The implications of nurse prescribing in stoma care

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It has become apparent that the bewildering array of appliances available in stoma care has led to confusion and misuse. This article looks at the implications and benefits of nurse prescribing for patients with stomas.

In 2002, a community pharmacist was employed in my area to oversee and advise GP prescribing in primary care. Although responsible for all aspects of prescribing, the GP shared my concerns regarding the escalating costs of stoma appliances and, in some instances, their misuse.

It seemed particularly important to involve the whole practice team if we were to make any impact on the cost of stoma prescribing while at the same time remaining the patients’ advocate as described by (Wright, 1998).

On the whole the GPs were enthusiastic. They admitted that, in general, they were unsure of the types of appliances they were being asked to prescribe and relied heavily on what patients requested. It was agreed that for a limited period the author would take over the prescribing needs of the stoma patients and audit the results.

**Method**

All the patients in the practice were e-mailed the following letter:

‘In an effort to streamline and cost-effect the stoma care service we would like to suggest the following way in which your prescription can be dispensed:

a) When you require a prescription for your supplies please telephone [01xxx xxxxxx];

b) If you are using one of the dispensing companies your supplies will automatically arrive by post;

c) If you are using a local pharmacist your “script” will be sent to you or to your pharmacy of choice. This can then be collected or delivered in the usual way.’

Local pharmacies were contacted and informed of the procedure.

**Pilot site**

It was decided to focus the audit on the urban general practice. Fifty patients were included in the study. The criteria for the choice of practice were:

- Central location. In accordance with guidelines, patients must be assessed every six months (UKCC, 1998) and no more than six repeat prescriptions should be issued without review. A central location would simplify this;

- Cost implications. The urban practice had already expressed concern at escalating costs;

- Ratio of established to newly discharged patients.

**FIG 1. RESULTS FROM STOMA CARE AUDIT OF 50 PATIENTS**
Most of the patients in the urban practice were well established and consequently had little or no recent contact with a stoma nurse.

**Establishing the service**

When a patient phoned an appointment was arranged to assess their current stoma care needs. This was either in the clinic or, in the case of the infirm, at home. Only one patient admitted to finding this intrusive, the majority welcomed the opportunity to discuss their needs.

This initial contact with each patient was the most time-consuming part of the study. Once this had been achieved, reviews took place approximately every six months. A copy of the patient’s first prescription was sent to the general practice for their records.

**Observations and findings**

In accordance with NMC guidelines for professional practice, the author approached the audit with the seven principles of nurse prescribing in mind (Prescribing Nurse Bulletin, 1999):

- Examine the holistic needs of the patient. Is a prescription really necessary?
- Consider the appropriate strategy;
- Consider the choice of product;
- Negotiate a ‘contract’ and achieve concordance with the patient;
- Review the patient on a regular basis;
- Ensure record-keeping is accurate and up to date;
- Reflect on your prescribing.

**Common problems**

Many skin barriers alter the pH of the skin. There should be a definite clinical need identified for the use of any sort of skin barrier. Films, gels and wipes can dehydrate the skin and often contain alcohol. In some instances, barrier creams keep the peristomal area moist and can act as a medium for fungal infection. Also, some may contain lanolin, which can be allergenic.

Microporous tapes used as security around the flange should be unnecessary with a well-fitting appliance. Hydrocolloid adhesives adhere by body heat alone to the peristomal skin, rather than relying on a reaction with the skin. A barrier of any kind between the hydrocolloid and the skin may therefore impair adhesion.

Pre-cut appliances may not match the actual size of the stoma. Not all stomas are ‘round’ and may need a unique template. Particular care must be taken to ensure a perfect fit around a small bowel stoma, for example, to maintain skin integrity.

Swabs are not necessary to clean the stoma. Soft wipes such as those supplied by dispensing companies can be used, or alternatively good-quality tissue or kitchen roll. Warm tap water and a mild soap (if required) are sufficient.

It is important to consider if the appliance is appropriate. Having to remove it several times a day will lead to epidermal stripping. Consider using a drainable appliance. In general, excoriated skin looks shiny and is intensely irritating. Treat with an appropriate compound and ensure that peristomal skin is scrupulously cleaned thereafter.

Allergy is rare with hydrocolloids but is often seen with microporous adhesives. If extra adhesion is required, the suitability of the appliance should be considered. For example, is a convex pouch more appropriate or would a belt be useful? Topical steroids can be inappropriately prescribed. Often, simply adjusting the template may alleviate peristomal excoriation. Examine for fungal infection first before using more than one per cent hydrocortisone.

If diarrhoea is left untreated it will lead to dehydration and malabsorption, particularly with small-bowel stomas. Investigate dietary habits and consider the use of loperamide or codeine phosphate. To be effective, such medications should be taken 30 minutes before food.

If appliances are on a repeat prescription and automatically arrive on a monthly basis. Problems with stockpiling may arise.

**The benefits**

Of the 50 patients audited 47 said they benefited from assessment of their stoma care.

There was a very substantial reduction in the overall cost of stoma care appliances for the period of the audit. In addition, relationships with the practice team and local and community pharmacists have improved.

However, it should be noted that the audit was extremely time-consuming.

**Conclusion**

A systematic approach using the seven-step model helps to ensure that the prescription is both appropriate and cost-effective. Because of the time-consuming nature of the study only one practice can be audited at a time. Once completed, detailed information regarding prescription details should be entered into the GP practice computer for each patient (alongside patient records for the stoma care service).

Guidelines should be drawn up and sanctioned by the pharmaceutical adviser to the trust. These should be issued to each practice, the idea being that the practice manager would flag up any discrepancies in repeat prescriptions.

The study described here was successful, primarily in improving patient care, but also in providing evidence that specialist nurses can be both efficient and cost-effective.

**REFERENCES**


**KEYWORDS**  ■ Primary care  ■ Stoma care  ■ Nurse prescribing