

GASTROINTESTINAL CARE

Module 5

I. Statement of Purpose

The purpose of this module is to review concepts and introduce procedures related to patients with altered gastrointestinal function and altered nutritional status.

II. Terminology

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| 1. Aspiration | 32. Hiatal hernia |
| 2. Barium enema (BE) | 33. Ileostomy |
| 3. Bile | 34. Ileus |
| 4. Bowel obstruction | 35. Impaction |
| 5. Bowel retaining | 36. Intravenous (IV) |
| 6. Cholecystectomy | 37. Jackson-Pratt (JP) |
| 7. Cholecystitis | 38. Jaundice |
| 8. Chyme | 39. Mastication |
| 9. Colitis | 40. Nausea |
| 10. Colostomy | 41. Nothing by mouth (NPO) |
| 11. Common bile duct (CBD) | 42. Occult |
| 12. Computerized axial tomography (CAT) | 43. Ostomy |
| 13. Crohn's disease | 44. Pancreatitis |
| 14. Diarrhea | 45. Peptic ulcer disease |
| 15. Digestion | 46. Peristalsis |
| 16. Emesis | 47. Procedural sedation (conscious sedation) |
| 17. Endoscopy | 48. Rectal instillations |
| 18. Enema | 49. Regurgitate |
| 19. Enzyme | 50. Salem sump |
| 20. Esophagogastroduodenoscopy (EGD) | 51. Saliva |
| 21. Feces | 52. Sitz bath |
| 22. Fistula | 53. Soap suds enema |
| 23. Flatus | 54. Sphincter |
| 24. Gall bladder (GB) | 55. Stoma |
| 25. Gastrectomy | 56. Stomatitis |
| 26. Gastric resection | 57. Strangulation |
| 27. Gastroenteritis | 58. Tap water enema |
| 28. Gastrointestinal (GI) bleed | 59. Toileting behavior |
| 29. Harris flush (HF) | 60. Ulcerative colitis |
| 30. Hernia | 61. Upper gastrointestinal (UGI) |
| 31. Herniorrhaphy | 62. Villi |

III. Performance Standards (Objectives)

Upon completion of 4 hours of class plus assignments and 4 hours of clinical experience, the learner will be able to:

1. Define basic terminology.
2. Explain the basic purpose/function of the gastro-intestinal (GI) system. Define and identify the location of the GI organs
3. List common diseases/disorders of the GI system.
4. Explain specific GI diagnostic tests. Describe how to prepare a patient for diagnostic tests. Explain how to collect various stool specimens.

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5. Explain the three types of enemas, including purpose and procedure.
6. Recall the steps in performing a sitz bath.
7. Explain guidelines in caring for the patient with a colostomy or ileostomy.
8. Describe how to perform oropharyngeal suctioning.
9. Explain how to empty drainage collection systems.
10. Describe significant changes in the patient's condition to report to the licensed nurse.

IV. References:

1. Gerdin, J. (2004) *Health careers today* (3rd ed.) St. Louis: Mosby.
2. Gerdin, J. (2004) *Workbook to accompany health careers today*. (3rd ed.) St. Louis: Mosby.
3. Hegner, B., & Caldwell, E. (2003). *Nursing assistant: A nursing process approach* (9th ed). Albany, NY: Delmar.
4. Sorrentino, S. A. (2004). *Mosby's textbook for nursing assistants* (6th ed.). St. Louis: Mosby Lifeline.

MODULE 5 - GASTROINTESTINAL CARE

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
Objective 1 Define basic terminology A. Terminology B. Clinical setting application	A. Lecture/ Discuss B. Bingo game 1. Make vocabulary flashcards on small squares of paper (2-3 copies of each word depending on grouping size). 2. Make bingo cards. a) Give each student a piece of construction paper divides into 5 rows and 5 columns. b) Use glue sticks to apply vocabulary words to cards. c) Collect cards and redistribute. 3. Play Bingo C. Written test	Recognizes the vocabulary in clinical setting.
Objective 2 Explain the basic purpose/function and location of organs in the GI system. A. Ingestion B. Mastication C. Deglutition D. Digestion E. Absorption F. Elimination G. Review oral anatomy as it relates to oral hygiene. H. Organs:	A. Lecture/ Discuss B. Written test	

