Australian Association of Stomal Therapy Nurses Inc.

ABN 16 072 891 322

Stoma / Wound / Continence

Clinical Guidelines

For

Stomal Therapy Nursing Practice

March 2013

Disclaimer

These guidelines have been developed to assist the Stomal Therapy Nurse in practice and are not binding on the Nurse or the Organisation that employs them. They constitute neither liability nor discharge from liability. While every effort has been made to ensure accuracy of information the Australian Association of Stomal Therapy Nurses Inc. (AASTN) does not give any guarantee of the information contained within the guidelines or accept any liability with respect to injury, expense, damage or loss arising from omission or errors contained within the content of these guidelines.

BACKGROUND

There are approximately 400 Stomal Therapy Nurses (STNs) in Australia who specialise in the care of individuals and their significant support people with stomas, wounds and continence needs.

Research into Stomal Therapy Nursing Practice to date is limited. Current practices are primarily guided by case series or expert opinion (Level 1V) resulting in little documented evidence of best practice from the higher research levels generally accepted as evidence.

The level of evidence for these guidelines on the most part reflects expert opinion. STNs will be able to refer to these guidelines in the knowledge that they represent the expert opinions of the AASTN Inc. National Executive and the Education and Professional Development Subcommittee (E & PDS) members as at 2013.

LEVELS OF EVIDENCE

1a	**Systematic review**	Evidence is obtained from meta-analysis or systematic review of randomised controlled trials
1b	**Randomised controlled trial**	Evidence obtained from at least one randomised controlled trial
11a	**Cohort Study**	Evidence obtained from at least one well designed controlled study without randomisation
11b	**Case control studies**	Evidence obtained from at least one other type of well designed quasi-experimental study without randomisation
111	**Case series / case reports**	Evidence obtained from well designed, non experimental descriptive study i.e. case study, correlation study, comparative study
1V	**Editorials / expert opinion**	Evidence obtained from expert committee opinions / reports or clinical experiences of respected authorities

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DIGITAL EXAMINATION OF AN ILEOSTOMY / COLOSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Medical staff • Registered Nurse
CLINICAL ALERT	• Do not perform on neonates • Caution with children and adolescents • Perforation • Bleeding
RELATED GUIDELINE	Administration of a Suppository into a Colostomy
RATIONALE	Performed to examine the lumen e.g. patency and direction [1, 2, 3]
EXPECTED OUTCOMES	• To ascertain patency of bowel proximal to stomal egress point • To identify the direction of the lumen
CONSIDERATIONS	• Ensure verbal permission has been obtained • A loop stoma will have two lumens: insert gloved, lubricated index finger into the proximal (functioning) or distal lumen as required • Carefully feel for the direction of the lumen • If no blockage is felt and the lumen is stenosed (tight), repeat procedure using ring or middle finger to establish diameter of the lumen [1, 2]
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Black P. Holistic stoma care. London: Bailliere Tindal. 2000. 2. Breckman B. Stoma care and rehabilitation. London: Elsevier. 2005. 3. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004.

ORAL BOWEL PREPARATION FOR A PATIENT WITH A COLOSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Clinical Nurse
CLINICAL ALERT	• Depending on the Medical Officer's preference – no bowel preparation may be required pre-operatively • **Contraindicated** in patients with gastrointestinal obstruction, inflammation of the bowel, undiagnosed abdominal pain, nausea, vomiting, colic and abdominal cramps • Need to ascertain bowel patency – potential for perforation if obstructed [1] • Check hydration status – dehydration or electrolyte imbalance may result • Up to 50 % of patients will experience abdominal fullness, bloating and nausea • Observe for adverse reactions e.g. abdominal cramps and vomiting
RELATED GUIDELINE	Digital Examination of an Ileostomy / Colostomy
RATIONALE	To cleanse the bowel free from faecal matter: o reduces bacterial load and the risk of infection with surgery o provides optimal visibility of the bowel wall during imaging and diagnostic tests[2]
EXPECTED OUTCOME	An empty colon with reduced bacterial load
CONSIDERATIONS	• Ensure a written order has been obtained prior to administration • Ensure flatus is being passed prior to administration of any oral aperients • Change appliance to an irrigation sleeve or drainable pouch • Monitor hydration status in frail patients
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004. 2. Burch J. Stoma care. Hong Kong: Wiley-Blackwell. 2008.

