

FECAL DIVERSIONS: POSTOPERATIVE CARE OF ILEOSTOMY AND COLOSTOMY

Within the past 50 years major advances have occurred in ostomy surgery, including continent diversions such as the Kock pouch and the ileoanal reservoir. However, each year in the United States, 100,000 people still undergo surgery to create ostomies. These so-called incontinent diversions are the primary focus of this plan of care.

An *ileostomy* is an opening constructed in the terminal ileum to treat regional and ulcerative colitis and to divert intestinal contents in colon cancer, polyps, and trauma. It is usually done when the entire colon, rectum, and anus must be removed, in which case the ileostomy is permanent. A temporary ileostomy is done to provide complete bowel rest in conditions such as chronic colitis and in some trauma cases.

A *colostomy* is a diversion of the effluent of the colon and may be temporary or permanent. Ascending, transverse, and sigmoid colostomies may be performed. Transverse colostomy is usually temporary. A sigmoid colostomy is the most common permanent stoma, usually performed for cancer treatment.

CARE SETTING

Inpatient acute care surgical unit.

RELATED CONCERNS

Cancer

Fluid and electrolyte imbalances, see Nurse Care Plan CD-ROM

Inflammatory bowel disease: ulcerative colitis, regional enteritis

Psychosocial aspects of care

Surgical intervention

Total nutritional support: parenteral/enteral feeding

Patient Assessment Database

Data depend on the underlying problem, duration, and severity (e.g., obstruction, perforation, inflammation, congenital defects).

TEACHING/LEARNING

Discharge plan considerations:	DRG projected mean length of inpatient stay: 9.4 days Assistance with dietary concerns, management of ostomy, and acquisition of supplies may be required Refer to section at end of plan for postdischarge considerations.
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NURSING PRIORITIES

1. Assist patient/SO in psychosocial adjustment.
2. Prevent complications.
3. Support independence in self-care.
4. Provide information about procedure/prognosis, treatment needs, potential complications, and community resources.

DISCHARGE GOALS

1. Adjusting to perceived/actual changes.
2. Complications prevented/minimized.
3. Self-care needs met by self/with assistance depending on specific situation.
4. Procedure/prognosis, therapeutic regimen, potential complications understood and sources of support identified.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS: Skin Integrity, risk for impaired

Risk factors may include

- Absence of sphincter at stoma
- Character/flow of effluent and flatus from stoma
- Reaction to product/chemicals; improper fitting/care of appliance/skin

Possibly evidenced by

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Bowel Elimination (NOC)

