Post-Op Ostomy
Documentation Guide

This provincial document guides the documentation process, electronic health record or paper, in acute, community and long term care settings for the post-op ostomy period:

- Post-op ostomy assessment (see below).
- Post-op ostomy management plan (see page 5).
- Post-op ostomy patient teaching record (see page 5).

If the patient has both an ostomy and a mucous fistula, document each separately.

***Post-Op Ostomy**: 8 weeks post ostomy surgery regardless of care setting for adults, children and neonates.*

Post-Op Ostomy Assessment

Type & Frequency of Assessment		
Care Setting	**Full Assessment** Performed when pouching system changed.	**Partial Assessment** Done through a clear pouch of an intact pouching system.
Acute Care	• Initial (within 48hrs of surgery) • As per Management Plan (scheduled) • When client/family teaching is done. • When leakage occurs.	• Each shift. or • As per management plan.
Community Care	• On admission. • With each visit as per management plan. • When client/family teaching is done.	Not applicable.
Long Term Care	• On admission. • As per Management Plan (scheduled). • When leakage occurs. • When client teaching is done if applicable.	• Each shift. or • As per management plan.

Assessment Parameters to be Completed as per the Type of Assessment				
Assessment Parameters*	**Full Assessment**	**Partial Assessment**		
	All Care Setting	**Acute**	**Comm**	**LTC**
Date of Surgery	Initial			
Type of Surgery	Initial			
Surgical Plan	Initial			
Ostomy Type	Initial			
Ostomy Construction	Initial			
Pouching System Change	Initial and ongoing			
Stoma Shape & Size	√			
Device Insitu	√	√		
Stoma Appearance (characteristics & %)	√	√		
Stoma Os	√			
Stoma Height	√			
Mucocutaneous Junction	√			
Peristomal Skin	√			
Bowel Output (if applicable)	√	√		√
Urinary Output (if applicable	√	√		√
Pain w pouch change	√			

A **parameter is a 'question' used to ensure a comprehensive assessment.*

The table below lists the ***assessment findings***, *terms used as an 'answer' for a parameter*. It shows both frequently used terms, as well as, other terms that may be listed on the documentation form/screen or could be used when the 'Other' option is chosen.

- If an assessment parameter is not needed, document "Not Applicable", (e.g., device insitu).
- If an assessment finding term is not listed, use 'Other' and add in the finding. If required by HA documentation processes, document 'Other' elsewhere in the client's chart, (e.g., narrative notes).
- **Some HA/sites documentation systems may have less assessment finding terms available for selection, or there may be different terms available.**

Assessment Findings for the Parameters		
Assessment Parameter *The 'question'.*	**Frequently Used Findings** **(Provincial Nursing Ostomy Committee standard)** *A possible 'answer' for the parameter.*	**Additional Findings** **(Provincial Nursing Ostomy Committee standard)** *May be used in some documentation systems or used to describe findings when 'other" is chosen.*
Surgical Plan – all information is available on the Operating Room Report		
Date of Surgery	Use Month/Day/Year format	
Type of Surgery	Free text	
Surgical Plan	Choose one: • Permanent • Temporary • To Be Determined • Unknown	
Ostomy Type	Choose one: • Ileostomy • Colostomy • Urostomy • Mucous Fistula Use image of the abdomen to show location of ostomy 'O" and/or mucous fistula "MF".	Other: write in the following • Enterocutaneous Fistula
Ostomy Construction	Choose one: • New • Revision • End • Loop • Double Barrel	
Ostomy Assessment		
Pouching System Change	Choose one: • Not Needed • Routine • Teaching • Leakage For leakage, use clock to describe where the leakage occurred, (e.g., 2-5 o'clock). For Teaching, document teaching session on the Ostomy Teaching Record.	
Stoma Shape & Size	Choose one: • Round (in mm) • Oval (LxW in mm)	
Device Insitu	Choose one: • Not Applicable • Rod/Bridge • Stent(s) For stent(s), chart number of stents.	

Assessment Parameter *The 'question'.*	Frequently Used Finding **Provincial Nursing Ostomy Committee standard)** *A possible 'answer' for the parameter.*	Additional Findings **Provincial Nursing Ostomy Committee standard)** *May be used in some documentation systems, or used to describe findings when 'other' is chosen.*
Ostomy Assessment continued		
Stoma Appearance	Choose Yes (Y) or No (N) • Moist • Edematous For those starred *, use percentage (%) to describe amount of stoma area characterized by the finding(s) – the total must add up to 100%, (e.g., red/pink 50% & slough 50%). • Red/pink* • Dusky* • Purple/maroon* • Slough* • Necrotic* • Other*	Other: write in one of the following • Stenosed • Trauma
Stoma Os	Choose one: • Centered • Off-centered • Tilted • Flush	
Stoma Height	Choose one: • Raised • Flush • Retracted • Prolapsed (greater than 2cm)	

