



A basic guide to discharging the postsurgery patient with an ostomy to the community

It's often the direct care nurse's responsibility to provide education on the discharge process from the time of admission to enhance the patient's overall well-being postsurgery.

By Thureiyya Rodriguez, DHA, RN, WOC Nurse

Ileostomy, colostomy, and urostomy are terms used to describe different types of surgical procedures that create a diversion for bodily waste (fecal waste and urine) to empty through a stoma (an opening created through the abdomen). The variation in the bodily waste is related to the portion of the colon used to create the diversion. The effluent (output) may be thick stool (colostomy), watery stool (ileostomy), or urine (urostomy). A transverse colostomy is another type of diversion with fecal output that can either be firm or paste-like but is more frequently loose. The consistency and type of effluent will determine the type of ostomy pouch used in ostomy care. Approximately 725,000 to 1 million people in the US live with an ostomy or continent diversion device. On an annual basis, approximately 100,000 surgeries are performed, and each patient must go through the discharge process.¹ The discharge process is an integral part of the patient's well-being and outcomes in the community. The first day of admission begins with developing a plan of care. The plan of care includes a discharge

plan that will reduce readmission to the hospital. After discharge, some patients will transfer back to the community with home care services or discharge to a rehabilitation program.

Home care services are an extension of care outside of the hospital. Patient's receiving home care services will have a healthcare provider and nurse assigned to them. Insurance qualifications determine the length of time and type of services the patient will be allowed. Ostomates discharged with home care services will receive care and supplies from the home care agency while receiving services.

Depending on the hospital's policy, the direct care nurse may be responsible for providing ostomy education. In most institutions, if there's a wound, ostomy, continence (WOC) nurse on staff then most of the education will be provided to the patient by the WOC nurse. Patients discharged with a new ostomy have multiple concerns when leaving the hospital. This includes the fear of leakage, body image, odor, participating in sports, sexuality, and socializing with friends.² Educating and training the new ostomate



Additional resources

Access a WOC nurse online for additional assistance

www.wocn.org/learning-center/patient-resources/find-a-nurse/

Peristomal Skin Assessment Guide for Clinicians

<https://psag.wocn.org/index.html#home>

Ostomy manufacturers with educational material for clinicians and consumers:

- Coloplast
- Hollister
- Convatec

Wound, ostomy, and continence societies

www.wocn.org/membership/regions-affiliates/

involves discussing ostomy care, psychosocial changes, and sexuality.

An interdisciplinary team can address the different needs related to this life-altering surgery and potentially provide a positive patient outcome postdischarge. The interdisciplinary team develops a plan of care with key clinicians; educates and trains the patient or caregiver; and assists the patient with locating a medical supplier for ostomy supplies. This article highlights steps for direct care nurses to consider while providing care to a new ostomate. Each step is an overview of planning the new ostomate's discharge from the time of admission.

Who's part of the education process?

Before providing education and training, the first step is to identify the stakeholders who will be involved in the discharge planning process. Stakeholders to consider for the interdisciplinary team are direct care nurses, discharge planners (social workers or case managers), WOC nurses, nutritionists, surgeons, and psychologists/psychiatrists. If there's a WOC nurse in the facility, they'll be the key educator in teaching ostomy care to the patient or caregiver. WOC nurses are specialists with expertise in ostomy care. WOC nurses are certified to assess patients with an ostomy for proper pouch fitting and troubleshoot stoma complications.

If the facility doesn't have a WOC nurse on site, there are free resources for direct care nurses and discharge planners. Ostomy manufacturers provide free educational videos and materials for patients; in addition, they provide a concierge service for patients after discharge. United Ostomy Associations of America (UOAA) has downloadable material for clinicians and patients to learn more about ostomies (see *Additional resources*).

The surgeon can provide information on the type of surgery performed and the portion of the colon used to create the diversion. The next step is to determine who will perform ostomy care for the patient. Determining who will perform ostomy care is important because your training will be influenced by who is learning.

