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I sincerely hope everyone is surviving this cold, wet winter and not succumbing to any viruses. Darwin, of course is remaining warm and I will be visiting there in late August. The rain in South Australia has been very welcome and my water tanks are overflowing.

As you are all aware by now, South Australia and Queensland put in a bid for the 2012 WCET Congress. I would like to thank both states for the time and preparation that was put into preparing the bids and thank you to all those who voted. South Australia was voted to represent Australia and now we have to wait a further outcome as another country has placed a bid. If Australia is the winning bidder, I hope everyone supports South Australia in their endeavour and wishes them good luck.

The ACSA Conference this year is in Canberra. Unfortunately I will not be able to attend, but Kellie Burke, the ACT state representative is attending for the AASTN.

We have a new website coordinator in Karen McNamara. She is enthusiastic and would appreciate any ideas for additions to the website.

All scholarship criteria can now be viewed on the website and state meeting dates, study days and other activities can be advertised on the site.

A copy of the AASTN handbook is available on the website. This is currently under review by the Executive and an updated version will be available hopefully towards the end of the year.

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All the things you love, but now in 30’s
I have been very fortunate again this month to have more than enough articles for the journal. I would like to thank everyone who has submitted an article and apologise to those of you who have not got it published in this journal, but it will appear in the next.

Two of the articles were poster presentations at the AASTN conference in Perth. Reading ‘Improving the quality of life in an ileostomy patient’ reminds us of the importance of education to the patient and family. No matter what products are used, if they are not fitted correctly they can lead to harm to the patient physically, with skin breakdown and psychologically with the leaking bags and the effects that this has not only on the patient but also on family members. We are reminded of the psychological aspects of ostomy care in the article by Julia Thompson.

Similarly, reading the two articles from case studies with patients with complex wounds, it made me think not only do we have to think about the psychological aspects in ostomy care but also about the psychological aspects when caring for patients with complex wounds. Even some of our medical and nursing colleagues find it difficult to observe or assist with some of the wounds we manage, so how must the patient themselves be feeling? As Andrea Farrugia states, at times the patient in her case study was “at breaking point emotionally” and in Lisa Kimpton’s case study her young patient had “self-image issues”. Stress itself can delay wound healing by influencing the secretion of proinflammatory cytokines at the wound site. As health professionals we need to assist the patient and their family to adjust to their situation by providing appropriate information, interventions and referrals to other members of the healthcare team.

As you will notice, an insert has been placed in this journal as a reminder that CPD is due by 31 December. The example portfolio has been inserted to help members recognise how you can achieve 100 points. You can photocopy this to give to colleagues or further copies can be found on the AASTN website.

There are quite a few dates coming up that need to go in the diary, including World Ostomy Day on 3 October 2009. If anyone is holding any activities please send in photographs and so on for the next journal. Brenda gives some dates for conferences in the WCET report and then in the next journal will be information on the 2011 conference in Cairns, which will be a joint conference organised by our Victorian branch and the tripartite Colorectal Surgical Society of Australia and New Zealand (CSSANZ).

Please keep submitting articles since they will get published and at the same time you will earn some CPD points. We can all learn from each others’ experience and this journal is a great way of sharing our knowledge and experiences. It is amazing to think that when the next journal gets published it will almost be Christmas! Enjoy the next few months.

We make a living by what we get, we make a life by what we give.

(Sir Winston Churchill)

REFERENCE:

AASTN OVERSEAS TRAVEL GRANT

The Australian Association of Stomal Therapy Nurses Overseas Travel Grant is open to applications in the year 2009. The grant to the value of $2,000 is awarded biennially to assist an active AASTN full member to travel overseas in order to participate in research, conferences or other worthy projects.

SELECTION CRITERIA AND GUIDELINES

The applicant is to submit to the AASTN Secretary by 31 October 2009:
• A completed official application form, which is to be obtained from the secretary.
• A letter of endorsement from the candidate’s state branch verifying their status as a full member, active within the branch.
• A letter of endorsement from the candidate’s employer verifying the candidate’s commitment to excellence in the field of stomal therapy nursing.
• A current curriculum vitae.
• A commitment by the candidate to continue working for at least 6 months after their return. A medical certificate must be supplied to the AASTN Executive if the applicant is unable to fulfil this contract due to illness or other circumstances.

In addition, the successful candidate will submit to the AASTN Executive a report for publication that acknowledges the award within 3 months of their return. The project must be commenced within 2 years of the award. Receipt of a grant automatically excludes members from re-applying for 5 years. The successful candidate will be notified within 6 weeks following the closing date.
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INTRODUCTION
Can all nurses learn to become effective leaders or is it a trait you either have or you do not? Leaders are people who can inspire others to participate in a vision. This paper will look at clinical leadership. A relevant definition will be given and then the paper will explore common models and styles of clinical leadership including transformational, transactional, situational and congruent. Characteristics of clinical leaders will be discussed. Lastly this paper will address the importance of effective clinical leaders for stomal therapy nursing and for nursing in general, applying it to the standards of stomal therapy nursing practice and provide some recommendations to facilitate clinical leadership.

DEFINITION
Hannagan (cited in Beech) defines leadership as a process of motivating others to act in particular ways to achieve specific goals by using different leadership styles. The term leadership is heard and used commonly in a business setting but not in a nursing context. Nurses are frequently given the title of manager, for example nurse unit manager (NUM). But leaders and managers have specific differences and the two can not be used interchangeably. Watson (cited in Beech) states managers use strategy, structure and systems, while leaders use staff, skills and shared goals.

A clinical leader as defined by Cook (cited in Cook & Leathard) is an expert clinician involved in providing direct clinical care, who influences others to improve the care they provide continuously. This definition reinforces the idea that managers are not necessarily clinical leaders as often they do not provide direct clinical care. Harper (cited in Stanley) adds to the definition by saying a clinical leader has clinical expertise in a specialty practice area and uses interpersonal skills to enable others to deliver quality patient care. Stomal therapy nurses (STNs) are in a prime position to become clinical leaders. Not only do they have expertise in a specialty area but they have the opportunity to influence others to improve patient care.

MODELS OF CLINICAL LEADERSHIP
Available leadership models or theories supply nursing leaders with a solid base in which to develop their leadership style. It appears that no clinical leader has or works to all the traits of one specific model, but instead they use aspects from each. Sellgren, Ekvall and Tomson found in their research study of preferred and perceived leadership styles in nursing that some managers had no specific leadership profile.

The main features of transformational leadership include vision, effective communication, enabling others, creativity and innovation and the ability to establish direction and produce change. Jarman states transformational leadership gives power to interpersonal skills and personal relationships. Transformational leadership appears to fit well with nursing in that it focuses on communication, relationships with others and personal skills. All these aspects are integral components of nursing. Frankel says the transformational model is complex but beneficial in a hospital setting in that it provides longevity in relationships between senior and junior nurses and has a positive effect on team building and communication. But Stanley found in his study, which aimed to identify clinical leaders, that visionary leadership is not a characteristic sought or identified even though this is a main component of transformational leadership.

The other commonly referred to model is transactional leadership. Bass and Avolio (as cited in Sellgren, Ekvall and Tomson) state transactional leaders are focused on structure, role expectations and the point that extra effort from staff must be rewarded. Transactional leadership aspects are evident in the nursing setting. For example, having extra days off as a reward for working X amount of days in a row. Role expectations can tie in with knowing scope of practice. Frankel says the effects of this leadership are short-lived and would suit being used in short-term project settings.

Situational leadership is another model applied in nursing practice due to its flexibility and adaptability. Situational leadership shares some common characteristics with transformational leadership, such as the importance of values and the focus on interpersonal skills. Situational leadership acknowledges that different leadership styles may be required in different situations and that they can be altered when needed. Sellgren, Ekvall and Tomson say that to use this model, leaders must be aware of their own leadership profile, the system and the task and if they can combine these points they will have the potential for success.

When Stanley did a study to identify clinical leaders he found a gap in the available leadership models that failed to explain why clinical leaders are followed or identified, so he proposed...
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congruent leadership. Congruent leadership is based on the values and principles of the leader, which is matched by their actions and is the reason they are followed.

Many leadership models exist. It appears none are right or wrong and that clinical leaders need to adapt them to suit their individual role and the situation. Leadership models are a useful tool for senior nurses and should be used as a framework to build an effective leadership style that suits the leader and their followers.

CHARACTERISTICS OF CLINICAL LEADERS

Most nurses, especially nurses practicing in a new area, will model on a more experienced nurse’s characteristics, whether they are aware they are doing it or not. Seeing common values in another nurse and respecting their way of practice provides a level for nurses to aspire to. Many clinical leaders identified by others are not aware that this is how others perceive them. In his study, Stanley found that the identified clinical leaders practised at a spectrum of levels, that the nurse manager is often not identified as a leader and those that are identified do not recognise themselves as leaders.

