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New Zealand Stomal Therapy Nurses

In this issue:

MARCH 2016

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New Zealand Stomal Therapy Nurses

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We apologise for these errors and they have also been corrected on the NZNO Stomal Therapy Section website

IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT

Jackie Hutchings

Email: jacquelynh@nursemaude.org.nz

Your Executive Committee Members

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NZNOSTS Section: Chairperson's Report

MARIE BUCHANAN

Kia ora, Hello and Hi.

Welcome to your first Outlet journal for 2016. The festive season is now over once again for 12 months and we are now well into the New Year. I hope that 2016 is good to you all and not too many New Year's resolutions have been broken already!

2016 is set to be an exciting year for the section. It has begun well with us submitting the application to NZNO to apply for transition from a Section to College status. This is a huge achievement and an immense feeling of accomplishment which has been the direct result of the hard work and commitment of the present and past committee members in seeing it through. It will now be assessed by NZNO and we will await their feedback and anticipate that we will be able to announce a positive outcome at conference in October. This brings me to the next big event this year being the conference, "New Beginnings". New Beginnings is the theme as Christchurch rebuilds itself from the devastating earthquakes and for the section transitioning to College status. Planning is well underway for 27 - 28th October in the beautiful city of Christchurch. We are putting together a very informative, educational programme and of course the greatly anticipated social event. We would like to extend an open invitation to you all to attend. Look out for the flyer for early registration in the journal or on the NZNOSTS website. Early registration is always good as it saves you money and allows us to secure numbers early. As always it is guaranteed to be a great opportunity for networking, learning and lots of fun.

In October I attended the Australian Association of Stomal Therapy Nurses (AASTN) conference which was held in Melbourne in partnership with Asia Pacific Federation of Coloproctology Congress, as a representative from NZNOSTS. I would like to thank the section for funding me to attend this conference which I found to be very informative and educational with a great opportunity to network with our Australian peers. It was great to see several other NZ delegates attending and well done to Maree O'Connor for presenting her case study on "The women who tried everything". It was a great representation from NZNOSTS and we were all made very welcome. I had a chance to meet with the conference convener, Helen Nodrum. She was very welcoming and we tentatively discussed the possibility of arranging a joint Australasian conference in the future, so watch this space as they say!

The committee continues to work hard for you all. Our next meeting is on 16th February in Christchurch. This is to allow us to view the venue and to make further arrangements for conference. The committee are your representatives so please contact any of us if you have any concerns, ideas or suggestions you would like us to discuss. We are here to represent the membership and encourage your input and comments.

Unfortunately it is with regret that I have to inform you that Ginnie Kevey-Melville has resigned from the NZNOSTS committee and subsequently as Secretary, due to personal reasons. It is with sadness that we have accepted her resignation and she has our full support and understanding for this decision which I know she did not make lightly. I acknowledge and thank her for the time and commitment she has put into the section over the past 3 years, especially in the role of secretary but also her time and energy into conference organisation and the endless reviewing of documents in regards to section to college transitioning. Taking on the role of secretary was not easy for Ginnie but she accepted the challenge and has excelled in fulfilling the role to a high standard. Thank you Ginnie for your time and commitment to the section and all the work you have put into it over the past 3 years. Your contribution, secretary skills and comradery within the committee will be sadly missed. We wish you all the very best, enjoy spending more time with your family, friends and beautiful dogs. Best wishes and again Thank You Ginnie.

Last year we received one application for the Bernadette Hart Award. Rachel Pasley was awarded $1000 to assist her to attend the WECT conference in Cape Town, South Africa, in March 2016. Rachel is a well deserving recipient of this award with several years of stomal therapy commitment and actively contributes to our journal by submitting articles. She will be presenting a case study at the conference and I am sure she will be a great ambassador for us. We wish her a safe journey and look forward to hearing her feedback on the conference. I want to take this opportunity to remind everyone that this award is available to all members to apply for. All applications are considered on their own merit by the current committee. Application forms are included in the journal and are available on our website. I encourage you to make use of these funds as they are there for your benefit and support.

Kia ora everyone, your ongoing commitment to Stomal Therapy and the section is very much appreciated. Enjoy the rest of the summer, stay safe and look out for each other.

Kind regards

Marie Buchanan, Chair NZNOSTS

Co-editors Report

BRONNEY LAURIE AND JACKIE HUTCHINGS

In the last edition it was mentioned that we would like to start a "Letter to the Editor" page to be used as a forum to comment on articles, ask questions or seek advice from other stomal therapists or bring issues to the attention of all those interested in the field of stomal therapy nationwide. As no one has sent anything in we have no page for this in this edition but would be happy to add it in at any time. Any "Letters" can be sent to jacquelynh@nursemaude.org.nz.

Please remember that if you have work published in The Outlet you can enter the Liberty Award for the best published article. This is not an automatic entry - you must complete the entry form found either in The Outlet or on the NZNO Stomal Therapy Section website. Entries need to be received by 30 September 2016. If you have already had an article published in either the July or November 2015 editions you are still eligible to enter. These entries are to be sent to jacquelynh@nursemaude.org.nz.

We would like to thank those who have provided articles for this edition. E**verybody else please consider submitting something for our July edition. You do not need to be a practicing stomal therapist to write a case study about an interesting patient whose care you have been involved with.** We would need to receive this by the end of the first week in June. It is great to have this local content in our Journal rather than having to use articles that have already been published in international stomal therapy journals such as the AASTN.

The invitation to have articles published is also extended to the trade companies. This is as long as it is not just product focussed as it is not just an avenue to advertise your products. Many companies though, have interesting case studies or research articles they have conducted which would be interesting learning opportunities for us all.

The **Bernadette Hart application form** is once again included in this Journal. Please consider applying. The closing date is November 30 each year. Rachel Palsey from Northland was the recipient of the award this year and we wish her well on her trip to Cape Town to the WCET conference. We look forward to reading about her experiences in The Outlet.

We hope you all found the National Contacts List in the last edition to be of use. There were some errors and these have been corrected on the updated list on the NZNO Stomal Therapy Section website.

Once again I will conclude with a personal note. In the last edition I wrote a case study about "Courtney". She has since sought a second opinion and is now having small bowel studies with a view to having an ileostomy formed in the near future as she still has active Crohns in her colon.

At Nurse Maude we are starting to look at a competency framework for stomal therapy. This is important to have as Jenny, Beth and I are not getting any younger and we need to look at succession planning. Claire Ward has joined the team and is currently doing the NSW stomal therapy course but we would like to develop a competency framework that reflects our practice. Does anyone in New Zealand have such a framework or even a modified one from another clinical area or a list of core competencies that you use? I would really appreciate any feedback to jacquelynh@nursemaude.org.nz.

We hope to see as many of you as possible at our Stomal Therapy conference here in Christchurch in October. The content looks to be varied and informative and the venue inviting. Further information can be found further on in this Journal.

