Wound healing against all odds – a case study of complex fistula management

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AASTN Code of Ethics

• The stomal therapy nurse must at all times maintain the highest standards of nursing care and professional conduct.

• The stomal therapy nurse will provide needed services to persons irrespective of their race, colour, creed, sex, sexual preference, age and political or social status.

• The stomal therapy nurse must respect the beliefs, values and customs of the individual and maintain his/her right to privacy by maintaining confidentiality, sharing with others only information relevant to that person’s care.

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

• The stomal therapy nurse must maintain competency by keeping abreast of new developments in the theory and practice of stoma care and related fields.

• The stomal therapy nurse will participate actively in professional, inter-professional and community endeavours in order to meet the highest professional standards.

• No full member shall be in the employ of a company or self employed in the manufacture or sale of products, prostheses or pharmaceuticals where it could be perceived that the use or selling of products prostheses or pharmaceuticals could disadvantage or contradict the personal preference of clients or be construed to result in unethical conflict of interest.

Published four times a year by

CAMBRIDGE PUBLISHING

a division of Cambridge Media

A Wells Drive, Osborne Park WA 6017
Web www.cambridgemedia.com.au
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Disclaimer The opinions expressed in the Journal of Stomal Therapy Australia are those of the authors and not necessarily those of the Australian Association of Stomal Therapy Nurses Inc., the editor or the editorial board.
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Another year has begun. I hope you all had a joyous Christmas with family and friends and that you will have a happy, safe new year.

In November–December I travelled to China to attend the 3rd APETNA (Asian Pacific Enterostomal Therapy Nurses Association) Congress. The temperature was a mild 20–22 degrees, compared with 5–13 in Beijing, Xian and Shanghai, where I had a holiday, prior to the Congress. The Congress was held at the Dong Fang Hotel, which is a huge complex of hotel and conference rooms, restaurants and shops. In the centre of the square-shaped structure was a beautiful pool – closed for winter – and a garden for quiet, relaxing strolls before and after the day’s programme.

Elizabeth English, Merle Boeree and I represented Australia. Liz and Merle presented a workshop on skin care. Liz also spoke of The challenge of managing difficult stomas.

Elizabeth Ayello – WCET Editor – from America – presented a paper on Diabetic foot ulcers and Publishing your ostomy care experiences. There were 400 delegates from 15 countries. Topics included stoma, wound and continence care. My friend Irma Aristanty from Indonesia received the best oral presenter prize. There were also 90 poster presentations – all very impressive and professional with both subject and content.

Our website coordinator, Karen McNamara, has added an events calendar to the website. This site will list meetings, seminars, study days and conferences for each state. If you have any updates, please contact her.

If you have presented a paper at conference or had a case study that may interest your colleagues, post or email to Theresa Winston for publication in the journal.

With the start of the new year, you can begin collecting CPD points. Don’t forget to copy certificates or programmes of seminars, conferences or study days as evidence of these points.

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Diversity of a stomal therapy nurse

Theresa Winston

Reading the state representative reports it sounds like all states had a busy 2009 with plans already ahead for 2010. I find it hard to believe that by the time you read this journal we will be almost a quarter of the way into 2010. Where does the time go? With the AASTN AGM in March, followed shortly after by the AWMA conference in Perth and then WCET conference in June, the first half of 2010 is going to be very busy. Not to forget Stomal Therapy Week, 14-18 June.

National Stomal Therapy Week was approved in 1986 following the WCET congress in Perth, WA. The approval for the event was announced by Mr Neal Blewett, the then federal Minister for Health and it is held annually from the second Sunday in June. Please let me know if you are preparing anything special for Stomal Therapy Week so it can feature in the next journal.

In this journal we have a report from Sandy Hyde-Smith, who was the recipient of the Colorectal Surgical Society of Australia New Zealand (CSSANZ) scholarship. It sounds as if Sandy really enjoyed the conference and found it educationally beneficial. I hope this encourages others to apply for any of the scholarships or grants on offer in the JSTA journal.

I found it very interesting that three of the articles received for this month’s journal all involved the use of Negative Pressure Wound Therapy (NPWT) or Vacuum Assisted Closure (V.A.C.®) therapy in the healing of complex wounds. It shows how diverse our skills are as stomal therapists that we can use the knowledge we have and the products we use for our stoma patients to help manage complex wounds. Various seals were used to border the wounds prior to applying the NPWT. By reading case studies such as these we can take some of the ideas and use these to help manage complex wounds that we may come across. Recently in my own work area we did not have a NPWT device available for the surgeons to use on a large abdominal wound. I politely suggested that maybe they could manage it the way they would have done prior to NPWT. NPWT has been around since 1996, but I think it would be interesting if anyone has any interesting case studies on how we treated these complex wounds prior to the introduction of NPWT.

I hope you enjoy reading the journal and I look forward to receiving some more interesting articles.

“Strive not to be a success, but rather to be of value”

Albert Einstein

Stoma Appliance Scheme: updated schedules

Available from the Department of Health website www.health.gov.au/stoma
If the page does not show immediately, use the www.health.gov.au search system and you will find it by typing in stoma appliance scheme

Smith & Nephew Stomal Therapy Education Grant

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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This case study illustrates the challenges in managing enterocutaneous fistulae, not only for the individual and their family, but also for the stomal therapist, ward nurse, surgeon, dietician, general practitioner (GP) and community nurse. Containment of fistula output, maintenance of nutrition, monitoring and maintaining fluid and electrolyte balance, promotion of wound healing and maintaining dignity are paramount. Barriers to effective management in this case have included a high, liquid fistula output, multiple fistulae, poor nutritional state, geographical distance and the enormous requirement for expensive consumables. Technology such as digital wound photography, wound measuring devices and negative pressure wound therapy equipment have been integral to the effective management of this case and positive wound healing outcomes.

Mr R presented to our facility with a 1-week history of abdominal pain and distension. Five days ago, Mr R had presented to a peripheral hospital, was diagnosed with a small bowel obstruction and had been treated conservatively. Treatment consisted of remaining nil by mouth, a nasogastric tube (NGT) to straight drainage and intravenous therapy (IVT). Past medical history includes high alcohol intake, atrial fibrillation (treated with Warfarin) and hypertension. On arrival to our facility, an abdominal x-ray confirmed small bowel obstruction.

On 7 April 2008, Mr R was taken to theatre for an emergency laparotomy under the general surgical team. He was found to have a stenosing proximal transverse colon tumour, owing to an incompetent ileocaecal valve. He underwent a right hemicolectomy. At closure, drains to the pelvic floor and hepatic floor were placed. Mr R was admitted to the nurse special unit (NSU) postoperatively. Overnight, urine output was low and Mr R received several fluid challenges with little to no effect on urine output. Pain control was a problem. The pelvic drain yielded 300ml and the hepatic drain 90ml.

On 8 April 2008, urine output remained poor, Mr R’s abdominal distension became more apparent and the NGT continued to drain copious amounts of dark green liquid. Mr R received two units of packed cells for a haemoglobin (Hb) of 71. He became agitated and confused. Several fluid challenges for low urine output resulted in Mr R being in a 6.5L positive fluid balance. He was reviewed in view of commencing total parenteral nutrition (TPN), but it was agreed that this would not be appropriate at this time.

On 9 April 2008, Mr R remained confused, oliguric, hypotensive and tachycardic. He was reviewed by the medical registrar and was confirmed to be in acute renal failure with rhabdomyolysis. Mr R was having difficulty breathing and a chest x-ray (CXR) revealed bilateral pleural effusions. His abdomen remained distended and an abdominal computed tomography (CT) scan showed faecal content superoanterior to his anastamosis. He was transferred to the intensive care unit (ICU). Later that day, Mr R was taken to theatre for a laparotomy, washout, change of dressing and formation of ileostomy. At operation, bile-stained fluid was found in the right upper quadrant (RUQ), but no source for this leak could be identified. A drain was placed alongside the gall bladder. Another drain was placed in the left upper quadrant (LUQ) at the intrahepatic space. The KCI abdominal vacuum assisted closure (V.A.C.®) dressing was applied. The target pressure was set at 125mmHg on continuous suction.

On 10 April 2008, Mr R was ventilated and commenced on IV inotropes to maintain cardiac function. He had a large bore NGT, draining large amounts of dark green liquid. Urine output was satisfactory. The stoma was pink, warm and moist. The drain in the RUQ was draining bile-stained fluid. On 11 April 2008, Mr R was reviewed by the general surgical team, who felt that the fluid in the RUQ drainage bag was likely to be small bowel content. Mr R was febrile, with a temperature of 38 3. He was commenced on TPN.

On 12 April 2008, the dressing was changed in ICU. The ileostomy became active. Urine output remained satisfactory. NGT continued to drain large amounts of dark green liquid. On 13 April 2008, Mr R became septic.