Cain lists five practices of exemplary leadership: model the way, inspire a shared vision, challenge the process, enable others to act and encourage the heart. Cook and Leathard identified five attributes characteristic of an effective clinical leader in their research study: creativity, highlighting, influencing, respecting and supporting. Common themes are apparent in clinical leaders. Being an effective clinical leader requires the ability to facilitate change for the benefit of the workers and patients and to be able to bring new ideas and perspectives to the table. These are characteristics leaders are more likely to be aware of in themselves and to portray.

Clinical competence and knowledge are also areas leaders are likely to be aware they excel at as they have probably actively worked to improve these areas. Clinical competence, clinical knowledge, effective communication and decision-making, empowerment or motivator, openness or approachability, role model and being visible are aspects cited by participants in a study by Stanley as factors that identified people as clinical leaders. The research found others wanted clinical leaders to be self-empowered so they could empower others. Respondents preferred openness, where values and beliefs are on show and they are not seen to be controlling of others.

The ability to follow through with your ideas and be honest with others helps clinical leaders to earn respect. Frankel states that by being dynamic, passionate, motivational and inspirational, nurse leaders can earn respect and trust from team members. Clinical leadership characteristics are many and varied, determined by who is perceiving them. Every individual looks for different characteristics in a leader to inspire and motivate them.

APPLICATION TO PRACTICE

The role of the STNs can include clinician, consultant and educator; it can involve the education of staff, advice to staff and policy and procedure development. STNs have many roles because they are an advanced practice nurse, so clinical leadership is one of those responsibilities. They can be identified as clinical leaders as they have specialty knowledge in their area of practice, they are in a position to influence others and they have developed interpersonal skills.

The Australian Association of Stomal Therapy Nurses (AASTN) states in their philosophy that STNs have a responsibility to share their knowledge with others, to encourage personal and professional growth and to participate in the refinement of clinical competencies to improve the quality of care. Many of the criteria and standards of the AASTN can be applied to clinical leadership. The most specific one is Standard 1 (professional role and development). It states STNs must develop leadership skills appropriate to the multidisciplinary healthcare environment. This standard allows the nurse to take responsibility for a high level of nursing through evaluation, reflection, continuing education, professional development, research and by contributing to the professional growth of others.

Clinical leadership is required in all healthcare settings, whether it be in the community or hospital setting. Dynamic nurse leaders are required to shape and direct clinical practice to ensure optimal patient outcomes and to meet challenges in healthcare, such as the shortages of nurses. Leadership is an integral aspect of an advanced nurse’s role in that it provides opportunities for nurses to influence development at local and strategic levels and gives them the authority to change practice.

Effective clinical leaders have opportunities to positively influence policies, which can directly or indirectly affect patients and staff. They can aid in the development of personal and professional aspects of other staff. Clinical leaders can influence many areas.

Pintar, Capuano and Rosser found a gap in the leadership abilities in their hospital. Areas identified for development included stress management, communication, human resource policy application and team building. They designed a 2-year programme to develop leadership among clinical services staff called the Ventura Programme. This programme allowed the hospital to retain clinical nurse leaders for the future and to create and sustain an organisational culture of excellence and continual development and improvement.

The Heath report (as cited in Davidson, Elliot and Daly) recognises the need for nurse leaders in Australia and recommends that governments should utilise the knowledge of nurses and that work places should support the development of nurse leaders by mentoring, coaching and by encouraging involvement. Davidson, Elliot and Daly recommend strategies
to foster clinical leadership in Australia which include:

- mentorship and clinical supervision programmes
- designated paths of career progress
- inter and intra-professional collaboration
- development of skills, research and knowledge.

These strategies would benefit all areas of nursing, allowing effective clinical leaders to be fostered.

CONCLUSION

Clinical leadership is an important dimension of being an STN. It is important that STNs recognise clinical leadership as an integral component of their role. As an advanced practicing nurse, it is their duty to maintain levels of competency that reflect clinical leadership so they can benefit other professionals and their clients. The characteristics that others look for in a leader are varied and are more specific to those who are identifying the leader. There is not one single model of leadership that appears to be more effective than another; it depends on the context in which it is being applied. But the models provide a building block that clinical leaders can use to develop their own style. It appears clinical leadership is slowly becoming more recognised in the nursing profession but definitive and consistent aspects are required between organisations. In the writer’s opinion all nurses have the potential to become clinical leaders; they just need to be given the opportunity.

REFERENCES


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

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

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

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

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

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

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

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

SELECTION CRITERIA
The decision of the judges is final and based on the following criteria:
- Presentation
- Originality
- Appropriateness to stomal therapy nursing and colorectal surgery
- Demonstrated integration of theory and practice
- Suitability for publication following the JSTA Guidelines for Authors found in current JSTA.
Management of a complex faecal fistula within a wound dehiscence using Eakin and KCI Medical VAC®

Andrea Farrugia • Clinical Nurse Consultant, Stomal Therapy, Epworth Eastern Hospital, Box Hill VIC

ABSTRACT

As a clinical nurse consultant, stomal therapy, my role does not usually include wound care. I became involved with this patient’s complex abdominal wound by referral to manage his faecal fistula. The process of trying to manage the fistula and protect the wound from faecal matter called for some creative measures and lateral thinking. A team approach (the patient included) and commitment from staff ensured continuity of dressing regimes. The use of Eakin cohesive seals and fistula pouches ensured protection of skin surrounding the wound and the prevention of further skin breakdown. The use of KCI Medical VAC® rapidly reduced the wound size, especially when the wound could be isolated from faecal matter by ‘walling’ the fistula off from the wound bed. The clinical support from KCI Medical’s Chris Mann was invaluable and helped lead us in the right direction. Fortunately, although the wound was life-threatening, we had a successful outcome.

PATIENT DETAILS AND HISTORY

The patient was a 65-year-old male, with a height of 168cm and weighing 85kg; a BMI of 30. In 2007 he was diagnosed with bladder cancer. His past history included an AMI during 2005 – two arrests at different hospitals, requiring angiogram and stents. He suffered intermittent angina on exertion and asthma, although had had no hospital admissions for the latter.

His bladder cancer had been managed by a cystectomy and the formation of an ileal conduit. He suffered leaking ileal anastomosis, wound dehiscence and faecal fistula and 6 days after ileal conduit formation was transferred to Epworth Eastern Hospital, Box Hill. He was taken back to theatre for attempted defunctioning ileostomy but this was unsuccessful due to short mesentry; therefore the fistula remained in situ in the abdominal wound. The wound was initially dressed with Betadine packs post-theatre, but the patient experienced copious ooze while in ICU, so KCI Medical was contacted and the patient commenced VAC® therapy.

Over the following few days, the VAC® dressing remained intact, with minimal drainage and the patient underwent 125mmHg continuous therapy. A dressing change one night by the night staff was necessary due to a leakage of 280ml. The patient suffered cellulitis in the right lateral abdominal area and commenced IV antibiotics. However, the VAC® was intact and the wound remained clean. The patient was being maintained with total parenteral nutrition (TPN) before commencing on diet and fluids.

Five days after VAC® was commenced and 1 day after commencing diet and fluids, the patient became febrile and blood cultures were taken. The VAC® dressing was changed, but refilled again due to excessive drainage; bile was noted to be draining from the wound site. The VAC® dressing ceased. After a CT scan, a ‘low volume fistula’ was diagnosed. TPN and IV antibiotics continued and the patient was commenced on nil orally. The abdominal wound was dressed with Exudry and combine dressings. The patient was referred to stomal therapy for management of the faecal fistula and abdominal wound. There was a request by the surgeon for pouching, ‘drip and suck’ (continuous irrigation and continuous low-grade suction). The patient had been managed by ward staff with frequent combination pad changes; this was uncomfortable for the patient and was not effective in managing faecal fluid output.

WOUND MANAGEMENT

On initial assessment in the stomal therapy department, there was a large (200x150mm, approximately 30mm deep) abdominal wound, with areas of slough and a faecal fistula which was expelling bile stained fluid over the surface of the wound. The wound tissue was red, although the surrounding skin was generally in good condition.

The patient was commenced on an Eakin vertical incision (bung closure) fistula drainage pouch (839226 – cutting edge 290x130mm), with continuous normal saline irrigation (1000ml 12-24/24 rate) and clement’s low-grade suction (30-50mmHg). We were able to maintain on average a 3-day wear time using this method.

To accommodate the wound, the pouch was cut to the maximum cutting margin and then manipulated round the wound edges. Another layer of Eakin cohesive seal was applied to the fistula pouch adhesive edges to help prolong wear time. In order for the fistula pouch to mould to shape and adhere quickly to the skin surface, the prepared Eakin fistula pouch was wrapped in a hand towel and warmed in the microwave on high for 13 seconds. Once the fistula pouch was applied round the wound, it was again warmed by the heat of the patient’s body and my hands over the adhesive edge. This was to ensure Eakin had molded into uneven skin surfaces and created a good seal. To
help support the pouch, Mefix tape was applied around the adhesive edges.

