Nursing Care for Patients After Urostomy Surgery

What nurses need to know about urostomy management

ABSTRACT
When an ostomy care nurse is not available, bedside nurses must assume responsibility for providing necessary care and educating patients who undergo a urinary diversion. However, staff nurses often lack the necessary knowledge and experience to provide the best care, rehabilitation, and patient education. This article details pre- and postoperative interventions for nurses who encounter patients undergoing urostomy surgery in order to help eliminate gaps in care, increase nurses' and patients' competence and confidence, and optimize patient outcomes and quality of life. It also includes a tear sheet that nurses can use to provide patients with the basic information and skills they need for effective self-care.

Keywords: ileal conduit, ostomy care, patient education, urinary diversion, urostomy

Urinary diversion is a surgical procedure to reroute the flow of urine from its normal elimination pathway from the body. (For a description of the normal urinary system, see *Normal Urinary System Anatomy and Function*.[1-4]) Diversions are performed to address both malignant conditions (those affecting the urothelial lining of the bladder, for example) and nonmalignant ones.[5] For example, for select high-grade non-muscle-invasive or muscle-invasive bladder cancer, the gold standard treatment is radical cystectomy. In men, this involves removal of the bladder, prostate, and pelvic lymph nodes; in women, this entails removal of the bladder, uterus, fallopian tubes, ovaries, and anterior vagina.[5] As a result, there needs to be a new pathway for urine to exit the body. Nonmalignant indications for a urinary diversion include neurogenic bladder (a neurologic condition that impedes bladder control), radiation cystitis, interstitial cystitis, birth defects, and severe pelvic trauma that injures either the urethra or the urinary sphincter resulting in intractable urinary incontinence.[5] While these conditions may not necessitate removal of the bladder, a urinary diversion will be required for urine to pass from the body.

The most common type of diversion, and a focus of this article, is an ileal conduit or urostomy. This procedure is accomplished through a surgically resected intestinal segment that creates a passageway for elimination of urine from the ureters to an exterior stoma (opening) on the abdomen. An external pouch or ostomy bag is used to collect the urine. In the case of an ileal conduit, the patient does not control the flow of urine into the pouch; hence, it is considered an *incontinent* urinary diversion. By contrast, *continent* urinary diversions, such as an Indiana pouch or orthotopic neobladder, involve the creation of an artificial bladder inside the body and will not be discussed here.

When a certified wound, ostomy, and continence (WOC) nurse is not available, bedside nurses must assume responsibility for providing necessary care and educating patients who undergo ostomy surgery. However, staff nurses often lack the knowledge and experience to provide the best care, rehabilitation, and patient teaching. Patients frequently express frustration that nurses do not know how to care for their ostomy. Bedside nurses often experience frustration when they encounter complications such as persistent leakage. A recent survey found that many nurses believe they did not receive adequate education on skin and wound care.[6] Moreover, about 25% reported not feeling confident in their ability to apply ostomy barriers and pouches in patients with a urinary diversion.[6]

This article details pre- and postoperative interventions for nurses who encounter patients undergoing a urostomy in order to eliminate gaps in care, increase nurses' and patients' competence and confidence, and optimize outcomes and quality of life. It is a follow-

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Normal Urinary System Anatomy and Function[1-4]

The urinary system is composed of the upper urinary tract, consisting of the kidneys, renal pelvis, and ureters (tubes that carry urine from the kidneys to the bladder), and the lower urinary tract, consisting of the bladder, bladder sphincter, urethra, and pelvic floor muscles.[1] Filtration occurs in the upper urinary tract, where up to 200 L of blood are filtered daily through the kidneys, removing approximately 2 L of toxins, waste, and excess water as urine.[2] The ureters facilitate the one-way flow of urine into the bladder, a hollow, muscular organ that stores urine (usually up to 300 to 600 mL).[1] A healthy and functioning urinary system—and the kidneys in particular—is crucial to maintaining homeostasis. This includes fluid, electrolyte, and acid–base balance, as well as regulation of endocrine function via the release of hormones (erythropoietin) that promote the production of red blood cells and regulate blood volume and blood pressure (via the renin–angiotensin–aldosterone system). The kidneys are also central to vitamin D activation to promote the formation of bones and teeth.[1]

