The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

NOVEMBER 2020

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The Outlet

New Zealand Stomal Therapy Nurses

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Chairperson's Report

NICKY BATES

Greetings to you all and welcome to the final edition of the Outlet for 2020.

I am Nicky Bates your new chairperson of NZNO College of Stomal Therapy Nursing. I look forward to representing you and, along with the committee, will work on your behalf to address current issues while promoting the specialty field of Stomal Therapy Nursing.

My sincere thanks to our 2 outgoing committee members. Leeann Thom has been a wonderful chairperson. Her objectivity and leadership, sensitivity and hard work are but a few of her personal qualities. Kat Neiman leaves the committee and treasurer role. Kat has done a great job and developed invoice templates which will be extremely helpful for the next treasurer. Kat we will miss your event organising skills and knowledge of most places in NZ- accommodation, eateries etc. You have ensured our books are balanced and always brought an objective view to the table.

The BGM was held on 9th of October via Zoom. A small number of members attended, and I thank them for doing so. Rochelle Pryce, Dawn Birchall and Angela Makwana are staying on the committee. With pleasure we welcome new committee member Emma Ludlow. Emma will bring fresh young eyes to the committee. With no other nominations and despite canvassing nurses' country wide prior to the BGM, we are currently a committee of 5. However, we have continued to shoulder tap nurses and are hopefully in the process of securing our 6th member. Given our term will involve a conference 6 committee members are a must! Julia Anderson (NZNO PNA) will continue with the College, her skills and input are invaluable. Sandy Izard was awarded honorary life membership at the BGM, for her contribution to Stomal Therapy. Sandy qualified as a Stomal Therapist in 1995 and retired earlier this year. Sandy kindly submitted a profile of her working life which was published in the March 20 edition of The Outlet.

Thankfully, Outlet editors Dawn and Angela are staying on for another term which means we will continue to have a high-quality publication filled with all sorts of interesting articles. I would like to extend a sincere thanks to them both. You do a great job!

Completion of the knowledge and skills framework is top priority for the committee. This large piece of work has taken longer than anticipated but we are reaching the tail end. The framework represents core aspects of Stomal Therapy Nurse practice required for career development in the specialty and ultimately leading to the delivery of expert nursing care to the patient with a stoma. The committee strongly encourage members to provide feedback on the framework to dawn.birchall@middlemore.co.nz by Wednesday 18th November. Your feedback on the current draft will ensure the final framework is one we can all be proud of. The committee will meet on 25th November to collate and discuss your feedback on the framework. We are hoping Te Runanga will have their feedback to us at this point too.

Please don't hesitate to contact your stoma committee. We are committed to working for the membership and rely on you to let us know of any issues you would like us to address.

What a strangely different year it has been! We must acknowledge the extra stress circumstances have placed upon us all. Not only in our role as nurses but as mothers, fathers, partners, friends etc. Please make sure you take regular time out for yourself – you are so worth it!

Best wishes,

Nicky Bates
Chairperson NZNOCSTN

Editor's Report

ANGELA AND DAWN

Welcome to the final edition of The Outlet for 2020.

What a whirlwind 2020 has been for us all, both personally and professionally. The way we practice as clinicians has changed which has often been challenging as we meet the needs of people with stomas as well as the educational needs of our colleagues. Meetings via "zoom" are now an integral part of the way we interact with colleagues and we believe this mode of communication is here to stay. As well as the provision of education, the way we receive education has now been adapted to the confines of travel and the way we engage with others.

We would like to thanks Paris Purnell and the team at Liberty for organising the "Liberty Medical Virtual conference" which was held 26-28th October. The program and speakers were all outstanding. We appreciate the forward thinking that has been devoted in the production of this format and it has been greatly appreciated by the NZ college of Stomal Therapy. We encourage our members to take advantage of these educational opportunities as we continue to learn as clinicians.

Very special thanks to Convatec for the provision of three scholarships to enable one of our members to be able to complete the Australian based certificate in Stomal Therapy. The scholarships were open to members of the NZNOCSTN as well as the AASTN. Our member Rochelle Pryce was the recipient of the NZ scholarship – congratulations Rochelle.

Thank you to those people that have submitted their work for this publication, we are aware that great work is being produced by our college members and we continue to encourage members to submit their work for publication.

We are going to be updating our Stomal Therapists contact list, with a view to inclusion in the March 2021 edition of "The Outlet". If you have an updates that you wish to submit please e-mail directly to angela.makwana@waitematadhb.govt.nz or dawn.birchall@middlemore.co.nz.

Wishing everyone a very happy and safe Christmas.

Regards,

Angela and Dawn

CALLING FOR SUBMISSIONS

We know there are A LOT of patients that have benefitted from the expertise and persistence of Stomal Therapists or those nurses with an interest in caring for people with a stoma or fistula. WE WANT YOUR STORIES for this journal. Spread your good work for the benefit of others.

Please send your submissions to either:

angela.makwana@waitematadhb.govt.nz or

dawn.birchall@middlemore.co.nz

WE would LOVE to hear from you.

Meet our New Secretary

EMMA LUDLOW

I completed my Bachelor of Nursing at AUT and qualified as a registered nurse in 2009. I decided to go overseas straight away and was able to complete my graduate year at the Lyell McEwin hospital in Adelaide.

I then went on to spend five years working in general surgical wards in Darwin, Alice Springs and Saudi Arabia. I fell into Stomal Therapy nursing by happy accident, thanks to my first mentor, Jenny Burns, in Darwin. I completed the Graduate Certificate in Stomal Therapy, whilst in Alice Springs, in 2014. I returned to New Zealand in 2016, where I started working as a district nurse before starting my current part time position as CNS Stomal Therapist for Counties Manukau DHB in 2017.

My other part time role is with The University of Auckland and The Insides Company as research nurse and consultant stomal therapist. I am part of a multi-disciplinary team working with innovative medical devices to help Ileostomy patients.

I have just finished my dissertation to complete my Master of Nursing qualification. Some would say, just in time to start my new role with the committee as secretary.

I have my own little slice of paradise in semi-rural south Auckland, where I have just completed a sizable renovation to accommodate many more people to come and stay! I have a fabulous group of friends locally and internationally, whom I catch up with as often as possible. I enjoy spending time with family, reading, and a spot of gardening here and there.

This is my first time on the committee. Any committee, actually. So, I look forward to learning the ropes, meeting and representing the wider community of stomal therapists and promoting our speciality.

Emma Ludlow

Profile Page - Vicky Beban

CNS STOMAL THERAPY
HUTT VALLEY DISTRICT HEALTH BOARD

I trained at Hutt Valley DHB, graduated in 1978, and have been working there ever since in numerous nursing positions, except for short breaks for maternity leave. In 1998 when I was working as a DN I was approached by my manager, who asked me if I could cover the stomal therapy role for a year while the current stomal therapist was on maternity leave as I had previously worked on the surgical ward. During that year she went on to have baby no. 2 and I was offered the position. As a result I have been the CNS stomal therapy ever since.

Prior to working as a DN I had spent seven years working on the surgical ward and it would be fair to say stomas were not my thing. I was the nurse who had to deal with bags that fell off at the change of shift and often had bags leak an hour after I had put one on so why I thought I could do the stomal therapy role was beyond me.

Needless to say the first few months were a steep learning curve. I remember spending weekends worrying about whether someone with a challenging stoma was managing okay. Or had the bag actually stayed on?? A valuable piece of advice I was given during this harrowing time was "you always know more than the patient about a stoma. " This helped give me some confidence in those early days and gradually over time my knowledge grew and situations became a little less challenging. You make some special bonds with patients and it is a huge privilege to be a significant part of their journey. Stomal therapy is challenging and frustrating at times but also incredibly rewarding and fulfilling.

I enjoy working autonomously and organising my day as I wish and love being part of the surgical team and asked for my input.

The Hutt Valley is quite small geographically which means I can travel from one end to the other in an hour so it is an advantage for patients as they are very accessible to me. There are significant areas of social deprivation and a high elderly population with comorbidities within the valley. This translates into more permanent stomas than temporary. My patient population tends to sit at about 280 – 300 and I work in both the hospital and community in a 0.9 position. It's a busy role with not a lot of downtime.

My stomal therapy training was at Waiariki Polytech in Rotorua in 1999 or thereabouts and Nicky Bates, from Whanganui was also on the same course. At the time I had been an Ostomy nurse for about 18 months and I remember feeling disappointed that there were no magical solutions presented for difficult to manage stomas and that you actually had to think outside the square to find a solution. I think I thought all the answers were going to be handed to me on a plate.

A big milestone was completing my Clinical Masters at Victoria University in 2011. My focus during my Masters was on patients with colorectal cancer and how they adjusted to life with a bag as well as a cancer diagnosis. I have served on the Stomal therapy Committee twice.

