

URINARY DIVERSIONS/UROSTOMY (POSTOPERATIVE CARE)

Incontinent urinary diversions: These ostomies require permanent stoma care and external collecting devices.

Ileal conduit: Ureters are anastomosed to a segment of ileum, resected with the blood supply intact (usually 15–20 cm long). The proximal section is closed, and the distal end brought to skin opening to form a stoma (a passageway, not a storage reservoir).

Colonic conduit: This is a similar procedure using a segment of colon.

Ureterostomy: The ureter(s) is brought directly through the abdominal wall to form its own stoma.

Continent urinary diversions: Continent urinary reservoirs (CURs) have become one of the major options for patients to improve their quality of life regarding stoma care and the ability to sleep and travel.

Kock reservoir or Indiana (ileocecal) pouch: A section of intestine is used to form a pouch inside the patient's abdomen, creating a reservoir that the patient periodically drains by inserting a catheter through the stoma, thus negating the need for an external collecting device.

CARE SETTING

Inpatient acute surgical unit.

RELATED CONCERNS

Cancer

Peritonitis

Psychosocial aspects of care

Surgical intervention

Patient Assessment Database

Data depend on underlying problem, duration, and severity, e.g., malignant bladder tumor, congenital malformations, trauma, chronic infections, or intractable incontinence due to injury/disease of other body systems (e.g., multiple sclerosis). (Refer to appropriate CP.)

TEACHING/LEARNING

Discharge plan **DRG projected mean length of inpatient stay: 5.5 days**

considerations: May require assistance with management of ostomy and acquisition of supplies.
Refer to section at end of plan for postdischarge considerations.

DIAGNOSTIC STUDIES

Intravenous pyelogram (IVP): Visualizes size/location of kidneys and ureters and rules out presence of tumors elsewhere in urinary tract.

Cystoscopy with biopsy: Determines tumor location/stage of malignancy. Ultraviolet cystoscopy outlines bladder lesion.

Bone scan: Determines presence of metastatic disease.

Bilateral pedal lymphangiogram: Determines involvement of pelvic nodes, where bladder tumor easily seeds because of close proximity.

CT scan: Defines size of tumor mass, degree of pelvic spread.

Urine cystoscopy: Detects tumor cells in urine (for determining presence and type of tumor).

Endoscopy: Evaluates intestines for use as conduit.

Conduitogram: Assesses length and emptying ability of the conduit and presence of stricture, obstruction, reflux, angulation, calculi, or tumor (may complicate or contraindicate use as a urinary diversion).

NURSING PRIORITIES

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

DISCHARGE GOALS

1. Complications prevented/minimized.
2. Adjusting to perceived/actual changes.
3. Self-care needs met by self/with assistance as necessary.
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 [actual] with continuous flow of urine
 Character/flow of urine from stoma
 Reaction to product/chemicals; improper fitting of appliance or removal of adhesive

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

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Tissue Integrity: Skin and Mucous Membranes (NOC)
 Maintain skin integrity.

