Title:	**Stoma management and nursing care guideline**
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Main Author (s)	Penny Heap, Surgical Nurse Specialist St Mary's Hospital, Manchester Centre for Newborn Surgery. Sue O'Neill, Lead Nurse Liverpool Neonatal Partnership LWH & AHCH
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1. Introduction

The NWNODN supports a standardised approach to stoma management across the North West and has produced a North West Stoma management guideline with contribution from clinical experts in the region. This stoma management guideline provides support to all the providers in the North West in their approach to stoma management. The intention of this guideline is to support the transfer of infants with on-going stoma care requirements to be undertaken at their local neonatal unit (LNU). The decision for repatriation would be facilitated by the two North West surgical units - Saint Mary's Hospital and Liverpool Neonatal Partnership to ensure acute surgical care requirements are completed and the infant has been discharged from the surgical team.

Infant referral criteria:

- Surgical management completed and stoma care established. Neonate assessed by the neonatal consultant and suitable for repatriation.
- Preterm infant with achievable stoma care, waiting for surgical intervention but needs to grow prior to further surgical intervention e.g. stoma closure.
- Infant with established refeeding on a case-by-case referral e.g. well established and tolerated and/or plan for discharge home.
- The infant's overall general condition should be considered prior to transfer.

Referral contra indications:

- An infant with peristomal skin issues and ineffective stoma management
- An infant with poor weight gain and ineffective stoma management
- High risk stoma care including stoma refeeding with previous gram-negative sepsis risk e.g bowel translocation.
- Infants determined vulnerable e.g. still requiring intensive care.

What is a Stoma?

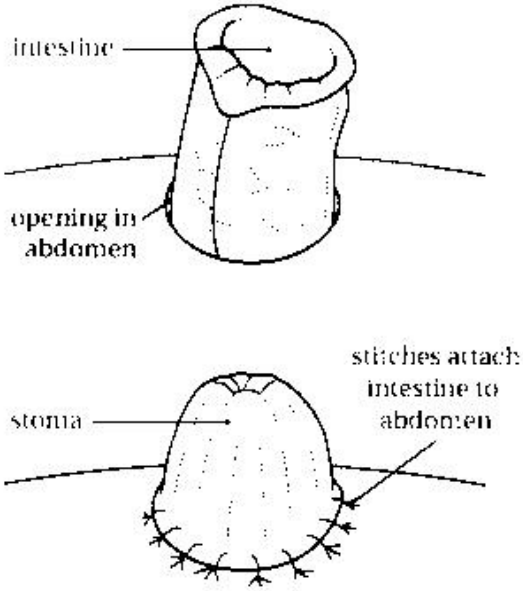
Stoma is the Greek word for 'mouth' or opening. It is surgically created opening of the bowel (intestines) through the skin onto the abdomen to divert and aid in the removal of body waste such as faeces or urine. The stoma mucosa is red and moist (like the mouth). There are no nerve endings and therefore no sensation, stoma care should be pain-free.

Neonatal indications for stoma formation
Congenital anorectal malformations
Gastrointestinal anomalies
Hirschsprung's disease
Meconium ileus
Imperforate anus
Cloacal anomalies
Intestinal malrotation
Intestinal volvulus
Intestinal atresia, stenosis, and webs
Necrotizing enterocolitis
Iatrogenic intestinal perforation or stricture

