

Caring for Children that Require Ostomy Care in a Community Program

**Unified Referral and Intake System (URIS)
2017**



OSTOMY CARE

This document was developed in consultation with health care professionals in the areas of ostomy care and community health. The Unified Referral and Intake System (URIS) wishes to acknowledge the contribution of the following individuals.

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TABLE OF CONTENTS

INTRODUCTION..... 4

CLINICAL INFORMATION 5

HEALTH CARE PLAN 19

TRAINING..... 24

MONITORING 26

REFERENCES 27

SUPPLEMENTS

- Ostomy Health Care Plan
- Continent Urostomy Health Care Plan
- Ostomy Training & Monitoring

INTRODUCTION

The Unified Referral and Intake System (URIS) is a collaboration among various government departments, health service organizations, school divisions and child caring organizations. URIS supports community programs in the care of children with specific health care needs. Community programs that are eligible for URIS support include schools, licensed childcare facilities and agencies providing respite service.

URIS provides a standard means of classifying the complexity of health care needs and establishes the level of qualification required by personnel to support children with these health care needs. Health care needs that are classified as 'Group B' can be delegated to non-health care personnel who receive training and monitoring by a registered nurse. For children with 'Group B' health needs (e.g. ostomy care), the nurse provides the following support:

- develops and maintains a written health care plan
- provides training to community program personnel that are responsible for the child
- monitors community program personnel that receive child specific training

This document provides standard clinical information that is relevant to the care of children with an ostomy during their attendance in a community program setting. Supplemental documents are provided to assist the nurse with the development of health care plans and training and monitoring of community program personnel.

CLINICAL INFORMATION

The following information is considered best practice in community program settings and is the basis for all ostomy information contained in this document and its supplements.

Anatomy of the gastrointestinal system

The gastrointestinal system breaks down food into the basic nutrients that feed the cells of the body. The gastrointestinal tract can be divided into two parts: upper and lower. The *upper gastrointestinal (GI) tract* is where digestion and absorption of most of the nutrients occur. It includes the mouth, throat, esophagus, stomach and small intestine. The *lower gastrointestinal tract* is where water is re-absorbed and undigested food is consolidated into fecal waste. It includes the colon, rectum and anus.

The *esophagus* is a muscosal like structure that extends from the base of the throat to the stomach. The esophageal sphincter prevents food or fluid from 'backing up' after reaching the esophagus. The 'backing up' of food or fluids is called *reflux*.

The *stomach* is a curved, pouch-like organ that is located in the upper left portion of the abdomen. It partially digests food and regulates passage of food into the intestine.

The *small intestine* is where most digestion and absorption of nutrients occurs. The *duodenum*, *jejunum* and *ileum* are parts of the small intestine. Food is absorbed through the lining of the small intestine and enters the blood stream where it is then carried to the tissues and cells throughout the body.

Water is re-absorbed in the *colon or large bowel* and food by-products are consolidated to create fecal waste. The *rectum* opens to the outside of the body through the anus where fecal waste is expelled.

Anatomy of urinary system and external genitalia

The urinary system filters water and waste material from the blood and removes it from the body as urine. The urinary system includes the kidneys, ureters, bladder, urethra and urethral opening.

The kidneys are two fist-size organs, one on each side of the body in the lower back area. They clean the blood by taking out waste products and combining it with fluid to make urine. The kidneys cannot store urine. If urine collects in the kidneys, pressure builds up and damage occurs. If the kidneys are damaged, they cannot effectively clean the blood.

Ureters are narrow tubes that carry the urine from the kidneys to the bladder. They have a one-way valve that stops urine from backing up into the ureters and kidneys. Backflow of urine into the kidneys is called *reflux*.

The bladder stores the urine. It is like a balloon made of muscle which stretches as urine collects in it. When the bladder is full, nerves send a signal to the brain that gives

a person the feeling of having to go to the bathroom (void). When the nerves in and around the bladder do not work, there is no feeling of having to void (neurogenic bladder).

The urethra is a tube leading from the bladder to the outside opening of the body. It is surrounded by a muscle called the urinary sphincter, which opens to allow urine to flow out or remains closed to keep urine from leaking to the outside. The urethra also has one-way valves which help the urine flow only one way and prevent urine from leaking out until they are open.

The urethral opening is the external opening of the urinary system. In males, it is at the tip on the penis. In females, it is between the labia, just above the vagina. There are three openings in the female perineum, these are the urethral opening, vagina and anus.

Ostomy

An ostomy is a surgically created opening into the intestine or urinary tract to allow stool or urine to drain out of the body. An ostomy may be necessary when a part of the intestine or urinary tract is not able to function normally. Some health care conditions that may require an ostomy include bowel obstruction, inflammatory bowel disease (e.g. diverticulitis, Crohn's disease), birth defects (e.g. spina bifida, imperforate anus), nerve damage or malfunction and cancer.

