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• The stomal therapy nurse will not participate in unethical practice.

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ADO026
Welcome to the March 2009 edition of the journal. It is with pleasure that I write this report, my last in my role as President of the association.

The Executive continues to strive for the best for the members and to promote and support stomal therapy nurses across Australia. The journal and website are vital parts of our association and Diana Hayes (editor) and Mary Ryan (website) have worked to ensure that objectives have been met. However, there remains other work to continue; for example updating the policy manual is an ongoing process. We are also preparing to hand over half of the Executive positions and aim to ensure a smooth transition. Thank you to the state branches for your nominations for the next members of the Executive team to take over in March.

In looking forward to the next 2 years, I suggest that we need to consider how we can facilitate a face to face March 2010 meeting of the Education and Professional Development Subcommittee of the association to progress objectives in the alternate year. It may also be an opportunity to provide a 1 day study day for continuous professional development for both stomal therapy nurses and interested nurses. It would also provide an opportunity to hold the AGM. This will be for further discussion in March in Perth.

In July 2011 the Colorectal Surgical Society will be holding the Tripartite Conference in Cairns. Further details of the Colorectal Tripartite conference can be found on the web on the CSSANZ site. We have an opportunity to link with this prestigious international event. Currently our constitution states that we must have our AGM within 60 days of 1 March of the year. We need to consider if we can make an amendment to the constitution to enable both the biennial conference and the AGM to be held in July 2011. Again, we will discuss this together in Perth. The AASTN Victorian branch is due to host the national conference for that year and initial discussions have been very positive to progress this opportunity.

Whilst we remain focused on our key objectives, we are aware that we do not work in isolation. We have strong relationships with both the stoma associations and our surgical colleagues. Having a conference linked with the colorectal surgical society really embraces multidisciplinary care and a collaborative approach to practice. We currently have CPD and credentialing status and further opportunities related to advanced practice and the role of the nurse practitioner are on the near horizon. I hope we can join the tripartite conference in Cairns in 2011. We appreciate the support of CSSANZ in supporting the scholarship for stomal therapy nurses as listed in the journal. Our apologies to those members who made enquiries for not having the application forms on the website but we are currently attending to this. The Elinor Kyte scholarship is now open for 2009 so please get your applications in.

The Perth conference team has put together an amazing programme with excellent guest speakers. In particular, I am looking forward to hearing from Paula Erwin-Toth and Prilli d’E Stevens. Please encourage everyone to come to Perth and we wish the Western Australian team a very successful conference. We look forward to seeing you all in Perth and we wish the new Executive members all the very best as they take over.

By now everyone will be preparing for the 2009 AASTN conference in Perth. The programme looks astounding and I am sure that it will be well attended. Congratulations to the WA organisers.

This wraps up my 2 year term as editor of the JSTA. In summary, the changes during my term include converting to the Cambridge Manuscript system to submit papers, adding a report from the Australian Council of Stoma Associations (ACSA), and fine-tuning the referencing to Vancouver. Another feature has been having the journal on the AASTN website and also changing the colour of the website to the same as the journal (Phil’s suggestion, have you noticed it?).
Being the journal editor and an Executive committee member has been very rewarding and I have learned a great deal about how the AASTN operates. Everyone who is involved with our association both at state and national level does it for the absolute love of it. As I have mentioned previously, emails and telephone calls are constantly happening across our vast nation in order to maintain our professional integrity.

One of the aspects of our profession that unfortunately lacks is clinical practice guidelines (CPGs). This will soon be addressed but will be a mammoth task. If you are invited to contribute, you will be part of the history of our organisation.

Thank you to our President of the past 2 years, Leeanne White. Leeanne epitomises professionalism and leadership. I enjoyed working alongside Leeanne both in this role and on the Stoma Products Assessment Panel in Canberra. Despite all of our hard work, we actually found time for some entertainment in Canberra. I shall stay on the panel but Leeanne will hand her membership over to the new President.

Finally, a huge thank you to Sandra and her fantastic team at Cambridge Media. I cannot speak highly enough about our publishers. Everything was clearly explained which made my job so much easier.

Farewell everyone. I hope to be involved in the AASTN more in the future.

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ERRATUM

In the last issue of JSTA, the above photo was incorrectly captioned. It should have read “Adele King demonstrating her prowess with the Doppler on Paula Kulkewycz, with Keryn Carville observing her progress.

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¹ Source: J Junkin, J L Selekof; J Wound, Ostomy, Continence, Nurs. 2007; 34(3): 260-269 ² Applicable for MoliCare® Premium, MoliCare® Comfort and MoliForm only ³ Applicable for MoliCare® Premium and MoliCare Comfort
Stenosing vesicostomy: a novel solution

Judy Wells RN STN • Continence Consultant, Royal Children’s Hospital, Melbourne VIC

ABSTRACT

This is a case study of the use of stenosing vesicostomy on a small child.

INTRODUCTION

A vesicostomy is a surgical anastomosis of the bladder mucosa to an opening in the skin. It is positioned midway between the umbilicus and pubic symphysis and creates a stoma for drainage of urine from the bladder. This is most commonly done in young children, infants and toddlers who have an obstruction in the urinary tract or vesicouretric reflux. Generally, vesicostomies are not difficult to manage and as they are often in young children the urine drains into a nappy.

Some children use urostomy bags; however, it is often quite difficult to get a bag to stay on reliably due to the positioning of the stoma, which is not able to be sited and is often in a skin fold. Some children have problems with the vesicostomy narrowing/stenosing, causing problems with bladder emptying and sometimes resulting in an increase in urinary tract infections and/or vesicouretric reflux [VUR] occurring. In this case the stoma needs to be dilated with a suitably sized nelaton catheter at least daily to maintain patency.

Researching the literature

Gastrostomy buttons have reportedly been placed in vesicostomies in other countries; I discovered this when researching for this article. However, this is not the case at the Royal Children’s Hospital (RCH) while I have been working since 1984.

CASE STUDY

I first remember contact with Teah (not her real name) when she was aged 2 and had a vesicostomy fashioned. Teah had a neurogenic bladder of unknown origin. This basically means that the nerve supply to the bladder is deficient and as a result the bladder does not completely empty. Children with this condition are at risk of developing recurrent urinary tract infections and/or VUR and, if they do not have complete bladder emptying, are at risk of renal damage. Teah’s stoma functioned well and the urine drained out continuously into a nappy and pad. She needed no special care other than the use of a barrier cream to prevent skin breakdown. The family lived in a country area and was seen erratically at RCH as they often failed to attend appointments. They received good care by local paediatrician and continence nurses.

Clean intermittent catheterisation

The next contact the stomal therapy department had with Teah other than quick stoma reviews was when her urologist needed to trial clean intermittent catheterisation (CIC). The plan was for her to have 3-hourly catheters and have her vesicostomy closed. Teah’s social situation, emotional status and home environment were not conducive to this. Her mother reacted very negatively to this idea from the outset. We are used to teaching parents and children as young as 5 years to perform CIC and we went very gently, using dolls for play therapy etc.

However, we met with no success and then tried a referral to a local continence nurse whom we thought might be able to build up a trusting relationship over time. This plan met with failure and things were put on hold. We persisted with trialling various urostomy appliances as Teah was now at school wearing nappies, which was becoming an issue. We did manage to find appliances that were successful when she was compliant with emptying and wearing a belt. Teah was an engaging little girl with a mind of her own, having to deal with lots of social issues at home and ongoing health concerns.