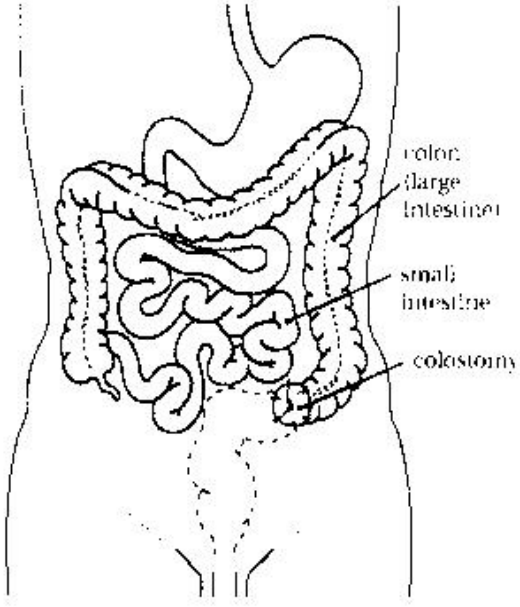
Stomas are performed to bypass an obstruction in the bowel or defunction inflamed bowel. Obstruction of the bowel can occur as a result of a congenital abnormality e.g. atresias, imperforate anus, Hirschsprung's disease and meconium ileus. In the pre-term infant, the most common reason for stoma formation is necrotizing enterocolitis (NEC). The most common sites are the lower ileum and any part of the large bowel i.e. ascending, transverse, descending or sigmoid colon.
80 % of stomas in children are formed in the neonatal period of which the majority of these are temporary. Stomas are frequently closed within the first year of life and some depending on infant factors including nutrition and growth outcomes may necessitate stoma closure before discharge home (minimum 6-8 weeks post formation). The type of stoma formed (jejunostomy, ileostomy or colostomy) will impact on the complexity of stoma management for the infant including milk type, fluid requirements and electrolyte management.

Stoma type and bowel location

At operation, the surgeon will locate the stoma (jejunostomy, ileostomy or colostomy) where the blood and nerve supply will best support its formation. The siting of the stoma is individual to the infant's bowel condition, and it is essential to refer to the surgeon's operation notes to understand and identify the stomas that have been formed as this will determine and impact the infant's stoma management. The stoma ends are referred to as the proximal stoma (functioning) and distal stoma (non-functioning or mucous fistula).



The end of the intestine is pulled through an opening made in the abdominal wall (top). The intestine is then folded outwards onto itself (bottom) and attached to the abdomen with stitches

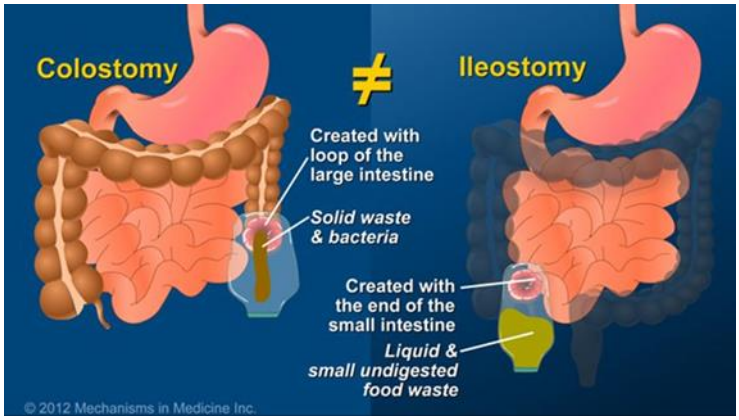


A colostomy

Different types of stomas

Duodensotomy – most proximal stoma. Output will be very high even with minimal trophic feeds. Infant will be dependent on parental nutrition.

Jejunostomy - more proximal small intestine, the jejunum is brought through the abdomen. Output will be very watery and contain digestive acids corrosive to the skin. A catheter may be sited and referred to as Tubal stomas. Infant will be dependent on parental nutrition.
Ileostomy - a section of the small intestine, the ileum which has been brought out through the abdomen. Output from ileostomies is usually liquid and can contain digestive acids which can cause harm the skin of the neonate.
Colostomy - a section of large bowel, the colon is diverted through the abdomen. Output can often initially be meconium, becoming yellow, curdy and semi solid.
Mucous fistula or distal stoma - the non functioning part of the bowel leading to the rectum is brought through the abdomen- also referred to as the distal stoma.



The stomas can be side by side (looped bowel) or sited separately with the stomas placed either end of the wound.

Double barrel stoma and normal appearance red colour

2. **Purpose**

The purpose of the guideline is to outline the management of an infant with a stoma and the pathway requirements.

- To identify the specific nursing management of an infant with a stoma and care requirements.
- To optimise infant nutrition and growth through MDT involvement and monitoring.
- To facilitate parental/career involvement and discharge planning requirements.
- To identify specialist nurse support for stoma care to review common stoma problems, aid decision making and effective use of resources.

3. **Management of Neonatal Stomas**

The management of the infant following stoma formation will be dependent on the underlying pathology, individual infant condition and the type of stoma formed.
This will include:

- **Stoma care and peristomal skin integrity** through application of the appropriate stoma care products.
- **Nutrition and growth** - monitoring of stoma output and hydration, fluid and electrolyte balance, liver function and weight gain that is tracking on the growth chart.

