President’s Message

Wanda Rose PhD, RN, BC

I just returned from the American Nurses Association’s 2008 House of Delegates which met in Washington, D.C. June 25–27, 2008 at the Washington Hilton & Towers Hotel. It was a privilege to be able to represent North Dakota with three other delegates; Karen Macdonald, Moffit; Cynthia Braseth, Grand Forks; and Deb Swanson, Grand Forks. It was very stimulating to be part of the decision making process of our professional organization.

As the business of the HOD progressed the theme “Being flexible and harmonious” emerged. This included ANA developing better relationships with the CMAs. President Patton expressed the need for ANA to recognize the needs of the CMAs and how we can work together to be a strong voice for nurses and the patients we care for. Multiple amendments to the ANA bylaws created more flexibility for CMAs and for the CMAs to be harmonious with ANA bylaws. I will briefly summarize a few of the bylaw changes that I believe impact NDNA.

A major bylaw change occurred when the HOD delegates voted to delete Section 2 of Article II Associate Organization Members, which removed Associate Organizational Members (AOM) from the bylaws. The removal of the United American Nurses (UAN) and the Center for Nurses (Center) from the ANA bylaws occurred because the UAN the Center and ANA are separately incorporated entities; therefore there is no need to reference them in the bylaws. ANA also recognized the CMAs would be better served if the relationships between the CMAs and the UAN and/or the Center were made directly by the state associations. This means each CMA will decide if they wish to develop a relationship/contract with the UAN or the Center. North Dakota has been a member of the Center and a decision will need to be made by NDNA to determine if we continue to have a relationship with the Center.

Another bylaw change included the ability to create a multi-state nurses association that is recognized as a CMA and is entitled to a minimum of three delegates for each state or territory of the multi-state or territory. This bylaw change will allow states to join together to support their vision, but will allow with each state to have a voice at the HOD with a minimum of three delegates.

The HOD also recognized the outstanding leadership of new nursing graduates and amended the bylaws to reserve one of the director-at-large seats for a recent graduate of a RN licensure program. I believe this is a move forward in recognizing what our new graduates have to offer the nursing profession. Is there a place for new graduates in NDNA?

To be more harmonious and to provide greater flexibility to the CMAs the HOD amended the bylaws to allow CMAs to have bylaws that are harmonious with the ANA bylaws on matters that are not a matter of absolute compliance for maintenance of membership within the ANA. This allows CMAs greater flexibility regarding rights afforded members. This change will allow NDNA more flexibility in associate membership status for groups of RNs. It also allows for flexibility when purposing bylaw amendments that will address organizational structure change. These bylaw changes provide a framework for NDNA to move forward in organizational change.

I believe NDNA can move forward in a harmonious manner when going through our organizational structure change that will allow for more flexibility. Its been said that the best way to predict the future is to invent it. NDNA must take control of changing times by strategically transforming the organization, shaping how it will look and perform in the future. One of the key challenges will be ensuring the NDNA structure is appropriate to its current and future strategic needs. It is imperative that NDNA is flexible, not only to adapt to environmental changes, but to support organizational learning and innovation. The proposed NDNA organizational structure change provides for more flexibility in these changing times. NDNA needs to enhance our relationships, between individual members but also with external partners. The linkage with external organizations through strategic partnering or alliances is something NDNA must consider to extend the Voice of Nursing.

I invite members to join the bylaws committee on July 22, 2008 via BTWAN to review bylaw amendment proposals. Check the NDNA website calendar for July for details.

Flexible and Harmonious
Member registration is now completed at the ANA website. See the link below. https://nursingworld.org/memapp/index.cfm?fuseaction=renew&onelogin=y or call 1-800-284-2378 (direct to member services).

ANA now manages membership services. Paper registration does not occur through NDNA any longer due to the switch over to ANA. Members will receive notices for renewal from ANA.

Writing for Publication in the Prairie Rose

The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to becky@ndna.org. Please write Prairie Rose article in the address line.

Articles submitted for continuing education need a purpose, objectives, and a post-test. You may request the necessary contact hour forms from Becky at becky@ndna.org.

Articles are peer reviewed and edited by the staff and RN volunteers at NDNA.

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don't know how or where to start, contact the office at NDNA: 701-223-1385.

The Prairie Rose is one communication vehicle for nurses in North Dakota.
Membership in a Professional Association

Becky Graner MS, RN
Executive Director, NDNA

The importance of membership in a professional association is usually not the first topic nurses think of when discussing professional practice issues. The reality is our present state of practice, research and education is due in large part to the environment of collaboration created by professional associations.