Catheter phobia

Over time there was slow deterioration of renal function and worsening reflux. More attempts at self-CIC were unsuccessful and exhausting for everyone. Teah had developed a very real

Figure 1. MicKey gastrostomy button inserted into the patient’s vesicostomy.
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phobia of catheters. As soon as she saw a catheter she would scream. In 2005 she had a large renal calculus removed. She was now in chronic renal failure and had grade 5 ureteric reflux. She had catheters inserted into her vesicostomy to stop it from stenosing but these either came out, leaked or caused infections. Teah had indwelling catheters for many months and a general anaesthetic was required to reinsert the catheter if it came out. The family was aware of her failing kidneys and that she may need a transplant.

**A multidisciplinary approach**

In late 2007 she became unwell, lost weight, and was admitted to the renal ward. There was a concerted team effort to try and get Teah to allow her mother to dilate the vesicostomy or do it herself. This would solve the problem of stenosis and mean she would not have to use indwelling catheters. This was unsuccessful yet again, but not from lack of trying.

A play therapist, stomal therapists, doctors ready for a challenge, other patients holding her hand and letting her watch when they had their catheters done showing it did not hurt, a music therapist – we even tried aromatherapy to create a soothing environment with her favourite music playing and dimmed light, not to mention the psychologist and psychiatrist. Sarah, my stomal therapy colleague, and I were not against bribery and took her to McDonalds for low potassium chips which were the only choice she was allowed on their menu if she had been even slightly cooperative. She frequently ran away and curled herself up and hid. We could not get near her and she screamed so much we had to leave. When we were not there to try catheters she was quite chatty and we even played games.

It was decided that at this stage peritoneal dialysis and transplant were not an option, leaving haemodialysis as the only option. She was commenced on dialysis 3 times per week for 3 hours and had supplements of sustagen and poly joule to try and put on weight. The family relocated from the country to Melbourne to be close to the hospital.

**Further complications**

Teah was an inpatient for 5 months apart from a 2-week respite interstate with her grandmother where she had dialysis. She arrived back from interstate with MRSA and septicaemia. She required multiple resiting of vascular access and her recovery was complicated by pleural empyema. She was malnourished and refusing to eat and ended up having a nasogastric tube passed.

The next time Teah’s catheter needed replacing another paediatric surgeon decided to put in a MicKey gastrostomy button. This was inserted into the vesicostomy. The retainer balloon was filled and the feeding connector connected to drain urine. The end of the connector fitted onto a moveen leg bag and it all drained perfectly. Teah wears this bag in front with leg straps around her waist. She reports that she feels comfortable with this and the connector dips down low so there is no problem with drainage. She has been so much better with this button. She has had a couple of infections but not nearly as many as she used to have.

**A POSITIVE OUTCOME**

In closing, her urologist commented last visit how pleasing it was to see her in reasonable health. He did comment that the MicKey buttons do not have a good history in the urinary tract as they tend to get covered with calcareous deposits. He ends his correspondence by saying about Teah and the MicKey button, “In her case it has been a Godsend”. Teah currently is handling dialysis, happy at school and many have noted an improvement to her self-esteem. She is rarely wet and quite happy with her urine drainage bag set up. She has regular renal ultrasounds to check for stone formation. Teah is now 11 years old.

**REFERENCE**

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Obesity in Australia: a population health issue

Diana Hayes RN CNC STN (Cred) • Western Health VIC

ABSTRACT

One of the recommendations of the National Health and Hospitals Reform Commission (NH&HRC) is to broaden the focus of the Australian Health Care Agreements (AHCAs) to include public health issues. The purpose of this paper is to identify the potential impacts in broadening of the AHCAs in regards to obesity in Australia. The advantages and disadvantages of this agreement broadening will be discussed as well as identifying the characteristics of the Australian health system that may impact on the realisation of AHCAs based reform and systemic changes that might help support it. The focus of this paper, therefore, is one of the most significant targets for reform, which is how the Australian health system might deal with the obesity epidemic within this nation.

This paper was a requirement for the University of Melbourne Australian Health Systems elective subject, 2008, for the Master of Advanced Nursing Practice degree.

INTRODUCTION

The National Health and Hospitals Reform Commission (NH&HRC) is a Commonwealth government initiative established to deal with healthcare issues within Australia. The terms of reference include improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness. Obesity is one such healthcare issue that may be preventable and therefore is suitable for inclusion in a healthy lifestyle promotion. Obesity is described as an abnormal increase in the proportion of fat cells, mainly in the viscera and subcutaneous tissues of the body. It is claimed that obesity is not only a preventable chronic illness but is second only to cigarette smoking in causing early deaths.

The NH&HRC recommended that the focus of the Australian Health Care Agreements (AHCAs) be broadened to include public health issues. The AHCAs are bilateral 5-year agreements between the Australian government and each state and territory. However, it allows healthcare funds to flow from the Australian government to its states, second only in cost amount to the Goods and Services Tax (GST). Before proceeding to this particular healthcare issue, namely obesity, the healthcare reform will be examined and critiqued.

HEALTHCARE REFORM: A REVIEW OF THE LITERATURE

The NH&HRC intends to broaden the focus of AHCAs. Reformism refers to political and societal policies which require modification without altering its elementary constitution. Therefore, having acknowledged problems with previous AHCAs, the Federal and State Health Ministers have established working groups in nine health policy areas. It is proposed that creating reform that has any credibility needs to, in fact, transform our healthcare system in Australia, not just modify it. Several key issues have been purported as the causal factors in the healthcare system. These include: poor leadership; a shortfall in political transparency; an internal perspective rather than thinking outside the square; a squandering in promoting private health funds as well as the inappropriate use of hospitals and inferior healthcare resources which lead to unfavourable outcomes.

The most recent of AHCAs is the 2003-2008 accord. It is speculated that previous thoughts have simply been rehashed and that the scope of the agreements needs to move further than free community hospitals and into the realms of fundamental primary care. In April 2002 the federal and state health ministers announced that the centre of attention needs to be in the wellbeing of all Australians rather than just the financial support of healthcare. This created a new paradigm and so the 35-page document, Beyond the blame game: accountability and performance benchmarks for the next AHCAs (a report from the NH&HRC, April, 2008), was written and presented to The Minister for Health and Ageing, The Hon. Nicola Roxon (Member of Parliament). This document will be critically assessed, focusing on the most significant targets for reform.

BEYOND THE BLAME GAME: A CRITIQUE OF A REFORM PROPOSAL

As the title implies, accountability of healthcare in Australia needs to evolve and not continue to be passed from the states to the Australian government and back again, in an attempt to shift the culpability of our insidiously failing healthcare system. Accountability is the third of the three constituents of which a new strategic structure is based; the other two constituents are scope and funding. In the executive summary, the states are allocated accountability for public hospitals, maternal and child health and public health whilst the Australian government is accountable for primary care. Primary care is defined as, “all other aspects of care in the community, primary medical care and community healthcare”.

In the introduction, the document gives a brief account of its origin. It also explains the need for creating a point of reference within the healthcare system in areas, including elective surgery and quality of healthcare (page 6). Visualisation is another feature in the introduction, suggesting that healthcare experiences and effects of Australian citizens are unquestionably on the agenda. The document is written in such a way as to encourage all Australians to offer feedback by using plain English and avoiding political jargon. Laypersons as well as healthcare professionals are invited to submit their views and actively
participate in the healthcare future of Australia. This suggests a flexible and open-minded attempt to embrace a new horizon in Australian politics. Where technical terminology is required, a simplified explanation is offered in parentheses. The broadening of the focus of the AHCA is noticeably set in the introduction as going beyond public hospitals and creating reform within all healthcare services in Australia (page 7).

The document then questions what it is that Australians require from a healthcare structure. An overview of perceived expectations is given as one that supports its residents as a lifetime commitment, inclusive of end-of-life support, to each and every person, incorporating a high standard of care.