Risk Control (NOC)
 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. Note irritation, bruises (dark, bluish color), rashes, status of sutures.</p>	<p>Monitors healing process/effectiveness of appliance and identifies areas of concern, need for further evaluation/intervention. Stoma should be pink or reddish, similar to mucous membranes. Color changes may be temporary, but persistent changes may require surgical intervention. Early identification of stomal necrosis/ischemia or fungal infection provides for timely interventions to prevent skin necrosis.</p>
<p>Clean with water and pat dry (or use hair dryer on cool setting).</p>	<p>Maintaining a clean/dry area helps prevent skin breakdown.</p>
<p>Handle stoma gently to prevent irritation.</p>	<p>Mucosa has good blood supply and bleeds easily with rubbing or trauma.</p>
<p>Measure stoma periodically, e.g., each appliance change for first 6 wk, then monthly times six.</p>	<p>As postoperative edema resolves (during first 6 wk), size of appliance must be altered to ensure proper fit so that urine is collected as it flows from the stoma and contact with the skin is prevented.</p>
<p>Apply effective sealant barrier, e.g., Skin Prep or similar product.</p>	<p>Protects skin from pouch adhesive, enhances adhesiveness of pouch, and facilitates removal of pouch when necessary.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Ostomy Care (NIC)</p>	
<p>Independent</p>	
<p>Make sure opening for adhesive backing of pouch is at least 1/8 in larger than the base of the stoma (Wound, Ostomy and Continence Nursing Society [WOCN] standard), with adequate adhesiveness left to apply pouch.</p>	<p>Prevents trauma to the stoma tissue and protects the peristomal skin. Adequate adhesive area is important to maintain a seal. <i>Note:</i> Too tight a fit may cause stomal edema or stenosis.</p>
<p>Use a transparent, odor-proof drainable pouch. Keep gauze square/wick over stoma while cleansing area, and have patient cough or strain before applying pouch.</p>	<p>A transparent appliance during first 4–6 wk allows easy observation of stoma and stents (when used) without necessity of removing pouch and irritating skin. Covering stoma prevents urine from wetting the peristomal area during pouch changes. Coughing empties distal portion of conduit, followed by a brief pause in drainage to facilitate application of pouch.</p>
<p>Avoid use of karaya-type appliances.</p>	<p>Will not protect skin because urine melts karaya.</p>
<p>Apply waterproof tape around pouch edges if desired.</p>	<p>Reinforces anchoring.</p>
<p>Connect collecting pouch to continuous bedside drainage system, when necessary.</p>	<p>May be needed during times when rate of urine formation is increased, e.g., while IV fluids are administered. Weight of the urine can cause pouch to pull loose/leak when pouch becomes more than half full.</p>
<p>Cleanse ostomy pouch on a routine basis, using vinegar solution.</p>	<p>Frequent pouch changes are irritating to the skin and should be avoided. Emptying and rinsing the pouch with vinegar not only removes bacteria but also deodorizes the pouch.</p>
<p>Change pouch every 3–5 days or as needed for leakage. Remove appliance gently while supporting skin. Use adhesive removers as indicated and wash off completely.</p>	<p>Prevents tissue irritation/destruction associated with “pulling” pouch off.</p>
<p>Investigate reports of burning/itching around stoma.</p>	<p>Suggests peristomal irritation or possibly <i>Candida</i> infections, both requiring intervention. <i>Note:</i> Continuous exposure of skin to urine can cause hyperplasia around stoma, affecting pouch fit and increasing risk of infection.</p>
<p>Evaluate adhesive product and appliance fit on ongoing basis.</p>	<p>Provides opportunity for problem solving. Determines need for further intervention.</p>
<p>Monitor for distension of lower abdomen (with ileal conduit); assess bowel sounds.</p>	<p>Intestinal distension can cause tension on new suture lines with possibility of rupture.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Ascertain whether counseling was initiated when the possibility and/or necessity of urinary diversion was first discussed.</p> <p>Answer all questions concerning urostomy and its function.</p> <p>Encourage patient/SO to verbalize feelings. Acknowledge normality of feelings of anger, depression, and grief over loss. Discuss daily “ups and downs” that can occur after discharge.</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.</p> <p>Provide opportunity for patient to deal with ostomy through participation in self-care.</p> <p>Maintain positive approach during care activities, avoiding expressions of disdain or revulsion. Do not take patient’s angry expressions personally.</p> <p>Plan/schedule care activities with patient.</p> <p>Discuss possibility of contacting ostomy/urostomy visitor and make arrangements for visit if desired.</p>	<p>Provides information about patient’s/SO’s level of knowledge about individual situation and process of acceptance.</p> <p>Establishes rapport and conveys interest/concern of caregiver. Provides additional information for patient to consider.</p> <p>Provides opportunity to deal with issues/misconceptions. Helps patient/SO to realize that feelings experienced are not unusual and that feeling guilty for them is not necessary/helpful. Patient needs to recognize feelings before they can be dealt with effectively.</p> <p>Suggestive of problems in adjustment that may require further evaluation and more extensive therapy. May reflect grief response to loss of body part/function and worry over acceptance by others and fear of further disability/loss of life from cancer.</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-esteem. In the case of a continent diversion, patient needs the energy, ability, and time to intubate the stoma four times a day.</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 the individual caregiver.</p> <p>Promotes sense of control and gives message that patient can handle this situation, enhancing self-esteem.</p> <p>Can provide a good support system. Helps reinforce teaching (shared experiences) and facilitates acceptance of change as patient realizes “life does go on” and can be relatively normal.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Discuss sexual functioning, medications that promote erection, and penile implant, if applicable, and alternative ways for sexual pleasuring. (Refer to ND: Sexual Dysfunction, risk for.)</p>	<p>Patient may experience anticipatory anxiety, fear of failure in relation to sex after surgery, usually because of ignorance, lack of knowledge. Surgery that removes the bladder and prostate (removed with the bladder) may disrupt parasympathetic nerve fibers that control erection in men, although newer techniques are available that may be used in individual cases to preserve nerve function.</p>

