

Manual removal of stool

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Manual removal of stool

Manual removal of poop. Manual stool removal is contraindicated in which of the following scenarios.

Introduction, Aims and Objectives there has been much debate in recent years regarding the digital rectal stimulation interventions (DRS) and manual evacuation of faeces (ME). The discussion seems to depend on the invasive nature of the procedure and potential charges of abuse⁵⁴. Therefore it is vital to clarify the legal and professional aspects of care and also provide guidelines for these interventions. Therefore, this document will provide information and guidance for health professionals within the Leeds Teaching Hospitals. For many patients DRS and ME are essential aspects of care and operators must be ready to perform these procedures in a safe and effective manner.4, 37, 38, 55, 57, also the employers have the responsibility to provide information and training to appease practitioners& fears and finally ensure effective bowel care is provided.37, 40, 55, 57 the main points of reference for these guidelines are three Royal college of Nursing publications; digital rectal examination and manual removal of stool (2006) 55 Bowel care, including digital rectal examination and manual removal of stool (2008) .56 Management of Lower erectile Bowel, including DRE and DRF (2012) .57 More information they are available at the multidisciplinary Association Cord Injury Professionals (MASCIP) spinal publication & Guidelines for the management of neurogenic bowel dysfunction in individuals with central neurological conditions. (2012) .37 It is suggested that all practitioners are familiar with these documents... * NB Please note that these guidelines are familiar with operators within a care setting for adults only. The RCN issued separate guidance on me to nurses working with children and teens, you should ask that. (It rectal exam. Guidelines for nurses working with children and young people& (2005). Back to top What is DRS and ME? DRS is a procedure that involves inserting a gloved finger in / anus, the finger is rotated in a clockwise direction, this technique increases muscle activity reflected in the rectum, rectal increases the pressure that stimulates the rectum to contract Expel feces and relaxes the external sphincter to facilitate this action. ME is the digital removal of feces to prevent accumulation of feces in the rectum, which in turn could lead to incontinence, constipation and increased obstruction of feces. ME usually lasts 15-20 seconds, but usually no more than a minute, but it can be repeated every 5-10 minutes until complete.35 evacuation, 52, 55 Who can perform the procedure? DRS and ME are considered suitable procedures for the undertake 1,37 nurses, 50, 57 registered nurse can perform these procedures if they act within the code Professor of Conduct sexual and scope of professional practice skill requirements 49, 61 Therefore, should ensure that they have the necessary knowledge and skills in the field of DRS and ME and reduce these duties if: are not able to carry out the procedures safely and competently, 47 Back to top Legal and Professional Aspects for Registered Nurses Many nurses are confused about the professional and legal aspects of DRS and ME. These procedures are invasive and risks include colon perforation and bradycardia due to vagal nerve stimulation, 50, 51 However, after a review of the RCN, Continence Counselling Association (ACA) and National Agency for Patient Safety (NPSA) there has never been in recent history a documented incident of perforation during normal neurogenic bowel management. As mentioned above, nurses must act within the Code of Professional Conduct and the purpose of professional practices, thereby ensuring that nurses remain accountable for their own practice. 47 Therefore, if a nurse fails to perform a procedure, which the patient requires, fails to ensure that it is done competently and/or fails to seek advice and/or help, the Board of Nursing and Osteria (NMC) may call the nurse in consideration of their actions.37, 47, 55, 57. The nurse may still be called into consideration if the patient does not suffer any damage and/or/ legal negligence is not able to be established. 55. Employers are also explicit in their expectations of employees. Once a nurse has contracted both orally and in writing, practitioners must perform professional tasks competently and adhere to procedures/policies. 55. Therefore, if a nurse feels less competent in this provision of care, she should inform her line operator and identify their requested training needs. They must also keep their knowledge and skills up-to-date throughout their professional life and thus must regularly participate in learning activities that develop skills and performance. 