It is stipulated that health promotion is a key aspect of health, rather than solely a non-existence of illness. Processes to help people quit smoking and breast screening are two examples of health promotion that are given (page 8). Acknowledgment is also given to embrace new information and technology and using it to the advantage of the healthcare system. Research is an example. This implies that Australia needs to keep abreast of new medicines and treatments to maintain its international integrity and credibility. It also suggests that Australian health related businesses would prosper.

The next section confronts 12 healthcare issues. The second challenge is titled Investing in prevention. Unfortunately, a definition of prevention is not offered. It is, however, stipulated that preventable conditions is not only the responsibility of the health professionals but a major player is each individual. Regrettably, no examples are given. Examples such as obesity and smoking-related illnesses may have created a greater impact in this section.

In the fourth section, Accountability and performance benchmarks, the purpose of the AHCA is discussed. Regrettably, there is no clear representation of who should be accountable in this particular section. Ideas that are tossed around include allowing accountability to be with the Australian government, to the states and even to the people in the form of elections. However, that is justified by suggesting that feedback from the Australian public is a prerequisite to assigning accountability to the appropriate division. It is also proposed that some would prefer sole accountability to rest within one, and only one, portion of the government rather than the sharing of accountability. As benchmarking is a major component of the reform, the 12 health challenges are tabled with a performance benchmark and accountability proposal.

All of the prevention strategies are assigned to the Australian government. It is here that obesity is included in 2.5: Proportion of adults and children who are overweight or obese. This does not appear to have any clarity. Simply stating that a benchmark will be set will not help the epidemic of obesity in this country. A much more detailed account of what the AHCA hopes to achieve in this healthcare predicament needs to be addressed.

The overall impression of this document is favourable as it suggests an open and transparent approach to the future of healthcare in Australia. Obesity will now be discussed as one of

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the major healthcare issues that require AHCA based reform and the systemic changes that might help support the argument.

**OBESITY: PREVENTABLE OR INEVITABLE?**

Obesity affects one in three children in America\(^\text{12}\). Australia is not far behind, with one in five Australian adults being classified as obese in 1999-2000 and about 5% of children and adolescents suffering childhood obesity\(^\text{13}\). In a national health survey conducted in 2001, it was discovered that obese employees were 17% more prone to taking sick leave than their non-obese counterparts and that obesity-related absenteeism accounted for in excess of 4 million days\(^\text{14}\).

Obesity is the result of dietary intake being well in excess of the body’s requirements. As a result, fat accumulates and is stored. It may be argued that high fat storage may be a consequence of medical intervention, for example, cortisone or medications for type-two diabetes. Nonetheless, this cannot account for the global and the Australian incidence in this healthcare issue\(^\text{15}\).

According to a newspaper article *Take-away outlets saturate poor suburbs, fast-food tax call*, which featured in the *Sunday Herald Sun* in August 2008, the proliferation of major take-away food outlets is contributing to the growing rate of obesity and health problems among residents in those (outer suburb) areas\(^\text{16}\). This article suggests that people living in the poorer suburbs of Melbourne have greater access to fast food outlets.

However, using these facilities is totally optional. A recent source of community and media-based protest occurred following the introduction of a new burger. Newspapers and current affairs television programs questioned the blatant and irresponsible efforts of this particular fast food chain to impose such an unhealthy and unnecessary product onto the Australian market. Furthermore, it is reported that this [quad burger] contains 71g fat, 34.7g saturated fat, 1900mg of sodium and 74.8g of protein\(^\text{17}\). The recommended daily intake value of these ingredients is 70g of fat; 24g of saturated fat; 2300g of sodium and 50g of protein\(^\text{18}\).

If people protested with their feet, and did not purchase food items from this and similar fast food outlets, their numbers might decline. This is one example of self-accountability. However, as pointed out in the first-mentioned newspaper article, people living in the poorer suburbs have less access to nutritional education and exercise less\(^\text{19}\).

Obesity is determined by using the body mass index (BMI) estimation\(^\text{20}\). It is calculated by weight in kilograms divided by height in metres squared (m\(^2\)). The World Health Organization (WHO) in 2000 outlined the following BMI guidelines: 18.5-24.9 (normal), 25-29.9 (overweight) and 30 or greater (obese)\(^\text{21}\).

As obesity is mostly preventable, it should be high on the agenda for reform. Not only is obesity unsightly, it also has the potential of causing other healthcare complications. These include: cardiovascular disease; heart failure; ischaemic stroke; atherosclerosis; hypertension; high cholesterol and type two diabetes\(^\text{22}\). The broadening of AHCA on obesity in Australia must therefore be a priority to assist those people most vulnerable and at risk within the Australian community.

**THE POTENTIAL IMPACTS OF A BROADENING OF AHCAS ON OBESITY IN AUSTRALIA**

One of the most significant targets for reform in Australia, must be the obesity epidemic. Many people within our community need to be educated, supported and possibly even rewarded for following a healthy lifestyle.

The positive impacts of such a reform would mean a healthier and leaner nation. The disadvantages may mean that more money would need to be spent on the obesity crisis and that take-away food outlet operators may need to close their doors as fewer people are frequenting them. The national obesity taskforce of 4 years ago is coming to a close and the problem of obesity in Australia does not seem to have been solved.

**National obesity taskforce – a healthy weight in 2008, or not?**

In 2004 a national obesity taskforce was created to deal with the obesity epidemic in Australia. It was an initiative with a limited tenure of 4 years that would revolutionise the level of physical activity and improve eating patterns for all Australians, including children.

The document that was produced on 15 February 2005 titled *National obesity taskforce 2004 overview* proposed many national- and state-lead programmes. It stated that Australia had participated in the worldwide approach with four named goals. These goals were: to decrease the threat of illness that results from poor eating habits and low exercise; to raise the awareness of the positive effects of a healthy lifestyle, and to use all possible aspects of media and education to raise awareness and promote further research\(^\text{23}\). Within the document each Australian state and territory outlined its strategies for combating obesity by providing healthy alternatives. These options were to be provided by programmes funded by the Australian government. A great deal of the obesity focus would be promoted within the media. An example of this is the Victorian, Go For Your Life campaign.

However, in a research paper, it is argued that the Australian media does not portray the obesity crisis as a national problem but more as an issue for each individual\(^\text{24}\). The results of the study demonstrated that each person was responsible for their own weight and level of activity and that adult obesity was considered twice as important as childhood obesity when comparing the amount of media coverage for each of the two age groups\(^\text{25}\). The authors claim that although individual accountability is a major factor, it is vital that the media continues to raise the awareness of the sociopolitical and structural changes needed to tackle overweight and obesity at a population level\(^\text{26}\).

**Reform strategy**

As obesity and overweight can lead to, amongst other illnesses and medical conditions, diabetes type two, and as diabetes cannot be cured, then perhaps preventing diabetes by preventing obesity should be part of the next reform. Table 1 outlines the targets for good health as depicted in a handbook titled *Diabetes, your heart, your health*.ABA
Everyone in Australia could be made aware of exactly what healthcare issues, such as obesity, will always be an agenda item for governments and putting less focus on blaming individuals. Showing a greater contribution from the Australian and state governments and putting less focus on blaming individuals. The characteristics of the Australian health system that may impact on the realisation of AHCA based reform, consequently, must include both individual accountability and government assistance and funding in fighting this mostly preventable disease. Systemic changes that might help support the awareness within the community include continuing with media coverage showing a greater contribution from the Australian and state governments and putting less focus on blaming individuals. Other concerns include each person being held responsible for their own lifestyle choices. History, however, shows that many people cannot or will not accept responsibility for preventable conditions such as obesity.

