

Stoma Care for Health Care Assistants

SecuriCare



Introduction

To the Healthcare Assistant

The role of the Healthcare Assistant (HCA), also known as the Healthcare Support worker (HCSW), is increasingly recognised and valued in a variety of healthcare settings. As HCAs take on a wider range of activities, they require the knowledge, understanding and skills to become competent practitioners.

Skills for Health (SfH), the Sector Skills Council for UK health care, has developed a range of workforce competencies including one for stoma care – Unit CHS10, Undertake stoma care (level 3). Stoma Care for Healthcare Assistants has been designed to reflect the performance criteria and knowledge detailed in CHS10. Working through this booklet and the accompanying workbook, together with practical experience in your workplace, will help you to become competent in caring for patients with a stoma.

Although the booklet is aimed at healthcare assistants who work in hospitals, most of the knowledge it contains may be applied in a variety of settings, including primary care.

Learning outcomes.

On completion of the booklet the reader should be able to:

- Identify the different types of stoma, why they are formed and their normal function.
- Recognise stoma abnormalities.
- Discuss the importance of effective communication in stoma care, including cultural and religious considerations.
- Describe the role of the Stoma Care Nurse and the HCA in caring for patients with a stoma.
- Describe care of the stoma patient in the immediate post-operative period.
- Describe the support a patient may need to become independent with stoma care.
- Demonstrate an understanding of the general dietary requirements for the 3 types of stoma.
- Demonstrate an understanding of products used in stoma care.
- Describe requirements for the safe discharge from hospital of a patient with a stoma.

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What is a Stoma?

The word stoma is from the Greek word for mouth and is a surgically created opening in the body.

There are three main types of stoma –

- ◆ **Colostomy** – a stoma formed in the colon (large intestine or bowel).
- ◆ **Ileostomy** – a stoma formed in the ileum (small intestine or bowel).
- ◆ **Urostomy** – different from the other two types of stoma because it is not formed in the digestive system but in the urinary tract (see page 9).

Common reasons why a stoma may be necessary include:

- Obstruction or blockage of the bowel/bladder
- Perforation of the bowel
- Removal of severely diseased bowel or bladder

Common conditions which may sometimes require a stoma include:

- Bowel or bladder cancer
- Diverticular disease
- Ulcerative colitis
- Crohn's disease
- Birth abnormalities of the bowel or bladder in children

A colostomy and an ileostomy may be carried out as a temporary measure (while, for example, another area of the bowel is being allowed to heal), or as a permanent measure.

A urostomy is usually carried out as a permanent measure.

With all three types of stoma, the patient has no control over the output and so will have to wear a pouch or bag on their abdomen to collect either faeces (colostomies and ileostomies) or urine (urostomy).

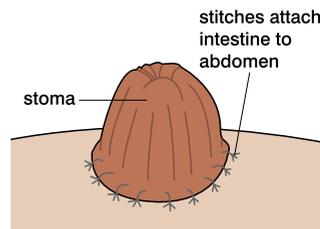
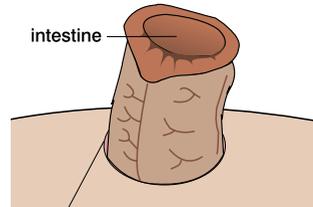
End Stoma

An end stoma is when just one end of the bowel is formed into a stoma.

Loop Stoma

A loop of bowel is brought out through the abdomen. The opened edges are then sutured to the skin. The stoma has two different openings, a functioning opening (proximal loop) and a non-functioning end (distal loop). A loop is sometimes supported by a bridge in the early stages.

Formation of a stoma



How the digestive system usually works

Digestion begins in the mouth where food is chewed. Swallowed food passes down the oesophagus (1) into the stomach (2).

The stomach acts like a liquidizer, churning the food in digestive juices until it is reasonably liquid and passing it into the ileum (3) – also known as the small intestine or small bowel.

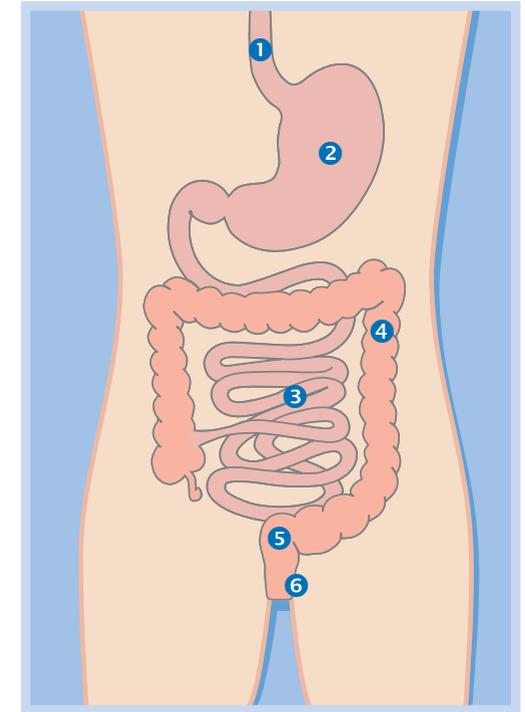
The small intestine is the longest portion of the digestive system – it is more than 6 metres long.

The food passes along the small intestine (the walls of the intestines contain muscles that expand and contract to move the food onwards – this is called peristalsis).

During its journey through the small intestine most of the nutrients in the food are absorbed into the body, leaving a fairly liquid mixture of indigestible matter and water.

