CH 31: Promoting Bowel Elimination

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Objectives: Theory

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1. Describe the process of normal bowel elimination
2. Identify abnormal stool characteristics
3. Summarize the physiologic effects of hypoactive bowel, as well as nursing interventions to assist patients with constipation
4. Analyze safety considerations related to giving a patient an enema
5. Analyze the psychosocial implications for a patient who has an ostomy
6. Discuss the stoma and peristomal assessment and skin care
7. Describe three types of intestinal diversions

Objectives: Clinical Practice

page 592

1. Summarize nursing measures to promote regular bowel elimination in patients
2. Collect a stool specimen
3. Perform a focused assessment of bowel function
4. Write a nursing care plan for a patient with bowel problems
5. Prepare to administer an enema
6. Assist and teach a patient with a bowel retraining program for incontinence
7. Evaluate the performance of a patient who is self-catheterizing a continent diversion
8. Provide ostomy care, including irrigation and changing the ostomy appliance.

The term *BOWEL* refers to intestine. Bowel elimination, the excretion of solid waste, is the final step in the process of digestion. The are ways to assist the patient in achieving and maintaining regular elimination of stool and procedures to alleviate problems related to alterations in elimination.

Which structures of the intestinal system are involved in waste elimination?

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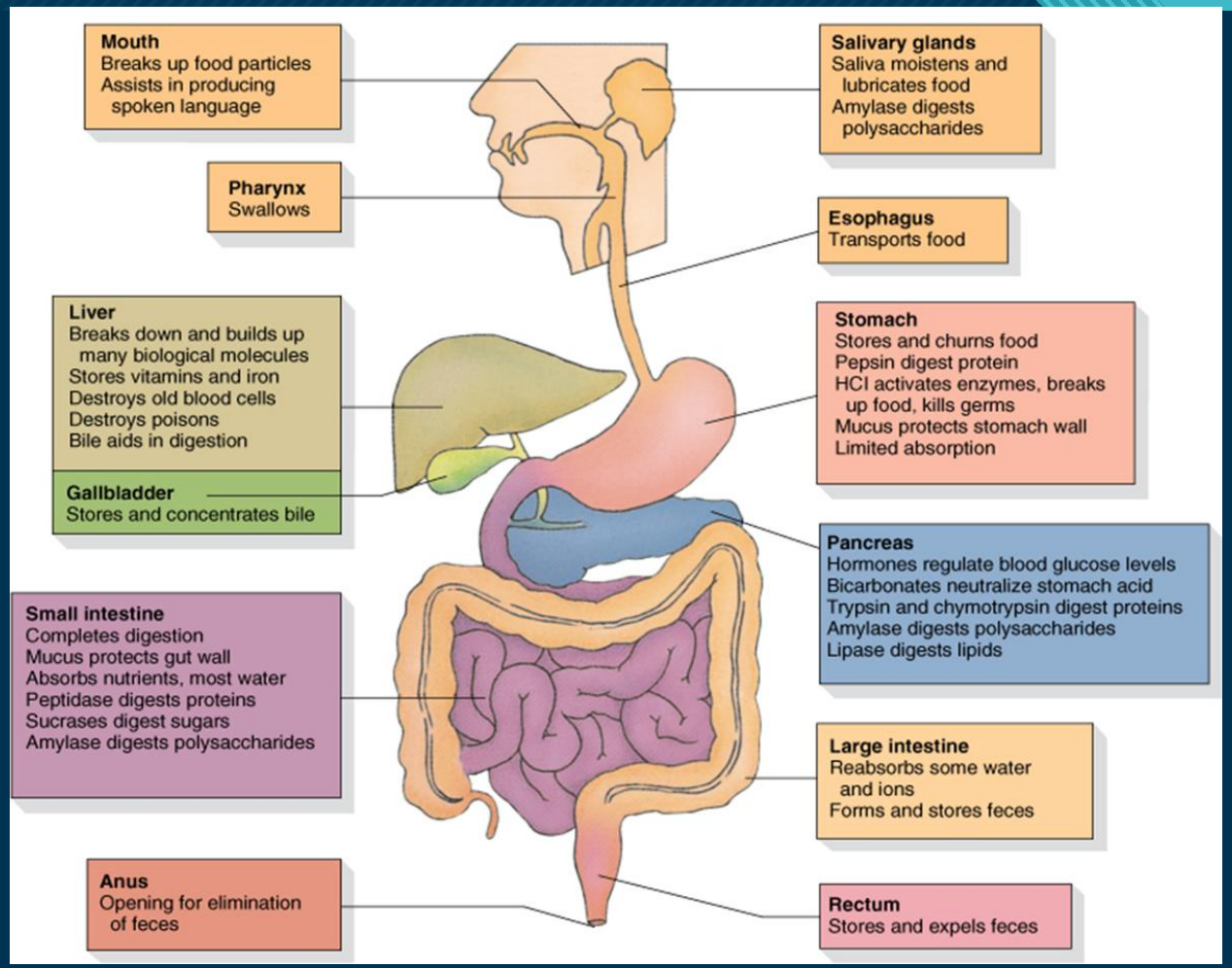
- The small intestine- consisting of the duodenum, the jejunum, and the ileum-carries chyme from the stomach to the large intestine.
- The small intestine attaches to the large intestine at the cecum. The ileocecal valve controls the progress of substances into the large intestine.
- The large intestine has four main sections: ascending colon, transverse colon, descending colon, and sigmoid colon. It is larger in diameter than the small intestine but only about 59 inches long.
- The rectum connects to the anus
- The walls of the intestines have four layers: mucosa, submucosa, muscular layer, and a serous layer called the serosa
- Fig 31.1 page 593


Mouth
Breaks up food particles
Assists in producing spoken language
Salivary glands
Saliva moistens and lubricates food
Amylase digests polysaccharides
Pharynx
Swallows
Esophagus
Transports food
Liver
Breaks down and builds up many biological molecules
Stores vitamins and iron
Destroys old blood cells
Destroys poisons
Bile aids in digestion
Stomach
Stores and churns food
Pepsin digest protein
HCl activates enzymes, breaks up food, kills germs
Mucus protects stomach wall
Limited absorption
Gallbladder
Stores and concentrates bile
Pancreas
Hormones regulate blood glucose levels
Bicarbonates neutralize stomach acid
Trypsin and chymotrypsin digest proteins
Amylase digests polysaccharides
Lipase digests lipids
Small intestine
Completes digestion
Mucus protects gut wall
Absorbs nutrients, most water
Peptidase digests proteins
Sucrases digest sugars
Amylase digests polysaccharides
Large intestine
Reabsorbs some water and ions
Forms and stores feces
Anus
Opening for elimination of feces
Rectum
Stores and expels feces

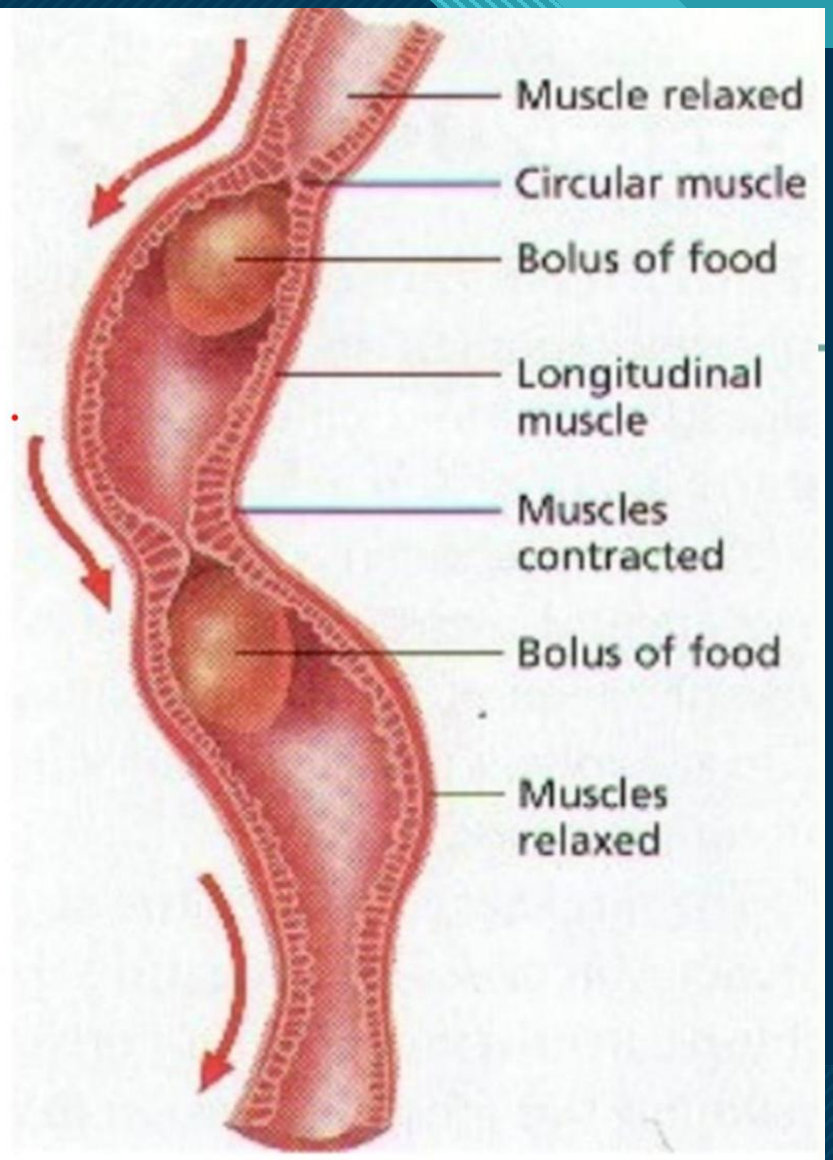
What are the functions of the intestines?

