The Outlet

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THERAPY NURSES

IN THIS ISSUE:

AUGUST 2022

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NEW ZEALAND STOMAL
THERAPY NURSES

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Your Executive Committee Members

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Chairperson's Report

NICKY BATES

Happy Mid-winter!

Hi Everybody

The committee had planned a face to face meeting last month (we were all excited to see each other in the flesh, as we have been zooming for what feels like forever), but due to illness and workloads we had to reschedule We will now meet on 3rd August in Palmerston North. Just to keep you updated with what we are doing, agenda items will include:

- Curtin University STN programme and the opportunity for the College to undertake responsibility of clinical placement in NZ for NZ nurses doing the programme. Emma Ludlow recently met Keralyn Carville at the WOCN in Texas and will update us on their conversation.
- National Clinical Guidelines. This large but important piece of work is in the initial phase, we need to make some key decisions to move into the development phase. We will keep you posted!
- Discuss the invitation from the AASTN to host a session and/or have a booth at their conference which is in Fremantle 13-16th April 2023.
- We will be making changes to the membership application form, which will switch to an online form.

If you have any issues, suggestions etc you would like your committee to work on please email anyone of us or ring me 027 334 4272.

A big congratulations to Sharryn Cook from Blenheim. Sharryn is the worthy recipient of a Convatec Scholarship to undertake the Graduate Certificate in Stomal Nursing at the Australian College of Nursing. Sharryn, we wish you all the best in your studies.

Rochelle and I hope to attend at least one day of the 3 day NZNO conference, AGM and Colleges and Section Day. As you are very aware it is becoming increasingly difficult to take time away from work to attend such events. Zoom platforms make attendance slightly easier in that you don't need to factor in travel time and can attend to a few work chores in the zoom breaks so there is not the mayhem to return to the next day! I am also aware that some areas have had education and/or annual leave put on hold as DHBs grapple with staffing shortages.

Don't forget we need a "hands up" of 4 new committee members by end October. Please contact one of us if you are interested. Remember everyone has skills to offer, sometimes you just don't know you have them until you set yourself a new challenge!

Lastly, a huge thank you to Angela and Dawn for producing yet another "top notch" Outlet issue. Your hard work is greatly appreciated.

Kind regards, **Nicky**

Editors' Report

DAWN AND ANGELA

Welcome to the August edition of "The Outlet".

We hope everyone is staying well and practicing some self-care as the pressure as senior nurses to support a workforce under duress continue and as we contend with a health system under pressure. The value of what we do can never be underestimated, we need to remind ourselves the importance of what we do to support our colleagues and those recipients of our care and expertise.

Thank you to the contributors of this edition, as always, the sharing of knowledge is an integral aspect in the growth of our body of knowledge, there is an acknowledgement of the great work that is being done around improving the provision of care utilising a holistic approach. The care of the "whole" and not just the "hole", to optimise care and improve health outcomes.

Nutritional advice and support are such an integral aspect of our provision of wholistic care for those having had colorectal surgery which can result in the formation of a stoma. We have been very fortunate to have submissions for this edition from Andrew Xia Clinical Lead dietician at Counties Manukau Health and Emma Ludlow - CNS – Stomal Therapist and Global Clinical Support Co-ordinator for the Insides Company.

We would like to further encourage other members of our college to submit their work for publication, being a unique and small group, the sharing of knowledge and skills is vital.

Since our last edition we have said goodbye to Fran Martin who retired after her many years of service at Auckland Hospital – thank you for your expertise, Fran and we wish you well. We welcome back very experienced and highly skills Stomal Therapists Lorraine Andrews and Marie Buchanan. Lorraine is now based in the community at Auckland Hospital and Marie based in the community at Waitemata.

November will mark the end of a four year term on the committee for four of the six current members, so we wish to strongly encourage our members to become part of this committee. Two of the current committee will continue on and will guide the way for those new members, so please put yourself forward for selection.

Finally, another big thank you to Nicky Bates for leading the team – your energy and enthusiasm is greatly appreciated.

Best wishes, stay safe and take care.
Dawn and Angela

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.

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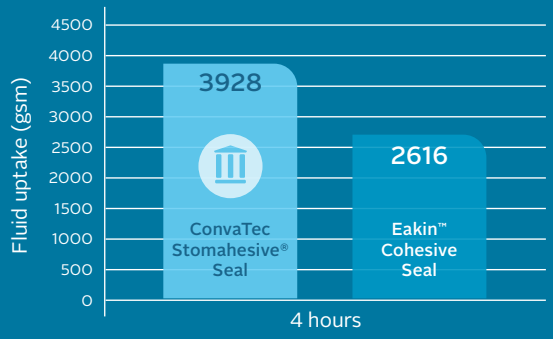

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Marie Oldridge

OLDRIDGE, MARIE MAURCLE (Q.S.M)
14 JULY 1935 - 07 APRIL 2022

It was with sadness to hear of Marie's passing on the 7th of April 2022.