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Policy for Bernadette Hart Award Selection

PROCESS

- The Bernadette Hart Award (BHA) will be advertised in the NZNOSTS Journal "The Outlet".
- The closing date for the BHA applications is 30 November each year.
- The NZNOSTS 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 NZNOSTS 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 applicant(s) will be published in the NZNOSTS Journal "The Outlet".
- The BHA Policy will be reviewed annually by the NZNOSTS Executive Committee

CRITERIA

- The applicant(s) must be a current member of the NZNOSTS 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 NZNOSTS and/or the BHA will be taken into consideration by the NZNOSTS 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

(a) 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

or

(b) To present at the next NZNOSTS 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 Stomal Therapy Section 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:

Marie Buchanan
Email: marie.buchanan@waitematadhb.govt.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

_____

_____

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

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

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

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

◯ Yes I will be presenting at the next National Stomal Therapy Section Conference.

Signed: _____ Date: _____

The Liberty NZ Stomal Therapy 'Publishing Excellence' Award

THE AIM

The Aim: of the Liberty New Zealand Publishing Excellence Award is to recognise the endeavors of nurses working in the field of stomal therapy, encouraging them to achieve excellence by publishing in the NZNOSTS Journal "The Outlet".

All NZNOSTS members, who meet the award criteria, can submit their article to be assessed for the award. The award is to the value of $1000. In the event that there is more than one worthy recipient the amount may be shared.

THE PURPOSE OF THE AWARD

The Liberty Publishing Award is to be used towards the cost of:

- Travel / accommodation / registration to attend a national or international conference related to stomal therapy

  or

- To facilitate participation in an accredited post graduate study program leading to qualification as a Stomal Therapist or appropriate study in the associated area intended to advance the knowledge and understanding of the discipline of stomal therapy

ENTRY CRITERIA

- Be a member of NZNOSTS, both at the time of publishing and at the time the award is made
- Have submitted an article, which has been published in The Outlet and which complies with the Award Criteria
- Have completed the entry form and submitted to The Outlet editors by September in the year of the award. The Liberty Publishing Excellence Award will be made in the same year as the NZNOSTS biennial conference.
- Only one article per author can be submitted for assessment
- The journals from which articles can be submitted for assessment will be published in the two years prior to the biennial conference as follows;
  - First Year: July and November 2015
  - Second Year : March and July2016
- By submitting and applying for the Liberty publishing award, the publisher agrees that their name and /or article can be used by Liberty Medical for Education and Marketing.

The assessment panel will critique submitted articles for value to Stomal Therapy practice, contribution to understanding the patient experience, innovation in practice and contribution to the body of Stomal Therapy knowledge.

The successful award recipient will be announced at the NZNOSTS biennial conference and the award will be made by a Liberty representative.

Best Published Article Entry Form

Please complete and return to The Outlet Editor by the last day of September in the year of the Award submission.

Name: _____

Address: _____

_____

_____

Telephone _____

Email: _____

Qualifications _____

Employment position _____

NZNO Number _____

Article Title and Date of Publication

_____

_____

Note: If there are constraints as to when you can and cannot publish your paper, please bring this to the attention of the Executive Committee or The Outlet Editors.

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International Delegate for the World Council of Enterostomal Therapists

Francesca Martin
Stomal Therapist
Auckland DHB

I have volunteered to be the International Delegate for New Zealand. This does not appear to be a very onerous role, mainly requiring an annual report of the New Zealand Stomaltherapy scenario and what the local WCET nurses are doing. I feel it is important to have a presence in the world arena of Stomaltherapy to be able to share our experiences and learn from other countries' experiences.

I encourage STNs to join the WCET. They post an excellent publication, the WCET Journal, four times a year which has articles on wound care, continence, ostomy care and management and professional issues. The subscription is GBP30 a year. My subscription for two years was NZ$114.88. WCET members receive a discount for WCET conference enrolments.

If anyone is planning on going to the WCET conference in Cape Town, South Africa, please be prepared to represent New Zealand at the Parade of Nations at the opening and closing ceremonies. When I attended the conference in Gothenburg two years ago I, and fellow Kiwis, thought that only WCET members could represent their countries. This is not the case, so please get up onto the stage and wave the flag!

If anyone wishes to contact me my email address is franmartin100@hotmail.com

Francesca Martin

Auckland DHB

NEW ZEALAND NURSES ORGANISATION

NZ NURSES ORGANISATION
STOMAL THERAPY SECTION

New Beginnings

Stomal Therapy Conference

Rydges Latimer, Christchurch
October 27 - 28, 2016

NZNO STOMAL THERAPY SECTION CONFERENCE

New Beginnings - Information

27 - 28TH OCTOBER 2016
RYDGES, 30 LATIMER SQUARE, CHRISTCHURCH, NEW ZEALAND

A TENTATIVE PROGRAMME HAS BEEN DEVELOPED FOR THIS CONFERENCE

Topics included are :
- Paediatric stomas and complications post reversal
- Familial GI Cancer Registry
- Parastomal Hernias: Treatment and Complications
- Neobladder versus Ileal conduit formation
- Motivational speaker - a patient's story
- Problem solving and getting back to basics
- Inflammatory Bowel disease for Dummies
- Medical and radiation oncology
- Psychosocial issues

A CALL FOR ABSTRACTS

Please consider presenting at conference. There is a 15 minute time limit for your presentation and it could be a case study or something about your practice.

To enter the Liberty Best Presenter Award which has a prize of $3000 complete the entry form below and return with your abstract. This is open to anyone who has been a member of NZNO Stomal Therapy Section for more than one year. Further information can be found on the NZNO Stomal Therapy website.

Abstracts and entry forms are to be sent to Jackie Hutchings at jacquelynh@nursemaude.org.nz

CONFERENCE ACCOMMODATION

Please organise your own accommodation. There are limited rooms at the conference venue or the nearby Rendezvous and Novatel hotels as well as a range of other accommodation nearby but you do need to book early as accommodation in Christchurch is limited still.

LIBERTY BEST PRESENTER AWARD ENTRY FORM

Name: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

Qualifications: _____

Employment position: _____

NZNO Number: _____

Presentation Title: _____

Note
If there are constraints as to when you can present, please bring this to the attention of the Executive Committee. Applicants will need to formally register for the conference as per the conference registration form.

NZNO STOMAL THERAPY SECTION CONFERENCE

New Beginnings - Registration Form

27 - 28TH OCTOBER 2016
RYDGES, 30 LATIMER SQUARE, CHRISTCHURCH, NEW ZEALAND

Tax invoice GST # 10 386 969

Please print clearly

Name: _____

Address: _____

_____

Telephone: _____ **Email:** _____

NZNO Member: ◯ Yes ◯ No **Membership number:** _____

Full fee	**$320**	Includes morning and afternoon teas, lunches and social event - Thursday night
Early bird - before 01/09/2016	**$290**	Includes morning and afternoon teas, lunches and social event - Thursday night
One day only	**$135**	Includes morning and afternoon tea and lunch
Social Event	**$65**	Partners or single day registrants

NB All registration fees (above) are inclusive of GST

All registrations are entered into a Lucky Draw - one registration fee reimbursed

Please tick ◯ I will be attending the Thursday evening social event

Theme: Graduation: Dress accordingly. Entertainment guaranteed!

◯ Do you have any special dietary requirements?