This matter passes into the large intestine, or colon (4), which is about 1.5 metres long. The colon's main job is to take water back into the body, maintaining the body's fluid balance. This leaves the indigestible or waste matter (faeces) in a semi-solid form.

At the end of the colon, waste material is stored in the rectum (5) before being expelled through the anus (6).

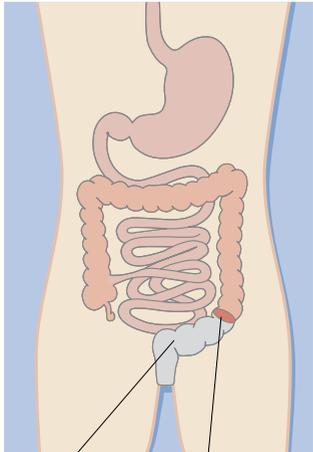


- 1 Oesophagus
- 2 Stomach
- 3 Small intestine - Ileum
- 4 Large intestine – Colon
- 5 Rectum
- 6 Anus

Stoma operations

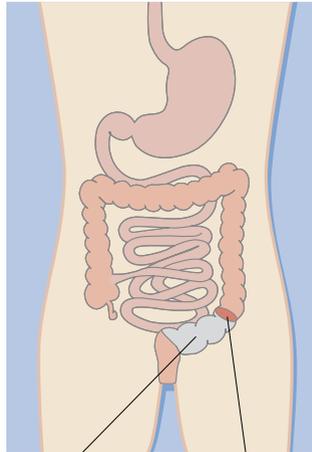
Colostomy

Abdominoperineal Excision of Rectum



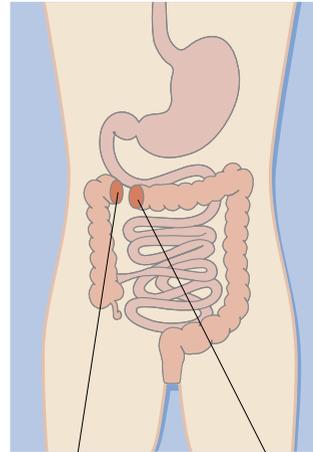
Resected bowel Sigmoid Colostomy

Hartmann's Procedure



Resected bowel Sigmoid Colostomy

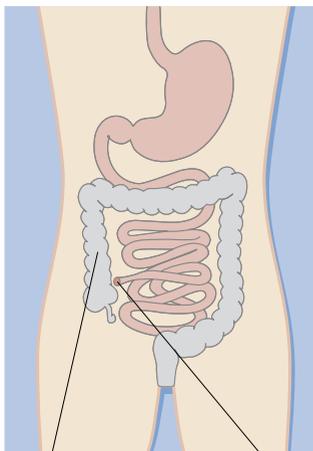
Right Transverse Colostomy (Defunctioning)



Proximal loop Distal loop

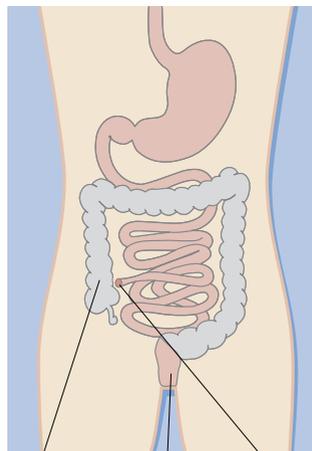
Ileostomy

Panproctocolectomy



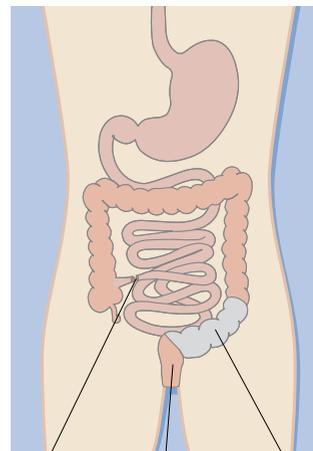
Resected bowel End Ileostomy

Total Colectomy



Resected bowel Rectum End Ileostomy

Anterior Resection with defunctioning ileostomy



Loop ileostomy Rectal stump Resected bowel

Colostomy

Sometimes a part of the rectum and/or colon has to be removed completely (or temporarily bypassed). This means the faeces produced by the body can no longer leave the body via the anus in the usual way.

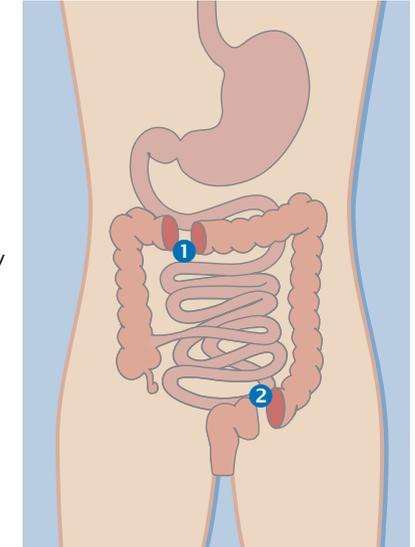
The surgeon therefore needs to create a new outlet for waste material to be passed and this is done by making an opening onto the abdomen at the front of the body.

How it is formed

A colostomy is a surgically created opening in the large intestine or colon. The colon (bowel) is brought through the abdominal wall and sutured to the skin. A colostomy can be formed anywhere in the colon but is commonly positioned on the left side of the abdomen. It may be either a temporary or permanent measure.

Appearance

A colostomy looks like a small spout, deep pink in colour similar to the inside of the mouth. Although it looks raw, it has no feeling. Waste matter (faeces) comes out of the stoma and is collected in a special stoma pouch fitted over it.