DISTAL LOOP OR MUCOUS FISTULA WASHOUT

PERFORMED BY	• Stomal Therapy Nurse • Other nurses trained in the procedure • Medical staff
CLINICAL ALERT	Potential complications include: o trauma to - stoma - bowel wall (including **perforation**) - lesions if present in distal bowel o vasovagal episode o discomfort /cramps
RELATED GUIDELINE	Digital Examination of an Ileostomy / Colostomy
RATIONALE	To flush the distal colon and rectum with water (or solution as ordered) to clear faeces / mucus as diagnostic or pre-operative preparation
EXPECTED OUTCOME	The distal bowel is clean and empty
CONSIDERATIONS	• Ensure verbal permission has been obtained • Examine the bowel digitally (see digital examination guideline for paediatric patients) to rule out presence of local tumour [1] and to identify the direction of the lumen • Apply lubricating jelly to tip of irrigation cone or catheter and insert into the distal loop of the stoma or mucous fistula • Slowly administer tepid fluid from the irrigation set or syringe, monitoring the patient for any signs of discomfort • Monitor for return of fluid through the anus • Volume instilled dependent upon individual requirements [2] • **Document** the **procedure** and **result** in the patient's records
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Breckman B. Stoma care & rehabilitation. London: Elsevier. 2005. 2. Cesaretti R., de Gouveia Sabtos V., Schtan S. & Vianna L. Colostomy irrigation: review of technical aspects. Acta Paulista Enfermagem. 2008. 212 (2): 338 – 344.

ADMINISTRATION OF A SUPPOSITORY INTO A COLOSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Medical staff • Registered Nurse
CLINICAL ALERT	Potential complication – perforation
RELATED GUIDELINE	Digital Examination of an Ileostomy / Colostomy
RATIONALE	• Relieve symptoms of constipation • Administer medication directly to the bowel wall • Utilise alternative medication route when oral route is unavailable or contraindicated eg fasting
EXPECTED OUTCOMES	Relief of symptoms of constipation Effective medication use

CONSIDERATIONS	• Ensure verbal permission has been obtained
	• Examine the bowel digitally (see digital examination guideline for paediatric patients) prior to insertion of suppository to rule out the presence of local tumour [1] or blockage
	• Slowly insert lubricated digit into the colostomy to identify the direction of the lumen
	• Apply lubricating jelly to each suppository and slowly insert, monitoring for any discomfort
	• The suppositories will need to be held in place while dissolving
	• A stoma plug (e.g. Conseal ™ plug) or anal plug may be used to hold the suppositories in place (not paediatric patients)
	• Remove any plug when sufficient time has elapsed for the suppositories to dissolve – follow package instruction
	• Ensure a drainable bag or irrigation sleeve is applied
	• Follow up outcome / result and document
	• For constipation:
	  ○ review medication list for drugs with this side effect
	  ○ educate patient on importance of high fibre diet, exercise and fluid intake

IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCE	1. Breckman B. Stoma care & rehabilitation. London: Elsevier. 2005.

ADMINISTRATION OF AN ENEMA VIA A COLOSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Registered nurse competent with the procedure • Medical staff

CLINICAL ALERT	• Potential complications include:
	  ○ Perforation
	  ○ Water & electrolyte disturbances

RELATED GUIDELINES	Digital Examination of an Ileostomy / Colostomy Distal Loop or Mucous Fistula Washout
RATIONALE	Performed to evacuate the bowel, usually to relieve symptoms of constipation / faecal impaction or to cleanse the bowel prior to a diagnostic or surgical procedure
EXPECTED OUTCOME	An empty bowel, either proximal or distal, dependant upon reason for procedure

CONSIDERATIONS	• Ensure verbal permission is obtained
	• Apply a long bag over the stoma with opening at top for insertion of the enema
	• Identify the proximal and / or distal lumens
	• Slowly insert a digit (see digital examination guideline for paediatric patients) into the appropriate lumen to identify the direction before instilling the solution
	• Apply lubricating jelly to tip of enema container and insert or alternatively:
	  ○ attach the tip of the enema container to an irrigation cone
	  ○ insert a Foley catheter well into the stoma and inflate the balloon to 5 ml so it will aid retention of the enema [1]
	• Slowly administer enema contents, monitoring the patient for any signs of discomfort
	• The solution will need to be retained within the stoma for the recommended length of time. The irrigation cone or Foley catheter will assist with this. Deflate the balloon immediately after recommended length of time
	• **Document** the **procedure** and **result** in the patient's records

IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCE	1. Breckman B. Stoma care & rehabilitation. London: Elsevier. 2005.

