ST. MONICA'S HOME FOR THE ABANDONED ELDERLY
STOMA CARE

NAME:	DATE SERVICE STARTED:

Nursing Diagnosis		Features		Prioritize Nursing Response by using number	Expected Outcome
Colostomy Care	Risk for injury, excoriation and infection due to poor fit of pouch over stoma			Inspect stoma and peristomal skin at each pouch change. Note bruising, rash or irritation and treat immediately.	Skin integrity will be maintained
				Prevent damage of stoma with a too tight fit of bag over stoma as stoma has no pain receptors and client can't tell that it's too tight.	
				Prevent drainage of fecal matter onto skin by ensuring proper fit of bag over stoma.	
				Clean with warm water and pat dry. Use soap only if sticky stool is present.	
				Measure stoma at least once weekly for the first six weeks then once monthly for next six months to ensure right size bag is used.	
				Ensure that adhesive backing of pouch is at least 2 - 3mm larger than stoma base with adequate backing left to attach pouch.	
				Support surrounding skin while gently removing appliance. Apply adhesive removers as indicated then wash thoroughly.	
				Empty, irrigate and cleanse ostomy pouch on a routine basis and apply appropriate skin protectant	
				Evaluate all reports of burning, itching or blistering and apply corticosteroid spray and prescribed antifungal.	

	Nursing Diagnosis	Features		Prioritize Nursing Response by 1,2,3,4….	Expected Outcome
Colostomy Care	Risk for back-up or overflow due to extended time between empying of pouch	Leakage from pouch, odor and soiling of personal and bed clothing		Empty pouch when it's 1/3 - 1/2 full	Integrity of the system will be maintained and emotional distress will be averted.
				Change pouch every 2 - 7 days depending on it's condition.	
				Change pouch when the bowel is less active i.e 2 - 4 hours after a meal.	
				Maintain **Nursing Progress Notes.**	
	Emotinal distress due to presence of stoma	Refusal or reluctance to talk about or look at stoma; display obvious embarrassment such as trying to cover stoma when attention is placed on it; verbalizing distress at the presence of stoma.		Encourage client to verbalize concerns and reassure client that feelings of anger, loss and grief are normal.	Emotional issues will be resolved and client will verbalize and/or demonstrate acceptance of the stoma
				Maintain positive approach during care activities, avoiding expressions of revulsion and demonstrating acceptance of client by ease in touching and being around them especially during stoma care.	
				Plan and schedule stoma care with client.	
				Provide opportunity for the client to view and touch the stoma and use opportunity to point out signs of healing.	
				Ensure that stoma is kept clean and fresh at all times and use appropriate deodorizers to minimize odours.	

	Nursing Diagnosis	Features		Prioritize Nursing Response by 1,2,3,4….	Expected Outcome
Colostomy Care	Acute Pain due to surgical intervention, other disease processes and fear/anxiety	Reports of pain, self-focussing, guarding, restlessness, change in vital signs		Assess pain noting location, characteristics and intensity (use pain scale 0-10)	Client will verbalize that pain is relieved / controlled, and is able to sleep and rest appropriately
				Encourage client to verbalize concerns and provide support by acceptance, remaining with client and giving appropriate information	
				Provide comfort measures e.g. mouth care, back rub, repositioning with use of proper support devices as needed (pillows, rolled towel, donut, wedge etc)	
				Encourage use of relaxation techniques e.g. guided imagery, visualization; provide diversional activities.	
				Investigate and report abdominal muscle rigidity, involuntary guarding and rebound tenderness **for immediate medical Care**	
				Provide sitz bath if perineal wound is present, to promote healing.	
				Assist with or provide Range of motion (ROM) exercises and encourage early ambulation.	
	Impaired skin integrity related to surgical intervention, drainage; altered circulation, edema and malnutrtition	unhealed incision, ulceraion, presence of sutures and/or drains		Change dressing as needed using aseptic techniques and inspect wound and drainage during the process.	Wound will heal timely with no presence of infection
				Encourage lying in lateral position and discourage prolonged sitting until would has healed.	
				Irrigate wound with normal saline, diluted hydrogen peroxide or antibiotic solution.	

	Nursing Diagnosis	Features		Prioritize Nursing Response by 1,2,3,4….	Expected Outcome
Colostomy Care	Deficient fluid volume due to normal fluid loss, altered absorption and or restricted intake.	dry skin and mucous membrane; poor skin turgor and capillary refill; rapid pulse and postural hypotension		Monitor intake and output (I&O) including liquid stool and chart on Fluid Balance Chart. Weigh regularly if possible.	Adequate hydration will be maintained as evidenced by moist mucous membrane, good skin turgor and capillary refill, stable vital signs, and appropriate urinary output.
				Monitor vital signs noting changes in BP when client sits up and stand (postural hypotension); evaluate skin turgor (elasticity); capillary refill and mucous membrane.	
				Advocate for monitoring of electrolytes and replacement of deficient electrolyte until normal bowel activity is established.	
	Risk for imbalanced Nutrition: less than body requirements related to anorexia; restriction of bulk and residue containing foods and altered absorption.			Make a nutritional assessment to determine what the needs are and to plan diet.	Client will maintain a suitable weight or steadily regain weight to normal.
				Ensure that bowel sounds are present and if present, slowly resume solid foods.	
				Identify foods that cause high odours (cabbage, beans, fish etc) and restrict from diet temporarily.	
				Teach client the relationship between swollowing air and the build up of gas in the intestines, and encourage avoidance of drinking through straws, smoking, gulping down food, anxiety…	
				Recommend inclusion of yogurt in diet to reduce gas and odor formation.	

	Nursing Diagnosis	Features		Prioritize Nursing Response by 1,2,3,4….	Expected Outcome
Colostomy Care	Disturbed sleep pattern related to fear of leakage or puch injury; emotional stress or disturbance for stoma care.	verbalization of interrupted sleep; irritability; listlessness		Reassure client that the stoma will not be injured when sleeping	Client will report feeling rested and will rest well between disrutbances
				Restrict caffeine in the diet	
				Take necessary action to reduce flatulence.	
				Support on-going bedtime ritual and provide complete bedtime preparaton: empty bladder; empty pouch; change into comfortable clothing; offer suitable drink; ensure lighting to client's perference; ensure that temperature is conducive to rest and that noise is restricted.	
				Administered analgesics and/or sedative as ordered and indicated.	
	Risk for constipation or diarrhea			Determine client's previous bowel habits and investigate absence of stool. Listen for bowel sounds	Normal bowel activities will be maintained
				Review food and fluid intake and make any necessary changes such as including necessary bulk and or fluid or removing offending food from the diet.	
				Use closed-end pouch or patch when excreta becomes more manageable with stool expelled every 24 hours.	
				Report constipation to the doctor and follow instructions to irrigate.	