

NGN NCLEX 2026 · GI / GENITOURINARY ELIMINATION

Ostomy *Care*

Colostomies · Ileostomies · Urostomies — high-yield clinical judgment review built on the NCJMM framework

SURGICAL

ELIMINATION

SKIN INTEGRITY

BODY IMAGE

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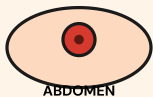
Definition & Overview

WHAT IT IS · WHY IT MATTERS

- ▶ An **ostomy** is a surgically created opening (a **stoma**) through the abdominal wall that diverts **stool or urine** when the normal route is diseased, obstructed, or removed.
- ▶ The **location of the stoma along the bowel** determines stool consistency — the more proximal, the more liquid and enzyme-rich the output (and the higher the risk for skin breakdown and dehydration).
- ▶ Ostomies may be **temporary** (allowing bowel rest and healing) or **permanent** (after total resection, e.g., abdominoperineal resection for rectal cancer).

Colostomy

LARGE INTESTINE → STOOL



Output ranges from **liquid** (ascending) to **formed** (sigmoid). Sigmoid is the most common.

Ileostomy

SMALL INTESTINE → LIQUID STOOL



Constant liquid effluent rich in digestive enzymes — **highest** risk of skin breakdown, dehydration, and electrolyte loss.

Urostomy

URINARY DIVERSION → URINE

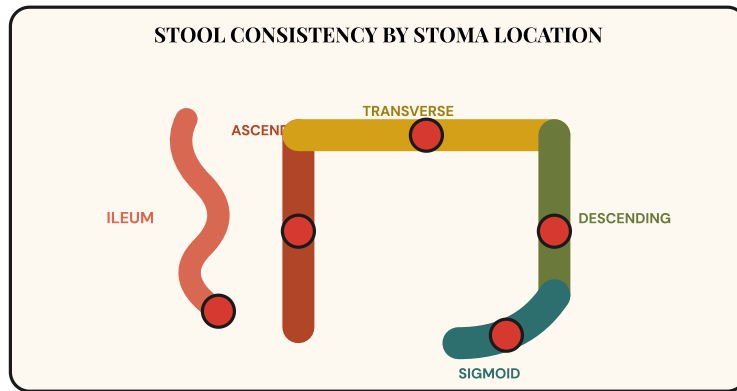
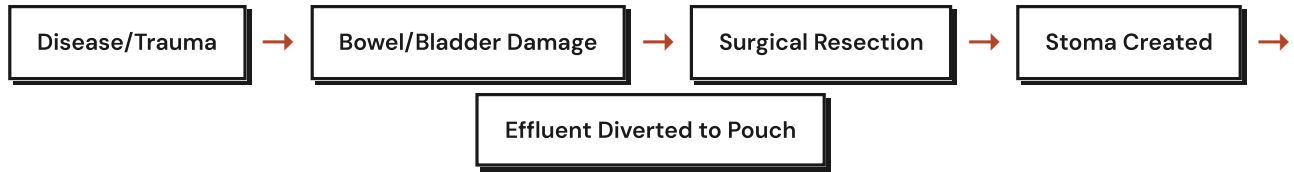


Ileal conduit diverts urine via a section of ileum. Urine should always have **mucus** (from the bowel segment) — this is normal.

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Pathophysiology — Output by Location

WHERE THE STOMA SITS DETERMINES WHAT COMES OUT



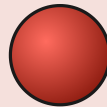
Stoma Location	Stool Consistency	Frequency	Skin Risk
Ileostomy	Liquid, enzyme-rich	Continuous	● HIGHEST
Ascending Colostomy	Liquid → Semi-liquid	Continuous	● High
Transverse Colostomy	Mushy, semi-formed	Frequent	● Moderate
Descending Colostomy	Semi-formed → Formed	Less frequent	● Low
Sigmoid Colostomy	Formed (most like normal)	1–2× daily	● Lowest

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Stoma Assessment & Red Flags

HEALTHY VS. DANGEROUS FINDINGS

Normal stoma: beefy red or pink, moist, slightly raised above skin, painless. Initial post-op edema and small amounts of bleeding when wiping are **expected**.

 Beefy Red / Pink Moist, slightly raised NORMAL	 Pale / Dusky Pink Possible anemia or low perfusion NOTIFY HCP	 Dark / Purple / Black Ischemia → necrosis EMERGENCY	 Excessive Bleeding Beyond minor capillary ooze NOTIFY HCP
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Expected Post-Op Findings

- ▶ Stoma **pink/red, moist**; slight edema for 4–6 weeks
- ▶ Colostomy: **function within 2–4 days**
- ▶ Ileostomy: **functions almost immediately** (within hours)
- ▶ Initial **liquid** output even from a colostomy until bowel adapts
- ▶ Small amount of **mucus in urostomy urine** = normal

Complications to Watch

- ▶ **Prolapse:** stoma protrudes > expected length
- ▶ **Retraction:** stoma sinks below skin level
- ▶ **Stenosis / Necrosis:** narrowing or tissue death
- ▶ **Peristomal skin breakdown:** excoriation, fungal rash
- ▶ **Parastomal hernia** — bulge around stoma

