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1. The Stomal Therapy Nurse will at all times maintain the highest professional standards of nursing care and professional conduct by the use of sound judgement and practice which meets the Standards developed by the Association.

2. The Stomal Therapy Nurse will provide needed services to persons irrespective of race, colour, creed, gender, sexual orientation, age and political or social status.

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6. The Stomal Therapy Nurse will maintain competency by keeping informed of new trends, practice-related products and relevant research and be able to apply this current knowledge to promote change and innovation in practice.

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Do you use the AASTN website to its full advantage?

I recently gave a presentation on what the AASTN can do for you and was surprised to discover what I didn’t know was on the website. For example, I learned that:

- the inaugural meeting was held in 1971
- we were known as the Australian Association of Stoma Therapists
- the original committee included Elinor Kyte, Helen Tucker, and Elizabeth Arnold
- the very first stomal therapy course was held in Victoria at the Royal Melbourne
- the first Scientific Meeting and AGM was held in 1972, which was well attended by STNs, surgeons and other members of the nursing profession
- in 1984 we became the Australian Association of Stomal Therapy Nurses
- in September 1987 the newsletter was converted to the present Journal of Stomal Therapy Australia.

All of this information and more can be found under “About us”. What about the other headings on the website?

**Education** provides us with access to information on CPD, credentialling, stoma therapy courses, preceptorship, the all-important pamphlets developed by the Education and Professional Development Subcommittee, to name but a few.

**Find an STN** Have you ever had to refer a client back to the country or interstate and wondered who you should refer to? This site enables you to refer to the right person. I encourage everyone to have their work details listed. As a rural nurse, I find it very handy to refer someone if they are having their surgery in Sydney, for instance, and haven’t made contact with an STN prior to surgery.

**Noticeboard** Have you ever wondered what actually goes here? Well, take a look: it has interesting information on upcoming conferences, state calendars and general news. Anyone can add information; you just need to contact the web coordinator Sue Vaughan so that she can upload it.

**Membership** is vital to our existence. It helps us to network with our colleagues, both nationally and internationally; provides information for scholarship applications; gives access to resources and the members’ only area, to name a few.

At my recent presentation there were 55 participants—all nurses working within colorectal or the community—and there were four trade members; of those present only six were members of the AASTN. It is up to us to promote our membership and its many benefits. Each of those people at the presentation will be getting a personal letter from me with a membership form. Have you thought about doing the same for all those that you work with?

**Useful links** What an excellent tool this is. This provides links to all the companies for stoma, wound and continence products, all located in one spot. No more trying to work out which is the right site. There are also links to schemes, and other useful links such as the Department of Health and Ageing or WoundsWest—an easy access to complete your CPD!

If you would like to see new additions to the website or have information you would like to add, please do not hesitate to contact Sue Vaughan.

The Executive Committee has been meeting regularly via Skype. For me it is the busiest time of year with the ski season in full swing and it can be a challenge balancing work, home and the Executive. But let me assure you to date it has been incredibly interesting and rewarding.

The Executive Committee will be meeting together in October, followed by the Education and Professional Development Subcommittee meeting. During this time, among many things, the Executive will be reviewing the handbook.

The Education and Professional Development Subcommittee will, among many things, be looking at reviewing documents and setting the credentialling exam. It is usually a very busy meeting with much achieved.

By the time this is printed, spring will have sprung; enjoy the longer, warmer days. Spring is a beautiful time, a time of new beginnings—enjoy!
After a great conference in Tasmania and a dose of cold weather, motivation has been difficult. The eastern states have been shivering through cold mornings and some unseasonably warm weather. Confusing to say the least.

Thanks for the wonderful support for the last issue of the Journal, June 2013. I hope you enjoyed reading about Duncan Armstrong; a truly remarkable man and story. Perhaps the essence of coping with disease or life’s problems is the ability not to become a victim. We see in our own practice people’s ability to cope with a number of issues at one time.

Cambridge Publishing is currently introducing a new system for submission of manuscripts, Scholar One. The system should be up and running in the near future and I hope you will find it easier to navigate. There have been some glitches with the previous system and I look forward to a more streamlined and generally easier process.

In this issue, Ian Whiteley has written about the challenges presented in teaching a visually impaired person requiring stoma management. Managing a colostomy in this situation can be difficult; however, teaching the management of an ileostomy has another set of issues. The main issue is that there is no room for error as the consequences can be dire. The STN team used a combination of experience and literature review to facilitate a satisfactory outcome for the patient and his family. With easy access to the internet, literature searches are much easier than in the past. The changing face of our profession requires us to look at the best evidence available and combine it with experience.

The handover tool developed by our ACT colleagues is also excellent. It is simple, yet covers the main aspects required for communication between the hospital STN and the community STN or other health professionals. Clarity is important to ensure the best outcomes.

Lastly, the topic of colostomy irrigation is of great interest and certainly covers all aspects of stomal therapy from identifying suitable patients, through to educating them to succeed. This can be an extremely liberating skill for a group of patients who may otherwise struggle with a permanent colostomy.

As a regular user of the AASTN website to locate colleagues, this is just a reminder to send your details to Sue Vaughan and she will be pleased to update them. There are some excellent tools on the website, so have a look to keep up to date.

Keep your articles coming. I look forward to hearing from first-time authors as well as those with experience. The editorial team is always pleased to mentor authors. It can be daunting at the beginning but we all just need to ‘keep writing’.

Best wishes,

Lisa

Editors note: We apologise for photos not published but the quality and the size of the photos determines if they can be reproduced. We appreciate photographic material so continue to send us your efforts.
ABSTRACT
The purpose of this paper is twofold: firstly to review the limited literature available to guide the stomal therapy nurse (STN) in the provision of ostomy education to patients with a visual impairment. Secondly, it presents a case study outlining how the ideas gained from the literature were used to assist a legally blind patient to achieve independence with caring for his ileostomy. Providing ostomy education to this elderly patient posed considerable challenges for the STNs and was a slow and arduous process.

INTRODUCTION
“Visual impairment” includes both low vision and blindness. The current Australian definition of “legally blind” is 6/60 vision, meaning the person with severe visual impairment can see at six metres what someone with standard vision could see from 60 metres away or has a visual field of less than 10 degrees where someone with standard vision has a visual field of 100–135 degrees. This definition is based on the International Classification of Diseases where the legally blind person is not able to see the 6/60 letter on the top row of a standard eye chart, while wearing the best possible prescription glasses to correct their visual deficit. Most people who are legally blind can make out shapes and shadows.

Adaptation to life with a stoma presents certain challenges for all patients, including coping with the underlying condition requiring surgery, body image, alterations in a familiar bodily function, learning of new skills and what feels and looks “normal” for the stoma and the peristomal skin, monitoring volume and consistency of output and managing discomfort from surgery. Cognition, age, manual dexterity, psychological adjustment and restricted vision are cited as factors influencing the patient’s ability to adjust. Combining a number of these factors frequently culminates in some degree of emotional turmoil which we found to be exaggerated in the person who is legally blind.

STOMA EDUCATION
We were faced with the situation of needing to provide stoma education to a 79-year-old man who underwent an ultralow anterior resection for adenocarcinoma. This was a planned procedure so the patient had been educated and assessed in the pre-admission clinic and reassured that the STNs would face the challenges with the patient should he require a stoma. Prior to the surgery the patient had been living alone and independently since he lost his vision many years ago. The patient was able to manage all activities of daily living including cooking and tending to his small garden. Over the years he had become inventive in developing ways to deal with these tasks and after lengthy discussions with the patient and his family we learned he developed new skills through determination and creating routine.

The patient was classified as legally blind and could only see what he described as “vague shadows”. The literature recommends a low-vision specialist be consulted to determine what, if anything can be done to ensure optimal visual correction, such as using bright light and a magnifying glass. Glare reduction and telescopic glasses have also been identified as potentially beneficial. All of these recommendations had been attempted but proved ineffective with our patient.

Unfortunately, 26 days after the initial operation the patient’s condition suddenly deteriorated and an emergency laparotomy was performed. At laparotomy there was a segment of ischaemic colon that included the original anastomosis. The ischaemia resulted in a large anterior defect in the anastomosis leading to faecal peritonitis. It is well recognised that anastomotic leaks are a serious complication that may occur following a restorative procedure for colorectal cancer. Anastomotic leaks are associated with significant morbidity and have been reported to occur in 5.1% of patients at this facility.

In this subsequent laparotomy, the remaining colon was removed and an end ileostomy was fashioned. Unfortunately, the second operation was an emergency and the patient was not “re-sited” for a stoma and this, in combination with abdominal distension which necessitated the operation, resulted in the ileostomy

Figure 1: Abdominal plane and intact peristomal skin
being fashioned in a suboptimal position. The stoma was at the level of the umbilicus with a skin fold distally (Figure 1). Stoma siting is an important consideration of STNs as stoma location can significantly impact on the patient’s ability to care for their stoma without encountering complications.

