The Outlet

New Zealand Stomal Therapy Nurses

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- **Faecal Occult Blood Testing**
- **Clinical Champion Promoting Colostomy Irrigation**
- **Prolapsed Stomas**

JULY 2020

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The Outlet

New Zealand Stomal Therapy Nurses

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Chairperson's Report

LEEANN THOM

The past few months have been unprecedented for nurses –indeed for New Zealand. We have been through a profound experience together, but as we entered level 1, while we cannot say our challenges in fighting COVID-19 are over, this does feel like a milestone to acknowledge.

I want to express my thanks to everyone that worked to eliminate COVID -19 from our shores. As we return to a more normal way of working it is good to remember the messages of the COVID-19 lockdown. The messages of kindness and random acts of gratitude for our fellow mankind. While we move on these messages are good to carry with us into the future.

The COVID-19 crisis has meant the postponement of the Tripartite colorectal conference. This will now be held in Auckland on the 21st- 24th of February, 2022. Save the dates as it will be a world class conference. It is not often we get the change to attend international conferences on our own shores. It will be a valuable opportunity for information sharing, listening to world class speakers and networking with our Australasian nursing colleagues and colorectal surgeons.

Due to the postponement of the Tripartite conference the Colleges BGM has had to be moved to an online forum. The NZNO College of Stomal Therapy Nursing BGM will now be held via zoom on the 9th of October 2020 at 3.30pm. The committee will be looking for two new members as Katrina Neiman and myself will have completed our four-year term. The call for nominations will come out soon and I strongly encourage you to consider joining the committee. It is a unique opportunity to make a difference to the field of Stomal Therapy nursing and the patient group we care for. I personally have found being part of the committee a hugely rewarding experience.

The Bernadette Hart award is open for applications with applications closing on the 30th of November. This scholarship is designed to support members of the College to attend conferences, or to support study. The committee would love to be able to award the Bernadette Hart award in 2020 so make sure you get your applications in.

The NZNOCSTN Knowledge and Skills framework is now in its final edit stage. The committee hopes to have this ready to present to you at our BGM in October.

The committee next meet in Auckland in August and the Knowledge and Skills framework will our main focus.

Lastly the committee has been in contact with ACC on behalf of the stoma nursing community. There has been concerns expressed about the inequity of products available to ACC stoma patients. At times requests for non-catalogue products were being declined. ACC have responded to our concerns. If good clinical evidence is given, there is no reason a request for ACC non-catalogue products should be declined. ACC has responded to the concerns raised and this can be viewed on the following page.. ACC were happy for us to share the letter of response with you.

Enjoy your read of the July edition of The Outlet. I hope to see you all, be it via zoom, at our BGM in October.

Best wishes,

Leeann Thom, Chairperson NZNOCSTN

Chairperson's Report ACC Letter

LEEANN THOM

Dear Leeann,

Thank you for your recent letter on the provision of stomal care products to ACC clients to which I have been asked to respond. ACC is, of course, committed to ensuring that our clients receive the products and services they need to support their fullest practicable return to health, independence and participation in society.

As you note medical consumables including stomal care products, are available to order from the CommunityClient website. Stock levels of all standard items in the catalogue are held by ACC's consumables supplier to ensure delivery of items to our clients.

If a client has an injury related need for an item which is not already in the catalogue, their nursing provider is able to request the specific item is added and is then able to place an order for that item. This can be done by the nurse or assessor completing the 'non-catalogue request' section of the ACC178 form (or on the Community Client website).

Where an equivalent item is already available on the catalogue, it is expected that this will be considered by the nurse/assessor prior to a non-catalogue item being requested. However, if the catalogue items will not meet the client's specific needs there should be no barrier to requesting an alternate and no requirement to trial the catalogue items first. When our supplier receives a non-catalogue request, they will seek approval from the portfolio management team at ACC, who consider any request.

When approved, it is usual for products to be added to the catalogue and then sufficient stock levels to be held. However due to the range and diversity of stoma products, it is not possible for our supplier to hold stock of all pouching systems, or indeed of any type of consumable. As a result, for any non-catalogue product there may be a delay while the initial order is processed and stock delivered. Where delays are expected, the supplier should advise the stomaltherapist and assist with sourcing an alternate product as an interim measure.

I am sorry to hear that some of your colleagues have been challenged by ACC when requesting non-catalogue pouching systems and appreciate you raising this issue with us.

On the basis of your letter, I have sought further information from our supplier, who advises that requests for approval which considered by the portfolio team are rarely declined. It is possible that in some cases requests are being declined without being forwarded to the portfolio team for consideration. I will take this opportunity to ensure information is available to case owners to support the process on the provision of non-catalogue consumables, including stomal pouching systems.

On outdated or obsolete pouching systems in the catalogue, I would welcome the opportunity to discuss this further and would be happy for you to contact me directly at your convenience.

Kind regards,

Ceri Martin

Acting Portfolio Manager, ACC Provider Service Delivery

Phone: +64 4 816 5605 / 021 521 206

Email: ceri.martin@acc.co.nz

Editor's Report

ANGELA AND DAWN

Welcome to the second edition of The Outlet for 2020.

We hope everyone is well and managing/coping with these interesting times we find ourselves in - living through a pandemic. We know that many of our STN colleagues have been seconded to other roles during the lockdown period to support nursing teams as they navigate the challenges that frontline nursing has created. Patients having stoma forming surgery during the lockdown period has also been very challenging as they attempt to learn to cope with a stoma without the support and presence of loved ones, this coupled with the isolation and reduced contacts when home. There was great relief to see a greater level of freedom with the start of level one, there seems to be some sort of normality, not having to wear a mask during patient contacts is very welcoming.

We would like to thank the contributors to this edition of The Outlet. We would also like to strongly encourage Stomal Therapists or those with an interest in the care of people with stomas to submit their work for publication. We are a small college with some clinicians working in relative isolation so it is a great opportunity to share, learn and stay connected.

We having been getting some great feedback on the professional profiles that we have been publishing, there is a strong level of interest in what leads to a career in Stomal Therapy along with the longevity of the specialty. We are interested in new clinicians as well as those that are more experienced, so we again encourage nurses to share their story.

We also say goodbye to our colleagues from Waitemata DHB – Sandy Izard, Julie Skinner and Jennifer Rowlands, your skills and expertise will be greatly missed and we wish you all the very best.

We wish everyone well going forward, stay well.

Angela and Dawn

CALLING FOR SUBMISSIONS

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

Please send your submissions to either:

angela.makwana@waitematadhb.govt.nz or

Dawn.birchall@middlemore.co.nz

WE would LOVE to hear from you.

Treasurers Report

KAT NEIMAN, TREASURER

This year there will be no formal BGM due to the Covid-19 pandemic, the NZNOCSTN conference in conjunction with the Tripartite conference has been postponed until February 2020.

Please accept this Summary and the Statements of Movements in Equity and Financial Position and Performance as of March 2020.

There was a greater surplus in the 2018/19 year compared to 2019/20 this is related to the advertising and sponsorships at the 2018 Auckland Stomal Therapy Conference. General investment and Bernadette Hart Investment show a gradual increase each year with interest paid from term deposit investments, sadly with no Bernadette Hart being given again this year the account continues to accrue.

Travel expenses have increased 2019/2020, this is a direct reflection of the demographics of the current committee members. The other large expense has been the undertaking of developing a Knowledge and Skills Framework, this has been in the forefront of what the Committee have wanted to achieve for stomal therapy collectively over a number of years. As this was a large undertaking the committee felt that the NZNOCSTN were financially sound to pay for the ground works of this to be developed, the total cost being $5,000.00. The Outlet Magazine continues to break even with the much-appreciated advertising from supportive companies.

Overall, our total equity increased slightly in the last financial year , going from $80,795.00 2018/19 to $81,298.25 2019/20.

Kat Neiman
Treasurer

Treasurers Report

KAT NEIMAN, TREASURER

NZNO College of Stomal Therapy Nursing

Statement of Movements in Equity
For the Year Ended 31 March 2020

	2019/20 Actual $	2018/19 Actual $
EQUITY AT START OF PERIOD	80,794.95	70,678
SURPLUS & REVALUATIONS		
Net Surplus/(Deficit) after taxation	503.30	10,117
Total Recognised Revenues & Expenses	503.30	10,117
EQUITY AT END OF PERIOD	81,298.25	80,795

NZNO College of Stomal Therapy Nursing

Statement of Financial Position
As at 31 March 2020

	Note	31-Mar-20 Actual $	31-Mar-19 Actual $
CURRENT ASSETS			
Accounts Receivable		-	1,313
ANZ - Cheque Account		20,973.05	20,509
ANZ - Term Deposit (1000)	1	42,393.98	41,233
ANZ- Term Deposit (B Hart Award)	1	15,989.72	15,621
GST Refund Due		186.99	1,404
Interest Receivable		537.88	843
Prepaid Expenses		1,237.50	-
TOTAL ASSETS		81,319.12	80,923
NON CURRENT ASSETS			
Fixed Assets		-	-
		0.00	0
CURRENT LIABILITIES			
Accounts Payable		20.87	-
NZNO Current Account		-	128
GST Due for Payment		-	-
Income Received in Advance		-	-
TOTAL LIABILITIES		20.87	128
NET ASSETS		81,298.25	80,795
Represented by:			
TOTAL EQUITY		81,298.25	80,795

Note 1

ANZ Term Deposits	%	Maturity Date	$
ANZ Term Deposit 481000	2.75%	2-Jun-20	42,393.98
ANZ Term Deposit 480001 B Hart Award	2.70%	25-May-20	15,989.72
Total			58,383.70

20-04-24 Stomal YTD Mar 20 Fin State.xlsx 6/05/2020 2:56 p.m.