On 15 April 2008, Mr R went to theatre for a laparotomy, debridement of necrotic wound edges and a small and large
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bowel resection. The previous anastomosis was found to have dehisced in 50% of its circumference with local contamination. A 24Fr gauge Foleys catheter was inserted through the skin into the colon, to fashion a tube colostomy. Abdominal mesh and a V.A.C.® dressing were used to close the abdomen. By 16 April 2008, 1.5L had drained into the V.A.C.® canister. The ileostomy was active with serous fluid only.

On 17 April 2008, the STN reviewed the patient and noted a dark green fluid collecting at the right (R) lateral margin of the V.A.C.® dressing. This fluid was malodorous. The fluid draining via the NGT was similar to the wound loss. The V.A.C.® dressing was removed and a large wound management bag was placed over the entire wound, until the patient was reviewed by the surgeons. The surgeons ordered that the V.A.C.® dressing be replaced at a lower target pressure of 50mmHg. Mr R remained febrile.

On 18 April 2008, the wound drainage described above continued. Methylene blue was instilled into the NGT. No blue dye was seen in the wound. Mr R’s Hb dropped to 76. He remained febrile. On 19 April 2008, the ileostomy was not active. The malodorous, faecal-looking fluid in the wound remained. Mr R remained febrile.

On 20 April 2008, Mr R went back to theatre for a laparotomy, washout, V.A.C.® dressing change and tracheostomy. A leak was found at the anterolateral margin of the gall bladder. A T-tube was laid alongside the gall bladder bed. No other contamination was found. The abdomen was lavaged. The abdomen was closed with sterile plastic, mesh and a V.A.C.® dressing. That evening, there was bleeding into the RUQ drain. The V.A.C.® dressing was changed as the foam had become engorged with blood. The patient remained febrile.

On 21 April 2008, there were problems with maintaining a seal with the V.A.C.® dressing. The dressing was changed. The ileostomy was not active. Intra-abdominal pressure (IAP) was recorded at 16mmHg. On 22 April 2008, the ileostomy was still not active. On 23 April 2008, the patient was ordered Jevity feeds via the NGT by the general surgeon. The ileostomy remained inactive. Bowel sounds were not present. IAP was recorded at 17mmHg. The LUQ drain was removed. Faecal fluid collected under the V.A.C.® dressing. V.A.C.® therapy was ceased.

On 24 April 2008, Mr R’s care was taken over by the colorectal team. V.A.C.® therapy was initiated. Mr R was taken to theatre for a laparotomy, washout, colonic lavage and V.A.C.® dressing change. The STN was called to theatre to assist with the application of a modified V.A.C.® dressing. At operation, a leak was found in the transverse colon. Faecal matter was washed from the wound. There was a haematoma over the omental layer in the RUQ. All drains were removed except for the T-tube adjacent to the bile leak. To separate the fistula from the remainder of the wound, the STN inserted a Foley’s catheter into the transverse colon fistula and then built a wall of Eakin rings over the fistula and around the Foley’s. The rings were then smoothed out with Stomahesive® paste. A ring of V.A.C.®

(Photographs taken 17 April 2008.)
Application of V.A.C.® dressing.
Completed dressing.

granufoam was fashioned and then encased in V.A.C.® drape. This encapsulated foam ring was then threaded over the Foley’s catheter and sat on top of the Eakin rings. With the fistula isolated from the remainder of the wound, the V.A.C.® dressing was applied to the wound, but not the fistula. The V.A.C.® remained intact until 28 April 2008 without incident. Large amounts of wound exudate collected in the canister. There was no drainage from the Foley’s catheter. Mr R was stable, his sepsis resolved. The ileostomy was active and the NGT feeds and TPN continued.

On 28 April 2008, the V.A.C.® dressing was changed as per the above plan by the STN and the ICU nursing staff. There was a small area of necrosis present distal to the fistula. The remainder of the wound was granulating. There had been no drainage from the Foley’s catheter. On 30 April 2008, the V.A.C.® dressing was changed. There had again been no drainage from the Foley’s catheter, just a small amount of semi-solid matter at the point of insertion. The ileostomy active with dark green liquid.

On 1 May 2008, the NGT feeds were turned off due to large aspirates and nausea. There was high output from the ileostomy. Blood cultures negative, inflammatory markers improving, IV antibiotics ceased.

On 2 May 2008, the V.A.C.® dressing was changed. There was some slough present in the base of the wound, which was removed with gentle irrigation. As the pressure had been fluctuating between 75mmHg and 125mmHg overnight, the target pressure was increased to 150mmHg. Ileostomy output remains high. NGT feeds recommenced.

On 3 May 2008, NGT aspirates high, feeds ceased again. On 5 May 2008, the V.A.C.® dressing was changed. The wound base was well vascularised, granulating. Some fluctuation in pressure. On 6 May 2008, Mr R was reviewed by the colorectal surgeon, who was happy with his progress. Mr R was informed that he would not be suitable for restoration of intestinal continuity for some months.

On 7 May 2008, Mr R was discharged to the ward. The V.A.C.® dressing was changed. A moderate amount of grey, tenacious fluid drained around the Foley’s catheter into the wound bed. The wound was irrigated and Foley’s catheter flushed with 20ml normal saline. Wound dimensions as follows: 21cm in length, 19.5cm in width, depth minimal, 4cm undermining in RLQ.

On 8 May 2008, a nasojejunal tube (NJT) was inserted. On 9 May 2008, the V.A.C.® dressing was changed. There was similar drainage around the Foley’s to the last dressing change. The Foley’s catheter was flushed and placed on straight drainage. The wound was granulating.

On 14 May 2008, the V.A.C.® dressing was changed. On 16 May 2008, food content was noted under right side of the V.A.C.® dressing. The V.A.C.® dressing was removed. A small spontaneous fistula below the original fistula was visible. The wound was irrigated. The STN used Eakin rings and Stomahesive® paste to build a wall around the two fistulae and isolate them from the remainder of the wound. A strip of granufoam was then wrapped in V.A.C.® drape and placed over the Eakin wall. With the fistulae isolated from the remainder of the wound, the V.A.C.® dressing was applied to the wound, but not the fistulae. A wound drainage bag with a window was placed over the fistulae. Nursing staff were requested to open the window and gently suction drainage from the area regularly. Medical illustrations were in attendance and digital wound photography was attended at each step of the dressing. The photographs were used to provide a care plan for the nursing staff.
Fashioning of a ring using V.A.C.® granufom and drape

Using the Eakin rings over the fistula and around the Foley’s
The seal of the V.A.C.® dressing was poor over the next 2 days. Faecal fluid in the V.A.C.® canister was suspected. The new distal fistula output has increased and resembles the ileostomy output. On 18 May 2008, the V.A.C.® dressing was changed by the STN and nursing staff as per the above plan. Mr R commenced on Loperamide.

On 19 May 2008, the plan for fistula management was discussed with the colorectal surgeon, who was keen for V.A.C.® therapy to continue, with the fistulae isolated. Smaller, distal fistula was not suitable for catheterisation. Silicone wound contact layer was laid over the wound bed to protect the underlying tissue. The V.A.C.® dressing was applied.

On 21 May 2009, the V.A.C.® dressing has been problematic over the last 2 days, with fistula output leaking into the V.A.C.® dressing, requiring changes daily. V.A.C.® therapy ceased and a large wound drainage bag was applied over the entire wound. A window was applied to the wound drainage bag and nursing staff were requested to suction pro re nata (PRN) through the window.
On 28 May 2008, the wound bag required daily changing since its application. The output from the fistulae has been greater than the ileostomy output for several days now. Suction is required 2- to 3-hourly. Mr R was issued with a portable suction unit and given education on how to suction through the window 3-hourly and 1 hour after meals. Mr R is very keen to go home as soon as possible.

On 31 May 2008, the wound management bag was changed by STNs with Mr R’s wife present. Mr R is to go home for weekend leave with daily bag changes by his wife. Silver Chain will take over bag changes after the weekend if Mr R manages well at home and does not wish to return to hospital.

On 26 June 2008, Mr R was reviewed in the stomal therapy outpatient clinic. He continues to have a large wound drainage bag in situ, changed by either Mr R’s wife or Silver Chain. The wound is now 16cm in length and 15cm wide. The peri-wound skin is moist and eroded from 5:00 to 7:00. Otherwise he and his wife are managing well with the wound and the stoma. The skin

(Photograph taken 24 July 2008.)

Technique to separate fistula from V.A.C.® dressing
is treated with Stomahesive® powder and Eakin sheets. Silver Chain advised.

On 24 July 2008, Mr R is reviewed in the stomal therapy outpatient clinic. The wound was now 10cmx8cm. The larger (colonic) fistula prolapses intermittently. The smaller fistula is very active, causing the bag to require emptying up to 12 times per day. The smaller wound drainage bag is in place. The colorectal surgeon reviewed Mr R and is also happy with his progress. The fistula output remains higher than ileostomy output.