◯ Vegetarian ◯ Gluten Free ◯ Other (please specify) _____

Accommodation

Each delegate is responsible for booking their own accommodation. Christchurch has some great deals on the internet.

Registration

Please complete and return this form with payment before 1 September 2016 for early bird registration or at the latest 20th October 2016.

Payments

Internet banking/direct, credit card: using your bank's internet banking website. Account details : ANZ Bank, NZNO Stomal Therapy Section a/c no: 010505-0097186-00. Please ensure that your payment quotes the initial of your first name and your full surname.

NB: Scan and send completed registration form to section treasurer: maryv@adhb.govt.nz

Cheques

Please make payable to ***NZNO Stomal Therapy Section***. Include registration form with payment and post to section treasurer:

Mary Vendetti, 1/2090 Great North Road, Avondale, Auckland 0600.

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Auckland
New Zealand
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A Long and Winding Road

JENNY COULSON

Jenny Coulson
Stomal Therapist,
Taranaki Base Hospital

In writing this I would like to thank Wendy for consenting to the case study and allowing photographs to be taken. I also wish to thank MDT members for assisting with continued care. Together we have aided Wendy on her journey to adaptation and acceptance of an unplanned life changing surgical outcome and eventual independence in managing the multifaceted issues of living with a high output, loop ileostomy.

HISTORY

52 yr old female.

Ischaemic Heart Disease with longstanding angina, Myocardial Infarction (MI) and stenting 2003, Systolic Dysfunction, moderate left Ventricular Hypertrophy, Hypertension, Hyperlipidaemia, Asthma, Migraine, Psoriasis, Insulin Dependent Diabetes, Depression, Smoker, Unemployed due to health issues, Living alone with support from elderly parents, sister and friends.

WORKUP AND SURGERY

Colonoscopy and histology indicated a malignant adenoma, mid transverse colon.

June 2013 - admitted as an elective Hand Assisted Laparoscopic (HALS) transverse colectomy. Surgery was uncomplicated and histology indicated T1 N0 MO- Dukes A, requiring no adjuvant therapies.

POST SURGERY

Post surgery progress was slow and day 4 Wendy's condition deteriorated. Symptoms included worsening confusion, hypotension and developing pneumonia requiring inotropic support in ICU. CT scans indicated bilateral pneumonia and dilated caecum but no evidence of anastomotic leak or ischemic bowel at this stage.

Wendy's ongoing morbid state necessitated a return to theatre for an exploratory laparotomy. Findings included a dilated caecum at 12cm with probably viable but threatened ascending colon and proximal transverse colon. 3 cm of transverse colon distal to the anastomosis was overtly dead with a threatened splenic flexure; therefore a subtotal colectomy was performed. Anastomotic leak is predictive of diminished survival after potentially curative resection for colorectal cancer (Walker et al 2004). A side to side anastomosis was formed and a right sided loop ileostomy fashioned proximally to protect this. Approximately 30cms of colon remain.

Verbal referral was received day 3 informing us of a new patient with an acute stoma formation. A follow up phone call to HDU revealed Wendy to be in a critical but stable condition, thus stoma care education was delayed. On questioning, staff stated they had no stoma or pouching related issues at this time.

By day 8 Wendy's condition improved sufficiently for stoma care education to commence. Staff stated Wendy had not shown any curiosity or interest in the pouch up to this point. On assessment the loop ileostomy appeared healthy and adequately everted but situated closer than ideal to the midline incision. Peristomal skin was macerated and itchy due to leakage and probable Candida infection. Wendy's response to seeing the stoma for the first time was predictable. "Pooh what's that, God I'll never ever be able to look after that?" Several studies indicate that patients who undergo emergency surgery may have greater difficulties adjusting to the sudden body image change and functional loss (Borwell 2009b, Burch J 2008, Williams. J, 2005).

This first visit was aimed at simply engaging Wendy in conversation about how she thought she might cope with a stoma, whilst encouraging some involvement in the pouch changing procedure. Her responses were, "yeah, yeah" or "yep" to everything said but I accepted this as fear more than disinterest. She stated that she had a terrible memory, but she didn't know why and despite knowing nothing about stoma management, expressed a keenness to discharge. This provided an opportunity to tell her that a reasonable level of independence in stoma cares would be required prior to discharge and she needed to work actively with staff to achieve this. Bekkers et al, 1996, states that "if patients are expected to care for their stoma they are more likely to manage the stoma better". However stomal therapy nurses (STN) recognise and studies (Turnbill 2008) confirm that the acute patient, often in a shocked and exhausted postoperative state finds difficulty in absorbing information and may only learn survival skills in order

A Long and Winding Road *...continued*

JENNY COULSON

to get out of hospital and back to normality. Wendy asked who might help her at home and was reassured STNs and District Nurses (DN) would be available post discharge for support and continued stoma care education. Home visits have been found to improve quality of life and decrease stoma related problems (Addis, 2003), and verbal information found to be slightly more preferred over written information. (Stott et al 2002).

What coping strategies had Wendy used in the past? Was she proactive or reactive? STNs know little history about the patient with an acute stoma and previous coping skills and lifestyle choices that may impact on rehabilitation. What social support did Wendy have and would this support be of help in aiding Wendy to accept her stoma. Wu, 2009, suggests social support is critical to acceptance and quality of life for the person with a stoma. Much of our time is spent not only in educating patients, but understanding how they best learn and cope and subsequently building on that information. Meanwhile stoma education and dietician input continued. Ileostomy output varied, making leakage due to rapid filling more likely. Loperamide, Codeine Phosphate and Metamucil were prescribed and the importance of stool thickening foods reiterated. An indelible pen line was drawn across the mid-section of the pouch as a guide when to empty, avoiding overfilling, explosive emptying and leakages. Dehydration and blockage were discussed at length and action plans developed and agreed upon should either occur.

Day 16: Despite two episodes of angina, a urinary tract infection and thrush infection, Wendy was desperate to discharge. It was agreed she would go to her parents' home for support, provision of meals and general supervision. She also agreed to a DN visit that evening to check pouch security, output consistency and volume, providing reassurance for not only Wendy but her parents. We also discussed recurrence of angina and she agreed to call an ambulance if chest pain was unresolved by usual treatments.

POST DISCHARGE

A supportive nursing care plan was implemented and the evening DN visit reported all was well. We were all encouraged by this. Over the next 4 days, assessments, evening phone checks or PRN visits were made. Despite this, the medication situation unravelled, an urgent call was received about leakages only to find that Wendy forgot to close the opening. Wendy's mum was concerned about her lack of insight to the impact her surgery may have on daily living. Her appetite seemed to fluctuate and stress levels in the home were understandably rising. Day 5, a doctor's visit was arranged where Wendy's longstanding GP indicated that she should start looking after herself properly and learn to cope with the situation. She agreed with Wendy it would be better for her to return to her own home. Home help was arranged but meals on wheels were declined.