The opened part of the colon (1) Transverse or (2) Sigmoid is brought through the abdominal wall and stitched to the skin on the surface of the abdomen.



End colostomy



Loop colostomy

Appliance

A closed stoma pouch is generally used and is attached over the stoma. A colostomate usually changes their appliance once, twice or up to three times a day.



Normal output

The colon usually absorbs water from the waste as it moves along towards the rectum. So the further along the colon the stoma is sited, the thicker and more formed the waste matter or faeces coming out of the stoma will be.

Ileostomy

An ileostomy is a similar type of procedure to a colostomy, except that the stoma is created in the ileum (small intestine) rather than in the colon (large intestine). An ileostomy may be created as a temporary or permanent measure.

How it is formed

An ileostomy is a surgically created opening in the small bowel, the ileum. The end part of the ileum (terminal ileum) is brought through the abdominal wall and sutured to the skin. An ileostomy is generally formed on the right side of the abdomen, usually with a slightly longer spout than a colostomy (because the output is more liquid).

Appearance

The stoma looks like a spout, deep pink in colour similar to the inside of the mouth. Although it looks raw, it has no feeling. Waste matter (faeces) comes out of the stoma and is collected in a special stoma pouch affixed over it.

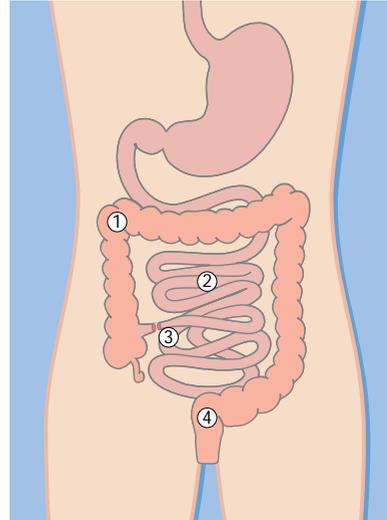
Normal Output

Because the waste matter has not travelled round the colon, little water is absorbed from it and the faeces that comes out of an ileostomy is usually more liquid and in greater amounts than that from a colostomy. The average volume of output is between 500-800ml in 24 hours. An abnormal output would be more than a litre of liquid passed.

Mucous Fistula

Sometimes, if the rectum has not been removed but is left in place, the cut end of that may also be brought to the surface to make a small opening called a mucous fistula. Initially after surgery, excess mucus will drain through the mucous fistula and sometimes, especially when surgery is undertaken as an emergency procedure, retained faeces may pass through.

At first, a small drainable pouch will be used; usually after two weeks or so a stoma cap or small dressing is adequate.



All or part of the colon (1) is removed and sometimes the rectum (4) too. The end part of the ileum (2) is brought through an opening made in the abdomen (3) and stitched in place.

Appliance

An ileostomate usually needs to wear a drainable pouch, so that the pouch may be easily emptied several times a day, on average between 4-6 times in twenty-four hours. The pouch itself is generally changed every day or every other day, according to choice.



Urostomy

How the urinary system usually works

In carrying out its functions, the body naturally produces waste chemicals that pass into the blood.

The kidneys continuously filter the blood to remove the waste matter.

The resulting urine travels from the kidneys through the ureters to the bladder, where it is stored. It is then passed or excreted out of the body via the urethra.

What happens with a urostomy

With a urostomy, urine is no longer passed in the usual way. Instead of being excreted via the bladder and urethra, the urine passes down the ureters from the kidneys and is then diverted out to the surface via an opening (a stoma) on the abdomen. The stoma is usually situated on the right hand side of the abdomen.

How is the stoma formed?

To create the stoma that opens onto the abdomen, the surgeon usually removes a short piece of the ileum (small intestine) and uses it to fashion a kind of tube or spout known as an 'ileal conduit'. (The rest of the ileum is rejoined so that the digestive system functions just the same as before.)

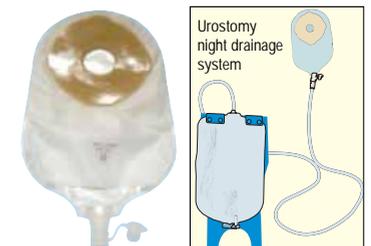
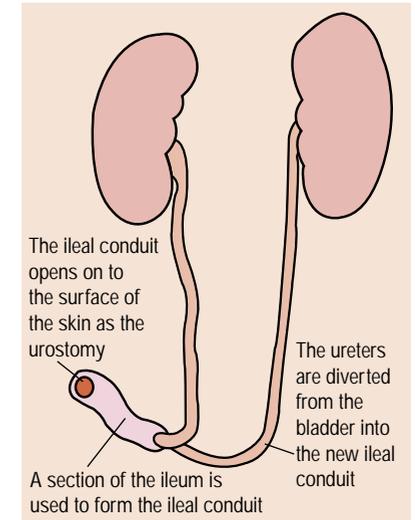
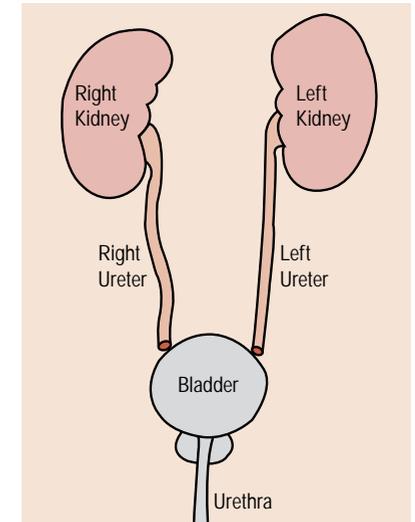
The two ureters are 'plumbed in' to the ileal conduit which opens on to the abdomen as a stoma.

