TEACHING PLAN FOR: **Ostomy Care of the Adult Patient**

DESIRED PATIENT OUTCOMES:

1. Patient and/or significant other will verbalize understanding of anatomical changes related to bowel/bladder diversion procedure.

2. Patient and/or significant other will verbalize understanding of type, and consistency/frequency of drainage expected for the bowel/bladder diversion.

3. Patient and/or significant other will demonstrate basic skills in ostomy management including emptying pouch, changing the pouching system and describing diet and fluid guidelines.

4. Patient and/or significant other will verbalize understanding of potential complications of stoma type and appropriate management of complications (e.g. peristomal skin irritation).

CLINICAL ASSESSMENT AND CARE:

1. Assess patient’s and/or significant other’s ability to learn necessary content needed for post-operative ostomy management, e.g.:

   a. Ability to attend during teaching sessions

   b. Ability to follow verbal instructions

   c. Ability to read/comprehend written material

2. Assess patient’s and/or significant other’s ability to verbalize understanding of/return demonstrate:

   a. Psycho motor skills need for ostomy management (e.g., changing appliance, emptying and cleaning pouch)

   b. Methods/techniques of managing potential ostomy and peristomal complications

3. Content should be presented as often as possible during hospitalization. Patient and/or significant other will need repeated opportunities to review information and to practice skills needed for independent ostomy management. Change appliance every two to three days post-op, and with any leakage, providing a teaching session with each change.

Pre-operative Session:

1. Review with patient and/or significant other his/her understanding of planned surgical procedure.

   a. Colostomy – may be located in the right lower quadrant (RLQ) or left lower quadrant (LLQ). The consistency of stool can be liquid to pasty, semi-formed, or formed depending on the portion of the colon used to create the stoma (i.e. ascending, transverse, descending/sigmoid)

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b. Ileostomy – usually located in the RLQ. The consistency of stool can be liquid to pasty, and is highly irritating to the skin due to the high levels of caustic proteolytic enzymes.

c. Urostomy/Ileal Conduit – usually located in the RLQ. The drainage is liquid and almost continuous and uncontrollable. An ileal conduit may also produce some mucous as well as urine.

2. Consult with WOCN (Wound Ostomy Continence Nurse) regarding marking of stoma per LIP order.

3. Review/discuss post-operative care specific to diversion procedure:

   a. Location of stoma

   b. Presence of pouch

   c. Type of drainage

4. Provide patient with written educational materials. See nursing website: nursing.uchc.edu.

5. Use written educational materials to review:

   a. Definitions of ostomy, stoma, peristomal skin

   b. What a colostomy, ileostomy, or urostomy/ileal conduit is

   c. Appearance/size of stoma

   d. Type of drainage expected from stoma

   e. Types of appliances appropriate for diversion – show examples of one piece and two piece pouching systems – explain that two piece pouching systems are typically used in the initial post-op period.

   f. Management of odor, gas, constipation, diarrhea, etc.

   g. Results of anticipated surgery on Activities of Daily Living (ADL’s): diet, clothing, hygiene, activity, sexual function

Post-Operative Sessions:

- All patients should participate in the care of their ostomy to the level of their ability, whether by listening, watching, or assisting with/performing care.

- Every nurse and patient interaction provides a teaching opportunity.

- Nurses may refer to Appendix A: Discharge Planning with a New Ostomy – Best Practice for Clinicians.

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Session I – Patient/significant other observes first appliance change during this session.

1. Arrange time for first appliance change to be done (usually post-op day #2) so that significant other can be present if applicable.

2. Review material presented in pre-operative session, especially if patient did not receive the teaching packet.

3. Assess patient's mental status and comfort level prior to initiating session. Medicate for pain relief, if appropriate, prior to initiating appliance change.

4. Review: type of diversion and anatomical changes, current functioning of stoma and presence/function of any tubes or drains.

5. Remove old appliance, reviewing the following:

   a. Gently press down on skin as you lift off skin barrier to decrease tension on skin.

   b. Begin at an upper corner and work around barrier toward the bottom in circular fashion.

   c. When barrier is completely loosened, lift off.

6. Review appearance of stoma and characteristics of healthy/viable stoma:

   a. Color varies from pink to red, and should be moist

   b. Because of superficial blood vessels, may bleed slightly during cleaning or rough handling

   c. Size varies for each patient: stoma is swollen when first created and shrinks for approximately eight (8) weeks

   d. Shape is usually round or oval and may vary with peristaltic movement

   e. Stomas have no sensory nerves (i.e., no feeling)

7. Review cleansing of stoma and peristomal skin:

   a. Gently cleanse skin with warm water, using a soft washcloth, making sure all skin barrier and/or paste is removed. Rinse well with warm water and <u>pat</u> skin dry.

   b. Soap should be avoided if it contains moisturizers or lanolin. Baby wipes should not be used. They will leave a film on the skin that can interfere with the skin barrier sticking to the skin.

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8. Inspect peristomal skin:

   a. The peristomal skin should be intact and without signs of irritation, e.g., rash, erythema, edema, ulcerations.

   b. Review methods of treating symptoms.

9. Explain risk factors for peristomal irritation related to urine, feces and appropriate fitting of appliance.

10. Using measuring card supplied with product, measure stoma. Cut skin barrier to appropriate size and shape, assuring that the opening is no more that 1/8″ larger than the stoma. Explain methods of monitoring/wicking drainage from stoma while stoma is uncovered.

