

**Standard Operating Procedures**

**Stoma Management in the Community**

**March 2024**

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# Introduction

The purpose of this Standard Operating Procedure (SOP) is to establish minimum practice standards for faecal and urinary stoma and nephrostomy management for community patients.

Stoma care is a fundamental area of nursing practice that all registered nurses should have the competence to undertake. It has been recognised that many of the core nursing skills in stoma care are being carried out by healthcare assistants and carers. All practitioners undertaking bowel care must be able to demonstrate competence in bowel care assessment and interventions by being assessed as competent. In order to carry out invasive bowel care all staff should attend relevant training, achieve competency, and be working within their job description ([Appendix 1 & 2](#_Appendices)).

This SOP will remove unwanted variation in clinical practice and following best practice guidelines aims to reduce inappropriate care (overuse, misuse and underuse of appliances and accessories) thus improving health outcomes, reducing preventable harm and decreasing wastage. It provides information for clinicians that care for a person with a stoma in community settings, where patients require treatment, monitoring, and education in relation to their stoma.

This SOP does not refer to Gastrostomy (see Policy and Procedures for Adults who require Home Enteral Nutrition) or Tracheostomy management.

Examples of faecal and urinary stomas include:

* Colostomy: an opening into the colon
* Ileostomy: an opening into the ileum
* Urostomy: an opening into the urinary tract, the most common being an ileal conduit which is formed to act as a passage for the urine to exit the body

# SOP 1 Referral and Clinical Triage of Patients with Stomas

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| **Purpose** |

To promote appropriate referral and triage to the District Nursing service to ensure access to all patient information in order to make safe and effective decisions about the patient’s nursing needs ([appendix 7](#_Appendices)).

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| **Scope** |

All patients with stomas referred to District Nursing Service come from a range of sources

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| **Core Requirements/Procedure** |

All Referrals to the District Nursing (DN) services are received through email [Adult.Referrals@fnhc.org.je](mailto:Adult.Referrals@fnhc.org.je) or telephone call direct to admin hub team (AHT) 43603 Mon-Fri 08.30-5pm or the clinical coordinator (CC) outside of admin hub hours.

Referrals from Jersey General Hospital will be accepted providing they are submitted using the electronic referral form JGH DN referral

Patients with stomas can self-refer to FNHC if already on EMIS. If not, then a referral would need to be sent from either the Stoma CNS or the patient’s GP.

It is expected that Grade 5/6 Nurses would undertake the initial assessment on all patients with anything other than simple/routine care needs. When this is not possible, the Grade 5/6 should review the assessment and care plan developed by their team members within 7 days and record their review on EMIS.

The nurse will admit the patient with a stoma as per the Patient Pathway (EMIS) District Nursing Services SOP (Admission to the District Nursing Caseload).

The nurse will carry out an assessment of the stoma ([SOP2](#_SOP_2_Performing) /[Appendix 4](#_Appendices)) if complication found ([SOP3](#_SOP_3_Managing)) then advice and treatment will be provided.

If patient has a new stoma or a change of appliance or the addition of accessories (Appendix 8) is required, than the nurse will complete a voucher for stoma products and send this to the Subsidised Products Scheme (SPS) ([appendix 9](#_Appendices))

Patients with stomas should be encouraged to self-care if they or other family members are unable to do this then referral to Social worker for stoma care will be required.

# SOP 2 Performing an assessment of the stoma

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| **Purpose** |

Stoma care is very individual and requires full holistic patient assessment. The principal aim is to encourage patient independence by providing care and advice on managing the stoma, thus permitting the patient, to continue with their activities of daily living.

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| **Scope** |

All community patients with a stoma

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| **Core Requirements/Procedure** |

Conduct a full holistic assessment of the patient—including full medical history, medication taken ([Appendix 3](#_Appendices)), diagnosis requiring stoma, mobility status, comorbidities, history of skin problems and any interventions/ treatments already undertaken

Perform a visual inspection and physical examination of the stoma and peristomal skin - including general appearance, skin integrity, presence and distribution of hair; compare the peristomal skin with adjacent abdominal skin, checking for any changes

Assess the patient’s current appliance and any effect this has on the skin. Consider switching to another appliance if necessary, and use appropriate accessories to protect the skin

Educate the patient on hygiene, and pouch application and removal. Provide information and support on self-care and ongoing management.