PERISTOMAL SKIN – ROUTINE MANAGEMENT

PERFORMED BY	• Stomal Therapy Nurse (STN) • Nursing staff • Medical staff • Carers and persons with a stoma

CLINICAL ALERT	• Skin interruption / damage may result from:
	  o mechanical trauma (shearing, pressure, friction) [1]
	  o irritant contact dermatitis (due to faeces, urine, chemicals) [1]
	  o allergy
	  o problems related to existing disease (eg Psoriasis, Crohn's disease) [1]
	  o infection by pathogenic microorganisms [1]
	• Potential complications include:
	  o pain / soreness / itch
	  o poor appliance adherence
	  o faecal / urinary leakage
	  o psychological distress and lack of confidence

RELATED GUIDELINE	Management of Leaking Stoma Appliance
RATIONALE	To maintain integrity of peristomal skin
EXPECTED OUTCOMES	• Peristomal skin integrity is maintained • Stomal appliance adhesion and functionality is enhanced

CONSIDERATIONS	• Assess peristomal skin to determine skin integrity
	• In presence of skin integrity disturbance, identify the cause and initiate appropriate management
	• Selection of an appliance with consideration of:
	  o size and shape of stoma
	  o peristomal skin and abdominal wall contours
	  o frequency and consistency of output
	  o patient and carer ability to manage stoma and skin
	  o avoiding the use of unnecessary products
	• Water and a lint-free cloth are generally all that is required for cleaning the peristomal skin [2]

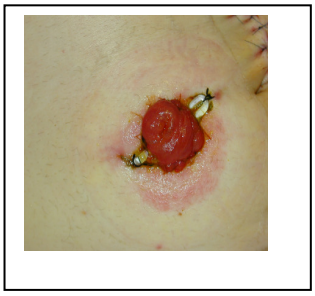
	• As indicated, periodic or ongoing review of the peristomal skin • Use of a specific skin assessment tool is beneficial [3] • Patient / carer education in maintaining healthy peristomal skin, the signs and symptoms of skin complications and when to consult a health care professional [1]
IN CONSULTATION WITH	• Dermatologist, Colorectal Surgeon, Urologist, Gastroenterologist, STN • Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Claessens I., Cobos Serrano J., English E., Martins L. & Tavernelli K. Peristomal skin disorders and the ostomy skin tool. World Council of Enterostomal Therapists Journal. 2008. 28 (2): 26 – 27. 2. Lyon C. & Smith A. (Eds). Abdominal stomas and their skin disorders: An atlas of diagnosis and management. 2nd ed. UK: Informa. 2010. 3. Martins L., Tavernelli K. & Cobos Serrano J. Introducing a peristomal skin assessment tool: The Ostomy Skin Tool. World Council of Enterostomal Therapists Journal. 2008. 28 (2) Supplement: 10 – 13.

LEAKING STOMA APPLIANCE – ROUTINE MANAGEMENT

PERFORMED BY	• Registered Nurse • Patient • Carer educated in stoma management
CLINICAL ALERT	• Identify why and how the appliance is leaking • Skin integrity can be compromised very quickly by effluent • Stoma or abdominal wall changes may affect adhesion • Life style activities can be severely altered due to lack of confidence and embarrassment
RELATED GUIDELINE	Routine Management of Peristomal Skin
RATIONALE	Stoma appliances should not leak when selected appropriately and applied correctly
EXPECTED OUTCOME	A correctly fitting stoma appliance which does not leak
CONSIDERATIONS	• Reassure patient that the problem can be solved • Obtain detailed description of problem • Identify the leakage site and effects by observing the: o patient's techniques for emptying and removing appliance o pouch and wafer for evidence of cause of leakage o stoma and muco-cutaneous junction o peri-stomal skin condition [1] o abdominal wall for creases, hernia, granuloma, etc o changes in abdominal wall contours in different positions (sitting, lying, standing) • Identify any inflammation, infection, allergy etc and refer to Stomal Therapy Nurse as appropriate • Ensure skin is clean, dry and protected prior to wafer application • Measure stoma and ensure wafer fits close to the stoma • Select appropriate appliance to remedy identified issues • Educate patient regarding appliance and identified solution • Provide written material for on-going support • Document findings • Provide feedback to other care workers as appropriate [2]

	• Consult Stomal Therapy Nurse if problems persist
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Martins L., Tavernelli K. & Cobos Serrano J. Introducing a peristomal skin assessment tool: The Ostomy Skin Tool. World Council of Enterostomal Therapists Journal. 2008. 28 (2) Supplement: 10 – 13. 2. Perrin A. Using the Ostomy Skin Tool to assist communication between ostomy care nurses. World Council of Enterostomal Therapists Journal. 2008. 28 (2) Supplement: 14 – 15.