In our department, the STNs are experienced in providing stoma education to people with a visual impairment; however, these have generally been patients with a colostomy where precise placement of the pouch is not as crucial and some peristomal skin can be left exposed without risk of compromise. We have one legally blind patient (with a guide dog) who has both a colostomy and ileal conduit and manages his stoma care and lives independently. From our previous experiences we recognised the difficulties this patient would face and the challenges we would encounter.

In spite of living alone, the patient had three children who were all emotionally supportive, but were not willing to participate in stoma care due to other family commitments and one lived interstate. It was the expressed wish of the patient and his family for him to be able to return home and live independently.

It soon became evident that in order to achieve this goal the STN team would need to individualise the teaching sessions and be creative in educating the patient to care for his ileostomy. For each of our three STNs it was vital that we agreed on a protocol so that each taught the patient in exactly the same way to ensure our education sessions were consistent. We identified clear objectives for each teaching session and broke the session down into small, manageable parts. Therefore, we asked the ward nurses to only continue with teaching the patient how to empty the pouch, while the pouch change regime was taught solely by the STNs.

LITERATURE SEARCH

A literature search was conducted to determine if the experiences of others may aid our teaching, as our initial sessions were relatively unsuccessful and somewhat frustrating for the patient (and the STNs). We soon acknowledged this was going to be a long and challenging process. The teaching sessions were delayed by a 15-day stay in the intensive care unit with sepsis due to intra-abdominal collections requiring respiratory support. Early stoma care lessons were complicated by a high-output ileostomy, a small, persistently exudating wound in the umbilicus causing the pouch wafer to lift, de-conditioning of the patient due to the prolonged hospitalisation and poor sensation in his fingers. Initially, lessons consisted of getting the patient to feel his abdominal skin and feel the difference between this and the feel of his stoma: this was so the patient could learn the location of his stoma and participate in cleaning. This follows the recommendations of Benjamin5 who suggests the patient is taught what the stoma will feel like in order to confirm they can distinguish the difference between abdominal skin and the stoma. In our patient this was a slow, arduous process due to peripheral neuropathy.

In spite of the small number of articles identified in the literature review some worthy techniques were found. Ramos and Glosson4 recommended using a two-piece ostomy appliance so the patient could place their finger through the wafer, feel their stoma and guide the wafer into place. In their case report the patient had a colostomy and the aperture of the wafer was cut larger than the stoma to allow for variation in placement4. The pouch used clipped on to the wafer with an audible click to give the patient added confidence the pouch was securely attached4. Our patient had an ileostomy and needed to be exact with placement to ensure protection of the peristomal skin, but we followed the recommendation of a two-piece pouch system.

Benjamin5 and Jeffres and MacKay6 described placing tape “guide strips” on the patient’s abdominal skin to create the outline of where the wafer needed to be positioned in order to provide a tactile guide to ensure accurate placement. This technique was not successful with our patient due to his peripheral neuropathy. Alternatively, the literature outlines how an appropriately sized syringe barrel or medication bottle can be cut down to size and have any sharp edges removed to guide placement of the ostomy appliance wafer. The patient feels for the stoma, places the tube over the stoma and then places the wafer over this tube. The tube can be filled with cotton balls to absorb any stoma output4. This was the method we found successful with our patient. We used a 30 ml syringe, which was slightly smaller than the stoma and slightly smaller than...
the aperture of the opening on the wafer, allowing the wafer to fit snugly around the stoma with minimal peristomal skin exposure (Figures 2–4). We did not find it necessary to fill the syringe barrel with cotton balls as we chose to conduct the teaching sessions prior to breakfast in the morning when the ileostomy was least likely to be active and when the patient was most alert and receptive to education. We found that later in the day the patient was exhausted from the day’s activities, including the rehabilitation program. Eliminating the insertion of the cotton balls also negated the need to extract them prior to cleaning the syringe barrel for future use.

PREOPERATIVE EDUCATION

Benjamin highlights the importance of preoperative education. It is essential to gain an understanding of what the stoma means from the patient’s perspective. Pre- and postoperative counselling is paramount to ensure that any patient is psychologically prepared to cope with life with an ileostomy. Preoperative education and counselling sessions provide an opportunity for the STN to allay fears and anxiety and to reassure patients regarding ongoing care and education. For our patient, he was determined to return to his home and live independently. His anxieties surrounded how he would manage without support, with issues of cleanliness and fears of pouch leaks.

After some trial and error, we selected a flexible, pre-cut, two-piece ileostomy pouching system — we used the Dansac Nova 2® Soft Convex wafer. Fortunately, the patient’s ileostomy was almost round and this product came in an appropriately pre-cut size. Our education goals were similar to all other ostomy patients, to achieve independence with care, to be able to identify complications and to know when to seek outpatient review by their STN. It has previously been documented that peristomal skin complications are the most common problem encountered by patients with an ileostomy. However, due to blindness it was necessary to teach the “feel” of the physical signs of skin irritation, such as soreness, itch or poor pouch adhesion rather than combining these factors with the visual signs which would be our usual focus.

After four weeks of lessons we had the patient assessed by the geriatricians for rehabilitation but they deemed him to be unsuitable as he was not improving with his stoma lessons and they did not believe he would become independent. A family conference was held and the patient and family reiterated their determination that the patient should return home. The geriatricians remained reluctant to accept care of the patient as there was no plan extant for care if the pouch was to leak. The difficulty created by the possibility of an overnight leak led to the patient undergoing his rehabilitation whilst remaining an inpatient of an acute care colorectal surgical unit and by this time the patient was emptying the pouch independently.

During the family conference the patient and family stated they were willing to pay for a private community nurse to assist if this would enable the patient to return home. The STN team researched a variety of private nursing services with the cheapest being $65/hour for an enrolled nurse. This was only a Monday to Friday service and did not include penalty rates if services were required outside usual business hours. It was determined this was not to be a viable option.

An application for additional stoma supplies was completed allowing the patient to get 30 wafers per month (rather than

Figure 2: Feeding the wafer over the syringe barrel

Figure 3: Feeding the wafer over the syringe barrel and adhering the wafer to the skin

Figure 4: Following removal of the syringe barrel, moulding the wafer into position
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the usual 20 allowed under the Australian Stoma Appliance Scheme) to allow for errors in application or leaks due to poor application. The STN team persisted with lessons, always setting the supplies up in front of the patient in the order he would use them (Figure 5). Figure 5 shows that the belt was the only accessory product used and was required due to the abdominal contours. Excluding all other accessory products simplified the stoma care regime. Lessons would often take over an hour, with much of this time spent encouraging the patient with clipping the pouch to the wafer and then connecting the belt. We eventually used a Coloplast belt with the Dansac pouch as the patient found this easier to connect.

It was important for the STNs not to let our frustration at the slow progress become evident to the patient. Over time we provided more supportive verbal encouragement and minimised “hands-on” assistance. We had to be patient and slowly and consistently go through the stoma care routine time and time again, allowing the patient to practise and gain confidence.

PROGRESS

The patient continued to make slow progress with stoma lessons and was finally accepted by the geriatricians to the rehabilitation unit where the focus was on regaining strength and independence. At a second family conference, an occupational therapy home visit was arranged with several alterations to the patient’s home recommended. Finally, after two months of daily lessons, the STN team were satisfied the patient could manage independently and the peristomal skin remain intact (Figure 1). Community nursing services were organised to supervise the patient with the first few wafer and pouch changes once he returned home.

This decision was supported by the literature, which recommends community nursing to transition the patient back into their home environment to offer continued encouragement with independence, gaining confidence and maintaining self-esteem5. The patient was discharged with a Transitional Aged Care Package and other services, including ongoing physiotherapy services, home cleaning and transport to appointments.

The STN team contacted the patient by phone on a number of occasions following discharge to offer continued support and advice. The patient has been reviewed in the outpatient clinic on a number of occasions since discharge and we are pleased to report he continues to live independently. For these outpatient appointments the patient catches a taxi and asks the hospital reception staff to page one of the STNs who then meets the patient in the main foyer and escorts him to the clinic. This is consistent with the literature where the benefits of regular contact with their STN by phone or outpatient clinic visits assists the patient’s smooth transition from the supportive hospital environment to independent living at home6.

CONCLUSION

Finally, we conclude that patience and persistence from the STN team and a patient determined to succeed overcame the obstacles encountered. Our patient proved the combination of blindness, age, peripheral neuropathy and sepsis were not insurmountable challenges in the learning of ileostomy care with the use of innovating teaching techniques. In spite of a prolonged admission, what many believed impossible became possible and two years later the patient is still living independently.

