TABLE OF CONTENTS

Assumptions ........................................................................................................................................... 1

Competencies ........................................................................................................................................ 3

1. Integumentary System ....................................................................................................................... 3

2. Wounds ........................................................................................................................................... 6

3. Ostomy, Fistula and Percutaneous Sites ......................................................................................... 15

4. Continence ..................................................................................................................................... 22

5. Bibliography ................................................................................................................................... 25
ASSUMPTIONS

The Enterostomal Therapy Client:

• is an individual of any age with an integumentary, wound, ostomy, or continence issue is the focus of enterostomal therapy nursing.

• is an individual, a family, a group, and/or a community. The family is defined by the client.

• is viewed within the biological, psychological, social, cultural, ethnical, developmental, environmental and spiritual dimensions of a total life experience.

• is a health care provider, organization or community group.

The Enterostomal Therapy Nurse:

• is a registered nurse

• has completed an enterostomal therapy nursing education program recognized by the C.A.E.T.

• promotes efficient, effective and appropriate health care programs/services in a variety of settings including acute care, ambulatory care, rehabilitation, continuing care/long-term care, alternate housing options, the client’s own home and the community.

• works in collaboration with the client and those individuals whom the client identifies to be significant to his/her care, to incorporate the individual wishes, needs and experiences into the plan of care.

• applies a specialized and expanding body of knowledge of integumentary, wound, ostomy and continence care to the practice of nursing.

• applies evidence-based and best practice.

• influences administrative decision-making related to cost-effective health care delivery and outcomes.

• pursues professional growth and development and maintains competence through: continuing education; on-going experience in the specialty of enterostomal nursing; identifying potential research topics; initiating and/or participating in nursing research; applies and disseminates research findings.

• disseminates knowledge related to enterostomal therapy nursing care and practice with others.

• participates in the professional development of enterostomal therapy nursing colleagues through mentorship and preceptorship.

• provides leadership in the specialty of enterostomal therapy nursing.

• applies technology in the specialty of enterostomal therapy nursing (e.g.,
electronic and telecommunications, new technologies).

- facilitates self care management.
- establishes age-appropriate therapeutic relationships with clients.
- applies information regarding pre-existing health conditions and altered manifestation of illness.
- advocates for clients by facilitating effective navigation of the health care system.
- applies critical thinking in the use of products and equipment.
- advocates for health policy changes.
- applies the Canadian Association for Enterostomal Therapy standards of practice for clinicians, consultants, educators, researchers and administrators.
- exercises ethical and legal judgments relevant to relationships with industry.
- exercises ethical and legal judgments relevant to the use of technology.
- initiates and participates in continuous quality improvement programs at local, provincial, national and international levels.
- initiates and participates in activities to promote enterostomal therapy nursing.

**Well-being:**

- is a personal concept which includes biological, psychological, social, cultural, ethnical, developmental, environmental and spiritual dimensions.
- is the extent to which an individual, group or community is able to realize aspirations and to function in his or her environment.
List of Competencies for Enterostomal Therapy Nursing

INTEGUMENTARY SYSTEM

General Principles of the Integumentary System

The enterostomal therapy nurse:

01.01 Understands the anatomy, physiology and function of the integumentary system including:
   01.01a epidermis
   01.01b dermis
   01.01c subcutaneous tissue
   01.01d accessory organs
   01.01e protection
   01.01f immune response
   01.01g thermoregulation
   01.01h sensation
   01.01i metabolism
   01.01j communication
   01.01k identification
   01.01l age-related factors

01.02 Understands factors affecting integumentary integrity (e.g., age, medications, nutrition, hydration, infection, comorbidities, trauma, contamination, tissue perfusion, stress, activity, mobility, cognitive and sensory status)

01.03 Understands the indications for and use of integumentary products and applications (e.g., moisturizers, creams, no-rinse cleansers, protective barriers)

Assessment of the Integumentary System

The enterostomal therapy nurse:

01.04 Performs a focused assessment of the integumentary system including:
   01.04a history and physical (e.g., presenting symptoms, integumentary, wound, health, medications, allergies, lifestyle factors, self-care ability, height and weight, comorbidities, smoking, substance use, nutrition, hydration, pain, tissue perfusion, mobility, age, assistive devices, immune status, diagnostic and laboratory tests)
01.04b biopsychosocial (e.g., e.g., cognitive status, safety factors, quality of life, socioeconomic status, motivation, education level, living arrangements, body image, cause/effect of injury, family support, lifestyle, culture, ethnical, spirituality, language, coping skills, resource availability, social impact of integumentary alteration, functional impact of integumentary alteration, conservation of energy, impact of disease on self and family dynamics, adherence to treatment plan, gestational age)

01.05 Identifies integumentary system risk factors (e.g., continence, friction, shear, falls, moisture, sensitivities, sensory perception, external contributing factors, activity level, mobility)