Over the years in this role there has been memorable conferences I have attended. The ones that stand out include one in Hanmer, the Australasian conference in Rotorua and one in Christchurch in 2000.

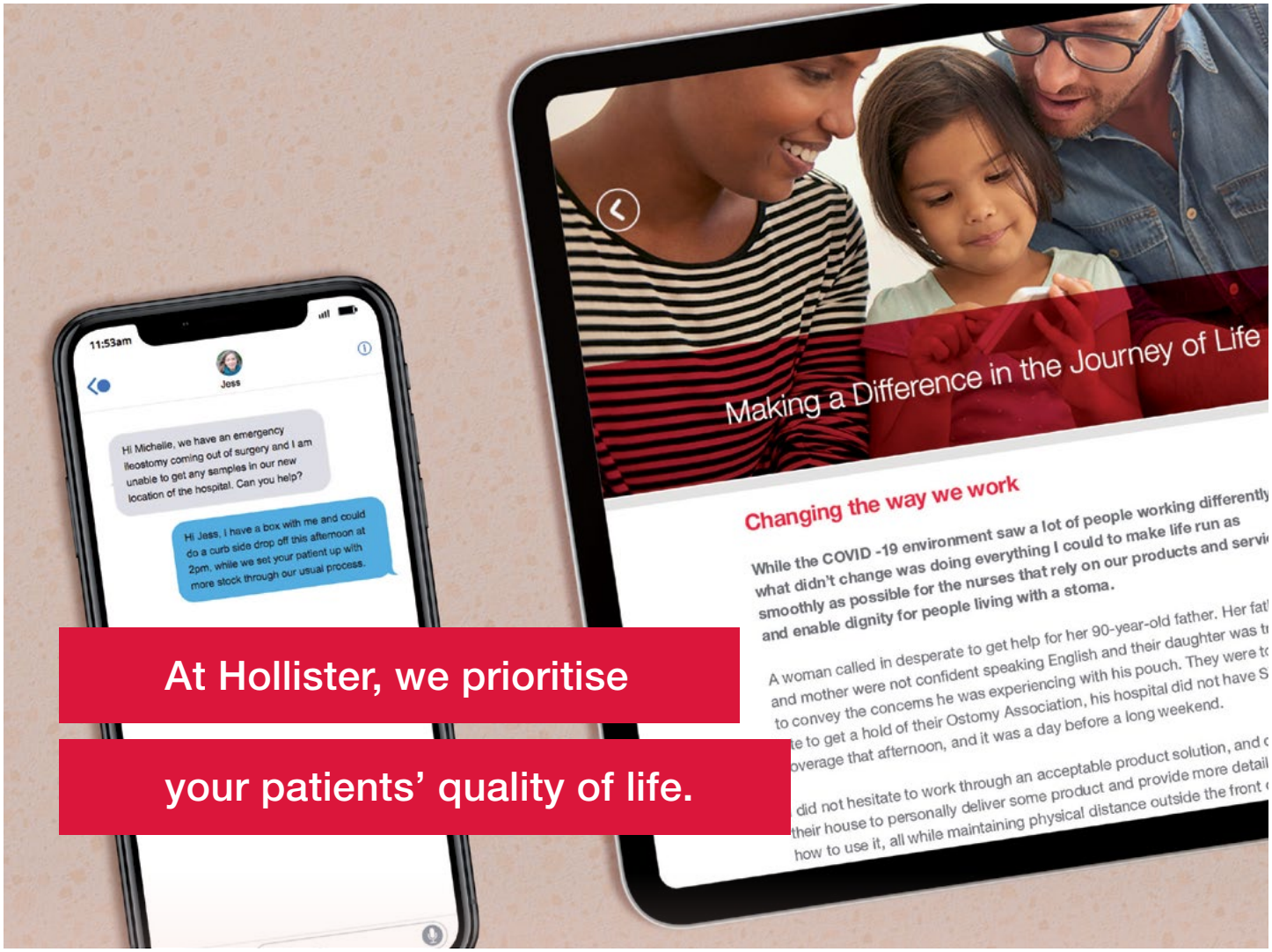
Products have also changed a lot during my time in this role. The Convatec 2 piece system was the "go to" and convexity was achieved with little plastic inserts. Over the years the 1 piece caught up and overtook the 2 piece. Velcro fastening systems, filters, aesthetic covers and advanced skin barriers are some of the changes that have occurred in my time as a CNS. These changes are happening quite fast and benefitting patients and I believe it is really important stomal therapy nurses continue to have access to all products as well as keep their knowledge up to date on available products so patients have best outcomes.

In my spare time I enjoy spending time with my family and partner Mike. I have two married children — a son and a daughter and they both live near me. Weekends often involve seeing or minding one or the other of my grandchildren and dancing or gardening.

Dancing is my passion and I have done ballroom dancing for many years but gave it up about 3 years ago to focus more on my rock and roll, as I got an offer to compete with a fantastic dancer from our club and I wasn't going to turn that down. This has been a lot of fun, bruises and lead to a lot of camaraderie with other competitive dancers in the club. My dancing has improved and it is a great stress reliever after a hard day at work. Unfortunately in March Covid came along and changed all our dancing plans and we have only just started training again recently in the hope there may be some competitions next year.

Gardening is the other activity I enjoy and I have a large garden that is always requiring some work.

The goal is to spend more time in the garden when I retire which is coming up on the horizon.



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NZNO Conference and AGM 2020

ANGELA MAKWANA, STOMAL CLINICAL NURSE SPECIALIST, WAITEMATA DHB

On behalf of the Stoma committee I recently attended the NZNO conference and AGM.

Initially this was to be a face to face meeting in Wellington but as with many things this year COVID-19 changed those plans to an on-line conference and AGM. I must admit as the day grew closer the thought of spending 8 hours in front of a computer was not appealing. Not to mention the fear that my technology would fail and I would end up staring at a blank screen. So with lap top, I-pad and phone ready and a few tips from my tech savvy 12 and 10 year old daughters I zoomed in with success.

The days as a whole was very enjoyable and I did not feel like I was sitting looking at my screen for hours on end. There were several breaks and the MC kept us entertained when there was the odd hick up. There were several presentations from nurses who spoke passionately about their field of practice. There is some excellent innovative work being undertaken by nurses throughout the country that has a positive impact on patient outcomes. The Southern Institute of Technology presented a programme established by the nursing students to support and mentor each other through the years of their training.

There were several presentations that stood out for me. The first being Professor Michael Baker. I am sure many of you will have seen him on TV speaking frequently about New Zealand's (NZ) response to COVID-19.

His talk was very sobering when he presented the figures he did for the Ministry of Health (MOH) in Feb of this year. It was modelled that the virus would peak after 5 months and 57% of the population would be infected. New Zealand's original plan was to control the disease to "flatten the curve". In March when it was established there was community transmission in NZ the plan switched to elimination and a "lockdown" was required. NZ's lockdown was the most stringent lockdown of any country. Without these restrictions, the prediction was NZ would have had over 28,000 hospital admissions and nearly 13,000 deaths due to COVID-19. This death rate is equivalent to 25 years of Influenza deaths in NZ at one time. When looking at these figures and reading the news daily of the on-going global pandemic it makes me very happy to be living in NZ.

The Controller and Auditor General, John Ryan, spoke about his review of the government's handling of Personal Protective Equipment (PPE) in relation to COVID-19. This role is entirely independent of the government and is to "look in" on what the government does and how it uses it resources. It does have a strong financial focus. The report the office produced specically looked at PPE. The office decided to investigate after hearing concerns raised about the availability of PPE throughout the country. What was being promoted publically was different to what the office was hearing from health workers. This office does not provide clinical guidance on things such as when PPE should be used. The review looked at the MOH and 5 District Health Boards (DHB's) throughout the country and identified that plans in place were inadequate to respond to a pandemic.

THE REVIEW FOUND:

- DHB's were procuring PPE individually or in regional groupings, often competing against each other and this system did not work. This has since changed to a more to centralised procurement.
- The MOH did not know how much PPE was held in the National reserve supply in total. Several DHB's were out of stock or their stock had expired and the national reserve of PPE was based on a population 19% smaller then actually in NZ in 2020.
- The MOH changing guidelines and mixed messages caused confusion. Some public statements delivered mixed messages. One such message the report highlights was from the Director General of Health who said that people need to be safe and feel safe but also act in consistency with clinical guidance. The Auditor General felt this was difficult message to understand clearly. Following this message there was a lot of demand for PPE from people that wanted it but did not need it when following the clinical guidance. The Director General of Health had also mandated that DHB's had to distribute PPE to community providers in their areas. The DHB's did not have relations with many of these community providers but were having to give out their reserve of PPE.
- The national reserve was set up to provide PPE only for health workers. It did not cater for workers in this pandemic deemed essential such as police, prison officers or super markets workers. The question was raised regarding who should supply private providers with PPE? Should this be the MOH or should these private companies supply themselves? There was no guidance on this.

