Clinical case study of a high output stoma and the AF300 filter

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Evaluating a postoperative see-through dressing

The implementation of traffic light guidelines for hospital-based stoma management

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In August, the Convention Centre and the Northern Territory Convention Bureau invited me to Darwin. There were 25 participants, whose positions included editors, event coordinators, business owners, CEOs, directors and project officers. The purpose of the invitation was to enable us to visit the new convention centre and become aware of the many attractions of Darwin. We were given a tour of one of the hotels to see the various types of accommodation, several venues for conference or business dinners and numerous tourist activities. The ‘Meet Darwin’ team were all extremely friendly, enthusiastic and helpful. The highlight of the trip, for me, was the Blue Water Fishing – I caught the biggest fish of the day! Darwin is an interesting town to visit for a conference or holiday. When discussed with the Executive, it was decided that it is a potential site for one of our conferences in the future.

I attended the Stoma Product Appliance Panel meeting with the Health Department in Canberra, at the end of August. Diana Hayes was also present. Prior to the meeting, Carmen Smith, Diana and I decided that Diana would be the liaison person between ACSA, the Health Department and STNs. If you have any concerns relating to stoma products or forms, you can contact Diana – her contact details will be in the journal and also on the AASTN website.

The AASTN website is easy to access and has links to ACSA, stoma, wound and continence companies. If your contact details are not listed, you can contact Karen McNamara and she will assist you – her contact details are in the journal.

Continuing professional development and credentialling are evidence of continuing self-education. If you have already acquired the necessary points for CPD, please send the documentation to Sue Delanty – her contact details are in the journal and on the website.

On 12 March 2010 we will be having a telephone link between the states for the AGM. Executive rotation of positions are as follows;

NSW – Vice-President; ACT/NT/Tas – Treasurer; WA – Committee member; Victoria – Committee member.

It would be appreciated if new nominees could attend the AGM in Geelong to ensure an efficient handover from outgoing members.

As this is my last report for the year, I wish everyone a merry Christmas and a happy new year.

### Caring and Sharing

**Theresa Winston**

It is hard to believe that Christmas will soon be upon us and it was this time last year that I was considering my option of becoming the editor. Thank you to my Queensland colleagues who had the confidence that I could fulfill the role.

Thank you to those who have submitted articles for this journal. We again read about the impact of a stoma on the patient’s quality of life and the difference we as stomal therapists can make by finding the correct product for the patient, even though this may mean several trial and errors. Lyons and Riccardi’s article ‘Should colostomy irrigation be a last resort?’ illustrates that it is important to research information but if there is not a lot of information out there, as long as what you plan to do has been discussed with colleagues, you can try new things. I feel it also illustrates how important the JSTA is for us to share our information and case studies so that when someone else is trying to look for information they have more articles to review.

Reading this particular case study made me think about a colostomate who visited me this week and is changing the whole of his two piece appliance two to three times a day! He states that he does manual work and ‘nothing sticks’. It was the first time I had met him and he seemed reluctant to change products. I did persuade him to think about a one piece appliance and gave him some to try. I had not thought of irrigation, but will discuss it with him next week; it may save him embarrassment from leaking appliances when he is at work.

Also included in this journal is an article by Sandy Hyde-Smith who was received the CSSANZ scholarship for 2009. The article discusses the implementation of guidelines for hospital-based stoma management that resulted in better use of the stomal therapy nurse’s time, improved communication and continuity of patient care. If anyone else has developed similar guidelines it would be interesting to hear about them.

As 2009 comes to a close we look towards 2010. Apart from the WOCT/WCET joint conference in June, there is an important change for nurses across Australia with National Registration due to come into force in July 2010. All nurses will need to comply with continuing professional development (CPD) registration standards, which looks as if nurses will need to participate in at least 20 hours of CPD a year. It is fortunate that we already keep a record of our CPD and it will be very easy to show we have met our 20 hours. So don’t forget to complete your CPD record of activities and submit by the end of the year.

I wish you all a safe and happy Christmas and look forward to continuing with the role of editor in 2010.
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Clinical case study of a high output stoma and the AF300 filter

OVERVIEW

Lynn is a 63-year-old woman who suffered for many years with faecal incontinence due to ulcerative colitis. At the age of 44, she underwent surgery for a permanent colostomy.

After her colostomy, Lynn led a very active life; running the London and Vancouver marathons, as well as travelling extensively. However, at 49 years old, she underwent elective surgery for the repair of a parastomal hernia. Unfortunately, she commenced irrigation too quickly postoperatively (at just a few days and in the absence of any bowel sounds). This resulted in her bowel perforating and pelvic septicaemia.

An emergency laparotomy revealed dense bowel adhesions, necessitating an extensive bowel resection. Five years later, medical tests revealed that the anastomosis between the large and small bowel had stenosed further. The adhesions and associated surgical risks made any further surgery impossible. Due to the stenosis at the site of the anastomosis, Lynn is no longer able to eat and has to be fed intravenously overnight via a Hickmann line.

PROBLEM:

Lynn is able to only drink decaffeinated tea and coffee with skimmed milk, as caffeine increases her stomal output and can lead to further dehydration. She administers her own intravenous feed overnight via her Hickmann line: 2L of parenteral nutrition infused at 200mL/hr and 50mL for the last 2 hours. During the summer, in warmer climates, or with episodes of diarrhoea, Lynn needs to administer 2L of normal saline to stay hydrated. Lynn has experienced many problems finding a stoma pouch that can cope with the large amount of fluid her stoma produces whilst she is having her feed. She also needed a filter that could cope with the copious amount of effluent from her stoma Flange In situ during the night.

SOLUTION:

Lynn recently tried the Hollister New Image two-piece system with the new AF300 filter. She believes this system is the most secure product she has found. The AF300 filter copes well with the wet and copious amount of effluent from her stoma. It provides internal and external liquid protection (eliminating the need for filter covers), deodorises gases and helps reduce pouch ballooning. Additionally, the AF300 filter has stopped any strike-through of faeces through the filter and her underwear is no longer soiled from these mishaps. This is because the filter has dual membranes that help prevent fluids from entering the filter from the inside or outside the pouch.

OUTCOME/CONCLUSION:

Since being on parenteral feed, Lynn has never been on holiday. This has been due to the combination of needing intravenous nutrition and not having the confidence and trust in her stoma pouch. Since using the Hollister New Image pouching system with the AF300 filter, Lynn has felt confident and secure enough to enjoy a 3-week holiday in the north of England.

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Our world is what we make of it*
This paper aims to use a case study to revisit colostomy irrigation and to examine if it should be offered to more patients. It also documents the results from an eight-item questionnaire completed by NSW stomal therapy nurses (STNs). The responses from the STNs and a review of the literature focused on the following four areas of colostomy irrigation:

1. Why it is not performed very often?
2. When should it be commenced?
3. How much fluid to insert?
4. What are the benefits as opposed to using a pouch?

We chose not to focus on the procedure of colostomy irrigation as this has been well documented in prior literature. The formation of a colostomy can have a very debilitating effect on a person, whether that is physical, mental and/or social. Edwards focused on the different stages of acceptance postoperatively for the emergency patients. These stages can also be pertinent for the elective surgical formation of a colostomy. Initially a person may feel relief, as it is often performed for life-threatening reasons, for example, patients with cancer or inflammatory bowel diseases such as Crohn’s disease, ulcerative colitis or diverticular disease. At this stage, the patient is dealing with or coming to terms with accepting this need for surgery.

Once the surgery is performed, however, and they are left with the resulting consequences of a permanent colostomy, it is often a very different picture they are focusing on. This is where we, as STNs, need to utilise all the options for problem solving available to us to support our patients. This we believe must include the skill of teaching irrigation, regardless of how often we teach the skill, we need to possess it so that we can offer our patients every available resource that may enhance their quality of life.

**CASE HISTORY**

Mary, a 79-year-old, obese female with a body mass index (BMI) of 39.3 (30+ being obese). Mary was admitted on 1 April 2008 for low anterior resection with formation of loop ileostomy for rectal cancer (pathology A-grade). Mary had her ileostomy closed approximately 4½ months later. Mary was admitted approximately 8 months later with recurrent rectal cancer and underwent an abdominal perineal resection (APR) and long division of adhesions.

Initially following surgery there were minimal problems with stoma care. However, Mary was oedematous and her abdomen was quite distended. Mary also had problems with urinary retention, which prolonged her admission. She had three trials of void with no success so was discharged home with a catheter in situ. Fifteen days following surgery, the pouch began to leak as contours on her abdomen changed due to decreasing oedema. This created a chain of unsuccessful pouch changes over the next couple of days (Figures 1-3).

We trialled a convex, two-piece appliance with a flat and a convex seal to a one-piece deep convex with a convex seal secured with a belt. We achieved 1-2 day’s success with a two-piece, deep convex appliance with a flat and a convex seal secured with a belt. Mary was discharged to her daughter’s home 18 days after surgery.

Mary was having great difficulty after discharge keeping the appliance on at night as the stoma was active and the contents were pancaking and undermining, thus causing Mary and her family great distress. As Mary sat or bent forward her skin folds would push the convex appliance off. Again we tried various...
My colleagues and I had discussed what options we had left. Irrigation was our choice, our problem being that Mary was less than 5 weeks post-surgery and the protocol in our hospital is generally 3 months post-surgery before commencing irrigation. This prompted us to seek the advice of fellow STNs here in NSW in the form of an eight-item questionnaire. We presented the questionnaire at the AASTN 2nd monthly meeting in June 2009. The results shall be discussed further in this paper.

We discussed the possibility of teaching colostomy irrigation to Mary with her surgeon, outlining the difficulties with managing her colostomy and he gave us permission to commence teaching Mary colostomy irrigation.

**WHY IS IRRIGATION NOT OFTEN OFFERED TO PATIENTS?**

Woodhouse states, according to her internal figures, the majority of stomas now formed are loop ileostomies. These figures were taken from her hospital database from 1999 to 2005. She suggests this as being one of the reasons so few patients are taught to perform irrigation.