Complete assessment document ([Appendix 4](#_Appendices))

Complete individualised care plan ([Appendix 5](#_Appendices))

***Observations:***

|  |  |
| --- | --- |
| Colour | A stoma should appear pink/red, moist and shiny in appearance.  Report pale, dark, dusky or black stoma’s to HCS CNS |
| Oedema | Observe and report oedema in the presence of colour changes e.g. pale, dark, and dusky.  During the initial post-operative period the stoma may appear oedematous but it will decrease in size over 6-8 weeks. |
| Bleeding | Minor bleeding may occur as a result of contact trauma to the stoma, however this should spontaneously resolve through the application of light pressure.  Observe and report active bleeding at the stoma or the mucocutaneous junction. |
| Peristomal skin | The skin immediately surrounding the stoma should appear similar to the skin on the other side of the abdomen. It should be intact and healthy. Impaired skin integrity may indicate appliance leakage and requires review.  When the appliance has been removed, there may be some transient erythema.  However, it should not remain red nor be painful. Assess at every appliance change.  Observe, document and report any:   * redness, erythema, rashes, irritation * impaired skin integrity * pain/ tenderness |
| Protrusion/Stoma Height | An ideal stoma should protrude 2-2.5cm from skin level to facilitate effluent draining into the pouch. Stoma retraction is when the stoma lies beneath the level of the skin. The degree of stoma protrusion described as:   * retracted (below skin level) - report any signs of retraction * flat/flush * moderately protruding (1-3cms) * long / well spouted (>3cm) * prolapsed, a falling out or telescoping of the bowel through the stoma creates the appearance of a long stoma length |
| Effluent Produced | Observe and document the colour and consistency of output from the stoma.  Output from Ileostomy should be below 1.2L in 24 hours if more follow Management of High Output Stomas for Acute and Community patients. ([Appendix 6](#_Appendices)) |

# SOP 3 Managing complications of patients with stomas

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| **Purpose** |

Managing complications of patients with stomas

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| **Scope** |

All community patients with a stoma

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| **Core Requirements/Procedure** |

