Urinary Diversions: 
A Review of Nursing Care

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The nurse plays an important part in the preoperative and postoperative management of the patient with a urinary diversion. Although urinary diversion as a surgical alternative has been performed since the mid 1800s, improvements in technique and management over the past 10 years warrant discussion. Three types of urinary diversion procedures are discussed along with suggestions for optimal nursing management during the postoperative period.

Objectives

This educational activity is designed for nurses and other health care professionals who care for and educate patients regarding urinary diversions. The multiple choice examination that follows is designed to test your achievement of the following educational objectives. After studying this offering, you will be able to:
1. Discuss postoperative management techniques for patients undergoing urinary diversion.
2. Describe an education plan for the patient with a urinary diversion.
3. List three types of urinary diversions.

Indications for Urinary Diversions

Urinary diversion is indicated in invasive bladder cancer, hostile neurogenic bladder, refractory interstitial or radiation cystitis, and congenital anomalies of the lower urinary tract. Bladder carcinoma, resulting in approximately 2.2% of all deaths due to cancer (American Cancer Society, 2000), is commonly treated with surgical intervention. The extent of the surgery ranges from local resection and fulguration (destruction of tissue by electrical current) of superficial tumors to radical cystectomy requiring diversion of normal urinary flow.

Neurogenic bladder refers to several bladder dysfunctions caused by lesions of the central or peripheral nervous systems. Conditions in which neurogenic bladders may occur include cerebrovascular accidents (CVA), multiple sclerosis (MS), diabetic

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neuropathy, pernicious anemia, poliomyelitis, tumor, infection, trauma, spinal anesthesia, and malignancy. Although bladder training is initially attempted for the patient with neurogenic bladder dysfunction, other conservative therapy and less-invasive surgical treatment may include rhizotomy, electrode implantation, and sphincterotomy. If conservative therapies are unsuccessful, urinary diversion may be performed to provide the patient with a more manageable urinary system (Polaski & Tatro, 1996).

Individuals with refractory interstitial cystitis or radiation-induced cystitis often have a severely reduced bladder capacity and may develop incapacitating symptoms. Although surgery is not the preferred treatment for interstitial cystitis or radiation-induced cystitis, individuals who do not respond to conservative therapy, or whose condition worsens, may be candidates for partial or complete cystectomy and urinary diversion (Gray et al., 2000).

Congenital anomalies of the lower urinary tract, such as exstrophy of the bladder, are also indications for urinary diversion. In exstrophy of the bladder, the abdominal wall and the anterior bladder wall are absent, allowing the open bladder to protrude through the abdomen. Diversional surgery for this condition requires repeated revision as the child matures.

Types of Urinary Diversions

Urinary diversions require use of isolated segments of the bowel to divert urine flow and act as a reservoir for urine collection. Selected examples of these diversions include the ileal conduit, continent urinary reservoir, and the orthotopic neobladder.

Ileal conduit. The ileal conduit, also known as ureteroileostomy, ileal bladder, or Bricker’s procedure, is the most commonly performed type of urinary diversion. In this procedure, a small segment of the intestine is used as a conduit to construct a system for the urine to be channeled from the ureters to an abdominal stoma. The ureters are implanted into the ileal segment, with one end of the bowel segment sutured closed and the other end brought through the abdominal wall to create a stoma (see Figure 1). The conduit drains continually and requires the use of an external collection device for storing urine (Raleigh, Berry, & Montie, 1995). Urine flows into the conduit and is continually propelled out of the body through the stoma via peristalsis. There is minimal absorption of electrolytes as the ileal segment is not used as a reservoir and urine is only briefly in contact with it.

In elderly patients and patients with recurrent bladder cancer or advanced malignancy, the ileal conduit is the procedure of choice (Razor, 1993). It is also preferred for treating muscle-invasive or advanced bladder cancer. Patients are typically older adults with sedentary lifestyles or concurrent medical conditions that contraindicate the additional surgery time required to create a continent diversion (Pontieri-Lewis & Vates, 1993).