Urination involves a complex interplay between the somatic nervous system (there is some voluntary control over urination) and two divisions of the autonomic nervous system: the sympathetic and parasympathetic nervous systems, which regulate involuntary functions. The sympathetic nervous system enables urine retention; specifically, sympathetic activation causes relaxation of the detrusor muscle in the bladder wall (allowing the bladder to expand) and the simultaneous contraction of the sphincter/bladder neck. This makes it possible for urine to be stored in the bladder without leakage. The parasympathetic nervous system enables the actual flow and excretion of urine, causing contraction of the bladder's detrusor muscle and simultaneous relaxation of the sphincter/bladder neck, allowing for bladder emptying.[3,4]

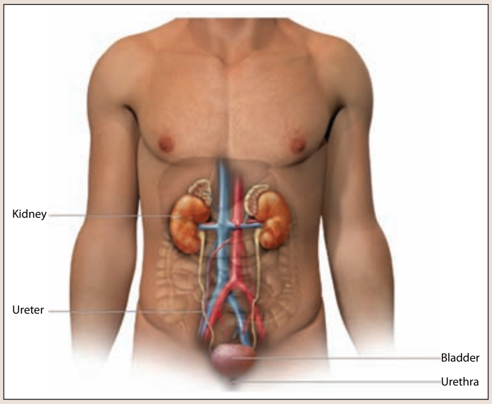

Figure 1. Urinary tract. Image courtesy of Convatec.

up to a previous article in *AJN* by one of us (HHC) on nursing care for patients undergoing ostomy surgery of the bowel.[7]

PREOPERATIVE CONSIDERATIONS

Ideally, patients with planned urostomy surgery should meet with a WOC nurse for preoperative ostomy site marking and teaching. When a WOC nurse is not available, then bedside nurses, if given the opportunity, should be prepared to meet with the patient and family to address their concerns and to provide basic information about the rationale for site marking; the type of surgery they will undergo; and what to expect during the initial postoperative period in terms of diet, activity, and pain management. Nurses should discuss the basics of ostomy care, demonstrating a urostomy pouching system, and provide reassurance to an undoubtedly anxious patient.

Site marking. Preoperative site marking is important for optimal placement of the stoma to reduce skin problems, avoid postoperative complications including leakage of the pouching system, and improve patient self-care and quality of life. Siting is optimally done by a surgeon or trained ostomy nurse during the preoperative period, when surgery is planned.[8] Discussion of this step is beyond the scope of this article, but a description is included in the Wound, Ostomy, and Continence Nurses (WOCN) Society, American Urological Association, and American Society of Colon and Rectal Surgeons position statement on preoperative stoma site marking for patients undergoing ostomy surgery.[8] Nurses can discuss this step with the surgeon if there is opportunity to do so and explain to patients why site marking is important.

Incontinent urinary diversion/ileal conduit surgery. Minimally invasive methods are preferred. With newer robotic cystectomy procedures, there is less blood loss and a quicker recovery than with open surgery. However, based on intraoperative findings, an open resection may be required. Diseased or cancerous bladders are removed, but on rare occasions, the bladder may be left intact and simply bypassed, depending on the reason for the surgery. The most common approach is to use a segment of the ileum. A 12-to-18-cm section of the ileum is excised,[9] avoiding the distal ileum so as not to interfere with absorption of bile salts and vitamin B_{12}, which may lead to fat malabsorption, steatorrhea, and loss of fat-soluble vitamins,[10] and used as a conduit (meaning "channel") for urine. The remaining small intestine is anastomosed to reestablish continuity of the bowel (see Figure 2).

The ureters are disconnected from the bladder and implanted into a proximal portion of the conduit,

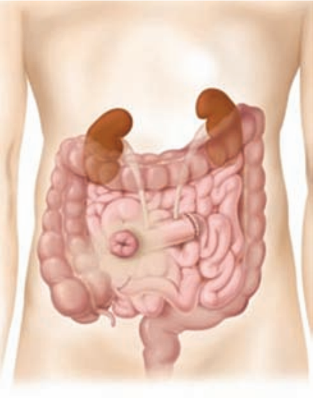

Figure 2. Ileal conduit. Image courtesy of Convatec.

forming a uretero-intestinal anastomosis.[5] The opposite end of the conduit is then brought to the surface of the abdominal wall, and everted to expose the mucosa and form a "rosebud" stoma with ideally a 2-to-3-cm elevation.[9] The bladder is removed.