01.06 Performs an initial and ongoing integumentary assessment including:
  01.06a etiology
  01.06b location
  01.06c extent of epidermal damage (e.g., erythema, hematoma)
  01.06d phase of healing (e.g., bruising, ecchymosis, candidiasis, dermatitis)
  01.06e exudate (e.g., weeping dermatitis)
  01.06f infection
  01.06g thermal environment (e.g., internal, external)
  01.06h odour
  01.06i colour
  01.06k pain
  01.06l induration

Principles of Integumentary Management

The enterostomal therapy nurse:

01.07 Determines healability of the integumentary system (e.g., symptom control, maintenance, palliation)

01.08 Controls or eliminates factors causing or contributing to integumentary alteration (e.g., effects of medication, chemotherapy, radiation therapy, nutrition)

01.09 Optimizes integumentary environment
  01.09a prevents and eliminates infection
  01.09b cleanses integumentary
  01.09c maintains and restores moisture balance (e.g., absorb exudate, add moisture)
  01.09d maintains and restores pH
  01.09e controls odour
  01.09f protects integumentary from trauma and contamination (e.g., pressure, shear, friction)
  01.09g maintains thermal environment (e.g., internal, external)
  01.09h teaches avoidance of ultraviolet radiation
01.09i teaches avoidance of soaps  
01.09j manages pain  

01.10 Evaluates integumentary assessment data to adjust treatment plan  

01.11 Collaborates with other health care professionals about clients with integumentary alterations (e.g., vascular surgeons, dermatologists, plastic surgeons)  

01.12 Educates clients, caregivers and health care providers regarding prevention and treatment of integumentary alterations
WOUNDS

General Principles of Wounds

The enterostomal therapy nurse:

02.01 Understands the physiology of wound healing including
   02.01a repair (e.g., partial thickness)
   02.01b regeneration (e.g., full-thickness)
     02.01b.i hemostasis (e.g., platelet aggregation)
     02.01b.ii inflammatory (e.g., phagocytosis)
     02.01b.iii proliferative (e.g., granulation, fibroplasia, angiogenesis, contracture, re-epithelialization)
     02.01b.iv remodeling (e.g., maturation)

02.02 Identifies factors affecting wound healing (e.g., age, medications, nutrition, infection, comorbidities, trauma, contamination, tissue perfusion, stress)

Assessment of Wounds

The enterostomal therapy nurse:

02.03 Performs a focused assessment of wounds including:
   02.03a history and physical (e.g., presenting symptoms, wound, health, medications, allergies, lifestyle factors, self-care ability, height and weight, comorbidities, smoking, substance use, nutrition, hydration, pain, tissue perfusion, mobility, age, assistive devices, immune status, diagnostic and laboratory tests)
   02.03b biopsychosocial (e.g., cognitive status, safety factors, quality of life, socioeconomic status, motivation, education level, living arrangements, body image, cause/effect of injury, family support, lifestyle, culture, ethical, spirituality, language, coping skills, resource availability, social impact of wound, functional impact of wound, conservation of energy, impact of disease on self and family dynamics, adherence to treatment plan, compression techniques, gestational age, birth history, sexuality)

02.04 Identifies wound risk factors (e.g., continence, friction, shear, falls, moisture, sensitivities, sensory perception, external contributing factors, activity level, mobility, foreign bodies)

02.05 Performs an initial and ongoing wound assessment
   02.05a etiology
   02.05b location
   02.05c extent of tissue damage (e.g., classification, staging)
   02.05d phase of healing
02.05e wound size
02.05f undermining, sinus tracts, tunnels
02.05g wound bed
02.05h wound edges
02.05i exudate
02.05j periwound skin (e.g., induration, edema, colour)
02.05k infection
02.05l odour
02.05m pain
02.05n wound duration
02.05o functional impact
02.05p wound history

Principles of Wound Management

The enterostomal therapy nurse:

02.06 Determines wound healability (e.g., symptom control, maintenance, palliation)

02.07 Controls or eliminates causative/contributing factors related to wounds (e.g., nutrition)

02.08 Optimizes wound environment
   02.08a prevents and manages infection
   02.08b cleanses wound and periwound
   02.08c removes nonviable tissue (debridement)
   02.08d maintains moisture balance (e.g., absorb exudate, add moisture)
   02.08e maintains and restores pH
   02.08f eliminates dead space (e.g., cavity packing)
   02.08g controls odour
   02.08h protects wound from trauma and contamination (e.g., pressure, shear, friction)
   02.08i protects periwound skin
   02.08j maintains thermal environment (e.g., internal)
   02.08k manages pain

02.09 Evaluates wound assessment data to adjust treatment plan

02.10 Collaborates with other health care professionals about clients with wounds (e.g., vascular surgeons, dermatologists, plastic surgeons)

