The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

IN THIS ISSUE:

Nurse Profile: Teressa Wingate

Accessible basic stoma therapy
on line for everyone

Faecal Microbiota Transplantion

MARCH 2023

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The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

CONTENTS

PROFESSIONAL SECTION

04 EXECUTIVE COMMITTEE MEMBERS

05 CHAIRPERSON'S REPORT

06 EDITORS' REPORT

08 NURSE PROFILE: TERESSA WINGATE

24 STOMAL THERAPY SERVICES CONTACT DETAILS

33 WRITING FOR THE OUTLET

34 POLICY FOR BERNADETTE HART AWARD

35 APPLICATION FOR BERNADETTE HART AWARD

EDUCATIONAL SECTION

10 ACCESSIBLE BASIC STOMA THERAPY ON LINE FOR EVERYONE

14 FAECAL MICROBIOTA TRANSPLANTION

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Chairperson's Report

EMMA LUDLOW

My name is Emma Ludlow and it is a privilege to represent you as the new Chairperson of the NZNO College of Stomal Therapy Nursing.

I look forward to working on your behalf to address some of the issues facing stomal therapy nurses in New Zealand.

Firstly, I wish to send my thoughts to everyone affected by the natural disasters that have struck the north island over January and February this year. The added stress and anxiety of ensuring our families are safe and what will be added to our burgeoning workloads will be immense. Please take care of yourselves first and foremost and please reach out to the NZ network of stomal therapy nurses where needed. Who knows, someone in a neighbouring region might just have that box of soft convex drainable ready and waiting to go!

I would like to send my sincere thanks to the outgoing committee. You were so wonderful to work with over the last two years. A priceless combination of passion and black humour. I thank Nicky for her exceptional leadership as chairperson and designated pastry supplier. I thank Dawn for her spirited and objective discussion on all things stomal therapy. I thank Angela for her unparalleled editing skills. I thank Rochelle for her empathy and real-world practicableness.

I wish to extend a big thank you to Chris Cameron for continuing as Treasurer and Cathy Leigh who continues as our Professional Nursing Advisor. I warmly welcome new committee members, Maree Warne from Hawkes Bay as Secretary, Marie Buchanan and Preeti Charan from Waitemata as Co-Editors of The Outlet, and Holly Dorizac from Counties Manakau as committee member and WCET delegate. We have had our first meeting and I look forward to us all working together to continue to promote stomal therapy and advocacy for our patients!

The committee this year will be focusing on completing and publishing the stomal therapy clinical guidelines that were started by the previous committee. We hope this will be an excellent addition to your stomal therapy arsenal. Later in the year, we will start organising the next stomal therapy conference, earmarked for February/March 2024, which will include the next BGM.

We strongly encourage anyone with a passion in stomal therapy to undertake the formal qualification via the Australian College of Nursing or Curtin University. Both Graduate Certificates are endorsed by the New Zealand College of Stomal Therapy, take a year to complete, and are completed by distance learning. The committee will support and help arrange your placements here in New Zealand.

This year's Bernadette Hart award was awarded to Angela Makwana. She will utilise the funds to attend the AASTN conference in April this year. Thank you for representing New Zealand and we look forward to reading your article in The Outlet Angela! The Bernadette Hart award is awarded annually with submissions closing November 30 each year. I would also like to highlight the Liberty "Beyond the Ostomy Clinic" funding that is available to a nurse who requires extra assistance with funding a project or support the attendance to a conference. Details on how to apply for these awards can be found on the NZNOCOSTN website.

As we continue to wade through this new COVID world, and current extreme weather challenges please do not hesitate to contact your stomal therapy committee members as we are all here to support you and we welcome all feedback and enquires to improve your collage. We are all in it together!

Best wishes,

Emma

Editors' Report

PREETI AND MARIE

What an unbelievable start to 2023 for the upper North Island.

While in the process of cleaning up after significant flooding cyclone Gabrielle hit mercilessly, leaving behind a trail of distraction and pain. Not only is there the physical destruction to homes, belongings and infrastructure but the mental challenges everyone is facing in continue on to ensure patients continue to receive the care they need as well as dealing with challenges and hardships personally incurred is a credit to you all.

Our thoughts and best wishes are with everyone, your families and friends - kia kaha e hoa ma.

As the new co-editors of The Outlet, we would like to acknowledge and thank the outgoing editors, Angela Makwana and Dawn Birchall, for their hard work and achievement in producing an informative and motivating journal for our members. We too are committed to maintain their high standard and continue producing a quality journal for the membership.

On a much brighter note, for those going to Perth to attend the Australian Association of Stomal Therapy Nurses conference in April have something to look forward to and are sure to be educated and entertained. Remember what happens at conference does not need to stay there! Attending these International conferences provides us with the opportunity to meet and greet our ostomy colleagues internationally and learn about the progress within the ostomy world. It would be great to hear your experiences from those that are attending to share your learnings with those who are not attending.

Thank you to the NZNOCSTN members who have supported the production of The Outlet through contributing an article or profile for printing.
The membership's input is essential to the ongoing success of the journal. Please consider submitting articles of interest, educational material or a profile. Story telling is well known to one of the best educational tools. Profiles are a great opportunity to tell story and to get to know our peers around New Zealand. These stories will also inspire up and coming nurses with an interest in stoma care. We will be contacting members directly requesting profiles, we appreciate that everyone is busy and workloads can be very demanding but we would appreciate if you could make a conscious effort to complete and submit it. Please support us by submitting early and do not hesitate to contact as on below emails anytime for support or advice on doing this. Information on submitting an article.

