

**Royal Hospital for Women (RHW)  
NEONATAL BUSINESS RULE  
COVER SHEET**



**Health**  
South Eastern Sydney  
Local Health District

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<b>SUMMARY</b>	To guide clinicians in the process for refeeding stoma output via the distal stoma when medically or surgically ordered/ indicated.
<b>KEY WORDS</b>	Stoma, Refeeding, Neonate, Stoma bag

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## Stoma- Refeeding Management (Neonate)

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*Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.*

## 1. BACKGROUND

Stoma refeeding is the collection of stool from the proximal stoma (ileostomy/colostomy) and re-introduction into the distal stoma or mucous fistula as a continuous infusion or as a bolus infusion via a gentle purging over a few minutes.

The aim of this process is to maximise nutrient, electrolyte and water absorption, resulting in sustained weight and decreased use of parenteral nutrition.<sup>1-3</sup> Another benefit of refeeding is to enhance bowel adaptation to prepare the distal end of the bowel for re-anastomosis.

## 2. RESPONSIBILITIES

**2.1.1 Medical (including SCH Paediatric Surgeons)**– To identify neonates that require refeeding, to identify if distal stoma flushing is required prior to initiation of refeeding. To identify volume and frequency of refeeding. To determine when refeeding can cease.

**2.1.2 Nursing Staff** – perform refeeding when required, to manage neonates that require refeeding, to identify neonates that may have complications from refeeding.

**2.1.3 POW Stoma CNC** – to identify and liaise with medical staff for neonates that require refeeding. To support NCC nursing staff in how to perform refeeding.

## 3. PROCEDURE

### 3.1 Indications

A medical or surgical order is required prior the initiation of stoma refeeding. Refeeding is currently attended to once a day by trained staff members.

Indications for refeeding include:

- Stoma output greater than 20mL/kg/day or as medically indicated
- A moderate discrepancy in proximal and distal bowel calibre
- Poor nutritional status
- Developing cholestasis
- Neonates with enterostomies and poor weight gain
- Difficult venous access
- Improve bowel adaptation prior to stoma closure

### 3.2 Equipment

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- 2-piece stoma appliance- either Coloplast or Dansac (Coloplast only for <1.2kg, Dansac for > 1.2kg) [This is determined by stoma CNC]. (Picture 1 and 2)
- 2x 20mL enteral feeding syringes (one for refeeding and one for measuring stoma output).
- Coloplast Self-Cath® catheter (size 14 Fr) for drawing up stoma bag content- only for Dansac bag (Picture 3)
- Feeding adapter (Picture 3)
- Size 5, 6 or 8 feeding tube (based on weight of neonate and size of stomas).
- Lubricant
- Sucrose 24% or Expressed Breast Milk (EBM) for pain relief
- Redi- wipes
- Plastic container with warm water
- Non- sterile gloves
- Trolley or work surface
- Disinfectant/cleaning wipes
- Waste bag Coloplast Stoma Bag

