
6. Establish adequate lighting. Stand on the client is right if you are right-handed, on the client is left if you are left-handed.	Because one hand is needed to hold the catheter once it is in place, open the package while two hands are still available.
7. If using a collecting bag and it is not contained within the Catheterization kit, open the drainage package and place the end of the tubing within reach.	
8. Apply clean gloves and perform routine perineal care to cleanse gross contamination meatus relative to surrounding structures	
9. Remove and discard gloves. Perform hand hygiene.	
10. Open the catheterization kit. Place a waterproof drape under the buttocks (female) without contaminating the center of the drape with your hands	
11. Apply sterile gloves	
12. Organize the remaining supplies: • Saturate the cleansing balls with the antiseptic solution. • Open the lubricant package. • Remove the specimen container and place it nearby with the lid loosely on top.	
13. Attach the prefilled syringe to the indwelling catheter inflation hub. Apply agency policy and/or manufacturer recommendation regarding pretesting of the balloon	There is little research regarding pretesting of the balloon; however, some balloons (e.g., silicone) may form a cuff on deflation that can irritate the urethra on insertion
14. Lubricate the catheter 2.5 to 5 cm (1 to 2 in.) and place it with the drainage end inside the collection container.	
15. If desired, place the fenestrated drape over the perineum, Exposing the urinary meatus	
16. Cleanse the meatus. NOTE: • The non-dominant hand is considered contaminated once it touches the client's skin. Use your non dominant hand to	

spread the labia so that the meatus is visible. Establish firm but gentle pressure • Location of the urethral meatus is best identified during the cleansing process. Pick up a cleansing ball with the forceps in your dominant hand and wipe one side of the labia majora in an anteroposterior direction.	
17. Use great care that wiping the client does not contaminate this sterile hand. Use a new ball for the opposite side. Repeat for the labia minora. Use the last ball to cleanse directly over the meatus	
18. Insert the catheter • Grasp the catheter firmly 5 to 7.5 cm (2 to 3 in.) from the tip . • Ask the client to take a slow deep breath and insert • Insert the catheter as the client exhales. Slight resistance is expected as the catheter passes through the sphincter. • If necessary, twist the catheter or hold pressure on the catheter until the sphincter relaxes. • Advance the catheter 5 cm (2 in.) farther after the urine begins to flow through it. • If the catheter accidentally contacts the labia or slips into the vagina, it is considered contaminated and a new, sterile catheter must be used. The contaminated catheter may be left in the vagina until the new catheter is inserted to help avoid mistaking the vaginal opening for the urethral meatus.	
19. Hold the catheter with the non-dominant hand. • For an indwelling catheter, inflate the retention balloon with the designated volume. • Without releasing the catheter without releasing the labia, hold the inflation valve between two fingers of your non dominant hand while you attach the syringe(if not left attached earlier) and inflate with your dominant hand. • If the client complains of discomfort, immediately withdraw the instilled fluid, advance the catheter farther, and attempt to inflate the balloon again. • Pull gently on the catheter until resistance is felt to ensure that the balloon has inflated and to place it in the trigone of the bladder.	This is to be sure it is Fully in the bladder.
20. Collect a urine specimen if needed. • For an indwelling catheter preattached to a drainage bag, a specimen may be taken from the bag this initial time only. If necessary (e.g., open system), attach the drainage end of an indwelling catheter to the collecting tubing and bag..	

21. Examine and measure the urine. In some cases, only 750 to 1,000 mL of urine are to be drained from the bladder at one time. Check agency policy for further instructions if this should occur.	
22. Secure the catheter tubing to the thigh to prevent movement on the urethra or excessive tension or pulling on the retention balloon Secure with adhesive and nonadhesive catheter-securing devices	This prevents unnecessary trauma to the urethra.
23. Hang the bag below the level of the bladder. No tubing should fall below the top of the bag.	
24. Wipe any remaining antiseptic or lubricant from the perineal area. Return the client to a comfortable position. Instruct the client on positioning and moving with the catheter in place	
25. Discard all used supplies in appropriate receptacles.	
26. Remove and discard gloves. Perform hand hygiene.	
27. Document the catheterization procedure including catheter size and results in the client record using forms or checklists supplemented by narrative notes when appropriate.	