Gastrointestinal Care – Module 5

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
1. Mouth 2. Oropharynx 3. Esophagus 4. Stomach 5. Small intestine 6. Large intestine 7. Liver 8. Gallbladder 9. Pancreas 10. Rectum		
Objective 3 List common diseases/disorders of the GI system. A. Congenital: cleft palate B. Inflammation: stomatitis, esophagitis, gastro-enteritis, colitis, cholecystitis, pancreatitis, hepatitis, cholelithiasis C. Ulceration: stomach, duodenum, colon D. Hernias: inguinal, umbilical, hiatal, incisional. E. Tumors: benign, malignant F. Bowel disorders: distension, diarrhea, constipation, and impaction	A. Lecture/ Discuss B. Written test	
Objective 4 Describe patient preparation for GI diagnostic tests. A. Radiology Testing 1. UGI 2. Small bowel series 3. Gall bladder series 4. Barium enema B. Direct Visualization 1. Colonoscopy/sigmoidoscopy 2. Esophagogastroduodenoscopy (EGD) 3. Gastroscopy 4. Endoscopy	A. Lecture/ Discuss B. Specimen Collection- manual skill 5.4a C. Stool specimen- manual skill 5.4b D. Written test 1. GI diagnostic test 2. Patient preparation E. CNA-MC Module 9, objective 5, pp.9.9: Collecting stool specimens	Explains testing process to patient accurately Demonstrates correct preparation of patients for diagnostic tests. Collects stool specimen correctly.

Gastrointestinal Care – Module 5

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
5. Swallowing evaluation 6. Gastric sampling 7. Ultrasound C. Preparing the patient for diagnostic tests 1. NPO for at least eight hours (or as ordered) 2. Give enemas as ordered. 3. Laxatives given by licensed nurse as ordered. 4. Special diets as ordered. D. Collecting various stool specimens 1. Review and discuss application of Standard Precautions as related to bodily fluids. 2. Review procedure and purpose for collecting stool specimens.		
Objective 5 Explain the three types of enemas. A. Review procedure and purpose for enemas. B. Review hospital policy for administration re: scope of practice. C. Purpose of enemas: to aid in illumination during x-rays, before surgery, before deliveries, before direct visualization tests, for bowel retraining, to relieve constipation, to expel flatus, to instill medicine. D. Types of enemas 1. Cleansing: SSE, TWE, saline, Fleet's phosphosoda. 2. Retention: medicinal, nutritional, Fleet's oil retention. 3. Return Flow: Harris flush (HF).	A. Lecture/ Discuss B. Lab practice C. Written test D. CNA-MC Module 9, objective 11, p. 9.14: Purpose for enemas	

Gastrointestinal Care – Module 5

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
Objective 6 Recall the steps in performing a sitz bath. A. Purpose of the sitz bath. 1. Cleansing 2. Heat 3. Healing after perineal/rectal surgery or infant delivery B. Review hospital policy for administration, re: scope of practice.	A. Lecture/ Discuss B. Sitz bath- manual skill 5.6 C. Written test	Correctly performs a sitz bath.
Objective 7 Explain guidelines in caring for the patient with a colostomy or ileostomy. A. Types B. Emptying ostomy pouch C. Removing ostomy pouch D. Applying ostomy pouch	5-5 A. Lecture/ Discuss B. Lab practice C. Ostomies- manual skill 5.7 D. Written test E. CNA-MC Module 8, objectives 31-32, pp. 8.28 – 8.31 - Ostomy care.	Demonstrates competent care of a patient with a colostomy or ileostomy.
Objective 8 Describe how to perform oropharyngeal suctioning. A. Suctioning the oral cavity 1. Nursing assistants should not suction patients who have had oral or maxillofacial trauma or surgery unless instructed to do so by the licensed nurse. 2. Used for patients who have dysphagia from conditions such as cerebrovascular accidents or are having trouble swallowing their secretions for some reason (i.e., irritated throat from a nasogastric tube). 3. Used when doing oral care for a comatose patient to prevent aspiration of fluid. It is especially useful when the secretions are thick or abundant. 4. The Yankauer suction tip, or tonsillar tip, is only used to suction oral secretions or those secretions external to the nares. Patients frequently are taught how to use this type of suctioning on their	A. Lecture/ Discuss B. Demonstration C. Lab practice D. Suctioning the Oral Cavity- manual skill 5.8 E. Written test	Correctly demonstrates oral suctioning of a patient.