| **Complication** | **Appearance** | **Problem** | **Treatment** |
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| Skin Issues |  | Redness, irritation, broken skin | Use of adhesive remover spray/ wipe  Check appliance for leaking  Check size of aperture of flange  Change appliance to different make or to convex  Use barrier spray until skin healed |
| An external file that holds a picture, illustration, etc. Object name is 2432-3853-4-0025-g003.jpg | Ulcers/Peristomal pyoderma gangrenosum (PPG) - Purple edged, very painful ulcers which ooze exudate | Review by CNS  Dermatologist for further assessment  Take a microbiology swab to culture the ulcer.  Treatment with steroid |
| \\ois.gov.soj\sojdata\HSS_HomeDirs_I-L\LeBerF\My Pictures\mM Jan 2023.jpg | Peristomal Caput Medusae  Due to portal Hypertension related to liver pathology. | Peristomal skin with varices may be fragile and bleed very easily.  Gentle pouch removal using an adhesive remover wipe and gentle skin cleansing should be performed to prevent trauma to the fragile skin.  Less frequent pouch changes and the use of skin barrier wipes may reduce the possibility of bleeding.  If minor bleeding occurs, calcium alginate materials |
|  | Granuloma (Bleeding from stoma site) | Management options may include:  - Silver nitrate  - Steroid cream  - Liquid nitrate  - Convex products |
| Device issues |  | Leakage  Sore skin | Check size of stoma and aperture of flange ensure no more than a 2mm gap  Use of convex appliance |
| Retraction |  | Leakage  Sore skin | Use of convex appliance soft/ light / firm  Use of paste or rings to fill creases |
| Ballooning |  | Device issues and leaking | Discuss diet with an aim to reduce foods that cause wind.  Review appliance to ensure effective filter / change to 2 piece appliance |
| Pancaking |  | Device issues and leaking | Cover filter  Tissue paper in pouch  Lubricating gel  Diet |
| Parastomal Hernia |  | Pain  Strangulation  Obstruction | Use of support garments or abdominal belts are only effective if the hernia is reducible  If patient experiencing pain or obstruction will need urgent referral to HCS |
| Stenosis |  | Obstruction | Referral to surgeon/CNS  Dilatation |
| Prolapse | prolapse left iliac fossa end colostomy | Ulceration  Ischaemia | Cut hole of the appliance larger, this will cause the peristomal skin to be exposed. The use of seals/ washers will protect the exposed skin.  Reduce prolapse were possible with cold water compress and glucose powder  Cover the stoma with a swab while placing the pouch; this will stop the flange getting wet.  Use lubricating gel in bag to prevent friction |
| Low output | Blockage – no output or liquid stool which is not normal for patient, bloating/abdominal swelling, cramps, swollen stoma site, nausea and vomiting | Obstruction  Strangulation | Avoid eating solid food for the time being  Drink plenty of fluids including hot fluids  Massage abdomen and the area around the stoma  Get ostomates to lie on back, pull knees up to chest, and roll from side to side for a few minutes  Take a warm bath for 15 to 20 minutes to help relax your tummy muscles  Administer suppositories/ enema via stoma if constipated see SOP 6 |
| High output | An output of 1.2L or more | Dehydration  Acute Kidney Injury | ([See appendix 6](#_Appendices)) |
| Rectal  discharge |  |  | Encourage ostomates to sit on toilet daily to pass mucous  Glycerine suppositories, make the mucus more watery, so it's easier to get rid of.  The mucus can sometimes irritate the skin around the anus bottom. Use a barrier skin cream |

# SOP 4 Care of Nephrostomy

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| **Purpose** |

To provide community nursing care for patients with a nephrostomy tube.

A nephrostomy tube is needed when the ureter becomes blocked and urine cannot flow through from the kidney to the bladder. This can be caused by a stone, cancer growth or stricture.

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| **Scope** |

All community patients with a nephrostomy tube

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| **Core Requirements/Procedure** |

The nephrostomy tube may be stitched in place or initially attached with a Drain Fix’ dressing, and will exit the skin from the side of the patients back. Once home the tube should will be inserted into a urostomy bag / high output which will be stuck to the patient’s back this prevents the tube getting dislodged. A longer tube bag leg bag can be attached to aide emptying if required.

The skin around the nephrostomy tube insertion site should be kept clean and dry to prevent infection, placing the tube into a urostomy bag which fits snug around the site where the tube leaves the skin. The bag should be changed at least twice a week.

Urostomy / High output bags and adhesive remover spray are available from the SPS scheme via the stoma voucher ([appendix 9](#_Appendices))

Procedure as per Nephrostomy tube care and bag change care plan ([appendix 10](#_Appendices))

Possible Complications (see troubleshooting chart [Appendix 11](#_Appendices))

The risks of developing complications from having a nephrostomy are low. Possible complications are infections, bleeding from the kidney or urine leaking from the kidney and collecting in the abdomen.

# SOP 5 Colostomy Irrigation

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| **Purpose** |

Colostomy irrigation is a mechanical method of controlling bowel elimination. The large bowel is emptied by infusion of warm tap water into the large intestine via the stoma.

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| **Scope** |

All adults that require colostomy irrigation in the community

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| **Core Requirements/Procedure** |

Not all patients with a colostomy will be suitable candidates and not all colostomies are suitable for irrigation. A consultant must agree to colostomy irrigation and a Stoma CNS should assess the patient and discuss the procedure prior to commencement.

