Unit G and H

Unit G: Assisting with a Simple Dressing Change

Unit G: Assisting with a simple Dressing Change

- A patient may have a wound or a cut that requires a simple dressing change. This could be anything from a simple bandage to changing a dressing in order to prevent infection.
- When changing a dressing always observe for changes in the skin:

  A. Color: Is the skin blue, black, red, pink, …

  B. Odor: Is the wound foul smelling?

  C. Condition: Is the skin healing? Is the wound still open? Is there swelling?

  D. Drainage: Is anything leaking from the skin? What color is the drainage-is it clear, bloody?

Any changes to the skin is considered unstable skin surface. Any scars, open cuts/wounds, scabs, bruising, redness/rash is considered unstable skin.

Healthy skin is intact, smooth, not too dry or wet, and warm to touch.

Unit G: Simple Dressing Change

- When doing a simple dressing change; you will need:
- A. Gloves
- B. Type of dressing: bandage, gauze
- C. Scissors (if necessary)
- D. Tape
- E. Waste Bag

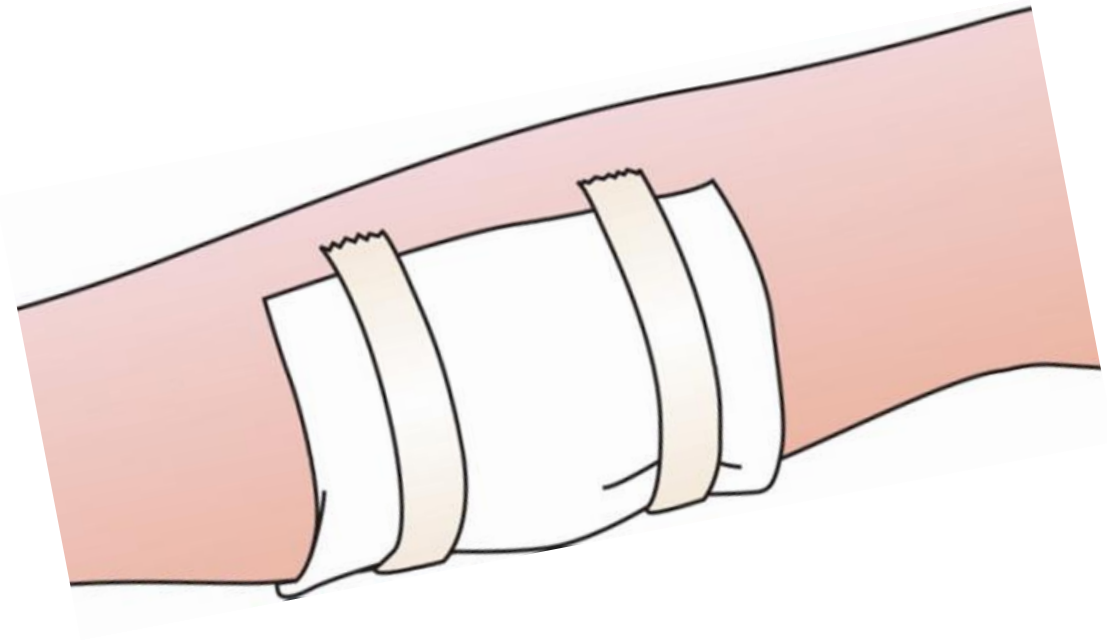
Unit G: Simple Dressing Change

- Procedure:

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. With scissors, cut pieces of tape long enough to secure the dressing. Hang tape on the edge of a table within reach. Open the four-inch gauze square package without touching the gauze. Place the opened package on a flat surface.
5. Put on gloves.
6. Remove soiled dressing by gently peeling tape toward the wound. Lift dressing off the wound. Do not drag it over the wound. Observe the dressing for odor or drainage. Notice the color and size of the wound. Dispose of used dressing in the waste bag.
7. Remove gloves. Discard in the waste bag. Wash your hands

Unit G: Simple Dressing Change

8. Put on clean gloves. Touching only outer edges of new four-inch gauze, remove it from package. Apply it to the wound. Tape gauze in place. Secure it firmly.
9. Discard supplies.
10. Remove and discard gloves.
11. Wash your hands.
12. Document the procedure and your observations.