ACKNOWLEDGEMENTS

I appreciate the patient consenting to the photographs in this manuscript being taken during his hospitalisation and allowing me to share them for the benefit of others. I extend my gratitude to Gael Sinclair (Colorectal Data Manager — Concord Repatriation General Hospital) and Professor Pierre Chapuis (The University of Sydney, Clinical Professor of Surgery — Concord Clinical School) for critiquing this paper.

REFERENCES


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Nursing handover is an important process that indicates transference of patient responsibility from one nurse to another. The practice of handover is essential for continuity of care. Inconsistencies in handover and a lack of relevant information can have a detrimental impact on patient outcomes and compromise patient safety.

Preparation for discharge from hospital for stoma patients is integral for successful rehabilitation and is made in partnership with the patient. Additionally, continuity of care from a stoma therapist and liaison with community nurses can aid in the transition from hospital to the home environment. A standardised approach to handover can actually improve that continuity of care and reduce the rate of errors and adverse events. Communication errors between a hospital and community setting can also be attributed to a lack of a standardised protocol for the handover process. Improvement in the clinical handover can be easily achieved with the use of standard specialised tools.

In 2008 Wong et al. identified that handover practices that are poorly structured can result in information breakdown between clinicians, which can negatively impact on patient care. This impact can ultimately result in readmission to hospital which is costly for both the health care system and consumer.

With this background knowledge, a collaborative between stoma therapists in the Canberra Hospital and ACT Community Health developed a standardised method of handover for stoma patients. Jefferies et al. identified the need for the development of a system to ensure conformity between the nursing handover and subsequent documentation to minimise the risk to patients' safety. The Stomal Therapy Nursing Handover tool would be able to be used for patient transfer between the acute sector and community settings and would be a two-way process.

This handover tool would primarily be used between the stoma therapists in the acute setting to transition patients to the community setting. Although, in addition to the primary use, the tool needed to allow the community sector to communicate quickly and specifically if a community patient entered the acute sector with a stoma therapy issue. This would ensure the tool complied with Standard 6 of the National Safety and Quality Health Service Standards: Clinical Handover. This standard calls for “structured clinical handover that is relevant to the health care setting and specialities” inclusive of the tools used to facilitate this process.

The aim of the collaborative was to participate in a quality improvement activity to develop a tool that captured the information specific to the requirements of a stoma therapy nurse. This information included:

- Type and date of surgery
- Operating surgeon
- Type of stoma
- Preoperative counselling
- Factors that impact on stoma care
- Stoma appearance
- Appliances trialled in hospital
- Association joined and whether an order was placed
- Discharge kit order date
- Appliance and accessories used on discharge
- Self-care level

The form was trialled from November 2012 to March 2013 and was used for all patients with a newly formed stoma in that time period discharged from Canberra Hospital to ACT Community Health. The form was also used for discharge between Canberra Hospital and surrounding NSW local area health services. Feedback was sought from all areas which had used the trial form.

The feedback received was positive and no issues were identified in the tool that required immediate amendment. There were suggestions to add, in the appearance section, boxes for well-spouted and oedematous. These suggestions have been submitted to be addressed in the next review period scheduled by the clinical forms committee. One stoma therapy nurse commented on the usefulness of the tool for inter-ward transfers, enabling less experienced staff to gain an understanding of terminology regarding stomas and providing a baseline for future assessment. Therefore the Stomal Therapy Nursing Handover tool was adopted and implemented as a standard operating procedure at Canberra Hospital. The tool is being modified for a second ACT hospital to comply with their clinical documentation requirements and will then be implemented there.

The Stomal Therapy Nursing Handover tool achieved the objective of the quality improvement process. The information imparted was meaningful and specific to the needs of the stoma therapists. In addition, the conformity of the tool ensured consistent information to facilitate continuity of care.
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**ACT Government Health Directorate**

**Stomal Therapy Nursing Handover**

**Type of Stoma**

- [ ] Ileostomy
- [ ] Colostomy
- [ ] Urostomy
- [ ] Other
- [ ] Temporary
- [ ] Permanent
- [ ] Uncertain

**Surgery Details**

- Date __/__/____
- Surgeon: __________________________
- Surgery performed: __________________

**Seen by STN preoperatively?**

- [ ] Yes
- [ ] No

**Allergies:**

- __________________________

**Factors that may impact on stoma care:**

- [ ] Poor eyesight (e.g. cataracts)
- [ ] Limited dexterity (e.g. arthritis)
- [ ] Cognitive factors (e.g. dementia)

**Stoma Appearance**

- Red
- Size mm
- Pink
- Round
- Dusky
- Oval
- Black
- Irregular
- Retracted
- Mucocutaneous separation
- Flush
- Prolapsed

**Stoma Association**

- [ ] ACT
- [ ] Other

**Appliances trialled in hospital**

- [ ] Yes
- [ ] No

**Order Placed?**

- [ ] Yes
- [ ] No

**Discharge Kit ordered?**

- [ ] Yes
- [ ] No

**Discharge Kit ordered __/__/____

**Appliance used on discharge**

- [ ] One piece
- [ ] Two piece
- [ ] Closed
- [ ] Drainable
- [ ] Flat
- [ ] Convexity

**Product Numbers:**

- __________________________

**Accessories**

- [ ] Paste
- [ ] Seal
- [ ] Powder
- [ ] Belt
- [ ] Support garment

**On Discharge**

- [ ] Independent
- [ ] Supervision
- [ ] Partial assistance
- [ ] Full assistance

**Name:** __________________________

**Date:** __/__/____

**Signature:** __________________________

**Designation:** __________________________
QUALITY IMPROVEMENT PROJECT MEMBERS
Lesley Baddeley
Vicky Browne
Kellie Burke
Brigette Green
Cheryl Jannaway

REFERENCES

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AASTN MEMBERSHIP RENEWALS AND RECEIPTS

The AASTN Executive Committee would like to notify and/or remind all members:
• Membership fees are due by 31 December of each year (AASTN Constitution 2003).
• Membership ceases if in arrears for 60 days, that is 1 March. (AASTN Constitution 2003).
• Please note from 2011 AASTN will implement the late fee charge ($20) for members who renew later than 1 April.
• Late fees DO NOT APPLY to new members applying after 30 March.
• AASTN’s preferred method of fee payment is by direct banking. Please consider this payment method. Your membership ID (MID) and surname should be included in the payment description for easy identification.
• From 2011 receipts will not be issued unless the request is indicated on the renewal form. The preferred format of issue will be via email. Please ensure your provided email address is current.

This notification by the Executive Committee has been prompted by the large number of AASTN members renewing late into the membership year, and increasing postage costs.

Thank you for your understanding and cooperation. 😊
Your patients experience many changes during the first six months following surgery including variations in their stoma dimensions (diameter and height), output consistency, skin sensitivity and in their overall body profile (weight, scars, hernias etc.).

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References
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Colostomy irrigation: retraining continence and regaining confidence

Diana Hayes • Master of Advanced Nursing Practice (University of Melbourne)

ABSTRACT

People who have an abdominal stoma become incontinent following their stoma surgery. However, a colostomy which is anatomically fashioned within a specific region of the colon may sanction faecal continence retraining. The procedure which offers this option is known as colostomy irrigation. The expert support and education of the patient’s stomal therapy nurse (STN) is paramount in order to succeed.

Colostomy irrigation offers benefits such as: a timely and convenient evacuation of stool from the colon; the possibility of not having to wear a colostomy pouch; a potential decrease in the volume of gas passed through the colostomy; improved peristomal skin; earlier rehabilitation; assimilation back into society but, most significantly, the regaining of confidence and self-esteem. The downside may be the sharing of one toilet with others and the time that it takes, which is between 45 and 60 minutes to perform the procedure.

The most significant aspect of colostomy irrigation is its awareness, support and promotion within the ostomy domain. STNs around the world, who offer this simple-to-learn and execute methodology, are at the forefront of assisting people, who have a colostomy, and who are suitable to learn colostomy irrigation. Unfortunately, not all people who are suitable to irrigate are offered this procedure as an alternative to wearing an external colostomy pouch.

This paper aims to offer quality-of-life awareness to practitioners, globally. Its main objective is the promotion of colostomy irrigation as an integral part of the pre- and postoperative educational journey for our patients who meet the criteria. It furthermore explores the possibility of re-establishing colostomy irrigation as a worldwide educational tool which will uphold it as a standardised lifestyle option. Therefore, by retraining continence, our suitable colostomy patients may regain their confidence.

INTRODUCTION

Following gastrointestinal, gynaecological or urological surgery, which results in the formation of an abdominal stoma, the person now endures life with a stoma and is rendered incontinent for its transitory or perpetual duration. The usual option for these people is the use of a disposable appliance which collects the stoma output.