We hope you enjoy this edition of "The Outlet". There are some great articles to review and look out for the information of a newly developed online Stoma Therapy course just launched. We are also pleased to include an updated national contact list for Te Whatu Ora Health New Zealand Ostomy services. The editors will maintain this list in the future, please email any changes/updates so as to maintain the information.

noho haumaru me nga hiahia mahana

Preeti Charan

Marie Buchanan

CALLING FOR SUBMISSIONS

We know there are MANY patients that have benefitted from the expertise and persistence of Stomal Therapists/Ostomy nurses. WE WANT/NEED YOUR STORIES. Share your good work for the benefit of others.

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Please send your submissions to either:

- Preeti.charan@waitematadhb.govt.nz or
- Marie.buchanan@waitematadhb.govt.nz

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CE

dansac

Nurse Profile

TERESSA WINGATE
COLORECTAL/ERAS CLINICAL NURSE SPECIALIST

I'm about to reach the exciting and daunting milestone of turning 50 years old and have also now been nursing for over 29 years.

Looking back at my younger years growing up in the small rural town of Martin, I had plans to become an accountant. However after developing Guillian Barre' just before my 14th birthday I spent several years undergoing treatment and recovery and was inspired to become a nurse like those who had shown me such empathy, humour and skill throughout my health journey.

I went straight from school to undertake the Diploma of Nursing at Manawatu Polytechnic and still have fond memories of my student days in Palmerston North with great tutors such as Prof Jenny Carrier who was so inspiring. On graduation I followed a good friend and fellow new graduate to the "big smoke" of Auckland where I count myself lucky to get a job within Waitemata DHB on the Rehabilitation Ward, at a time when it was difficult to get a job as a new graduate nurse. I was a very shy person when I began my career but quickly gained confidence and thoroughly enjoyed working collaboratively within a team. I know I have carried the principles of rehabilitation into all my surgical roles since and likely influenced my appreciation for the principles of Enhanced Recovery after Surgery (ERAS) pathways later in my career.

I have been working within the field of General Surgery for the majority of my career and in 2008 after a couple of years travelling and working in the UK I returned to New Zealand and I feel blessed to have been employed as an RN on Ward 8, General Surgery at North Shore Hospital. It was a highlight of my career working on this very busy and high acuity ward. We had an excellent professional and collaborative team of nurses and I have many friendships with colleagues from this time in my life. I completed a Postgraduate Certificate in Perioperative Specialty Nursing and continued to build on my knowledge and skills in managing complex surgical patients, particularly in colorectal surgery.

I advanced my leadership and senior nursing skills as an Associate Charge Nurse and then Acting Charge Nurse over the next three years. During that time I collaborated on developing ERAS protocols for Elective Colorectal Surgery and I strongly identified with what at the time was a new approach to the way we managed our surgical patients.

In 2011 I was employed as a ERAS and Colorectal Clinical Nurse Specialist (CNS) and at that time the colorectal component of my role was one and a half days a week and my colleague Karen Pollock, Colorectal CNS and I covered stoma therapy within our Colorectal roles. I am thankful for the excellent support and mentorship by Karen during my transition to CNS. As I developed as a CNS I also continued to build on my stoma and colorectal knowledge I had gained on the general surgical wards to an expert level where I was now competent managing complex stoma issues and providing clinical coaching to both patients and staff.

After successfully implementing ERAS pathways in Colorectal Surgery and demonstrating sustained improved surgical outcomes and patient experience ERAS has become standard care in the Waitemata Colorectal Surgery. I was seconded for 18 months to the Orthopaedic service as a Project Manager for the National Collaborative for the development and implementation of ERAS clinical pathways in the management of patients presenting with acute fractured neck of femur and patients undergoing elective hip and knee joint replacement. This challenging role advanced my experience in quality improvement and the complex project management required with practice change within multiple hospital departments.

I happily returned to my Colorectal CNS role in 2014 and have continued to expand my knowledge and skills in cancer coordination, management of colorectal conditions including IBD, LARS, chronic conditions and complex stoma management. At Waitemata we are lucky to have Angela Makwana, our inpatient Stoma CNS who works part-time she has brought a wealth of experience to the role and is very generous with her time and knowledge. With her support, I have continued to gain confidence and skill in complex stoma siting and management of complex stoma complications.

I've always felt there was a shortage of stoma therapy resource both locally and nationally particularly now as our populations and the number of acute presentations with complex stoma management needs continues to increase. I have often felt that ostomates lack the support that other patients groups have access to e.g. cancer patients. As a senior nurse, I aim to promote stoma therapy and provide mentorship to our nursing teams with hope that we can continue to grow our stoma therapy workforce. I feel privileged in my role to be able to spend the time with our patients during their perioperative journey to listen to their fears and concerns and to support them in their journey to becoming independent and more confident with their stoma management, time that our nursing colleagues on the wards often do not have.

As I now approach 50 years of age I have finally reached the milestone of purchasing my first home and I hope to maintain my health and fitness so I can continue my passion for nursing within the Colorectal and Stoma Services for another 20 years. I aim to progress my clinical skills in the colorectal field and enhance my nursing practice further with postgraduate study.

Accessible basic stoma therapy on line for everyone

BY SASHA DRENNEN, NURSE EDUCATOR PRIMARY HEALTH, WDHB.
EDITED BY MARIE AND PREETI.

As with all aspects of the nursing profession, stoma therapy is not only an art but also a science and demands a sound knowledge and skill base to ensure safe and consistent care.

Many of us as Stoma Therapy Nurses, (STN's) are "old hands" at stoma management. Experienced STN's have an in-depth solid knowledge and skill base built on many years of clinical experience and supported by participating in ongoing education. Those with this knowledge and skill base could be guilty of forgetting that colleagues may only see a stoma patient 2 or 3 times a year and have very limited knowledge/experience and skill base around stomas' and the management of these.