REMOVAL OF A ROD FROM A LOOP STOMA

PERFORMED BY	• Stomal Therapy Nurse • Medical staff
CLINICAL ALERT	• Early removal of the rod may result in the stoma retracting into the abdominal cavity • Trauma to the stoma if there is too much tension over the rod • Trauma to the peristomal skin caused by pressure from the rod (if a rigid flat rod is used) • Rod is removed on day five to seven unless contraindicated, or as per Surgeon's preference [1]
RELATED GUIDELINE	
RATIONALE	The rod is removed once the spur or ridge between the two openings has formed [1]
EXPECTED OUTCOME	To safely remove the rod without stomal retraction
CONSIDERATIONS	• Clinical assessment of stoma indicating readiness for rod removal • Check that the rod is loose and mobile (free to move beneath the loop of bowel) and there are no sutures   • Review peristomal skin and mucocutaneous junction after removal • Document procedure and findings • There are a number of rods available which work the same way but are removed slightly differently
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCE	1. Breckman B. Stoma care and rehabilitation. London: Elsevier. 2005.

OEDEMATOUS STOMA MANAGEMENT

PERFORMED BY	• Stomal Therapy Nurse • Clinical Nurse • Medical Officer
CLINICAL ALERT	• Some oedema is expected in a newly formed stoma but may become excessive if a haematoma forms [1] • If oedema develops in well established stomas, the cause must be identified – may be due to prolapse, chemotherapy, radiotherapy, low blood albumin, • Appliance may be too tight and cause oedema / trauma • Need to measure stoma as baseline for wafer sizing and to prevent it becoming too tight • Note colour of mucosa – venous and lymphatic drainage may become congested / compromised
RELATED GUIDELINE	Routine Management – Peristomal Skin
RATIONALE	Reduction of oedema enables correct appliance fitting
EXPECTED OUTCOME	Gradual reduction in oedema and stoma size over 24 – 48 hours
CONSIDERATIONS 	• Carefully remove appliance and review aperture size • Cut wafer larger than stoma and use seals to protect skin integrity and provide flexibility. Radial slits may also add flexibility [2] • Reapply post-operative appliance with adequate clearance of stoma without compromising skin integrity • Reassure patient that post-operative oedema is to be expected • Advise Medical Officer and document findings • Review daily (or more frequently if needed) • A small sprinkle of sugar on mucosa of an established stoma may reduce swelling and assist with reducing any prolapse
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004. 2. Stelton S. and Homsted J. An ostomy-related problem solving guide for the non-ostomy therapist professional. World Council of Enterostomal Therapists Journal. 2010. 30 (3): 10.

PARASTOMAL HERNIA MANAGEMENT

PERFORMED BY	• Stomal Therapy Nurse (STN) • Nursing staff • Medical staff • Carers and persons with a stoma
CLINICAL ALERT	Potential complications include: o contour deformity adjacent to stoma o alteration to shape and / or size of stoma o bowel incarceration [1] o bowel obstruction (partial or complete) o bowel perforation [1] o compromise to the abdominal wall skin and tissue due to stretching associated with the hernia sac [1] o complication of colostomy irrigation as mode of stoma management o urinary conduit interruption e.g. deteriorating upper tract [2], infection [2], metabolic disturbance, distortion of urinary conduit o discomfort / cramps o nausea and vomiting o psychological distress o exacerbation of respiratory problems [1] o back pain [1]
RELATED GUIDELINE	Routine Management – Leaking Stoma Appliance
RATIONALE	Management of the parastomal hernia to: o relieve pain and discomfort o minimise body image disturbance o minimise disruption to appliance and stoma management associated with the parastomal hernia o minimise complications associated with herniation [3]
EXPECTED OUTCOME	The effects of the hernia are minimised
CONSIDERATIONS	• Patient education about: o exercises to increase core abdominal strength [1]: if possible, preoperatively as well as postoperatively

	○ avoidance of activities that increase intra-abdominal pressure (lifting weights) and early intervention for coughs [1] ○ signs and symptoms of bowel obstruction and incarceration [1] • Fitting of hernia support garments to relieve symptoms • Review and advise on appropriate stoma appliance • Regular follow-up by the STN to monitor progress of hernia [1] • Document the outcome / education in the patient's records
IN CONSULTATION WITH	• Colorectal Surgeon, Urologist, STN • Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Thompson J.M. Parastomal hernias revisited, including a cost effectiveness analysis: Is an ounce of prevention worth a pound of cure? Journal of Stomal Therapy Australia. 2008. 29(2): 6 – 15. 2. Burch J. Stoma care. UK: Wiley-Blackwell. 2008. 3. Hardt J., Herrl F. & Kienle P. Lateral para-rectal placement versus transrectal stoma siting for the prevention of parastomal herniation. (Protocol) The Cochrane Collaboration. The Cochrane Library: Issue 12. John Wiley. 2011.

