STOMA CARE

5.1 PRE-OPERATIVE CARE

PRE-OP PROCEDURE

Contact the stoma therapist who will ensure:

1. Pre-operative counselling: The patient fully understands the reasons for the impending surgery which involves the formation of the stoma.
2. The patient fully understands the support and education which will be provided.
3. The stoma is appropriately sited.
4. A small selection of appliances are shown and explained.

ADDITIONAL INFORMATION

An unplanned stoma can be a devastating occurrence. Appropriate and individualised information prior to the procedure has a positive effect on the woman's recovery.

To enable the patient to return to independent living as soon as appropriate.

To ensure as little interference as possible in patients dress standards, whilst meeting the surgical requirements.

Patients are generally apprehensive about the kind of appliances which are available, and about odour and continence.
POST-OP PROCEDURE

- Type: Include details of the stoma.\(^1\)
- Bridges/ rods (in a looped stoma) or urethral stents in a urostomy
- Output.\(^{1,2}\)

2.2 Record and observe for the following in the first 24-48 hours\(^1\):

- Colour of mucosa (e.g. pink, red, dusky, pale, plum, black, and the amount of colour change if not all the same colour) and any ischemia/ necrosis\(^1\)
- Oedema\(^1\)
- Bleeding\(^1\)
- Other complications\(^{1,2}\)
- Activity – record in notes.

2.3 Colostomy

Record the following:

- Flatus
- Faeces (Colour, amount, consistency).

2.4 Urostomy

Record the following:

- Volume and colour
- Haematuria
- Presence of stents and date should be marked on new bag daily.

3. Stomal Formation

Note initially post operatively whether it is small, large oval shaped, flat or convex.

A bridge (loop colostomy/ ileostomy) is usually removed after 7 - 8 days. Post operatively, peristomal sutures are removed at 8 days.

4. Urinary stents are **never** removed without the medical officer’s permission; usually about 10 days post operatively.

A two piece appliance with clear drainable pouch is always used post operatively and whilst the patient is in hospital. A two piece appliance offers ease of care when attending to hygiene needs.

5. Cleanse the stoma at least daily in shower and as required.

ADDITIONAL INFORMATION

- End of loop, flush, retracted, size.\(^1\)
- Presence of stoma and free-flowing urine.\(^1\)
- Volume, colour, consistency & passing flatus.\(^{1,2}\)

Normally pink, moist and healthy looking mucosa. Important to monitor viability. A darkened stoma may denote compromised circulation.

Appliance may be too tight or on crooked. Possibly a small suture bleed; should cease two to three hours post operatively

For example: Retraction, mucocutaneous separation, prolapse, skin allergy, folliculitis, parastomal hernia.\(^1\)

Can denote return to normal gut function, possible constipation or complications (e.g. bleeding).

High output stomas can lead to electrolyte imbalance. Urea & electrolytes should be monitored as required.\(^1\) Diminished output can denote dehydration, or blockage.

Blood may be coming from anastomosis. Stents are in place to protect the anastomosis. Used as a base line for daily observations. A well-formed stoma often determines the patient's ability to manage same at home with comparative ease.

Blood may be coming from anastomosis. Stents are used to provide patency for the transposed ureters into conduit.

It is important to be able to visualise the new stoma. Any change in colour, shape, or size should be reported to the stomal therapist or Senior Nurse at once.

Normal hygiene requirements.
<table>
<thead>
<tr>
<th>POST-OP PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Document the woman's independence, ability and self-management of stoma care.¹</td>
<td>Emptying, changing &amp; fitting the appliance; measuring &amp; cutting aperture &amp; aligning over stoma; skin care and ability to use hydrocollloid powder if pinpoint bleeding across mucosa.¹</td>
</tr>
</tbody>
</table>
5.3 APPLICATION OF STOMA APPLIANCE

EQUIPMENT

- Tray
- 2 Medium plastic bowls
- Warm water
- 1 cut Chux square or non-sterile gauze
- Personal protective equipment (PPE)
  - Optional extras:
    - Skin protective wipes
    - Tape to “picture frame” wafer.