What is the work of a professional nursing association? Three major categories emerge: professional development, growing/advancing the profession, and policy and advocacy. Let’s look at these categories more closely.

Professional development includes competency and leadership development through education, credentialing and socialization. Growing the profession includes dedication to research, establishing standards of practice, and dissemination of research findings. Advocacy and policy development include establishing government relations, legislative advocacy, and promoting a healthy, productive, and safe work environment. Now you may ask; how does membership in a professional association accomplish this?

Huston (2006) writes nurses value membership because “it conveys professional status, a willingness to uphold the standards of the profession and a vested interest in the issues and concerns the professional association takes on for benefit of the members” (p. 467). Associations are created by the membership. Opportunities abound for leadership development, for collaboration across practice arenas in the form of task force work, and for development and growth of the profession by having a voice in practice standards, competency definition and policy development. Membership allows nurses from all disciplines to come together to synthesize the knowledge and skills of various specialties; it creates a force to be reckoned with!

Research done by five specialty nursing associations found nurses identified the following three (3) main reasons for not joining a professional association: family responsibilities, lack of time to participate, and lack of information about the association (White & Olson, 2004). Other findings indicate the typical age of association members is the 40-60 year old age group. This falls in line with the White and Olson findings, where younger members find it difficult to participate in the traditional manner, such as attending meetings, holding office, or participating in committees and councils. Unfortunately, by choosing to wait to participate until family responsibilities are less pressing, many nurses miss out in making their voices heard when it comes to practice and policy development. Traditionally, the younger age group is the predominant age group that provides the hands on care to patients; it is your voice that is missing.

With these issues in mind the North Dakota Nurses Association met last summer and began the work of re-structuring the present association into one that embraced the concept of inclusion, flexibility and communication.

Progress to date finds us at the following location in the journey. The association leadership has met and determined with membership input to organize in a manner that allows anyone interested in participating in association activities to be included. Proposed rule changes include removal of the “X years as member” before one can serve in a leadership position. Flexibility has been built in to allow for busy members to participate as able. A website has been created that fosters communication and allows all to access events, news, and continuing education activities. In keeping with the vision “North Dakota Nurses Association, a professional association for Nurses, is the voice of Nursing in North Dakota,” it became apparent the association needed to be a vehicle where all nurses could create the future of nursing in collaboration with other well established professional nursing association. A key service is open communication, so the NDNA website was built to provide full access to information and provide a method for others to communicate/announce events and news items. NDNA invites you to take a look at the new website www.ndna.org.

The councils (research, practice, and education) now include administration as these are the four (4) major domains of practice. And instead of each council working alone, it is a goal that all will communicate and produce integrated work under one of the Vice-Presidents of the NDNA Board of Directors. Topics addressed in the past include: work place safety, fatigue, health literacy, stress, and staffing. It was recognized nurses do not function in isolation; every nurse needs to know about practice to be able to do research, education, and administration. Every nurse needs to know about education to be able to practice, research, and be an administrator. Every nurse needs to know about administration to practice, educate, and research. And every nurse needs to know about research to practice, educate, and be an administrator. It is by not knowing the diverse roles and responsibilities of all nurses that we separate ourselves, which ultimately diminishes our power.

It is important to support the activities of a professional nursing association so those who can and want to participate in professional development, growing/advancing the profession, and policy/advocacy work are able to do so and have the resources to create an environment where opportunities for leadership/professional development abound. Members of the nursing profession need to financially support association activities to ensure nurses in every practice arena are equipped to practice, educate, and research.

Traditionally, the younger age group is the predominant age group that provides the hands on care to patients; it is your voice that is missing. Unfortunately, by choosing to wait to participate until family responsibilities are less pressing, many nurses miss out in making their voices heard when it comes to practice and policy development. And every nurse needs to know about policy that affects the profession. Every nurse who can and wants to participate in association activities is encouraged to do so. With these issues in mind the North Dakota Nurses Association met last summer and began the work of re-structuring the present association into one that embraced the concept of inclusion, flexibility and communication.

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The Nightingale Tribute

The Nightingale Tribute Project is a tribute to any Registered Nurse or Licensed Practical Nurse for their years of service, to be given during the nurse’s funeral by a nurse colleague or friend. The original work for the Nightingale Tribute Project was designed and developed by the Kansas State Nurses Association in 2003. The poem “She Was There” was written by Duane Jaeger, RN, MSN.

The North Dakota Nurses Association would like to keep this tribute alive. In an effort to gather and record names of nurses who have passed away, we ask anyone who knows, reads, or happens to see an obituary or attends a service of a colleague to collect, clip and send this info to NDNA. Newspaper clippings memorials, etc. are of a colleague to collect, clip and send this info to NDNA. Newspaper clippings memorializing a colleague to collect, clip and send this info to NDNA at 531 Airport Rd., Suite D, Bismarck, ND 58504.