In contrast, our hospital database shows there is a marginal difference: between 2001 and 2007, 305 colostomies and 332 ileostomies were fashioned. Therefore we can rule this out as a reason so few patients perform irrigation. More evidence is required from Ostomy Associations throughout Australia.

One of the main reasons found in the literature for not offering irrigation as an option is the length of time it takes to teach a patient and the length of time it takes out of the patient’s day. Another reason also contributing to the lack of numbers for irrigation is the quality and availability of pouches nowadays.

Bolton and Peterson conducted a search of the three major stomal therapy nursing journals (World Council of Enterostomal Therapists Journal, The Journal of Stomal Therapy Australia and Journal of Wound, Ostomy and Continence Nursing) and found very little on teaching irrigation. They suggest this as one of the obstacles for new STNs in teaching the procedure.

We searched ostomy irrigation/colostomy irrigation through CINAHL; we searched full text from 1999-2009 and retrieved only two results. We also found a similar result on searching the three major stomal therapy journals. On the other hand, we did a search via the Google search engine and found several articles with similar information on colostomy irrigation, one main article being from the ostomy company Coloplast, which discussed various questions colostomy patients may have regarding irrigation. Also on Google was a video from a patient’s perspective regarding irrigation, which we have found very helpful and we offer this website address to our patients considering irrigation. Stapleton also found Google to be helpful regarding teaching material.

It is from our professional journals we seek our initial information, as one would expect this to be the most accurate source. From there we can elaborate with outside sources, since unfortunately the journals did not offer adequate information.
WHEN IS THE BEST TIME TO IRRIGATE?

The literature reviewed regarding when to commence irrigation varied from country to country. For example, the literature from Turkey suggested 3 months\(^3\) and above; Woodhouse\(^5\) from the UK suggests 3 months. Bokey and Shell\(^13\) from Australia suggest 6 weeks, while Bolton and Peterson\(^9\), also from Australia, did a small scale research on 10 STNs and found varying degrees of responses from 1-6 months. Their suggestion was to allow the patient to be the decision maker once it has been determined they are a suitable candidate\(^9\).

Cesaretti\(^14\) did a comprehensive literature review on the above topic and her conclusion was quite similar.

One postulates that 3 months would be a good time to commence irrigation, since the patient:

1. has had time to recover from surgery and understand their colostomy
2. has had time to use the pouch and have a comparison
3. will be in a better mental state to absorb information and be motivated to follow the routine of irrigation to train the bowel
4. will have a bowel routine or pattern that allows STNs to predict if they are a suitable candidate.

One must also remember there are always exceptions to situations, as in the case of Mary. Once the patient meets the selection criteria and the operating surgeon gives permission, irrigation teaching can commence. It is important to assess and meet the needs of the individual as best we can with the resources we possess.

HOW MUCH FLUID DO WE IRRIGATE WITH?

The recommended volume of fluid used for irrigation varies from 500ml to 1000ml\(^1,7,15\), while Bolton and Pearson\(^9\) received results of up to 1500ml, yet none of the literature researched suggested less than 500ml.

In our hospital we vary the amount of fluid inserted, commencing with 700ml and increasing up to 1500ml, depending on the output from the stoma. Another contributing factor is the weight and size of the individual\(^6\), known as the BMI. The following is a guideline to BMI categories:

- Underweight = <18.5
- Normal weight = 18.5-24.9
- Overweight = 25-29.9
- Obesity = BMI of 30 or greater

In the case of Mary, we commenced with 1000ml and increased to 1500ml. This was sufficient to allow for a 24-hour period of no activity from her stoma, this being the main aim of colostomy irrigation.

WHAT ARE THE BENEFITS OF COLOSTOMY IRRIGATION?

The findings of the literature search suggest the benefits are:

1. No activity in between irrigations\(^3\).
2. No unexpected surprises, such as flatus\(^14\), pouch filling up at inappropriate times.
3. Patient feels more confident sexually that the activity in the pouch will be absent during those intimate moments\(^3\).
4. Fewer skin problems from leakages, erosion of the wafer or stripping of the skin during pouch changes.
5. Fewer sleep disturbances, with flatus and pouch activity during the night, especially with those patients who snore.
7. Work/business less/no interruptions with activity and flatus.
8. A major improvement in quality of life\(^2,5,17\).

The negative aspects of colostomy irrigation are:

1. Time-consuming for the STN at the initial introduction when providing education.
2. Time-consuming for the patient each day.
3. Convenience for travelling for the patient: they can pack their pouches in their suitcases and not worry whether they have the convenience of a toilet for an allocated set time each day and if the water is of a standard suitable for irrigation.

As the above suggests, the positives outweigh the negatives by far. In addition to this, Burch\(^18\) supports the use of irrigation in the management of patients with constipation; this again would help relieve anxieties associated with a colostomy, promote confidence and improve quality of life.

The following is the results of the eight-item questionnaire completed by NSW STNs to assess if their responses reflected that reported in the literature as already highlighted.

STN COLOSTOMY IRRIGATION QUESTIONNAIRE

Total of nine questionnaires received back out of 10 distributed (a 90% response rate).

1. Do you consult the surgeon prior to educating patients on irrigation?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 = yes 89%</td>
<td>1 = no</td>
</tr>
</tbody>
</table>

2. How many patients a year do you teach to irrigate?

<table>
<thead>
<tr>
<th>Number of patients/year</th>
<th>0</th>
<th>1-2</th>
<th>2-3</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>STNs</td>
<td>2 (22%)</td>
<td>4 (45%)</td>
<td>2 (22%)</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>
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New ALLEVYN Ag combines ALLEVYN’s unique fluid-handling technology with silver in one easy-to-use dressing. So now you can choose a dressing that provides the optimal moisture balance and up to seven days of antimicrobial activity.

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3. When postoperatively do you commence irrigation?

<table>
<thead>
<tr>
<th>N/a</th>
<th>2 months</th>
<th>3-6 months</th>
<th>1 year postop</th>
<th>Determined by patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (11%)</td>
<td>2 (22%)</td>
<td>4 (45%)</td>
<td>1 (11%)</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

4. How many lessons do you give?

<table>
<thead>
<tr>
<th>N/a</th>
<th>1-2</th>
<th>2-3</th>
<th>3-4</th>
<th>Up to 5</th>
<th>Depends on patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (11%)</td>
<td>2 (22%)</td>
<td>1 (11%)</td>
<td>3 (34%)</td>
<td>1 (11%)</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

5. How long does each lesson take?

<table>
<thead>
<tr>
<th>N/a</th>
<th>30-40 minutes</th>
<th>45 minutes</th>
<th>1 hour</th>
<th>1-2 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (11%)</td>
<td>1 (11%)</td>
<td>1 (11%)</td>
<td>4 (45%)</td>
<td>2 (22%)</td>
</tr>
</tbody>
</table>

6. How much fluid do you irrigate with?

<table>
<thead>
<tr>
<th>N/a</th>
<th>500ml</th>
<th>500-750ml</th>
<th>750ml-L</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (11%)</td>
<td>1 (11%)</td>
<td>2 (22%)</td>
<td>5 (56%)</td>
</tr>
</tbody>
</table>

7. What is the frequency of irrigation?

<table>
<thead>
<tr>
<th>N/a</th>
<th>Daily</th>
<th>Daily/2nd daily</th>
<th>2nd daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (11%)</td>
<td>2 (22%)</td>
<td>4 (45%)</td>
<td>2 (22%)</td>
</tr>
</tbody>
</table>

8. Why would you NOT teach irrigation?

4=N/a Poor dexterity, cognitive impairment, mental illness, ileostomy/urostomy, frequent bowel habits, active disease, dementia, commitment.

DISCUSSION

Question 1

Few STNs teach irrigation. Of those who teach irrigation, 45% taught one to two patients per year, not a lot considering the amount of colostomies performed per year. Statistics received from the Colostomy Association of NSW up to June 2009 revealed 3996 colostomy patients, of which only 173 irrigation kits were ordered for the year June 2008-June 2009. While this is not an accurate figure, as patients already irrigating would be included, what it does demonstrate to us is that only 4% of colostomy patients in NSW are irrigating their colostomies compared to 8% in the period 1990-1999.

Question 2

Of those STNs who teach irrigation, the majority (89%) seek permission from the consultant surgeon.

Question 3

The majority (45%) of STNs waited a period of 3-4 months to commence irrigation, which is the typical time from the literature examined.

Question 4

The average number of irrigation lesions required was 1-3. One of the STNs reported the number of lessons required depends on the individual patient’s ability to retain information.

Question 5

The majority (45%) of STNs reported the average duration of a colostomy irrigation lesson is about 1 hour.

Question 6

The average volume of irrigation fluid the STNs reported using is between 500ml and 1000ml. The majority of STNs (78%) reported teaching patients to use an amount between these two volumes of fluid. This is consistent with the literature reviewed.

Question 7

The majority of STNs (45%) reported that they teach patients to irrigate their colostomy either daily or second daily.

Question 8

This question was not answered as expected. It was anticipated that we would find the reason why irrigation was not performed as opposed to reasons for selection criteria. This reinforced to us the importance of wording a survey clearly. It also highlighted individual interpretation of questions.

When the question was approached after the survey was completed the majority of the STNs expressed that it was too time-consuming and impinged too much on their workload.

CONCLUSION

The literature review had similar findings in regard to colostomy irrigation to the findings from the questionnaire completed by NSW STNs.

Researching and writing this paper has encouraged us to offer colostomy irrigation to more of our patients, both old and new. We feel this would help improve the quality of life for a high percentage of colostomy patients suitable for irrigation.

The questionnaire highlighted a deficit in information in our professional journals on colostomy irrigation, with so little information written from the patient’s perspective. These two areas of concern are areas we will address or rectify and reflect on.
in future studies. An ethics application has been approved for our future qualitative study, examining a patient’s perspectives and quality of life issues surrounding colostomy irrigation.

Finally, we feel colostomy irrigation is a valuable alternative management regime for colostomy patients and should not only be used as a last resort. As the above paper demonstrates, colostomy irrigation helps improve quality of life without a doubt. As STNs we must possess the knowledge of irrigation and offer it as an option to suitable patients with a colostomy.