Page 593

- The small intestine further process chyme into a more liquid state.
- The large intestine, water, sodium, and chlorides are reabsorbed, and waste material is propelled to the anus
- The large intestine contains bacteria that break down waste products. Water is extracted from the waste during transit.
- **Peristalsis are wavelike movement through the intestines, moves chyme and gas formed by bacterial action through the intestine.**
- The movement of liquid and gas causes the rumbling noise in bowel sounds. **It takes about 18-72 hours for food to move from the mouth to the anus**.
- Feces (intestinal waste material) are stored in the sigmoid colon until they move into the rectum for expulsion through the anus.
- As the rectum fills, the pressure on the sphincter (circular muscle that closes an orifice) of the anus increases until the urge to defecate occurs.

Peristalsis

- series of involuntary wave-like muscle contractions which move food along the digestive tract



The slower transport allows reabsorption of minerals, electrolytes, and water.

The pH continues to become more alkaline to neutralize the acid waste left by the digestive bacteria.

The mucus secreted in the large bowel is sticky and allows the feces to form a solid mass.

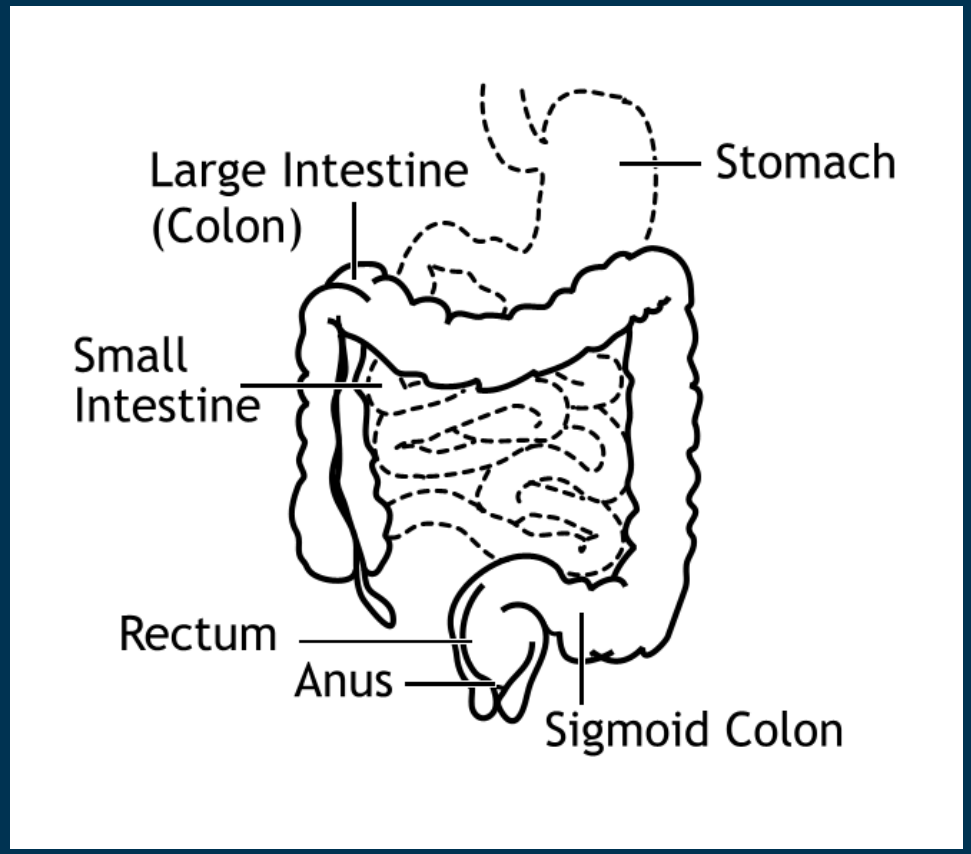
Can an individual live without a large intestine?

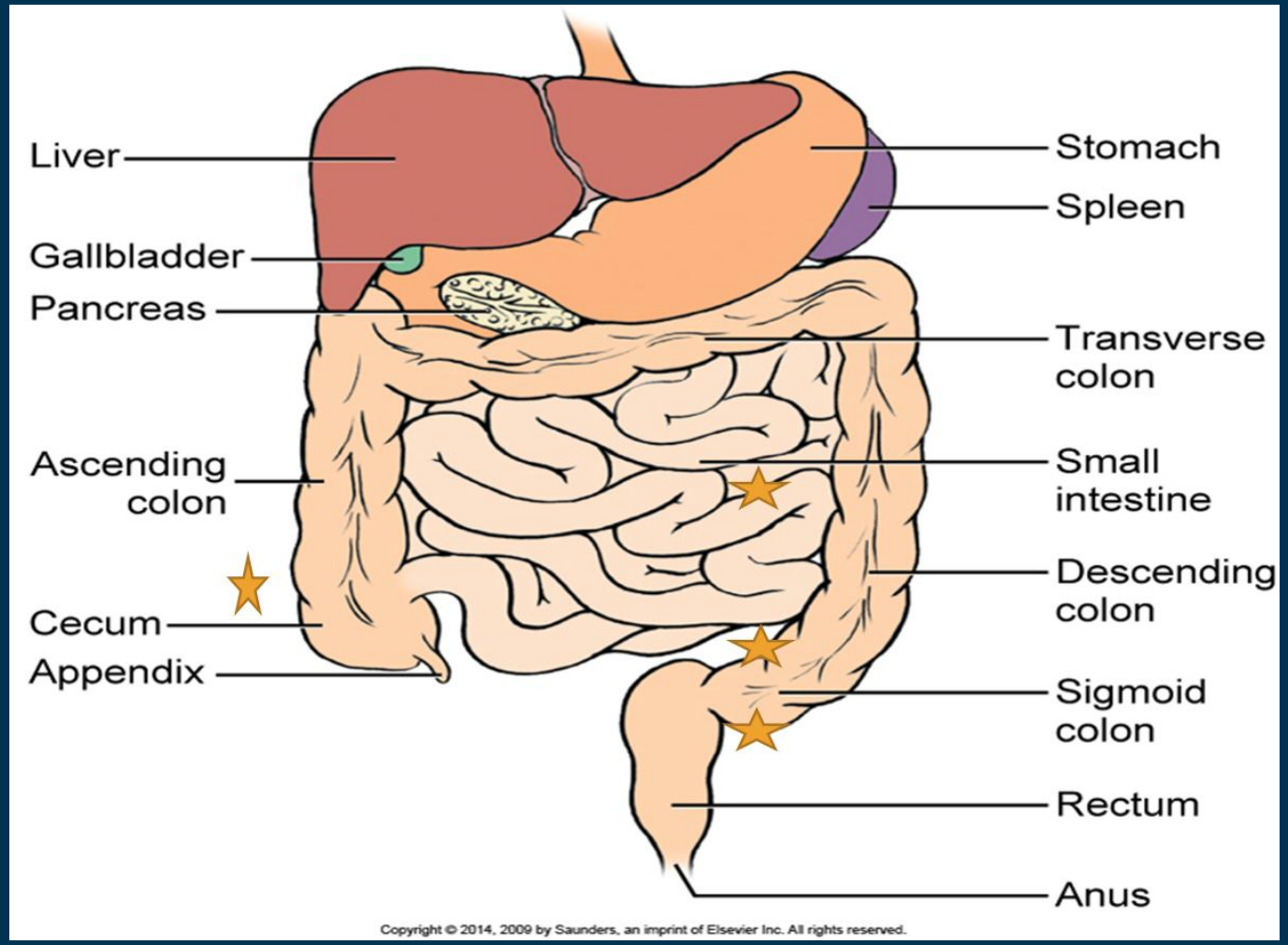
Yes, because the large intestine basically serves as a storage device for stool. Patients without large intestines have ileostomies.

What are the functions of the intestines?

Page 593

- The internal anal sphincter, located at the top of the anal canal is under involuntary control; the external anal sphincter at the end of the anal canal is controlled voluntary.
- The gastrocolic reflex initiates peristalsis, which in turn initiates the urge to defecate; it is stimulated by eating. Reflex emptying of the rectum can be stopped by tightening the voluntary anal sphincter.
- Intra-abdominal pressure increases when a person holds their breath, closes the glottis, and tightens the abdominal muscles. This initiates voluntary defecation and is called the Valsalva maneuver.
- The vermiform appendix attaches to the cecum of the ascending colon, and it has no known digestive function.