***Contraindications***

Active IBD, active Diverticular disease, presence of fistulae, radiation damage, presence of existing colonic primary/ metastatic disease symptomatic parastomal hernia

***Equipment:***

* colostomy irrigation kit containing water bag with flow regulator, irrigation cone and irrigation sleeves (supplied by SPS scheme and ordered by the Stoma CNS)
* warm water in a clean jug for filling the water bag as prescribed Stoma CNS
* warm water for cleaning the peristomal skin
* dry wipes
* hook to hang up water bag
* lubricant
* towel
* new stoma appliance as used by the patient
* stoma accessory items as used by the patient
* waste receptacle
* personal protective equipment (PPE)

***Procedure***

Check the patient’s record for recommended amount of fluid to be instilled into the colostomy

Attend hand hygiene before touching the patient by either hand washing or the use of ABHR

Ensure privacy

Explain the procedure and obtain verbal consent.

Check patient identification and allergies

Attend hand hygiene by either hand washing or the use of ABHR

Don PPE

Hang the water bag at shoulder height. Ensure the flow regulator is closed. Fill up the water bag with the recommended amount of water

Attach the irrigation cone to the water bag.

Open the flow regulator to flush the line of air. When the line is flushed close the flow regulator

Place a towel across the patient’s abdomen to protect the patient from water spills

Remove the patient’s old stoma appliance and clean the peristomal skin with the warm water and dry wipes

Attach the irrigation sleeve to the patient

Lubricate the end of a gloved finger and digitally examine the lumen/s of the colostomy to determine the insertion direction of the irrigation cone

Remove gloves, attend hand hygiene and apply new gloves

Lubricate the end of the irrigation cone and gently insert into the correct lumen of the colostomy. An end colostomy will have one lumen; a loop colostomy will have a proximal and distal lumen.

Hold the irrigation cone in place without force

Open the flow regulator to obtain a steady flow of water into the colostomy. Some leakage around the cone is expected and the cone may need to be adjusted to ensure even flow

Once the prescribed amount of water has been instilled close the flow regulator and remove the irrigation cone

Ensure the irrigation sleeve is secured at the top and bottom as per the manufacturer’s directions

Ensure the patient is comfortable

Discard equipment or clean and keep non-disposable items such as the water bag, flow regulator and irrigation cone as per manufacturer’s directions

Remove PPE

Attend hand hygiene by either hand washing or the use of ABHR

Record the procedure in the patients clinical record including:

* date and time of procedure
* amount of water instilled
* result (if any) of irrigation
* patient’s tolerance for procedure

Record input and output on the patient’s fluid balance chart

Return to review patient at 30 minute intervals until bowel evacuation is completed

When evacuation is completed perform hand hygiene, don PPE and remove irrigation sleeve

Clean the stoma and surrounding skin.

Dry skin well.

Apply a new appliance

Ensure the patient is comfortable

Discard equipment

Attend hand hygiene by either hand washing or the use of ABHR

Record the procedure in the patient’s clinical record

***NOTE***

Patient may experiences a vasovagal episode during the procedure; ensure that there is another person available, or a telephone to call for help. Patients are advised to sit during procedure

Cease the irrigation if the patient complains of pain, or has a vasovagal response resulting in hypotension or bradycardia. Wait until pain subsides and blood pressure and pulse returns to normal limits before recommencing the procedure

Cease completely if pain persists or vasovagal response does not subside and seek medical advice

# SOP 6 Colostomy Suppository and Enema Administration

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| **Purpose** |

Colostomy suppository and enema administration is performed to:

* relieve symptoms of constipation
* administer medication directly to the bowel wall
* cleanse the bowel prior to a diagnostic or surgical procedure

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| **Scope** |

All adults that require administration of a suppository or enema via their colostomy in the community.

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| **Core Requirements/Procedure** |

Suppository administration can be performed by Stoma CNS, RN or SHCA that has been deemed competent. Enema administration can only be performed by a nurse trained in this procedure and has been competently assessed.

A hospital consultant/GP will need to prescribe the suppository or enema and the Stoma Nurse should be consulted if an irrigation cone is required, as a colostomy has no sphincter muscle to aid in retention of suppository or enema.