Unit G: Simple Dressing Change

- As HHAs; you will only do simple non-sterile dressing change in order to make sure there is no infection.
- Any dressing changes that require sterile technique will be done by the RN as the process as more steps and is more involved.
- Always report any changes in the skin to your agency RN.
- Whenever doing a simple dressing change or any other task; always explain to the patient what you are doing and maintain eye contact. Ask how the patient is feeling throughout the task.
- Always wash your hand and change any soiled sheets/clothes.

UNIT H: Assisting with Ostomy Care

Unit H: Assisting with Ostomy Care

- In this section, you will:

  -Define what a stoma is

  - learn why some patients get stomas

  - learn about the 5 different types of stomas and how to care for them (including what to observe, report, and how to assist in changing them/cleaning them)

- Due to conditions such as inflammatory diseases; blockage, and/or cancer; the MD may state client needs an ostomy.
- An ostomy is an artificial opening from an are inside the body to the outside
- A Stoma is the artificial opening of the body.

Unit H: Assisting with Ostomy Care

- There are different types of Ostomies:
- A. **Colostomy**: A surgically created opening through the abdomen into the large intestine to allow feces to be expelled.
- B. **Ileostomy**: A surgically-created opening into the end of the small intestine to allow feces to be expelled.
- C. **Gastrostomy**: surgically-created opening the skin into the stomach or intestine for the purpose of feeding nutrients/food into the body.
- D. **Tracheostomy**: a surgically-created opening in the neck and into the windpipe (trachea) for the purpose of assisting in breathing.
- E. **Urostomy**: a surgically-created opening in the abdominal wall into the bladder to allow urine to be expelled.

Unit H: Change and care of a Colostomy

- **When caring and changing a colostomy bag be observant of the following**:
- Is the Stoma red and moist (think of the color and condition of your mouth).
- Any color changes to the stoma: it is VERY red; blue, swollen, or bleeding.
- Any skin breakdown around the stoma
- Is there an unusual odor
- The stool is leaking, watery stool with green, stringy material, odor has changed, frequency (is the patient going too much or too little); abdominal cramps, vomiting.
- A stoma can be very embarrassing for a patient, so observe if patient is depressed, sad, angry and report to nurse.
- Food Blockages can occur if large amounts of high-fiber are ingested and/or if food is not chewed well.
- Always ensure client is on the proper diet
- In some cases, clients will have experience with the ostomy couch and teach the aides about the products
- Familiarize yourself with the commercial product. Wash your hands always
- Empty and clean the pouch whenever stool is eliminated.

Unit H: Assisting in Ostomy Care

- Equipment needed for Colostomy Change:

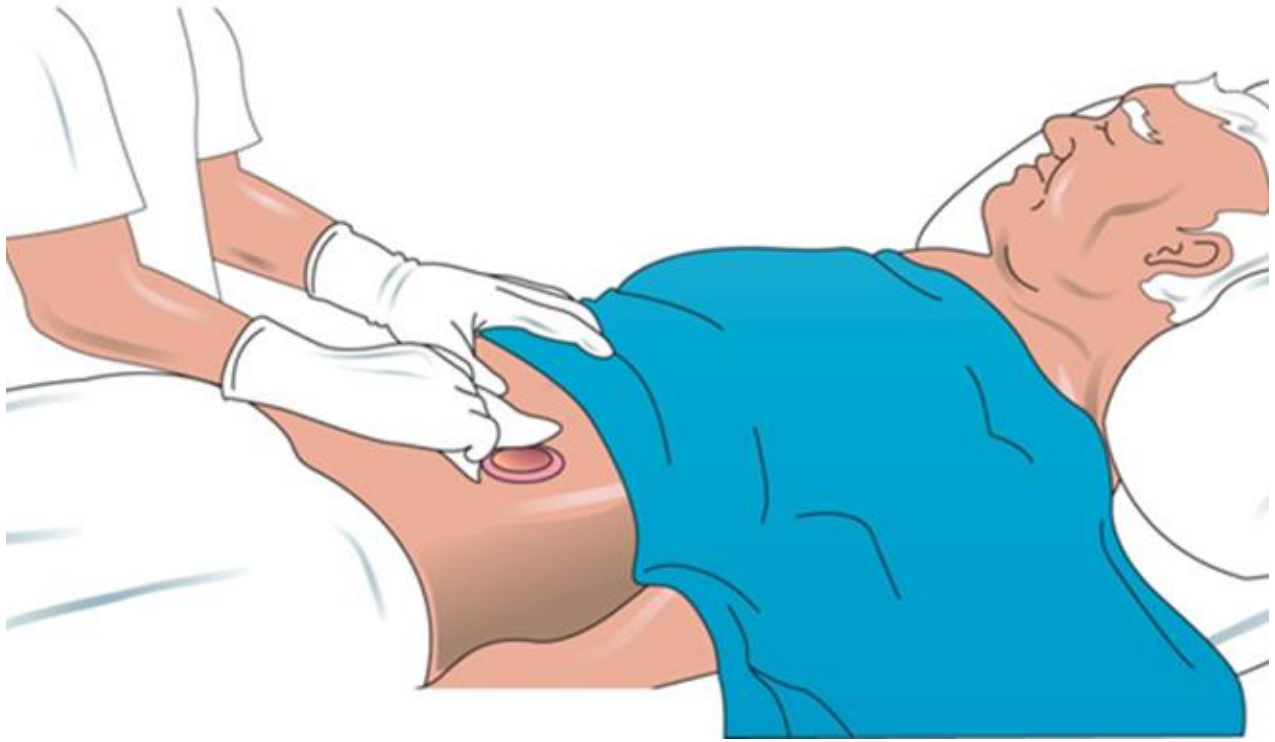
-clean pouch system
-gauze/toilet paper
-bed protector
-bath blanket
-basin of warm water
-soap/cleanser
-wash cloth
-skin barrier cream
-2 towels
-disposable waste bag
-gloves

Unit H: Caring for a colostomy

- Procedure:

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If bed is movable, lock bed wheels.
5. Put on gloves.
6. Place bed protector under client. Cover client with a bath blanket. Pull down the top sheet and blankets. Expose only the ostomy site. Offer client a towel to keep clothing dry.

Unit H: Caring for a colostomy



7. Undo the ostomy belt if used. Remove ostomy pouch carefully. Place it in the plastic bag. Note the color, odor, consistency, and amount of stool in the pouch.
8. Wipe the area around the stoma with disposable wipes for ostomy care. Discard wipes in plastic bag.
9. Using a washcloth and warm soapy water, wash the area in one direction, away from the stoma. Rinse. Pat dry with another towel.

Unit H: Caring for a Colostomy

10. Place the clean ostomy drainage pouch on the client, following your supervisor's instructions. Hold in place and seal securely. Make sure the bottom of the pouch is clamped.
11. Remove disposable bed protector and discard. Place soiled linens in proper containers. Discard plastic bag properly.
12. Remove and discard gloves.
13. Wash your hands.
14. Return bed to lowest position if adjusted.
15. Document procedure and any observations. Note any changes to the stoma and surrounding area. A normal stoma is red and moist and looks like the lining of the mouth. Call your supervisor if stoma appears very red or blue or if swelling or bleeding is present. Report any sign of skin breakdown around the stoma.

Changing of a system can be done very 3-4 days depending on amount of usage of the pouch. It can also be changed when the client feels skin irritation or discomfort.

Otherwise, just drain the bag of the pouch when it is at most 1/3 to ½ full.

