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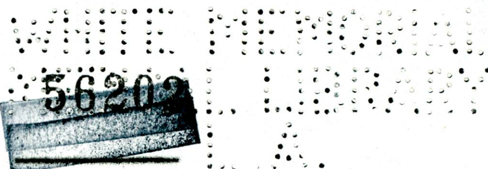
A STUDY OF THE HOME-CARE INSTRUCTION NEEDS OF COLOSTOMY PATIENTS

by

Nadine C. Lewis

A Thesis in Partial Fulfillment
of the Requirements for the Degree
Master of Science in the Field of Nursing



July, 1961

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I certify that I have read this thesis and that in my opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Science.

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CHAPTER I

DESIGN OF THE STUDY

INTRODUCTION

In the work of the hospital nurse today ever increasing emphasis is being placed upon teaching patients self-care. This study is directed toward a collection of data to be used as a basis for one area of this teaching; namely, teaching the colostomy patient self-care.

The importance and usefulness of patient teaching in colostomy self-care has been attested to by patients, physicians, and nurses alike. In a research study done on 92 colostomy patients one physician stated: "We have found that the colostomy patient can adjust rapidly to his new hygienic routine if adequate educational preparations are afforded to him prior to his discharge postoperatively."[1]

Another physician has stated a similar view on the subject: "A colostomy is compatible with a useful and happy life but the initial training is most important."[2]

One colostomy patient has expressed her views of the discouraging experience of having a new colostomy in the following words:

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[1]Robert J. Samp, "The Results of a Questionnaire Survey of Colostomy Patients." Surgery, Gynecology and Obstetrics. 105:497, October, 1957.

[2]James Moroney, Surgery for Nurses, (London: E. & S. Livingstone Limited, 1958), p. 391.

"I was in desperate need of a workable plan to help me get back to normal, productive, self-supporting, and self respecting life."[3] This same patient went on to state the need of the teaching program in the following words: "Hope and courage must be backed up by accurate, practical knowledge that will enable him (the colostomy patient) to go ahead on his own."[4] Another patient makes this statement: There is "nothing more demoralizing than being left to work out one's salvation in the matter of colostomy control."[5]

The need of colostomy patients for instruction in self-care is thus repeatedly emphasized. The medical team finds itself in an opportune position to provide the needed instruction, and the professional nurse, by virtue of her prolonged and close contact with the patient, bears a major share of this responsibility. The physician, of course, has the over-all responsibility of directing the care and the instruction according to the patient's need.[6] The role of the nurse falls in the area of reinforcement and clarification of the

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[3]Sophia M. Secor, "No One Knows I Have a Colostomy," The American Journal of Nursing, 51:704, December, 1956.

[4]Ibid. p. 704.

[5]Eoline C. Dubois, "Hints on the Management of a Colostomy," The American Journal of Nursing, 55:72, January, 1955.

[6]Miriam Jacobson Saletz, "An Intestinal Rehabilitation Clinic," The American Journal of Nursing, 53:687, June, 1953.

instruction and in the implementation and choice of method of approach of the instruction program.

In order for the nurse to function effectively in this capacity she must have a thorough understanding of the medical and nursing aspects of the care of the colostomy patient, as well as an insight into the patient's point-of-view and reactions to this situation. Although each patient's teaching situation will be governed by the personality and needs of the individual patient, it is thought that a compilation of common teaching needs of colostomy patients will be of benefit to the nurse who is endeavoring to plan instruction for such a patient.

The following statement points up the nurse's responsibility in helping the new colostomy patient.

> No one can be more miserable than the individual with a poorly managed colostomy. The nurse's aim is to help the patient leave the hospital fully convinced that he can return home, a useful and active member of a family and community group. The nurse herself must believe this before she can help her patient to achieve such an outlook. The patient must understand every step of his care and be thoroughly familiar with it before he leaves the hospital.[7]

In this statement is found the challenge to the nurse that the patient be thoroughly prepared to execute his own care before discharge. He must understand his diet, medications, the proper technique for

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[7]John P. West, Manelva Keller, and Elizabeth Harmon, Nursing Care of the Surgical Patient, sixth edition, (New York: The MacMillan Company, 1957), p. 308.

irrigating, the care of the equipment, and a host of other items important in self-care of a colostomy.

Authorities agree that the goal of successful self-care and adjustment to a colostomy is an attainable one for these patients, and that the avenue to this attainment is effective instruction.[8,9,10]

In order to provide effective instruction the patient and the nurse must both have certain preparation. The "listening" approach, that is allowing the patient opportunity to express his feelings, is one of the most useful methods in helping to prepare the patient. The nurse is also prepared somewhat for her teaching role by using this approach with the patient, but many other factors enter into her preparation.

The nurse will need an adequate background of skills and understandings in order to provide effective teaching. She must understand the basic anatomy and physiology and other physical aspects related to the particular patient's condition.[11,12] She must possess specific nursing skills in irrigation, dilitation, skin care, wound care, etc., in order to provide the patient with adequate physical care.

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[8]Bernice Thompson, "Use of the Binkley Colostomy Irrigator", The American Journal of Nursing, 48:235, April, 1948.

[9]Miriam Jacobson Galetz, "An Intestinal Rehabilitation Clinic," The American Journal of Nursing, 53:687, June, 1953.

[10]Edward S. Stafford and Doris Diller, Surgery and Surgical Nursing, 3rd. ed., (Philadelphia: W. B. Saunders Co., 1958).

[11]Ibid., p. 156.

In addition to this she must have good understanding of the psychological aspects of the patient's care.[13] She needs to have some understanding of this patient's basic personality. It he is a person who found it difficult to accept himself before this surgery, certainly his adjustment problems will be multiplied.[14] The nurse needs also to understand the patient's family position and his role in life in order to learn some useful points about his motivations and ways of motivating him in learning self-care.[15]

The nurse also needs to possess teaching skills in order to make her instruction effective. She must realize that teaching is more than telling and that her understanding of the subject and the patient plays a basically important part in the success of this aspect of nursing.[16] She must have skill in demonstration accompanied by meaningful explanation in terms which are understandable to the patient.[17]

12Genevieve Waples and Bernice Thompson, "Colostomy Care, American Journal of Nursing, 48:233, April, 1948.

13Stafford, op. cit., p. 156.

14Shirley Graffam, Care of The Surgical Patient, (New York: McGraw-Hill Book Company, Inc., 1960), p. 165.

15Ibid., p. 164.

16Stafford, op. cit., p. 156.

17Ibid., p. 158.

She must realize the effectiveness of repetition of instruction and practice by the patient.[18] The entire teaching program must be suited to the patient's ability, or it will prove ineffective.[19]

The nurse also needs a positive attitude toward this teaching program. She must be convinced that she can be of help to the patient, and have confidence that the patient can successfully learn to assume this self-care. This attitude will do much more to help the patient than much time spent in teaching without it.[20]

Very little research has been done which could offer guidance in the teaching program for the colostomy patient. It was the goal of this study to make some useful contribution to this area.

STATEMENT OF THE PROBLEM

It was the purpose of this study to determine how well colostomy patients were prepared to undertake self-care at home. Related to this goal was the secondary purpose of preparation of a basic list of instructional needs of colostomy patients. Such a list should be useful in determination of content for colostomy self-care teaching programs in hospitals. The instructional needs were considered in reference to knowledge about self-care possessed by the patient at the time of discharge from the hospital.

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[18] Stafford, *op. cit.*, p. 159-160.

[19] *Ibid.*, p. 157.

[20] *Ibid.*, p. 157.

DEFINITION OF TERMS

Within the scope of this study, the term Colostomy Patient will refer to patients who have had surgery which has resulted in the formation of an artificial anus. Because of the limited number of patients (twelve) available for this study patients having either a temporary or a permanent colostomy were used. The need for instruction is very much the same for both types of patients, but the overlying need for acceptance of the colostomy is an obstacle of much larger proportion to those with a permanent colostomy. In the analysis of data comparison of findings between these two groups was made.

Satisfactory Colostomy Care refers in this study to the adherence to commonly accepted health principles by the patient in performing self-care, and the expression, by the patient, of the attainment of satisfactory adjustment in care.

In this study Colostomy Patient Needs refers to any part of the colostomy care about which the patient expresses concern and also any verbal expression by the patient showing poor understanding of colostomy self-care.

JUSTIFICATION OF THE STUDY

As mentioned previously, home care instruction is considered a basic and necessary part of nursing care, and as such is provided in many different forms to the majority of colostomy patients prior to discharge from a hospital. As yet, very little research has been done

to provide a lucid foundation for the composition of this instruction. This study is an attempt to lay a foundation in this one small area.

The following statement made by a colostomy patient should provide justification for an attempt to study the home-care instruction needs of colostomy patients.

> When I came home, I realized that my experience in the hospital had not prepared me to face an active life. I had to learn the hard way how to manage and adjust my life so that I might live as normally as my associates. I was entirely on my own -- groping around in the dark for a successful method of handling my handicap. It took me two years of trial and error, of fear and anxiety, before I learned the right way to manage my colostomy.[21]

As has been proved many times in the past, well formulated research can solve problems and provide the answers to varying types of questions, with evidence to substantiate suggested solutions.

By indentification of problems met in self-care, as related to home-care instruction received, the material gained from this study should prove to be useful in preparing a basic outline for home care instruction of colostomy patients.

SCOPE AND LIMITATIONS OF THE STUDY

The scope of this study covered a time period of fifteen months, from February 1, 1960 to May 1, 1961. The length of time which may have elapsed between the discharge of the patient from the hospital and

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[21] Secor, *op. cit.*, p. 704.

the interview of this patient was several months in some cases. This factor introduced one possible limitation in that at the time of interview a patient may have forgotten some aspect of care which presented a problem shortly after discharge but was no longer of such great concern to him. However, the small number of patients (twelve) available for this study necessitated the use of a comparatively long time period.

The study included both patients with temporary as well as with permanent colostomies. This was necessary again because of the limited number of patients available. While the adjustment problems of these two groups were somewhat different, the problems of physical care remained quite comparable.

The study was limited to patients discharged from the hospital within approximately one year after surgical construction of a new colostomy. These patients were meeting and adjusting to self-care at home, and at the same time should have had good recollection of home-care instruction given prior to discharge. A shorter time period would be preferable if more patients were readily available for the study. It was assumed in this study that the patients used had good recollection of the teaching program used in the hospital.

Added limitations were imposed by the varying circumstances of the individual patients. The home instruction given each individual patient was limited or governed by the philosophy, goals and administration of the hospital and staff concerned with the particular patient.

Each institution's accepted definition and concept of home-care instruction influenced the type and amount of instruction received by the patient.

The home-care instruction was also limited or governed by each individual patient's knowledge and ability to understand and accept the learning experiences offered by the hospital.

Since these are variables which cannot be controlled in the scope of this study, and since they present an approach which should characterize this home-care instruction situation in other hospitals, they should not present a barrier to the assumption of applicability of the study results.

Home-care instruction was limited to learning experiences given colostomy patients while hospitalized for colostomy surgery. These learning experiences were intended to prepare the patient mentally, and emotionally as well as with the needed physical abilities in giving self satisfactory colostomy care.