What effects does aging have on the intestinal tract? Page 594

- Atrophy (decrease in size) of the villi in the small intestine may decrease the total absorptive surface.
- Sometimes twisting of blood vessels supplying the large intestine compromises the blood flow to the large intestine. Motility in the large intestine may decrease in some individuals, but bowel habits do not change with aging in the healthy individual.

Characteristic of stool

page 594

- Stool is another term for feces. Normal feces are one quarter solid material and three-quarters water. The solid material consists of about 30% dead bacteria and 70% undigested roughage from carbohydrate, fat, protein, and inorganic matter. ***The appearance of stool is influenced by diet and metabolism.***

Characteristic of stool

page 594

- **Normal characteristics of stool:**

- Normal stool is light to dark brown, soft, and formed in children and adults. Infants stool may be dark yellow and unformed, depending on the type of feedings. The light to dark brown color is caused by bile (orange or yellow digestive fluid produced by the liver). The color of feces may be changed by certain vitamins, drugs or diet.

Characteristic of stool

page 594

- **<u>Abnormal characteristics of stool:</u>**

The most serious abnormality is BLOOD in the stool .

Fresh blood in the stool is easily visible as bright red on the surface of the stool. Occult (hidden) or old blood is suspected when the stool changes from a normal brown appearance to a dark black color with a sticky appearance.

- Conditions that cause blood in the stool include hemorrhage from ulcers in the stomach or duodenum; severe inflammation or irritation, as in ulcerative colitis or diverticulitis; and cancer.
- Bright red blood mixed in the stool is a sign of a recent gastrointestinal (GI) bleeding that has occurred in the large intestine. The color indicates that the blood has not undergone digestion in the upper part of the bowel, nor has it been in the intestinal tract for a prolonged time.

Characteristic of stool

page 594

- **Abnormal characteristics of stool:**

- As blood moves through the stomach or small intestine, it undergoes partial digestion, which changes it to a dark, tarry substance (melena)
- Pale white or light gray stool indicates an absence of bile in the intestine. This is usually due to an obstruction in the bile or common duct leading to the intestine from the liver and gallbladder.
- Unusual amounts of mucus in the stool indicate an irritation or inflammation of the inner surface of the intestine. The mucus coats the stool and gives it a slimy appearance.
- Stools with an abnormally high fat content (steatorrhea) are usually foul smelling and float on water.
- The presence of purulent material indicates drainage of an ulcer that is inflamed or infected.
- The most common parasitic worms found in the intestine are a tapeworm, pinworm, and roundworm.
- 2-Clinical Goldmine box page 594

Question

The most serious abnormality in the stool is:

1. mucus.
2. pale white appearance.
3. parasites.
4. blood.

Rationale: **Blood in the stool is the most serious abnormality.** It may indicate active bleeding if bright red. Mucus may indicate an irritation or inflammation of the inner surface of the intestines. A white stool indicates an absence of bile in the intestines. Parasites are usually tapeworm, pinworm, or roundworms.

What symptoms may indicate upper GI bleeding?

Some pain and discomfort; the nurse should also look for signs and symptoms of decreased blood volume; i.e., fatigue, shortness of breath, pale conjunctiva, low blood pressure

WHAT THE COLOR OF YOUR POO MIGHT BE TELLING YOU

BLACK
Abnormal, some cause for concern
POSSIBLY FROM:
bleeding, black jelly beans, black licorice, antidepressants or anti-diarrheal meds.

GRAY/WHITE
Abnormal, some cause for concern
POSSIBLY FROM:
antacids, cirrhosis, hepatitis or pancreatic illness.

BROWN
Light brown to dark brown is normal, no cause for concern.

YELLOW
Abnormal, some cause for concern
POSSIBLY FROM:
gallbladder problems, giardia infection.

GREEN
Somewhat normal, no cause for concern
POSSIBLY FROM:
eating lots of leafy greens or iron supplements.

PINKISH HUE
Abnormal, some cause for concern
POSSIBLY FROM:
bacteria, or eating too many beets, tomato-based products or cranberries.

BRIGHT RED
Abnormal, cause for concern
POSSIBLY FROM:
bleeding ulcer near intestinal tract, hemorrhoids.

MANDATORY.com

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Bowel elimination problems: Hypoactive Bowel & constipation

page 594-595

Some injuries and diseases cause a hypoactive bowel, but often this condition is a complication of immobility.

After abdominal surgery, patients can develop a paralytic ileus; peristalsis stops due to the manipulation of the bowel during surgery.

A lack of sufficient dietary fiber and decreased exercise may produce a sluggish or hypoactive bowel. Encouraging an increase in fiber sources, such as fruit, vegetables, ad whole grains.

Sometimes irritable bowel syndrome (IBS) causes hypoactivity of the bowel, although hyperactivity is more common.

Constipation (decrease frequency of bowel movement or passage of hard, dry feces) is the most common problem of a hypoactive bowel

. Many medications, barium, x-ray studies, or recovery from surgery can contribute to constipation –patients are risk should be identified early

Bowel elimination problems: Hypoactive Bowel & constipation

page 594-595

Health promotion box pg 595

Box 31.1 page 595

Nurses must be aware of the potential of illness induced constipation.

Any patient restricted to bed rest is at risk for constipation.

Abdominal distention is caused by flatus (gas) accumulation in the intestinal tract when peristalsis is reduced or absent. Just as fecal matter will collect in the hypoactive bowel, so will flatus. Distention and gas pains occur frequently after abdominal surgery. The discomfort and pain are caused by the stretching of the intestinal wall and spasm of the muscle layers.

Think critically box page 595

Lifespan consideration box page 596

Drugs used for Constipation

- Stool softeners

Colace, Surfak, Dialose, senna

- Bulk-forming laxatives

Fibercon, Metamucil, Citrucel

- Irritant/stimulant laxatives

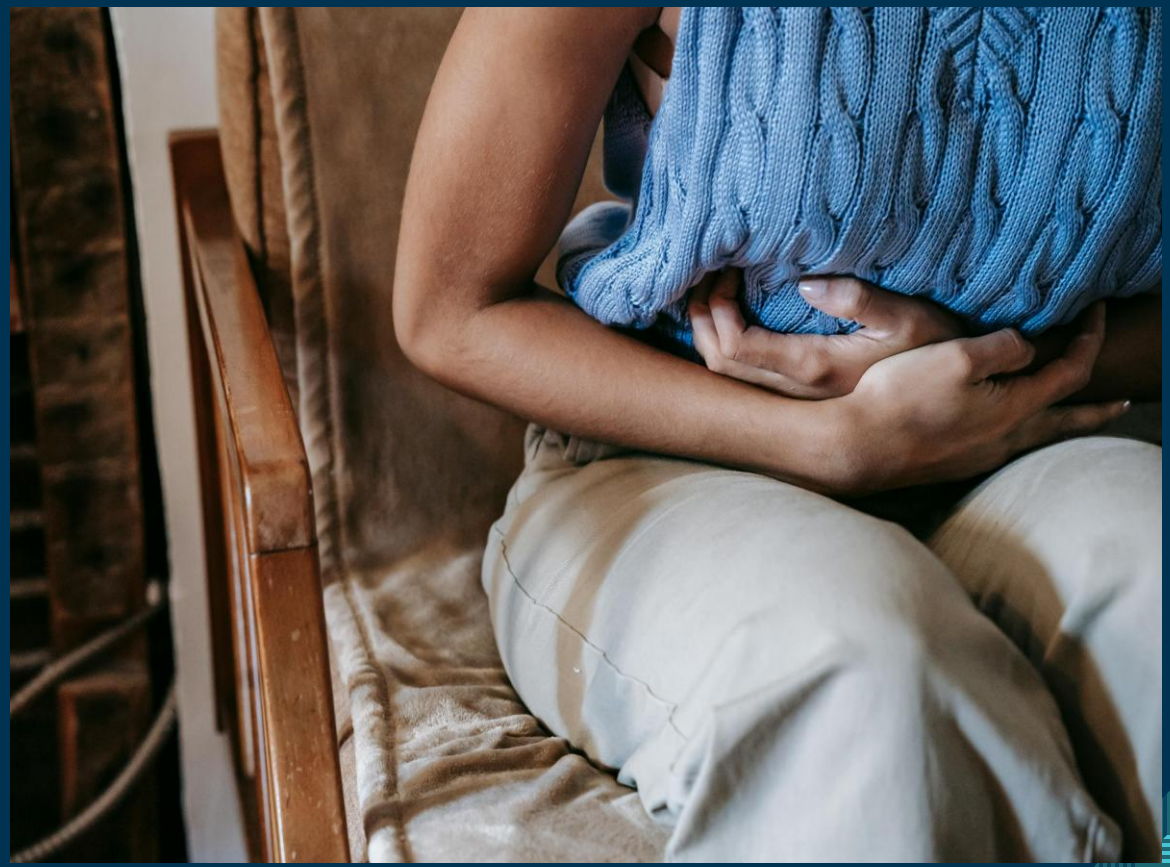
Dulcolax, Neolid, Ex-Lax, Correctol, Senokot