REFERENCES


Colorectal Surgical Society of Australia and New Zealand (CSSANZ) Scholarship for Stomal Therapy Nurses

PURPOSE
To foster and further develop the relationship between the Australian Association of Stomal Therapy Nurses Inc. (AASTN Inc.) and CSSANZ, the CSSANZ will present a scholarship for a novice stomal therapy nurse (stomal therapy nursing education programme completed within the previous 3 years) to attend their annual Spring Meeting. This is an annual award and will be presented at the AASTN Inc. Annual General Meeting.

AWARD VALUE
This scholarship will cover registration to the annual CSSANZ Spring Meeting, economy class airfare and $500 towards accommodation.

ELIGIBILITY CRITERIA
Applicants must:
• Be a full member of the AASTN Inc.
• Be currently registered in the state where they are working and utilising their stomal therapy nursing skills.
• Have completed an AASTN Inc. recognised stomal therapy nursing education programme within the previous 3 years.
• Be able to attend the Spring Meeting in or outside Australia.

PROCESS
Submit an article suitable for publication in The Journal of Stomal Therapy Australia (JSTA). The article may be in the form of, but not limited to:
• A clinical case study.
• Research project.
• Book review not previously published in JSTA.
• Educational poster or teaching tool.
• Professional issue pertinent to either speciality.

The article, plus a completed official application form with a copy of current nursing registration, must reach the national executive secretary by 15 May in the relevant year. Contact details for the secretary can be found in the current JSTA. Application forms are available from the AASTN Inc. executive secretary and AASTN Inc. website www.stomaltherapy.com

All applications will be reviewed by the judging panel. A decision will be available and all applicants notified within 6 weeks. The judging panel will consist of:
• The Editor, JSTA (or delegate).
• Committee member of the AASTN Inc Education and Professional Development Subcommittee.
• Nominated member of the CSSANZ.

Late applications will not be considered. The scholarship award is not transferable.

SELECTION CRITERIA
The decision of the judges is final and based on the following criteria:
• Presentation.
• Originality.
• Appropriateness to stomal therapy nursing and colorectal surgery.
• Demonstrated integration of theory and practice.
• Suitability for publication following the JSTA Guidelines for Authors found in the current JSTA.
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Evaluating a postoperative see-through dressing

Diana Hayes • CNC Stomal Therapy (cred.), Master of Advanced Nursing Practice (University of Melbourne), Western Health, VIC

ABSTRACT

A small, non-comparative, non-blinded evaluation was implemented at Western Hospital in 2008-2009 to determine the efficacy and cost-effectiveness of a new postoperative wound care product.

A submission was made to the Western Health Product Evaluation Committee (PEC) and was accepted. The findings of the evaluation suggested a viable and economical alternative to contemporary postoperative wound care management.

INTRODUCTION

In 2008, Smith and Nephew approached me, to assess a new concept in postoperative wound care management. The concept was a postoperative wound care dressing that is see-through. As a clinical nurse consultant in stomal therapy, I also manage the postoperative wounds in patients who have a stoma, given the close proximity of the stoma and the wound. After seeing the new dressing, I agreed to an evaluation, but first needed to submit an application to the Western Health Product Evaluation Committee (PEC).

The arguments presented against contemporary management were:

- Hydrocolloids usually leak within 24 hours, creating an opening for bacteria.
- Rather than removing the leaking hydrocolloid, nurses tend to apply a combine and tape over the leaking area.
- Doctors remove dressings on their surgical rounds, to inspect the wound, leaving dressings hanging and the wounds exposed for prolonged periods.
- Hydrocolloids can be difficult to remove from over staples. The dressing is well adhered and can pull at the staples. This can lead to cutaneous separation and wound infection.
- There is a degree of discomfort for the patient, on removal of hydrocolloids.
- The wet hydrocolloid has a characteristic odour when wet, which can aggravate the patient’s postoperative nausea.
- There may be an unsightly mess due to the pooling of blood into the patient’s umbilicus from the leaking hydrocolloid.
- The residue left from the hydrocolloid is difficult to remove.

The see-through product description by the manufacturer included that:

- It is comfortable and conformable.
- It is highly absorbent.
- It has a high moisture transmission rate.
- It is cost-effective.

THE PRODUCT

The dressing is similar in appearance to the Opsite Post-Op dressing, which consists of an island-style Telfa and film. However, the Opsite Post-Op Visible dressing uses lattice-shaped Allevyn®, a foam product, in place of Telfa. This highly absorbent lattice pad, according to the manufacturer, allows lateral spread across the lattice pad to maximise absorbency without impairing visibility. Figure 1 shows the product prior to application.

Figure 1: Opsite Post-Op Visible dressing prior to application.

THE RECRUITMENT PROCESS

In order for me to oversee the evaluation, the patients who were recruited for the Opsite Post-Op Visible dressing were those having major surgery that would or might result in the formation of a stoma. This also included reversal of Hartmann’s as there was a
small chance of these patients requiring a covering loop ileostomy. The packaged sterile dressing was attached to each patient’s history with a note of explanation. Informed consent was sought from each patient and they were checked for wound dressing sensitivities.

THE PARTICIPANTS

Fifteen patients participated in the evaluation. Ten were male and five were female. The age range was 39-82 years. All patients had major abdominal surgery between August 2008 and March 2009.

EDUCATING STAFF MEMBERS

The sales executive manager from Smith and Nephew ensured that all relevant staff members within Western Hospital were given an in-service introduction to the product. Posters were displayed that described the product and the contact details if there were any queries during the evaluation period.

EVALUATION

An evaluation form was completed by the theatre staff and by the ward staff. The theatre nurses were asked to rate the following criteria:

- Ease of application.
- Conformability to site.
- Adhesiveness and visibility of wound site.

Table 1 shows the average scores of the theatre evaluation. Scores: 4=excellent; 3=good; 2=average; 1=poor.

<table>
<thead>
<tr>
<th>Ease of application</th>
<th>3.78</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conformability to site</td>
<td>3.71</td>
</tr>
<tr>
<td>Adhesiveness</td>
<td>3.64</td>
</tr>
<tr>
<td>Visibility of wound site</td>
<td>3.78</td>
</tr>
</tbody>
</table>

The ward nurses were asked to rate the following criteria:

- Ease of application.
- Conformability to site.
- Exudate management.
- Absorbency.
- Adhesiveness.
- Visibility of wound site.
- Protection of peri-wound skin.
- Waterproofing.
- Patient comfort and ease of removal.

Table 2 shows the average scores of the ward evaluation. Scores: 4=excellent; 3=good; 2=average; 1=poor.

<table>
<thead>
<tr>
<th>Ease of application</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conformability to site</td>
<td>3.8</td>
</tr>
<tr>
<td>Exudate management</td>
<td>3.73</td>
</tr>
<tr>
<td>Absorbency</td>
<td>3.63</td>
</tr>
<tr>
<td>Adhesiveness</td>
<td>3.81</td>
</tr>
<tr>
<td>Visibility of wound site</td>
<td>3.81</td>
</tr>
<tr>
<td>Protection of peri-wound skin</td>
<td>3.8</td>
</tr>
<tr>
<td>Waterproofing</td>
<td>3.8</td>
</tr>
<tr>
<td>Patient comfort</td>
<td>4</td>
</tr>
<tr>
<td>Ease of removal</td>
<td>3.36</td>
</tr>
</tbody>
</table>

The wear time of the visible dressing was 2-6 days. None of the 15 patients in the evaluation developed a postoperative wound infection. A comments section was also included in the evaluation forms. This allowed the nurses and surgeons to add any positive or negative feedback about the product. Figure 2 shows the 12 comments that were offered.

Love the way you can see the suture line so that doctors will not be pulling the dressing down every day just to have a look.
Lovely product.
Excellent product.
Nice to be able to see the wound.
Wound clean and dry.
Nil visible exudate on dressing.
Visibility wins me over.
Correct length.
No need for further comment.
Why are we doing unfunded market research for a company? (surgeon)
Dressings could be longer.
Dressing not big enough.

Figure 2: Written comments on the evaluation forms.

The dimensions of the dressings used were 25x10cm, 20x10cm and 15x10cm. A longer dressing, measuring 30x10cm will be launched towards the end of 2009. This will address the concerns that the dressing was not long enough for all of the postoperative wounds.

RECOMMENDATIONS

At the conclusion of the evaluation, the PEC was given the results. This is the only fully visible wound care product available. It is easy to apply and remove without shearing or pain. It may reduce nursing clinical time, as wound and dressing assessments will be more efficiently managed. Dressings can stay intact during surgical
rounds, instead of being pulled off and left hanging until the patient’s nurse is able to redress the wound.

Furthermore, no wound infections nor skin allergies were reported and the nurses appeared pleased to evaluate and use it. Some nurses asked when it would be on our shelves. One intensive care nurse asked if he could use it on his patient who was not involved in the evaluation.

CONCLUSION
Finding the best product for wound care is always challenging. Inspection of the wound via an intact dressing and high-quality exudate management decreases the need for costly dressing changes and overcomes the issue of early dressing removal post surgery.

This see-through dressing may possibly address the needs of all health professionals involved in wound care and ultimately improve patient outcomes.

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**Australian Association of Stomal Therapy Nurses Inc.**
**Education and Professional Development Subcommittee**

**POSITION STATEMENT**

Scope of nursing practice for stomal therapy nurses

It is recognised that stomal therapy nurses practise in a variety of settings and must operate in accordance with their scope of practice as determined by their relevant state registering body.

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**ELECTRONIC SUBMISSION OF MANUSCRIPTS TO THE JOURNAL**

The *Journal of Stomal Therapy Australia* now requires all submissions to be made online

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- Login.
- Create an account if first time using the system. This will be retained for future enquiries and submissions.
- Enter your personal details: all fields must be completed.
- Confirm your details.

**SUBMITTING AN ARTICLE**

- Step 1 – Type the title, type of paper and abstract. Select publication – JSTA.
- Step 2 – Confirm author. Add co-author details (all fields) if applicable.
- Step 3 – Upload files. Only Word documents are accepted. Please ensure your document contains the required information and is formatted according to the author guidelines.
- Step 4 – Add any comments for the editor.
- Step 5 – Review your information then click submit.

