GUIDELINE

Stoma Care

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

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Aim

To outline the management of abdominal stomas in the neonate. To identify what observations should be carried out and why. To outline the process for changing a stoma bag.

Risk

Infants with a stoma may not receive appropriate care which may result in increased length of stay.

Background

A stoma is a surgical opening in the gastrointestinal tract. The majority of stomal surgeries that are performed on neonates are reversible, the length of time that the

stoma is required varies from weeks to months dependant on the initial diagnosis and subsequent management.

The types for conditions that may require a stoma formation are:

- Hirschsprung disease
- Imperforate Anus/ Anorectal Malformation.
- NEC (Necrotising Enterocolitis).
- Intestinal Atresia (duodenal/jejunal)
- Intestinal Malrotation
- Spontaneous ileal perforation.
- Gastroschisis

Definitions

- **Stoma:** A surgical created opening in the gastrointestinal tract. The word stoma derives from the Greek word for mouth.
- **Colostomy:** Bowel diversion of the colon, it may be formed from any section of the large bowel. The output will be semi-liquid to paste consistency.
- **Ileostomy:** Bowel diversion of ileum. It can be formed anywhere along the small bowel. The output will be liquid faeces.
- **Vesicostomy:** The bladder is externalised to the abdominal wall.
- **Jejunostomy:** Bowel diversion of the proximal small intestine. Output maybe very watery and corrosive.
- **Mucous Fistula:** The other end of the non-functioning bowel brought through the abdomen – the distal bowel end.

Key points

- All infants with stomas should be referred to the Stomal /Wound Management Nurse Practitioner (NP).
- Report the presence of gross oedema, prolapse, pale, dark, dusky or black stomas to the shift coordinator, Neonatal consultant, Surgical team and Stomal /Wound Management NP.

Observations

- In the acute post-operative period, a visual check of the stoma should be recorded at the same time and frequency as the post-operative observations.
- Ongoing stoma observations are to be undertaken at a minimum of each shift and/or if clinically indicated and at each pouch change.
- Any changes to the peristomal skin will require review by the Stomal / Wound Management NP.

Observation
Colour. • The stoma should appear pink/red in colour and be moist and shiny in appearance. • Any deviation from this colour should be documented in the patient's progress notes and also be reported to the treating Consultant and Stoma / Wound Management NP.
Oedema. Immediately post-operatively the stoma may appear oedematous, but this should settle after 6-8 weeks. Observe the Stoma for any swelling or oedema and document.
Bleeding. • It is normal for there to be some blood at the junction of the stoma to the skin postoperatively and during stoma care. • Excess bleeding from the stoma or mucocutaneous junction should be documented and reported to the stomal Therapy NP or treating surgical team.
Mucocutaneous Junction. This is where the abdominal skin and stoma attach. It should be continuous with sutures evident. Disruption to this junction should be documented and reported to the Stoma Therapy NP.
Peristomal Skin. • This is the skin around the stoma and should be intact without any redness or discomfort. • Check for redness, integrity and pain.
Degree of protrusion. The stoma should protrude 5-10mm from the skin level. The degree of protrusion can be described as either flush (at skin level), protruding (state length), or retracted (below skin level).

Present of bridge.

- A bridge is a plastic rod used to support a loop stoma and is to be documented in the patient's progress notes.
- It is removed by the Stoma Therapy NP after 5 days or at the instruction of the surgeon.

Output.

- Initial postoperative output may be haemoserous. Ileostomy output will vary from thin to thick paste like consistency. These infants may become dehydrated quickly and have electrolyte imbalance with high losses. See Replacement of Gastrointestinal Fluid Losses in Surgical Neonates if replacement is required.
- Colostomy output is soft stool
- Document the amount, colour and consistency of all stoma losses. Record on fluid balance chart and in the patient's progress notes.

Related CAHS internal policies, procedures and guidelines

- Abdominal Stoma Care
- Replacement of Gastrointestinal Fluid Losses in Surgical Neonates

References and related external legislation, policies, and guidelines

1. Carmel JE, Calwell JC & Goldberg MT. Wound< Ostomy and Continence Society, Core Curriculum Ostomy Management, Wolters-Kluwer, Philadelphia. 2016

2. Global UK Stoma CPOC Paediatric Stoma Care Guidelines

3. The Royal Children's Hospital Melbourne Faecal Stoma Care guideline

Useful resources (including related forms)

- Stoma Care SDLP (See SDN's for Package).