55. If the work organization allows DRS and ME can be delegated to Health Care Assistants on a patient name basis.6, 55 However, existing care must not be compromised and the registered nurse remains responsible for the delegation of this aspect of care. 55 Medical assistants are also responsible for ensuring that they feel competent in both the theoretical and practical aspects of this procedure and are also familiar with local procedures and guidelines. 55 DRS and ME procedures may also be delegated to care patients and/or patients, as appropriate. Whether a healthcare worker, a worker or a patient should all be assessed as competent and should be subject to regular review/evaluation. These skills should include understanding of the anatomy of the lower gastrointestinal tract, indications for DRS and Me and the indications and exclusions for the procedures. 55 Supervision During the execution of the DRS and of me should also be undertaken on an individual basis at least three times. The Department of Health, Health and Professional Organisms are clear in their expectations but the difficulties still occur in practice. Consequently, following a survey of the Spinal Injury (SIA) (and) association These procedures in general hospitals, the National Agency for the Safety of Patient58, 39 issued four recommendations for all NHS trusts to follow. The NHS Trust should have a policy for me. NHS Trusts must ensure that employees are aware of the risks and dangers of not providing these interventions and know where to access the members of staff who can perform these procedures. No Trusts should ensure that the relevant healthcare professionals are constantly available to teach and procedures are undertaken. No Trusts should recognize that patients with established spinal cord injuries are experts in managing their bowel care. In addition, the Royal College of Nursing55 states that the employment contract or job description must ensure that the employer has given approval for these procedures to be undertaken, that policies and procedures are in situ and training / education are also provided . The Care Quality Commission 10 states that the powers should be evaluated at regular intervals agreed and recently the RCN 57 has recently supported the mandatory study sessions of half a day. Training can be achieved in the clinical area, caring for patients with a competent registered nurse. 64 The training can also be evaluated through local Continence Advisory Services. A factory service is available through the Foundation Ruder and Bowel examination 01536 533255. The related skills Bow from Skills for Health website may also be useful for the practice. 36. It is vital that nurses possess the necessary theoretical knowledge and practical skills to ensure safe and effective care. These theoretical knowledge and basic skills should include knowledge of anatomy and physiology of the gastrointestinal tract in relation to the normal gut. An understanding of the disease and / or dysfunction of the rectum and colon. Awareness of anal and peri-anal common conditions. Ability to discuss the management of constipation options. Knowledge of the type of stool and the ability to identify the type of stool for rectal palpitation. Use of drugs in the intestinal dysfunction. Professional Responsibility. Issues of consent. Documentation. Familiarity with DRS and ME guidelines, including guidance, procedures and precautions. 55 Consideration of cultural and religious.30 convictions, 34, 37, 57 Return to start of Consent Consent is an important, necessary and acceptable professional practice, stating the patient's right to self-determination and alia autonomia.28, 37, 55, 57, 62. When you get the consensus discussion / I offer the opportunity to provide detailed explanations and clear with regard to the treatment and / or interventions and risks. If the patient to have alternative options of intervention can also be discussed. 55. This provision of information can reduce the patient's anxiety and is vital if informed consent is to be truly obtained from a professional and legal position.28, 55 The nurse should not explain any risks or benefits to the patient however all questions questions answer honestly. If a nurse retains information the nurse should have been able to justify this decision court.55 Other factors to consider include. The patient must give the consent to express freely implicit threats or threats should be used. If consent has been obtained in this way is illegal and therefore invalid.55, 67 If there is a lack of consent procedure should not be carried out in litigation against the trust may result.28,55 The patient must have the mental ability to provide consent. Individuals older than 16 years are considered by law to have the mental ability to give permit.55 If there is no doubt about a patient's mental ability advice should address to psychiatric service of the trust. The consent of the patient, verbal or written or implicitly through patient cooperation is the legal means of authorization. There should be documented evidence that the patient has accepted of procedure including that it was present, what information was provided and if the consent was verbal or written.55 a signed consent form is not necessary as it does not demonstrate the consent is valid. However it is normally a good proof that a discussion about consent has maintained.55 The consent must be sought according to the RCN guidelines and in line with the Leeds Teaching Hospital policy on consent. Due to the invasive and intimate nature of these procedures, it is expected that the doctor will seek voluntary consent from the competent patient on every occasion. 