Gastrointestinal Care – Module 5

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
own. 5. The licensed nurse or respiratory therapist will initially instruct the patient on its proper usage. The nursing assistant can then reinforce its appropriate use by the patient or use it for patients as instructed by the licensed nurse. B. Indications for oral suctioning. 1. Dysphagia (CVA, inability to handle secretions) 2. Thick, copious oral secretions 3. Vomitus in mouth 4. Oral care (to prevent aspiration of fluid) C. Oral suctioning techniques D. Review Standard Precautions		
Objective 9 Explain how to empty drainage collection systems. A. Review procedure for accurately emptying and measuring drainage. 1. Foley 2. Hemovac/Constavac 3. Jackson-Pratt/Duvall 4. Nasogastric suction tube B. Discuss the importance & use of Standard Precautions when handling body fluids.	A. Lecture/ Discuss B. Demonstration C. Lab practice D. Written test E. Review <i>CNA-MC</i> Module 9, pp. 9.54 - 9.55: Measuring Output	Demonstrates accurate documenting of drainage. Demonstrates aseptic handling of body fluids.
Objective 10 Describe significant changes in the patient's condition to report to the licensed nurse. A. Abnormal signs and symptoms to report to licensed nurse. 1. Weakness 2. Rapid, weak pulse 3. Low blood pressure 4. Rapid or labored respirations 5. Fatigue	A. Lecture/ Discuss B. Use case study and have students identify reportable signs and symptoms C. Practice documentation D. Written test E. <i>CNA-MC</i> Module 9, objective 15C, pp. 9.17-9.18: Signs/Symptoms reported to nurse.	Demonstrates appropriate reporting of significant changes to licensed personal. Accurately and legibly documents changes in patient's condition.

Gastrointestinal Care – Module 5

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
6. Dizziness 7. Fainting 8. Bleeding (coffee grounds emesis, black, tarry stools, rectal bleeding) 9. Change in drainage 10. Change in stool B. Explain how to document changes in the gastrointestinal patient's condition.		

SAMPLE TEST QUESTIONS

Directions: Circle the best answer

1. The responsibilities for caring for a patient receiving enteral feedings include:
 - a. Elevate head of bed 45 degrees.
 - b. Watch the level of fluid in the bag.
 - c. Observe for significant patient responses.
 - d. Observe for shortness of breath.
 - e. All of the above.
2. The nursing assistant's responsibilities in suctioning a patient include:
 - a. The trachobronchial tree
 - b. The trachea
 - c. The bronchi
 - d. The oral cavity
3. Your patient has just returned from surgery for gallstones. She will be most comfortable in the
 - a. Dorsal recumbent position
 - b. Lithotomy position
 - c. Semi-Fowler's position
 - d. Sims' position
4. The drainage from a new cholecystectomy incision is normally
 - a. Yellowish-green
 - b. Reddish-brown
 - c. Greenish-brown
 - d. Pinkish-red
5. Direct visualization of the rectum is called
 - a. Proctoscopy
 - b. Sigmoidoscopy
 - c. Gastroscopy
 - d. Cholecystoscopy
6. What substance aids in the digestion of fats, is produced by the liver and stored in the gallbladder?
 - a. Chyme
 - b. Bile
 - c. Pepsin
 - d. Glucagon
7. A hemorrhoid causes
 - a. Inflammation of the stomach lining.
 - b. Frequent heartburn or chest pain.
 - c. Painful burning sensation in the esophagus.
 - d. Painful dilated veins in the lower rectum or anus.
8. Inflammation of the liver is called
 - a. Cirrhosis
 - b. Metastasis
 - c. Hepatitis
 - d. Liveritis

SAMPLE TEST QUESTIONS – KEY

Directions: Circle the best answer

1. The responsibilities for caring for a patient receiving enteral feedings include:
 - a. Elevate head of bed 45 degrees.
 - b. Watch the level of fluid in the bag.
 - c. Observe for significant patient responses.
 - d. Observe for shortness of breath.
 - e. **All of the above.**
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SPECIMEN COLLECTION

General Procedure

Nursing Preparation

1. Know which test is needed, correct equipment, review procedure.
2. Identify patient to be sure procedure for right patient.
3. Consent form if necessary.
4. Obtain help, if necessary (assisting heavy patient to BSC, lifting equipment).
5. Determine if any special equipment needed (wheel chair to assist to bathroom, water-proof bed pads, etc).