The MOH has said it is committed to addressing all of these issues (some of which they already have) and is working on the 10 recommendations advised by the auditors general's office.

NZNO Conference and AGM 2020

ANGELA MAKWANA, STOMAL CLINICAL NURSE SPECIALIST, WAITEMATA DHB

Dr Graham Gulbranson works as an addiction specialist and prescribes medicinal cannabis to patients, from children to adults. He opened the first medicinal cannabis service in NZ in 2018. The majority of his patients suffer from chronic pain issues but he also prescribes for management of cancer symptoms or adverse effects from cancer treatments such as chemotherapy, neurological conditions (multiple sclerosis responds very well to cannabis) and mental illness such as anxiety related issues.

He discussed the different forms of cannabis. Tetrahydrocannabinol (THC) dominant gives the euphoric, intoxicant effect whereas Cannabidiol (CBD) has a therapeutic effect. A balanced combined THC/CBC also has a therapeutic effect and can work very well for patients. It is about getting this balance right for the individual patient.

One of the difficulties he experiences as a prescriber of medicinal cannabis is government regulations. Companies that manufacture cannabis cannot advertise their products. Therefore they cannot educate health workers on their products and how to prescribe as this would be seen as advertising. Which raises the question how do health professionals learn about medicinal cannabis so it can be used correctly?

Howard Catton, Chief Executive of the International Council of Nurses (ICN) discussed the issues facing the 27 million nurses worldwide. Again COVID-19 was a big topic. The ICN's data set reports the 8% of all COVID-19 infections globally are health care workers with nurses being the most commonly infected group followed by doctors. At the end of August over 600 nurses had died globally and this number will continue to rise. The availability of PPE globally was an issue for health care workers.

Wendy McGuiness from the McGuiness Institute presented her findings of a survey regarding PPE. This survey reflected nurse's experience of the availability of PPE. It reinforced the previous presentation by the Auditor General that NZ did not have enough PPE. Availability of PPE did vary around the country and how supported nurses felt in general. There were reports of nurses being told to save PPE or not use or waste the PPE they had.

Margaret Broodkoorn, outgoing Chief Nursing Officer, talked about investing in domestic production of nurses. Currently 30% of the nursing workforce in NZ qualified overseas. The prediction before COVID-19 was that NZ's nursing workforce will keep pace with population growth over the next 10 years if current entry and exit patterns continue. This has since changed with COVID-19. There are concerns that some practice settings and regions show a decrease in the ratio of nurses per population which obviously affects the ability to deliver services to patients.

The next day I moved onto the AGM. My fellow committee member Nicky Bates also zoomed in for the AGM. There were several hold ups regarding the technology and being able to vote on-line which was frustrating and lengthened the AGM considerably. At one stage Nicky and I found ourselves staring at each other on-line. Members of every college or section had been re-directed to discuss the minutes from last year's AGM. Unfortunately we were not told that before we were looking at each other. We did joke maybe we had been thrown out of the AGM. As neither Nicky nor I attended the 2019 AGM we could not comment on the minutes that some members had objected to. So we made use of our time and caught up on committee business. After a little while we were returned to the main AGM.

The financial report was presented. There has been no membership growth in NZNO and a large sum of money was spent on legal expenses. Probably not a great surprise there.

The new president Heather Symes spoke. The keys words I wrote down from her presentation as she spoke were: honest, collaborative, working in unison, only on official websites, going forward as a union. The recent in-fighting at NZNO has left myself and I'm sure many others feeling totally disinterested in the union that represents me. It was refreshing to hear those words. The proof will be in how NZNO functions over the next few years. Especially as the new MECA is currently being negotiated, albeit once again interrupted by COVID-19.

The NZNO strategic plan 2021-25 was presented. It was raised that violence and aggression towards nurses and midwives was not mentioned in the document. The board has agreed to add in this into the strategic plan.

All of the constitution and policy remits were passed. Out of 50,418 eligible voters to vote on the constitution and policy remits, 3,185 (just over 6% of eligible voters) cast a vote.

So after a lengthy 2 days of being in front of my computer I was glad when the AGM was closed. It was a new experience for me doing a conference and AGM on-line. I do think that it is one the will become more common for all of us in this ever changing world.

Angela Makwana

*** The conference presentations are available to view on YouTube.*

ANZ ConvaTec Scholarships for Stomal Therapy Nurses announced

MEDIA RELEASE, JUNE 2020

ConvaTec ANZ is delighted to announce that three nurses have been awarded scholarships to take the Graduate Certificate in Stomal Therapy Nursing.

As part of a collaboration between The Australian College of Nursing (ACN), the Australian Association of Stomal Therapy Nurses (AASTN) and The New Zealand Nurses Organisation (NZNO), the scholarships, provided by ConvaTec, will help support the nurses to progress their careers in what is a dynamic and very demanding area.

Rochelle Pryce

This year's recipients, chosen by the nursing organisations' committee, are Vivian Nguyen who works within NSW Health; Linda (Ching Yi) Chen from The Wesley Hospital, Qld; and Rochelle Pryce from Capital and Coast District Health Board, NZ.

Vivian Nguyen is a Wound and Stoma Clinical Nurse Specialist who's passionate about her work within the NSW public health system supporting highly vulnerable patients with complex care needs, throughout the state.

Linda Chen has been nursing for more than ten years and recently became a Clinical Nurse in Stomal Therapy and Wound Management. Inspired by her colleagues, she's enthusiastic about progressing her career in Stomal Therapy Nursing.

In New Zealand, Stomal Therapy Nurse, Rochelle Pryce, values her ability to deliver and co-ordinate evidence-based care for her patients, whilst staying abreast of new innovations that continue to shape the future of ostomy patient care.

Each of the nurses has a clinical background and the completion of the Graduate Certificate in Stomal Therapy Nursing will provide them with the skills and expertise necessary to deliver and coordinate evidence-based care in the highly specialised area of stomal therapy nursing.

"This is a very challenging area and ConvaTec is delighted by the collaboration between the nursing organisations to provide Vivian, Linda and Rochelle with the opportunity to progress their careers in Stomal Therapy nursing," explained Karen O'Connor, General Manager of ConvaTec Australia and New Zealand.

"The calibre of applicants was very high and we'd like to thank everyone who applied. It was a hard decision for the independent selection committee to make but we are sure that the three recipients will really value and embrace the knowledge and leadership skills that this course brings."

"The scholarships are part of ConvaTec's commitment to improving stomal therapy care - valued at just over $12,000 each, they bring an enormous saving to nurses' keen to advance their career.

"By supporting this specialist education and pioneering trusted medical solutions, ConvaTec seeks to help those with stomas to live the life they want," she concluded.

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Quality Of Life Case Study

Angela Makwana, Stoma Clinical Nurse Specialist, Auckland, New Zealand

This case study represents my experience in using Dansac NovaLife TRE soft convex barrier with this specific patient and may not necessarily be replicated.

Patient Overview

The patient is a 74 year man who lives on his own and enjoys an independent and active lifestyle.

Patient History

The patient presented to hospital with severe abdominal pain, subjective fevers, diarrhoea and vomiting. He had been aware of gradual weight loss over the last six months and had noticed that his clothes were getting looser, but had not been unduly concerned. He also reported that his bowel motions had altered and that he had been feeling extremely lethargic.

A CT scan revealed the appearance of bowel ischemia involving distal small bowel, with thromboembolism within the superior mesenteric artery and vein. Mesenteric artery thrombosis is a condition involving occlusion of the arterial vascular supply of the intestinal system. It is a severe and potentially fatal illness typically of the superior mesenteric artery, which provides the primary arterial supply to the small intestine and ascending colon. (Ankush Sarwal., *et al*. "*Superior Mesenteric Artery Thrombosis Risk and Treatment (SMART): Review of Literature*". Acta Scientific Gastrointestinal Disorders 2.5 (2019): 54-56.)

The patient was taken to theatre for a laparotomy (small bowel resection, adhesiolysis and laparostomy). The ischemic bowel section was removed leaving 120cm of small bowel jejunum with 10cm distal terminal ileum, in place. The abdomen was left open. The following day, the patient returned to theatre for end to end bowel anastomosis and closure of the laparostomy. Initially, the patient seemed to be doing well, but his blood results showed increasing inflammatory makers which indicated infection from anastomosic leakage. The following week, the patient went back to theatre for a second laparotomy with takedown of the anastomosis and the formation of a double barrel stoma.