- **Stoma complications** – Common problems which may occur, recognising and managing such issues such as stoma prolapse, granulation or stricture formation.

The Surgical Centre Neonatal Stoma Nurse and Neonatal Consultant should complete the general information section of the **Badgernet discharge summary** to communicate the individual infant's stoma care needs and plan of care prior to transfer of the infant to the non-surgical centre. This should include details of surgical care, nutritional needs and on-going stoma care 48 hours prior to discharge the receiving unit should be contacted and the plan of care outlined to ensure the non-surgical centre have a robust plan and at least 48 hours to prepare and plan for the transfer. If the referring unit has a care plan specific to a baby's needs, for example a 'Stoma Care Plan for Dansac Bags' then a copy of this should be given to the receiving unit.

If the receiving unit wishes to have a 'cot side' care plan an example can be found in Appendix 1.

Stoma Care Provision

Provision of stoma products and specialist support

When the infant is transferred from the Surgical Centre, they should be transferred with an appropriate supply of stoma.

If the infant is to go home with the stoma, the home stoma equipment prescription service (Fittleworth) should have been set up by the referring surgical centre and parents can provide the stoma equipment required to the LNU.

Provision of stoma specialist support

Inform the Local Hospital Neonatal Link Surgical Nurse to facilitate stoma care needs, review nurse education and training requirements.

Inform the Hospital Stoma Nurse (adult or paediatric trained) to support ongoing stoma care to review and advise on going stoma care and appropriate stoma products.

Inform the neonatal outreach or children's community team to provide stoma support and in preparation for discharge.

The NWNODN is keen to foster LNU stoma care support by the surgical centre using telemedicine. This should aid effective interhospital communication and a review process to support on-going stoma care.

The Surgical Centre should provide a review process bespoke to the infant needs for stoma support during the working week (Monday to Friday). This should be ideally provided by the surgical centre surgical nurse specialist or stoma nurse to the LNU surgical link nurse or deputy on an individual case. A bespoke plan should be agreed for on-going support requirements and communicated to the designated medical consultant and nurse leads.

Out of hours service, should any urgent stoma care concerns be raised, these should be communicated to the surgical centre senior nurse/shift co-ordinator to seek immediate support or surgeon referral.

Saint Mary's Hospital NICU Shift co-ordinator Telephone 0161 701 0946 or MRI switchboard 0161 701 9600 VOCERA Neonatal shift co-ordinator.
Who to contact at Alder Hey/ LNP?

Liverpool Women's Hospital Shift leader Tel 0151 7089988 bleep 203
Alder Hey Hospital Ward 1C Neonatal Surgical Unit- Tel 0151 252 5378

Stoma Care and Peristomal skin integrity

Stoma appearance

The stomas should always appear red or pink in colour and be moist. They are prone to bleed slightly on contact and this is normal demonstrating a healthy blood supply. The stoma should always have a stoma bag applied to aid and maintain surrounding skin integrity**.**

Stoma bag placement

How to Care for the Stoma

Stoma observation:

At every nappy change, the stoma should be reviewed to ensure they appear red/pink, moist and healthy looking. Observe for stoma concerns e.g. dusky pink, blueish tinge or dark/black (necrosis) stoma colour. This may indicate the blood supply to the stoma is compromised by the stoma bag opening being too small or a bowel problem. Immediately remove the stoma bag and observe the stoma for improved colour. Then apply a stoma bag with a larger opening 2mm bigger than the stoma. If however the blood supply remains compromised cover with a silicone based non adherent dressing e.g. Mepitel or Jelonet and gauze dressing and refer to surgical centre for advice.

Stoma bag review:

Review the stoma bag to ensure intact, flange adhering around stoma and there is no leakage under the stoma bag. The stoma bag should be emptied with every nappy care 3-4 hourly when 1/3 full of bowel motion or flatus to ensure that the bag does not lift or leak.

Routine changing of the stoma bag only needs to be undertaken every 3 days if the bag is fully intact. However, the stoma bag can be changed daily to aid parental/carer teaching e.g. in preparation for discharge.