HOME

Daily DN or STN visits continued, monitoring progress, assisting and educating with pouch management as required. Wendy's mum and sister were also visiting, supplying food and helping out where needed. However by day 6 Wendy was found to be vomiting, hypotensive and revealed she hadn't taken Insulin for 2 days due to a broken pen. She also admitted to angina and was subsequently readmitted to hospital and diagnosed with a STE - MI and dehydration. Her condition was stabilised and she improved quickly. An urgent referral was made to the diabetes educator to provide a new pen and BSL monitor and Wendy was ready for discharge again. A midline incision dehiscence had developed, making the pouch edge moist and malodorous with discharge. A simple dressing was devised for Wendy to replace PRN. Subsequent investigations revealed a fistula from the colonic anastomosis. Fortunately this healed spontaneously.

Over the ensuing 18 months Wendy presented weekly for assessment or just a chat. A specialist stoma nurse utilizing expert stoma skills can enable living with a stoma to be more acceptable (Gray, 2011). However despite guidance and many interventions Wendy was readmitted acutely on 8 occasions for angina and or dehydration. Interventions included medication reviews, trying to establish correlation to high ileostomy outputs despite maximizing Loperamide, Codeine, bulking agents, both prescribed and natural (eg. Slippery Elm), screening for Coeliac disease, trials of lactose and dairy free diets done without any noticeable change to outputs. Wendy assured us she was eating appropriately but the general consensus of opinion was that her eating habits were erratic. White & Unwin 1998 have found that "physical complications and symptoms were shown to be strongly related to psychological distress after stoma surgery".

One of these visits revealed Wendy to be intoxicated. She admitted to drinking alcohol and was driven home. There was an upside to this incident. Wendy voiced all her frustrations at once, blaming the stoma for everything that was wrong with her current life. Unemployment, no money, heightened anxiety in relation to socialising, inability to drink with her mates as it caused hyperactivity of her stoma and subsequent leakage, low self-esteem and lack of physical intimacy. She revealed that

A Long and Winding Road *...continued*

JENNY COULSON

she had met a guy in the pub and asked him home, but when he saw the bag he took off, never to be seen again. Although Wendy regaled this tale with much humour the experience again compounded the feeling of separation and loss of her pre stoma life. White & Unwin 1998 found that "cognitive factors contribute significantly to variances in psychological outcomes when they concluded that this is associated with a patient's belief as to whether they are a complete person, that the stoma rules their life and whether they feel in control of their body".

A quick call to the GP and Wendy was referred to the Drug and Alcohol Team and she subsequently willingly agreed to be admitted to the medical ward for managed detoxification. The team organised counselling which Wendy undertook for three months and found helpful. A mental health assessment was undertaken as an inpatient but they accepted the problem as a situational depression and that the arranged counselling would be sufficient.

Meanwhile as Wendy regained lost weight, a fold from the medial stoma edge to the midline incision deepened. Through a number of different ostomy pouch trials, trying in vain to find one that wouldn't leak prior to 24hrs usage, Wendy continued to prefer a Dansac firm convexity and Dansac seal. The volume it contains, particularly overnight and the pliable diamond shaped fabric backings are the most favoured features and she uses a belt for security. However, despite warnings not to do so, understandably Wendy has been inclined to pull her belt tight in an effort to stop leakages and thus the proximal limb has prolapsed to approx 10cms (Fig 1). Added to this is a ring barking effect on the superior aspect of the prolapse (Fig 2). She now prefers the Dansac soft convexity but this is currently only available in a 35mm pre-cut midi size which she feels is not sufficient to accommodate a reasonable overnight output. She is trialling the 40mm soft convex maxi which accommodates the stoma at its most prolapsed.

Her surgeon was made aware of leakage problems, the stoma's proximity to the midline and subsequent prolapse and it was agreed Wendy would undergo work up examinations toward either ileostomy closure or refashioning and repositioning.

A thorough cardiac assessment was also required by the high risk anaesthesia team.

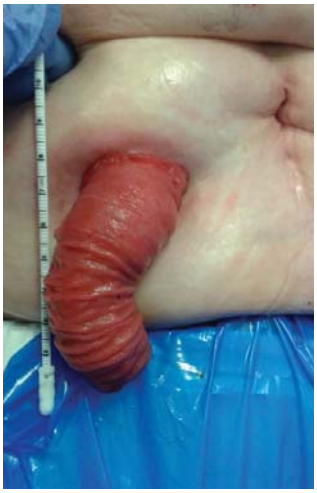

Fig 1

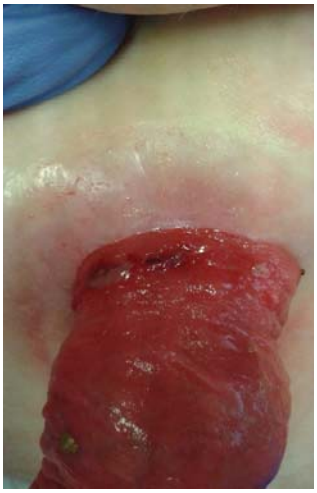

Fig 2

PROGRESS

Over the last 12 months Wendy has only had one readmission, her diabetes has been stable and insulin intake reduced. She undertakes two pamphlet delivery rounds, and is generally in the most positive frame of mind in many years. The past few months have seen smoking reduction, evidenced by the absence of nicotine stains on her fingers and the smell on her clothes. Wendy says she is motivated predominantly by monetary gains and her GP and surgeon would be really pleased to see her quit for good.

Regular STN contact is now maintained with a text received to request a suitable time to attend clinic for a chat, review or extra supplies. At a recent dietician appointment a 7 kg weight loss was noted over the past few months. Wendy attributes this to her pamphlet round but the dietician's suggestion to quit the job was not one Wendy was prepared to consider. I suggested it was due more too irregular eating habits and she was reminded that to be seriously considered for reversal she needed to optimise her health. The dietician changed her diabetic supplement drink to standard Ensure in an effort to increase her weight. This has been effective and Wendy has seen no change in her blood sugar levels using Ensure rather than the diabetic equivalent.

A Long and Winding Road *...continued*

JENNY COULSON

WENDY'S DILEMMA

Despite prolapse and pouching issues Wendy has adjusted to her changed life. Her confidence has increased and she has learned about caring and being more respectful of her body. Preoperative workup assessments have been positive and clearance to proceed to either closure of her ileostomy or refashioning and repositioning of the stoma was given. She was asked to go home and take time to consider her choices. Many times she has asked me "If you were in this situation what would you do?" and as many times I have helped her work through the pros and possible cons I have asked her to make the decision herself. Wendy's greatest hurdles are being afraid of another anastomotic leak, subsequent sepsis and the effect it would again have on her elderly parents.

At the time of publication Wendy has chosen to proceed with reversal as she is in the best physical and mental health that she has been in for years. Bowel control is a concern but an assurance she has an intact anal sphincter with excellent tone is a significant benefit in a reversal procedure.

REFLECTION

Over the past 20 years of practising stomal therapy nursing I have seen many positive developments in relation to bowel surgery. These include laparoscopic surgery, advancement in surgical techniques allowing restorative procedures, acknowledgment of pre-operative education as being important for patients and implementation of ERAS programmes facilitating shortened length of stays. However, through learned experience and confirmation by research articles written over many years, the ostomate in the journey of recovery and adaptation remains the same person as always, a vulnerable person with that something extra, a stoma that demands their attention from its formation. As a stomal therapy nurse I feel privileged to play a part in providing nursing care and continuity of support, aiding this group of patients.