- https://www.youtube.com/watch?v=h8CtsPAaa5Y: How to clean and change a colostomy bag
- https://www.youtube.com/watch?v=FXKM1r5L8U8&t=136s: How to drain a colostomy bag
- https://www.youtube.com/watch?v=KhllKlM9D-U: What is a colostomy

Unit H:Caring for an Ileostomy

- The care and guidelines for an ileostomy is similar to that of a colostomy.
- An ileostomy is an opening from the small intestine. Therefore, the stool may look more watery than from the colon. Due to this, the pouch has to be drained at least 4 to 6 times a day.
- As with the colostomy; always observe that status of the stoma and report any changes that you see.
- The procedure for changing an ileostomy bag is the same as a colostomy.
- Depending on client's condition, an MD may decide to do an ileostomy instead of a colostomy.
- https://www.youtube.com/watch?v=JV8L5EOHX1U: Changing ileostomy/colostomy pouch
- Ileostomy: https://www.youtube.com/watch?v=_h9gXzi7KtU

Unit H: Caring for a Urostomy

- An urostomy is an opening in the abdomen in order for urine to be expelled from the body.
- The stoma would be red, moist like a stoma in any other part of the body (like a colostomy)
- Always be observant of any changes in the skin and/or the stoma.
- Report any skin breakdown, irritation, the stoma is very red; blue, etc…
- Although the stoma can change size over time; report sudden changes and if the stoma look like it is retreating back into the body.
- Report leakage out of the urostomy bag
- Always wash your hands and wear gloves
- Report any emotional changes of the patient

Unit H: Changing a Urostomy Bag

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If bed is movable, lock bed wheels.
5. Put on gloves.
6. Place bed protector under client. Cover client with a bath blanket. Pull down the top sheet and blankets. Expose only the ostomy site. Offer client a towel to keep
   clothing dry.

Unit H: Changing a Urostomy Bag

7. You might like to use a skin barrier to protect your skin and provide an ideal base for the adhesion of the next urostomy bag. Simply wipe around the stoma area and leave to dry for a few seconds.

8. You may need to cut a hole in your stoma pouch flange to the correct size.

9. Remove the protective cover from the adhesive flange. Fit the pouch over the stoma and smooth from the center to the edges, making sure there are no creases which might cause leakage.

10. Cover the adhesive with your hands for 30-50 seconds, as the warmth will increase the adhesion to your skin.

Unit H: Draining a urostomy bag

- When the bag containing the urine is at most 1/3 to ½ full, assist the patient in draining the pouch.
- Sit on or stand in front of the toilet. Put a layer of toilet paper in the toilet bowl to keep urine from splashing. If client is not ambulatory; then drain into a basin.
- Pull any clothes away from the pouch.
- Hold the pouch drain at the bottom of the bag over the toilet bowl.
- Open the pouch drain so that urine flows into the toilet.
- Empty all the urine and mucus from the pouch. While holding the pouch with one hand, slide the fingers of your other hand down the pouch. This will help empty any mucus from the pouch.
- https://www.youtube.com/watch?v=yyuwDCrHPsc: Draining urostomy pouch

Unit H: Care of a Tracheostomy

- A Tracheostomy is an opening in the neck to assist in a patient breathing.
- A tube is inserted into the trach for assistance in breathing and is covered.
- When taking care of someone with a trach, be careful not to get water into the trach as the patient may drown.
- When taking of the stoma; always observe for changes in the skin
- If client has difficulty breathing after clearing out secretions
- The secretions are thick, and malodorous. The secretions are red, yellowish in color.
- If they feel increased pain.

