

Care for patient undergoing a ileostomy nursing essay



**ASSIGN
BUSTER**

The patient involved was supposed to make care of an ileostomy. In this scenario, the patient must eat a well balanced diet regularly and also drink at least six glasses of water. The patient should also try about six small meals per day instead of three large meals. The patient should also insist on eating solid food before taking in any liquid to avoid gurgling in the stomach. Food such as garlic, onions, cabbage, broccoli or asparagus may produce odor. Even if the pouch is odor proof, eating this type of food may create a strong odor while emptying the pouch. It is therefore advisable for the patient to avoid these kinds of foods. Meals with parsley, buttermilk and yogurt can reduce the odor.

Thought

I intended to reduce the odor that comes as result of the food that the patient may be consuming ignorantly. The odor generates a lot of comfort to the patient and even those who are around him and this can easily lead to stigmatization of the same patients who wanted a close monitoring to ensure quick recovery.

Feelings.

The feeling at the time was that of sympathy because most of the patients with this condition are highly stigmatized not because of their wish but because of their ignorance. The reason why i designed this schedule was to ensure that such kind of situations is minimized.

Evaluation

Everything went as planned with a few mistakes due to little exposure to these form of treatment to the patient. Most patients have not been exposed

<https://assignbuster.com/care-for-patient-undergoing-a-ileostomy-nursing-essay/>

to this kind of medical care and therefore very few of them know either nothing or little about the condition. Fear is a major concern to the patient with some of them still sticking to their traditions and thinking that certain practices are considered taboos in their culture

Analysis

The reason why there was some success is because of the cooperation by the target patient and also some education on the benefits that are going to be realized if the patient sticks to the highlighted rules e. g. avoiding certain types of food to stop the smell. This was mainly influenced positively by the use of examples and close monitoring of the same patient. Examples highly motivated the patients and giving them chances to test on the issue.

Reframe

The alternative to this situation is the use of force especially if the patient refuses to follow or adhere to instructions as it was in many cases. Use of force can make most patients to stick to the rules and adapt to them with time.

Future action

From this case, it is advisable that before any kind of teaching is perform, it is imperative that the patient be thoroughly exposed to some of the practices the are going to help him or her to an easy time during the teaching. The mode of teaching should not entail much detail but just an overview of the practices that are intended to be adhered to on a regular basis by the patient.

Reflective account

Various gastrointestinal and genitourinary etiologies may need the creation of urinary or fecal diversion. These may include inflammatory bowel disease, diverticular disease, intestinal obstruction, colon-rectal cancer, gynecological cancers and gastrointestinal trauma (Beitz, 2004). Indications for coming up with the urinary stoma include; neurogenic bladder, bladder cancer, refractory radiation cystitis and interstitial cystitis. The cause of the disease will determine if the condition will be a temporary or permanent one (Thomas & McGinnis, 2004).

Among various types of surgically created ostomies, colostomy involves the opening made on the large intestine to allow for the passage of stool. The location of colostomy can be in sigmoid, transverse or ascending position. In this case, surgical resection will ultimately determine the stool output consistency. Ileostomy is a surgical construction from the small intestine and it is located high in the gastrointestinal route hence the stool output is comparatively of high quantity and liquid consistency (Gordon and Vasilevsky, 2004). Ileal conduit or urostomy is made using a short portion of the ileum to assist in urine elimination. Ureters are connected to conduit to allow urine to flow out of the body into ostomy pouch through the stoma (McGinnis & Tomaselli, 2004). Whether the ostomy is temporary or permanent, nurses must possess the knowledge to give the patient and the family the necessary information to improve recovery and enable a positive experience when obtaining information about ostomy care.

Patient Education

Any patient who is scheduled for an ostomy surgery can experience a number of feelings like fear, anxiety, depression and loss of body image especially if the cause of the surgery is a diagnosis related to cancer. Pre operative teachings assist the patient by receiving these feelings and contribute to quick recovery of the patient (O'shea, 2001). A very important ingredient in the teaching procedure before the operation is the Wound Ostomy and Continence Nurse (WOCN). Counseling before the operation allows for the assessment of the patient's knowledge about the disease, support systems, level of education, employment, physical activity involvement, financial concerns and hobbies. Assessment of any physical shortcomings is also necessary because poor manual dexterity, poor vision and loss of hearing may affect the patient's ability to undertake ostomy self care. Patient's spiritual and cultural beliefs should be also assessed because certain particular rituals concerning ostomy care may need to be taken in. Employing all these factors can assist the patient to recover successfully and feel confident in managing the condition (O'shea, 2001).

WOCN reviews the cause of the disease, stoma characteristics, surgical procedure, peristomal skin care, dietary considerations and a variety of ostomy appliances. If appropriate teaching proceedings may enable the patient to have an insight of the ostomy pouching system. Use of teaching booklets and illustrations helps to improve the education.