Choice of bag

There are several companies that make neonatal stoma bags. The type of stoma bags recommended for neonates are Dansac stoma bags. The surgical centres should advise regarding individual infant stoma bag requirements and provide the recommended stoma bag required.

If indicated, seek advice from the hospital stoma nurse or children's community team if there are concerns and the stoma bag needs changing to identify the most appropriate appliance.

When to change the stoma bag

If the bag is well adhered and not leaking, it is not necessary to change the bag routinely. If the wafer hydrocolloid appears to be stained or distorted, then the bag has leaked around the stoma and will require changing.

Where there are two stomas proximal and distal stomas sited apart

Ideally the distal stoma should be positioned at appropriate distance from the proximal stoma and a stoma bag should **only be applied over the proximal stoma (the functioning stoma).**

If the two stomas are positioned close to each other, the template should ideally have a hole for each stoma i.e. there should be 2 holes in the wafer.

DO NOT cut one large hole to encompass both stomas. The holes should **always** be the exact size of each stoma or leakage will occur and cause skin breakdown.

If the stomas are sited close together and it is not possible to cut 2 holes, a strip of DuoDerm Hydrocolloid dressing or a moulded Dansac TRE seal can be placed between the 2 stomas thus minimising exposure of

skin, this may give better contact with the wafer of the bag. However, frequent bag changes will be required to inspect and ensure the preservation of the peristomal skin.

Placement of Dansac TRE Seal around proximal stoma prior to stoma bag application

Care of the Distal Stoma (non-functioning)

If the distal stoma is not positioned close to the proximal stoma, a bag is not required on this stoma as there will be no effluent. Protect the skin around the stoma by applying a silicone based non adherent dressing e.g Mepitel or Jelonet and gauze before securing by the nappy on closing. The dressing should be changed with each nappy care and the condition of the distal stoma assessed. Avoid using tape to secure the stoma dressing as this may cause epidermal stripping and discomfort when removed.

Procedure to change Stoma Bag

Preparation:

Gather and prepare infant's hygiene care requirements and stoma equipment.

Stoma Equipment:

Bowl of warm tap water (Preterm <34 weeks use sterile water – this can be warmed in a milk warmer)

Enteral Syringes (10ml or 20ml)

Container for emptying contents of bag (gallipot/foil bowl/nappy)

2 packets of sterile gauze

Scissors - curved stoma ones if possible

Non alcoholic adhesive remover wipes (Dansac/Apeel)

Non sterile gloves and apron (not required for parents, effective hand hygiene)

Stoma Template

*S*toma bag

Stoma skin protector wipe or other skin protector product

Waste bag for nappy care

Procedure:

Wear personal protective equipment (apron and gloves) as per hospital infection prevention and control (IPC) protocol as handling body fluids.

Ensure infant is warm, undress lower body and maintain warmth with blanket as indicated.

Removal of the stoma bag:

First empty the contents of the stoma bag for measurement, empty using a syringe or into a galipot to measure effluent volume.

Document stoma effluent volume, colour and consistency in nursing records. (see nutrition and growth section)

In order to remove the stoma bag, support the skin gently and using a non alcoholic adhesive remover wipe to aid removal of the stoma bag by gently wiping around the edges of the stoma bag. It can then be gently lifted to aid removal from the skin. To minimise epidermal stripping and skin soreness.

Observe the colour, condition and size of the stomas, the condition of the skin and document findings in the nursing records.

Preparation of the peristomal area:

- Wash and cleanse the peristomal skin area to gently remove any stoma effluent with warm water and gauze.
- Ensure that all the adhesive from the old bag is removed.
- For preterm infants (< 34 corrected gestation) use sterile water rather than tap water as per hospital guidance.
- Dry the peristomal skin with gauze then cover the stoma with clean gauze while preparing the bag.
- Avoid using cotton wool as this leaves fibre strands that will impede stoma bag adherence.
- Avoid wiping the stoma unnecessarily as this will cause the stoma to function excessively during the bag change creating issues with bag adherence.
- A small amount of bleeding from the stoma is normal on touching.

