

STANDARDIZED PROCEDURES

ANAL DILATATION (Neonatal/Peds)

I. Definition

Anal dilation may be required following surgical correction of anorectal malformations including Hirschsprung's disease and imperforate anus or for patients with congenital anal stenosis.

II. Background Information

A. Setting: The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

B Supervision

The necessity of the procedure will be determined by the AHP in verbal collaboration with the attending physician or his/her designee. Direct supervision will not be necessary once competency is determined, as provided for in the procedure. At that time, general or indirect supervision is acceptable.

Designee is defined as another attending physician or fellow who works directly with the supervising physician and is authorized to supervise the AHP.

C. Indications

Congenital stenosis and stenosis of the surgical anastomosis site by exam.

D. Precautions/Contraindications

Clinical instability

III. Materials

Anal dilators are available in Material Services.

IV. Anal Dilations

A. Pre-treatment evaluation

Congenital anal stenosis by exam or surgical correction of an anal malformation.

B. Set up

Ensure correct patient by obtaining two patient identifiers prior to the procedure.
Ensure appropriate equipment is available for procedure.

C. Patient Preparation

Explain procedure to patient.

D. Procedure

1. Patient will be supine with knees flexed. Dilator will be lubricated with water soluble jelly.

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2. A rectal exam will be performed and dilation of the neo-anus will be initiated by the surgeon or surgical nurse with the appropriate size dilator.

E. Post-procedure

1. The patient will be seen two weeks postoperatively. A rectal exam will be performed and dilation of the neo-anus will be initiated by the surgeon or surgical nurse with the appropriate size dilator. Some patients will not require dilation.
2. Anal dilation will be demonstrated to the patient by the surgical nurse or surgeon, followed by a return demonstration.
3. The AHP will instruct the patient in the technique of anal dilation, using water soluble lubricant with the dilator, twice daily for one week. The size of the dilator will be advanced weekly. The patient will be given written instructions and advised when to return to the clinic.
4. Once the maximum size is achieved, dilations will be weaned or discontinued by the surgeon.

F. Follow-up treatment

Return visits to the clinic will be scheduled as needed until dilations are stopped and then PRN.

G. Termination of treatment

Patients will be seen annually once dilations are completed.

V. Documentation

A progress note will be dictated to the referring physician indicating the size of the anal dilator, the frequency of anal dilations and the next scheduled follow-up visit.

A. Documentation will be in the electronic medical record.

1. Documentation of the pretreatment evaluation and any abnormal physical findings.
2. Record the time out, indication for the procedure, procedure, type and size of tube used, method used, EBL, the outcome, how the patient tolerated the procedure, medications (drug, dose, route, & time) given, complications, and the plan in the note, as well as any teaching and discharge instructions.

B. All abnormal or unexpected findings are reviewed with the supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The Advanced Health Practitioner will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.

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2. The Advanced Health Practitioner will demonstrate knowledge of the following:
 - a. Medical indication and contraindications of anal dilation
 - b. Risks and benefits of the procedure
 - c. Related anatomy and physiology
 - d. Consent process (if applicable)
 - e. Steps in performing the procedure
 - f. Documentation of the procedure
 - g. Ability to interpret results and implications in management.
3. Each Advanced Health Practitioner is to directly observe this procedure at least once in its entirety..
4. The attending surgeons or designee will directly supervise each nurse practitioner a minimum of **three** times for each procedure, or more often if needed, until competency is demonstrated.
5. Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the Advanced health Practitioner.
6. A copy of the signed competency certificates will be retained by the practitioner's department for the personnel file and will also be sent to the medical staff office for the credentialing file.

B. Continued proficiency

1. The Advanced Health Practitioner will demonstrate competence by successful completion of the initial competency.
2. Each candidate will be initially proctored and signed off by an attending physician. Advanced Health Practitioner must perform this procedure at least **three** times per year. In cases where this minimum is not met, the attending, must again sign off the procedure for the Advanced Health Practitioner. The Advanced Health Practitioner will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

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VIII. HISTORY OF PROCEDURE

Revised February 2012 by Subcommittee of the Committee for Interdisciplinary Practice

Reviewed February 2012 by the Committee on Interdisciplinary Practice

Prior revision June 2008

Approved February 2012 by the Executive Medical Board and the Governance Advisory Council.

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