**HACKETTSTOWN REGIONAL MEDICAL CENTER**
**NURSING POLICIES**
**CARE OF THE PATIENT WITH AN OSTOMY**

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**Effective Date: 8/28/2007** | **Policy No: 8620.225b**
**Cross Referenced: old 8620.082a,083a** | **Origin: HRMC Division of Nursing**
**Reviewed Date: 12/2013** | **Authority: Chief Nursing Officer**
**Revised Date: 8/2014** | **Page: 1 of 4**

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## SCOPE
All RNs in inpatient and outpatient departments caring for patients with ostomies.

## PURPOSE
To identify the types of bowel and urinary diversions and the nursing management of the patient with a newly created ostomy.

## DEFINITIONS
Ostomy- A surgical intervention to create an opening into the abdominal wall for fecal or urinary elimination.
Types of ostomies are

1. Bowel – ileostomy, colostomy
2. Urinary – ileoconduit, ureterostomy

## POLICY
- All patients with a newly created stoma will be referred to the wound/ostomy nurse.
- All patients with a newly created ostomy will receive education regarding care of the ostomy.
- Patient and/or caregiver must return demonstration on how to empty appliance prior to discharge.
- Patient or caregiver should be shown how to re-apply appliance prior to discharge
- When cleansing periostomal area do not use bed in bath wipes as they contain lubrication
- When measuring stoma for ostomy appliance, the wafer opening should be 1/8 of an inch from the edges of the stoma
- Do not discard clip or adaptor for urostomy pouches as only one is provided in each box of bags
- When irrigating a colostomy hang irrigation bag 18-20 inches above stoma
- An order from a Provider is required to irrigate a colostomy. The type of solution and amount to be used for irrigation must be part of the order.

## PROCEDURE

### A. ASSESSMENT
1. Observe stoma and skin around stoma for color, skin integrity (budded, flush or retracted).
2. Observe effluent from stoma, smell, color, consistency.
3. Observe existing skin (wafer) and pouch for leakage

### B. INTERVENTION
1. Empty pouch when 1/3 full
2. Change pouch ever 3 - 4 days or prn if leaking or seal disrupted
3. Release gas from pouch as needed

**Note:** for ileostomy, apply skin barrier to skin around stoma and a thin bead of paste around opening in bag.

**C. PATIENT EDUCATION**

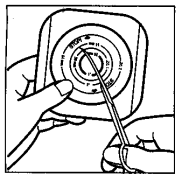
1. Provide educational teaching material
2. Provide teaching video/dvd
3. When educating patient and/or family provide privacy, drape the patient as appropriate and position the patient for education so he/she can participate with pouch change and care
4. Demonstrate how to apply wafer to stoma and apply pouch.
5. Demonstrate application and clamp closure
6. Demonstrate release of gas from pouch
7. Demonstrate procedure for emptying pouch in toilet
8. Patient and/or family return demonstrate on the above.

**D. COLOSTOMY IRRIGATION**

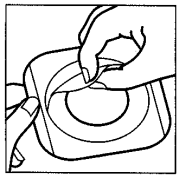
1. Fill irrigating bag with 500 to 1000ml tepid water or saline as amount ordered by Provider
2. Purge air from tubing by allowing the irrigation solution to flow to the tip of the catheter
3. Seat patient in bathroom. Wash hands and Don gloves and dilate stoma using small finger
4. Apply irrigation bag to stoma wafer. Lubricate distal end of catheter cone with water-soluble lubricant and insert cone tip gently into stoma
5. Allow fluid to enter colon and if cramping occurs, clamp tubing and allow patient to rest and alter position slightly. Cramping can be caused by solution flowing too rapidly.
6. Clamp and remove catheter when patient has taken as much solution as possible. Gravity and peristalsis will aid evacuation, which may take about 20 minutes; however, it may require a longer period.
7. After satisfactory irrigation is completed, cleanse area with soap and water and pat dry
8. Replace colostomy bag and wafer if wafer has become loose.
9. Clean equipment with soap and water. Dry before storing in well-ventilated area. Remove gloves and wash hands.

**E. OSTOMY APPLICATION**

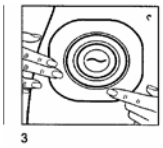
1. Equipment needed:
    a. Stoma measuring guide
    b. Perineal cleanser or soap and water
    c. Stoma wafer
    d. Stoma pouch
    e. Gloves
2. Cleanse the peristomal area with non-medicated soap (periwash), water and pat dry
3. Using stoma measuring guide, measure the stoma and select the smallest opening, which fits comfortably around the stoma without actually touching it.
4. Using cutting guide on the back of the stoma wafer, cut out the appropriate stoma opening.



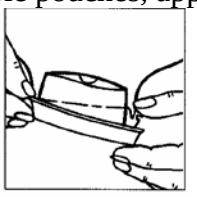
5. Remove and discard the barrier, release paper from the barrier.



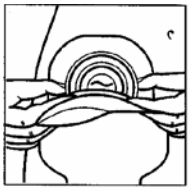
6. Holding the barrier, center the opening in the skin barrier over the stoma. Beginning at a point just below the stoma, gently press the skin barrier against the skin. Avoid wrinkles. Remove the remaining strips of tape backing paper if applicable and press the entire exposed tape adhesive against the skin.



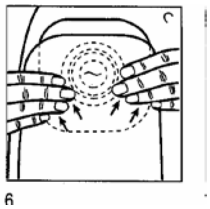
7. For drainable pouches, apply the pouch clamp and press the inner and outer bars together.



8. For urostomy pouches, close the drainage spout or connect to bedside drainage bag using the adaptor found in the box of bags.
9. Holding the pouch flange between your fingers, place your thumbs under the flange of the skin barrier. Place the lower edge of the pouch flange against the lower portion ("6 o'clock position") of the skin barrier flange.



10. Starting at "6 o'clock," press both flanges together while moving upward toward "12 o'clock" and then back down to "6 o'clock." Gently tug downward on the pouch to confirm it is attached securely.



11. Ensure that an adequate seal has been obtained.

12. Gently open top of pouch to release any gas and then seal back into place.

13. Have patient place his/her hand across the stoma and pouch for a few minutes to ensure adherence to the skin.

**E. DOCUMENTATION:**

Document the following in the EHR**:**

1. The date/time, amount of fluid used and results of any colostomy irrigation
2. The application and change of pouching system
3. Any patient and family education regarding ostomy care
4. The date/time of any stoma care provided
5. Assessment finding of the stoma appearance, character of discharge

**REFERENCES:**

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