For some people who have a colostomy there is an alternative. People who have a colostomy that arises from within the descending or sigmoid colon may be suitable to learn colostomy irrigation. This would allow continence retraining and offer confidence regaining. However, there are certain criteria that must be met, prior to offering this approach.

Creation of a colostomy exerts a profound impact on a person’s life with physical disfigurement, loss of bodily functions and a change in personal hygiene. Therefore, if the person who has a colostomy that arises from within the descending or sigmoid colon suits the criteria, it stands to reason that colostomy irrigation is part of the preoperative and postoperative educational journey.

Colostomy irrigation has been documented as a method of controlling colostomy output since or before 1920. By allowing a reawakening of this easy-to-learn and perform task, stomal therapy nurses (STNs) may not only retrain continence for these people, but also help them to regain their confidence. This may also expedite these patients’ return to society and allow them to continue to enjoy a lifestyle conducive to their pre-morbid circumstance, or even better.

The benefits of irrigation are:
- A timely and convenient evacuation of stool from the colon.
- The possibility of not having to wear a colostomy pouch.
- A potential decrease in the volume of gas passed through the colostomy.
- Improved peristomal skin.
- Earlier rehabilitation.
- Assimilation back into society.
- The regaining of confidence and self-esteem.
- Intimacy may be more comfortable and relaxed for both partners within a relationship.

The downsides include:
- The sharing of one toilet with others.
- The time that it takes, which is between 45 and 60 minutes to perform the procedure.
- Having to learn something new.
- Being more involved in bodily functions.
It is purported that colostomy irrigation is less prevalent than in previous years due to enhanced appliances, a decline in nursing awareness and a decrease in ongoing case management. Another suggestion is the possible misapprehension of doctors.

**COLOSTOMY IRRIGATION EXPLAINED**

Colostomy irrigation is a procedure that allows a timely and convenient evacuation of stool from the colon. The optimal time is six weeks post-surgery if all of the criteria are met. The procedure consists of irrigating the colon, via the colostomy, with warm, safe drinking tap water or still bottled water. The temperature of the water needs to be body temperature, 37 degrees Celsius (°C). The volume will vary between 500 and 1000 millilitres (ml). The duration of the procedure is between 45 and 60 minutes. People who are in the preliminary learning phase will need to allow a full hour.

By irrigating and emptying the colon, the person who has a colostomy may eventually use an alternative to a colostomy appliance or pouch. It may take several weeks for the stoma to have no spillage between irrigations. Therefore, continuing to wear an appliance during this initial period is strongly advised.

Once there is no stoma output between irrigations, a mini pouch, cap or plug may be worn. These are preferable to wearing a dressing, as gas will still pass out without any control. The specialised colostomy products have filtering systems that help to prevent odour when the gas escapes.

**SUITABILITY FOR LEARNING**

There are strict criteria for colostomy irrigation. They include:
- Consent by the surgeon.
- A colostomy fashioned within the descending or sigmoid colon.
- An ability and a willingness to learn.
- Adequate personal hygiene practices.
- Access to clean drinking tap or still bottled water.
- Good hand and eye coordination.
- Formed stool output.
- The understanding that patience and persistence are required in the initial learning phase.
- The appreciation that colostomy irrigation is an ‘all-or-none’ process. It cannot be implemented on an occasional or ad hoc basis.
- The facility to use a toilet for an extended period on a daily or second-daily basis.

**CONTRAINDICATIONS FOR COLOSTOMY IRRIGATION**

Reasons not to offer colostomy irrigation comprise:
- Current chemotherapy/radiotherapy.
- Regular diarrhoea-type output.
- Bowel disease such as active diverticulitis, Crohn’s disease, ulcerative colitis.
- Coronary or renal disease.
- Large parastomal hernia or stoma prolapse.
- Stomal stenosis.
- Poor prognosis.
- Refusal or complacency.
- Dementia.

**PREPARATION FOR COLOSTOMY IRRIGATION**

When starting out advise the patient to wear old clothes during the procedure as they may become soiled.

Have a strong hook at shoulder height to hold the irrigating bag, close to the toilet.

It is important to prepare the equipment.

Collect the following:
- Lined rubbish bin.
- Irrigating bag with 1000 ml warm tap or bottled water at 37°C.
- Tubing and cone.
- Water-based lubricant.
- Irrigation sleeve and matching baseplate.
- Drainable colostomy bag.
- Remover wipe or spray.
- Moist towelettes (alcohol-free).
- Disposable gloves.
- Scissors.

**Procedure**

Wash hands.
Sit on or near the toilet.
Remove the current appliance and dispose.
Attend to stoma care as usual.
Apply the baseplate and attach irrigation sleeve.
Allow the sleeve to hang in the toilet.
Lubricate the tip of the cone.
Run water through the tubing to prime it.
Put on glove and lubricate gloved index finger.
Insert lubricated finger into the stoma to determine the direction of the colon and take finger out.
Remove glove and dispose.
Insert the cone into the stoma in the correct direction and gently allow the water to flow by regulating the valve.
If there is no flow, slightly withdraw the cone.
If there are any cramps, clamp the tubing and relax.
Resume when the cramps subside.
Allow any stool to pass out.
Allow 5–8 minutes for water to flow in completely.
Wait a few minutes for any immediate outflow through the sleeve.
Once this ceases, remove the end of the sleeve from the toilet and cut off the end.
Clean and dry the new end of the sleeve.
Fold it up and secure to the top of the sleeve.
Clean up equipment.
Wash hands.
Allow up to 45 minutes for complete return of water and stool.
Remove the sleeve.
Attend to usual stoma care and apply a drainable colostomy bag.
Wash hands.

Troubleshooting

Table 1: Troubleshooting

<table>
<thead>
<tr>
<th>Problem</th>
<th>Possible reason</th>
<th>Suggested solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cramps during irrigating</td>
<td>Water too cold or too hot</td>
<td>• Stop until cramps subside</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Test water is at 37°C (run it over the wrist area)</td>
</tr>
<tr>
<td>Cramps during irrigating</td>
<td>Flow is too fast or too slow</td>
<td>• Stop until cramps subside</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure steady flow over 5–8 minutes</td>
</tr>
<tr>
<td>No return at all</td>
<td>Dehydration</td>
<td>• Terminate procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wear a drainable bag</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rehydrate orally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid heavy alcohol intake the night before irrigating</td>
</tr>
<tr>
<td>Feeling faint</td>
<td>Vasovagal response</td>
<td>• Stop procedure</td>
</tr>
<tr>
<td></td>
<td>Col on may be distended</td>
<td>• Recomence when feeling well again</td>
</tr>
</tbody>
</table>

Indications of success

· It may take several weeks to be proficient in colostomy irrigation. Perseverance and patience are essential for its success.

· Once there is no spillage between colostomy irrigation sessions, it may be deemed as appropriate to start wearing an alternative appliance instead of a large colostomy pouch.

· Ensure that the new, smaller appliance is filtered as gas will continue to pass.

· Colostomy plugs are easy to insert but need a demonstration by the patient’s STN. The shiny surface of the stem must not be removed. This breaks down once inserted and allows the plug to swell to accommodate the lumen of the colon. Plugs can be changed twice a day.

· Caps are a very petite and easy-to-use appliance that fit over the stoma, externally.

· People who irrigate may also choose to continue to employ a smaller pouch.

Accessing irrigation supplies

People who have an abdominal stoma and who reside in Australia have access to government-subsidised stoma care products and equipment. This includes a colostomy irrigation kit and spare parts annually. To be eligible to receive products under the Stoma Appliance Scheme a person must have a temporary or permanent artificial body opening (whether created surgically or otherwise) which facilitates the removal of urine and products of the gastrointestinal tract where the person does not have normal gastrointestinal tract or bladder functions. Before access is granted an Irrigation Kit Authorisation Form must be completed by the patient’s STN. The following declaration is included on the form:

The above-mentioned patient has received education from or has agreed to return to the above-mentioned STN for education and training on irrigation or use of conseal™ plug before attempting to use these items.

The STN has consulted with the relevant surgeon who agrees irrigation is appropriate for this patient.

CONCLUSION

People who have a colostomy and who fit certain criteria should be offered a lifestyle which is an alternative to wearing a disposable pouch. This alternative is known as colostomy irrigation. It requires endurance and determination during the learning phase. However, the outcome may mean that the person who is suitable to learn will have a speedier recovery both physically and psychologically.

As STNs, it is essential that we offer and support colostomy irrigation to our suitable patients. By raising the awareness of retraining of continence, we may also promote regaining of confidence within this specialised group.

REFERENCES

With the introduction of National Nursing Registration through the Australian Health Practitioners Regulation Authority (AHPRA) on behalf of the Nursing and Midwifery Board of Australia, expectations of continuing professional development (CPD) for nurses followed.