Unit H: A Tracheostomy

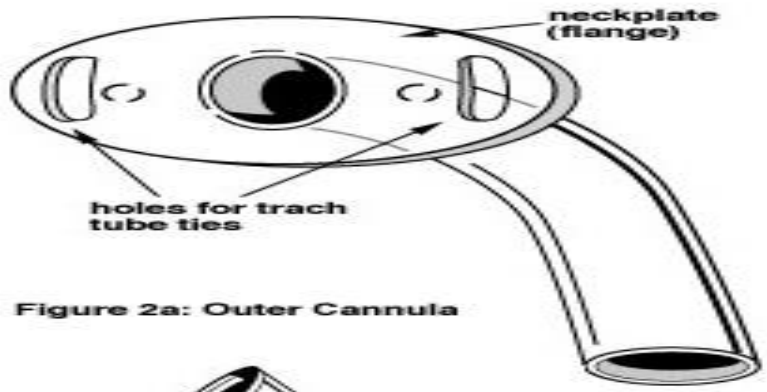


Figure 2a: Outer Cannula

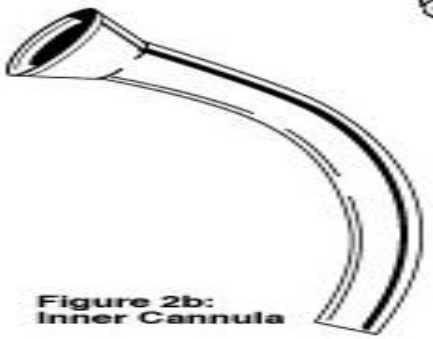


Figure 2b: Inner Cannula

Unit H: Changing and caring for the Tracheostomy

- Items needed:
- Two non-sterile gloves
- A clean basin (or sink)
- Hydrogen peroxide
- Clean 4 x 4 fine mesh gauze pads
- Normal saline or tap water (Use distilled water if you have a septic tank or well water)
- Clean cotton-tipped swabs
- Clean pipe cleaners or small brush
- Clean washcloth
- Clean towel
- Trach tube ties
- Clean scissors

Unit H: Changing and caring for the Tracheostomy

1. Wash your hands thoroughly with soap and water.

2. Stand or sit in a comfortable position in front of a mirror (in the bathroom over the sink is a good place to care for your trach tube).

3. Put on the gloves.

4. Suction the trach tube. (Your healthcare provider will give you more information about the suctioning procedure).

5. If your tube has an inner cannula, remove it. (If the trach tube does not have an inner cannula, go to step 12.)

6. Hold the inner cannula over the basin and pour the hydrogen peroxide over and into it. Use as much hydrogen peroxide as you need to clean the inner cannula thoroughly.

7. Clean the inner cannula with pipe cleaners or a small brush.

8. Thoroughly rinse the inner cannula with normal saline, tap water or distilled water

Unit H: Changing and Caring for the Tracheostomy

9. Dry the inside and outside of the inner cannula completely with a clean 4 x 4 fine mesh gauze pad.

10. Reinsert the inner cannula and lock it in place.

11. Remove the soiled gauze dressing around your neck and throw it away.

12. Inspect the skin around the stoma for redness, hardness, tenderness, drainage or a foul smell. If you notice any of these conditions, call your nurse or physician after you finish routine care.

13. Soak the cotton-tipped swabs in a solution of half hydrogen peroxide and half water. Use the swabs to clean the exposed parts of the outer cannula and the skin around the stoma.

14. Wet the wash cloth with normal saline, tap water or distilled water. Use the wash cloth to wipe away the hydrogen peroxide and clean the skin.

15. Dry the exposed outer cannula and the skin around the stoma with a clean towel.

16. Change the trach tube ties.

Unit H: Tracheostomy

How to use the neck tie of a tracheostomy

Unit H: Tracheostomy

- https://www.youtube.com/watch?v=25BkOeGO16k: Clean and Care of a tracheostomy
- https://www.youtube.com/watch?v=J8vtW-RkkMA: What is a tracheostomy

Unit H: Caring and cleaning a Gastrostomy

- A gastrostomy is an opening in the stomach for assistance in feeding. After the stoma is created, a tube is then placed for food, medication, and fluids directly into the stomach.
- As an aide; you will not do the feedings.
- If a client is fed through a feeding tube, the client cannot have anything by mouth. All fluids must be given via the tube going into the stoma.