A stoma is the opening of the ostomy on the skin. A piece of intestine or urinary tract is brought out to the surface of the abdomen and folded back onto itself, then stitched in place on the skin. The stoma is shiny, wet and of a color similar to the inside lining of the mouth. Stomas are rich in blood supply and may bleed when touched or rubbed. Depending on the child's medical condition, the stoma may be temporary or permanent.

The child usually wears a pouch over the stoma to collect stool or urine. Some children may have a continent (i.e., self-containing) ostomy that does not require a pouch but requires periodic drainage by temporarily inserting a tube into it.

Ostomies are located on different parts of the abdomen depending on which part of the intestine or urinary tract is affected. Common types of ostomies include:

- colostomy - large intestine
- ileostomy – small intestine
- urostomy - urinary tract

Colostomy

A colostomy is a surgical opening in the large intestine (colon) that is used to drain stool when part of the large intestine does not function properly. The position of the colostomy on the abdomen will depend on the reason for the colostomy and the section of colon affected. The consistency of stool varies depending on its location. The further away the ostomy is from the anus, the more watery the stool and more digestive

enzymes it contains, as it has not had opportunity to pass through the water-absorbing large intestine.

A transverse or ascending colostomy is located in the upper abdomen. The discharge from a transverse colostomy is liquid to paste-like and occurs at irregular intervals. An ascending colostomy discharges liquid stool at frequent intervals. A sigmoid or descending colostomy is usually located on the lower left side of the abdomen. The discharge is typically solid to semisolid in consistency and occurs at less frequent intervals.

Some children have two stomas which is called a double-barrel colostomy. In such cases, the last part of the colon may not function and only part of the colon may have been removed. One of the stomas will function as a colostomy where the stool comes out. The other stoma, which is closer to the rectum, is a mucus fistula. Mucus comes out of this stoma. A dressing is worn over this stoma and is changed as required, usually daily or more frequently as indicated.

The rectum may or may not be removed when a child has a colostomy. If it is not removed, mucus may pass from the rectum when they sit on the toilet.

Ileostomy

An ileostomy is a surgical opening in the small intestine that is used to drain feces if the colon has been removed or is not able to function. The end of the ileum (lowest part of the small intestine) is brought out to the surface of the abdomen to create the stoma. The stoma is usually in the lower right part of the abdomen. The stoma may seem to protrude like a nipple (unlike the flatter stomas in a colostomy) because the fecal matter from an ileostomy is very irritating to the skin and the nipple helps to direct drainage into the ostomy pouch. Drainage will be runny in consistency because the food was not able to pass through the water-absorbing colon. Discharge will be fairly constant with more drainage noted after meals and less drainage during the night.

Some children may have a continent ileostomy, which has an internal pouch that is constructed from the end of the ileum under the skin. A valve is also made from the end of the intestine, which keeps most gas and stool inside of the pouch until it is emptied. The internal pouch is emptied 4-6 times a day by putting a tube (catheter) through the stoma to open the valve and drain the contents. Children with a continent ileostomy will still have a stoma but the care for their stoma is usually simpler than for other types of ostomies.

A well balanced diet is recommended for a person who has an ileostomy. An adequate amount of fluid, sodium and potassium is very important because the large intestine, which absorbs fluids, sodium and potassium, has been removed or by-passed. This is especially important during periods of hot weather, exercise and increased physical activity because of increased sweating. Foods that are high in fibre (e.g. corn, celery, peas, oranges, grapefruits, popcorn, nuts, cucumbers, bran muffins) will remain undigested. They will pass from the ileostomy looking very much the same as when

eaten. Sometimes this undigested food can cause a blockage or obstruction of the bowel (intestine). These foods should be eaten in small quantities and chewed well prior to swallowing them. Drinking fluids while eating these foods can aid in digestion.

Urostomy

A urostomy (or ileal conduit) is a surgically created opening in any part of the urinary tract that is used to drain urine from the body. A urostomy is made when the bladder has been removed or bypassed. Ureters are attached surgically to a piece of intestine and brought to the surface of the abdomen to form a stoma. The appearance is like an ileostomy but stool does not drain out. It is located in the right lower part of the abdomen. Since this segment of intestine continues to produce mucous, both mucous and urine will be discharged through the stoma almost continuously.

Ureterostomy

One or both ureters are brought to the surface of the abdomen. Sometimes the ureterostomy stoma will be pale pink or look as if it is covered by skin. Because the bladder has been bypassed, the ureterostomy will continuously drain urine into the pouch. It is located in the upper part of the abdomen.