Profile Page - Sue Wolyncewicz

CNS STOMAL THERAPY, CAPITAL & COAST DISTRICT HEALTH BOARD

When I left secondary school so many years ago (1972) the career options available to me were nursing, teaching, secretarial work and a few went to University.

After some time I thought I would like to go teaching but my mother suggested I try nursing and within weeks I had an appointment with the matron of Wanganui Hospital and 2 days later received a letter to say I was accepted.

This was hospital - based training for 3 ½ years. I graduated in 1977 and continued to work at Wanganui Hospital until I transferred to Wellington Hospital where I spent 3 years working in the Geriatric /Rehabilitation ward.

In 1980 I moved to West New Britain Province in Papua New Guinea with my husband and toddler. The company who employed my husband was looking for a company nurse at the same time so this became the start of a wonderful experience dealing with tropical diseases and treating the employees and their families for all sorts of conditions. We did not have a doctor onsite but there was a basic local hospital. We ran a clinic (known as"Haus Sik") every day and would see approx. 100 – 150 patients each day.

The role was very autonomous. There was an Australian doctor on the mainland and she would come over for 3 days every 6 weeks to deal with any major problems and I had regular phone contact with her in between her visits.

I believe this experience helped to develop skills essential for my future nursing roles. I had to be resourceful and adaptable.

After 6 ½ years we returned to Wellington but it was difficult to know what kind of nursing I would want to do after my time in PNG.

In 1987 I started work as a District nurse in Lower Hutt working alternate weekends while my children were small. I really enjoyed this position and felt priviliged to support patients in their homes. And then in 1991 my husband and I bought a Rest Home in Upper Hutt. This was another big learning curve. Being the owner, licensee and the only Registered Nurse was rewarding, challenging and a very busy time was had.

In 1997 after selling the Home I went back to District Nursing in Lower Hutt. It was on my return that I realized that becoming a specialist nurse was something I would like to do. It wasn't long before the part time Continence Nurse position became available so I took this on and completed my Continence Management papers in 2000.

At the same time (2000) I was asked if I would like to do 6 hours a week in stomal therapy. I didn't think twice and there I started to learn the intricacies of stomal therapy nursing under the expertise of Vicky Beban, the current CNS Stomal Therapy

Profile Page - Sue Wolyncewicz

CNS STOMAL THERAPY, CAPITAL & COAST DISTRICT HEALTH BOARD

Nurse. While my stoma day was once a week, I used to really look forward to it. I remember going into the stoma supply cupboard and wondered how I was ever going to know about all the different types of bags! But the thing that struck me the most was how vulnerable the stoma patients are when they first get their stoma and the huge difference we make in their lives.

In 2003 I accepted the role of Continence Nurse at Wellington Public Hospital. This also involved caring for the patients with ileal conduits so at least I still had some stomal therapy component.

It was in 2005 that the previous Stomal therapy nurse left after 24 years in the role and I applied for the position of stoma nurse working alongside the CNS, Sharon Elson,

I became the CNS in 2008 and continue to work full time.

I completed the Stomal Therapy PG Cert via Australian College of Nursing in 2007 and this study really influenced my practice giving me a deeper knowledge base and assisted me with my clinical assessment skills.

It is now 15 years since I started Stomal therapy in Wellington and I have enjoyed all that in entails. I often reflect on our role that offers so much to our patients but I have gained so much from them as well. Being able to bring a patient from a vulnerable situation with a new stoma to becoming fully independent and getting back to their normal life is what gives me job satisfaction.

It is interesting reflecting back to 1972 when I had plans to become a teacher and didn't but now spend a large portion of my working day educating!

I love empowering other nurses in their care of stoma patients on the wards and in the community. I believe my journey through my years of nursing has provided skills in problem solving, thinking "outside the square," being creative and a depth of understanding of the patient in a holistic way.

There are always challenges but the rewards are greater and I wouldn't consider doing anything else.

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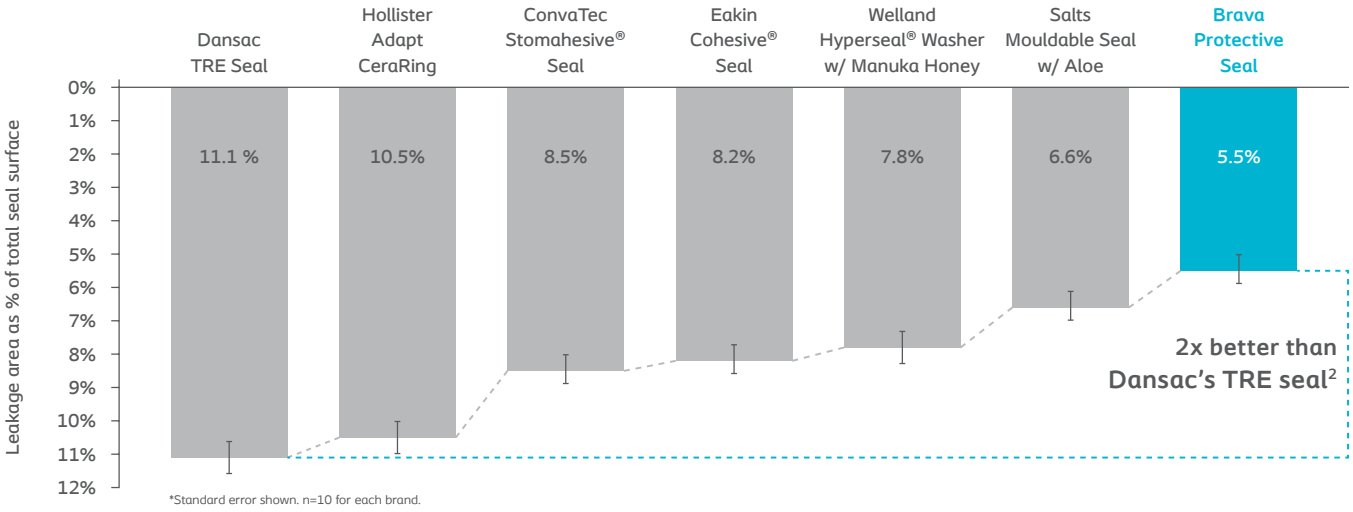

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1. Rolstad, B. S. & Erwin-Toth P. L. Peristomal Skin Complications: Prevention and Management. Ostomy Wound Manage. 2004;50(9):68-77.
2. TM7064 Leakage test. Coloplast. Data on file. Data from 2019. VV-0283280

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Faecal Occult Blood Testing

DAWN BIRCHALL, R(COMP)N, MNURS(HONS), PG CERT. STOMAL THERAPY, COMMUNITY STOMAL THERAPIST, CMDHB

Determine the efficacy of faecal occult blood testing for the early detection of colorectal cancer, as part of a bowel screening program in a general population. Does this positively affect rates of mortality?

Colorectal cancer (CRC) is the third most prevalent cancer in the world (World Health Organisation (WHO) 2015; Whiffin & Houlston, 2014). Internationally, New Zealand (NZ) has one of the highest rates of CRC (Ministry of Health (MoH), 2018). In NZ, more than 3000 people are diagnosed with bowel cancer annually and in excess of 1200 people will die as a result of their disease (MoH, 2017).

A well organised bowel screening program, has the potential to reduce the incidence of bowel cancer and mortality by routinely screening an entire and well defined population at regular intervals (MoH, 2013). Bowel screening in the general population works on the premise that early stage CRC emits small traces of blood into the lumen of the bowel, therefore is present in the faeces. The faeces are then tested for the presence of occult blood. The faecal occult blood test (FOBT) is simple to perform, low cost as well as non-invasive (Bretthauer, 2010). There are many modifiable risk factors for development of CRC; however, CRC is a disease of aging with an increased incidence over the age of 60 years (Bevan & Rutter, 2018). The gold standard for those considered to be at risk of developing CRC or symptomatic of CRC is colonoscopy and not available as a general screening tool (Bevan & Rutter, 2018).

Three randomised controlled trials (RCT) have been selected, looking at the efficacy of FOBT for the early detection and therefore the early treatment of CRC, when participating in a bowel screening program in a general population. The pathophysiology of CRC will be discussed in particular in relation to NZ. The studies presented will outline that a bowel screening program does positively affect mortality, by earlier diagnosis. In NZ, there is an increase in cancer incidence for those living in low socio-economic areas as well as the indigenous population and people with low health literacy, these groups are disproportionately represented with higher levels of mortality and morbidity (Morrison et al. 2013).