Unit H: Gastrostomy

- Gastrostomy will generally be placed if a client has difficulty swallowing through the mouth and esophagus. Difficulty swallowing can be caused by diseases such as cancer, neuromuscular condition that interferes with swallowing. Birth defects, Dementia, …
- When a client has a gastrostomy with a tube, please be respectful of the patient and do not act frightened or judgmental. This is very sensitive to the family and the patient.

Unit H: Gastrostomy

- Possible problems with the Tube:
- **Blocked tube:** Food or medicine may build up in the tube or body fluids may crust around the opening and block the tube. The patient and family will follow the care of the provider when flushing out the tube. You can assist by gathering of items.
- **Drainage around the gastrostomy:** Some drainage around the gastrostomy is normal, especially soon after the gastrostomy is put in. Clean the skin around it often with mild soap and water. Make sure you remove all crusted areas from the tube itself. This helps prevent infection. Call the healthcare provider if leaking or drainage continues or if the site becomes painful.
- **Vomiting:** Vomiting may be caused by the tube moving forward into the stomach and blocking the stomach outlet. Follow your healthcare provider's instructions for checking the placement of the tube. Excessive gas and overfeeding can cause bloating of the stomach and vomiting. Removing the clamp or the plug or opening the button at the end of the G-tube will allow air to escape and gradually relieve the problem.
- **Diarrhea:** Diarrhea is a common problem for people with a gastrostomy tube. There are many possible causes of diarrhea, such as the type of liquid food, medicines, changes in the normal bacteria levels in the stomach and intestines, and how fast the liquid food is given. If you have diarrhea, talk to your healthcare provider about possible causes and treatment.
- **Breakdown of the G-tube:** Over time, the rubber tube will break down and get harder to use. Many times the end used to add the feeding formula will break off or split. These are signs that the tube needs to be replaced. Most tubes last for 3 to 6 months, if you need one for that long

Unit H: Caring for the Gastrostomy

- Items needed for cleaning for a Gastrostomy Tube:
- Warm water
- Soap
- Clean towel
- Hydrogen peroxide
- Cotton swab

Unit H: Cleaning Gastrostomy site

1. Wash your hands with soap and water before and after you touch the area.
2. Use warm water and soap to clean around the gastrostomy site 2 to 3 times a day or as needed.
3. Make sure that you gently soak or scrub off all crusted areas on the skin around the tube and on the tube itself. You may need to use a diluted solution of hydrogen peroxide (1/2 peroxide and 1/2 water) and cotton tipped swabs to clean around the tube site.
4. After cleaning, rinse around the area with water and pat dry.
5. Ask your healthcare provider if you should use an antibiotic ointment on the area if it looks red or sore.
6. Secure the tube as instructed by your healthcare provider.

https://www.youtube.com/watch?v=850LQtmIyBs: Tube site Care

Bibliography

- https://www.fairview.org/sitecore/content/Fairview/Home/Patient-Education/Articles/English/u/r/o/s/t/Urostomy_Emptying_Your_Pouch_89993
- https://my.clevelandclinic.org/health/treatments/17568-tracheostomy-care
- https://www.youtube.com/watch?v=h8CtsPAaa5Y: How to clean and change a colostomy bag
- https://www.youtube.com/watch?v=FXKM1r5L8U8&t=136s: How to drain a colostomy bag
- https://www.youtube.com/watch?v=KhllKlM9D-U: What is a colostomy
- Providing Home Care: A Textbook for Home Health Aides - 5th Edition
- https://www.summitmedicalgroup.com/library/adult_health/aha_gastrostomy_care/
- https://www.youtube.com/watch?v=JV8L5EOHX1U: Changing ileostomy/colostomy pouch
- Ileostomy: https://www.youtube.com/watch?v=_h9gXzi7KtU

Bibliography

- https://www.youtube.com/watch?v=yyuwDCrHPsc: Draining urostomy pouch
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