- Saline laxatives

Citrate of magnesia, milk of magnesia, phospho-soda

Hyperactive bowel and diarrhea page 596

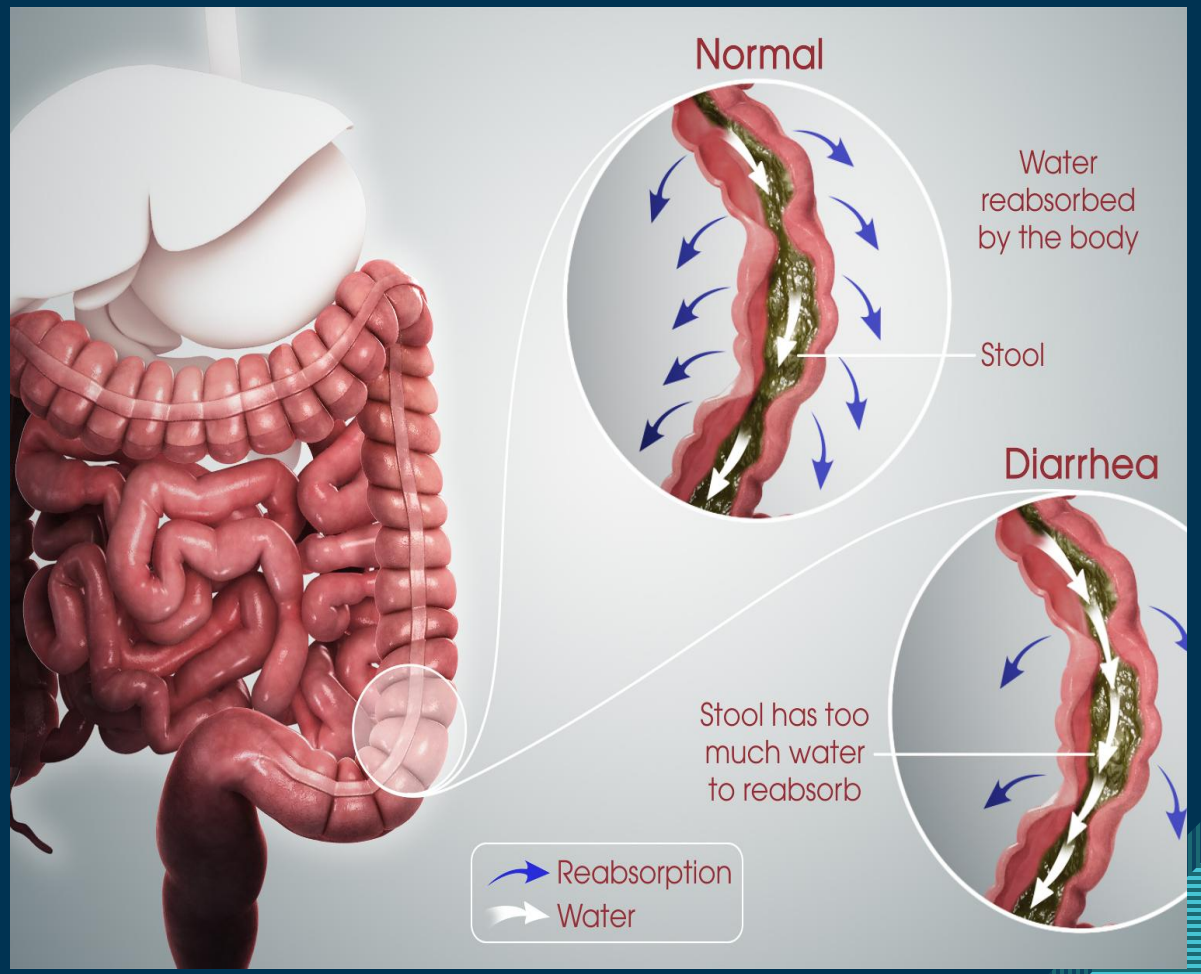
- Increased motility of the GI tract or increased peristalsis results in hyperactive bowel.
- Causes: inflammation in the GI tract, certain drugs, infectious agents, and diseases such as diverticulitis, ulcerative colitis, Crohn's disease, and IBS.
- Diverticulitis-an infection or inflammation of small pouches in the intestinal wall.
- Ulcerative colitis-chronic inflammatory bowel disease that causes inflammation and sores in the lining of the colon and rectum.
- Crohn’s disease-chronic inflammatory bowel disease that causes inflammation of the digestive tract.
- Irritable bowel syndrome (IBS)- chronic disorder affecting the large intestine.



Hyperactive bowel and diarrhea

page 596

- Patients who have gastric bypass surgery may also experience diarrhea (frequent loose stools)
- Diarrhea occurs when increased peristalsis pushes food through the intestinal tract too quickly.
- The increased speed does not allow enough time for the absorption of nutrients, electrolytes, and water, and the feces are liquid or semi-formed.
- Diarrhea is simply the body trying to rid itself of pathogens or toxins for spoiled food.
- Moderate diarrhea lasting a couple of days usually resolves by itself.
- Diarrhea can lead to fecal incontinence (the lack of voluntary control over the anal sphincter) and the inability to retain feces.
- Cultural consideration box page 596
- Box 31.2 page 596
- Life consideration box page 596
- Evidence based-practice box page 596



Drugs that can cause diarrhea

- Many antibiotics kill normal bowel bacteria, resulting in diarrhea
- Patients who experience diarrhea from antibiotics should replace normal flora by:
- Eating yogurt
- Drinking buttermilk
- Taking acidophilus (available OTC)

Medications Used to Control Diarrhea

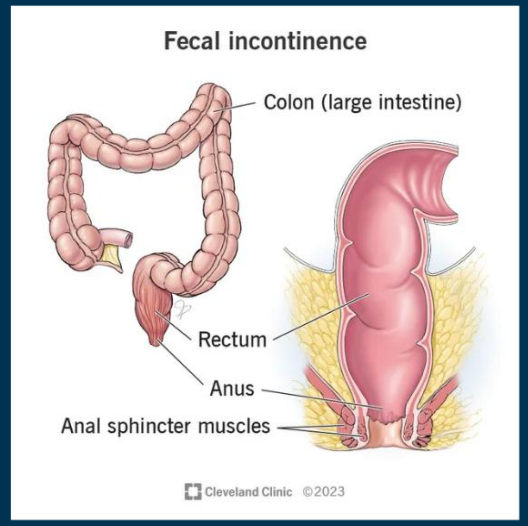
- Camphorated tincture of opium (paregoric)
- Diphenoxylate hydrochloride with atropine sulfate (Lomotil)
- Loperamide hydrochloride (Imodium)
- Difenoxin hydrochloride with atropine sulfate (Motofen)

- BRAT diet: Bananas, Rice, Applesauce, Toast-These foods are typically bland, low in fiber, and easy to digest, making them suitable for individuals recovering from gastrointestinal issues such as stomach flu, diarrhea, or nausea. The diet was once widely recommended, especially for children, to help manage symptoms and provide some nutrition when the stomach is upset.

Fecal incontinence

page 597

- People of all ages may become incontinent of feces because of illness such as a stroke, traumatic injury, or neurogenic dysfunction (nerve damage interferes with normal bodily functions).
- Incontinence is a distressing condition that causes a loss of dignity, embarrassment, or anxiety.
- People also can experience loss of self respect or fear of loss of control.
- It is important to reassure them that measures are available to assist them with the problem.
- Lifespan consideration box pg 597



Assessment (data collection)