Mucocutaneous Junction	Choose one:
	• Intact
	• Separated: if separated then chart:
	  ○ Depth in cm
	  ○ Location, use the clock to describe, (e.g., 7 o'clock to 9 o'clock
	• Granuloma	

Peristomal Skin	Choose all that apply: • Intact • Erythema • Indurated • Excoriated/Denuded • Macerated • MARSI • Bruised • Wound • Rash • Other	Other: write in one of the following • Ulceration • Rash – Fungal • Rash – Contact Dermatitis • Rash – Folliculitis • Rash – Allergy • Psuedoverrucous Lesion • Malignant Lesion • Peristomal Psoriasis • Pyoderma Gangrenosum • Caput Medusae
Bowel Output (if applicable)	If not applicable, then check the N/A box. **Ostomy producing**: choose one • Yes • No **Stool Characteristics**: choose one • Flatus • Mucous • Watery • Mushy	Other: • Write in the finding noted

Assessment Parameter *The 'question'*	Frequently Used Finding **Provincial Nursing Ostomy Committee standard)** *A possible 'answer' for the parameter*	Additional Findings **Provincial Nursing Ostomy Committee standard)** *May be used in some documentation systems, or used to describe findings when 'other is chosen'*
Ostomy Assessment continued		
	• Pasty • Semi-formed • Formed • Hard • Other Colour: choose all that apply • Brown • Yellow • Green • Clay • Black • Bloody	
Urinary Output (if applicable)	If not applicable, then check then N/A box. **Urine Characteristics**: choose apply that apply • Clear • Concentrated • Mucous shreds • Cloudy • Clots • Sediment • Malodourous (foul smelling) • Other **Colour:** choose one • Pale yellow • Yellow • Amber • Orange • Pink • Red	Other: • Write in the finding noted
Pain w pouch change	On a scale of 0 – 10, the patient's indication of the level of their pain.	

Documentation of Care Provided	
Change done as per Management Plan	Use a √ to indicate care provided as per the Management Plan.
See Narrative Notes for concerns	Use a √ to indicate a concern and/or care provided was different from the current Management Plan; provide rationale for change in care.
See NSWOC Notes	Use a √ to direct the reader to the NSWOC Notes.
Initials (paper version only)	Write in first/last initial of name.

Post-Op Ostomy Management Plan

The management plan is developed following the initial pouching system change and assessment. The plan is updated, as needed, with each subsequent Full Assessment. The referral section documents which Health Care Professional was the client was referred to and when.

Referrals	
Health Care Professional (HCP)	For each HCP, write in date of when referral was done and add signature (paper version only).

Management Plan	
Title	Write in if plan is for ostomy or mucous fistula.
Initial Plan or **Revision to Plan**	Choose "Initial Plan' for the first plan and 'Revision to Plan' whenever there is a change in the management plan. For a revision, document the reason why a change was needed.
Pouching Concerns	Choose No or Yes. If Yes, write in the concern(s).
Pouching System	Choose as many of the characteristics as needed to describe the pouching system, (e.g., 2-Piece, Flat, Cut-to-Fit, and Drainable Pouch). Use "Other' if needed to further describe the pouching system. Write in the vendor & product numbers if known.
Additional Ostomy Supplies	Choose all the additional supplies needed to complete the management plan.
Plan	Indicate when pouching system is to be change, (e.g., Monday & Thursday). Write out the plan in detail. When preparing the client for discharge/transition of care, indicate the supplies and the amount of each sent with client.
Date/Signature (paper version only)	Write in date plan was initiated or revised and signature.

Post-Op Ostomy Teaching Record

The teaching record is updated following each teaching session to document patient's learning progress.

Ostomy Teaching Record	
Ostomy care to be done at home by	Choose one: • Patient • Family • Caregiver Add comments as needed.
Resources	Write in ostomy resources provided to patient/family. Indicate if the offered Ostomy Visitor (if available) was accepted or declined.
Who is the learner	Indicate who is the principle learner: • Patient • Family • Caregiver

Skills	For each teaching session, write in date & time. For each skill, indicate what action the learner did: • O = Observed Nurse • P = Participated w Nurse • NP = Needs Practice • I = Independent
See Narrative Note	Use a √ to direct the reader to the Narrative Notes for additional information.
Nurse's Initials (paper version only)	Write in initials of first and last name.
Knowledge Learning points identified with a * must be taught prior to discharge to ensure patient safety at home.	For each of the learning points, indicate: • The point was discussed • With whom (patient, family or caregiver) • Date of the discussion • Date if/when point was reinforced
See Narrative Note	Use a √ to direct the reader to the Narrative Notes for additional information.
Nurse's Initials (paper version only)	Write in initials of first and last name.
Ready for Discharge	NSWOC to indicate patient is ready for discharge by signing name (paper version only) and entering date of decision.