Patient concerns. Nurses can show support by giving patients an opportunity to express concerns and pose questions. Patients may be anxious about the surgical procedure, possible complications, and receiving anesthetic. They may express concerns about the impact of the surgery, and in particular of the ostomy, on their lives. Nurses should address these concerns while also reassuring patients that following surgery most people are able to resume work, engage in recreation, and enjoy life with family and friends.

POSTOPERATIVE CONSIDERATIONS

Following urostomy surgery, nurses will need to take steps to ensure proper healing, monitor patients' overall health, and promote the resumption of normal activity. Usually, patients remain in the hospital for about four to seven days. By the end of their stay, they should be on a full diet without experiencing any nausea, be urinating and defecating regularly, have returned to their preoperative functional capabilities, have their postoperative pain under control, and be taught to care for their ostomy.

Wound care. If there is an open wound on the abdomen, nurses may perform dressing changes as ordered by the surgeon. A Jackson-Pratt drain may be present to remove any fluids that might collect in the surgical site to prevent abscess formation.

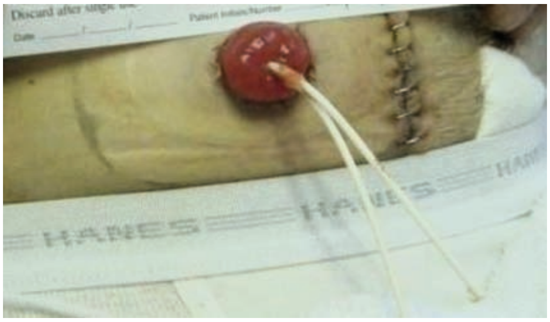

Figure 3. Stents. Photos courtesy of the authors, except where noted.

Nutrition/hydration. Patients may initially require IV fluids for hydration until normal food and fluid intake is established. The Enhanced Recovery After Surgery (ERAS) guidelines support early oral feedings, emphasizing that "normal diet as opposed to parenteral nutrition should be encouraged and reestablished as soon as possible since no evidence supports routine prolonged fasting after cystectomy."[11] First foods may be liquid or a low-fiber/low-residue diet, followed by a regular diet if this is well tolerated.[12] No further dietary modifications are needed apart from those having to do with any food intolerance or food allergy. Unless contraindicated, patients with a urostomy should be encouraged to drink at least eight glasses of fluid per day to prevent kidney infection and dehydration.[13]

Activity. Early mobilization is another key element of the ERAS protocols. Prolonged bed rest increases postoperative complications such as thromboembolism and pulmonary complications such as atelectasis, bronchospasm, pneumonia, and exacerbation of chronic lung disease. Nurses should encourage ambulatory patients to get up and walk as soon as possible following surgery.[11] Physical therapy may be necessary in some cases to help achieve this goal.

Pain management. Properly controlling pain is a key nursing intervention that will not only facilitate early mobilization but also promote recovery and enhance patients' ability to learn to manage stoma care independently.[14] Nurses should routinely assess pain, administer medication as ordered, and report any uncontrolled pain to the physician. Acetaminophen and nonsteroidal antiinflammatory drugs are the preferred treatment options, with opioid analgesia reserved for breakthrough pain because of the risk of side effects (such as an ileus).[15]

Stents. Patients with a urostomy will have urinary stents in the stoma postoperatively to maintain patency and allow the ureteral/conduit anastomosis to heal (see Figure 3). The length of time that stents remain in place depends on patient factors and the surgeon's preference,[16] but is usually no longer than seven to 10 days.

Appearance. A stoma should be red and moist and will be edematous after surgery, and ideally will protrude 2 to 3 cm. Mucus is common on the stoma because the small intestine was used to create the stoma, and patients can be reassured that this is normal. The ideal stoma has the os (opening) in the center and above skin level. The size of the stoma will shrink over time, reaching its permanent size at around six weeks. If the stoma appears dark red to purple or if dark nonvascular tissue is present, there may be a blood flow problem that could result in further tissue deterioration and necrosis.[16] The surgical team should be consulted immediately.