02.11 Educates clients, caregivers and health care providers regarding wound prevention and treatment

02.12 Understands the indications for and use of advanced wound care products and applications (e.g., hydrocolloid, alginates, foams, hydrofibres)
Wound Types

Integumentary alteration (e.g., skin tears, adhesive stripping, chemical, infectious factors, allergic factors, radiation, extravasation)

The enterostomal therapy nurse:

02.13 Interprets data related to a client presenting with integumentary alteration including
   02.13a history and physical (e.g., topical agent, purpose of adhesive, technique of adhesive removal, gestational age, duration of reaction)
   02.13b integumentary assessment (e.g., appearance, location, extent, exudate, odour, surrounding skin, infection, pruritis, moisture balance, hygiene, diaphoresis, rash, lesions, tears, blisters, skin fragility, senile purpura, bruising)
   02.13c wound assessment (e.g., Payne-Martin Classification System for skin tears)

02.14 Establishes a plan of care for a client with integumentary alteration

02.15 Implements nursing interventions to prevent and manage integumentary alteration (e.g., eliminate or minimize risk factors, refer to other health professionals, monitor extent of rash or lesions, hygiene, hemostasis)

Pressure ulcers

The enterostomal therapy nurse:

02.16 Interprets data related to a client presenting with a pressure ulcer including
   02.16a history and physical (e.g., previous skin breakdown)
   02.16b wound assessment (e.g., Shea staging, NPUAP staging, Red-Yellow-Black classification)
   02.16c risk assessment (e.g., seating, pressure off-loading devices, intensity and duration of pressure, tissue tolerance, client turning schedule, previous surgery)

02.17 Establishes a plan of care for a client with a pressure ulcer

02.18 Implements nursing interventions to prevent and manage pressure ulceration based on potential to heal (e.g., pressure reduction and relief, support surfaces, lifestyle modification, positioning, moisture management, control of shear and friction)
Venous leg ulcers

The enterostomal therapy nurse:

02.19 Interprets data related to a client presenting with venous leg ulcers including
   02.19a history and physical (e.g., family history of venous disease, deep vein thrombosis, major leg injury, vein surgery, leg surgery, prior leg ulceration, use of compression stockings, activity level and occupation, number of pregnancies, sleeping position, pulmonary embolism, congestive heart failure, renal failure, neuropathy, claudication, activity tolerance, vascular studies, past treatment)
   02.19b lower limb assessment (e.g., Ankle Brachial Pressure Index (ABPI), toe pressures, edema, eczema, ankle flare, ankle joint mobility, calf muscle pump, lipodermatosclerosis, varicose veins, colour, temperature, hyperpigmentation, atrophie blanche, gait, pulses, capillary refill, toenails, protective sensation testing, pain)
   02.19c wound assessment (e.g., location, edges, shallow, exudate)

02.20 Establishes a plan of care for a client with venous leg ulcers

02.21 Implements nursing interventions to prevent recurrence of venous leg ulcers (e.g., trauma, prolonged sitting/standing, compression for life, moisturize skin, avoid products that cause sensitivity, elevate limbs, leg exercise, weight reduction strategies, annual assessment)

02.22 Implements nursing interventions to manage venous leg ulcers (e.g., compression therapy, manage pruritis and xerosis, exercise, elevate limbs)

Arterial wounds

The enterostomal therapy nurse:

02.23 Interprets data related to a client presenting with an arterial wound including
   02.23a history and physical (e.g., smoking, sleeping position, trauma, comorbidity such as diabetes, dyslipidemia, hypertension, obesity, cardiovascular disease or surgeries, sickle cell disease, age, renal disease, COPD)
   02.23b lower limb assessment (e.g., skin appearance, pain, claudication, edema, sensation, temperature, bony deformity, pulses, ABPI, perfusion status, toe pressure, ischemic changes, capillary refill, venous return, pallor on elevation, dependent rubor, toes, nails, gait, muscle atrophy)
   02.23c wound assessment (e.g., necrotic, pale, desiccated, punched out, location)
   02.23d skin assessment (e.g., shiny, taut, hairless, dry)

02.24 Establishes a plan of care for a client with an arterial wound
02.25 Implements nursing interventions to prevent arterial wounds

02.26 Implements nursing interventions to manage arterial wounds based on potential for healing (e.g., dry or moist)

**Mixed venous/arterial leg ulcers**

The enterostomal therapy nurse:

02.27 Interprets data related to a client presenting with mixed venous/arterial leg ulcer

02.27a history and physical (e.g., family history of venous disease, deep vein thrombosis, major leg injury, vein surgery, leg surgery, prior leg ulceration, use of compression stockings, activity level and occupation, number of pregnancies, sleeping position, congestive heart failure, renal failure, neuropathy, activity tolerance, diabetes mellitus, smoking, hypercholesterolemia, ischemic heart disease, PVD, intermittent claudication, diagnostic tests such as vascular studies)