Vesicostomy

A vesicostomy is an opening from the bladder directly to the surface of the abdomen. Some vesicostomies are called “continent” if the pouch has been made out of the bladder under the skin to hold the urine until it is drained with a catheter. Continent vesicostomies also have a stoma. The more common types of vesicostomies allow the urine to drain continuously into a pouch or dressing covering the stoma. Most vesicostomies are used as a temporary means of draining urine. It is located in the middle of the abdomen.

Continent urinary diversion

When the urinary system does not store or release urine properly, a continent urinary diversion may be required. The cause may be spina bifida where the nerves that make the bladder and urethra work do not function properly.

A segment from the ileum is used to make a new pathway for the urine to exit the body. One end is attached to the bladder and other to a small opening (stoma) on the abdomen. It will not leak urine. To empty the bladder, a catheter is passed through the stoma and into the bladder to allow urine to drain out. A continent urostomy needs to be catheterized routinely every four to five hours.

Care of stoma

The goal of stoma care is to keep the skin and stoma clean and healthy. Good skincare is essential, as discharge from the ostomy can be irritating to the skin around the stoma and to the stoma itself.

- Good hand washing is important.
- Keep supplies clean to prevent infection.

- A skin barrier (e.g. cream, spray, paste) should be applied around the stoma to protect the skin from any leakage.
- Keep skin around the stoma clean and dry using mild soap and warm water. If soap is used, ensure the skin is rinsed well.
- Do not use baby wipes, oils, powders, ointments or lotions on the skin around the stoma as these products can prevent the skin barrier from sticking to the skin.
- Avoid vigorous rubbing of stoma.
- Avoid accidental scraping of stoma with jewelry or nails.
- Empty the pouch when it is no more than one third to one half full.
- Change the pouch system if it is leaking or loose.
- A child can be bathed with the pouch system on or off. Water will not enter or harm the stoma. Avoid using oily soaps or lotions around the stoma as they can interfere with the barrier adhering to the skin. If the child wears a pouch while bathing, dry it off afterwards and check the seal to ensure there are no leaks.
- A child is able to swim with a pouch system on. It is advisable for the child to keep the pouch system on when swimming for hygienic purposes. An ostomy belt or waterproof tape may help to make the pouch system more secure. The waterproof tape should be removed after swimming as it can irritate the skin.
- It is advisable to empty the pouch prior to naptime or bedtime.

Equipment and supplies

With a colostomy or ileostomy, waste leaves the body through the stoma instead of the anus. Since there is no muscle around the stoma, you are not able to control when waste or gas passes out of the body. An odor-proof plastic pouch surrounds the stoma to collect the waste and is held to the skin with an adhesive skin barrier. The pouch system is designed to protect the person's skin, provide a secure seal, control odor and be comfortable.

Pouch systems may be one-piece or two-piece. In a two-piece system, the pouch and skin barrier wafer are separate. The pouch contains a closing ring that attaches to or snaps onto the skin barrier wafer. The skin barrier wafer is the waxy part that sticks to the skin and fits around the stoma. It protects the skin from contact with stool or urine. It is made of a sticky substance that holds the pouch in place. In a one-piece system, the pouch and skin barrier wafer are a single unit. The type of pouch used will depend on the type of stoma.

Other accessories may include:

- Ostomy belt, which helps support the pouch
- Pouch cover, which conceals the pouch
- Skin barrier paste, cream or spray to fill in folds or skin irregularities of the abdomen to form a better seal
- Skin wipes or powders, which protect the skin under the barrier and around the stoma
- Adhesive , which supports the barrier and is used for waterproofing

- Adhesive remover, which cleans adhesive off the skin

Emptying an ostomy pouch

An ostomy pouch should be emptied when it is one third to half full. Emptying the pouch regularly can ensure that the pouch seal will last longer and remain secure. Waiting for the pouch to leak can be upsetting and can increase the chance of skin irritation around the stoma.

1. Wash hands with warm soapy water.
2. Gather supplies
 - Gloves
 - Container to collect drainage
 - Paper towel
3. Position the child to facilitate emptying of the ostomy pouch and ensure privacy. If able, the child can sit on the toilet when you empty the pouch.
4. Put on the gloves.
5. Hold the pouch up and open at the bottom end. You may need to roll the end back to keep it from getting soiled.
6. Lower the pouch opening to allow the content to drain and then squeeze the remaining contents out of the pouch.
7. Clean the end of the pouch using paper towel.
8. Close the end of the pouch.
9. If a container was used to drain contents, clean it well using mild soap and warm water; rinse thoroughly and wipe dry with clean paper towel. Dispose of paper towels in the garbage.
10. Remove gloves and discard.
11. Wash hands.
12. Document.

