Ostomy, Assessment and Management of

Site Applicability

All VCH & PHC sites

Practice Level

Basic skills for the following professions (within their respective scope of practice):

- RN, RPN, LPN, NP

Need to Know

- An ostomy is a surgically created opening between the urinary or GI tract and the skin to divert stool or urine. The types of ostomy include colostomy, ileostomy, jejunostomy, and urostomy (ileal conduit). The name of each ostomy indicates which part of the intestine is used to construct it. An ostomy can be permanent or temporary. This opening is referred to as a stoma. A healthy stoma is pink to red, moist, shiny, and raised above skin level. (see Ostomy Definitions, and Clinical Decision Grid for Assessment of Urinary or Fecal Stoma)
- The underlying etiologies for the ostomy may be cancer, crohn's disease, ulcerative colitis, diverticulitis, bowel obstruction, trauma, congenital conditions, spinal cord injury etc.
- Patients are required to wear pouching systems to collect and contain fecal or urinary output and to protect the skin from irritation. There are a variety of pouching systems available to meet different needs. A Wound Ostomy Continence Nurse (WOCN) / Enterostomal Therapist (ET) nurse can make recommendations to individualize the product choices to the patient's preferences and needs.
- Patients are expected to participate in all aspects of the care of their new ostomies. Health Care Providers (HCPs) should promote patient and family involvement. Patients with an existing ostomy are expected to continue with self care utilizing their own supplies.
- If a patient is unable to care for their own ostomy then a caregiver needs to be taught to care for the ostomy
- Patients with a new ostomies often struggle emotionally with acceptance of their altered pattern of elimination. Compassionate, empathic care will positively impact the patient during this phase of acute adjustment. Be aware of non-verbal expressions.

Practice Guideline

Assessment: (Clinical Decision grid for Assessment of urinary or fecal stoma)

Initial post-operative period which is considered to be the first 72 hrs:

1. General post-operative assessment for bowel or bladder surgery as per agency policy.
2. Stoma assessment should be done every shift in the post-operative period.
3. The stoma can be observed through a transparent pouch system for:
   - Appearance of stoma including location, size, height, colour (check for necrosis by looking for dusky, purple, or black areas) see Clinical Decision Grid for Stomal Complications
   - Amount, consistency and type of output (fecal / urine / gas).
   - Presence of stents in a urostomy or rod (if used) in a loop ostomy.

4. When removing and changing the pouching system within the first 72 hours assess the stoma and peristomal area for:
   - Appearance of stoma including location, size, height, colour (check for necrosis by looking for dusky, purple, or black areas)
   - Mucocutaneous separation (separation between skin and stoma) when changing the pouching system (see Clinical Decision Grid for Peristomal Complications)
5. Assess for urine or stool leakage from under the pouching system – see pouching system change procedure.

Ongoing Assessment:

1. With each pouching system change:
   - Assess as per point #4 above
   - Assess pouching system wear time (This is the length of time between pouch system changes)
2. Assess patient's ability to care independently for their ostomy.
   - Ability to visualize stoma
   - Willingness to participate in care
   - Ability to empty ostomy pouching system
   - Ability to participate with ostomy care including dexterity, vision, physical and mental limitations
   - Patient and family support system
3. Assess patient's psychosocial adjustment to having an ostomy:
   - Ability to visualize the stoma
   - Participates in ostomy management
   - Verbalizes incorporating ostomy management into lifestyle

Management:

1. Notify surgeon, NP, ET / WOCN or designate as soon as noted when:
   - Urostomy has decreased or no urine output (patient should have a urometer drainage bag in the immediate post-op period)
   - Stoma is dusky, gray, or black as this indicates ischemia (see Clinical Decision Grid for Stomal Complications)
   - Increased pain, vomiting and decreased Ileostomy output
   - Ileostomy has scant to no output after the first 24 hours post-operatively
   - Mucocutaneous separation is present
   - Colostomy output is greater than 1000 mL/24 hrs; ileostomy output is greater than 1500 mL/24 hrs
2. The ostomy flange is changed q4days or immediately if:
   - Excessive skin exposure around stoma i.e. greater than 2 mm
   - Leakage and/or odor
   - Patient has itching or burning under the skin barrier
3. Assist and/or teach patient or caregiver to empty pouching system of stool, urine, or gas when ¼ to ½ full.
4. Consult WOCN/ET when there is peristomal skin breakdown, pouching system leakage, frequent pouching system changes related to leakage, and concerns with current pouching system.
5. Consult WOCN/ET if any adjustment concerns or lack of progress with self care.
6. Psychosocial support
   - Refer to an ET/WOCN
   - Discuss emotional response to having an ostomy
   - Discuss impact this may have on their interpersonal relationships
   - Encourage the patient to resume prior activities
   - Discuss impact on financial status
   - Refer to social worker if needed
   - Refer to United ostomy association visitor

Expected Client/Family Outcomes

- To become independent in emptying and applying the pouching system
- Patient or caregiver recognizes when to seek medical attention

Patient/Client/Resident Education

- Teach patient/caregiver specific management related to type of stoma.
  See CPDs: *(link when completed)*
  - Procedure for Changing a One or Two-Piece Fecal Ostomy Pouching System with or without a Rod
  - Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System
- Instruct patient to avoid abdominal strain to prevent hernia formation at the stoma site i.e. lifting *(insert link to new pamphlet once developed)*
- Provide patient care education books to patients:
  (order through Patient Health Education Materials: PHC and VCH)
  - Living with a Colostomy (FK.235.G941)
  - Living with an Ileostomy (FK.235.G9411)
  - Living with an Urostomy (FP.123.G941)
- Provide patient with list of Distributors for ordering supplies as provided by ET/WOCN

Site Specific Practices

Acute Care:

- Patient to be referred to community health nurse upon discharge for all new or revised ostomies unless refused by patient.
- Patient/caregiver and/or family are able to empty the pouching system prior to discharge.
- Patient has spare ostomy supplies prior to discharge.
- Patient knows where to obtain supplies prior to discharge from hospital.
- Patient with an existing ostomy may need to provide own supplies as the hospital may not have access to individualized/custom supplies.
- Patient seen by ET/WOCN prior to discharge.
- Patient to be referred to a dietitian for new ileostomies/colostomies if needed.

Community Setting:

- Community Health Nurse to continue teaching patient and/or caregiver to change ostomy pouching system when at home.
- Patient will be discharged from community when patient and/or caregiver:
  - changes and empties the ostomy pouching system independently
  - knows signs of complication and where to seek help
- If patient or caregiver unable to change the pouching system, consider involving Home Support.

Documentation

As per agency policy

Related Documents

VCH-PHC:

- Procedure for Changing a One or Two-Piece Fecal Ostomy pouching system with or without a rod
- Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) pouching system
- Clinical Decision Grid for Ostomy Accessory Products

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