PREVIEW OF THESIS ORGANIZATION

Chapter two presents colostomy self-care and the procedures of the study. Chapter three deals with collection and tabulation of data, and in chapter four these data are analyzed and interpreted. The summary, conclusions, and recommendations are found in chapter five.

SUMMARY

This was a research study of the home-care instruction needs and problems of colostomy patients. Physicians, nurses, and patients alike have expressed a need for this more meaningful instruction. Nursing, as it expands and advances in home-care instruction, is in need of guide lines established on a research basis which will give meaningful approaches to the problem. It was hoped this study might be a contribution to this area of research.

CHAPTER II

COLOSTOMY SELF-CARE AND PROCEDURES OF THE STUDY

COLOSTOMY SELF-CARE

A great quantity of material has been written in journals and textbooks concerning home-care instruction for colostomy patients. Among the most helpful of these articles are those actually written by patients themselves.[22,23,24,25] These reports present an unstructured type of research approach to this problem by use of the empirical method. Because these are reports of actual experience, they are usually quite helpful to patients.

Also available in the field are articles by specialists which take a more theoretical approach and are designed for use by professional persons.[26,27,28,29] Very few of these are founded on facts

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[22] Sophia M. Secor, "No One Knows I Have a Colostomy," The American Journal of Nursing, 56:703-4, December, 1956.

[23] Sophia M. Secor, "Rehabilitation of Colostomy Patients," Hospital Progress, 33:58-60, June, 1952.

[24] Sylvia Perkins, "It Isn't the Pain Its the Worrying," The American Journal of Nursing, 39:341, April, 1939.

[25] Sophia M. Secor, "New Hope for Colostomy Patients," Nursing Outlook, 2:642-3, December, 1954.

[26] Genevieve Waples, and Bernice Thompson, "Colostomy Care," The American Journal of Nursing, 48:233-7, April, 1948.

[27] Shirley Graffam, Care of the Surgical Patient, (New York: McGraw-Hill Book Company., 1960), pp. 164-9.

resulting from research. This is one reason that a structured research approach to this problem and to many like problems is thought to hold some important answers for nurses.

Need for Good Self-Care

A colostomy is the procedure of making an artificial opening into the colon for drainage of the contents of the colon to the outside. The opening may be temporary or permanent.[30] This procedure is by no means new to medical science. The first recorded performance of a colostomy dates back to 1795 when it was performed on a patient who had a stab wound of the abdomen.[31] This patient lived for 24 years after the surgery; but many other instances of colostomy surgery since that time have not been so successful. "It was not until the present century was well on its way, with its improved diagnostic porcedures and surgical techniques, that this type of operative measure has become commonplace."[32]

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[28]Edward S. Stafford, and Doris Diller, Surgery and Surgical Nursing, third edition, (Philadelphia: W. B. Saunders Company, 1958), pp. 154-160.

[29]Robert K. Felter, et. al., Surgical Nursing, seventh edition, (Philadelphia: F. A. Davis Company, 1958), pp. 346-354.

[30]Ibid., p. 346.

[31]Eoline C. Dubois, "Hints on the Management of a Colostomy." The American Journal of Nursing, 55:71-2, January, 1955.

[32]Ibid., p. 72.

At the present time this surgery is a common procedure to hospital personnel, but it must be remembered that it is by no means common to the patient. The many refinements which have made this operation safe have not made its aftermath any less awkward for the patient.[33] The major change in body function which is brought about by colostomy surgery presents many new problems to the patient. The adjustments required in physical care and daily living routine are many. The emotional and social adjustments are great, and have a very definite influence on physical care as well.

Within the last few years the medical and nursing professions have become increasingly aware of the physical and mental adjustment problems faced by the colostomy patient, and have been making efforts to help the patient with these problems. A study was located which was performed under the direction of a group of psychiatrists and psychologists.[34] The major emphasis of this study was an understanding of the factors influencing the adjustment of the colostomy patients. and their families to this change in physical function.

Definition of Good Self-Care

In order to identify the important aspects in colostomy care

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[33] Ibid.

[34] Ruth B. Dyk and Arthur M. Sutherland, "Adaptation of Spouse and Other Family Members to Colostomy," Cancer, 9:123-138, January - February, 1956.

a literature review was done. The following are the aspects of self-care designated by many authors as essential in colostomy self-care:

Irrigation of the colon
Dilation of the stoma
Skin care around the stoma
Regulation of bowel movements
Consistency of feces
Diet
Medication
Control of odor
Abdominal wound care
Perineal wound care
Understanding of possible complications
General hygiene
Physical activity
Acceptance and emotional and social adjustment
Understanding of surgery and why done
Follow-up care
Community facilities available

Colostomy irrigation is used in the majority of cases at least for a period of time. The usual goal in the use of an irrigation is the regulation of bowel movements. Very often the irrigation may be discontinued following the establishment of regularity in movement. Some physicians prefer that an irrigation not be used if the colostomy is done on the ascending colon because of the tendency to cause or increase diarrhea. Also, in some cases satisfactory regulation is never attained without irrigation, and so the irrigation becomes a permanent part of this patient's colostomy care. Since this procedure is used by such a large percentage of colostomy patients it is essential that the procedure be well understood by the patient and that he be able to carry it out effectively.[35,36,37,38,39,40,41,42].

Dilation of the stoma is considered necessary in most cases. This is a simple procedure, but requires repeated emphasis in the teaching program in order to prevent contracture of the orifice.[43,44,45,46].

Skin care around the stoma, and the general hygiene of the patient receive repeated emphasis in literature concerning colostomy

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[35] James Maroney, Surgery for Nurses, (London: E. & S. Livingstone Ltd., 1958), p. 385.

[36] H. M. Wiley, and E. D. Sugarbaker, "Colostomy: Indications, Techniques, and Management," Surgery, Gynecology, and Obstetrics, 91:444, October, 1950.

[37] E. H. Weissenburg and H. M. Thompson, "A Colostomy Irrigator of Improved Design," Journal of the American Medical Association, 159:1201, November, 1956.

[38] F. Wilson Harlow, Modern Surgery for Nurses, third edition, (London: William Heinemann Medical Books Limited, 1954), p. 207.

[39] Henry S. Brooks, and Pearl Castile, A Textbook of Surgical Nursing, second edition, (St. Louis: The C. V. Mosby Company, 1940), p. 346.

[40] Cabot Hugh and Mary Dodd Giles, Surgical Nursing, fourth edition, (Philadelphia: W. B. Saunders Company, 1940), p. 351.

[41] Ruby Klass, "Abdominal-Perineal Resection, "The American Journal of Nursing, 51.53, January, 1951.

[42] Elizabeth Lister, "The Patient With a Colostomy," The American Journal of Nursing, 51:533, August, 1951.

[43] Robert J. Samp, "The Results of a Questionnaire Survey of Colostomy Patients," Surgery, Gynecology, and Obstetrics, 105:491-7.

[44] Graffam, loc. cit. [45] Wiley, loc. cit.

[46] Thelma Ingles and Emily Campbell, "The Patient With a Colostomy," The American Journal of Nursing, 58:1545, November 1958.

care.[47,48,49,50,51] Proper care of the skin around the stoma prevents such complications as tissue separation with retraction of the bowel and infection. Either of these complications greatly add to the problems the patient will have with physical care, as well as leading to social problems, due to inability to wear a tight fitting appliance without extreme discomfort.

Regulation and consistency of bowel movements are often related to diet. Most authors agree that proper diet holds the key to prevention of many problems in colostomy care.[52,53,54,55,56,57,58] In many references basic diet lists are available for study. These usually exclude the laxative and gas forming as well as a few other foods. However, most physicians, beginning with the basic list, encourage their patients to experiment with other foods. Many times

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[47]Virginia C. Dericks and Kathryn A. Robeson, "Problems of Colostomy Patients," Public Health Nursing, 41:16-27, January, 1949.

[48]John P. West and Manelva Keller, and Elizabeth Harmon, Nursing Care of the Surgical Patient, sixth edition, (New York: The MacMillan Company, 1957), p. 30.

[49]Bernice Thompson, "Use of the Binkley Colostomy Irrigator", The American Journal of Nursing, 48:235, April, 1948.

[50]Stafford, loc. cit.

[51]William F. MacFee and Manelva Keller, Textbook of Surgical Nursing, fourth edition, (New York: The MacMillan Company, 1942), p. 306.

[52]Graffam, loc. cit.

[53]Waples, loc. cit.

[54]Felter, loc. cit.

[55]Moroney, loc. cit.

the patient will find that he can tolerate several foods usually excluded from a colostomy diet. After a period of time of dietary experimentation the patient is quite well acquainted with the effects of most foods on bowel action. He thus regulates his eating habits to ensure a much greater measure of social confidence.

Understanding of medications ordered: use, dosage, and action, is emphasized in most programs of patient teaching. This is also necessary for the colostomy patient; however it is interesting to note that except in treatment of complications very few medications are prescribed for these patients. The main emphasis in literature is found to be the need to stress omission of any type of laxative medication because of its tendency to cause diarrhea.[59,60,61] Some orally taken deodorants (such as Charcoal tablets) are at times used, but use of these, due to varying effects, is not encouraged for most colostomy patients.

Control of odor is a problem faced by virtually every colostomy patient. The problem is most satisfactorily met by the majority of patients in wearing a tight-fitting appliance which does not allow

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[56] L. Kracer Ferguson and Lillian A. Sholtis, Eliason's Surgical Nursing, (Philadelphia: J. P. Lippincott Company, 1959), p. 417.

[57] Mildred R. Van Schoick, "Emotional Factors in Surgical Nursing," The American Journal of Nursing, 46:451, July, 1946.

[58] Ethel M. Strueben, "Nursing Care for the Patient With an Abdomino-perineal Resection," The American Journal of Nursing, 51:227, April, 1951.

odor to escape. Some deodorants for dressings and colostomy bags are also available.[62,63,64]

Care of the abdominal incision is a problem of early significance in colostomy care. The healing of the incision is usually considered as a prerequisite to discharge from the hospital. However when infection of the incision has occured and healing is prolonged, the patient may be discharged before the process is complete. In this case the patients needs to be well instructed in the changing of dressings, cleansing and applying of medication to the wound and prevention of contamination from the colostomy stoma.[65,66,67,68]

Care of the perineal wound is also an important aspect since quite often the patient who has had an abdomino-perineal resection will be discharged from the hospital before the perineal wound is healed. This is usually a deep wound which is most often irrigated or supplied with drains in order to ensure uncomplicated healing by second intention. Thus the healing period is prolonged and the

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[59] MacFee, loc. cit.

[60] Harlow, loc. cit.

[61] Hugh, op. cit., p. 351.

[62] Gamp, op. cit., p. 491.

[63] Dericks, loc. cit.

[64] Ferguson, loc. cit.

[65] West, loc. cit.

[66] Stafford, op. cit., p. 152.

[67] Klass, loc. cit.