The Australian Association of Stomal Therapy Nurses Inc (AASTN) has been offering a free-of-charge stand-alone CPD recognition program since 2002. Initially the CPD program commenced in 1999 specifically to ensure our credentialled stomal therapy nurses (STNs) maintained their knowledge and skills over a three-year period. This service was expanded with our first re-credentialling process to encourage all members to participate and in doing so consider the credentialling process.

The goal of CPD was to achieve 100 points in a 12-month period. A portfolio was designed with examples and suggested points. Any form of professionally based learning was accepted, for example annual mandatory updates of CPR and so on, and evidence by the way of a certificate or an attendance record was enough. Once the 100 points were achieved the portfolio with evidence was submitted to the AASTN CPD and Credentialling Officer and a certificate was issued at the following AGM.

In recent years the Education and Professional Development Subcommittee has shifted the focus from general learning to stomal therapy-specific learning and we have now moved from a points-based system to an hours-based method, with reference back to the Standards of Stomal Therapy Nursing Practice and the Advanced Nurse Competencies. In doing this the STN can demonstrate advanced nursing practice principles to justify their autonomous position and accountability within the nursing profession.

Examples of active learning includes:
- tertiary-based courses
- conferences, forums, seminars and symposia
- workshops, discussion groups, professional organisations
- self-directed learning (journal or book articles, web-based courses)
- short courses
- position on professional committees.
- presenting a paper or presentation to colleagues
- writing for publication
- involvement in preceptorship or mentoring of students
- research
- quality activities and much more …

EVIDENCE OF CPD

A written record must be kept as evidence, including dates, outcomes and the number of hours spent in active learning. All evidence must be able to be verified and must demonstrate the following:

- Learning needs based on an evaluation of your practice against relevant competency or professional standards.
- The development of a learning plan to identify learning needs.
- Participation in learning activities relevant to your context of practice.
- A brief reflection on what you have achieved from the learning exercise and how it impacts on your professional role and practice.

IT IS NO LONGER ACCEPTABLE TO JUST PRODUCE A CERTIFICATE OF ATTENDANCE.

EXPECTATIONS OF AHPRA

If you are a registered general nurse you MUST maintain and document 20 hours of CPD in a 12-month period and it must be directly relevant to your context of practice.

One hour of active learning will equal one hour of CPD. Active learning constitutes reading, writing, discussion, problem solving as well as listening to and giving lectures.

EXPECTATIONS OF AASTN

Now that we have looked at what AHPRA expects of us as registered nurses, let’s look at what the AASTN expects of us.

Essentially the AASTN Education and Professional Development Subcommittee has taken what AHPRA expects but made it stomal therapy nursing-specific hours only and added an extra 10 hours per year to the required time in order to challenge you as a specialist in your field.
In other words, if you are a practising STN and wish to participate in the AASTN CPD program you must maintain 30 hours of CPD specific to stomal therapy nursing in a 12-month period. For example, 30 hours of CPD in stoma, wound or continence, IT, nursing management, education and so on, specific to stomal therapy nursing practice.

You may include your annual mandatory competencies and other non–stomal therapy related learning in your AASTN Portfolio but this will not be counted within the 30 hours required by the AASTN as it is not specific to stomal therapy nursing practice.

TIME FRAME

Previously the AASTN ran their CPD program from January to December each year. AHPRA runs their registration and CPD processes from June to May each year. In order to come into alignment with the AHPRA time frame we have extended this initial transition year from January 2013 through until the end of April 2014 (that is, 16 months). Following this it will be from May to April every year.

HOW TO PARTICIPATE IN CPD THROUGH THE AASTN

To participate in CPD through the AASTN, visit the AASTN website www.stomaltherapy.com and click on the following:

- Education
  - Continual Professional Development
    - CPD Application Form.

You only need apply once. It carries over until you notify the Credentialling Officer in writing you wish to withdraw.

This year you may know someone who has been selected to be audited by AHPRA. This is a random process which occurs at the time of registration renewal.

CPD is a continual process and we cannot stress strongly enough how important it is to update your portfolio regularly rather than leaving it until the last minute! If your CPD documentation is not up to date it can be quite confronting and arduous.

With each activity you must refer back to the Advanced Nurse Competencies and the AASTN Standards of Stomal Therapy Nursing Practice. Both are available on the AASTN website www.stomaltherapy.com by clicking on the following:

- Education
  - Re-credentialling
    - Competency Evaluation Tool for Recredentialling

This document contains a brief outline of the AASTN Standards of Stomal Therapy Nursing Practice as well as the Advanced Nurse Competencies for Stomal Therapy Nursing. Every AASTN member received a copy of the latest edition of the AASTN Standards of Stomal Therapy Nursing Practice with their Journal of Stomal Therapy Australia in June 2013. Additional hard copies can be purchased from Robyn Simcock, Membership Coordinator by emailing rmsimcock@bigpond.com

To assist our members in following the AHPRA guidelines for CPD we have developed a CPD Toolkit with clear instructions on how to identify your learning needs, develop a learning plan, and document your activities and outcomes based on the relevant competency or professional standards. We have developed templates to use in most areas of practice with prompts to assist in reflection. These are all available on the AASTN website under Education then click on Continuing Professional Development. Alternatively you may prefer to use other templates such as the AHPRA or ANF CPD templates, or you could design your own!

We suggest you work through the AASTN CPD Toolkit slowly and don’t forget to add the time taken to set up your portfolio as a CPD activity!

Below is a sample of a portfolio using the AASTN template, courtesy of Sue Delanty (STN) who presented at the 39th Biennial AASTN Conference Hobart Tasmania, 2013 in “Have you ticked the box?”:

PLAN OF MY LEARNING NEEDS:
1 MAY 2011 – 30 APRIL 2012

AIM: Be responsible for my nursing practice at the highest level through evaluation, reflection, continuing education, professional development and research.

PROFESSIONAL DEVELOPMENT GOAL OR OBJECTIVE

1. Stay abreast of current knowledge in stomal therapy nursing (stoma wound and continence) to ensure patient outcomes are met.

2. Contribute to the growth of self, peers and public through education.

Other templates in the AASTN portfolio include:

1. Professional committee involvement
2. Record of attendance at CPD activities
3. Record of presentations given
4. Meeting with company representatives
5. Publication review format

REFLECTING ON YOUR PRACTICE

AHPRA has stipulated you must reflect on what you have learned. Reflection is an essential component for health care professionals and the need to provide evidence of reflective practice is becoming more widespread.

Reflection involves looking at your practice critically, learning from your experiences: what was done well, what could be improved upon and where there are deficiencies in your
knowledge base. Reflecting on events assists us to make sense of complex or challenging situations, questioning our attitudes, beliefs, values and skills. Duffy defines it as “an active process resulting in change”.

Assessing the outcomes and developing learning needs forms the basis of CPD. From reflecting, your professional practice evolves; your confidence increases, your focus may change to provide different challenges, all steadily improving your knowledge base specific to your context of practice. With this you are able to regulate your own professional needs and take an active role in your future direction whilst at the same time improving patient care.

Put simply, just a sentence or a few lines on what you gained out of the professional activity or active learning process is all that is required.

**KEEPING RECORDS**

AHPRA insists on keeping your CPD portfolio as evidence for a period of three years. AASTN will expect the same. When sending in your evidence, please do not send in original copies. Make a copy of everything and send the copies. You have an option of sending it by post or via email, depending on what you are most comfortable with.

For more information, contact your AASTN Education and Professional Development Subcommittee representatives. Contact details can be found on the AASTN website. Alternatively, you can visit the following websites for further explanation.

**REFERENCES**


<table>
<thead>
<tr>
<th>Date</th>
<th>Identified learning need</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2011</td>
<td><strong>Goal 2</strong>: Organise a professional session for education of peers</td>
<td>Action research with peers about topics</td>
</tr>
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<td>July 2011</td>
<td><strong>Goals 1 &amp; 2</strong>: Assistance with editing/finishing article on rectal irrigation</td>
<td>Identify, contact and work with experienced STN to finish article</td>
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<td>12.7.11</td>
<td><strong>Goal 2</strong>: Be able to use Cambridge Media’s electronic submission format</td>
<td>Collaborated with other STN and practised using website for article submission</td>
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One of the roles of the WCET Education Committee under the leadership of the chairperson, who is currently Vera, is to review Enterostomal Therapy Nursing Education Programs (ETNEPS) to make sure that they fit certain criteria, which is known as WCET recognition. As part of the review process a member of the WCET Education Committee attends for part of the course. This is usually for between one and two weeks. The country requesting the review pays the expenses of the reviewer.

I was fortunate enough to be asked to go to Malaysia to review their course, which was being run from Kuala Lumpur, the capital of Malaysia. The hospital — the University of Malaysia Medical Centre (UMMC) where most of the lectures were given — was actually in Petaling Jaya, which is the next city or town to Kuala Lumpur.

