Covenant Health Compassionate care led by Catholic values	**Enterostomy Care**	**Neonatal Policy & Procedures Manual** **Policy Group**: GI/GU
Approved by: **Gail Cameron** Senior Director Operations, Women's & Child Health **Dr. Paul Byrne** Medical Director, Neonatology **Dr. Sharif Shaik** Medical Director, Neonatology		**Date Effective** July, 2016 **Next Review** July, 2019

Purpose

To provide guidelines for the care and management of infants with enterostomies.

Policy Statement

Enterostomies of the bowel are created to relieve an obstruction and/or following a perforation of the bowel. The goal of enterostomy care is measurement of output, protection of peristomal skin and protection of the abdominal incision from the stoma's harsh enzymatic output. The name of the ostomy is determined by the section of the bowel that it is created from. The most common enterostomies in the NICU are colostomies (colon) and ileostomies (ileum). Stoma types include single barrel, double barrel and loop. In both the double barrel, and loop ostomies, the distal portion is referred to as a mucous fistula.

ASSESSMENT

The stoma should be assessed every shift. Observe the stoma's appearance for the following:

1. Colour – the stoma should be bright pink to beefy red and moist.
2. Size – the size and shape will vary as the edema reduces. The stoma may become edematous when exposed to air while changing the pouch, but should resolve quickly when the pouch is replaced.
3. Function – note the consistency, colour, and amount of drainage.
4. Skin – observe the integrity of the peristomal skin.
5. Stabilizing Feature – observe for the presence of sutures, rod or bridge.

Circulation to the stoma should be checked at least once per shift. Check the ostomy pouch attachment for leakage frequently and change if there is leakage. Report any deviation or change in appearance to the physician. Report a prolapse of more than one inch above skin level.

ENTEROSTOMY APPLIANCES

The stoma is covered with an ostomy pouch as soon as it is active, or as directed by the surgeon. The ostomy appliance should be changed every 2-5 days or when leaking.

ENTEROSTOMAL THERAPY NURSE CONSULTATION

The Enterostomal Therapy Nurse may be consulted on difficult ostomy care as required.

Applicability

All Covenant Health Neonatal Nursery staff.

Procedure

ASSESSMENT

- Inspect the stoma (either through the transparent pouch or after removing the appliance when changing it). Evaluate stoma colour, height (flush, moderately protruding, long), construction (end, loop or double barrel), abdominal location and size. The stoma should be bright pink to beefy red, with a smooth, moist budded surface protruding up to 1 cm. Note any change in appearance in the stoma including ischemia (deep red, purple or black colour) or bleeding from the stoma. Note that the stoma will turn a "snow white" colour if the baby is crying. Assess the skin around the stoma for irritation or rashes. Report any new or abnormal findings to the charge nurse.
- The ostomy will usually become active for drainage within 48-72 hours after surgery. Observe the transparent pouch for drainage with each diaper change and drain when 1/3 full to prevent the excess weight from pulling on the pouch and causing a leak. There is a closure at the bottom of the pouch that opens to enable drainage of the pouch. If the pouch is heavily soiled or foul smelling, you may rinse the pouch and reuse.
- Assess the adherence of the skin wafer. The wafer should be changed as soon as there is any leakage. An appliance should remain intact for at least 2 days. If more frequent changes are required due to leakage consult the Charge Nurse and Enterostomal Therapy Nurse for suggestions on managing the ostomy. Do not apply tape to leaky appliances in the hopes of preventing leakage as the excrement will still make contact with the skin under the appliance and will contribute to skin breakdown. Even if a pouch is secure, it should be changed every 2 - 5 days to assess the skin.
- Do pouch changes prior to a feed to reduce the drainage from the stoma during the appliance change.

SUPPLIES

- **Adhesive Skin Barrier/Wafer & Drainage Pouch**: This ostomy appliance consists of an adhesive skin barrier/wafer with a ridged plastic ring that snaps onto a transparent drainage pouch. There are different sizes of skin barrier adhesive rings and pouches, so make sure that the rings on the adhesive barrier and drainage pouch are the same size. This device is more suitable for larger infants.
- **Premi/Newborn Pouching system**: This ostomy appliance consists of a SoftFlex adhesive skin barrier with a soft plastic ring (It looks like a 2.5" circle of skin barrier) and a transparent drainage pouch with a white foam adhesive oval. This device is more suitable for the small premature infant.
- **Ostomy Ring**: Used to fill in creases to make a level surface. May also be used to protect any exposed peristomal skin. This product has no alcohol so is suitable for use on the premature infant.
- **Skin Barrier Powder**: Powder that may be applied around the stoma prior to application of the adhesive skin barrier in special circumstances when problems arise with the standard approach of applying the ostomy skin barrier and appliance. The specific use is outlined under troubleshooting.
- **No Sting Barrier Film**: A barrier film applied around the stoma prior to the application of the adhesive skin barrier in special circumstances when problems arise with standard approach. The specific use is outlined under troubleshooting. This product is not to be used on babies unless they are > 10 days old.
- **Duoderm**: This product absorbs water and should not be used under ostomy appliances.