On 28 August 2008, the wound is now 9.1cm long and 8.4cm wide (47.5cm² as per Visitrak.) The peri-wound skin is eroded. Attempt made to isolate fistulae with stoma bag and to dress remainder of wound with a dressing not successful. Small wound drainage bag reapplied. Reviewed by colorectal surgeon and plans made for restoration of intestinal continuity in 6 weeks.

On 25 November 2008, Mr R underwent a laparotomy for restoration of intestinal continuity. At operation, multiple adhesions were found, requiring extensive adhesiolysis.

Although both the small and large bowel were healthy, the surgery proved to be problematic. Despite careful entry into the abdomen, several enterotomies occurred. We resected 1.5m of ileum, including two fistulae and the ileostomy site. Mr R was left with approximately 2m of residual small bowel and half of his colon. Sadly, on his second postoperative day, Mr R rapidly deteriorated, with increasing abdominal pain and distension, followed by his abdominal wound dehiscing at the bedside and leaking faecal fluid. Mr R was taken for an emergency laparotomy, resulting in what may now be a permanent ileostomy. Postoperatively, Mr R’s abdomen was left open and managed with V.A.C.® therapy, which he was able to go home with. V.A.C.® therapy continued for 8 weeks, when he was reviewed by stomal therapy and the wound deemed suitable to be dressed with an alginate and foam dressing.

The challenges he faces now is controlling his high ileostomy output which resulted in acute renal failure and admission to hospital. With the involvement of dietician and gastroenterologist this is now well managed. He continues to see the surgeon, stomal therapist and gastroenterologist as an outpatient.
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More about working together!

Julie Metcalf • RN STN, Bega Community Health Centre, Bega NSW

Julie’s article was submitted for the CSSANZ scholarship, for which she was awarded 2nd place.

ABSTRACT

One of the main objectives of the Standards of Stomal Therapy Nursing is to maintain and improve professional standards and to promote awareness of the role and contribution of the stomal therapy nurse (STN). Rapidly changing work environments and an acute shortage of nurses competent in stomal therapy nursing is compromising appropriate care. Through strengthening collegiality between generalist and specialist nurses and doctors, collaborative care and interdependent learning will be stimulated to create a culture for critical reflection. As a consequence, new ideas and conflict will be used as an opportunity for growth in the delivery of a high-quality stomal therapy service.

Bega, like many rural communities, has severe nursing shortages with critical needs for people who have specialised nursing knowledge and skills. Stomal therapy is one such specialty area in which ostomates in our community rely on nurses to educate and problem-solve to cater for their diverse health needs locally without separation from significant physical and emotional supports and the associated costs of travel away from home.

Like most healthcare environments, the Bega Valley is rapidly changing with advancing technology, higher education, shifting professional boundaries and multiculturalism. Nursing practices are increasingly being questioned and challenged, especially as the general public becomes more aware of their rights, with higher expectations of professional knowledge and extensive clinical ability in service delivery. In this setting I am accountable for providing stomal therapy nursing in line with relevant area health and NSW Health strategic frameworks and programmes as well as local health service plans and the competency standards for the advanced registered nurse. These protocols allow me to guide and adapt my practice as I work with a large degree of autonomy, which increases my responsibility to provide competent care.

Despite being a novice in this new area of nursing practice I entered contemporary practice with extensive knowledge and research utilisation. Being able to reflect critically on modern issues and trends allows me to understand how theory relates to practice. Consequently, I am able to utilise the best available evidence to make safe and appropriate stomal therapy nursing decisions based on the needs of clients and their families.

I first met Earl following a colectomy for invasive bowel cancer to begin his education for ileostomy self-management. I observed a pale, unwell man, but he shook my hand firmly and talked of his recovery. Despite a possible reactive depression to his cancer diagnosis and surgery, my professional judgement and intuition assessed a positively motivated person with the mental ability to master the skills required to manage his permanent stoma.

On physical assessment, I noticed Earl’s dry, scaly skin, which warned me of possible breakdown in peristomal skin integrity. I was unable to view his stoma without disturbing the appliance, because an opaque pouch had been stuck directly to his skin without an adhesive coupling baseplate. The mucocutaneous junction was separated at the lateral and medial edges forming 1cm-deep sinuses, which exuded copious amounts of serous fluid. His peristomal skin was excoriated and painful. The stapled midline abdominal wound had bruised, tattered edges that overlapped and poorly aligned with haemoserous ooze. There were no recorded stoma observations on the appropriate chart. This clinical evidence demonstrated a lack of appropriate nursing care coupled with problems in wound healing and difficulties achieving a leakproof stomal appliance.

Equipped with nursing knowledge, experience and developed skills of communication, observation and self-awareness, I felt confident discussing issues based on the theoretical principles of stomal therapy nursing to offer Earl and the generalist ward nurse’s advice for stomal care with some authority.

As I explained the surgical outcomes, wound care and the importance of a snuggly fitting stomal appliance, Earl expressed his relief at being given clear explanations which he could understand. He felt frightened and insecure in the busy, understaffed surgical ward without the opportunity or support to identify and embrace his own learning needs as a new ostomate. The generalist nurses assigned to his care either avoided the stomal nursing aspect, due to a lack of interest in colorectal surgery, or opted out because they had become deskilled in that area of practice. Although this negatively impacted on Earl’s recovery, education and discharge planning for independent self-management, Walker states:

the idea that the registered nurse needs to be deployed across the entire spectrum of care-giving activities is simply not good or effective use of their individual skills and expertise especially as they are becoming a precious resource.

Lumby disagrees and says that one of the main problems in the current healthcare system is increasing specialisation, which often leads to fragmented care and possible conflict between specialist and generalist nurses. Unfortunately this is a reality perpetuated by inadequately staffed wards with skill mix deficits, heavy workloads, authoritarian commands of the general surgeon and nurse unit managers overwhelmed with ward administration rather than clinical leadership.

Without relevant clinical learning experiences or the support of advanced practice role modelling and mentoring generalist nurses (and doctors) are ill-prepared to practise with advanced levels of competence, because they lack education in research-based scientific and theoretical principles of stomal therapy nursing. While the ‘trial and error’ method of learning may develop hardiness and experience in problem-solving, there
is a need for specific knowledge and skills supported by credible academic standards, assessed competencies and strong benchmarks that underpin effective and efficient stomal therapy nursing performance 2-4.

Equally, specialist nurses in rural communities are expected to keep abreast of changes in their field of expertise whilst remaining legally accountable for their actions but often practise in professional isolation. As professional boundaries broaden, they must accommodate new technologies and rapidly changing fields of knowledge and are involved in policy making and strategic direction with increasing emphasis on integrated efforts between doctors, nurses and allied health professionals for multidisciplinary practice. This ever-increasing workload requires extensive professional and personal commitment, but distracts from continuing education, especially when the tyranny of distance may restrict educational opportunities but distracts from continuing education, especially when the tyranny of distance may restrict educational opportunities with rising travel costs and time away from reliant healthcare facilities and dependent families. Increasing demands of the specialist nurse’s time and energy without relevant peer support or the opportunity to upskill in the workplace is resulting in a sense of diminished mastery and burnout 10.

The medical workforce encounters similar problems. Professional isolation, a lack of educational opportunities and excessive workloads are well-documented and recognised as the main reasons for the shortage of generalist and specialist doctors in rural Australia. Compounded by a shortage of relevant specialist nursing support, the quality of service delivery is compromised 11.

Keeping this in mind and being aware of the required advanced registered nurse standards, I included ward staff in Earl’s overall care and progress on a day-to-day basis. Working together with clear communication, asking questions and sharing ideas facilitated a holistic approach and focused on knowledge and skills fundamental in providing high-quality stomal care for Earl’s recovery and independence.

Earl had always been a lean man with a low body mass index. The consequence of his cancer illness, anorexia and weight loss prior to surgery left little energy reserve, which was reflected in his pathology reports. A referral to the dietician was made to provide a diet high in protein, zinc, carbohydrate and vitamins A and C to fulfill the energy requirements needed in the restoration and ongoing function of cells for optimal wound healing. This was also necessary to replace the leakage of serum protein in the serous exudate from his poorly healing abdominal and mucocutaneous junction wounds.

Despite nursing advocacy and written reporting, the surgeon ordered the removal of Earl’s wound staples ignoring the clinical warning signs of insufficient healing 12. As predicted, Earl’s wound dehisced with his first cough, necessitating emergency surgery.

This incident raises the issue of teamwork. The nurses and doctors who are involved and interactive in ostomates’ care will actively listen, share experiences, contribute to discussions and develop the ability to recognise and respect the expertise of others so that conflict can be used as an opportunity for growth, rather than a battle to be won or lost 13. In a workplace with a culture of collegial collaboration and support, people will have the confidence to ask questions, seek advice without judgement, vent frustrations and share successes, providing incentive and motivation for continuing education and professional development. Augmenting clinical experience with further learning will improve competencies and expertise whilst prompting or reinforcing necessary practice changes 4,14,15,16,17.