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Performing Urinary Catheterization (Female)

Student Name _____ **Score** _____
No. _____ **Evaluator** _____

Legend:
2- Performed correctly
1- Performed incorrectly
0- Not performed

Equipment	**Prepared**	**Not Prepared**
• Sterile catheter of appropriate size		
• For an indwelling catheter:		
• Syringe prefilled with sterile water in amount specified by catheter manufacturer		
• Collection bag and tubing		
• 5–10 mL 2% Xylocaine gel or water-soluble lubricant for male		
• Urethral injection (if agency permits)		
• Clean gloves		
• Supplies for performing perineal cleansing		
• Bath blanket or sheet for draping the client		
• Adequate lighting (Obtain a flashlight or lamp if necessary.)		
• Catheterization kit or individual sterile items:		
• Sterile gloves		
• Waterproof drape(s)		
• Antiseptic solution		
• Cleansing balls		
• Forceps		
• Water-soluble lubricant		
• Urine receptacle		
• Specimen container		

2	**1**	**0**	**PROCEDURE**	**REMARKS**
			1. Introduce self and verify the client's identity using agency protocol.	
			2. Explain to the client what you are going to do, why it is necessary, and how he or she can participate.	
			3. Perform hand hygiene and observe other appropriate infection prevention procedures.	
			4. Provide for client privacy.	

			5. Place the client in the supine position, with knees flexed, feet about 2 feet apart, and hips slightly externally rotated. Drape all except the perineum.	
			6. Establish adequate lighting. Stand on the client is right if you are right-handed, on the client is left if you are left-handed.	
			7. If using a collecting bag and it is not contained within the Catheterization kit, open the drainage package and place the end of the tubing within reach.	
			8. Apply clean gloves and perform routine perineal care to cleanse gross contamination meatus relative to surrounding structures	
			9. Remove and discard gloves. Perform hand hygiene.	
			10. Open the catheterization kit. Place a waterproof drape under the buttocks (female) without contaminating the center of the drape with your hands	
			11. Apply sterile gloves	
			12. Organize the remaining supplies: • Saturate the cleansing balls with the antiseptic solution. • Open the lubricant package. • Remove the specimen container and place it nearby with the lid loosely on top.	
			13. Attach the prefilled syringe to the indwelling catheter inflation hub. Apply agency policy and/or manufacturer recommendation regarding pretesting of the balloon	
			14. Lubricate the catheter 2.5 to 5 cm (1 to 2 in.) and place it with the drainage end inside the collection container.	
			15. If desired, place the fenestrated drape over the perineum, Exposing the urinary meatus	
			16. Cleanse the meatus. NOTE: • The non-dominant hand is considered contaminated once it touches the client's skin. Use your non dominant hand to spread the labia so that the meatus is visible. Establish firm but gentle pressure • Location of the urethral meatus is best identified during the cleansing process. Pick up a cleansing ball with the forceps in your dominant hand and wipe one side of the labia majora in an anteroposterior direction.	
			17. Use great care that wiping the client does not contaminate this sterile hand. Use a new ball for the opposite side.	

			Repeat for the labia minora. Use the last ball to cleanse directly over the meatus	
			18. Insert the catheter • Grasp the catheter firmly 5 to 7.5 cm (2 to 3 in.) from the tip . • Ask the client to take a slow deep breath and insert • Insert the catheter as the client exhales. Slight resistance is expected as the catheter passes through the sphincter. • If necessary, twist the catheter or hold pressure on the catheter until the sphincter relaxes. • Advance the catheter 5 cm (2 in.) farther after the urine begins to flow through it. • If the catheter accidentally contacts the labia or slips into the vagina, it is considered contaminated and a new, sterile catheter must be used. The contaminated catheter may be left in the vagina until the new catheter is inserted to help avoid mistaking the vaginal opening for the urethral meatus.	
			19. Hold the catheter with the non-dominant hand. • For an indwelling catheter, inflate the retention balloon with the designated volume. • Without releasing the catheter without releasing the labia, hold the inflation valve between two fingers of your non dominant hand while you attach the syringe(if not left attached earlier) and inflate with your dominant hand. • If the client complains of discomfort, immediately withdraw the instilled fluid, advance the catheter farther, and attempt to inflate the balloon again. • Pull gently on the catheter until resistance is felt to ensure that the balloon has inflated and to place it in the trigone of the bladder.	
			20. Collect a urine specimen if needed. • For an indwelling catheter preattached to a drainage bag, a specimen may be taken from the bag this initial time only. If necessary (e.g., open system), attach the drainage end of an indwelling catheter to the collecting tubing and bag..	
			21. Examine and measure the urine. In some cases, only 750 to 1,000 mL of urine are to be drained from the bladder at one time. Check agency policy for further instructions if this should occur.	