### Table 1. Targets for good health

<table>
<thead>
<tr>
<th>Health issue</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cholesterol</td>
<td>&lt;4.0mmol/Litre</td>
</tr>
<tr>
<td>LDL cholesterol</td>
<td>&lt;2.5mmol/Litre</td>
</tr>
<tr>
<td></td>
<td>&lt;2.0mmol/Litre in people with existing coronary heart disease</td>
</tr>
<tr>
<td>HDL cholesterol</td>
<td>&gt;1.0mmol/Litre</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>&lt;1.5mmol/Litre</td>
</tr>
<tr>
<td>BMI</td>
<td>No greater than 25</td>
</tr>
<tr>
<td>Waist measurement</td>
<td>Men &lt;94cm</td>
</tr>
<tr>
<td></td>
<td>Women &lt;80cm</td>
</tr>
<tr>
<td>Fasting blood glucose</td>
<td>4-6mmol/Litre</td>
</tr>
<tr>
<td>HbA1c</td>
<td>No greater than 7%</td>
</tr>
<tr>
<td>Cigarette consumption</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol intake</td>
<td>Men – no more than 2 standard drinks a day</td>
</tr>
<tr>
<td></td>
<td>Women – no more than 1 standard drink per day</td>
</tr>
<tr>
<td>Physical activity</td>
<td>At least 150 minutes per week</td>
</tr>
<tr>
<td>Alcohol intake</td>
<td>Women – no more than 2 standard drinks a day</td>
</tr>
</tbody>
</table>
| Physical activity | No greater than 7%

By using this simple tool within the next healthcare reform, everyone in Australia could be made aware of exactly what our targets for good health are. As people with diabetes keep a record of their blood sugar levels, this could be expanded to allow every Australian citizen to monitor their own levels as shown in Table 1.

### CONCLUSION

Obesity is a major lifestyle issue both globally and nationally. Public healthcare issues such as this must unquestionably be included in the NH&HRC’s recommendations in an attempt to broaden the focus of AHCA. Despite attempts over the past years to combat obesity, this epidemic continues. Factors such as the abundance of fast food outlets are partly to blame. Other concerns include each person being held responsible for their own lifestyle choices. History, however, shows that many people cannot or will not accept responsibility for preventable conditions such as obesity.

The most significant targets for reform are continuing with funding, accountability and transparency by the Australian government, which will then filter down to each and every person living and prospering within this nation.

### REFERENCES

The challenges of treating an atypical leg ulcer

Nobuko Murphy RN STN • Benalla and District Memorial Hospital, District Nurse, VIC

ABSTRACT

This case study demonstrates the challenges faced when treating a patient with a leg ulcer of unknown origin. A usually fit and well man living in Victoria was affected physically, socially as well as emotionally. Treatment included antibiotics, negative pressure therapy and finally compression therapy. Furthermore, this paper outlines the importance of effective multidisciplinary collaboration and an appropriate and timely management plan.

INTRODUCTION

Mr S was a 56-year-old man with a right lower leg ulcer. He had been transferred from a metropolitan hospital to a local hospital and was then admitted to the district nursing service for second daily dressings. The cause of the ulcer was initially unknown but was thought to have been caused by a mosquito bite at a family camp in the Gippsland area.

The affected skin gradually became inflamed and infected. The ulcer was initially a pinpointed red mark. However, when Mr S was admitted to the city hospital, the wound measured 8cm in length x 5cm in width with the development of black necrotic tissue. A tissue biopsy, microbiology of wound swab and histology sample were sent to the pathology department and results were pending. I visited Mr S at the hospital acute and emergency department with a hospital wound management consultant. Mr S’s wound had been treated by a vacuum-assisted closure pump (VAC) every second to third day after excessive necrotic tissue and yellow slough were debrided under spinal anaesthetic.

Physical assessment

Mr S had neither a surgical history nor any cardiac/respiratory problems. He did not have diabetes, was a non-smoker and a social drinker (2-3 glasses of beer or wine for special social occasions). He had no history of hypertension, deep vein thrombosis and was not polypharmic. His physical status was generally very healthy and well above average fitness. There were no significant physical issues prior to the leg ulcer.

Social issues

Mr S lived with wife and three children all aged less than 12 years. He became quite distressed after developing this serious leg ulcer. The reason became apparent, as he was a self-employed painter and had to stop work for the previous month due to his condition. He was anxious about how long the ulcer would take to heal and how he might financially support his family without his income.

WOUND ASSESSMENT

The ulcer was located in the right lower leg posterior gait area. It was thought to be a result of an acute traumatic insect bite wound but became a chronic wound condition. The tissue loss was full thickness third (deep) degree. The clinical appearance of the wound was granulation 85%; yellow slough 10% and necrotic tissue 5% (one week post VAC therapy). The measurement dimensions were now length 6cm x width 4.5cm and depth 0.6cm. The wound was traced and photos taken (Figure 1).

There was a moderate amount of haemoserous exudate, with no odour. The wound edges had erythema present and were pink to red. The surrounding skin was oedematous and dry with scales. There was no obvious wound infection possibly due to Mr S taking oral antibiotics. His pain scale was four to five out of ten and controlled by one gram of Paracetamol four times per day as needed. Ankle brachial pressure index (ABPI) Doppler test showed the right leg: 1.1 and left leg: 0.99. This result suggested that it was safe to use compression therapy but due to the VAC therapy, the compression therapy was withheld.

TREATMENT GOALS

The treatment goals were to promote optimal healing, manage the pain, decrease the incidence of and debride devascularised or infected material whilst maintaining moisture balance. Protection of the surrounding skin and encouraging the patient to take balanced nutritional food and supplements were also part of the plan. Other important factors included communication with his physician, general practitioner and wound consultant regarding the wound progression.
The wound care nurse within the hospital organised VAC pump treatment for 2 weeks, which was financially supported by hospital-in-the-home (HITH). Mr S had been treated with a VAC pump during the last 7 days of his hospital admission and the initial plan in the community was to continue with this therapy for a total of 3 weeks. An arrangement was made for the district nurse to attend every second day to change the VAC pump dressing at the hospital’s acute and emergency (A&E) department for 2 weeks. Following this period, his doctor, wound consultant and district nurse met the client at A&E to discuss further treatment options. I received his biopsy results a few weeks later. His wound was caused by mycobacterium ulceran.

**Mycobacterium ulceran**

Mycobacterium ulceran causes slowly progressive, destructive skin and soft tissue infections. In Australia it was first diagnosed in the Bairnsdale area of East Gippsland Victoria in the 1940s and became known as a ‘Bairnsdale [or Buruli] ulcer’ (BU). BU infection is not usually fatal, but can result in significant morbidity and is expensive to treat. It has been reported as a significant public health problem in sub-Saharan Africa in Buruli. The infection is transmitted from the environment. In Victoria, there is new evidence that mosquitoes may transmit the infection in certain specific endemic areas.

In patients presenting with unresolved cellulitis or a suspected necrotising spider bite, BU should be considered. Nevertheless, there is no known connection between spider bites and BU. BU can be rapidly and accurately diagnosed by polymerase chain reaction testing of ulcer swabs or biopsies.

A fully developed BU is characteristically deeply undermined and can be passed under the edge into the space left by necrotic liquefied fat. Thus, Mr S’s ulcer had affected the full thickness of his skin and involved necrosis of subcutaneous tissue. The use of negative pressure dressing to encourage healing and reduce the area requiring grafting should be considered. Best outcomes are obtained when the diagnosis is made early and the local population kept informed of new outbreaks. To reduce an individual’s risk of infection, protective clothing is necessary to help avoid mosquito bites.

**Managing the VAC at home**

Most patients are willing to be discharged early if the wound can be treated in their own home. However, some patients may find it difficult to monitor the VAC portable machine used in the home situation. Potential problems need to be considered when discharging patients with a VAC machine. Differences include the alarm sounding, no charge of power or the suction not working. Educating the patients is essential so they know how to troubleshoot such problems or how to contact the hospital to seek advice. Re-admission may be required if the problem cannot be solved.