<p>NURSING DIAGNOSIS: Pain, acute</p> <p>May be related to</p> <p>Physical factors, e.g., disruption of skin/tissues (incisions/drains)</p> <p>Biological: activity of disease process (cancer, trauma)</p> <p>Psychological factors, e.g., fear, anxiety</p> <p>Possibly evidenced by</p> <p>Reports of pain</p> <p>Guarding/distraction behaviors, restlessness</p> <p>Self-focusing</p> <p>Autonomic responses, e.g., changes in vital signs</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Pain Level (NOC)</p> <p>Verbalize relief/control of pain.</p> <p>Appear relaxed, able to sleep/rest appropriately.</p> <p>Pain Control (NOC)</p> <p>Perform general comfort measures.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Pain Management (NIC)</p> <p>Independent</p> <p>Assess pain, noting location, characteristics, intensity(0–10 scale).</p>	<p>Helps evaluate degree of discomfort and effectiveness of analgesia or may reveal developing complications, e.g., because abdominal pain usually subsides gradually by the third or fourth postoperative day, continued or increasing pain may reflect delayed healing, peristomal skin irritation, infection, intestinal obstruction.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Pain Management (NIC)</p> <p>Independent</p> <p>Auscultate bowel sounds; note passage of flatus.</p> <p>Note urine flow and characteristics.</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., back rub, repositioning(using body 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, diversional activities.</p> <p>Assist with ROM exercises and encourage early ambulation.</p> <p>Investigate and report abdominal muscle rigidity, involuntary guarding, and rebound tenderness.</p>	<p>Indicates reestablishment of bowel function. Lack of return of bowel sounds/function within 72 hr may indicate presence of complication, e.g., peritonitis, hypokalemia, mechanical obstruction.</p> <p>Decreased flow may reflect urinary retention (due to edema) with increased pressure in upper urinary tract or leakage into peritoneal cavity (failure of anastomosis). Cloudy urine may be normal (presence of mucus) or indicate infectious process.</p> <p>Reduction of anxiety/fear can promote relaxation and comfort.</p> <p>Reduces muscle tension, promotes relaxation, and may enhance coping abilities.</p> <p>Helps patient rest more effectively and refocuses attention, which may enhance coping ability, reducing pain and discomfort.</p> <p>Reduces muscle/joint stiffness. Ambulation returns organs to normal position and promotes return of peristalsis/passage of flatus and feelings of general well-being.</p> <p>Suggestive of peritoneal inflammation, requiring prompt medical intervention.</p>
<p>Collaborative</p> <p>Administer medications as indicated, e.g., narcotics, analgesics; patient-controlled analgesia (PCA).</p> <p>Provide sitz baths, if indicated.</p> <p>Apply/monitor effects of transcutaneous electrical nerve stimulator (TENS) unit.</p> <p>Maintain patency of NG tube.</p>	<p>Relieves pain, enhances comfort, and promotes rest. PCA may be more beneficial than intermittent analgesia, especially following radical resection.</p> <p>Relieves local discomfort, reduces edema, and promotes healing of perineal wound associated with radical procedure.</p> <p>Cutaneous stimulation may be used to block transmission of pain stimulus.</p> <p>Decompresses stomach/intestines; prevents abdominal distension when intestinal function is impaired.</p>

