Ostomy Care: What the Bedside Nurse Should Know

- **There is an emotional adjustment after a patient gets an ostomy.** In addition to adjusting to the ostomy, the patient may also be dealing with a cancer diagnosis.

- **Empty the pouch when it’s 1/3-1/2 full of stool and/or gas.** It’s also good to empty it before patient tests/procedures and activities like physical therapy and showering. This will prevent it from pulling away from the skin and causing leakage. This should be the first skill you teach the patient. Once the patient learns this skill he/she can do this independently. Just keep in mind that some patients will still need assistance, just as some patients need help using a bedpan.

- **Know the normal and the red flags for a patient with an ostomy** (see the ostomy problem guide). Assess the stoma, peristomal skin and the output characteristics. Be aware that some foods will change the color of the stool like beets (see the ostomy food chart).

- **Monitor output and hydration status.** High-volume ileostomy output can put patients at risk for fluid and electrolyte imbalances. Becoming dehydrated can put a patient at risk for a bowel blockage. Other risk factors for blockage include certain foods like stringy vegetables, popcorn and mushrooms (see the ostomy food chart).

- **A patient with an ileostomy should never take a laxative**. This can cause severe dehydration. An ileostomy is pretty active, so having reduced or no output can be a sign of an obstruction (not constipation), especially if symptomatic.

- **Enteric coated pills and time-released capsules may not be absorbed especially with an ileostomy**. You will see the pill come out in the pouch in its original form. Liquid or liquid gel medicines tend to absorb faster and may work better for patients.

- **Gently clean the skin around the stoma with warm water and a cloth.** Soaps, lotions, gels and baby wipes are not recommended because they can leave a residue that prevents the pouch from adhering. Skin products are not needed unless the patient is having problems. *Less is more.*

- **Pouches should be changed on a routine basis and sooner when leaking occurs.** A leaking pouch can lead to skin breakdown and cause pouching problems.

- **Before applying a pouch, measure the stoma first.** The stoma shrinks over 6-8 weeks post-operatively and may also change with weight loss/gain. *After applying the pouch, place your hand over it to warm it for 30-60 seconds.* This will help it adhere better and longer.

- **Patience is a virtue.** It is time consuming to change a pouch. It’s not a skill that is best done rushed. Even the most experienced nurses need to redo pouch application at times. Taking the time to do it correctly will pay off in the future with better and longer pouch adherences.

- **Teaching is a joint venture between you and the Wound and Ostomy (WOC) nurse.** The WOC nurse is not available 24/7. The staff nurse should teach the patient/family basic skills when she/he is caring for the ostomy and reinforce what the WOC nurse has taught. If you have a patient that will be getting an ostomy, please ask the physician to order a pre-op WOC nurse consult for teaching. “Wound Ostomy Management” reports that teaching is a significant step in reducing complications. It can also help the patient cope better post-operatively.

* Not all physicians are aware of this. It’s a great opportunity for you to be an advocate.
There are many resources available to you and your patient for education re: ostomy care:

- **Eakin** [http://www.eakin.eu/](http://www.eakin.eu/) Has good educational guides and videos.
- **Shield Healthcare OstomyLife** [https://www.shieldhealthcare.com/community/ostomylife/](https://www.shieldhealthcare.com/community/ostomylife/)
- **United Ostomy Association of America** [www.ostomy.org](http://www.ostomy.org)
- **Wound, Ostomy and Continence Nursing Society (WOCN)** [www.wocn.org](http://www.wocn.org)