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The implementation of traffic light guidelines for hospital-based stoma management

Sandy Hyde-Smith • RN STN

Sandy Hyde-Smith from WA is the winner of the 2009 CSSANZ scholarship for stomal therapy nurses with her paper ‘The implementation of traffic light guidelines for hospital-based stoma management’. The AASTN executive committee would like to thank the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) for this opportunity to promote stomal therapy nursing in partnership with the colorectal surgeons. It is a fantastic opportunity and one we hope continues long into the future. Sandy will attend the CSSANZ spring meeting in Sydney and we look forward to reading about Sandy’s experience in the next journal. Sandy Hyde-Smith would like to acknowledge her colleague, Gail Ross-Adjie (Coordinator Nursing Clinical Practice, Policy & Research), who assisted her with the editing of the article.

ABSTRACT

This paper describes the introduction of a traffic light guideline system as a simple but effective tool to communicate the level of ostomy care required for ward-based hospital patients. Advantages include better use of stomal therapy nurse (STN) time, improved communication and continuity of patient care. Preliminary feedback from patients, their families and ward nursing and medical staff has been very positive, but a formal evaluation remains to be undertaken 6 months after implementation.

INTRODUCTION

Traffic light guidelines have been used successfully in other areas of healthcare, including infection control and radiology. They provide a simple visual tool used to improve communication between different members of the healthcare team. Our traffic light guidelines were implemented in response to a recognised need for improved communication between the stomal therapy nurse (STN) and ward nursing staff, to ensure continuity of stoma management and education of new ostomate patients.

BACKGROUND

The early teaching of stoma management skills to new ostomate patients is an essential part of their rehabilitation. The importance of self management skills is supported by Marquis et al. who found that patients who were confident in managing their stomas achieved significantly higher quality of life scores than those who were not confident.

Consequent to an increase in the number of clinical nurse speciality roles, including STNs over the past 20 years, the task of stoma education is now often the responsibility of the STN. It is imperative to ensure, however, that this education is continued when the STN is absent and there is clearly a need for ward staff to become more involved in stoma management and patient education. Bossom and Beard describe how non-specialist nursing staff often feel apprehensive about and even ‘avoid’ engaging in routine stoma care.

This situation has certainly been evident at this hospital. Over the past 3 years, allocated STN hours have doubled, resulting in the perception that ward nursing staff need not become involved with routine stoma care and patient education. As suggested by Bossom and Beard, our experience was that ward nurses were indeed becoming ‘deskilled and disempowered’. Furthermore, the STN was spending unproductive time on basic stoma care tasks, time which could be better spent dealing with more complex stoma problems and staff education. As a result, ostomate patients were not receiving optimal care in the absence of the STN.

The process of involving ward nursing staff in stoma management presents many challenges, including the need for the STN to shift focus from busy clinical routines to that of educator and communicator. The result is not only the up-skilling and empowering of the ward nursing staff, but ultimately improved patient care.

THE TRAFFIC LIGHT GUIDELINES TOOL

The traffic light guidelines tool for stoma management was implemented at this hospital after it was recognised that a simpler and more effective form of communication between the STN and ward staff was required. The traffic light system is a simple visual tool that illustrates, at a glance, the level of independence a patient has achieved in their stoma management (Figure 1). It also indicates the frequency of bag changes required and whether or not the STN will be reviewing the patient. The system is described below:

- Red=patient is unable to attend own stoma care.
- Orange=patient requires assistance with stoma care.
- Green=patient is independent with stoma care.
- STN=indicates that the patient will be reviewed by the STN for stoma education.
- Daily=indicates that the bag requires daily changing OR 2nd daily base plate=indicates a two-piece appliance with the base plate requiring 2nd daily changing.

In addition to these ‘light’ indicators, two other stickers can be placed on the tool:

- Green=patient is independent with stoma care.
IMPLEMENTATION

Prior to implementation, an education campaign was undertaken with posters placed around the ward (Figure 1) and short ward-based education sessions given. Ward nursing staff were given the opportunity to ask questions and provide feedback about the proposed system and any concerns were addressed at this stage.

At the initial postoperative patient review, the tool is placed in the patient’s room by the STN with the red sticker at the top of the traffic light. As the patient progresses towards independent stoma care, the traffic light is changed to orange and then green. If the STN will be reviewing the patient, the STN sticker is added. On a Friday afternoon, for example, the STN sticker is removed, which indicates that the ward staff will need to attend or assist the patient with their stoma care over the weekend. In addition, either a daily or 2nd daily sticker is added to inform staff (and remind the patient) how often the bag and/or base plate needs to be changed. Figure 2 shows a picture of the tool in use, indicating that the patient requires assistance with their stoma care, that the bag requires daily changes and that the STN will not be reviewing the patient that day. Therefore, ward nurses know, at a glance, that they will need to assist the patient with emptying and changing their appliance.

DISCUSSION

Prior to the introduction of specialist STNs, routine stoma care was the responsibility of ward nursing staff. Complex stoma problems were sometimes referred to a more senior or experienced nurse who may or may not have some short course qualifications in the management of stoma care. In some circumstances there simply was nobody with the appropriate experience to deal with these issues. Whilst the advent of specialist roles such as the STN has undoubtedly improved the outcomes for ostomate patients and their families, we recognise that, in some circumstances, it has resulted in deskilling ward nurses’ ability to manage and educate the patient on routine stoma care.

While non-specialist nurses may have some relevant knowledge, they need to expand this knowledge and apply it to practice with the help of specialist nurses such as the STN. Gould and Chamberlain describe the ward as “... the best venue for learning clinical skills” making this environment an excellent ‘classroom’ and opportunity for teaching and learning. With the ever increasing workloads for both ward and specialist nursing staff, it is imperative that all clinical skills and resources are used effectively. In addition, many healthcare facilities are now adopting the team nursing approach, making clear and effective communication between all team members imperative.

EVALUATION

Although the traffic light guidelines have only been recently implemented at this hospital, feedback has been very positive and the system has been well received by not only ward nursing staff but patients, their families and the medical staff involved in the patient’s care. There is already evidence of a reduction in the number of unnecessary phone calls to the STN and, more
importantly, evidence of an improvement in the continuity of patient care. A formal evaluation of the tool will be undertaken 6 months after implementation and will assess effectiveness from the perspective of the patient, ward nursing and medical staff and the STN.

CONCLUSION

Our early experience with the traffic light guidelines for stoma management has demonstrated that it is a simple, effective communication tool which improves the care outcomes for ostomate patients. We anticipate that the continued use of this tool will lead to further improvements in patient care, enhanced staff knowledge and communication and more efficient use of STN time.

Although the traffic light guidelines for stoma management appear to be an effective communication tool, they are not a substitute for formal documentation in the patient’s progress notes. Documentation remains a crucial part of nursing practice and allows a more comprehensive assessment of both the patient’s stoma needs and any other relevant issues to be documented.

REFERENCES


Profile:
Leigh Davies

Clinical Nurse Specialist/Stomal Therapy Nurse/Continence Advisor
AASTN WA Branch State Rep and Vice President National Executive Committee

I began working as a Silver Chain as a single mum of two wee boys approximately 19 years ago. During the first 10 years I worked alongside a number of inspiring specialist nurses. I admired their manner, their knowledge base, their enthusiasm and achievements.

Having always had a deep-seated love for wound care and, due to having constant involvement with several clients that had extensive complications related to their stomas and underlying medical conditions, I became increasingly interested in stomal therapy. I was able to observe and learn from these specialist nurses and, with their encouragement, attended and completed the stoma therapy course in 1999.

Since that time I have worked as a clinical nurse specialist (CNS) at various locations within Silver Chain. This has been both a fulfilling and challenging role. With the challenges faced in the community the level of satisfaction from resolving problems is amazing. The STN role is a ‘feel good role’ both for the client and myself.

Whilst being with the Silver Chain I have been able to work autonomously and I have gained such a variety of experience and growth that I feel this would be hard to achieve in any other position. I further specialised as a continence advisor in 2006 and with the new Continence Management and Assessment Service I was fortunate to be able to consolidate all I had learned.

Where am I now? Another new service has rolled out in Silver Chain and I have moved over to fulfil one of many CNS roles within that service. It is called The Priority Response Assessment Team. It is an innovative idea based on reducing hospital admission for those that could be managed in the home with additional support. Nurse practitioners head the teams also new to Silver Chain and it is a marked advancement for nursing recognition.

On a personal level my two impish boys have grown into 21- and 22-year-olds, not quite yet responsible adults! They are individuals with their own opinions and beliefs. They continue to think their mother has the most disgusting job in the world but admire me greatly as long as I don’t tend to their injuries. They are confused by my interest in Reiki and Thought Field therapy as it seems too way out. But who do they call when they need someone? They call MUM.

My Future? To achieve the best I can, continue to support and promote stomal therapy and wound management. To one day go overseas as a volunteer – to ‘give a little back.’

Thanks, Leigh
Following the 30 September 2009 Stoma Products Assessment Panel (SPAP) meeting, I have the following items to report:

1. It was agreed between the three AASTN representatives (Sharmaine, Carmen and myself), that I would take on the role of AASTN/SPAP liaison. This is to allow all correspondence to be made through me, so that it can be actioned. My email is diana.hayes@wh.org.au or phone 03 8345 6553.

2. Eligibility to the Stoma Appliance Scheme (SAS) will remain as follows:

To be eligible to receive products under the SAS, 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.

Eligibility includes GIT and urinary fistulae. However, fistulae, openings, draining wounds and drain tubes that occur outside these criteria are NOT eligible. Please remember that you are signing a declaration on the Certification for Eligibility form. It was agreed that any current members with non-GIT fistulae would be able to stay on the scheme. The following link will take you to all of the relevant forms on the Department of Health and Ageing website: http://healthyactive.gov.au/internet/main/publishing.nsf/Content/health-stoma-forms-copy2

3. Medicare Australia is working towards producing a new form, which will combine the Stoma Appliance Scheme Certification of Eligibility form and the PBS Health Insurance Commission form when joining up new members. For now, both forms must be completed and faxed to the Associations.