NURSING DIAGNOSIS: Infection, risk for

Risk factors may include

Inadequate primary defenses (e.g., break in skin/incision; reflux of urine into urinary tract)

Possibly evidenced by

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

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Immune Status (NOC)

Achieve timely wound healing, be free of purulent drainage or erythema, and be afebrile.

Knowledge: Infection Control (NOC)

Verbalize understanding of individual causative/risk factors.

Demonstrate techniques, lifestyle changes to reduce risk.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Infection Protection (NIC)</p> <p>Independent</p> <p>Empty ostomy pouch when it becomes one-third full, once IV fluids and continuous pouch drainage have been discontinued.</p> <p>Document urine characteristics, and note whether changes are associated with reports of flank pain.</p> <p>Test urine pH with Nitrazine paper (use fresh specimen, not from pouch); notify physician if greater than 6.5.</p> <p>Report sudden cessation of urethral drainage.</p> <p>Note red rash around stoma.</p> <p>Inspect incision line around stoma. Observe and document wound drainage, signs of incisional inflammation, systemic indicators of sepsis.</p> <p>Change dressings as indicated when used.</p> <p>Assess skin-fold areas in groin, perineum, under arms and breasts.</p>	<p>Reduces risk of urinary reflux and maintains integrity of appliance seal if pouch does not have an antireflux valve.</p> <p>Cloudy odorous urine indicates infection (possibly pyelonephritis); however, urine normally contains mucus after a conduit procedure.</p> <p>Urine is normally acidic, which discourages bacterial growth/UTIs. <i>Note:</i> Presence of alkaline urine also creates favorable environment for stone formation in presence of hypercalciuria.</p> <p>Constant drainage usually subsides within 10 days; however, abrupt cessation may indicate plugging and lead to abscess formation.</p> <p>Rash is most commonly caused by yeast. Urine leakage or allergy to appliance or products may also cause red, irritated areas.</p> <p>Provides baseline/comparative reference. Complications may include interrupted anastomosis of intestine/bowel or ureteral conduit, with leakage of bowel contents into abdomen or urine into peritoneal cavity.</p> <p>Moist dressings act as a wick to the wound and provide media for bacterial growth.</p> <p>Use of antibiotics and trapping of moisture in skin-fold areas increases risk of <i>Candida</i> infections.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Infection Protection (NIC)</p> <p>Independent</p> <p>Monitor vital signs.</p> <p>Auscultate breath sounds.</p> <p>Collaborative</p> <p>Use pouch with antireflux valve, if available.</p> <p>Obtain specimens of exudates, urine, sputum, blood as indicated.</p> <p>Administer medications as indicated, e.g.: Cephalosporins, e.g., cefoxitin (Mefoxin), cefazolin (Ancef);</p> <p>Antifungal powder;</p> <p>Ascorbic acid/vitamin C.</p> <p>Assist with injection of IV methylene blue.</p>	<p>RATIONALE</p> <p>An elevated temperature suggests incisional infection or UTI and/or respiratory complications.</p> <p>Patient is at high risk for development of respiratory complications because of length of time under anesthesia. Often this patient is older and may already have a compromised immune system. Also, painful abdominal incisions cause patient to breathe more shallowly than normal and to limit coughing effort. Accumulation of secretions in respiratory tract predisposes to atelectasis and infections.</p> <p>Prevents backflow of urine into stoma, reducing risk of infection.</p> <p>Identifies source of infection/most effective treatment. Infected urine may cause pyelonephritis. <i>Note:</i> Urine specimen must be obtained from the conduit because the pouch is considered contaminated.</p> <p>Given to treat identified infection or may be given prophylactically, especially with history of recurrent pyelonephritis.</p> <p>Used to treat yeast infections around stoma.</p> <p>Given to acidify urine, reduce bacterial growth/risk of infection. <i>Note:</i> Large doses of vitamin C can impair GI absorption of vitamin B₁₂, potentiating pernicious anemia.</p> <p>Dye appearing in wound drainage signifies urine leakage into peritoneal cavity and need for surgical repair.</p>