REFERENCES

Addis, G, 2003; The effect of home visits after discharge on patients who have had an ileostomy or a colostomy. Journal of Enterostomal Therapy Nursing, vol 23, no 1, p 26-35

Bekkers, MJTM, Van Knippenberg,EN, Borne FCE, VAN den Borne HW

& Berge-Henegouwen GP, Prospective evaluation of psychosocial adaptation to stoma surgery: the role of self efficacy, Psychosomatic Medicine, 1996, vol 58.pp 183-191

Burch J. Resuming a normal life. Holistic care of the person with an ostomy. BJ of Community Nursing 2008; 16(8) 366-373.

Borwell, B 2009b Continuity of care for the Stoma patient: Psychological

Considerations. BJ of Community Nursing, 14,326,328,330-331

Gray L. Journal of Stomal therapy nursing, Vol 31, No. 1 March 2011

Turnbill, G 2008. Using Education to increase self care for the person with an Ostomy.OWM. http://www.owm.com/content/using education-increase self care-person with-ostomy.

Stott, C, Graff, L, Morgan, P & Fairbrother, G 2002 'Complications, coping and subjective feedback among patients following a predictive study; Journal of Enterostomal Therapy Nursing, Vol 22, no4, pp16-22

Walker KG, Bell SW, Rickard MJFX, Mehanna D, Dent OF, Chapius PH & Bokey EL, Anastomotic leak is predictive of diminished survival after potentially curative resection for colorectal cancer. Annals of Surgery 2004; 240(2) 255-59.

Williams J, Psychological adaptation, psychological considerations in Gastrointestinal nursing; BJN 2005; 14(17);931-5

White, CA& Unwin, JC 1998 'Postoperative adjustment to surgery resulting in the formation of a stoma: the importance of stoma related cognition', British Journal of health psychology, vol 3 pp.85-93

Wu, A F. 2009 Study of relativity between social support and QOL in patients accepting colostomy and nursing care of them. Nursing research. 2009. Vol 23, No 11, 3037-3038

Wendy's Journey on that long and winding road

As you have read, it's been a long and winding road. I have had my stoma for over 2 and a half years now and although it hasn't been easy it's been a time of learning, adaptation and reflection. Believe it or not, life seems easier now, not perfect, but I tend to just get on with things and manage as well as I can. I was asked to list the negatives and positives of the past few years, so here they are.

POSITIVES

Still alive

Feel proud I was proactive in getting an early diagnosis for my rectal bleeding

Improved family relationships and spending quality time with my parents and sister.

I feel more grateful and thankful for everyday things and don't take people for granted.

Better understanding of quality food versus junk food and its effects on my gut.

Feel my diet is a 100% healthier and that makes me feel better in myself. Prior to surgery I ate no veggies and suffered from vitamin deficiency due to living on takeaways and junk food

Diabetes stable since surgery, massive reduction in insulin - now 4 units x 1 a day

Bag gives better control - 3 years of diarrhoea prior to surgery. However despite occasional diarrhoea now, I manage to keep hydrated and stay out of hospital

Anti-depressant medication has been halved.

Alcohol free

More active, early rising, getting more done in my home

Fitness has improved due to better diet and exercise (Pamphlet run)

Feel mentally and physically stronger

Social life is better than it's ever been

Have a boarder which helps me to cook more regularly

Financially better off - more organised with money and groceries - not buying expensive takeaways

Giving Mum savings each week is a big plus. I haven't needed to ask WINZ for supplements for a long time.

Nothing too much fazes me now.

NEGATIVES

Pouch leakages but coping much better particularly with night time leaks

High output from ileostomy at times

Begrudge the time it takes to pouch a prolapsed stoma rather than a non prolapsed stoma.

Continue to battle with smoking cessation

Anxious about reversal surgery and if it will be successful.

Will I have the control the bag gives me now?

Anxious about how my parents will cope with my surgery if it goes wrong again.

It has taken me many months to decide to go ahead with a reversal. If it doesn't give me a better quality of life I am prepared to have a stoma again.

Thank you

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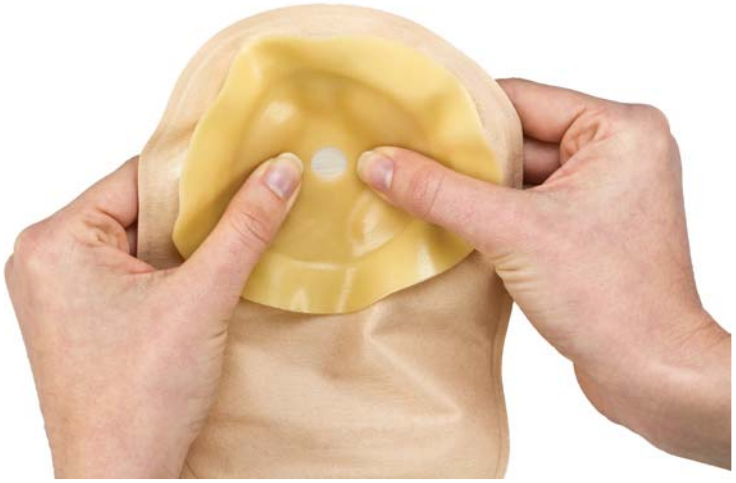

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Bet's Fistula Management

JULIE SKINNER

Julie Skinner
CNS Ostomy and
Continence
Waitemata DHB

As health professionals, we have a responsibility to offer our patients the best evidenced based practice possible. To facilitate this, we must be congruent with current literature, research and recommendations.

This case study is presented as an integration of theory and practice. It includes the incorporation of patient focused goals into care and details the assessment required to select an appropriate fistula / wound management treatment plan, which is validated by current research.

Due to the complex nature of Bet's wound and my ongoing involvement with her wound management, I requested Bet's permission to write a case study about her and her wound as part of my Post Graduate studies. Bet has given her informed consent to the use of her information for the enhancing of nursing knowledge and practice. All personal identifiers have been modified.

Bet is a 76-year-old Caucasian woman who initially presented to her General Practitioner with blood in her stools. She has no medical history of note. Her surgical history includes, an appendectomy in 1960, a hysterectomy in 1988, a cholecystectomy in 1990, and a right hemicolectomy for cancer in 1992.

Having previously worked as a museum curator Bet is now retired. She currently lives with her husband, however after 48 years of marriage they are in the process of ending their relationship. This is a significant stressor in Bet's life. They had just initiated the sale of their family home when the events described here occurred.

Prior to admission Bet was independent with activities of daily living. She and her husband have two sons; one lives in America with his wife and two children, the other lives locally with his wife and three children. Both sons are very supportive. Bet has a large circle of supportive friends. She normally drinks two glasses of red wine per night and has never smoked. Bet enjoys baking and hosting dinner parties and regularly attends a walking group.

