Colostomy Care

**Target group:** Nursing students **Recommended number of participants:** 1-2 learners

**Simulation time:** 10 minutes **Debriefing time: 20 minutes**

# Curricular Information

## Learning Objectives

**After completion of the simulation and debriefing session, learners will able to:**

* Assess and evaluate a colostomy site
* Explain procedures to the patient using an appropriate communication framework
* Provide colostomy care, including emptying bag (and reapplying if needed)

## Scenario Outline

In this scenario a 33-year-old female is in the surgical unit, two days post-operative after removal of the colon and rectum due to a long history of ulcerative colitis. A colostomy has been created. The learners are expected to assess and evaluate the colostomy site, explain the procedures to the patient using an appropriate communication framework, and provide colostomy care, including emptying the bag (and reapplying if needed).

## Debriefing

When the simulation is over, it is recommended that a facilitator-led debriefing be completed to discuss topics related to the learning objectives. The Event Log in Session Viewer provides suggested debriefing questions. Central discussion points could be:

* Assessment and evaluation of a colostomy site
* Managing colostomy care
* Communication with the patient

## Suggested References

Colostomy UK. *Managing your colostomy*, 2018. Retrieved from <http://www.colostomyuk.org/information/managing-your-colostomy/>

Macleod E, Johnstone N, Robertson I, et al. *Clinical nurse specialists Stoma care*; Royal College of Nursing, 2009. Retrieved from <https://matrix.rcn.org.uk/__data/assets/pdf_file/0010/272854/003520.pdf>

# Setup and Preparation

## Equipment

* Blood pressure cuff
* Colostomy site for the simulator
* Colostomy equipment (per local protocol)
* Patient gown
* Patient ID bracelet with name and date of birth
* Patient monitor
* Simulated brown fluid stool, to fill about 1/3 of the ostomy bag (150-200 mL)
* SpO2 probe
* Hand hygiene station
* Stethoscope
* Universal precautions equipment

## Preparation Before Simulation

* Apply the colostomy site to the simulator.
* Fill about 1/3 of the ostomy bag with simulated stool.
* Attach the ostomy bag to the simulator.
* Dress the simulator in a patient gown and place it in a hospital bed in Fowler’s position.
* Attach patient ID bracelet with name and date of birth.
* Print the patient chart from page 4 and hand it out to the learners after reading the learner brief to them. If you use an electronic patient chart, you can transfer the information to this system.

## Learner Brief

*The learner brief should be read out loud to the learners before the simulation starts.*

**Situation:** You are a nurse in a surgical unit and the time is now 10:00. You are caring for Jane Keys, a 33-year-old female who is two days post-operative after removal of the colon and rectum. A colostomy site has been created in her right side.

**Background:** The patient has a long history of ulcerative colitis.

**Assessment:** The patient was assessed 3 hours ago, and all vital signs were within normal range. Pain was rated 3 and 500 mg of acetaminophen were administered. Patient seems to be recovering well.

**Recommendation:** Please take a few minutes to review her chart (hand out chart to learners) and then go see the patient and check if her stoma bag needs to be emptied.

# Customization of the Scenario

The scenario may form the basis for creating new scenarios with other or additional learning objectives. Making changes to an existing scenario requires careful consideration of what interventions you expect the learners to demonstrate, and what changes you will need to make to learning objectives, progression of scenario, programming and support material. It is, however, a quick way to increase your pool of scenarios because you can reuse much of the patient information and several elements in the scenario programming and support material.

For inspiration, here are some suggestions on how this scenario can be customized:

|  |  |
| --- | --- |
| New Learning Objectives | Changes to the Scenario |
| Include learning objectives about using communication skills and clinical knowledge. | Have the patient be ready for discharge and create provider’s orders for discharge education.  The patient should ask questions about the information that the learners provide. |
| Include learning objectives about recognizing infection, pain management, and taking appropriate safety measures. | Have the patient be in pain and moulage the colostomy site so it looks infected.  The patient should be complaining about pain and feeling feverish. If the learners do not respond appropriately to the situation, the patient could ask about getting treatment or request to see a provider. |
| Include learning objectives about recognizing blood in the stool, using clinical reasoning skills, and taking appropriate safety measures. | Have the stool in the colostomy bag be colored red, to indicate bleeding from the colon.  The patient will be concerned with the findings, and if the learners do not respond appropriately to the situation, the patient could ask questions about the causes or request to see provider. |