To gain access for normal saline irrigation, a small opening was created at the uppermost part of the pouch. The end of an IV line was inserted so that the saline would drip onto top of wound and the saline irrigation was set at a 12-24 hourly rate. To drain the discharge, a Nelaton catheter was inserted at the drainage outlet of the pouch and positioned just below the base of wound. This was secured in place at the outlet port with Tegaderm film. Clements suction was attached to the Nelaton catheter. As the suction commenced, the catheter was positioned with the aim of not sitting in wound to avoid trauma. An air filter was not used, the idea being that space for effluent to pool and collect was reduced.

Using this method allowed for approximately a 3-day wear time and provided skin protection, irrigation of wound and removal of output. This method assisted in cleaning the wound of slough and faecal debris. Compared with having dressing pads changed frequently or PRN to manage the fistula output, using the Eakin fistula pouch was far more comfortable for the patient. Having the output better managed gave the patient confidence in our care and lifted his spirits. The patient became interested in the management of his wound and encouraged our attempts to document his wound’s progress by photographing and tracing the wound (Figures 1.1, 1.2 & 2).

An attempt was made to have access to the abdominal wound with Eakin fistula pouch in place by applying an access window (Figure 3). As Clements suction being utilised, the access window ‘sucked’ down onto the wound, causing discomfort. VAC® foam was inserted under access window to assist with cushioning. However, this method of management was not successful and was discontinued.

Although using ‘drip and suck’, the wound was not dramatically improving, but being maintained and the decision was made to recommence VAC® therapy. Eakin cohesive seals were adhered around the edges of wound to provide a durable protection of the surrounding skin from faecal fluid. An adaptic interface dressing was placed between the wound base and the foam. The foam was cut to fit the wound (Figures 4.1-4.3).

The film was positioned and adhered over the wound. After seeking advice from KCI Medical, the suction or track pad was placed in close proximity to the fistula opening. This was an attempt to force fistula closure by maintaining high pressure
over the fistula (Figures 4.4-4.7). With hindsight, the fistula had established itself (21 days) and would not have closed using this method, but we did not have the experience to know this (Figure 4.8).

Figure 4.2. Using an adaptic interface dressing on the wound bed (31 August 2007).

Figure 4.3. Using KCI black foam, cut to fit the wound (31 August 2007).

Figure 4.4. Applying the film.

Figure 4.5. Positioning suction track.

Figure 4.6. Activating KCl VAC®

Figure 4.7. Dressing completed, VAC® at work.
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The pressure was commenced at 125mmHg. We were advised to increase the pressure in 50mmHg increments if the effluent continued at high volumes at half-hourly intervals. The aim was to repeat the process until the effluent significantly decreased, reaching a maximum pressure of 200mmHg. Unfortunately, a forced closure was unsuccessful.

The VAC® dressing began leaking faecal fluid from the base of the wound where it has been pooling, despite suction being maintained. The dressing was taken down, with a large amount of faecal sediment collecting in the wound bed. The surgeon was contacted by staff and ‘drip and suck’ using Eakin fistula pouch recommenced, providing a 3-day wear time.

The patient was taking in high protein drinks orally and TPN was to discontinue. There was some discussion with the dietician regarding concerns that Sustagen and milky drinks were precipitating in ileal fistula output; Sustagen was changed to Resource fruit beverage.

The wound was traced and now measured 15.5x9.5cm, with a depth of approximately 2cm. The fistula pouch was discontinued and VAC® dressing recommenced. Some 4 days later, the wound was traced again and now measured 13x8cm (Figures 5.1 & 5.2). VAC® dressing was attended to second daily. A week later, the wound measured 11.5x7cm (Figure 6). Further, according to the fluid balance chart, output volume appeared to be gradually decreasing in amounts of bile-stained fluid. Day by day the output decreased – 980ml (oral input)/950ml (faecal fistula output); 1250ml/1000ml; 1020ml/500ml.

Following this, the wound decreased in size to 9.5x6cm. Eakin cohesive seals were adhered to edges of the wound to protect the surrounding skin. A rectangle of foam was wrapped in film, with the surface to be in contact with the wound, lined with

Figure 4.8. Staff ‘setting’ the VAC®.

Figure 5.2. Showing the wound with VAC® dressing in place (12 September 2007).

Figure 5.1. Showing the reduction in size (13x8cm) without VAC® dressing in place (12 September 2007).

Figure 6. Showing further reduction in size (11.5x7cm) (20 September 2007).
Figure 7.1. Showing the fistula cavity clearly visible (10 October 2007).

Figure 7.2. The wound (10 October 2007).

Figure 7.3. Showing the VAC® in place after the fistula was walled off and a pouch applied over the dressing to collect the fistula faecal fluid (10 October 2007).

Eakin cohesive seal to help create a seal or barrier. The aim was to ‘wall off’ the wound from exposure to faecal fluid exuding from the fistula, to enable wound healing. Adaptic interface dressing was placed at the wound base, while the fistula was suctioned as the output bubbled up (Figures 8.1-8.5).

Foam was placed into the wound cavity. Gauze was placed where the opening of the fistula was situated. The area was covered with film. An opening in the film was created above the gauze and the gauze was extracted, leaving an opening to allow the fistula fluid to escape (Figures 8.6-8.9). A convex adhesive drainable pouch was placed over this opening to collect the output (Figures 8.10-8.12). The wound continued to decrease in size and, over the next fortnight, reduced from 8.5x5.5cm to 6x3.5cm. This regime continued until the patient went back to theatre for surgical closure of faecal fistula with formation of

end ileostomy. The wound continued to improve and decrease in size (Figures 9.1-9.3).

Throughout the management of the abdominal wound and faecal fistula, the ileal conduit also required care and the patient needed education regarding stoma care. A crease had developed where the ileal conduit had been positioned, as the stoma retracted and the opening stenosed, which made it difficult for the patient to see. Eventually the mucosa was not really visible; however, the urine was flowing and the appliance was maintaining a good seal. The urine colour varied from yellow to caramel in colour. The patient would intermittently develop temperatures which would resolve with antibiotics. Eventually, the patient developed an area of tender inflammation to the right lateral side of abdomen, adjacent to his ileal conduit. When he returned to theatre for closure of the abdominal wound and formation of end ileostomy, he had his ileal conduit reviewed (Figure 9.4). It was found that the ileal conduit had necrosed. A new ileal conduit was created above the old site, where he was able to see and manage it well.

**CONCLUSION**

The patient was able to be transferred to rehab shortly after, where I continued to visit to offer support and education regarding stoma care for his ileal conduit and ileostomy. He was discharged from rehab to home with RDNS (Royal District Nursing Service) support. We continue to correspond by email – he has been to Hamilton Island with his lovely wife in February and has sent me photos of him in the snow during June. He is making the most of his second chance and trying to live life to the fullest. He has been offered closure of the ileostomy, but, understandably, is nervous and is in no rush!

The use of Eakin fistula pouches and Eakin cohesive seals was instrumental in protecting the patient’s para-fistula skin from the corrosive effects of his fistula output. The prolonged wear time of the Eakin fistula pouches provided comparative comfort and control of the fistula, ensuring the wound did not deteriorate further. When the VAC® dressings were commenced, the Eakin cohesive seals protected the skin from the potential trauma of the VAC® dressing coming in contact with the skin surrounding the wound. The seals also provided a buffer between the fistula output and the wound edges, protecting the surrounding skin and providing ongoing comfort. In this case, the Eakin cohesive seals were used successfully to line the ‘wall’, in an attempt to separate the fistula from the wound bed; this improved wound healing time significantly.

The use of VAC® dressing helped to quickly shrink the large abdominal wound in a relatively short period of time, whereas other methods (frequent pad changes and then containing fistula and wound in fistula pouch using ‘drip and suck’) were unable to significantly improve the wound size. Although my personal experience with VAC® was limited prior to this patient, the support offered by KCI Medical ensured that the use of VAC® was effective and efficient. KCI Medical’s input in helping us develop a ‘wall’ to segregate the fistula from the wound was the turning point in this patient’s recovery and contributed to a very successful outcome.
I recorded the progress of the patient’s wound by mobile phone camera and the patient did the same. He then forwarded his photos on to his surgeon to keep him up to date. A better quality camera would have been helpful, if available; however, my mobile phone proved invaluable.

ACKNOWLEDGEMENTS

Managing this patient’s abdominal wound and fistula was quite a challenge for the patient and for those caring for him. We witnessed his courage in dealing with the pain and discomfort of his wound and the dreadful fear that he may not survive his ordeal; his determination had a huge impact on his recovery. Throughout the process, he was very much part of the ‘team’ caring for his wound. He called himself the ‘foreman’ as he had overseen all the dressings, monitored his wound’s progress (even taking his own photos) and was involved in warming the Eakin cohesive seals at each change, encouraging the staff attending to his care and cracking jokes.

The huge collaborative effort from all the staff (Emma, Morven, Angela and Ben, among others) on 5 North at Epworth Eastern was the key to this successful outcome. Claire McLellon (ANUM, breast care nurse and VAC® queen!) and I made a commitment for one of us to be available for the patient’s second daily VAC® dressing changes. This was to ensure that the dressings were attended to consistently and to help allay the fears of the patient, who, at times, was at breaking point emotionally.