Nursing Contact Hour Offerings

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. Nurses in North Dakota need 12 contact hours every two (2) years to meet license renewal requirements. The North Dakota Nurses Association offers nursing continuing education activities that provide contact hours in each issue of the Prairie Rose. Members can complete these activities and submit the form found with each offering to the state office of the North Dakota Nurses Association to receive the contact hour(s). Additional offerings can be found at the NDNA website (www.ndna.org). Click on members and near the bottom of the page you will find articles from previous Prairie Rose editions as well as special offerings.

NDNA understands the issues related to being a nurse in a rural state with the added difficulties some nurses encounter such as being unable to be away from work and the expense of travel and lodging. It is NDNA’s intent to provide at least six (6) contact hours per year to assist nurses in North Dakota in accumulating contact hours needed for license renewal. For members of NDNA these contact hours translate into half the price of membership over a year’s time. Along with the contact offerings available at the state level, ANA also offers free contact hours to members through the member’s only area on the ANA website. NDNA members essentially get their entire membership fee back each year in free contact hour offerings! Every year, nurses in North Dakota could receive all the necessary contact hours needed for their license renewal through NDNA and ANA. NDNA strongly encourages members to take advantage of this valuable membership benefit!

NDNA is always seeking authors for future offerings. Topics related to specific clinical practice issues will be given priority. If you would like to write an article please contact becky@ndna.org. Staff is willing to work with potential authors to complete a publishable manuscript.

CNE-Net Update

The Refresher offerings are now completely electronic. All course materials are available through the website or as email attachments. Course participants are those seeking re-licensure in North Dakota and other states.

Courses are available for Nurses and Practical Nurses who previously held a valid license or in some states by those seeking a course to assist in preparation for licensing exams. The courses consist of theory (100 hours) and practice (60 hours).

To learn about our courses and to obtain all admission forms or learn about pre-requisites see the NDNA website (www.ndna.org) click on CNE-Net, at the bottom of the page click on Refresher. You will be asked to fill out a brief form, mark which course you would like to learn more about, and you will be given access to downloadable forms. Call us if you have any questions after you read through the frequently asked questions section. 701-223-1385. Hundreds of Nurses and Practical Nurses across the United States have achieved re-licensure after completing our course. If you or anyone you know is seeking to re-activate a nursing license, please have them contact us.

If your facility or your group plans to offer nursing continuing education the contact hour application forms are available on the website, please email us if you need any other forms, we have them available in both Word and PDF formats. Please remember to have applications in at least 4-6 weeks before the offering.

Contact hour offerings continue to be available on the NDNA website under the Member section. You may read the article, complete the post test, if you are a member the offering is free, non-members pay just $20. Offerings are also available in the Prairie Rose.

May 2008 NDNA Nurse Hero Award

Two nurses from Bismarck, ND were honored for their acts of heroism and kindness when they found themselves in situations where their knowledge and skills in nursing were used outside of their work place. Cheryl Page responded to a call for help for a downed baseball player at a local park. When it became apparent he was non-responsive, she administered CPR and assisted until she was airlifted to a regional trauma center. Chris Martin arrived. The gentleman and his family attended the awards ceremony at the Bismarck Heritage Center. Chris and his wife were traveling in South Dakota and came upon a single vehicle accident. Sadly, the driver of the car was gravely injured. A quick inspection at the site by Chris and other drivers did not at first indicate there were other passengers. Upon closer review, it was noted a nurse was among the items thrown from the car. A second passenger was located a distance from the car in very serious condition. Chris administered first aid while others called for help. He stayed and assisted until she was airlifted to a regional trauma center. Chris said she will be with him forever as she stopped her loading into the helicopter to say “thank you for helping me,” she later died at the hospital.

Cheryl Page; NDNA President, Wanda Rose; Chris Martin
12th Annual Pharmacology Seminar
Registration Form

Name
Address
City/ state/zip
Email (must provide)
Registration will not be accepted without email
Phone
Credentials
Employer
NDNA Member
Registration $200
Nonmember $270
Late fee $30
(after September 29, 2008)
Cancellation policy
No cancellations accepted after September 29, 2008
A $50 administrative fee will be assessed for each cancellation.
*Printing $100
Check payable to: NDNA
531 Airport Rd, Suite D
Bismarck, ND 58504
Credit Card
Type: VISA/ MC
Number:
Name on Card:
Expiration date:
TOTAL:
LIMITED ON-SITE REGISTRATION ACCEPTED
No handouts will be available with on-site registration.