CONCLUSION

It is essential that STNs as advanced registered nurses strengthen collegiality with generalist nurses and doctors to form productive working relationships in the delivery of optimal ostomate care. Combined with the diligent use of professional standards, guidelines and benchmarks, we will be able to respond positively to those who need our expert knowledge and skills.

Keeping abreast of changes affecting a sustainable quality stomal care service requires continuing education, a questioning mind and reflective research-based practice. As a team we are more likely to deliver a safe and continually improving quality performance.

REFERENCES


6. Lumbry J. From the specialist to the generalist. Nursing Australia 2006; 7(3).


Are your ostomy patients afraid of coming unstuck?

Summer can be a nervous time for many of your ostomy patients. Hot weather brings on an increase in perspiration, and unfortunately many ostomy appliances simply can't take the heat. Lack of adhesion leads to a loss of confidence, a worst-case scenario for any ostomy patient. During the long, hot Aussie summers, patients need their baseplate to deliver 5 key FEEAT benefits:

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BACKGROUND
Use of products in areas that are not always obvious is a right of passage for all stomal therapy nurses. Throughout our practice we are often called upon to solve problems that other nurses, without our product and specialist knowledge, would be hard pressed to do.

The following case study describes management of a scalp wound with topical negative pressure therapy (TNPT), which, due to the position of the wound required more than the usual thin hydrocolloid framing to maintain an airtight seal.

PATIENT/MEDICAL HISTORY
Miss M was a delightful 60-year-old Aboriginal lady involved as a pedestrian in a motor vehicle accident on 11 June 2009, sustaining a large, complicated scalp laceration. The wound was washed out and sutured on 12 June 2009 in theatre, with the patient being discharged the following day on oral Keflex and Chloromycetin ointment to apply to the wound margin.

She re-presented 11 days later on the 23 June 2009, with an area of necrotic tissue partially covering the scalp wound, with pus exuding through the sutures. The area had become infected. Pertinent aspects of her medical history included type 2 diabetes mellitus.

SOCIAL HISTORY
Miss M lives with a partner and has seven children, with several grandchildren living with her. She is a disability pensioner. She is a lively and caring person who regularly travels north to participate in Aboriginal Women’s Business.

SURGICAL INTERVENTION
She underwent excision of the necrotic tissue and further washing of the wound on 23 June 2009. Unfortunately, a 3cmx1.5cm area of bone without periosteum coverage was revealed; otherwise the wound bed was now clean and without slough. There was discussion by the medical staff of undertaking a split skin graft. However, due to the lack of tissue coverage over the bone it was felt the result would be poor. Therefore, the aim of treatment was to acquire good granulation tissue coverage over the rest of the wound bed and then undergo a flap procedure.

NURSE ASSESSMENT
We were asked to review this lady on 24 June 2009, the day following surgical debridement and 13 days after the initial injury.

The wound was 7cmx6cm at its widest points, with a very narrow section of necrotic tissue 2.5cmx0.5cm at the wound margin which was fixed. The wound was deep-walled with rolled edges and was clean.

To encourage granulation, we decided a topical negative pressure dressing would be the most effective, but were concerned that we may not be able to achieve an adequate airtight seal, which would undermine successful therapy.

METHOD/INTERVENTION
She was well enough to be treated as an out-patient with the dressing changed twice weekly. We needed to be convinced there would not be a leakage issue with the device. According to V.A.C.® Therapy guidelines, maintaining a seal around the dressing is the key to successful therapy. It is recommended to “…frame the wound with a skin barrier to enhance the seal”.

Normally, we would use a thin hydrocolloid for this; however, due to the hair stubble the adhesion was not adequate.

A Hollister Adapt Large Seal was chosen for its mouldable properties and was applied easily to the wound margin, providing an excellent airtight seal for the dressing.
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At this stage we applied a non-adherent interface and a White Foam V.A.C.® dressing to avoid any ingrowth of foam into the bone. A pressure of 150mmHg on continuous therapy was applied due to the use of white foam and to help create a seal.

She was discharged on 29 June 2009, 6 days following debridement and with the first dressing change revealing successful growth of healthy granulation tissue.

Figure 5

At this stage we applied a non-adherent interface and a White Foam V.A.C.® dressing to avoid any ingrowth of foam into the bone. A pressure of 150mmHg on continuous therapy was applied due to the use of white foam and to help create a seal.

From this point we shared care of Miss M with the community nursing team, who undertook the dressing each Monday and with an out-patient review by us each Thursday.

At the first visit, we were still unable to debride the small area of necrotic tissue and the bony area showed no granulation growth. We felt that Miss M may have this patch of bone on view forever.

Figure 6

On 9 July 2009, day 16 following debridement, there were a few spots of granulation tissue on the bone. A trial of decreased suction to 125mmHg but maintained on continuous therapy was applied successfully and continued for another week until full granulation was achieved over the wound bed.

Miss M had stubble around the wound margin and we didn’t regularly shave the area. The Hollister Adapt Large Seal moulded without any difficulty and was easily removed with the dressing. Importantly, Miss M found it to be comfortable in situ and painless on removal.

By this stage, Miss M was becoming weary of the machine so this was ceased and we applied a second daily dressing of a hydrofibre and waterproof adhesive foam dressing bordered with a tape.

By week 11, the wound had contracted by one third with complete coverage of the bone and granulation to skin level. The hydrofibre was ceased and a simple non-adherent dressing was applied.

DISCUSSION
Scalp wounds can be difficult to maintain a dressing and even more so using TNPT, which requires an airtight seal. The use of the Hollister Adapt Large Seal around the wound margin to create an even, smooth surface for the dressing to adhere to was extremely useful. It was quick and easy to mould and didn’t require the head to be fully shaved. It left little to no residue on removal.

Using another hydrocolloid product such as Duoderm or Comfeel, which are less robust and would not be able to mould around the uneven scalp contours or adhere to the hair follicles, would not have been successful.

Without this product, we would not have been able to utilise TNPT and may not have achieved the speed of granulation and bone coverage that we did.

CONCLUSION
This case highlights the adaptability of use for Hollister Adapt seals, especially where the dressing is to be applied to a difficult anatomical site. We would not have achieved an airtight seal nor been able to utilise TNPT without its use. Importantly too, it was comfortable on removal and left little to no residue. Overall, we achieved excellent wound healing and improved the patient outcome.

REFERENCES
PELICAN UROSTOMY

In all sizes great and small.

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Effective use of a faecal management system to aid healing of a grade-four pressure ulcer

Ian Whiteley • BNurs, Grad Cert (STN), Grad Cert (Nurs Ed), Grad Dip (Acute Care Nurs), Cert IV Workplace Assessment and Training, Clinical Nurse Consultant – Stomal Therapy & Wound Management

ABSTRACT

As a clinical nurse consultant in stomal therapy and wound management, my role involves the review of patients with complex wound and healthcare requirements. In this case, the patient was admitted with grade-four pressure ulcers primarily involving the sacral region and left and right ischial areas and extending to within 2cm of the anus. The wounds were contaminated by faeces from incontinence and the decision was made to insert a ConvaTec Flexi-Seal® Faecal Management System (FMS) to protect the wounds.

DETAILS AND HISTORY

The patient was an 85-year-old male, who underwent a right above knee amputation (AKA) 4 months prior to this admission. The amputation was required due to an ischaemic ulcer resulting from severe peripheral vascular disease. Other history included cerebrovascular accident, ischaemic heart disease, abdominal aortic aneurysm, osteoarthritis, open reduction and internal fixation of a fractured right femur, dementia and falls.

Following the AKA, the patient was discharged to a residential aged care facility since he was assessed as unsafe to return home. Six weeks prior to the current admission, the patient self-discharged from the residential aged care facility citing dissatisfaction with the care, food and cost. The patient returned to his own home with no community services and limited family support.

The patient’s brother or niece would come to assist 6 days per week with hygiene and transfer to the wheelchair in the morning. No lifting equipment had been arranged and it is likely that sheering and friction forces played a role in the development of the pressure ulcers. As the patient was unable to transfer independently, he stayed in his wheelchair all day. The patient had multiple falls, poor nutrition and was often left sitting or lying in excreta. It is recognised that incontinence is a contributing factor to the development of pressure ulcers 1. Other risk factors this patient possessed for the development of pressure ulcers included: insufficient nutrition and hydration; peripheral vascular disease; urinary and faecal incontinence; inhibited sense of pressure; limited mobility; age greater than 60 years 2. Many of these factors have a direct impact on ‘tissue tolerance’ which is the amount of pressure an individual can withstand before capillary occlusion occurs, leading to tissue damage 3.