Colon cancer refers to tumours that are malignant, they develop from cells in the large intestine (Keun & Giovannucci, 2017). Cancer is characterised by the uncontrolled growth and spread of cells which are abnormal (Mathur, Nain & Sharma, 2015; Virshup, Barnette & McCance, 2004). The large intestine is the last portion of the gastrointestinal tract; its function is the completion of absorption, production of some vitamins, as well as the formation and expulsion of faeces. The large bowel consists of four layers mucosa, sub mucosa, muscularis and the serosa (Tortora & Derrickson, 2014).

CRC is considered to be a disease of aging and is rare under the age of 40 years, the rate of developing CRC increases rapidly after the age of 50 years (Keun & Giovannucci, 2017). The risk of developing CRC at age 50 is 0.6%, this risk increases to 5.6 percent by 75 years of age (MoH, 2018). Eggert (2016) outlines that all cancers are a result of acquired genetic and /or inherited mutations which cause oncogene activation, the activation of the tumour suppressor gene as well as the production of telomerase, an enzyme which enables continued cancer growth. Eggert further discusses Knudson's random two-hit model of carcinogenesis, this model outlines that a single "hit" by a DNA damaging agent, causes damage to a single cell of a chromosome pair, a second "hit" is then required in the undamaged chromosome for the function of the gene to be lost and for cancer to then develop. Carcinogens are known as the class of substances that are responsible for causing damage to DNA, and therefore promoting or assisting cancer to develop (Mathur et al., 2015)

Only 2-5 per cent of CRC occurs as a result of hereditary gene mutations such as adenomatous polyposis and Lynch Syndrome (Akagi, 2017). Other non-modifiable risk factors also include a history of inflammatory bowel disease and family history of CRC. The increased risk due to a family history of CRC may be associated with inherited genes, sharing the same environment or a combination of the two factors (Keum & Giovannucci, 2017). Frucht & Lucas (2017) further outline this group account for approximately 25% of all CRC. This cohort is offered colonoscopy as it is more sensitive and specific (Bevan & Rutter, 2018). Approximately 70% of CRC are considered as sporadic and develop as a result of modifiable environmental risk factors (Frucht & Lucas, 2017). The rates of CRC are higher in westernised countries, with a lifetime risk of developing CRC being around 5% (Bevan & Rutter, 2018; Keum & Giovannucci, 2017).

Polyps are abnormal tissue growths which arise from the inner tissue lining of the large intestine, the most common types include hyperplastic and adenomatous. Hyperplastic polyps are generally considered as benign; however, serrated polyps

which are considered as a subgroup of hyperplastic polyps are now recognised as a type which has malignant potential. Bevan and Rutter (2018) outline the serrated polyp pathway is being increasingly recognised and may well account for up to 35% of all CRC. Adenomatous polyps or adenomas are polyps which originate from the mucous- secreting epithelial cells of the large intestine and are benign but have the potential to become malignant (Keum & Giovannucci, 2017). Keum and Giovannucci (2017) further outline that whilst less than 10% of adenomas will progress to cancer, more than 95% of malignancies which are considered sporadic in nature will develop from an adenoma. The adenoma-carcinoma sequence is outlined by Bevan and Rutter (2018), where adenomas increase in size slowly over a prolonged period, if these dysplastic polyps amass genetic alterations, they will ultimately develop into cancer.

Modifiable risk factors associated with an increase risk of developing CRC is well documented in the literature to include being overweight or obese, high alcohol consumption, tobacco smoking, high consumption of processed and red meat, and sedentary lifestyle (Johnson et al, 2013; Keum & Giovannucci, 2017; Mathur et al., 2015; Richardson, Hayes, Frampton & Potter, 2016). In NZ obesity is the leading risk factor for the development of CRC, 29.9% of the population are obese with a Body mass index (BMI) of 30 or higher (Richardson et al., 2016). The second highest modifiable risk factor for the NZ population is the consumption of alcohol, with 16.1 percent of adults considered to have a hazardous drinking pattern (Richardson et al., 2016).

The aim of a screening program is to detect the polyps in their pre-cancerous stage, or early stage of malignancy before they progress and metastasise. There is a direct link between the stage at which bowel cancer is detected and rate of survival (MoH, 2018). MoH (2018) further outline that NZ is the only country in the group of countries that make up the Organisation for Economic Co-operation and Development (OECD) that does not have a national established bowel screening program. Given that NZ has one of the highest rates

of CRC in the world there is significant scope for improving mortality rates. Bowel screening programs using FOBT work on the premise that polyps will bleed, with a positive result, the person will then go forward for a colonoscopy.

An RCT was conducted looking at the survival benefit of FOBT for the detection of CRC. Lindholm, Brevinge & Haglind (2008) conducted a single-blinded RCT which examined the effects of FOBT screening for the detection of CRC on mortality and compared this to a control group. The study used a cohort of 68 308 participants who reside in Goteburg, Sweden. The study was conducted over 19 years, starting in 1982 and was first published in 2008, in the British Journal of Surgery.

The gender was mix was not identified, the age of participants 60-64 years. The control group were not contacted and were unaware that they were part of the trial. All individuals in both the screening and control groups were traced during the study using the National Cancer Register as well as the local pathology register. The trial received approval from the Goteborg ethics committee. There were no exclusions at the initial stage of the study, other than age. The number in the screening group totalled 34 144, and the control group number totalled 34 164. The screening group was further divided into three cohorts depending on year of birth.

The overall compliance in the screening group was 70 per cent. The rates of positive FOBT were consistent throughout the three rounds of screening ranging from 3.8 per cent (n=801) to 4.4 percent (533). A positive FOBT resulted in a referral for further investigations. There were a total of 104 cancers detected by the screening.

After 19 years the trial results conclude, the incidence of CRC did not differ between the control group and the screening group with an incidence ratio of 0.96 (95 per cent confidence interval (c.i) 0.86 to 1.06). The trial also concluded there was no overall difference of overall mortality rates between the groups (p= 0.174). The screening and control cohorts differed significantly in CRC mortality with an odds ratio 0.84 (95 per cent c.i 0.71 to 0.99). The number of deaths from CRC in the screening group was 252 and the number of deaths from CRC in the control group was 300. Survival from CRC from diagnosis was higher in the screening group than the control ($p<0.0001$), indicating the data lends support away from the null hypothesis. The result of the trial did show an overall 16 per cent reduction in mortality from CRC in the screening group.

The second RCT was conducted over a 10 year period by Kronburg, Fenger, Olsen, Jorgensen & Sondergaard (1996) looking at the survival benefits of biennial FOBT in a general population. The cohort of 45-75 year olds was conducted in Funen, Denmark and was single blinded. There were several exclusions in the study prior to randomisation which included those with a history of CRC, known adenomas and well as those that had participated in the initial pilots study. Spouses were allocated together. There were a total of 30 967 assigned to biennial screening of FOBT and 30 966 allocated to the control group with no screening. The control group were not aware of their participation in the study. Over the 10 year period both group were monitored by a central database and cross checks were conducted with the Danish Cancer Society to ensure no cases of a CRC diagnosis had been missed.

Positive FOBT for each screening round ranged between 0.8-1.8 per cent (n=159-261), these participants were invited for an assessment and colonoscopy. Within the 10 year period, the number of participants diagnosed with CRC in the control group was 483 and in the screening group 481, incidence ratio 1.00(95% CI 0.87-1.13). Death from CRC was 230 in the control and 182 in the screening group, with a mortality ratio of 0.79 (95% CI, 0.65-0.96). The 95% confidence interval indicates the likely hood that the sample used is a true representation of population parameter (Sedgwick, 2014).

Death from causes other than CRC was similar in both groups, indicating both groups were comparable. The survival rate for people in the screening group was higher than in the control group log rank test ($p<0.01$). The study concluded, independent of sex and within the age range of 45-75 years, the overall survival benefit by screening FOBT every 2 years yields to an 18 % reduction in CRC mortality.

A further single blinded RCT was conducted by Hardcastle et al. (1996) over a 10 year period looking at the survival benefit of a biennial screening program using FOBT to detect CRC and

the effects on mortality through early detection. The study was conducted using a general population of people aged between 50-74 years in Nottingham, England and was published in The Lancet in 1996. A total of 152 850 participants were identified, with 75 253 in the screening group and 74 998 in the control group. General Practitioners were asked to identify any participants who they felt were to unwell to participate in the study, households were also grouped before randomisation to ensure all occupants in the same household were in the same arm of the study. The control group were not aware they were part of the study and accessed healthcare in the usual way. The screening group were given Haemoccult FOB test kits from the Health Centre in which they were registered as patients, every two years. The compliance in the screening group was relatively high with 59.6 per cent (n=44 838) completing at least one screening round.

Death from all causes in both the screening (n= 12 624) and control group (n= 12 515) were relatively even indicating a good representation of the population. There were 4.3% more cancers identified in the screening group than the control group. The total number of deaths attributed to CRC was less in the screening group than in the control group (360 vs. 420). A total reduction of 15% in the verified mortality from CRC in the screening group (odds ratio = 0.85 [CI 0.95 0.74-0.98] p=0.026). The odds ratio is used to summarise the effects of a treatment, in this situation being part of the screening group as opposed to the control group (Cook & Sackett, 1995).