Normal Output

The normal output from a urostomy is a continuous flow of urine, which sometimes contains mucus.

Appliance

Urostomates use a urostomy pouch with a tap which will require emptying several times in twenty-four hours. Urostomates often use a continuous drainable bag at night. The pouch is usually changed every day or every other day.



Role of the Stoma Care Nurse Specialist

Patients who have a stoma formed have particular needs for specialist information, technical skills to manage their stoma and also emotional support. The Stoma Care Nurse (SCN) is responsible for providing a service which meets these needs.

The specific role of the Stoma Care Nurse Specialist varies between localities but many see patients both in the hospital and the community as well as holding nurse led clinics.



There are several components to the role of the stoma care nurse as detailed below.

Component	Example
Clinical	Manages a clinical caseload - provides direct patient care and guides management of stoma care for new and established patients.
Resource	Provides specialist advice on stoma care as member of hospital Multi-Disciplinary Team (MDT). Liaises with community team. Resource for other parties concerned, e.g. voluntary groups, appliance manufacturers.
Education	Provides formal stoma care teaching e.g. study days. Informal ward based teaching. One-to-one & shadowing. Develops educational resources.
Management	Management and administration of Stoma Care Service in hospital and primary care.
Change agent	Development of stoma service in line with medical advances and changes in healthcare provision.
Research/Audit	May be involved in formal stoma care research, product trials. Audit of stoma care service.

Role of the SCN and HCA in the patient pathway

Pathway	Stoma Nurse activities	HCA activities
Pre-operatively Before admission: Patient referred to SCN if stoma surgery indicated Elective patients normally referred prior to admission <i>Emergency patients should be referred to SCN at earliest opportunity</i>	<ul style="list-style-type: none"> Gives detailed stoma information Demonstrates pouch change Provides psychological support Arranges voluntary visitor if required 	<ul style="list-style-type: none"> Check that patient has been referred to SCN Provide reassurance
	Patient admitted	<ul style="list-style-type: none"> Marks stoma site
Post-operatively All HCA actions to be carried out on each shift	<ul style="list-style-type: none"> Assesses stoma & output regularly for any abnormalities 	<ul style="list-style-type: none"> Monitor and record stoma function. Report any abnormalities Assist patient with diet to maintain stoma function
	<ul style="list-style-type: none"> Selects appropriate pouch & reviews according to individual needs 	<ul style="list-style-type: none"> Carry out stoma care according to care plan; record activity Report any problems Ensure adequate supply of appliances available at patient's bedside at all times
	<ul style="list-style-type: none"> Teaches patient self care of stoma 	<ul style="list-style-type: none"> Provide active support for patient in learning self care, maintaining privacy and dignity Record progress & report any problems
	<ul style="list-style-type: none"> Provides ongoing psychological support to patient 	<ul style="list-style-type: none"> Encourage patient to communicate feelings and concerns Report as required to enable needs to be met
Discharge	<ul style="list-style-type: none"> Liaises with MDT & community team to enable safe discharge 	<ul style="list-style-type: none"> Check patient understands arrangements made for discharge and knows how to contact SCN
	<ul style="list-style-type: none"> Arranges appropriate supplies for home 	<ul style="list-style-type: none"> Check patient has adequate (2 weeks) supplies to take home
	<ul style="list-style-type: none"> Provides home visit within 1 week of discharge 	
Rehabilitation	<ul style="list-style-type: none"> Regular follow up at nurse-led community stoma clinic (or home visits) for 3-6 months Liaises with community team 	
Ongoing support	<ul style="list-style-type: none"> Telephone support as required Stoma clinic appointments as required Annual Stoma check-up offered 	

Effective Communication – Verbal

A stoma has a great impact on a patient's body image and self esteem.

- Take a moment to consider how you would feel if you were told you had to wear a pouch on your abdomen to collect faeces or urine – and how this would affect the way you thought about your body.

In communicating with patients with regard to stoma care, you need to take account of both their practical and emotional needs.

- **Practical** needs – how the stoma is managed/looked after – particularly when the patient has just undergone major surgery and/or is elderly or frail.
- **Emotional** needs – how the patient feels about their condition.

Sensitive communication includes using the **right kind of language** and being aware of your **facial expressions**. Dealing with a stoma is a very intimate and personal subject.

- Consider how you can ensure a private, confidential and safe environment when you are communicating with a stoma patient.
- **Listen** to the patient – let them talk about their concerns and worries. These might include: worry about the appearance of the stoma, whether it shows under clothing, is there any odour, how will they manage their stoma, fear of leakage, reaction from other people, effect on work or social activities.
- You may feel that the SCN or other nursing staff should be informed so that the patient's concerns can be dealt with and their needs met.
- There are also patient booklets that give information and support.

On the practical side, when helping patients with stoma management/care, you need to support them in a manner which promotes dignity, privacy and self-respect. You can do this by:

- Obtaining consent before proceeding.
- Agree the best place for pouch changing, e.g. the bathroom.
- Assist patients to retain their modesty during the procedure.
- Recognise any concerns about odour, e.g. by using a special deodorant spray.

You can help stoma patients to achieve **independence** in looking after their stoma by encouraging them to **participate** in stoma care (according to their stage in the care pathway). Observe their technique and give guidance accordingly.