Another component of preoperative teaching is the stoma site marking. This is recommended for all who are set to undergo a permanent or temporary stoma (Goldberg and Carmel, 2004). A poorly located stoma on the patient's abdomen can lead to peristomal skin complications, stool and urine leakage, <https://assignbuster.com/care-for-patient-undergoing-a-ileostomy-nursing-essay/>

stoma, emotional and physical stress for the patient. During stoma site marking, there is abdomen assessment with the patient in sitting standing and lying positions. Also the abdomen can be assessed for the skin folds, bony, creases, scars and prominences. Patient's belt and line should be avoided from the stoma site and not affect any prosthetic devices. The stoma site should also be put in an area that the patient can visualize and access. Ideal stoma site is situated in the anal muscle that extends to symphysis from the xyphoid process (Goldberg and Carmel, 2004).

Nursing Education

In stoma assessment the patient must enter the operating room with the pouching system on stoma. Immediately after the operation the, a transparent pouch is recommended to enable the nurse to have a view of stoma characteristics and stool and urine presence (Goldberg and Carmel, 2004). Initially after the operation period, the stoma can appear edematous, red, shiny and moist. In general terms, the stoma is red to pink in color according to tissue that was used in construction. Brown to dark color may show stoma ischemia and the consultations must be made with the physician.

The shape of the stoma ranges from round to oval. It changes its shape and size in a period of six to eight weeks after the surgery. Since the stoma decreases in size with time, the nurse must use a skin barrier that has been cut to fit to the stoma (Goldberg and Carmel, 2004). For the first six to eight weeks after the surgery, measurements of the stoma should be taken each time the barrier of the skin is changed. Measuring guides are provided to

measure round stomas, oval stomas will need the length and width measurements of the stoma (Colwell, 2004). Lack of sphincter by the stoma to regulate the passage of urine or stool, then the opening should be placed near the center of the stoma to aid the flow of urine and stool (McCann, 2002).

The stoma may not or may protrude out of the skin surface. Stomal protrusion varies from a flush stoma at the skin level to a moderate one which is about 1-3 cm in length (Erwin-Toth and Doughty, 2002). Actually, stoma protrusion should be at least 0.8 inches above the skin level (Colwell, 2004). Protruding stoma helps urine and stool to flow into the pouch directly. A flush stoma is not suitable because it can cause difficulties when skin barrier attaches to it and leakage of stool below the skin barrier leading to peristomal skin irritations.

The stoma output is determined by the location of ileostomy. The output resulting from the ascending colon produces a semi liquid consistency whereas the one from the transverse colon produces a semi-liquid to pasty consistency and the one located in a sigmoid or descending colon will be more of a solid stool (McCann, 2002).

An ileostomy stool output is constant and watery with a lot of digestive salt and digestive enzymes. At the initial postoperative stages, the stool may be greenish and thick. The stool output from ileostomy range from 800-1,700 cc in one day (Colwell 2004). When the patient comes back to the regular diet, there is development of the stool consistency from the ileum and a reduced output in a daily basis ranging from 500-800cc/day. With time the

small intestines recovers and with a decrease in stool output (McCann, 2002). Urine is immediately produced after the surgery by the Ileal conduit stomas. It is usually normal for the urine to be blood-tinged after the operation. Also the small intestines produce mucous which may be seen in urine (Colwell, 2003).

Peristomal skin care involves the protection of the peristomal from coming into contact with the urine and stool to stop the occurrence of peristomal skin complications. Skin barrier needs to be properly measured to suit the stoma. If the skin barrier opening is too large, urine or stool will cause irritation on the peristomal skin area. The opening should not be more than 2cm larger than the size of the stoma. Cleanliness of the peristomal skin can be done by gently using warm water then dry it. Moisturizing soaps must be avoided because they affect negatively the skin barrier attachment. Male patients need to be taught trimmed peristomal using electric razor, scissors and other safety devices in an outward manner from the stoma (McCann, 2002).

When choosing the pouching system of the patient, the information that was gathered before the operation is heavily relied upon. Other factors to be considered include location of the stoma, its size and shape plus the anatomical location. Pouching system should give anticipated wear time and protect the underlying skin from stool and urine (Colwell, 2003). Most of the pouching systems are designed in a way that the weight is light, easy to maintain and odor-proof (Colwell, Carmel and Goldberg, 2001).

One of the most important components of the pouching systems is the skin barrier because it protects the peristomal skin from stool and urine (Colwell, 2004). Skin barriers can be found in either cut-to fit or pre-cut product. The pre-cut models are meant for the round stomas. Barrier opening should fit stoma size to limit the probability of the urine and stool coming into contact with the peristomal skin. The cut-to fit models can be used in oval stomas or the ones which are irregular in shape. The cut-to fit barriers are the commonly recommended in initial postoperative stage because the size of the stoma will reduce for not less than six to eight weeks from the day the surgery was performed. A large skin barrier may cause peristomal skin problems resulting from the exposure to stool or urine (Colwell, 2004).