11. If skin is irritated, cleanse the skin with warm water and pat dry. Apply Cavilon No Sting Skin Barrier to peristomal skin except for ileoconduit patients. Cavilon contains no alcohol, so it will not burn the skin.

12. For weeping and excoriated skin, cleanse the skin with warm water and pat dry. Sprinkle a small amount of stoma powder on the affected area and “fan off” excess powder. Apply Cavilon No Sting Skin Barrier over stoma powder and let dry. Stoma powder may be used on patients with ileoconduits, but not Cavilon.

13. If there is any dimpling, creases or irregular surfaces, stoma paste can be used to fill the creases or dimpling. Stoma paste serves as a caulking agent under skin barriers to “fill in” creases or irregular surfaces.

14. To improve skin barrier adherence and wear time, “warm” barrier. Teach patient to “warm” barrier in their hands before application.

15. Remove paper backing from the center of the skin barrier, and apply skin barrier/pouch reviewing the various components of the new post-op usual two piece pouching system:

    a. Place barrier over stoma. Using gentle pressure, rub over barrier until it molds and conforms to the skin. Contact with the skin surface/body heat helps the seal to adhere.

    b. Snap the pouch onto the skin barrier. Tug pouch firmly to check seal of pouch to skin barrier.

    c. Press out majority of air and secure end of pouch with clamp. Roll tail of pouch over clamp once, leaving 1 to 2 inches of pouch tail extending over clamp.

    d. Close spout/valve at bottom of urostomy pouch or attach to foley drainage bag using drain-tube adapter.

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16. Review frequency of emptying pouch (when pouch is 1/3 to 1/2 full). Demonstrate process of "burping" pouch to release gas for colostomy or ileostomy. Demonstrate flipping valve for urostomy to empty pouch.

17. With an urostomy, review attachment of pouch to night collection bags. Review need for drainage of urine away from stoma to prevent stagnation of urine and risk for infection.

18. Discuss with patient requirements for appropriate appliance fit: a) proper fit, b) effectiveness in collecting drainage, c) ease of movement, d) ease of use and e) cost considerations.

19. Review process of emptying appliance and encourage patient to assist with emptying procedure. Provide patient with skin barrier, pouch and clamp to use for practice.

20. Review questions patient/significant other may have related to teaching materials given at this and previous sessions.

Session II – Patient and/or significant other assist with appliance change.

1. Arrange time for appliance change so that significant other can be present if applicable.

2. Ask patient/significant other to review equipment needed for procedure: appliance, measuring card, pen, scissors, skin-prep (Cavilon), stoma powder and paste, warm water and receptacle for used appliance.

3. Have patient/significant other remove old appliance reinforcing instructions regarding process given in Session I.

4. Have patient/significant other review appearance of stoma – Note: color, texture.

5. Have patient/significant other inspect peristomal skin for signs/symptoms of irritation. Have patient review possible etiologies of irritation and methods of management. Assist patient with monitoring/wicking drainage from stoma while stoma is uncovered.

6. Have patient/significant other measure stoma (use mirror to assist with visualizing stoma), and mark and cut skin barrier to appropriate size and shape.

7. Have patient/significant other apply stomahesive powder and Cavilon skin-prep as appropriate.

8. Assist patient/significant other with application of skin barrier/pouch.

9. Have patient/significant other attach clamp or use roll closure with colostomy/ileostomy drain pouch.

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10. Review any questions patient/significant other may have related to: procedure, written material or discharge planning.

11. Have patient begin assuming responsibility for emptying pouch with nursing assistance.

Session III – Patient/significant other perform procedure with nurse providing assistance as needed.

1. Review steps of Session II, monitoring patient's/significant other's ability to adequately perform appliance change and verbalize understanding of: stoma functioning, stoma management, appliance fitting, and management of complications.

2. Review product selection and order numbers and community resources.

3. Review any adaptations needed in home environment to facilitate independent management (e.g., mirror in bathroom, location of all materials in one place, etc.).

4. Review availability of community resources (United Ostomy Association, American Cancer Society, Visiting Nurses Association). Initiate referrals per patient interest and need.

5. Review any questions regarding diet. Refer to Clinical Dietitian.

Additional Sessions:

1. Repeat steps of Session III, encouraging as much independence of patient/significant other as possible.

2. Review any questions regarding: procedure, written material and community resources.

3. Review with patient/significant other signs of potential complications and when to seek assistance:

    a. Changes in output

    b. Skin complications

    c. Stoma complications

    d. Unresolved leaking

    e. Signs of dehydration

    f. Signs of food blockage (ileostomy)

    g. Signs of constipation (colostomy)

    h. Signs of UTI (urostomy)

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4. Review with the patient/significant other how to manage gas and odor:

   a. For colostomy and ileostomy patients: instruct the patient to consider the use of filtered pouches, dietary modifications and deodorants.

   b. For urostomy patients: teach patient to rinse night drainage container with vinegar and water weekly or as needed.

***Consult with MD/LIP if*:**

1. *Patient/significant other exhibits difficulty learning content related to ostomy care.*

2. *Patient/significant other exhibits difficulty performing appliance change/stoma management.*

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/90

REVISION DATES: 5/03, 9/03, 10/05, 12/06, 7/09