MECHANISM OF INJURY

Five days after undergoing surgery for an extended right hemicolectomy due to cancer in the mid distal transverse colon, Bet developed an anastomotic leak. She returned to surgery where she underwent an exploratory laparotomy, re-do ileocolic anastomosis and debridement of part of the abdominal wall. Three days post operatively Bet developed an ileus and the abdominal wound dehisced. Four days later there was further dehiscence of the abdominal wall and a VAC ™ dressing was applied. Three days after initiating VAC ™ therapy brown faecal fluid was noted in the tubing of the VAC ™ machine. The dressing was taken down and an enterocutaneous fistula was diagnosed.

A fistula is an abnormal passage that connects an organ to another organ or to the skin surface. An enterocutaneous fistula is an abnormal passage between the small intestine and the skin (Carville 2012). Bet has a complex, moderate output fistula; there is complete disruption of the bowel and leakage of effluent in to the surrounding area (Burch 2008).

Bet's enterocutaneous fistula was diagnosed 17 days post-operatively, contributing factors in this event were probably her developing a post-operative ileus leading to an anastomotic leak and that she had surgery for cancer (Majercik, Kinikini & White 2012). Seventy-five to eighty-five per cent of faecal fistulas usually occur in the post-operative period after some type of surgical event. (Falconi, cited in Burch 2008, p. 251). If a fistula develops later than ten days post operatively, it becomes problematic. Due to the development of adhesions the abdomen is regarded as a hostile environment for any further surgical procedure. The presence of new adhesions increases the risk that further surgery, at this stage will lead to further, iatrogenic fistulas (Lloyd, cited in Burch 2008, p.256).

Early closure of an enterocutaneous fistula is not recommended in this situation and the management plan should be to stabilise the patient, allowing the wound to heal around the fistula. Closure of wounds, which contain a fistula, can take many months of intensive nursing care. (Schecter et al. 2009). Approximately one-third of enterocutaneous fistulas will close spontaneously if adequate support measures are in place (Schecter et al. 2009) and the fistula output is low (Thompson & Epanomeritakis 2008). Due to the complexity of Bet's fistula and the moderate fistula output, spontaneous closure is not a valid treatment option.

Management of enterocutaneous fistulas includes three phases. The first being recognition of the fistula and acute stabilization

Bet's Fistula Management ...continued

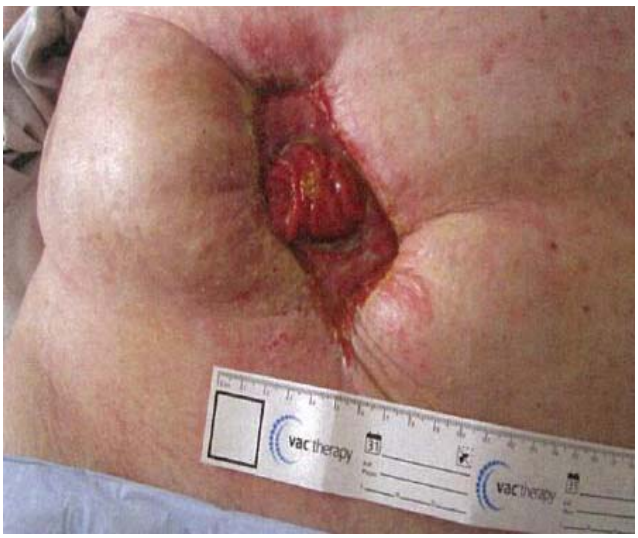
JULIE SKINNER

of the patient, this includes fluid and electrolyte imbalance, infection control measures and nutritional support. Phase two involves robust wound management to facilitate containment of the effluent, protection of the peri-wound, and promotion of wound healing. Phase three involves complex surgery to close the fistula (Bleier & Hedrick 2010). Bet is in the second phase. The plan is for her to undergo surgical closure of the fistula in two months time, which will be four months after her initial surgery. This timeframe will allow a return to optimal health and for her abdomen to become a less hostile environment for surgery.

WOUND ASSESSMENT

The wound is an open cavity, measuring 95mm in length, 30mm across the proximal edge, 40mm across the distal edge tapering down to a point and 10mm deep. The external fistula lies in the centre of the wound bed with slough present at the proximal and distal edges; this is surrounded by 90% granulation tissue. The epithelial wound edges roll into the cavity. The peri-wound is erythematous at the superior and lower medial aspect and denuded at the top medial aspect extending to approximately 5mm and at the base of the lower medial aspect to approximately 10-15mm. The peri-wound skin contours undulate and contain some deep creases, which run vertically and horizontally.

The fistula effluent is moderate, varying between 200-500mls in 24 hours. The effluent is thin, dark brown and moderately odorous.



NORMAL ANATOMY AND PHYSIOLOGY OF INTEGUMENT

The skin is the largest organ of the body accounting for 15% of body weight and 33% of the circulating blood. It contains appendages consisting of hair, nails, sebaceous and sweat glands and consists of three different layers. The outer thinner, waterproof layer is the epidermis, which contains stratified and squamous epithelial cells. Its thickness varies depending on which part of the body it is on and it is divided into four or five layers. It has no blood supply; it receives nutrients from the dermal layer beneath. Its outer cells are constantly being replaced. The second layer is the dermis; this is very vascular containing nerve endings, lymphatics, collagen and elastin and has two layers. The hypodermis is the thickest layer and supports the skin. It is a protective layer for the structures and organs beneath. It also regulates temperature and stores lipids (Carville 2012).

The functions of the skin are protection to the underlying structures, sensory reception to positive or negative stimuli, communication to others, regulation of body temperature, metabolic synthesis of melanin, keratin and vitamin D and cosmetic appearance (Carville 2012). Bet's open abdominal wound comprises of full thickness skin loss, including underlying structures, muscle and exposed bowel. The large, open wound puts Bet at high risk of loss of protection to the underlying structure from trauma and pathogen invasion. Bet is also at risk of a lack of sensation to positive or negative stimuli.

The large bulky dressing has the potential to impact negatively on Bet's personal communication to others due to the dressings appearance and the potential of leakage and odour. Bet's perception of her altered body image has the potential to adversely affect her psychological wellbeing. Bet is potentially at risk of the loss of regulation of body temperature and the synthesis of melanin, keratin and vitamin D.

Bet's Fistula Management *...continued*

JULIE SKINNER

BET'S GOALS

- For my fistula pouch to remain intact for 24 hours and not leak or cause sore skin.
- To be well enough to have surgery to close the fistula.
- To finalise the sale of my house so that I can move on with my life and find my own place to live.

WOUND AND CARE MANAGEMENT GOALS

- To contain the fistula effluent with a suitable pouching system.
- To maintain peri-wound integrity by applying suitable skin protection products.
- To prevent infection.
- To maintain normal fluid and electrolyte balance.
- To maintain nutritional support via Total Parenteral Nutrition.
- To provide psychological support

CURRENT DRESSING PLAN

The wound pouch is changed every 24 - 48 hours or immediately if the pouch starts to leak. Bet is offered pain relief half an hour prior to the dressing being changed. Suction is always at hand in case the fistula leaks during the dressing change. The pouch is carefully removed using Coloplast Brava ™ adhesive remover spray. The open wound is irrigated with warmed saline and the peri-wound gently cleaned with warmed saline using gauze and cotton buds, ensuring any residue of faeces or skin protection products are removed.