Marie was one of the pioneers of Stomal Therapy Nursing in NZ, when she retired 7 years ago, she had given 40 years to Stomal Therapy nursing here in Northland.

I'm not sure where she did her Stomal therapy qualification, but she did have a Stomal Therapy badge which I was a bit envious of.

She was the first and only Stomal therapy Nurse here in Northland for many years before first Ginny joined the team in 2001 and then I joined in 2006.

I had a close work association with her from 2000, as I worked on the Surgical ward at Whangarei Hospital where the Bowel surgery patients were cared for post-surgery. She soon realised I too had an interest and passion for Stomal Therapy nursing, and she took me under her wing. When the opportunity came to join the Stomal therapy team of her and Ginny, I jumped at it.

Marie was a wealth of knowledge in all thing's stoma and wound, and she also covered Continence in the earlier years as well.

Marie was awarded a Queens Service Medal in 1999 Queens birthday honours for services to Ostomy, I believe nominated for setting up the Ostomy society here in Northland amongst other things, not that she ever mentioned this.

She was made a life member of then Stomal Therapy NZ section (prior to becoming a College) this announced at the Hamner Springs Conference approximately 2010 which she was very proud and deserving of.

As you may see Marie worked many years past retirement age but still had the passion and drive to make a difference in the stoma world. She was the instigator of many study days and conferences here in Northland with a desire to educate and provide education to all who wanted it, these conferences were always full to capacity.

Marie was wife to George and mother to Stephen and Mark and grandmother to five and great grandma to two.

Her wishes were to have an intimate family service.

Thank you Marie for your passion, drive, dedication and service, and for pathing the way in the Stomal Therapy world.

Rest easy.

Profile Page – Preeti Charan

OSTOMY CLINICAL NURSE SPECIALIST
WAITAKERE COMMUNITY WDHB

"At the age of 7 I told my mum one day I will become a nurse. I had a first aid book where I use to look for ways to treat cuts and burns and treat fever at home. Today I am proud that I fulfilled my dream and I enjoy every moment of being a nurse."

I am originally from Fiji Islands. Most of my family resides in New Zealand and Canada. I am married and have two beautiful girls called Prisha and Ritisha. Yes my favourite holiday destination is still Fiji.

I trained in Suva and worked as a Registered Nurse at Colonial War Memorial Hospital in Suva. I enjoyed my first placements in the general surgical unit, Plastic and vascular, Burns, ENT, maternity, Neo natal. Worked through these units over a period of 2 years. Migrated to New Zealand in 2002 and went off to Tairawhiti Gisborne and did my placement and got my New Zealand practising certificate and worked in the General surgical ward for almost 2 years before moving to Auckland.

In Auckland I joined a private hospital and worked in the general surgical ward which specialised in colorectal, hepatobiliary, Upper GI surgery, Major Head and Neck surgeries, minor and major abdominal surgeries and worked for 16 years. Completed my Post Graduate Diploma in Health Science from University of Auckland. During this time, I was involved with a lot of colorectal patients and did pre-operative consultation, stoma siting and post-operative stoma education to patients and nurses. I enjoyed this and at the end of the day it felt good making a difference in somebody's life. Then I went ahead and completed my Stoma Therapy course through Australian College of Nursing and completed my certificate. By this time, I was ready to try something new as being in one place for many years you get use to the place and people and this becomes your comfort zone.

I have not worked for the DHB for so many years and taking this step was hard for me. But I thought what can go wrong, so I applied for the Ostomy CNS role at WDHB and I got the job. I am happy I have the surgical background of colorectal/ urology patients as this gives me better understanding of patients with stoma and their experience after surgery and this makes it easier to advise and educate patients in the community. Was very challenging at first as I did not know the system, then new people around me, seeing patients

with varying personalities and the biggest of all this role can be isolating. Not many people understand our role except for people who has the stomas to be honest.

Today, I feel it wasn't a bad idea to move out of my comfort zone and try something new. There is always a new challenge out there waiting and this not only tests my boundaries but gives me a new experience to reflect upon. I have good team of ostomy CNS's who help out if I have a complex case and the team is always there if needed which is reassuring.

Hoping all my experience and knowledge will make a difference to my patients and their quality to life today and in many more days ahead of us. As hope is what we can give to our patients during the difficult times in their life.