Preparing The Patient For Tests

1. Communication skills
2. Clear instructions as to right time, need for test, what patient must do.
3. Obtain the patient's cooperation to participate in the test (Remain NPO if necessary, call next time need to void, drink extra water, etc.).
4. Answer patient's questions about the test or find information.
5. The more informed the patient, the more cooperative she/he will be.

Perform The Procedure

1. Use aseptic technique (wash hands).
2. Gather equipment.
3. Prepare the environment (privacy, draping, assist with positioning).
4. Obtain the:
 - right amount of specimen
 - in the right container
 - at the right time
 - from the right patient.
5. Wear gloves if contact with body fluids (follow Standard Precautions and Category Specific Isolation procedures).
6. Re-establish comfort (reposition patient, straighten bedding, notify nurse of need for pain medication, etc).

Delivery And Documentation

1. Handle and label specimen correctly (may need to be refrigerated or delivered immediately to lab).
2. Document procedure correctly or report to nurse that specimen obtained.

STOOL SPECIMEN

1. Follow general procedure for stool collection.
2. Wear gloves.
3. Assist patient to bathroom, commode or use bedpan.
4. Remind patient to prevent urine from entering specimen.
5. Assist patient to cleanse perineum and help back to bed if necessary.
6. Use tongue blade to obtain specimen (may need entire specimen).
7. Place specimen in container and close lid.
8. Remove gloves, wash hands.
9. Label container.
10. Take specimen to lab immediately.

STOOL FOR OCCULT BLOOD

1. Follow general procedure for stool collection.
2. Wear gloves.
3. Assist patient to bathroom, commode or use bedpan.
4. Collect stool specimen.
5. Return patient to position of comfort.
6. Follow steps on hemoccult slide test:
 - Open flap
 - With tongue blade smear small amount of stool onto box A
 - From another part of stool, smear another small amount onto box B
 - Close card and label
 - Send specimen to lab
7. Remove gloves and wash hands.

STOOL FOR OVA AND PARASITES

1. Follow general procedure for stool collection.
2. Collect exudate, mucus, and blood with stool.
3. Keep specimen at body temperature.
4. Take to lab immediately.
5. Collect complete stools after purgative medications given.
6. Laxative, barium and mineral oil precautions (interferes with accuracy).
7. Use only normal saline or tap water enemas if enema must be used.
8. Prevent urine from entering specimen.
9. Collect three random specimens to ensure accurate results.

SITZ BATH**EQUIPMENT:**

1. Plastic disposable sitz bath basin (fits over the toilet after seat raised) or portable sitz bath chair
2. Bath blanket
3. Towels
4. Soap or disinfectant solution (per hospital policy)

CRITERIA:**Safely assists the patient with a sitz bath**

1. Follow standard beginning procedure (knock, introduce self, wash hands, identify patient, explain procedure, provide for privacy).
2. Prepare bath water, either in portable bath chair that can be brought to side of bed or disposable sitz bath basin that sits on toilet after seat raised. A tub room bath may be used, but is not as therapeutic because the warm water dilates blood vessels in the entire lower portion of the body, whereas the purpose of the sitz bath is to localize treatment to the pelvic area. Follow facility policy and instructions from licensed nurse.
3. Fill basin with water about two-thirds full. The purpose of the sitz bath will determine the temperature of the water. If the bath is to provide cleansing and heat, as in the case of hemorrhoids, the water temperature should be between 105° and 110°. If the purpose is to promote healing after infant delivery or perineal/rectal surgery, the temperature should be lower, between 98° to 102°. Check with licensed nurse for facility policy and doctor's orders. The disposable sitz bath usually has an attached bag that can be filled with water and hung to allow fresh, warm water to flow into the basin, keeping the temperature more constant throughout the entire soak.
4. Assist patient to raise gown or clothing up out of the way or remove clothing and cover with bath blanket to provide privacy and prevent chilling.
5. Assist patient to sit in basin or chair, allowing her/him to test the water for comfort. It should feel hot, but not too hot to be tolerated. Pad basin or back of chair with towels as needed to reduce pressure and provide for comfort and good body alignment.
6. Check patient every 5 minutes. Monitor blood pressure and pulse after the first five minutes to check for hypotension that might lead to dizziness or fainting. If the patient has had surgery recently, it may be necessary to stay with the patient during the whole procedure. Observe for the following signs:
 - Weakness, rapid, weak pulse, low blood pressure, rapid respirations, extreme fatigue, drowsiness, dizziness, fainting.If patient has adverse symptoms, call for help and assist back to bed if able.
7. The sitz bath should last for about 20 minutes, or as ordered by the doctor. Make sure signal cord is within patient's reach.
8. After soaking for about 20 minutes, assist the patient to stand, and observe for any dizziness. Assist the patient to dry body, and put on a clean gown if necessary.
9. Help the patient back to bed. Observe for any signs of bleeding or discomfort in the perineal or rectal area.
10. Assist the patient to a position of comfort and good body alignment. Prevent chilling by covering with adequate linen or blanket as needed.
11. Place signal cord within patient's reach.