[68] Brooks, loc. cit.

patient may have need of special instruction in care of this wound also.[69,70,71]

Many complications may occur in any post-operative recovery period. Prolapse of the bowel, intestinal obstruction, retraction or contraction at the orifice, diarrhea, and urinary infections are a few which are seen more commonly following colostomy surgery. Whatever the complication, if it is still present at discharge, the patient must receive instruction in any special care needed in relationship to it.[72,73,74,75]

The amount of physical activity which would be beneficial and yet not harmful to the post-operative patient is always a question to be answered by the cooperative efforts of physician, nurse, and patient. The physician or nurse may set some prescribed limits for the patient and yet much area remains for experimentation. The patient needs to be informed of types of activities which would adversely affect his recovery, and also how much freedom he may have to plan his own program at home.[76.77,78.79]

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[69]Graffam, loc. cit.

[70]Waples, loc. cit.

[71]Klass, loc. cit.

[72]Samp, loc. cit.

[73]Waples, loc. cit.

[74]Moroney, loc. cit.

[75]Wiley, loc. cit.

[76]Dubois, loc. cit.

[77]Thompson, loc. cit.

[78]Moroney, loc. cit.

[79]Klass, loc cit.

Emotional and social adjustment are difficult for any colostomy patient. Many are helped by the realization that others have also experienced this change in body function and are still able to follow normal lives. The patient needs opportunity to express his feelings in this regard and thus will find help in solving his problems himself. Many patients need the reassurance that they will eventually be able to follow most social and physical activities just as they did before surgery. An understanding of the surgical procedure, the resulting alteration in function and why this was necessary often is helpful to the patient in adjusting to this change.[80,81] This is an area of need in the teaching program which cannot be over emphasized.[82,83,84,85]

Teaching for Good Self-Care

The health professions have found two successful avenues of approach in dealing with the problems faced by colostomy patients. One of these is the "listening" approach in which the patient is encouraged in expression of his feelings, which has gained much ground under the sheltering wing of psychiatrists and psychologist. This approach has been most successful in dealing with the emotional adjustment and acceptance needed by the colostomy patient. Nurses have also been learning to use this approach in helping the patient with the less complicated adjustment problems.[86]

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[80]Samp, op. cit., p. 596. [81]Ferguson, loc. cit.

[82]Stafford, loc. cit. [83]Graffam, loc. cit.

[84]Van Schoick, loc. cit. [85]Strueben, loc. cit.

The other approach, which has received longer and greater emphasis, is that of providing needed information in a meaningful way. This "teaching" approach for colostomy patients has been in operation in some form since the first colostomy surgery was done. The usefulness of this approach is determined by the skill of the teacher, the patient-teacher relationship, and the magnitude and type of the patients' problems. Even though the "teaching" approach has had greater emphasis this should not indicate that it is the most important. Today it is well understood that "listening" and "teaching" must go hand-in-hand, and in most cases the listening must proceed the teaching. Listening is the avenue by which the teacher determines the basis and the starting point for the teaching, as well as identifying problems and airing conflicts in order to prepare the way for the teaching program.

In reference to the research basis for teaching colostomy patients, the following studies have been located and investigated: One nursing research study concerning colostomy patients was located.[87] This was an interview study approaching the problem of emotional adjustment to a colostomy. It placed little emphasis upon the teaching of the physical aspects of colostomy care. It was felt by the author of this study that acceptance of the colostomy and emotional and social

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[86]Betty L. Hart and Anne W. Rohweder, "Support in Nursing," The American Journal of Nursing, 59:1400, October, 1959.

[87]Anita Sater, (Under Direction of Priscilla S. Normark) "Reactions to Colostomy, Follow-up Interviews with 20 Former Patients" University of Washington, 1958. (Unpublished).

adjustment of the patient may be the greatest problem the patient faces. In this study it was pointed out that valuable assistance from the medical professions may be offered the patient to aid in solving this problem.

Another research study under the direction of several members of the medical profession was a general survey of colostomy patients done by questionnaire.[88] This revealed some specific problem areas faced by the colostomy patient, and suggested a well planned and organized patient teaching program as one of the best solutions to these problems. The problem areas presented in this study are duplicated in much of the literature concerning colostomy care. These problem areas are included in a list given previously in this chapter.

An interview study was carried on by various members of the health team in another hospital.[89] Colostomy patients in the hospital, the out-patient department and in the home were interviewed in an effort to gather suggestions to be used in improvement of hospital care and teaching of this type of patient. This study was useful in reaching its intended purpose, but was done on an empirical basis, reaching its intended purpose without specifically designated research goals, procedures and boundries.

Many authorities advocate that an outline of the essential points in diet and care be available in written form. This may then

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[88]Samp, loc. cit. [89]Dericks, loc. cit.

be sent home with the patient to reinforce the teaching done in the hospital.[90,91]

It is also important that the patient not be left on his own follwoing discharge and that follow-up care or appointments be scheduled as needed.[92,93,94] No teaching program can anticipate all of the problems or questions which may arise after discharge, and the follow-up care should be directed toward helping the patient with these. If community facilities such as a visiting nurse service or a colostomy club are available to help the patient these will make the transition from hospital to home much easier.[95]

Because of frequent duplication of important teaching points in literature several of the most helpful references have been combined in a bibliography.[96]

PROCEDURES OF THE STUDY

The Interview Schedule

To what extent are colostomy patients able to give themselves satisfactory self-care? It was the purpose of this study to find the answer to this question. The interview schedule was constructed

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[90]Stafford, loc. cit.

[91]Wiley, op. cit., p. 446.

[92]Samp, op. cit., p. 491.

[93]Thompson, loc. cit.

[94]Stafford, loc. cit.

[95]Graffam, loc. cit.

[96]See Appendix D.

to answer the questions about self-care as described in the first part of this chapter.[97] The interview method was chosen in order to facilitate more complete and adequate returns from the investigation. In the preliminary development of the interview schedule literature on colostomy care was surveyed in order to locate important areas for investigation. In order to aid in elimination of bias and circumscribed answers the open-ended type of question was used throughout. Follow-up questions were supplied to gain information on subjects that were omitted by the respondent.

Data on home-care instruction were obtained from the patients themselves. Their evaluation of the problems they had met in self-care in relation to the home-instruction they had received identified the points which had been particularly emphasized in this instruction.

Development of the schedule. The information gathered in the literature review on colostomy care was incorporated into the interview schedule. This information was covered in question form, using open-ended introductory and follow-up questions. In use of the interview schedule it was intended that data be gathered on each area of importance from each patient interviewed.

Content of the schedule. The first page of the interview schedule contains a sample introduction given to the patient at the time of the interview. It was felt that the following items should be included in an introduction:

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[97]See Appendix A.

-introduction of the interviewer

-the nature and purpose of the study

-how the interviewee was chosen

-assurance of anonymity for the interviewee

-explanation for the need of taking some notes during the interview

-opportunity to ask any questions desired before beginning the interview

The second page seeks information regarding the patient's evaluation of his own performance of self-care since discharge from the hospital. Information in this respect was sought regarding most of the areas of importance listed previously. In use of this portion of the interview schedule the interviewer endeavored to ascertain the specific points in which the patient felt he had a definite problem with self-care, or those in which he felt somewhat uncertain, and those in which he felt confident in self-care. The follow-up questions were used as needed to help the patient pin-point his response in a given area.

The third page of the interview schedule dealt with the patient's evaluation of his preparedness to carry out self-care at the time of discharge. This information was sought in relationship to the patient's understanding of self-care; the three areas being designated as: did not understand; somewhat uncertain; and good understanding. Information was sought on each specific point listed in this portion of the interview schedule using the same procedure as on the previous

page.

Pages four and five of the interview schedule sought specific information regarding the hospital teaching program. Information was gathered regarding which classification of hospital personnel participated in the teaching program; on whether lay persons participated and how; on whether any opportunity was provided for the patient to observe and practice self-care prior to discharge; on the patient's feelings about this type of teaching program; and on whether the patient received any written form of instructions during this program. The patient was also questioned as to whether a family member was also taught his care. Two follow-up questions were included to give opportunity to gather any information possibly missed here-to-fore. These asked about the patient's feelings of confidence on discharge and whether there was any aspect of self-care still not understood at the time of discharge. In termination of the interview the patient was asked whether any part of the teaching he received had not been mentioned in the interview and whether he had any suggestions for improvement of the teaching he received.

The last page of the interview schedule included an outline for the thanks of the interviewer for the patient's participation and the assurance that the information gathered should be of help to other colostomy patients.

Revision of the schedule. Originally it was the intention of the author to revise the interview schedule according to suggestions obtained from the thesis committee and other experts, and follow this with further revision as indicated by a pilot study. The first part of the plan was carried out, and some revision of the interview schedule was made according to the suggestions given. It was, however, impossible to conduct a separate pilot study, because of the limited number of patients (twelve) available for participation in the study. The interview schedule was therefore used as completed. It was found during collection of data that one or two questions contained in the interview schedule were unnecessary, but use of the schedule as a whole proved to be efficient for the purpose of data collection. The use of the interview schedule in data collection is discussed further in Chapter 3.

Sources of Data

In order to increase the usefulness of the results of this study patients from two different hospitals were used. Since the purpose of the study was the identification of a research basis for home-care instruction no attempt was made to compare the teaching programs of these hospitals. The focal point is the identification of the areas of need in home-care instruction of colostomy patients, regardless of the hospital from which they were discharged.

Permission for the study was obtained from the administrative

officer and the executive board of each hospital, and the patients' names and addresses and other necessary data were obtained by a chart survey through the medical record department.

Treatment of Findings

The material obtained from the interviews was tabulated and analyzed in making a list of areas needing emphasis in home-care instruction.

SUMMARY

Most of the written material available on home-care instruction for the colostomy patient is not founded on a research basis. This fact does not necessarily hinder its usefulness to the patient or practitioner, but neither does it substantiate any broad application of such material. It is for the purpose of establishing a firmer basis for application of information that this research study was undertaken.

The fact that colostomy surgery has been used since 1795 does not necessarily indicate that the patient faces any less of an adjustment problem than with any of our more recently developed surgical procedures. Indeed, because of the major change in bodily function the physical as well as mental adjustment is great for any colostomy patient. The medical and nursing professions have endeavored to help the patient with these problems by opening avenues of communication and by setting up an endless variety of teaching programs.

Some of these teaching programs are informal and some highly structured, however the basic aim of providing aid to the patient remains the same for either type.

Several research studies related to this topic have been located and briefly summarized, but none were found which duplicated the aims or the research design of this particular study. At present there is still an urgent need for a research approach to patient teaching in colostomy self-care.

In discussion of the present status of the problem the needful preparation of the nurse for effective patient teaching is discussed. It is again emphasized that a research basis for this teaching program is essential to the validity of the program itself.

In determination of the research design the interview method was chosen as the most potentially effective method of data accumulation available for this purpose. An interview schedule was constructed and revised in implementation of use of this method. A pilot study for validification of the interview schedule was not carried out because of the limited number of patients (twelve) available for the actual research data collection.

Patients for the study were obtained through the cooperation of two hospitals. The necessary information about the patients was obtained through permission of the administrative officer and the executive board of each hospital.