NURSING DIAGNOSIS: Urinary Elimination, impaired

May be related to

Surgical diversion; tissue trauma, postoperative edema

Possibly evidenced by

Loss of continence

Changes in amount, character of urine; urinary retention

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Urinary Elimination (NOC)

Display continuous flow of urine, with output adequate for individual situation.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Urinary Elimination Management (NIC)</p> <p>Independent</p> <p>Note presence of stents/ureteral catheters. Label “right” and “left” and observe urine flow through each.</p> <p>Record urinary output; investigate sudden reduction/cessation of urine flow.</p> <p>Observe and record color of urine. Note hematuria and/or bleeding from stoma.</p> <p>Position tubing and drainage pouch so that it allows unimpeded flow of urine. Monitor/protect placement of stents.</p> <p>Demonstrate self-catheterization techniques and reservoir irrigations as appropriate.</p>	<p>Use of stents/ureteral catheters assists in healing of anastomosis by keeping it urine-free. It is necessary to verify that both kidneys/ureters are functional.</p> <p>Sudden decrease in urine flow may indicate obstruction/dysfunction (e.g., blockage by edema or mucus) or dehydration. <i>Note:</i> Reduced urinary output (not related to hypovolemia) associated with abdominal distension, fever, and clear/watery discharge from incision suggests urinary fistula, also requiring prompt intervention.</p> <p>Urine may be slightly pink, which should clear up in 2–3 days. Rubbing/washing stoma may cause temporary oozing because of vascular nature of tissues. Continued bleeding, frank blood in the pouch, or oozing around the base of stoma requires medical evaluation/intervention.</p> <p>Blocked drainage allows pressure to build within urinary tract, risking anastomosis leakage and damage to renal parenchyma. <i>Note:</i> Stents inserted to maintain patency of ureters during period of postoperative edema may be inadvertently dislodged, compromising urine flow.</p> <p>Patients with continent diversions do not require an external collection device. Periodic catheterization empties the internal reservoir and reduces risk of injury from overdistension. Daily irrigations remove accumulated mucus from the reservoir. <i>Note:</i> Patients with Kock pouches connected to the urethra are instructed to void every 2 hr during the day and every 3 hr during the night. This is done by bearing down and applying hand pressure on the lower abdomen to aid in emptying the reservoir.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Urinary Elimination Management (NIC)</p> <p>Independent</p> <p>Encourage increased fluids and maintain accurate intake.</p> <p>Monitor vital signs. Assess peripheral pulses, skin turgor, capillary refill, and oral mucosa. Weigh daily.</p> <p>Collaborative</p> <p>Administer IV fluids as indicated.</p> <p>Monitor electrolytes, ABGs, calcium.</p> <p>Prepare for diagnostic testing, procedures as indicated.</p>	<p>Maintains hydration and good urine flow.</p> <p>Indicators of fluid balance. Reflects level of hydration and effectiveness of fluid replacement therapy.</p> <p>Assists in maintaining hydration/adequate circulating volume and urinary flow.</p> <p>Impaired renal function in patient with intestinal conduit increases risk of severe electrolyte and/or acid-base problems, e.g., hyperchloremic acidosis. Elevated calcium levels increase risk of crystal/stone formation, affecting both urinary flow and tissue integrity.</p> <p>Retrograde ileogram may be done to evaluate patency of conduit; nephrostomy tube or stents may be inserted to maintain urine flow until edema/obstruction is resolved.</p>