43RD AASTN & 10TH APETNA CONFERENCE

NEW HORIZONS

Advancing Wound, Ostomy & Continence Practice

13–16 APRIL 2023, FREMANTLE, WESTERN AUSTRALIA

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SPEAKERS INCLUDE:

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AM, FRCOG, FRANZCOG (Hon)

Chair | FIGO Fistula and Genital Trauma Committee
Chair | FIGO Expert Advisory Group on Obstetric Fistula

Keryln Carville
RN, PhD, STN(Cred), FWA

Professor Primary Health Care and Community | Silver Chain Group, Curtin University

Ong Choo Eng
RN, WOCN

Senior Nurse Clinician | SGH, Specialty Nursing Department

Widasari Sri Gitarja
BN, MBA, PhD Candidate

CEO | Wocare Clinic

Emily Haesler
PhD, PGradDipAdvNurs (Gerontics), BNurs, FWA

Adjunct Professor | Curtin University

Gojiro Nakagami
RN, PhD

Professor, Graduate School of Medicine | The University of Tokyo

Vicki Patton
RN, MN(Hon), PhD, GC-STN

Clinical Nurse Consultant | Royal Prince Alfred Hospital

Kylie Sandy-Hodgetts
BSc MBA PhD

Associate Professor | Murdoch University
Director | Skin Integrity Research Institute
Honorary Senior Lecturer | Cardiff University

Yajuan (Julie) Weng
RN, ET, M. N, MBA

Vice-Chief Nurse Executive | Nanjing Drum Tower Hospital
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Fiona Wood
AM, FRCS, FRACS

Director | Burns Service of WA
Director | Burn Injury Research Unit UWA

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Tripartite Colorectal Meeting 2022

22-24 FEBRUARY 2022, AUCKLAND, NEW ZEALAND
LOOKING FORWARD, LOOKING AFTER – MĀ MURI KI MUA

Tripartite 2022 was finally held over three days in February after having been delayed several times. It also changed from a face to face conference held at the Aotea centre in Auckland to an online virtual platform.

The theme of Looking forward, Looking After – Mā Muri Ki Mua, was to remind us despite the challenges we are facing around the world we need to embrace the new while learning from the past and keeping patient care central to our vision. The organising committee must be thanked for all their hard work to ensure the conference was run as smoothly as possible.

For many of us this was our first opportunity to "attend" a conference in several years. Attend meant many different things such as watching virtually from your office (rushing out to see patients in breaks), sitting at the dining table, perched on the end of your couch or watching the sessions in your own time over the following 3 months. If you did manage to get online, the 3 days were packed full of presentations by experts in their field from New Zealand and around the world. Topics included rectal cancer, inflammatory bowel disease, biomedical innovations, intestinal failure, robotic surgery and pelvic floor.

The New Zealand College of Stomal Therapy Nurses (NZCOSTN) conference ran parallel to this, running combined and separate sessions over the 3 days. Presentations included chyme reinfusion, high output stoma and clostridium difficile, nutrition and fluid management of intestinal failure, medicinal cannabis, oral rehydration solution reduces readmission and faecal transplantation.

There was a huge amount of information on offer but 2 key themes to emerge out of the conference were pre-habilitation prior to surgery and psychological support for patients, particularly from people who have stoma.

Enhanced recovery after surgery (ERAS) protocols have become the main stay for hospitals throughout out the world. However, ERAS focuses on the intraoperative and post-operative strategies, whereas prehabilitation aims to optimise the patients prior to surgery. The key factors of a pre-habilitation programme are physical activity, psychological support and nutrition.

Several presentations empathised the importance of taking a thorough pre-operative functional assessment. This can identify potential issues and plans can be implemented to lessen the impact these issues may have on their post-operative recovery. Susan Moug, Colorectal Surgeon from Royal Alexandra Hospital in Scotland, demonstrated in her research that patients who were unable to climb 2 flights of stairs without stopping pre-operatively had a 3-fold increase in length of stay and post-operative complications.

Early evidence from various trial and meta-analysis is pointing towards a reduction in postoperative complications by approximately 50% as well as improved exercise tolerance and reduced length of stay.

Ideally prehabilitation should start several weeks prior to surgery. This may not be possible but can be commenced even if only a few weeks prior to surgery. Encouraging patients to take measures such as reducing their smoking and alcohol intake, walking for a 30 minutes a day, reducing portion size, if trying to lose weight and increasing their protein intake prior to surgery can have a beneficial impact on their post-operative recovery.

Several presentations focused on psychological support to patients going through stoma forming surgery and the how important this is to how they will adjust to living with a stoma.

Julia Kittscha from The Wollongong Hospital presented on measured adjustment outcomes in stoma patients for the first 9 months after stoma forming surgery. The questionnaire was taken at 2 weeks, 3, 6 and 9 months' post-surgery. The 4 domains of interest were

- acceptance of the stoma
- anxious preoccupation
- social engagement
- anger

It demonstrated that people who talked to other people with a stoma had a better acceptance of their stoma. They were also able to socially engage better. Anxious pre-occupation, the fear of leaking, smelling or the stoma making noises, sexual attractiveness and always being a patient, showed a downward trend in adjusting to a stoma suggesting that this may get worse over time for patients. Younger patients adjusted better to having a stoma and were less angry about their stoma. Social media may play a role in this as we live in a world where younger people have grown up using these various platforms from an early age. There are numerous Facebook pages, Instagram's, snap chats of people living with a stoma showing themselves at the gym or on the beach and offering advice and support. It should be remembered that these platforms are unregulated and offer that person's view or experience of their own stoma.