TREATMENT OF GRANULOMAS WITH SILVER NITRATE

PERFORMED BY	• Stomal Therapy Nurse (STN) • Medical staff
CLINICAL ALERT	• Silver nitrate can cause burns if used incorrectly [1] • Long-term use may cause inflammatory responses or metabolic disturbances [1] • Check for extraneous material e.g. sutures [2] • Medical consultation to identify other causes or factors for consideration is advisable before cauterisation [3]
RELATED GUIDELINE	
DEFINITION	Excess granulation tissue can form around the stoma, sometimes as a result of an ill-fitting appliance or in response to a foreign body e.g. sutures [2, 3.] It is friable and bleeds readily. Silver nitrate is used to cauterise a problematic bleeding point
RATIONALE	Treating bleeding granulomas cauterises the bleeding point and makes stoma management easier for the patient
EXPECTED OUTCOME	Bleeding is reduced / ceased, allowing easier management of stoma
EQUIPMENT	• Clean stoma appliance • Warm water • Dry wipes • Rubbish bag • Gloves • Silver nitrate match-sticks  
PROCEDURE	• Explain the procedure to the patient and prepare the equipment • Apply gloves • Remove soiled stoma appliance: clean and dry stoma site • Identify bleeding points • Apply silver nitrate to the granulomas to seal the bleeding point: the mucosa will turn grey in colour [1]. Reassure the patient • Care must be taken to avoid contact with the skin – silver nitrate can cause painful burns [1, 2, 3] • Ensure the peristomal skin is clean and dry: re-apply appliance

	• Dispose of silver nitrate match-stick in accordance with Health & Safety procedures [4] **Post Procedure** • Ensure patient understands that the discolouration is normal, and that normal colour will return over the next 24 – 48 hrs [1] • Arrange a follow-up appointment, as further treatment may be necessary • Large granulomas may not resolve with silver nitrate and may need to be surgically excised [2] • Document procedure in patient's medical history
CONSIDERATIONS	The STN: o Understands need for treatment and reasons for granuloma formation o Treats granulomas with an understanding of the expected outcome o Ensures appropriate follow-up of the patient for further treatment or review
REFERENCES	1. Minkes R., Chen L. & Mazziotti M. Disorders of the umbilicus. Accessed 30/1/2012. http://emedicine.medscape.com/article/935618-overview 2010. 2. Breckman B. Stoma care & rehabilitation. London: Elsevier. 2005. 3. Connolly M., Armstrong J. & Buckley D. Tender papules around a stoma. Clinical and experimental dermatology. 2005. 31(1): 165 – 166. 4. G.F. Health Products Inc. 2011.

PROLAPSED STOMA MANAGEMENT

PERFORMED BY	• Stomal Therapy Nurse (STN) • Medical Officer • Registered Nurse

CLINICAL ALERT	• Protrusion of a stoma may arise:
	  ○ Suddenly or gradually and increase in length and diameter
	  ○ With increased intra-abdominal pressure from coughing, urinary retention, pregnancy, constipation or malignancy
	• Protrusion of a stoma may cause:
	  ○ Constriction of venous return or arterial supply
	  ○ Damage to mucosa from a too tight wafer
	  ○ Obstruction to effluent
	  ○ Difficulty applying a wafer or pouch
	  ○ Patient distress

RELATED GUIDELINE	
RATIONALE	Intussusception of (usually) a distal loop bowel segment may be sliding (retracts when patient is supine) or fixed [1, 2]
EXPECTED OUTCOMES	• Retraction or reduction of stoma • Effective stoma management with a suitable appliance • Prevention of further complications

CONSIDERATIONS	• Reassurance of the patient
	• Observe stoma for:
	  ○ Perfusion status
	  ○ Constriction / trauma
	  ○ Faecal or urinary output
	• Attempt reduction of stoma in supine position after cold pack or sugar application to reduce oedema
	  

	• Select appliance size and style with size of prolapse in mind • Refer for surgical review and STN follow-up • Consider the use of supportive undergarments • Document findings and outcome • Educate patient about expected ostomy colour and management [1, 2]
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004. 2. Breckman B. Stoma care and rehabilitation. London: Elsevier. 2005.

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URINE SPECIMEN COLLECTION FROM A UROSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Registered Nurse trained in procedure • Medical Staff
CLINICAL ALERT	• Urine from a conduit may be cloudy due to presence of mucus – do not confuse for infection • Specimen must not be collected from a urostomy appliance as it will be contaminated • Understanding of anatomy of an ileal / colonic conduit [1]
RELATED GUIDELINE	
RATIONALE	To collect a specimen of urine from a patient with an ileal conduit for microscopy and culture [2] Urine from a patient with an ileal / colonic conduit for microscopy and culture must reflect actual urine content, not contamination [2]
EXPECTED OUTCOME	To safely obtain an uncontaminated specimen of urine
CONSIDERATIONS	• Specimen may be obtained by insertion of a Nelaton catheter into the stoma or by holding a sterile specimen container at the underneath edge of a clean stoma • Stoma must be washed with sterile water or saline prior to collection • Encourage oral fluid intake prior to procedure **Equipment:** • Sterile gloves • Sterile water or saline for washing stoma • Nelaton catheter no larger than 14 Fr • Sterile specimen container **Procedure:** • Prepare equipment and wash hands • Remove stoma appliance and cover stoma with a swab • Clean stoma with sterile solution from centre outwards • Insert catheter tip gently into stoma and beyond abdominal wall fascia to a depth of 2.5 – 5 cm only • If urine does not flow, ask client to change position / cough