- Use a step-by-step changing guide to assist the patient through the process.
- Consider what factors affect the amount of assistance they require, e.g. medical condition, age, disability, level of dexterity, confidence and etc.

Effective Communication – Written

Effective communication also includes **written** communication – recording events in writing.

- It is important to have accurate and timely recording and reporting in order to maintain the continuity of stoma care, so that everyone knows what is going on and what has been done.
- You should know how and when to refer to the SCN for advice and information.

When stoma patients are admitted, promptly **notify** the Stoma Care Nurse.

- Have you got the contact details of the SCN readily available?
- When does the SCN routinely visit your ward/department?

On every shift, **record all stoma care procedures** in the appropriate documentation, e.g. Care Plan, Care Pathway, Fluid Balance Chart. You need to record:

- any procedure being carried out and why.
e.g. pouch emptying – routine
pouch change – routine
pouch change – because of leakage
- stoma output – record the amount (volume), colour and consistency.
- stoma condition/colour and report any changes or problems, e.g. sudden swelling, stoma unusually pale or dark, sore skin around the stoma.
- the patient's progress towards independence with self-care of stoma; note anything which the patient finds difficult.

When stoma patients are due for discharge, promptly **notify** the Stoma Care Nurse of the planned discharge date. (See also further information on discharge on page 28 – Safe Discharge).



Cultural and religious considerations

Religious and cultural influences may affect how a patient and their family reacts to a stoma and have implications for stoma care. For example, in certain cultures, having a stoma may be regarded as “unclean”, adding to the difficulties for the patient in adjusting.

Ritual washing before prayer is required within some faiths, such as Islam or Hinduism. This may mean changing the stoma pouch more frequently; they may also wish to use running water. The siting of the stoma above or below the level of the umbilicus may be important to a devout Muslim who may also be reluctant to use their right hand when cleaning their stoma (the right hand being used for eating, the left hand for cleaning and hygiene).

Particular dietary requirements or the need for fasting can affect the frequency and consistency of the stoma output and therefore how often the pouch needs emptying or changing.

Caring holistically for a patient means you need to be sensitive to the religious and cultural issues which may affect them and ask for further information when you are unfamiliar with particular requirements. However, there can be wide variety of different beliefs and practices even within the same religious group. How strictly practices are observed can also vary, so it is important not to make assumptions but to make sure you understand the needs of each patient as a unique individual.

Post-operative care

In the immediate post-operative period the patient relies on nursing staff to provide care. In addition to general nursing care, the patient with a stoma has specific care needs at this stage.

- **Monitor and record the condition of the stoma** (colour/size/surrounding skin). It should be checked daily, or more frequently if there is cause for concern. Report any abnormality immediately. *(see section – Stoma Management – recognising abnormalities pages 17 & 18).*

- **Monitor, measure and record the stoma output**
Empty the pouch frequently as a pouch which is allowed to become too full may leak. Leakage can contaminate a wound leading to infection. It is also very unpleasant and demoralising for the patient, causing them unnecessary anxiety which may make it more difficult for them to come to terms with having a stoma. You should report any leakage so that the cause can be assessed and remedied.

Sometimes, certain types of stoma may pass large amounts of very watery output (more than 1 litre of fluid in a day), especially during the first week or so after surgery. In this case, a urostomy pouch and continuous drainage bag may be fitted as a temporary measure to contain the high output.

- As soon as the patient returns to the ward after their operation, **make sure that a stock of the correct stoma equipment is available in the patient’s locker.** Check their supplies every day so that they do not run out of any item.

Typical contents of patient’s individual stock holdall

(these may vary according to individual patient needs and your unit’s own procedures)

- Pouches (clear, drainable pouches for first few days after surgery; then the type may change according to individual needs)
- Pouch clips (if required)
- Small bowl for water
- Disposal bags
- Wipes/swabs (non sterile) – to clean and dry skin
- Adhesive remover
- Ostomy deodorant spray
- Barrier wipes – to protect skin
- Additional accessories as specified in care plan
- Template/measuring guide
- Paper towel/pad to protect clothing



Post-operative care

- **Ensure that the patient is fitted with suitable, leak proof appliance** at all times. A clear drainable pouch should be used in the first few days post-operatively. This allows for frequent emptying of the pouch when the output is very fluid; the clear plastic enables the colour and condition of the stoma to be checked more easily.
- If the patient has a colostomy or ileostomy, you need to **monitor that they start passing wind (flatus) from their stoma**. Therefore, for the first few days post-operatively, the flatus filter on the pouch should be sealed with a special filter cover (these are provided by the manufacturer in each box of pouches). Alternatively, a pouch without a filter may be used.
- Once the stoma has begun to work, **a routine for emptying and changing the pouch should be adopted**. You should record every pouch change in the care plan, stating whether it was a routine procedure or due to an untoward event, such as leakage. Encourage the patient to assist with pouch emptying and changing as soon as their condition allows.



Bridges and Stents

Bridges

The purpose of a bridge or rod is to support a loop colostomy or loop ileostomy following surgery. The rod or bridge is usually external and prevents the loop of bowel which forms the stoma from retracting into the abdomen. Bridges can be made of plastic, rubber or glass. Sometimes they are sutured at each end to the skin surface which may make fitting a pouch more difficult. A bridge usually remains in place for 5-8 days after which time it is gently removed by the stoma nurse, once medical permission has been obtained.