37, 57 Revocation of consent may be an indicator that a patient is struggling to understand or cope with the treatment being offered.31 Patients also have the right of a companion during the procedure and must be informed of this. If a companion is able to provide the patient must be told and asked if they wish to continue. This should be documented in notes.42 patient However to safeguard the professional health firm the procedure is recommended to have a companion present especially in acute patients who are relatively familiar with these procedures. It is important to note that in emergency situations such as in an unconscious or sedated patient and/or unavailable subsequent consent kin is difficult to get. Therefore if the treatment is necessary to safeguard the health or life of the patient is not a legal obligation that the patient's consent is obtained.55 Further consideration must be given to patients who may have communication problems, such as language barriers and/or those with a tracheostomy. Return to high diagnosis, investigation, treatment and management. When should nurses undertake DRS and/or ME? The current opinion is that ME can be avoided the improvement of intestinal techniques have been developed.1, 9, 16, 52, 53, 55 Advances in oral, rectal and surgical treatments have also assisted in reducing the need for ME.23, 55 However RCN55, 57 state patients suffering from fecaloma, fecaloma, Defecation and / or incapacity of defecate may require an assisted evacuation. This is more evident in patients suffering from neurogenic intestine. If the usual techniques emptying techniques have not worked DRS and me are essential aspects of the patient's intestinal care regime, guaranteeing an effective evacuation and the prevention of incontinence. The normal intestinal management routines of the Patient should not be interrupted independently of the health setting.1, 23, 29, 31, 55, 58 The RCN55 states that the digital rectal examination (DRE) can be used to establish the following: presence of fecal matter in the rectum, including quantity and consistency. To check if the anal tone is present and the ability to start a voluntary contraction, to what extent, and also to teach pelvic floor exercises. Evaluate anal pathology. Evaluate the anal and rectal sensation. The need and the effects of rectal drugs. Necessity of manual removal of the faeces and evaluation If the intestine is empty after me of the faeces. The result of the Rectal and Coloman Washout / Irrigation. Necessity and results of using digital stimulation to trigger defecation by stimulating the right-anal reflection. It must be recognized that the DRS and ME are invasive procedures and must be carried out only when necessary and after an individual assessment that includes the consideration of cultural and religious convictions and psychological and emotional support.29, 43 the complications of me, whether it is carried out in an acute way that as a consolidated procedure, include anxiety, discomfort, pain, collapse, intestinal drilling, bradycardia, damage to nerve fibers and muscle at the inside the anal sphincter if performed without care and autonomic disreflex (AD) in patients With spinal cord injury (skiing). 27, 37, 50, 51, 52, 55 However, patients with acute and chronic spinal cord injury (skiing) remain the most common patient group, which can rely on DRS and me to ensure an effective intestinal care regime and efficient.12, 29, 37, 43, 55, 57 bankruptcy In these patients the surgery can cause overload, intestinal obstruction, autonomic deafness and, in serious cases, death. It is therefore imperative that the personnel who dealt with the patient's spinal cord injury is able to perform, if necessary, the manual evacuation procedure of the intestine. Back to the starting patients with spinal cord injury A spinal cord injury at any level generally affects the spinal reflex to return is the anal reflex, the anal reflex, which normally returns about 48 hours after injury.27 The patient contracts and then relaxes when touched. This reflex can be used to facilitate the insertion of the finger. Within 24 hours of admission it is essential that the assessment and planned care/intervention are documented. After is absorbed, resulting in a higher risk of constipation, which can lead to obstruction and an increased risk of intestinal perforation.27, 40, 44 If stool accumulation in the rectum is allowed over-tensioning of the