This document can be made available in alternative formats on request.

Document Owner:	Neonatology		
Reviewer / Team:	Neonatology		
Date First Issued:	May 2023	Last Reviewed:	May 2023
Amendment Dates:		Next Review Date:	May 2026
Approved by:	Neonatal Coordinating Group	Date:	23rd May 2023
Endorsed by:	Neonatal Coordinating Group		
Standards Applicable:	NSQHS Standards: Child Safe Standards: 1,10		

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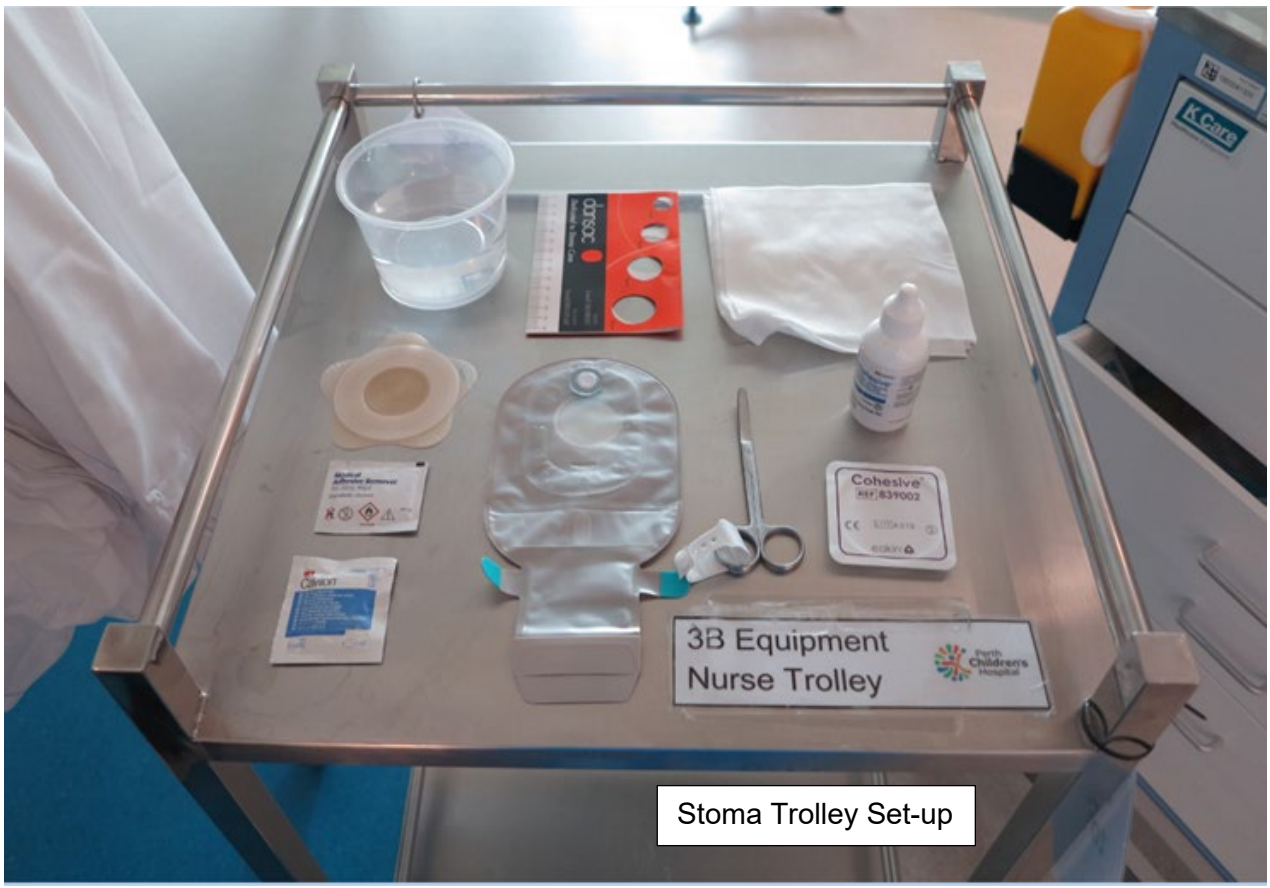
Appendix 1: Procedure for Stoma Bag Change.