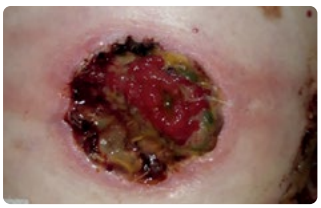

Photo 1: 6 days post-surgery: double-barrel stoma, proximal lumen healthy, distal lumen sloughy

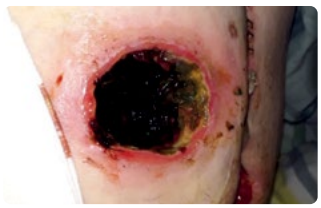

Photo 2: 13 days post-surgery: both lumens retracted below skin level, necrotic, no viable bowel seen

Intervention

The patient was referred to me in hospital one week later. At this point, he was in a great deal of pain and discomfort from the surgery as well as dealing with the shock of what had happened to him and the impact this would have on his quality of life.

On examination, I found that the Ileostomy proximal end was healthy but the distal end was sloughy. The stoma was flush with the skin and the laparotomy wound had dehisced. Three days later the ileostomy appeared more oedematous and was dark red and protruding. Four days later the ileostomy had retracted with necrotic tissue. At this stage the patient was too ill to undergo any further procedures. Clots were present on removing the patient's bag and the stoma was bleeding. Three weeks later the stoma had retracted and previously healthy peristomal skin had become damaged.

> A retracted stoma discharges effluent at the skin level and causes peristomal irritation and is more prone to leakage. (Michael Kwiatt, MD and Michitaka Kawata, MD. *Avoidance and Management of Stomal Complications*, Clin Colon Rectal Surg. 2013 Jun; 26(2): 112–121).

Whilst the patient was in hospital, I tried various pouches and accessories and showed him how to care for his stoma and change the bag on his own. Generally, the bag would last up to a maximum of 24hrs, but it had to sometimes be changed three times a day as the patient had a very high stoma output. Despite these challenges, the patient gave the impression that he was coping well and did not want assistance with his bag changes. He also received intensive dietary input during his admission. Nine and a half weeks later, he was discharged to sheltered accommodation with a prescription for Loperamide 12mg QID and enerltye 1L/day to help control the output.

However, within 12 hours of discharge, the patient was readmitted to hospital with stoma complications. His output was extremely high and he was experiencing continuous leakage. He was also feeling exhausted and "washed out" and explained that he had not filled his prescription on discharge, or eaten or drunk anything in an attempt to control his output. He was extremely anxious and admitted that he could not cope with changing the bags on his own. He did not want to mention this before as he was fearful of the future and becoming dependent on others.

On examination, I discovered that his peristomal skin was red and sore due to the continuous leakage and his DET score was 10. To help improve his skin health, I decided to trial the Dansac NovaLife TRE soft convex pouch (3081-44) as the pH buffering properties of this product provide peristomal skin protection and high absorbency. I also used powder and a seal for better adhesion as his skin was so wet.

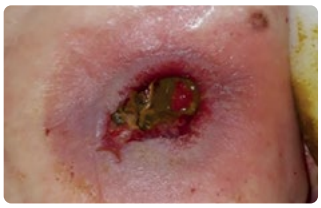

Photo 3: 5 weeks post-surgery: stoma retracted, skin continued to deteriorate, bag lasting 24hrs maximum (prior to commencing NovaLife TRE soft convex pouch)

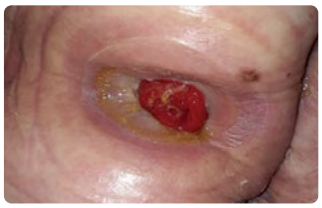

Photo 4: 10.5 weeks post-surgery: Dansac NovaLife TRE soft convex being used.

As the stoma was sited near the laparotomy wound, I spent time re-educating the patient on best practice and reinforced the message as to why it was so important to follow our instructions to avoid potential infection. He recognised the importance of this and agreed to take his time when changing his bags and to follow our procedures.

> **“The patient was managing well with his bag changes and was confident with the products he was using.”**

The patient was discharged 14 days later with Loperamide 18mg QID; Codeine 30mg QID, St Marks Solution and Psyllium Husk 1tsp daily. He also received dietary support.

Three weeks later, the patient’s stoma appeared red and healthy and was now flush with his skin. His peristomal skin had visibly improved with a DET score of 2. He felt comfortable and confident using the Dansac NovaLife TRE soft convex pouch (3081-44) and belt, and only needed to change his bag every 24 hours.

He still attended hospital three times a week for IV infusion of fluids and potassium, to help prevent dehydration from the high stoma output.

Conclusion

Two months later, the patient only had to change his bags every two to three days. He was coping well with the bag changes and felt confident with the products he was using as part of an overall care plan. The laparotomy wound had successfully healed and the patient regained his independent lifestyle. The following month, the patient’s stoma was successfully reversed.

Key Learnings

- Be aware of the patient’s quality of life and how stoma care nurses can make a direct and positive impact
- Keep up to date with new product technology and innovation. Selecting the right product at the right time can improve both physical and emotional outcomes
- Make sure that patients are confident in managing their bag changes, particularly when they live alone. Patients may sometimes be reluctant to admit they are not coping

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About Dansac NovaLife TRE

Living with a stoma does not have to mean accepting peristomal skin complications. Helping the skin around the stoma stay healthy goes a long way in enhancing the quality of people’s lives.

The **Dansac NovaLife TRE** ostomy barrier is designed to help keep skin naturally healthy with 3 levels of protection: **Adhesion, Absorption** and **pH Balance.**

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Stoma Skin Soul

Quality Of Life In Post-Ostomy Surgery Patients: A Cross Sectional Survey

KRISTINA ALUZAITE[1], JAMES W. NUTTALL[1], MAREE O'CONNOR[2], RUTH HARVIE[1], MICHAEL SCHULTZ[1,2]

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INTRODUCTION

Ostomy serves as a treatment for serious underlying diseases such as Inflammatory Bowel Diseases (IBD) and Colorectal Cancer (CRC), prolonging life and/or ending suffering. However, due to the aggressive nature and body-altering effects along with complications, ostomy is often associated with decreased quality of life (QoL) and increased health burden in these patients. Altered body image, social isolation, embarrassment, psychological distress and perceived loss of control are just some of the challenges patients deal with that often result in decreased quality of life. How well the stoma appliance works and its therapeutic outcomes are also associated with overall changes in the reported quality of life. Around 20-70% of ostomy patients will experience complications such as peristomal skin irritation, parastomal hernias, stoma prolapse and other.

Approximately 8000 people in New Zealand live with stoma bags, and to our knowledge, no in-depth data are available on the quality of life in these patients. In this study we quantified quality of life in post-ostomy patients in the Otago region and attempted to decipher factors associated with specific quality of life outcomes.

While no single study can give justice to the complexities that arise when quality of life, lifestyle expectations and complicated disease intertwine, we hope that the data we collected will be of use to the treating clinicians, and will aid future interventions attempting to improve health ant quality of life outcomes for post-ostomy patients.

METHODS

In this study, we surveyed 241 patients (response rate 55%) from the Otago arm of the Southern District Health Board region, recruited via local database. Each of the study participants signed a written informed consent and completed validated quality of life surveys: the General Stoma Quality of Life Measure (1) (for IBD and CRC), IBD Questionnaire (IBDQ) (2) (for IBD), and the European Organization for Research and Treatment of Cancer CRC quality of life (QLQ-CR29) (3) and core modules (QLQ-C30) (4) (for CRC), along with demographic and dietary questionnaires designed by the research team.

STUDY SAMPLE

Study participants were on average 71 years old (with a standard deviation of 14 years), 61% of them were male and 90% were of New Zealand European ethnicity. 53% of the study participants had a colostomy, and 56% and 22% received their stoma due to Colorectal Cancer and Inflammatory Bowel Disease, respectively. Median (25th -75th percentile) duration since ostomy for overall study sample was 6.9 (3.3 -15.1) years.

OVERALL QUALITY OF LIFE SCORES

We found that the mean Stoma Quality of Life score for all the patients was 60.3 (standard deviation 10.8) points in a scale 20 to 80. Median (25th -75th percentile) IBDQ total score in IBD patients was 182.5 (145.5-201.8). We did not find any evidence that stoma-underlying disease and type of stoma would be associated with Stoma-Quality of Life scores. However, age significantly predicted the Stoma-QoL and IBDQ scores; older age adults had higher quality of life scores (scores per group are illustrated in Figure 1). More years since surgery was significantly associated with higher QLQ-C30 global health/quality-of-life scores.