APPLICATION OF OSTOMY APPLIANCE

ACTION	RATIONALE
PREPARATION OF THE SKIN	
Remove the pouch and skin barrier. Hold the barrier with one hand and gently push the skin away with the other hand when removing the barrier device. If the skin barrier is difficult to remove, place a warm facecloth over the pouch and wafer for 15 minutes to help loosen it or use **SPROAM** to loosen the barrier.	To avoid mechanical trauma.
If the stoma is very active, place a dry 2X2 gauze over the stoma to contain bowel contents during the appliance change.	To keep cleansed skin clean and dry.
If there is any paste or residue on the skin remove with dry gauze before washing the skin.	
Wash skin around stoma with warm water and dry. Avoid use of harsh soaps and chemicals on the skin.	To protect the peristomal skin
If the peristomal skin is injured, apply skin barrier powder in a thin layer. Moisten the powder with a thin layer of **No Sting Barrier Film** only on infants >10 days of age to seal the injury and promote adhesion of the skin barrier.	The powder will absorb skin exudate to allow adhesion of the skin barrier.
PREPARATION OF THE ADHESIVE SKIN BARRIER AND POUCH	
Measure the diameter of the stoma using the measuring guide ▪ Trace the appropriate circle or shape of the stoma onto the white paper backing of the adhesive skin barrier and cut out the hole. The hole in the adhesive skin barrier should be 1/16 inch larger than the stoma.	A large opening exposes the peristomal skin to bowel contents. A tight fit will irritate the stoma.
▪ If the hole is too large, then apply skin barrier powder to the exposed skin around the stoma to fill in the exposed skin prior to applying the pouch.	The powder will protect the peristomal skin.

APPLICATION OF THE ADHESIVE SKIN BARRIER AND POUCH

ACTION	RATIONALE
Remove the backing from the barrier device and centre the hole of the adhesive skin barrier over the stoma. Press the adhesive skin barrier firmly to the skin for 1-3 minutes to promote adherence to the infant's skin.	The heat from your hands promotes adherence of the barrier to the skin
Apply the drainage pouch to the barrier device so that it is oriented in a direction that facilitates drainage to the bottom while on the infant.	If the fecal material drains, there will be less skin contact and pull on the ostomy attachment.
The adhesive oval on the transparent drainage pouch should be placed on the skin barrier and not on the skin.	The adhesive oval is the bag sealant.
The opening at the bottom of the premie/newborn pouching system is a narrow spout with a stopper. Sometimes this closure is cut off and the pouch is secured with a twist tie closure to make a larger opening in the pouch to facilitate cleaning.	

CARE OF THE MUCOUS FISTULA

In both the double barrel and loop ostomies, the distal portion is the mucous fistula. The mucous fistula may excrete mucous or have no discharge.

If the mucous fistula is right next to the ostomy, it is pouched together in the bag. If there is sufficient distance between the mucous fistula and the ostomy, then you may cover the mucous fistula with a small gauze and Vaseline. The mucous fistula dressing should be changed once a day.

DOCUMENTATION

1. Date the appliance with the date that it is changed.

2. Document on the patient care record that the ostomy appliance was changed. Note the stoma type, viability, height, abdominal location and size. Document any change in appearance of the stoma including ischemia or bleeding. Document the characteristics of the drainage from the stoma.

3. On the Kardex, document the date of the appliance change and any tips on managing the stoma and appliance that may help the next nurse.

TROUBLESHOOTING

Whenever problems arise with the management of the stoma and adherence of the appliance, notify the charge nurse. The neonatal team should be involved with discussions about the stoma appearance and function. If you need assistance managing a stoma consult the charge nurse, a clinical nurse educator, or enterostomal therapist.