4. If a member needs extra supplies:

In relation to the certificate requirements for additional stoma supplies, all instances of additional supplies require the STN or medical practitioner to fill out Medicare form 4050.

In each instance where more than twice the maximum quantity is sought, a separate clinical justification is to be provided along with the certificate.

Where more than four times the maximum quantity is sought, a separate clinical justification is to be provided along with the certificate. Departmental approval is also required for this quantity.

www/qldstoma.asn.au/Medicare%20form%204050.pdf

This link will get you to the latest version of the certificate.

Feel free to contact me if you have any concerns that are relevant to the Stoma Appliance Scheme.

The next SPAP meeting in Canberra is in April or May 2010.

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Sudocrem® assists in the management of excoriated skin and can be used under and around stoma appliances and after stoma reversal.

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**ACSA report**

**Australian Council of Stoma Associations Inc. (ACSA)**

*Ed Webster • ACSA Secretary*

When asked to write this article for *The Journal of Stomal Therapy Australia* I was taken back nearly 30 years to the time of my first meeting with the STN at the hospital where I had just had my surgery. A competent lady but one who was reportedly railroaded into doing the STN course. Sad because she fitted me with an appliance which in no way resembled the shape of my stomach and it translated to a bout of depression on my part.

For 3 weeks I moped about the house moving from the bed to lounge chair to toilet. A visit from a friend mentioned a different type of appliance being worn by her ostomate father. She recommended a visit to the STN at another hospital. An appointment was made, she changed the appliance and turned my life around. On that very first visit she was instrumental in pointing me in a direction I have followed for all the years since I became an ostomate. My recognition and acknowledgement that the STNs at the ‘coalface’ are capable of setting all new ostomates on the road to complete recovery.

As I have progressed through various positions over the years I have become aware that the need to support STNs as they guide new patients through those first 12 months of recovery is essential. The passing of information is essential but sometimes tardy and occasionally causes disharmony between STNs and the Associations. Providing the latest information from all sources to those STNs is the responsibility of AASTN committees both national and state but sometimes it doesn’t happen and patients and Associations come unto conflict. I hasten here to state that my intentions have always been to assist STNs to deliver the best possible care to ostomates. It has also been a wish to have closer contact between STNs and Associations and, whilst this is easier in metropolitan areas, it could be better in regional areas.

Quite recently (early July) the Department of Health and Ageing released the latest version of the *SAS Operational Guidelines for Stoma Associations*. I suggest that all STNs obtain a copy to make themselves aware of the requirements of Associations including the issuing of appliances. I will forward a copy to the Editor of your magazine and readers can ask for a copy to be sent to them from that source.

My best wishes to all STNS. Keep trying to improve your good work.

Please be advised that these comments are mine alone and in no way are they to be perceived as policy of the ACSA and its Executive.

**WCET report**

**Phoenix, Arizona 2010, Adelaide, Australia 2012**

*Brenda Sando CNC STN • The Wesley Hospital, Brisbane QLD*

Christmas wishes and blessings to you! Yes it is almost Christmas! Where has the year gone? Seems to me that each year is going faster than the last, which is a scary thought, but hopefully the reason is because I am becoming more productive in what I do. I will hang onto this thought as I see the hours fly by.

I am very much looking forward to the 2010 joint congress with WCET and WOCN being held in Phoenix, Arizona from 12 to 16 June. The title of the congress is *Universal Focus on Patient Care*. The WOCN Society and WCET will unite to educate the world on the most up-to-date patient care treatments, evidence-based research and techniques aimed to advance the profession. The knowledge gained will assist us to improve the lives of patients within our care. This will be an event not to be missed as it is the first time these two Associations have joined to produce what will be a very stimulating, educational and enjoyable event. Not only will we hear new information relating to our profession but the network opportunities will be valuable as we talk to colleagues from many different parts of the world. We will also be able to visit one of the many great wonders of the world: the Grand Canyon, which will be a great place to see after the conference. Watch for the registration information on our website, wcetn.org. and submit early as I am sure it will be a popular congress.

Preparations are well under way for the planning of the WCET congress being held in Adelaide in 2012. Fiona Bolton from Adelaide has been very busy engaging the services of a conference organising group and in October sent a message out to all members of the AASTN calling for those interested in being on the organising committee. Our thanks go to all those who have expressed interest in this venture and although there is a lot of work to do over the next few years leading up to this event, I know, due to the great group of people who will be giving of their time and talents, we will have a congress event in Adelaide of which we can be very proud.

Our annual fees are due by 31 December. You can pay for 2 years if you wish and payment is received online through our website. If you do not have a credit card and would like to become a member of WCET or are having difficulty making a payment, please contact me by email, brenda.sando@uchealth.com.au

I do hope you have an enjoyable Christmas and wish you good health, good work and much happiness in 2010.
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*Hos-cology - no-smells!
Oncology & Palliative Care. Odours of fungating & necrotic tissue. The answer to mal-odours & wound care, needing better management.

*Hos-togel - no-smells!
Aged Care, Oncology, Palliative Care, Pathology, Laboratories, Operating Theatres. Available on: CAAS & D.V.A. Schemes.

*Hos-toma - no-smells!
Dropper & spray packs for Ostomate, Hirshsprungs, I.A., Crohn, Colitis, & I.B., patients. Wonderful when sprayed while demonstrating and instructing patients. For those who have returned to the work force or lead an active social life, spray packs are available from Ostomy Associations on a cash sale basis.

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and One 250ml. *Hos-toma - lube!
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State reports

**Australian Capital Territory**

Hello all from the ACT.

It was exciting to attend the 2009 ACSA conference held in Canberra this year. They were lucky with the weather as the days were quite warm at the time. I attended for a short time on Friday 11 September for the General Meeting. It was interesting to hear of the issues, concerns and work occurring within ACSA.

Our state branch AGM was held on 8 September. The results of the AGM are:

Kellie Burke – President and State Representative
Clare Love – Secretary
Therese Verdon – Treasurer
Education Subcommittee – Kirsti Dixon.

Regards.

Kellie

**New South Wales**

Our August meeting on 4 August was our AGM with the election of officer bearers and ordinary members. The results were:

Jenny Rex – State Representative
Patricia Morgan – Secretary
Susan Dunne – Treasurer
Heather Hill – Educational Organiser
Ordinary members – Mark Murtagh, Lisa Graff, Kris Louis, Diana Mannix, Sally Auld
Lesley Everingham and Susan Dunne remain on the AASTN Professional and Education Subcommittee.

Thank you to Carol Stott for all her hard work as the State Representative for the last 4 years. Grand job Carol! Another big thank you to Diana Mannix who stood down as Treasurer.

Four Graduate Certificate in Stomal Therapy students have been the recipients of the Ostomy NSW Ltd yearly scholarship. They are:

Naomi Houston
Sarah Lyons
Brooke Taylor
Charmaine Richards

Congratulations to these students and we hope to see them at further meetings for support and networking.

Lee Gavegan, CNC Stomal Therapy, is organising a study day at Westmead Hospital on Saturday 27 February 2010. The programme looks very good, including stomal therapy and complex wounds. Phone Lee for information on 02 9845 7969.

The guest speaker at our October meeting was Dr Kirk Austin, Surgical Superintendent RPAH. He has just published a paper on pelvic exenterations, titled *Quality of life after pelvic exenteration, a retrospective review*. He presented this paper, discussed the procedure and explained the surgical technique of this surgery. All of these patients usually have two stomas postoperatively. We all found this very interesting and it created lots of discussion.

The NSW branch continue our bimonthly meetings with educational guest speakers at every meeting with a light supper supplied by our company representatives. Our meetings now are teleconference meetings. This has proved to be successful – please contact me for information. The venue is in the Tutorial Room, Level 9 East Ambulatory Care, RPAH. Our next meeting will be Friday 4 December followed by Christmas dinner at Emma’s on Liberty, Enmore, at 7.30pm. All welcome. Please RSVP to me on 95158990 by 27 November.

The dates for 2010 are 2 February, 6 April, 1 June, August, 3 October and 3 December, which will be followed by our Christmas dinner.

If you are an AASTN member and do not get our branch minutes please contact me.

Cheers.

Jenny Rex

**Queensland**

We are busy organising a STN professional education day to coincide with the national AGM meeting next March. We have had a large list of suggestions for the education day. It will be held in Brisbane at the Princess Alexandra Hospital.

We have had a great attendance to our bimonthly meetings and Shirley Jones presented *Managing Complications in the Community Setting* in September. Four STN students attended our last meeting and we welcome any new members. We are meeting for a friendly game of lawn bowls and dinner for our Christmas breakup.

A group of Queensland branch STNs gathered at the PA Hospital to assist Shirley Jones to get started on her proposed research project to determine the effects of stoma care delivery on the quality of life of ostomy clients in RACFs. A questionnaire was emailed to AASTNQ members with a request to contact five facilities in their area to answer questions about existing stoma care management or procedures in their facility for residents with a colostomy, ileostomy or urostomy.

While the questions were very general, it was agreed that the results would confirm what STNs already think, that is, the delivery of stoma care and procedures or resources is not uniform across aged care and supported accommodation facilities.

A number of responses were received and provided for collation. Colleagues not able to attend forwarded their questionnaires, ideas or education tools. Twenty-five responses were tabled at the meeting. The overwhelming majority indicated there were no specific procedures in place for the management of stomas.

Discussions at the workshop were fruitful and provided some options for determining or developing a uniform way for the
South Australia

The South Australian branch of the AASTN has continued the year in a busy style with the annual quiz night fund-raising event being well-attended. Everyone enjoyed the evening with the winner being decided by some last minute guesswork. The big prize for the night was a weekend away at the Penny Hill Winery in McLaren Vale.

Our branch meetings have been graced by some interesting speakers, starting with Maggie Roediger and Sheryl Rochford from the Bowel Cancer Screening Programme who spoke about their role in the surveillance of colorectal cancer in this state. With the early detection this offers, patients with bowel cancer are offered a much better chance of survival. In July, one of our members, Sylvia Evans presented a case study about a patient who was an ICU retrieval and had severed their hand in a meat grinder. This came with detailed pictures and commentary and was very interesting. Last month our speaker was Tabatha Rando, who presented her research into the incidence of skin tears in an acute care setting which she did as part of her masters degree. It was obvious from her talk that these are a big problem which need our attention to improve the care given to patients who sustain them.