“NDNA supports “going green.” You will receive handouts prior to seminar via email attachment. You must provide a working email to receive these documents. If you want handouts available on paper a $100 fee will be assessed. Handouts will not be available the day of the seminar.

Lunch will be on your own, breakfast & snacks will be provided.
10.0 contact hours
NDNA reserves the right to cancel this seminar.

See www.ndna.org for full seminar details.
10.0 contact hours

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
Silver Spring—More than 600 elected registered nurse delegates to the American Nurses Association (ANA) passed several proposals designed to improve nurse retention rates while simultaneously advancing the public's health at its House of Delegates meeting held in Washington, D.C.

With one half of all new graduate nurses leaving their first professional assignment in less than one year, delegates resolved to support the successful integration of new nurses into the work environment, including residency programs, and to support nursing research efforts that demonstrate effective plans for successful integration of new nurses into the work environment.

“Retention of nurses is a vital element in combating the critical nursing shortage. Nurse residency programs that provide a structured, mentored environment will help new nurse graduates progress from beginners to competent nurses. At a time when the nursing shortage threatens to impact the quality of patient care, we owe it to the nursing profession, and the public we serve to work toward the successful integration of newly graduated nurses into the work environment as well as improving the working conditions for experienced nurses,” said ANA President Rebecca M. Patton, MSN, RN, CNOR.

ANA members also resolved to increase awareness and education among nurses about the effects of intimate partner violence on the health, safety and welfare of families, children and communities, and advocate for the use of evidence-based clinical guidelines in caring and treating victims of violence. ANA endorses the use of routine, universal and culturally sensitive intimate partner violence screening tools and protocols in all nursing specialties and settings.

Additionally, ANA delegates passed the following measures, many of which could have significant impact on public health:

- Delegates approved a resolution that recognizes the impact global climate change has on the health of the world's population and encourages nurses to advocate for change on both individual and policy levels. The measure calls on ANA to incorporate global climate change into its legislative agenda, and support public policies that endorse sustainable energy sources and reduce greenhouse gases.
- ANA also resolved to advocate for research to identify real or perceived gaps and barriers to health care for veterans and their families.
- Recognizing concerns over the adverse affects linked to food additives and contaminants, ANA has resolved to work collectively with CMAs, affiliates and health care organizations to eliminate purchasing milk and dairy products for use in the health care industry that contain hormones.
- ANA resolved to recognize the impact human trafficking has on the public health and the profession of nursing, and to advocate for and seek opportunities to ensure nurses have the skill sets to properly identify and refer victims of human trafficking. ANA has also resolved to advocate and support legislation that further enhances protection and prosecution in an effort to decrease the incidence of human trafficking.
- ANA, one of the original supporters for the establishment of the nation's Social Security program, resolved to work with Congress and the President to strengthen Social Security and extend its solvency beyond 2042.
- ANA resolved to advocate for the expansion of Medicare from the traditional “medical model” to include a focus on prevention, wellness and primary care services.
- ANA resolved to advocate and promote legislative and educational activities that support advanced degrees in nursing.
- ANA resolved to advocate and promote legislation that increases access to oral health care for older adults and support efforts to raise awareness of the importance of oral health and preventive care for older adults.
- ANA resolved to begin a dialogue with the American Red Cross over the elimination of its Chief Nurse Officer position, and to urge the Red Cross to re-instate a Chief Nurse Officer position at its national headquarters.
ANA delegates elect officers, board members and other leaders at House of Delegates meeting

SILVER SPRING, MD—Delegates of the American Nurses Association (ANA) elected Rebecca M. Patton, MSN, RN, CNOR, of Lakewood, OH, to serve a second consecutive two-year term as president of the nation's leading professional nursing organization representing the major health policy, practice and workplace issues of registered nurses (RNs) in the United States. A slate of 30 candidates vied for various leadership positions during ANA's 2008 elections. Patton and other nurse leaders were elected during the ANA Biennial House of Delegates meeting, June 25-27, in Washington, DC.

A nurse since 1980, Patton has extensive inpatient and outpatient experience and has been responsible for the start up, and ongoing operations of ambulatory surgical centers, and of an inpatient acute and a skilled nursing facility. Currently, Patton is on leave from her position as the director of Perioperative Services for EMH Regional Healthcare System in Elyria, OH. Previously, she has served as director of Nursing, director of Surgical Services and director of Ambulatory Operations for hospitals in the University Hospitals Health System.