To protect and heal the denuded peri-wound, Eakin™ cohesive paste is applied; this paste does not contain alcohol and protects the skin by containing output and keeping it from contaminating the skin. To protect the erythematous skin and surrounding peri-wound, Eakin™ skin barrier rings and sheets are cut to fit and manipulated into the undulating skin to protect and even out the irregular skin contours allowing the pouching system to adhere to a flat skin plane. An oval Eakin™fistula/ wound management pouch is prepared cutting the Eakin™ adhesive base slightly larger than the wound to prevent the effluent from damaging the skin beneath. The pouch is warmed using a hairdryer and placed over the wound then manipulated gently to aid adhesion. Bet lies on the bed under warm covers for at least one hour after each pouch change, keeping still and manipulating the base plate to aid adhesion.

An appropriate alternative wound product that could be used is negative pressure wound therapy (NPWT). This involves isolating the fistula from the granulating wound. The effluent is not contaminating the wound bed and effluent is not suctioned from the fistula. This involves segregation of the fistula by applying the sponge with the hole cut round the fistula and applying suction to the wound and a stoma pouch to the fistula (Becker, Willms & Schwab 2007).

As the pouching system's wear time was 24-48 hours the aim was to extend the wear time and reduce the amount of produce use. This allows the wound to granulate more rapidly and reduces the time required for wound healing in preparation for surgical closure

(Schecter et al. 2009). With Bet's and the colorectal surgeon's consent, this was trialled on her wound. The dressing remained intact for three days and in this time a huge reduction was seen in the size of the wound base. Unfortunately, subsequent attempts to apply the same dressing failed, as we were unable to maintain a good seal around the fistula.

While many authors report the successful use of NPWT in the management of enterocutaneous fistulas (Becker, Willms & Scwab 2007, Bleier & Hedrick 2010, D'Hondt et al. 2011, Schecter et al. 2009) it has also been reported that there are no large studies comparing NPWT to traditional wound pouches and that NPWT has not been approved for the management of enterocutaneous fistulas by the manufacturer of NPWD therefore it should be used with caution (Bleier & Hedrick 2010, Carville 2012, Schecter et al. 2009).

Therefore, NPWT is both an appropriate and inappropriate wound product choice as studies have shown it to be effective but there is not enough evidence to support this and more research is required.

Bet's Fistula Management *...continued*

JULIE SKINNER

MANAGEMENT PLAN

Due to the challenges and complexities of Bet's wound and her risk factors, a comprehensive management plan has been devised incorporating Bet's goals and employing a multi-disciplinary team approach to provide Bet and the multi-disciplinary team with the best health outcome.

To promote Bet's comfort and meet her needs a suitable pouching system is used that contains the fistula output and promotes wound healing. The effectiveness of the pouch is regularly assessed and re-evaluated. To facilitate Bet's goal of the fistula pouch remaining intact for24 hours and not leaking, which in turn causes sore skin, a clear concise care plan containing photographs of the steps to changing the dressing has been devised. This allows junior members of staff to change the dressing when experienced staff are not on duty (Schecter et al 2009).

Due to the corrosive nature of the fistula effluent, skin protection is of paramount importance (Schecter et al 2009). Currently, Bet's peri-wound has minimal excoriation due to the effectiveness of the skin care products being used. But this has not always been the case as we have struggled in the past to contain the effluent and prevent the pouches from leaking therefore causing extensive erosion of the peri-wound and severe discomfort.

Bet is at high risk of sepsis and mortality due to having an enterocutaneous fistula (Andrews 2013). She is regularly assessed for local or systemic signs and symptoms of infection (Carville 2012). Bet has had two episodes of wound infection over the last two months these were successfully treated with intravenous antibiotics.

To assist in maintaining a normal fluid and electrolyte balance, Bet is prescribed Loperamide and Codeine to thicken the fistula output and Omeprazole to reduce gastrointestinal secretions. Because Bet's fistula output remains stable she does not receive intravenous fluids to replace fistula losses to maintain an adequate fluid and electrolyte balance, this is incorporated into her Total Parenteral Nutrition (TPN) (Carville 2012). To prevent malnutrition Bet receives her nutritional requirements via TPN (Carville 2012). The nutritional support team that includes a Pharmacist, Dietician and Nutritional Support Nurse reviews Bet daily. The TPN formulation is prepared according to Bet's specific needs and blood results (Becker, Willms & Schwab 2007). The essential nutrient Bet receives optimises her wound healing and general wellbeing. This is vital for Bet to meet her goal of being well enough to have surgery to close the fistula.

Bet eats a small amount of soft food at each mealtime; this does not increase the fistula output and establishes some normalcy. Eating food is a pleasurable and social ritual; not being allowed to eat for a long period of time can have a negative psychological impact. (Majercik, Kinikini& White 2012).

Due to Bet's prolonged hospital stay, ongoing fistula management issues and Bet's psychosocial issues she requires ongoing psychological support (Carville 2012). The ward Social Worker regularly reviews Bet and the multi-disciplinary team also provides support. Bet has been reviewed in the past by Psychiatric liaison due to the potential for the development of depression / anxiety but no acute issues were found that required Psychiatric input. Bet occasionally becomes tearful and expresses her concerns about the impact the wound may have on her finding a new partner in the future and starting a new relationship, time is allowed for Bet to express her feelings.

Bet is encouraged to maintain as much independence and mobility as possible. She is regularly taken out by her friends in a wheelchair around the hospital grounds. Bet has a very good sense of humour, which has been needed at times when we have had problems with pouch leakage. To facilitate Bet's goal of finalising the sale of her house, her son is currently visiting from America and has assisted Bet with finances and arranged for her lawyer to visit Bet in hospital to sign the paperwork necessary for the sale of her house and her divorce.

OUTCOME

Shortly after completing this case study Bet underwent adhesiolysis/ enterocutaneous fistula excision and small bowel anastomosis. Unfortunately, Bet's abdominal wound dehisced post-operatively and she had a VAC™ dressing applied. Bet was discharged four weeks later with a small abdominal wound.

CONCLUSION

This case analysis has discussed a patient with a complex wound and presented the assessment of the patient and their wound. Using current literature the patient's goals, wound management plan and current treatment plan have been analysed ensuring the patient receives the best-evidenced based care in her wound management.

Bet's Fistula Management *...continued*

JULIA SKINNER

REFLECTION

On reflection, when I first met Bet I had very limited knowledge or experience of fistula management. Through reading current literature and research, I rapidly learnt about the complexities of fistula management and enhanced my knowledge, this allowed me to offer the best evidence based management plan I could to Bet. I also learnt that fistula management presents many challenges for all members of the multi-disciplinary team as well as the patient. Teamwork is vital to ensure the best health outcome for the patient and that this is only achieved through good channels of communication, multi-disciplinary meetings and staff education.

It was a pleasure and a privilege caring for Bet through what was a very stressful time in her life, but her positivity and sense of humour always shone through.