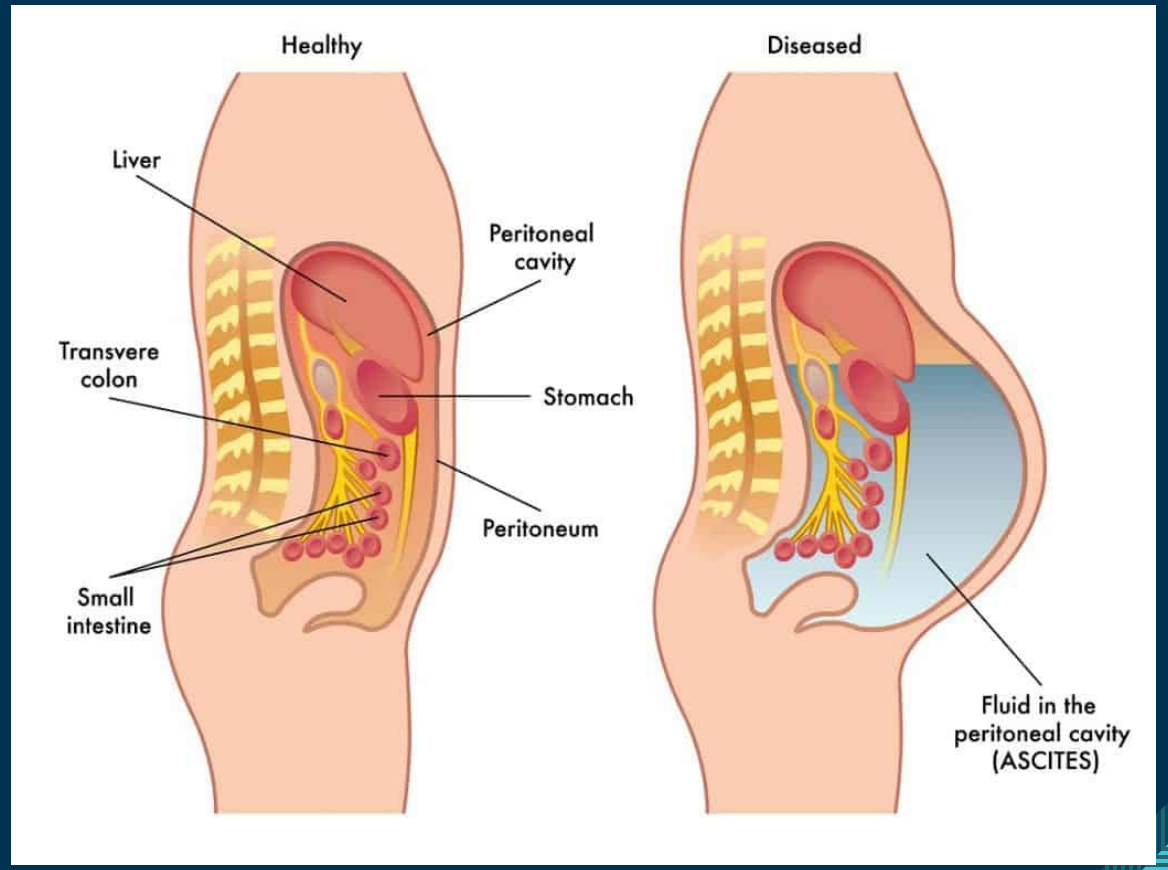
page 597

- Recognize cues: every patient is assessed regarding bowel status every day in an inpatient facility. The patient is questioned about the regularity of bowel evacuation, problems, and any abnormal characteristics of stool. **Many people think that it is abnormal not to have a bowel movement everyday but having a bowel movement every 2 or 3 days is normal for some people.**

Assessment (Data collection)

page 597

- Clinical goldmine box page 597
- Distension is revealed by an abdomen that is rounder and tighter in appearance that normal. The patient's abdomen is assessed for distention by percussion, and the nurse gently palpates the four quadrants of the abdomen to check for tenderness and masses.
- The patient may complain of abdominal discomfort and often describes it as gas pain.



Data analysis/Problem identification

page 597

- Analyze cues and prioritize hypotheses: problem statements for patients with alteration in bowel elimination include:

- Constipation related to hypoactive bowel
- Diarrhea related to food intolerance
- Fecal incontinence related to loss of anal sphincter control
- Acute pain related to abdominal distention
- Altered self-care ability related to body cast
- Altered body image related to bowel incontinence
- Insufficient knowledge related to factors that contribute to constipation.

Planning

page 597-598

- Generate solutions: A care plan is developed by writing short or long term expected outcomes for each problem statement chosen. Sample expected outcomes for the previous problem statements are:

- Constipation will be relieved by walking 1 mile each day
- Episodes of diarrhea will decrease within 3 days
- Patient will improve bowel control within 2 months of starting a restraining program
- Pain from distension will be decreased within 24 hours
- patients will use an over the bed trapeze and urinal during shift
- Body image will improve as incontinence lessens
- Patient will identify foods to add to the diet to increase fiber during this shift.

- Assignment and supervision box page 598

Implementation

page 599

- Take action: you must assist the patient on bed rest with use of the bedpan or bedside commode. Privacy is important.
- **When the average patient has not experienced bowel evacuation within 3 days, measures should be taken to assist elimination.**
- The lease invasive measures are used first. Encouraging ang monitoring activity, adequate fluid intake, and a diet with sufficient fiber may lead to regular bowel elimination.
- Noninvasive measures that can be used to promote bowel elimination include the consumption of 1-3 tablespoons of bran mixed with applesauce, small amounts of prune juice, warmed prune juice and cola, hot water with lemon juice, or stewed or dried prunes.
- If these actions are not successful, implement more invasive measures to promote bowel elimination.
- **Administration of medications to soften the stool, suppositories to stimulate the urge to defecate, laxatives to stimulate bowel activity, and enemas to empty the rectum. ALL these measures require a medical order for hospitalized patients.**

Implementation

page 599

- When the patient experiences incontinence, cleansing should occur as soon as possible. Skin care must be thorough and gentle because feces irritate the skin and can cause excoriation (abrasion of the skin).
- Products such as petroleum jelly, A &D ointment, cod liver oil ointments with zinc oxide, and commercial skin barriers are helpful to protect the skin with patients who have diarrhea.
- When diarrhea is thought be caused by bacteria or virus, the PCP may want to let is run its course for at least 24 hours sot that the body has a chance to rid itself of the offending organism.
- Diarrhea from other causes simply leads to fluid and electrolyte loss an should not be allowed to continue for long periods.
- Treatments: placing the patient on clear liquid diet to rest the bowel, replacing fluids and electrolytes, and seeking medication to stop the loose stool.

Implementation

page 599

- Observe for signs of dehydration when the patient has severe diarrhea: decreased skin turgor, dry mucous membranes with thick saliva, as increased thirst.
- **Self medication for diarrhea should NOT continue for more than 48 hours without consulting a primary care provider.**
- Interprofessional partnership box page 599
- Patient education box page 600

Evaluation

page 600

- Evaluations for patients with problems of bowel function is based on whether expected outcomes and goals have been met. Examples:
- Patient is walking 1 mile a day
- Patient has increased fluid intake to 3500ml and is producing stool every other day
- Patient is participating in a bowel program and is assisted with toileting every 2 hours
- Patient reports less pain and abdominal distention compared with yesterday
- Patient can use the trapeze to lift self onto bedpan
- Patient reports feeling better about self since bowel regimen has produced continent stool for 3 days in a row.
- Patient verbalized that white bread and noodles are contributing to constipation.

Documentation

- Document any changes in bowel habits, stool characteristics, episodes of constipation or diarrhea, and measures taken to remedy the problem.
- Document the patient education plan
- All measures to promote bowel elimination must be documented.
- Document the number and approximate number of diarrheal stools.

Rectal suppositories

page 600

- Rectal suppositories used to promote bowel movements are glycerin and bisacodyl suppositories.
- Suppositories promote bowel evacuation by:
- 1. stimulating the inner surface of the rectum and increasing the urge to defecate.
- 2. forming gas that expands the rectum
- 3. melting into a lubricating material to coat the stool for easier passage through the anal sphincter.
- Think critically box page 600

Enemas

page 600

- An enema is the introduction of fluid into the rectum and colon by means of a tube.
- Enemas are given to stimulate peristalsis and the urge to defecate or to wash out waste products or feces.
- Cleansing enemas are give when the bowel is to be examined by x-ray, colonoscopy, or sigmoidoscopy or when the bowel is distended by flatus.
- Volume of cleansing enemas:
- Infant or toddler-50ml-150ml (normal saline only)
- Age 3-5 yrs-200ml-300ml
- School age- 30ml-500ml
- Adult- 500ml-1000ml.
- **Enemas can be given at any time but is best to try to give them before the morning bath and bed linen change.**

Types of enemas

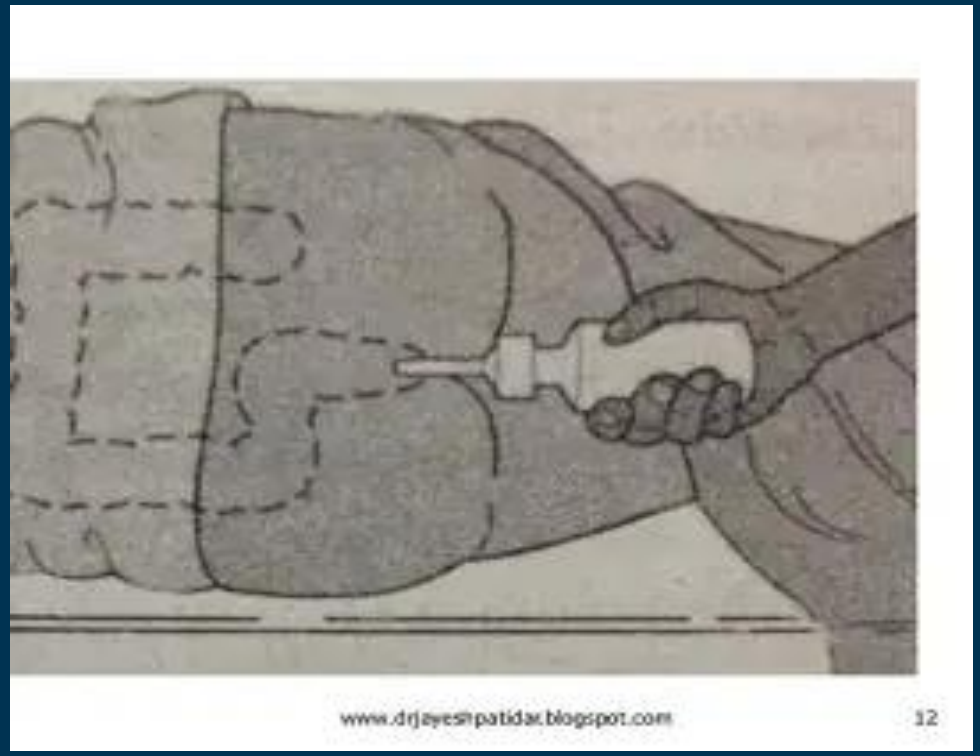
page 600

- The type of enema to be given is prescribed by the PCP, and it varies depending on the patients age and condition, the purpose of the enema, and the primary care providers preference.
- Table 31.1 page 601
- **What three factors determine the type of enema given to the patient? The patient's age and condition, the reason for the enema, and the physician's preference.**