elongation receptors The wall inhibits the return of reflected ano-rectal activity, which can further complicate the rehabilitation of patients with an SCI of the upper motor neuron. (UMN), "Automatic", "spastic" or "reflexive bowel" are terms used in UMN lesions. This is where the lesion is located in the center or above the cone marrow (above T12), so these are patients with a cervical or thoracic lesion. In UMN lesions, spastic paralysis of the intestine occurs with an inability to control defecation.8, 15, 56 Even if the nerve pathways are disrupted, the reflexes, which partly control the intestine, are intact and the reflected activity is not inhibited. Therefore, when the rectum is stimulated, it contracts and the reflex emptying of the intestine can be achieved with minimal intervention.7, 52, 66 A whole rectum may be enough to stimulate the intestine, but it may also be necessary to use openings and/or digital removal of the stools.7, 15 People with inferior motor neuron (LMN) SCI have sacral cord segments in the conus medullaris or sacral sacral in the conus or sacral sacral sacral The nerve roots of the equine cauda are damaged (T12 and lower).52 The lower motor neurons, the center of reflected defecation, are damaged with consequent Flaccid bowel analysis.8, 15, 66 Therefore, there is no reflected activity in the rectum, there is a relaxed anal sphincter, and pharmacological or digital stimulation is not effective.18, 68 7, 15, 26, 68 Oral aperitifs should include a stimulating laxative. A lesion around the T12 area of the spine can cause the intestine to adopt a mixture of intestinal effects and functions UMN and LMN. Regardless of whether the SCI is classified as UMN or LMN immediately after the injury, the rectum and ligament are flaccid due to spinal shock, so the use of rectal stimulants and DRS are considered largely ineffective.15, 27 The first resolution of the spinal shock, intestinal training should be initiated which should be relevant to the patient's BSI level. Patients with acute SCI should have a daily PR to assess anal tone.14A If anal tone is not evident and the faeces are present gently, remove the faeces digitally.14 If anal tone is present in UMN SCI, the spinal shock has resolved. Bowel management should be done at about the same time of day, however, a lack of flexibility is equally disadvantageous for the patient with ICS.14 If the lesion is unstable, intestinal care/interventions should be performed while maintaining spinal alignment, i.e. logroll. DRS and ME are established and accepted bowel emptying methods for patients with SCI, which Throughout their entire life.5, 36 It is essential to evacuate patients with an individual SCC and provide intestinal assistance as a result of an evaluation through the evaluation.11, 62 The aim is to produce an effective evacuation, i.e. avoiding the incontinence / constipation of the fecal within a reasonable period Recommended acute hospitalization right now. Therefore, if a patient with a long-term SCI is admitted and uses intestinal irrigation as part of their regimen council should be sought by relevant sources such as the patient, assistants, district nurses and continence counseling service. It is important to reiterate that SCI TM TM patients with established injuries should not have their essential interrupted routine regardless of the setting in which the treatment is provided. Even the motors signals traveling down to control the sphincter and the framework of national services for long-term conditions (neurological) emphasizes the importance of listening to the advice and suggestions.39 It may prove useful to discuss potential changes in bowel management regimes with the patient and local spinal injury nurse to alleviate any unnecessary discomfort or implementation of new routines.55 If the care is denied the nurse can be called into question by the NMC. Finally, health workers should be familiar with the care of the intestine in patients with an SCI. Unfortunately constipation and/or impactivity of the intestine are a common complication in SCI patients outside the specialized setting of spinal wounds, which can involve the autonomous Sflexia dose.27 Back to top Dyrreflexia Autonomus (AD) Failure to run in SCI patients can cause ad, which can be dangerous for life. However, it should also be noted that rectal stimulation can also cause an advertisement in patients with cervical or high thoracic SCI. Therefore, if there is any indication of announcement deriving from the rectal stimulation lidocaine 2%gel should be used to reduce any potential side effects. 66 The ad may occur in any patient with an SCI at T6 or above. 