While the ileal conduit is relatively simple to perform and most patients adjust well, there are potential complications. Skin irritation, stomal pouching difficulties, and renal deterioration may affect social adjustment and health care costs (Razor, 1993). The most common complication is the late development of obstruction at the ureteroileal anastomosis. Pyelonephritis, leakage at the anastomosis site, stenosis along the system, hydronephrosis, calculi, peristomal herniation, skin irritation, ulceration, and stomal defects are also possible. Severe complications occur in only 2% to 3% of individuals undergoing this procedure. Indications, contraindications, and potential complications for selected urinary diversion procedures are listed in Table 1.

Continent urinary reservoirs. A continent urinary diversion is constructed to replace a diseased or defective bladder system. It involves constructing a reservoir for urine storage internally and permits emptying of the reservoir...
Table 1.
Indications, Contraindications, and Potential Complications of Specific Types of Urinary Diversion

<table>
<thead>
<tr>
<th>Type of Diversion</th>
<th>Indications</th>
<th>Contraindications</th>
<th>Potential Complications</th>
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<tbody>
<tr>
<td>Ileal Conduit</td>
<td>Elderly patients; sedentary lifestyle; co-morbid conditions that would prohibit prolonged anesthesia; patients with recurrent disease or advanced malignancy; muscle invasive or advanced bladder cancer.</td>
<td>Mental impairment (with no available caregiver); unable to comply with followup care or treatment.</td>
<td>Skin irritation; stomal pouching problems; late development of obstruction at the ureteroileal anastomosis; pyelonephritis; leakage at the anastomosis site; stenosis; hydronephrosis; calculi; peristomal hernia; ulceration; stomal defects.</td>
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<tr>
<td>Continent Urinary Reservoir</td>
<td>Physically able to withstand lengthy surgery; &gt;1 year life expectancy; serum creatinine of &lt;2.5 mg/dl; gross and fine motor coordination; willing and able to participate in self-care.</td>
<td>Significant bowel resection with malabsorption or chronic diarrhea; irritable bowel syndrome; ulcerative colitis; extensive diverticular disease; bowel cancer; neuropathic bowel syndromes; progressive neurologic disorders; gross obesity; pelvic radiation, unable to comply with followup care or treatment.</td>
<td>Incontinence; difficult catheterization; urinary reflex; anastomotic leaks; pyelonephritis; obstruction; bacteriuria; urolithiasis; electrolyte imbalances; absorptive problems; rupture of the reservoir.</td>
</tr>
<tr>
<td>Orthotopic Neobladder (Ileal W-Bladder, Hemi-Kock)</td>
<td>Technical simplicity; no stapling; daytime continence; normal anatomic appearance; natural voiding through urethra; total continence in 84%-96% at 5 years.</td>
<td>Bladder tumors of trigone; diffuse carcinoma in situ; multifocal tumors; bladder cancer involving the prostate; radiation therapy; renal insufficiency, unable to comply with followup care or treatment.</td>
<td>Pouch rupture due to over-distention; metabolic changes; urolithiasis; urinary retention; stomal stenosis.</td>
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Sources: Black, Hawks, & Keene, 2001; Polaski & Tatro, 1996; Pontieri-Lewis & Vates, 1993; Razor, 1993.

at convenient intervals by self-catheterization of a continent stoma (Gray et al., 2000; Leaver, 1994). One type of continent urinary reservoir, the Indiana pouch, is formed from an isolated bowel segment, usually the ileum or ascending colon that are made into a reservoir. Ureters are implanted into the side of the reservoir, and a special nipple valve is constructed to attach the reservoir to the skin (see Figure 1). The Indiana pouch typically stores up to 800 ml of urine inside the body (Polaski & Tatro, 1996). It has a continence rate of 95% to 100% (Razor, 1993).

The major advantage of the continent urinary diversion is the capability for continence because of the internal reservoir. After a period of adjustment, this allows for nocturnal continence as well.

Orthotopic neobladder. When malignancy does not involve the urethra, patients may be candidates for an orthotopic neobladder using procedures such as the ileal W-bladder or Hemi-Kock. Creating the neobladder is similar to that of a continent reservoir except that the neobladder empties via a pelvic outlet to the urethra rather than through an abdominal stoma (see Figure 1). It is constructed using the ileum or a portion of the large colon. Once the reservoir is constructed, the neobladder is anastomosed to the urethra to allow for drainage of urine (Pontieri-Lewis & Vates, 1993).