Intake and output. It is important to document urinary output following cystectomy surgery to confirm adequate urine excretion, assess kidney func-

Urostomy Care for Patients: A Step-by-Step Guide

General Urostomy Tips

- Empty your pouch into the toilet regularly, and do not let it get more than about one-third full.
- Change your entire ostomy system every three to seven days. If you cannot keep a good seal for at least three days, you may need a different system or a different changing technique.
- For the first six to eight weeks after surgery, measure your stoma with each pouch change to ensure you are correctly cutting/shaping the opening of the stoma hole of the skin barrier. After that time, periodically measure your stoma to make sure the size remains correct.
- The best time to change your pouch system is usually first thing in the morning, when you have had the least to eat and drink, and urinary flow is less.
- Keep your equipment well organized in one spot and have everything ready before removing the old skin barrier (also known as a wafer) and pouch.
- Always keep a bag or kit of supplies with you in case you need to change your system away from home.
- Prescriptions are necessary for insurance to cover your supplies. Some pharmacies stock or can order supplies, or you can order supplies online from mail-order companies.
- It's fine to get in the shower with the pouching system on, and gently towel it dry afterward. It is also fine to shower without the pouch on, especially on days you will be changing the system anyway. Have everything ready when you get out of the shower.
- At nighttime, you may want to connect to a nighttime drainage system, using a connector piece that is in your box of pouches. The nighttime drainage system should be rinsed after use and cleaned every other day or so with one part white vinegar to three parts water.
- When traveling, keep a small travel kit stocked with ostomy supplies, and take at least twice the supplies you normally need. When flying, be sure to stow the kit in carry-on luggage.

Diet.

- Usually there are no ostomy-related dietary restrictions, and foods can be enjoyed as before. It is important, however, that you drink fluids to prevent urinary tract infections and dehydration.

Swimming and water activities.

- Swimming with a secure pouch is fine, but before swimming empty the pouch and perhaps secure it in place with waterproof tape to create a "picture frame." Women may find that tankinis work best as they make it easier to empty the pouch.

Intimacy and sexuality.

- Ostomy surgery should not negatively affect a close and loving relationship. It is normal to feel self-conscious and sensitive about your body image. Share your concerns with your partner and discuss them with your doctor. The United Ostomy Associations of America (www.ostomy.org) is a good source of information on sexuality and intimacy. A few tips include having a clean, secure, and empty pouching system for sexual activity. However, research shows that many people with urostomies experience sexual dysfunction. Men can develop erectile dysfunction, retrograde ejaculation, and loss of libido, while women can experience loss of desire, pain during intercourse, and vaginal dryness. Please acknowledge your feelings, including depression, and seek psychological or medical help as needed.

Changing the Ostomy System

Step 1: Old pouch and skin barrier removal.

- Empty the ostomy pouch before removal. Wash your hands.
- Place a towel on your abdomen underneath the pouch.
- To prevent tearing the skin, use a warm washcloth or an adhesive-remover wipe. Gently pull on the skin barrier with one hand, working it loose from top to bottom as you push against and support the skin with the other hand.

- Wash the skin with warm water only, and pat dry. There is no need to use soap.
- Using a mirror, examine the skin and the stoma all around. Minor redness is normal, as is mild bleeding from the surface of the stoma.
- If there is open weeping skin irritation, treat it with a light dusting of stoma powder, and seal it with a no-sting skin barrier wipe.

Step 2: Preparing the skin barrier (or wafer)—the part of the ostomy system that sticks to your abdomen.

- If using a one- or two-piece cut-to-fit skin barrier: Measure the stoma using the stoma measuring guide, which is usually provided in the box of ostomy products. The guide should sit at the base of the stoma, with at most one-eighth of an inch of skin around the stoma showing.
  - Using this measurement, draw the correct size hole on the skin barrier.
  - Cut the stoma hole of the skin barrier, placing it around your stoma to make sure you have the right size. It should sit directly around the stoma, with no more than one-eighth of an inch of skin showing. Make any needed adjustments.
- If using a moldable skin barrier (one that has a center that you mold, rather than cut, to the size of the stoma), place your thumbs at the center of the starter hole and begin to roll the adhesive back on itself to fit the size of the stoma. Hold the molded skin barrier up to the stoma to ensure you have the best size.