CHAPTER III

COLLECTION AND TABULATION OF DATA

INSTITUTIONAL SOURCES OF PATIENTS FOR DATA COLLECTION

Five hospital's serve the vicinity and surrounding area. It was decided to use patients from each of these institutions if possible. Thus, it was thought, a better patient sampling could be obtained. A letter was prepared requesting the permission of the administrator and executive board of the hospital to pursue this study including patients from the institution in question.[98] This letter was accompanied by an abbreviated copy of the research outline.[99] Both the letter and the research outline were delivered to the hospital by the author, and in some cases it was possible to discuss the proposed research with the hospital administrator or an assistant. Four of the hospitals were private community or church supported institutions, and the fifth was a County Hospital.

One of the private hospitals returned a prompt reply that it was the opinion of the Executive Board that the patient records were for the private use of the staff and physicians of the hospital, and they felt that they would be violating a confidence placed in them by the patients in relinquishing the information requested for this research study.

A second private hospital, after deliberation at two board

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[98]See appendix B. [99]See Appendix C.

meetings stated the following in a letter:

> The Committee wishes to commend the study you are undertaking and wish you all the success in the world in obtaining this necessary information. However, because this is a private hospital, we would have to obtain permission from each individual surgeon prior to granting permission for this study on our patients. This would be administratively extremely difficult and we are unable to help you with your study.

Had the author been able to arrange an appointment for a personal interview with the administrator or even discuss the matter by phone this might have helped to clarify this problem which was solved easily with another private hospital. It was, however, impossible to accomplish either of the above even though three different attempts were made to do so. This was not thought to be due to unwillingness on the part of the administrator, but rather due to many pressing administrative duties.

A third small private hospital indicated their willingness to cooperate, and even went so far as to locate all colostomy patients of that hospital within the past year. The total number of these patients was five: of these, two turned out to have had ileostomies rather than colostomies, one was a baby under one year of age, two had temporary colostomies which had been closed for quite some time and so were no longer concerned with colostomy care, and the private physician of the remaining patient felt that the patient would object to such an interview. Thus, none of the patients from this hospital were included in the study.

The administrative personnel of the remaining two hospitals, one private, and the other a County hospital, readily agreed to the research study and were most helpful in gathering of necessary preliminary data on the patients to be interviewed.

SELECTION OF PATIENTS FOR DATA COLLECTION

In both of the cooperating institutions it was necessary to examine the surgery schedule records for the past year in order to identify those patients who had had colostomy surgery. The medical records departments of both of these hospitals catalogue patient diagnoses in this way, but neither of these departments had been able to keep their records up to date enough to include all colostomies done within the past year, and particularly those done in recent months.

Following identification of patients who had had colostomy surgery between February 1, 1960 and May 1, 1961 by name and chart number from the surgery schedules, the chart of each patient was obtained and studied for verification of necessary qualifications. A total of forty-seven patient records were studied. Thirty-five of these were disqualified for use in the research study for various reasons.[100] Three of these patients were still hospitalized at the time this study was done. These patients were not yet concerned with self-care in the hospital. Four other patients had had colostomies for varying periods of time exceeding 15 months, and had had only colostomy revision surgery within the last year. Three patients had had their colostomies closed for over

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[100]See Table I.

TABLE I

REASON FOR THIRTY-FIVE PATIENTS BEING DISQUALIFIED
FOR USE IN THE RESEARCH STUDY

Number of patients	Reason for Disqualification
3	Still in the hospital and not doing self-care.
4	Have had colostomy $1\frac{1}{2}$ years or more and had only revision surgery within the last year.
3	Colostomy had been closed for over 3 months.
5	Moved or lived too far away for interview.
7	Had cecostomy or ileostomy instead of colostomy.
13	Deceased.
35	Total

three months and these could not be expected to retain an accurate picture of the problems they had met in self-care. Five had moved or lived too far away to make an interview possible. Seven of the patients had had cecostomy or ileostomy surgery instead of a colostomy. Many of the physical aspects of care of a cecostomy or ileostomy are quite different from the care of a colostomy, and so it was decided to omit these patients from the study. Thirteen of the patients orginally identified as prospects for interview had expired prior to the time at which the interviews were undertaken. Twelve patients were thus identified as candidates for this interview study. The private hospital participating in the study requested that the author obtain the permission of the private physician of each patient for the interview before approaching the patient. This permission was readily granted by each physician contacted.

The County hospital administrator requested only that each patient interviewed from the hospital sign a release form granting permission for use of material from the patient's clinical record in this research study. Each one of the patients interviewed from the County Hospital signed this release.

Each patient was then contacted and gave personal permission for participation in the study prior to the interview. Each of the twelve patients interviewed were quite receptive of the purpose of the study and kindly cooperated in an interview which averaged 45 minutes to an hour in length.

COLLECTION OF DATA

In use of the interview schedule it was first considered necessary to provide the patient with a certain amount of introductory information. This included: a personal introduction of the interviewer, the nature and purpose of the study, the way in which this patient was chosen as a participant in the study, assurance of anonymity on the part of the patient, and an opportunity for questions before beginning the main portion of the interview.[101]

Open-ended questions were used in order to obtain free response from the interviewee. A portion of the interview schedule was reserved for data recording and classification of responses to various questions. Efforts were made by the interviewer to draw the interviewee out as much as possible with little interruption of the conversational flow. The patients did not seem to mind some note-taking during the interview, and most of them talked very freely. Any specific points omitted during the conversation were picked up by use of clarification questions later in the course of the interview.

It was felt that the use of this conversational method facilitated more complete explanation by the patient and brought to view some hidden problems as well as enhancing interviewer-interviewee rapport much more than a strict question and answer method could have done. The interview schedule thus was not always filled in in a routine

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[101]See Appendix A.

order, but responses were recorded as topics arose in the course of conversation. Later in the course of the interview the conversation was directed more by the interviewer in order to complete any portion of necessary information which had not been discussed thus far in the interview. Of course, some extraneous material enters in during the course of such an interview, but the value of the conversational method was deemed worth the added use of time.

At the close of the interview the patient was thanked for participating, and given the assurance that the use of this material should be of help to other colostomy patients. All of the interviewees seemed to appreciate this fact and many expressed their interest and stated that they were glad for the opportunity to participate.

TREATMENT OF DATA

The data were tabulated in several different ways in order to provide the widest possible range of usefulness. (Further analysis of these data is discussed in Chapter 4) Tabulation was made of all of the material gathered on the interview schedule for all twelve patients as a group. The following comparisons were then made of information gained using the first two pages of the interview schedule: (The first page having to do with patients' problems, and the second with their early adjustment in self-care at home with reference to the hospital teaching program.)

Responses of patients who had a colostomy 3 months or less

Responses of patients hospitalized for 20 days or less and those hospitalized for over 20 days.

Comparison of responses of patients having had:
1. Temporary colostomy.
2. Permanent colostomy.

Comparison of responses according to two age groupings of the patients.

Comparison of responses of male and female patients.

An effort was made to analyze any significant differences in these groupings, because of the application of such findings to the setting-up of future teaching programs.

SUMMARY

Two hospitals, one private and one a County hospital indicated willingness to participate in this study.

Patients were identified first by an examination of the surgery schedules for the past year and later by examination of the clinical records. Forty-seven patients were originally identified, only twelve of which qualified for the research study. Permission for this study was obtained from the two hospitals, from private physicians, and from the patients. County hospital patients signed a release on medical information obtained from their clinical records.

The conversational method was used in the interview in order to facilitate more complete and natural response from the patient. Most of the patients indicated satisfaction at being able to participate in such a study to benefit other patients.

The data were tabulated in several ways in an effort to identify significant differences which might have important bearing on setting-up of future teaching programs.

Analysis and interpretation of data is discussed in the next chapter.

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CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Analysis of the data resulting from a research study is an essential step leading to meaningful interpretation and use of these data. In order to be able to make useful comparisons of findings and figures resulting from this research study the data gathered were analyzed in several ways. An effort was made to clearly represent the patient group which served as the data source. The data gathered were then grouped and compared in several ways to aid in interpretation of results.

DESCRIPTION OF PATIENTS SAMPLED

Of the twelve patients used in the study,[102] five had undergone surgery and received post-operative care and teaching in a private hospital under the care of private physicians and seven were County hospital patients under the care of the staff of the County hospital. The age range of the patient group was 30 to 78 years. The average age for the group of twelve patients was 57.75 years. Four of the patients interviewed were males and eight were females.

The patients in the group had experienced colostomy surgery for a variety of reasons. Six had the diagnosis of cancer of the colon, sigmoid or rectum. Three had colostomy surgery because of diverticulitis. One each had surgery for the following reasons:

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[102] See Table II.

TABLE II

PRESENTATION OF PATIENTS SAMPLED ACCORDING TO REASON FOR SURGERY, TYPE OF SURGERY, SEX AND AGE

	Causes	Type of Colostomy	Male or Female	Age of Pt.
1.	Ca. Colon	Permanent	Male	73
2	Ca. Colon	Temporary	Female	57
3	Ca. Sigmoid	Permanent	Female	53
4	Ca. Sigmoid	Temporary	Female	78
5	Ca. Rectum	Permanent	Female	60
6	Ca. Rectum	Permanent	Female	73
7	Diverticulitis	Temporary	Female	60
8	Diverticulitis	Temporary	Female	52
9	Diverticulitis	Temporary	Female	47
10	Intestinal Adhesions	Permanent	Male	75
11	Colon Fistula	Temporary	Male	35
12	Stab Wounds of Abdomen	Temporary	Male	30

intestinal adhesions, colon fistula, and stab wounds of the abdomen. Five of these patients had surgery resulting in a permanent colostomy, and seven had temporary colostomies which would be closed in the future or had been closed within three months prior to the interview.

At the time of the interview some patients had had their colostomies for 10 months and others for lesser periods of time on down to two months. The variations here are shown in Table III. Only two patients had had their colostomies closed at the time of interview. One had been closed for one month and the other for two.

Three of the twelve patients also had had perineal surgery for removal of the lower colon and the rectum in addition to the colostomy procedure. One of these patients was a male, 73 years of age, and the other two were females ages 60 and 73.

The length of hospitalization at the time of colostomy surgery varied greatly, the range being 5 to 49 days with an average of 19.58 days hospitalization. The private and county hospital presented quite a little variation in this respect. The number of days stay in the private hospital ranged from 5 to 18 days with an average stay of 10.8 days. In the County hospital the range was 11 to 49 days with an average of 23 days.

The time between discharge from the hospital and the interview also varied greatly. Patients were interviewed as early as one month following discharge and as late as ten months following discharge. The average time between discharge and interview for the whole group was four months.[103]

TABLE III

PRESENTATION OF PATIENTS SAMPLED ACCORDING TO TYPE OF SURGERY AND TIME OF INTERVIEW IN RELATION TO DATE OF ORIGINAL SURGERY OR OF CLOSURE SURGERY

	Type of Colostomy	Time Patient Had Had Colostomy at the Time of interview	Length of Time Colostomy Had Been Closed at Time of Interview
1	Permanent	10 Months	---
2	Permanent	8 Months	---
3	Permanent	7 Months	---
4	Permanent	3 Months	---
5	Permanent	2 Months	---
6	Temporary	10 Months	---
7	Temporary	4 Months	1 Month
8	Temporary	3 Months	2 Months
9	Temporary	3 Months	---
10	Temporary	2 Months	---
11	Temporary	2 Months	---
12	Temporary	2 Months	---

PRESENTATION OF FINDINGS

It was felt that tabulation of findings would be most meaningful. Following are several tables which portray the responses of the patients to the questions asked in data collection. The orgainization of these tables was based on the construction of the interview schedule, and an introduction to and explanation of each is made as necessary.