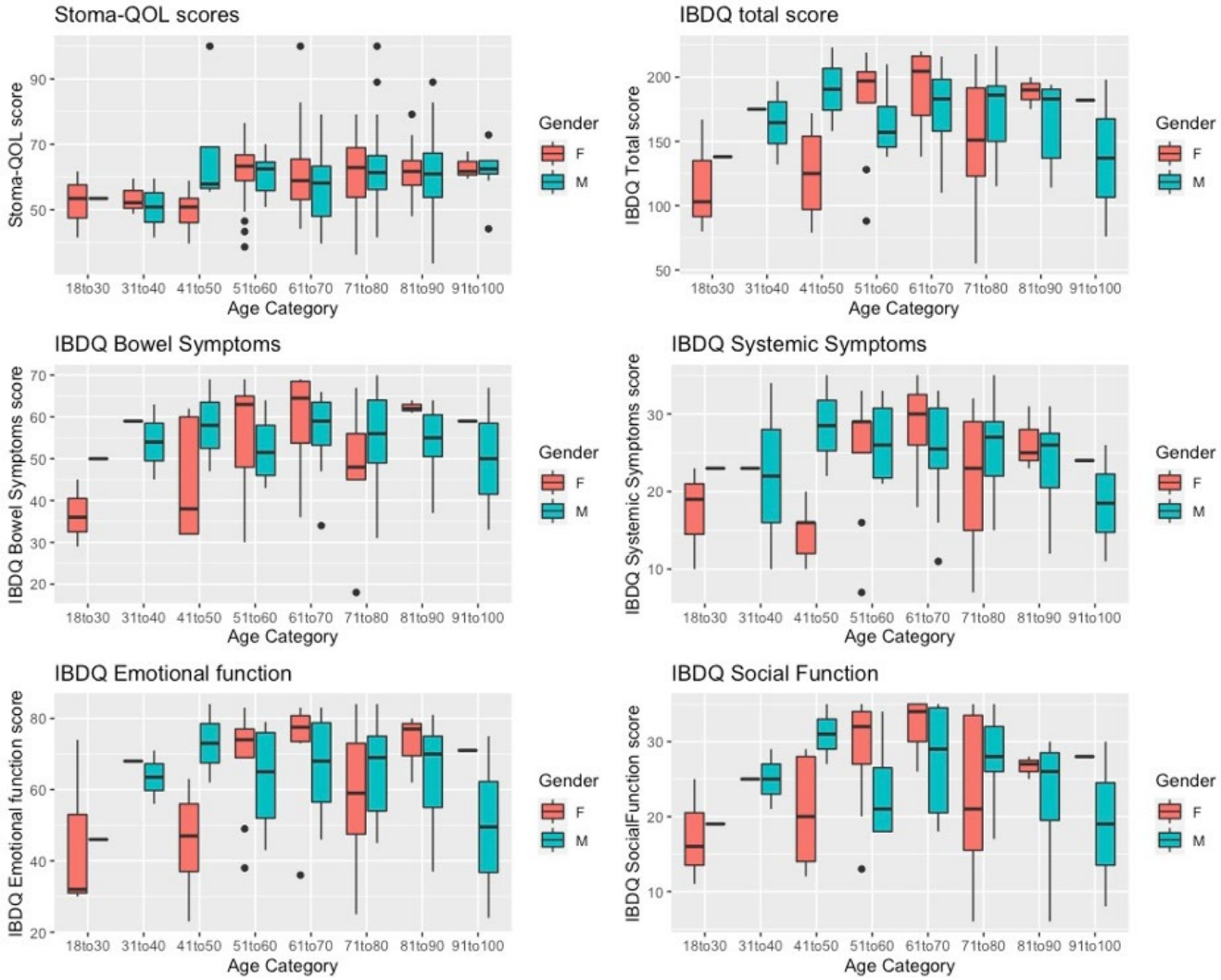
DIETARY RECOMMENDATIONS

73% of the study participants received dietary recommendations for their stoma and 56% changed their diet as a result of having a stoma. Most of the participants (51%) found it easy to adhere to dietary recommendations, and only 9% said it was quite difficult/very difficult. Only 27% have discussed their stoma management with a dietitian. Importance of fluids, electrolytes and B12 intake was discussed with 76.3%, 42.1% and 20.3% patients, respectively.

CONCLUSIONS

This study found high quality of life scores in post-ostomy patients, and no significant association between the underlying disease, time since ostomy, level of comorbidities and how the appliance worked that highlight the multifactorial nature of quality of life concept and difficulties measuring it.

Figure 1. Stoma-QoL scores by age group and gender: Stoma-QoL, IBDQ Total, IBDQ Bowel Symptoms, IBDQ Systemic Symptoms, IBDQ Emotional Function, IBDQ Social Function scores †



† *The boxplots show median, 25th and 75th percentile of scores per age group along with distribution of all the scores for males (blue) and females (red) separately, divided by age categories; higher scores indicate higher quality of life*

We encourage the readers of this publication to access the full article for more detailed results and in-depth discussion: **https://doi.org/10.1002/jgh3.12383**;
For any questions or comments, please contact Kristina Aluzaite (kristina.aluzaite@otago.ac.nz) or Professor Michael Schultz (michael.schultz@otago.ac.nz)

ACKNOWLEDGEMENTS AND DISCLOSURES

The study was approved by the University of Otago Ethics committee (HD15/014).

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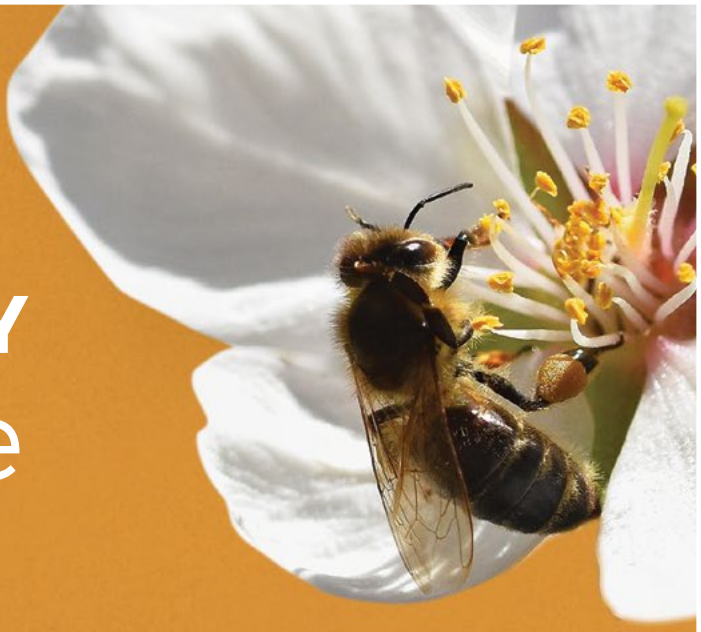

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Maxitrol, Is it Useful in Wound Care? A Case Study

CHYVON GRAY, STOMA CLINICAL NURSE SPECIALIST, WHANGAREI, NEW ZEALAND

This case study represents my experience with using maxitrol on a peristomal pressure ulcer wound and may not necessarily be replicated.

May's journey started in November 2016. For an 80 Plus year old, May is a robust interactive and humorous lady. She began the path towards a urinary diversion surgery in 2017 with a TURBT for a tumour in her bladder.

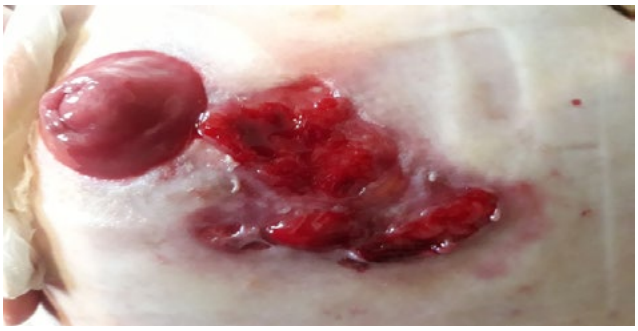
She seemed to have recovered well from her surgery.

Then May presented with high grade Transitional Cell Carcinoma with lamina propria but not with definite muscle invasion. This was her first re-resection. In February 2017 a staging CT scan had not shown any abnormality away from her bladder. However, the histology confirmed that she had an invasive moderately to poorly differentiated urothelial carcinoma with some squamous and adenocarcinoma components. Of note, she underwent a mastectomy in the past with a breast malignancy. The tumour in her bladder most likely represented a second primary tumour.

May had high grade urothelial cancer with squamous and mucinous differentiation. Her staging investigations were negative for metastatic disease and after discussion in the multi-disciplinary team meeting and following discussion with the patient it was decided that the most appropriate treatment in terms of quality of life and cancer clearance was for her to have an ileal conduit urinary diversion in February 2018 a year after her first resection. At this point I first met May as her stoma nurse. May had come to terms with losing her bladder, she had pre-operative education and had connected with a lady already living with a urostomy.