DISCUSSION

Earlier diagnosis of cancer improves the outcome by providing earlier treatment, which is generally less complex and less cost (WHO, 2015). The single-blinded RCTs presented conclude that testing for the presence of faecal occult blood in bowel screening programs in a general population does have a positive effect on CRC mortality by 15-18 per cent. There was a high level of compliance 56.6%-70%. Death from all causes was similar in all three studies, therefore providing a good representation of the population. All studies followed both the control and screening groups throughout the trial period 10-19 years, to gain accurate data. The trials outlined did not specifically identify a number needed to treat. Towler et al. (1998) conducted a systematic review of the effects of screening for CRC using biennial FOBT in people over the age of 40 years in five countries. Towler outlined the number needed to treat based on 10 000 people being offered screening with an uptake of about 66 percent who took part in at least one screening round, 8.5 (3.6 to 13.5) deaths could be prevented over a 10 year period.

The relevance to the NZ population is significant, having the sixth highest mortality rate of CRC in the OECD (MoH, 2013). The NZ Bowel Screening pilot (BSP) was started in Waitemata in 2011, with the aim to determine the age range as well as the FOBT positivity threshold that is suitable for the needs of the NZ population. The NZ BSP used the faecal immunochemical tests (FITS) which has gained favour in recent years as the test enables a pre- determined cut-off value to be set, according to the selected population (Grobbee et al., 2017). This level will then determine the point at which referral for colonoscopy needs to be done, reducing unnecessary, risky and costly testing. There is a need to balance both the harms and benefits, ensuring there is an alignment with the resources available (MoH, 2013). The pilot findings found that the NZ BSP experience was in line with the results from other westernised countries. As with other international studies, the NZ BSP concluded that 82 per cent of CRC occur in those aged between 60-74 years (MoH, 2017b). The roll out of the NZ bowel screening project is expected to be complete by the end of 2021, by which time it is projected that 500-700 new cases of CRC will be detected per year (MoH, 2018). Health disparities between Maori and non-Maori is a concern, this is in line internationally with health disparities and inequalities in relation to indigenous populations (Teng et al, 2016). Maori present with more advanced CRC and are 30% more likely to die from their disease (MoH, 2017a). As health professionals we have a significant role to place to utilising resources to ensure Maori engage to improve outcomes.

Early diagnosis of CRC has a positive effect on mortality. Bowel screening programs using faecal tests to detect for occult blood is low cost, non-invasive and simple to perform. The FIT testing kits are now more refined, to enable a level occult blood in the faeces to be set, signalling the need for further testing, and preventing more costly, invasive and unnecessary procedures. The roll out of the bowel screening program in NZ will have a positive effect on mortality by earlier detection and therefore earlier treatment.

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Clinical Champion: Promoting Colostomy Irrigation and its Benefits

ROCHELLE PRYCE, STOMAL THERAPIST, CAPITAL & COAST DISTRICT HEALTH BOARD (CCDHB), WELLINGTON

ABSTRACT

Colostomy irrigation has been implemented since the 1920s and has been demonstrated as an effective alternative for achieving continence for permanent colostomy patients.[1] Irrigation enables patients to gain some control over their bowel function by forming a pattern for elimination, reducing uncontrollable flatus, odour and leakage and significantly improving their quality of life.[2,3,4]

INTRODUCTION

A survey was undertaken to review the practice of colostomy irrigation for permanent colostomy patients and to gain an insight into how many STNs teach and support colostomy irrigation within New Zealand.

An online survey was developed using SurveyHero comprising of 14 questions which were electronically sent to 25 randomly selected national STNs. Of the 25 STNs invited to participate, 18 responded giving a response rate of 72%. Additionally, 22 paper questionnaires comprising of 16 questions were posted to randomly selected patients who currently irrigate. Of the 22 questionnaires there were 20 returned, giving a response rate of 90%.

Key findings showed that within the New Zealand context, STNs do routinely teach and support the technique of irrigation. Furthermore, it is seen that those patients who currently irrigate still find this technique to be beneficial and continue to have significant improvements on their quality of life.

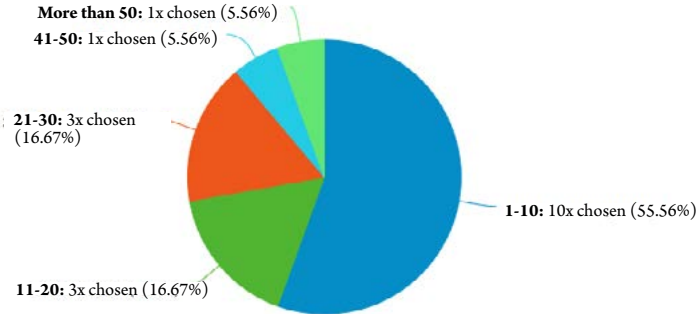
BACKGROUND

Within the New Zealand context, it is mentioned that bowel cancer is the most frequently diagnosed cancer and the second highest cause of cancer death.[5] Depending on the type of disease or part of the intestine needing to be treated, surgical intervention may be required to improve underlying pathology and quality of life.6 Depending on the severity of the disease and whether follow up interventions such as chemotherapy or radiation are needed, a stoma may be created assisting with the bypassing of faecal effluent allowing the body time to heal, this could either be temporary or permanent.

Within the writer's geographical area, specialized stoma care is provided to 450 patients in both hospital and community settings and 180 of these patients have received either a temporary or permanent colostomy. Presently, we have 32 patients that currently irrigate.

My survey asked STNs how many of their patients within their geographic area currently irrigate their colostomy. Of the 18 responses it appears the majority of STNs have between 1-10 patients (55.56%) that irrigate, with others indicating 11-20 (16.67%), 21-30 (16.67%), 41-50 (5.56%) and more than 50 (5.56%).

Approximately how many patients within your demographical area currently irrigate? Number of responses 18



STOMA FORMATION

As STNs we know stoma formation can cause tremendous changes in a patient's life.[7,8] Individuals may experience many challenges and have anxieties around managing their stoma, including uncontrollable flatus, odour and leakage from the appliance.[9] These issues can contribute to psychological and physical impacts and possibly have a detrimental effect on the patient's quality of life.[10] The main psychological issue faced by stoma patients is altered body image.[11] Some patients react with shock and disgust at the thought of having a stoma and experiencing these thoughts can have an overwhelming effect on the mind as well as the body.

The role of the STN is to provide specialized care and management that promotes independence and quality of life. Additionally, clinical experience and supportive care is provided to patients and family members by promoting a standard of excellence through consultation, education and evidence- based best practice. Colostomy irrigation is a practice taught by STNs who can combine the above-mentioned attributes and be able to incorporate theory into practice when undertaking person-centered care. Additionally, it is suggested in literature that colostomy irrigation is extremely beneficial to patients with permanent colostomies and should be included in all STNs scope of practice.

My survey found that seventeen (94.44%) of STNs questioned actively teach and support colostomy irrigation in their current practice, with only one not teaching and this was due to being new to the STN role.

COLOSTOMY IRRIGATION

As mentioned earlier, colostomy irrigation is a technique that has been demonstrated as an effective alternative for achieving continence for permanent colostomy. Pathophysiology suggests tepid water is instilled into the colon resulting in colonic dilatation and an increase of luminal pressure within the colon. This pressure encourages peristaltic waves and reflex contractions which results in the elimination of bowel contents and the instilled water from the colon.[12] The length of the large bowel is approximately 150cm and its main role and function is to reabsorb water and minerals from the remaining indigestible food and transport waste material from the body.[13] Depending on placement of the colostomy (ascending, transverse, descending) this will affect the type and consistency of the stool eliminated. Stomas positioned in the descending or sigmoid colon will contain formed stools with no digestive enzymes which makes this stoma ideal for colostomy irrigation.[14] The desired outcome is to teach the bowel to form a routine pattern for elimination, enabling patients to have reassurance in knowing that their colostomy may not be active for between 24-48 hours, which will give them the power and freedom to confidently engage in normal activities such as work, travel and socializing.[8,15]

The survey of patients in my geographic area supports this. Nineteen of the twenty respondents who reported that they currently irrigate their colostomy also felt that it had improved their quality of life and the majority of these patients had been irrigating for longer than two years. Within these respondents, eight indicated that they irrigated every 24 hours, and the remaining twelve irrigated every 24-48 hours plus.

Teaching irrigation is very private and individualized and must be undertaken in a negotiated partnership. Patients are taught in their own home in a relaxed and stress-free environment usually by STNs competent in this subject or by the patient's doctor. In my patient survey nineteen of the twenty respondents were taught by their STN, and one was taught by their doctor. All participants felt the teaching was not rushed, was calm and easy to follow with only one patient requesting additional support.

A colostomy kit is provided, and all components of the kit are shown and discussed before teaching begins (see figure 1)

Figure 1. Colostomy Irrigation Kit
Note: From https://www.google.co.nz/search?q=hollister+irrigation

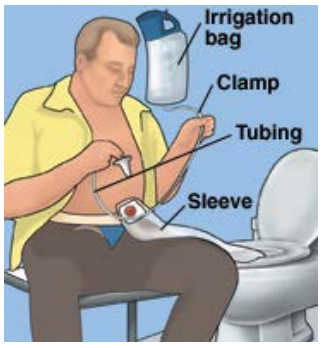


Figure 2. Irrigating your colostomy
Note: From https://mychart.geisinger.org/staywel/html

The technique of irrigation is explained in detail to the patient allowing time for any questions and/or concerns. Irrigation is undertaken in the toilet (see figure 2) and the STN sets up the equipment ensuring patient safety and comfort at all times.