NB: *Baby wipes, bubble bath and emollients will affect the way the bag will adhere and should not be used***.**

- Check the skin around the stoma – document any irritations or skin breaks and use the wound assessment chart with medical images to document any changes to the condition of the stoma or skin breakdown.
- Ensure the skin surface is clean and dry, then the skin protector and allow to dry. Next apply the new stoma wafer and bag.
- At each stoma bag change, the colour, size and shape of the stoma should be recorded and any deviation from a pink/ red colour and moist appearance must be reported to the medical staff/ local hospital surgical link nurse or stoma nurse.
- If skin is raw, wet or excoriated, a wound swab should be taken for microscopy. Consider candida treatment if skin rash with thrush appearance. **Seek immediate advice from the surgical link nurse, local hospital stoma nurse or tissue viability lead. (*Orahesive* powder can be applied to wet or open skin).**

Alternatively, *ilex skin protector* or *orobase* paste can be applied –These may help skin healing but orobase paste may create issues with stoma bag adherence – availability of products may vary. Please contact surgical centre for advice if difficulty in obtaining skin protection products.)

If there is evidence that there has been a problem with the peristomal skin, or the adherence of the stoma bag contact the local hospital surgical link nurse or adult stoma nurse. Staff should be cautious in altering the plan of care without consulting the surgical link nurse or stoma nurse for advice. Also consider contacting the surgical centre surgical nurse specialist for advice if the local interventions have not made an improvement.

Preparation and application of the stoma bag

Use the stoma care plan provided to guide stoma bag size and stoma resources required (Appendix 2 Stoma Care Plan).

The stoma template (adhered to back of bag) should be used in order to trace the size and shape of the stoma to ensure that the wafer of the bag fits close around the stoma leaving minimal skin gaps as these may cause skin irritation due to leakage of stoma effluent and the erosive nature of the bowel contents.

Place the template over the stoma and draw out the size of the stoma - this must be **exact to fit around the stomas but** not too large or too small. Place the template onto the stoma bag and copy hole size. Cut the hole(s) in the wafer with the curved stoma scissors to create a smooth edge. Run a finger around the side of the hole(s) to ensure that there are no sharp edges which may cut into the stoma causing bleeding and ulceration. Ensure not to cut into the clear stoma bag whilst cutting the hole or it will leak.

Ensure the stoma bag avoids covering the umbilical cord if not healed, as this will become moist and delay separation. Cut the outer stoma bag flange edge to fit around the umbilicus and ensure position away from the infant's groin so the flange lie flat on the abdomen. Only trim the stoma bag outer flange to fit onto the abdomen, removing minimal flange wafer. Date the template and keep the revised template for future stoma bag changes. These measures should aid effective adherence of the stoma bag.

Re measure and check the size of the stoma opening as this may change, either decrease or increase in size as swelling resolves or stoma prolapse occurs. This is to ensure a precise stoma bag fit. The revised new stoma bag template should be used for each bag change and discard the previous one.

Warm the stoma bag wafer between your hands or place under the warm water bowl to make it more pliable, remove the backing from the wafer and starting at the area around the stoma apply the bag gently running your finger around the stoma opening. Ensure if cover into the groin to straighten baby's leg. Hold the stoma bag in place for a minute with a warm hand so the stoma adhesive softens and adheres to the skin more securely.

If the area where the bag is to be applied is uneven it may be necessary to use the Dansac TRE seals to help the wafer adhere and prevent leaking (image

The stoma bag should be positioned pointing downwards towards the infant's lower limbs at 5 or 7 o'clock. The stoma bag should be kept away from any central venous catheter or intra venous lines to minimise infection risks.

The stoma bag used, size of hole required, and the direction of the bag should be documented in the nursing care plan notes.

Drainable stoma bags can remain in place for 2-3 days so long as there is no evidence of leakage. The bag will need to be emptied when 1/3 full of bowel motion or flatus to ensure that the bag does not lift or leak.

A leaking stoma bag must **ALWAYS** be removed to prevent damage to the peristomal skin. Never add tape to help seal the stoma bag as this is will not be effective and contribute to sore skin.

NOTE

All infants are different, and some products may not adhere effectively to the skin or modifications may be required. If you are unsure, please enlist the help of the local hospital surgical link nurse or stoma nurse.

If a stoma care plan has been written for an individual infant, please do not change the plan without consultation with the local hospital surgical link nurse or stoma nurse.