Gemma Davidson gave her story of living with a stoma and how health professionals can learn from stoma patients. Gemma commented on the limited formalised professional resources available to her when she first had her stoma.

TRIPARITITE shared a wealth of knowledge from around the world. However, the one thing that was missing was the interaction we have with our colleagues when meeting face to face. This interaction, where get to catch up with colleagues, discuss cases and share our knowledge and hands on experience can never be underestimated. I look forward to meeting with colleagues again and hope to see you all at the conference.

Angela Makwana
Stomal Therapist, Waitematā
Te Whatu Ora, Health New Zealand

Nutrient absorption in the gastro-intestinal tract

RN, MNURS(HONS), PG CERT. STOMAL THERAPY
CNS – STOMAL THERAPIST COUNTIES MANUKAU HEALTH
GLOBAL CLINICAL SUPPORT CO-ORDINATOR – THE INSIDES COMPANY

INTRODUCTION

What sustains life and keeps every bodily system functioning, from the tiniest component (cell) to the largest (organ)? Glorious, nutrient rich food. How does nutritious food do this? When food is ingested, the small intestine, in the gastro-intestinal (GI) tract, absorbs all the electrolytes and minerals from food and starts the process of sending them all over the body to be utilised in all bodily systems. This paper will look at the physiological process of nutrient absorption and how this affects our ostomy patients.

CHYME

Chyme is the medical term used to describe the pulpy and semi-fluid composition of partly undigested food, fluid, gastric juices, and digestive enzymes such as bile and pancreatic enzymes. Chyme is initially formed in the stomach through both mechanical and chemical processes when breaking down food that is ingested. Chyme is then passed on into the small intestine for absorption. Chyme is a critical component of gut health and the digestive system. It contains valuable digestive secretions crucial in the maintenance of fluid, electrolyte balance and the microbiome.

HOW DOES THE DIGESTIVE SYSTEM MAKE CHYME?

The stomach is where chyme is initially produced. Located on the left-upper side of the abdomen, the stomach is a long cylindrical organ which breaks down boluses of food through an involuntary churning action called peristalsis. The muscular contractions of peristalsis crush the food but also churn the food back and forth so that the food boluses can get more and more coated in gastric juices as the surface area increases. This mechanical process couples with a release of clear gastric juice/stomach acid to produce acid chyme (this is the first state of chyme). The main constituent of gastric juice is hydrochloric acid, a highly acidic chemical capable of breaking down some types of fats and proteins present in food. In 24 hours, a person would produce 3 – 4 litres of gastric juice. Together, these two processes allow for the nutrients in chyme to be absorbed by the small intestine. Peristalsis and pressure control the pyloric sphincter and as chyme moves down, small portions of chyme are expelled through the pyloric sphincter into the duodenum.

The duodenum is the first segment of the small intestine and is approximately 30 cm in length. The duodenum is the location where pancreatic enzymes and bile are secreted. These fluids aid in breaking down the nutrients present in the chyme arriving from the stomach. In 24 hours, a person would produce 1 – 1.5 litres of pancreatic enzymes and 1 – 1.5 litres of bile. The pancreas sits behind the bottom half of the stomach and produces clear alkaline pancreatic juice which contains enzymes that enable starch (carbohydrates) and proteins to be broken down. The liver produces an alkaline fluid called bile which is has a bright green, yellowish or olive in appearance. Bile is transported and stored in the gallbladder ready for secretion into the duodenum when it is recognised a person is eating.

All the digestive enzymes continue to break down carbohydrates, proteins, and fats in chyme as it travels from the duodenum into the jejunum. The jejunum is approximately 2.5 metres in length and is where most of the now digestible nutrients are absorbed from in chyme. The jejunum is responsible for absorbing at least 80% of the nutrients from chyme. The jejunum has micro and macroscopic villi, which are finger like projections that capture and absorb the nutrients when they pass by. Each villi have a vascular complex contained within that absorb the nutrients and transport it first to the liver and then systemically. Peristalsis assists absorption from the jejunum by segmental muscle contractions that wash the chyme back and forth, further coating the villi to ensure every nutrient is absorbed.

By the end of the jejunum, the thin liquid appearance of chyme begins thickening as increasing amounts of nutrients and some fluids are absorbed. From the jejunum, chyme travels through into the ileum. The ileum is the last part of the small intestine and is 3.5 metres in length. This is where the last 20% of the nutrients are absorbed and some fluids. Nearing the end of the ileum there are no nutrients left in chyme and it travels through the ileo-caecal valve which is a sphincter that controls the flow of chyme into the colon. Once in the colon, chyme transitions into waste or faeces where fluid and salts are absorbed to keep the body hydrated and stool is formed from the waste products.

MICROBIOME

The fibre that we eat is unable to be broken down or absorbed until it reaches the colon. The bacteria located in the colon, collectively known as the microbiome, ferment fibre in anaerobic conditions to produce short chain fatty acids. Short chain fatty acids are integral to the health and integrity of the gut but play a large role in the immune system, glucose and lipid metabolism within the body, and regulate the inflammatory response. A lot of focus in research is now on the role of the microbiome, improving and expanding the bacteria forming colonies in the gut and the role the microbiome plays in every bodily system.