			22. Secure the catheter tubing to the thigh to prevent movement on the urethra or excessive tension or pulling on the retention balloon . Secure with adhesive and nonadhesive catheter-securing devices	
			23. Hang the bag below the level of the bladder. No tubing should fall below the top of the bag.	
			24. Wipe any remaining antiseptic or lubricant from the perineal area. Return the client to a comfortable position. Instruct the client on positioning and moving with the catheter in place	
			25. Discard all used supplies in appropriate receptacles.	
			26. Remove and discard gloves. Perform hand hygiene.	
			27. Document the catheterization procedure including catheter size and results in the client record using forms or checklists supplemented by narrative notes when appropriate.	
			Total Score ____ X 2 = Score ____ X 15 marks = _____	

OVER ALL REMARKS

_____

_____

_____

_____

Name and Signature of Evaluator _____

Date _____

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Inserting a Nasogastric (NG) Tube
Procedure

PURPOSES

The tube is passed into the patient's stomach without any complications

Equipment	
• Nasogastric tube (8 – 18 French)	• Stethoscope
• Water soluble lubricant	• Irrigation set
• Normal Saline solution or sterile water for irrigation	• Tongue blade
• Flashlight	• Nonallergenic tape
• Tissues	• Glass of water with straw
• Topical anesthetic	• Clamp
• Suction apparatus	• Bath towel or disposable pad
• Emesis basin	• Safety pin and rubber band
• Non sterile, disposable gloves	• Additional PPE
• Tape measure	• Skin barrier
• pH tape	•

Procedure	Rationale
1. Verify the medical order for insertion of an NG tube. Ensures the patient receives the correct treatment	
2. Perform hand hygiene and put on PPE, if indicated	
3. Identify the patient	
4. Explain the procedure to the patient and provide the rationale as to why the tube is needed. Discuss the associated discomforts that may be experienced and possible interventions that may allay this discomfort. Answer any questions as needed	
5. Gather equipment, including selection of the appropriate NG tube.	
6. Close the patient's bedside curtain or door. Raise bed to a comfortable working position;	
7. Assist the patient to high Fowler's position or elevate the head of the bed 45 degrees if the patient is unable to maintain upright position	
8. Drape chest with bath towel or disposable pad. Have emesis basin and tissues handy.	
9. Measure the distance to insert tube by placing tip of tube at patient's nostril and extending to tip of earlobe and then to tip of xiphoid process. Mark tube with an indelible marker	Measurement ensures that the tube will be long enough to enter the patient's stomach

10. Put on gloves. Lubricate tip of tube (at least 2– 4 inches) with water-soluble lubricant. Apply topical anesthetic to nostril and oropharynx, as appropriate.	• Lubrication reduces friction and facilitates passage of the tube into the stomach. • Topical Anesthetics act as local anesthetics, reducing discomfort. Consult the physician for an order for a topical anesthetic, such as lidocaine gel or spray, if needed
11. After selecting the appropriate nostril, ask patient to slightly flex head back against the pillow. • Gently insert the tube into the nostril while directing the tube upward and backward along the floor of the nose. Patient may gag when tube reaches pharynx. • Provide tissues for tearing or watering of eyes. Offer comfort and reassurance to the patient	• Following the normal contour of the nasal passage while inserting the tube reduces irritation and the likelihood of mucosal injury.
12. When pharynx is reached, instruct patient to touch chin to chest. Encourage patient to sip water through a straw or swallow even if no fluids are permitted.	• Bringing the head forward helps close the trachea and open the esophagus. • Swallowing helps advance the tubes, causes the epiglottis to cover the opening of the trachea, and helps to eliminate gagging and coughing
13. Advance tube in downward and backward direction when patient swallows**. If gagging and coughing persist**, stop advancing the tube and check placement of tube with tongue blade and flashlight. If tube is curled, straighten the tube and attempt to advance again.	• Excessive gagging and coughing may occur if the tube has curled in the back of the throat. Forcing the tube may injure mucous membranes.
14. Keep advancing tube until pen marking is reached. Do not use force. Rotate tube if it meets resistance.	
15. Discontinue procedure and remove tube if there are signs of distress, such as gasping, coughing, cyanosis, and inability to speak or hum.	• The tube is in the airway if the patient shows signs of distress and cannot speak or hum. If after three attempts, NG insertion is unsuccessful, another nurse may try or