Possible Stoma Complications and Concerns

Stoma Colour

A healthy stoma is red/pink in colour, moist and shiny. It is very important to review and check the colour of the stoma regularly with hygiene needs.

Pale pink may indicate anaemia or poor perfusion.

Dark red/ purple may indicate bruising or blood flow impedance e.g. stoma bag opening cut too tight.

Grey to black indicates ischaemia and potentially necrosis- this requires immediate surgical review and referral to surgical centre surgeon.

Stoma size and protrusions

Normally the stoma should be approximately 0.5-1cm above the skin, protruding slightly.

Occasionally they can be flush to the skin.

Some stomas can retract below the skin level. This is not a concern if this is the distal stoma. But if the proximal stoma retracts it may cause issues with stoma bag adherence. Consider Dansac TRE ring use to form a “spout” then apply the stoma bag.

It is not uncommon for stomas to prolapsed occasionally >2-3cms visible. This usually does not require any treatment and is common, if concerned report to the medical staff who will contact the surgical centre surgeon to review the stoma. Provided the prolapsed bowel remains pink/red and moist there is no cause for concern. Resize the stoma bag opening to comfortably contain the bowel.

Oedema

In the early postoperative period, all stomas will be oedematous. This will subside within the first two weeks. Stoma bags applied prior to the oedema settling will require frequent review to ensure the appliance is secure with no leakage onto the skin.

Stricture

If the bowel becomes dark red, blueish or blackened this may be due to stricture and requires referral to the surgical centre for a review from the surgical team.

Peristomal skin

The skin surrounding the stoma should be healthy in appearance and the same as normal healthy skin. It is essential to monitor for skin breaking down looking out for maceration, erosions, rashes and ulcerations.

Stenosis

Stenosis of the stoma can also occur. Often the narrowing of the bowel is at the skin surface, but it can occur internally. This may present with:

- A reduction in the amount of stool passed
- Stoma effluent may appear ribbon-like
- The passage of stoma effluent may cease

Granuloma

Nodules of granulation tissue can form on the surface of the stoma. These can bleed easily and may cause concern, as they will bleed whenever the stoma bag is changed

Bleeding

Slight bleeding from the stoma's surface is not unusual as stomas are highly vascular. Excessive bleeding from inside the stoma should be reported to the medical staff and referral to the surgical centre on call surgeon.

Prolapse

A slight prolapse of the bowel may occur over time, but this usually does not require any treatment and is common in infants, if concerned report to the medical staff who will contact the surgical centre on call surgeon for review of the stoma. If the prolapsed bowel remains pink/red moist there is no cause for concern. Resize stoma bag or opening to fit bowel and not compromise bowel circulation.

Rectal or Mucus Fistula Discharge

A mucus discharge from the rectum or distal stoma is not unusual as the remaining bowel can continue to produce mucus. Monitor and document.

Surgical Wound

The surgical wound should have healed prior to transfer to the LNU. If specific wound care requirements are required these should be communicated by the surgical centre. Otherwise, the wound should be monitor for healing, or signs of infection and exudate as per local hospital tissue viability protocol. Any concerns should be communicated to the surgical centre and discussed with the surgeon on call.

Pain

Stoma care should not be painful and local comfort measures should be employed during stoma care. Stoma care is better tolerated when the infant is not hungry. Should the infant become distressed during stoma care give part of the feed, a dummy or sucrose to calm first.

Peristomal Skin Irritation Management

If there are signs of peristomal skin irritation:

In the first instance a skin barrier protector can be prescribed and applied to the surface of the skin taking care to protect the stoma with gauze before application. Do not apply direct onto the stoma. Availability of products varies therefore no specific product is recommended , units are advise to use whichever skin barrier protector is available locally.

If further skin breaks occur this may be due to the bag failing to adhere properly or the hole has been cut is too large. Orobase paste can be prescribed to cover any broken skin or bleeding areas. This must be applied sparingly with care as too much will prevent the stoma bag from adhering to the skin.
In the event of severe peristomal skin damage, instead of applying a stoma bag, apply a **very thick layer** of Orobase stoma paste around the peristomal area. Alternatively, for infants (> 36 weeks gestation, Ilex paste covered with Vaseline can be used (refer to surgical centre stoma guidelines). The stoma is then covered with gauze swabs to catch the effluent along with a nappy over the area in order to allow time for the skin to heal. More frequent stoma care is advised 2 -3 hourly.
Always consult the local hospital surgical link nurse before commencing 'bag off time' as this should only be used as a last resort. Wound care photographs should be taken and stored in the medical records and a wound assessment documented in the nursing records. Consider referral to the Surgical centre and tissue viability team for further advice.