Have a discussion with the patient and family about who will perform ostomy care and who will be involved. For instance, a patient performing self-care will be taught how to change an ostomy pouch in front of a mirror while standing versus teaching a caregiver how to perform care while the patient is either lying or sitting down. If there's a disagreement among the family about who will perform care, include the discharge planner in the discussion.

Once you've identified who will be performing the ostomy care, you're ready to provide education. If the WOC nurse is involved, coordinate a time for the WOC nurse to provide education. In addition, set up a time for the nutritionist to discuss diet plans. Each facility has an average length of stay which can impact the amount of time allotted for training and education.

Try to maximize training time by setting up more than one clinician on the same day (if possible). For example, have the WOC nurse and nutritionist see the patient on the same day. The next day you can reiterate the information and discuss areas of concern. Use this time to discuss psychosocial concerns. On the third day, have the WOC nurse return prior to the

patient's discharge to review information and clarify any questions or concerns about health-related quality of life. This discussion would ideally occur during the preoperative education but should be addressed prior to discharge. Address the patient's concerns on how ostomy surgery will impact their quality of life.

UOAA can provide resources for online or in-person support groups and ostomy visitors (visitors aim to reassure the new ostomate to look forward to a normal and fulfilled life). Ostomy surgery is a life-altering event. Regardless of whether the ostomy is temporary or permanent, ostomies can affect one's psychosocial view postsurgery. Allowing the patient to explain their perspective on the surgery will provide an indicator on the patient's level of acceptance and psychosocial needs. If the patient is having difficulties accepting the ostomy, then consider having the psychologist/psychiatrist meet with the patient. If the patient has a sigmoid or descending colostomy, they can meet with an experienced WOC nurse to discuss irrigation of the colostomy for improved quality of life. Irrigation of the colostomy allows for the patient to have more control over their ostomy output. To continue with the coping process, provide the patient with guides to support services in the community. Twelve months of follow-up is recommended post-op to promote effective coping.⁴

Teaching the patient, family, or caregiver

Providing education to the patient will differ from teaching a family member or caregiver. Unless the patient has major stomal complications, changing the ostomy pouch is standard. The stoma will continue to shrink post-op for 6 to 8 weeks. The changes in the stoma size and the abdomen will alter the ostomy pouch chosen. For instance, the patient may start with a medium convex moldable wafer, but as the stoma shrinks, the

wafer might change to a small convex moldable wafer. Ostomy manufacturers provide tear sheets with a step-by-step guide on changing a pouch. This information can be given to the patient as a reference after discharge.

If you have a patient with an ileostomy, stress the importance of hydration. Patients with an ileostomy have a high readmission rate postdischarge due to dehydration.⁵ Fluids are crucial to the well-being of these patients. Not just water: the patient with an ileostomy needs to balance their fluid intake with electrolytes. The nutritionist can provide vital information on this. Just make sure to reiterate the importance of staying hydrated, especially during the hot summer months.

The ostomy pouch chosen for the patient will be based on the type of effluent from the stoma and the patient's body contour. Each ostomy wafer has a different wear time. The wear time is the length of time a patient with an ostomy can wear a pouching system before the next pouch change. The type of effluent (stool and urine) affects the wear time on ostomy barriers. The exposure to stool and urine breaks down the barrier on the wafer, causing the skin to be exposed to the output. Ileostomy effluent is alkaline with proteolytic enzymes.⁶

Effluent damages peristomal skin by breaking down the epidermis. Choosing an appropriate pouch system is important in wear time for patients with ostomies. Urinary pouch systems have a spout at the end that attaches to a leg bag and a night drainage bag. Ileostomy pouches have a tail-clip or self-fastener closure. Durahesive wafers are the preferred choice for patients with ileostomies because the barrier has a longer wear time than a stomahesive wafer. A colostomy pouch has filters with the option of closed-end or open-end. The next few sections will discuss key points to include in your teaching based on who is performing ostomy care.