Retention Enema

page 600

- An oil-retention enema is ordered for a patient with constipation. The oil must be retained In the rectum to soften and coat the hardened feces.
- **Instill between 120ml-180ml of warm oil rectally in the same manner as the cleansing enema, except the oil should be retained for at least 20 minutes or as long as possible.**



Amount and temperature of solution

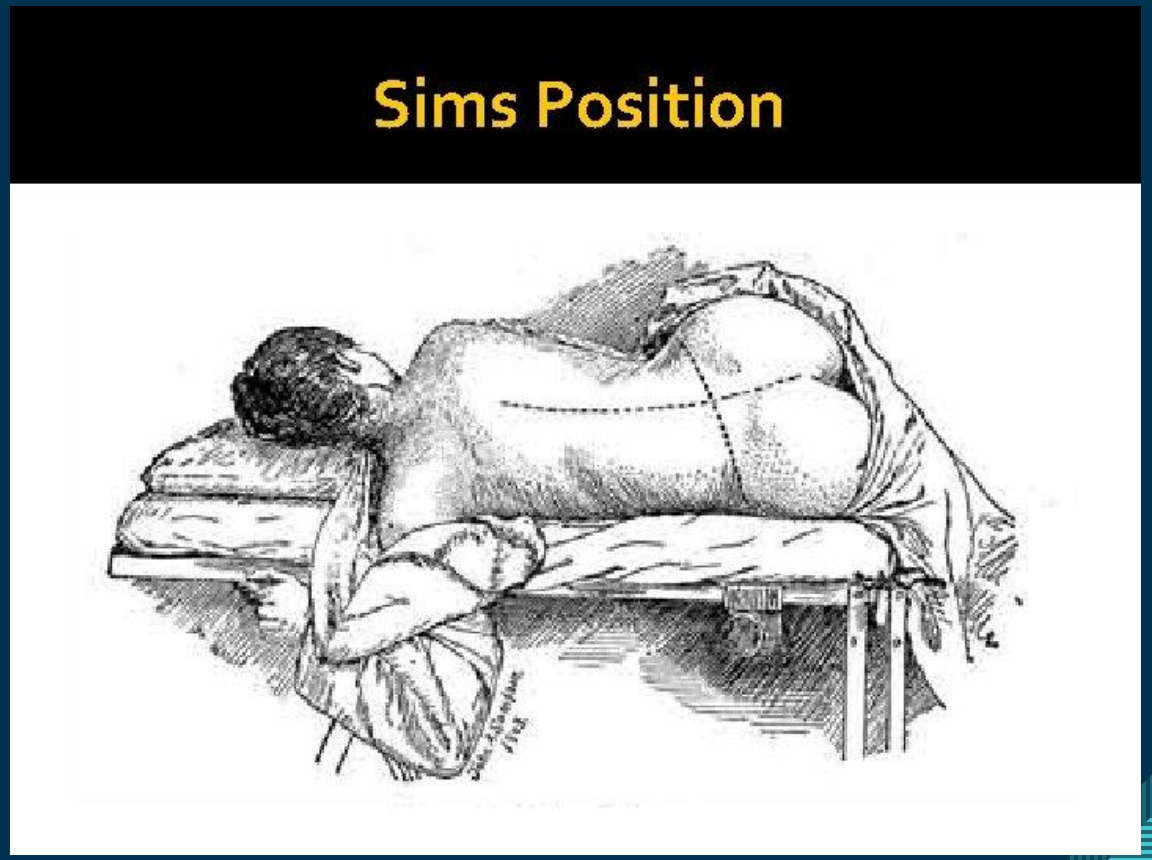
page 601

- Disposable enema units contain about 241ml of solution
- They may be given at room temperature but work best when slightly warmed.
- Quality and safety box page 601
- **The amount of solution used for a cleansing enema for adults is between 500ml-1000ml.**
- Hold the container approximately **12-18inches** above the patient's anus and allow the warm solution to run in slowly; **greater height creates to much pressure because the fluid runs in too rapidly and caused painful distension of the rectum and colon**
- Quality and safety box page 601
- Why should a cleansing enema not be given too rapidly? Causes painful distention of the rectum and colon. This stimulates the urge to defecate immediately, so that the patient cannot retain the fluid.

Recommended position

page 601

- The position of choice when giving an enema is the modified left latera recumbent position (left sims) with the hips slightly elevated
- Fig 31.4
- This allows the fluid, aided by the force of gravity, to flow downward along the natural curve of the rectum and descending colon.



Rectal tube

page 603

- When a patient is uncomfortable because of flatus in the lower bowel, a rectal tube can be inserted in the anus. The tube is like enema tubing.
- This allows the gas to be expelled without the patient straining to open the anal sphincter.

Fecal Impaction

page 603

- Fecal impaction means that the rectum and sigmoid colon become filled with hardened fecal matter. The most obvious sign is the absence of bowel movement for more than 3 days in a patient who usually has a bowel movement more frequently.
- Impactions occurs in patients who are very ill, are on bed rest, or are not fully aware of their surroundings because of a state of confusion.
- The very young and very old are more prone to fecal impaction.
- Clinical goldmine box page 603
- Lifespan consideration box page 604

Fecal Impaction signs

What are signs of fecal impaction?

- Passage of small amounts of liquid or semisoft stool onto the bed linens is a sign of fecal impaction.
- Absence of bowel movement for more than 3 days in a patient who usually has a bowel movement more frequently.

Fecal Impaction

page 604

- Nursing responsibilities includes the prevention of fecal impaction by daily assessment of bowel patterns of all patients.
- Fecal impaction is easier to remove when an oil-retention enema is ordered and given, followed by a cleansing enema 2-3 hours later.
- DIGITIAL removal of fecal impaction must be done gently, ad the patient must be watched for signs of vagal response (activation of vagal nerve) from stimulation of the sphincter and rectal wall.
- Fig31.5
- **The vagal response may cause a slow pulse and cardiac arrhythmia, an alteration in blood pressure may develop. Should this occur, immediately stop the procedure, place the patient in supine position, monitor VS and notify PCP.**

Bowel training for incontinence

page 605

- A bowel training program is based on the principles for establishing regular bowel elimination: adequate diet, sufficient fluid, adequate exercise, and sufficient rest.
- **A regular time for evacuations should be established.**
- **A reasonable goal is to achieve defecation within 1 hour of the established time.**
- Box 31.3 page 605
- After establishing a regular time for evacuation provide the patient with an environment conducive to evacuation.