- Maintain skin integrity around stoma.
- Identify individual risk factors.
- Demonstrate behaviors/techniques to promote healing/prevent skin breakdown.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Ostomy Care (NIC)</p> <p>Independent</p> <p>Inspect stoma/peristomal skin area with each pouch change. Note irritation, bruises (dark, bluish color), rashes.</p> <p>Clean with warm water and pat dry. Use soap only if area is covered with sticky stool. If paste has collected on the skin, let it dry, then peel it off.</p> <p>Measure stoma periodically, e.g., at least weekly for first 6 wk, then once a month for 6 mo. Measure both width and length of stoma.</p> <p>Verify that opening on adhesive backing of pouch is at least $\frac{1}{16}$ to $\frac{1}{8}$ in (2–3 mm) larger than the base of the stoma, with adequate adhesiveness left to apply pouch.</p> <p>Use a transparent, odor-proof drainable pouch.</p>	<p>Monitors healing process/effectiveness of appliances and identifies areas of concern, need for further evaluation/intervention. Early identification of stomal necrosis/ischemia or fungal infection (from changes in normal bowel flora) provides for timely interventions to prevent serious complications. Stoma should be red and moist. Ulcerated areas on stoma may be from a pouch opening that is too small or a faceplate that cuts into stoma. In patients with an ileostomy, the effluent is rich in enzymes, increasing the likelihood of skin irritation. In patient with a colostomy, skin care is not as great a concern because the enzymes are no longer present in the effluent.</p> <p>Maintaining a clean/dry area helps prevent skin breakdown.</p> <p>As postoperative edema resolves (during first 6 wk), the stoma shrinks and size of appliance must be altered to ensure proper fit so that effluent is collected as it flows from the ostomy and contact with the skin is prevented.</p> <p>Prevents trauma to the stoma tissue and protects the peristomal skin. Adequate adhesive area prevents the skin barrier wafer from being too tight. <i>Note:</i> Too tight a fit may cause stomal edema or stenosis.</p> <p>A transparent appliance during first 4–6 wk allows easy observation of stoma without necessity of removing pouch/irritating skin.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Ostomy Care (NIC)</p> <p>Independent</p> <p>Apply appropriate skin barrier, e.g., hydrocolloid wafer, karaya gun, extended-wear skin barrier, or similar products.</p> <p>Empty, irrigate, and cleanse ostomy pouch on a routine basis, using appropriate equipment.</p> <p>Support surrounding skin when gently removing appliance. Apply adhesive removers as indicated, then wash thoroughly.</p> <p>Investigate reports of burning/itching/blistering around stoma.</p> <p>Evaluate adhesive product and appliance fit on ongoing basis.</p>	<p>Protects skin from pouch adhesive, enhances adhesiveness of pouch, and facilitates removal of pouch when necessary. <i>Note:</i> Sigmoid colostomy may not require use of a skin barrier once stool becomes formed and elimination is regulated through irrigation.</p> <p>Frequent pouch changes are irritating to the skin and should be avoided. Emptying and rinsing the pouch with the proper solution not only removes bacteria and odor-causing stool and flatus but also deodorizes the pouch.</p> <p>Prevents tissue irritation/destruction associated with “pulling” pouch off.</p> <p>Indicative of effluent leakage with peristomal irritation, or possibly <i>Candida</i> infection, requiring intervention.</p> <p>Provides opportunity for problem solving. Determines need for further intervention.</p>
<p>Collaborative</p> <p>Consult with certified wound, ostomy, continence nurse.</p> <p>Apply corticosteroid aerosol spray and prescribed antifungal powder as indicated.</p>	<p>Helpful in choosing products appropriate for patient’s particular rehabilitation needs, including type of ostomy, physical/mental status, abilities to handle self-care, and financial resources.</p> <p>Assists in healing if peristomal irritation persists/fungal infection develops. <i>Note:</i> These products can have potent side effects and should be used sparingly.</p>

<p>NURSING DIAGNOSIS: Body Image, disturbed</p> <p>May be related to</p> <p>Biophysical: presence of stoma; loss of control of bowel elimination</p> <p>Psychosocial: altered body structure</p> <p>Disease process and associated treatment regimen, e.g., cancer, colitis</p> <p>Possibly evidenced by</p> <p>Verbalization of change in body image, fear of rejection/reaction of others, and negative feelings about body</p> <p>Actual change in structure and/or function (ostomy)</p> <p>Not touching/looking at stoma, refusal to participate in care</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Body Image (NOC)</p> <p>Verbalize acceptance of self in situation, incorporating change into self-concept without negating self-esteem.</p> <p>Demonstrate beginning acceptance by viewing/touching stoma and participating in self-care.</p> <p>Verbalize feelings about stoma/illness; begin to deal constructively with situation.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Ascertain whether support and counseling were initiated when the possibility and/or necessity of ostomy was first discussed.</p> <p>Encourage patient/SO to verbalize feelings regarding the ostomy. Acknowledge normality of feelings of anger, depression, and grief over loss. Discuss daily “ups and downs” that can occur.</p> <p>Review reason for surgery and future expectations.</p> <p>Note behaviors of withdrawal, increased dependency, manipulation, or noninvolvement in care.</p> <p>Provide opportunities for patient/SO to view and touch stoma, using the moment to point out positive signs of healing, normal appearance, and so forth. Remind patient that it will take time to adjust, both physically and emotionally.</p> <p>Provide opportunity for patient to deal with ostomy through participation in self-care.</p> <p>Plan/schedule care activities with patient.</p> <p>Maintain positive approach during care activities, avoiding expressions of disdain or revulsion. Do not take angry expressions of patient/SO personally.</p> <p>Ascertain patient’s desire to visit with a person with an ostomy. Make arrangements for visit, if desired.</p>	<p>Provides information about patient’s/SO’s level of knowledge and anxiety about individual situation.</p> <p>Helps patient realize that feelings are not unusual and that feeling guilty about them is not necessary/helpful. Patient needs to recognize feelings before they can be dealt with effectively.</p> <p>Patient may find it easier to accept/deal with an ostomy done to correct chronic/long-term disease than for traumatic injury, even if ostomy is only temporary. Also, patient who will be undergoing a second procedure (to convert ostomy to a continent or anal reservoir) may possibly encounter less severe self-image problems because body function eventually will be “more normal.”</p> <p>Suggestive of problems in adjustment that may require further evaluation and more extensive therapy.</p> <p>Although integration of stoma into body image can take months or even years, looking at the stoma and hearing comments (made in a normal, matter-of-fact manner) can help patient with this acceptance. Touching stoma reassures patient/SO that it is not fragile and that slight movements of stoma actually reflect normal peristalsis.</p> <p>Independence in self-care helps improve self-confidence and acceptance of situation.</p> <p>Promotes sense of control and gives message that patient can handle situation, enhancing self-concept.</p> <p>Assists patient/SO to accept body changes and feel all right about self. Anger is most often directed at the situation and lack of control individual has over what has happened (powerlessness), not with the individual caregiver.</p> <p>A person who is living with an ostomy can be a good support system/role model. Helps reinforce teaching (shared experiences) and facilitates acceptance of change as patient realizes “life does go on” and can be relatively normal.</p>