	• Allow approx 10 – 15 ml of urine to drain into sterile specimen container • Remove catheter and replace stoma appliance • Alternatively, hold the sterile specimen container below the underneath edge of the cleaned stoma to collect urine • Label and send specimen
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Glasgow University Hospitals NHS Division Clinical Procedure Manual. Section G. 2. Dougherty L. & Lister S. (Eds) The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Wiley-Blackwell. 2011.

REMOVAL OF URETERIC STENTS FROM A UROSTOMY

PERFORMED BY	• Stomal Therapy Nurse • Medical Officer
CLINICAL ALERT	• Awareness of surgery and purpose of ureteric stents is necessary [1] • Urology team must document removal date in patient's notes • Stents may be left insitu for 10 days or as per Urologist's preference – may be left longer if pre-operative radiotherapy has been given • If stents do not dislodge with gentle traction do not continue • Stents are sometimes sutured within the stomal orifice [2]
RELATED GUIDELINE	
RATIONALE	• Ureteric stents are fine bore tubes which protrude from the lumen of the stoma and into the urostomy appliance [3] • Stents maintain the patency of the uretero-ileal anastomosis (ileal conduit) or uretero-colonic anastomosis (colonic conduit) and prevent stenosis and urinary obstruction during the initial post operative period [2]
EXPECTED OUTCOMES	• Ureteric stents are safely removed • Patient requires monitoring for any adverse effects (i.e. infection due to disturbance of localised bacteria)
CONSIDERATIONS	• Prior to removal check for documentation requesting removal • Discuss with the Urologist if sutures were used to anchor the stents inside the orifice of the stoma • Explain procedure to patient • Remove appliance and wash stoma • Note whether one or two stents are present and colour of stents • Cut retaining sutures, if present, under a flexible shield • Gently pull and twist stent, one at a time. Minimal resistance should be felt. Stents are long and may be straight or with a pigtail. Stop immediately if patient complains of pain or discomfort • Continue with the remaining stent

	• If too much resistance is felt, cease procedure • Once removed, visually check stents for intact appearance [2] • Clean stoma and apply new appliance **Post Procedure** • Document outcome in progress notes, including that stents were intact on removal • Monitor vital signs and stomal output for signs of haemorrhage or infection due to disturbance of localised bacteria for 24 hours [4] **Note:** Patient may be discharged with stents insitu. If so: • Ensure plan for stent removal is in place and documentation sent to appropriate health care professionals
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004. 2. Colwell J., Goldberg M. & Carmel J. Fecal and urinary diversions – management principles. St Louis: Mosby Inc. 2004. 3. A.R.M.C. Clinical Guidelines: Removal of Ureteric Stents. 2011. 4. Fillingham S. & Douglas J. Urological nursing. 3rd ed. London: Bailliere Tindall. 2004.

NEPHROSTOMY TUBE CARE

PERFORMED BY	• Stomal Therapy Nurse • Registered Nurse trained in procedure • Support person trained in procedure
CLINICAL ALERT	• Awareness of type of surgery and site of placement of tube is necessary [1, 2] • Awareness of infection potential • Tubes may be temporary or permanent • There are different percutaneous tube types and each have specific self-retaining mechanisms (eg pigtail, Molnar disc) • Pigtail catheter has Leur-lock connector for drainage bag • Two piece urostomy pouching required for tube with Molnar disc to secure disc to skin • Extreme care required to prevent dislodgement / traction on tube and collection system • Nephrostomy tube may need to be changed under Medical Imaging guidance
RELATED GUIDELINE	Urine Specimen Collection from a Urostomy
RATIONALE	• Tube is placed in renal pelvis to divert urine when lower urinary tract is compromised by calculi, stricture, fistula or malignancy [1, 2] • Renal function may be restored by this decompression [1]
EXPECTED OUTCOMES	• Closed system urinary drainage • No renal infection
CONSIDERATIONS	• Tube can be attached to straight drainage or enclosed in a urostomy pouch [1, 2] • Client / Carer education about drainage system • Weekly (depending on dressing type) sterile dressing of insertion site or more often if needed • Urostomy pouching change as required • Monitor site for signs of inflammation, infection, leakage and pain • Remove tube on Urologist's written order and as per the requirements of the specific tube

	• Do not continue if tube does not dislodge with gentle traction • Ensure tube site care as necessary
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004. 2. Colwell J., Goldberg M. & Carmel J. Fecal and urinary diversions: Management principles. St Louis: Mosby. 2004.

PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE – PERISTOMAL SKIN CARE

PERFORMED BY	• Registered Nurse • Carers educated in peristomal skin care • Patient educated in peristomal skin care

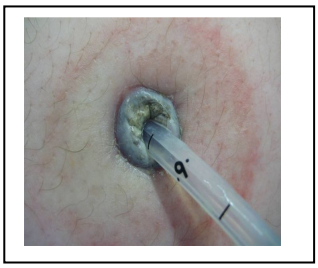
CLINICAL ALERT	• Awareness of a normal gastrostomy stoma and what action to take if problems occur
	• No dressing necessary, as this can increase risk of:
	  ○ Skin erosion
	  ○ Infection
	  ○ Pressure

RELATED GUIDELINE	Removal of Hypergranulation Tissue Around a PEG Tube
RATIONALE	• Maintain hygiene around the PEG tube • Check for any sign of potential problems around PEG tube
EXPECTED OUTCOMES	• Healthy gastrostomy stoma • Maintenance of skin integrity • Patient comfort • Increased psychosocial wellbeing
CONSIDERATIONS	• New stomas may need to be cleaned more than once a day until they mature (approximately 2 – 4 weeks) • Ensure the bolster is cleaned as well as the skin • Barrier creams should not be necessary if hygiene maintained
	Daily stoma care / hygiene • Note any leakage or skin erosion • Observe for inflammation, hypergranulation or infection (e.g. Candida) • Clean skin under disc as well as skin disc • Wash with soap and water, rinse and dry well • Check skin disc position is correct – the position should be recorded in the documentation received from service provider who inserted the tube (markings in cm generally on the tube itself). There should be a little space between the disc and the skin • Rotate the tube 360 degrees daily, once tract has matured (takes approximately 2 weeks)

	• Check if tube is too tight or loose. Notify appropriate person to assist in adjustment of tube if necessary • Check tube integrity [1, 2]
IN CONSULTATION WITH	Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee
REFERENCES	1. Barrett C. Gastrostomy care: A guide to practice. Melbourne: Ausmed Publications. 2004. 2. Dept of Children's Services, Cambridge University Hospitals (NHS Foundation Trust) July. 2010.

REMOVAL OF HYPERGRANULULATION TISSUE AROUND A PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE

PERFORMED BY	• Stomal Therapy Nurse (STN) • Gastrostomy Care Nurse • Medical staff  Hypergranulation tissue around PEG tube
CLINICAL ALERT	• If Silver Nitrate sticks are used, this being the most common course of treatment, potential complications include: [1] o Staining of surrounding skin – will be absorbed but can cause tingling [2] o Possible tube damage if prolonged contact is made o Bleeding from hypergranulation tissue • Discontinue use once hypergranulation has resolved
RELATED GUIDELINE	PEG Tube – Peristomal Skin Care
RATIONALE	Hypergranulation tissue around a PEG tube is removed to: o Reduce pain as hypergranulation can be very painful o Increase patient comfort o Prevent infection to both patient and carer o Ensure better tube fit o Reduce staining to clothes from bleeding and excessive moisture o Reduce exudate which can be odorous and offensive o Increase tube conformability o Eliminate moisture production o Reduce risk of haemorrhage due to mechanical trauma
EXPECTED OUTCOMES	• Increased patient comfort • Reduced pain • Reduced infection risk • Ease of management • Increased psychosocial benefit

CONSIDERATIONS	• **Patient Assessment**
	  ○ It is important to determine the effect of hypergranulation tissue on the individual and then treat accordingly [3]
	• **Aetiology**
	  ○ Excessive moisture
	  ○ Excessive movement of the tube
	  ○ Altered skin integrity
	  ○ Poorly fitting tube [3]
	  ○ Normal response by the body to a foreign body insitu
	• **Correct identification and treatment of hypergranulation tissue**
	  ○ Eliminate the cause of hypergranulation tissue if possible
	  ○ Petroleum jelly may be used to coat and protect the surrounding skin whilst treating with silver nitrate if preferred – silver nitrate can cause painful burns [1, 2, 3]
	  ○ Apply silver nitrate to the hypergranulation tissue: the mucosa will turn grey in colour [1]. Reassure the patient
	  ○ The "under lip" of the hypergranulation tissue should be treated as well as the top surface for complete and more rapid resolution
	  ○ May need to treat hypergranulation tissue more than once [3]
	  ○ Dispose of silver nitrate match-stick in accordance with Health & Safety procedures [2]
	 