	the patient should be referred to another health care professional.
16. Secure the tube loosely to the nose or cheek until it is determined that the tube is in the patient's stomach:	• Securing with tape stabilizes the tube while position is being determined.
a. Attach syringe to end of tube and aspirate a small amount of stomach contents.	• The tube is in the stomach if its contents can be aspirated. pH of aspirate can be tested to determine gastric placement. If unable to obtain a specimen, reposition the patient and flush the tube with 30 ml of air. • Current literature recommends that the nurse ensures proper placement of the NGT by relying on multiple methods and not on one method alone.
b.Measure the pH of aspirated fluid using pH paper or a meter. Place a drop of gastric secretions onto pH paper or place small amount in plastic cup and dip the pH paper into it. Within 30 seconds, compare the color on the paper with the chart supplied by the manufacturer.	• Current researches demonstrates that the use of pH is predictive of the correct placement. The pH of gastric contents is acidic (less than 5.5). • If the patient is taking an acid-inhibiting agent, the range may be 4.0 – 6.0.
c. Visualize aspirated contents, checking for color and consistency	• Gastric fluid: green with particles, off white, or brown if the old blood is present. • Intestinal aspirate : clear or straw colored to a deep yellow color; greenish brown if stained with bile. • Respiratory or tracheobronchial fluid : off white to tan , may be tinged with mucus.
d. Obtain radiograph (x-ray) of placement of tube, based on facility policy (and ordered by physician).	• The x-ray is considered the most reliable method for identifying the

	position of NG tube
17. Remove gloves and secure tube with a commercially prepared device (follow manufacturer's directions) or tape to patient's nose. To secure with tape:	
a. Cut a 4 inch piece of tape and split bottom 2 inches or use packaged nose tape for NG tubes	
b. Place unsplit end over bridge of patient's nose.	
c. Wrap split ends under tubing and up and over onto nose. Be careful not to pull tube too tightly against nose	
18. Put on gloves. Clamp tube and remove the syringe. Cap the tube or attach tube to suction according to the medical orders	• Suction provides for decompression of stomach and drainage of gastric contents
19. Measure length of exposed tube. Reinforce marking on tube at nostril with indelible ink	• Tube lengths should be checked and compared with this initial measurement , in conjunction with pH measurement and visual assessment of aspirate. • An increase in the length of the exposed tube may indicate dislodgment. • The tube should be marked with indelible marker at the nostril. • This marking should be assessed each time the tube is used to ensure the tube has not become displaced.
20. Ask the patient to turn their head to the side opposite the nostril the tube is inserted.	• Turning the heads ensures adequate slack in the tubing to prevent tension when the patient turns the head.
21. Secure tube to patient's gown by using rubber band or tape. For additional support, tube can be taped onto patient's cheek using a piece of tape. If a double-lumen tube (e.g., Salem sump) is used, secure vent above stomach level. Attach at shoulder level	• Securing prevents tension and tugging on the tube. Securing the double lumen tube above the stomach level prevents seepage of gastric contents and keep the lumen clear for venting air.
22. Assist with or provide oral hygiene at 2- to 4- hour intervals. Lubricate the lips generously and clean nares and lubricate as needed	• Oral hygiene keeps mouth clean and moist, promotes comfort and reduces thirst.