Dansac Stoma Bag



Picture 1

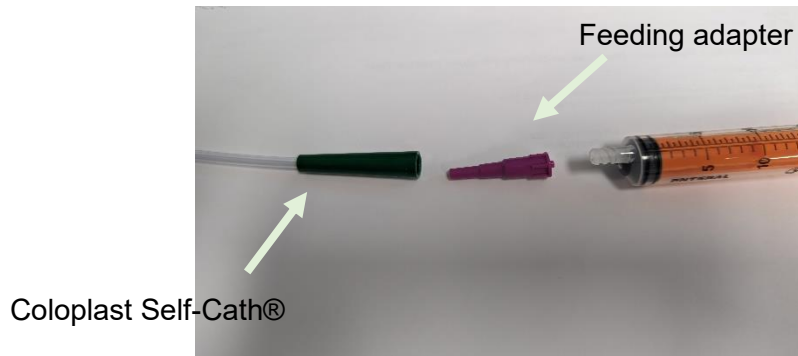


Picture 2

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Picture 3

### 3.3 Clinical practice

#### 3.3.1 Refeeding using Coloplast stoma bag

1. Identify the distal stoma.
  - The operation report indicates the position of same
2. At the first episode of refeeding-
  - 2mL of sodium chloride 0.9% flush via the distal stoma may be required to determine patency
  - The medical or surgical team will indicate if this is needed, and who will perform this
3. Identify and collect all equipment for procedure on a clean work surface. See equipment list.
4. Perform hand hygiene, don gloves.
5. Prepare patient, implement appropriate neurodevelopmental settling techniques as needed.
6. Administer sucrose 24% or EBM for pain relief.
7. Attach 20 mL enteral syringe and feeding adapter to the blue port of stoma bag. (Picture 4)
8. Draw up refeeding volume with 20mL syringe from stoma bag. (Picture 5)
9. Attach the syringe to the feeding tube in preparation for refeeding, prime the feeding tube and apply lubricant to the end.
10. Peel back the blue tab from stoma bag to reveal the hole opening. (Picture 6)
11. Insert the feeding tube into this hole and then insert feeding tube up to 5cm into the distal stoma. (Picture 7)
  - If resistant felt during insertion into distal stoma, stop and wait for neonate to relax
  - Once neonate has relaxed, continue inserting feeding tube to desired length
12. Hold the feeding tube at the desired length at the distal stoma to prevent it from slipping out.
13. Gently pulsate the output into the distal stoma in 0.2- 0.5 mL increments (Picture 7).
  - If resistance felt while refeeding, stop and wait for neonate to relax, continue with pulsating motions once neonate settled
  - Some regurgitation of fluid from distal stoma is expected, giving an impression of excess stoma losses (losses from proximal stoma + regurgitated fluid from distal stoma)
14. Remove the feeding tube from distal stoma and re-seal the bag by placing blue tab back over hole.
15. Using second 20mL enteral syringe, reattach to blue port and empty stoma bag completely.
16. Remove the enteral syringe and feeding adapter from blue port and close the port.
17. Dispose waste.
18. Remove gloves and perform hand hygiene.
19. Clean trolley and perform hand hygiene.
20. Document procedure in input/ output tab on eRIC. Record refeeding and total drainage volume. (Picture 8)



Picture 4



Picture 5



Picture 6



Picture 7

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Neostomy			
Drainage Volume			16
Refeeding Volume			8
Estimated Output Amount			
Output Description			Curd/Watery
Output Colour			Yellow
Appliances			Stoma bag present

Picture 8

### 3.3.2 Refeeding via Dansac stoma bag

1. Identify the distal stoma.
  - The operation report should indicate the position
2. At the first episode of refeeding-
  - 2mL of sodium chloride 0.9% flush via the distal stoma may be required to determine patency
  - The medical or surgical team will indicate if this is needed
3. Identify and collect all equipment for procedure on a clean work surface. See equipment list.
4. Perform hand hygiene, don gloves.
5. Prepare patient, implement appropriate neurodevelopmental settling techniques as needed.
6. Administer sucrose 24% or EBM if needed for pain relief.
7. Attach 20mL enteral syringe to feeding adapter and then to coloplast Self-Cath® catheter. (Picture 3)
8. Unclip stoma bag from base
  - Using both hands, place index and middle fingers underneath the clear lips of the stoma bag (Picture 9)
  - Gently peel the bag from the base ring secured to the abdomen. (Picture 10 and 11)
  - The base ring and adhesive dressing remain secured to the abdomen (Picture 12)
9. Empty the stoma bag using enteral syringe and Coloplast Self-Cath® catheter.
10. Draw up required refeeding volume.
11. Attach the syringe to the feeding tube in preparation for refeeding, prime the feeding tube and apply lubricant to the end.
12. Clean stomas and base ring with warm water and redi- wipes
13. Insert the feeding tube up to 5cm into distal stoma. (Picture 13)
  - If resistant felt during insertion into distal stoma, stop and wait for neonate to relax
  - Once neonate has relaxed, continue inserting feeding tube to desired length
14. Hold the feeding tube at the desired length at the distal stoma to prevent it from slipping out.
15. Gently pulsate the output into the distal stoma in 0.2- 0.5 mL increments (Picture 13).
  - If resistance felt while refeeding, stop and wait for neonate to relax, continue with pulsating motions once neonate settled
  - Some regurgitation of fluid from distal stoma is expected, giving an impression of excess stoma losses (losses from proximal stoma + regurgitated fluid from distal stoma)
16. Clean stoma with warm water and redi- wipes.
17. Re- apply stoma bag back to base. (Picture 14 and 15)
18. Check the entire ring is sealed to the base ring by visually inspecting site and gently pressing down on entire ring. (Picture 15)
19. Ensure the bottom of the bag is done up securely.
20. Dispose waste.
21. Remove gloves and perform hand hygiene.
22. Clean trolley and perform hand hygiene.