	Hypergranulation tissue treated
	NOTE
	If the formation of hypergranulation tissue is minimal, a daily application of a steroid ointment is very effective in obliterating the hypergranulation tissue in many cases. [4]

REFERENCES	1. Lynch C. & Fang J. Prevention and management of complications of PEG tubes. Practical gastroenterology. Nov. 2004. p 69. 2. G.F. Health Products Inc. 2011. 3. Barrett C. Gastrostomy care: A guide to practice. Melbourne: Ausmed Publications. 2004. 4. Cambridge University Hospitals. NHS Foundation Trust – Addenbrooke Hospital. July, 2010. pp.8 – 10.

REFERENCE LIST

A.R.M.C. Clinical Guidelines: Removal of Ureteric Stents. 2011.

Barrett C. Gastrostomy care: A guide to practice. Melbourne: Ausmed Publications. 2004.

Blackley P. Practical stoma wound and continence management. 2nd ed. Victoria: Research Publications. 2004.

Breckman B. Stoma care & rehabilitation. London: Elsevier. 2005.

Burch J. Stoma care. Hong Kong: Wiley-Blackwell. 2008.

Cambridge University Hospitals. NHS Foundation Trust - Addenbrooke Hospital. July 2010. pp. 8 – 10.

Cesaretti R., de Gouveia Sabtos V., Schtan S. & Vianna L. Colostomy irrigation: review of technical aspects. Acta Paulista Enfermagem. 2008. 212 (2): 338 – 344.

Claessens I., Cobos Serrano J., English E., Martins L. & Tavernelli K. Peristomal skin disorders and the ostomy skin tool. World Council of Enterostomal Therapists Journal. 2008. 28 (2): 26 – 27.

Colwell J., Goldberg M. & Carmel J. Fecal and urinary diversions – management principles. St Louis: Mosby Inc. 2004.

Dept of Children's Services, Cambridge University Hospitals. NHS Foundation Trust. July 2010.

Dougherty L. & Lister S. (Eds). The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Wiley-Blackwell. 2011.

Fillingham S. & Douglas J. Urological nursing. (3rd ed.) London: Bailliere Tindall. 2004.

G.F. Health Products Inc. 2011.

Glasgow University Hospitals. NHS Division. Clinical Procedure Manual. Section G. (No Date).

Hardt J., Herrl F. & Kienle P. Lateral para-rectal placement versus transrectal stoma siting for the prevention of parastomal herniation. (Protocol) The Cochrane Collaboration. The Cochrane Library: Issue 12. John Wiley. 2011.

Lynch C. & Fang J. Prevention and management of complications of PEG tubes. Practical gastroenterology. 2004. Nov. p. 69.

Lyon C. & Smith A. (Eds). Abdominal stomas and their skin disorders: An atlas of diagnosis and management. 2nd ed. UK: Informa. 2010.

Martins L., Tavernelli K. & Cobos Serrano J. Introducing a peristomal skin assessment tool: The Ostomy Skin Tool. World Council of Enterostomal Therapists Journal. 2008. 28 (2) Supplement: 10 – 13.

Minkes R., Chen L. & Mazziotti M. Disorders of the umbilicus. Accessed 30/1/2012 http://emedicine.medscape.com/article/935618-overview 2010.

Nelson L. Points of friction. Nursing Times. 1999. 95 (34): 72 –75.

Perrin A. Using the Ostomy Skin Tool to assist communication between ostomy care nurses. World Council of Enterostomal Therapists Journal. 2008. 28 (2) Supplement: 14 – 15.

Stelton S. & Homsted J. An ostomy-related problem solving guide for the non-ostomy therapist professional. World Council of Enterostomal Therapists Journal. 2010. 30 (3): 10.

Thompson J.M. Parastomal hernias revisited, including a cost effectiveness analysis: is an ounce of prevention worth a pound of cure? Journal of Stomal Therapy Australia. 2008. 29 (2): 6 –15.

BIBLIOGRAPHY

Chamberlain J., Gorman R. & Young G. Silver nitrate burns following treatment for umbilical granuloma. Pediatric emergency care. 1992. 8 (1): 29 – 30.

Connolly M., Armstrong J. & Buckley D. Tender papules around a stoma. Clinical and experimental dermatology. 2005. 31 (1): 165 – 166.

Registered Nurses' Association of Ontario & St. Elizabeth Health Care. Best Practice Guideline Implementation: Project Plan. Toronto, Canada: Registered Nurses' Association of Ontario & St. Elizabeth Health Care. 2007.

Silver Nitrate. The pharmaceutical journal. 2002. 265 (7125): 823 – 826.