ON ADMISSION

A wound consultation was requested the day following admission. A thorough examination revealed multiple superficial wounds and pressure ulcers to the face, upper right arm (thought to be a rope burn from the patient trying to reposition himself at home), right shoulder, left heel, bilateral hips (over the trochanter), sacral and ischial areas. The worst of these wounds was a grade-four pressure ulcer to the sacral and ischial regions, which is the focus of this case study. Grade-four pressure ulcers can be defined as those involving extensive tissue destruction or necrosis, damage to the muscle, bone or supporting structures and, in this case, involving full-thickness skin loss 3.

At a family conference, the family stated they first noticed the wounds on the buttocks 5 days before bringing him to the emergency department for review and subsequent admission.

Image 1. Taken on day 3 of admission.
The main wound in the sacral and ischial region measured 22cm long from the sacrum to the right ischial area, 14cm long from the sacrum to the left ischial area and 13cm wide.

The patient had faecal loading on admission and was given enemas and commenced on aperients. On day 4 of the admission, a ConvaTec Flexi-seal® Faecal Management System (FMS) was inserted to protect the wounds from further faecal contamination. The stool was modified to a loose consistency through the administration of a combination of aperients to aid the flow of stool through the FMS.

The use of an FMS has been shown to protect skin from the protease and lipase in faeces that can damage soft tissue. It has previously been documented that the use of an FMS can effectively divert, collect and contain liquid stool to prevent further contamination and breakdown of wounds 1.

In-service education on the FMS was provided to the ward nursing staff by myself and reinforced in a formal session by the ConvaTec company representative. This education involves trouble-shooting, care and management of the device and policy or protocol.

WOUND MANAGEMENT

A low air loss (LAL) mattress was hired and the patient was nursed on this for the duration of his admission. LAL mattresses have been found to be effective in the pressure care of individuals with pressure ulcers or identified at high risk of the development of pressure ulcers 4. The benefits of LAL mattresses include: less frequent turning is required; shear and friction forces are reduced and the moisture control function aids in wound healing. LAL pressure relieving devices contain humidity sensors and vary air flow through the device to maintain optimal rate of humidity to patient skin. In a prospective randomised trial it was determined that the rate of healing is three times greater in the LAL bed and that pressure ulcers are 2.5 times more likely to heal 4.

A heel boot was used to protect the necrotic ulcer to the left heel from further damage through the effects of pressure and friction.

The aim of the initial treatment was to implement autolytic wound debridement techniques to remove the devitalised tissue from the wound. Autolytic debridement relies on the creation and sustenance of a warm, moist environment to stimulate enzymatic activity 5. This process enables the body’s natural enzymes to digest necrotic tissue 6. Comfeel® paste was used to rehydrate the wound and secondary dressings of Biatain® adhesive were used to absorb exudate, maintain moisture balance and protect peri-wound tissue.

Following a review by the plastic surgical team silver sulfadiazine cream (SSD) was substituted for the Comfeel® paste due to its antimicrobial action. Biatain® adhesive was continued as the secondary dressing, to maintain the moist environment required for autolytic debridement. This continued for a period of 13 days and sharp instrument debridement was periodically used to remove the necrotic tissue as it began to slough off. It has been documented that sharp instrument debridement may be painful 7; however, we did not find it necessary to apply topical anaesthetic or to give analgesia as only devitalised tissue was debrided and the patient stated there was no pain or discomfort.

On day 13 of the admission Vacuum Assisted Closure (V.A.C.®) therapy was commenced.

V.A.C.® therapy continued for the next 17 days and the FMS ensured the dressing was protected from faecal contamination as there was only a margin of approximately 2cm from the wound edge to the anus on which to seal the V.A.C.® drape. The V.A.C.® machine was set on continuous therapy 125mmHg, using the continuous setting. This setting minimised the possibility of the development of an air leak from poor sealing of the V.A.C.® drape near the anus.

The V.A.C.® dressings were changed every 3-4 days until the wound bed was granulating and had reduced in size. The dressing was then changed to Aquacel® and Allevyn® sacral.

The FMS was removed after being in for 29 days (as per protocol) and replaced with a new FMS. The second FMS remained in situ for a further 12 days. Aperients ceased 6 days prior to removal and once the stool had become semi-formed the device was removed.

CONCLUSION

The combination of: comprehensive patient assessment; consultation with the multidisciplinary team; use of appropriate pressure relieving devices and faecal diversion via an FMS all aided in wound healing. A variety of wound management techniques including: wound bed preparation via autolytic debridement; sharp instrument debridement; V.A.C.® therapy
and moist wound healing were implemented to achieve wound healing.

During the 49-day admission, the wound dimensions decreased to 3.5cm long and 1.5cm wide. This is a significant decrease from the dimensions recorded on admission, where the wound measured 22cm long from the sacrum to the right ischial area, 14cm long from the sacrum to the left ischial area and 13cm wide.

Following further consultation with the patient and family, an alternative residential aged care facility was selected for permanent placement on discharge. A comprehensive discharge plan for ongoing wound management and pressure relieving requirements was communicated and documentation was forwarded to the new residential aged care facility.

REFERENCES:

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Firstly, I would like to thank the Colorectal Surgical Society of Australia – New Zealand (CSSANZ) for awarding me the scholarship to attend this meeting.

The CSSANZ annual meeting in 2009 was combined with other surgical and medical organisations, which brought together many health professionals from Australia and New Zealand, including surgeons, physicians, scientists and nurses. The five participating organisations were: CSSANZ, Gastroenterological Society of Australia (GESA), Australian and New Zealand Hepatic Pancreatic and Biliary Association (ANZHPBA), Australian and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA) and Gastroenterological Nurses College of Australia (GENCA). Although this was the first combined meeting, it is anticipated that they will be held every 3 or 4 years.

The venue for this exceptional event was the Sydney Convention & Exhibition Centre, Darling Harbour, which was a perfect location to combine business with pleasure. The 4-day programme offered an outstanding array of both national and international speakers. With five collaborating organisations, it was an extremely busy programme and it seemed that every topic was covered in the hundreds of papers and posters that were presented. At times there were up to eight concurrent sessions and there were over 200 posters on display, so one had to be selective and decisive about which sessions to attend!

Topics covered a full range of specialities, from the beginning to the end of the gastrointestinal tract. Being a stomal therapy nurse (STN), my interest was more in the latter end, so my selection was mostly colorectal-related. Some presentations were very scientific, while others had a more clinical focus. Topics included prevention and screening, medical and surgical treatments of both benign and malignant diseases and functional bowel disorders. There was a thought-provoking paper presented on the risk factors for bowel cancer, suggesting significant risk for red-meat eaters. Intriguingly there were also presentations of studies, suggesting potential benefits of grapeseed extract and emu oil as adjuvant treatments for ulcerative colitis. There were also some interesting discussions on the management of constipation and faecal incontinence. With a roomful of colorectal specialists, very comfortable with the topic of faeces, it made for some amusing comments! Overall there was a strong sense of the multidisciplinary approach, with a common desire to achieve the best outcomes for patients.

Being awarded this scholarship was a truly educational experience. Not only attending this amazing conference, but also the writing of an article, as part of the application process. I would encourage all novice STNs to apply; it honestly is a very worthwhile and rewarding experience. I would again like to thank CSSANZ for offering this wonderful opportunity for STNs to continue their professional development.
One of the important roles of ACSA is to manage the operation of the Stoma Appliance Scheme so far as it relates to the distribution of products to members of Associations. There have recently been a number of significant issues which will affect the operation of the scheme and result in some changes in how Associations provide stoma products to members.

As part of ACSA’s ongoing liaison with the Department of Health and Ageing we have for some time been reviewing the Stoma Appliance Scheme Guidelines, which set out how the scheme operates. These new guidelines were released in 2009. The previous guidelines were somewhat outdated and the purpose of the review was to make them more effective and relevant to the actual operation of the scheme. There are a number of important changes included in the new guidelines which are posted on the department’s website. I would like to encourage all stomal therapy nurses (STNs) to download a copy as a reference source as they set out details of how the scheme operates.

The new arrangements require that a standard fee for ostomates to access the scheme (at present $45 full member and $35 concessionary) must be included in the membership fee of all Associations as a contribution to the operation of the scheme. All ostomates are required to pay the fees as a condition of participating in the scheme. Members experiencing financial difficulties can enter into a payment arrangement to pay the fees on a monthly basis over the course of the year. However, to obtain this benefit, the member must sign a written agreement setting out the payment arrangements before they receive their first lot of appliances each financial year.

Another significant change included in the new guidelines is that all new ostomates must now be certified by an STN or a medical practitioner as having a stoma which meets the requirements for membership of the Stoma Appliance Scheme. The department has provided an approved certificate which must be attached to the usual Application for Membership of the Stoma Appliance Scheme form. The new certificate is included on the department’s website and is available from all Associations. It is expected that the certification will be incorporated in the Application for Membership form when that is reprinted. STNs are asked to ensure that all new patients who they refer to associations are provided with the approved certificate.