Within the Te Whatu Ora Health NZ, Waitemata district, the Ostomy service has an Ostomy Clinical Nurse Specialist (CNS), at each community base and within the inpatient setting which offers a wide cover of support for staff and availability for stoma patients.

It could be argued that by having, a CNS's in stomal management readily available could run the risk of deskilling the general nurse as their input and management is reduced. But the reality is, the Ostomy CNS has to have the support of the general nurses as the demand is higher than the FTE allocated, we are not available 7 days a week (although with mobiles and computers this is debatable!), and leave is not covered. We are aware that there are some areas do not have an STN to offer support, therefore stoma knowledge and education becomes of even a greater need. Through having the Ostomy CNS's I would agree that the reality of regularly managing a stoma patient in the general service is reduced but definitely not negated and paramount to ensure the continuum of care for this cohort of patients.

Over the recent years with the advancement in medicines, treatments, diagnostic tools and better surgical techniques people tend to be living longer and often with multiple co-morbidities. With increasing longevity, the demand for residential care is increasing. Unfortunately, it could be stoma management that drives the need for care. With impaired dexterity, cognition, eyesight, or general health status, stoma patient's ability to remain independent with the stoma care at home can be the catalyst in moving into ARC. This increase in demand has highlighted another area in need of stoma education, residential care nurses.

Sasha Drennan, Nurse Educator Primary Health Care, identified the desperate need for easily accessible stoma education for staff within the aged residential care (ARC) sector, and was determined to ignite this and make it happen.

Sasha acknowledged that registered nurses within New Zealand ARC environments are very knowledgeable and practice in an autonomous manner covering all aspects of nursing. Stoma therapy is one of these areas that there is an expectation of knowledge and skill base but the access to the education for this was not radially available.

Sasha enlisted the support of STN's at Te Whatu Ora Waitemata, Satoko Keneko, Preeti Charan, Zara Schofield and Angela Makwana to develop, write, peer and review an on line education programme for stoma therapy and management. The online course was developed over several months and demanded a lot of personal input and time.

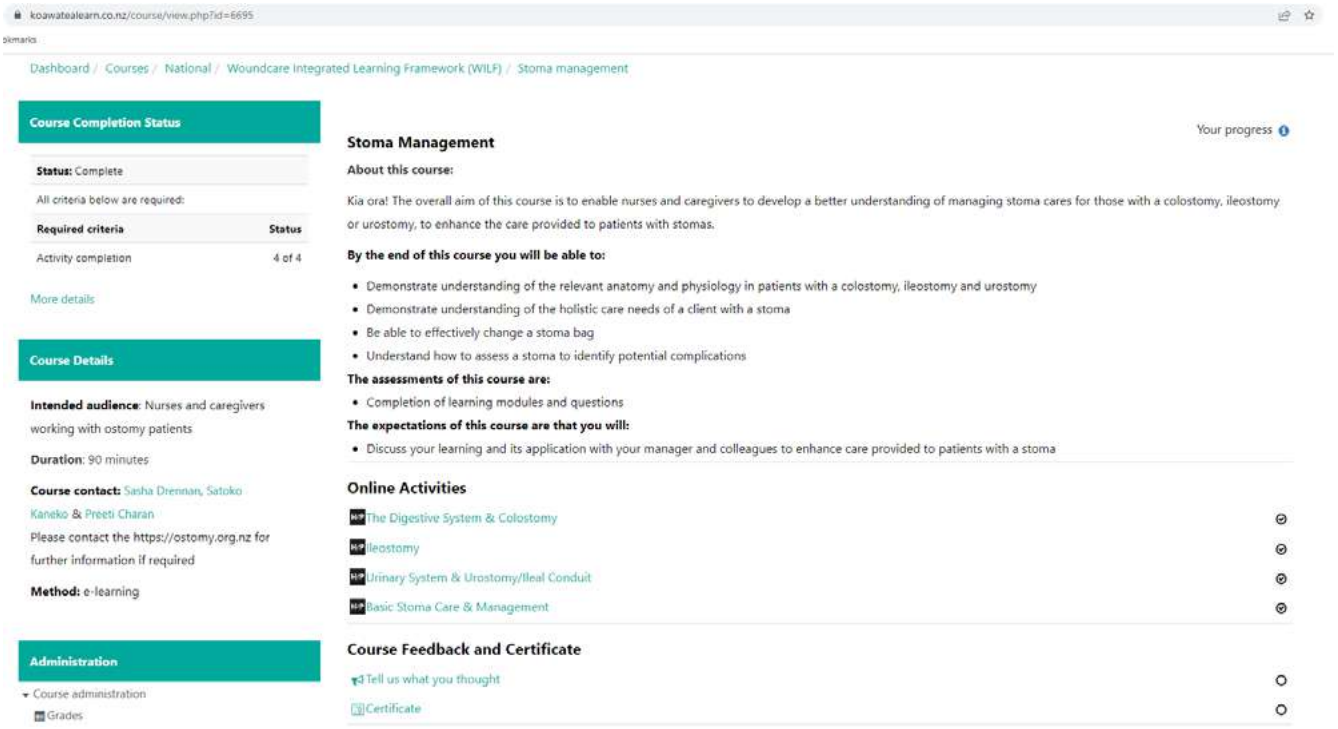
Sasha's main aim was to ensure that the education was accessible to anyone hence the focus on the development of the digital education revolution programme. Although the original intent of the programme was, originally aimed at ARC staff it was quickly recognised as an excellent resource for the District Nursing teams and could easily be used by anyone to gain a basic knowledge and understanding of stomas and their management.