The images below show breakdown of peristomal skin that was successfully treated as above.

Before

During

After

Nutrition and growth

Faltering growth is a common problem for newborns who have had a stoma formed and the management can be complex. Any patient with a stoma transferred to a non-surgical unit should meet the following criteria:

- They are expected to achieve enteral autonomy once the stoma is reversed
- Growth is following an appropriate centile
- Stoma output is of an acceptable volume and consistency
- If being recycled they are passing stool of a reasonable consistency and frequency
- Stoma is healthy and effluent can be reliably collected
- There is a nutrition plan (including Dietician) for managing feeds and a point of contact at the surgical unit to discuss any problems

Monitoring

- Accurate recording of stoma and nappy stool volume and consistency
- Weigh twice weekly and head circumference weekly plotting both on a growth chart
- Serum electrolytes and urinary sodium at least weekly
- Liver function and conjugated bilirubin levels weekly if on parenteral nutrition

Parenteral nutrition
Babies with a stoma often need parenteral nutrition (PN) until they are being recycled or the stoma is reversed. If central access is lost then it should be replaced as soon as possible, although if the

baby is nearing full feeds and stools are acceptable progress could first be monitored for a week. If a baby reaches full feeds, it is reasonable to retain central access for one week in case growth falters and PN needs to be restarted.

Management of feeds
Unlike medical patients, feeds should be advanced gradually so that changes in stoma output or weight gain can be identified. This is especially important once they are receiving 50% of their requirements enterally when it may be best to increase feeds only once or twice a week.

Milk should only be changed after discussion with a dietician, and ideally one experienced in managing stoma patients. There may be circumstances that require a change and that advice is not available, but if it is associated with growth failure specialist input is essential.

Management of stoma losses
It is important to measure stoma losses and their consistency. If not recycling losses of around 20-30mls/kg, or 15-20% of feed volumes, are typically considered acceptable. However, the consistency is also important and if they become loose, it suggests poor absorption. Excess losses are best managed by reducing feed volumes (and increasing parenteral nutrition) rather than simply replacing them with clear intra venous fluids.

If a patient is being recycled the volume of stoma output is not important provided it is being collected and can be delivered into the distal bowel. Instead, the frequency of stooling into the nappy should be monitored and if frequent or loose the feeds reduced.

Use of loperamide and sodium supplements
Loperamide may help improve absorption by slowing transit time. However, there are some concerns about the effect of loperamide on newborns and it primarily works on the large bowel. It can be prescribed as described in the BNF-C.

There is some debate about the use of sodium supplements in patients with a stoma. They can improve growth, but also increase osmolality and reduce absorption of nutrients. Monitor urinary sodium levels weekly. If less than 20mEq/L consider starting 30% oral sodium solution at 2mmol/kg/day in 4 hourly divided doses. If the stool becomes, or is already, loose it may be better to give the additional sodium intravenously.

When to discuss care with the surgical centre
Care of patients with a stoma can become difficult and require experienced advice. Teams at the surgical centre are always happy to be contacted as good growth is necessary to be ready for surgery. The following are criteria for discussion with the surgical centre:

- Unable to secure central access for parenteral nutrition
- Deterioration in liver function or an increasing conjugated bilirubin
- Significant slowing of growth
- High stoma or nappy losses
- Difficulties with collecting or recycling stoma losses
- Problems or concerns about the stoma/stoma bag adherence

Parental Stoma Information

The parents/care givers should be actively involved in their infant's care needs and facilitated to learn and provide stoma care requirements.