The course was 12 weeks, with six weeks’ theory and six weeks’ practical. Tan Teng Peng (past president and now advisor to METNA) and Mariam Nasir (ETNEP program director) who is also the current president of the Malaysian Enterostomal Nurses Association (METNA) and the other committee members organised and ran a very good course. Rozita Mohamad, the program co-director, and the other preceptors and committee members gave their time and expertise to ensure that the course was a huge success and 31 new ET nurses graduated, mainly from Malaysia but some from other countries in South East Asia.

The course covered all theoretical aspects of stomal therapy nursing, wound management and promotion of continence with clinical placement at several hospitals with trained ET nurses as preceptors. The work that is being carried out in the wards and stoma and wound clinics is very impressive, mirroring the dedication of the Malaysian ETNs, doctors and other health care workers.

The hospitals are massive, with Kuala Lumpur General Hospital having 3,800 beds and UMMC 1,500 beds. The logistics of running something this big are just mind-blowing. Most people attend the hospitals for much of their primary health care as it is made very convenient for them. Such things as community nurses and community outreach programs are in their infancy in Malaysia but will be coming. I was asked to talk to senior nurses and medical staff at UMMC about discharge planning when I was there. We had a very lively, interactive discussion about bed managers, patient discharge lounge and other initiatives which are ‘tried and tested’ in Australia but being introduced in Malaysia.

During the course I gave about eight hours of lectures on a wide range of topics from paediatrics, congenital gastrointestinal tract — conditions requiring a stoma; stoma and wound management in gynaecological oncology patients; and hyperbaric oxygen therapy and wound care

During the course the students organised an ostomate gathering where there was entertainment and ‘interactive fun’ — all the participants including ostomates, student ET nurses and ET nurses all enjoyed themselves. The students also helped to organise the inaugural Malaysian Enterostomal Therapy Nursing Conference, which ran over two days with several national and international speakers. The students all had to present their case studies at this conference and were marked on such things as content, presentation skills and PowerPoint presentation preparation. I was very impressed by all of the presentations.

Widasari Sri Gitari from Indonesia attended the conference with 11 of her own students. Wida, who is the director of the Indonesian ETNEP, gave a very interesting presentation about ET nursing in Indonesia and their achievements over the past few years.

Dr Harikrishna, a renowned international speaker, gave a very good presentation on diabetic wound management in Asia. His views on such things as collagen dressings were very entertaining and kept the conference amused.

Another notable presentation was by Dr Christina Ong, who is the president/founder of EMPOWERED, which is an awareness
program for early detection of bowel cancer. One of their initiatives is to advertise that Empowered is going to be coming to a poor socio-economic area by leaflet drops and posters advertising an information evening. Time and effort is spent fundraising for this so that there are such things as food raffles to ‘entice’ people to attend. The FOB testing kits are given out at the meetings and currently there is an 85% return rate, which is extremely good. If a person has a positive test, a medical student volunteer with training from Empowerment and a nurse volunteer with Empowerment training break the news to the person. The medical student supports the patient through any treatment that they require, which is all free of charge.

I gave two talks at the conference on nursing informatics and nursing research and there were many other interesting presentations, which were all very well received. The students also helped to organise the graduation dinner, which was attended by ET nurses — both new and older, colorectal surgeons and company representatives.

Malaysia is a fascinating, safe country with very friendly people who were always helpful to me when I got lost and needed directions or even more importantly needed a western toilet! Although I did spend a lot of time working, I did get some time for sightseeing and shopping.

Kuala Lumpur is the capital of Malaysia and even though it was only established as a mining town in the 1850s it is now a metropolis achieving city status in 1972. It is a thriving tourist centre with world-class hotels and many shopping malls. One of my favourite shopping malls is Suria KLCC, which is situated below the Petronas Twin Towers, which are set in landscaped gardens with an artificial lake and beautiful fountains.

Tan Teng Peng took me to Malacca sightseeing one day. Malacca is a historical town with many interesting sites to see, which illustrate very well Malacca’s turbulent past with Portuguese, Dutch, Chinese Vietnamese and British invasions over the previous five centuries. A very strong rickshaw driver managed to manoeuvre Tan Teng Peng and myself into his rickshaw and give us a conducted tour of the wonderful sites of Malacca. He was very proud of his Portuguese ancestors and told us all about their community and their traditions in Malacca.

It is always good to spend time with hard-working, enthusiastic ETNs who have a passion for stomal therapy nursing and the Malaysian ETNs certainly have that in abundance. Hopefully they will run many more courses in the years to come.
A BRIEF HISTORY OF THE AUSTRALIAN COUNCIL OF STOMA ASSOCIATIONS INC. (ACSA)

While historical records suggest that ostomy surgery has been performed since biblical times, it wasn’t until a vast improvement in medical procedures and technology during the early 20th century that ostomy surgery became routine treatment for certain medical conditions and abdominal injuries. However, while advancements in surgical techniques had greatly improved the medical outcomes for persons undergoing ostomy surgery, the quality of life experienced following ostomy surgery was largely influenced by post-surgical care and management. Generally, ostomates were discharged from hospital poorly prepared for life with a stoma and such was the paucity, expense and quality of available ostomy appliances that skin problems and leakage were common place. Stomal therapy nursing had not yet evolved and there was a general deficit of knowledge amongst most health care professionals for dealing with the many skin and appliance problems experienced by ostomates. As a result, many ostomates found that quality of life was quite poor.

Such is human nature that it wasn’t long before ostomates, having experienced and managed the problems associated with post-surgical stoma care, began to band together to offer support and guidance to other new ostomates. While these groups met informally at first, over the years they developed into an organised network of support organisations.

During the 1950s, the concept of ostomy support groups grew rapidly throughout the world and Australia was no exception. The eminent surgeon, Dr Edward Hughes, who had learned of the developments of the ostomates’ support groups in UK and USA and who had recognised the benefit of such a support group to his patients, played an instrumental role in the establishment of the first Australian ostomy support group, QT* Australia (later to become the Ileostomy Association of Victoria) on 18 May 1957. All other states and territories soon followed Dr Hughes’ lead. Together, the Australian associations played an important role in the recovery and rehabilitation of persons with a stoma, including acting as buying groups for ostomy equipment for members. The support groups were also called upon to provide visiting services to hospitals and communities and, in some instances, invited to give lectures to student doctors, student nurses and outpatient clinics to give advice on stoma care and appliances. *(QT was named after Q (men’s) and T (women’s) wards which housed patients following ostomy surgery.)

One major objective of the combined Australian associations was to lobby government for the provision of free ostomy appliances for those people that needed them. It was recognised, however, that a united voice for advocacy purposes may be more credible in the eyes of government and thus in 1962 a proposal was made to form a national ostomy group. The Federal Council of Stoma Associations was established thereafter in 1963. A second attempt was made to establish a unified body, and at a meeting convened in Canberra on 4 April 1970, the Australian and New Zealand Council of Stoma Associations (ANZCSA) was founded.

In February 1971 a letter was received from the Department of Health in Canberra detailing arrangements for the Commonwealth to provide pharmaceutical benefits to persons with an ileostomy or colostomy. The letter agreed that some assistance from the Government should be forthcoming and attached a list of considerations to be addressed.

At the second Annual Council Meeting of the Australian and New Zealand Council of Stoma Association held in Sydney in March 1971, it was recommended that individual state associations should omit the initials QT from their name and adopt the word “colostomy”, “ileostomy”, or “stoma” association.

The ANZCSA celebrated a significant achievement when, on Tuesday 17 September 1974, the Federal Treasurer announced in his Budget Speech that:

... it is intended to introduce legislation in 1974–75 to authorise the supply, without charge, of stoma appliances to all persons in the community who need them.

The Ostomy Associations of Auckland and Canterbury, New Zealand, remained members of the Australian and New Zealand Council of Stoma Associations until 1975 when it was decided that it was appropriate for both countries to stand alone. The peak body was renamed the Australian Council of Stoma Associations (ACSA).

In conclusion, ACSA represents 22 Associations throughout Australia. It is managed primarily by volunteers and some paid staff. The Stoma Appliance Scheme cost $80,000,000 in 2012 with a membership of 40,467 in 2012 (member numbers for 2013 were not available at the time of writing). The Stoma Appliance Scheme has over 2000 product lines available to its members. ACSA has a Charter of Responsible Use, which is a document to make members aware of their responsibilities not to over-order supplies, to be aware of the costs involved and to be in regular contact with their stomal therapy nurse. Always foremost in our discussions with professional bodies is the ostomates’ welfare. We welcome and appreciate the support we receive from stomal therapy nurses throughout Australia.
The AASTN 40th National Conference will be held at the Melbourne Convention Centre, Melbourne, from 5 to 7 October 2015 inclusive.