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23. Document procedure in input/ output tab on eRIC. Record refeeding and total drainage volume.  
(Picture 8)



Picture 9



Picture 10



Picture 11



Picture 12

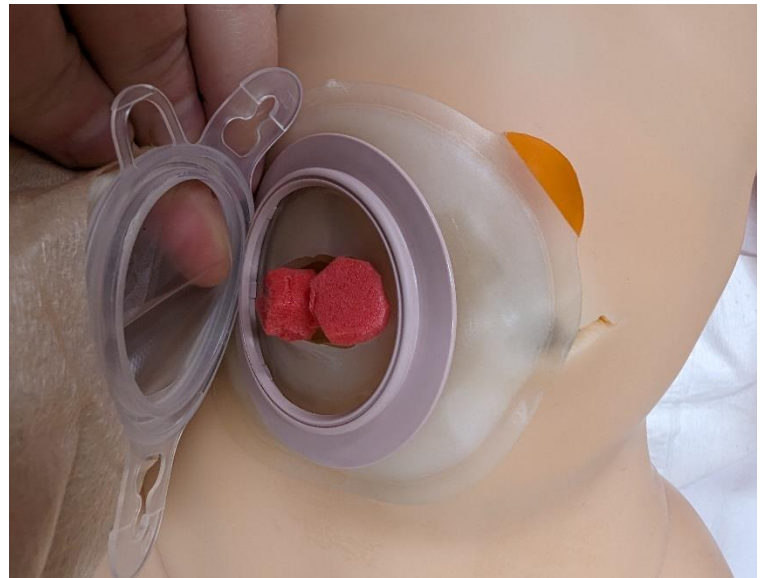
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Picture 13



Picture 14



Picture 15

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#### 3.3.3 Complications

Complications that may occur can involve the stoma, the surgical wound or the peri-stomal skin.<sup>12</sup>

1. Bleeding stoma
  - A small amount of bleeding is accepted when the stoma is being cleaned as the bowel is very vascular
  - Excessive bleeding is not normal and should be reported to the medical team. Apply calcium sodium alginate dressing while awaiting review
2. Prolapsed stoma
  - Is not uncommon complication.
  - Not able to be controlled but needs to be monitored
  - Document approximate length of protrusion and observe for signs of reduced perfusion, such as darkening, cooling or drying of the stoma
  - Document the prolapse in eRIC and report to neonatal and surgical medical teams and Stoma CNC
3. Ischaemia/necrosis
  - An emerging medical emergency
  - Escalate to the neonatal and surgical teams immediately for urgent surgical review and report to stoma CNC
4. Muco-cutaneous separation
  - If sutures separating between stoma and skin, report to medical staff immediately to request surgical review and notify stoma CNC
  - Skin integrity and wound healing differs greatly between neonates
5. Wound breakdown
  - Document wound details, including size and depth of opening, colour of surrounding skin, inflammation contours, exudate and odour in eRIC under Wound Manage
  - Report to medical staff and stoma CNC
  - Dressing modifications and surgical review may be required
6. Peri-stomal skin breakdown
  - This can occur at any stage
  - Inform the stoma CNC and medical staff
7. Risk of infection
  - If improper infection control practices are performed, the stoma and surrounding skin can become infected.
  - Ensure to always follow proper infection control procedures
  - Use a new feeding tube and 20 mL syringe for each refeeding procedure
8. Perforation<sup>7</sup>
  - Is a rare complication of refeeding
  - Often caused by inappropriate catheter size, untrained staff performing the procedure and incorrect insertion method
  - With proper training and standardised processes, the risk is significantly minimised. Refeeding should always be performed by staff members trained and skilled in the procedure.
  - Immediately contact medical and surgical teams for urgent review if perforation occurs. Manage symptoms and escalate respiratory support as needed