Patton has a Bachelors of Science in nursing from Kent State University and a Masters of Nursing from Case Western Reserve University. She has held numerous ANA positions including treasurer (1998-2002), Board of Directors member (1994-1998), and delegate to the ANA House of Delegates (2003-2005). In addition she has served in several Ohio Nurses Association (ONA) positions, including ONA first vice president (1990-1992), ONA delegate (2005-2006), ONA finance committee member (2003-2005,) and on an Association of PeriOperative Registered Nurses task force on competencies (1999-2000.)

Elected to serve two-year terms as officers of the board were Debbie Hatmaker, PhD, RN, SANE-A, chief programs officer, Georgia Nurses Association, who was elected first vice president; Colene “Kim” Armstrong, RNC, BSN, staff nurse, Tacoma General Hospital, who was elected second vice president; Susan Foley Pierce, PhD, RN, acting dean at the University of North Carolina Wilmington, who was elected secretary; and Marilyn Sullivan, RN, DSN, LNC, CPE, staff nurse, Northshore Regional Medical Center, Slidell, LA, who was elected treasurer.

The director-at-large board members elected include Florence Jones-Clarke, MS, RN, clinical instructor, Virginia State University; Karen Daley, MS, MPH, RN, FAAN, PhD candidate, Boston College; Carrie Houser James, MSN, RN, CAN,BC, CCE, health educator, Brooks Health Center at South Carolina State University.

The director-at-large staff nurse members include Linda Gural, RN, CCRN, staff nurse/intensive care unit, Community Medical Center, Toms River, NJ; and Julie Shuff, RN, CCRN, staff nurse, Bay Area Hospital, Coos Bay, OR.

The five nurses elected to the Congress of Nursing Practice and Economics include Merilyn Douglass, APRN-C, ADM, family nurse practitioner, St. Catherine Hospital, Garden City, KS; Sara McCumber, RN, CNP, CNS, nurse practitioner/care coordinator, Duluth Clinic-Elder Care, Duluth, GA; Mary Callan, MS, RN, FNP, BC, family nurse practitioner, Highland Family Medicine, Rochester, NY; Thomas Stenvig, PhD, MPH, RN, CNAA,BC associate professor, South Dakota State University College of Nursing, Brookings, SD; and Linda Olson, PHD, RN, CNAA,BC dean and professor of nursing, North Park University, Chicago, IL.

Four nurses were elected to the Nominating Committee: Ernest Grant, MSN, RN, nursing education clinician—burn outreach, UNC HealthCare, Chapel Hill, NC; Alice Wyatt, MSN, APRN-BC, nurse practitioner, Kulbersh Women's Center, Columbia, SC; Barbara Vogel, BSN, GNP, RN-BC, nursing supervisor, Monroe Community Hospital, Cape Girardeau, MO; and Desma Reno, MSN, RN, CS, assistant professor of nursing, Southeast Missouri State University, Brookings, SD.
The North Dakota Nurses Association is pleased to bring you this continuing nursing education article. Nurses wishing to earn contact hours for Ostomy Management in the Obese Client require the following:

1. Read the complete article. It takes approximately 60 minutes to complete.
2. Complete the post-test found at the end of the article.
3. Non-Members: Please return the entire completed enrollment form, post-test, evaluation, and check or money order for $20 payable to NDNA.
4. NDNA MEMBERS WILL RECEIVE CONTACT HOURS FREE-OF-CHARGE.
5. Please send to: NDNA @ 531 Airport Road, Suite D, Bismarck, ND, 58504
6. Upon receipt of all required materials and completion of the post-test, you will receive a certificate of completion for 1.0 contact hours from CNE-Net.

Please allow approximately four weeks from the time you submit your completed information for your certificate of completion to be processed. Those wishing to receive their certificate by email will need to supply a functional email address.

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Accreditation as a provider refers to recognition of educational activities only and does not imply ANCC Commission on Accreditation or CNE-Net approval or endorsement of any product.

This continuing education activity expires July 2010.

Ostomy Management in the Obese Client

Author: Patricia Cropley MSN, RN, CWOCN

AUTHOR DISCLOSURE STATEMENT
Patricia Cropley has no conflicts of interest to disclose.

Discuss the challenges of caring for an obese patient with an ostomy.

Objectives
- Describe challenges to ostomy care when the client is obese.
- List possible complications.
- Describe care of the obese ostomy patient.

A Review of Words
Stoma—It is an intentional opening constructed to manage traumatic bowel injury. Definition from a surgeon from the mid 18th century (Colwell et al., 2004).
Effluent—drainage that flows from the stoma (Colwell et al., 2004).
Peristomal—Skin surface surrounding the stoma (Colwell et al., 2004).