12. Using soap or disinfectant according to facility policy, clean the disposable sitz bath basin or portable bath chair.
13. Return equipment to storage area.
14. Wash hands.
15. Record observations:
 - Length of time patient is in sitz bath (start and end time)
 - Temperature of water
 - Patient's response to treatment (how patient tolerated sitz bath)
16. Report anything unusual to the licensed nurse.

OSTOMIES

Ostomy definition

An artificial opening created on the abdomen for passage of feces or urine.

Indications

Cancer, inflammatory bowel diseases, trauma, perforations of colon (i.e., ruptured diverticulitis)

Types of ostomies

Colostomy: The colostomy is a surgically created opening between the colon and the surface of the abdomen through which body wastes are excreted. Where the colostomy is located in the colon is important, as it will influence care. Ascending, transverse and sigmoid colostomies may be formed, depending on where the surgeon must locate the incisions. The further down the descending colon the colostomy is located, the more closely the stool will resemble a normal bowel movement. The opening created in the abdomen is called a stoma. The stoma has no nerve endings so no sharp pain is felt when it is touched. It has no muscles, so the patient will not be able to open or close it at will. However, the patient can learn to control bowel movements by irrigating the colostomy. The patient will wear a colostomy pouch to collect any wastes that drain from the stoma.

Ileostomy: The removal of the entire colon and rectum results in the ileum being brought through the abdominal wall, forming an ileostomy stoma. The stool from the ileostomy is liquid to semi-formed and contains residual digestive enzymes. Fluid and electrolyte imbalance is a potential problem with an ileostomy and may result in problems for the patient. A continent ileostomy (Koch pouch) may be used. This procedure involves the creation of an internal pouch constructed of ileum and of a nipple valve that maintains continency of stool and flatus. The stoma is flush with the skin and is located in the lower right quadrant.

Urinary Diversion or Ileal Conduit: A urinary diversion is any one of a number of surgical procedures that establishes an unimpeded flow of urine, usually through a stoma. It is possible to divert the urine at any level in the urinary tract. Diverting the urine at the level of the kidney is done by nephrostomy or pyelostomy. Nephrostomy is a high urinary diversion involving the placement of a catheter through the renal pelvis and into the renal calyces. A pyelostomy is an opening into the renal pelvis made by catheter placement or by the creation of a stoma. It is possible to isolate any segment of the healthy intestinal tract at any point after the jejunum for use as a conduit for urine. A continent urinary diversion (Koch pouch) provides the patient with an internal reservoir for urine and eliminates the need for an external appliance.

Stomal characteristics

Stoma is formed like a sock with a cuff, then sewed down.

Stomal characteristics – moist, wet, red, never looks healed. Blood supply just under thin layer of cells. Will always look like raw meat. With time and healing, the skin and stoma margins will look like your lips to your surrounding mouth.

Pouch (bag) types

One-piece versus two-piece, odor proof, waterproof. Patient can shower and swim.

Fecal pouches – demonstrate on torso model.

Urinary pouches – demonstrate on torso model.

Emptying procedure – cleansing requirements.

Empty when 1/3 to 1/2 full of stool or gas to prevent dislodging.

Check at least every four hours. Ask the patient to let you know if it is full.