23. Offer analgesic throat lozenges or anesthetic spray for throat irritation if needed.	
24. Remove equipment and return patient to a position of comfort. Remove gloves. Raise side rail and lower bed.	
25. Remove additional PPE, if used. Perform hand hygiene.	

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Inserting a Nasogastric (NG) Tube

Procedural Checklist

Student Name _____ **Score** _____

Student No. _____

Legend:

2- Performed correctly
1- Performed incorrectly
0- Not performed

Equipment	**Prepared**	**Not Prepared**
• Nasogastric tube (8 – 18 French)		
• Water soluble lubricant		
• Normal Saline solution or sterile water for irrigation		
• Flashlight		
• Tissues		
• Topical anesthetic		
• Suction apparatus		
• Emesis basin		
• Non sterile, disposable gloves		
• Tape measure		
• pH tape		
• Stethoscope		
• Irrigation set		
• Tongue blade		
• Nonallergenic tape		
• Glass of water with straw		
• Clamp		
• Bath towel or disposable pad		
• Safety pin and rubber band		
• Additional PPE		
• Skin barrier		
•		

2	**1**	**0**	**PROCEDURE**	**Comments**
			1. Verify the medical order for insertion of an NG tube.	
			2. Perform hand hygiene and put on PPE, if indicated.	
			3. Identify the patient.	
			4. Explain the procedure to the patient and provide the rationale as	

2	1	0	PROCEDURE	Comments
			to why the tube is needed. Discuss the associated discomforts that may be experienced and possible interventions that may allay this discomfort. Answer any questions as needed.	
			5. Gather equipment, including selection of the appropriate NG tube.	
			6. Close the patient's bedside curtain or door. Raise bed to a comfortable working position;	
			7. Assist the patient to high Fowler's position or elevate the head of the bed 45 degrees if the patient is unable to maintain upright position	
			8. Drape chest with bath towel or disposable pad. Have emesis basin and tissues handy.	
			9. Measure the distance to insert tube by placing tip of tube at patient's nostril and extending to tip of earlobe and then to tip of xiphoid process. Mark tube with an indelible marker	
			10. Put on gloves. Lubricate tip of tube (at least 2– 4 inches) with water-soluble lubricant. Apply topical anesthetic to nostril and oropharynx, as appropriate.	
			11. Ask patient to slightly flex head back against the pillow. • Gently insert the tube into the nostril while directing the tube upward and backward along the floor of the nose. Patient may gag when tube reaches pharynx. • Provide tissues for tearing or watering of eyes. • Offer comfort and reassurance to the patient	
			12. When pharynx is reached, instruct patient to touch chin to chest. Encourage patient to sip water through a straw or swallow even if no fluids are permitted.	
			13. Advance tube in downward and backward direction when patient swallows**.** • **If gagging and coughing persist**, stop advancing the tube and check placement of tube with tongue blade and flashlight. • **I**f tube is curled, straighten the tube and attempt to advance again.	
			14. Keep advancing tube until pen marking is reached. Do not use force. Rotate tube if it meets resistance.	
			15. Discontinue procedure and remove tube if there are signs of distress, such as gasping, coughing, cyanosis, and inability to speak or hum.	
			16. Secure the tube loosely to the nose or cheek until it is determined that the tube is in the patient's stomach:	
			a. Attach syringe to end of tube and aspirate a small amount of stomach contents.	

2	1	0	PROCEDURE	Comments
			b. Measure the pH of aspirated fluid using pH paper or a meter. Place a drop of gastric secretions onto pH paper or place small amount in plastic cup and dip the pH paper into it. Within 30 seconds, compare the color on the paper with the chart supplied by the manufacturer.	
			c. Visualize aspirated contents, checking for color and consistency	
			d. Obtain radiograph (x-ray) of placement of tube, based on facility policy (and ordered by physician).	
			17. Remove gloves and secure tube with a commercially prepared device (follow manufacturer's directions) or tape to patient's nose. To secure with tape:	
			a. Cut a 4 inch piece of tape and split bottom 2 inches or use packaged nose tape for NG tubes	
			b. Place unsplit end over bridge of patient's nose.	
			c. Wrap split ends under tubing and up and over onto nose. Be careful not to pull tube too tightly against nose	
			18. Put on gloves. Clamp tube and remove the syringe. Cap the tube or attach tube to suction according to the medical orders	
			19. Measure length of exposed tube. Reinforce marking on tube at nostril with indelible ink	
			20. Ask the patient to turn their head to the side opposite the nostril the tube is inserted.	
			21. Secure tube to patient's gown by using rubber band or tape. For additional support, tube can be taped onto patient's cheek using a piece of tape. If a double-lumen tube (e.g., Salem sump) is used, secure vent above stomach level. Attach at shoulder level	
			22. Remove equipment and return patient to a position of comfort. Remove gloves. Raise side rail and lower bed.	
			23. Remove additional PPE, if used. Perform hand hygiene.	
			Total Score ____ X 15 marks = _____ marks	