NURSING DIAGNOSIS: Pain, acute

May be related to

Physical factors: e.g., disruption of skin/tissues (incisions/drains)

Biological: activity of disease process (cancer, trauma)

Psychological factors: e.g., fear, anxiety

Possibly evidenced by

Reports of pain, self-focusing

Guarding/distraction behaviors, restlessness

Autonomic responses, e.g., changes in vital signs

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Pain Level (NOC)

Verbalize that pain is relieved/controlled.

Display relief of pain, able to sleep/rest appropriately.

Pain Control (NOC)

Demonstrate use of relaxation skills and general comfort measures as indicated for individual situation.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Pain Management (NIC)</p> <p>Independent</p> <p>Assess pain, noting location, characteristics, intensity (0–10 scale).</p> <p>Encourage patient to verbalize concerns. Active-listen these concerns, and provide support by acceptance, remaining with patient, and giving appropriate information.</p> <p>Provide comfort measures, e.g., mouth care, back rub, repositioning (use proper support measures as needed). Assure patient that position change will not injure stoma.</p> <p>Encourage use of relaxation techniques, e.g., guided imagery, visualization. Provide diversional activities.</p> <p>Assist with ROM exercises and encourage early ambulation. Avoid prolonged sitting position.</p> <p>Investigate and report abdominal muscle rigidity, involuntary guarding, and rebound tenderness.</p>	<p>Helps evaluate degree of discomfort and effectiveness of analgesia or may reveal developing complications. Because abdominal pain usually subsides gradually by the third or fourth postoperative day, continued or increasing pain may reflect delayed healing or peristomal skin irritation. <i>Note:</i> Pain in anal area associated with abdominal-perineal resection may persist for months.</p> <p>Reduction of anxiety/fear can promote relaxation/comfort.</p> <p>Prevents drying of oral mucosa and associated discomfort. Reduces muscle tension, promotes relaxation, and may enhance coping abilities.</p> <p>Helps patient rest more effectively and refocuses attention, thereby reducing pain and discomfort.</p> <p>Reduces muscle/joint stiffness. Ambulation returns organs to normal position and promotes return of usual level of functioning. <i>Note:</i> Presence of edema, packing, and drains (if perineal resection has been done) increases discomfort and creates a sense of needing to defecate. Ambulation and frequent position changes reduce perineal pressure.</p> <p>Suggestive of peritoneal inflammation, which requires prompt medical intervention.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Pain Management (NIC)</p> <p>Collaborative</p> <p>Administer medication as indicated, e.g., narcotics, analgesics, patient-controlled analgesia (PCA).</p> <p>Provide sitz baths.</p> <p>Apply/monitor effects of transcutaneous electrical nerve stimulator (TENS) unit.</p>	<p>Relieves pain, enhances comfort, and promotes rest. PCA may be more beneficial, especially following anal-perineal repair.</p> <p>Relieves local discomfort, reduces edema, and promotes healing of perineal wound.</p> <p>Cutaneous stimulation may be used to block transmission of pain stimulus.</p>