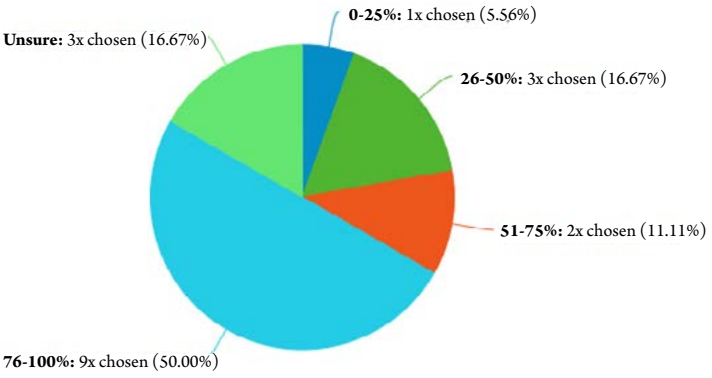
To begin the STN will digitate the colostomy with a lubricated gloved finger to ascertain the direction of the colon. STNs need to be aware that not all stomas are vertical to the skin and can be formed in varying angles. The irrigation bag is filled with tepid water and hung at shoulder height allowing gravity to assist with water flow. The patient fits the irrigation sleeve, sits on the toilet and with assistance from the STN, inserts the lubricated cone into the stoma at the angle previously found. The water flow begins and is run slowly over a period of 5-10 minutes, then as explained previously colonic dilatation occurs which encourages peristaltic waves resulting in the elimination of bowel effluent.

Colostomy irrigation can take up to an hour and needs to be continued routinely until a pattern is formed. Once this occurs patients may only need to irrigate alternate days or every third day. Results from my survey revealed that four patients complete the irrigation process up to 30 minutes, nine patients take 30-45 minutes and seven take 45 minutes to an hour.

Patients choose to irrigate either morning or night, depending on lifestyle and routine commitment. Findings from the patient survey revealed an even result of ten irrigating in the morning and ten irrigating at night.

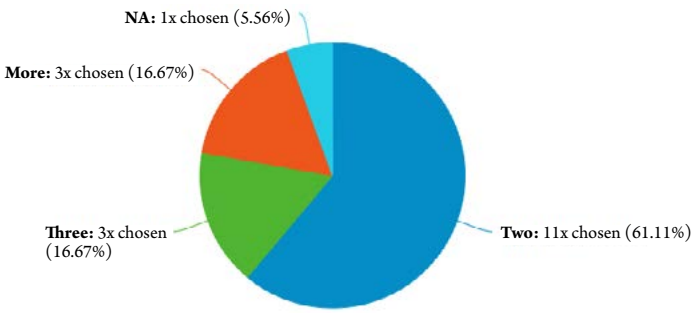
We need to be aware that there are many variances in how individuals learn, and must alter or adapt our style of teaching to accommodate this. For irrigation to be successful, stoma patients require continued access to their STNs who can provide clinical assessment and skills needed to teach the technique of irrigation. The majority of STNs surveyed felt that 76-100 (50%) of their patients were successfully taught to irrigate.

In your opinion, what percentage of patients who are taught to irrigate are successful? Number of responses: 18

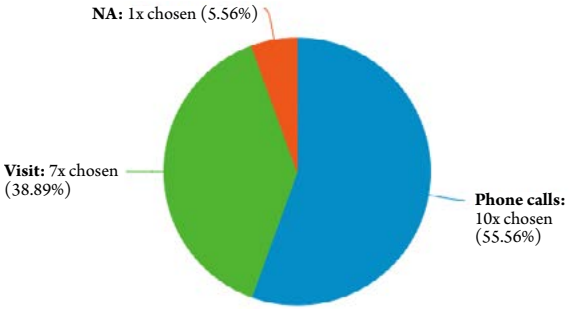


Generally, 1-2 teaching sessions are required for patients to become confident and then are followed up with weekly phone calls. This follow up care is vital as it identifies any areas that need to be rectified and reduce any unnecessary stress caused to the patient. When questioned about how many sessions STNs scheduled and what follow up care was provided, the results showed that mostly two sessions were scheduled (61.11%) with a few STNs providing three or more sessions to patients until the technique is understood. Additionally, 55.56% of STNs provided follow up phone calls and 38.89% would re visit if further teaching was needed.

If you are teaching colostomy irrigation how many sessions do you schedule to teach? Number of responses: 18



What follow up do you provide to your patients that irrigate Number of responses: 18



CRITICAL THINKING AND REFLECTING PRACTICE AS AN STN

Critical thinking is a necessary skill utilized every day for nurses, and when used in combination with reflective practice, provides a method for sharpening our critical thinking skills.[16] The integration of these two concepts offers nurses a process for analyzing perplexing and complex events.

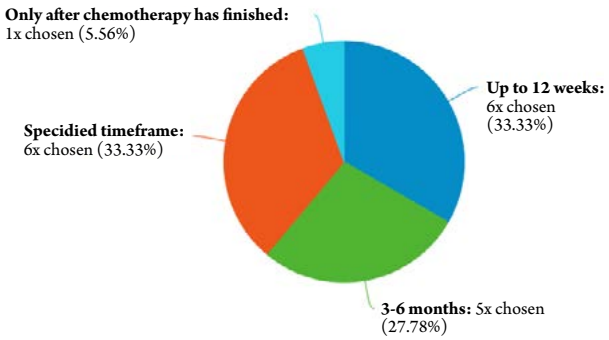
STNs need to have a holistic view of the person and be aware that not all colostomy patients see irrigation as the solution to managing their bowel evacuations, some patients see it as impractical and inconvenient. However, we do need to ensure our patients are informed of this technique pre-operatively as an alternative method of bowel management if they are to receive a permanent colostomy. Those that appear genuinely interested and motivated should be provided with education and ongoing support to become successful irrigators.[15] STNs were asked whether they discussed colostomy irrigation during the pre-assessment phase. The results showed eight (44.44%) did discuss at pre-assessment and ten (55.55%) chose not to. Additionally, patients were asked how did they learn about colostomy irrigation, sixteen advised they were informed by their stoma nurse at pre-assessment and the remaining four heard from others, publications and their doctor.

In contrast, not all permanent colostomy patients are able to irrigate, and in our role, we need to have knowledge and understanding around these reasons. Ideal candidates for irrigation are patients that have their colostomy positioned in the descending or sigmoid colon and have no residual disease in the remaining colon. Contraindications include patients still having some form of irritable bowel syndrome, Crohn's disease or diverticulitis, colostomy positioned in the ascending or transverse colon, poor bowel habits resulting from radiation or chemotherapy damage, prolapse or parastomal hernia, poor vision, altered mental alertness and poor manual dexterity.[2,12] Prior to teaching irrigation, it is essential STNs conduct a thorough comprehensive assessment to ensure their patient meets the relevant criteria, and confirmation and consent needs to be obtained from the surgical consultant before teaching can begin.

Do you discuss colostomy irrigation during the pre-assessment phase as an option for faecal management for permanent colostomy patients? Number of responses: 18

Research reveals there does appear to be some controversy around when the right time is to begin teaching irrigation. Additionally, it is mentioned there seems to be no rules around when to commence irrigation and points out that the patient may be more receptive to teaching three months post-surgery.[4] Due to this conflict, the writer asked STNs when they teach irrigation. Results showed the majority of STNs (61.11%) teach irrigation within a six-month period of patients receiving their colostomy.

In your experience, how much time postoperatively would you allow before colostomy irrigation can be taught? Number of responses: 18



There are some complications that may occur when teaching irrigation and it is essential the STN have advanced knowledge around these. Historically, irrigation was carried out using an irrigation catheter from a rectal enema kit, however this method lead to colonic perforations.[17] The use of a malleable cone and gravity bag has largely eliminated the risk of perforation which is now considered to be a rare complication.[18,19,8,20] Minor bleeding from the stoma, abdominal cramps and incomplete emptying of the inserted water are some side effects of irrigation that STNs need to be aware of when teaching. If the patient experiences any of these latter side effects, the STN needs to intervene and correct before the patient can continue. As the bowel has no nerve

endings, it is imperative the water to be instilled is the correct temperature of tepid tap water 37 degrees Celsius. If the water is too cool or inserted too quickly, this will result in abdominal cramps and in contrast, if the water is too hot, may result in a burn injury to the colon, causing a stricture, resulting in the patient needing to have surgical reconstruction of their colostomy.

Other potential risks that may occur when teaching irrigation is fluid overload with those who have a history of renal or cardiac impairment.[21] Caution must be taken with this population group as fluid overload may occur if the bowel absorbs fluid through the mucous membranes resulting in a fluid imbalance.[22,4] Additionally, vasovagal episodes can happen due to the colon being distended, which can result in dizziness and a drop in blood pressure and heart rate.[12,15]

Break through bowel activity between irrigations can occur and the STN needs to critically examine the reasons for this. Some possible solutions could be volume of water administered, slow transient time and not waiting long enough post water administration, diet, gastrointestinal infection or in some cases, alcohol intake. All of these can have a significant impact when trying to achieve the desired outcome.