WHEN ARE SPECIFIC NUTRIENTS ABSORBED?

The following diagram demonstrates where individual electrolytes and minerals are absorbed from within the GI tract.

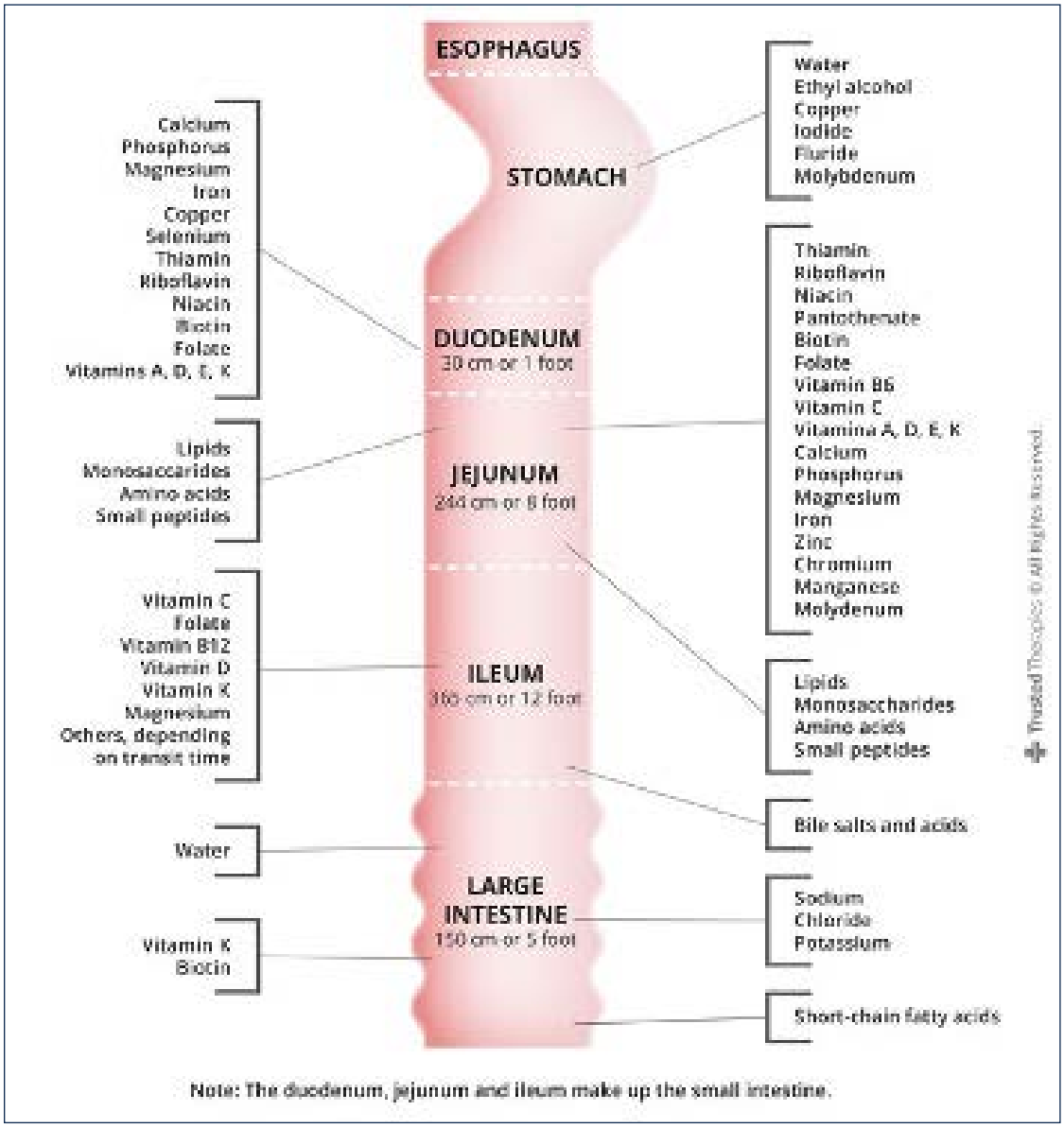

Figure 1: Demonstrates where individual electrolytes and minerals are absorbed from within the GI tract.

HOW DOES THIS AFFECT OSTOMY PATIENTS?

If a patient has an enterocutaneous fistula or stoma located anywhere along their small intestine, they will be losing large volumes of fluids, enzymes, and nutrients from their body. Furthermore, they may have also lost their ability to absorb certain nutrients because they are only absorbed more distally. Consideration of micro and macro nutrient levels for small bowel stoma patients is paramount when providing holistic care to ostomy patients.

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Using Latest Evidence to Proactively Match the Characteristics of the Convex Skin Barrier to Those of the Patient

Case Study

Abstract:

"Knowledge is power? No. Knowledge on its own is nothing, but the application of useful knowledge, now that is powerful." – Rob Liano.