Since a total urethrectomy is
typically considered as part of radical cystectomy in women, the orthotopic neobladder procedure is commonly indicated for men undergoing cystectomy (Ghoneim, 1997; Pontieri-Lewis & Vates, 1993). However, as a result of increasing clinical experiences with orthotopic bladder substitution in women, equally functional results have been reported (Ghoneim, 1997).

The ileal W-bladder is routinely preferred over the continent urinary diversion because it preserves micturition and avoids the need for an abdominal stoma (Pontieri-Lewis & Vates, 1993). Urinary continence rates are reported from 83% to 96% during the day (Arai et al., 1999) with full diurnal continence achieved in some patients (Ghoneim, 1997). The major advantage of this procedure is the ability to void naturally through the urethra, eliminating external appliances (Pontieri-Lewis & Vates, 1993). Patient satisfaction is high because the normal anatomic appearance is maintained (Razor, 1993).

Postoperative Nursing Management

Nurses closely monitor the patient for 2 to 3 days postoperatively for fluid imbalances and hemorrhage. A nasogastric tube, or gastrostomy tube, is used to decompress the bowel to prevent vomiting, protect the incision, and provide a route for medications such as carafate to prevent Curling's ulcers (Gowing-Farhat, 1994). Incentive spirometry, coughing, and deep-breathing exercises help to minimize postoperative respiratory complications. Sequential compression stockings are used to prevent venous stasis and thromboembolism. Ambulation usually begins by the 3rd postoperative day.

Metabolic balance. Metabolic changes are common when urine is stored in intestinal reservoirs. Unlike the normal urinary bladder mucosa, neobladders created from ileum or colon segments secrete sodium ions in exchange for hydrogen ions, bicarbonate in exchange for chloride, and ammonium ion absorption causing an increase in urea and creatinine levels. These electrolyte problems may occur at any time after surgical intervention (Leaver, 1994). If the ileocecal valve and ileal segments are removed during the procedure, there may be decreased digestion and absorption because of increased intestinal transit time. The decreased digestion can also contribute to metabolic acidosis and diarrhea.

Resecting small amounts of ileum can cause malabsorption of bile salts and vitamin B12, while resection of larger amounts of ileum is associated with malabsorption of fat and fat-soluble vitamins A, D, E, and K (Leaver, 1994; Razor, 1993). The malabsorption of bile acid salts increases the synthesis of bile acids that predisposes the patient to gallstones, kidney stones, and steatorrhea (Leaver, 1994). The nurse carefully monitors fluid and electrolyte balance for early signs of problems.

Diversion-specific management. Specific management of the ileal conduit involves assessing the patient for changes in stoma color and elasticity of skin turgor every 8 hours. An ostomy pouch is usually applied in the operating room. To accumulate and measure urine output, the pouch is connected to a gravity drainage bag. It is normal to observe mucus in the urine drainage bag since the intestinal mucosa, unlike bladder mucosa, normally produces mucus. The urine is initially blood-tinged, progressing to a straw color over several days.

Ureteral stents (see Table 2) allow healing of the ureteroenteric anastomoses. Urine may be observed draining around the stents primarily as a result of edema around the anastomosis site during the first 5 to 7 days postoperatively. These stents are irrigated with 10 to 20 ml of normal saline every 6 to 8 hours. Care is taken not to dislodge the stents by using excess force during the irrigation procedure.

Specific management of a continent diversion involves assessing the stoma similar to the ileal conduit. Ureteral stents are also used with continent diversions to maintain ureteral patency and may exit through the cutaneous stoma or around the suprapubic catheter. Catheters and stents should be stabilized to prevent accidental dislodgment. Use of Velcro®-type catheter holders will help prevent the tubes from kinking and obstructing urine flow and prevent dislodgment.

Urinary extravasation. Early signs of urinary or fecal leakage indicating an anastomotic leak include increased abdominal girth, fever, and drainage through the incision, tubes, or drains (Gray et al., 2000). The surgeon may control the leakage by diverting the urine using nephrostomy tubes until healing occurs because most leaks are self-limiting and will self-seal if adequate drainage is provided. Fecal anastomotic leaks, while infrequent, may be a potential surgical emergency because of the danger of peritonitis (Razor, 1993).