The aim of the course is to offer basic knowledge of stomas accessible to anyone. The course is aimed to take 90 minutes and includes anatomy and physiology of the bowel, basic stoma management, basic trouble shooting for stoma management, example of changing an uncomplicated stoma pouch. It incorporates several different learning tools to ensure engagement create a safe and supportive learning environment. It is interactive with a quiz to test knowledge on each topic.

Recently the course was used as pre reading for a Stoma therapy workshop for new district nurses. The participants had the morning to complete the on line course and then brought questions or clarification to the workshop for discussion and clarification. The feed back on the course was overwhelmingly positive with comments of “very clear”, “easy to understand”, “interactive” and “well worth it”. The course is available to access by any service nationally through Ko Awatea learn.

Below is a screen shot of the Ko Awatea learn page and the link to - Stoma Management:

https://koawatealearn.co.nz/course/view.php?id=6695



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Faecal Microbiota Transplantion

FIONA WILLIAMS
CNS GASTRO, TE WHATU ORA, WAITEMATA

BACKGROUND

Faecal Microbiota Transplantation (FMT) though relatively new to western medicine was first practiced 1700 years ago. Ge Hong was a Chinese researcher in the fourth century, who used what he called 'yellow soup' to treat his patients with severe diarrhoea (*Ref 1*). More recent records show that camel stool was used to treat bacterial dysentery in German soldiers during World War 2. It was not until 1958 that faecal transplant started to gain traction, after being first reported in the English Language by Eiseman et al. (*Ref 2*), who had success using faecal enemas to treat pseudomembranous colitis.

To date, faecal transplant at Te Whatu Ora- Waitemata has been used predominantly to treat recurring Clostridium difficile (C. diff) infection. The premise of the treatment is very simply the placement of donated healthy faecal matter into an empty recipient bowel, the idea being that the introduced healthy stool will overwhelm the destructive harmful bacteria in the gut to correct the dysbiosis caused by the C.diff infection.

DONOR SCREENING

In order to do the transplant, healthy stool must be available. At Te Whatu Ora-Waitemata, we rely on voluntary stool donation, whether from a relative or person known to the patient requiring the transplant, or from an anonymous donor. Irrespective of whether the prospective donor is known or not to the recipient, they must meet with the Gastro Clinical Nurse Specialist (CNS) in clinic for explanation and assessment for donor suitability. An information sheet supporting the explanation by the CNS during the clinic visit is given for reference with CNS contact details for possible further questions.

The discussion and information sheet details:

- What faecal transplantation is
- The criteria for donating stool
- What happens before donation, ie the assessment, primarily in the form of a questionnaire, vital signs, weight, blood and stool testing, the results of which will be made known to the candidate.
- The safety of stool donation.

Assessment

Prospective donors answer an extensive list of questions screening for potential risk. These include symptoms of current infection (both gastro and others such as Covid), along with their full vaccination history. Patients with a history of at- risk behaviour for other blood-born infection are excluded, including those who have engaged with sex workers, had multiple sexual contacts or needle use. Patients with new tattoos or piercings and recent acupuncture are delayed for 6 months to avoid any early false negatives of the antibody testing. We also exclude a number of conditions with the potential to cause harm in the recipient. These include a history of cancer or blood-born disease, auto-immune disease, and a strong family history of Gastrointestinal malignancy. There is no direct evidence that these conditions can be transferred with gut bacteria, but as with all forms of donation it is better to use caution.

Prospective donors need to have a normal bowel habit without Irritable Bowel Syndrome gut symptoms such as constipation, bloating or diarrhoea. Recent antibiotic use may alter the gut microbiome so donation is put on hold for 3 months after completion of the course of antibiotics. Overseas travel or having resided in U.K. during the period 1980-1996 prohibits stool donation to rule out Creutzfeldt-Jakob Disease. Bone, skin or hair transplants will also exclude a possible stool donation.

Due to this vigorous screening, there is unfortunately often a shortage of stool donors as only 1 in 30 prospective donors meet the criteria for safe donation (*Ref 3*).

Once the questionnaire is completed the candidate signs to attest that the health information they have provided is true.

The candidate's undergo a limited physical examination including temperature, pulse, blood pressure, respiration rate and weight all of which are documented. Due to a case report of a recipient becoming obese after receiving stool from an obese donor (*Ref 4*), the candidate must have a BMI less than 30.

If there are no alarms from the questionnaire, the potential donor is given a blood form to have blood drawn to check general health (renal, FBC, LFTs, CRP) but also screen for significant infectious diseases. These include:

- Hep A,
- Hep B S Ag
- Hep B S Ab
- HIV
- CMV and Syphilis status.

Stool pottles are given for samples to check for:

- C.difficile
- H.pylori
- Trichrome Stain for parasites like Giardia and Cryptosporiduim Ag and any others,
- Culture for Enteric Pathogens, ESBL, VRE (vancomycin resistant enterococcus), Norovirus, Rotavirus.

Blood and stool results along with the completed questionnaire are then seen by the Consultant and if all the criteria is met, the candidate is asked to donate.

Most people produce around 200g in an average bowel motion. For transplant 50g of stool is needed, so one donation provides approximately 4 transplants.

Candidates are encouraged to bring as many donations as they can within a week as delay of more than 2 weeks would necessitate a repeat of all the testing. Similarly, if the donor should develop any symptoms or receive a new diagnosis during the donation process the donations would need to cease and any donations already received and banked would need to be destroyed. The candidate must get the fresh donated stool to microbiology for processing within 4 hours of passing the stool to prevent stool degradation.

This means that a stool donor needs to either travel a lot during the donation week, or arrange for their stool to be delivered to the lab by a family member who works nearby. The logistics of getting the donation to us each day can be a major barrier due to the travel involved, even if we compensate donors for the cost of petrol.