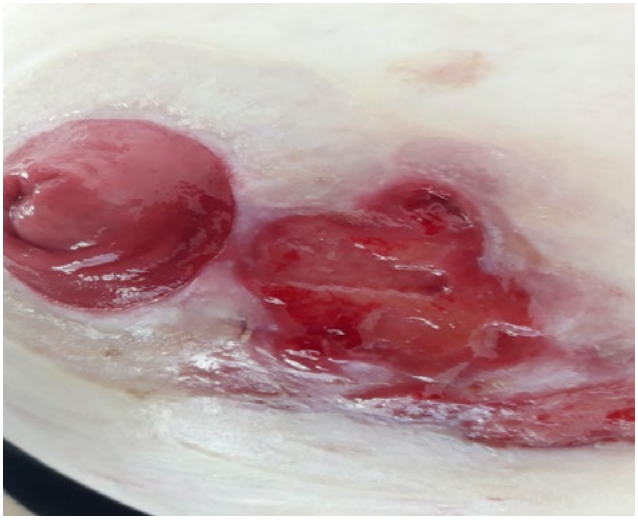
May had gained independence with looking after her urostomy. May had family overseas, so she arranged to travel abroad with them. In 2019 they went to Switzerland and she tells me for "two weeks I was in and out and in and out of vehicles and did a lot of walking and rock hoping all the while looking at fantastic views".

After a month of travel May returned to New Zealand June 2019 with what can only can be described as the worst pressure ulceration I had seen adjacent to a stoma. Treatment began, I initially changed the stoma appliance to remove the pressure, she was wearing a soft convex urostomy bag with a belt. The wound bed was a friable granular tissue and the exudate was haemo purulent. A swab of the wound was taken and due to the amount of exudate from the wound I visited three times a week to assess and provide treatment. It was difficult to achieve an adequate seal, so the appliance was changed to a flat two piece with a protective seal. Stoma powder was used to bridge the ulcer and stoma and an algisite fibre dressing was used to cover the area of ulceration. An Eakin cohesive was applied over the wound before placement of the baseplate of the two piece appliance.



Picture 1. May 2019 - 1st visit

The swab result revealed a staphylococcus infection; I added iodine liquid to the treatment plan by cleansing the ulcer and breaking the bio film, after two weeks the wound bed settled and the exudate was contained within the fibre dressing.



Picture 2. June 2019 - After treatment with iodine for 2 weeks

However months passed, some weeks would look better than others with the wound status unchanged as in picture 2. On occasion there was less exudate and the wound bed less inflamed,

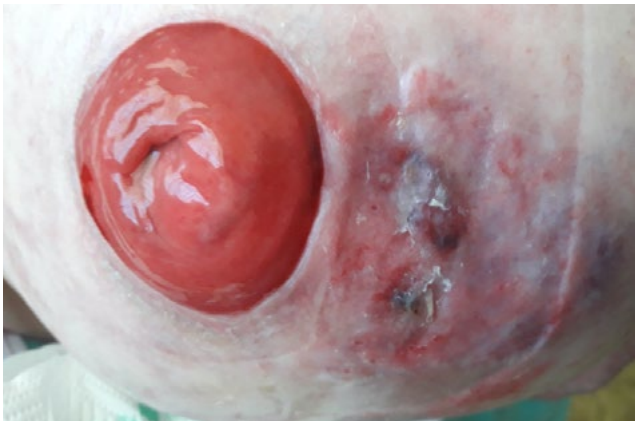
friable and weepy. Other occasions the exudate would break the confines of the dressing lifting the baseplate. A silver antimicrobial fibre dressing was utilised when the exudate increased. The wound bed remained static for a further 3 months. We had exhausted all our routine dressing products. With a holistic approach to wound care, factors which affect wound healing were discussed, we reviewed nutritional requirements to optimise wound healing. May was becoming increasingly depressed with the odour and she had lost trust in her body to heal She did not want to leave the house and she did not trust the wound products to hold the exudate. My colleague and I began to question how to move the wound out of the inflammatory phase, to the healing phase.

Some of my more experienced colleagues had used Maxitrol in wound care for hyper granulation, a condition where there is excess moisture (urine) bacteria (staph was always a battle) or movement (Mays' abdomen was soft and flaccid). I approached the urologist for the prescription of Maxitrol an eye ointment. He deferred us to the GP where I advocated for the use of Maxitrol for a 2 week trial to reduce the inflammation and treat the bacterial load.

The controversy of using Maxitrol is the fear of building antibiotic resistance in wound care. As Registered Nurses it is important to be informed with the aim to maximise the best possible outcome for the patient. A trial of an anti microbial to reduce biofilm is a warranted treatment modality against biofilms in wound care. Mays wound had impacted on all areas of her life and was now impacting on her mental health. I had visited three to two times a week for months costing the district nursing department in supplies, not to mention the energy cost, I was so frustrated I couldn't make headway with this wound.

MAXITROL'S MECHANISM OF ACTION

MAXITROL has a dual effect: suppression of inflammation symptoms by the corticosteroid component dexamethasone, and an anti-infective effect due to the presence of two antibiotics, polymyxin B and neomycin. Dexamethasone is a synthetic glucocorticoid with potent anti-inflammatory activity. Polymyxin B is a cyclic lipopeptide that penetrates the cell wall of gram-negative bacilli to destabilize the cytoplasmic membrane. It is generally less active against gram-positive bacteria. Neomycin is an aminoglycoside antibiotic that primarily exerts its effect on bacterial cells by inhibiting polypeptide assembly and synthesis on the ribosome. Effective to shift the wound bed from the inflammatory phase of wound healing to the proliferative phase of wound healing, full healing can be seen in two to six weeks.



Picture 3. Early December 2019 - After Maxitrol was added to the wound plan

After months of a static wound; we have seen Maxitrol work by enabling the wound to transition from the inflammatory phase to the healing and then the proliferation phase of wound healing. May's ulcer healed in a period of one month from mid October 2019 to early December after Maxitrol was applied.

MAXITROL OINTMENT IN WOUND CARE

What do I need to know about aminoglycoside antibiotics?

The aminoglycosides are broad-spectrum, bactericidal antibiotics that are commonly prescribed, primarily for infections caused by Gram-negative pathogens. The aminoglycosides include gentamicin, amikacin, tobramycin, neomycin, and streptomycin.

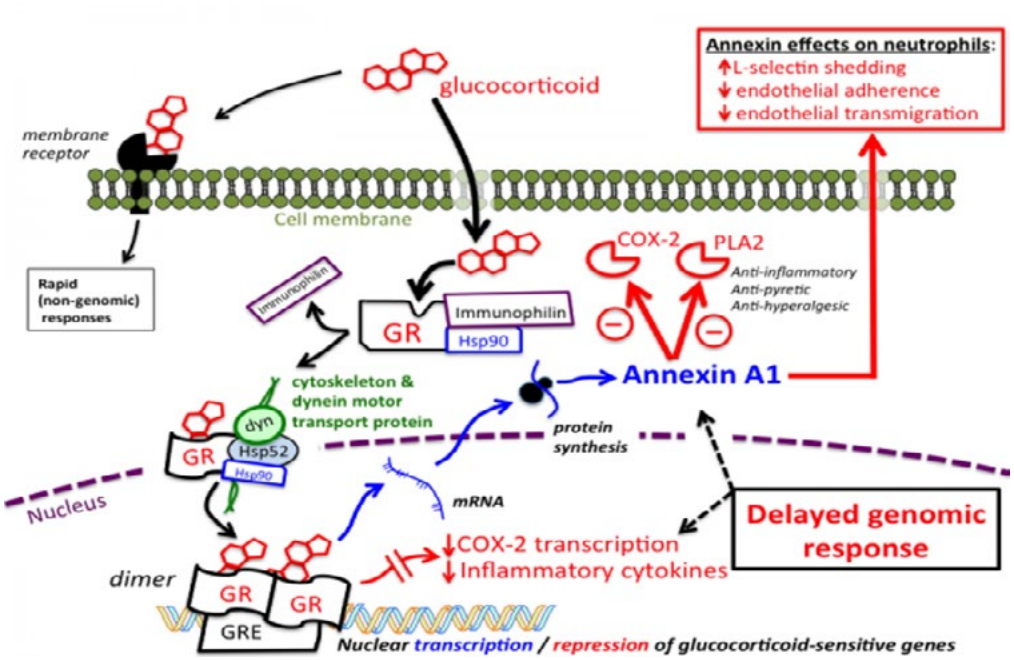
Aminoglycosides are a class of antibiotics used mainly in the treatment of aerobic gram-negative bacilli infections, although they are also effective against other bacteria including Staphylococci and Mycobacterium tuberculosis. They are often used in combination with other antibiotics.