This case study has provided a tangible opportunity to apply some new theory that we found exciting to learn and adopt into clinical practice at our hospital. Until very recently, confusion around convex product use has been made all the more challenging with differing descriptors used by both manufacturers[1,4,5] and frequently a clinician's subjective experiences. This recent publication has greatly assisted in clarifying some of the perceptions regarding product features that were both known and unknown to us. Importantly, it provided clinical application statements that are highly relevant to the practice of stoma care.

Patient Relevant Background & Surgical History

Mr. W was a middle-aged male who presented to our hospital's emergency department after experiencing significant alterations in his bowel habits over the period of a month. Additionally, he had become quite cachectic and undergone some significant weight loss. Cachexia is characterised by a dramatic loss of skeletal muscle mass and often accompanied by substantial weight loss, where the body breaks down muscle and adipose tissue, which stores fat. It occurs in many cancers, usually at the advanced stages of disease and seen in certain subset of cancers including that of colorectal cancer.[2]

Mr. W underwent a CT scan (computerised axial tomography) which confirmed a right abdominal and pelvic mass associated with the sigmoid colon, with fistula formation involving his bladder. Subsequently he proceeded to have a biopsy which confirmed the presumed diagnosis of cancer. His primary cancer was a sigmoid adenocarcinoma. As a matter of urgency, Mr. W was taken to the operating theatre to undergo an open, high anterior resection, small bowel resection with formation of a loop ileostomy and a partial cystectomy.

Early on, Mr. W experienced few if any challenges with his well-spouted loop ileostomy and learned to manage his stoma care quite well. His peristomal planes were only slightly irregular when he was sitting, and he had a relatively soft abdominal tone. His output while liquid, was relatively thick and expected to thicken further as it was established. *(See Figure 1).* However, his recovery was complicated by a post-operative bladder leak which was managed prior to discharge. He was discharged to his home with a two-piece soft convexity product, as there were concerns for potential leakage regarding the semi-liquid nature of his output, despite how well-spouted his loop ileostomy was. *(See Figure 2).* This product had the additional benefit of having a skin barrier infused with ceramide, the Hollister CeraPlus™ skin barrier with Remois Technology. CeraPlus has robust evidence illustrating its support in helping maintain healthy peristomal skin. This is a core goal of care for managing our patients. Thus, there was a proactive deliberation to choose a skin health supporting product with convexity from the outset based on recommendations from a consensus panel that liquid output is a clinical consideration for using convexity of some form.[3]

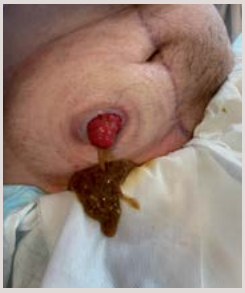

Figure 1 Thick discharge from his ileostomy.

Figure 2 Two-piece soft convex skin barrier in place. Well-spouted stoma.

Challenges:

After approximately three months post surgery, he was readmitted to our hospital with high output and dehydration. He had been experiencing chronic challenges from leakage and the stomal therapy nurse (STN) was asked to review his situation. He had been undergoing adjuvant chemotherapy after discharge before his situation deteriorated. The patient reported that the incidences of leakage had been increasing since discharge to multiple times a day over the last week.

What had changed since his return to home was the development of high output draining from his ileostomy. His stoma was discharging up to six litres per day and he had become severely dehydrated. Coupled with his chemotherapy, there are reports that there can be a three-fold increase in ileostomy output between post-operative discharge and hospital readmission.[4] The potential for kidney damage resulting from such a scenario is high and correct rehydration and stoma management is important.[4]

Nursing Interventions:

Based on the change in his circumstances, his pouching system needed review to meet his changed needs. Recently, additional information to assist clinicians in selecting the right convexity feature based on a characteristic or a set of characteristics has been published. In this article, five (5) characteristics of convex products were identified and defined, and clinical implications

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& application statements were developed.[5] Using this new source of knowledge helped enable the STN to select the right product for this patient. Previously, it was understood that while convexity was well-used and well-regarded, it was not clear how and why it worked in some clinical situations. This framework can now be used when reviewing our patients for the use of convex products.

Depth was our first consideration. His stoma was well-protruding, and the recommendations are that the depth used should be just enough to afford a secure skin seal.[5] Excessive depth was not required. This narrowed convex choices in this instance. As mentioned previously, Mr. W's peristomal planes had slight irregularities that were more distal to his stoma. As such tension location, our second consideration, was of high consideration to flatten areas that might impinge of the overall skin seal by causing challenges on movement. Positioning the apex of the convex barrier further out from the stoma can help flatten creases and folds that could interfere with a secure seal. As such, a cut-to-fit skin barrier, one size up from what the measuring guide indicates, can help provide the greatest tension away from the stoma to help flatten the peristomal skin for a secure seal.[5]

Compressibility had now become an interesting consideration. His previous system was soft, with tension location further afield as well. However, he was experiencing leakage. Now with his changed medical circumstances, he required something less compressible. Noting his soft abdominal tone, the recommendations are that he may now require a less compressible convex skin barrier to provide adequate support around the stoma.[4,5] Interestingly, his previous soft convex product was deeper than the suggested firm convex under assessment. However, it was noted in the journal article that the compressibility of the convex dome influences the depth of convexity.[5] As such, the firmer type of product was now less deep, yet provided the support and secure skin seal now required to manage the changed nature of his output.