If the child has a two piece pouching system, it may be easier to snap off the pouch to empty it. In such situations, an extra pouch may be used to snap onto the skin barrier wafer when the full pouch is removed. The stoma may also be covered with moist paper towel or wiped clean if drainage occurs.

The inside of the pouch does not need to be cleaned when the child is wearing it. If the stool is difficult to remove from the pouch, a lubricating product may be used to keep the inside of the pouch slippery so that content empties more easily. Do not use other products such as cooking oil, baby oil or soap.

Changing a pouch system

Changing a pouch system should be planned ahead of time and done at home by the child or parent/guardian whenever possible. Typically, a pouch system can be worn by an infant for one to two days. Some children may wear a pouch for up to three days. Wear time is influenced by several factors such as the amount of stool or urine, consistency of the stool and the child's level of activity. A stoma that drains urine or

more watery stool can dissolve the skin barrier seal faster than the output from thicker, less frequent stool.

The pouch system will need to be changed at the community program if it leaks or becomes loose.

1. Wash hands.
2. Gather supplies
 - New pouch system
 - Disposable gloves
 - Water
 - Mild soap
 - Plastic-lined container
 - Measuring guide, if needed
 - Skin barrier paste, if needed
 - Tape, if needed
 - Pen and scissors, if needed
 - Protective powder, if needed
3. Position the child to facilitate changing of pouch and ensure privacy. If able, the child can sit on the toilet when you empty the pouch.
4. Put on the gloves.
5. Empty the pouch.
6. Carefully remove the used pouch and skin barrier wafer by pushing the skin away from the bag. Do not pull the skin barrier wafer off the skin.
7. Clean the skin around the stoma with mild soap and warm water. Rinse and gently pat dry.
8. Inspect the skin for redness, rash, bleeding or blistering. Notify parent/guardian if any of these signs of skin irritation are present.
9. Apply protective powder, if available, to any red area around stoma. Brush excess powder off the skin.
10. If the skin barrier wafer requires fitting, measure the stoma and cut the wafer using the measuring guide. Cut the opening 1/8 inch larger than the stoma.
11. Peel off the paper backing from skin barrier wafer and apply skin barrier paste/spray/cream, if needed, around the opening. Allow to air dry.
12. For the 1-piece system, center the new pouch directly over the stoma, firmly press the pouch and skin barrier wafer so there are no wrinkles or leaks.
13. For the 2-piece system, center the skin barrier wafer directly over the stoma, firmly press and then snap the pouch to the plastic ring.
14. Dispose of the used pouch into a plastic lined container.
15. Remove the gloves and wash your hands with mild soap and warm water.
16. Document.

Catheterizing a continent urostomy/vesicostomy

1. Wash hands with mild soap and warm water.
2. Gather supplies
 - Catheter
 - Catheter storage bag

- Water-soluble lubricant
 - Soap, water and facecloth OR disposable wipes
 - Container to collect drainage or toilet
3. Position child to facilitate catheterization and ensure privacy. If able, the child can sit on the toilet when you empty the continent urostomy
 4. Put on gloves.
 5. Wash stoma with mild soap and warm water.
 6. Lubricate the catheter tip with water soluble lubricant. Do not use Vaseline.
 7. Insert the catheter into the stoma until urine begins to voluntarily flow out. You may feel some resistance as you push the catheter through the bladder. Gently push past the resistance until urine flows. Make sure the other end of catheter is in toilet or container to collect the urine. Ask the child to breathe in slowly through the nose and out through the mouth to ease pain/discomfort.
 8. Leave the catheter in the stoma until flow of urine stops. Then slowly insert the catheter one half to one inch further until there is no more urine flow.
 9. Slowly pinch the catheter and remove it from the stoma.
 10. Place catheter in the garbage or plastic disposable bag.
 11. Reapply the bandage covering the stoma.
 12. Remove gloves and wash hands with mild soap and warm water.
 13. Wash equipment with mild soap and warm water.
 14. Document.

Cleaning the catheter

1. After each use, wash the catheter with mild soap and warm water. Rinse the catheter well, letting the water run through the catheter until clear and no soap remains.
2. Dry the catheter with a towel or paper towel and store in plastic container.
3. If the child has a urinary tract infection, dispose of the catheter. Do not reuse the catheter.

A catheter may be used for up to one month depending on frequency of use, diligence with cleaning and other factors.

Emergency situations and Emergency Response Plan (ostomy)

Bowel obstruction

Stomach pain, irregular watery spurts from stoma, watery discharge followed by an absence or decrease of stool, strong odor being emitted from the stool, nausea, vomiting and/or fever may indicate a bowel obstruction.

This may be an emergency.