24, 55, 63, 70 Occurs when there is irritation, pain or stimulation below the SCI level. This irritated area sends a signal to the brain so that the stimulus can be removed or rectified. However, in SCI patients the message is not able to reach the brain as it is blocked at the level of the lesion. UN UN action occurs including the release of norepinephrine and dopamine, causing vasoconstriction, which in turn increases the patient's s blood pressure (BP) to potentially dangerous levels, which may cause myocardial infarction, convulsions, cerebral hemorrhage and death.35, 63 Classic causes of AD they are over bowel distension due to constipation and occlusion and excessive pressures or irritation of the bladder including urinary tract infections and blocked any catheter.63A any irritant below the level of the lesion can initiate an episode of ad between those bedsores and clothing.35A tight symptoms include palpitations, sweating, headaches, hives and severe hypertension.A If ad occurs, the cause must be discovered and rectified immediately.27, 63 I implementation of an appropriate bowel management program can drastically reduce the incidence of AD.3 It is important to note that patients with SCI may be som ministered sodium citrate micro-enema (Micollette, Microlax, Relaxi) but should not rou tinely give phosphate enemas as they are difficult to maintain and can cause AD.14 The use of lidocaine gel 2% compared to standard lubricant gel for intestinal invasive interventions and re-catheterization is also indicated for this reason, in patients who are already known to suffer with ad. If the interventions to determine the cause are ineffective and / or the patient's s remains elevated BP should be treated with GTN spray 400 micrograms, sub-lingual.7 If GTN spray is not available, a compressed form of GTN 500 micrograms inserted under the language or a 5mg patch applied to the chest or arm may also be used. However it is important to note that the drug should be discontinued or the patch removed as soon as the BP is reduced. Prescribers should be aware of these signs are not licensed for GTN. If no one else has little or no effect on the patient's s BP in 5-10 minutes after administration, a second dose should be administered. Up to three doses can be given in a 30-minute term.6, 35A If the high BP remains of intravenous drugs may be indicated including morphine and epidural anesthesia. (Ibid). It is important to note that patients with SCI above the level of the T6 can have a relatively low BP due to the actual SCI same then evaluation of patient's s BP must be carried out in individual basis. 63,35However, AD must always be suspected in SCI patients vulnerable in which the systolic pressure increases above the 20-40mmHg INDIVIDUALA s normal level of rest. 35 Also important to consider is if the patient has or had recently taken the drug for erectile dysfunction. The use of phosphodiesterase inhibitors (sildenafil, tadalafil, vardenafil) is contraindicated in patients taking nitrates. Patients recently taken phosphodiesterase inhibitors should have 10mg capsules (unmodified release tablets). These capsules must be swallowed, whole and you can take 15-20 minutes to be effective.35 An acute episode of AD can lead a to a the susceptibility to further attacks in the coming 24/72 hours and increases susceptibility to causes and / or irritants that were not previously problematic. 35 It is evident that DRS and ME are vital aspects of care, especially in patients with a SCI. However, there are warnings and contra indications for these procedures in all patients. For patients needing ME Caution, you must use the following guidelines, CHILDREN (There are separate guidelines). RCN. (2005) Digital Rectal Examination. Guide for nurses working with children and young people. The active inflammation of the bowel. For example, the Crohn's disease, ulcerative colitis. Recently radiation therapy to the pelvic area. Rectal surgery / trauma. abdominal pain, rectal and / or anal. fragility of the tissue due to age, radiation, loss of muscle tone due to neurological or malnutrition diseases. bleeding obvious rectal. the SCI patients who are known to suffer with AD. History of abuse, the history of allergies, ie latex, lanolin. 52, 55, 69 Return to start of contrast indications for patients who require ME Contra indications include the following, lack of patient consent is written, verbal or implied, the doctor the patient is given a specific waste material for the procedure, the patient gain sexual satisfaction from the procedure, abnormalities of the perineal and perianal region. (See more details below) 55, 69 Before es allow DRS or ME nurse must observe the perineal and perianal area. If any of the following are present, council should be required by a trained nurse or doctor. However DRS and ME can still be undertaken if the nurse feels confident and competent. 55 Prolancia rectally. Hemorrhoids & annotates the number, the position and condition. Seals / garments / download, anal lesions. Anu you are giving. Skin conditions, including pressure sores of all grades and areas broken. Bleeding & old / cool. Faecal. Infestation. foreign bodies. Anal Fissure (small tear around the anal area) due to tension or trauma to the intestinal lining and / or the actual procedure of ME. It can be very painful for patients who have sensation and increase the spasm in SCIs no sensation. 