Problems With Self-Care

Tables V to IX represent the findings from page two of the interview schedule. As previously stated the purpose of this page was the identification of problem areas in colostomy self-care at home. The responses of the patients were categorized during the interview as to whether they: 1) Had a definite problem with self-care, 2) Were somewhat uncertain about self-care and 3) Were confident in performing the various procedures in self-care, or in understanding of self-care and adjustment.

In an effort to evaluate any possible significant difference in these data various additional grouping of the patients were used for analysis purposes. The results for all twelve patients as a group were recorded. An additional group (six in number) consists of those patients who had had a colostomy for only three months or less. This breakdown was used in order to see whether the newer colostomy patient reported more problems or uncertainty in regard to self-care than those

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[103]See Table IV.

TABLE IV

PRESENTATION OF PATIENTS SAMPLED ACCORDING TO LENGTH OF HOSPITALIZATION, TYPE OF HOSPITAL AND TIME LAPSE BETWEEN DISCHARGE AND INTERVIEW

	Time Spent in Hospital for Colostomy Surgery and Recovery	Time Lapse Between Discharge from Hospital and Interview	Type of Hospital
1	49 Days	4 Months	County Hospital
2	26 Days	9 Months	County Hospital
3	26 Days	4 Months	County Hospital
4	25 Days	1 Month	County Hospital
5	23 Days	1 Month	County Hospital
6	21 Days	2 Months	County Hospital
7	18 Days	3 Months	Private Hospital
8	12 Days	3 Months	Private Hospital
9	11 Days	10 Months	County Hospital
10	10 Days	8 Months	Private Hospital
11	9 Days	1 Month	Private Hospital
12	5 Days	2 Months	Private Hospital

who had been doing self-care for a longer period of time. It was also felt that a comparison of those having a temporary colostomy (seven) with those having a permanent colostomy (five) might be helpful in analysis. The younger and older age groups were also compared; those between 30 and 59 with those 60 years and over. The responses of the male patients were compared with those of the female patients. It was also felt that a comparison based on the length of hospitalization might be useful in determining whether a longer period of hospital care would contribute to more satisfactory self-care performance at home. Thus the responses of those patients hospitalized 20 days or less were compared with the responses of those who were hospitalized over 20 days. For the tabulation of the results of comparisons of these various groups several tables were used.[104]

In comprehension of the responses recorded on these tables it is important to note that two patients did not use irrigation or dilation in self-care, five patients were not taking any medication at the time of interview, nine did not have perineal surgery in addition to the colostomy, and ten reported no complications.

Patients' Evaluation of Readiness to do Self-Care at Time of Discharge

The responses collected using the third page of the interview schedule have been summarized in the same way as those from the previous page.[105] The purpose of the use of page three of the interview

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[104]See Tables V - IX.

TABLE V

PROBLEM WITH SELF-CARE: RESPONSES OF ENTIRE GROUP SAMPLED COMPARED WITH SIX OT THE GROUP WHO HAD HAD COLOSTOMY ONLY THREE MONTHS OR LESS

	Responses of all 12 patients			Responses of 6 patients having had colostomy 3 months or less		
Area of Care	Definite Problem	Somewhat Uncertain	Confident in Self-Care	Definite Problem	Somewhat Uncertain	Confident in Self-Care
Irrigation			10/12			6/6
Dilation			10/12			6/6
Skin Care		4/12	8/12		1/6	5/6
Regulation	3/12	5/12	4/12	1/6	2/6	3/6
Consistency of Feces	1/12	5/12	6/12		3/6	3/6
Diet	1/12	8/12	3/12		4/6	2/6
Medication			7/12			4/6
Control of Odor	3/12	2/12	7/12	1/6	2/6	3/6
Abd. Wound Care		1/12	11/12			6/6
Perineal Wound Care			3/12			2/6
Complications		1/12	1/12		1/6	1/6
General Hygiene			12/12			6/6
Activity	1/12	5/12	6/12		3/6	3/6
Acceptance	4/12	4/12	4/12	3/6	2/6	1/6

TABLE VI

PROBLEMS WITH SELF-CARE: RESPONSES OF PATIENTS WITH TEMPORARY COLOSTOMY AS COMPARED WITH THOSE OF PATIENTS HAVING PERMANENT COLOSTOMY

	Responses of 7 patients with a Temporary Colostomy			Responses of 5 patients with a Permanent Colostomy		
Area of Care	Definite Problem	Somewhat Uncertain	Confident in Self-care	Definite Problem	Somewhat Uncertain	Confident in Self-care
Irrigation			6/7			4/5
Dilation			5/7			5/5
Regulation	2/7	3/7	2/7	1/5	2/5	2/5
Consistency of Feces	1/7	4/7	2/7		1/5	4/5
Diet	1/7	4/7	2/7		4/5	1/5
Medication			5/7			2/5
Control of Odor	3/7	1/7	3/7		1/5	4/5
Abd. Wound Care		1/7	6/7			5/5
Perineal Wound Care						3/5
Complications		1/7	1/7			
General Hygiene			7/7			5/5
Activity	1/7	3/7	3/7		2/5	3/5
Acceptance	3/7	3/7	1/7	1/5	1/5	3/5

TABLE VII

PROBLEM WITH SELF-CARE: RESPONSES OF YOUNGER AND OLDER AGE GROUPS COMPARED

	Responses of 6 patients between 30 & 59 years of age			Responses of 6 patients 60 years of age and over		
Area of Care	Definite Problem	Somewhat Uncertain	Confident in Self-care	Definite Problem	Somewhat Uncertain	Confident in Self-care
Irrigation			5/6			5/6
Dilation			5/6			5/6
Skin Care		3/6	1/6		1/6	5/6
Regulation	2/6	2/6	2/6	1/6	3/6	2/6
Consistency of Feces	1/6	4/6	1/6		1/6	5/6
Diet	1/6	4/6	1/6		4/6	2/6
Medications			4/6			3/6
Control of Odor	3/6	1/6	2/6		1/6	5/6
Abd. Wound Care		1/6	5/6			6/6
Perineal Wound Care						3/6
Complications		1/6				1/6
General Hygiene			6/6			6/6
Activity	1/6	4/6	1/6		1/6	5/6
Acceptance	2/6	2/6	2/6	2/6	2/6	2/6

TABLE VIII

PROBLEMS WITH SELF-CARE: RESPONSES OF MALE PATIENTS COMPARED WITH THOSE OF FEMALE PATIENTS

	Responses of 4 Male Patients			Responses of 8 Female Patients		
Area of Care	Definite Problem	Somewhat Uncertain	Confident in Self-care	Definite Problem	Somewhat Uncertain	Confident in Self-care
Irrigation			3/4			7/8
Dilation			4/4			6/8
Skin Care		2/4	2/4		2/8	6/8
Regulation	1/4	2/4	2/4	2/8	3/8	2/8
Consistency of Feces	1/4		3/4		5/8	3/8
Diet	1/4	1/4	2/4		7/8	1/8
Medications			1/4			6/8
Control of Odor	1/4	1/4	2/4	2/8	2/8	4/8
Abd. Wound Care			4/4		1/8	7/8
Perineal Wound Care			1/4			2/8
Complications		1/4				1/8
General Hygiene			4/4			8/8
Activity	1/4		3/4		5/8	3/8
Acceptance		2/4	2/4	4/8	2/8	2/8

TABLE IX

PROBLEMS WITH SELF-CARE: RESPONSES OF PATIENTS HOSPITALIZED FOR SHORTER AND LONGER PERIOD OF TIME COMPARED

	Responses of 6 patients Hospitalized 20 days or less			Responses of 6 patients Hospitalized more than 20 days		
Area of Care	Definite Problem	Somewhat Uncertain	Confident in Self-care	Definite Problem	Somewhat Uncertain	Confident in Self-care
Irrigation			4/6			6/6
Dilation			4/6			6/6
Skin Care		2/6	4/6		2/6	4/6
Regulation	2/6	2/6	2/6	1/6	3/6	2/6
Consistency of Feces	1/6	3/6	2/6		2/6	4/6
Diet	1/6	4/6	1/6		4/6	2/6
Medication			4/6			3/6
Control of Odor	2/6		4/6	1/6	2/6	3/6
Abd. Wound Care		1/6	5/6			6/6
Perineal Wound Care			1/6			2/6
Complications			1/6		1/6	
General Hygiene			6/6			6/6
Activity	1/6	3/6	2/6		2/6	4/6
Acceptance	2/6	2/6	2/6	2/6	2/6	2/6

schedule was to assess the patient's evaluation of his understanding of self-care at the time of discharge. In gathering data in this area the interviewer attempted to direct the patient's attention to the hospital teaching program in evaluating his own understanding at the time of discharge. The responses of the patients were thus categorized into the three following areas: 1) did not understand, 2) somewhat uncertain in understanding, 3) had good understanding at the time of discharge from the hospital.

The responses of the patients to the questions on pages 4 and 5 of the interview schedule will be discussed in the section of this paper dealing with interpretation of data.

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[105]See Tables X - XIV.