An end colostomy will have one lumen in which a suppository or enema is administered. A loop colostomy will have two lumens – proximal and distal. The lumen in which the suppository or enema is to be administered will be prescribed by the doctor.

Complete individualised care plan ([Appendix 12](#_Appendices))

**Administration of Suppository via Colostomy**

***Equipment:***

* Personal Protective Equipment (PPE)
* Alcohol base hand rub (ABHR)
* Lubricant
* Suppository as prescribed
* Warm water
* Dry wipes
* New stoma appliance as used by the patient
* Stoma accessories if used by the patient
* Waste receptacle

***Procedure***

Check the patient’s clinical record for prescribed suppository to be administered into the colostomy

Attend hand hygiene before touching the patient by either hand washing or the use of ABHR

Ensure privacy

Explain the procedure and obtain verbal consent.

Check patient identification and allergies

Attend hand hygiene by either hand washing or the use of ABHR

Don PPE

Remove and discard the old stoma appliance

Lubricate gloved index finger

Digitally examine the colostomy

Insert the suppository the full length of the index finger

The suppository will need to be held in place whilst dissolving.

Apply the patient’s usual stoma appliance

Ensure the patient is comfortable

Discard equipment

Attend hand hygiene by either hand washing or the use of ABHR

Record the procedure in the patients clinical record including:

Date and time of procedure

Result (if any) of procedure

Patient’s tolerance for procedure

**Administration of an Enema via Colostomy**

***Equipment:***

* lubricant
* alcohol base hand rub (ABHR)
* personal protective equipment (PPE)
* waste receptacle
* enema as prescribed
* irrigation cone if required
* warm water
* dry wipes
* stoma accessories if used by the patient
* new stoma appliance as used by the patient

***Procedure***

Check the patient’s clinical record for medical orders and prescribed enema to be administered into the colostomy. If the patient has a loop colostomy ensure the loop (proximal or distal) to receive the enema is documented

Attend hand hygiene before touching the patient by either hand washing or the use of ABHR

Ensure privacy

Explain the procedure and obtain verbal consent.

Check patient identification and allergies

Attend hand hygiene by either hand washing or the use of ABHR

Don PPE

Remove and discard the old stoma appliance

Lubricate gloved index finger

Digitally examine the colostomy

Remove gloves, attend hand hygiene and apply new gloves

Lubricate the tip of the enema and insert into the colostomy OR lubricate the tip of an irrigation cone and insert the cone into the colostomy and the attach the enema to the other end of the cone

Slowly administer the contents of the enema observing the patient for signs of discomfort

The enema will need to be retained for the recommended length of time.

Apply the patient’s usual stoma appliance

Ensure the patient is comfortable

Discard equipment or clean and keep non-disposable items such as the irrigation cone as per manufacturer’s directions

Attend hand hygiene by either hand washing or the use of ABHR

Record the procedure in the patients clinical record including:

Date and time of procedure

Result (if any) of procedure

Patient’s tolerance for procedure

# SOP 7 Small Bowel Enterocutaneous Fistula (ECF) Management

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| **Purpose** |

An enterocutaneous fistula (ECF) is defined as an abnormal connection between the gastrointestinal tract and the skin. Almost 75% of ECF are secondary to surgery, with other causes including inflammatory bowel disease, trauma, radiation, diverticular pathology and malignancy. ECF carry a high incidence of morbidity including dehydration, electrolyte disturbances, Sepsis and skin excoriation. ([Appendix 5](#_Appendices))

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| **Scope** |

Adult patients with a Small Bowel Enterocutaneous Fistula in the community

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| **Core Requirements/Procedure** |

**Application of a Wound Manager Bag / Stoma Bag**

Using the template of the wound manager bag / stoma bag, flip this over and place over the wound/fistula, then draw around the wound edge

Cut the template out (using curved scissors if possible)

Flip the template back over so that it is the correct way around and place this over the wound manager/ stoma bag (the writing will now be lined up)

Draw onto the wound manager bag and cut out shape required

Prepare the peri-wound skin by applying a barrier film (spray or wipe)

Apply stoma paste to any skin creases to ensure a flat surface

Consider applying a hydrocolloid around the wound margin to enhance the efficiency of the adherence of the bag and further protect the skin

Apply wound manager/ stoma bag and press down for at least 30 seconds, paying attention to the lower end.