Home treatment is not easy if the patient needs to be involved in the machine maintenance and the taking of some of the responsibilities for it. Ideally the VAC machine needs to be monitored every 1-2 hours by staff for 24 hours in the home situation. I needed to rely on the patient to monitor the machine as much as he could. Fortunately, Mr S managed well and did not have any trouble using the VAC machine at his home.

**Final stages of healing**

Mr S’s BU wound responded well to VAC pump treatment. The wound became hypergranulated but its condition improved and became almost healed (Figure 2). Mr S expressed his relief after he learned of his diagnosis and stated that he was surprised about the cause of his ulcer. A compression stocking was applied to his affected leg after the cessation of VAC treatment which also contributed to the healing time.

**CONCLUSION**

Assessment of any wound needs a holistic approach. It may be difficult if the cause of a wound is unknown and deterioration progresses rapidly. Psychosocial and financial issues were a major concern in this patient case. It was important to refer to the wound experts in a timely fashion and to use a multidisciplinary approach to investigate the diagnosis and to plan the management of the wound, appropriately and cost effectively.

**REFERENCES**


![Figure 2. Despite some hypergranulation, wound healing progressed.](image)
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To find out more about SenSura 2-piece Click and Flex systems, please speak with your Coloplast representative or call us on 1800 333 317.
This article is not an academic paper, rather a brief look at the time I have spent and some of the people that I met in Indonesia whilst assisting with the second Indonesian ETNEP. It is a peek at the types of patients and situations the students and clinical preceptors deal with on a daily basis. It is a reminder of how wonderful our health system is in Australia and how necessary it is for Indonesia to continue to train nurses in the important nursing speciality of stoma, wound and continence nursing so that more people will receive appropriate healthcare.

The second WCET-recognised Indonesian enterostomal therapy nurse education program was successfully completed in December 2008. The 15 graduates from this course came from across the islands of Indonesia. They graduated from the program enthusiastic to implement their new knowledge and skills in their work environments (Figure 1).

The program was conducted by WOCARE Management; WOCARE stands for wound, ostomy, continence care (Figure 2). WOCARE is a NGO specifically set up as a nurse-lead wound, stoma and continence clinic and education centre in Bogor Java, Indonesia. Bogor is a 2-hour drive from Jakarta (in good traffic conditions).

The theoretical component of the program was run from classrooms and a clinical laboratory in the small hospital behind the WOCARE centre. The clinical practicums were held in three different hospitals, the WOCARE clinic, an aged care facility and in the Indonesian Ostomy Association clinic in Jakarta.

None of the hospitals where the students went for their clinical placements had stoma therapy nurses. This meant it was the role of the clinical preceptor to find patients and negotiate with the medical officers for our students to ‘practise’ on their patients. This certainly added an important dimension to the skills learnt by the students, i.e. negotiation and marketing of one’s nursing ability, skills and knowledge.

The hospitals were a challenge in themselves. These were government hospitals treating poor patients in this user-pays system. No air-conditioning, no ceiling fans, little equipment or consumables, the patients’ families doing what we would call the nursing and the nurses doing something else – it was not always easy to understand quite what the role of nurses was (Figure 3).

The patients were ill-informed, scared, in the main un-educated, yet grateful and trusting. Meet ‘Maria’ – she came to the IOA clinic to pick up some supplies for her stoma. In obvious pain and unable to sit down, we asked if we could examine her ‘fistula’. On examination, a fungating rectal tumour was observed growing through and into the surrounding tissue (Figure 4).

Her current management was numerous menstrual pads changed 10 times a day after she had washed herself; this cost her up to $10.00 daily. The periwound skin was moist and intact, odour was managed with the frequent pad changes, but quality of life was not good, with fear for the future being expressed. She had a
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husband and a 3 year old child. She was unable to work and her husband took time off work to look after her when she had bad days. She managed her stoma independently using sugar bags.

Following consultation, Maria was shown how to get better periwound protection with a zinc-based cream. She was advised on where to obtain incontinence products available within her price range for better management of exudate. She was also advised to ask her doctor about having radiotherapy to reduce the size of tumour. Appropriate stoma supplies were given from donated stock and a follow-up appointment was made.

Meet ‘Agus’, a 40 year old doctor struggling to keep his GP practice going to earn enough money to pay for his full-time carers, stoma equipment and general living costs (Figure 5). Agus had no immediate family; he had put himself through medical school after finishing his schooling. Two years after graduating he became a paraplegic following a motorbike accident. He had had a stoma created after developing a Stage 3 sacral pressure ulcer, but it had never fully healed in spite of his spending all his savings on three flap repairs.

Agus slept on an iron bed with an old mattress; when he was in his wheelchair, there was no pressure-relieving device. He was obese and had no upper torso strength; he was patently depressed. He had to spend $10.00 a month on stoma equipment – two base plates and one drainable bag and clip.

After consultation, we set him up with donated and appropriate stoma supplies. We educated his carers and him on the importance and benefits of relieving pressure and position change. Nutrition was discussed. However, what this man really needed was a good pressure-relieving mattress and a proper wheelchair with pressure-relieving cushion.

Meet Ari – a relatively young man who came to the Indonesian Ostomy Association (IOA) clinic for stoma supplies (Figure 6). He was bent over with pain and said he had been unable to straighten up because of kidney pain. He had decreased his fluid intake because when he drank it hurt more. Some 16 months prior to this appointment he had had ileal conduit surgery and cystectomy for a bladder tumour. Postoperatively, one stent had fallen out whilst in hospital; the second stent had never fallen out – at his 6 week postop doctor’s visit he had been told it would fall out. He had not been back to doctor or hospital as he could not afford it.

On examination, the stoma was well perfused and had a large bore stent still in situ. Out of the midline wound was a growth of uncertain origin which could have been hypergranulation tissue or possibly a tumour. Ari said his main problem was applying a secure leak-proof stoma appliance. Ari was reluctant to go back to the hospital as he could not afford any more treatment and felt that they would or could not help him.

The stent was removed in the clinic. On removal, heavy crustations of calculi were noted around the renal end of the stent (Figure 7). Ari was advised to see his local doctor after leaving the clinic to obtain antibiotics, to drink plenty of fluids,
to expect further small calculi to be passed, to take analgesic and to go to hospital if he developed a fever. Phone contact was maintained daily for 1 week post removal of the stent. The chronic back pain he had been experiencing had gone, he had passed some small calculi, he had increased his fluid intake, his urine output was good and he stated he was feeling much better. He was to return to the clinic on a regular basis for review of midline growth and to obtain suitable stoma supplies.

There were many things to be taught and learnt. As seen in Figures 8-11, there were also plenty of clinical challenges and opportunities for both students of the program and for the local and guest Australian preceptors involved in the program. The most wonderful part was seeing and experiencing the difference informed evidence-based nursing care had on the patients.

We were heartened by being able to provide leak-proof, odour-proof skin-friendly stoma appliances through the donations of supplies from Australia (via the ACSA Australian fund) and the knowledge that, through this ongoing partnership, supplies will continue to be available.

I commend the enterostomal therapy nurses of Indonesia and WOCARE who have worked hard to get their own Indonesian

ETNEP up and running. I thank Carol Stott, Sharmaine Peterson and Susan McKay for donating their time, knowledge and skills to the success of this last program.