- Stoma measuring guide
- Scissors
- Wafer (base plate)&drainable clear pouch
- Stomahesive paste
- Adhesive solvent (e.g. Remove wipe)

PROCEDURE

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Recommendations for Changing Stomal Appliances</td>
<td>For ease of observation, hygiene and to prevent post-op discomfort associated with appliance change.</td>
</tr>
<tr>
<td>1.1 During hospitalisation the woman wears a clear two piece drainable pouch.</td>
<td>Daily wafer changes in the initial post-op period are simply not required and could cause unnecessary pain and skin tenderness. With encouragement, daily wafer changes, give the woman practice with appropriate assistance whilst in hospital.</td>
</tr>
<tr>
<td>1.2 The base plate is changed every third day until the patient is able to shower independently, and is then done daily whilst in hospital.</td>
<td>Normal hygiene requirements.</td>
</tr>
<tr>
<td>1.3 Reverts to changing the wafer every 3 – 5 days when at home.</td>
<td>It is important to protect peristomal skin at all times thus promoting the woman's comfort and confidence whilst preventing chemical or enzymatic injury damage.</td>
</tr>
<tr>
<td>1.4 The drainable pouch should be changed daily.</td>
<td></td>
</tr>
<tr>
<td>1.5 The baseplate (wafer) should be changed immediately if it is uncomfortable or leaking.</td>
<td></td>
</tr>
<tr>
<td>2. Application of Stomal Appliances</td>
<td>Patients are frequently anxious about stoma care and need to attend to appliance changes as smoothly and efficiency as possible.</td>
</tr>
<tr>
<td>2.1 Advise the woman of the proposed procedure, answer questions and provide privacy.</td>
<td>See Stomal Therapy care plan for size/ type. Wafers are cut to fit individual stomas.</td>
</tr>
<tr>
<td>2.2 Prepare the equipment:</td>
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<tr>
<td>• Measure the stoma</td>
<td>This will increase the woman’s confidence in care of her stoma, thus enabling return to independent daily living.</td>
</tr>
<tr>
<td>• Cut wafer to size (2mm larger than the stoma).</td>
<td>It is important at all times to be gentle when removing appliances thereby conserving integrity of peristomal skin.</td>
</tr>
<tr>
<td>2.3 Involve and encourage the woman’s participation as tolerated.</td>
<td></td>
</tr>
<tr>
<td>2.4 Remove the baseplate gently – in the shower if possible. Commence at the top of the wafer, and moving down; wipe each side with a damp</td>
<td></td>
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</tbody>
</table>
square (or adhesive solvent wipe if required), lifting the wafer as you wipe.

2.5 Cleanse the peristomal skin gently but thoroughly, using disposable cloth and warm water. Important to cleanse skin, gentle attention protects areas under wafer preventing later skin problems and promoting optimum adhesion.

2.6 Pat dry the peristomal skin with clean gauze. Wafer will not adhere to damp skin.

2.7 Inspect the skin for integrity and signs of infection. Early intervention prevents pain and risk of leakage.

2.8 Note & document in the woman's medical record the stoma:
- The size, shape, colour of mucosa, oedema, peristomal skin condition
- The presence of sutures, integrity of mucocutaneous junction, end of loop, Change in size and shape may denote compromised blood supply, incorrect wafer size etc. Diminished output may suggest dehydration, constipation or blockage.
- Output (flatus, colour, volume, consistency)
- The woman's level of ability with appliance change. Document the woman's cooperation, viewing of stoma, questioning & participation to assist future planning and education.

2.9 Make a template if the stoma is an irregular shape and save. Saves time at next wafer change. Still requires measuring each time.

2.10 If using skin preparation (protective / barrier wipe), allow the peristomal skin to dry. For optimal adhesion, skin must be very dry, preventing frequent wafer changes.