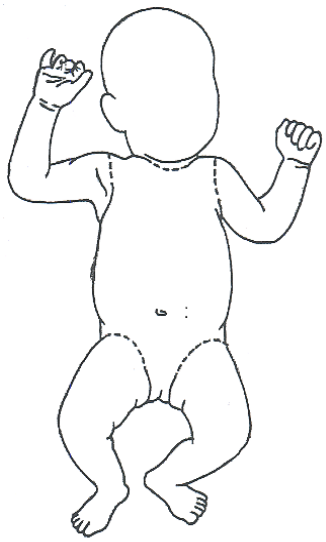
Parents should be provided with stoma resources and information to support their education and training in stoma care. It is anticipated the surgical centre will initiate parental/carer stoma training and where possible try to complete this prior to repatriation to the LNU. For some families travelling to the surgical centre can be an issue. Repatriation to the LNU may facilitate greater family integrated care opportunities and the surgical centre stoma training package and progress should be shared with the LNU.

The Hollister “Caring for your child with an Ostomy” booklet is an excellent resource and a Button Bear teddy with story book and colouring book for siblings can be provided. The infant should have a bespoke stoma kit bag with the individual stoma equipment requirements.

Prior to the infant’s discharge from hospital, a discharge planning meeting should be undertaken with the medical lead, nurse, local stoma nurse and the children’s community and AHP teams. The surgical centre surgical nurse specialist can support should this be indicated. The home stoma equipment resources are provided by Fittleworth and should be reviewed to ensure stoma equipment order appropriate and order requirements confirmed. The surgical centre should be contacted to advise and support if there are any concerns.
The infant will receive a surgical centre surgeon outpatient appointment (6-8 weeks post discharge) and Surgical Centre clinician contact details should be provided.

Appendix 1: Example of a Neonatal Stoma Assessment Chart and Plan

Add Pt ID Sticker



Date of Procedure:
Surgeon:
Diagnosis:
Surgical Centre contact details:
Surgical or Stoma Nurse:

Select type of stoma and label proximal and distal stomas on infant:

- Ileostomy
- Colostomy
- Mucous Fistula

<u>Problem:</u>
Aim:

- To provide stoma care and appropriate stoma appliance for effective management of the stoma.
- To teach and support parents in caring for their infant so that they are involved in care needs particularly where the infant may be discharged home with a stoma.

- Recommended appliance:

Record any resource changes in Stoma Care:

Stoma Care Delivery:

- Refer to NWNODN Stoma Management and Nursing care Guidelines
- The stoma bag should be checked with all nappy changes to ensure effective adherence and no signs of leakage. Empty the stoma bags with cares 4 – 6 hourly. The stoma bag should be changed every 3 days.
- Rational: To maintain hygiene needs, stoma bag adherence with healthy skin and prevent peristomal complications.
- Measure stoma losses and record colour and consistency. Document all stoma care provided.
- Review feeding plan if losses above > 20mls/kg/day or consider fluid replacement per surgical team plan
    - Reduce enteral feeds as dietician recommendation or neonatal/surgical plan
    - Use of Loperamide as instructed by surgical team

Mucus Fistula and Refeeding (recycling) of Stoma Losses:

NB: Refeeding of stoma effluent into the distal stoma/mucus fistula may reduce the risk of the complications, do not refeed unless instructed to do so by the surgical centre. Refeeding is mainly carried out on infants post bowel surgery depending on their condition and diagnosis. A contrast study through the mucus fistula may be advised by the surgeons before refeeding can be considered.

Contraindications to refeeding include compromised integrity of distal bowel, anal stenosis or imperforate anus, Hirschsprung's disease or dysmotile gut or effluent being too thick to infuse. Adverse reactions to refeeding are rare, but may include bleeding from the mucus fistula, distal stoma perforation of bowel by the catheter, leakage of stoma effluent onto peri-stomal skin causing excoriation. The procedure may cause distress to the infant and parents need to be informed of the reasons.

Refer to Surgical Centre Stoma Refeeding guidelines

Surgeon's Stoma Refeeding Plan:

Volume of stool to refeed…… and frequency of refeeding……..

Date &Time	Bag type used & when changed	Condition of stoma/Mucus fistula/Pink & healthy or state other	Peristomal Skin condition Redness/Broken down Action taken Stoma/TV Nurse referral	Stoma Output Watery Loose Colour	Any other concerns e.g. Prolapsed Hernia

References:

Fittleworth Delivering an easier Lifestyle for Babies, children and their carers available at www.fittleworth.com

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Ilex Healthproducts.com (2013) Ilex Skin Protectant: The best Protection for excoriated skin

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Images provided with consent from parents.