Bridge

Ureteric Stents

When a urostomy is first formed the ureters are plumbed into the piece of bowel which forms the stoma. The join is temporarily protected by using fine bore plastic tubes or ureteric stents. The stents pass along the ureters and out through the urostomy, where the ends of the tubes should be visible at all times. They remain in place for 7-10 days then are gently removed by the stoma nurse, once medical permission has been obtained.

Stoma Management – recognising abnormalities

It is important to be able to recognise the normal from the abnormal in order to monitor, record and report any problems.

Stoma colour

- Normal – pink/red/warm to touch.
Abnormal – black/dusky/pale/sloughy.



Skin

- Normal – Skin surrounding the stoma should be intact.
Abnormal – Any soreness/ulceration/inflammation or broken skin.



Oedema (swelling)

- Normal – In the post-operative period the stoma can be quite swollen. It may reduce in size for about 6 weeks after surgery.
Abnormal – Any sudden or unexplained swelling of the stoma.

Bleeding Stoma

- Normal – A slight smear of blood on the wipe when washing or drying the stoma.
Abnormal – Excessive bleeding when cleaning the stoma/blood in the pouch/bleeding from inside the stoma.

Type of stoma	Normal output	Abnormal output
Colostomy	Passing flatus (wind) is the first sign that the bowel has started to work again after surgery. Soft/formed stool 1-3 times daily (may take a few days to work and can be fluid in the post-operative period).	Constipation - hard stool/no output for over 2 days. Obstruction - no output associated with pain/vomiting/distended abdomen. Diarrhoea. Blood mixed with output.
Ileostomy	Fluid to soft faeces – consistency may vary between "porridge" and watery. [Haemo-serous fluid (pink, clear fluid) and flatus (wind) is normal during the first 48 hours after surgery]. In a 24 hour period output should be approximately 500/800ml.	Should never be constipated. Excessive watery/bile stained output (common in the first few days after surgery). No output for longer than 12 hours. Blood mixed with output.
Urostomy	Continuous flow of urine, should be clear, straw-coloured. Sometimes contains mucus.	Cloudy/offensive/dark/concentrated urine. Increased mucus production/ blood in urine. No urine.
Rectal discharge	Mucus, and sometimes a small amount of faeces may be passed via the rectum when this has been left in place after bowel surgery.	Blood/pus.

Stoma Management – recognising abnormalities

Complications

The following events can cause problems with stoma management and/or leakage from the pouch. You should report if any of these problems occur.

Prolapse

Where an excessive length of bowel protrudes through the stomal opening.



Retraction

Where the stoma shrinks back below the level of the skin.



Skin creases

Creases in the skin radiating from the stoma. Sometimes only evident when sitting.



Stenosis

Where the opening of the bowel has become narrowed.



Parastomal hernia

Abnormal swelling around the stoma due to a weakness of the muscle wall.



Muco-cutaneous separation

Partial or total breakdown of the sutures joining the stoma to the skin edge.

This can be caused by local infection or by a stoma that has been formed under tension.



Sore skin

Products used in the management of stomas

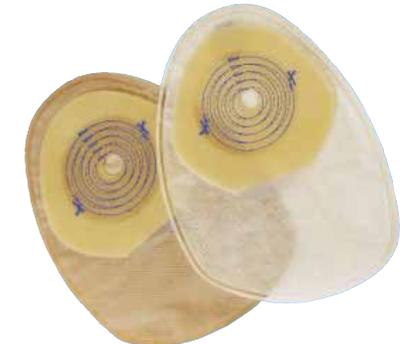
The types of pouches used include:

One-piece, drainable or closed; Two-piece, drainable or closed.

- **Drainable pouches** are generally used when the output will need to be drained frequently, e.g. ileostomies. Special drainable pouches with a tap outlet are used for urostomies.
- **Closed pouches** are generally used for the firmer, less frequent motions of colostomies.
- **One-piece pouches**, as the name suggests, are all in one piece, i.e. the whole thing is removed when the pouch is changed.
- **Two-piece pouches** – available for all types of stoma – have a separate baseplate flange to which a pouch is fitted. The baseplate flange is left in place on the abdomen, with a new pouch fitted when necessary. Every 2-4 days the baseplate flange will need to be changed too.



One-piece drainable pouch



One-piece closed pouch



One-piece urostomy pouch



Two-piece drainable pouch

Products used in the management of stomas

Product	How to use	Purpose	
Adhesive remover <i>Aerosol spray or wipes.</i>	Apply to flange prior to removing pouch.	Softens flange adhesive, makes flange easier to remove, preventing trauma to skin.	
Barrier wipes/sprays/creams <i>Sachet wipes, sprays or sticks.</i>	Apply to the skin around the stoma before fitting the pouch. Some versions contain alcohol – avoid use of these on sore or sensitive skin.	Protects the skin from the corrosive effects of stoma output.	
Protective paste	Apply to broken skin, especially around edge of stoma.	Healing of sore, broken skin.	
Hydrocolloid powder	Apply to sore peristomal skin. Use sparingly, too much may prevent flange adhesion.	Healing of wet, excoriated (sore) skin.	
Washers <i>Discs, varying in size, made from the same hydrocolloid material as pouch flanges.</i>	Position around stoma/on sore skin. Alternatively place on the pouch prior to positioning over stoma.	Assists in skin protection and management of flush and recessed stomas.	
Filler paste <i>In a tube or strips.</i>	Apply to uneven skin prior to fitting the pouch.	Management of leaking pouch caused by uneven skin areas and crease.	
Flange extenders <i>Semi circles or strips of hydrocolloid/microporous adhesive.</i>	Apply around the edge of the flange.	Extra adhesion to flange and increased security for patient.	