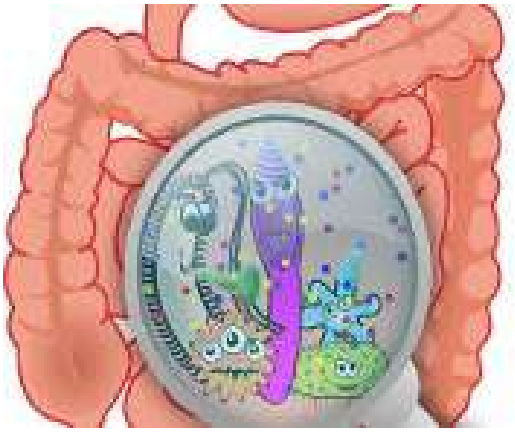
MICROBIOLOGY

The microbiologist on receiving the donation will check for any visible pathology e.g., contamination, discoloration, blood, mucus or for poor consistency -Bristol stool scale 5,6 and 7 is unacceptable. Evidence of any of these will result in the donation being destroyed along with donations that do not meet a minimum weight of 50 grams as these are not cost-effective to process.

After visual inspection and weighing, the stool is transferred to a sterile blender and blended with 200mls sterile saline.

Once processed, the stool that is not being used is stored in a freezer in Microbiology at minus 80 degrees Celsius, where it can remain for a maximum of 6 months. Sadly after that time period a stable microbial community is not maintained so the donation then needs to be discarded. Frozen stool to be used for FMT will need to be defrosted for approximately 4 hours prior to use.

TREATMENT OF C. DIFF



First line of treatment for C.diff is antibiotics, including Metronidazole and Vancomycin. Fidaxomycin has also shown to be effective, but unfortunately is not funded in New Zealand. Most patients respond to treatment initially, but some will relapse with a rapid return of their diarrhoea, and recurrent C. diff which has a low cure rate with repeat antibiotics. If antibiotic treatment for C. diff fails, the persistence of the relentless life affecting symptoms can bring patients to the point of desperation and willing to do whatever it may take to get free from the infection. This need overrides any possible psychological and social stigma associated with the inherent 'yuck' factor associated with faecal transplant. Some patients prefer to ease this further by knowing their donor in the form of a relative or close friend. Others prefer their donor to be anonymous.

The potential recipient initially presents to the CNS clinic, where an overview of faecal transplant and preparation for the treatment is discussed. Assessment is performed to check that colonoscopy and transplant will be safely tolerated.

For transplant via colonoscopy, prep starts with a low fibre diet 3 days prior to the procedure. Bowel preparation is explained and information sheets are given to the potential recipient to take home as a reference and instruction. CNS contact details are also given.

Further discussion in clinic includes what to expect immediately post treatment and for the next subsequent few days. The Gastro CNS contacts the recipient daily for as long as required following the transplant. Recipients are given contact details and are encouraged to use them if any questions, queries or concerns arise.

Due to the nature of the treatment, the potential recipients usually have many questions.

- Some common ones include:
- What will I feel at the time of the transplant?
- What will I feel afterwards?
- How do I know how safe the procedure is?
- How do I know that the donor is clean?
- Are there any side effects that I should be concerned about?
- How will I know that the treatment has worked?

Preparation prior to the transplant, as well as the bowel prep and consideration/alteration of the recipients regular medications, includes stopping vancomycin 24 hours prior if being taken.

Two consent forms need to be completed prior. The first is consenting to undergo colonoscopy and the second is consenting to the faecal transplant. The recipient as mentioned will have had a thorough explanation of the procedure and opportunity to ask questions in clinic. This is repeated prior to commencement by the endoscopist performing the transplant. The recipient understands that they can change their mind at any time even after signing the consent form.

The transplant consent form is unique and includes acknowledgment that:

- The donor is safe and screened.
- There has been a discussion of the benefits of having the transplant verses the risk of not having it.
- There are some short-term risks which may include a degree of abdominal bloating, diarrhoea, cramping, constipation, fever and rarely bacteria in the blood.
- That there may be some longer-term risks.

Because faecal transplant is comparably recent to western medical practice, possible long- term effects are as yet unknown. Some of these could theoretically include weight alteration, development of metabolic syndromes, diabetes as an example, development of altered bowel function including Inflammatory Bowel Syndrome and chronic constipation and development of autoimmune disorders such as Sjogren's Disease and rheumatoid arthritis.

The recipient is also asked to acknowledge in signing the consent form that there is no guarantee that the transplant will improve the condition and a further transplant or further antibiotic therapy may be required.

THE PROCEDURE

Once in the procedure room, the patient is connected for vital signs monitoring and given oxygen via nasal cannula.

They are asked to lie on their left side and unless there are allergies or contraindications, sedation in the form of Midazolam and Fentanyl is given intravenously. 4 x 50ml syringes containing the faecal slurry, plus x1 extra 50ml syringe of water for irrigation/flushing are prepared prior ready for deployment.

The endoscopist manoeuvres the colonoscope via the anus, around the colon to the terminal ileum from where it is slowly withdrawn with the slurry deployed by inserting the prepared syringe into the biopsy channel and advancing the plunger on instruction from the endoscopist, disposing of the faecal matter into the bowel.

Once the 4 syringes are emptied of the faecal slurry, the remaining 50ml syringe filled with water is used to clear the biopsy channel and deposit any residual slurry.

Documentation is two fold. The colonoscopy and faecal transplant report plus a recipient labelled document started in the microbiology lab. This form details the date of transplant, the donor details, including their biobank number and the number of vials stored. This is completed in Gastro at the time of transplant with the route of the delivery, eg colonoscopy, the time and the endoscopist. This form is then returned to the lab.