<p>NURSING DIAGNOSIS: Skin/Tissue Integrity, impaired</p> <p>May be related to</p> <p>Invasion of body structure (e.g., perineal resection)</p> <p>Stasis of secretions/drainage</p> <p>Altered circulation, edema; malnutrition</p> <p>Possibly evidenced by</p> <p>Disruption of skin/tissue: presence of incision and sutures, drains</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Wound Healing: Primary Intention (NOC)</p> <p>Achieve timely wound healing free of signs of infection.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Wound Care (NIC)</p> <p>Independent</p> <p>Observe wounds, note characteristics of drainage.</p> <p>Change dressings as needed using aseptic technique.</p> <p>Encourage side-lying position with head elevated. Avoid prolonged sitting.</p>	<p>Postoperative hemorrhage is most likely to occur during first 48 hr, whereas infection may develop at any time. Depending on type of wound closure (e.g., first or second intention), complete healing may take 6-8 mo.</p> <p>Large amounts of serous drainage require that dressings be changed frequently to reduce skin irritation and potential for infection.</p> <p>Promotes drainage from perineal wound/drains, reducing risk of pooling. Prolonged sitting increases perineal pressure, reducing circulation to wound, and may delay healing.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Wound Care (NIC)</p> <p>Collaborative</p> <p>Irrigate wound as indicated, using normal saline (NS), diluted hydrogen peroxide, or antibiotic solution.</p> <p>Provide sitz baths.</p>	<p>May be required to treat preoperative inflammation/infection or intraoperative contamination.</p> <p>Promotes cleanliness and facilitates healing, especially after packing is removed (usually day 3–5).</p>

<p>NURSING DIAGNOSIS: Fluid Volume, risk for deficient</p> <p>Risk factors may include</p> <p>Excessive losses through normal routes, e.g., preoperative emesis and diarrhea; high-volume ileostomy output</p> <p>Losses through abnormal routes, e.g., NG/intestinal tube, perineal wound drainage tubes</p> <p>Medically restricted intake</p> <p>Altered absorption of fluid, e.g., loss of colon function</p> <p>Hypermetabolic states, e.g., inflammation, healing process</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Hydration (NOC)</p> <p>Maintain adequate hydration as evidenced by moist mucous membranes, good skin turgor and capillary refill, stable vital signs, and individually appropriate urinary output.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Fluid/Electrolyte Management (NIC)</p> <p>Independent</p> <p>Monitor intake and output (I&O) carefully, measure liquid stool. Weigh regularly.</p> <p>Monitor vital signs, noting postural hypotension, tachycardia. Evaluate skin turgor, capillary refill, and mucous membranes.</p> <p>Limit intake of ice chips during period of gastric intubation.</p> <p>Collaborative</p> <p>Monitor laboratory results, e.g., Hct and electrolytes.</p> <p>Administer IV fluid and electrolytes as indicated.</p>	<p>Provides direct indicators of fluid balance. Greatest fluid losses occur with ileostomy, but they generally do not exceed 500–800 mL/day.</p> <p>Reflects hydration status/possible need for increased fluid replacement.</p> <p>Ice chips can stimulate gastric secretions and wash out electrolytes.</p> <p>Detects homeostasis or imbalance, and aids in determining replacement needs.</p> <p>May be necessary to maintain adequate tissue perfusion/organ function.</p>

NURSING DIAGNOSIS: Nutrition: imbalanced, risk for less than body requirements

Risk factors may include

Prolonged anorexia/altered intake preoperatively
Hypermetabolic state (preoperative inflammatory disease; healing process)
Presence of diarrhea/altered absorption
Restriction of bulk and residue-containing foods

Possibly evidenced by

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Nutritional Status (NOC)

Maintain weight/demonstrate progressive weight gain toward goal with normalization of laboratory values and be free of signs of malnutrition.

Plan diet to meet nutritional needs/limit GI disturbances.