Products used in the management of stomas

Product	How to use	Purpose	
Convex pouches/baseplates	Has a flange/baseplate with a noticeable raised area. This puts pressure on the skin around the stoma and encourages faeces/urine to flow into the pouch.	Management of flush and recessed stomas, prevention of leaks. <i>Only to be used when instructed by SCN.</i>	
Belts <i>Narrow elasticated material.</i>	Attach to belt hooks on flange/baseplate.	Assists in the management of flush/recessed stomas	
Ostomy Deodorant Spray or Drops <i>Perfumed sprays or drops.</i>	Spray into the air or drop into pouch.	Disperses odour after emptying and changing pouch.	
Thickening agents <i>Sachets, capsules or strips of special absorbent granules.</i>	Insert into pouch before fitting and after emptying. Thickening agents should not be used immediately post-operatively for at least two weeks, as it gives a false observation of the stoma output.	Absorbs moisture from output. Reduces likelihood of leakage. Reduces frequency of pouch emptying. Useful for excessive and watery output.	
Filter covers <i>Adhesive patches.</i>	Apply over pouch filter to seal it.	Prevents filter becoming wet and ineffective during bathing or showering. Also used to prevent faeces pancaking.	
Stoma Measurement guides <i>Cards displaying holes of various mm sizes.</i>	Apply over stoma to gauge correct aperture of flange.	Ensures correct size of aperture, prevents sore skin/or damage to stoma from incorrect fit.	

Teaching the patient self care

The process of teaching the patient to care for their stoma starts as soon as possible. When the patient is having a planned (elective) operation, the Stoma Care Nurse will normally have begun the teaching process prior to the patient's admission to hospital. If the patient has undergone an emergency operation, they will have had little or no pre-operative preparation and so they are likely to take longer to adjust to having a stoma. Some patients resist taking part in their care in an effort to avoid confronting the reality of having a stoma.

Until the patient has recovered sufficiently for them to learn self care, the procedure for stoma care will be as below, except that the HCA or nurse carries out the actions listed under Patient Action. Explaining each stage helps to familiarise the patient with the process.

Preparation

- Explain the procedure to the patient.
- Apply standard infection control precautions for handling body fluids.
- Assess the patient's level of competence and confidence so that supervision and guidance can be given where needed.
- Encourage the patient to wash their hands before and after the procedure.
- Encourage the patient to think through each step for themselves.
- Report any situation which may prevent you carrying out the procedure.

The importance of good hygiene

The bowel is inhabited by a variety of organisms generally called coliforms; Escherichia coli, Enterococci, Klebsiella and Enterobacters are a few of the more common ones. These can become pathogens (which means capable of causing disease) when they enter other areas of the body such as the urinary tract and wounds. The Urinary Tract is supposed to be free from any organisms, however if hand hygiene or stoma hygiene is not good then either infection or colonisation can occur.

The skin has many organisms that are natural to it such as Staphylococcus epidermidis and Staphylococcus aureus which are potential pathogens if they get in to the body via wounds, catheters, drain sites etc.

In order to minimise the possibility of such organisms causing infection, it is important that you observe standard precautions for infection control when emptying or changing a stoma pouch. These will include hand washing/cleansing before and after the activity, using disposable gloves and aprons, appropriate handling of soiled pouches and equipment and disposing of waste safely.

Teaching the patient self care

Teaching the patient to empty their pouch

Learning to empty their pouch is often the first step towards self care which the patient will undertake. This gives the patient some control over their stoma management.

Empty pouch when half full (the possibility of leaks is reduced if a pouch is not allowed to overfill).

Steps for emptying the pouch

Patient Action	HCA Action	Rationale
Wash hands.	Encourage the patient to wash their hands.	Good hygiene.
If output is being measured, drain into a suitable container. <i>Or</i> To empty directly into the toilet: patient sits on toilet as far back as possible, with legs apart, alternatively they can stand over or kneel by the toilet if they prefer. <i>Toilet paper placed in the bowl will reduce splashing.</i>	Hold container for patient if necessary. Help patient to find a suitable position.	Patient has both hands free to control pouch emptying. Patient is in comfortable position for emptying pouch.
Hold the bottom of the pouch upwards and release the fastening.	Observe patient technique.	Prevent accidental spillage of contents.
Direct contents into the toilet (or container).	Observe patient technique.	Prevent spillage.
Clean the opening of the pouch using tissue.	Observe patient technique.	Prevent soiling of outside of pouch.
Fasten closure securely.	Check fastening secure.	Prevent accidental leakage.
Wash hands.	Encourage the patient to wash their hands.	Good hygiene.

Teaching the patient self care

Changing a pouch

(N.B. The HCA or nurse carries out the whole procedure until the patient is able to take part in self-care)

Set out the following equipment in the area to be used, preferably in the bathroom:

- Bowl or basin of warm water
- Disposal bag
- Adhesive remover
- Wipes/swabs – to clean and dry skin
- Barrier wipe– to protect skin
- Prepared appliance (and clip if required)
- Template/measuring guide
- Ostomy deodorant spray
- Paper towel /cloth to protect clothing
- Additional accessories as specified in care plan
(items may vary according to individual patient needs and your unit's own procedures)



Steps for changing a pouch

	Patient Action	HCA Action	Rationale
	Prepare equipment. Use towel or pad to protect clothing.	Explain product usage.	Familiarises the patient with the procedure.
	Empty drainable pouch.	Encourage patient to empty pouch into the toilet whenever possible.	Prevents spillage when pouch is removed. Promotes normality (this is what they'll do at home).
	Remove pouch.	Encourage the patient to gently remove pouch using an adhesive remover. (If changing a urostomy pouch, use swab over stoma).	Prevents trauma to the skin. (Soaks up urine that comes constantly through the stoma).
	Remove excess soiling on the stoma and surrounding skin with dry swab. Wash stoma and surrounding area with water and dry thoroughly.	Observe patient technique. Note any abnormalities with the stoma and surrounding skin.	Promotes good standard of hygiene minimising the risk of sore skin. Aids adherence of new pouch.