Demonstrate:

- emptying into graduate
- cleansing the pouch with peri bottle
- urinary emptying and night drainage setup

If pouch leaks, it needs changing. Do not add tape, because that is like taping a soiled diaper on a baby.

Emotional support

The patient may experience a change in body image (personal view of how one's body looks). Normal function of defecating has been altered. Not only has the opening for stool to pass changed, this opening is now quite visible and the odor is stronger. What was once a private function (BM), is now more public, with nurses enterostomal therapists, and physicians checking and assisting with the function of the ostomy. The nurse assistant should maintain as much of the patient's privacy as possible. She/he must also control any personal feelings of disgust regarding the odor or appearance of the ostomy. The nurse assistant's acceptance of the ostomy helps the patient accept it. Note: Not all colostomies are permanent. Some may be reversed at a later time.

Intake and output

Every shift

Gloves for prevention of contamination

REMOVING AN OSTOMY POUCH

The ostomy pouch must be changed on a regular schedule. This will help prevent skin irritation and leakage. Check with the licensed nurse for the individual patient's care plan for changing the pouch.

HOW OFTEN SHOULD THE POUCH BE CHANGED?

This depends on the type of ostomy, the patient's activities, and the type of pouch worn. For this course, the nurse assistant should only change the ostomy bag that is attached to an appliance like a Tupperware® lid. The nurse assistant should not change the type of pouch that is combined with an adhesive to the skin. The authors of this curriculum felt that only a licensed nurse should change this part of the appliance because preventive skin care and a thorough assessment must be done when changing this type of appliance. However, nurse assistants in the field often perform this procedure, so the steps are included here. If an employer wishes to train the acute care nurse assistant to perform this procedure, be sure to follow the procedure carefully and report any skin irritation to the licensed nurse.

The ostomy bag may need to be changed more often in hot, humid weather. However, the pouch should not be changed daily because this can cause skin stripping and irritation. It is usually changed twice weekly initially and progresses to weekly if there is no leaking. If the patient thinks the pouch may need changing daily, contact the enterostomal therapy nurse or the doctor for guidelines.

REMOVING THE POUCH

- Gather a wash cloth, gloves, towel or paper towels, adhesive solvent and an eyedropper (if needed), karaya powder or Stomahesive powder, protective film wipes and karaya or pectin-based skin barriers.
- Remove the old pouch by gently pulling up on the adhesive with one hand while carefully pushing down on the skin with the other. Most disposable pouches will come off easily without a solvent. If the pouch being used requires a solvent, follow the product directions. Make sure the solvent is completely removed from the skin before applying the new pouch. If a reusable pouch is being used, set it aside to clean after the new pouch is applied.
- Wash the skin well with warm water and pat dry. Soap is usually not needed, but if it is used, *rinse the skin thoroughly*. Soap residue will interfere with pouch adhesion and may irritate the skin.
- Check the skin for redness or irritation. The most common causes of irritation are stool leakage under the seal or an overly large pouch opening, which allows stool to come in contact with the skin and cause irritation. Measure the stoma routinely to ensure that the stomal opening on the pouch is correct.

If the skin is red but intact, use a protective film wipe to provide a clear, thin film between the adhesive and the skin or follow facility policy.

If the skin is weeping, contact the nurse. The nurse will usually dust the affected area lightly with karaya powder or Stomahesive powder and wipe off any excess. She will then cover the skin with a protective skin barrier. This may be either a karaya or pectin-based wafer cut to fit the stoma. The pouch is then applied over this wafer. Many disposable pouches have a protective wafer as part of the system itself. Skin irritation will usually clear in a few days. If it doesn't, the licensed nurse may need to notify the enterostomal therapist or doctor.

APPLYING AN OSTOMY POUCH

APPLYING A ONE-PIECE DISPOSABLE POUCH

1. Measure the stoma to determine the correct size of the pouch opening.
2. If the pouch opening is *precut*, remove the release papers from the pouch, press the pouch to the abdomen, and seal well. Attach the tail closure so that it follows the contour of the patient's body (the clip that secures the pouch bottom for later drainage).

3. If the pouch is *custom-cut*, cut the opening to the correct size, remove the release papers, and then apply as above.