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The applicant is to submit to the AASTN Secretary by 31st 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.

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

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Psychological aspects in ostomy care

Assoc Prof Julia M Thompson RN STN PhD • Practice Development Facilitator
St Vincent’s Private Hospital, Sydney NSW

ABSTRACT

The main psychological concerns of people with an ostomy have been identified through research and should be familiar to stomal therapy nurses. More importantly, they should know what to do about those concerns and their effects on the patient’s psyche. Nurses should be aware of the factors that impact on adjustment to disease, surgery and other treatments and be able to differentiate between normal and abnormal adjustment. Normal adjustment may involve coping and defence mechanisms and grief; also tied in with the surgery is the need to adapt to changes in body image. Nurses therefore need to incorporate therapeutic interventions into the nursing care plan. Some patients experience adjustment disorders and these need to be recognised and dealt with, including referral to a mental health specialist if dealing with these problems is beyond the capabilities of the stomal therapy nurse.

This paper was presented at the 5th Congress of the Asian Society of Stoma Rehabilitation held in Malaysia in 2008 and is reproduced with kind permission of Prof Katsuhisa Shindo, editor of the congress proceedings.

INTRODUCTION

Anyone undergoing surgery that may result in an ostomy should be screened to determine their specific concerns. Patients may not volunteer this information to staff, believing it to be inappropriate, so it is important to conduct interviews, teaching and counselling sessions in an environment that is calm, quiet and conducive to the disclosure of concerns and other personal matters. White identifies the main concerns as:

- Not being complete as a person.
- General impact of the stoma on their life (for example, “it rules my life”).
- No longer feeling in control of their body.
- Whether other people will hear or smell the stoma.
- Influence on intimacy and sexual function.
- Being able to deal with stoma care.

While it is interesting to know the usual concerns and to identify the specific concerns of particular patients, the most important thing is to know what we can do about those concerns and their effects on the patient’s psyche.

PSYCHOLOGICAL ASPECTS

A common saying among stoma nurses is that one must look after the ‘whole’ not just the ‘hole’, so patients cannot ever say “My stoma had excellent care but I did not”. We must see those in our care as whole people who happen to have an ostomy and not regard them only as ‘stoma patients’ or ‘ostomates’ – such labelling tends to narrow our perceptions and distract our attention from the whole picture of the circumstances that the individual is facing.

The ostomy is only a part of the picture. The individual is facing much more, such as a diagnosis, effects of disease or treatments and whatever is going on in their lives. We may not identify an individual’s concerns unless we ask them and then we must listen carefully to their answers, to determine exactly what they are telling us. For example, a young woman with a 2-year-old child may have a diagnosis of familial adenomatous polyposis and, while the stoma is a concern, it may be of lower priority than her worries about early death, passing on genes for a hereditary condition to her child and worries about whether she should have other children.

Each person is a unique blend of many factors. Each factor impacts on their adjustment to disease, ostomy and other treatments and can include:

- Age and developmental stage.
- Culture and ethnicity.
- Religion.
- Personality.
- Past experiences or current circumstances.
- Pre-existing or co-existing psychological or psychiatric conditions.
- Other economic and psychosocial factors.
- Expectations about what healthcare staff should do or be.

Nurses may have a general knowledge about how developmental stage, religion, culture and/or personality may affect adjustment to disease, an ostomy and other treatments. However, together with this general understanding, they need to be flexible enough not to stereotype people. For example, some people may call themselves a Christian, Muslim or Jew, but they may not actually practise their religion. The only way one can know what is important for an individual is to ask them. A simple open-ended question will usually gain that information, such as “Are there any things about your beliefs, religion or culture that we need to
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know when caring for you?” or “If we ask you to do things that are contrary to your beliefs or values, please tell us”.

Although it usually takes months, most people have a ‘normal’ adjustment to having surgery resulting in an ostomy, but some do have adjustment disorders. According to White, there is a greater risk of having psychological problems in certain circumstances, including those people with preoperative psychiatric problems, inadequate preoperative preparation, increased physical problems with ostomy (such as leakages and sore skin), negative beliefs about stomas, negative or strong beliefs about loss of control of body functions and/or decreased stoma self-care efficacy.

Most people do have a ‘normal’ adjustment, but during the process they may utilise various common coping mechanisms such as humour, crying, shouting, talking things over, overindulging in food, alcohol or cigarettes, deep breathing or meditating. It is useful to ask people how they usually cope with stressful times and whether they believe they need any assistance with their current stresses. Clearly some coping mechanisms are more advantageous and healthy than others and these ought to be encouraged above the less healthy ones. Sirotu’s work on therapeutic interactions will be discussed later in this paper. A useful study by Tusek et al. validated the use of audiotapes with a soothing voice and soft music to encourage people facing elective colorectal surgery to relax. Techniques of guided imagery are now relatively common and suitable audiotapes are available from many sources (including Australia Post).

People also commonly use various defence mechanisms to try to protect themselves from the threats imposed by their illness or surgery. Defence mechanisms include mechanisms to move away from the problems (such as withdrawal, denial, evasion, fantasy, regression), mechanisms to move against others to discharge the tension (such as aggression, which may be disguised as negativism, criticism and being uncooperative) and finally mechanisms to move towards others so that they may solve the problem (such as over-dependency and illness).

These mechanisms are commonly used to deal with all sorts of stressful circumstances and sometimes we must allow people to use such defences, recognising them for what they are, not stripping them away to leave the person defenceless, even though their words or behaviour may leave us feeling uncomfortable. For example, in circumstances where a person is very angry, it is appropriate to say, “I can see that you are very angry … many people feel angry in these circumstances. Would you like to talk about your feelings?” If they say no, then try saying, “Would you prefer me to come back later when you may be feeling more settled?” Most people work through their feelings, talking them over with staff, family and friends. If they are having problems doing this then it is appropriate to refer them to a counsellor.

Many people are going through a process of grief and mourning over the permanent loss of their normal body structure and function and possible temporary or permanent loss of health, independence, dignity, control and various other things. Some people experience grief preoperatively, called ‘anticipatory’ grief; after surgery it is simply called grief. Further, ‘uncomplicated grief’ may lead to denial, sadness, bargaining and social isolation and those experiencing it need to have therapeutic interactions with family, friends and healthcare workers. ’Complicated’ grief (which is delayed grief or failure to grieve) may lead to clinical depression or extreme anxiety. Such people may, in addition, need referral to expert counselling, if it is available.

Tied in with surgery and the formation of an ostomy is the notion of body image. This is the mental image we have of ourselves and how others see us. Salter has made a major contribution to understanding the nurse’s role in assisting people with altered body image. She summarises a model by Price who proposes that we have “body reality” (how the body really is – it has a stoma), “body ideal” (how we’d like it to be – as it was before surgery) and “body presentation” (what we present to others and how we maintain it in grooming, to look normal). Price suggests that supportive care is directed to any of these concepts. For example, helping the person to change their pouch supports body reality, removing a drain helps support the body ideal and encouraging a person to wear attractive clothes supports body presentation.

Further, Salter’s work is very useful for nurses because she describes things nurses can do and say to facilitate patients’ adaptation to changing body and changing body image. Many of her ideas are simple and include:

- Encourage expression of feelings.
- Give appropriately timed advice, information and counsel.
- Be available.
- Admit when you have no answer … but find someone who may have one.
- Let them choose a confidant.
- Emphasise their positives.
- Affirm their self-worth.
- Engage them in participation – this empowers people.
- Help them to set short- and long-term goals.

While body image develops slowly and adapts to gradual changes, stoma surgery is a sudden change and it takes about a year to adjust. Sprangers cites research demonstrating clear relationships between concern over stoma-related issues and feelings of lowered self-esteem, body image and depression and proposes that these are more pronounced in men.

Most people do adjust through interactions with family, friends and healthcare workers who incorporate therapeutic interventions into the nursing care plan. Management of psychosocial health starts with good preoperative preparation, which informs the patient about the procedure and also about sensory aspects. The preoperative interview is a time to identify risk factors for psychosocial problems and, if any are identified, then relevant members of the team should be informed so a plan can be made to avoid or reduce problems.
Preoperative identification of concerns should be followed up with strategies to assist the patient to deal with those identified concerns. Strategies include active listening and therapeutic communication. It is also important to undertake interventions to address the physical problems such as leukages, because it is difficult for a person to deal with psychological problems when physical problems persist. Self-care efficacy is important for self-esteem and may require skills to be taught in steps with the aid of a confidence diary that documents and reminds the person of how well they are progressing. Psychological problems and symptoms should be monitored along with the physical aspects during post-discharge visits and may be the reason for the outpatient appointment.

It is important to openly discuss and deal with negative thoughts and, if the person is not making progress, to refer them to a mental health specialist. In addition, many people gain support from visits by well rehabilitated people who have undergone similar surgery, or by attending support group meetings.

