Confident Care of the Ostomy Patient: Pouching, Supplies and Managing Skin Breakdown.

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Objectives
- By the end of this Presentation you Should:
  - Understand Basic Indications for Fecal Ostomies
  - Indicate Whether an Ostomy is Permanent or Temporary
  - Understand the Differences Between a Colostomy and Ileostomy
  - Understand General Goals for Patient Education
  - Demonstrate Basic Post Operative Pouching
  - Identify Basic Ostomy Supplies
  - Recognize the Most Common Peristomal skin Complications and Demonstrate Basic Interventions

Indications for Fecal Ostomy

- **Permanent**
  - Removal of sphincters
  - APR
- **Temporary Diversion**
  - Protection of distal anastomosis r/t delayed healing
- **Ileal Anal Reservoir (staged procedure)**
  - Ulcerative Colitis or FAP

End Ostomy

- **End Ostomy – one opening**
  - Division of bowel with proximal end brought through ABD wall
  - Brooke Stoma:
    - Surgical
    - Hartman’s por
    - Nothing per rectum
    - Rectal Evacuation
    - Reanastomosis possible
  - APR (Abdominal Perineal Resection)
  - Permanent Ostomy
    - Abdominal and Perineal incision

Loop Ostomy

- **Loop Ostomy – 2 openings**
  - Temporary Diversion to allow healing
  - Proximal/ Distal End
  - Bridge Device ma

Colostomy

- **Colostomy – Opening created in large intestine**
  - Sigmoid & Descending
    - Generally LLQ
    - May resume NBF
    - Mange with Irrigation
    - Formed stool
  - Transverse or Ascending
    - Uncommon
    - Stool liquid to paste
    - Pouching
    - Closed end
    - Drainable
Ileostomy

- Ileostomy – Created from small bowel
  - Generally LRQ
  - Loose → soft mushy stool
  - Risk of dehydration
    - Teach s/s
  - Skin breakdown
  - Decreased absorption of enteric or time release medications
  - Pouching
    - Only drainable
  - Diet
    - Chew food well
    - Low residue (some teach this)
  - No Bowel Prep Necessary
  - No laxatives

General Post Op Assessment

- Stoma
  - Red/pink/moist/soft
  - MCJ
  - Necrosis, MCJ Separation
- Output
  - Asses for flatus
- Peristomal Skin
  - Should appear similar to skin on the rest of the ABD

General Ostomy Education

General Ostomy Education

- Stoma
  - 6-8 weeks of edema
  - Inversion
  - Use Cut to Fit Hole
  - Pre Cut
  - Post healing

- Pouch
  - Average Change
  - 2x per week
  - Odor Proof & Waterproof
  - Empty 1/2 – 1/3 Full
  - Cleanse with soft cloth
  - Water or mild soap
  - Assess peristomal skin
  - Skin must be clean and dry to place new pouch

- Activities of Daily Living
  - No absolute dietary restrictions
  - Can bathe with or without the pouch
  - Lifting limitations
  - Sex

Prior to Discharge

- Patient should:
  - Demonstrate how to empty and change
  - Verbalize how to obtain supplies
  - Know their resources
    - MD
    - WOCN
    - UOAA

Ostomy Stations

Basic Pouching
**Pouching Goals**

- Secure pouching system for predetermined period of time.
- Independence with Pouch Changes.
- Independent Emptying.

**Emptying**

1. 1st goal for patient education.
2. Start when patient is ambulatory.
3. Allow patient time to practice with assist.

1. Prepare the pouch.
2. Open against gravity.
3. Empty into toilet.

**Pouching Assessment**

1. Consistency of stool
2. Budded, flat, retracted, creases
3. Abdominal contours

**Basic Pouching**

**Goal:** protect Peristomal skin while clearing the stoma & maintaining the seal!

1. Clean the peristomal skin
2. Measure or utilize pattern
3. Cut or mold the wafer
4. DRY, DRY, DRY
5. DRY AGAIN!
6. Apply additives as needed
7. Apply system to clean dry skin
8. Apply gentle pressure/warmth