The Indonesian enterostomal therapy nurses will require ongoing assistance from clinical preceptors from developed countries such as Australia for some time to come. Experiencing clinical situations like this can be extremely challenging and frustrating for the visiting preceptors but on the whole are very rewarding. Going to a cupboard and the cupboard being bare is not an experience we often have here in Australia. Wound, stoma and continence nursing becomes very much principle-based rather than product-based. Understanding the environments and challenges that the students will be going back to once they are qualified makes one appreciative of how important it is that Indonesian nurses have access to a culturally-relevant enterostomal therapy nursing program in Indonesia.
In the article I wrote for the AASTN journal last year I outlined the extent of the task carried out by ostomy associations in providing appliances and personal support for our 36,000 ostomates throughout Australia. The work involved in the supply of appliances and ancillary products takes up so much of the time of the staff and volunteers of associations that it is often difficult for them to find the time to develop and deliver support programmes which help members resume their normal lives after the trauma of major surgery and the need to adapt to living with a stoma appliance. Whenever I visit associations during their opening times I see the pressure under which staff and volunteers work to provide for the ongoing needs of all members while at the same time dealing with the many urgent supply and support requirements of new members and others who have encountered some additional problems which require special assistance.

As President of ACSA, part of my role is to overview the operations of associations generally and make recommendations on how they can develop improved means of meeting the needs of members in the most efficient ways possible. In this regard it is clear that the provision of appliances has become so large and complex that the task can only be carried out by associations adopting effective business practices. Associations each year collectively fill over 300,000 orders with a total value of nearly $70 million. This equates the operations to those of many medium sized national commercial enterprises. This supply of ostomy products is always the first priority and every ostomate rates this as their number one requirement.

The problem faced by associations is how they can achieve operational efficiency while still carrying out their role of providing care and support to members. This role is an equally important one – even though it is often overshadowed by having to meet the more immediate need to ensure the availability of stoma supplies – and associations do work hard to get the balance right. Experience has shown that members tend to prefer to seek association support in conjunction with the ordering and collection of their supplies. They do not respond as well to structured support arrangements such as support group meetings or open days. As a result, associations have had to adapt to this quite noticeable preference by providing support at the point of order and collection of appliances.

The provision of support in this way leads to operational arrangements, which tend to act against the need for business efficiency. Because of the unstructured nature of the support it is difficult to provide properly trained staff, volunteers and professionals to meet unknown and therefore unplanned requirements. The simple solution is to provide support arrangements which meet all potential support requirements. However, this then conflicts with the more immediate workload needs involved in product supply. Staff and volunteers then have to divert their efforts and the result is less than ideal. There is no practical solution to this problem other than to accept a level of operational inefficiency as a trade off for meeting member needs when and how they arise.

When I speak to associations about how best to provide a balance in their support work, one aspect they find most difficult is how they can best cater for the needs of new members. Associations do provide personnel to do all of the work associated with new members because, with about 8,000 new members annually, they are a feature of every working day. The problem, which does create more insurmountable difficulties, is the lead-time to order in the specific appliances needed by the new member. Over recent years the supply companies have ceased overnight supply of goods to all associations other than those in Victoria. All other states face delays in delivery, with those worst affected being Western Australia, Northern Territory and Queensland where appliances can take up to a week to be received. Here, again, the simple and best solution would be for STNs to give sufficient notice that the supplies would be ready at discharge but this does not take into account that STNs also have to work under pressure and that hospital stays are getting shorter.

To address this problem I can only suggest ongoing regular communication between STNs and associations so the best solution can be provided from the limited choices that are available for supplying new members. If STNs could supply the appliances necessary on discharge to meet the local delivery gap, this would be ideal. In addition, many supply problems would be overcome if the local association knew and kept stock of the STNs’ generally preferred product. Where this is not possible, it would be appreciated if the STN would advise on the Association membership form the date by which discharge supplies will be used and suggest a ‘cut to fit’ alternative to cover any shortfall. As membership forms are redesigned, it is hoped to include a section for this information.

I hope that ongoing communication between all STNs and their local associations will become an effective means of providing the maximum coordination of product supply and support for new patients/members and, as a result, ensure that they are provided with the best possible service at a time when they need it most.
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Coalition of National Nursing Organisations (CoNNO) report

Lesley Everingham RN STN (NSW) & Wendy Samsom RN STN (Cred) (VIC)

The following report is from the Coalition of National Nursing Organisations (CoNNO) meeting held in Melbourne on 20 October 2008. Issues discussed included the following.

CoNNO vision and strategic plan

The vision of the CoNNO is as a strong alliance influencing healthcare for the Australian community and the profession of nursing for nurses. In order to achieve this vision, the CoNNO will:

• Be a forum for discussion and consultation on professional matters.
• Facilitate communication between members and other stakeholders.
• Influence and contribute to public discussion on health policy.
• Advocate to increase nursing research capacity.
• Assist the development of governance and capacity of other member organisations.
• Contribute to professional frameworks.
• Promote recognition as a prominent representative group.
• Influence the development of a sustainable nursing workforce.
• Review and establish a coalition of CoNNO structure.

A 4-year strategic action plan has been implemented to enable the CoNNO to achieve these nine identified objectives.

Nurses’ award

Nick Blake from the Australian Nursing Federation (ANF) reported on the award modernisation campaign currently in progress. Further details are available at: www.anf.org.au

Australia & New Zealand Council of Chief Nurses (ANZCCN)

Belinda Moyes, the Chair of ANZCCN, reported that Rosemary Byrant has recently been appointed as the Chief Nursing and Midwifery Officer for Australia.

The ANZCCN has formed two working groups with the Council of Deans of Nursing and Midwifery (CDNM). One group is reviewing research. The main goal is to build a national strategy for nursing and midwifery research in Australia that will increase the productivity and quality of research outcomes that have a positive impact on client care and increase capacity. The second group is looking at the workforce, including education/training, skill mix, nursing shortages/workload, safety and quality.

Other activities being undertaken by the ANZCCN include:

• The availability, accessibility, perception and appropriateness of the English Language Proficiency Testing.
• The role of the advanced practice nurse in relation to prescribing and accessing the MBS and PBS.
• Endorsement of the National Cancer Nursing Education Framework.

HESTA Australian nursing awards

Natasha Drage, representing HESTA, announced that nominations for the 2009 Australian Nursing Awards will open mid November and close on 29 February 2009. There are three categories of awards – Nurse of the Year, Innovation in Nursing and Graduate Nurse of the Year.

The winners will be announced at an award night on Thursday 14 May 2009 at Melbourne’s Crown Casino. HESTA received over 700 nominations for the 2008 awards. Details about the 2008 winners and nomination forms for the 2009 awards are available at: www.hestanursingawards.com

Australian Nursing and Midwifery Council (ANMC)

Projects currently being undertaken by ANMC include:

• Development of National Standards for the Assessment of Internationally Qualified Nurses and Midwives for Registration and Migration.
• A research project to review the Code of Ethics for Nurses in Australia (2002); Code of Professional Conduct for Nurses in Australia (2003); Code of Ethics for Midwives; and development of a Code of Professional Conduct for Midwives in Australia.
• Development of ANMC National Guidelines on Boundaries of Professional Practice for Nurses and Midwives.
• Development of a National Framework for the Demonstration of Continuing Competence for Nurses and Midwives.
• Development of standards and criteria for the accreditation of nursing and midwifery courses leading to registration, enrolment, endorsement and authorisation in Australia.
• Implementation of the National Decision Making Tools for Nursing and Midwifery Practice Decisions.

Updates on these projects can be accessed on the ANMC website www.anmc.org.au
CoNNO Research Symposium

The CoNNO Research Symposium, held in Melbourne on 22 August 2008, was both well attended and positively received by the delegates. The CoNNO Research Committee will progress with recommendations highlighted at the symposium and develop a strategic plan. Consideration is being given to the symposium being a biennial activity. A report and the recommendations from the symposium are available on the CoNNO website www.conno.org.au

Submission to research inquiry

The CoNNO contributed a submission through its Research Committee and Council to the Standing Committee for Science and Innovation Inquiry into research training and research workforce issues in Australian universities. This referred to the recommendations of the 2002 report, Our duty of care, regarding the importance of nursing research and the need for the development of nursing researchers to contribute to sound health policy decision making and improvements in clinical nursing practice and education. The submission also highlighted the four priorities for nursing research in Australia as identified by the N3ET taskforce – contributing to research on national health priority areas; developing a research critical mass; growing generations of researchers; and translating research into practice.