44, 55 For all aspects of bowel care is vital that the documentation is clear and complete. What promotes better patient care, including early detection of potential problems, improved communications, evidence and face care legal issues. 57. The guidelines provided by DRS and ME stool have been developed and adapted from the publications of the Royal College of Nursing, Sheffield Teaching Hospital, Southampton University Hospital Trust and East Lincolnshire Primary Care Guidelines for the care dell'intestino.7, 21, 25, 26, 27, 31, 33, 34, 43, 38, 55, 57, 69 Louise Dunsmure Advanced Patient Caust for Neurology and Neurosciences at Leeds General Infirmary also provided advice and information. It is vital to note that all practitioners need to controlBefore using any of the products recommended in the procedures. Returns to the start of procedural guidelines for digital rectal stimulation materials necessary for intervention; Lactex-free exam gloves. Standard lubricating gel / anesthetic gel (lidocaine 2% gel). Disposable cleaning wipes. Disposable protective bearings / incontinence. Materials for cleaning skin. Clinical waste bag. Procedural guidelines guarantee the adequacy of the procedure, including the assessment of the understanding and consent of the patients. Ask if the person wants an escort. Document in breastfeeding notes. Prepare the equipment for the procedure so that it is performed with the minimum possible disturbance. Ensure that privacy and dignity are maintained at any time, even by carrying out the procedure in an undisturbed area. If the intervention was not previously executed or takes place in a basic environment, measure the patient's pressure and the heartbeat before the intervention since the vagal stimulation can slow down the heart rate. In patients suffering from ICS at risk of monitoring blood pressure and pulsations in all health contexts. Wash and dry your hands accurately. Apply an apron and two pairs of latex-free gloves to reduce the risk of cruciate infections. (The patient can develop a latex allergy due to repeated contacts during this procedure). Place the patient in a left side position with the flexed knees. (If the left side position is contraindicated in a patient, the procedure can be performed with the patient lying on the right side. The doctors must be aware of the changed position of the rectal anatomy in this position). Make sure that protective bearings are initiated to protect the sheets. Inform the patient of the imminent exam. Evaluate the anal area for any anomalies, which must be documented and reported to medical personnel. Make sure that the index is well lubricated that reduces superficial friction while helping to prevent trauma to the anal and rectal mucosa. Lubrication also facilitates the insertion of the finger, reduces the feeling and discomfort during the intervention. If the patient previously suffered anesthetics for AD disease (lidocaine 2% gel) it must be used. It takes 5-10 minutes to take effect and can last up to 90 minutes. Insert the index finger gently through the anus with finger bearings facing the intestinal wall 1-2 inch towards the navel. The reason for what is that the finger nail is farther from the intestinal wall and therefore less likely to cause damage. Note Any resistance or contraction reflected by the anal sphincter. If the feeling is obvious or the patient has previously suffered from to, use the anesthetic gel and wait 5 minutes the effect of the anesthetic. If there are feces in the rectum remove pressing the feces towards the spine and remove with the finger. Use a circular movement following the intestinal wall towards the spine to stretch/stimulate the wall and /sfniters internal anal for 15-20 seconds (not more than 1 minute) or until you hear the inner/anal sphincterNB: avoid the pressure toward the prostate, vagina or the bladder. A The circular motion originates from the wrist and the forearm not from the finger. Camps the finger and wait uñ reflected evacuation. Clean your finger between the insertions or remove one of the gloves and replace it if necessary. When you exit the intestine, the buffer wheel to face again the intestinal wall. The digital stimulation can be repeated every 5-10 minutes up to 3 times until the evacuation is complete and the internal sphincter / anal shaking. L complete evacuation is indicated in the case in which two consecutive stimulations not only produce more feces or mucous membranes. When the procedure is over, ensure that the patient is clean and dry. Dispose of the used equipment and maintain strict hygiene measures. Physicians should document the date, time and duration of the procedure, stool consistency and the amount using the Bristol Stool Form Guide. It should also document the use of stimulants rectal (see below) and the number of DRS necessary to ensure a complete evacuation. It is important to note that