Of course the South Australian branch was delighted to win the bid for the WCET Congress 2012 and the Executive Committee is already starting to evolve plans for this event. Our condolences go to the Queensland branch who also put in an excellent bid for this conference. We hope that STNs throughout Australia will participate in helping to make this an occasion to remember.

Lynda Staruchowicz

Tasmania

Hi from Tassie,

We all continue to motor along, looking after our special patient groups and keeping the education flowing to our colleagues.

Our Northern Journal Club Dinner Meeting, organised by Sue Delanty and supported by Andre Gall from Coloplast will be held in November. We are excited that Mr Hung Nguyen, colorectal surgeon from the Launceston General Hospital will be presenting. A patient will give us their perspective on having surgery that required a stoma and their experience. Many AASTN TAS members will be involved with smaller presentations including Teena Cornwall, Heather Lees, Sonia Hicks, Vanessa Rhodes and myself. It is great to see us all braving the limelight and sharing what we have learnt from our sometimes challenging days! And since we will all be together we are going to make this our AASTN TAS branch Christmas get-together.

Sonia, Margot and Vanessa from the Royal Hobart Hospital (RHH) have conducted a workshop Stomas in and out. They also spoke, at our last AASTN branch video link-up, of attending the Bowel group for Kids video conference recently, which they found insightful and added to their knowledge of caring for our much younger clients and their families. Debbie Franklin conducted an informative wound, continence, soma and PEG study day for Presbyterian Care.

Helleen Purdy

Delivery of stoma care based on best practice. Some of the outcomes of the workshop included:

- Possible separation of the research project into two projects.
- A project proposal to be put to the October 2009 Education Committee meeting regarding a policy procedure guidelines or competency tool or education package.
- A second more specific questionnaire is to be sent out to aged care facilities to determine stoma care education or resource needs and the number/s of ostomy residents.
- Shirley will be submitting an application for the Eleanor Kyte Research Grant before the end of year.

The Queensland branch will continue to provide support to Shirley with her project for which Shirley is very grateful (and very much in need of).

Thanks to those who generously gave of their precious private time to attend and who participated in the questionnaire, especially the ‘out of towners’.

With all your responses to benchmarking STN positions, Brenda Sando was successful in employing another STN to assist at the Wesley Hospital. Congratulations to Kelly Dunk who was the successful applicant. Louise Walker has also been appointed to job-share the CNC role at Mater Private with Petra and has resigned from Logan and Greenslopes. Logan will shortly be advertising to fill her position which is a 5-day fortnight CN.

Pat Kennedy has retired from the Princess Alexander Hospital and Bev Gaudie has resigned from the Royal Children’s Hospital. We sincerely thank them for their dedication and contribution to stoma therapy over many years.

We send our special wishes of love, happiness and health for you all to have at Christmas and all through the year.

Helleen Purdy

Workshop attendees.
Back to front/left to right: Linda Durham, Theresa Winston, Elaine Lambie, Colleen Taylor, Brenda Sando, Pat Sinasac, Shirley Jones, Pat Walls

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Sue, Teena and I continue with our ongoing in-house study days organised for our transition to practice, re-entry and enrolled nurses.

Congratulations to Sue Hoyle, our Ostomy Association Secretary and Treasurer who has joined the Stoma Products Assessment Panel (SPAP). Sue is pictured here cutting the cake for World Ostomy Day on 5 October with Andre from Coloplast and other Association members.

Congratulations go out to Kristie Willis who not only achieved her Stomal Therapy Graduate certificate this year but who also managed to become a mum with the birth of Sydney David.

We will keep the rounds of applause going for Sue Delanty and Teena Cornwall who have worked extremely hard this year achieving their Masters in Advanced Clinical Nursing and Tracey Beattie for completing her Graduate Diploma in Nursing. We are very proud of our high standards of ongoing education in Tassie.

In closing, I’d like to wish all of our colleagues across Australia the very best Christmas and a happy and safe new year.

Cheers for now.

Tracey Beattie

Victoria

After a hectic start in the first 6 months of the year, branch activities have now levelled out to a moderated pace.

World Ostomy Day on 3 October was celebrated in Melbourne at Northcote Town Hall. It took the format of a community awareness day and discussed Wellness support in chronic illness and Getting back on your feet after stomal surgery. Our thanks to Genevieve Cahir, as STN organiser on the committee for this day.

A very successful education evening was organised through Coloplast on 28 September. It was held at Box Hill Hospital and we were fortunate to have Mr Chris Love, urologist with a special interest in Sexual Dysfunction, give a talk on just that subject pertaining to surgery outcomes with deep pelvic resection. This invitation was extended to urology nurses in surgeon’s rooms and diabetes educators, who responded most favourably with good representation. The mix of speciality made for lively discussion and we all enjoyed the evening. Our thanks to Coloplast for supporting the ongoing education for the branch.

The October meeting was held at the Nurses Memorial Centre, the education topic for this was Compiling statistics and how to use these figures to enhance your department’s submissions or validate its work.

The committee planning the 2011 national conference is meeting every second month and positive steps to ensure a first-class programme are well under way. The advertising, call for abstracts, and so on will be rolled out midway through next year. Stay tuned for journal updates as they are organised.

We will be organising a conference day to coincide with the AGM next March, plans are under way to host that day in Geelong.

We noted that South Australia received the Aussie nod as host bidding state for WCET IN 2012. We hope this comes to fruition for them and assure SA of our unqualified support in planning and development.

As I write this report, Lisa Wilson, from the Royal Melbourne Hospital is presently overseas, being the recipient of the Jane Bell Scholarship, which is an overseas travel grant of some $10,000.

Lisa is looking at “fast-track surgery” and “multidisciplinary meetings”. I believe the majority of her travel is throughout the UK. We will be looking forward to Lisa’s reporting on her return.

Our December meeting will be our Christmas get-together; this date is set for Thursday 3 December at the Nurses Memorial Centre, 431 St Kilda Road Melbourne, commencing at 6pm. All are welcome. BYO plate, drink and, as a Christmas gesture an unwrapped present for a child which will be directed to an appropriate charity for Christmas. This is to be an informal evening that allows all involved to sit and have a social catch up chat.

At the close of this year and with the beginnings of the festive season, the Victorian branch would like to wish all our friends throughout Australia and New Zealand greetings for the season, peace, health and a very Merry Christmas and a safe and enjoyable new year.

Helen Nodrum

Western Australia

This is the first report for that you will receive from me as the newly elected WA State Representative. For the past year it has been held by Carmel Boylan who did such a wonderful job that I hope I too can succeed in this position.

The new WA branch committee members:
President – Carmel Boylan
Vice-President – Karen McNamara
Secretary – Shannon Tassell
Treasurer – Rita McIlduff
State Representative – Leigh Davies
Educational Representative – Lorrie Gray and Sandy Hyde-Smith
Committee – Brigid Keating
Keryn Carville
The Smith & Nephew Stomal Therapy Education Grant is awarded annually to financially assist a registered nurse who is currently undertaking or has applied to undertake a recognised AASTN Stomal Therapy Nursing Education Programme. The award is administered by the AASTN Executive but presented by Smith & Nephew. The value of the scholarship is $1,000.

**SELECTION CRITERIA AND GUIDELINES**
The applicant is to submit to the AASTN Secretary by 31 July 2010:

- A completed official application form which is to be obtained from the Secretary.
- Proof that the candidate has been accepted, is undertaking, or has completed a recognised AASTN Stomal Therapy Nursing Education Programme within the period January to December in the year of application.
- A current curriculum vitae.
- Written confirmation from the applicant’s employer that the candidate is able to utilise their stomal therapy nursing skills on completion of the course.

Incomplete applications will not be considered.

The AASTN Executive will announce the successful candidate within 6 weeks of the closing date.
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2007

**Ostomy management**

*March 2007 issue*
- Take a walk in my shoes: an insight into paediatric bowel disorders
  Eunice Gribbin
- Case studies using convexity
  Julia Kittscha, Carol Stott & Paris Purnell
- Managing complications associated with a high output jejunostomy using convexity
  Ian Whiteley
- Making sense of convexity
  Rae Bourke, Elizabeth Davis, Susan Dunne, Carmen George, Julia Kittscha, Carol Stott & Paris Purnell
- Thank you Mr Eakin, I love your seals (letter)
  Jessica

*June 2007 issue*
- The challenge of changing consistency: a case study using Convexity
  Maria Stapleton

*September 2007 issue*
- Challenge of managing a retracted stoma on a large abdomen
  Liz Howse
- From community to acute care: an audit study of clients living with a stoma
  Susan Farquhar, Charne Flowers, Patricia Griffin, Margaret Rigoni, Mary Ryan, Paul Ryan, Debbie Streames & Ann Watt
- Right product, right fit
  Leonie Cartlidge-Gann
- Beneath the waves (ileostomate and scuba diver)
  Grant McLaren

**Wound management**

*June 2007 issue*
- Case study: Sacral pressure ulcer
  Emily Brown
- Compression, compression, compression!
  Lucy Daniels

**Continence Management**

*December 2007 issue*
- The prevention and management of faecal incontinence
  Sule Sutcu
- Current research: randomised controlled trial of biofeedback guided anal sphincter exercises in faecal incontinence
  Jenny Rex

**Professional Issues**

*March 2007 issue*
- Using De Bono’s six thinking hats (Editorial)
  Julia Thompson
- AASTN Education and Professional Development Subcommittee: Chairperson’s report October 2006
  Cynthia Smyth
- NNO meeting report
  Lesley Everingham
- Congratulations to Brenda Fowler (ACT Community Nurse of the year)

*June 2007 issue*
- AASTN Education and Professional Development Subcommittee: Chairperson’s report – Conference March 2007
  Cynthia Smyth
- New national database for stomal therapy nurses (START)
  Nola Polmear
- AASTN 36th Annual Conference report (Wollongong NSW)
  Lorrie Gray
- Life membership awarded to Julia Thompson
  Lesley Jack
- Open Forum

*September 2007 issue*
- It’s our website and journal (President’s report)
  Leeanne White
• Risk management in stomal therapy practice
   Nola Polmear

• YOU Inc. President’s report March 2006 – Feb 2007
   Margaret Allan

• WCET report (Indonesian Enterostomal Therapy course)
   Carmen George

• Maintaining professional respect (Editorial)
   Diana Hayes

• AASTN Education and Professional Development Subcommittee: thinking about your Continuing Professional Development portfolio?