The partnership between STNs and ostomy associations, which has been so effective in providing postoperative and ongoing support for ostomates in all parts of Australia, should be enhanced by the new guidelines which clarify the arrangements under which stoma products are supplied under the scheme.

Another important issue which arose last year was the announcement by the government of a review of the operation of some aspects of the scheme. The decision to undertake this review was incorporated in the last Commonwealth Budget (May 2009) and it is directed towards the pricing and contracting arrangements under which ostomy supplies are included and maintained on the scheme. Because the principal focus of this review is on the arrangements for the purchase of products, it is expected to mainly involve the ostomy supply companies. However, the review will be likely to have some implications for ostomates in respect of product range and quantities. The ACSA Executive is monitoring the development of the review closely and will consult with the department on any adverse consequences for ostomates. Representatives of stomal therapy nurses are also being consulted by the department as part of the review.

Another matter I would like to mention is the operation of the Australia Fund, which was inaugurated by ACSA in 2001 to provide support and assistance to ostomates in need anywhere in the world. The ACSA Relief Coordinator, Bruce Harvey wrote about the operation of the fund in a previous issue of the AASTN Journal. The fund is operated as part of ACSA but is managed as a separate entity. The overall management is carried out by a committee appointed by ACSA.

The fund is the principal way in which ACSA provides assistance to needy ostomates at an international level. It continues to operate very effectively in Indonesia and maintains a very high level of support by sending ostomy supplies for distribution to ostomates there. The fund has also commenced to provide support for Nepal and there have been a number of shipments of appliances to that country also. The Australia Fund assistance has been carefully targeted at disadvantaged ostomates in countries where many ostomates cannot afford to purchase appliances. As chairperson of the Australia Fund Committee, I would like to express my appreciation for the involvement of an increasing number of STNs who are participating in the programme by donating and sending surplus supplies from their clinics.
The last 6 months have been very productive for the Education and Professional Development Subcommittee (E&PDS).

The committee met in Adelaide in October 2009 for our annual weekend workshop. We had full attendance and were pleased with the outcomes. The following was achieved:

**Review of the archives of the committee:** In an attempt to decrease the storage requirements of hard copy records, a small committee looked at current records to determine what was already on disc and what was needed to be kept in hard copy. The AASTN archives are held by Wendy Humphreys in South Australia, so it was then taken back to the AASTN South Australian branch to act upon finalising our mission to ensure the Association’s records are kept in a safe and responsible manner. This essentially means we need to cull unnecessary hard copies, save documents to disc and make certain we are storing our documents in a safe place. We intend to store the records at a storage facility for safe keeping, with two South Australian members having access to add or retrieve documents.

To this end, the South Australian branch met on Sunday 17 January at Wendy Humphreys’s home to sort through the records. Approximately 11 STNs spent the afternoon at Wendy’s. All were amazed at the volume of documents and the time it took to perform a preliminary sorting and shred the unwanted items. We still need to sort the items for scanning to disc but this will be another day’s work.

**Credentialling and continuing professional development (CPD):** Sue Delanty (Tasmania) continues to oversee these two vital areas with the assistance of Wendy Sansom (Victoria). We are delighted to say that six people successfully completed the credentialling exam in 2009 and will be presented with their certificates in March. These members are Andrea Farrugia (VIC), Jill Fairhall (NSW), Karen McNamara (WA), Petronella Prokop (QLD), Pam Thompson (WA) and Carolyn Atkin (VIC). Congratulations.

A reminder that applications for becoming a credentialled STN must be submitted to Sue Delanty by 30 June. Details about the criteria and the process are available on the AASTN website at www.stomaltherapy.com

This year we decided to trial the inclusion of a copy of the updated CPD portfolio as an insert in the September Journal of Stomal Therapy Australia and sending out a reminder email in December to have all CPD applications in by the end of the year. These have had a positive effect on timing and the sending in of evidence to justify the portfolio, with 87 members participating in CPD. However, people are still referring to the old CPD portfolio and points value. By downloading the new portfolio from the website it will make reaching 100 points per year easier. Please remember CPD does not mean just stomal therapy-related topics. Any activity where professional development is enhanced should be included (for example, mandatory
education CPR/manual handling, infection control updates, other study days and seminars unrelated to stomal therapy but part of your role as a nurse).

You can send your CPD portfolio prior to December if you have reached 100 points and have evidence to support these points.

**AASTN website:** The committee reviewed the AASTN website and made numerous recommendations to Karen McNamara, the AASTN website coordinator, which are being discussed at Executive meetings prior to implementation. The aim is to make the website easy to navigate, avoid duplication and ensure material is up-to-date. If any members are having difficulty downloading credentialling and/or CPD information please notify either Sue Delanty or me and we can forward a copy to you in the interim. However, we do prefer you to refer to the website in all instances first.

**CoNNO:** Lesley Everingham attended the Coalition of National Nursing Organisations’ (CoNNO) biannual meeting in October. The next meeting is in May this year. In October they had three major speakers: Peter Fleming, Chief Executive Officer of the National E-health Transition Authority (NEHTA) talking about the importance of E-health in the future; Chris Baggoley, Chief Executive of the Australian Commission of Safety and Quality in Health Care about the activities of his group; and Belinda Moyes represented the Australia and New Zealand Council of Chief Nurses, talking about the challenges facing the nursing profession.

**AASTN credentialling model:** Lorrie Gray (WA) has written an update on the AASTN model used in the credentialling process including outcomes, limitations and highlights. The National Cancer Nursing Education Project commissioned a report by the University of Sydney to look into models of credentialling used for specialist nurses in Australia. Since our journal is not a peer-refereed journal it does not register when a formal literature search is undertaken. Hence the AASTN process, one of the oldest in Australia and previously published in our national journal, was not included in the study results. The E&PDS decided to submit our updated report to a refereed journal and hope to see this achieved later this year. In the future we will have some evidence of our existence as a specialist nursing group with clear credentialling processes to support our speciality to which others may wish to refer.

**Documents:** In October we continued to work on standards for clinical practice guidelines. This will take some time to complete, with the hope we are ready to launch at the AASTN Inc. biennial conference in 2011. We also reviewed the criteria for overseas-trained STNs to become full members of the AASTN Inc. This is in the process of being ratified by the National Executive and then will be published on the website. We hope this will allow nurses from other countries to be recognised by our Association, whilst at the same time maintaining some level of standardised education requirements.

As an ongoing quality improvement project we review all documents every 3 years. In October, this included the credentialling process paperwork and the patient information booklets. We hope to be adding a booklet on paediatric stoma care to our growing list soon.

Our next meeting is to be held the day before the AGM in Melbourne at the Ciloms Airport Motel on Thursday 11 March.
An extraordinary meeting of the Stoma Products Assessment Panel (SPAP) was held in Melbourne, on 14 December 2009 to allow the panel to meet with the consultant assisting with the review of the Stoma Appliance Scheme, Liliana Bulfone, Senior Research Fellow, Deakin University.

SPAP members attending the meeting were: Peter McQueen representing ACSA, Brett Andrews representing MTAA, myself representing AASTN and Chris Bedford representing the Department of Health and Ageing.

AASTN SPAP representatives, Sharmaine Peterson and Carmen George were also invited, but due to the late notice, could not attend. Gerry Barry, President of ACSA, attended as an observer. Other members of the AASTN were also invited, but, once again, due to the late notice, Freda Pace was the only other AASTN member who could attend.

In addition, I also represented the AASTN at a meeting between the consultant and our organisation.

Both meetings sought information concerning the objective of the scheme, and the principles and policies, which should underpin and guide the operation of the scheme.

Everybody was given the opportunity to discuss attributes and concerns regarding the scheme. However, it was stipulated by Liliana that this was not the only platform for stakeholders to voice their concerns. Stakeholders were asked to contact their members, Australia-wide, and seek feedback.

AASTN members were contacted via email. To date I have received 16 replies.

Concerns that were received include, but are not limited to, the following:

- Associations are not able to receive returned goods, even if the parcel is still intact.
- Oversupply of baseplates and drainable bags.
- Convexity products should have the same allowance as flat ones.
- Draining wounds and other types of stomas and fistulae not being eligible for the SAS.
- Not enough belts, which attach to the appliance, per year.
- Not having a system for distributing clean, unwanted products to poorer countries or to others within Australia who have to purchase appliances.
- Australian states that are disadvantaged by fewer ostomy association options.

Thank you to everyone who responded.

**Australian values, purpose and vision**

**Our values**

Quality, respect, accountability, commitment and innovation.

**Our purpose**

To provide support and leadership to stomal therapy nurses in their endeavour to provide quality nursing practice.

**Our vision**

Enduring recognition for excellence and innovation in stomal therapy practice at a national and international level.
Happy New Year to you all and I trust you had a wonderful Christmas and a break from work activities over the Christmas and New Year period! For those of you who didn’t have a break, I do hope you can look forward to holidays in the near future or maybe you are saving them to come to the WCET congress in Phoenix, Arizona USA from 12 to 16 June this year.