Urine leakage at the site of the anastomosis or ureteral separation from the conduit may cause urine to seep into the peritoneal cavity (Polaski & Tatro, 1996). The nurse observes the patient for signs and symptoms of peritonitis such as fever, abdominal pain and rigidity, and absence of bowel sounds (Bernier, 2001).

Stomal viability. The nurse inspects the size, shape, and color of the stoma every hour for the first 24 hours after surgery to provide baseline assessment data. If no problems occur within this time period, the intervals can be
Table 2.
Overview of Tubes/Drains for Specific Urinary Diversion Procedures

<table>
<thead>
<tr>
<th>Type of Diversion</th>
<th>Jackson Pratt</th>
<th>Ureteral Stents</th>
<th>Suprapubic Catheter</th>
<th>Foley Catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ileal Conduit</td>
<td>Two drains present; one on either side of the pelvis.</td>
<td>Two stents; one for each kidney. Left stent cut on bevel. Stents carry the majority of urine output the first 5-7 postoperative days.</td>
<td>Not used.</td>
<td>Functions as a pelvic drain. Does not contribute to urine output.</td>
</tr>
<tr>
<td>Continent Urinary Reservoir (Indiana Pouch, Mainz, Kock, Florida)</td>
<td>Same as ileal conduit.</td>
<td>Same as ileal conduit.</td>
<td>Functions to prevent tension on pouch suture line. As urine output from stents decreases, urine output from suprapubic catheter should increase.</td>
<td>Functions as a pelvic drain.</td>
</tr>
<tr>
<td>Orthotopic Neobladder (Ileal W-Bladder, Hemi-Kock)</td>
<td>Same as ileal conduit</td>
<td>Same as ileal conduit</td>
<td>Keeps neobladder drained. As urine output from stents decreases, urine output from suprapubic catheter increases.</td>
<td>Drains urine from the neobladder. Initially, minimal urine output. As urine output from stent decreases, urine output from Foley catheter increases.</td>
</tr>
</tbody>
</table>

extended to every 4 hours, then progress to every 8 hours (Polaski & Tatro, 1996). The stoma should appear red and moist with the peristomal sutures adherent to the skin and mucosal bowel edge. When the site is cleansed, slight bleeding is normal (LeMone & Burke, 1996).

Other changes may indicate complications that warrant immediate communication with the physician (Polaski & Tatro, 1996). Compromised circulation results in a stoma that appears pale, gray, or cyanotic or that blanches upon touch (LeMone & Burke, 1996). Signs of darkness or diskiness may indicate a loss of vascular supply (Black, Hawks, & Keene, 2001). Necrosis limited to the mucosal stoma on the skin surface is not a surgical emergency as the upper portion will slough off, leaving a retracted or flush stoma. If the necrosis is extensive, surgical intervention may be required. The reduced blood supply may result from surgical technique, incorrect size or fit of the urostomy appliance faceplate, or improperly applied peristomal protective materials (Black et al., 2001). Consultation with the enterostomal therapy or wound ostomy continence nurse is invaluable to assist with treatment options to encourage wound healing.

Other stomal complications include prolapse (protrusion from the skin), or retraction into the abdomen beneath the skin. Stenosis of the stoma may occur from scarring during stomal maturation. If the opening on the urostomy appliance faceplate is too large, epithelial hyperplasia, or thickening of the peristomal skin may contract the stoma (Polaski & Tatro, 1996).

Maintenance of drainage tubes. The variety of drains and tubes is unique to the urinary diversion procedure and may be located through the stoma, urethra, or a cutaneous exit site depending on the surgeon’s preference. The patient may initially be overwhelmed by the variety of tubes, stents, and pouch drains and should have the purpose of each explained including the anticipated removal date (see Table 2).

In the immediate postoperative period, all catheters, stents, and their related drainage containers must be clearly labeled and a separate closed-gravity drainage system used for each tube. Clear identification of each tube may prevent errors in irrigation and calculation of output. Using separate closed systems for drainage minimizes the risk or extent of potential bacterial contamination and infection (LeMone, 2001).
Urine flow should never stop after surgery and maintaining patent catheters and stents, if present, is a high priority for the nurse. Ureteral stents originating from the renal pelves extend through the ureters and through the reservoir, conduit, or neobladder. The stents usually exit through the stoma and are typically contained in the pouch. With the continent reservoir, a catheter is placed through the stoma to drain the internal reservoir for 2 to 3 weeks until healing occurs. In the case of a neobladder, a catheter may be placed through the abdominal wall into the reservoir to keep it drained, while another catheter will be placed through the urethra to be used as a stent to protect the anastomosis of the urethra and neobladder. The stents and catheter are removed once adequate healing has occurred (Bernier, 2001).