OVER ALL REMARKS

_____

_____

Name and Signature of Evaluator _____ Date _____

Administering an Enema

PURPOSE

• To achieve one or more of the following actions: cleansing, carminative, retention, or return-flow.

Equipment
• Disposable linen-saver pad.
• Bath blanket.
• Bedpan or commode.
• Clean gloves.
• Water-soluble lubricant if tubing not prelubricated.
• Paper towel.
• **Large-Volume Enema:**
• Solution container with tubing of correct size and tubing clamp.
• Correct solution, amount, and temperature.
• **Small-Volume Enema.**
• Prepackaged container of enema solution with lubricated tip

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PROCEDURE	**RATIONALE**
1. Prepare the equipment	
2. Lubricate about 5 cm (2 in.) of the rectal tube.	Lubrication facilitates insertion through the sphincter and minimizes trauma.
3. Run some solution through the connecting tubing of a large-volume enema set and the rectal tube to expel any air in the tubing, then close the clamp.	Air instilled into the rectum, although not harmful, causes unnecessary distention.
4. Introduce self and verify the client's identity using agency protocol.	
5. Explain procedure to the client and provide for client privacy.	
6. Indicate that the client may experience a feeling of fullness while the solution is being administered.	
7. Explain the need to hold the solution as long as possible.	
8. Perform hand hygiene, apply clean gloves and observe other appropriate infection prevention procedures.	
9. Assist the adult client to a left lateral position, with the right leg as acutely flexed as possible, with the linen-saver pad under the buttocks.	This position facilitates the flow of solution by gravity into the sigmoid and descending colon, which are on the left side. Having the right leg acutely flexed provides for adequate exposure of the anus.
10. Insert the enema tube. For clients in the left lateral position, lift the upper buttock	This ensures good visualization of the anus.

11. Insert the tube smoothly and slowly into the rectum, directing it toward the umbilicus	The angle follows the normal contour of the rectum. Slow insertion prevents spasm of the sphincter.
12. Insert the tube 7 to 10 cm (3 to 4 in.).	Because the anal canal is about 2.5 to 5 cm (1 to 2 in.) long in the adult, insertion to this point places the tip of the tube beyond the anal sphincter into the rectum.
13. If resistance is encountered at the internal sphincter, ask the client to take a deep breath, then run a small amount of solution through the tube.	This relaxes the internal anal sphincter.
14. Never force tube or solution entry. If instilling a small amount of solution does not permit the tube to be advanced or the solution to freely flow, withdraw the tube. Check for any stool that may have blocked the tube during insertion. If present, flush it and retry the procedure. If resistance persists, end the procedure and report the resistance to the primary care provider and nurse in charge.	
15. Raise the solution container and open the clamp to allow fluid flow or compress a pliable container by hand.	
• During most low enemas, hold or hang the solution container no higher than 30 cm (12 in.) above the rectum.	The higher the solution container is held above the rectum, the faster the flow and the greater the force (pressure) in the rectum.
• During a high enema, hang the solution container about ,30 to 49 cm (12 to18 in.).	Fluid must be instilled farther for a high enema to clean the entire bowel. See agency protocol.
16. Administer the fluid slowly. If the client complains of fullness or pain, lower the container or use the clamp to stop the flow for 30 seconds, and then restart the flow at a slower rate.	Administering the enema slowly and stopping the flow momentarily decreases the likelihood of intestinal spasm and premature ejection of the solution.
17. After all the solution has been instilled or when the client cannot hold any more and feels the desire to defecate (the urge to defecate usually indicates that sufficient fluid has been administered), close the clamp, and remove the enema tube from the anus.	
18. Place the enema tube in a disposable towel as you withdraw it.	