If pinpoint bleeding is present, apply a hydrocolloid powder to the mucosa (Stomahesive). Dust off excess to ensure appliance adhesion. Gravity causes urine or faeces to drip down onto peristomal skin. By applying wafer as described, this situation is avoided and thus a good adhesion is achieved.

2.11 Remove the backing paper from the wafer, fit the wafer over the stoma, placing the lower aperture of the wafer directly under the bottom aspect of stoma first, then smooth the remainder of the wafer up over the top of the stoma, ensuring a neat fit, smoothing out creases and wrinkles with finger tips. Ensure no creases within the immediate or peripheral area. Gravity causes urine or faeces to drip down onto peristomal skin. By applying wafer as described, this situation is avoided and thus a good adhesion is achieved.

2.12 Attach the bag to the base plate ensuring connection along the inner circular rim. Ensure the pouch is closed with a roll-Velcro closure or clip if drainable. Gravity causes urine or faeces to drip down onto peristomal skin. By applying wafer as described, this situation is avoided and thus a good adhesion is achieved. Ensures dryness, thus promoting the woman's comfort and confidence.

3. Urostomy pouches are drainable pouches with a tap and maybe capped or attached to a straight drainage bag.

4. **One piece drainage appliance for colostomy:**
- Change as above
- When emptied of faeces, the bag is rinsed via the bottom opening with warm water (large syringe or squeegee bottle is used). Bags to be emptied into the toilet when 1/3 full. If allowed to fill may cause pouch to leak and wafer to shear off. Not normally used post-op. The woman may elect to use a one-piece appliance later at home when recovered from surgery and bowel patterns have returned to normal daily habits.
5.3.1 OBTAINING A SUPPLY OF STOMA APPLIANCES

1. Complete the application forms to register the woman with:
   - West Australian Ostomy Association (joining fee)
   - Commonwealth Department of Health
2. Order supplies as required e.g. Pouches, wafer, skin preparation, deodorant. The nurse with stoma therapy knowledge and experience will decide the number of appliances required. The woman is usually allocated enough equipment for one month, but must be advised to be aware to reorder the appliances when they have approximately a 2 week supply remaining.
3. Supplies can be collected from Ostomy Association which is the only supply point. Alternatively, supplies may be mailed out to Ostomate, who will be responsible for the postage, as all equipment is free.
4. Ensure the patient has complete understanding of use and application of appliances, where to obtain supplies (not available anywhere else except Ostomy Association) and written information on how to contact a Stomal Therapist.
5. A letter of referral must be faxed to the Stomal Therapist, if applicable, particularly if the patient is from the country.
6. A patient referral must also faxed to Silver Chain or the Domiciliary Nurse, for follow-up.

5.4 EMPTYING STOMA BAGS

- Empty all bags when 1/3 full.

**PROCEDURE**

<table>
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</thead>
<tbody>
<tr>
<td>1. Encourage the woman to empty the contents of pouch whilst either sitting beside or standing next to the toilet.</td>
<td>The woman is encouraged to empty the appliance early post-op as it introduces the woman to personal care. Recognise the need for, and provide, the woman and her family with physical and psychological support in the post-operative stage.² ³</td>
</tr>
<tr>
<td>2. If using a 2-piece appliance the drainable pouch may be rinsed through at this time.</td>
<td>It is not necessary to change pouch with each bowel movement.</td>
</tr>
<tr>
<td>3. One-piece appliances may be rinsed. See also previous section 5.3 Application of stoma appliance.</td>
<td></td>
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</tbody>
</table>

All guidelines should be read in conjunction with the Disclaimer at the beginning of this manual.
5.5 REMOVAL OF BRIDGE

BACKGROUND INFORMATION

Bridges support most loop stomas, and allow the stoma to mature by supporting, maintaining eversion and allowing the mucocutaneous junction to heal.