Lastly, it is well known that New Zealand has the third highest obesity rate in the OCED and continues to increase.[23] Obesity has a significant impact on stoma patients and can cause post-operative complications, retracted or poorly sited stomas and skin excoriation due to stoma appliances not adhering well to the abdomen. By teaching irrigation to the obese patient, it can reduce some of these issues and benefit quality of life. However, obstacles can occur if the bathroom is too small to teach, the patient is unable to see their stoma, or the abdominal wall is thick with fat folds which will make it difficult to instill the water and get a good return.

EVIDENCED BASED PRACTICE

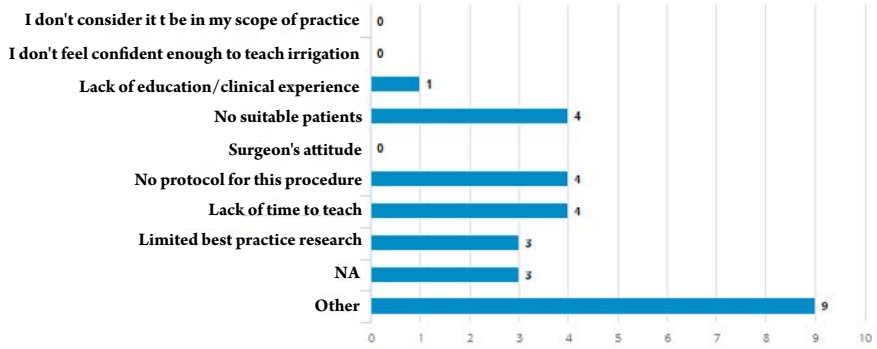
As STNs it is essential we identify solid research findings on colostomy irrigation and implement these within our current nursing practice, this will result in providing optimum patient care. However, the literature suggests that there appears to be a lack of knowledge about colostomy irrigation among healthcare professionals despite the positive advantages it can have to both patient's quality of life and the cost savings to healthcare facilities.24 What's more, research shows that there is indeed a requirement to further develop education and knowledge for STNs which will enable them to have more insight into the irrigation technique and to dismiss myths that have accumulated around the procedure.[25,4]

Using a mixed-method approach Cobb et al. (2015)[26] conducted a study to view current knowledge, attitudes and practices of STNs on colostomy irrigation. 4191 wound, ostomy and continence nurses were targeted and captured 985 responses providing a response rate of 24%. The results showed 181 (18.4%) of STNs routinely teach colostomy irrigation, 193 (19.6%) only teach if the patient requests, 93 (9.4%) if the physician orders it, 467 (47.4%) did not routinely teach irrigation and 51 (5%) chose not to respond.

In combination with the above, additional questions were asked in relation to advantages and disadvantages faced by STNs when teaching irrigation, and any challenges STNs faced when assisting patients to learn this technique. The study also asked whether STNs believed colostomy irrigation was evidenced-based.[260] Of the 985 responses, 64.4% (P=.002) believed that colostomy irrigation is evidenced-based but they feel more education and additional resources need to be made available to STNs who care for this population group. Lastly, there still also appears to be lack of literature on trouble shooting and causes of unsuccessful irrigation.[26]

My survey asked STNs to identify the barriers they faced which prevented them from teaching irrigation to their patients. Results showed eight (44%) STNs felt there was either lack of education/ clinical experience, no protocol for this procedure or limited best practice research. Of the STNs that chose "other" for this question, see comments below.

What barriers do you find (if any) prevent you from teaching colostomy irrigation? (tick all those that apply)
Number of responses: 18



- There is no barrier other than finding the time to do 2-3 home visits to teach. There should be no barrier for this quality of life procedure
- Geographical location of the patient. They may live 2 to 3 hours drive away
- The only barrier for me is that patients don't want to do it
- Often I find the surgeon may suggest irrigation to a patient and then I will follow up on that. I don't always promote irrigation for a number of reasons. The patient needs to be able to manage colostomy irrigations. My workload is high and teaching irrigations can be time consuming. The patient has to be keen to learn and stick to a regular routine.
- I am hospital based so do not teach irrigation to post op patients in hospital
- Other
- We do very few permanent colostomies
- Its probably more a lack of suitable patients than not enough
- Patients having chemotherapy I do not teach, patient lifestyle, age and other co morbidities

These findings are supported by Clow, Disley, Greening and Harker (2015)[21] who explains there appears to be a great deal of information available regarding the actual irrigation process but there is very little to suggest best practice guidelines for the nurse that would ensure patient safety and independence and nurse competence in this area.

CLINICAL CHAMPION

Soo, Berta and Baker (2009)[27] suggests the role of a clinical champion is essential in moving new innovations through the phases of initiation, development and implementation. Furthermore, it is mentioned that the role of a clinical champion has been hugely underdeveloped within the current healthcare context.[28] The overall goal of a clinical champion is to implement change and convince others to accept the innovation.[27] To achieve this, clinical champions need to engage in several key activities recognized as educating, advocating, building relationships and navigating boundaries.[27]

Education is a major concept of the clinical champion role. Knowledge and clinical expertise need to be shared with all healthcare professionals and associates. Within the STN role, to emphasis the advantages of irrigation, education and sharing of information needs to be provided at every given opportunity.

Advocacy is another way that enables clinical champions to convince others to accept irrigation as an innovation and the advantages it has for permanent colostomy patients. Therefore, STNs need to be an advocate for this topic and share their knowledge and success stories of those who have been taught to irrigate.

Building relationships has a positive effect on healthcare professionals when implementing an innovation. To promote the positive effects of irrigation, it is essential STNs build working relationships with colorectal surgeons, ward nurses, practice nurses and clinic nurses.

Navigating boundaries between varied professions, hospital units and departments is also an essential component of being a clinical champion. As STNs work both autonomously and in collaboration with others we have excellent knowledge of organizational layout and community services, this provides us with access to multiple areas of practice in which we can communicate and share our stomal therapy knowledge and the benefits of irrigation.

Within stomal therapy, extensive research supports the advantages irrigation has for permanent colostomy patients. Therefore, STNs that believe in the merits of this innovation should take every opportunity to endorse irrigation to improve patient care and quality of life.

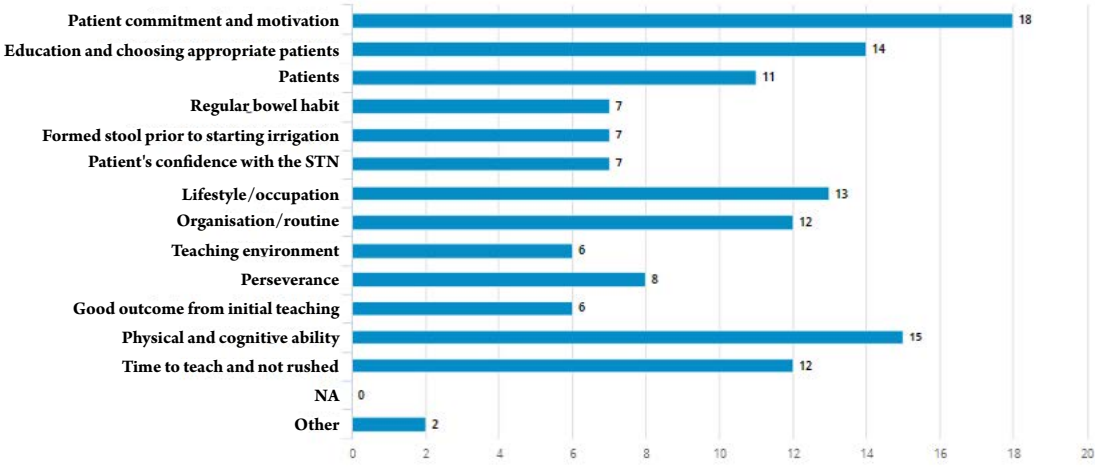
My survey asked STNs if they felt irrigation is a viable management strategy for people who have a permanent colostomy. 100% of STNs do believe that colostomy irrigation is a viable management strategy and with this in mind, we need to advance the role of the clinical champion to convince others that this technique has substantial benefits to this population group.

CHALLENGES AND OBSTACLES FACED BY PATIENTS AND STNS

It is seen that irrigation is a safe and effective method and has significant beneficial outcomes for patients who have received a permanent colostomy. However, it must be pointed out that there can be both advantages and disadvantages that STNs and patients face when teaching and learning this technique. There is specific patient criteria required before STNs can teach irrigation, with the most important indicators identified as patients being motivated and committed to learn the procedure, have good manual dexterity and eyesight and are not cognitively impaired.26,20,29 As the aim of irrigation is to teach the bowel to form a pattern, these indicators are crucial in the success of irrigation. Lastly, it is mentioned for irrigation to be successful, patients need to be made aware that irrigation is an "all or none" process and cannot be applied occasionally or on an ad hoc basis.[1]

My survey asked STNs what factors they believed assisted with successful colostomy irrigation and what factors they believed caused a patient to be unsuccessful with colostomy irrigation.