02.27b mixed venous/arterial leg ulcer assessment (may be a combination of the following symptoms of venous and arterial disease) (e.g., Ankle Brachial Pressure Index 0.5 – 0.8 (ABPI), segmental compression studies, toe pressures, edema, eczema, ankle flare, ankle joint mobility, lipodermatosclerosis, varicose veins, color, temperature, hyperpigmentation, atrophie blanche, gait, pulses, capillary refill, toenails, protective sensation testing, pain with elevation (rest pain) plus pain with dependency, ulcers with 'punched out' appearance, base of wound poorly perfused and pale, cold legs/feet (in a warm environment), shiny, taut skin, dependent rubor and pallor with elevation, pale or blue feet, gangrenous toes)

02.27c wound assessment (e.g., edges, shallow, exudate ulcer may be circumferential, pale in colour with punched-out edges, may contain necrotic tissue and eschar)

02.28 Establishes a plan of care for a client with mixed venous/arterial leg ulcer

02.29 Implements nursing interventions to prevent mixed venous/arterial leg ulcer (e.g., avoid trauma, avoid prolonged sitting/standing, ensure effective, mild level of compression, moisturize skin, avoid products that cause sensitivity, elevate limbs, promote leg exercise, weight reduction strategies, decrease blood glucose levels, stop smoking, decrease cholesterol)

02.30 Implements nursing interventions to manage mixed venous/arterial leg ulcer based on potential for healing (e.g., light compression therapy, manage pruritis, exercise, elevate limbs, decrease blood glucose levels, stop smoking, decrease cholesterol, adequate analgesia to allow sleeping in bed at night)
Neuropathic

The enterostomal therapy nurse:

02.31 Interpret data related to a client presenting with a neuropathic ulcer
   02.31a History and physical (e.g., presence and duration of diabetes, previous ulceration, coexisting lower-extremity arterial disease, past treatment, ulcer duration, diagnostic tests such as plethysmography, ABPI, Doppler exam, Arterial Duplex Scan, Transcutaneous Oxygen (TcpO2), X-ray, bone/gallium scan, CAT scan, MRI, ESR, blood glucose, HgbA1C, Serum B12, TSH)
   02.31b Lower limb assessment (e.g., pain, sensation, bony deformity, nails, musculoskeletal/biomechanical status, gait, pressure mapping, neurological assessment, foot and nail care, footwear, pulses, callus, anhydrosis, fissures/cracks, tinea pedis, inflammation, temperature, hair, edema)
   02.31c Wound assessment (e.g., callus, sinus tract probing, bone exposure)

02.32 Identifies risk/wound classification for ulceration and amputation (e.g., Wagner, University of Texas, Lower Extremity Amputation Prevention)

02.33 Establishes a plan of care for a client with a neuropathic ulcer

02.34 Implements nursing interventions to prevent neuropathic ulceration

02.35 Implements nursing interventions to manage neuropathic ulceration based on healability (e.g., pressure offloading, glucose levels, remove callus, lifestyle modification)

Lymphedema

The enterostomal therapy nurse:

02.36 Interpret data related to a client presenting with primary and secondary lymphedema
   02.36a History and physical (e.g., lymphatic obstruction, previous vascular and orthopedic surgery, congestive heart failure, renal failure, previous skin breakdown, vascular studies, pain and symptom management, latex allergies, duration of lymphedema, impact on mobility, hygiene and continence, travel to tropical climates; lymphedema treatments such as compression garments and bandages, sequential compression therapy, decongestive therapy)
   02.36b Assessment of affected body part (e.g., location, limb circumference, skin appearance, edema, ankle joint mobility)
   02.36c Wound assessment
02.37 Establishes a plan of care for a client with primary and secondary lymphedema

02.38 Implements nursing interventions to prevent primary and secondary lymphedema (e.g., hygiene, skin care, exercise, foot care, footwear, sequential compression, complex decongestive therapy, compression bandaging, limb elevation, diet)

02.39 Implements nursing interventions to manage primary and secondary lymphedema (e.g., compression garments)

**Surgical wounds**

The enterostomal therapy nurse:

02.40 Interprets data related to a client presenting with surgical wounds including

  02.40a history and physical (e.g., diagnosis, date, length and type of surgery, malignancy, postoperative edema, length of hospitalization, tension on suture line, obesity, medications such as corticosteroids, preoperative status)

  02.40b wound assessment (e.g., healing ridge, seroma, hematoma, drains, fistula, abscess, necrosis)

02.41 Establishes a plan of care for a client with surgical wounds

02.42 Implements nursing interventions to manage surgical wounds and prevent complications

**Traumatic wounds**

The enterostomal therapy nurse:

02.43 Interprets data related to a client presenting with a traumatic wound including

  02.43a history and physical (e.g., date and time of trauma, mechanism of injury, past trauma, immunization such as tetanus and rabies)

  02.43b wound assessment (e.g., hematoma)

02.44 Establishes a plan of care for a client with a traumatic wound

02.45 Implements nursing interventions to prevent recurrence of traumatic wounds (e.g., self-inflicted)

02.46 Implements nursing interventions to manage traumatic wounds
Thermal wounds

The enterostomal therapy nurse:

02.47 Interprets data related to a client presenting with a thermal wound including
   02.47a history and physical (e.g., sensation, circumstances, exposure to chemical agents, electricity and extreme temperatures)
   02.47b wound assessment (e.g., infection, classification system, calculation of area)

02.48 Establishes a plan of care for a client with a thermal wound

02.49 Implements nursing interventions to prevent recurrence of thermal injury (e.g., care of vulnerable populations, scar and contracture prevention)

02.50 Implements nursing intervention to manage thermal injury (e.g., manage fluid and electrolyte balance, optimize nutrition, manage pruritis)

Autoimmune wounds

The enterostomal therapy nurse:

02.51 Interprets data related to a client presenting with a wound of autoimmune etiology including
   02.51a history and physical (e.g., pyoderma gangrenosum, vasculitis, comorbidities such as rheumatoid arthritis, inflammatory bowel disease, scleroderma, systemic lupus, bullous pemphigoid, epidermolysis bullosa)
   02.51b wound assessment (e.g., pain)

02.52 Establishes a plan of care for a client with a wound of autoimmune etiology

02.53 Implements nursing intervention to manage client with a wound of autoimmune etiology

Malignant wounds

The enterostomal therapy nurse:

02.54 Interprets data related to a client presenting with a malignant wound including
   02.54a history and physical (e.g., pain and symptom management, oncology treatment)
   02.54b wound assessment (e.g., location and relation to underlying structures, odour, extent of tissue erosion, bleeding, pain, satellite lesions)

02.55 Establishes a plan of care for a client with a malignant wound
02.56 Implements nursing interventions to manage malignant wounds (e.g., control bleeding, bioburden/infection, protect periwound skin, cosmetic appearance, symptom management)
OSTOMY, FISTULA AND PERCUTANEOUS SITES

General Principles of Ostomy, Fistula and Percutaneous Sites

Gastrointestinal

The enterostomal therapy nurse:

03.01 Understands the anatomy of the gastrointestinal system including
   03.01a upper gastrointestinal tract (e.g., mouth, esophagus, stomach)
   03.01b small intestine (e.g., duodenum, jejunum, ileum)
   03.01c large intestine (e.g., cecum, ascending colon, transverse colon,
       descending colon, sigmoid colon, rectum, anal canal)
   03.01d accessory organs (e.g., biliary system, pancreas, liver)

03.02 Understands the physiology of the gastrointestinal system including
   03.02a motility (e.g., esophagus, stomach, small intestine, colon)
   03.02b absorption (e.g., stomach, small intestine, colon)
   03.02c secretion (e.g., small intestine, biliary system, pancreas, liver)
   03.02d elimination and storage (e.g., liver, colon, rectum, anus)

03.03 Understands the pathophysiology of the gastrointestinal system including
   03.03a inflammatory (e.g., ulcerative colitis, Crohn’s disease, radiation enteritis,
       diverticular disease)
   03.03b infectious (e.g., enteritis, pseudo membranous colitis)
   03.03c ischemic (e.g., necrotizing enterocolitis, mesenteric thrombosis)
   03.03d obstructive (e.g., volvulus, intussusception, Hirschsprung’s disease,
       Ogilvie’s syndrome, meconium ileus, motility disorder)
   03.03e malignant (e.g., bowel, rectal, anal, metastatic disease of prostate,
       uterus, cervical, ovarian, vaginal)
   03.03f other (e.g., familial adenomatous polyposis, intestinal trauma)
   03.03g congenital (e.g., imperforate anus)

03.04 Understands surgical procedures involving the gastrointestinal system (e.g.,
   abdominoperineal resection, low anterior resection, Hartmann’s procedure,
   subtotal colectomy, ileorectal anastomosis, total proctocolectomy with end
   ileostomy, ileoanal anastomosis, colectomy bowel decompression, Bishop Koop
   procedure, jejunostomy, esophagostomy)
   03.04a types of continent diversions (e.g., Kock continent ileostomy, ileoanal
       reservoir performed as a one, two or three step procedure)
   03.04b types of stoma construction (e.g., end stoma, loop stoma, double barrel
       stoma, end-loop stoma, mucous fistula, non mature stoma)
Genitourinary

The enterostomal therapy nurse:

03.05 Understands the anatomy of the urinary system including
   03.05a upper urinary tract (e.g., kidneys, ureters)
   03.05b lower urinary tract (e.g., urinary bladder, urethra, pelvic floor support structures)

03.06 Understands the physiology of the urinary system including
   03.06a urine formation and elimination
   03.06b homeostasis (e.g., water and hydration, sodium, potassium, calcium, phosphate and magnesium)

03.07 Understands the pathophysiology of the urinary system including
   03.07a congenital (e.g., cloacal extrophy, cloacal anomaly, bladder extrophy, prune belly syndrome, myelomeningocele, ureteropelvic junction obstruction, gastoschisis, omphalocele, atresias, posterior urethral valves)
   03.07b malignant (e.g., bladder, ureters, urethral, prostate, uterus, cervical, ovarian, vaginal)
   03.07c other (e.g., trauma)

03.08 Understands surgical procedures involving the urinary system (e.g., radical cystectomy and ileal conduit, ileal conduit, colon conduit, nephrostomy, vesicostomy, cystostomy, ureterostomy, continent diversions)
   03.08a types of stoma construction (e.g., end stoma, loop stoma)
   03.08b indications and types of urinary diversions (e.g., continent cutaneous diversions, orthotopic neobladder)

Reproductive

The enterostomal therapy nurse

03.09 Understands the anatomy of the reproductive system
   03.09a male (e.g., testes, epididymis, vas deferens, spermatic cord, seminal vesicles, prostate, penis, scrotum)
   03.09b female (e.g., ovaries, fallopian tubes, uterus, vagina, mons pubis, labia majora, labia minora, clitoris, vestibular glands, hymen)

03.10 Understands the physiology of the reproductive system
   03.10a male (e.g., vasculature, neurology, impotence, erectile dysfunction)
   03.10b female (e.g., dyspareunia, scar tissue, fertility, pregnancy)
Containment Products and Applications

The enterostomal therapy nurse

03.11 Understands the indications for and use of containment products and applications (e.g., convexity, paste, powder, belt, type of closure, extended wear barrier, transparent pouches such as one piece, two piece, closed-end, drainable)

Assessment of Ostomy, Fistula, Percutaneous Sites

The enterostomal therapy nurse

03.12 Performs a focused assessment an ostomy, fistula or percutaneous site including

03.12a history and physical (e.g., presenting symptoms, health history, family history, medications, allergies, nutrition, height and weight, comorbidities, smoking, substance use, pain, mobility, pregnancy, age, assistive devices, immune status, sensori-motor impairment, intake and output, visual impairment, diagnostic and laboratory tests)

03.12b biopsychosocial (e.g., cognitive status, safety factors, quality of life, socioeconomic status, motivation, education level, living arrangements, body image, cause/effect of injury, family support, lifestyle, culture, ethnical, spirituality, language, coping skills, resource availability, social impact of ostomy, functional impact of ostomy, conservation of energy, impact of disease on self and family dynamics, adherence to treatment plan, gestational age, birth history, sexuality)

03.12c stoma (e.g., type, colour, moisture, turgor, profile, location, mucocutaneous junction, function, output, edema, size, shape, friability, perfusion, devices such as rods, catheters, stents, retraction, prolapse, lacerations, necrosis/ischemia, bleeding, stenosis, polyps)

03.12d peristomal skin (e.g., intact, maceration, denuded, irritant contact dermatitis, pseudoverrucous lesions, encrustations, pressure ulcers, stripping injury, mucocutaneous separation, mucosal transplantation, candidiasis, folliculitis, allergic contact dermatitis, Caput Medusa, pyoderma gangrenosum, malignancy, psoriasis, bacterial infections, viral infections, hypergranulation, hernia)

03.12e abdomen (e.g., contours, incisions, scars, folds, creases, bony prominences, belt line, drains, distension, bowel sounds, hernia)

Principles of Ostomy, Fistula and Percutaneous Site Management

The enterostomal therapy nurse

03.13 Establishes a plan of care for a client with an ostomy, fistula or percutaneous site
03.14 Facilitates understanding of diagnosis and surgical procedures for a client with an ostomy, fistula or percutaneous site

03.15 Implements interventions including
   03.15a Teaches and counsels (e.g., perioperative, preoperative, long-term, diet, emergency identification, troubleshooting, product use and care, provides information to resume optimal lifestyle, sexual counseling, skin breakdown, prolapse, hernia, pouch leakage, obstruction)
   03.15b Assesses and determines stoma site location
   03.15c Selects products
   03.15d Manages complications (e.g., stomal, peristomal)
   03.15e Refers to community resources and other health care professionals (e.g., funding programs, support groups, retail outlets)

Fecal and Urinary Diversions (Colostomy, Ileostomy, Urostomy)