Step 3: Applying the ostomy system.

- For a one-piece system:
  - Prepare the skin barrier (wafer) as described in Step 2.
  - Remove the protective plastic shield from the back of the skin barrier, leaving the outer release tape intact.
  - Make sure the skin is clean and dry.
  - Stretching the skin around the stoma, center the skin barrier opening around the stoma, ensuring a snug fit.
  - Press gently on the inner part of the skin barrier for a minute or two, letting the warmth of your hand help it to stick.
  - Now remove the outer papers, one section at a time, while stretching the skin. Press the outer section of the skin barrier down on the skin from the center outward.
- For a two-piece system:
  - Prepare the skin barrier (wafer) as described in Step 2.
  - If your pouch is transparent, you can either connect it prior to applying the skin barrier to your abdomen or snap it on after placing the skin barrier. Either way, make sure the pouch is completely on and snugly applied.
  - Make sure the skin is clean and dry.
  - Remove the inner release paper, leaving the outer release tape intact (if your skin barrier has outer release tape).
  - Stretching the skin around the stoma, center the hole around the stoma, ensuring a snug fit. Now remove the outer papers.
  - Press gently on the inner part of the skin barrier for a minute or two, letting the warmth of your hand help it to stick.
  - If you have not already applied/snapped on the pouch to the skin barrier, do so at this point. Be sure it is completely applied by pulling on the pouch all the way around while visually checking it for separation.

Step 4: Finish up.

- Close the closure device on the end of the pouch as directed or attach to a nighttime drainage system.

tion, and detect anastomotic leaks. Normal urinary output is defined as 800 to 1200 mL per day.[17] For optimal monitoring, the ostomy pouch is usually connected to a bedside drainage bag during hospitalization. Patients should be taught to disconnect from and reconnect to this bag, because they will likely be using a drainage unit during the night after discharge.

Education. Ostomy teaching should be initiated as soon as possible and involve not only the patient but also the family or caretaker, if present. Nurses should begin by encouraging patients to empty their own pouch, and then progress to teaching them how to change the pouch.

POSTOPERATIVE COMPLICATIONS

Nurses should be aware of the following possible early complications, which should be reported to the surgical team as soon as possible.

Mucocutaneous separation, which is detachment of the stoma from the peristomal skin, can be partial or complete (that is, circumferential around the stoma). Separation may be the result of excessive bowel tension during surgery.[18] It may also be caused by poor healing, which is more common in patients with malnutrition or a history of steroid use. Treatment will depend on the degree of severity, but in minor cases, the separation can be filled with a stoma powder, hydrofiber, or a calcium alginate, and covered with a hydrocolloid-type dressing.[18]

Stomal necrosis, which occurs when there is a loss of blood flow to the stoma, initially presents as a dark red to purple discoloration of the stoma, potentially progressing to entire loss of the stoma.[16] The surgical team must be notified immediately.

Stoma retraction is the "disappearance" of stoma tissue protrusion in line with or below skin level.[18] There are many causes for retraction, including obesity, as large abdominal adipose layers may make it difficult to mobilize the bowel during surgery. Treatment is usually conservative and may involve the application of a convex ostomy system to raise the stoma above skin level. Severe retraction cases may need surgical revision.

Excessive bleeding. Patients should receive reassurance that small amounts of bleeding from the surface of the stoma during changing and washing is normal. However, frank red blood from inside the stoma should be reported.[12]

Other postoperative concerns include uncontrolled pain, nausea, abdominal distention, and developing signs of depression.