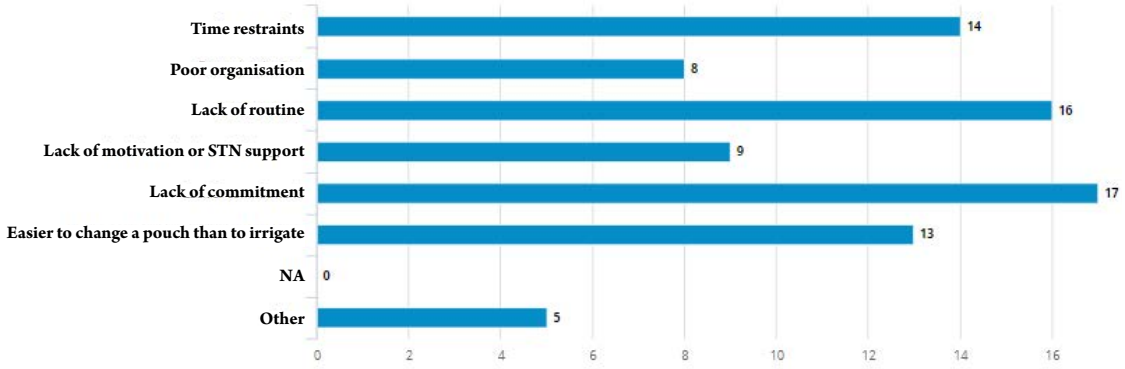
As an STN, what factors do you believe assist with successful colostomy irrigation (tick all those that apply)
Number of responses: 18



From the findings it is shown that 100% STNs identified patient commitment and motivation as the main indicator necessary for successful irrigation, followed by physical and cognitive ability. These findings fully support and back up research findings mentioned previously. To gather information from a patient's perspective, I asked patients what they felt contributed to positive irrigation and their results showed less anxiety, less flatus, less odour, training the bowel to be regular and feeling confident in intimate situations.

When asked to identify factors that cause patients to be unsuccessful with irrigation, seventeen (90%) of STNs felt lack of commitment was the main reason, followed by lack of routine and time restraints.

As an STN, what factors do you believe cause a patient to be unsuccessful with colostomy irrigation (tick all those that apply) Number of responses: 18



Regarding patients surveyed, they identified routine and lifelong commitment as the main negatives to irrigation.

FUNDING

Within today's economic climate, health care facilities are more and more focused on cost effectiveness.20 Irrigation has proven to be a cost-effective method and has significantly reduced pouch usage when compared to spontaneous evacuation.2 An American study found annual costs associated with patients who do not irrigate were more than halved with the introduction of irrigation.[30]

To show the cost effectiveness of irrigating vs not irrigating the writer chose a random supplier and will analyze the costs. Colostomy patients generally use 1-2 pouches per day and in some instances, depending on bowel habits, food and fluids may use up to three per day.

Supply cost for patients that do not irrigate

$4.00 per closed colostomy pouch x 30/box $240 month	
12 month supply	$2880
Plus accessories if skin irritation/imperfections	$100
Total annual cost	$2980

Supply cost for patients that do Irrigate

Irrigation Kit 2 x annually	$160
Caps or plugs 6 month supply	$360
Total annual cost	$880
Total cost of not irrigating	$2980
Total cost if irrigating	$880
Cost savings per year	$2100

A question was asked to STNs whether they believed irrigation saved money. The response shows that fourteen (77.78%) agreed and four (22.22%) disagreed. From the above calculations, it can be seen there are indeed significant savings to healthcare facilities which is another reason why irrigation should be utilized more.

My survey asked patients what products they used post irrigation, the results showed ten used caps three still used a pouch and interestingly seven still used both.

CONCLUSION

To conclude, it is evident that colostomy irrigation is a well-established technique that assists permanent colostomy patients to regain bowel control. Irrigation is seen as a safe and effective alternative for bowel evacuation and when taught correctly can have significant benefits to improve many aspects of life for permanent colostomy patients.

Research shows stoma formation can impact on patients psychological and physical wellbeing and they may experience many challenges and anxieties around managing their colostomy. Therefore, as STNs we need to inform our patients at the earliest opportunity, how colostomy irrigation can improve quality of life and empower them.

It is noted that more education and best practice guidelines are required which will assist STNs to feel more confident to teach irrigation. Evidenced based research utilized in conjunction with sound clinical practices will result in providing optimum patient care for this population group.

Evidence shows colostomy irrigation is a cost-effective approach for stoma management and has substantial benefits to both patients and healthcare facilities.

This article has highlighted there can be both advantages and disadvantages for STNs and patients regarding irrigation. Advantages patients identified from the paper survey was a reduction in uncontrollable flatus and odour, reduced anxiety, feeling confident in intimate situations, not having to wear a stomal pouch and having control back over their bowel evacuation. Disadvantages were seen as lifelong commitment, routine and slow transit time. STNs felt patient commitment, physical and cognitive ability and appropriate patients type contributed to advantages of teaching irrigation and lack of commitment, lack of routine and time restraints were the biggest indicators for patients being unsuccessful.

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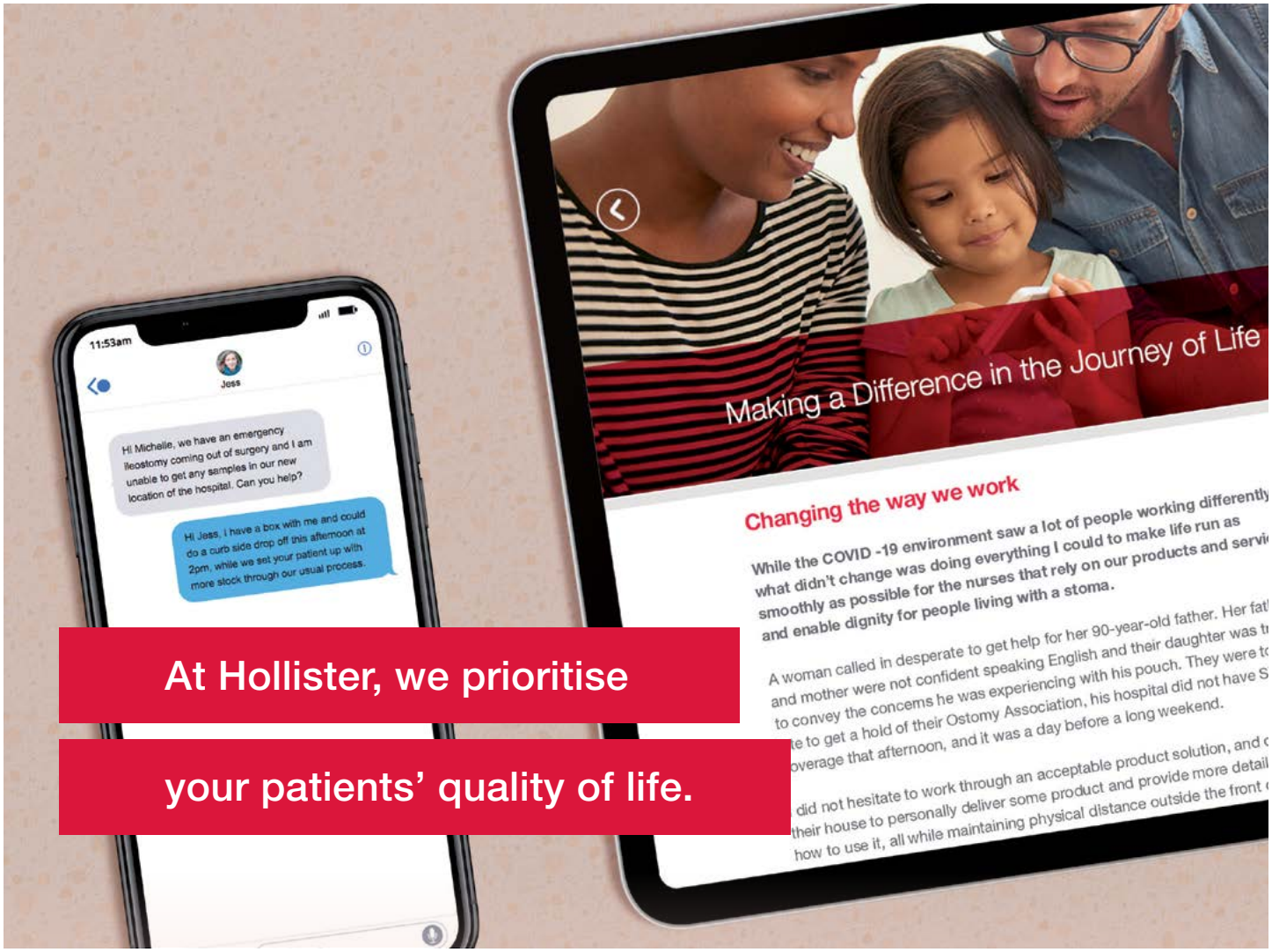

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Development of Patient Information Regarding Prolapsed Stoma's

JULIE SKINNER, OSTOMY CLINICAL NURSE SPECIALIST, WAITEMATA DHB

For stoma patients or their care givers, a prolapsed stoma can be very distressing and it requires immediate assessment.

A prolapsed stoma can be managed conservatively but if complications arise surgical intervention may be required.