Overall, he required some degree flexibility in his product due to his high activity levels, yet the dome need to be somewhat firmer to manage his peristomal contours. The overall design of the product with the adhesive border and floating flange contributed to a more flexible product that still provided the level of support through some rigidity where it was required, and this proved to be the solution he required. Slope is the last consideration, and this was not seen as a critical consideration in this case given his peristomal contours and the stomal protrusion.

Lastly however, was the consideration of his pouch. With high volumes of output that was essentially all liquid, he required a high output pouch. *(See Figure 3).* This enabled the capture of excessive fluid for short periods, for example walking, and the easy connection to a secondary collection system for drainage. *(See Figure 4).* This new system was easy for both ward staff and patient management throughout his readmission. The plan was to have his colorectal assessment and early stoma reversal.

Patient Outcomes:

Mr. W was able to easily manage this system as it was so similar to the one he had been discharge home with in the first instance. Teaching time for this process was reduced as a result. However additional education regarding vigilance around maintaining his skin health due to the new nature of his output was important. Additionally, education about the warning signs of dehydration and management methods was also crucial for his overall wellbeing. Despite his high output stoma, his peristomal skin remained visually healthy with no observable skin issues with this revised system until his stoma was ultimately reversed.

Conclusion:

Obtaining knowledge is always important. However, more important is embracing that knowledge and applying it. This can lead to optimised outcomes for our patients and reduce some of the confusion regarding product selection. Convexity products have been available for some time now, however, we have had little understanding of the dynamics and characteristics of the differing types of convexity and their application. This new nomenclature now provides stoma care nurses with a more consistent means to communicate with each other their patient management techniques and to also document them. This is an important consideration for future research in stoma care. It is hoped that these descriptors and measurement are also adopted by ostomy product manufacturers to ensure consistency of labelling, and to remove some of the subjectivity often associated with product selection.

Figure 3 Thick discharge from his ileostomy.

Figure 4 Two-piece soft convex skin barrier in place. Not well-protruding stoma.

Prior to use, be sure to read the Instructions for Use for information regarding Intended Use, Contraindications, Warnings, Precautions, and Instructions.

Disclaimer: This case study represents this nurse's experience in using the CeraPlus skin barriers with the named patient, the exact results and experience will be unique and individual to each person.

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ANDREW XIA, MSC – NUTRITION AND DIETETICS
ADVANCED CLINICAL DIETICIAN AND PHD CANDIDATE

Intestinal failure (IF) is defined by the European Society for Clinical Nutrition and Metabolism (ESPEN) as the reduction of gut function below the minimum necessary for the absorption of nutrients, such that intravenous nutrition (IVN) is required to maintain health (1).

The main symptoms of IF are diarrhoea or a high fistula/stoma output, which when severe, can lead to dehydration and malnutrition. Hence, maintaining hydration status is a vital component in the care of these patients. But failure to recognise dehydration can lead to rapid weight loss, fatigue and hospital readmission (2). Readmission rate due to dehydration and/or acute kidney injury (AKI) in patients with an ileostomy ranges from 7% to 65% internationally (5). If dehydration is chronic and untreated, it can result in nephrolithiasis and renal injury that may be irreversible. Therefore, educating patients to identify and prevent signs of dehydration should be a priority.

WHAT ARE THE SIGNS OF DEHYDRATION?

Symptoms of dehydration vary but may include any of these:

- Feeling thirsty/dry mouth
- Feeling faint
- Feeling tired or lethargic
- Muscle weakness/cramps
- Headaches
- Dark urine (deep yellow or amber colour), with a strong smell

To prevent dehydration, IVN is often used in the management of IF (3). But it is not without its own complications, high cost, and decrease in quality of life in the long term (4). The degree of fluid and electrolyte abnormalities occurring in IF varies depending on the remaining bowel anatomy, specifically the length, location, and presence of disease in the residual small bowel and the presence of a colon in continuity. Whether an IF patient can produce adequate urine volume is critical to determine their ability to maintain hydration status orally without IV fluids (IVF).

While evidence to guide an optimal daily urine output in IF is lacking, clinical recommendations often suggest 1200 mL of urine each day is crucial for long-term renal health among those with normal kidney function.

SO ARE ALL ORAL FLUIDS GOOD FOR HYDRATION?