Post transplant, along with recovery from the colonoscopy, the recipient stays in recovery and is asked to lie for 30 minutes with the foot of the bed tilted head up to approximately 30 degrees. Loperamide 4mg is given to try to prevent immediate bowel motion. Ideally, no stool is passed for 2 hours post transplant.

As mentioned earlier, starting the first day post procedure daily follow up commences in the form a phone call from the Gastro CNS to monitor any post procedural symptoms. As explained to the patient in clinic, common minor immediate symptoms may include abdominal discomfort, bloating, flatulence, diarrhoea, constipation, borborygmy, vomiting and transient fevers.

Serious Adverse Events are rare but include complications from colonoscopy (adverse sedative reactions/bowel perforation, aspiration risk) and the transfer of enteric pathogens.

"CURE"

Recognition of cure from C. diff is the absence of symptoms following faecal transplant which can happen 0-5 days post successful FMT, but a full 'cure' in most studies is the resolution of symptoms at 8 weeks post FMT (*Ref 5*). The mean cure rate is 90% based on many published studies of clinical cohorts (*Ref 6, Ref 7*). A randomised controlled trial to see the effectiveness of FMT in a first or second recurrent C.diff infection was stopped early because of vastly superior results for FMT. After that there was no doubt of its efficacy.

(*Ref 8*)

POTENTIAL FUTURE APPLICATIONS

There is ongoing worldwide research in experimental phases to trial the success of faecal transplantation for health issues other than C.diff. This is because many diseases have a potential link to the gut microbiome. Some health issues that are being considered for FMT treatment include:

Small Intestine Bacterial Overgrowth (SIBO) which affects the bacteria within the small intestine. Because FMT is used to balance the microbiome, it is not a stretch to think FMT might be worth attempting to correct this, although to date there have been no studies on FMTs efficacy for treating SIBO. Due to the location of the affected bowel, donated stool would need to be deposited either by capsule, nasojejunal tube or via a long gastroscope rather than via colonoscope as practiced at Waitemata for C.diff infection.

Another area for possible faecal transplant success in the future is the treatment of autism. Promising studies have been done in Australia and Arizona, however the sample size was unfortunately small, with only 18 children as part of the trial, so by no means conclusive. Further studies however with a larger, placebo-controlled trial of FMT for autism in adults is soon thought to be embarked upon.

There is increasing evidence showing the link between Parkinson's and gut health, which has led to a current study in Adelaide. The aim of the study is to assess the biological impact of FMT on patients using dopamine scans to monitor the brain for abnormalities. The study will also provide some preliminary information on whether FMT can improve motor and non-motor symptoms of Parkinson's, including chronic constipation.

The Centre for Digestive Diseases treated its first patient with Ulcerative Colitis using FMT in 1988 and it is still used in some centers to treat patients that previously have been unresponsive to standard therapy. Recent randomized controlled trials have been done to support the clinical practice with published response rates greater than 50%.

As for Irritable Bowel Syndrome (IBS) there has been some experience of FMT helping IBS symptoms, however this not guaranteed. A recent randomised, double-blind, placebo-controlled study using FMT to treat IBS (*Ref 9*) found FMT to be an effective treatment, although FMT is not yet widely used to treat this condition.

Worldwide, numerous centers are in the infant stages of research to test the success of FMT on a host of varying conditions such as: Diabetes, metabolic syndrome, hepatic encephalopathy, chronic fatigue syndrome, fibromyalgia, obesity, mood disorders, such as depression, non alcoholic fatty liver disease, hay fever, arthritis, asthma and eczema.

CONCLUSION

FMT is highly-effective treatment for recurrent C. difficile infection, and is the treatment of choice for this condition. Finding successful donors for FMT is complex but well worth the effort given the morbidity this condition causes. The human gut microbiome is an evolving area that we are only beginning to define. It is hoped that FMT may play a significant part in the future management of symptoms and diseases that to date have been troublesome not only to the patients but to the managing clinicians. It is gratifying that there have been some positive resolutions already and it is exciting to be part of this continually growing field.

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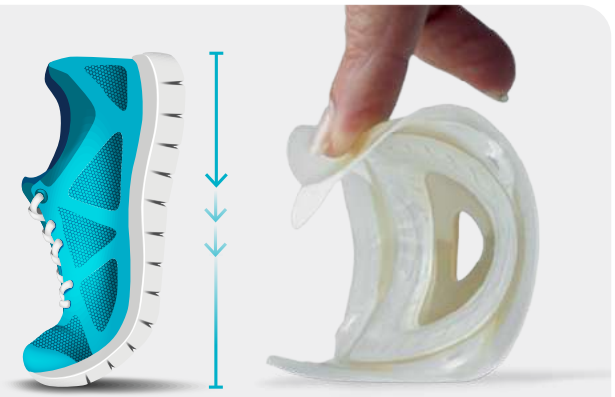