MECHANISM OF RESISTANCE

Resistance of bacteria to polymyxin B is of chromosomal origin and is uncommon. A modification of the phospholipids of the cytoplasmic membrane appears to play a role. Resistance to neomycin occurs by several different mechanisms including (1) alterations of the ribosomal subunit within the bacterial cell; (2) interference with the transport of neomycin into the cell, and (3) inactivation by an array of adenylating, phosphorylating, and acetylating enzymes.

Corticosteroids modify the functions of epidermal and dermal cells and of leukocytes participating in proliferative and inflammatory skin diseases. After passage through the cell membrane corticosteroids react with receptor proteins in the cytoplasm to form a steroid-receptor complex. This complex moves into the nucleus, where it binds to DNA. The binding process then changes the transcription of messenger RNA (mRNA). Because mRNA acts as template for protein synthesis, corticosteroids can either stimulate or inhibit the synthesis of specific proteins. Thus corticosteroids are known to stimulate the production of a glycoprotein called lipocortin. The formed lipocortin inhibits the activity of phospholipase A2, which releases arachidonic acid, the precursor of prostanoids and leukotrienes, from phospholipids. In contrast, corticosteroids inhibit mRNA responsible for interleukin-1 formation. These actions of corticosteroids on arachidonic acid metabolism and interleukin-1 formation produce anti-inflammatory, immunosuppressive and anti-mitogenic effects. Although this theory based on protein synthesis may not explain all effects of corticosteroids, these examples illustrate that a specific action on the molecular level can explain some of the characteristic and typical pharmacological effects of topically applied corticosteroids. PMID: 253377 [Indexed for MEDLINE]

Topical corticosteroids: mechanisms of action.



SPECIAL WARNINGS & PRECAUTIONS FOR USE

Corticosteroids may reduce resistance to and aid in the establishment of non-susceptible bacterial, fungal, parasitic or viral infections and mask the clinical signs of infection, or may suppress hypersensitivity reactions to substances in the product. Fungal infection should be suspected in patients with persistent corneal ulceration who have been or are receiving these drugs and corticosteroid therapy should be discontinued if fungal infection occurs

Sensitivity to topically applied aminoglycosides may occur in some patients. Cross-sensitivity to other aminoglycosides may also occur. Severity of hypersensitivity reactions may vary from local effects to generalized reactions such as erythema, itching, urticarial, skin rash, anaphylaxis, anaphylactic reactions, or bullous reactions. If signs of serious reactions or hypersensitivity occur, discontinue use of Maxitrol.

MAXITROL OINTMENT

• This product contains methylparahydroxybenzoate and propylparahydroxybenzoate which may cause allergic reactions (possibly delayed).

• This product also contains lanolin which may cause local skin reactions (e.g. contact dermatitis).

QUALITATIVE & QUANTITATIVE COMPOSITION

- 1 gram ointment contains 1 mg dexamethasone, 6000 IU polymyxin B sulphate, and 3500 IU neomycin sulphate (as base).
- Excipients: 1 gram ointment contains
- Methyl parahydroxybenzoate 0.5 mg,
- Propyl parahydroxybenzoate 0.1 mg and Liquid lanolin 30 mg

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Biofilm and Wound Healing

PRAVIN DEO, COLORECTAL CNS/STOMAL THERAPIST
COUNTIES MANUKAU DHB

While wound care has been a part of the nursing role over the last 150 years, nurses still face many challenges to optimally manage acute and chronic wounds.

Chronic and acute wounds are not only causing pain, discomfort and having a detrimental effect on patients' quality of life, but are also causing a significant amount of financial burden on healthcare providers all over the world

Wound healing is a critical process that follows a series of reactions and interactions (Janis & Harris 2016). It is a multidisciplinary specialty that requires physiologic, immunologic, physical, social, and societal factors (Quain & Khardor 2015). Oxygen and blood supply play an important role in wound healing as they induce important wound healing factors such as angiogenesis, fibroblast proliferation, cell migration, epithelisation, collagen synthesis, and increased keratinocyte differentiation (Parrish & Roides 2017). However, factors such as diabetes, obesity, smoking, stress, poor nutrition and biofilm can slow wound healing process and cause wound infection by impairing blood and oxygen supply to the wound tissues (Guo & DiPietro 2010). This article looks at the importance of managing biofilm in wound healing.

Although inflammation is a normal part of wound healing process, bacteria and endotoxins can lead to prolonged elevation of pro-inflammatory marker elongating the inflammatory phase of wound healing which can lead to wound entering into a chronic stage with delayed healing (Sood, Franick & Tomaselli 2012). While all kinds of wounds are contaminated with some forms of bacteria, they do not show signs and symptoms of impending infection until when they are critically colonized (Sood, Franick &Tomaselli 2012). This is when the bacteria causes reactions to host cell by reproducing and showing signs and symptoms of impending infection such as exudates, friable granulation tissue, a change in colour of granulation tissue to bright red, and an increased pain (Sood, Franick & Tomaselli 2012).

Bacteria are also known to form a protective polysaccharide coating, especially in chronic wounds, called a "biofilm (Guo & DiPietro 2010). Biofilm is bacteria growing in organized slime-enclosed aggregates in the human host, often leading to an infection that turns out to develop into a chronic state (Bjarnshol 2013). These kinds of infection are extreme resistance to antibiotics and many other conventional antimicrobial agents and have an extreme capacity for evading the host defenses (Bjarnshol 2013). Biofilm impairs epithelization and granulation tissue formation and lowers inflammatory response interfering with wound healing (Metcalf & Bowler 2013)

In a wound with biofilm, it is important to identify biofilm as biofilm may not be visible to naked eyes (Hall-Stoodley et al. 2012; White & Cutting 2012). This will help with more effective preparation of wound bed for healing and selection of the most appropriate and effective antimicrobials and dressings that are cost-effective (Metcal & Bowler 2013). Physical debridement and antimicrobial therapy have shown to enhance wound recovering in a wound with biofilm (Metcal & Bowler 2013). Debridement removes biofilm from the wound (White & Cutting, 2012), forcing the remaining bacteria to revert to more metabolically active form so antibiotics and topical antiseptics work more effective (Welcott, Kennedy & Dowd 2009). Debridement could range from sharp surgical to gentler mechanical debridement with curettes, fabric pads, lavage or ultrasound, to autolytic debridement with moisture-retentive dressing (Strohal et al. 2013). However, debridement should be done regularly as biofilm grows rapidly (Bjarnshol 2013).

Hence, it is important to identify biofilms in wounds and take measures to remove them for faster wound healing.

Biofilm and Wound Healing

PRAVIN DEO, COLORECTAL CNS/STOMAL THERAPIST
COUNTIES MANUKAU DHB

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Policy for Bernadette Hart Award

Process

- The Bernadette Hart Award (BHA) will be advertised in the NZNOCSTN Journal The Outlet
- The closing date for the BHA applications is 30 November each year
- The NZNOCSTN Executive Committee will consult and award the BHA within one month of the closing date
- All applicants will receive an email acknowledgement of their application
- All applicants will be notified of the outcome, in writing, within one month of the closing date
- The monetary amount of the award will be decided by the NZNOCSTN Executive Committee. The amount will be dependent on the number of successful applicants each year and the financial status of the BHA fund
- The name of the successful applicants(s) will be published in the NZNOCSTN Journal The Outlet
- The BHA Policy will be reviewed annually by the NZNOCSTN Executive Committee.

Criteria

- The applicant(s) must be a current member of the NZNOCSTN and have been a member for a minimum of one year
- Successful applicant(s) must indicate how they will use the award. The award must be used in relation to Stomal Therapy nursing practice
- The applicant(s) previous receipt of money (within the last five years) from the NZNOCSTN and/or the BHA will be taken into consideration by the NZNOCSTN Executive Committee when making their decision. This does not exclude a member from reapplying. Previous receipt of the BHA will be taken into account if there are multiple applicants in any one year
- The funds are to be used within 12 months following the receipt of the BHA.

Feedback

- Submit an article to The Outlet within six months of receiving the BHA. The article will demonstrate the knowledge gained through use of the BHA

and/or

- Presentation at the next NZNOCSTN Conference. The presentation will encompass the knowledge/nursing practice gained through the use of the BHA.