ACTIONS/INTERVENTIONS	RATIONALE
Nutrition Therapy (NIC)	
Independent	
Obtain a thorough nutritional assessment.	Identifies deficiencies/needs to aid in choice of interventions.
Auscultate bowel sounds.	Return of intestinal function indicates readiness to resume oral intake.
Resume solid foods slowly.	Reduces incidence of abdominal cramps, nausea.
Identify odor-causing foods (e.g., cabbage, fish, beans) and temporarily restrict from diet. Gradually reintroduce one food at a time.	Sensitivity to certain foods is not uncommon following intestinal surgery. Patient can experiment with food several times before determining whether it is creating a problem.
Recommend patient increase use of yogurt, buttermilk, and acidophilus preparations.	May help prevent gas and decrease odor formation.
Suggest patient with ileostomy limit prunes, dates, stewed apricots, strawberries, grapes, bananas, cabbage family, beans, and avoid foods high in cellulose, e.g., peanuts.	These products increase ileal effluent. Digestion of cellulose requires colon bacteria that are no longer present.
Discuss mechanics of swallowed air as a factor in the formation of flatus and some ways patient can exercise control.	Drinking through a straw, snoring, anxiety, smoking, ill-fitting dentures, and gulping down food increase the production of flatus. Too much flatus not only necessitates frequent emptying, but also can cause leakage from too much pressure within the pouch.
Collaborative	
Consult with dietitian.	Helpful in assessing patient's nutritional needs in light of changes in digestion and intestinal function, including absorption of vitamins/minerals.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Nutrition Therapy (NIC)</p> <p>Collaborative</p> <p>Advance diet from liquids to low-residue food when oral intake is resumed.</p> <p>Administer enteral/parenteral feedings when indicated.</p>	<p>Low-residue diet may be maintained during first 6–8 wk to provide adequate time for intestinal healing.</p> <p>In the presence of severe debilitation/intolerance of oral intake, parenteral or enteral feedings may be given to supply needed components for healing and prevention of catabolic state.</p>

<p>NURSING DIAGNOSIS: Sleep Pattern, disturbed</p> <p>May be related to</p> <p>External factors: necessity of ostomy care, excessive flatus/ostomy effluent Internal factors: psychological stress, fear of leakage of pouch/injury to stoma</p> <p>Possibly evidenced by</p> <p>Verbalizations of interrupted sleep, not feeling well rested Changes in behavior, e.g., irritability, listlessness/lethargy</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Sleep (NOC)</p> <p>Sleep/rest between disturbances. Report increased sense of well-being and feeling rested.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Sleep Enhancement (NIC)</p> <p>Independent</p> <p>Explain necessity to monitor intestinal function in early postoperative period.</p> <p>Provide adequate pouching system. Empty pouch before retiring and, if necessary, on a preagreed schedule.</p> <p>Let patient know that stoma will not be injured when sleeping.</p> <p>Restrict intake of caffeine-containing foods/fluids.</p> <p>Support continuation of usual bedtime rituals.</p>	<p>Patient is more apt to be tolerant of disturbances by staff if he or she understands the reasons for/importance of care.</p> <p>Excessive flatus/effluent can occur despite interventions. Emptying on a regular schedule minimizes threat of leakage.</p> <p>Patient will be able to rest better if feeling secure about stoma and ostomy function.</p> <p>Caffeine may delay patient's falling asleep and interfere with REM (rapid eye movement) sleep, resulting in patient not feeling well rested.</p> <p>Promotes relaxation and readiness for sleep.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Sleep Enhancement (NIC)</p> <p>Collaborative</p> <p>Determine cause of excessive flatus or effluent, e.g., confer with dietitian regarding restriction of foods if diet-related.</p> <p>Administer analgesics, sedatives at bedtime as indicated.</p>	<p>Identification of cause enables institution of corrective measures that may promote sleep/rest.</p> <p>Pain can interfere with patient's ability to fall/remain asleep. Timely medication can enhance rest/sleep during initial postoperative period. <i>Note:</i> Pain pathways in the brain lie near the sleep center and may contribute to wakefulness.</p>