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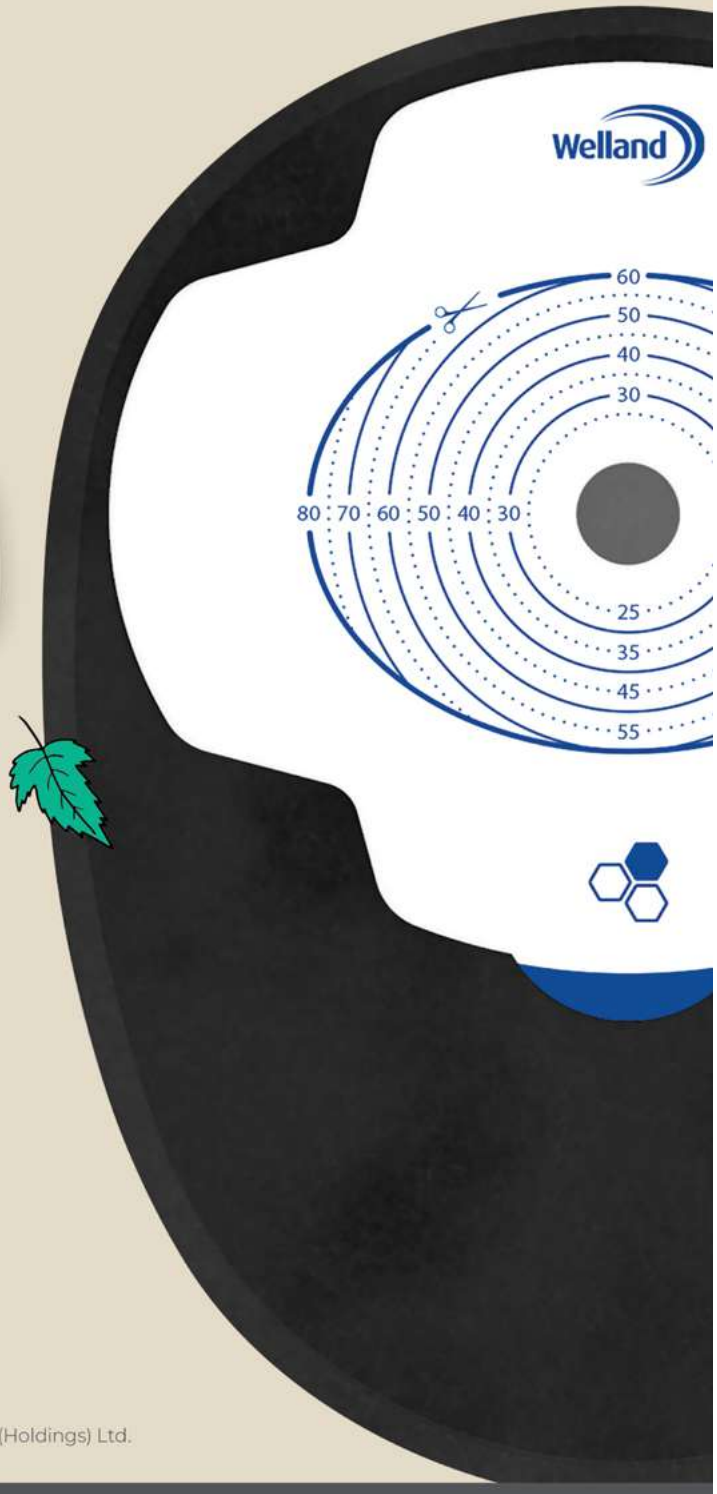

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Swift Resolution of a Peristomal Skin Complication Utilising a Ceramide Infused Barrier

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Abstract:

People with ostomies can face a variety of challenges. Many of these challenges might be avoided with the correct initial product selection that is based more on evidence than on experience. This case explores the set of challenges a patient experienced that appeared mainly due to using ostomy products lacking both fit and formulation properties to manage his stoma.

Relevant Medical History:

Mr. B (initial changed to protect privacy) is a sixty-one-year-old male originally from Samoa. In 2004, he was diagnosed with a gastrointestinal stromal tumour (GIST) and underwent his first surgical procedure for removal of the tumour and formation of a temporary ileostomy. GISTs are soft tissue sarcomas that may be found any part of the digestive system but most frequently in stomach and small intestine.[1] Most GISTs remain 'silent' until reaching a large size and symptoms can vary according to location and size.[2] In the case of Mr. B, his tumour was assumed to be in the small intestine. GISTs can develop in people of all ages, but most commonly between age 50 and 70, and almost never occurring before age 40.[1,2]

Later, his ileostomy was reversed, however the GIST spread to his rectum, and in 2007 after refusing an abdomino-perineal resection (APR) he required further surgical excision with another temporary ileostomy formed that was also reversed at a later date. Metastatic spread occurs often and usually 10-15 years after original surgery.[2] However, his symptoms worsened at a faster pace, and he underwent an APR with vertical rectus abdominis myocutaneous flap (VRAM) in 2012 and formation of a permanent colostomy. The VRAM flap is preferred for pelvic reconstruction as it is a combination myocutaneous flap comprised of three layers: skin, subcutaneous fat, and muscle. This triple-layer anatomy makes the VRAM flap durable, and the flap can be used to cover skin defects.[3]

Background:

Originally, Mr. B was managed at another district health board (DHB) further south in New Zealand, so access to some of his information proved challenging. He spoke little to no English and communication was mainly through his wife. Additionally, to complicate things further, he previously had a cerebrovascular accident (CVA) in 2017 that left him with expressive dysphasia but no other residual deficits such as motor skill challenges. He was still ambulatory and independent in self-care. However, this expressive dysphasia often left him feeling frustrated, resulting in him becoming non-conversant with his wife.

He also suffered with chronic renal failure (his creatinine was 211). Of note, people of all genders and ages suffering with chronic renal failure, are also prone to pruritis (chronic itching).[4] He was also obese with a body mass index of 40. Generally, a healthy BMI is between 18.5 and 24.9, however this may be higher in people of Polynesian origin.[5]

Lastly, he had recurrence of tumour locally in the perineal region requiring treatment in Auckland at our hospital. This required both he and his wife move into emergency accommodation near our hospital.

Skin Profile:

At initial review, his skin had multiple broken areas that appeared visually reddened and inflamed fully circumferential to the stoma. The affected skin was only directly under the barrier footprint and did not extend beyond the skin barrier edges. This type of skin reaction was determined to be a Peristomal Medical Adhesive Related Skin Injury (PMARSI) as he was not

continued on back

Figure 1 CeraPlus one-piece pouching system with flat cut-to-fit skin barrier.