Teaching the patient self care

Steps for changing a pouch (contd)

	Patient Action	HCA Action	Rationale
	Check stoma size.	Encourage patient to measure stoma using either a prepared template or a measuring guide.	A well fitting pouch prevents leakage and minimises the risk of skin damage.
	Prepare new appliance.	If the pouch flange needs adjusting, encourage patient to cut the hole to the required size (using a template if required).	As above.
	Apply skin barrier to skin around stoma. Leave for a few seconds to dry.	Observe patient technique.	Skin barrier helps prevent skin damage and aids adherence of the new pouch.
	Remove the protective cover from the adhesive flange. Apply pouch.	Check the appliance is well adhered with no creases around the flange. For drainable pouches, ensure the outlet is closed!	Prevents leakage and odour.
	Dispose of pouch safely.	Ensure patient is aware of how to dispose of soiled waste bag. When the patient is at home, the used (emptied) pouch and the used swabs are put in a disposal bag, sealed and put into the domestic refuse bin. If the patient is using a flushable pouch, manufacturer's instructions for disposal should be followed.	Adhere to Trust guidelines for the disposal of soiled waste.
	Wash hands.	Encourage the patient to wash their hands. Record activity in care plan and report findings.	Good hygiene. Maintain continuity of care.

You can view the Securicare pouch changing video on our website – www.securicaremedical.co.uk/Pouch-Changing – or visit our site on Youtube. SecuriCare also produce a DVD on pouch changing.

Basic dietary advice for patients with stomas

The aim for all patients who have a new stoma is to return to a normal diet as soon as possible. After stoma surgery, a patient's appetite may be poor, but they may be encouraged to eat small meals at regular intervals until their appetite returns.

New stoma patients may experience excessive wind and odour after eating certain foods, but things often settle down. Precise dietary advice is impossible to give as everybody reacts differently to various foods. Patients with stomas need to experiment with each food several times before excluding it from their diet. The most important advice is to relax and enjoy their food!



Dietary advice for colostomates

General advice:

- There are no dietary restrictions, but individuals vary and some foods may cause a problem, especially in the first few weeks after surgery.
- Eat regular meals.
- Drink a variety of fluids, e.g. water, squash, tea, coffee, milk.
- Aim for 8-10 large cups or mugs per day.

To prevent constipation:

- Increase fibre intake by gradually increasing the amount of fruit and vegetables eaten to at least 5 portions a day.
- Add Bran to a meal (about 2 teaspoons).
- Increase fluid intake, especially water, squash, fruit juice.
- Gentle exercise helps the bowel to function.

If the colostomy functions fewer than two or three times a week, the patient may be constipated. Medical advice should be sought.

Basic dietary advice for patients with stomas

Dietary advice for ileostomates

General advice:

- Because the output is quite fluid, ileostomates should have a good fluid and salt intake to prevent dehydration. Aim for 8-10 large cups or mugs per day (e.g. water, squash, tea, coffee, milk).
- Certain foods, e.g. spicy foods may cause diarrhoea.
- High fibre foods may cause a blockage. Foods to be cautious with include: celery, dried fruit, nuts, coconut, mushrooms, fruit skins, sweetcorn.
- Chew food well – and peel fruit before eating.

If an ileostomy has not functioned for twelve hours medical advice must be sought.



Dietary advice for urostomates

General advice:

- There are no dietary restrictions.
- Drink plenty of fluids to help prevent urinary infections.
- A urostomate can be prone to constipation for the first few weeks after surgery due to disturbance caused by a small piece of bowel being used to form the urostomy.
- Some foods and medicines may discolour the urine.

Patient leaflets giving nutritional advice are available



All SecuriCare information leaflets are available as downloadable PDF files on our website – www.securicaremedical.co.uk.

Safe Discharge

Is the patient ready for discharge?

The patient, or their carer, must be able to manage stoma care when at home. Having helped in teaching the patient self care, do you think he or she (or the carer) is ready to safely manage stoma care? Has the SCN assessed them?

- If you think by the date of discharge that the patient or their carer cannot manage stoma care, you should alert the appropriate member of the hospital team.

When a patient is ready for discharge:

- **Notify** the **Stoma Care Nurse** of the planned discharge date.
- Provide the patient with **contact details** for the SCN.
- Advise the patient who to contact outside normal hours if problems arise following discharge (normally their GP or District Nurse).
- Has the patient been provided with **2 weeks' supplies** to take home, according to their type of stoma? (This will allow time for the patient's first prescription to be processed and delivered).
- Check that the patient can explain how they will **safely dispose of used stoma pouches** at home.
 - Generally, the patient may dispose of used pouches with domestic refuse. Used pouches should be emptied and wrapped securely before disposal. Local regulations vary and may sometimes require that a special waste collection service is used. Check with the stoma care nurse that you know what regulations apply in the patient's area.
 - Flushable pouches have a liner which can be flushed down the toilet.



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