Elimination, Ostomy and Catheter Care

Stomas and pouching, high-output ileostomy, ileal conduit, irrigation, bowel programs, impaction, bladder training, catheters, CAUTI, specimens, sitz baths and PD sites for the NCLEX

STOMA CHECKS

FINDING	MEANING	ACTION
Pink to red, moist, a little shiny, slightly raised	Healthy stoma	Check at every pouch change
Swollen at first, shrinking over several weeks	Expected	Remeasure at each change for the first 8 weeks
Slight bleeding when cleaned; a little mucus	Expected: the mucosa is vascular	Report bleeding beyond usual
Dusky, purple, black, gray, pale or dry	Poor blood supply	Report to the provider now
At or below skin level, swollen over 1/2 in beyond normal, lengthening, or a bulge around it	Retraction, edema, prolapse, hernia	Report
Red, raw, itchy or burning skin under the wafer	Leak or poor fit	Refit; report breakdown

OUTPUT DEPENDS ON THE OSTOMY

TYPE	OUTPUT	KEY TEACHING
Ileostomy	Liquid to pasty, constant; about 1,200 mL a day at first	Empty 5–8 times a day; 8–10 glasses of fluid; chew well, go slow with nuts, popcorn, celery, corn, raw pineapple; ask before enteric-coated pills; never irrigate
Ascending or transverse colostomy	Watery to mushy	Drainable pouch, skin protection
Descending or sigmoid colostomy	Less watery, often formed	Some clients regulate it by irrigation
Ileal conduit (urostomy)	Urine, constant, no control; some mucus is normal	Empty every 2–4 h or at one-third full; night drainage bag; 8–10 glasses of fluid; report blood, fever, less urine

POUCHING

- Empty at one-third full so the weight does not break the seal
- Cut the wafer to hug the stoma without pressing: about 2 mm larger, no more than 1/8 in of skin showing
- Wafer lasts about 4–7 days; change sooner for leaks, odor, itching or burning. Needing a change every day or two is reported
- Clean with warm water, pat dry; no alcohol or oily products; cover the stoma with gauze while cutting
- No disgust on your face; WOC nurse and support group referral; discharge when the client or caregiver can empty the pouch

SAFETY High-output ileostomy: watch the 24-hour total. Over about 1–2 L a day (reviews say 1–2 L, MedlinePlus says call above 2 L, some practice items use 1.5 L), dizziness on standing, a rising heart rate, dark scant urine or weakness means dehydration and potassium and magnesium loss: report. An empty pouch for 4–6 h with cramping, nausea or a swollen stoma suggests blockage: report, no laxatives.

COLOSTOMY IRRIGATION

- Descending or sigmoid colostomy only, taught by a WOC nurse; same time daily, within 1 h after a meal or hot drink
- Warm water, never hot or cold; bag about 18 in above the stoma; lubricated cone, never forced; volume built up as taught (to 1,000 mL at most)
- Cramping: stop the flow, breathe slowly, lower the bag or slow the clamp
- Not with diarrhea, prolapse or a parastomal hernia, or during chemotherapy or abdominal or pelvic radiation: use a pouch

CONSTIPATION, IMPACTION AND ENEMAS

PROBLEM	CLUES	ACTION
Constipation	Under 3 stools a week, hard stool, straining; opioids, immobility, low fiber or fluid	Fluids, fiber, activity, toilet after breakfast first; then softener and stimulant as ordered; psyllium with a full 8 oz of water
Impaction	Days without stool, distention, cramps, liquid stool seeping around the mass	Rectal check as ordered; no bulk laxative or antidiarrheal; enema as ordered; manual removal by order, watching for a slow pulse or faintness
Enema	Left side-lying (see Client Positioning)	Tap water first for impaction, then a small hypertonic enema; avoid phosphate enemas in kidney disease; not routinely

BOWEL PROGRAM AFTER SPINAL CORD INJURY

- Same time daily, 20–30 min after a meal or warm drink
- Suppository and gentle digital stimulation as ordered; upright on a commode if possible
- Fiber up to 30 g and 6–8 glasses of water a day
- Sensation is lost: never wait for the urge

SAFETY Injury at T6 or above: a full rectum, a suppository or digital stimulation can trigger autonomic dysreflexia (pounding headache, very high BP, flushing above the injury). Stop the stimulation, sit the client up with legs down, loosen clothing, then check bladder, bowel and skin and call. Full sequence: Physiological Adaptation: Conditions at a Glance.

VOIDING, BLADDER TRAINING AND INCONTINENT SKIN

NEED	DO
No void after catheter removal	Aim for a void within 6 h; privacy, normal position, running water; none in 4–6 h or under 180 mL: bladder scan; residual over 300 mL: notify (policies vary)
Bladder training	Toilet on a set schedule, urge or not, lengthening toward 4 h; fluids by day, less at bedtime; less caffeine; Kegel exercises
Incontinence-associated dermatitis	Diffuse redness with blurred edges in skin folds: no-rinse cleanser instead of soap, pat dry, barrier after each episode; no Foley for incontinence alone

INDWELLING CATHETER AND CAUTI

- Valid reasons only: retention or obstruction, critical-illness output, selected surgery, open sacral or perineal wound with incontinence, prolonged immobilization, end-of-life comfort
- Sterile technique; smallest size that drains (often 14 Fr). Female: until urine flows, then 1–2 in (about 2–5 cm) more. Male: penis at 90°, to the bifurcation. Inflate to the port volume; pain: deflate, advance, retry, else remove and report
- Secure to the leg with slack; bag below the bladder, off the floor; empty into a clean container per client
- Meatal care with bathing and after stools; no antiseptic there; no routine irrigation or scheduled changes; review need daily
- No drainage: check kinks, clamps and bag height first, then scan and report; never push the catheter further

SAFETY CAUTI: fever over 38 °C (100.4 °F), new confusion, chills, suprapubic or flank pain. Cloudy or smelly urine alone in a long-term catheter is not a reason to culture.

SELF-CATHETERIZATION AND SPECIMENS

TASK	KEY POINTS
Self-catheterization	Every 4–6 h by schedule, plus on waking and at bedtime; clean technique at home; water-soluble lubricant; steady fluids through the day; report fever, burning, leaking, odor
Clean catch	Clean front to back, start in the toilet, catch midstream, lid on without touching inside
From a Foley	Clamp below the port if needed, wipe the port, draw with a sterile syringe, unclamp; never from the bag
24-hour urine	Discard the first void, save all urine for 24 h including the last, keep it cold

SITZ BATHS AND PD CATHETER SITES

- Sitz bath: 3–4 in of warm, not hot, water a few times a day, 10–20 min (MedlinePlus says 10–15); softener and fiber to avoid straining
- PD exit site: hand hygiene, mask for exchanges, daily site care; report redness, pus, swelling, tenderness
- Cloudy effluent, abdominal pain or fever: peritonitis until proven otherwise; send the effluent for culture, report, and expect antibiotics

EXAM TIP LPN/VN: inserts, maintains and removes urinary catheters, gives ostomy care, collects specimens, reinforces teaching and reports new findings (NCLEX-PN: The LPN/VN Role).