Consider this

Ms. B is a 29-year-old female with a 20-year history of Crohn disease. She's admitted to the unit for an ileostomy due to complications from her disease. Prior to admission, Ms. B has never had surgery and is anxious about the procedure. Preoperatively, Ms. B met with her surgeon to discuss the procedure. She was informed that the ileostomy is permanent with a possible removal of the rectum and anus. Ms. B still hasn't come to terms with the ostomy being permanent and is in denial. During her preoperative visit, Ms. B didn't meet with an ostomy nurse and has minimal knowledge of ileostomies. She's in college to become a lawyer and is currently dating. Her boyfriend is supportive, but Ms. B hasn't given him the full story about what the surgery entails. Her parents are involved in her life and are supportive. She is 20 lb underweight due to Crohn disease and has problems maintaining her diet due to the stress of finishing school and maintaining her relationship. Ms. B has had failed results with infliximab, methotrexate, budesonide, and other medications for her disease. She is currently taking prednisone 30 mg daily and multivitamins. Ms. B has multiple drug allergies and sensitivities that limit her ability to take newer medications available for Crohn disease. Ms. B is on a low-fiber diet, but she said she has an erratic meal plan due to school and she eats fast food three to four times per week. Ms. B's fluid intake consists of coffee three times a day, water on occasion, juice, and tea. She has occasional alcohol consumption and no drug use. Her physical activity is limited because of pain and weakness in her legs, but she expressed she does enjoy swimming when she's feeling well. Ms. B lives about an hour away from the hospital. She doesn't drive, but her family provides transportation. She's interested in pregnancy once everything improves and she can return to her daily activities. There's a clinic about 30 minutes away from her home, and they have an experienced WOC nurse on site.

Patient performs care

- First, assess the patient's physical limitations in performing ostomy care. For example, lack of dexterity due to arthritis, limited vision, difficulty retaining information, psychosocial barriers, and more. Any limitation can impact the learning process. Several types of ostomy supplies can aid the patient with physical barriers. Placement of an ostomy isn't intended to limit a patient's quality of life.
- Ensure that the patient can perform ostomy care independently. An ideal time to change an ostomy pouch is first thing in the morning before eating or drinking. In the morning, the colon is quiet and there's little to no output during ostomy care.
- Discuss how to change an ostomy in public if there's an emergency.

- Discuss acceptance of the ostomy; if the ostomy impacts sexual function, this will need to be addressed. Pelvic surgeries that affect the nerve can also impact a patient's sexual function. Provide information for support groups. Prostate surgery can lead to erectile dysfunction, but there are options for coping to improve sexual function.
- Discuss showering with an ostomy. Once cleared to bathe, discuss removal of the ostomy pouch when in the shower.
- Clothing, swimming, or daily activities aren't limited. Different companies offer underwear and swimming covers specifically designed for patients with ostomies. In addition, there are stoma guards available if a person is participating in contact sports or working with heavy machinery.

Family or caregiver providing care

- Talk about caregiver burnout, and make sure they're aware of what it means. Include a discussion on the signs of caregiver burnout.
- Have a secondary person designated to provide ostomy care if the primary caregiver is unavailable or in emergency situations.
- Discuss scheduling ostomy care every 3-4 days.
- Offer support services for caregivers providing ostomy care. UOAA has a wealth of resources for the patient and family.
- Teach the patient how to empty the ostomy pouch even if they aren't involved in ostomy care. Best practice based on WOCN guidelines is to empty the ostomy pouch when it's $\frac{1}{3}$ to $\frac{1}{2}$ full and before bedtime. Urostomy patients should have a leg bag and a night drainage bag. The leg bag is for use during the day and the night drainage bag will be used at bedtime.

Alright, so far so good, but there are a few more steps to complete. Make sure to give a thorough handoff to the incoming nurse and leave detailed notes in the chart about the ostomy education. It's important to maintain continuity of care. The

final steps involve preparing for discharge back to the community.

Where will the patient go after leaving the hospital?