<p>NURSING DIAGNOSIS: Sexual Dysfunction, risk for</p> <p>Risk factors may include</p> <p>Altered body structure/function; radical resection/treatment procedures</p> <p>Vulnerability/psychological concern about response of SO</p> <p>Disruption of sexual response pattern, e.g., erection 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.</p> <p>Identify satisfying/acceptable sexual practices and explore alternative methods.</p> <p>Resume sexual relationship as appropriate.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Sexual Counseling (NIC)</p> <p>Independent</p> <p>Ascertain patient's/SO's sexual relationship before the disease and/or surgery. Identify future expectations and desires.</p> <p>Review with patient/SO anatomy and physiology of 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 resumption of sexual activity 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 patient/SO. Suggest wearing pouch cover, T-shirt, or shortie nightgown.</p> <p>Stress awareness of factors that might be distracting (e.g., unpleasant odors and pouch leakage).</p> <p>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 mean patient is necessarily sterile.</p>	<p>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.</p> <p>Understanding normal physiology helps patient/SO understand the mechanisms of nerve damage and need for exploring alternative methods of satisfaction.</p> <p>Reiteration of previously given information 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 achieve sexual fulfillment.</p> <p>Disguising urostomy appliance may aid in reducing feelings of self-consciousness, embarrassment during sexual activity.</p> <p>Promotes resolution of solvable problems.</p> <p>Laughter can help individuals deal more effectively with difficult situation and promote a positive sexual experience.</p> <p>Minimizing awkwardness of appliance and physical discomfort can enhance satisfaction.</p> <p>Rehearsal helps deal with actual situations when they arise, preventing self-consciousness about "different" body image.</p> <p>Confusion about impotency and sterility can lead to an unwanted pregnancy.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Sexual Counseling (NIC)</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>