1. Notify the parent/guardian immediately.
2. If you are unable to contact the parent/guardian or alternate emergency contact, call 911/EMS.

Potential problems and required actions (ostomy)

Swelling of the stoma may occur if it is constricted by the appliance.

1. Remove the appliance and cover the stoma with a clean towel to absorb leakage.

2. Notify the parent/guardian immediately.
3. If you are unable to contact the parent/guardian or alternate emergency contact, call 911/EMS.

Stoma is longer than normal (intestine is prolapsing or pushing out through the stoma). The stoma may appear swollen and the child may experience cramping and vomiting.

1. Notify the parent/guardian immediately.
2. If you are unable to contact the parent/guardian or alternate emergency contact, call 911/EMS.

Leakage may occur if the pouch is too full or the seal is broken in the pouch system. Other causes may include inadequate or ineffective stoma care, improper pouch size for stoma, incorrect measuring and cutting of the skin barrier wafer or a change in stool patterns (e.g. diarrhea).

1. Empty the pouch.
2. If the pouch is still leaking, change the pouching system. If you have not been trained to change the pouching system, call the parent/guardian.

Bleeding from the stoma may occur if it is rubbed roughly during cleaning, nicked with a fingernail or jewelry, irritated from a belt or accidentally bumped. The bleeding usually stops quickly on its own and does not cause discomfort for the child.

1. If the bleeding does not stop on its own, apply gentle pressure and notify the parent/guardian.
2. If a large area of the stoma is bleeding, cover the stoma and apply gentle pressure. Notify the parent/guardian immediately.
3. If you are unable to contact the parent/guardian or alternate emergency contact, call 911/EMS.

Redness, irritation of skin around stoma may be due to improper stoma care, improper size of appliance, leakage, ingestion of acidic foods, allergy or sensitivity.

1. Provide proper stoma care
2. Make sure the skin barrier wafer is applied properly and is the correct size (1/8 inch larger than the stoma).
3. Change the pouching system if it is not fitting properly. If you have not been trained to change the pouching system, call the parent/guardian.
4. Inform the parent/guardian.

Change in stool pattern may be due to diet changes or illness.

- If the child is having stool that is looser or more frequent, notify the parent/guardian.

Odor

A properly cared for ostomy should not have a persistent odor when the pouch is closed. Pouches are odor-proof provided they are emptied as needed, cleaned properly and changed regularly.

1. Check for a leak around the stoma or in the pouch itself.

2. Inform the parent/guardian.

Gas

Suggested strategies to decrease gas

- Eat slowly and chew food well
- Avoid drinking with a straw
- Avoid chewing gum
- Limit intake of gas-forming food such as cabbage, brussel sprouts, onions, beans, cauliflower, cucumber, radishes, carbonated drinks

Potential Problems and required actions for (continent urinary diversion)

Catheter is unable to enter the stoma

This may occur if the bladder is too full because the end of the passage into the bladder gets pinched within the bladder muscle.

1. Have the child lie down as this can relax the muscles within the abdomen and allow the catheter to pass through.
2. If this does not work, have the child rest for 20-30 minutes and try again.
3. If still unable to catheterize the child, notify parent/guardian.

Abdominal cramping or pain

This may occur if the bladder is too full.

1. Catheterize the child.
2. If the cramping or pain does not go away, notify parent/guardian.

Only a small amount of urine comes out

This may be due to mucous blocking the catheter.

1. Move the catheter in or out a bit.
2. If unable to get urine out, notify parent/guardian.

Urine leaking between catheterizing

This may occur if the bladder is not emptied completely when catheterized.

1. Catheterize again. Make sure to empty all of the urine, as able.
2. If it is still leaking, notify parent/guardian.

Foul-smelling or cloudy urine, abdominal pain, leaking urine, pain on insertion of catheter, blood in urine, chills and/or fever

This may be signs of a urinary tract infection (UTI).

- Notify the parent/guardian.

Ways to prevent a UTI

- Always use a clean catheter
- Good hand washing
- Empty the bladder completely each time
- Empty the bladder as often as directed
- Ensure the child is drinking enough fluids

Infection Control Guidelines

Infection control is important for the health of the child being cared for as well as for the health of the community program personnel who are providing care to the child. The following practices are intended to prevent transmission of infection when caring for children. These practices are to be used when caring for all children, not just those who pose a risk.

Good hand washing is the single most important way to prevent the spread of infection. Proper hand washing includes the use of mild soap and warm water, rubbing hands together to create some friction for at least 30 seconds, rinsing under running water, drying of hands and turning off the faucet using a paper towel to avoid germs from the tap. When soap and water are unavailable, antiseptic handrubs may be used as a temporary method. With handrubs, a small amount (approximately 3 mL) is applied to the hands and rubbed together until the agent has dried. Handrubs should not be used if hands are visibly soiled.