TABLE X

PATIENTS' EVALUATION OF READINESS TO DO SELF-CARE AT TIME OF DISCHARGE ENTIRE GROUP SAMPLED COMPARED WITH SIX OF THE GROUP WHO HAD HAD COLOSTOMY ONLY THREE MONTHS OR LESS

	Responses of all 12 patients			Responses of 6 patients having had a colostomy 3 months or less		
Area of Instruction	Did not Under-stand	Somewhat Un-certain	Good Under-standing	Did not Under-stand	Somewhat Un-certain	Good Under-standing
Surgery & Why Done	2/12	3/12	7/12		2/6	4/6
Irrigation		2/12	9/12		1/6	4/6
Dilation			10/12			5/6
Skin Care		4/12	8/12		2/6	4/6
Regulation	2/12	7/12	3/12		4/6	2/6
Diet	3/12	4/12	5/12		2/6	4/6
Medication			6/12			4/6
Control of Odor	3/12	4/12	5/12	1/6	3/6	2/6
Abdominal Wound Care		1/12	11/12			6/6
Perineal Wound Care	1/12		2/12			2/6
Complica-tions		2/12			1/6	
Follow-up Appt. & Care	1/12		11/12			6/6
General Hygiene			12/12			6/6
Activity	3/12	4/12	5/12	1/6	2/6	3/6
Community Facilities			1/12			1/6
Emotional & Social Adj.	1/12	9/12	2/12	1/6	5/6	

TABLE XI

PATIENTS' EVALUATION OF READINESS TO DO SELF-CARE AT TIME OF DISCHARGE: RESPONSES OF PATIENTS WITH TEMPORARY COLOSTOMY AS COMPARED WITH THOSE OF PATIENTS HAVING PERMANENT COLOSTOMY

	Responses of 7 patients with a Temporary Colostomy			Responses of 5 patients with a permanent Colostomy		
Area of Instruction	Did not Under stand	Somewhat Un-certain	Good Under-standing	Did not Under-stand	Somewhat Un-certain	Good Under-standing
Surgery and Why Done	1/7	2/7	4/7	1/5	1/5	3/5
Irrigation		1/7	5/7		1/5	4/5
Dilation			5/7			5/5
Skin Care		4/7	3/7			5/5
Regulation	1/7	4/7	2/7	1/5	3/5	1/5
Diet	2/7	2/7	3/7	1/5	2/5	2/5
Medication			4/7			2/5
Control of Odor	3/7	1/7	3/7		3/5	2/5
Abdominal Wound Care			7/7		1/5	4/5
Perineal Wound Care				1/5		2/5
Complica-tions		2/7				
Follow-up Appt & Care			7/7	1/5		4/5
General Hygiene			7/7			5/5
Activity	1/7	3/7	3/7	2/5	1/5	2/5
Community Facilities						1/5
Emotional & Social Adj.	1/7	5/7	1/7		4/5	1/5

TABLE XII

PATIENTS' EVALUATION OF READINESS TO DO SELF-CARE AT TIME OF DISCHARGE: RESPONSES OF YOUNGER AND OLDER AGE GROUPS COMPARED

	Responses of 6 patients between 30 & 59 years of age			Responses of 6 patients 60 years of age and over		
Area of Instruction	Did not Under-stand	Somewhat Un-certain	Good Under-standing	Did not Under-stand	Somewhat Un-certain	Good Under-standing
Surgery and Why Done	1/6	1/6	4/6	1/6	2/6	3/6
Irrigation			5/6		2/6	4/6
Dilation			5/6			5/6
Skin Care		2/5	4/6		2/6	4/6
Regulation	2/6	2/6	2/6		5/6	1/6
Diet	2/6	3/6	1/6	1/6	1/6	4/6
Medication			3/6			3/6
Control of Odor	3/6	1/6	2/6		3/6	3/6
Abdominal Wound Care			6/6		1/6	5/6
Perineal Wound Care			6/6		1/6	5/6
Complica-tions		2/6				
Follow-up Appt. And Care			6/6	1/6		5/6
General Hygiene			6/6			6/6
Activity	1/6	4/6	1/6	2/6		4/6
Community Facilities						

TABLE XIII

PATIENTS' EVALUATION OF READINESS TO DO SELF-CARE AT TIME OF DISCHARGE RESPONSES OF MALE PATIENTS COMPARED WITH THOSE OF FEMALE PATIENTS

	Responses of 4 male patients			Responses of 8 Female patients		
Area of Instruction	Did not Under-stand	Somewhat Un-certain	Good Under-standing	Did not Under-stand	Somewhat Un-certain	Good Under-standing
Surgery and Why Done		1/4	3/4	2/8	2/8	4/8
Irrigation		1/4	3/4		1/8	6/8
Dilation			4/4			6/8
Skin Care		2/4	2/4		2/8	6/8
Regulation		2/4	2/4	2/8	5/8	1/8
Diet	2/4	1/4	1/4	1/8	3/8	4/8
Medications			1/4			5/8
Control of Odor	1/4	1/4	2/4	2/8	3/8	3/8
Abdominal Wound Care		1/4	3/4			8/8
Perineal Wound Care	1/4					2/8
Complications		2/4				
Follow-up Appt. & Care	1/4		3/4			8/8
General Hygiene			4/4			8/8
Activity	2/4		2/4	1/8	4/8	3/8
Community Facilities						1/8
Emotional and Social Adj.		3/4	1/4	1/8	6/8	1/8

TABLE XIV

PATIENTS' EVALUATION OF READINESS TO DO SELF-CARE AT TIME OF DISCHARGE
RESPONSES OF PATIENTS HOSPITALIZED FOR SHORTER
AND LONGER PERIODS OF TIME COMPARED

	Responses of 6 patients Hospitalized 20 days or less			Responses of 6 patients Hospitalized over 20 days		
Area of Instruction	Did not Under-stand	Somewhat Un-certain	Good Under-standing	Did not Under-stand	Somewhat Un-certain	Good Under-standing
Surgery and Why Done		2/6	4/6	2/6	1/6	3/6
Irrigation		2/6	3/6			6/6
Dilation			4/6			6/6
Skin Care		2/6	4/6		2/6	4/6
Regulation	1/6	5/6		1/6	2/6	3/6
Diet	3/6	1/6	2/6		3/6	3/6
Medications			3/6			3/6
Control of Odor	2/6	3/6	1/6	1/6	1/6	4/6
Abdominal Wound Care		1/6	5/6			6/6
Perineal Wound Care	1/6					2/6
Complica-tions		1/6			1/6	
Follow-up Appt. & Care	1/6		5/6			6/6
General Hygiene			6/6			6/6
Activity	2/6	2/6	2/6	1/6	2/6	3/6
Community Facilities						1/6
Emotional & Social Adj.		5/6	1/6	1/6	4/6	1/6

INTERPRETATION OF FINDINGS

The responses of patients to this interview study yielded much interesting information. The patients were all cooperative, interested in discussing their surgery and self-care, and desirous of being of help to other patients with similar problems. Identification of the patient sampling, and tabulation of similarities and differences in the patient sampling are discussed in the first part of this chapter, and presented in Tables 2, 3 and 4.

Problems With Self-Care

The three major problem areas which became evident through the interviews were 1) Regulation of Bowel Movement, 2) Control of Odor, and 3) Acceptance. Even those patients who had been doing self-care for a longer period of time designated these problems as the most bothersome.

Regulation and control of odor. Regulation and control of odor were cited by one patient as a source of constant embarrassment, and another stated that these caused her constant worry when visiting friends. Some of the patients felt that they had been able to solve these very satisfactorily, but most agreed that it was more difficult to handle these aspects of self-care. Control of odor seemed to pose a worse problem to the younger age group of patients than to the older age group.

Acceptance. Acceptance was cited as the major problem to be overcome. Even those patients who felt that they had now satisfactorily adjusted to the colostomy agreed that this was most difficult. It is interesting to note that patients who had had a permanent colostomy had less problems with acceptance than those with a temporary colostomy. This may be due in part to the fact that the patient with the permanent colostomy realizes that there is nothing that can be done to maintain or reinstate normal function and therefore simply makes the best of an unpleasant situation. The patient with a temporary colostomy, on the other hand, is looking forward quite eagerly to the day that normal function will once again be returned. Several of these patients expressed very strong feelings of rejection of the colostomy and felt that they could never adjust to it permanently.

It is interesting to note in Table VII that age seemed to make no difference in attitude toward acceptance of the colostomy. Table VIII shows that the female patients expressed more problems with acceptance than did male patients. However, since only four of the twelve patients were males it is difficult to establish the validity of this finding. As may be noted in Table IX length of hospitalization did not seem to play any role in whether the patient had definite problems with acceptance or not.

Some patients stated that they preferred not to discuss their surgery with neighbors or friends, but did not mind doing so with professional persons. Many of the twelve stated that early acceptance

was extremely difficult and that they had wished they had not lived through the surgery. None of the patients seemed to feel this way after the initial adjustment and training period in the hospital and after difficult parts of transition to home care were passed. One patient, even though stating that things were much better now, shed some tears while discussing this in the interview. Some patients stated that even though they felt they had personnally accepted the colostomy they preferred to remain at home and not attend church or social gatherings or go shopping. These feelings would seem to indicate that acceptance was still a major problem to them; the main aspect of the problem being fear of embarrassment.

Diet. While diet was not often designated as a definite problem area, it was very often designated as an area of uncertainty. Many of the twelve patients stated that they had received diet instruction and several had this in written form. However, diet instruction, even in written form cannot even approach the inclusiveness of direction wished by the patient. The main reason for this is that a very large number of foods react differently on different colostomy patients, and so no set rules may be made governing these foods. One point of interest is that several of the patients were having regulation problems due to diet mainly because they did not understand how to carry on any form of systematic dietary experimentation. A greater degree of uncertainty about diet was expressed by female patients than by male patients.

Consistency of feces. Consistency of feces also presents mild problems to some patients, Probably the major reason for this is that the function of the colon does not seem to regain it's normal level for several weeks after a surgery of this type. Also very much related to this problem is the patient's dietary regulation, which may be the major contributing factor to it. The younger age group of patients expressed more uncertainty about consistency of feces than the older age group. In this connection it should be noted that the younger group were much more adventuresome in the dietary area than the older group.

Physical activity. The amount of physical activity which would be allowed or would be beneficial to the patient was the only other aspect of self-care which brought forth many expressions of uncertainty. However, most of the patients who expressed the fact that they did not have much instruction in this area also stated that this had not been a worry to them. The majority of the patients stated that they simply presumed they could progressively increase their activities following discharge, and used physical manifestations and feelings as indicators for limiting or expanding the amount of physical activity. This was an area that patients often mentioned as not included in home-care instruction, but also one which did not cause them much worry.

Lesser problems with self-care. Most of those interviewed stated that they felt quite confident in self-care in the area of irrigation, dilation, skin care, medication, abdominal wound care,

understanding of complications, and general hygiene.

Concerning the understanding of possible complications, it is felt that this was not designated as a problem area simply because most of the patients did not have any complications following this surgery. None of the patients interviewed gave evidence of having received instruction about possible complications or their prevention.

A finding of some interest is the emphasis which colostomy patients place on general hygiene and cleanliness. All of the patients interviewed expressed their feelings that this is a most important aspect of care. This, in several cases, seemed to be an aid which the patient used in making the colostomy a more acceptable part of their lives.

Patients' Evaluation of Readiness to do Self-Care At Time of Discharge

The importance of problems in self-care has already been discussed in the previous section. This section is devoted to a discussion of the patients' evaluation of readiness to do self-care.

Emotional and social adjustment was again cited as an area of great uncertainty to the patient. Control of odor, diet, and physical activity were the items most often cited as those which were least understood at the time of discharge. Factors contributing to the importance of these items have already been discussed in the section on problems with self-care of this chapter.

As will be noticed on examination of Tables X through XIV

many of the same problem areas are evident as causes of uncertainty to patients. These areas include irrigation, dilation of stoma, skin care, regulation, medication, abdominal and perineal wound care, complications, follow-up care and general hygiene.

In discussing with the patients their understanding of the type of surgery and why it was done it was found that the two patients reporting that they did not understand the surgery and its necessity at the time. Both had this surgery performed under emergency conditions. Both of these patients stated that they were in such serious condition at the time of surgery that no attempt at explanation to them personally was made until after the surgical procedure was performed. Three patients stated that, even though the explanation of the surgery was made to them they did not fully understand its nature until the post-operative period. This may be partially due to inadequate teaching, but it must also be considered that the patient's emotional response may block understanding even though teaching is fairly adequate in coverage. It must, however, also be considered that the teaching program should be geared to the individual patient and that the preceptive teacher will be at least partially aware of lack of understanding and the reasons for this on the part of the patient.