I have heard of quite a number who are going from Australia and it is always good to have a good representation from Australia. I am sure you will be enriched by your experience, especially as it is the first joint conference with the American WOCN group.

As you know, the 2012 congress will be held in Adelaide and I do thank all of our members who have volunteered to be part of the organising committee under the guidance of our chairperson, Fiona Bolton. I was privileged to be part of the group late last year, when we interviewed prospective conference organising groups. It was a very interesting couple of days, resulting at the end of the 2 days in the appointment of an Adelaide-based group called SAPMEA. We were most impressed with their organisation and what they could offer us with assistance and we look forward to working with them in the next 2½ years.

We will be doing a presentation at the end of the 2010 congress, inviting people to come to Adelaide in 2012, so we need as many Australians to be part of this presentation as possible. Please consider coming to Phoenix to assist in being part of this Cecil B de Milne production.

Thank you to all the members who have already paid their membership for 2010 and especially to those who have paid until 2011 and even 2012. I realise due to the busyness of the Christmas period it may have slipped the mind of some members who haven’t paid, but there are quite a number who I urge to renew their membership as soon as possible, especially as our dollar is in a favourable position with the English pound. Our membership fee is 20 English pounds and the conversion rate is good.

I wish you well for the new year and trust your work loads will be manageable and I look forward to seeing you in Phoenix in June.

Cheers, Brenda

**WCET congress Phoenix, Arizona USA 2010, Adelaide, South Australia, 2012**

Brenda Sando CNC STN • The Wesley Hospital, Brisbane QLD

*STATE REPORTS*

**Australian Capital Territory**

Happy New Year for 2010. Once again the numbers of people undergoing stoma surgery rose in 2009, so we are expecting another busy year for 2010. In the ACT we have three nurses currently studying for their postgraduate certificate in stomal therapy so we wish them all the best for their last 6 months.

All meetings are held at Phillip Health Centre Conference in Room 3 and this year we are introducing an education session following the meeting. The meeting dates for 2010 are:

- 9 February
- 13 April
- 8 June
- 10 August
- 12 October
- 7 December.

Kellie Burke

**New South Wales**

Welcome 2010!

Our last meeting of the year, held on 4 December, was followed by Xmas dinner at Emma’s on Liberty Lebanese Restaurant nearby the hospital. Twenty attended and all continued to network over good food and a glass or few of beverages into the night!

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

Beverley Radmore OAM STN has finally succumbed to retirement after 50 years of nursing. Bev will be missed by all.

The guest speaker for our 2 February meeting is Associate Professor Peter Zelas OAM, colorectal surgeon at Blacktown Hospital. He is the clinical dean at the University of Western Sydney and volunteer surgeon with Médecins Sans Frontières and will be presenting his experience in Somalia.
The venue for the national AGM will be held on Friday 12 March 2010 from 2pm till 3.30pm, at RPAH. After this meeting all members are invited to attend a dinner for Sharon and Julie who have resigned from ONL.

All members are invited to the branch bimonthly meetings with educational guest speakers every meeting with a light supper supplied by our company representatives. Our meetings now are conducted via teleconference. This has proved successful – please contact me for information. The venue is in the Tutorial Room, Level 9 East Ambulatory Care, Missenden Road, Camperdown RPAH. The meeting dates for 2010 are 6 April, 1 June, 3 August, 5 October and 3 December. If you are an AASTN member and do not get to our branch minutes please contact me on 9515 8990.

Cheers and best wishes from everyone in NSW.

Jenny Rex

Queensland

After a very hectic year, fun and laughter was had by all that attended our Xmas breakup. Children, partners and members all joined in with a game of lawn bowls. This was followed with a sumptuous Thai meal.

At present we are planning our Professional Study Day on 12 March, which includes the AGM. We have a variety of speakers as requested by our members. This includes Writing a journal article, Role of Nurse Practitioner, Colostomy irrigations, DEM assessment tool and case studies.

Our meetings will continue 2nd monthly at the Mater Hospital, South Brisbane at 1700 and will continue with an educational component. All new members are welcome. Our meeting dates for 2010 are:

- Tuesday 19 January
- Tuesday 2 March
- Tuesday 4 May
- Tuesday 6 July
- Tuesday 7 September
- Tuesday 9 November.

Patients have many different ways of showing their appreciation of our cares. A patient of Petra Petroff, at the Mater Private Hospital, expressed his feeling in this poem. Patient, STN and doctor’s permission were given to reprint this poem.

**BAGS OF A FASHION**

_A door of opportunity,_
_To prove that all with me was well,_
_I placed my faith and confidence_
_In ‘Cycling Surgeon, Andrew Bell._

_A new ‘red nose’ to be installed,_
_Protruding smartly from one side,_
_It was to be a major op,_
_It had me feeling ‘Petrified’._

_A great instructor, ‘Petra’ proved,_
_To ease and calm a troubled mind,_
_Though I’d felt zonked and ‘stomatose’_
_Our ‘Blue Eyes too, is ultra kind._

_So hands-on now, with new-found friend,_
_His burping, bubblings and aroma,_
_Tis only for a little while?_  
_And then ‘AriverDerchy’ stoma._

Helleen Purdy

South Australia

The holiday season has now all but finished with 2009 ending well for stomal therapy nurses (STNs) in South Australia. To grace our October meeting the guest speaker was Anne Schloithe, who works as a technician at Flinders Medical Centre. She carries out the anal manometry and endoanal ultrasounds on patients requiring these procedures and she gave a very informative talk on her work.

For the November meeting the state’s STNs went to the Hackney Hotel for a Christmas dinner. A private function room was booked and it was an occasion enjoyed by all who attended. The food, drink and company were all good. Hollister sales representative, Dianne Field, announced her resignation after many years in her position and South Australia’s STNs are sad to see her leave. We wish her all the best in her future endeavours and thank her for her efforts and support in the past.

On Saturday 14 January the group is to meet at Wendy Humphries’s house for a barbecue lunch and to go through the archival material of the Association. I am sure it will be an interesting day with a lot of material to sort through.

The 2012 WCET Congress continues to be the subject of a lot of hard work and emails. The conference committee and others are constantly discussing ideas for themes and subjects for presentation and I guess that this will continue to be a source of much work until it is over. Meanwhile those fortunate enough to be attending this year’s combined WCET and WCON Conference in Arizona are becoming more excited as plane flights are booked and conference programmes looked over. On perusal of the many presenters, it is pleasing to see that many Australian nurses are involved and we are very proud of their endeavours and knowledge.

The students in the South Australian-run Stomal Therapy Nursing course are getting towards the end of their time with only the Advanced Module to be attended and a further week of clinical placements at the Royal Adelaide Hospital to round out
their learning. This group has included a number of country and community nurses, which will help ensure adequate continuity of stomal therapy care after their period of acute hospitalisation and must surely be a bonus to patients.

This promises to be a busy year for South Australian STNs and I trust that we will all work together to ensure positive outcomes for stomal therapy.

**Tasmania**

Hi and Happy New Year to all.

This year has started well but busy as we settle into another exciting year in stomal therapy.

We continue our state branch AASTN meetings via video link this year to allow all the opportunity to participate and be kept updated.

Our booked dates this year are 19 May, 21 July, 29 September and 17 November and closer to the festive season a combined Christmas luncheon and meeting will hopefully be achievable; stay tuned.

Our Northern Journal club dinner meetings were hugely successful last year and at our end of year event received confirmation from Coloplast that they will continue to support these valuable evenings. Thank you to Andre Gall and Coloplast for their ongoing commitment; it is greatly appreciated.

Sue Delanty and Teena Cornwall from the Launceston General will travel to Phoenix, Arizona in June for the WCET conference. We wish them a fantastic trip and can’t wait for their feedback on their return. Safe travels girls.

Margo Hickman and I are busy planning a statewide PEG education workshop this year, open to all interested healthcare professionals. The seminar is planned for 14 May and will be held in the Rural Clinical School on the North West Coast. This is professionally very exciting to be joining forces to update this knowledge and especially for our rural region to have this opportunity.

On the education front, Carolynne Partridge is taking on study within her continence advisory role and combining this with commencing her Master of Clinical Nursing. We wish you every success with this Carolynne.

Keep up the great work one and all.

Cheers from Tassie

Tracey Beattie

**Victoria**

**ANNUAL GENERAL MEETING**

It gives me great pleasure to present the Victorian Branch report for the AGM – 12th March 2010.

I am happy to report another active year. Our meetings have been spread around metropolitan Melbourne, on different weeknights, with the primary intention of giving as many of our members the opportunity to attend a meeting at some stage of the year as possible.

Our educational meetings this past year included Presentation, Speaker skills for lectures, Compiling Statistics at the workplace, Wound care with emphasis on V.A.C.® Therapy, Ostomy case presentations.