**Managing Exudate**
# Supplies

- **Supplies**

## Pouching Options

<table>
<thead>
<tr>
<th>Pouching Options</th>
<th>Drainable</th>
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<tbody>
<tr>
<td>Ileostomy or Colostomy</td>
<td></td>
</tr>
<tr>
<td>Closed End</td>
<td>Sigmoid Colostomy or patient with regular Bowel Movements</td>
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<tr>
<td>Cut to fit</td>
<td>Post operative period</td>
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<tr>
<td></td>
<td>Irregular shaped stoma</td>
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<td>Precut</td>
<td>6-8 weeks post op</td>
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<td></td>
<td>Round</td>
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<tr>
<td>Moldable</td>
<td>6-8 weeks post op</td>
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<tr>
<td></td>
<td>Irregular shaped stoma</td>
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<table>
<thead>
<tr>
<th></th>
<th>Closed End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat</td>
<td>Colostomy</td>
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<tr>
<td></td>
<td>Budded stoma</td>
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<tr>
<td></td>
<td>Flat abdomen</td>
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<tr>
<td></td>
<td>Stump abdomen</td>
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### Products

- **Products**
  - **Barriers – Rings/Strips/Paste**
    - Protect from high output or caustic enzymatic drainage
    - Improve the pouch seal by creating a uniform surface
    - DO NOT increase stickiness
    - Use directly around stoma or use as “filler” uneven skin surface
  - **Paste**
    - Similar function - use to fill small defects
    - Most contain alcohol

## Basic Pouching

### Skin Creases at 3:00 and 9:00

#### Utilizing Paste to “Caulk”

Correct

Incorrect

Yikes!

#### Utilizing Barrier strips to “Caulk”

Incorrect

Correct
**Powders and Sealants**

- **Stoma Powder**
  - Used on wet weepy skin
  - Used to dry adhesive for removal

- **Barrier Film or Sealants**
  - Used to seal in stoma powder or antifungal
  - Used to protect skin against moisture or adhesive stripping

**Odor Elimination**

- **Drops**
- **Lubricating Deodorant**
- **Spray**
- **Other Alternatives**

**Belts & Support**

Additional support at 3:00 and 9:00

**Complications**

**Peristomal Complications – Stomal Necrosis**

- **Cause:**
  - Death of stomal tissue r/t inadequate blood supply
- **Evidenced by:**
  - Change in color, hydration, and turgor
  - Brown, black, dry, limp
  - Extent varies
- **Managed by:**
  - Notification to surgeon
  - Monitor during post operative period 3-5 days
  - Necrotic tissue can slough
  - Can result in retraction or MCJ separation

**Peristomal Complications – Irritant Dermatitis**

- **Cause:**
  - Contact between skin and enzymatic drainage due to leaking pouch
- **Evidenced by:**
  - Denuded area surrounding the stoma and extending
  - Matching Pattern of leakage on back of pouch
  - **Pain**, burning, stinging
- **Managed by:**
  - Treating the cause
  - “Crusting” over weepy skin
  - Hydrocolloid dressing
**Denuded Skin**

Note Hydrated Area

**Treatment - CRUSTING**

1. Dust Area with Stoma Power
2. Gently brush off excess (powder will stick to denuded area)
3. Seal in with a “Sting Free” Barrier

**Leaking Ileostomy Damage Crusting Technique**

**Hydrocolloid Barrier Sheet**

1 Week after Treatment

**Peristomal Complications - Mechanical**

- Causes:
  - Scrubbing, picking
  - Traumatic removal of pouching system
- Evidenced by:
  - Patchy skin loss
  - Folliculitis
- Managed by:
  - Treating the cause
    - Push pull technique
    - Gentle cleansing of stool from skin
    - Skin sealant
  - “Crusting” over weepy skin
    - Shaving or clipping

**Complications - Fungal/ Yeast Dermatitis**

- Causes:
  - Moisture
  - ABX
- Evidenced by:
  - Maculopapular rash
  - Satellite lesions
  - Pruritis
- Managed by:
  - Treating the cause
  - “Crusting” with antifungal powder
Peristomal Wounds

- Causes:
  - Pressure
  - Convex pouching over hernia or protruding abdomen
  - Inflammatory process (Pyoderma)
  - Crohn’s, Ulcerative Colitis, RA
  - Mucocutaneous separation
    - Malnourished, steroid use
- Recommend:
  - Consult to WOCN, MD, Dermatologist

Peristomal Complications - Hernia

- Causes:
  - Protrusion of bowel into subcutaneous tissue
  - Obesity, Weight gain
- Evidenced by:
  - Bulge in peristomal area
- Recommend:
  - d/c Irrigation
  - Hernia Belt
  - Monitor for complications
    - Incarceration
    - Strangulation
  - Prevention
    - Avoid lifting 6-8 weeks
    - Avoid weight gain

Thank You!

References