<p>NURSING DIAGNOSIS: Constipation/Diarrhea, risk for</p> <p>Risk factors may include</p> <p>Placement of ostomy in descending or sigmoid colon Inadequate diet/fluid intake</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Bowel Elimination (NOC)</p> <p>Establish an elimination pattern suitable to physical needs and lifestyle with effluent of appropriate amount and consistency.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Bowel Management (NIC)</p> <p>Independent</p> <p>Ascertain patient's previous bowel habits and lifestyle.</p> <p>Investigate delayed onset/absence of effluent. Auscultate bowel sounds.</p> <p>Inform patient with an ileostomy that initially the effluent is liquid. If constipation occurs, it should be reported to enterostomal nurse or physician.</p> <p>Review dietary pattern and amount/type of fluid intake.</p>	<p>Assists in formulation of a timely/effective irrigating schedule for patient with a colostomy, if appropriate.</p> <p>Postoperative paralytic/adynamic ileus usually resolves within 48–72 hr, and ileostomy should begin draining within 12–24 hr. Delay may indicate persistent ileus or stomal obstruction, which may occur postoperatively because of edema, improperly fitting pouch (too tight), prolapse, or stenosis of the stoma.</p> <p>Although the small intestine eventually begins to take on water-absorbing functions to permit a more semisolid, pasty discharge, constipation may indicate an obstruction. Absence of stool requires emergency medical attention.</p> <p>Adequate intake of fiber and roughage provides bulk, and fluid is an important factor in determining the consistency of the stool.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Bowel Management (NIC)</p> <p>Independent</p> <p>Review physiology of the colon and discuss irrigation management of sigmoid ostomy, if appropriate.</p> <p>Demonstrate use of irrigation equipment per institution policy or under guidance of physician or certified wound, ostomy, continence nurse.</p> <p>Instruct patient in the use of closed-end pouch or a patch, dressing/Band-Aid when irrigation is successful and the sigmoid colostomy effluent becomes more manageable, with stool expelled every 24 hr.</p> <p>Involve patient in care of the ostomy on an increasing basis.</p> <p>Collaborative</p> <p>Instruct in use of TENS unit if indicated.</p>	<p>This knowledge helps patient understand individual care needs.</p> <p>Irrigations may be done on a daily basis if appropriate, although there are differing views on this practice. Many believe cleaning the bowel on a regular basis is helpful. Others believe that this interferes with normal functioning. (Most authorities agree that occasional irrigation is useful for emptying the bowel to avoid leakage when special events are planned.)</p> <p>Enables patient to feel more comfortable socially and is less expensive than regular ostomy pouches.</p> <p>Rehabilitation can be facilitated by encouraging patient independence and control.</p> <p>Electrical stimulation has been used in some patients to stimulate peristalsis and relieve postoperative ileus.</p>