19. Encourage the client to retain the enema. Ask the client to remain lying down. 20. Request that the client retain the solution for the appropriate amount of time, for example, 5 to 10 minutes for a cleansing enema or at least 30 minutes for a retention enema.	It is easier for the client to retain the enema when lying down than when sitting or standing, because gravity promotes drainage and peristalsis.
21. Assist the client to defecate: Assist the client to a sitting position on the bedpan, commode, or toilet.	A sitting position facilitates the act of defecation.
• Ask the client who is using the toilet not to flush it. The nurse needs to observe the feces.	
• If a specimen of feces is required, ask the client to use a bedpan or commode.	
22. Remove and discard gloves and perform hand hygiene.	
23. Document the type and volume, if appropriate, of enema given. Describe the results.	

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Administering an Enema

Procedural Checklist

Student Name _____ **Score** _____

Student No. _____

Legend:

2-Performed correctly
1-Performed incorrectly
0-Not performed

Equipment:	Prepared	Not Prepared
Disposable linen-saver pad.		
Bath blanket.		
Bedpan or commode.		
Clean gloves.		
Water-soluble lubricant if tubing not prelubricated.		
Paper towel.		
Large-Volume Enema: • Solution container with tubing of correct size and tubing clamp. • Correct solution, amount, and temperature		
Small-Volume Enema: • Prepackaged container of enema solution with lubricated tip.		

2	1	0	PROCEDURE	Comments
			1. Prepare the equipment	
			2. Lubricate about 5 cm (2 in.) of the rectal tube.	
			3. Run some solution through the connecting tubing of a large-volume enema set and the rectal tube to expel any air in the tubing, then close the clamp.	
			4. Introduce self and verify the client's identity using agency protocol.	
			5. Explain procedure to the client and provide for client privacy.	
			6. Indicate that the client may experience a feeling of fullness while the solution is being administered.	
			7. Explain the need to hold the solution as long as possible.	
			8. Perform hand hygiene, apply clean gloves and observe other appropriate infection prevention procedures.	
			9. Assist the adult client to a left lateral position, with the right leg as acutely flexed as possible, with the linen-saver pad under the buttocks.	
			10. Insert the enema tube smoothly and slowly into the rectum, directing it toward the umbilicus, For clients in the left lateral position, lift the upper buttock	
			11. Insert the tube 7 to 10 cm (3 to 4 in.).	
			12. If resistance is encountered at the internal sphincter, ask the client to take a deep breath, then run a small amount of solution through	

			the tube.	
			13. Never force tube or solution entry. Check for any stool that may have blocked the tube during insertion. If present, flush it and retry the procedure.	
			14. If resistance persists, end the procedure and report the resistance to the primary care provider and nurse in charge	
			15. Raise the solution container and open the clamp to allow fluid flow or compress a pliable container by hand.	
			16. During most low enemas, hold or hang the solution container no higher than 30 cm (12 in.) above the rectum.	
			17. During a high enema, hang the solution container about ,30 to 49 cm (12 to18 in.).	
			18. Administer the fluid slowly. If the client complains of fullness or pain, lower the container or use the clamp to stop the flow for 30 seconds, and then restart the flow at a slower rate.	
			19. After all the solution has been instilled or when the client cannot hold any more and feels the desire to defecate close the clamp, and remove the enema tube from the anus.	
			20. Place the enema tube in a disposable towel as you withdraw it.	
			21. Encourage the client to retain the enema. Ask the client to remain lying down. Request that the client retain the solution for the appropriate amount of time, for example, 5 to 10 minutes for a cleansing enema or at least 30 minutes for a retention enema.	
			22. Assist the client to defecate.	
			23. Remove and discard gloves and perform hand hygiene.	
			24. Document the type and volume, if appropriate, of enema given. Describe the results.	
			Total score : 24X 2 = 48 Score _____ x 15 marks = _____ marks 48	

OVER ALL REMARKS

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Name and Signature of Evaluator _____
Date _____