The short answer is No. There is a major misconception on the part of the patients is to drink more water as they feel thirsty. But this only leads to an increase in stool or stoma output, which further exacerbates fluid and electrolyte disturbances. Instead, IF patients, particularly those with an end jejunostomy, may benefit from the use of a glucose-electrolyte oral rehydration solution (ORS) to enhance absorption and reduce secretion, whereas most patients with a colon can usually maintain adequate hydration without excessive fluid loss with hypotonic fluids such as water.

Fluids come as hypotonic, isotonic and hypertonic. Water is hypotonic, which means it has a lower concentration of sugars and salt than blood. Hypertonic fluids, on the other hand, like sodas, fruit juices, fruit drinks, and sweet teas, have a higher concentration of sugars and salt than blood. They should be avoided by patients with IF, because the amount of sugar in them will drive the output high. ORS is an isotonic drink that contains 6% glucose plus electrolytes. It uses the sodium-glucose-coupled transport system, operating primarily in the jejunum, to promote sodium and water absorption. The optimal sodium concentration of ORS should be between 90 and 120 mEq Na+/L (2).

To improve palatability, ORS can be made into ice cubes or popsicles, or with sugar-free flavouring. Homemade ORS recipes are also available to increase variety.

HOMEMADE RECIPES FOR ORAL REHYDRATION SOLUTION:

Apple Juice Mix
250ml apple juice
750ml water
¾ teaspoon of salt

Tomato Juice
2½ cups plain tomato juice
(not V8 or bloody mary mix)
1½ cups water

Cranberry Juice
¾ cup juice
3¼ cups water
¾ teaspoons table salt

St Mark's Solution
6 level teaspoons of glucose powder
1 level teaspoon of salt
½ teaspoon bicarbonate of soda
1 litre of water

Mizone – Active Water
¾ teaspoon of salt

Regardless of how patients try to hydrate themselves, it is important to recognise the patient who is struggling with oral fluids alone and may need IVF support. We should keep an eye out for their fluid needs based on urine output, hypotension, and recurrent dehydration and AKI.

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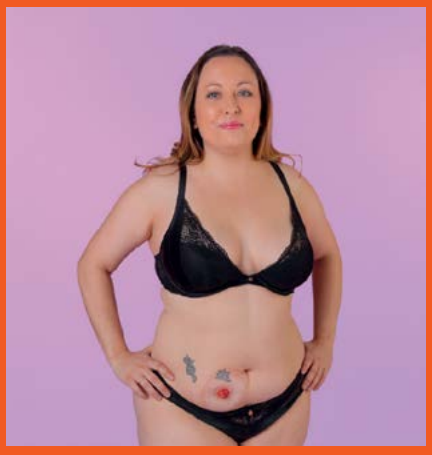




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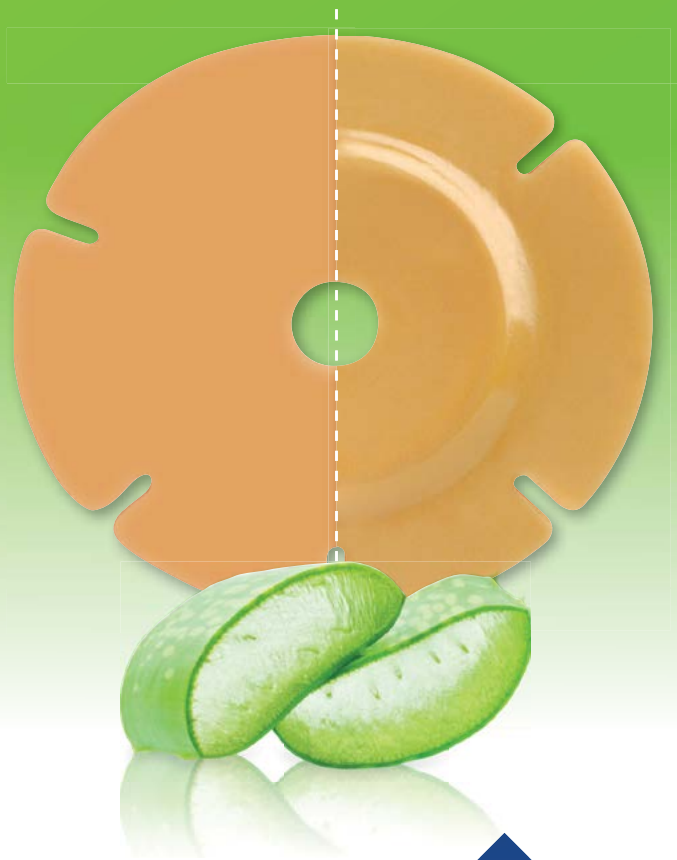

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1. T.G. Eakin Product Evaluation, eakin dot® 1-piece soft convex drainable pouches, (n=29) 2020 (Data on file) **2.** T.G. Eakin Product Evaluation, eakin dot® 1-piece flat drainable pouches, (n=20) 2020 (Data on file)

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)

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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

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EXPECTED COSTS TO BE INCURRED

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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: _____

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The Outlet

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