Convexity—An insert or integration into the flange or wafer system to create a downward pressure in the peristomal region. It is a bowl shaped configuration to help make the stoma protrude outward (Milne et al., 2003).
Mesentery—supports and anchors the abdominal organs to the abdominal wall. It is a double fold of peritoneum that contains blood vessels, lymphatics, and nerve fibers that supply and innervate the intestine (Milne et al., 2003).

Ostomy Management and Obesity
Approximately 34% of the adult population is overweight and 30% of the population is obese in the United States. Obesity can be defined as the excess of body fat or one who has a Body Mass Index of 30. A Body Mass Index or BMI of 30 is the general standard to define obesity by the U.S. Department of Health and Human Services. A BMI is calculated by weight in kg/height in meters (Diagnosing and treating overweight and obese patients, n.d.).

Obesity results in over 300,000 premature deaths and nearly $120 billion in associated costs. Obesity is a risk factor for numerous diseases such as diabetes and coronary artery disease. Obesity places patients at a higher risk for medical problems (Diagnosing and treating overweight and obese patients, n.d.).

There is a clear association between obesity and certain cancers such as colorectal and urinary cancer, resulting in patients that require a fecal or urinary diversion (Colwell & Fichera, 2005). The purpose of this paper will discuss the challenges of caring for an obese patient with an ostomy.

Challenges
Care of the obese patient with an ostomy presents many challenges. There is a higher risk of complications for the obese patient compared with a higher incidence of comorbid conditions affecting surgical outcomes (Colwell & Fichera, 2005).

Obese patients that have ostomy surgery have been shown to have more complications than the general population; these complications affect their outcome. Complications include difficulties with airway management, anastomotic failure, stomal complications, infection, cardiovascular events, deep vein thrombosis, pulmonary embolism, increased blood loss and increased operative time (Colwell & Fichera, 2005).

Obese patients have more difficulties with stomal complications. There is an increased incidence of intraoperative and postoperative complications for the obese patient, including intraoperative blood loss, anastomotic failure and septic complications (Colwell & Fichera, 2005).

Preoperative Care
It is important to provide preoperative and postoperative care. Postoperative care involves the patient, including intraoperative blood loss, and postoperative complications for the obese patient (Turnbull, 2006).

Preoperative Education
It is important to provide preoperative and postoperative care. Preoperative patient education should include a review of the Gastrointestinal and Urinary System. If a facility is fortunate to have a Wound Ostomy Continence Nurse (WOCN) on staff, the WOCN can prepare the patient with the appropriate teaching and proper stoma marking (Mulligan & Gates, 2004).

The wound ostomy continence nurse is a specialist in the management of wounds, such as vascular ulcers, chronic wounds, pressure ulcers, neuropathic wounds and fistulas. The WOCN manages ostomy patients related to cancer, trauma, urinary and bowel diseases and patients with fecal and urinary incontinence (Wound, Ostomy & Continence, n.d.).

Before surgery, patients are marked on their abdomen for the proper placement of their stoma. This is done either by the surgeon or WOCN. Prior to stoma marking, the educator should review with the patient the process for stoma creation, visualization of a stoma, and how the stoma functions and what the patient's expectations are after surgery. This may be done through teaching booklets and pictures. Time should be spent (Continued to page 9)
Stoma Marking

When marking the abdomen for a stoma, it is important to avoid skin folds, deep creases, uneven and scarred areas, bony prominences, and the belt line if possible. Other considerations include: placing the stoma within the borders of the rectus muscle, and placing the stoma in a location visible to the patient. Another consideration is to place the stoma on the abdomen with approximately 2.5 inches of adhesive surface for a pouching system and placing the stoma in an area that is acceptable to the patient (Colwell et al., 2004). When marking an obese patient with a protruding abdomen, the rectus muscle may not be easily palpated. It would then be best to follow the nipple line down to the abdomen where the possible stoma site is to be considered (Colwell et al., 2004). For the obese male patient, the belt line is often in the lower abdominal fold. Since there is no flat pouching surface below the lower abdominal fold, the stoma site is marked in the upper quadrant, where it is also visible to the patient. The patient should be assessed in the sitting position. Patients, either male or female should be evaluated for site marking in the lying, sitting and standing position if possible (Colwell et al., 2004). In some cases, it may be a good idea to mark more than one stoma site, because the location of the stoma may change once the surgeon enters the abdomen. As a general rule, marking a stoma higher on the obese abdomen should allow the person good visualization of the stoma and make the stoma accessible for self care (Colwell & Fichera, 2005).