<p>NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care, and discharge needs</p> <p>May be related to</p> <p>Lack of exposure/recall; information misinterpretation Unfamiliarity with information resources</p> <p>Possibly evidenced by</p> <p>Questions; statement of misconception/misinformation Inaccurate follow-through of instruction/performance of urostomy care Inappropriate or exaggerated behaviors (e.g., hostile, agitated, apathetic, withdrawn)</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Knowledge: Disease Process (NOC) Verbalize understanding of condition/disease process, prognosis, and potential complications.</p> <p>Knowledge: Treatment Regimen (NOC) Verbalize understanding of therapeutic needs. Correctly perform necessary procedures, explain reasons for the action. Initiate necessary lifestyle changes.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Evaluate patient's emotional and physical capabilities.</p> <p>Review anatomy, physiology, and implications of surgical intervention. Discuss future expectations.</p> <p>Include written/picture resources.</p>	<p>These factors affect patient's ability to master tasks and willingness to assume responsibility for ostomy care.</p> <p>Provides knowledge base from which patient can make informed choices and an opportunity to clarify misconceptions regarding individual situation.</p> <p>Provides references after discharge to support patient efforts for independence in self-care.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p>	
<p>Independent</p>	
<p>Instruct patient/SO in stomal care as appropriate. Allot time for return demonstrations and provide positive feedback for efforts.</p>	<p>Promotes positive management and reduces risk of improper ostomy care.</p>
<p>Ensure that stoma and appliance are odorless, nonleaking.</p>	<p>When patient feels confident about urostomy, energy/attention can be focused on other tasks.</p>
<p>Demonstrate padding to absorb urethral drainage; ask patient to report changes in amount, odor, character.</p>	<p>Small amount of leakage may continue for several weeks after prostate surgery with bladder left in place (temporary diversion procedure).</p>
<p>Recommend routine clipping/trimming of hair around stoma to edges of pouch adhesive.</p>	<p>Hair can be pulled out when the pouch is changed, causing irritation of hair follicles and increasing risk of local infection.</p>
<p>Encourage patients with Kock pouch to lengthen voiding interval by 1 hr each week unless discomfort noted.</p>	<p>Increases capacity of reservoir to achieve a more normal voiding pattern. Presence of discomfort suggests reservoir is full, necessitating prompt emptying.</p>
<p>Instruct patient in a progressive exercise program to include Kegel exercises and stop/start of urinary stream.</p>	<p>Improves tone of pelvic muscles and the external sphincter to enhance continence when patient voids through urethra.</p>
<p>Encourage optimal nutrition.</p>	<p>Promotes wound healing, increases utilization of energy to facilitate tissue repair. Anorexia may be present for several months postoperatively, requiring conscious effort to meet nutritional needs.</p>
<p>Discuss use of acid-ash diet (e.g., cranberries, prunes, plums, cereals, rice, peanuts, noodles, cheese, poultry, fish); avoidance of salt substitutes, sodium bicarbonate, and antacids; and cautious use of products containing calcium.</p>	<p>May be useful in acidifying urine to decrease risk of infection and crystal/stone formation. Products containing bicarbonate/calcium potentiate risk of crystal/stone formation affecting both urinary flow and tissue integrity <i>Note:</i> Use of sulfa drugs requires alkaline urine for optimal absorption, so acid-ash diet/vitamin C supplements should be withheld.</p>
<p>Discuss importance of maintaining normal weight.</p>	<p>Changes in weight can affect size of stoma/appliance fit. <i>Note:</i> Weight loss of 10–20 lb is not uncommon because of intestinal involvement and anorexia.</p>
<p>Stress necessity of increased fluid intake of at least 2–3 L/day; of cranberry juice or ascorbic acid/vitamin C tablets; avoidance of citrus fruits as indicated.</p>	<p>Maintains urinary output and promotes acidic urine to reduce risk of infection and stone formation. <i>Note:</i> Oranges/citrus fruits make urine alkaline and are therefore contraindicated. Large doses of vitamin C can inhibit vitamin B₁₂ absorption, requiring periodic monitoring of vitamin B₁₂ levels.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Discuss resumption of presurgery level of activity and possibility of sleep disturbance, anorexia, loss of interest in usual activities.</p> <p>Encourage regular activity/exercise program.</p> <p>Identify signs/symptoms requiring medical evaluation, e.g., changes in character, amount and flow of urine, unusual drainage from wound; fatigue/muscle weakness, anorexia, abdominal distension, confusion.</p> <p>Stress importance of follow-up appointments.</p> <p>Identify community resources, e.g., United Ostomy Association and local ostomy support group, enterostomal therapist, visiting nurse, pharmacy/medical supply house.</p>	<p>Patient should be able to manage same degree of activity as previously enjoyed and in some cases increase activity level except for contact sports. “Homecoming depression” may occur, lasting for up to 3 mo after surgery, requiring patience/support and ongoing evaluation.</p> <p>Immobility/inactivity increases urinary stasis and calcium shift out of bones, potentiating risk of stone formation and resultant urinary obstruction, infection.</p> <p>Early detection and prompt intervention of developing problems such as UTI, stricture, intestinal fistula may prevent more serious complications. Urinary electrolytes (especially chloride) are resorbed in the intestinal conduit, which leads to compensatory bicarbonate loss, lowered serum pH (metabolic acidosis), and potassium deficit.</p> <p>Monitors healing, disease process; provides opportunity for discussion of appliance fitting problems, generalized health, and adaptation to condition. <i>Note:</i> Extensive surgery requires prolonged recuperation for regaining strength and endurance.</p> <p>Continued support after discharge is essential to facilitate the recovery process and patient’s independence in care. Enterostomal nurse can be very helpful in solving appliance problems and 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)

In addition to postsurgical concerns:

Urinary Elimination, impaired—anatomical diversion.

Self-Esteem, situational low—loss of/altered control of body function.