Where the patient is going to be discharged is an ongoing discussion that the interdisciplinary team should have throughout the admission. If the patient is going home (with family or alone), establish which home care agency will provide service. The patient's individual insurance plan will affect the length of time a patient can receive home care services. Consider the following when discharging a patient home with services:

- The home care nurse may not have experience in ostomy care.
- The patient may not receive a visit from the home care nurse on the day of discharge.
- The home care nurse may make the first visit without supplies, and the agency may not have the same ostomy supplies.

There are steps the direct care nurse can take to create a smooth transition back to the community. If there's no WOC nurse on staff, write down all the steps taught to perform ostomy care or provide the tear-sheet guide from an ostomy manufacturer. In your instructions include information about the size of the stoma (how often to measure post-op), ostomy pouch used, and resources available in the community. Give the material directly to the patient or caregiver.

Provide the patient with 5 days of supplies (pouching system and accessories such as paste, powder, or skin prep).³ Register the patient with educational resources through an ostomy manufacturer and have the patient request free samples to be delivered to their home. Give the discharge planner the same information and include any challenges encountered when educating the patient or caregiver.

If the patient is discharged to a rehabilitation facility, it's not a guarantee that the

Consider this: Response

How will you help your patient have a positive experience postsurgery and discharge?

- Establish an interdisciplinary team that will include the social worker, nutritionist, surgeon, case manager (if the hospital has one), and psychologist (if needed for mental health safety).
- Discuss the importance of having the nutritionist speak to the patient about diet postsurgery and long-term. Include hydration and dietary restrictions.
- Have the social worker and/or psychologist talk with the patient and family about the surgery and her acceptance of the body image change. See if the patient wants to include her boyfriend in the discussion. The discussion can include her feelings about her boyfriend's involvement in her care.
- Educate the patient on ostomy care and life with an ostomy. Provide resources from the Crohn's & Colitis Foundation and UOAA. Have the patient sign up for the concierge program with Hollister, Convatec, and Coloplast. If you can have another patient with an ostomy around at the same time, try to set up an interaction.
- Discuss sex and dating with the patient. If you're uncomfortable having this discussion, ask your team to assist. It's important to have this discussion.
- Have the social worker/case manager contact the clinic near the patient's home and set up an appointment after discharge with the WOC nurse (this is essential for the patient's quality of life).
- Have a discussion with the team about the length of time the patient will be on prednisone and alternative immunosuppressant therapy.
- At discharge, ensure that the patient can provide return demonstration of ostomy care, that the family and the patient feel their questions have been answered, and that patient is at ease with having the ostomy and their body image change. Schedule follow-up appointments.

facility will have the same supplies. If the ostomy pouch used by the patient is the preferred system or best choice, speak to the discharge planner about the pouch system chosen for the patient. Discuss the option of continuing with the same pouching system after discharge and the availability of other types of pouching systems. Patients should feel comfortable wearing an ostomy pouch.

Discuss options with the discharge planner if the rehabilitation facility doesn't have the same pouching system as the hospital. Nurses can advocate for the best possible outcomes for the patient. Explain your concerns, if there are any, to the discharge planner.

Discharge day

Discharge day is here. The discharge packet for the patient should include the discharge instructions, educational material, and additional supplies. In addition, schedule follow-up appointments with the provider and a WOC nurse (if available).³

Congratulations, the patient was discharged to the community. Before you go off and start teaching patients with ostomies with this new approach, let's recap the steps:

1. Establish an interdisciplinary team.
2. Determine who will provide the bulk of the education (you or the WOC nurse).
3. Determine who will perform ostomy care (patient or caregiver).
4. Find out if the patient will be discharged home or to a rehabilitation facility.
5. Discharge the patient with the discharge instructions and educational materials you prepared and schedule any follow-up appointments.

Creating a plan for each step of the process will help with the transition. Even if you don't have all the answers, work with the interdisciplinary team from the onset of admission. The interdisciplinary team can assist with creating a plan of care. There are multiple factors in discharging an ostomy

patient, but it doesn't have to be overwhelming. Plan, take your time, and ask questions. Think about all the "what-ifs" during the teaching process to ensure the patient receives the best information possible. ■

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