Although no known community facilities specifically for the aid of colostomy patients exist in this vicinity it was considered of value to question the patients interviewed regarding any community

assistance they may have received. Only one patient reported such assistance in stating that she had been visited and assisted with care by a nurse sponsored by the American Cancer Society. This nurse visited the home shortly after the patient's discharge and several times thereafter. The patient stated that she had received much benefit from these visits. All of the other patients stated that they were not aware of any community assistance available to them and several expressed the desire for such help as might be afforded by a colostomy club. Others stated that they would rather keep the discussion of their personal problems to a very minimum, and thus would not favor a colostomy club.

Types of Teaching Programs

All of the patients stated that the physical care demonstration of methods of self-care and supervision of practice in self-care was carried out by the nursing personnel in the hospital. Most of the patients stated that physicians participated by giving verbal explanations of various aspects of the surgery and self-care as they saw need for it, but did not participate in teaching physical care. None of the patients were assisted in learning self-care by family members. Some reported that after discharge they, themselves taught some family member to assist with care as needed. One patient reported that a friend who was a nurse helped her with self-care at home.

In some instances the patients were aware of a well-planned

teaching program carried out in their behalf. One or two patients stated that they learned their self-care in the hospital when they were so short of nurses that they had to take care of themselves for a day or two and then just continued self-care after that. A few of the patients gave quite severe general criticism of the hospital teaching program, but even these patients stated that they were able to do satisfactory self-care upon discharge. This factor is probably due to the absolute necessity which faces the colostomy patient in learning self-care. The results of rejection of learning self-care only serve to prolong hospitalization, and when discharge is desirable, as it is to most patients, the stimulus to learn is great.

Patients Comments About Teaching Programs

Eleven of the twelve patients stated that they felt confident in doing self-care at the time of discharge. The one remaining patient stated that his wife took over the colostomy care at first and that she had been instructed at the hospital and had very little trouble with it.

Seven patients stated that they were familiar with all aspects of their self-care upon discharge. The other five patients each reported that there was one portion of their care which they did not know about at the time of discharge. These areas were as follows: dilation of stoma, dressing of perineal wound, skin care around stoma, administration of a medication, diet, and control of leakage

around appliance. These show no pattern of deficiency in teaching programs and are portions of care which most of the other patients reported as well covered. It is therefore necessary to attribute their lack in each specific case to differences in teaching coverage and situation for this particular patient.

All of the patients stated that they had ample opportunity to observe methods of colostomy care as done for them by the hospital personnel. All agreed that this was very useful to learning self-care and felt it to be a most important learning experience. One patient who did not practice self-care stated that she felt that observing the care done for her was all she needed in preparation for doing self-care at home. Another patient stated that she believed that the observation period was too short and that she was urged into doing self-care in the hospital while she was still too ill to benefit much by the experience.

Four of the patients stated that they did not practice self-care before discharge. These patients felt that they would have benefited by the opportunity for actual practice, but they also did not express greater problems with self-care at home than the other patients interviewed. Practice in self-care is emphasized as a very important part of such teaching programs and those patients who did have this opportunity stated that it was most helpful. Patients who practiced self-care stated that their practice included irrigation of the colon, dilation of the stoma, cleansing the skin, use of dressings and in some

cases use of appliances.

Five of the patients stated that no other member of the family had been taught any of the colostomy care. Some stated that they would much prefer to do the colostomy care themselves and not subject someone else to such an unpleasant experience.

One patient stated that no one else in her family had been taught colostomy care at the hospital, but that she thought it would have been most helpful if they had done so.

Two patients reported that a family member had received instruction in colostomy care by the hospital staff. This was a daughter in one case and a wife in the other. Two patients reported teaching their wives to do some part of the colostomy care after discharge, and two of the female patients reported taching their husbands in the same way. One patient taught her sister to help her with the colostomy care. All of the patients who received help from a family member were very appreciative of this added support and assistance at home and most did not seem to feel self conscious about it. Two stated that they would rather have done all of the care themselves, but did not feel able to do so at first. One stated that she asked for help only with the less-messy parts of her care.

Six of the patients reported that they were given written instruction regarding all or part of their care either prior to or at the time of discharge. In some instances these were general instructions covering most of the important aspects of their care.

However one or two reported that this consisted of a diet sheet only. The dietary portion of these instruction sheets were the part most often referred to by the patients. Some patients stated that they did not need to refer to other portions of the written instruction since they felt quite confident in the physical aspects of their care at the time of discharge.

SUMMARY

In this study twelve colostomy patients were interviewed about colostomy self-care. A number of different aspects of the patient sampling have been presented in order to clearly identify important factors about this group.

Tabulation of findings has been used in an endeavor to show similarities and differences. These findings have been commented on at some length in an effort to aid in interpretation.

Regulation of bowel movements, control of odor, diet, physical activity, and acceptance and emotional and social adjustment have been discussed at some length as the outstanding need areas in home-care instruction.

A list of factors considered essential in a teaching program has been presented.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

It was the purpose of this study to determine how well colostomy patients were prepared to undertake self-care at home. Related to this goal was the secondary purpose of preparation of a basic list of instructional needs of colostomy patients. Such a list should be useful in determination of content for colostomy self-care teaching programs in hospitals. A list of the points of importance in a teaching program was compiled and recommendations in teaching colostomy self-care were presented.

The interview method was used in this study in order to ensure more complete returns. Twelve colostomy patients were interviewed using an interview schedule. These patients had had colostomy surgery within the last year in one of two local hospitals. One of the hospitals was a County hospital and the other was a private institution.

Permission for the study was obtained from the administrative officer and the executive board of each institution. Information about patients was obtained from the clinical record of each patient through the cooperation of the medical records department of each hospital.

Permission for the interview was obtained from private physicians as necessary. Permission was also obtained from each patient prior to the interview. Each interview took place following the patient's

discharge from the hospital and was conducted in the patient's home.

An interview schedule was developed as a result of literature survey into methods of interviewing and into care and teaching of the colostomy patient.

A statistician was consulted regarding possible statistical analysis of the findings. It was his opinion that this study represented a set of twelve case studies, and that as such statistical analysis would not be required. It was felt that tabulation of data under several headings would be adequate. Thus the findings from the interviews were tabulated and analyzed. This was followed by interpretation.

Of the twelve patients used in the study, five had undergone surgery and received post-operative care and teaching in a private hospital and seven were county hospital patients.

The age range of the patient group was 30 to 78 years, the average age being 57.75 years. Four of the patients were males and eight were females. Six of these patients had had surgery in treatment of cancer of the colon or rectum, three in treatment of diverticulitis, and one each for intestinal adhesions, colon fistula, and stab wounds of the abdomen. Five had permanent colostomies and seven temporary ones.

At the time of interview the patients had had their colostomies for between two and ten months. Only three of the twelve patients had also had perineal surgery for removal of the lower colon and rectum.

The length of hospitalization at the time of surgery ranged from five to forty-nine days, with an average stay of 19.58 days. Patients were interviewed as early as one month and as late as ten months following discharge. The average time between discharge and interview was four months.

The findings resulting from the interviews were tabulated.

Patients designated three areas as the outstanding problems areas concerned with self-care. These were 1) regulation of bowel movement, 2) control of odor and 3) acceptance of the colostomy. In addition to these dietary management and regulation of physical activity were designated as areas in which the patient felt a lack of information at the time of discharge from the hospital.

Nursing personnel in the hospitals had carried the major responsibility for the teaching programs. Physicians added verbal explanations as they felt the patient needed this. In some instances the teaching program seemed to have been well-planned and organized, and in other instances it was less structured and based upon the patient's need and the adequacy in numbers of hospital staff.

Four of the patients stated that they did not practice self-care before discharge, but that they were able to do self-care without many problems at home. All of the patients reported ample opportunity to observe self-care before discharge. Six of the patients were also given some form of written instructions at or before the time of discharge.

Two of the patients reported that a family member was taught colostomy care by the hospital staff. Five other patients reported teaching a family member themselves to assist with their care after discharge.

Eleven of the twelve patients reported that they felt confident in doing self-care at the time of discharge. The remaining patient stated that his wife gave him competent colostomy care at first, and that he later took over the self-care under her direction.

CONCLUSIONS

Conclusions and recommendations were made cautiously because of the limited number of patients available for the study. It was also recognized that patients may have sought to preserve the reputation of the institution in which they received medical care. Feelings of loyalty toward physicians, nurses, and other personnel with whom the patient became pleasantly acquainted may tend to somewhat color their responses. Some patients may, consciously or unconsciously, yield to the desire to minimize their problems of adjustment. This, in some cases, may be on a self-protective basis from a desire to present a picture of good ability to solve one's own problems. However, even in view of these considerations it was felt that some valuable points have been gained from this study.

The main conclusion which can be drawn from this study is that the present teaching programs in these two hospitals are

meeting the home-care information needs of the colostomy patients. This factor may be due partially to the physical necessity for this type of patient to learn self-care.

Patients hospitalized for a longer period of time presented less problems with self-care than those hospitalized for a short period. This would logically seem to be due to the fact that more time can be devoted to preparation for self-care when the patient remains in the hospital for a longer period of time.

Patients with temporary colostomies present more problems with self-care than those with permanent colostomies. This may possibly be related to the fact that the patients with temporary colostomies also reported more difficulty in acceptance of the colostomy than did those patients having a permanent colostomy.

The younger patient group gave evidence of more problems with self-care than the older patient group. This factor may be related to a greater tendency toward participation in social functions by the younger patient group, or to the fact that younger patients more often are engaged in pursuit of some type of employment, while the older patient is often retired.

RECOMMENDATIONS

Recommendations Regarding Teaching Programs

Problem areas for content needs. Some items in self-care have been pointed out as problems to the greater number of patients, it is also true that any one of the problem areas may be of special significance to a particular patient. It is for this reason that each of these problem areas should be covered in a teaching program. These problem areas are as follows:

Irrigation of the colon

Dilation of the stoma

Skin care

Regulation of bowel movement

Consistency of feces

Medications

Control of odor

Abdominal wound care

Perineal wound care

Understanding of possible complications

General hygiene

Physical activity

Acceptance and emotional and social adjustment

Understanding of surgery and why done

Follow-up care

Community facilities

Approaches for teaching. While a secondary purpose of this study was to prepare a basic list of instructional needs of colostomy patients, some thought was given to instructional approaches also. Through patient's comments and review of literature the following recommendations are made.

The most difficult and outstanding problem was that of acceptance and emotional and social adjustment. This should be given ample consideration in every teaching program. The patient needs assistance with this problem beginning as early pre-operatively as possible and extending into the post-hospitalization period through follow-up care. Giving the patient opportunity to express his feelings and to seek solutions to problems together with help from other colostomy patients have been useful in the past. Also pre-operative discussion of the nature of the surgery and of self-care should be helpful. The patient is in need of the whole-hearted support of the health team and of his family during this entire period of adjustment.