It is important for nurses caring for people with a stoma to distinguish between education, counselling and therapeutic interventions. Education is the process whereby one helps the patient to understand their condition and the treatments involved. From the preceding discussion, it is clear that education on its own is not enough. Counselling is the process whereby a person is helped to cope with his condition and the treatments involved. Proper counselling is usually done by a qualified counsellor. What nurses usually do is something similar called therapeutic communication or therapeutic interaction. This is well described by Sirota 3, 4 who gives many examples whereby open-ended questions facilitate discussion to help people gain insight into their unconscious and to cope with their feelings and situation. Some examples of open-ended questions are “Tell me more about ...” and “You were saying ... what is it that you were specifically worrying about?”

Common skills include listening actively and empathetically to determine exactly what the person is trying to communicate. Expect strong feelings – they are part of normal coping mechanisms and are not to be interpreted as being aimed at determining exactly what the person is trying to communicate. Sirota 3, 4 discusses cognitive behavioural interventions whereby patients are assisted to have more realistic perceptions of circumstances. She describes a technique whereby the person is asked to describe the worst possible scenario they are fearing (such as a bag dislodging during a social function) and then working through or rehearsing what they would do. An example of this is the ‘emergency kit’ provided by some stoma nurses when they teach a person how to change their bag in a public toilet. The general idea is that the patient will then acknowledge that, although a bag may dislodge, it is not a catastrophe because there is something they can do to remedy the situation. This helps them to re-frame fears more positively.

Sadly some people do experience adjustment disorders. These include panic disorder, depressive disorder, generalised anxiety disorder, social phobia and post-traumatic stress disorder. It is very useful for nurses to be able to identify these disorders and White 1 gives a comprehensive list of the main symptoms of each of the disorders and suggested screening questions to assist with their identification. It is useful for nurses to be familiar with these because such patients need timely identification and referral to a mental health specialist as they are probably requiring treatments that are beyond the scope of the nurse and surgeon.

Some people develop other severe disorders related to their inability to adjust to their ostomy. For example, the need to focus on the ostomy to manage it may lead to shame, embarrassment and humiliation. Others cannot cope with the loss of control. These feelings may dominate their lives, causing them to develop psychiatric problems. These are beyond the scope of this paper, but are well described by Stern 8, a psychiatrist who works at St Mark’s Hospital in the UK and specialises in people with psychiatric issues related to bowel disorders.

**CONCLUSION**

In summary, it is important to recognise that the psychological aspects are as important as the physical aspects of dealing with an ostomy. One needs to combine knowledge about human characteristics and psychological issues. Sometimes the most significant thing is to be there, available to listen empathetically and carefully, to accept the person’s feelings and ask open-ended questions to encourage more discussion, even when it makes the listener uncomfortable. Use techniques of therapeutic interaction to assist the person to work through their concerns. If the person has symptoms of adjustment disorder, then continue to do what you can but also seek extra help from a mental health specialist.

**REFERENCES**

INTRODUCTION

One of an ostomate’s rights is to “receive experienced and professional medical support and nursing care in the preoperative and postoperative period both in the hospitals or community”. However, being an ostomate in a big archipelago country such as Indonesia, with a population of greater than 200 million people and only 29 enterostomal therapy nurses, is a challenge. Finding the right person to help seems difficult, especially if the healthcare provider does not employ an enterostomal therapist.

CASE

A 56-year-old female with an ileostomy presented to the clinic with irritation of the peristomal skin and constant leakage from her stoma bag. In Indonesia, patients can self-refer even if they have had their surgery elsewhere. This lady had heard of the clinic and decided to see if the staff could support her.

The ileostomy was created in another hospital. No other history was known except colorectal cancer. On presentation, the patient used a one-piece, self-modified stoma bag. She and her family had tried many ways to prevent the bag from leakage, including the use of paste, powder and even coconut shells as suggested by her doctor. This problem with continual leakage had made her dependant on her family and had confined her to the home for about 1.5 months. The clinic visit was her first time out of the house since her discharge from the hospital.

 MANAGEMENT

Initial assessment revealed a peristomal disorder (irritation), leakage, an inappropriate self-modified stoma bag and a lack of patient education and information about using products correctly from the previous healthcare provider.

The patient brought her own products of paste, powder and the one-piece drainable stoma bag, which was hydrocolloid-based. To prevent further costs to the patient, the enterostomal therapy (ET) nurse in the clinic utilised these products in the treatment plan.

Management included the application of a lightly dispersed stoma powder to the irritated area, followed by filling the shallow surface surrounding the stoma with the stoma paste. The one-piece drainable bag was applied correctly and the patient and her family were educated regarding appliance application.

After 4 days, the patient and family visited the clinic for the second time. The ET nurse noticed that the irritation around the peristomal skin had healed completely. The bag had been changed by the family without any incidence of leakage. The patient had been shopping for the first time since discharge from the hospital and had felt confident and comfortable. During this second visit, the patient expressed a willingness to learn how to change the bag by herself and this was achieved with minimal assistance.

DISCUSSION

Even though the availability of a wide range of stoma products presents many benefits for nurses to provide the best stoma care, this will not be helpful to the patient without knowledge and education of management.

In this case, even though the patient was already using a one-piece, drainable stoma bag, paste and powder leakage problems had prevailed because of a lack of education on ‘how’ best to apply these products. Therefore, the patient had stopped using the bags and reverted to ‘home-made’ models. In the clinic, the ET nurse explained the cause of leakage and the effect of it on peristomal skin and demonstrated application techniques. The only product change that was made was to change the stoma paste from an alcoholic base to a non-alcoholic base.

CONCLUSION

Managing a stoma is not only about using a good product. The knowledge to use it appropriately as well as family education will result in a better quality of life. Healthcare providers in Indonesia and around the world must continue to invest in stoma nurses for better patient management.

Special thanks to all the AASTN 37th conference committee – Lorrie Gray, Keryln Carville, Robyn Simcock, Helen Simcock and others – for supporting us – Arum and Sofia – to attend the wonderful AASTN 37th conference and provide us with clinical placement opportunities. We learnt a lot of things while we were in Western Australia.

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INTRODUCTION
Pyoderma gangrenosum is an inflammatory, ulcerative skin condition associated with arthritis, inflammatory bowel disease and hepatitis. It presents with painful lesions which start as small pustules and quickly ulcerate and it can be difficult to treat 1.

DESCRIPTION OF PATIENT
This case demonstrates the outcome of using a nanocrystalline silver dressing on the skin lesions of a 17-year-old girl with probable pyoderma gangrenosum. She had suffered with skin lesions all over her body for 14 years. Miss C’s past history included IDDM, arthritis, mouth ulcers and numerous skin lesions. The lesions were very red in appearance and were painful. The lesions would ulcerate, produce thick green exudate and then heal, leaving an obvious scar.

Her diagnosis had been difficult to determine and she had been reviewed by specialists in other Australian states over a period of 14 years. Many specialists concluded that she was probably suffering from pyoderma gangrenosum. Diabetes added a complexity in relation to her treatment.

As a teenager, Miss C has had to deal with her self-image issues, using clothing to cover the areas of her body which are affected. Consequently she had been too self-conscious to be involved in activities such as swimming and so on.

CLINICAL HISTORY
Case note entries were as follows:
• 18 April 2006 – tiny ulcerations, antibiotics, tetracycline. Possible actinic prurigo.
• 8 May 2007 – constant ulcers, weeping green pus, long-term antibiotics, salt baths, hydrocolloid dressing.
• 13 November 2007 – trialling different creams, some improvement. Hyper-pigmented scars.
• 12 February 2008 – ulcers persistent, possible pyoderma gangrenosum. Minomycin experiencing less ulceration.

My first review of the patient was on 13 May 2008. She had a skin lesion 5-6mm in diameter on her back. She stated the area became wet, increased in size and drained large amounts of green pus. A hydrocolloid dressing was too moist and lifted off.

TREATMENT
We decided to apply a nanocrystalline silver dressing covered with a white porous tape on Miss C’s ulcers. This management was easy to control while Miss C was an outpatient. Miss C was able to have a shower each day to moisten the dressing and reinforce the tape as required. The dressings were easily applied by the patient when further ulcerations presented.

A follow-up telephone call 9 days post-initiation of treatment showed some improvement, no green pus, quicker healing and a minimal increase in the size of the ulcer. At her follow-up appointment on 14 July 2008, it was seen that her dressing regime had worked well. The ulcers were smaller, not as deep, granulating well and there was less scarring. Ongoing management includes following the current dressing plan. The tape has been changed to a tan colour so it is less obvious on Miss C’s skin and is working well.

CONCLUSION
After many different topical applications and dressings over 14 years, Miss C and her family had come to the conclusion that nothing was going to help. In May 2008 Miss C trialled a nanocrystalline silver dressing on her skin lesions. The outcome has been a marked reduction in the size of lesions with minimal exudate production, reduced scarring and increased comfort for Miss C. Ease of application and care of the dressing has also provided a favourable outcome.