The nurse ensures that all catheters and stents drain freely. Urine output is monitored for amount, color, and clarity every hour for the first 24 hours, and then every 8 hours. Urine output of less than 30 ml/hour or no output for more than 15 minutes should be reported to the physician as this may indicate low vascular volume, renal insufficiency, or impaired patency of the drainage system. The nurse also monitors the urine for any changes in color or clarity that might indicate complications such as hemorrhage or infection (LeMone & Burke, 1996).

Patient Education

Preoperative and postoperative education depend on the type and extent of the surgical procedure. Patient education about bladder management after urinary diversion or orthotopic neobladder construction begins before surgery and is restarted as soon as possible after surgery. While education focuses on the patient, family members are included whenever possible. Because most patients are unable to focus on instructions during the first 72 hours following surgery because of anxiety, pain, fatigue, andalgesics, etc., discharge instructions are delayed until the 5th postoperative day or when effective pain management is achieved.

Pain control. Pain management focuses on identifying the cause of the discomfort, correcting modifiable causes, and pharmacologic and nonpharmacologic interventions to alleviate pain (Gray et al., 2000). Epidural or patient-controlled analgesia is used for pain control during the first 4 to 5 days. During this early postoperative period, the patient’s response to pain, along with vital signs and intake and output volumes, are monitored hourly (Gray et al., 2000). When the patient tolerates oral feedings, oral narcotic analgesics are substituted for intravenous or epidural narcotics for the remainder of the hospitalization and for about a week after hospital discharge.

Ostomy care. Patients with an ileal conduit are encouraged to demonstrate the ability to perform ostomy care prior to discharge (Pontieri-Lewis & Vates, 1993). Because the patient may be preoccupied with postoperative pain, family members are also included in the education process.

With continent urinary diversions, patients are discharged with a suprapubic tube for urine drainage and should be instructed to irrigate the tube daily and as needed with 30 to 60 ml of normal saline or water. The frequency of irrigation varies with the amount of mucus produced in the pouch. Scheduled irrigation of the reservoir postoperatively will help in removing excessive mucus. The suprapubic tube will be removed after 2 to 3 weeks if no leakage is present.

Self-catheterization. Once the suprapubic tube is removed, the patient with a continent urinary reservoir is taught to self-catheterize the pouch with a 14 to 16 French catheter at intervals during the day and night. Extending the interval between each catheterization will allow for increased urine storage capacity and increased periods of continence. Self-catheterization is done on a progressive schedule to permit the reservoir to expand capacity slowly without compromising the suture line and the continence mechanism. Most reservoirs have the capacity to hold 500 to 1,000 ml; over-distention may result in urinary leakage. The patient may insert a tube into the stoma and attach a dependent drainage system overnight or may be instructed to continue the daytime self-catheterization schedule throughout the night.

For patients with Indiana pouches, a Medina catheter will remain in place to drain urine continuously. This catheter may be irrigated with normal saline to wash our any clots or mucus that may accumulate, preventing drainage. The Medina catheter will be removed 3 to 4 weeks following surgery (Polaski & Tatro, 1996). Patients with Indiana pouches are instructed on how to self-catheterize and empty the pouch (Polaski & Tatro, 1996). Patients will develop their own routines, eventually self-catheterizing every 4 to 6 hours, depending on the volume of urine that they can tolerate and the sensation associated with the filling of the neobladder. It is essential that patients continue to be monitored by health care professionals at 3 months, 6 months, and have yearly appointments with blood testing, renal function tests, urine cultures, X-rays, and either ultrasound or pouchogram (Leaver, 1994).