Patients have also expressed need for added help with regulation of bowel movement and control of odor. One suggestion made by a patient was that if an appliance is to be used it be obtained and fitted well in advance of the discharge date. Two patients who had special problems with fitting of appliances stated that they went to surgical supply houses after discharge and were able to obtain much more comfortable and satisfactory appliances than

those obtained through the hospital. It is important to note that one type of appliance will not be satisfactory for all patients and that the hospital staff should evaluate the type of colostomy, noting especially its position before helping the patient choose an appliance. Patients should be told that deodorants for dressings and for colostomy bags are available and these may well be obtained and used in the hospital. The use of orally taken deodorants, such as charcoal tablets, is useful for some patients, and may be considered as a possible means of control of odor.

In relationship to dietary instruction it is recommended that the patient be supplied with a basic list of foods which usually cause colostomy patients problems with flatulence or diarrhea. In addition to this the patient should have some special instruction in a useful method to use in dietary experimentation. The fact that only one new food should be tried at a time will greatly simplify an evaluation of the effect of new foods upon the patient. It would be worthwhile to recommend that the patient keep a record of the effect of various foods as they are added to the diet experimentally. It is also well to inform the patient that some favorite foods, even though they may cause trouble with odor, may be taken at times when the patient has no plans for social contacts in the few hours following a meal. This suggestion is sometimes helpful to the patient who becomes discouraged about certain dietary restrictions.

In regard to the relationship of diet, regulation and control

of odor, it is recommended that patients be informed that these areas may be problems for a longer period of time than some other parts of self-care. Thus the patient will be mentally prepared for a fairly long adjustment period and is not so apt to become discouraged soon after discharge when some problems persist.

One aspect of the teaching program for colostomy patients which seems to have been at times overlooked is the patient's understanding of some of the possible complications with a colostomy. One of the patients interviewed told of experiencing a ten to twelve inch prolapse of the bowel shortly after discharge from the hospital. This was a genuinely frightening experience to this patient and one which adversely affected his progress in emotional acceptance of the colostomy for a period of time thereafter. Two other possible complications which it would be well for the patient to understand are retraction of the bowel and contraction of the orifice at the stoma. Good skin care around the stoma may be helpful in preventing infection and tissue separation which often leads to retraction. Daily dilation of the stoma is usually the only measure needed to prevent contraction of the orifice. The patient's understanding of these points is often helpful in aiding the patient in realization of the importance of good self-care.

It is also recommended that each patient be supervised in self-care prior to discharge from the hospital. In this way some needless problems may be avoided in home care. If possible a family

members should also receive instruction in colostomy care while the patient is still hospitalized.

Recommendations Regarding Further Study

It is recommended that another study of this same type be undertaken in hospitals not connected with educational programs. Such a study might produce results differing from those presented in this study since both of the hospitals used in this study were connected with educational programs.

It would also be well to repeat this same type of study on a much larger scale to aid in validification of findings.

It is strongly recommended that medical institutions consider their responsibility in improvement of medical and nursing care by participation in research programs by bona fide researchers. The confidence of the patient need not be violated in any way, since medical research is most careful in preservation of anonymity of subjects. Indeed, all of the patients interviewed in this study seemed to appreciate the opportunity to be of help to other patients with similar problems.

It is recommended that a study be done regarding the most effective teaching methods to be used in hospital teaching for colostomy self-care.

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APPENDICES

APPENDIX A.

INTERVIEW SCHEDULE

INTRODUCTION OF INTERVIEW:

Good evening (Miss, Mrs., or Mr.)______________, I am Mrs. Lewis I called you______________________regarding an interview. I am conducting this study with persons who have a colostomy, in order that I may gather some information that will help nurses in teaching patients in the hospital. You were chosen to take part in the study through the record office and with the permission of the physicians and administration at______________________________Hospital. The information you give me about yourself and your colostomy will be used as factual data in this study only. Your name will not be used at all, and in connection with the study will be known only to me.

In order to see that I include everything of importance I'll be taking some notes down as we talk.

Do you have any questions before we continue?

1. How have you been getting along with your care since you came home?

Follow-up Questions:

a. Have you had any problems with ____________________?

b. How do you feel about ____________________?

Terminate:

Do you have any problems with anything we have not mentioned?

Check Off:

Topic	Definite Problem	Somewhat Uncertain	Confident in Self-Care
Irrigation			
Dilation of Stoma			
Skin Care			
Regulation			
Consistency of Feces			
Diet			
Medication			
Control of Odor			
Abdominal Wound Care			
Perineal Wound Care			
Complications			
General Hygiene			
Activity			
Acceptance			

Notes:

2. How much did you understand about your care when you were discharged?

Follow-up Questions:

a. Did you know how to ______________________?

b. What did you know about ______________________?

c. Was ______________ mentioned to you?

Terminate:

Anything we have not covered?

Check Off:

Topic	Did not Understand	Somewhat Uncertain	Good Understanding
Surgery and Why Done			
Irrigation			
Dilation of Stoma			
Skin Care			
Regulation			
Diet			
Medication			
Control of Odor			
Abdominal Wound Care			
Perineal Wound Care			
Complications			
Follow-up Appointment and care			
General Hygiene			
Activity			
Community Facilities			
Emotional and Social Adjustment			

Notes:

INTERVIEW SCHEDULE
-4-

3. Who did this teaching when you were in the hospital?

nurse? doctor? family? friend?

Follow-up Questions

a. Did you receive instruction from someone not in the medical field?

How Much?

About what?

b. Did you practice any of your care?

Which parts?

c. Did you have a chance to observe this before practicing it?

d. How did you like this type of instruction?

e. Were you given any written instructions?

What was included in this?

INTERVIEW SCHEDULE
-5-

f. Was a member of your family taught some of your care also?

g. Were there some aspects of your care you did not know about when you came home?

h. Did you feel confident about doing your own care when you were discharged?

Terminate:

Is there anything that was included in your instruction which we have not mentioned?

Do you have any suggestions that might have improved this instruction for you?

EAGLE
OLD AGAWAM

INTERVIEW SCHEDULE

-6-

CLOSING INTERVIEW

I certainly thank you for your time and cooperation in helping with this study. This material should prove to be of value in helping nurses give better instruction to colostomy patients.

APPENDIX B

LETTER TO HOSPITAL ADMINISTRATORS

Dear :

As a graduate student of the College of Medical Evangelists School of Nursing I wish to engage in research in connection with colostomy patients of this institution. The object of this study is the identification of patients' problems in reference to home care instruction. The study in no way attempts to compare or pass judgment upon different programs of patient teaching.

I would like permission to interview these patients in their homes in order to find out if their home-care has been satisfactory, and to ascertain the types of questions they might still have about care or equipment. I wish to find out whether these patients understand the teaching received in the hospital or if different emphasis is needed in these teaching programs.

I am enclosing an outline of the proposed research. It is my request that the Executive Board of ______________________________ grant permission for this study.

Sincerely yours,

APPENDIX C

THESIS OUTLINE SENT TO HOSPITALS

TITLE: A study of the home-care instruction needs of colostomy patients

PROBLEM The purpose of the study is to compile and classify a list of the main problems in home care met by colostomy patients in order to facilitate improvement of the home care instruction of this type of patient. The problems will be considered in reference to knowledge about self-care possessed by the patient at the time of discharge from the hospital.

LIMITATIONS:

1. Limited to patients discharged from a hospital within one year following a new colostomy
2. Home care instruction is limited to learning experiences given colostomy patients while still hospitalized after primary colostomy surgery. These learning experiences are intended to prepare the patient mentally and emotionally as well as with the needed physical abilities in giving self satisfactory colostomy care.
3. The home care instruction will be limited by each hospital's definition or concept of this teaching function.
4. The home care instruction will be limited by the patient's knowledge and ability to understand and accept the learning experiences offered by the hospital.

DEFINITION OF TERMS

1. Satisfactory Colostomy Care: This refers to the adherence to good health principles by the patient in performing self-care and the expression, by him of the attainment of satisfactory adjustment in giving self-care.

2. Colostomy Patients: This refers to patients who have had surgery which has resulted in an artificial anus.
3. Colostomy Patient Needs: Any part of the colostomy care about which the patient expresses concern (past or present). Also any vital expression by the patient showing poor understanding of colostomy self-care

METHOD OF STUDY:

1. Literature Survey:
   a. Identification and examination of research studies related to the subject of the study
   b. Background study for preparation of the interview schedule:
      (1) colostomy information
      (2) interviewing information
2. Construction and Revision of the interview Schedule:
3. Hospital records survey to locate interviewees.
4. Collection of Data:
   (Interview of colostomy patients using the interview schedule.)
5. Tabulation and analysis of data
6. Summarization of findings and interpretation of data.
7. Conclusions and recommendations.
8. Outline of needed home instruction with suggestions as to methods of approach.

APPENDIX D

THE FOLLOWING ARTICLES ARE REPRESENTATIVE OF THOSE WHICH HAVE BEEN USEFUL IN DEFINING GOOD COLOSTOMY SELF-CARE

Agnew, James W. "Abdominal-Perineal Resection," American Journal of Nursing, 51:225-6, April, 1951.

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LOMA LINDA UNIVERSITY

Graduate School

A STUDY OF THE HOME-CARE INSTRUCTION NEEDS OF COLOSTOMY PATIENTS

by

Nadine C. Lewis

An Abstract of a Thesis

In Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

July, 1961

ABSTRACT

It was the purpose of this study to determine how well colostomy patients were prepared to undertake self-care at home. Related to this goal was the secondary purpose of preparation of a basic list of instructional needs of colostomy patients. Such a list should be useful in determination of content for colostomy self-care teaching programs in hospitals.

The interview method was used in this study in order to ensure more complete returns. Twelve colostomy patients were interviewed using an interview schedule. These patients had had colostomy surgery within the last year in one of two hospitals used in the study. One of the hospitals was a county hospital and the other was a private institution.

Permission for the study was obtained from the administrative officer and the executive board of each institution. Information about patients was obtained from the clinical record of each patient through the cooperation of the medical records department of each hospital.

Permission for the interview was obtained from private physicians as necessary. Permission was obtained from each patient prior to the interview. Each interview took place following the patient's discharge from the hospital and was done in the patient's home.

The interview schedule was developed, and the patients were interviewed in their homes. The findings from the interviews were

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tabulated, analyzed, and interpreted.

The main over-all conclusion which was drawn from this study was that the existing teaching programs in these two hospitals were quite adequate in meeting home-care information needs of colostomy patients.

Patients designated three areas as the outstanding problem areas concerned with self-care. These were regulation of bowel movement, control of odor, and acceptance of the colostomy. In addition to these dietary management and regulation of physical activity were designated as areas in which the patients felt a lack of information at the time of discharge from the hospital.

A list was prepared as a guide for coverage in a program for teaching colostomy self-care.

While a secondary purpose of this study was to prepare this list of instructional needs of colostomy patients, some thought was given to instructional approaches also. Through patients' comments and review of literature recommendations for teaching were made.

Conclusions were reached on a tentative basis because of the small number of patients used in the study. A larger study of the same type is recommended.

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