Welcome to this first report for our organising communication.

Following an invitation from our surgical colleagues, the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), the AASTN will again combine our national meeting with theirs. This time, however, CSSANZ is meeting with their Asian Pacific group (not the tripartite as previously in Cairns 2011). This will then provide us with the opportunity to invite our Asian Pacific nurse colleagues to our conference.

Our 40th meeting will truly be a national event with the organising committee numbering 25 with representation from each state providing input into the program. Funding for this event will come through National Executive treasury and the proceeds from this conference will go back into the National funds.

As you will notice in 2015 we will meet much later in the year than historically we ever have. Spring in Melbourne is a beautiful season, with warm days and cool nights.

The theme of this conference is Preventative and Proactive strategies in Stomal Therapy Nursing — this will complement CSSANZ’s theme Preventative Strategies in Colon and Rectal Surgery.

The plan is to have the program concentrate on proactive stomal therapy practice rather than reactive practice. We will address future health care expectations and focus on what is coming rather than what has been.

The dates are set and the venue is locked in.

The conference will run from Monday 5 October to Wednesday 7 October.

Initial planning suggests that the opportunity for workshops on Sunday 4 October may well be included for those arriving early.

There will be plenary sessions, concurrent sessions and one plenary joint session on Tuesday 6 October in the morning with CSSANZ.

Again the program will be a half day on Tuesday to incorporate some sightseeing for all delegates in the beautiful Yarra Valley during the afternoon.

Meetings have been locked in and are as follows:
Monday 5 October, 1600–1730: AASTN Annual General Meeting
Monday 5 October, 1800–2000: combined welcome cocktail drinks
Tuesday 6 October, 0700–0800: National Education and Professional Development Subcommittee’s breakfast workshop for all delegates
Tuesday 6 October, 1400 onwards: the Melbourne Experience Yarra Valley Wine Tour
Wednesday 7 October, 0700–0815: continental breakfast/WCET meeting
Wednesday 7 October, 1900 onwards: Combined Conference Dinner

The conference website has been set up and will be updated as the organisation progresses:
Go to www.apfcp2015.org and the AASTN link will appear on that home page.

The secretariat again is ASN events, who may be contacted via the website or on 03 5983 2400.

So, remember to save the dates: 5–7 October 2015 in Melbourne and book early!
**Australian Capital Territory**

The ACT AASTN is a group of approximately 12 stoma nurses who are scattered across NSW and the ACT working within Community Health and various hospitals within the region. At present, only one of these nurses has a dedicated position of clinical nurse consultant stomal therapy at Canberra Hospital — Kellie Burke. The rest of us are multiskilled and multitalented, working in many different areas as well as keeping up our skills in stomal therapy.

There are two stoma clinics held at Community Health in the ACT, on Tuesday and Thursday afternoons of each week. There is also a walk-in clinic at the ACT Stoma Association held on the second Tuesday of the month. One of the Community Health stoma-trained nurses attends this, giving advice to the ostomates.

On 28 May approximately eight stoma nurses attended a masterclass sponsored by Convatec. It was an educational session interlaced with fun activities that provided for a relaxed, informative session.

At our most recent AASTN meeting a representative from Salts presented us with information on their products, with approximately six stoma nurses attending.

For the recent Stomal Therapy Week/Norma Gill Day, Cheryl Jannaway presented to a forum of nurses and medical personnel on the “Role of the Stoma Nurse”. Hopefully they are now enlightened on what a pivotal role the STN plays in the journey of the ostomate.

One of the tertiary hospitals within the ACT recently looked at the effectiveness of the handover referral form. This was developed into a quality improvement project. The draft forms were distributed across the spectrum for analysis and comment and have recently been rolled out. Kellie Burke has recently submitted an article to the JSTA on this project, which comprehensively examines the process that was undertaken.

*Editor’s note: please see page xx for a report about this project.*

On 30 July Coloplast is sponsoring an educational evening. Dr David Rangiah will be presenting “Colonic Surgery and Stomas” and our own President, Kirsti Dixon, will be presenting “How can the AASTN help you?” We hope to have as many STNs as well as general staff present to enjoy this presentation, raising the awareness of colonic surgery and the AASTN.

Thank you,

Cheryl Jannaway

**Northern Territory**

Central Australia is beautiful at this time of year.

Stomal therapy-wise, I am kept very busy and am never bored.

It was great to be able to attend the recent study day in Adelaide, organised by the urology/continent nurses and the stomal therapists. Thanks to the women with the vision and commitment to organise such an event — the content and presenters were of very high quality and it was wonderful to catch up with people, learn a whole lot more and eat delicious food in between sessions.

I hope to arrange for Kath Gribble from South Australia to visit Alice Springs in August to do some teaching here in the hospital. We will make you very welcome, Kath!

Clients with stomas here are often from remote areas with English as a third or fourth language. The stomas created in Alice Springs Hospital are mostly emergency or urgent — and done by general surgeons, as would be the case in many smaller centres. For some of my clients, hospital discharge can be like being set adrift into a chaotic, overcrowded environment with little privacy to manage a brand-new stoma. People don’t know where they will live or don’t want to go back to the place they were previously. Ordering supplies and paying a yearly membership can also be difficult for people.

Every day, it seems, I see people with reserves of good humour and resilience they didn’t know they had. Somehow they manage incidents like leaking all over the floor in Woolworths, or having the scissors confiscated at the airport, five days postoperatively and heading back home alone. It is very humbling and heartening at the same time.

In the past couple of years I have learned a lot:

- Loop ileostomies are often troublesome and tricky to seal. If you stay engaged long enough, it is time to be reversed.
- Dissolving sutures can take months to dissolve.
- Emergency stomas tend to be large and often dehisce. Sometimes they are larger than almost all the appliances on the Schedule!
- People with nephrostomies or feeding jejunostomies have been incredibly ill and have long and uncertain journeys ahead.
- People with stomas because of infective or chronic wounds often have delayed healing and an extended wait for reversal surgery.
- People with stomas because of trauma are traumatised, especially those who have been assaulted. It’s obvious — but good to keep in mind.
- I try to help people get home, managing independently and believing they will be OK — usually in the reverse order.

The company representatives have repeatedly saved the day for me — sending samples and discharge kits at a moment’s notice. Everything feels urgent when you have few resources, both in terms of supplies and knowledge — which is the way it was for me initially.

I have been lucky to have great colleagues, including at Cancer Council NT, and in Darwin and Adelaide. The handover here
was from a remarkable woman, an EN, who became the stoma expert for this community before there was a stomal therapist position. So I have big shoes to fill.

A lot goes into the quality of service we provide and it all makes a difference, I think.

Jenny Pechey

New South Wales

Our educational session at our June meeting was Bob Newman from ONL (Ostomy NSW Ltd) discussing the ONL Scholarship offered to nurses completing the Graduate Certificate in Stomal Therapy Nursing and also Susan Dunne and Lesley Everingham presented the new AASTN CPD format.

At our August meeting representatives from the Colostomy Association will present their scholarship for existing STNs to undergo advance training.

Report from Julia Kittscha

Stomal Therapy Week in the Illawarra

In the lead-up to Stomal Therapy Week, the local Advertiser featured a news article promoting Stomal Therapy Week and the upcoming study day organised and run by Helen Richards and Julia Kittscha. The week was of great significance as the Illawarra celebrated 10 years of the Illawarra Ostomy Information Group and 20 years working in stomal therapy for Helen. Stomal Therapy Week was aptly marked by a patient information day on 12 June held at Figtree Anglican Church, who kindly provided the venue for free. The day was attended by approximately 140 community members who have a stoma or who support someone with a stoma and are living in the Illawarra. The attendees listened to talks about stoma management, diet and travelling with a stoma. Bowel Cancer Australia (BCA) provided the ‘big bowel’ and Mandy Richardson, STN POW Private Hospital, represented BCA, providing a talk about bowel cancer. During the lunch period attendees perused an extensive

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trade display including a clothing line for people with stomas, accessories and stoma associations. A question and answer session completed the successful day. Sixty per cent completed evaluation forms and the feedback was all positive. The patient day will continue as a biannual event.

At Wollongong Hospital an information display relating to stomal therapy in the Illawarra showing different types of stomas and information about bowel cancer was displayed in the main entrance.

Our meetings for the remainder of the year are Tuesday 6 August, 1 October (AGM), and 3 December (please note this change of date). Our annual branch Christmas lunch will be on Saturday 9 November (details to follow and keep the date free).