PROBLEM	INTERVENTION
Skin around the stoma is irritated or abrasions are present.	▪ Apply a light dusting of skin barrier powder to the skin around the stoma to absorb discharge. Too much powder will prevent the adhesive skin barrier from adhering to the skin. **OR** ▪ Apply **No Sting Barrier Film** on the skin around the stoma before applying barrier device (on infants >10 days of age). **OR** ▪ Alternate 3 layers of skin barrier powder and barrier film as a "crusting" technique to protect the skin. ▪ Consider consulting the Enterostomal Therapy Nurse for advice.
Appliance requires frequent changes, as the skin barrier does not adhere & leaks	▪ Assess the skin contour. If the perisotomal skin is not flat due to incisions, scars, or umbilicus, the skin wafer will tend to leak at the uneven areas. Fill in uneven areas with pieces of ostomy ring. ▪ Try applying **No Sting Barrier Film** (on infants > 10 days old) on the skin before applying the barrier if the skin is injured. Exudate from the injury "wets" the area and prevents adhesion of the skin barrier. A thin film will "seal" the skin. ▪ Try using a different ostomy pouching system. ▪ Consider consulting the Enterostomal Therapy Nurse for advice.
The skin surface around the stoma is uneven preventing the appliance from adhering to the skin.	▪ Use a small amount of **ostomy ring** to fill in the uneven skin surface. The **ostomy ring** can be moulded to fit the area. Apply the adhesive skin barrier and transparent pouch over the **ostomy ring**. ▪ Consider consulting the Enterostomal Therapy Nurse for advice.

The skin surface around the stoma is moist due to drainage from a nearby incision preventing the appliance from adhering to the skin.	▪ Take a small amount of **ostomy ring** and roll it in your hands to soften. Place a piece of this product between the incision and the skin barrier. Apply the adhesive skin barrier and transparent pouch over the **ostomy ring**. ▪ Take calcium alginate or **Aquacel** and place it in the wound bed to absorb the exudate. If you need to place something over the top of the calcium alginate or **Aquacel,** use a piece of extra thin **Duoderm** or **Restore** extra thin. Apply the adhesive skin barrier and pouch over the **Duoderm/Restore.** ▪ Discuss this problem with the charge nurse and Neonatologist/Designate so that they are aware of the amount of exudate and that they agree with the use of absorptive products in the wound bed. ▪ Consider consulting the Enterostomal Therapy Nurse for advice.
The stoma and mucous fistula are right next to each other	▪ To protect the skin between the stoma and mucous fistula, use the **ostomy ring** and shape it into a small bridge to place on the skin in between the two. If the area of skin is too small to cover then cut the hole on the appliance large enough to encircle both the stoma and the fistula. Then use the **ostomy ring** to patch any areas of skin that are open. ▪ Consider consulting the Enterostomal Therapy Nurse for advice.

Definitions

Enterostomy - Formed surgically by opening part of the bowel to the outside of the abdomen to evacuate bowel contents. It may be permanent or temporary. The opening is called a stoma.

Related Documents

Adapted with permission from Stollery Children's Policy and Procedure Manual:
http://insite.albertahealthservices.ca/assets/policy/clp-capital-nicu-pp-gigu-enterostomy-care-pol.pdf
Enterostomy Care Policy – September, 2007

http://insite.albertahealthservices.ca/assets/policy/clp-capital-nicu-pp-gigu-enterostomy-care-pro.pdf
Enterostomy Care, Procedure – April, 2010

Skin Injury Prevention Guidelines, September 2015

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Hampton & Bryant (1992) *Ostomies and Continent Diversions.* Mosby: St. Louis.

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Revisions

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Signing

Original Signed

GAIL CAMERON
SENIOR DIRECTOR OPERATIONS
WOMEN'S & CHILD HEALTH
COVENANT HEALTH
GREY NUNS & MISERCORDIA HOSPITALS

July, 2016

DATE

Original Signed

DR. PAUL BYRNE
MEDICAL DIRECTOR
NEONATAL PROGRAM
COVENANT HEALTH
GREY NUNS HOSPITAL

September, 2016

DATE

DR. SHARIF SHAIK
MEDICAL DIRECTOR
NEONATAL PROGRAM
COVENANT HEALTH
MISERCORDIA HOSPITAL

DATE

Trio Ostomy Care provides ostomy and stoma care supplies in the UK and Worldwide. Experience the difference Trio products can make today!Â The next generation of silicone liquid skin barriers has arrived! Ostomy Care - pouches. The soothing and hypoallergenic Trio Elisseâ„¢ formulation creates a breathable and durable barrier between the wafer and skin. Due to the unique & innovative formulation, Trio Elisseâ„¢ will sooth reddened and sore skin and reduce itching. Enterostomy â€“ surgery on the abdominal wall and intestines. In the intestine performed hole, to bring its content to the outside or put it in tube enteral nutrition. There are many different types enterostomy. One example is the jejunostomy, during which the opening is performed in the jejunum, part of the small intestine. Reasons for enterostomy. The operation is performed, when you need a new exit for intestinal contents or feces. It may be necessary, if feces can not pass through the intestine to the anus. Enterostomies play an important role in the management of numerous gastrointestinal conditions in the pediatric age group. Indications for such stomas comprise a broadÂ Pediatric stomas differ from those in adult patients in many aspects, including the criteria for the selection of the most appropriate type, the importance of technical precision in the placement, the specialized age-related care, growth, and the consideration of the psychologic needs of the child.