APPLYING A TWO-PIECE REUSABLE POUCH

1. Measure the stoma to determine the size of the faceplate opening.
2. Follow the manufacturer's directions to apply new adhesive to the faceplate or to the skin with each change. First, peel off one side of the adhesive disk's paper backing. Then center the disk over the faceplate and press firmly to expel any bubbles from between the faceplate and the adhesive.
3. Next, peel the remaining paper backing off the adhesive disk. Center the faceplate over the stoma. Gently press around the stoma so that the adhesive sticks to the abdomen.
4. Secure the pouch to the faceplate, attach the supporting O-ring around the faceplate collar, and attach the tail closure.

DRAINING AN OSTOMY POUCH

Depending on the type of ostomy, the pouch may need to be emptied from 1 to 8 times daily. Empty it when the pouch is about one-third to one-half full.

1. A bedpan or graduated cylinder is necessary for collecting the stool. If able, the patient can sit on the toilet and direct the pouch opening into the toilet bowl. To prevent splashing, some toilet paper may be placed on the surface of the water or flush the toilet as the pouch is being emptied.
2. Turn up the bottom of the pouch and remove the tail closure. Then empty the pouch into the bedpan, graduated cylinder or toilet.
3. Slide the thumb and index finger down the outside of the pouch, squeezing the contents into the receptacle you are using.
4. Use toilet paper to clean any stool from around the outside and just inside the pouch opening. It is not necessary to clean far up inside the pouch.
5. If desired, rinse the pouch with cool water. Remember that the pouch is odor-proof, so this step isn't necessary.
6. Reattach the pouch tail closure to complete the procedure.
7. Remove gloves, wash hands.

SUCTIONING THE ORAL CAVITY**EQUIPMENT:**

1. Tonsillar-tip suction device (Yankauer)
2. Disposable cup
3. Water
4. Towel
5. Washcloth
6. Suction setup including:
 - Wall or portable suction apparatus
 - Collection bottle or canister
 - Connecting tubing
 - Y-connector (if catheter has no control valve)
7. Gloves (mask, gown, goggles, if necessary)

CRITERIA:

Provides safe oral suctioning as needed

Oral Suctioning

1. Observe for signs and symptoms indicating build-up of secretions in oral cavity or back of throat (gurgling respirations, restlessness, drooling, vomitus in mouth).
2. Wash hands thoroughly before and after procedure. Gather equipment, identify patient, provide for privacy and explain procedure. Explain that gagging is normal, but you will stop the procedure if gagging occurs.
3. Attach the collection bottle to the suction unit and connect the suction tubing and suction tip according to facility policy. Put the Y-connector between the suction tip and the suction tubing, if necessary to have a control valve. Place a cup in an easily accessible area and fill it 2/3 full with water.
4. Properly position the patient. An alert patient should be positioned in a semi-Fowler's position, turning the head to one side. A comatose patient is placed in a side-lying position with the head **slightly elevated**.
5. Place a towel across the patient's chest or under the chin.
6. Turn on the suction unit and set the suction level according to orders from the licensed nurse or facility policy. The usual settings for wall suction units are:
 - Adults: 110 – 120 mm Hg.(maximum)
 - Children: 90 – 100 mm Hg.
7. Put on gloves. Remove the catheter from the package and dip the tip into the cup of water to lubricate it. Test the suction set up by placing your finger over the control valve or open side of the Y-connector and suctioning a small amount of water.
8. Gently insert the suction catheter into one side of the patient's mouth along the gumline, with your finger off the control valve. **Do not suction as you insert the catheter.**
9. Apply suction as you gently rotate the catheter in your fingers and slowly draw it out of the patient's mouth. Suction both sides of mouth and under tongue. Suction intermittently for about 5 seconds each time. Let the patient rest for 20 – 30 seconds before inserting the catheter again. Ask the patient to deep breathe and cough between suctioning.

10. Clear the catheter between each suctioning attempt by suctioning a small amount of water from the cup.
11. After suctioning is complete, clean the suction catheter and tubing by suctioning water from the cup. Turn off suction. Observe the patient's respiratory status. Clean the patient's face and provide mouth care.
12. Rinse catheter tip in hot, soapy water to remove any crusting that has built up. Wrap in clean washcloth or paper towel and store in emesis basin at patient's bedside. Check with facility policy for length of time catheter tips may be used and for cleaning and storing policy.
13. Discard gloves and wash hands.
14. Record amount, consistency, color and odor of secretions and patient's response.