REFERENCES

BIBLIOGRAPHY


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Cairns 2011

Helen Nodrum • Victorian Branch, Conference Committee

TRIPARTITE CONFERENCE

The Victorian branch is pleased and excited to announce to all members that we will be convening a tripartite conference in 2011 with the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The conference will be held at the Cairns Convention Centre.

Since our AGM in Perth last March, the Victorian branch committee has met on many occasions, sought independent advice and taken our agenda to two committee meetings with the CSSANZ, the end result being that a memorandum of understanding or contract has now been signed to run this inaugural joint meeting – we are hopeful that this may well open the door to further such events in the long-term future.

The conference dates are 4-7 July 2011 inclusive. The official joint meeting will commence with a welcome reception on the foreshores of the Cairns esplanade on Monday 4 July in the evening. However, if delegates would like to attend the CSSANZ programme commencing on Monday morning, then the registration is inclusive of this day. The AASTN programme will commence on Tuesday 5 July. There will be concurrent, joint sessions and we will combine some programme sessions as a joint meeting.

There is a diverse range of accommodation in Cairns from five-star hotels to backpackers-style, all within 5-10 minutes’ walk of the Convention Centre. Accommodation packages will be negotiated by the conference secretariat, Mike Pickford of ASN events. Stay tuned next year for special offers. It is strongly recommended that, once accommodation packages have been made available, you book early to achieve the best rates.

SO WHY COME TO CAIRNS IN JULY?

Cairns is a vibrant, tropical destination, fringed by two unique, environmental treasures. These are the world heritage-listed Great Barrier Reef and the Wet Tropics Rainforest. July is high season for tourism, school holidays and the best weather imaginable – 28°C during the day and it drops to 16-18°C at night. The lifestyle of Cairns is relaxed and laid-back; it is the perfect place for a holiday. It has an excellent Convention Centre, dedicated to providing the best venue for an event such as this. We encourage delegates to bring their families and, for this reason a partner’s social programme will be arranged.

Although the conference programme concludes on Thursday 7 July, a Great Barrier Reef tour will be organised for Friday 8 July. If sufficient numbers are gained, then the option of having our own boat and tour may be possible – this day is highly recommended and will be a lot of fun.

A website has been established and this will be updated regularly as the event is organised. Go to www.tripartite2011.org This site will have a link to the stomal therapy website so plans will be accessed through our channels as well. Go to www.stomaltherapy.com

The preliminary tripartite colorectal surgical programme may be found by using Google and searching for tripartite 2011 program.

See you in Cairns in 2011.
What is the consensus?

How do you organise preoperative assessments?

Assoc Prof Julia M Thompson RN STN PhD •
Practice Development Facilitator, St Vincent’s Private Hospital, Sydney NSW

Do you have any resources, tools, charts or systems you can share with your colleagues? Please send them to the Editor, Theresa Winston, whose address appears in the front of this journal, for this new regular feature.

ASSESSING THE ‘WHOLE’ AS WELL AS THE ‘HOLE’

Assessment is a primary nursing skill forming the basis of the so-called ‘nursing process’ – assessment, planning, implementation and evaluation. A comprehensive assessment underpins comprehensive management. Ideally, stomal therapy assessments should begin before admission, as soon as possible after the decision for surgery has been made and should be redone each time there is a change in circumstances. This discussion focuses on preoperative assessment.

Before you even speak with the patient, read their notes or speak with the medical officer and find out about the history, diagnosis, prognosis and plan. Next, find out what the patient already knows and understands, how they feel about it and what needs to be explained in more detail. Then you may begin to educate, dispel myths and calm fears. You may need to replace outdated or exaggerated stories about ‘wearing a bag’ with factual information, but you won’t know this unless you give them a chance to tell you what they already ‘know’.

The nature of this work requires that it be undertaken in a quiet, private place, free from distractions. Use open-ended questions and encourage the patient to talk. Be organised, systematic and purposeful with the questions you ask and document relevant information for the rest of the team so they may also use it to optimise patient care.

Here are some examples of some useful open-ended questions:

• “Tell me about your illness …”
• “What are you expecting to happen?”
• “Have you ever known or heard of anyone with a stoma or colostomy bag? How did they seem to you?”
• “Have you ever had a major illness or operation before? How did you cope with that?”
• “Can you tell me about yourself …”
• “What sort of work do you do?”
• “Do you live alone or is there someone else at home with you?”

Preoperatively, one aim is to establish a baseline and to discover actual or potential problems so individualised care can be planned, implemented and evaluated. These may be in relation to physical or mental differences or disabilities, for example in relation to vision, hearing, manual dexterity, motor skills, skin sensitivities, allergies or any other challenges. Examples of questions include:

• “Do you have any problems with hearing or seeing things?”
• “How has your stroke/illness/accident affected your ability to care for yourself?”
• “Are you able to manage doing up small buttons on your clothes?”

Find out whether there are any issues relating to culture, language or religion. Useful questions include:

• “Are you able to read English?”
• “Is there anyone you want included in discussions when decisions are being made?”
• “Is there anything you want us to know about your beliefs? Is there anything we need to do or to avoid in relation to your beliefs?”

It is wise to assess their cognitive abilities, disabilities and needs as soon as possible. Furthermore, assess what they need to know now and their level of readiness to learn:

• “How much information would be helpful to you right now?”
• “What do you already know about …?”
• “How do you learn best?” (diagrams, demonstrations, didactic instruction, written information, video).

Develop a collection of resources that incorporate various modes of teaching. Use whatever means they indicate.

It is not useful to ask someone “Do you understand what I am saying?” How would they know? Rather, ask them to explain back to you, in their own words, what you have been telling them. Then you can ascertain whether they have understood what you were saying.

USEFUL READING


The following report is from The Coalition of National Nursing Organisations (CoNNO) meeting held in Melbourne on 15 May 2009.

Representatives from 50 nursing specialty groups attended this meeting, presenting reports and engaging in discussion, which will help steer the future of nursing and midwifery in Australia.

Peter Carver, executive director for the National Health Workforce Taskforce, discussed the key directions of this newly established government body, being National Workforce reform and to establish an agency to implement these reforms.

The taskforce has a $1.55 billion budget and will provide the key source of policy advice to ministers for national reform.

The agenda for this has three arms:
1. Innovation and reform.
2. Research and workforce planning.
3. Education and training.

There was further discussion around the need to look at different training options as traditionally this has been done in the acute environment; however, this no longer meets healthcare needs.

To address the shortage and increase the numbers of nurses, doctors and some Allied Health staff, there is ongoing dialogue with universities to increase their annual intakes. This will, in turn, impact upon the availability of clinical placements and present challenges to address this.

As new roles emerge in the healthcare setting, there is a growing need for a national evaluation framework.

There is a need to improve databases to enable national standards and capture the number of nurses, midwives and doctors registered in Australia. Currently the information collected is state-specific and there is no correlation between the states.

Key stakeholders representing all groups will form the membership for advisory groups and deans of nursing have been asked for nominations www.nhwt.gov.au

Chief Nurse and Midwifery Officer for Australia, Rosemary Bryant, was appointed to the above position in July 2008. She summarises her position as a government official acting as an advisor and is involved in any issue that has a large nursing involvement.

Since her appointment, she has undertaken a review of maternity services in Australia; the results of this fuelling the recent budget announcement endorsing nurse practitioners and advanced practice midwives with MBS and PBS status. She has also been an advisor to the Organ and Transplantation Authority and was heavily involved in the process for national nursing registration, which is effective from 1 July 2010.

Currently Rosemary is working on the implementation of a nursing review.

PRIMARY HEALTHCARE WORKING GROUP

This group has produced a booklet titled Primary Healthcare in Australia – A nursing and midwifery consensus view April 2009. This publication is written for nurses, midwives and others, who influence health policy in Australia and it outlines a vision for primary health care for people in Australia. Nursing and midwifery organisations in support of this consensus view have been asked to contact CoNNO.

POSITION STATEMENT ON UNDERGRADUATE NURSING EDUCATION IN AUSTRALIA – A DRAFT

This draft document has been prepared by CoNNO and supports nurse education at universities. It addresses academic enquiry, professional competencies, inter-professional education and academic scholarship. Comments to this document need to be forwarded to CoNNO within 2 weeks.

GENERAL DISCUSSION

There was mention of the ICN conference to be held in May 2013. It is highly recommended for nurses to attend this conference.

Two resignations from council have been received, namely Robyn Cook and Cynthia Smythe. Both were thanked for their contributions and nominations for these positions will soon be posted.

During the course of the meeting a message was received stating that The National Nurses Registration Board will be based in Melbourne and evidence of Continuing Professional Development (CPD) will now be required to fulfil national registration.

The next meeting will be held in Sydney on Friday 9 October 2009.
Greetings to my AASTN colleagues. I do hope you are continuing to enjoy your role in stomal therapy and/or wound or continence care and the challenges you experience are not too insurmountable!