If you would like to join us at the meetings or even teleconference these meetings, please contact me on 9515 8990 or jenny.rex@sswhs.nsw.gov.au

Best wishes,

Jenny Rex

South Australia

South Australia has been keeping busy. The AGM in February saw a few changes to office bearers, with Kelly Vickers taking on the role of Secretary and Lyn Sandford became Treasurer, while Sally Lundborg continued in the position of President, which also combined with the role of State Representative. This then allowed the creation of the new position, Journal Liaison to the Editor, which was given to Lynda Staruchowicz. Fiona Bolton, Merle Boereê and Lisa Naeher stayed on for education and Erica Taylor continued with the CASA/IASA Liaison.

In March we gave assistance with conference funding to four of our members to attend the wonderful AASTN conference in Tasmania. Many more members also attended and all came home with a glowing report of the event. Thank you very much Tassie for putting on such a splendid conference. We in SA know how much work goes into holding a conference, after last year’s WCET Convention.

The AASTN AGM in Hobart welcomed Bronwyn Overall as Secretary and Tanya Webber as our Committee Representative, to the National Executive. We wish them well in their positions for the next two years.

It was at this meeting we also saw one of our dedicated members Merle Boereê obtain AASTN Life Membership. This was a great surprise to Merle but a well-earned achievement. The SA STNs and trade representatives took Merle and her husband, Willem, out for an enjoyable celebratory dinner in May, which was well attended at The Wellington Hotel.

The stomal therapy course is continuing and we have 11 students doing theory and clinical practice in and around Adelaide. The last module was focused on wound care and the next module will be continence. We have gained three new AASTN members this quarter with two being associate and one commercial member joining.

SA members have been enjoying interesting meetings with our guest speaker for April, Fiona Bolton, focusing on CPD points and portfolios for the STN. At this meeting we also celebrated the 80th birthday of a retired but still active STN Pat Robinson, who is held in high regard around the South Australian members and beyond.

A combined study day with the Nurses for Continence Interest Group and the South Australian Urological Nursing Society was held in June to coincide with Stomal Therapy Awareness Week. It was called “Nurses in Collaboration” and there were 160 delegates in attendance, with concurrent sessions running on continence and stomal. The speakers were well chosen by the committee of Fiona Bolton and Leigh Pretty with such talks as sacral nerve neuromodulation (Dr Sam Pillay), neobladder or urostomy (Dr John Bolt), Pharmacology and anal sphincter incompetence and surgical intervention (Dr Elizabeth Murphy), just to name a few. Fiona and her team did an outstanding job for this day and we thank them all very much for their dedication and hard work.

At our upcoming meeting in July Merle Boereê will be informing us on how she used her Shelly Simper Award which she was
awarded from the AASTN SA. This is a biennial monetary award that is given to an outstanding achiever in the field of stomal therapy nursing from South Australia. We look forward to listening to her talk.

A joint education night is scheduled on 19 August with the Vascular Nurses of SA, with speaker surgeon Darren Tonkin presenting; it should be a very interesting and well attended night.

Stomal Therapy Week was well advertised around SA with lectures, displays and many Bristol Stool Tarts appearing at morning teas throughout the hospitals, which got people talking (if you don’t know what this is, try to Google it) which is what we wanted to achieve.

I hope this gives you an insight into what SA has been doing, so until next journal ...

Regards,
Sally Lundborg

**Tasmania**

The AASTN Tasmanian branch continues to have regular meetings via teleconference, enabling more members to attend. I must say our first meeting post conference was considerably shorter than they have been for a very long time. The advances in technology over the years have helped with our ability to communicate. Teleconferencing and group emails have certainly been an asset to our committee. Recently I have attended webinars for the purpose of education, where hundreds of people logged in at work or at home, being able to benefit from education sessions that once would have required travel and time off work. Down the track it may be something we as a group consider as an option to provide education sessions around the state. At the moment it is something to ponder.

Kimberly-Clark sponsored a PEG tube education day at the Launceston General Hospital organised by Sue Rushton and Robyn Wortel. Margot Hickman as usual provided exceptional presentations as did Dr Ray Wilson, whose use of a flashlight and orange rope provided a memorable example of PEG tube insertion. Other presentations discussed types of tubes, ethics, trouble shooting, nutrition, pharmacology and radiological insertion, as well as an interesting carer’s perspective from a mother with a child that has a gastrostomy tube. The only thing we need to change for next time: a smaller lectern or a milk crate for Margot to stand on!

We held another successful Journal Club evening in June, sponsored by Coloplast and arranged by Sue Delanty and Andre Gall. The evening was well supported and talks were given by Laurelle Robinson, a clinical nurse educator on the National Standards, who generated an interesting group discussion. Another interactive presentation was provided by continence advisor, Sue Walker. The evening was enjoyable and informative. As usual, the event provided not only education, but the ability to network.

Stomal Therapy Week saw poster presentations throughout the state.

On behalf of all the Tassie STNs, kindest regards to all,
Andrea Hicks

**Victoria**

Hello to all our AASTN colleagues here in Victoria and around Australia. It is with relief that we leave the winter months behind and note that spring has finally sprung. The cold and wet has not dampened the AASTN Vic branch activities of the past months and we look forward to a lot more to come.

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On behalf of all the Tassie STNs, kindest regards to all,
Andrea Hicks

In April, Genevieve Cahir, her WWII veteran father and Marg Lucas represented the AASTN Vic branch at the Nurses’ Memorial Centre’s ANZAC commemorative Service in St Kilda Road. The moving service remembered the loss of life 70 years ago, on the HMAS Centaur, a hospital ship that was torpedoed...
by the Japanese off the coast of Queensland in 1943. Many of the wounded, doctors and accompanying nursing staff drowned and it remains an infamous event in our war history. The event was well attended by a number of different nursing organisations and will become a regular event on our calendar.

Our May meeting was very well attended and held at the Box Hill offices of the RDNS. We are thankful to our RDNS colleagues and their management team, for allowing the use of their venues. We were spoilt with two guest speakers for the evening. Kiri White, a psychologist, enthusiastically addressed the audience on the flavour of the month topic, “Writing for Publication”. This obviously is a topic close to Lisa Wilson, recently appointed editor of *The Journal of Stomal Therapy Australia*. Lois Maunder presented to the attendees a DVD in development related to travel tips for ostomates — it was well received and many in the audience were busy scribbling down the hints and tips.

We acknowledged both Stomal Therapy Week in the month of June and Norma N Gill’s newly announced dedicated day on 26 June 2 and plan to further develop these days in the years to come.

The July meeting provided an informal ‘roundtable’ discussion about events being held at our workplaces. Helen Nodrum, representing Wendy Sansom, spoke to her PowerPoint presentation, “50 Shades of Stoma Care”. Wendy had delivered this paper at the recent ECET conference held in Paris in June. We congratulate Wendy on her paper to the conference and the development of a new learning tool for staff based in aged care. Stefan Demur enthusiastically gave an overview of an educational day presentation at Geelong and we have heard it was very well received.

We have welcomed to our fold since the middle of the year, two esteemed interstate colleagues. Carmen George, SA, has settled into the sounds and lights of Melbourne, covering maternity leave for St Vincent’s Public and Penny de Winter, our colleague from Queensland, has eased into life in the regional township of Traralgon. They are part of the furniture already!

We pass on our congratulations to Trish Griffin, RDNS STN, who was a successful applicant for the WCET educational contingent to Kenya in November. Well done.

Our September meeting is an oncological evening to be held at Peter MacCallum Cancer Centre and we thank Carolyn Atkins for hosting the event and suggesting a topic so relevant to stomal therapy care. A reminder that the meeting on 22 October is a committee planning meeting for 2014. Branch members are welcome to attend. There is more information on the website.

Our Christmas gathering will be in November at a venue still to be announced.

In conclusion, the AASTN Vic branch would like to encourage all its members to consider making their name, workplace details and contact numbers available to the website coordinator, for the “Find an STN” drop-down box. The numbers look a little poor, yet the page is certainly accessed by many requiring an STN contact in their area. We also encourage a weekly sign-in to the website — it is a tool well worth exploring.

Genevieve Cahir

### Western Australia

It has been a quiet couple of months since the last WA state report was submitted.

The clinical update in May was presented by Mary King, continence nurse consultant from Sir Charles Gardiner Hospital. Those that were able to attend certainly benefited from her presentation on continence and from her experience. We thank her for filling in for Joy Sears who was unwell that evening. We also thank the trades for their ever-reliable presence and support at these updates.

Anne Capes and Lorrie Gray will be attending the next Ostomy Association meeting on Saturday 3 August, representing the AASTN WA branch and will be making themselves available to answer queries from the members.

Usually our next clinical update would be held in August. Instead, we are looking forward to a wine and cheese evening following the AGM on Tuesday 20 August. We are hopeful that it will be a chance to welcome some new faces to the committee, in a more social environment!

In the interim, planning continues for the combined AWMA and AASTN State Conference, to be held on 29–30 November. The theme is *Corner Stones — essential elements of wound and ostomy care*.

Until the next state report, regards,

Lynette Beelitz
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