PPE, Gloves and disposable plastic gown are required when changing a stoma.

Equipment required

1. Bowl for warm water
2. Rubbish Bag
3. Stoma Bag and fixings
4. Adhesive Remover
5. Skin Barrier Wipe
6. Cloths or gauze for cleaning site
7. Curved Scissors
8. Syringe and Extension Cannula (may be needed when emptying pouch)
9. Kidney dish for emptying pouch contents

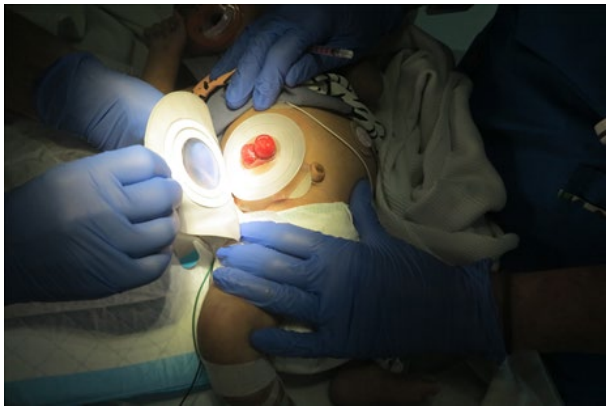
The use of sucrose for pain relief should be considered for the procedure.

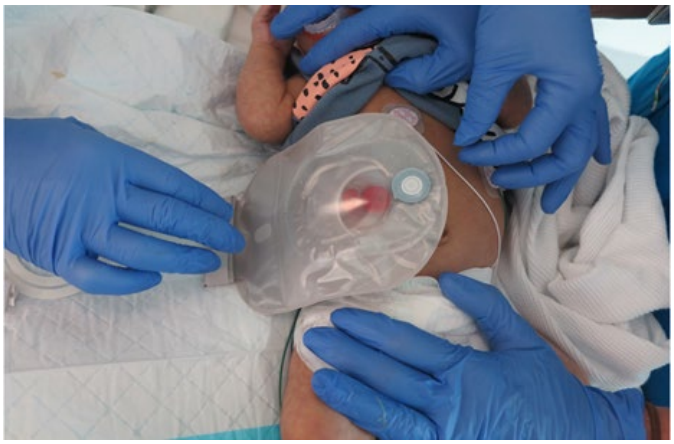


Stoma Trolley Set-up

Procedure / Process

Steps	
1. Explain the procedure to the parent/Carer (if Present).	
2. Position the infant for best access to the stoma. i.e. supine or side lying.	
3. Perform Hand Hygiene and don PPE. Empty stoma bag. You may need to use a syringe and extension cannula to empty the bag, depending on the amount/consistency of the stoma contents.	
4. Use an adhesive remover to assist in removing the stoma bag. Using a remover wipe will help to dissolve the adhesive and will result in less trauma to the neonate's peristomal skin.	
5. Remove the bag from the neonate's abdomen, starting from the top and peel off in a downwards direction. Discard the old bag in the rubbish bag	
6. Clean the surrounding skin using warm water and a disposable cloth or gauze. Ensure that the entire old adhesive is removed. Then dry skin thoroughly.	
7. Measure the stoma size using the measuring guide and cut the opening in the base plate 1-2mm larger than the measurement.	It is important to make sure that the opening in the baseplate is the correct size, there may be a template that can be used. If the opening is too big the peristomal skin can become excoriated.

Steps	
	If the opening is too small there could be damaged to the actual stoma.
8. Apply the bag over the stoma starting below the stoma and then over the stoma.	 
9. Ensure good adhesion by placing gentle pressure immediately around the stoma with your finger.	Occasionally pre warming the base plate in your hands my help it to adhere better to the neonate. A good seal around the bag will prevent leakage of stoma fluid.

Steps	
10. Ensure bottom of the bag is closed securely.	
11. Dispose of used equipment in clinical waste, ensure patient is comfortable and perform Hand Hygiene.	
12. Accurately record the stoma output volume, to ensure that there is a complete fluid balance. Document bag change in the patient's progress notes, noting size and colour of stoma and record the output volume on the observation chart.	