In our roles, especially when we work autonomously, it is good to be able to network with our colleagues to assist us to find answers to often difficult problems. We can do that in many different ways, one of which is by attending conferences in our specialty. An opportunity to do this is coming up in December this year with the 3rd Asian Pacific Enterostomal Therapy Nurses Association (APETNA) conference being held in Guangzhou, China, 11-12 December 2009. Then, next year in June is the World Council of Enterostomal Therapists (WCET) Congress being held in conjunction with the WOCN (Wound, Ostomy, Continence Nurses) in Phoenix, Arizona. Watch for the call for abstracts on the WCET website after September. I would love to see a number of you in Phoenix as we usually have a good representation from Australia.

As you are now aware, the place the Australian members voted for the 2012 WCET congress was Adelaide. A committee is in the process of being appointed and the conference details worked out in conjunction with the WCET Executive. Exciting times lay ahead for us as this will be the first time this congress has been held in the Southern Hemisphere for over 25 years. Thank you to all those who submitted a vote.

I would like to thank the Gold Coast Entertainment and Convention centre personnel and the Adelaide Convention centre personnel, who put in many hours preparing the bids for the Congress, that were of a very high standard and at no cost to us.

Don’t forget to check out the WCET website at wcetn.org and look for the links to the bulletin. The next bulletin will have a report and pictures from the AASTN conference, which was held in Perth earlier this year. If you would like to become a member you can join online at that website.

Please contact me if you have any problems.

Visit the AASTN website
www.stomaltherapy.com

AASTN: 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

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First may I say that it gives me great pleasure to have an article included in your journal and how grateful I am for the support I am receiving for our projects from stomal therapy nurses (STNs) in Australia. Without your help we would not have achieved a great proportion of our results so far.

The Australia Fund was set up in 2001 by the Australian Council of Stoma Associations (ACSA) to help unfortunate ostomates around the world who are worse off than we are.

The fund has a management committee of four people: the president of ACSA, the treasurer of ACSA and two members from the International Ostomy Association, both from Canada. It is funded by ACSA member associations, donations from suppliers and association members.

In 2005 I was elected to the position of relief coordinator at the Perth national conference and, since then, have overseen parcels from many Australian Stoma Associations and STNs going to Indonesia, Fiji and Ethiopia. We are now ready to give the OK to send shipments to Nepal after hearing a plea from Shanti Bajracharya, which was supported by Liz English from the Royal Adelaide Hospital.

Shanti’s application for support from Nepal tells us that she has been running the stoma clinic for 14 years. Patan Hospital has 430 beds and she oversees 3000 ostomates. Shanti has run out of urostomy bags and fistula bags, but will be grateful for anything.

I must say that, after having received so much help from the STNs in Australia, I was very disappointed with the results in Ethiopia. I know that the trial parcel did not get to the contact I designated as the receiver. Parcels have been sent to Fiji; however, I received no feedback that the last one we dispatched had arrived, so, until the political climate settles down there, it has been put on hold at present.

Indonesia is very successful, due to the efforts of Dr Dieta Parengkuan, coordinator for the Indonesian Ostomy Association, under the umbrella of the Indonesian Cancer Foundation, ensuring that supplies are distributed to those most needing them and giving me a regular report as required by the Australia Fund.

Carmen Smith, STN, and I are in contact regularly. On one of her trips to Indonesia, she has seen our supplies and helped sort them out over there. She has also seen that some are now going to a clinic in Bogor.

The Australia Fund has also provided a part-training scholarship for a nurse who has been attending an STN course in Jakarta.

Approval has now been granted by the Executive of the fund to send Robin Gill, the Australia Fund administration coordinator to Indonesia with an STN from here later this year, to help STNs form ostomy associations on return to their region after their training in Jakarta. This will also give us the opportunity to see firsthand the effectiveness of our project. Robin is from the WA Ostomy Association and is well versed in the running of that association.

I am pleased to say that a number of STNs have been in touch about making donations of their surplus supplies to one of the Australia Fund projects. The arrangements for these donations are that they be posted directly overseas by the STN unless one of the local ostomy associations are involved in sending parcels on behalf of the Australia Fund. The posting process needs to be very exact to meet Customs procedures overseas, but I am happy to guide anyone interested in making arrangements. Once I have cleared the contents of the parcel, the Australia Fund reimburses the postage costs on presentation of the receipts from the post office.

**ELECTRONIC SUBMISSION OF MANUSCRIPTS TO THE JOURNAL**

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

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- Go to the publisher’s website: www.cambridgemedia.com.au
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- 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 Capital Territory

As I write this we are 1 week away from our AGM. In Canberra and the surrounding areas we have seen an increase in interest in stomal therapy. Congratulations to Vicky Browne, who completed the Graduate Certificate in Stomal Therapy Nursing through the College of Nursing. Vicky works on the colorectal ward at Canberra Hospital, so I am particularly pleased to see another qualified STN in the hospital. Well done to you Vicky. The surrounding areas of Greater Southern Health have also seen a couple of nurses return to stomal therapy or express an interest in postgraduate studies.

The meetings in Canberra continue to be held every 2 months. The next meeting will be in September. Feel free to contact me for any more information.

Kellie Burke

New South Wales

Hello everyone. This will be my last report as the NSW state representative as we are due to hold the AGM in August and I am standing down.

It has been an eventful year in NSW as stomal therapy nurses are retiring. The latest escapee was Susan Dunne. The AASTN (NSW branch) held a lunch for Susan at the Watsons Bay Hotel where, despite the inclement weather, a good time was had by all and Susan became the proud owner of 2 glass elephants!!!!!!! Susan has a passionate interest in the animals.

Students are just in the process of finishing their distance education Graduate Certificate in Stomal Therapy Nursing through the College of Nursing. I have just been told that there are 40 people enrolled for this year mainly from Australia but some overseas students.

We continue to have bimonthly meetings with an education session prior to the business meeting. These start at 17:45 and are held at Royal Prince Alfred hospital in the seminar room on the 8th floor:

On Tuesday 4 August Dr Katelaris will be speaking about penile implants.

On Tuesday 6 October and Friday 4 December we will have dinner afterwards in a restaurant in Newtown.

Carol Stott

Queensland

The Gold Coast STNs again held a very successful afternoon seminar on Saturday 20 June, at the Gold Coast Ostomy Association building at Arundel, to celebrate Stomal Therapy Week. Approximately 100 people attended, which is the largest group to attend this seminar. This year was the 3rd time they have conducted this session. Ostomates and STNs travelled from Lismore to attend as well. The trade supported the afternoon with their presence and supplied a lovely afternoon tea.

Frank Hughes from the Queensland Cancer Council spoke on the services available to Gold Coast folk, Bill Tyrell from the Northern Rivers area described the preoperative counselling for an ileal conduit to the group and Kim from Vision Australia, Southport, showed the ostomates a range of glasses, watches, clocks and other aids available for the visually impaired. The feedback from the afternoon was very favourable and the ostomates also commented on the attendance of the STNs.

Shirley Jones, Community STN, is researching “quality of stoma care in the nursing homes”. As part of this project the Queensland AASTN is having a workshop in October to review the education available and collate an education package to meet their needs. This is our main project for this year as we are receiving a lot of feedback about the lack of education and poor management of stomas in nursing homes. Our meetings continue bimonthly with good attendance. We have a presentation on case studies at our September meeting. Our email has also been an excellent tool for problem-solving issues around the state and discussing feedback at our meetings.

News from around the state

We congratulate Theresa Winston for her excellent production of the first journal from Queensland. We are very appreciative of her expertise and involvement.

Congratulations to Emma Vernon on her new position as stoma therapist at Prince Charles Hospital, Chermside. Emma worked previously at Ashford Hospital, Adelaide.

Pam Das has also recently arrived from Britain and is doing some contract work as an STN at Selangor Private Hospital, Nambour.

Jan Denyer had a very surprised phone call recently from a long-lost cousin from New Zealand. He had Googled her name into the computer and her details came up from the stoma therapy website. This is another useful benefit of this website and a reminder for all STNs to check that your information is recorded correctly.

Helleen Purdy
**Tasmania**

Hi from Tassie, where the winter woollies are well and truly out and in full use!

We have been keeping quite busy in stomal therapy, with new patient numbers significantly up for the same time last year.

To keep us motivated we have enjoyed a stomal therapy workshop come retreat in the beautiful Hepburn Springs in May. Some of us accepted a kind and very much appreciated invitation from the Victorian branch to join them on the retreat, which was great!

We hope to reciprocate and organise a similar workshop in Tassie next year.

Congratulations go to Carolynne Partridge, our state secretary, for completing her Graduate Diploma in Nursing. Well done Carolynne. Carolynne has also accepted a part-time position as the continence nurse advisor at the Launceston General Hospital (LGH), so we wish her well with this new endeavour.

Study continues for Sue, Teena and myself, as we continue to encourage and support each other to our individual finish lines.

Both Sonia at the Royal Hobart Hospital (RHH) and I at the North West Regional Hospital (NWRH) have presented stomal therapy education evenings on behalf of the ANF in May. Both had good attendance numbers and received positive feedback.