LIFESTYLE CONSIDERATIONS AND QUALITY OF LIFE

Ostomy surgery can exact a physical, emotional, and mental toll on patients. Patients may fear ostomy-related events that cause embarrassment. Nurses can reassure patients that the vast majority of people with urostomy surgery go on to lead active and healthy lives. When cleared by their health care providers, patients can resume their normal preoperative routines, including work, aerobic activities like dancing and swimming, and travel. They can attend places of worship, enjoy family relationships, and continue sexual intimacy.[19]

In a small 2014 study of patients with urothelial cancer managed by radical cystectomy, 95% of patients ranked overall quality of life as "good."[20] The authors concluded that urostomy remains a viable treatment option for bladder cancer and allows an acceptable health-related quality of life. A systematic review published in 2023 concluded that nurse-led interventions for patients with urostomy, such as those detailed in this article, can improve self-efficacy and health-related quality of life.[21]

However, another recent systematic review concluded that depressive symptoms are present in nearly half of patients who underwent stoma surgery, which is higher than in the general population.[22] This occurred mostly at a level of clinical severity below major depressive disorder. The authors noted that "stoma patient outcomes and postoperative psychosocial adjustment may be enhanced by increased psychological evaluation and care in the perioperative period."[22] These findings underscore the crucial importance of perioperative nursing care and support, and of monitoring patients for signs of depression.

SUPPLIES

Hospitals should have ostomy supplies on hand and available for patients. These include a variety of ostomy systems and accessory items.

Pouching systems. There are several types of pouching systems, among them one- and two-piece ostomy systems. Facilities should stock a few different kinds to accommodate patient preference and need.[23] Both systems include a pouch and a skin barrier (also known as a wafer) that adheres to the skin around the stoma, protecting the skin from urine. One-piece systems (see Figure 4) combine the pouch and skin barrier, show less under clothing,

Figure 4. One-piece pouching system.

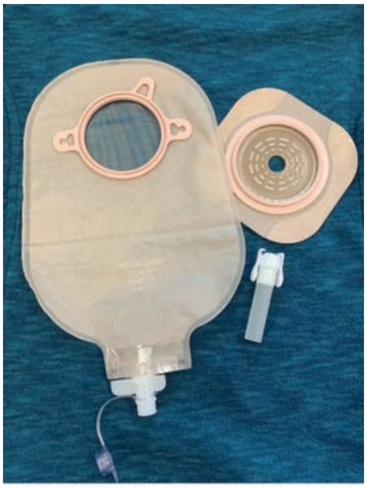

Figure 5. Two-piece pouching system.

and are simple to use (customize the size of the stoma opening, then peel and stick). Two-piece systems (see Figure 5) are composed of a skin barrier and a separate pouch that must be connected to the skin barrier either before or after application to the abdomen. This makes it possible to replace the pouch while the skin barrier remains in place, if desired. The two-piece system also makes it easier to center the skin barrier around the stoma before the pouch is in place.[24]

Options of skin barriers include cut-to-fit, precut round, and moldable/stretch-to-fit barriers. For the cut-to-fit type, the center opening of the barrier should be cut one-eighth of an inch larger than the stoma using a stoma measuring guide. For moldable or other options, it is important to follow the manufacturer's directions.

For difficult stomas, there should be an option of a pouching system with convex features. Companies now offer moldable or cut-to-fit convex systems that can be customized for different stoma sizes. If a patient needs an item that is not available at the hospital, reasonable efforts should be made to procure it. Nurses should also remind patients with established ostomies that it is fine for them to bring in their own ostomy supplies to best suit their needs while hospitalized.

Accessory items. There are many accessory items on the market, and facilities cannot stock them all. At a minimum, facilities should have skin barrier rings and stoma powder available for patients with a urostomy. Skin barrier rings are hydrocolloid-type "washers" that can be used to enhance the seal around the stoma by leveling out uneven contours while providing an additional solid skin barrier.[24] They are often necessary when a stoma has minimal height, if the stoma opening is not ideally centered or is at skin level, or if there are creases or folds in the peristomal field. Barrier rings can be applied directly to the skin around the stoma or to the back of the skin barrier at the edge next to the stoma (see Figure 6). Stoma powder is an absorbent powder to be used when there is denuded peristomal skin. It should be lightly dusted onto the irritated skin and sealed with a no-sting skin barrier wipe. This is known as "crusting" and creates a dry surface to improve adhesion of the skin barrier.[25]