Bowel training for incontinence

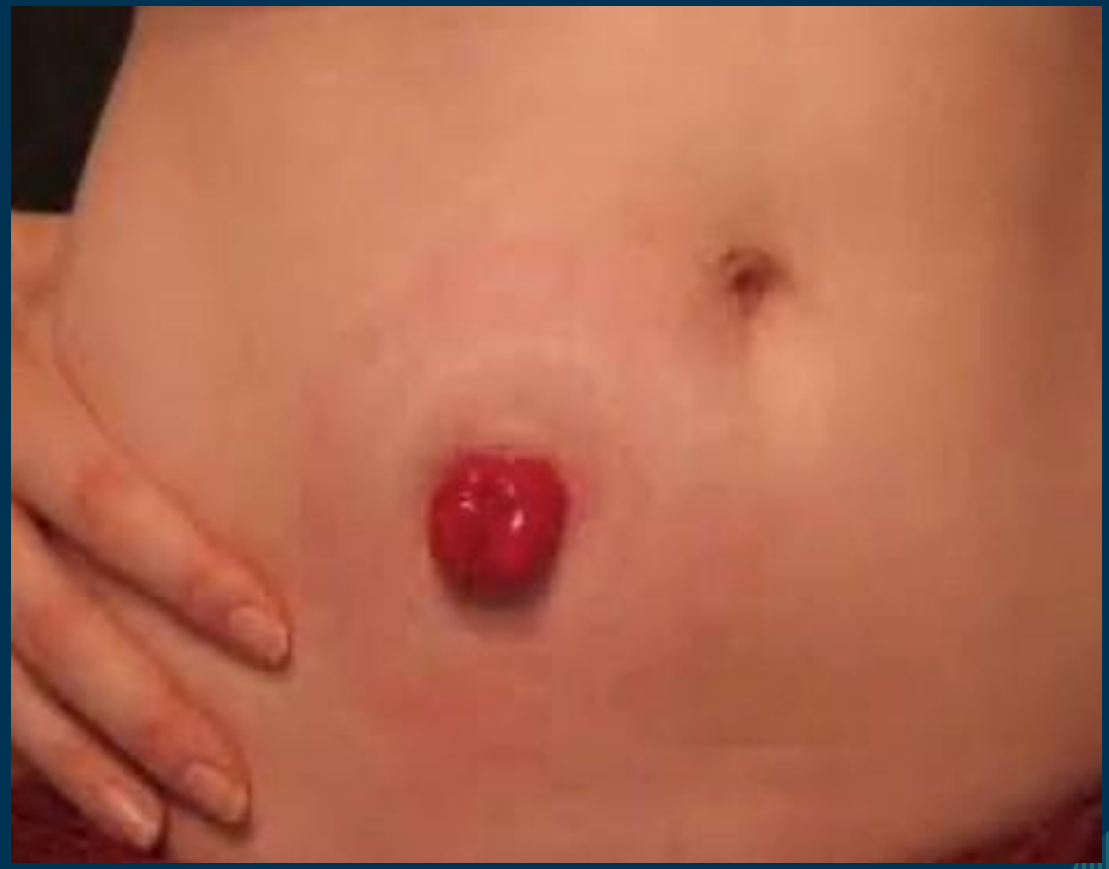
page 605

- Some patients with neurogenic dysfunction may require digital stimulation to relax the anal sphincter.
- Using a gloved and lubricated finger, insert the finger 1-2cm into the rectum and gently rotate the finger for 30-60 seconds.
- Suppositories, stool softeners, and bulk laxative may be used to assist in establishing a normal, regular bowel pattern.

Bowe ostomy: Uses of bowel ostomies

page 605

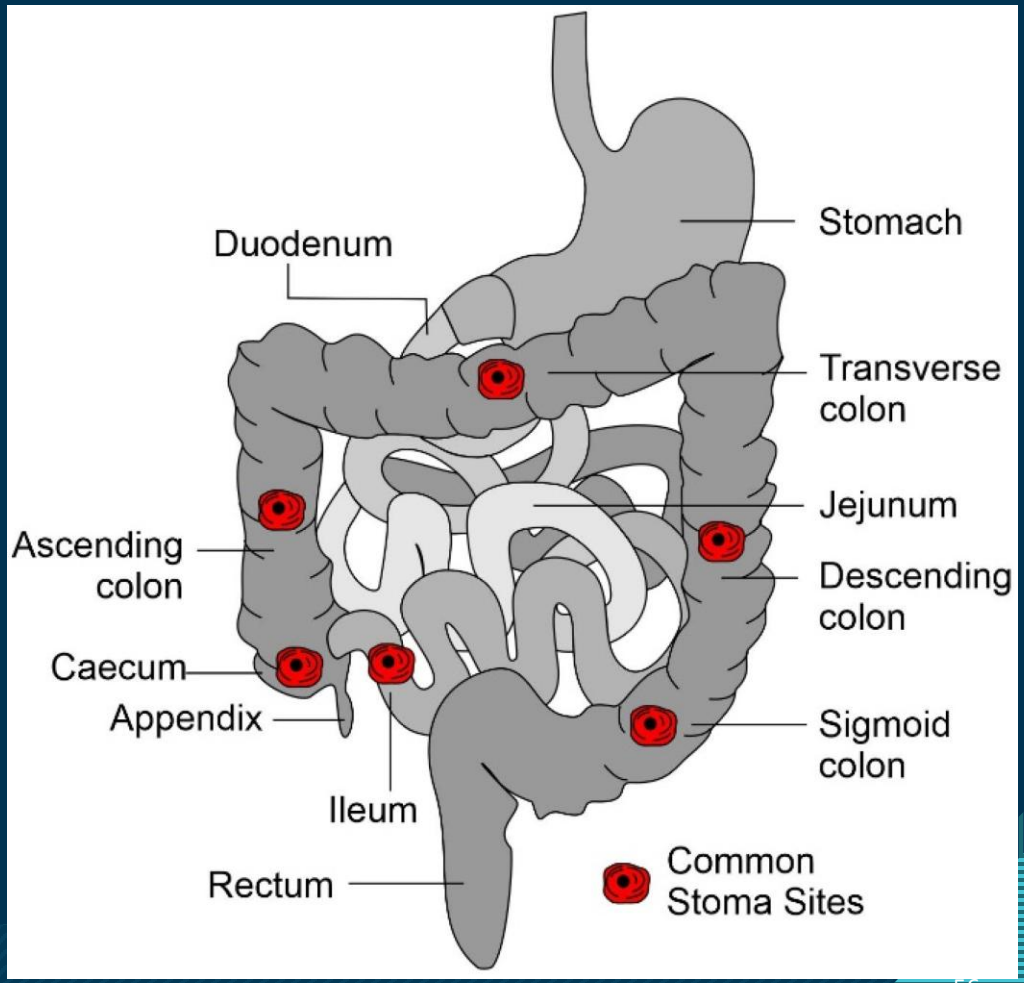
- Disease or trauma can damage the intestinal system and require surgical intervention, which alters the process of elimination.
- A diversion of intestinal contents from the normal path is called an ostomy.
- An ostomy results in the formation of an external ***stoma(opening)*** or an internal tissue pouch with a valve nipple opening.
- The internal pouch forming the continent ostomy is usually constructed from a segment of bowel. This type of ostomy is emptied with a catheter.



Bowe ostomy: Uses of bowel ostomies

page 605

- The location of the ostomy is determined by where the damage to the bowel is situated. Fig 31.6
- Some ostomies may be temporary to allow a portion of the bowel to “rest”, others will be permanent, with the damaged portion of the bowel removed.
- **Conditions that can require ostomy include cancer, abdominal trauma, congenital bowel malformation, and sever chronic Crohn disease or ulcerative colitis.**
- Patient teaching box page 607



Ostomy & Ostomy Care

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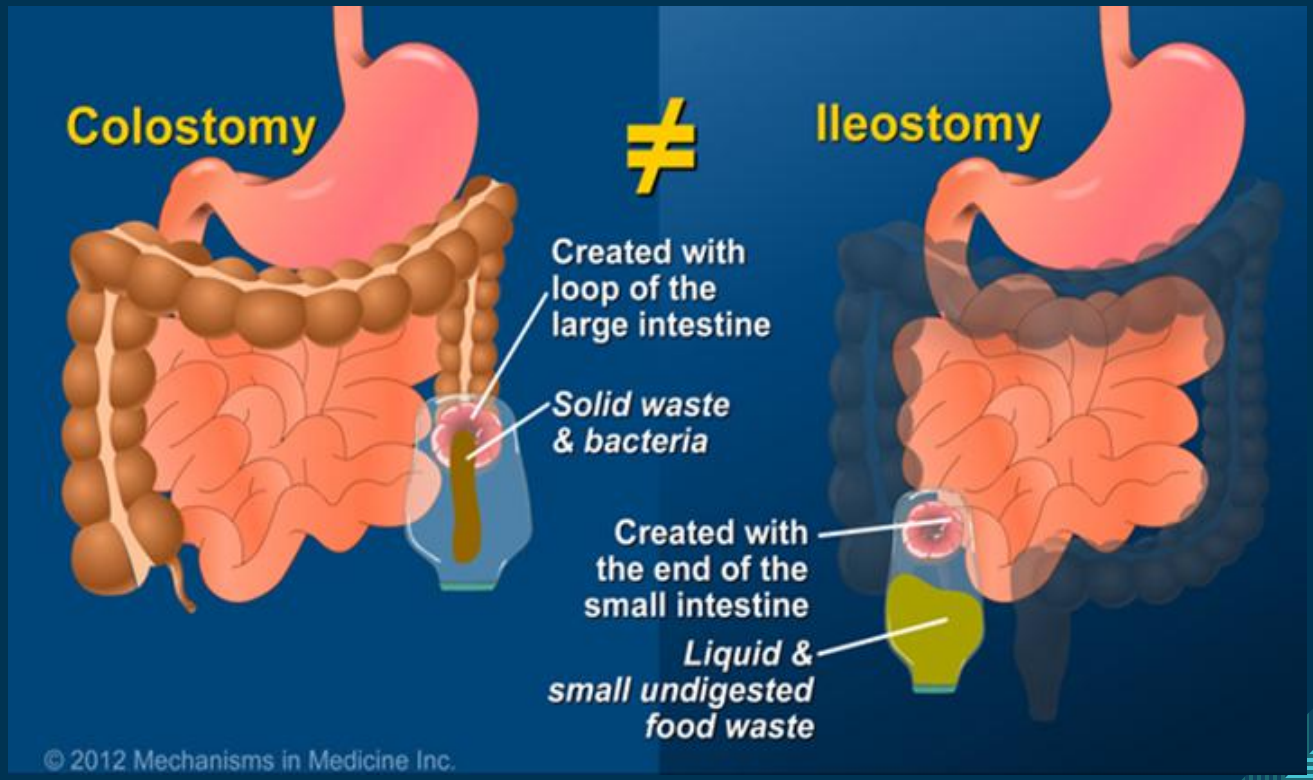
- **Ileostomy** is an opening surgically created at the ileum to divert intestinal contents. Effluent (discharged fecal matter) from an ileostomy is **liquid.**
- A **colostomy** is an opening into the colon. The stoma is the entrance to the opening. An appliance is the apparatus that attaches to the skin plus a pouch (bag) worn over the stoma to collect effluent. Fig 31.7 colostomy effluent is more **formed.**