<p>NURSING DIAGNOSIS: Sexual Dysfunction, risk for</p> <p>Risk factors may include</p> <p>Altered body structure/function; radical resection/treatment procedures Vulnerability/psychological concern about response of SO Disruption of sexual response pattern, e.g., erectile difficulty</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Sexual Functioning (NOC)</p> <p>Verbalize understanding of relationship of physical condition to sexual problems. Identify satisfying/acceptable sexual practices and explore alternative methods. Resume sexual relationship as appropriate.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Sexual Counseling (NIC)</p> <p>Independent</p> <p>Determine patient's/SO's sexual relationship before the disease and/or surgery and whether they anticipate problems related to presence of ostomy.</p> <p>Review with patient/SO sexual functioning in relation to own situation.</p> <p>Reinforce information given by the physician. Encourage questions. Provide additional information as needed.</p> <p>Discuss likelihood of resumption of sexual activity in approximately 6 wk after discharge, beginning slowly and progressing (e.g., cuddling/caressing until both partners are comfortable with body image/function changes). Include alternative methods of stimulation as appropriate.</p> <p>Encourage dialogue between partners. Suggest wearing pouch cover, T-shirt, shortie nightgown, or underwear sexual activity.</p> <p>Stress awareness of factors that might be distracting (e.g., unpleasant odors and pouch leakage). Encourage use of sense of humor.</p> <p>Problem-solve alternative positions for coitus.</p> <p>Discuss/role-play possible interactions or approaches when dealing with new sexual partners.</p> <p>Provide birth control information as appropriate and stress that impotence does not necessarily mean patient is sterile.</p>	<p>Identifies future expectations and desires. Mutilation and loss of privacy/control of a bodily function can affect patient's view of personal sexuality. When coupled with the fear of rejection by SO, the desired level of intimacy can be greatly impaired. Sexual needs are very basic, and patient will be rehabilitated more successfully when a satisfying sexual relationship is continued/developed as desired.</p> <p>Understanding if nerve damage has altered normal sexual functioning (e.g., erection) helps patient/SO to understand the need for exploring alternative methods of satisfaction.</p> <p>Reiteration of data previously given assists patient/SO to hear and process the knowledge again, moving toward acceptance of individual limitations/restrictions and prognosis (e.g., that it may take up to 2 yr to regain potency after a radical procedure or that a penile prosthesis may be necessary).</p> <p>Knowing what to expect in progress of recovery helps patient avoid performance anxiety/reduce risk of "failure." If the couple is willing to try new ideas, this can assist with adjustment and may help to achieve sexual fulfillment.</p> <p>Disguising ostomy appliance may aid in reducing feelings of self-consciousness, embarrassment during specifically designed for sexual contact.</p> <p>Promotes resolution of solvable problems. Laughter can help individuals deal more effectively with difficult situation, promote positive sexual experience.</p> <p>Minimizing awkwardness of appliance and physical discomfort can enhance satisfaction.</p> <p>Rehearsal is helpful in dealing with actual situations when they arise, preventing self-consciousness about "different" body image.</p> <p>Confusion may exist that can lead to an unwanted pregnancy.</p>
<p>Collaborative</p> <p>Arrange meeting with an ostomy visitor if appropriate.</p> <p>Refer to counseling/sex therapy as indicated.</p>	<p>Sharing of how these problems have been resolved by others can be helpful and reduce sense of isolation.</p> <p>If problems persist longer than several months after surgery, a trained therapist may be required to facilitate communication between patient and SO.</p>

NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care, and discharge needs

May be related to

Lack of exposure/recall information misinterpretation
 Unfamiliarity with information resources

Possibly evidenced by

Questions; statement of misconception/misinformation
 Inaccurate follow-through of instruction/performance of ostomy care
 Inappropriate or exaggerated behaviors (e.g., hostile, agitated, apathetic, withdrawal)

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Knowledge: Disease Process (NOC)

Verbalize understanding of condition/disease process, prognosis, and potential complications.

Knowledge: Treatment Regimen (NOC)