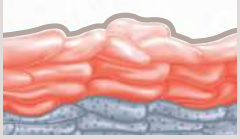

Figure 2 Ceramides help with TEWL by holding cells together, retaining moisture, and replenishing the skins' natural barrier.

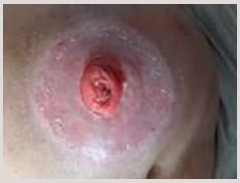

Figure 3 Peristomal skin condition appears visually improved after 3 days.

Swift Resolution of a Peristomal Skin Complication Utilising a Ceramide Infused Barrier

Emma Ludlow RN STN
Middlemore Hospital
Counties Manukau District Health Board
New Zealand

Case Study

experiencing leakages. PMARSI differs from irritant contact dermatitis where skin is exposed to stoma effluent. Here, the issue is related rather to the exposure of skin to an adhesive.[6]

His wife reported that he had been tried three different brands of ostomy products with poor success. She said he expressed that his skin was very itchy and painful. As described, his history was vague on some of the aspects of his care, but it appeared they may have also tried cortico-steroid creams, and other topical agents such as wipes without success. His wife reported that he could guess when his stoma would be active and would often leave the pouching system off and his skin exposed to air to gain relief.

Products Used and Outcomes:

A skin barrier infused with ceramide (CeraPlus skin barrier with Remois Technology*) was chosen. (See Figure 1). Ceramides are naturally occurring waxy lipids that occur naturally in human skin that help reduce trans-epidermal water loss (TEWL) which is water loss through the stratum corneum.[7] (See Figure 2) .When peristomal skin is healthy, skin keeps moisture in and irritants out. The product type chosen was a flat, cut-to-fit one-piece closed pouching system. While Mr. B had no dexterity issues, his wife would cut the barriers to the desired template size and shape as instructed. The output from his stoma was regular and thusly, he only needed to change the pouching system once per day. Within only three days, his skin appeared markedly improved visually. (See Figure 3). It was unfortunate a 'before' image was not captured to clearly demonstrate how severely compromised his skin had been. No accessories or other materials were required.

Mr. B (via his wife) expressed how happy they were with the results. He reported a quick resolution in his itching and discomfort, and she commented how much healthier his peristomal skin appeared visually. They are reporting that his skin continues to improve.

Conclusion:

Clearly, not all skin barrier adhesives are the same. Products are often chosen based on style when the more important consideration is the critical goal of proactively attaining and maintaining healthy peristomal skin. Without healthy peristomal skin, other product features become irrelevant. This was his fourth pouching system evaluated and the only one to provide Mr. B with rapid resolution of his skin condition and itching. CeraPlus skin barriers through their fit and formulation attributes, may help assist patients in the prevention of peristomal skin complications such as PMARSI and TEWL from occurring.

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Te Whatu Ora Health New Zealand

STOMAL THERAPY SERVICES CONTACT DETAILS – FEB 2023

NOTE

In accordance with the New Zealand Nurses Organisation College of Stomal Therapy Nursing, a Stomal Therapy Nurse is one who has completed a Certificate in Stomal Therapy with a provider approved by NZNOCSTN. An Ostomy Nurse is a Nurse practising in the field of Stomal Therapy but who is uncertificated.

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Email: greydn@westcoastdhb.health.nz
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Westport

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Hokitika

Annie Hughes

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Waitaha – Canterbury

Referral and Generic Stoma Email	stomal@nursemaude.org.nz

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Ashburton

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Belinda O'hara
Ostomy Nurse
Clinical Nurse Specialist: Wound and stoma therapy
Community

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Ashburton 7700
Phone: 03 307 8465 ext: 28879
Cell: 027 531 8691
Email: Belinda.ohara2@cdhb.health.nz

South Canterbury

Referral and Generic Stoma Email	dnstomal@scdhb.health.nz
Bronney Laurie **Stoma Therapy Nurse** **Clinical Nurse Specialist:** Colorectal and stoma therapy Community	District Nursing, Private Bag 911, Timaru **Phone:** 03 687 2310 **Cell:** 027 2734809 **Email:** dnstomal@scdhb.health.nz
Coralie Bellingham **Stoma Therapy Nurse** Inpatient	Surgical Ward, Timaru Hospital, Queen Street, Timaru **Phone:** 03 6872100 ext 8286 Hospital 03 6872310 District – Thurs **Email:** dnstomal@scdhb.health.nz

Dunedin/Otago District

Referral and Generic Stoma Email	stomal.therapyotago@southerndhb.govt.nz
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Jillian Woodall **Ostomy Nurse** Hospital and Community	ISIS Centre, Private Bag 1921, Dunedin 9054 **Phone:** 03 4769724
Ruth Macindoe **Ostomy Nurse** Hospital and Community	ISIS Centre, Private Bag 1921, Dunedin 9054 **Phone:** 03 4769724
Anna Wallace **Ostomy Nurse** Hospital and Community	ISIS Centre, Private Bag 1921, Dunedin 9054 **Phone:** 03 4769724

Southland/Invercargil

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Nicola Braven **Stomal Therapy Nurse** **Clinical Nurse Specialist:** Stomal Therapy Hospital and Community	Southland Hospital, PO Box 828, Invercargill **Phone:** 03 214 5783 **Cell:** 027 2947 531 **Email:** nicola.braven@southerndhb.govt.nz
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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

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 30 NOVEMBER (ANNUALLY)

SEND APPLICATION TO:

Email: emma.ludlow@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: _____

The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

NGĀ MIHI NUI