OSTOMY CARE

A. COLOSTOMY: Descending  
   Sigmoid  
   Transverse  
   Ascending

1. The nurse shall complete and send a written consult to WOC (ET) Nurse (before the patient’s surgery if possible.)

2. Stool should be present in appliance by the 5th postoperative day. If no stool is present, the MD should be notified and orders followed.

3. When flatus and/or stool is present in pouch and the patient is alert (nasogastric tube out preferably), teach the patient to work the clamps and empty contents into toilet.

4. If the colostomy irrigation is indicated, instructions may begin when IV’s, nasogastric tube, and foley catheter are discontinued.  
   (See instructions on colostomy irrigation.)

5. Using the patient teaching standards, the nurse shall begin self-care instructions as soon as the patient is able to tolerate learning (after nasogastric tube and foley are discontinue).

6. The nurse shall distribute written booklets/instructions, and supplies to the patient prior to discharge. 
   (Booklets are located in the WOC Nurses’ office and sample booklets are located in the WOCN manual at the nurses station.)

7. The WOC Nurse shall provide the patient with the telephone number of the WOC Nursing Department. (675-6924)
B. ILEOSTOMY

1. The nurse shall complete and send a written consult to WOC (ET) Nurse (before the patient’s surgery if possible.)

2. Stool should be present in appliance by the 3rd postoperative day. If no stool is present, the MD should be notified and orders followed.

3. When flatus and/or stool is present in pouch and the patient is alert (nasogastric tube out preferably), teach the patient to work the clamps and empty contents into toilet.

4. Using patient teaching standards, begin self-care instructions as soon as patient will tolerate. (After N-G tube / foley are discontinued.)

5. Written booklets / instructions and supplies given to patient prior to discharge. (Booklets kept in WOC Nurse Office. Sample booklets available in ET Manual.)

6. The WOC Nurse shall provide the patient with the telephone number of the WOC Nursing Department (675-6924).

C. URINARY DIVERSION

1. Written consult to Wound Ostomy Continence Nurse (Before surgery if possible.)

2. Using patient teaching standards begin self-care instructions as soon as patient will tolerate.

3. Written booklet / instructions and supplies given to patient prior to discharge. (Booklets kept in ET Nurse Office.) Sample booklets available in ET manual at each Nurses Station.

4. Name and phone number of Wound Ostomy Continence Nurse given to patient prior to discharge.
D. EXPECTED PATIENT OUTCOMES

1. Patient / family demonstrates ostomy self-care skills at least 2 days prior to discharge.

2. Patient verbalizes feelings and acceptance of body image change.

3. Patient / family lists potential complications and action to be taken.

4. Patient / family verbalizes understanding of process in obtaining supplies.