# Patient Chart

|  |  |
| --- | --- |
| **Patient name:** Jane Keys **Gender:** Female **Allergies:** No known allergies **DOB:** 17/5-XXXX | |
| **Age:** 33 years **Height:** 173 cm (68 in.) **Weight:** 66 kg (146 lb.) **MRN:** 57343330 | |
| **Diagnosis:** Ulcerative Colitis **Adm date:** 3 days ago | |
| **Facility:** Surgical unit **Advance directive:** No  **Isolation precautions:** None | |
|  | |
| |  | | --- | | **Past Medical History**  11-year history of ulcerative colitis with increasing severity. Two days post-operative after removal of the colon and rectum. A colostomy site has been created in her right side. | | |
|  | |
| **Notes** | |
| **Date/Time** |  |
| Today 07:00 | Patient rates pain at 3 on a scale from 1 to 10, 500 mg acetaminophen administered. Vitals signs obtained. Colostomy bag emptied. /RN |
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| **Provider Orders** | |
| Activity: Out of bed as tolerated | |
| Diet: Clear liquids, advance to normal diet as tolerated | |
| Vital signs every 4 hours | |
| Record intake and output | |
| Acetaminophen 500 mg orally, prn for pain, every 6 hours | |
| Provide colostomy care per local protocol | |
|  | |
|  | |
| **Medical Administration Record** | |
| **Date/Time** |  |
| Today, 07:00 | Acetaminophen 500 mg, orally |
|  |  |
|  |  |
|  | |
| **Vital Signs** | |
| **Date/Time** |  |
| Today, 07:00 | **BP:** 121/76 mmHg **HR:** 81/min **RR:** 13/min **SpO2:** 98% **Temp:** 37.0oC (98.6oF) |
|  | **BP:**  **HR:** **RR:** **SpO2:** **Temp:** |

# Intake & Output

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient name:** Jane Keys **Gender:** Female **Allergies:** No known allergies **DOB:** 17/5-XXXX | | | | | | | | | | |
| **Age:** 33 years **Height:** 173 cm (68 in.) **Weight:** 66 kg (146 lb.) **MRN:** 57343330 | | | | | | | | | | |
| **Diagnosis:** Ulcerative Colitis **Adm Date:** 3 days ago | | | | | | | | | | |
| **Facility:** Surgical unit **Advanced directive:** No  **Isolation precautions:** None | | | | | | | | | | |
|  | | | | | | | | | | |
| **Notes:** | | | | | | | | | | |
|  | **Intake** | | | | | **Output** | | | | |
| **Time/Date** | **Oral** | **NG** | **IV** | **IVPB** | **Other** | **Urine** | **Emesis** | **NG** | **Drains**  **type** | **Other** |
| **23-07** | 250 mL  150 mL |  |  |  |  | 200 mL |  |  |  |  |
| **Shift total** | 400 mL |  |  |  |  | 200 mL |  |  |  |  |
| **Time/Date** | **Oral** | **NG** | **IV** | **IVPB** | **Other** | **Urine** | **Emesis** | **NG** | **Drains**  **type** | **Other** |
| **07-15** | 320 mL  150 mL |  |  |  |  | 230 mL |  |  |  | 150 mL |
| **Shift total** |  |  |  |  |  |  |  |  |  |  |
| **Time/Date** | **Oral** | **NG** | **IV** | **IVPB** | **Other** | **Urine** | **Emesis** | **NG** | **Drains**  **type** | **Other** |
| **15-23** |  |  |  |  |  |  |  |  |  |  |
| **Shift total** |  |  |  |  |  |  |  |  |  |  |
| This is a worksheet to be used at the bedside to keep track of each intake and output. The totals will then be recorded on the 24 Hour Fluid Balance Sheet | | | | | | | | | | |
| **Fluid measurements:** 1 cc = 1 mL • 1 ounce = 30 mL • 8 ounces = 240 mL • 1 cup = 8 ounces = 240 mL  • 4 cups = 32 ounces = 1 quart or 1 liter = 1000 mL | | | | | | | | | | |