Hand washing should occur in the following situations

- Before and after contact with body fluids, even if gloves are worn
- Immediately if in contact with blood or body fluids
- Before adorning and after removal of gloves
- Before and after contact with child
- Before and after taking breaks

Gloves and other personal protective equipment (e.g. masks, protective eyewear) are intended to reduce the risk of spreading infection to the caregiver, from child to caregiver and from child to child.

Latex or vinyl gloves are to be worn in the following situations.

- During direct care with a child that involves possible contact with blood or body fluids (e.g. mucous, sputum, urine, feces, saliva, vomit, nasal secretions)
- When cleaning up spills of blood or body fluids
- When handling items soiled with blood or body fluids
- If in contact with open wounds or sores
- While performing mouth care
- When assisting child with toileting/diapering
- If the caregiver has broken skin on the hands

Removing Gloves

1. Grasp outer cuff of one glove using the other gloved hand.
2. Pull glove off the hand, allowing it to turn inside out directing away from your body.
3. Grasp and hold the removed glove within the palm of the gloved hand.
4. Place the thumb of the ungloved hand underneath the cuff of the gloved hand, and remove it by pulling it inside out, over the first removed glove.
5. Discard the gloves into a garbage or plastic lined container.

6. Wash hands with mild soap and warm water.

Disposal of contaminated items

Any disposable item (e.g., gloves, medical supplies) that is contaminated with blood or body fluids should be double bagged before discarding. A separate waste container should be designated for this purpose.

Needles, lancets, syringes and other sharp objects should be placed into a puncture-proof container which is labeled “sharps” immediately after use. The container should be stored in a safe location.

Cleaning of contaminated surfaces

Areas that have been contaminated with blood or bodily fluids should be promptly cleaned with absorbent disposable paper toweling which is then disposed into a plastic garbage container. The area should then be cleaned with water and detergent followed by disinfecting with a bleach solution (e.g. one part bleach to nine parts water) and allowed to air dry.

If mops have been used in the cleanup, they should be thoroughly washed with soap and water, disinfected with a bleach solution (e.g. one part bleach to nine parts water) and dried before re-use.

Latex alert

Some children with health care conditions that have been involved in multiple surgeries may have a clinical latex allergy while other children are at high risk for developing a latex allergy. For these children, allergic responses can occur when latex-containing items touch the skin or mucous membranes (e.g. mouth, urethra, genitals) and are allowed to enter the bloodstream or are inhaled.

Latex precautions are important in preventing allergic reactions for children who have a latex allergy or at high risk for developing a latex allergy. In order to be effective, latex avoidance must occur in all spheres of life – in hospital, home, school and in the community. Identifying areas and sources of potential latex exposure is crucial to provide a safe environment for the child.

Latex that comes in contact with mucus membranes has the highest potential to cause allergic reaction. When a child has a latex allergy or is at high risk for developing a latex allergy, the following precautions are recommended.

- Use of non-latex gloves.
- Use of latex free band aids.
- Balloons should not be used in the facility. When balloons break, the latex particles become aerosolized.
- Latex alert signage and/or listed on child’s file

Other items that may contain latex

- Classrooms items like erasers, rubber bands, art supplies and lab equipment may contain latex. Many of these will not cause allergic reactions if they do not come in direct contact with the child.
- Food prepared in a cafeteria with latex gloves may contain latex. In addition, it is important for personnel to understand the possible cross-sensitization between latex and certain foods such as bananas, kiwi and avocados.
- Gym and playground equipment such as rubber mats, balls, racquet handles and toys may contain latex.
- School buses may have floor mats with latex, airborne natural latex rubber from tires.
- Field trips can be challenging. Items to look out for may include latex gloves in first aid kits, gloves used in lunch facilities, balloon decorations.

Allergic reactions to latex may include watery eyes, wheezing, rash, hives, swelling and, in severe cases, life-threatening anaphylactic shock. Information on the signs of anaphylaxis and how to respond are included in the Anaphylaxis Clinical Practice Guidelines developed by the URIS program.

Self-care

It is important to encourage the child's participation in their health care and to foster their independence as appropriate. The ability of the child to provide their own health care can give them greater freedom and independence during their participation in the community program.

The amount of assistance a child requires with health care procedures will vary depending on the complexity of the procedure and the developmental and functional level of the child. Each child must be individually evaluated as to their physical and psychosocial abilities to assist in or perform their own health care procedures. Many children with physical disabilities can learn to direct the care provider and/or assist during aspects of the health care procedure. Some children may be capable of learning to perform health care procedures independently or with varying degrees of supervision.