EQUIPMENT

- Base plate and pouch
- Wipes
- Warm water
- Gloves
- Paper bag
- Sterile scissors
- Bluey

PROCEDURE

<table>
<thead>
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</tr>
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<tbody>
<tr>
<td>1. Inform the woman of the procedure. Provide privacy &amp; position the woman on the bed.</td>
<td></td>
</tr>
<tr>
<td>2. Perform hand hygiene and put on gloves.</td>
<td>Reduces exposure to microorganisms.³</td>
</tr>
<tr>
<td>3. Remove the old pouch and base plate carefully and discard.</td>
<td></td>
</tr>
<tr>
<td>4. Clean the stoma and peristomal skin with warm water and wipes, and then pat dry.</td>
<td></td>
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<tr>
<td>5. Examine the bridge closely. Identify both ends.</td>
<td></td>
</tr>
<tr>
<td>6. Remove the bridge sutures if present.</td>
<td></td>
</tr>
<tr>
<td>7. Gently manoeuvre the bridge apart and remove from stoma. Discard.</td>
<td></td>
</tr>
<tr>
<td>8. Observe the stoma and mucocutaneous junction.</td>
<td></td>
</tr>
<tr>
<td>10. Dispose of the gloves &amp; perform hand hygiene</td>
<td>Reduces microorganism transmission.³</td>
</tr>
<tr>
<td>11. Make the woman comfortable.</td>
<td></td>
</tr>
<tr>
<td>12. Document in the notes and on the stoma care plan.</td>
<td>Record the procedure and any abnormality.</td>
</tr>
</tbody>
</table>

*Contact the stoma nurse with any enquiries.
5.6 COLOSTOMY IRRIGATION
The insertion of luke warm water into a colostomy to promote peristalsis and evacuation of faeces.

KEY POINTS
1. Only descending or sigmoid colostomies are suited to regulated irrigation.
2. Assists the evacuation of faeces from the colon before surgery, or with chronic constipation.
3. Assists in regaining control over frequency of bowel actions.

EQUIPMENT
- Cone tipped irrigator
- Belt and base plate for sleeves
- Jug & lukewarm tap water (1000-1500mL)
- Wipes / gauze
- Gloves
- Adhesive Irrigation sleeves, pouch closure clip
- Drip stand
- Irrigation Reservoir (2 litre) and tubing with fluid delivery control mechanism and connecting tubing with safe flow control valve.
- Lubricant
- Paper bag
- Clean pouch and base plate(patient’s own)
- Bucket & lukewarm tap water (1000-1500mL)
- Drip stand
- Gravity assisted infusion.

PROCEDURE

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1. Inform the woman of the procedure &amp; explain.</td>
<td>Explain the rationale for the clean bowel.</td>
</tr>
<tr>
<td>2. Prepare equipment, perform hand hygiene and put on gloves.</td>
<td>Reduces transmission of microorganisms.</td>
</tr>
<tr>
<td>3. Sit the woman on the toilet. Ensure privacy.</td>
<td>Assist patient if necessary.</td>
</tr>
<tr>
<td>4. The woman removes the old pouch and base plate carefully. Discard.</td>
<td>Assist patient if necessary.</td>
</tr>
<tr>
<td>5. The woman cleans the stoma and peristomal skin with warm water and wipes. Pat dry.</td>
<td>Gravity assisted infusion.</td>
</tr>
<tr>
<td>6. Apply the base plate and adhesive irrigation sleeve on the woman &amp; secure the belt, if required.</td>
<td></td>
</tr>
<tr>
<td>7. Fill the reservoir with 1000 – 1500mL of lukewarm tap water. Connect the irrigation equipment and place on a drip stand. Hang the reservoir with the base at shoulder height to prevent the quick flow of water into the colon. Connect the irrigation tubing and cone tip.</td>
<td></td>
</tr>
<tr>
<td>8. Run the warm water through the tubing to expel all air.</td>
<td></td>
</tr>
<tr>
<td>9. Lubricate &amp; insert a little finger into the stoma.</td>
<td>Digital examination to determine angle of insertion.</td>
</tr>
<tr>
<td>10. Lubricate the cone tipped irrigator and gently insert into the stoma.</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>ADDITIONAL INFORMATION</td>
</tr>
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</tr>
<tr>
<td>11. Instil the lukewarm water slowly into the stoma by regulating the control valve. It takes 5-10 minutes to instil the contents of the reservoir into the colon.</td>
<td>Fast flow of water into the colon may cause vertigo, fainting, cramps and nausea. If the woman complains of abdominal pain, stop the procedure and contact a Senior Nurse or Stoma Therapy Nurse.</td>
</tr>
<tr>
<td>12. Remove the cone tipped irrigator, and observe the return of effluent.</td>
<td>Repeat as required.</td>
</tr>
<tr>
<td>13. Remove the irrigation sleeve. Fold the top of the irrigation sleeve and keep the sleeve directed into the toilet. The woman’s own appliance is to be replaced.</td>
<td>Explosive evacuation occurs over 15 minutes</td>
</tr>
<tr>
<td>14. Make the woman comfortable.</td>
<td></td>
</tr>
<tr>
<td>15. Clean the non disposable irrigation equipment, dispose of the other equipment and perform hand hygiene.</td>
<td>Not all equipment is disposable.</td>
</tr>
</tbody>
</table>