Over the years as an Ostomy Clinical Nurse Specialist I have encountered patients with prolapsed stomas and provided them with verbal advice. I thought it would be beneficial to give written advice to patients so that they could understand why they had developed a prolapsed stoma, how to manage this and when to seek help. Also, to reassure them that a prolapsed stoma is manageable and to keep as a handy reference tool.

The only patient information leaflet I could find was written by a UK Ostomy Clinical Nurse Specialist for the NHS. The leaflet was useful and I gave it to patients who developed a prolapsed stoma but I did not think it was appropriate to hand out an NHS leaflet to New Zealand patients. I contacted the author and she was happy for me to use her leaflet as a tool for developing my own leaflet.

There was no leaflet on managing a prolapsed stoma at my DHB and on discussion with the Northern Region Ostomy Clinical Nurse Specialists, there was no such leaflet within their DHB's. It was decided that developing a leaflet was beneficial for the patients and sharing it with the Northern Region Ostomy Clinical Nurse Specialists would ensure that we were all giving consistent advice to our patients.

I conducted research on "Managing a prolapsed stoma". There was very little information on this and not many recent articles. The literature I found, although old was consistent.

I developed an evidence-based leaflet and presented this at the Northern Region Ostomy Clinical Nurse Specialist Forum. The feedback was encouraging and some changes were made.

The leaflet was formatted on WDHB headed paper by the Quality Document Coordinator. The leaflet was then sent to a consultation group, including a surgeon, Ostomy Clinical Nurse Specialists, Stoma Resource Nurses, my Manager and the Community Director of Nursing. The feedback from the group was very positive and very few changes were made. The leaflet was then sent to the Community Health Literacy Group for review. The feedback received was that the leaflet was easy to read.

The leaflet was published on the WDHB intranet. I sent the leaflet to the Northern Region Ostomy Clinical Nurse Specialists for publishing within their DHB's, reminding them that they had to acknowledge WDHB.

I have given the leaflet to a few patients with prolapsed stomas and to a rest home looking after a patient with a prolapsed stoma and they have all stated that the leaflet is very clear and easy to follow. Patients have commented that they feel more confident with managing their prolapsed stoma.

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Development of Patient Information Regarding Prolapsed Stoma's

JULIE SKINNER, OSTOMY CLINICAL NURSE SPECIALIST, WAITEMATA DHB

Waitematā District Health Board
Best Care for Everyone

Managing a Prolapsed Stoma

What is a prolapsed stoma?

A prolapsed stoma is when a segment of bowel telescopes out of the stoma making the stoma longer than normal.

What causes a prolapsed stoma?

A stoma can prolapse due to weak abdominal muscles, obesity, chronic coughing, urinary retention, pregnancy or on-going constipation. Also, a prolapsed stoma can happen abruptly for no apparent reason. It is common for the stoma to lengthen when you are moving around during the day and reduce back to normal size when you lie down.

How to look after a prolapsed stoma

Having a prolapsed stoma can be distressing but providing the stoma remains a healthy pink/red colour and works normally it is not serious and there are ways of managing and reducing the prolapsed stoma. Surgery is not normally required.

Managing a prolapsed stoma

A prolapse can alter the size and appearance of the stoma and make pouch adhesion difficult. The hole in the pouch may need to be made bigger. Also, the stoma may rub on the pouch and cause bleeding and/or ulceration. A larger pouch may be required. The skin around the stoma may become sore and a protective ring around the stoma may be required. Your stoma nurse can assess you for products.

If you cannot apply a pouch over your stoma, put cling film or a plastic bag over the stoma to prevent it from drying out and seek medical advice.

How to reduce a prolapsed stoma

A prolapsed stoma can be reduced by lying down on the bed for about 20 minutes to relax the abdominal muscles and reduce pressure. If the stoma is swollen a cold flannel or ice pack wrapped in a towel can be applied for no more than five (5) minutes to reduce the swelling, and the bowel can be gently pushed back in to itself. If the stoma remains prolapsed for a long period of time there is a risk that it will become grossly swollen and may be difficult to reduce back to its normal size. It is advisable to lie down in the afternoon to allow the stoma to reduce back in and reduce the risk of gross swelling.

After a prolapsed stoma has been reduced it may be beneficial to wear a support garment to support the prolapse and weak abdominal muscles. Your stoma nurse can assess you for a support garment.

When to seek help

If the stoma becomes purple or black, ulcerated, painful, grossly swollen or does not function normally you must inform your stoma nurse or GP or, if after hours, go to hospital.

It is important to seek advice and support from your stoma nurse if you have any concerns about your stoma and they will be able to offer you support and guidance.

Issued by	CNS Ostomy/CND Community & Specialty Practice	**Issued Date**	February 2020	**Classification**	tba
Authorised by	Operations Manager, Community & Palliative Care	**Review Period**	**36mths**	**Page**	Page **1** of **1**

This information is correct at date of issue. Always check in the relevant Waitematā DHB policy manual that this copy is the most recent version.

Policy for Bernadette Hart Award

Process

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

Criteria

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

Feedback

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

and/or

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

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

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

BERNADETTE HART AWARD APPLICATION FORM

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Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

_____

_____

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

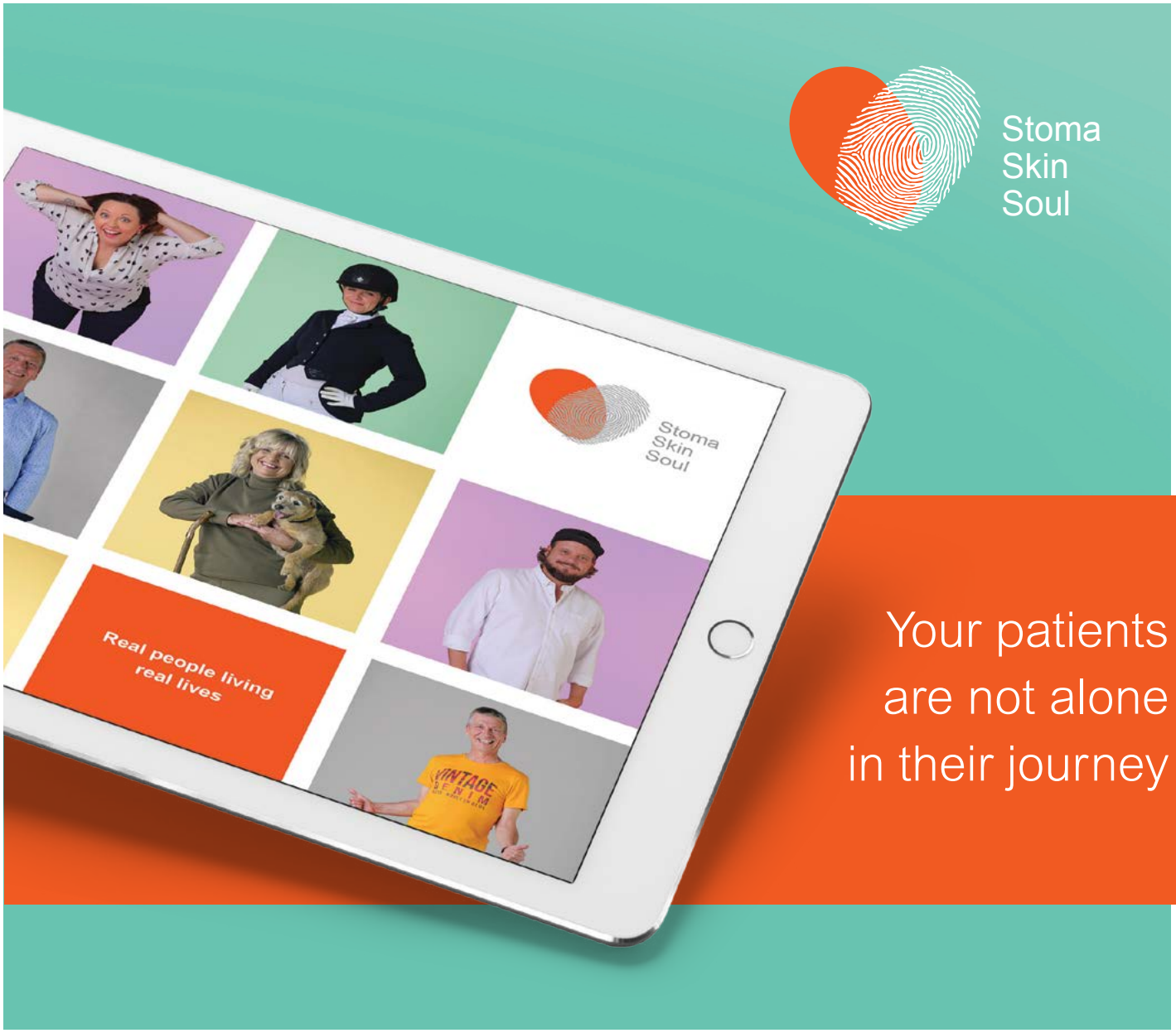
Have you been a previous recipient of the Bernadette Hart award within the last 5 years? ◯ No ◯ Yes (date) _____

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

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

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

Signed: _____ Date: _____



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Writing in The Outlet

PURPOSE

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

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

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

GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

Literature Review
If publishing a research paper.

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

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

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

NB: Written in conjunction with NZNO Kai Tiaki Publishing Guidelines

The Outlet

New Zealand Stomal Therapy Nurses