Colostomy

The enterostomal therapy nurse

03.16 Differentiates locations of colostomies and expected output

03.17 Identifies a plan of care based on location of colostomy and a client’s preferences and needs

03.18 Teaches management of retained distal segment of bowel (e.g., mucous fistula, rectal stump)

03.19 Instructs in dietary modifications (e.g. to prevent constipation or reduce gas)

03.20 Prepares for closure or permanent colostomy

03.21 Teaches irrigation to a client with a colostomy

Ileostomy

The enterostomal therapy nurse

03.22 Differentiates location of ileostomy and expected output

03.23 Teaches strategies to prevent and correct fluid and electrolyte imbalances

03.24 Teaches about changes in absorption (e.g. medications, diet, B₁₂)

04.25 Teaches management of retained distal segment of bowel (e.g., mucous fistula, rectal stump)
03.26 Teaches a client with an ileostomy about the signs and symptoms of
   03.26a obstruction
   03.26b fluid and electrolyte imbalance
   03.26c B₁₂ deficiency

03.27 Teaches strategies to prevent and manage food blockage to a client with an ileostomy

03.28 Performs ileostomy lavage

03.29 Prepares for closure or permanent ileostomy

**Urostomy**

The enterostomal therapy nurse

03.30 Differentiates location of urostomy and expected output

03.31 Teaches a client with a urostomy about
   03.31a adequate fluid intake
   03.31b dietary considerations
   03.31c use of night drainage system (e.g., blue bag syndrome)
   03.31d mucous management

03.32 Recognizes and manages peristomal complications related to prolonged contact with urine (e.g., alkaline encrustations, pseudoverrucous lesions)

03.33 Manages stents and catheters

03.34 Teaches a client with a urostomy about sign and symptoms of urinary tract infections

03.35 Teaches a client with a urostomy about the proper method to obtain urine specimens

** Continent Divisions**

**Fecal Divisions**

The enterostomal therapy nurse

03.36 Instructs a client regarding expected outcomes of fecal diversions (e.g., number of bowel movements per day, continence, dietary modifications)
03.37 Instructs a client regarding complications (e.g., pouchitis, valve failure, stricture, incontinence, pouch failure)

03.38 Implements a client nursing interventions in the immediate post operative period following fecal diversions (e.g., perianal skin protection, intubation, irrigation, dietary modifications)

03.39 Teaches a client how to integrate the management of a continent fecal diversion into daily care (e.g., skin protection, dietary modifications, intubation, irrigation, medication)

Urinary Diversions

The enterostomal therapy nurse

03.40 Instructs a client regarding expected outcomes with urinary diversions (e.g. continence, fluid intake, mucous management)

03.41 Instructs a client regarding complications (e.g., valve failure, pouchitis, stricture, infection, pouch failure, incontinence)

03.42 Implements nursing interventions in the immediate post operative period (e.g., managing drains and tubes, skin protection, intubation, irrigation)

03.43 Teaches a client how to integrate management of continent urinary diversion into daily care (e.g., skin protection, fluid intake, managing drains and tubes, intubation, irrigation, mucus management, urine specimens)

Fistula and Percutaneous Sites

Fistula

The enterostomal therapy nurse

03.44 Identifies etiologic factors and manifestations of a fistula

03.45 Assesses a client with a fistula
   03.45a source (e.g., bowel, bladder)
   03.45b location
   03.45c size (e.g., cutaneous opening, length of tract)
   03.45d topography (e.g., number of sites, proximity to bony prominences, scars, creases, incisions, drain, stoma, below, at, or above skin level, muscle tone surrounding opening)
   03.45e characteristics of output (e.g., type, source, volume, odour, consistency, gas, pH, colour)
03.45f perifistular skin (e.g., intact, macerated, erythematous, denuded, eroded, ulcerated, infected)
03.45g fluid and electrolyte, dietary, and nutritional considerations
03.45h factors that delay spontaneous closure (e.g., presence of foreign body, cancer, irradiated area, Crohn's disease, abscess)

03.46 Establishes a plan of care for a client with a fistula

03.47 Implements measures to manage a fistula (e.g., contain output, odor control, comfort measures, measurement of output, perifistular skin protection, optimize mobility, pouching system, dressing, suction, topical negative pressure therapy)

03.48 Suggests pharmacological management for a client with a fistula

**Percutaneous Sites**

The enterostomal therapy nurse

03.49 Identifies type and purpose of percutaneous tubes and drains (e.g., enteral, urinary)

03.50 Assesses patency and placement of percutaneous tubes and drains

03.51 Recommends stabilization method for of percutaneous tubes and drains

03.52 Initiates measures to prevent and manage complications for clients with percutaneous tubes and drains (e.g., tube migration, dislodgement, obstruction, leakage)

03.53 Initiates measures to prevent and manage peritube skin damage (e.g., infection, hypergranulation, chemical, mechanical, perform chemical cauterization)