CONTACT A STOMA NURSE WITH ANY QUERIES
### 5.7 OBTAINING A UROSTOMY SPECIMEN

**EQUIPMENT**

- Dressing pack
- Warm normal saline (0.9%)
- Sterile and non-sterile gloves
- Sterile fenestrated sheet (if available)
- Clean wafer (if due for a wafer change)
- Skin prep sachet
- Disposable bag
- Sterile disposable catheter (10-12FG male Nelaton catheter)
- Stomal appliance to apply at completion
- Sterile specimen pot
- Sterile gauze
- Sterile lubricant
- Blue disposable incontinence sheet
- Adhesive solvent sachet
- Personal protective equipment (PPE)

### PROCEDURE

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
</table>
| 1.   | Where possible, provide the woman with 3-4 glasses of fluid approximately 10 minutes prior to the procedure.  
Reduces anxiety, allows opportunity for questions, and promotes privacy. |
| 2.   | Provide an explanation to the woman and ensure privacy by closing curtains & doors.  
Standard precautions. |
| 3.   | Perform hand hygiene and put on the PPE.  
Standard precautions. |
| 4.   | Open the dressing pack. Add:  
- Gloves  
- Catheter  
- Lubricant  
- Normal saline.  
Use an aseptic technique. |
| 5.   | Protect the woman and the bed with an incontinence sheet.  
Standard precaution and promotes the woman’s comfort. |
Standard precaution. |
| 7.   | Remove the wafer (if due for wafer change), otherwise remove the drainable pouch and discard.  
Preparation for the procedure. |
| 8.   | Remove the non-sterile gloves, perform hand hygiene, and put on the sterile gloves.  
Adhesive solvent can be used to assist removal, as necessary. |
| 9.   | Clean the stoma with sterile saline and gauze.  
Clean from the inside of the stoma outwards. |
| 10.  | Place the sterile fenestrated sheet if available.  
Preparation for a sterile procedure. |
| 11.  | Lubricate the tip of catheter and insert the catheter into the stoma, no more than 5 – 6 cm.  
Care must be taken not to insert catheter too far, danger of perforation of bowel. |
| 12.  | Place the end of the catheter into the sterile pot and allow urine to drip.  
For sterile collection. Drain at least 5-10mL. |
| 13.  | If the urine output is slow, it may help to roll the patient onto her side.  
The urostomy is not a reservoir, and therefore may take several minutes to drain. |
| 14.  | Remove the catheter and drape, and reapply the drainable pouch.  
For the woman’s comfort. |
15. Label the specimen and send it with the form to the laboratory.
16. Dispose of all equipment appropriately.

REFERENCES (STANDARDS)

RESPONSIBILITY
Policy Sponsor Nursing & Midwifery Director OGCCU
Initial Endorsement April 2002
Last Reviewed July 2014
Last Amended
Review date July 2017

All guidelines should be read in conjunction with the Disclaimer at the beginning of this manual Page 11 of 11