One initiative of the branch was to organize a “Care for the Carer’s Retreat” this was at Hepburn Springs in country Victoria in May. We were delighted when Sue Delanty, Teena Cornwall, Tracey Beattie and their partners joined us from Tassie. It proved a great success and we are now hopeful of making this either an annual or second yearly event with Tasmania and Victoria.

To coincide with this national annual meeting we have organized a conference day, which is also this year’s country study day, at Geelong Hospital, the theme of the day is “Inflammatory Bowel Disease” with emphasis on the High Output Ileostomy. The Program includes presentations from hospital based, community based and Hospital in the Home teams – acknowledging the holistic approach to care.

To complement this conference day, the Geelong Ostomy Association have kindly agree to open their distribution centre for our members to visit on Saturday morning 13th March – we are very appreciative of this inclusiveness and hope that STN’s take up the opportunity throughout this year to work in partnership with their Ostomy Distribution Centre.

Other meeting dates for this coming year include

- 16th February – Cabrini Hospital – Discussion of Stoma Appliance Scheme
- 12th March, AGM and country study day
- 11th May – Southern Health, “Cultural Issues”
- 7th September – venue and topic to be decided.

A further initiative this year for education will be in conjunction with our trade colleagues and through their ever generous support, the instigation of “ad hoc” nights with guest speakers at various hospital venues. This is in the pipeline at present and will be programmed on the odd months in-between our scheduled meeting dates. I look forward to reporting further on this in next years AGM.

The 2011 conference committee is up and running, it is a small working group that includes Wendy Sansom, Loreto Pinnuck, Andrea Farrugia, Lisa Wilson, Jenny Davenport, Helen Nodrum and Anita Lynch who is representing the Business Consultant. As it is a joint meeting the social program will be in conjunction with the tripartite group, providing the opportunity for sightseeing this beautiful tropical paradise at reduced costs.

Our initial invitation for specific abstracts will have been sent to State Reps. by the time this report is filed.

Our thanks go to Genevieve Cahir for accepting nomination for committee position on the national executive for the next two years.

Carolyn Atkin has nominated as Victoria’s delegate on the WCET committee for 2012 international conference – exciting
The year began with the committee members working towards finalising all aspects of the Australian Association of Stomal Therapy Nurses 37th Conference at the Burswood Centre.

The IT/It’s Happening theme for this conference was embraced by all, bringing some very clever and interesting ways “that various hospitals or services utilise their…” By speakers ranging from novice to expert and reiterating their commitment and pride in their achievements and desire to improve the lives of the patients in our care.

There was no doubt that the 3-day conference was a great success. The feedback and responses of the delegates each day was very positive. For yet another conference year in Perth we have praise and thanks to Robyn Simcock, conference secretariat, who remained calm and so very, very organised from start to finish.

Education days:
Professional STN study day Mercy Hospital, Mount Lawley 24 October
Paediatric STN study day 14 September
Clinical updates are held 3rd monthly to coincide with the committee meeting dates.

For the country study day, Narrogin became the place of choice. However, due to circumstances out of our control this day was cancelled.

Surprised, saddened but understood was the retirement of Helen Simcock from the committee. She was a dedicated STN and advocate for the professional role and worked tirelessly to achieve the best patient outcomes. Helen was employed by RPH and ended her working life at Mercy Restorative Hospital. She now volunteers at the WA Ostomy association.

Coming in 2010:
24-27 March – Australian Wound Management Association Conference Journey into New Frontiers at the Perth Convention Centre.

2010 STN course, WA AASTN – location SCGH between 19 July and 11 September. Applications need to be forwarded to programme coordinator Lorrie Gray before the closing date on 14 May 2010.

Finally, we continue to meet monthly and have excellent representation from the hospitals and community setting. We have a close relationship with the WA Ostomy Association and appreciate the hard work put in by the volunteers to serve our ostomates.

Wishing each and every state an exciting year ahead.

Leigh Davies

Western Australia
Committee members:

President
Carmel Boylan

Vice-President
Karen Mcnamara

Treasurer
Rita McIlduff

Acting Secretary
Shannon Tassell

Education Rep
Lorrie Gray

Newsletter Coordinator
Debie D’Silva

Country Rep
Robyn White (Bunbury)

State Rep
Leigh Davies

Committee
Lynn Beelitz

Keryln Carville
Bridgit Keating
Mileva Basic

Sue Wilson, from Bass Health in Wonthaggi, has retired this year, to join her husband in his business. Sue has been in the STN role for some years now and a great supporter of Vic. Branch events. We wish her well for the future.

I am pleased to report that some Victorian members will be heading to the WCET/WOCN conference in Phoenix, to my knowledge they include Loreto Pinnuck, Bernie Hadfield, & Diana Hayes.

Fourteen students completed 2009 Mayfield Stomaltherapy Course. This years course due to start in February has been delayed over to May. I wish to once again acknowledge Nina Vucic for her tireless efforts in co-coordinating this course and her professional approach.

As I write this report there is a significant review in progress with regard the “NHS Stoma Appliance Scheme”, the Government having employed a consultant group from Deakin University Health Economics Unit to manage the review. The Victorian committee was disappointed at the timing of such an important review i.e. December, and at the lack of notice to attend a meeting in Melbourne two weeks prior to Christmas and indeed the lack of time to provide appropriate submissions from the Stomaltherapy Nurse Perspective. How efficiently this scheme is administered affects our clients outcomes considerably. The Victorian branch will keep this business matter on our agenda throughout this year.

Finally to end this report for a state branch to be effective it needs a hard working committee and support from its membership base. I wish to thank the committee of this branch for all the hard work over this last year, teamwork and support from everyone. Special thanks to Wendy Sansom and Jenny Davenport who are our National Education Representatives, there has been a lot of work go through that committee this past year. To Margaret Fraser, who is current National Secretary and has maintained her Vic. Branch interests and Diana Hayes, SPAP/AASTN Liaison for the Stoma Appliance scheme.

Special thanks to all our trade colleagues, your support and assistance to all our events this past year has been outstanding. We are indeed fortunate to have that total support.

Helen Nodrum
Stomal Therapy Nursing Education Programme 2010

Dates: 19 July – 10 September 2010
Venue: The Niche, Neurological Council of WA
Sir Charles Gairdner Hospital campus, Suite B, 11 Aberdare Road, Nedlands
Application closing date: 14 May 2010
Late applications will only be accepted if vacancies exist.

The Stomal Therapy Nursing Education Programme, conducted by the Australian Association of Stomal Therapy Nurses Inc. (WA Branch) is an accredited programme with the Australian Association of Stomal Therapy Nurses Inc. (AASTN) and the World Council of Enterostomal Therapists (WCET).

Aim of the programme
The aim of the programme is to prepare registered nurses to function as stomal therapy nurses in the care of people with ostomies, wounds and incontinence.

General objectives of the programme
The student will acquire the necessary knowledge, skills and attitudes to:
• Practise as a clinical specialist in stomal therapy nursing within the guidelines of their nursing registration requirements and the AASTN Inc. Code of Ethics.
• Promote nursing excellence within the specialty of stomal therapy nursing.
• Facilitate the recovery and rehabilitation of people with ostomies, wounds or incontinence.
• Support and educate significant others.
• Promote understanding of the needs of these people amongst other healthcare workers.
• Promote community awareness in the prevention and management of conditions likely to result in ostomies, wounds or incontinence.

Programme duration
The duration of the programme is 8 weeks (320 hours):
• 176 hours’ theoretical component.
• 144 hours’ clinical component conducted in various health agencies under the preceptorship of a qualified and expert stomal therapy nurse.

Entry criteria
• Current registration with Nurses and Midwives Board of Western Australia.
• Two years’ post-registration experience within a relevant clinical area.
• Evidence of a recent negative test for methicillin resistant staphylococcus (MRSA) will be required if the student has been employed outside Western Australia in the 12 months preceding the programme.
• Preference will be given to nurses who can demonstrate an intention to practice in an area where no stomal therapy nurse is available.
• Supporting letter regarding the agency’s future plan for utilisation of this new knowledge.

Programme fee
A registration fee of $2500 is payable by 12 June 2010. A refund of 50% of the fee will be given up to 2 weeks prior to the commencement of the programme for a valid reason accompanied by a medical certificate or other documentation.

Insurance
It is expected that your hospital insurance will cover you whilst attending this professional development programme, including the periods of clinical practice. A hospital letter of intent in respect of this issue will be required with your completed application.

Applications
To obtain a copy of the Stomal Therapy Nursing Education Programme information handbook and application form please contact:
Lorrie Gray
Programme Coordinator
3/13 Ednah St, COMO WA 6152
Tel: (08) 9367 3574
lorriegray07@yahoo.com.au

For further information contact:
Carmel Boylan, President
AASTN Inc. (WA Branch)
PO Box 8380, Stirling Street, PERTH WA 6849
Carmel.boylan@health.wa.gov.au
Tel: Princess Margaret Hospital, (08) 9340 8222 page 8009
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