REFERENCES

Andrews, L 2013, 'Fathoming fistula', The Outlet, March, pp. 12-15.

Becker, HP, Willms A & Schwab R 2007, 'Small bowel fistulas and the open abdomen', Scandinavian Journal of Surgery, vol. 96, pp. 263-271.

Bleier, JI & Hedrick, T 2010, 'Metabolic support of the enterocutaneous fistula patient', Clinics in Colon and Rectal Surgery, vol. 23, no. 3, pp. 142-148.

Burch, J 2008,Stoma care, Wiley-Blackwell, West Sussex.

Carville, K 2012, Wound care manual, 6th edn, Silver Chain Foundation, Osborne Park, Western Australia.

D'Hondt, M, Devriendt, D, Van Rooy, F, Vansteenkiste, F, D'Hoore, A, Penninckx, F & Miserez, M 2011, 'Treatment of small-bowel fistulae in the open abdomen with topical negative-pressure therapy', The American Journal of Surgery, vol. 202, no. 2, pp. e20-e24.

Majercik, S, Kinikini, M & White, T 2012, 'Enteroatmospheric fistula: from soup to nuts', Nutrition in Clinical Practice, vol. 27, no. 4, pp. 507-512.

Schecter, WP, Hirshberg, A, Chang, DS, Harris, HW, Napolitano, LM, Wexner, SD & Dudrick, SJ 2009, 'Enteric fistulas: principles of management',Journal of the American College of Surgeons, vol. 209, no. 4, pp. 484-491.

Thompson, MJ & Epanomeritakis, E 2008, 'An accountable fistula management treatment plan', British Journal of Nursing, vol. 17, no. 7, pp. 434-440.

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Christchurch Five Years on!

BY JACKIE HUTCHINGS

Jackie Hutchings
Stomal Therapist
Nurse Maude

On February 22, 2011 at 12.51pm I was in a bathroom with a patient on the Port Hills. Fortunately we were in that en suite as in his bedroom my patient had floor to ceiling drawers and as that devastating earthquake hit those drawers all came flying out and hurtled across the room.

The following week is a bit of a blur looking back. Surgical patients were sent home from hospital and our service consisted of a lot of phone calls. Patients in our area get their products from our Supply Department, not by direct delivery. During the earthquake and aftershocks the shelving collapsed and products were thrown about. Beth and I helped the procurement manager to sort out the stoma products and supplied patients who turned up needing bags etc.

Our files were all thrown out of the shelving so 1100 sets of notes had to be refiled once the shelving was securely attached to the walls, and then bungy cords were put across the front of each shelf so they wouldn't fall out again (these bungy cords have only recently been removed!)

I remember being called by Police Coms that first weekend to see a patient who had been discharged home and wasn't coping with a new stoma and while I was out I received another emergency call (via Police again) from a patient who had no bags left. Usually that round trip would have taken 60 – 90 minutes and instead it took 5 hours because of the road conditions but more especially because of the sightseers out in force. We also had to contend with humourless Aussie Police who had come over and army personnel who were there to keep us out of the red zones which had to be navigated around.

Many roads became impassable due to liquefaction and so calls were made on foot. As we were in uniform people would come out to ask us for medical advice – many GP practices and pharmacies were closed so they needed to know where to get help from.

Over time things settled down, we were still having problems locating some patients for follow up who had had to vacate their properties and notifying us of their new location was low on their priority list until they had issues.

Time has passed and suddenly we are five years on. We still have some patients living in badly damaged homes as well as patients who are now living in brand new homes. People are coping better emotionally but the scars are still there. Large tracts of land in the Eastern suburbs which used to contain suburban housing are now green areas with just the outlines of gardens remaining.

Colombo Street (one of the main streets in CBD)

Road collapses

Christchurch Five Years on! *...continued*

BY JACKIE HUTCHINGS

Liquefaction and Flooding

Large tracts of Green Space that used to be covered in houses

Christchurch Cathedral

Driveways going in from road showing where entrances into houses were

Christchurch Five Years on! *...continued*

BY JACKIE HUTCHINGS

Our daily workload is still earthquake affected as roading seems to change every day with closures and diversions sometimes leading to lengthy detours. Roads themselves are very bumpy and it actually feels quite weird when I find a smooth piece of road! Once a road is fixed that only means until next time it slumps as there are great cavities still under many of the roads. Services such as roading, water, sewerage and telecommunications don't know how to co-ordinate things so each one digs up a road and does their bit and then the next comes along and digs it up again to do their bit – VERY FRUSTRATING and those 30km signs and road cones are doing my head in!

Our Supply Department was refitted with shelving and was open again fully within a couple of weeks and worked out of the same building until early November 2011 when they moved into a purpose built warehouse at another location. Their previous building has since been demolished.

Portaloos and water tanks which were everywhere are disappearing from the landscape as are the shipping containers that were used everywhere to prop up buildings and rock faces.

People are becoming far more positive about the future direction of Christchurch with the rebuild taking shape in the CBD.

I would like to encourage you to come to Christchurch in October to the Stomal Therapy Conference and see the changes that are shaping our emerging new cityscape.

New Cardboard Cathedral (bottom left)
Common city skyline with the cranes (bottom right)

Coloplast SenSura Mio Educational Scholarship 2016

Coloplast would like to offer 2 x $1,500(NZ) Educational Scholarships for Stomal Therapy Nurses in New Zealand.

This scholarship can be used for any Educational Conference within an 18 month period from 1st November 2016.

Objective

Coloplast recognises the need to create innovative educational experiences for all nurses. Coloplast has 2 scholarships on offer to be awarded to financially assist a registered Stomal Therapy Nurse or a Registered Nurse with an interest in stomal therapy in New Zealand to attend an educational conference from 1st November 2016 to 1st June 2018.

Scholarship Application Guidelines

Applications must be with Coloplast by 5pm on 31st August 2016.
All applications will then be sent for impartial judging by a panel of New Zealand Stomal Therapy Nurses. A decision will be made in late September 2016. Incomplete applications will not be considered.

What must you do?

- Complete a case study using SenSura Mio. This may include, but is not limited to, how has Mio helped improve the life of an Ostomy patient, how has Mio changed your nursing practice etc.
- Write a one page letter of motivation (How would you benefit from attending an educational conference)
- Obtain written verification from your employer that you are able to be released to attend the conference and abide by your “Health Care Professional Code of Ethics”

The winners will be invited to present their case study at the Coloplast Breakfast Symposium that will be held during the NZ Stomal Therapy Conference held in Christchurch on 27th and 28th October 2016.

Upon returning from the conference winners are required to:

- Complete a reflective review on the key learnings and experience gained from the conference. This must be completed within 6 months of returning from the conference. It will then be published in the NZ Outlet Journal.

Scholarship applications open from 1st February 2016.
Completed applications must be received by 5pm on 31st August 2016.

For more information please contact your local Coloplast Territory Manager or Jenelle Guest, Ostomy Market Manager - Coloplast on aujegu@coloplast.com or +61 448 372 619

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Coloplast

The Outlet

New Zealand Stomal Therapy Nurses