🚩 RED FLAGS — Notify the HCP Immediately

- 🚩 **Dark, purple, or black stoma** → ischemia/necrosis (surgical emergency)
- 🚩 **No ileostomy output for 4–6 hours + cramping/distension/N&V** → obstruction
- 🚩 **Sudden severe abdominal pain or rigid abdomen** → perforation
- 🚩 **Decreased urinary output < 30 mL/hr** from a urostomy → obstruction or dehydration
- 🚩 **Signs of dehydration / electrolyte imbalance** (especially ileostomy): dry mucosa, dizziness, dark urine, leg cramps, low Na⁺/K⁺
- 🚩 **Bleeding from the stoma lumen** (not just wiping) — internal source

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Priority Nursing Interventions

ABCS · SAFETY · SKIN · HYDRATION

Stoma & Pouch Care

- ▶ **Assess stoma color** and output q4h × 24h, then per shift
- ▶ **Empty pouch when 1/3 to 1/2 full** — fuller pouches leak under their own weight
- ▶ **Change appliance q3–7 days** or sooner if leaking, itching, or burning
- ▶ **Cut wafer 1/8 inch (≈ 2 mm) larger than the stoma** — too small cuts the stoma, too large exposes skin to effluent
- ▶ Cleanse peristomal skin with **warm water only**; pat dry — no soap with oils, lotions, or alcohol
- ▶ Best time to change pouch: **before meals**, when output is lowest

Systemic & Safety

- ▶ **Monitor I&O strictly** — ileostomy output > 1000–1500 mL/day = high risk
- ▶ Encourage **2–3 L fluid/day** (unless contraindicated)
- ▶ Monitor **electrolytes** — especially K⁺ and Na⁺ for ileostomies
- ▶ Provide **privacy** during care; address **body image** concerns
- ▶ Position upright when changing pouch — easier visualization, reduces gas escape
- ▶ **Consult ostomy / wound nurse (WOCN)** early

Colostomy Irrigation

Only for sigmoid/descending colostomies. Goal: regulate bowel pattern so the patient may not need a pouch.

- 500–1000 mL warm tap water
- Bag held 12–18 inches above stoma
- Same time daily
- **Cramping = slow or stop, lower the bag**

Urostomy Specifics

- Use **night drainage bag** to prevent reflux
- Encourage **acidic urine** (cranberry, vitamin C) to prevent UTI
- **Mucus in urine is normal**
- Output should be **≥ 30 mL/hr**
- Watch for **UTI** — cloudy/foul urine, fever, flank pain

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Pharmacology

DRUGS THAT CHANGE OSTOMY OUTPUT · DRUGS TO AVOID

Loperamide (Imodium)

ANTIDIARRHEAL · SLOWS MOTILITY

USE

High-output ileostomy (>1000–1500 mL/day) to thicken effluent

WATCH

Constipation, ileus; hold if no output

Psyllium (Metamucil)

BULK-FORMING AGENT

USE

Thickens loose stool in colostomy/ileostomy

WATCH

Must take with adequate fluid; risk of obstruction if too little water

Oral Rehydration / Electrolyte Replacement

SODIUM · POTASSIUM · MAGNESIUM

USE

Ileostomy patients lose Na⁺ and K⁺ continuously

WATCH

Hyponatremia, hypokalemia → cramps, dysrhythmias

Topical Antifungals (e.g., Nystatin powder)

PERISTOMAL SKIN · CANDIDA

USE

Red rash with satellite lesions around stoma

WATCH

Apply *powder* first, then skin barrier — creams interfere with adhesion

⚠ Medications to AVOID with an Ileostomy

- 🚫 **Enteric-coated tablets** — designed to dissolve in the small intestine; pass through unabsorbed
- 🚫 **Time-release / sustained-release capsules** — same issue, no time to release
- 🚫 **Large or intact tablets** — may obstruct stoma; request liquid, chewable, or crushable forms
- 🚫 **Laxatives** — generally unnecessary and dangerous

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NCLEX Test Traps

WHAT STUDENTS GET WRONG

Stoma Color

✗ Pale / dark / black stoma noted — document and reassess in 1 hour.

✓ Pale or dark stoma → notify HCP *immediately*.
Black = surgical emergency (ischemia).

Pouch Emptying

✗ Empty the pouch only when it is full to maximize wear time.

✓ Empty when **1/3 to 1/2 full** — weight breaks the seal and causes leaks.

Wafer Sizing

✗ Cut the opening to fit snugly against the stoma.

✓ Cut **1/8 inch larger** than the stoma — snug = trauma; far too large = skin breakdown.

Urostomy Output

✗ Mucus shreds in the urine = infection → call HCP.

✓ Mucus in urostomy urine is **normal** (from the bowel segment used for the conduit).

Irrigation Indication

✗ Irrigate the new ileostomy daily to regulate output.

✓ Irrigation is for **sigmoid/descending colostomies only** — never for ileostomies.

Ileostomy + Meds

✗ Give the patient's enteric-coated aspirin as ordered.