03.54 Teaches a client with a percutaneous tube or drain about the care and use of equipment (e.g., hygiene)
CONTINENCE

General Principles of Continence

The enterostomal therapy nurse

04.01 Identifies goals and factors affecting outcomes for a client with incontinence

04.02 Understands the anatomy of micturition and defecation

04.03 Understands the physiology of micturition and defecation and age-related changes

04.05 Understands the pathophysiology of bladder and bowel dysfunction

04.06 Understands the surgical procedures that result in urinary and fecal incontinence

04.07 Understands the indications for and use of continence management products and applications

Assessment of Continence

The enterostomal therapy nurse:

04.08 Performs a focused assessment of a client with incontinence including
    04.08a history and physical (e.g., risk factors, psychosocial, cognitive impairment, environmental barriers, functional impairment, caregiver availability, motivation, obstetrical history, previous surgeries, neuromuscular disorders, age, medical comorbidities, bladder and bowel habits, diagnostic and laboratory tests)
    04.08b biopsychosocial (e.g., cognitive status, safety factors, quality of life, socioeconomic status, motivation, education level, living arrangements, body image, cause/effect of injury, family support, lifestyle, culture, ethinical, spirituality, language, coping skills, resource availability, social impact of incontinence, conservation of energy, impact of disease on self and family dynamics, adherence to treatment plan, gestational age, birth history, sexual health/trauma)

04.09 Identifies risk factors for a client with incontinence (e.g. smoking, obesity, exercise, sexual health, obstetrical history, environmental factors, diet and hydration, radiation, UTIs)

04.10 Performs an initial and ongoing assessment of a client with incontinence including
    04.10a abdomen
04.10b skin
04.10c urogenital exam – external
04.10d pelvic exam: visual/digital exam
04.10e rectal exam
04.10f neuromuscular testing (e.g., anal wink, bulbocavernosus reflex)
04.10g external sphincter assessment

**Principles of Continence Management**

**General Principles of Continence Management**

The enterostomal therapy nurse

04.11 Teaches measures for bladder and bowel habits
   04.11a dietary and fluid management
   04.11b toileting schedule
   04.11c emptying techniques (e.g., Credé manoeuvre, double voiding, abdominal massage)
   04.11d bowel and bladder training programs
   04.11e skin care
   04.11f pelvic muscle re-education

04.12 Selects containment products and devices (e.g., briefs, pouches, condom catheter, containment products and devices)

04.13 Identifies pharmacological treatment

04.14 Understands surgical options related to bowel and urinary incontinence

04.15 Initiates referrals to health care professional (e.g., sexual health counselling, dietitian)

04.16 Refers to community resources and other health care professionals

**Urinary Continence**

The enterostomal therapy nurse

04.17 Interprets data for a client presenting with urinary incontinence including
   04.17a history and Physical (e.g., associated conditions such as UTI, vaginitis, pelvic organ prolapse, prostatic abnormalities, interstitial cystitis, fistula, pelvic pain syndrome, malignancies, neuromuscular conditions, trauma, obstructions, diabetes, Paget’s disease)
   04.17b assessment of incontinence (e.g., diagnostic tests such as post-void residual urine measurement, EMG studies, bladder diary, urodynamics)
04.18 Identifies classification of urinary incontinence (e.g., stress, urge, overflow, functional, reflex)

04.19 Establish a plan of care for a client with urinary incontinence

04.20 Implements nursing interventions to prevent urinary incontinence (e.g., behavioural management techniques such as bladder retraining, urge suppression techniques, environmental modifications, pelvic floor muscle exercises, bladder emptying, clean intermittent catheterization, scheduled or timed voiding)

04.21 Implements nursing interventions to manage urinary incontinence (e.g., bladder emptying techniques such as double void, intermittent catheterization, indwelling urethral catheterization, suprapubic catheterization, catheter management)

**Bowel Continence**

The enterostomal therapy nurse

04.22 Interprets data for a client presenting with bowel incontinence including

04.22a history and physical (e.g., bowel diary, associated conditions such as infection, pelvic organ prolapse, fistula, pelvic pain syndrome, malignancies, neuromuscular conditions, trauma, obstructions, diabetes, hyperthyroidism, encopresis, congenital abnormalities)

04.22b assessment of Incontinence (e.g., diagnostic tests such as wink test, motility studies, anal-rectal manometry, endoscopic procedures)

04.23 Identifies classification of bowel incontinence (e.g., constipation, fecal impaction, neurogenic)

04.24 Establish a plan of care for a client with bowel incontinence

04.25 Implements nursing interventions to prevent and manage bowel incontinence (e.g., behavioural techniques such as bowel retraining, scheduled bowel evacuation, dietary management, pelvic floor muscle exercises, skin protection, containment devices, bowel cleansing, fluid and electrolyte management, antegrade colonic procedures, training and management followup)