In the home care setting, catheters may be washed in liquid detergent and warm water,
Skin irritation. Skin irritation or breakdown from the presence of urine is a constant threat. The skin surrounding the stoma must be assessed for redness, excoriation, or signs of breakdown. Intact skin is the first line of defense against infection. Impaired skin integrity may lead to local or systemic infection and impede healing (LeMone & Burke, 1996). The skin surrounding the stoma should be assessed for urine leakage from any catheters, stents, or drains (see Table 2). Using a well-fitted and properly attached appliance helps to prevent urine from contacting the skin and causing irritation.

Urine is cleansed from the skin by washing with mild soap and water. If urine crystals are present, use of a dilute vinegar solution will aid removal. A gauze pad may be placed over the stoma, or a tampon inserted just inside the stoma, during cleansing to prevent urine from flowing onto the skin. The pad, or tampon, can then be removed just prior to replacing the appliance. The patient is encouraged to change the appliance in the morning because urine production is slowest at this time (Polaski & Tatro, 1996).

Fluid intake. Patients are encouraged to drink adequate amounts of fluids to dilute the urine and to reduce the amount of mucus produced by the diversion. Intake is based on the Recommended Daily Allowance (RDA) for fluids (30 ml/kg or 5 ounces/lb). Increased fluid intake with resultant high urine output keeps the urinary diversion flushed and reduces the risk of infection. Diluted urine is also less irritating to the skin surrounding the stoma site. While electrolyte reabsorption from reservoirs may increase the risk of calculi, high fluid intake and urine output reduces this risk (LeMone & Burke, 1996). Regular fluid intake and adherence to the catheterization protocol is of utmost importance to the continent-diversion patient because a full reservoir can result in pressure on the nipple valve, making catheterization difficult.

Mucus management. It is important for the continent-diversion patients to learn the proper technique for irrigating the stoma. Irrigations are performed to break up and flush out mucus that may lead to reservoir obstruction (Black et al., 2001). Signs of catheter obstruction include decreased urine output and increased Penrose drainage. When obstruction occurs, reservoir irrigation is done more frequently to maintain catheter patency (Stein, 1995). Coughing or pressing gently on the abdomen can shift small mucus blockages in the pouch. In addition, rinsing the catheter may also free it of the debris (Leaver, 1994).

The principles for irrigating the stomal catheter are the same as with any other type of clean self-catheterization procedure. Using a catheter and syringe, the patient instills about 60 ml of normal saline or water into the reservoir. The fluid can then be gently aspirated or allowed to drain from the catheter by gravity. The irrigations are continued until the drainage returns free of mucus. The patient is cautioned not to over-irrigate the reservoir since only enough fluid to remove the mucus is needed. If the mucus is viscous, an increase in fluid intake (30 ml/kg or 5 ounces/lb) may decrease the viscosity. Drinking 4 to 8 ounces of cranberry juice daily or taking 12 cranberry capsules daily will help thin the mucus within the pouch and make catheterization easier (Leaver, 1994).

Odor management. Urine odor is a common problem with urinary stomas. Noxious odors usually result from poor hygiene, alkaline urine, normal breakdown of urine (ammonia), concentration of urine because of insufficient fluid intake, or the ingestion of certain foods such as asparagus or eggs. Because dilute urine is less odorous, adequate fluid intake should help in preventing odor. Deodorant tablets are available for externally worn urostomy appliances and can be placed in the pouch. If the continued on page 346
patient reuses appliances, they should be washed thoroughly with soap and lukewarm water. The pouch can also be soaked in dilute white vinegar or in a commercial deodorant product for 20 to 30 minutes. Additionally, ingestion of methionine, an essential amino acid, and taking ascorbic acid by mouth may help acidify urine and help suppress odors (Black et al., 2001).

Conclusion

Caring for the patient with a urinary diversion requires both the patient and family members to acquire many new skills. The patient’s primary nurse, enterostomal therapy nurse, and the wound ostomy continence nurse work closely with the patient and family to assist in all phases of managing the ostomy or neobladder. Verbal and written instructions are provided to the patient along with opportunities to practice and demonstrate the skills needed to manage urinary drainage. Involving at least one family member or significant other in the teaching process is invaluable should the patient be temporarily unable to complete the required care. The nurse facilitates integration of these new skills into daily life. Thus, the patient and family learn the necessary skills and achieve a level of confidence that eases the transition to home care.

References