• Congratulations to Lorraine Andrews (Winner ConvaTec Scholarship)

• An Indonesian experience
   Sharmaine Peterson

• WCET report: Professional worldwide connections
   Carmen George

• AASTN Education and Professional Development Subcommittee: Chairperson’s report – Workshop October 2007
   Cynthia Smyth

Book Review/Resources

March 2007 issue
• The Stoma Care Manual: A guide for people with a stoma
  Diana Hayes

• Group for Kids Inc. Information, handbook and order form


June 2007 issue
• Development of the STN Database

• Book review: The Stoma Care Manual: A guide for people with a stoma
  Mary Ryan

September 2007 issue
• Elinor Kyte Research Grant

December 2007 issue
• Book review: Wound care essentials – practice principles (Eds: Sharon Baranowski & Elizabeth Ayello, 2nd edn.)
  Julia Thompson

2008

Ostomy management

March 2008 issue
• Does a modified diet reduce the incidence of fluid output in people with an ileostomy? A preliminary study
  Diana Hayes

• Case study: Using a convex appliance to achieve a variety of positive Outcomes
  Carmen George

• Case study: conservative management of a necrotic colostomy
  Ian Whiteley

June 2008 issue
• Hirschsprung’s disease: my personal experience
  Carolynne Partridge

• Management of a retracted stoma
  Leonic Cartlidge-Gann

• Flatus: prevention and management
  Angela Castle

September 2008 issue
• Stoma, wound and fistula management in gynaecological oncology patients
  Carol Stott & Jennifer Duggan

• Case study: Partial jejunal resection for mesenteric infarction
  Lesley Jack

December 2008 issue
• How my first stoma encounter lead me to a career in stomal therapy nursing
  Nobuki Murphy

Wound management

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• A study to evaluate the effectiveness of daily TenderWet Active 24(R) dressings as a wound debridement agent
  Annie Thompson, Gaye Speed & Sunita McGowan

Professional issues

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• News and views from the Australian Council of Stoma Associations (ACSA)
  Gerald Barry (ACSA President)

• WCET Australian delegate election forthcoming
  Carmen George

• AASTN Education and Professional Development Subcommittee: Chairperson’s report – Workshop October 2007 (repeat)
  Cynthia Smyth

June 2008 issue
• News headlines: AASTN holds AGM via national tele-video for first time (President’s report)
  Leanne White

• Seeking stories on the history of stomal therapy in Australia (Editorial)
  Diana Hayes

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• Preoperative information for colorectal cancer patients: does it make a difference? 
  Maria Stirling, Veronica Knowles & P Livingston

• Patient story telling and qualitative nursing research 
  Ian Whiteley

• AASTN Education and Professional Development Subcommittee: Chairperson’s report – AGM March 2008 
  Cynthia Smyth

• WCET report: WCET 30th anniversary 
  Carmen George

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• Historical edition (Editorial including referencing) 
  Diana Hayes

• Probiotics 
  Teena Cornwall

• A stomal therapy nurse abroad: a Canadian experience 
  Patricia Sinasac

• Historical perspectives: Pioneer stomal therapy nurses welcome a new group beginning their STN journey (WA) 
  Lorrie Gray

• Historical perspectives: Early stoma appliances in Australia 
  Terry Carver (Ileostomy Ass Vic)

• Conference report: 1st international paediatric enterostomal therapy convention – caring for children! Montreal, Canada 
  Lisa Kimpton

• Behind the scenes: Phil Morton (Website Coordinator) and Robyn Simcock (AASTN Membership Coordinator)

• ACSA report: Partnerships in progress – AASTN/ACSA 
  Peter McQueen (ACSA Vice President)

• WCET report: Hello from your new WCET ID 
  Brenda Sando

• Credentialing report: Congratulations to all! 
  Sue Delanty

• WCET congress report: Ljubljana, Slovenia 2008 
  Carmen George

• Congratulations to Fiona Bolton (Winner of Shelley Simper Award – SA)

• Congrats to Sarah Axman-Friend (AASTN Treasurer) on birth of Chloe

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• Stomal therapy nursing: participation, publication and research (President’s report) 
  Leeanne White

• Towards nurse practitioner status (Editorial) 
  Diana Hayes

• Comparing the Australian and Danish health financing systems: a focus on health insurance and payment for medical services 
  Diana Hayes

• WA stomal therapy nursing education programme 2008: a student perspective 
  Beverley Offer

• Conference report: 17th Biennial WCET Congress 
  Ljubljana, Slovenia
  Heather Hill

• Coalition of National Nursing Organisations (CoNNO) report 
  Lesley Everingham

• Australian Council of Stoma Associations Inc. (ACSA) report: STNs and ostomates: an evolving relationship 
  Peter Lopez

• WCET report: Greetings from your Aussie ID! 
  Brenda Sando

2009

Ostomy management

March 2009 issue

• Case study: Stenosing vesicostomy: a novel solution 
  Judy Wells

June 2009 issue

• Parastomal hernias revisited, including a cost-effectiveness analysis: is an ounce of prevention worth a pound of cure? 
  Julia Thompson

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• Poster presentation: (37th AASTN Conference) 
  Case study: Improving the quality of life in an ileostomy patient 
  Arum Pratiwi

Wound Management:

September 2009 issue

• Case study: Management of a complex faecal fistula within a wound dehiscence using Eakin and KCI Medical VAC 
  Andrea Farrugia

• Poster presentation: (37th AASTN Conference) 
  Case study: Management of an adolescent patient using a nanocrystalline dressing with probable pyoderma gangrenosum 
  Lisa Kimpton

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  Leeanne White

• Obesity in Australia: a population health issue 
  Diana Hayes

• Indonesian experiences 
  Carmen George
• News and views from the Australian Council of Stoma Associations (ACSA)
  Gerald Barry (ACSA President)

• Coalition of National Nursing Organisations (CoNNO) report
  Lesley Everingham & Wendy Sansom

• In fond memory – Kim Robyn Holland (Obituary)

• WCET report: Happy New Year
  Brenda Sando

June 2009 issue
• Work and play (President’s message)
  Sharmaine Peterson

• Taking the journal forward (Editorial)
  Theresa Winston

• A global perspective: (37th AASTN Conference)
  Australia in review
  Leanne White
  Stomal Therapy in New Zealand
  Sue Wolyneciwicz
  The stomal therapy/wound care nurse in Indonesia
  Julie McCaughan
  China’s evolution
  Huo Xiaorong
  Iran – a new beginning
  Fariba Nasiri Ziba
  The meltdown in nursing
  Prilli d’E Stevens

• AASTN Education and Professional Development Subcommittee: Chairperson’s report – AGM 2008
  Fiona Bolton

• WCET report: More conferences to come
  Brenda Sando

• Australian Council of Stoma Associations (ACSA): A Partnership in progress continued
  Peter McQueen (Vice President ACSA)

September 2009 issue
• New website coordinator (President’s message)
  Sharmaine Peterson

• Psychological aspects of caring for our patients with wounds or a stoma (Editorial)
  Theresa Winston

• Clinical leadership
  Katie Bird

• Position statement: Scope of nursing practice for stomal therapy nurses
  E&PDS

• Psychological aspects in ostomy care
  Julia Thompson

• Poster presentation: (37th AASTN Conference)
  Case study: Improving the quality of life in an ileostomy patient
  Arum Pratiiri

• Cairns 2011 (Victorian Conference Cmtee)
  Helen Nodrum

• What is the consensus? How do you organise preoperative assessments?
  Julia Thompson

• CoNNO report
  Lesley Everingham & Wendy Sansom

• WCET report
  Brenda Sando

• ACSA: The Australia Fund
  Bruce Harvey, ACSA

• Profile: Sharmaine Peterson

• AASTN Membership fee structure notes
  Robyn Simcock

December 2009 issue
• Merry Christmas and Happy New Year (President’s message)
  Sharmaine Peterson

• Caring and Sharing (Editorial)
  Theresa Winston

• Clinical case study of a high output stoma and the AF300 filter

• Should colostomy irrigation be a last resort?
  Anne Marie Lyons & Roger Riccardi

• Evaluating a postoperative see-through dressing
  Diana Hayes

• The implementation of traffic light guidelines for hospital-based stoma management
  Sandy Hyde-Smith

• Profile: Leigh Davies

• AASTN/SPAP report: AASTN/SPAP liaison contact
  Diana Hayes

• ACSA report
  Ed Webster, ACSA

  Brenda Sando

• AASTN Membership fee structure notes
  Robyn Simcock

Visit the AASTN website
www.stomaltherapy.com
# AASTN membership fee structure notes

**From the membership coordinator**

The membership fee structure notes page details the necessary requirements for all membership types and financial hardship assistance requests. In recognition of those who undertake their training in stomal therapy, the National Executive has introduced the associate (student) membership category to the existing structure. The associate (student) membership option was created to assist nurses at the reduced fee of $40. Once the stomal therapy nursing training is complete, this membership option is no longer applicable.

Please do not hesitate to contact the membership coordinator rmsimcock@bigpond.com. for more information.

## FULL MEMBERSHIP APPLICATION REQUIREMENTS

- **Fee $75**
  - a. Provide a copy of the member’s Stomal Therapy Nursing certificate.
  - b. Completion of full membership application form (available from www.stomaltherapy.com, your state representative or the membership coordinator – rmsimcock@bigpond.com).
  - c. Full membership application form signed by a nominating STN who is a full member of AASTN.

## FULL (RETIRED) MEMBERSHIP REQUIREMENTS

- **Fee $40**
  - a. Available only to full members who wish to maintain their membership with AASTN after retirement from stomal therapy in their working life.