PATIENT TEACHING AND INFORMATION

Nurses can refer to the tear sheet, *Urostomy Care for Patients: A Step-by-Step Guide*, and let it guide their teaching and pouch application. They should also give patients a copy for home use. The tear sheet includes all the information new patients with a urostomy need, as well as detailed instructions nurses can follow. In general, before discharge, patients should be taught how to empty the pouch, how to connect it to a nighttime drainage bag, and how to change it. Nurses can also take advantage of patient teaching materials available from the United Ostomy Associations of America (UOAA) and from ostomy supply manufacturers (see Table 1[7]). In addition, manufacturers provide a "starter service" that includes an ostomy kit and postdischarge telephone counseling for patients with ostomy care nurses and other ostomy specialists (see Table 2[7]). Patient education is an essential part of enhancing patients' self-care abilities to cope and manage the stoma.

DISCHARGE

Patients should be sent home with at least five pouching systems and accessory items such as barrier rings. Nurses should make sure that patients are provided with a list of all the supplies they are given, along with the respective manufacturer's name and order number. Case managers should ensure that if a patient is going home and agrees, a referral has been made to home care services, preferably one with a certified ostomy specialist. To qualify for insurance coverage and supplies reimbursement, patients should have the necessary prescriptions. However, ostomy supplies can also be purchased without prescriptions from any durable medical equipment provider or from online sources. There are ostomy supply mail-order companies that deliver directly to a patient's home and provide ostomy support. Often, these companies will even contact the patient's physician to obtain the necessary prescriptions. Patients should be prepared to provide all the necessary information

Figure 6. Barrier ring.

Table 1. Ostomy Resources for Information and Support

Organizations	Services	Website/Contact
United Ostomy Associations of America	A nonprofit organization providing free teaching materials and a listing of support groups	www.ostomy.org (800) 826-0826
Wound, Ostomy, and Continence Nurses Society	A professional society of specially trained ostomy care nurses. Click on Patient Resources for free access to publications, services, websites, and ostomy care nurse referrals.	www.wocn.org (888) 224-9626
American Cancer Society	Information, research, support groups	www.cancer.org (800) 227-2345
Nurses Specialized in Wound, Ostomy and Continence Canada	Patient information	www.nswoc.ca (877) 614-1262 (Wound, Ostomy and Continence Institute Administrative Office)

Adapted from Cross HH.[7]

Table 2. Ostomy Supplies and Resources

Manufacturer	Website	Contact
Convatec	www.convatec.com/ostomy[a]	(800) 422-8811
Hollister, Inc.	www.hollister.com[b]	(888) 808-7456
Coloplast	www.coloplast.us	(888) 726-7872, ostomy, bladder, bowel
Nu-Hope Laboratories, Inc.	www.nu-hope.com	(800) 899-5017
Cymed	www.cymedostomy.com	(800) 582-0707

[a] See dropdown language menu for Spanish educational materials.
[b] See dropdown language menu for multilingual educational materials.
Adapted from Cross HH.[7]

when calling these companies, such as the exact list of supplies needed and the physician's contact information.

Insurance coverage and copays for supplies will vary depending on the insurance plan and policy type. Medicare Part B covers most of the costs of ostomy supplies once the deductible is met; however, it requires a prescription for the supplies and sets a limit for the type and number of supplies that are reimbursable. For uninsured patients, some manufacturers operate programs to provide free or low-cost supplies. The UOAA has a list of affiliated support groups, some of which may donate supplies.

Patients should be encouraged to contact an ostomy support group if one is available. The UOAA has local listings. Participation in such a group has been shown to decrease hospital readmissions and ED visits[26] and positively impacts a person's ability to independently adjust to and manage stoma care.[27, 28]

With appropriate support, encouragement, and education, patients undergoing urostomy can successfully transition to their new life with an ostomy with minimal trauma and disruption and be able to continue most, if not all, of the activities they pursued previously. Ideally, trained ostomy professionals such as WOC nurses should be involved to perform both preoperative and postoperative care, teaching, and follow-up, but this is not always possible. It is critical that staff nurses have the necessary preparation to step in and fill this role to ensure the best possible outcomes and quality of life for new ostomy patients.

For 225 additional nursing continuing professional development activities on medical–surgical topics, go to www.nursingcenter.com/ce.

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