CoNNO policies

The CoNNO travel policy / travel application form, membership application form and media policy have been revised and were accepted at the meeting. A template has been developed to assist member organisations in writing their reports. The CoNNO Policy committee has also developed a draft policy on Indigenous health.

CoNNO funding

The CoNNO has been successful in obtaining funding from the Department of Health and Ageing for the next 12 months.

Name change

The previously-known Australian Confederation of Paediatric Child Health Nurses has had a change in name and is now the Australian College of Children and Young Peoples Nurses.

Position statement:
Reuse of urinary catheters and catheter bags

The Australian Nurses for Continence have developed a position statement relating to the reuse of catheters and catheter bags. This position statement is available on their website: www.anfc.org.au

Member organisation reports and minutes

The member organisation reports and a copy of the meeting’s minutes can be accessed via the CoNNO website: www.conno.org.au

Next CoNNO meeting

The next meeting will be in Sydney on 8 May 2009.
In fond memory – Kim Robyn Holland

17 March 1957 – 14 September 2008

This tribute acknowledges and celebrates the life of our dear friend and colleague Kim Holland who has passed away after a brief and unexpected illness.

Born in Parramatta, NSW, Kim had three daughters Gabrielle (29), Alexandra (28) and Katriona (27) and was the adoring “Ninny” to her three grandchildren Callum (7), Charlotte (3) and Hugo (1).

Despite being a busy loving mum and grandmother, she had time for a long career as a highly regarded sales representative for Cello, then Dansac, then Coloplast and again back to Dansac. In her work Kim was known as a quiet, caring and gentle person, well respected by those of us who had her as our ‘rep’.

Even in her final days Kim maintained a peace and dignity, slipping away peacefully with her daughters by her side. Kim asked that her friends and colleagues remember her with a glass of champagne and happy thoughts. Her daughters have asked that if anyone wants to make a donation in Kim’s memory that it be sent to the palliative care unit at Mount Druitt Hospital where the staff worked so hard and took such loving care of their beautiful mum.

WANTED
AASTN WEBSITE COORDINATOR

Are you looking for an exciting and occasional volunteer position to enable your colleagues to be smart and up to date? This is just the opportunity you have been looking for. Sit back with your feet up, the keyboard on your knee and watch out as those bites and pixels jump across the screen on the AASTN website.

This is an interesting and rewarding position. Most of the hard work has already been done. However, there are still a few things that require work – this is a website that is active. You will have the able support of your stomal therapy nursing mates on the AASTN National Executive and Phil Morton.

I await the onslaught of the computer learner and/or professional to take on this enjoyable and dynamic role. Email or phone me and I’ll give you the ‘gos’.

Mary Ryan, Tel (03) 8387 2129
Email mary.ryan@mh.org.au

ELECTRONIC SUBMISSION OF MANUSCRIPTS TO THE JOURNAL

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

STEPS TO SUBMISSION AND PUBLICATION
• Go to the publisher’s website: www.cambridgemedia.com.au
• Click on Manuscript System.
• 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.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review.

Peer review
Peer reviewers will be asked to review the manuscripts through the electronic process.

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.
YOUR SAFE, ECONOMICAL & EFFECTIVE WAY TO NEUTRALISES SMELLS.

FUTURE ENVIRONMENTAL SERVICES.

*Hos-gon - no-smells!
Nursing Homes, where care of frail incontinent people is important. Removes & prevents odours, which upset staff, relatives & residents.

*Hos-coology - 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.

*Hos-toma - no-gas!
Pumps pack to prevent the build up of gas in the appliance, and neutralise mal-odours at the same time.

*Hos-toma - lube!
Deodorises & inhibits bacterial growth Stops matter adhering inside the appliance.

Monthly entitlement under the Stomal Appliance Scheme:
Two 45ml. Dropper bottles of *Hos-toma - no-smells!
and One 250ml. *Hos-toma - no-gas!
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Contact us for information, literature, a starter pack, material safety data sheets, or to place an order.
Trial packs NOW available.
Happy new year to all for 2009. In Canberra we are expecting a busy year as the number of people undergoing ostomy surgery continues to rise each year. We have plans to hopefully increase our member numbers and to encourage some more nurses to undertake formal education in stoma therapy.

Northern Territory

We now return to work for another fruitful year and the first of our biennial AASTN conferences. It will be great to catch up with old and new friends alike at the conference this year. 2008 proved a rather quiet year in the NT in regards to stoma management whilst wound care has been going full steam ahead. The actual number of stomal therapists still sits at three, with two specialising in wound management and one in continence. No other exciting news in the NT apart from myself winning the NT Ministers Nurse of the Year Award for 2008, a mighty big surprise I must say.

See you all in March, cheers,

Jenni Byrnes

ACT

Happy new year to all for 2009. In Canberra we are expecting a busy year as the number of people undergoing ostomy surgery continues to rise each year. We have plans to hopefully increase our member numbers and to encourage some more nurses to undertake formal education in stoma therapy.

We continue to work closely with the ACT Stoma Association and our three stomal therapy nurses based in the community coordinate a stoma review drop-in clinic once per month at the Association. This has proved very popular with ostomates; they can collect their supplies and get some expert advice at the same time.

Our meetings for 2009 will be held every second month on the second Tuesday in that month, commencing in March. The meeting commences at 1600, although the venue is yet to be decided at this stage.

Finally we wish the thank Diana for the great job she has done as editor. The journal continues to be an informative and professional publication. Congratulations Diana.

Kellie Burke

New South Wales

By the time this journal is published we will be meeting in Perth for the 37th biennial conference of the AASTN. It is now 2 years since the last conference, which was held in Wollongong NSW so members will be thirsty for knowledge and updates in stoma therapy, wound management and continence. The programme looks extremely interesting, with papers being presented by speakers from all over the world, on a variety of topics.

Looking through the programme there is a paper about management of bariatric surgical complications. The increase in obesity of the population has created huge problems for treatment of these patients. I know in NSW there are only a certain number of ambulances that can transport bariatric patients and sometimes the patients have to stay in the ambulance until a special bed is obtained – and that is before we even think of surgical or other treatment.

I recently returned from Indonesia after helping with the clinical aspect of the Indonesian ETNEP course. Carmen Smith and the Indonesian girls are doing a fantastic job developing and running this course. I found the experience extremely fulfilling, interesting and worthwhile. The Indonesian people were very welcoming, hospitable and stoical and, in the case of some patients, despite very adverse circumstances. If anybody is thinking of doing something similar to this, I would encourage them all the way.

Lee Gavegan and the other stomal therapists from the west of Sydney are busy organising a Stomal Therapy & Complex Wound Study Day to be held on 21 February at Westmead Hospital – phone (02) 9845 7969. Further, the NSW branch continues to have bi-monthly meetings – April, June, August, October (1st Tuesday of the month) and December (1st Friday of the month). All of the meetings are held at Royal Prince Alfred Hospital at 17:45. For further information contact Carol Stott on 0402 018790.

Carol Stott

Queensland

I hope you all had a safe and happy Xmas and new year break and your batteries are recharged for another challenging year. Our meetings will continue second monthly this year; we hope to have an education component each meeting. Colleen Pope, who graduated as an STN last year, is presenting a case study at our January meeting. We are hoping to have an education forum later in the year. Our meeting dates for the year are Tuesdays 3 March, 7 July, 1 September and 27 October.