## ASSOCIATE MEMBERSHIP APPLICATION REQUIREMENTS

- **Fee $60**
  - a. Completion of associate membership application form (available from www.stomaltherapy.com, your state representative or the membership coordinator – rmsimcock@bigpond.com).

## ASSOCIATE (STUDENT) MEMBERSHIP APPLICATION REQUIREMENTS

- **Fee $40**
  - a. Completion of associate membership application form (available from www.stomaltherapy.com, your state representative or the membership coordinator – rmsimcock@bigpond.com).
  - b. Must be completing their Stomal Therapy Nursing certificate.

## COMMERCIAL MEMBERSHIP APPLICATION REQUIREMENTS

- **Fee $65**
  - a. Completion of commercial membership application form (available from www.stomaltherapy.com, your state representative or the membership coordinator – rmsimcock@bigpond.com).

## GUIDELINES FOR FINANCIAL ASSISTANCE WITH AASTN FULL MEMBERSHIP FEE

The AASTN is able to provide discretionary financial assistance to those seeking full membership, full membership renewal to the AASTN, who can demonstrate financial hardship, unemployment or participation in self-funded and relevant nursing studies. The member must make application in writing addressed to Executive Committee PO Box 153 Floreat WA 6014, with a full explanation of their circumstances and preferred option of payment.

The AASTN Executive will consider the following three options upon written application:

1. Part-payment of full membership fee.
2. Payment of full membership fee through a process of instalments (e.g. quarterly payments).
3. Full membership fee waived.

The AASTN Executive Committee’s decision, regarding financial assistance to approved applicants and the payment option considered reasonable, will be notified by mail.

## PRECEPTORSHIP (FULL MEMBERS ONLY)

1. Once registered and endorsed by the AASTN as a preceptor it is the responsibility of the preceptor to update their information annually on the membership renewal. A member must advise the National Executive in writing should they wish to relinquish their status during that current year and have their name removed from the preceptorship list.

## MEMBERSHIP UPGRADE REQUIREMENTS (ASSOCIATE MEMBERS ONLY)

1. To upgrade from associate membership to full membership:
   - a. Provide a copy of the member’s Stomal Therapy Nursing certificate.
   - b. Completion of full membership application form (available from www.stomaltherapy.com, your state representative or the membership coordinator).
   - c. Full membership application form signed by a nominating STN who is a full member of AASTN.
   - d. Fee difference between membership type.
Guidelines for authors

The Editors and the Editorial Board of the Journal of Stomal Therapy Australia have specified guidelines for prospective authors to follow when compiling an article they wish to submit to the journal.

 TERMS OF SUBMISSION

The Journal of Stomal Therapy Australia is a quarterly publication which aims to provide educational material to the membership and any other interested bodies. Accordingly, the Editor welcomes contributions which relate, clinically or professionally, to stoma therapy nursing. These can include scientific papers, case studies, reports or letters to the Editor. Contributions can be four lines or four pages long. If necessary, you can phone the Editor or write for advice on preparing your submission.

Accompanying each submission must be a letter signed by all authors and stating that the work has not previously been published and will not be published elsewhere. Once it is published, the article and its illustrations become the property of the journal, unless rights are reserved before publication.

All work is sub-edited to journal style. The editors reserve the right to modify the style and length of any article submitted, so that it conforms to journal format. Major changes to an article will be referred to the author for approval prior to publication. The Editor will provide assistance to first time authors and may be contacted by email.

Authorship

All authors must make a substantial contribution to the manuscript and will be required to indicate their contribution. Participation solely in the acquisition of funding, the collection of data or supervision of such does not justify authorship. All participating authors must be acknowledged as such; proof of authorship may be requested by the editors. The first-named author is responsible for ensuring that any other authors have seen and approved the manuscript and are fully conversant with its contents. If the author wishes to reproduce copyrighted work, it is the responsibility of that author to obtain written permission from the copyright holder and to submit the original copy of that permission to the editor with the work as it is to be copied.

Conflict of interest: It is the responsibility of the submitting author to disclose to the Editor any significant financial interests they may have in products mentioned in their manuscript. Conflicts of interest should also be disclosed within the manuscript before the References section.

Ethics

Investigations in human and animal subjects must conform to accepted ethical standards. Authors must certify that the research protocol was approved by a suitably constituted ethics committee of the institution within which the work was carried out and that it conforms to the Statement on Human Experimentation or the Statement on Animal Experimentation by the NHMRC.

MANUSCRIPT TYPE

The journal publishes articles of interest to readers from the areas of stoma therapy nursing. Submitted work may take any of the following forms:

Discussion: Presentation of information from more than one viewpoint (for example, for and against) and usually ending with a recommendation or opinion based on the evidence presented.

Literature review: Narrative – describes and evaluates the current knowledge of a subject, identifies gaps or inconsistencies and includes critical evaluation with recommendations for future research. Systematic – describes planned analysis and evaluation of all available research studies on a particular clinical issue, conducted in accordance with scientific principles and may include recommendations for future research.

Research report: Presentation of study results in an ordered fashion, based on common practice. Research reports are expected to follow the uniform requirements for manuscripts submitted to biomedical journals, as published in the New England Journal of Medicine, Vol. 336, No. 4, 1997.

Case study: Combination of recount (retelling of events as they occurred) and information report (classification and description of something). Can be presented in different ways to give a cohesive account.

Exposition (incl letter to the Editor): Putting forward of a particular viewpoint/justification of a particular argument.

Narrative: The informing and/or entertaining account of a happening in the world (e.g. conference report).

PREPARATION OF MANUSCRIPTS

Manuscripts are to be no more than 4000 words and include an abstract of no more than 250 words. Use double spacing with Times Roman 12 font and margins 2.5cm. Title page to include title of manuscript, author’s names, qualifications and affiliations, corresponding author’s details including email address and contact phone number, total word count and up to five key words. Include title of work on the abstract page and first page of introduction. Include key points on what is already known on the topic and what your manuscript contributes. Define abbreviations in the summary and on first mention in the text. Avoid abbreviations unless terms are used repeatedly and abbreviating them will enhance clarity. Additionally, photograph(s) of the author(s) must be included in the submission and should be in .jpeg format.

Tables and figures are to be presented on separate pages, one per page. Tables should be clearly typed, showing columns and lines. Number tables consecutively using Arabic numerals in the order of their first citation in the text and supply a brief title for each. Place explanatory matter in footnotes, not in the heading. Explain in footnotes all non-standard abbreviations used in each table.

Figures must be submitted on separate pages. Photographs of the highest quality may be included in the submission and should be in .jpeg format. Legends for any figures supplied must be typed in sequence on a separate page(s). Illustrations and figures must be
clear, well-drawn and large enough to be legible when reproduced. Titles of illustrations should be supplied on a separate piece of paper, not in the figure or illustration. Each figure must include its place, its number and the orientation of figure. Patients or other individual subjects should not be identifiable from photos unless they have given written permission for their identity to be disclosed; this must be supplied.

Referencing guidelines

The referencing format is based on the Vancouver style, the main feature of which is the use of numbers at the point of reference so as not to interfere with the flow of words. Each number corresponds to a single reference provided in the reference list at the end and, once assigned a number, a reference retains that number throughout the text, even if cited more than once. If more than one work is quoted in a reference, each work must be assigned a number. That is, at any point in the text, the reference may be one or several numbers.

Following are examples of references from different sources:

- **Journal article (list all authors up to 6; above 6, use first author only, followed by et al).**

- **Book**

- **Edited book**

- **Chapter in an edited book**

- **Website**

- **Unpublished paper presented at a meeting**

SUBMISSION OF MANUSCRIPTS

Manuscripts are only accepted as an electronic submission with an attachment as a Word document. All tables, figures and photographs are to be included in the one attachment. Please ensure image files are no larger than 700kb. The manuscript must be accompanied by a covering letter indicating that the manuscript has not been submitted elsewhere and transferring copyright to the Journal.

Manuscripts are submitted electronically:

- Go to the publisher’s website: www.cambridgermedia.com.au
- Click on Manuscript System
- Login
- Create and account if first time using the system – this will be retained for future enquiries and submissions
- Enter your personal details – JSTA requires all fields to be completed
- Confirm your details

Follow the steps for submitting an article

- Step 1 – Type the title, type of paper and abstract. JSTA requires an abstract for all submissions. Select publication – JSTA.
- Step 2 – Confirm author. Add co-author details (all fields) if applicable.
- Step 3 – Upload files. Only Word documents are accepted by JSTA. Please ensure your document contains the required information and is formatted according to the author guidelines.
- Step 4 – Add any comments for the editor.
- Step 5 – Review your information then click submit.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review. You will be notified by email once your manuscript has been selected for peer review.

PEER REVIEW PROCESS

All manuscripts are initially reviewed by the Editorial Board and those deemed unsuitable (insufficient originality, serious scientific or methodological flaws, or a message that is too specialised or of limited interest to a general medical audience) are returned to the author(s), usually within 4 weeks. If the manuscript does not conform to the submission guidelines, the author will be asked to amend prior to peer review.

All manuscripts are reviewed by content and writing peers for relevance, construction, flow, style and grammar. All reviewers spend considerable time reviewing the manuscripts and providing feedback to the authors. The length of time of the publication process can vary and depends on the quality of the work submitted. Several revisions may be required to bring the manuscript to a standard acceptable for publication. The Editorial team undertake the final review and often have different questions for the author(s) to consider. When time permits, proofs of articles about to be published will be sent to the corresponding author for review. This requires rapid response; if such a response is not forthcoming, the article will be published irrespective of the author’s reply. Providing facsimile numbers facilitates this process. The final decision about publication is made by the Editor.

The peer review process is managed online. Decisions are communicated by email to the corresponding author. Authors without email are contacted by phone, fax or post. Submitted manuscripts are acknowledged by email.

PUBLICATION DEADLINES

All materials for publication must be in the hands of the Editor by the following dates for 2009. Please note that due to the editorial review process there is no guarantee of when accepted papers will be published.

- January 15 for the March 2010 issue.
- April 15 for the July 2010 issue.
- July 16 for the September 2010 issue.
- October 15 for the December 2010 issue.
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