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

- Must be a current full or life member of the NZNO College of Stomal Therapy Nursing (NZNOCSTN) for a minimum of one year
- Present appropriate written information to support application
- Demonstrate the relevance of the proposed use of the monetary award in relation to stomal therapy practice
- Provide a receipt for which the funds were used
- Use award within twelve months of receipt
- Be committed to presenting a written report on the study/ undertaken or conference attended or write an article for publication in The Outlet or to present at the next national conference

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

Email: angela.makwana@waitematadhb.govt.nz or dawn.birchall@middlemore.co.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

(If for Conference or Course, where possible, please attach outlined programme, receipts for expenses if available)

• Outline the relevance of the proposed use of the award to Stomal Therapy

_____

_____

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

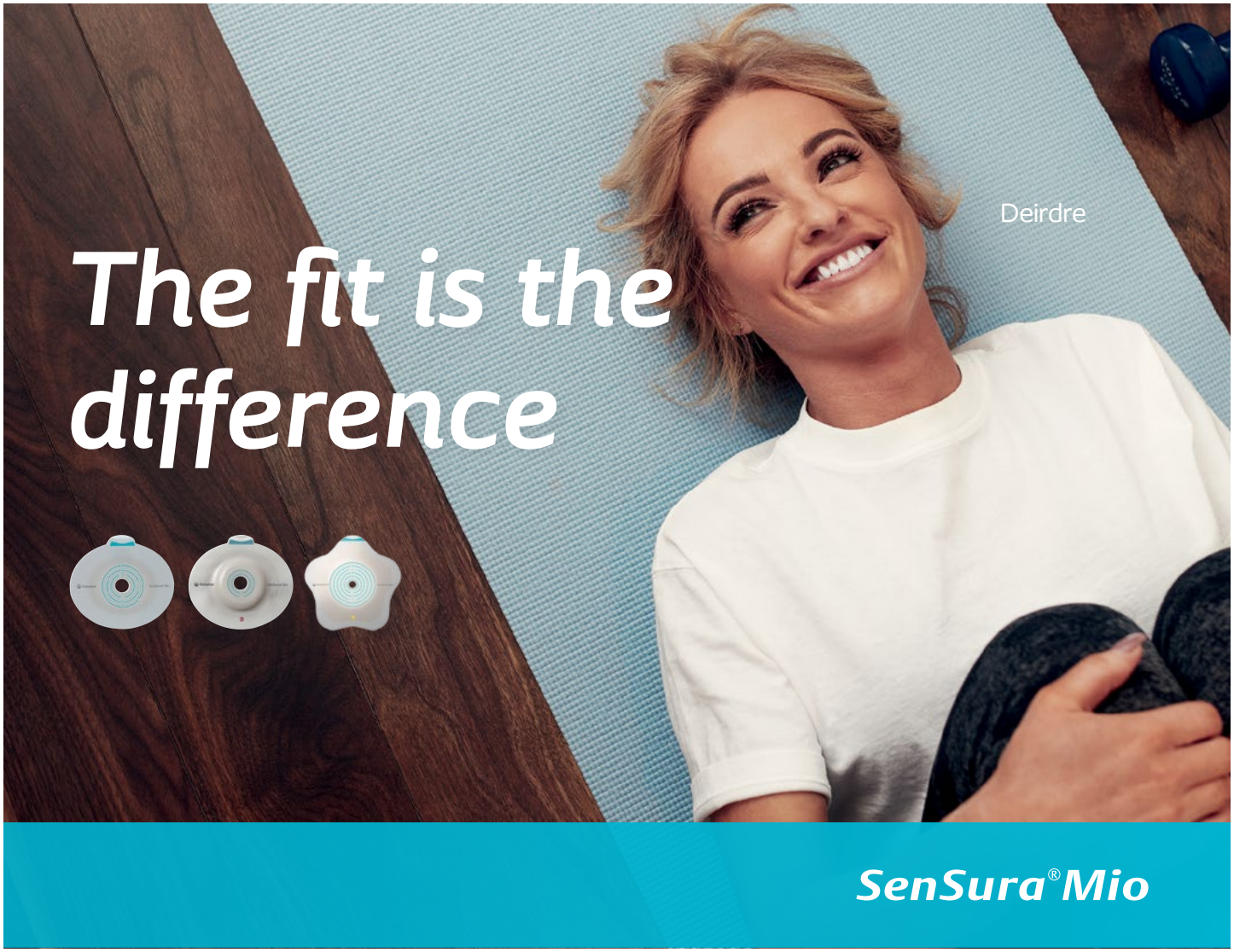
Have you been a previous recipient of the Bernadette Hart award within the last 5 years? ◯ No ◯ Yes (date) _____

Please Indicate ONE of the below: (please note this does not prevent the successful applicant from contributing in both formats).

◯ Yes I will be submitting an article for publication in 'The Outlet' (The New Zealand Stomal Therapy Journal).

◯ Yes I will be presenting at the next National Conference of NZNOCSTN.

Signed: _____ Date: _____



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1. Rolstad, B. S. & Erwin-TothP. L. PeristomalSkin Complications: Prevention and Management. Ostomy Wound Manage. 2004;50(9):68-77.
2. Kruse T. M & Størling Z. M. Considering the benefits of a new stoma appliance: a clinical trial. British Journal of Nursing, 2015 (Stoma Supplement), Vol 24, No 22.

Ostomy Care / Continence Care / Wound & Skin Care / Interventional Urology

Coloplast Pty Ltd, PO Box 240, Mount Waverley, VIC 3149 Australia
www.coloplast.com.au

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Writing in The Outlet

PURPOSE

The Outlet is the journal representing the New Zealand Nurses Organisation College of Stomal Therapy Nursing (NZNOCSTN), and has a strong focus on the specialty nursing area of Stomal Therapy. Local input is encouraged and supported. The editors of The Outlet are appreciative of the opportunity to assist and mentor first time publishers or to receive articles from more experienced writers. The guidelines below are to assist you in producing a clear, easy to read, interesting article which is relevant.

The main goal of writing for the Outlet is to share research findings and clinical experiences that will add value and knowledge to clinical practice of others. The essence of writing for The Outlet is a story or research study, told well and presented in a logical, straight forward way.

Readers of The Outlet are both generalist nurses and specialist Stomal Therapists. Articles should be focused on what a nurse/patient does; how a nurse/patient behaves or feels; events that have led to the situation or on presenting your research methodology and findings. Linking findings to practice examples often increases comprehension and readability. Addressing questions related to the who, what, why, when, where, and/or how of a situation will help pull the article together.

GUIDELINES

Writing Style
Excessive use of complicated technical jargon, acronyms and abbreviations does not add to the readability of an article and should therefore be avoided if possible. Short sentences rather than long running ones are more readable and generally promote better understanding. The Outlet has a proofing service to assist with spelling, grammar etc.

Construction of the Article
It may help in planning your article if you bullet point the key concepts or points, format a logical paragraph order and then write the article from that plan.

Article Length
There are no word limits for publishing in The Outlet. First time writers may like to limit themselves to 2500-3000 words which is approximately three published pages.

Photographs, Illustrations, Diagrams, Cartoons
These are all welcome additions to any article.
Please email these with your article providing a number sequence to indicate the order in which you wish them to appear and a caption for each.

Copyright
The NZNOCSTN retains copyright for material published in The Outlet. Authors wanting to republish material elsewhere are free to do so provided prior permission is sought, the material is used in context and The Outlet is acknowledged as the first publisher. Manuscripts must not be submitted simultaneously to any other journals.

Referencing
The preferred referencing method for material is to be numbered in the body of the work and then to appear in the reference list as follows:

1) North, N.& Clendon, M. (2012) A multi-center study in Adaption to Life with a Stoma. Nursing Research 3:1, p4-10

Most submitted articles will have some editorial suggestions made to the author before publishing.

Example Article Format Title
As catchy and attention grabbing as possible. Be creative.

Author
A photo and a short 2-3 sentence biography are required to identify the author/s of the article.

Abstract
Usually a few sentences outlining the aim of the article, the method or style used (e.g. narrative, interview, report, grounded theory etc.) and the key message of the article.

Introduction
Attract the reader's attention with the opening sentence. Explain what you are going to tell them and how a literature review must be included.

Literature Review
If publishing a research paper.

Tell Your Story
Ask yourself all these questions when telling your story.
Who was involved, history of situation, what happened, your assessment and findings, why you took the actions you did and the rationale for these? Your goals/plan. The outcome. Your reflection and conclusions. What did you learn? What would you do differently next time?

Remember there is valuable learning in sharing plans that didn't achieve the goal you hoped for.

Patient stories are a good place to start your publishing career and nurses tell great stories. As editors we encourage you to experience the satisfaction of seeing your work in print and we undertake to assist in every way that we can to make the publishing experience a good one.

NB: Written in conjunction with NZNO Kai Tiaki Publishing Guidelines

The Outlet

New Zealand Stomal Therapy Nurses