The Princess Alexandra Hospital Stomal Therapy Wound Management Department has scheduled some 2-day wound management courses for 2009 in March, May, July and September. Registration details are available through the Princess Alexandra Hospital HR Department on (07) 3240 7284 or nomination forms are available on the PAH website.

News around the state – congratulations to all. Louise Walker won the Mary Latimore Award for 2008. Leanne Bedwell has settled into Auckland NZ and is enjoying the weather. She is job hunting in that region at present. Lisa Clare has been appointed as the STN at the Gold Coast John Flynn Hospital. Cathy Fritz has been appointed the permanent position of STN at Bundaberg Base Hospital.

There is a large contingent of STNs from Queensland going to Perth for the AASTN conference. We look forward to the great
networking, social events and of course the great programme. We send our best wishes to the Perth branch for a very successful conference in March.

Lastly, we would welcome any new members. Please contact me if you require any further details. Cheers from the Sunshine State!

Helleen Purdy

South Australia

Happy new year to all readers! I hope everyone had an enjoyable festive season.

2008 finished off nicely at our Christmas Dinner held at The Hackney Hotel. We had a great night. The food was good and the company fun! Attendance was down a little on previous years due to the fact that Billy Joel was playing that night at the Entertainment Centre and our President, Wendy Humphreys chose Billy over us! Carmen Smith was also still roughing it in Indonesia. Carmen, Sharmaine Peterson and Sue McKay have recently returned from a stint in Indonesia. More on that next issue when we have an update...

South Australia will be well represented at the biennial AASTN 37th National Conference in Perth in March. A number of STNs will be attending. There are also a number presenting stomal therapy nursing papers at the conference – Liz English will give a world view, Carmen Smith will give an Indonesian view, Kath Gribble will give us a rural view and the RAH stomal therapy nurses together will show us how to “deal with the daunting!” We wish all of our presenters the best of luck.

Fiona Bolton and Merle Boeree will attend the Education & Professional Development Subcommittee meeting on Tuesday 10 March, Margie will attend the State Representatives Breakfast on Thursday 12 March; the Annual General Meeting is also being held on that Thursday. The conference programme looks amazing and full of wonderful sessions to attend. We would like to wish the WA branch of the AASTN the best of luck with the conference – we know it will be great!

Lisa Kimpton has been successful in obtaining a Women’s and Children’s Hospital Friends financial fellowship to attend the Canadian Ostomy ‘Camp Horizon’ in Calgary, Canada. The camp is held in the first week of July 2009 for young people aged 9-18 who have ostomies or other special related needs e.g. intermittent catheterisation, urinary or bowel incontinence, Crohn’s disease or ulcerative colitis. Lisa is hoping to gain valuable knowledge and hopes to start a youth support group and camp in South Australia.

A new form for hospital STNs has been developed by the Colostomy Association to order supplies for new members or inpatients from CASA. This should help streamline things a little more to allow for delivery of stock to the appropriate address and urgently. AASTN (SA) members can obtain a copy from CASA or by emailing Lisa Kimpton. Looking forward to seeing you in Perth!

Margie Reid

Tasmania

Happy new year to one and all. Hopefully everyone has settled into 2009 and is getting on well with the success and challenges of stomal therapy nursing.

In Tassie we held our state AGM in December followed by a Christmas bite and catch up which was very nice. At this meeting we re-elected the current office bearers unopposed and it was voted on, successfully, to continue in these positions for a minimum of a 2-year term.

President: Sonia Hicks; State Rep: Tracey Beattie; Treasurer: Carolyne Partridge; Secretary: Teena Cornwall; E&PD-SC: Sue Delanty. Sue has also been nominated asa National Executive Committee Member.

Teleconference dates have been scheduled and booked throughout the year, allowing as many members to participate and be involved with the AASTN as possible. These meetings have a 20-30 minute education session followed by a meeting. On the roadshow front, Sonia Hicks delivered the most recent workshop in the south at Huonville. It was so well received the staff have requested a return visit.

We congratulate the five Tassie STNs for their participation in presenting at the Perth conference. Well done girls. We are proud to say we will have had nine Tasmanian members in attendance at the conference, which we feel is a great achievement for our small state.

In the north of the state it is all go with study. Huge congratulations are extended to Sue Delanty and Teena Cornwall for successfully completing their graduate diplomas last year. They have both bravely continued onto masters this year, so all the very best with that girls. Carolyne Partridge has one semester to complete the graduate diploma and I myself have two semesters to go. So it is heads down this year in Tasmania! Best wishes from Tassie,

Tracey Beattie

Victoria

I hope that everybody had a safe and happy Christmas and new year. The last function for 2008 was a Christmas party at the home of Wendy and Ray Sansom; thank you for your hospitality. Maureen McKenzie was in attendance, and was presented with a gift for her recent retirement.
The Vic branch wishes WA every success with the forthcoming conference. Many of us from Victoria will be making our way across the Nullarbor to attend. We are in the early stages of planning for 2011, so watch this space!

Our branch activities commence on 29 January when we hold our first committee meeting for the year at Juliano’s Restaurant in Burwood, at 1800 hours. 11 February is the first general meeting to be held at RDNS, Essendon at 6.30pm (cnr Mount Alexander Rd and Grice Cres, Essendon 3040). Our guest speaker is Nina Vucic from Mayfield Education Centre. Her presentation will be on presentation skills for classroom teaching. The AGM Vic branch is to be held on 23 April at Cabrini Hospital, in Conference Room No 1; guest speaker to be announced. The meeting commences at 6.00pm starting with supper and the AGM will start by 6.45pm. In May, we are looking at a weekend of rest and relaxation in Daylesford; the proposed weekend is 17/18 May. The theme is stress management for the sole practitioner. We are also in the early stages of arranging a country study day in the latter half of the year, hopefully in Echuca.

I look forward to catching up with colleagues at the conference,

Margaret Fraser

Western Australia

Here in Perth we are busily organising the final plans for the conference, consequently we are putting clinical updates on hold until after the event.

WCET report

Happy new year!

Brenda Sando CNC STN • The Wesley Hospital, Brisbane QLD

As I am writing this early in the new year, I am reflecting on all the activities of 2008. A few sad times, some very busy times but mostly great and exciting... and now I wonder what 2009 will bring!

Hopefully when you receive this you will be setting out or just returning from the AASTN conference in Perth. I am excited to be going to this conference as the programme looks very interesting and challenging but most of all I am looking forward to catching up with colleagues from all over Australia. I love the sharing times we have during the breaks when we pick up hints and tips from each other; I found that to be one of the most important aspects of the WCET Congress held in Slovenia, June last year. It is so interesting meeting other STNs (or ET nurses as they are known in most other countries) and hearing their stories. They certainly have some tales to tell on how they problem solved with at times very limited resources. It helps you appreciate how well off we are with supplies and equipment. Please mark the next Congress in your forward planner – Phoenix, Arizona 12-16 June 2010.

Can members of the WCET please check your details on the WCET website www.wcetn.org and alter them if they are not correct? I have sent emails to members and unfortunately some have bounced back to me with incorrect details. I really would like to contact you but can’t if I don’t have your address.

I look forward to seeing all the members who will be attending the AASTN conference in Perth at the WCET meeting at 7am on Friday 13 March. I will let you know before the conference where at the complex it will be held. Don’t forget to encourage other STNs to join the WCET!

Hope your year is filled with much laughter, less frustrations and very good health.
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 stomal 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 stomal 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 \(^1\) or several \(^{1-4}\) 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.cambridgemedia.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 in 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 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.

- April 15 for the July 2009 issue.
- August 15 for the September 2009 issue.
- October 15 for the December 2009 issue.
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