#### 3.4 Documentation

- eRIC

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### 3.5 Education Notes

- Stoma formation is a common occurrence for neonates who have been treated for a variety of surgical conditions (NEC, SIP, volvulus, ileal atresia, anorectal malformation). The majority of these stomas are temporary, but the timing of re-joining can be lengthy, requiring several months.<sup>4</sup> Stoma formation is not a complication free surgery; in fact a stoma influences the normal adaptation of bowel after birth and its natural process of growth (including intestinal dilation and lengthening, growth of villi, alterations of motility and hormonal changes) leading to problems such as dehydration, abnormal acid- base status, impairment in nutrients absorption and poor growth.<sup>5,7</sup> Therefore these patients need a TPN with concomitant risk of impairment of metabolism of liver (cholestasis and hepatic failure) and with problems related to the presence of a central line (sepsis, thrombosis).<sup>6,7</sup>
- Recycling of small bowel content is a procedure that consists in taking the stools discharged from the proximal stoma and injecting them in the distal one. This has been demonstrated as a good bridge treatment in the period between the creation of the ileostomy until the anastomosis to permit to patient to absorb the nutrients and to distal bowel to grow and to improve in its functions.<sup>8</sup> This procedure also minimises fluid and electrolyte losses as well as dependence on PN.<sup>7</sup> In addition, this technique is supposed to shorten the time of stool canalization after anastomosis.<sup>8</sup>
- Re-feeding stoma losses may be a safe and effective alternative to long-term TPN.<sup>1-3</sup> It has been shown to stimulate mucosal growth and intestinal adaptation, decrease the formation of strictures, improve peristalsis, prevent atrophy of the bowel and decrease hepatic disease from cholestatic jaundice.<sup>1</sup> Recent evidence suggests that re-feeding improves weight gain, reduces electrolyte imbalance and total days on TPN.<sup>1,9-11</sup>
- Replacement of additional stoma outputs with intravenous fluids over a 24-hour period may be necessary to minimise the risk of dehydration. This will be decided by the medical team.

### 3.6 Abbreviations

EBM	Expressed Breast Milk	SIP	Spontaneous Intestinal Perforation
eRIC	Electronic Record of Intensive Care	TPN	Total Parenteral Nutrition
NEC	Necrotising Enterocolitis		

### 3.7 RELATED BUSINESS RULES AND POLICY DOCUMENTS

- RHW NCC CBR - Gastrointestinal Aspirate Replacement
- RHW NCC CBR - Post-operative Care
- RHW NCC CBR- Stoma Care (Neonatal)

### 3.8 References

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## 4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services

## 5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017 044-Interpreters Standard Procedures for Working with Health Care Interpreters.](#)

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### 6 NATIONAL STANDARDS

- Standard 1 Clinical Governance
- Standard 3 Preventing and Controlling Infections
- Standard 5 Comprehensive Care
- Standard 6 Communicating for Safety
- Standard 8 Recognising and Responding to Acute Deterioration

### 7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
21.2.24 24.7.25	1	R Jackson (NE), E Jozsa (CNS), L Graaf (POW Stoma CNC) Endorsed by NCC CBR Committee
4.8.25	1	RHW BRGC