Verbalize understanding of therapeutic needs.
 Correctly perform necessary procedures, explain reasons for the action.
 Initiate necessary lifestyle changes.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Learning Facilitation (NIC)</p> <p>Independent</p> <p>Evaluate patient’s emotional, cognitive, and physical capabilities.</p> <p>Include written/picture (photo, video, Internet) learning resources.</p> <p>Teaching: Disease Process (NIC)</p> <p>Review anatomy, physiology, and implications of surgical intervention. Discuss future expectations, including anticipated changes in character of effluent.</p> <p>Instruct patient/SO in stomal care. Allot time for return demonstrations and provide positive feedback for efforts.</p> <p>Recommend increased fluid intake during warm weather months.</p> <p>Discuss possible need to decrease salt intake.</p>	<p>These factors affect patient’s ability to master care-tasks and willingness to assume responsibility for ostomy care.</p> <p>Provides references for obtaining support, equipment, and additional information after discharge to support patient efforts for independence in self-care.</p> <p>Provides knowledge base from which patient can make informed choices, and offers an opportunity to clarify misconceptions regarding individual situation. (Temporary ileostomy may be converted to ileoanal reservoir at a future date; ileostomy and ascending colostomy cannot be regulated by diet, irrigations, or medications.)</p> <p>Promotes positive management and reduces risk of improper ostomy care/development of complications.</p> <p>Loss of normal colon function of conserving water and electrolytes can lead to dehydration and constipation.</p> <p>Salt can increase ileal output, potentiating risk of dehydration and increasing frequency of ostomy care needs/patient’s inconvenience.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Identify symptoms of electrolyte depletion, e.g., anorexia, abdominal muscle cramps, feelings of faintness or “cold” in arms/legs, general fatigue/weakness, bloating, decreased sensations in arms/legs.</p> <p>Discuss need for periodic evaluation/administration of supplemental vitamins and minerals as appropriate.</p> <p>Stress importance of chewing food well, adequate intake of fluids with/following meals, only moderate use of high-fiber foods, avoidance of cellulose.</p> <p>Review foods that are/may be a source of flatus (e.g., carbonated drinks, beer, beans, cabbage family, onions, fish, and highly seasoned foods) or odor (e.g., onions, cabbage family, eggs, fish, and beans).</p> <p>Identify foods associated with diarrhea, such as green beans, broccoli, highly seasoned foods.</p> <p>Recommend foods used to manage constipation (e.g., bran, celery, raw fruits), and discuss importance of increased fluid intake.</p> <p>Discuss resumption of presurgery level of activity. Suggest emptying the ostomy appliance before leaving home and carrying a fanny pack with fresh supplies. Recommend resources for obtaining attractive appliances and decorative cummerbunds as appropriate.</p> <p>Talk about the possibility of sleep disturbance, anorexia, loss of interest in usual activities.</p> <p>Explain necessity of notifying healthcare providers and pharmacists of type of ostomy and avoidance of sustained-release medications.</p> <p>Counsel patient concerning medication use and problems associated with altered bowel function. Refer to pharmacist for teaching/advice as appropriate.</p> <p>Discuss effect of medications on effluent, i.e., changes in color, odor, consistency of stool, and need to observe for drug residue indicating incomplete absorption.</p>	<p>Loss of colon function altering fluid/electrolyte absorption may result in sodium/potassium deficits requiring dietary correction with foods/fluids high in sodium (e.g., bouillon, Gatorade) or potassium (e.g., orange juice, prunes, tomatoes, bananas, Gatorade).</p> <p>Depending on portion and amount of bowel resected, lack of absorption may cause deficiencies.</p> <p>Reduces risk of bowel obstruction, especially in patient with ileostomy.</p> <p>These foods may be restricted or eliminated, based on individual reaction, for better ostomy control, or it may be necessary to empty the pouch more frequently if they are ingested.</p> <p>Promotes more even effluent and better control of evacuations.</p> <p>Proper management can prevent/minimize problems of constipation.</p> <p>With a little planning, patient should be able to manage same degree of activity as previously enjoyed and in some cases increase activity level. A cummerbund can provide both physical and psychological support when patient is involved in activities such as tennis and swimming.</p> <p>“Homecoming depression” may occur, lasting for months after surgery, requiring patience/support and ongoing evaluation as patient adjusts to living with a stoma.</p> <p>Presence of ostomy may alter rate/extent of absorption of oral medications and increase risk of drug-related complications, e.g., diarrhea/constipation or peristomal excoriation. Liquid, chewable, or injectable forms of medication are preferred for patients with ileostomy to maximize absorption of drug.</p> <p>Patient with an ostomy has two key problems: altered disintegration and absorption of oral drugs and unusual or pronounced adverse effects. Some of the medications that these patients may respond to differently include laxatives, salicylates, H₂ receptor antagonists, antibiotics, and diuretics.</p> <p>Understanding decreases anxiety regarding intestinal function and enhances independence in self-care.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Stress necessity of close monitoring of chronic health conditions requiring routine oral medications.</p> <p>Identify community resources, e.g., United Ostomy Association, the Crohn's and Colitis Foundation of America, Ostomy Rehabilitation Program, local ostomy support group, certified wound, ostomy, continence nurse, visiting nurse, pharmacy/medical supply house.</p>	<p>Monitoring of clinical symptoms and serum blood levels is indicated because of altered drug absorption requiring periodic dosage adjustments.</p> <p>Continued support after discharge is essential to facilitate the recovery process and patient's independence in care. Certified wound, ostomy, continence nurse can be very helpful in solving appliance problems, identifying alternatives to meet individual patient needs.</p>

POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)

Skin Integrity, risk for impaired—absence of sphincter at stoma, character/flow of effluent and flatus from stoma.

Coping, ineffective—situational crises, vulnerability.

Social Interaction, impaired—self-concept disturbance, concern for loss of control of bodily functions.