Postoperative Education and Complications

The creation of an ostomy creates the need for many adjustments, whether the stoma is temporary or permanent. There is a change in body image, to self-esteem and the adjustment to route of elimination (Colwell et al., 2004). Collaborating with the health care team is fundamental in encouraging the patient and their family/significant other to achieve optimal rehabilitation. The health care team includes the surgeon, the medical physician, the WOCN and the health care staff (Colwell et al., 2004).

Ostomy Adjustment

Ostomy sites may change due to alterations in body appearance and functioning. The new ostomy patient has many concerns such as stoma care, stool leakage, odor, pouch changing and the need to rely on others (Colwell et al., 2004). Coping styles vary from individual to individual and need to be assessed by asking patients to provide examples of how they have coped with other stressful situations. Patients should be assessed for prior knowledge or experience of ostomy care to reinforce or address any misconceptions (Colwell et al., 2004). The need to determine a patients self-efficacy is an important measure to evaluate and will determine the adaptive skills of a patient with a stoma. Being aware of patient's adaptive skills will assist health care practitioners to strengthen a patient's self-efficacy (Bekkers et al., 1996). The Psychological Adjustment to Illness Scale (PAIS-SR) has been utilized to measure a patient's self-efficacy and is the basis for creating a tool called the Stoma self-efficacy questionnaire. In the study utilizing the scale in the Netherlands Primary Health Care, 59 stoma patients were studied on medical, sociodemographic and psychological factors. Patients that had health problems before surgery such as heart disease and cancer had lower levels of adaptation after surgery and patients that had lower levels of adaptation after surgery also had many stoma problems (Bekkers et al., 1996). By having patients complete a self-efficacy questionnaire, insight was gained on both the patient's self-efficacy and also on how to address their problems. There were a number of issues raised. Some of the ways in which self-efficacy was enhanced was to encourage patients to take care of their stoma problems and by encouraging them to take care of their stoma. Patients were provided with information on taking care of their stoma at home and in social situations. (Bekkers et al., 1996).

Pouch Emptying

The majority of patients empty their pouch while sitting on the toilet but if the patient is having difficulty, there are other options to pouch emptying depending on the type of stoma. Emptying the pouch on the toilet is achieved by draining the output from the drainable pouch between one's legs into the commode. Since it is difficult for an obese patient to lean forward enough to allow the tail of the drainable pouch to drain into the toilet, a 2 piece pouching system may be more convenient. It can be removed from the flange and emptied into the commode and reapplied. A Pouch liner is another alternative. The liner is inserted into the pouch of a 2 piece system. The pouch is snapped off the flange, the liner is removed and disposed of and a new liner is inserted and the pouch is snapped back on. A closed end pouch is another choice depending on the type of stoma. The pouch can be applied, removed and discarded and a new pouch applied (Colwell et al., 2004).

Visualizing the Stoma

For some patients, the stoma may have been placed in the ideal area for pouching but maybe difficult to see because of a large abdomen. For the patient who has difficulty seeing the stoma, using a mirror can aid in visualizing the stoma. The mirror will aid in assessment and to assist in seeing the peristomal skin for cleaning but for most patients using a mirror to put on a pouch is difficult (Colwell & Fichera, 2005). By marking a line where the old pouch meets the adhesive with a marker, this leaves a guide for the patient to place the new pouching system. The patient simply lines up the new adhesive with the line (Colwell & Fichera, 2005).

Necrosis

A high rate of necrosis has been reported for both the obese and acutely ill patients. Stoma necrosis occurs when the blood flow is impaired or interrupted from or to the stoma. Ischemia can occur within 24 hours postoperatively (Barr, 2004). Necrosis can occur if there is tension on the mesentery, excessive stripping of the mesentery and if sutures are too narrowly spaced. An interruption of blood flow due to an embolism or an anomaly such as impaired blood flow can cause necrosis (Barr, 2004). Degrees of necrosis can vary. The stoma can appear either dark to maroon in color, or have a small patch of necrosis on the stoma or the entire stoma can be necrotic. To determine the degree of necrosis, the physician may insert a small lubricated glass test tube into the stoma and inspect the stoma mucosa with a pen light. If necrosis has occurred below the fascial level, urgent attention is needed. Necrotic tissue on the stoma above fascial level will usually slough off in time. Mucocutaneous separation or stenosis might occur and the stoma should be evaluated at frequent intervals (Colwell & Fichera, 2005).

(Continued to page 10)
Stomas may retracts if the patient has a high Body Mass Index (BMI) score (Barr, 2005). There is a high risk of retraction when there is a stoma located in the belt plane, it is a good idea to add a belt to the pouching system. A stoma in the upper ileum, or jejunum, is considered a high output stoma and the effluent is corrosive to the skin. These patients need to pay particular attention to leakage (Colwell et al., 2004).