In addition to the child's developmental/functional level, other factors that may be relevant in their ability to assist in or perform health care procedures include:

- ability of child to tolerate required position and/or procedure
- fine motor and self help skills
- ability to imitate others
- ability to develop independence
- acquisition of self-recognition and self-identity
- emotional development to feel comfortable with procedure
- ability to solve problems in unfamiliar settings
- ability to identify signs and symptoms of potential problems and emergency situations

Methods used to teach self-care might include simulation or demonstration. Using an anatomically correct doll to teach children how to perform health care procedures may enhance the child's participation. Simulation on a doll is non-invasive, enhancing the opportunity for teaching and possible reduction in feelings of embarrassment. It may lessen the child's anxiety so that he or she may perform the procedure on him/herself. Finally, the use of a doll allows errors to be detected and corrected before the actual performance of a procedure. Using anatomic illustrations, videotapes or other visual aids provide opportunities to demonstrate health care procedures to the child.

HEALTH CARE PLAN

When a community program receives URIS Group B support for children with URIS 'Group B' health care needs, a written health care plan is developed and maintained by a registered nurse minimally on an annual basis. The development and implementation of the health care plan should reflect the principles of inclusion and independence.

- A child with an ostomy is foremost a child within a family, child-care facility, classroom or other community program
- The environment should be changed to support the child, not the child changed to suit the environment
- Interventions should be as non-intrusive as possible and be delivered in a manner that respects the child's dignity and privacy as well as the regular routines and patterns of the community program
- The parent/guardian and child have rights and obligations and should be encouraged to actively contribute to, engage in and participate in decisions affecting them

Consultation with the parent/guardian and community program is required to develop a health care plan that is relevant to the child's needs and appropriate within the community program setting. For some children, the management of their ostomy may be complex and consultation with their physician and/or specialist(s) may be required to ensure appropriate care is provided within the community program setting.

When a child has multiple health care needs, all relevant information should be integrated into one comprehensive health care plan. The format should use plain language and include information that is required to manage the child's ostomy in a safe and appropriate manner during their attendance at the community program.

The health care plan should be kept in a location that is secure and accessible. Community program personnel that are responsible for the child should be aware of its location. The health care plan should accompany the child on excursions outside the facility.

Ostomy health care plan

The following information is required in the health care plan developed for children with an ostomy. The *Ostomy Health Care Plan* contains this information and is included as a supplement to this document.

Demographic information

- Child's name
- Birth date
- Community program name
- Parent(s)/guardian(s) name and phone number(s)
- Alternate emergency contact name and phone number(s)
- Specialist name and phone number
- Family physician/pediatrician name and phone number

Medical information

- Medical diagnoses and other relevant conditions
- Known allergies
- Availability of Medic-Alert® identification
- Prescribed medications
 - If medication is administered at home only, the name of medication is required
 - If medication is administered at the community program, the medication name, dose, location, time and route of administration is required. Community programs that have an internal policy for administration of medication, may have already obtained this information.

Ostomy information

- Reason for ostomy
- Type of ostomy
- Baseline information for stool (e.g. color, amount, consistency, frequency, volume, pattern of continence)
- Pouch system used
- Skin barriers used

Emptying an ostomy pouch

- Indications
- Preferred location
- Supplies needed
- Procedure

Changing an ostomy pouch (if applicable to child)

- Indications
- Preferred location
- Supplies needed
- Procedure

Stoma care

Emergency situations and how to respond

- Bowel obstruction
- Anaphylaxis, if the child has a latex allergy and is prescribed an adrenaline auto-injector (See Anaphylaxis Clinical Practice Guidelines)

Potential problems and how to respond

- Swelling of stoma
- Stoma is longer than normal
- Leakage
- Bleeding from the stoma
- Redness, irritation of skin around stoma
- Change in stool pattern
- Odor
- Gas

Documentation

- Template for recording interventions and actions performed by the nurse and/or community program personnel (e.g. communication, situation, intervention, response, actions taken)
- Signatures & dates
 - Nurse signature & date(s) of health care plan development/review
 - Parent/guardian signature & date

Continent urostomy health care plan

The following information is required in the health care plan developed for children with a continent urostomy. The *Continent Urostomy Health Care Plan* contains this information and is included as a supplement to this document.

Demographic information

- Child's name
- Birth date
- Community program name
- Parent(s)/guardian(s) name and phone number(s)
- Alternate emergency contact name and phone number(s)
- Specialist name and phone number
- Family physician/pediatrician name and phone number

Medical information

- Medical diagnoses and other relevant conditions
- Known allergies
- Availability of Medic-Alert® identification
- Prescribed medications
 - If medication is administered at home only, the name of medication is required
 - If medication is administered at the community program, the medication name, dose, location, time and route of administration is required. Community programs that have an internal policy for administration of medication, may have already obtained this information.