Sonia and Vanessa are working in conjunction with a colorectal surgeon at the RHH to present stomal education and management of complications to general practitioners, which sounds like an interesting initiative; well done girls.

Branch meetings continue successfully via video link. At our next meeting our education component will be presented by Mr David Lloyd, colorectal surgeon from the LGH, speaking on colorectal cancer and inflammatory bowel disease (IBD).

Hope this finds you all keeping warm in these winter months and keeping flu-free hopefully.

Cheers for now,
Tracey Beattie

**Western Australia**

Our clinical updates continue, with the most recent being a presentation by Smith & Nephew on the Versajet™ exact hydrosurgery system. It was interesting to see this new technology and to have the opportunity to practise using this system. We will watch its progress as it is utilised more in our various workplaces.

We are currently planning our country education and would welcome information from any areas that are in need of updating on stoma management. Our experienced stomal therapy nurses will travel to specified areas to deliver education or workshops to nursing staff and ostomates. If you would like to discuss the possibility of having a programme in your hospital, please contact our branch secretary Shannon Tassell.

On 24 October our professional development day will be held at Mercy Hospital, Mount Lawley. The programme is currently in progress and further details will be available on the AASTN website in the near future. This is a good opportunity to update or share your knowledge, meet colleagues and trade representatives. Please mark it in your diaries.

I would like to take this opportunity to acknowledge Helen Simcock, who has recently resigned from our committee. Helen has been an active member of the AASTN for many years and has given generously of her own time in the interest of stomal therapy nursing and ensuring ostomates are receiving the best nursing care available. She was employed as a stomal therapy nurse at both Royal Perth Hospital and Mercy Hospital, she volunteers at the WA Ostomy Association every week and has been an active member of our branch. Helen’s contribution to stomal therapy nursing has been exceptional and we wish her well in retirement.

Regards to all,
Carmel Boylan

**South Australia**

The cooler weather has brought some dampening down of activities at the AASTN (SA branch) but there have still been plenty of events to get involved in. In the last 3 months the main highlight has been the South Australian bid for the 2012 WCET conference and a meeting was held to discuss the bid and brainstorm ideas to increase the attractiveness of our state’s tender. Hopefully attending members will have helped to achieve this goal.

Planning for the annual fund-raiser quiz night is well under way and is to be held on 28 August. This is usually well-attended by members and is an evening of fun for all involved.

The Nurses for Continence Interest Group (SA Branch) organised its study day on 30 May this year. It was a very informative day, with a good array of speakers and interesting topics ranging from colorectal surgeon Dr Liz Murphy’s talk on the enteric nerve supply and neurogenic changes to nurse practitioner Libby Birchmore’s presentation on cardiovascular disease, fluid shift and impact on incontinence. The day was well-attended by STNs from country and city sites. On 15 June the Crohn’s and Colitis Association of SA held a series of short talks by gastroenterologists and a colorectal surgeon. The topics ranged from surgical management to medication issues and endoscopic or radiological investigations. This seminar night was well-attended by the public and by several STNs wanting to increase their knowledge in this area. Finally, I wish to mention that the
president of our South Australian branch, Lisa Kimpton, has been overseas in Canada. She has been increasing her knowledge of paediatric stomal therapy by attending a camp for teenagers in this country and we wish her well.

Lynda Staruchowicz

Northern Territory

Stomal therapy in the NT is still travelling at a regular pace. There have been no major changes at this point; however, with the implementation of the nurse practitioner in wound management at Royal Darwin Hospital (RDH), the baton of stomal therapy will remain with the wound CNC or STN role at RDH. Currently we have an acting person in this position until advertised. So the number of STNs will evolve, as the wound management nurse practitioner is an STN and will perform STN duties; however, core business will be passed onto the CNC role. These are exciting times for the NT as we slowly develop and more specialised people come into key roles.

We will keep everyone informed as this transition takes place. That’s all for now in the NT.

Take care and stay safe.

Cheers,

Jenni

Victoria

Recharged and refreshed, following a very successful national conference in Perth in March, we have continued to foster and develop our branch activities.

Following the AGM in April, the Victorian branch committee elect is:

President: Helen Nodrum
Vice-President: Stefan Demur
Secretary: Cheryl Prendergast
Treasurer: Lynne Bryant
State rep.: Patricia McKenzie
Committee: Lisa Wilson
Sue Vaughan
Ros Carmichael
Country rep: Celia Haberl
Education reps: Wendy Sansom
Jenny Davenport

Education

Several members attended the sixth National Inflammatory Bowel Disease Symposium at St Vincent’s Public Hospital in March of this year. The gastroenterology department of that hospital organises this event and it provides the latest research and management of inflammatory bowel disease (IBD).

This is a great day for the STN to attend and we are fortunate in Victoria to have this opportunity.

The Peter MacCallum multidisciplinary cancer symposium – an annual event in Melbourne – was well-attended by many of our members, both country and city alike. At this meeting, we are provided with the most up-to-date research and colorectal cancer treatments, including surgical, medical and oncology.

Guest speaker at the AGM in April was Andrea Farrugia, who updated us on her new part-time position, one day a week, consulting at the Ostomy Association of Melbourne Inc. for members of that organisation.

Wendy Wintersgill from Hollister provided a second presentation on “The guidelines for use of convexity products”. These guidelines are a collaborative work between the Victorian branch and Hollister Inc.

Thanks go to Wendy for also providing the supper at this meeting.

Our meeting in August was held at Western General Hospital. Thanks go to Diana Hayes for organising and coordinating this meeting. Ginny Johnson from Smith & Nephew presented their negative pressure vacuum device and kindly sponsored the supper on that evening.

The country study day for this year is planned for 18–19 September at Goulbourn Valley Hospital, Shepparton. As I write this report this day is in the process of being organised and I look forward to reporting on this event in the next journal.

Gabrielle Munro is our liaison at Goulbourn Base and Lisa Wilson the coordinator from the city end.

Organisational participation

Cheryl Prendergast convened a community information day for Ostwest Health in Melton. This day included a trade display and a speakers’ programme.

Lynne Nicholson did likewise for her health region, the Northeast Health in Wangaratta. This day was titled Life after Stoma.

Both of these events being well-attended by consumers and as always supported by trade.

Diana Hayes, Western Health, conducted a 2-day study day for Division 2 nurses, providing a contemporary overview of colorectal nursing and stoma-related issues. Diana’s attention to detail and professional approach always ensure a successful event.

Three members represented our branch at the International Nurses Day wreath-laying ceremony held at the Nurses Memorial Centre over the Anzac Day celebrations. This is a great opportunity to acknowledge those nurses who fought for our country’s freedom.

Journal of Stomal Therapy Australia – Volume 29 Number 3
1. What do you like best about your job?

As a stomal therapy nurse, I am able to work one on one with a patient or with a patient and family member. I am able to spend time with the patient, talking or just listening to them as they discuss their concerns, problems and try to help them through a difficult time.

2. Can you share a funny experience about your job?

An elderly gentleman (80+) was legally blind. He had to have a urostomy performed. When it came time to teach him how to manage the appliance, he decided the end of the bag (tap area) was too short. He asked his son to devise a connector that he could hold onto to empty the bag more easily. His son, seeing the yellow plastic tubing behind his Dad's bed, (used for suction), decided that was ideal! He cut a length off – about 10cm and attached it to the tap. The patient was very pleased as he could not only direct this extension into the toilet, but could shake it to get rid of any drips.

3. What was your first job?

 Babysitting our family GP’s two children with my sister.

4. The most interesting place you have visited?

The Great Ocean Road. It had incredible scenery and interesting bush walks. I also love Cianjur and the highlands in Indonesia where there is beautiful scenery, cheap fruit and friendly people.

5. How do you like to spend your free time?

Gardening, reading, swimming and being with the family.

6. Who is your favourite author?

I don’t really have one, but I like mystery and Australian history novels.

I am divorced, with two adult children. My daughter and her husband work on an Aboriginal community in the Northern Territory. Their son is at boarding school in Alice Springs, while their daughter is living with me, to go to school in South Australia. My son and his wife live in Melbourne. I always have somewhere to go for holidays. I began nursing in 1967 and became a RGN in 1971. I qualified as an STN in 1993.
AASTN membership fee structure notes

From the membership coordinator

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

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

FULL MEMBERSHIP APPLICATION REQUIREMENTS

Fee $75

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

FULL (RETIRED) MEMBERSHIP REQUIREMENTS

Fee $40

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

ASSOCIATE MEMBERSHIP APPLICATION REQUIREMENTS

Fee $60

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

ASSOCIATE (STUDENT) MEMBERSHIP APPLICATION REQUIREMENTS

Fee $40

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

COMMERCIAL MEMBERSHIP APPLICATION REQUIREMENTS

Fee $65

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

GUIDELINES FOR FINANCIAL ASSISTANCE WITH AASTN FULL MEMBERSHIP FEE

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

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

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

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

PRECEPTORSHIP (FULL MEMBERS ONLY)

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

MEMBERSHIP UPGRADE REQUIREMENTS (ASSOCIATE MEMBERS ONLY)

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