If fistula is high output, then consider attaching the bag to a catheter drainage bag as this will prevent the bag pulling on the skin when it’s full.

For Nutrition and Hydration advice liaise with Stoma CNS and Nutrition Nurse

# SOP 8 Treatment of bleeding / problematic granulomas at the mucocutaneous junction of a stoma (urostomy, colostomy, ileostomy) with Silver Nitrate

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| **Purpose** |

Excess granulation tissue can form around the stoma, sometimes as a result of an ill-fitting appliance or in response to a foreign body e.g. sutures. The granuloma is friable and bleeds readily. Silver nitrate is used to cauterise a problematic bleeding point. Treating bleeding granulomas cauterises the bleeding point and makes stoma management easier for the patient. ([Appendix 13](#_Appendices))

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| **Scope** |

Adult patients over 16 years of age presenting with bleeding and / or problematic stomal granulomas at the mucocutaneous junction.

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| **Core Requirements** |

**Caution**

Silver nitrate can cause burns if used incorrectly

Long-term use may cause inflammatory responses or metabolic disturbances

Check for extraneous material e.g. sutures

Medical consultation to identify other causes or factors for consideration is advisable before cauterisation

***Equipment:***

* Clean stoma appliance
* Warm water
* Dry wipes
* Rubbish bag
* Gloves
* Silver nitrate match-sticks
* Barrier cream/ spray
* Water

***Procedure***

Explain the procedure to the patient and prepare the equipment

Apply gloves

Remove soiled stoma appliance: clean and dry stoma site

Identify bleeding points

Care must be taken to avoid contact with the skin – silver nitrate can cause painful burns – apply barrier cream or spray to surrounding skin before applying silver nitrate

Apply silver nitrate to the granulomas to seal the bleeding point:

Wet the end of the stick

Apply to each Granuloma for 5 seconds

The mucosa will turn grey in colour.

Reassure the patient

Ensure the peristomal skin is clean and dry: re-apply appliance

***Post Procedure***

Ensure patient understands that the discolouration is normal, and that normal colour will return over the next 24 – 48 hrs

Arrange a follow-up appointment – treatment should be repeated weekly for 4 weeks.

Large granulomas may not resolve with silver nitrate and may need to be surgically excised

Document procedure on EMIS

***Further Information***

See [Appendix 13](#_Appendices) for guideline.

# References

Association of Stoma Care Nurses (2016) ASCN Stoma Care – National Clinical Guidelines; available at <https://ascnuk.com/_userfiles/pages/files/national_guidelines.pdf>

Dansac (date unknown) A Practical Guide for Stoma Problems; available at <https://www.dansac.com/-/media/files/dansac/dansac-practical-guide.ashx>

# Appendices

| **Appendix** | **Title** | **Document Link** |
| --- | --- | --- |
| 1 | Competency Document for clinical competence to be achieved when caring for an individual with a stoma RGN |  |
| 2 | Competency Document for clinical competence to be achieved when caring for an individual with a stoma SHCA |  |
| 3 | Medicines to Use with Care or Avoided in Stoma Patients |  |
| 4 | Community Stoma Assessment |  |
| 5 | Care Plan for Stoma/ Fistula Bag Change / Stoma Assessment |  |
| 6 | Management of High Output Stomas for Acute and Community patients. | Awaiting verification |
| 7 | Jersey Stoma referral pathway |  |
| 8 | Stoma Accessories formulary |  |
| 9 | Stoma Voucher for Subsidised Product Scheme |  |
| 10 | Nephrostomy tube care and bag change care plan |  |
| 11 | Nephrostomy Troubleshooting Chart |  |
| 12 | Insertion of suppository / enema into colostomy Care Plan |  |
| 13 | Guidelines for standardising the treatment of stomal granulomas at the muco-cutaneous junction |  |