Continent urostomy information

- Reason for continent urostomy
- Baseline information for urine (e.g. color, amount, pattern of continence)

Catheterizing a continent urostomy/vesicostomy

- Time/frequency
- Preferred location
- Supplies needed
- Procedure

Stoma care

- Time/frequency
- Preferred location
- Condition of stoma
- Supplies needed
- Procedure

Emergency situations and how to respond

- Anaphylaxis, if the child has a latex allergy and is prescribed an adrenaline auto-injector (See Anaphylaxis Clinical Practice Guidelines)

Potential problems and how to respond

- Catheter is unable to enter the stoma
- Abdominal cramping or pain
- Small amount of urine comes out only
- Urine leaking between catheterizing
- Foul-smelling or cloudy urine, abdominal pain, leaking urine, pain on insertion of catheter, blood in urine, chills, fever

Documentation

- Template for recording interventions and actions performed by the nurse and/or community program personnel (e.g., communication, actions taken)
- Signatures & dates
 - Nurse signature & date(s) of health care plan development/review
 - Parent/guardian signature & date

TRAINING

When a community program receives URIS 'Group B' support, training is provided to community program personnel by a registered nurse. Training is provided minimally on an annual basis. The training of community program personnel should reflect the principles of adult learning.

- The learning needs of participants should be identified and integrated into the training session
- Information should be applicable to the participants' responsibilities and focus on what is most useful to them
- Adults have accumulated a foundation of life experiences and knowledge and need to connect learning to this knowledge base
- An organized training session with clearly defined elements assists participants in identifying and attaining their learning goals

It is the responsibility of the community program to designate community program personnel to receive training. An adequate number of community program personnel should receive training to ensure there are trained personnel available throughout the child's attendance at the community program. In addition, community program personnel that receive training should be provided with adequate opportunity to perform the task of ostomy care so their knowledge and skill is retained. It is recommended that the child who requires ostomy care does not attend the community program if trained community program personnel are not available. In such situations, alternate arrangements should be made (e.g. parent/guardian performs ostomy care at the community program).

To promote the child's privacy and dignity, community program personnel that are designated to perform ostomy care should be familiar with and comfortable to the child. The number of personnel present during the procedure should be kept to a minimum.

Adequate time should be scheduled for training to ensure community program personnel obtain the knowledge and skill necessary to safely care for the child who requires ostomy care. The amount of time required to train community program personnel will vary depending on factors such as the existing knowledge of community program personnel and number of personnel trained. Ostomy care should be taught and performed in a low stress setting. It is required to keep a written record of training provided to community program personnel. The *Ostomy Training & Monitoring* document may be used for this purpose, it is included as a supplement to this document.

Content

The following clinical information and child specific information is included in the training session.

Clinical information

- Gastrointestinal system
- Ostomies
- Demonstration and return demonstration of emptying a pouch
- Demonstration and return demonstration of changing a pouch , if relevant to child
- Demonstration and return demonstration of catheterizing a urostomy/vesicostomy, if relevant to child
- Emergency situations
- Potential problems
- Stoma care
- Infection control guidelines
- Signs of anaphylaxis and how to respond, if the child is prescribed an adrenaline auto-injector for latex allergy

Child specific information

- Reason for ostomy
- Type of ostomy
- Baseline information
- Equipment/supplies used
- Child's ability for self care

MONITORING

Monitoring of trained community program personnel by a nurse is required to ensure that the knowledge and skill necessary to safely care for children that require CIC has been retained.

The frequency and timing of monitoring is based on the professional judgment of the nurse as well as the complexity of information taught and the demonstrated skills demonstrated by community program personnel. Some monitoring strategies are listed below.

- Community program personnel complete questions about their knowledge and skill. The *Ostomy Training & Monitoring* includes such questions and is included as a supplement to this document
- After training is complete, the nurse observes the community program personnel performing ostomy care for the child during a return visit

The community program may also request additional monitoring if personnel have questions/concerns and/or require additional support to ensure they are responding to the child's needs in a safe and appropriate manner.

REFERENCES

Health Sciences Centre. *Having a Bladder Augmentation (with or without a continent urinary diversion); Information for School-age Children and Teens*. Prepared by Ellen Ford RN in collaboration with the Children's Hospital Patient Education Committee, 2000.

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Porter, S., Haynie, M., Bierle, T., Caldwell, T.H. & Palfrey, J.S. *Children and Youth Assisted by Medical Technology in Educational Settings: Guidelines for Care*. Paul H. Brookes Publishing Co., Inc, 1997.