stimulants rectal can and may be needed to ensure effective defecation of the stool. In the case of the patient with a long-term SCI, the patient should be encouraged to use the toilet and to use a stimulant rectum and left in place for 20-30 minutes, anal reflex may have developed a strength and sufficient coordination to evacuate some feces on the protective clothing. However, a digital examination should take place after this to make sure that la gut is empty, except DRS may also be needed. If the rectum is an excessive amount of feces, can be used, if necessary, a second stimulant rectal dose. Back alla beginning Procedure guidelines for while manual evacuation of stool Materials required for the procedure; Lactex-free exam gloves. Standard lubricating gel / anesthetic gel (lidocaine 2% gel). Disposable protective bearings / incontinence. Disposable cleaning wipes. Materials for cleaning skin. Clinical waste bag. Procedural guidelines guarantee the adequacy of the procedure, including the assessment of the understanding and consent of the patients. Ask if the person wants an escort. Document in breastfeeding notes. Prepare the equipment for the procedure so that it is performed with the minimum possible disturbance. Ensure that privacy and dignity are maintained at any time, even by carrying out the procedure in an undisturbed area. If the intervention was not previously executed or takes place in a basic environment, measure the patient's pressure and the heartbeat before the intervention since the vagal stimulation can slow down the heart rate. In patients with ICS at risk of AD monitor your blood pressure and pulse rate in all contexts Wash and dry hands thoroughly. Apply one apron and two pairs of latex-free gloves to reduce the risk of cross-infection. (The patient may develop a latex allergy due to repeated contact during this procedure.) Place the patient in a left side position with the knees bent. Make sure that there are enough protective pads initu to protect the sheets. The anal area for any anomalies, which must be documented and reported to medical personnel. Inform the patient of an imminent exam. Make sure that the index is well lubricated to reduce superficial friction, which helps prevent trauma to the anal and rectal mucosa. Lubrication also facilitates the insertion of the finger, reduces the feeling and discomfort during the intervention. If the patient previously suffered anesthetics for AD disease (lidocaine 2% gel) it must be used. It takes 5-10 minutes to take effect and can last up to 90 minutes. Gently insert the index through the anus with the pads facing the intestinal wall. The reason is in place that the finger nail is farther from the intestinal wall and therefore less likely to cause damage. Slowly remove fecal material in small quantities to reduce the risk of trauma and / or pain for the patient. If a solid mass is perceived, gently push the index to the center to divide the stool and remove the pieces. When you exit the intestine, the fingertips rotate to tackle the intestinal wall again. A rest period can be needed to allow the stool to descend in the rectum. Repeat until the intestine is empty. If during the intervention the patient warns anguish and / or pain or vaginal activity, check the heartbeat, again and stop if the heart rate has decreased or if the patient is clearly distressed. Use the anesthetic gel and wait 5 minutes before continuing. With time the ano-rectal area can become desensitized to this procedure and almost all patients with an ascertained ICS use standard lubricating gel. Clean the glove finger between listings or changing the upper glove, if necessary. When the procedure is finished, make sure the patient is clean and dry. Dispose of the equipment used and keep rigid hygienic measures. Doctors must document the date, the time and duration of the procedure, the consistency of the faeces and the quantity using the Bristol Form Stool guide. The use of rectal stimulants (see below) must also be documented. During the intervention the person who lends the care can make an abdominal massage 57. If the rectum is full of soft stools, to remove the stools you can use a continuous and delicate movement of the finger, which is still classified as a digital removal of the feces. 57 In a case of ineffectiveness, the patient can be left for another 24 hours to allow the resorption of water content. If the faeces are hard and dried, the use of stimulants can be needed using 2 glycerine substitutes (4 g) or a microenema sodium citrate (Micollette, Microlax, Relaxi) (5 ml volume). Phosphatic enemas should not be used in patients with ICS since this can cause an AD episode.Top Addison, R. (1996) The last resort. 10; 8, 18-20. Addison, R. & White, M. (2002) Spinal lesion and intestinal management. Nursing 98: 4. www.nursingtimes.net. Access to January 2007. Adst, P. & Bishop, C. (1995) Dinareflexia Autonomic: don't let it be a surprise. 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