Skin Care

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- Peristomal (around the stoma) care includes assessment of the health of the stoma and skin surrounding it. The stoma should appear pink or red, which indicated adequate blood flow. It should look like healthy mucous membranes such as membranes inside the mouth.
- Clinical goldmine box page 608

Skin care

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- Assess the skin around the stoma for signs or irritation or breakdown. With an ileostomy, enzymes in the effluent can quickly cause excoriation.
- When changing the face plate (every 3-5 days) wash the stoma and skin with mild soap and water and pat dry.
- Lifespan considerations page 608

Applying an Ostomy appliance

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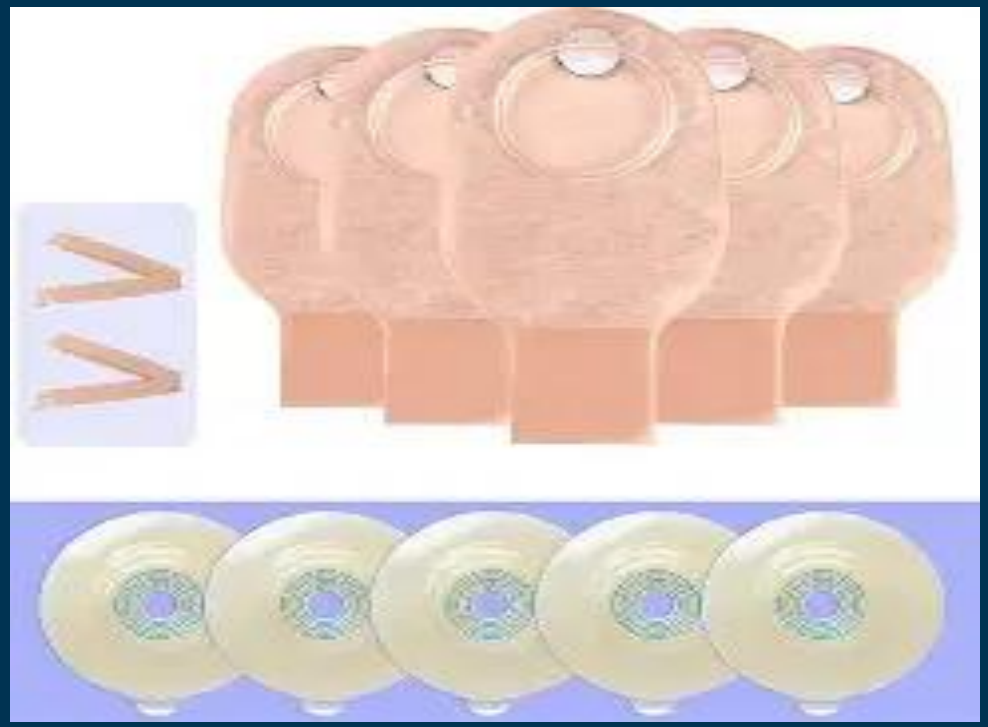
- Ostomy appliance come in many different size and types. All appliances have a faceplate, or disk, that attaches to the abdomen, and a pouch for collecting effluent.
- The appliance is positioned with the stoma protruding through the opening in the center of the faceplate.
- **It is essential that the appliance be the correct size for the patient's stoma.**
- **It is best to empty stool form the pouch when it becomes one-third to one-half full so that the weight of the effluent does not pull the appliance loose.**
- Lifespan consideration box page 609



Irrigating a colostomy

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- To irrigate a colostomy, instill a solution into the colon via the stoma; this procedure is similar to giving an enema.
- Think critically box page 609

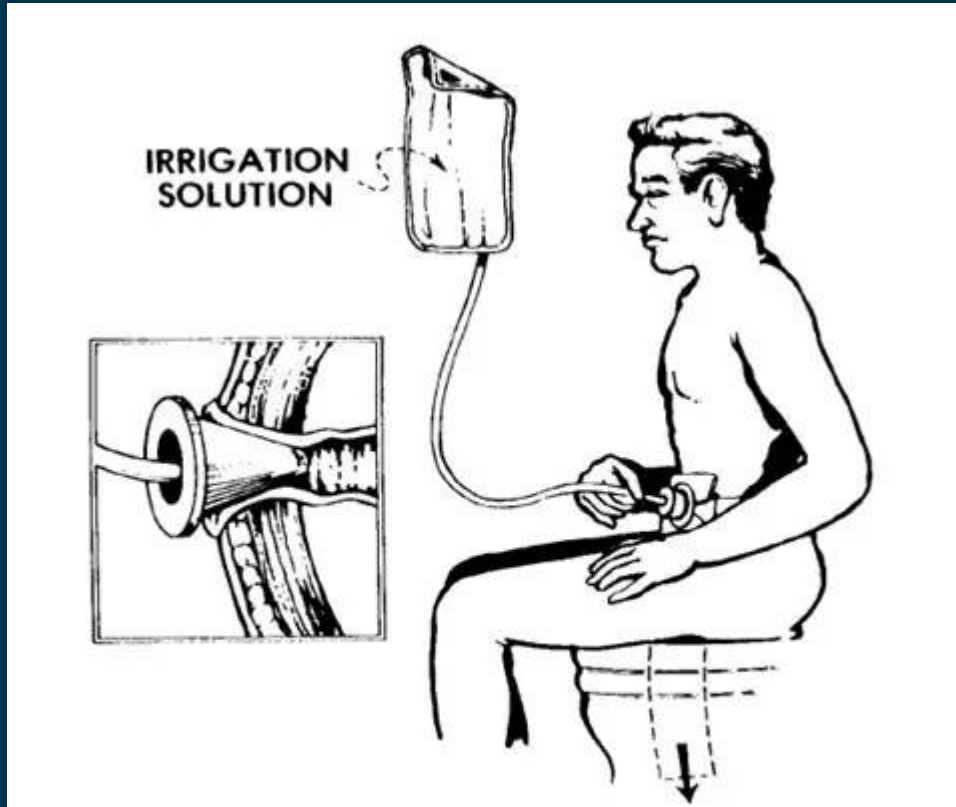

Figure 1-6. Colostomy irrigation.

Key points

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- The small and large intestines are involved in waste production and elimination
- The appearance of stool is affected by diet and metabolism, normal stool is light to dark brown, soft and tubular in shape with a diameter of about 1 inch.
- Black, sticky stool indicates bleeding in the upper intestinal tract; red blood indicates bleeding in the large intestine or rectal area. Pale white or light gray stool indicates an absence of bile in the intestine.
- Constipation is the most common problem of a hypoactive bowel; feces become compacted and hardened. Any patient restricted to bedrest is at risk for constipation.
- The older adult may develop constipation form a lack of fiber or from decreasing fluid intake. If a laxative is needed, a bulk forming type is best. (Metamucil, Fibercon etc.)
- Diarrhea occurs when increased peristalsis pushes food through the intestinal tract too fast; infants or older adult patients with diarrhea can become dehydrated very quickly
- Fecal incontinence may affect people of all ages because of illness, injury, or neurogenic dysfunction.
- Bowel status should be assessed for every patient every day!!

Key points

page 611-612

- Diarrhea caused by a virus or bacteria is usually not treated with medication for 24-48 hours. The patient is given clear liquids and allowed to rest.
- If diarrhea does not clear within 48 hours after starting medication, consult PCP
- Rectal suppositories are used to stimulate a BM. Enemas are give to cleanse the bowel, deliver medication, relieve distension, or soften stool
- Fecal impaction is first treated by oil-retention enema followed seveer hours later by a cleansing enema.
- Notify PCP if patient is not clear after three large volume enema
- A bowel training program takes 2-3months or longer.
- A ileostomy produces liquid effluent, whereas a colostomy produces a more formed stool .
- A pale, dusky, or black stoma indicates compromised blood supply, and it should be reported to the PCP.

Resourceful videos

- Ostomy Pouch: One-Piece vs Two-Piece | Lecturio Nursing
- How to Place an Ostomy Bag | Nurse Skills Training
- What is a Colostomy?
- Colostomy and Ileostomy Nursing Care | Types of Ostomies NCLEX | Ileostomy vs Colostomy – YouTube
- Colostomy and Ileostomy Nursing | Indications, Complications, Care EASY
- Large Volume Enemas | Nurse Skill Demo
- Vital Nursing Skill Demonstration: Fleet/Soap Enemas and Suppository Administration - YouTube