✓ Hold and contact HCP — enteric-coated and time-release meds are **not absorbed** through an ileostomy.

Initial Output

✗ A new sigmoid colostomy with liquid stool on day 2 indicates a complication.

✓ Expected — stool gradually **firms over weeks** as the bowel adapts.

Body Image / Communication

✗ "Don't worry — your ostomy will hardly change your life at all."

✓ Therapeutic: "Tell me what concerns you most about your ostomy." Acknowledge and explore feelings.

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Patient & Family Education

DISCHARGE TEACHING PRIORITIES

Diet

Avoid early post-op:

- Gas-producing: beans, cabbage, broccoli, onions, carbonated drinks
- Odor-producing: fish, eggs, garlic, asparagus
- **Ileostomy obstruction risk:** popcorn, nuts, seeds, corn, raw celery, mushrooms, coconut

Encourage:

- **Chew thoroughly**
- Add foods one at a time
- Yogurt, parsley, buttermilk reduce odor

Hydration & Activity

- **2–3 L fluid/day** (especially ileostomy)
- Replace electrolytes with sports drinks during heat or illness
- Most activities can resume — walking, swimming (pouch is waterproof)
- **Avoid heavy lifting** for 6–8 weeks → hernia risk
- Discuss **contact sports** (use stoma guard)
- Sexual activity may resume; intimacy concerns are normal

When to Call the HCP

- Stoma turns **dark, purple, or black**
- **No output** from ileostomy > 4–6 hrs with cramping/N&V
- Severe abdominal pain or distension
- **Fever**, increased redness or drainage at site
- Persistent skin breakdown around stoma
- Signs of dehydration: dizzy, dark urine, dry mouth, weakness
- Uncontrolled diarrhea or bleeding

Psychosocial Support

Acknowledge grief, altered body image, and fears about odor, leakage, intimacy, and identity. Refer to a **WOCN (wound, ostomy, continence nurse)** and to support groups (United Ostomy Associations of America). Involve the patient in care *as soon as possible* — looking at and touching the stoma is a major step in adaptation.

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NCJMM Clinical Judgment Scenario

APPLY THE 6-STEP FRAMEWORK

Scenario: A 58-year-old client is post-op day 2 from an ileostomy following a colectomy for ulcerative colitis. The nurse enters the room and assesses the stoma. The stoma appears **dusky purple**, the pouch is empty, and the client reports **cramping abdominal pain and nausea**. BP 92/56, HR 118, T 100.8°F, RR 22.

STEP 1

Recognize Cues

Dusky/purple stoma · empty pouch · cramping pain · N/V · ↓BP · tachycardia · low-grade fever.

STEP 2

Analyze Cues

Stoma color = ischemia/necrosis. No output + pain + N/V = obstruction. Vital signs suggest early sepsis or hypovolemia.

STEP 3

Prioritize Hypotheses

#1 Stoma ischemia/necrosis (surgical emergency). #2 Obstruction. #3 Hypovolemia/early sepsis.

STEP 4

Generate Solutions

Notify surgeon STAT · NPO · IV access + fluids · monitor VS q15min · prepare for possible OR.

STEP 5

Take Action

Notify HCP *immediately*; document stoma color, output, VS; place NPO; ensure 2 large-bore IVs; call rapid response if needed.

STEP 6

Evaluate Outcomes

Stoma returns to pink/red? VS stabilize? Output resumes? Pain controlled? Surgical revision required?

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Memory Boosters

MNEMONICS & QUICK ASSOCIATIONS

"S-T-O-M-A"

STOMA ASSESSMENT

- S** — Size & shape
- T** — Tissue color (beefy red = good)
- O** — Output (amount, consistency)
- M** — Mucosa moist?
- A** — Around the stoma — peristomal skin intact?

"ILEO = I LOSE"

ILEOSTOMY FLUID/ELECTROLYTE RISK

- I** — Intake of fluids must be high
- L** — Loss of Na⁺ and K⁺ is constant
- O** — Obstruction risk → no nuts/seeds/popcorn
- S** — Skin breakdown — wafer 1/8" larger
- E** — Enteric-coated meds = NO

"Ascend → Liquid • Descend → Formed"

STOOL CONSISTENCY BY LOCATION

Higher up = **more water + enzymes**

Lower down = **more reabsorption**, firmer stool

Sigmoid stoma stool ≈ normal stool

"Pink & Moist = Perfect"

STOMA COLOR RULES

- Pink/Red** → Perfect ✓
- Pale** → Poor perfusion (call HCP)
- Purple/Black** → Panic — ischemia/necrosis 🚑

"1/8 & 1/3"

SIZING & EMPTYING RULES

- 1/8 inch** — wafer opening larger than stoma
- 1/3 to 1/2 full** — empty the pouch
- 3-7 days** — change appliance

"DRAIN"

WHEN SOMETHING IS WRONG

- D** — Dark stoma
- R** — Retraction or prolapse
- A** — Absent output (ileostomy > 4-6 hrs)
- I** — Intense pain or distension
- N** — Notify the HCP