Support Systems

If the stoma is located in the belt plane, it is a good idea to add a belt to the pouching system. A stoma in the upper ileum, or jejunum, is considered a high output stoma and the effluent is corrosive to the skin. These patients need to pay particular attention to leakage (Colwell et al., 2004).

Conclusion

There are many challenges when managing a patient with an ostomy. Carrying the stoma bag can accumulate in the skin folds. Care must be taken to keep skin folds free of pouch contents if there is any concern for bacterial or leakage and spillage to occur (Gallagher & Gates, 2004). Establishing a pouch change schedule is important. However, it is important to change the system even if it is not possible on the pouch change schedule when there is leakage. Leakage is signaled by patient complaints of burning and excessive itching under the wafer even though there may not be visible signs (Roldat & Erwin-Toth, 2004). A stoma in the upper ileum or jejunum is considered a high output stoma and the effluent is corrosive to the skin. These patients need to pay particular attention to leakage (Colwell et al., 2004).

Summary

The stoma located in the belt plane is a good idea to add a belt to the pouching system. A stoma in the upper ileum, or jejunum, is considered a high output stoma and the effluent is corrosive to the skin. These patients need to pay particular attention to leakage (Colwell et al., 2004).

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There are many challenges when managing a patient with an ostomy. Carrying the stoma bag can accumulate in the skin folds. Care must be taken to keep skin folds free of pouch contents if there is any concern for bacterial or leakage and spillage to occur (Gallagher & Gates, 2004). Establishing a pouch change schedule is important. However, it is important to change the system even if it is not possible on the pouch change schedule when there is leakage. Leakage is signaled by patient complaints of burning and excessive itching under the wafer even though there may not be visible signs (Roldat & Erwin-Toth, 2004). A stoma in the upper ileum or jejunum is considered a high output stoma and the effluent is corrosive to the skin. These patients need to pay particular attention to leakage (Colwell et al., 2004).
I. ENROLLMENT FORM

Name  _________________________________________________________________________________________
Address  _______________________________________________________________________________________
City, State, Zip __________________________________________________________________________________
Phone _________________________________________ Email __________________________________________
State of Licensure _______________________________________________________________________________
License # _______________________________________________________________________________________
NDNA Membership #  _______________________________________________ No charge to NDNA members
Non-member $20 fee Please make check payable to NDNA

II. POST-TEST

Choose the one correct answer

Ostomy Care in the Obese Client  P2.44

1. There are many challenges when caring for an obese patient. T  F
2. Obese patients have more complications during surgery. T  F
3. The obese patient never has stoma complications. T  F
4. Tension on the mesentery can cause stoma retraction. T  F
5. A WOCN can prepare and educate the patient for ostomy surgery. T  F
6. An obese patient should be marked for stoma placement. T  F
7. It is a good idea to mark the stoma in the belt line. T  F
8. The creation of a stoma can alter a patient’s self-esteem. T  F
9. Stoma necrosis results in a red stoma. T  F
10. Retraction occurs above skin level. T  F
11. Obese patients never have problems pouching. T  F
12. Mucocutaneous separation can occur if you are malnourished. T  F
13. Stenosis can cause ribbon like stools and pain. T  F
14. Patients with mild stenosis should be on fluid restriction. T  F
15. A flat pouching surface is important. T  F
16. Having a pouch changing schedule is not necessary. T  F
17. Effluent can be corrosive. T  F
18. Teamwork is important when caring for the obese patient. T  F
19. Patients that have difficulty adapting with their stoma after surgery can have stoma problems. T  F
20. The skin surround the stoma is called periwound skin. T  F

III. EVALUATION

HAVE YOU ACHIEVED EACH OBJECTIVE? ✓Yes  ✓No

1. Objectives:
   • Describe challenges to ostomy care when the client is obese
   • List possible complications
   • Describe care of the obese ostomy patient

2. Did the objectives relate to the overall purpose/goal of the activity?
   Purpose: Discuss the challenges of caring for an obese patient with an ostomy.

3. Were the teaching/learning resources appropriate?

4. How would you rate your knowledge of this content before reading this article? (0- no knowledge to 10-expert knowledge) Write number

5. How would you rate your knowledge of this content after reading this article? (0- no knowledge to 10-expert knowledge) Write number

HOW LONG DID IT TAKE YOU TO COMPLETE THIS ACTIVITY? Write MINUTES

Please print your name as you would like it to appear on your certificate of successful completion:

COMMENTS FOR IMPROVEMENTS OR FUTURE CONTINUING EDUCATION: