NZ NURSES ORGANISATION
COLLEGE OF STOMAL THERAPY NURSING

The Outlet

NEW ZEALAND STOMAL THERAPY NURSES

IN THIS ISSUE:

NOVEMBER 2024

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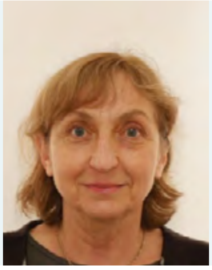

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Chairperson’s Report

MAREE WARNE

Dear Members

Tēnā koutou my friends and colleagues.

In September, we held our first face-to-face meeting of the committee at the NZNO office in Wellington. This meeting provided an opportunity for constructive dialogue with Paul Goulter and Mairi Lucas from NZNO, focusing on crucial issues currently affecting our nursing community.

A primary concern discussed was the recruitment freeze that has brought significant uncertainty to our workforce. During the meeting, we explored the nuanced and complex factors contributing to this situation. One critical point raised was the impact of bureaucratic language often used in media discussions, which can obscure the realities experienced by both nurses and patients. There was clarity among the participants that patients are acutely aware of and affected by the "lived reality" of health service cuts. Recognising this, NZNO emphasised the need to amplify the voices of nurses by sharing their personal stories that reflect the true impacts of the recruitment freeze. Such narratives are deemed far more powerful in engaging the public and advocating for meaningful changes.

In addition to the challenges posed by the recruitment freeze, concerns were expressed regarding the potential risks to nurses' professional roles amid discussions around the deregulation of nursing. This topic warrants ongoing attention as we consider the future of our profession.

The meeting also involved discussions about the Ministry of Health's Specialist Community Nursing Services Stomal Therapy Services Service Specifications. It was noted that a review of this document has been pending since 2017. The committee agreed on several minor amendments, and we plan to liaise with the Ministry of Health to kickstart the necessary adjustments to ensure these specifications meet current needs.

Furthermore, we had the opportunity to meet with the Pharmac Engagement Lead of the Device Programme. This discussion focused on strengthening our relationship with Pharmac to enhance the influence of Stomal Therapy Nurses on various issues, including procurement processes, consumable access, and supply chains essential for Ostomates in New Zealand. It was encouraging to hear that Pharmac recognises the importance of engaging with Stomal Therapy Nurses on ostomy products. They expressed an eagerness to keep our community informed and solicit expert input as their strategies develop. Pharmac also acknowledged the value of the College of Stomal Therapy Nurses’ experience in change management, emphasising the necessity of involving us in future processes.

Lastly, we reviewed updates to the CSTN Annual Plan, which emphasises our commitment to promoting Stomal Therapy Nursing in New Zealand. Among the initiatives planned are contributions to the National Clinical Guidelines and jointly celebrating Stomal Therapy Week with the Australian Association of Stomal Therapy Nurses in June 2025. Additionally, we will be collaborating with the NZNO website developer and database manager to improve the current online platform for CSTN, ensuring that it is user-friendly and engaging for our members.

In conclusion, our September meeting served as a vital platform for addressing the pressing challenges within our nursing community, including the recruitment freeze and the need for advocacy. Continued collaboration with key stakeholders such as Pharmac has been identified be essential in the future of Stomal Therapy in New Zealand. The initiatives outlined in the CSTN Annual Plan reflect our ongoing dedication to enhancing the practice of Stomal Therapy Nursing and ensuring that our voices are heard in crucial discussions affecting our profession. Together, we can continue to advance our profession and support our community effectively.

Ngā mihi,
Maree Warne

Nurse Profile

COMMITTEE MEMBER & SPECIALTY CLINICAL NURSE, STOMAL THERAPY TE WHATU ORA HEALTH NZ NELSON MARLBOROUGH

My name is Cathy Enright and I have worked in Nelson as a District Nurse for the past 6 years with 2 ½ years as part time Stomal Therapist.

I am married to Matt, with three adult daughters and one baby granddaughter. I have recently completed my second postgraduate nursing paper.

My hobbies are cooking, reading and making ceramics, taking daily walks and practising regular yoga.

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Editors' Report

ERICA AND PREETI

Welcome to the November 2024 edition of “*The Outlet*”.

As spring is quickly coming to an end and we stepping into summer, many of us must be planning for a nice break at the end of the year. Many thanks to all our committee members for their hard work in the background, benefitting our College.

We are able to produce and distribute “The Outlet” to our members due to the ongoing support from our Trades, so thanks for your advertising and sponsorship- we greatly appreciate you all. To all members, we encourage you to connect with company representatives and keep up to date with latest research, products, and developments.

We continue to advertise awards and grants our members can benefit from. The funds can be used for conference related costs and education related to Stomal Therapy Nursing. Please see the criteria for each award/grant when applying.

Please remember:

This is YOUR journal and college, it cannot function with just a few people supporting or contributing to it. The committee are all still working within their roles and putting in their own time to ensure these supports continue to be available to you all. PLEASE SUPPORT us through participating, submitting articles and/or profiles when approached. We are all fabulous storytellers and have a wealth of knowledge to share; with a unique passion for what we do. We encourage and support all collage members to showcase their work in The Outlet so other nurses can benefit and learn from your work. Please give it a go.

We will continue to provide an update on coming up projects the NZNOCSTN will be involved in coming months.

Please visit our College of Stomal Therapy Committee website for more information. A reminder that the **Stomal Therapy National Clinical Guidelines** and **Stomal Therapy Knowledge and Skills Framework** are freely available for all clinicians.

The Ko Awatea learning platform has an online module in stoma management available for those regions with access.

Preeti Charan **Erica Crosby**

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. We would LOVE to hear from you. Please send your submissions to either:

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- Preeti.charan@waitematadhb.govt.nz or
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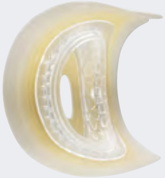

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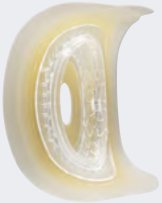

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Bariatric surgery and implications for stoma care

BY SHARRYN COOK,
CLINICAL NURSE SPECIALIST FOR WOUND AND STOMAL THERAPY,
TE WHARA ORA, HEALTH NEW ZEALAND, NELSON MARLBOROUGH

INTRODUCTION

Mrs. P, a 40-year-old female, underwent bariatric surgery to help her maintain a healthy lifestyle and weight. The surgeon performed a Roux-en-Y gastric bypass which involves creating connections, or anastomosis sites, between the stomach and intestines.

Post-surgery Mrs. P experienced some abnormal signs and symptoms, for example, fever, high blood pressure, and rapid pulse. During this time the contents of her bowels were leaking through the anastomosis sites into her abdominal cavity, where they were causing a systemic inflammatory response. Mrs. P was returned to the operating theatre for further surgery, as due to the infection, swelling and sepsis were disrupting the blood supply to a significant part of her bowel and the surgeon had to resect the necrotic sections of her bowel. When Mrs. P woke from surgery she had a colostomy bag. Post-surgery she learnt that she would have an "embarrassing, foul-smelling colostomy" for some months until there would be further surgery for a reversal. Mrs. P was referred to the Stomal Therapy Clinical Nurse Specialist (CNS) where she voiced her concerns and anxiety about the colostomy and stated she was very 'angry' that she had ended up with a stoma.

PATIENT

Past Medical History

- Morbidly Obese - BMI > 40
- Chronic Back pain
- Pre-Diabetes

Social History

- Married and has 3 teenage children

INITIAL ASSESSMENT

Challenges with Mr P after initial surgery

- Difficult to teach self-efficacy with stoma as she was angry that she had a stoma post-surgery.
- Initially she used post op soft flat stoma pouch which would often leak. Peristomal skin became irritated and painful.
- When patient discharged home directly from another hospital it was difficult to establish a time to visit her. Initially the stoma nurse only saw patient with stoma pouch on and she said Mrs. P stated she was managing. Until one day the Stomal Therapy CNS arrived, and Mrs. P had no pouch on and consequently she saw that the extra skin creases Mrs. P had were preventing the stoma pouch from adhering properly.

Initial assessment

Skin stretched to reveal stoma

Using Sensura Mio 2-piece soft convexity

TREATMENT

- The Stomal Therapy CNS established rapport with the patient, building up trust to allow other ideas of pouching to be considered.
- The use of Sensura Mio 2-piece soft convexity.
- A review of dietary intake to establish thicker stoma effluent. Written and verbal education given.
- Mrs. P reported no further leaks. The use of a stomal belt aided further comfort with the stoma pouch.
- A profound impact on Mrs. P's daily life, both physical and psychological.

RESULTS

- The Stomal Therapist CNS offered the SenSura Mio Convex drainable pouch.
- Flexible flanges also aided keeping the stoma pouch secure aiding to Mrs. P being more comfortable using t he pouches.
- A better quality of life and Mrs. P felt she could attend social events.
- No further leaks since commencing the use of Sensura Mio convex drainable.
- Mrs. P is suitable for a reversal of her stoma in four months.
- As Mrs. P had previously experienced significant 'physical, psychological and social' abilities to self-manage her care due to her weight post-surgery, she did not initially want to seek professional help. But once a good rapport was established with her Stoma Therapy CNS and the implementation of the Sensura Mio stoma pouch, Mrs. P's quality of life was vastly improved due the stoma pouch no longer leaking and her peristomal skin no longer becoming irritated and painful.

CONCLUSION

The role of the Stomal Therapy CNS in establishing a rapport with the patient is important to respect the uniqueness, rights, and choices of the person with a stoma and their family or whānau. The Stoma Therapy CNS used her knowledge, skill and experience to create a plan of care that optimise Mrs. P's quality of life and health. For Mrs. P this was important as she struggled initially to manage her stoma cares due to previous experience with other health professionals. The uniqueness of her situation where she had undergone life changing surgery to reduce her weight and then to have another physical challenge with a stoma formation was difficult at the start when she was not expecting this to occur.

There are approximately 8000 people living with a stoma in New Zealand and establishing a pouching system that works for them is part of the psychological process. For Mrs. P the use of the Sensura Mio stoma pouch along with good assessment, understanding, demonstrating and practise of Manaakitanga, (through supporting, caring for and promoting active listening, and cultural safety), Mrs. P was able to be empowered, enhanced, and to strengthen her ability to live with a stoma.

REFERENCES

1. Lee, C. (2009). Tikanga. Best practice guidelines for Māori ostomy patients [online]. Outlet: New Zealand Stomal Therapy Nurses, April 2009: 9-10. Available: ISSN: 2324 -4968.
2. Ministry of Health (2019). Bowel cancer quality improvement report. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/bowel-cancer-qualityimprovement-report-mar19v1.pdf
3. Ministry of Health (2012). Community health, transitional and support services. Specialist community nursing services-Stomal therapy services tier three service specification. https://www.nsfl. health.govt.nz/service-specifications
4. Swash, C. (2016). Bariatric surgery and implications for stoma care. British journal of nursing (Mark Allen Publishing), 25(5), S22–S27. https://doi.org/10.12968/bjon.2016.25.5.S22

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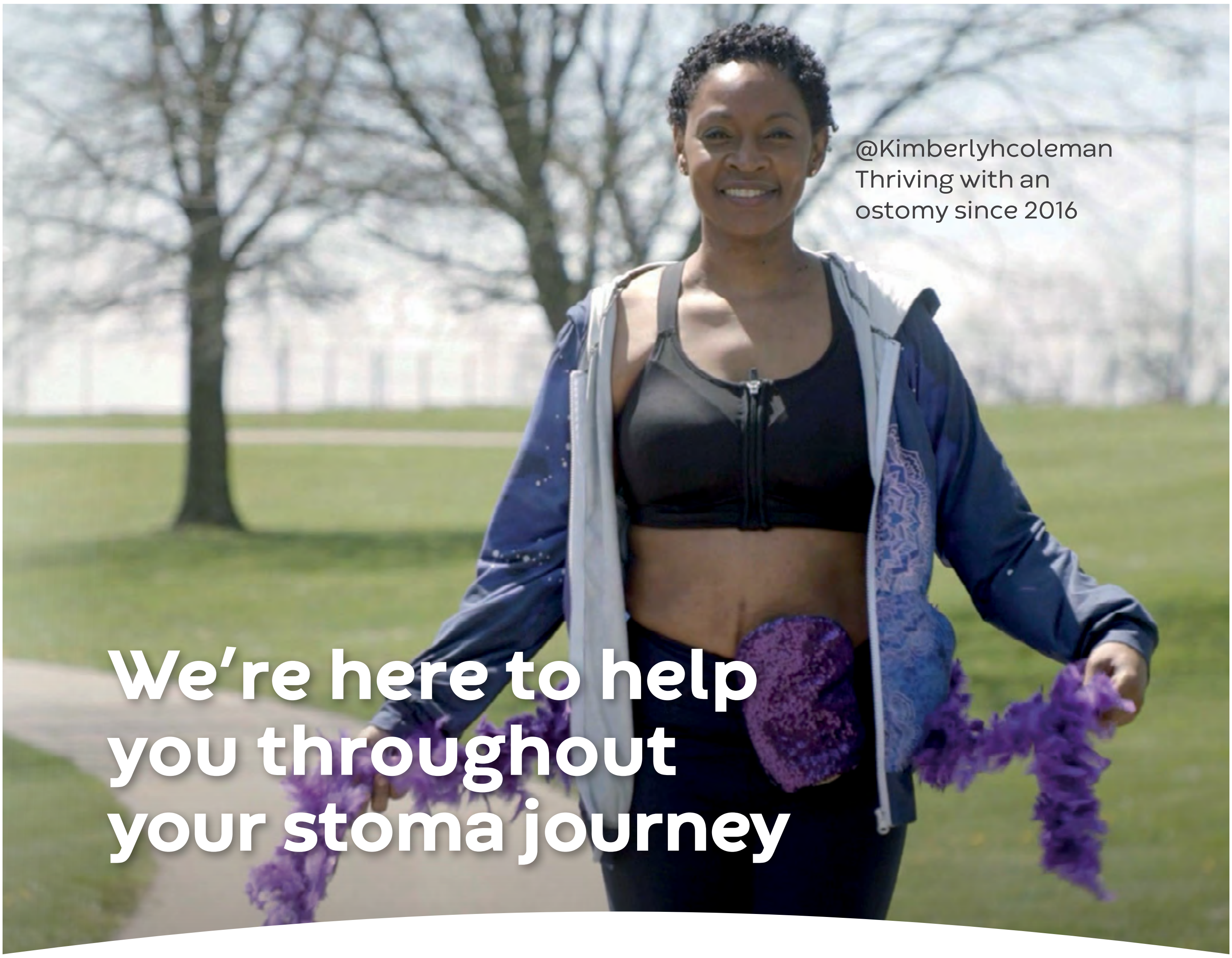
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Neonatal Chyme Reinfusion Therapy

BY EMMA LUDLOW[1,3]

ON BEHALF OF: T. HARRINGTON[1-3], R. DAVIDSON[3], J. DAVIDSON[3],
K. AIKINS2, G. O'GRADY[1,3], I. BISSETT1,[3]
UNIVERSITY OF AUCKLAND1, TE TOKO TUMAI AUCKLAND[2], THE INSIDES CO.[3]

INTRODUCTION

The following report is a summary of a paper titled "Evaluating the Efficacy and Safety of Neonatal Chyme Reinfusion Therapy: A Feasibility Study using a Novel Medical Device" which addresses a significant medical challenge in neonatal care—intestinal failure associated with enterostomies[1].

Intestinal failure in neonates related to diagnoses such as necrotising enterocolitis (NEC) and other conditions that can lead to enterostomy formation, have substantial morbidity and mortality[2]. The primary objective of the study was to evaluate a newly developed device, "The Insides Neo," designed to automate and enhance the process of chyme reinfusion therapy (CRT) for neonates with double enterostomies. The study provided critical insights into the feasibility, safety, and efficacy of this innovative device in a clinical setting.

BACKGROUND AND RATIONALE

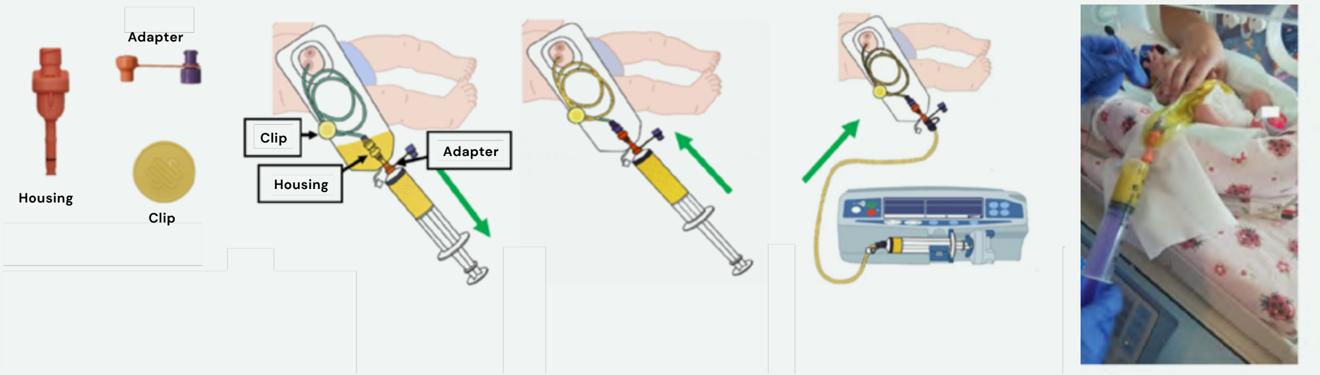
Intestinal failure in neonatal populations, although rare, presents a significant clinical challenge. The most common cause is short bowel syndrome following massive intestinal resection, often due to NEC in premature neonates. This condition necessitates double enterostomies, resulting in high-output losses and impaired gut function [2-6]. CRT has emerged as a beneficial treatment option, where chyme from the proximal limb of the enterostomy is reinfused into the distal limb[4,7]. CRT supports nutrition, growth, fluid balance, and electrolyte normalization, reducing dependency on parenteral nutrition (PN) and promoting enteral autonomy[4,7].

However, the manual execution of CRT is complex, labour-intensive, and presents practical challenges for healthcare teams, namely cot side nurses who manage day-to-day care. A lack of uniformity in technique and administration has led to erratic adoption and mixed clinical outcomes [7-10]. Recognising these challenges, the authors aimed to develop and validate a novel medical device that automates CRT, thereby improving the safety, efficacy, and usability of this therapy in neonatal intensive care units (NICUs).

METHODS

Device Development

The Insides Neo device was developed through collaboration between engineers and clinicians. The design was informed by empirical experience, literature, and clinician feedback on prototypes. The device was engineered to integrate seamlessly with common stoma appliances and consumables, ensuring minimal contact with chyme and reducing the time burden on nursing staff. The Insides Neo is a directional flow valve device that connects to a stoma appliance, an ENFit syringe, and a soft flexible enteral feeding tube inserted into the distal enterostomy (Figure 1). The device allows for both bolus and continuous reinfusion, with continuous reinfusion being recommended to minimise reflux.



The Housing contains a directional flow valving system that is purpose built to fit the bung closure of a standard stoma appliance. This couples with the Adapter that is secured externally (see B.). This allows for an ENFit syringe to be connected. The Clip is secured externally to the stoma appliance to secure the feeding tube.

Shows the three components of The Insides Neo that fit with a standard stoma appliance. In this image, the plunger of the syringe is withdrawn, drawing chyme into the syringe, through The Insides Neo.

To deliver bolus CRT: Depression of the syringe plunger directs chyme back through The Insides Neo, into the flexible feeding tube and into the distal limb of the enterostomy.

To deliver continuous CRT: Connect the full syringe (from A.) to a syringe driver and reinfuse over the following 4-6 hours via an extension set. During this time, chyme from the proximal limb is collecting in the stoma appliance, ready to be withdrawn into the newly emptied syringe.

Device in use with neonate: Stoma appliance sitting where comfortable with device in situ, with nurse withdrawing syringe plunger, emptying the ostomy appliance.

Figure 1: *(Photo shared with parental consent). Diagram of chyme reinfusion therapy with The Insides Neo*

FEASIBILITY STUDY

The feasibility study was conducted across two tertiary NICUs in New Zealand, where ten neonates with double enterostomies were enrolled. The study was designed to assess the device's impact on nursing workflows, its safety, efficacy, and its ability to facilitate weight gain and achieve enteral autonomy. The study also included a nurse feedback form to gather insights into the usability of the device. The primary outcomes focused on validating the safety, effectiveness, and tolerability of the device. Secondary outcomes included usability in a NICU setting and initial clinical data such as changes in weight gain, nutrition support, and surgical reinterventions.

RESULTS

The study recruited ten neonates, of which six were female. The median duration of device use was 37.5 days, with continuous CRT administered until the morning of enterostomy reversal. The results demonstrated a significant increase in weight gain from 68.8 ± 37.4 g/week prior to device use to 197 ± 25.0 g/week (p=0.024) following device use. Of the seven neonates dependent on PN at the start of CRT, four were successfully weaned off within a median time of 28.5 days, achieving enteral autonomy.

All neonates tolerated the device well, with no device-related adverse events reported. Notably, nursing feedback was uniformly positive, highlighting the ease of use and the improved workflow compared to manual CRT. The Insides Neo device also led to faster and more efficient assembly and application, reducing the time and effort required by nursing staff.

Overall, the frequency of stoma appliance changes was not impacted by the initiation of CRT. Half of the neonates were reported to have difficult abdominal landscapes, which made keeping a stoma appliance in place and intact challenging. Those neonates continued to have stoma appliance leaks, including occasional peristomal excoriation that is consistent with frequent leaks, which did not change following the initiation of CRT. Comparatively, the other half of the neonates with easier abdominal landscapes were able to maintain wear times of four days, their peristomal skin remained healthy, and their stoma appliances and the devices were changed on a schedule.

There were ten feedback forms completed and returned by the cot side nurses. There was a uniformly positive impact on nursing workflow with the device easy to learn and implement. Feedback from cot side nurses, outside of the study feedback form, commented that once they became familiar with the assembly and application of the device, they were astounded by the time saved. With manual reinfusion, the time spent 'spot repairing' and manipulation of the stoma appliance on the neonate to prevent leaking was considerable and more than likely, unsuccessful.

CASE STUDIES

The following two case studies were written by T. Harrington, a neonatal intensive care nurse, and demonstrate the outcomes that can be achieved at an individual level.

CHLOE*

(Photo shared with parental consent)

Chloe was born at 23 weeks weighing 535g.

She deteriorated on day of life 26 and developed a midgut volvulus and ischemia requiring a jejunostomy and mucus fistula formation.

She was commenced on chyme reinfusion therapy and used the device for 12 days.

Chloe went from gaining an average of 77 g/week prior to device use to gaining 219 g/week while on chyme reinfusion therapy.

Chloe had an excellent post-operative recovery and had her first bowel movement one day post-operatively

Read the full case study here:

https://www.theinsides.co/case-studies/auckland-hospital-nicu-first-use-of-the-insides-neo

SAI

(Photo shared with parental consent)

Sai was born at 24 weeks weighing 650g.

He had medically managed necrotising enterocolitis (NEC) and deteriorated on day of life 8.

He required a resection with ileostomy and mucus fistula formation.

Sai was commenced on chyme reinfusion therapy and used the device for 62 days.

He was able to wean off parenteral nutrition onto fortified breast milk in 14 days.

He went from gaining an average of 60 grams per week prior to device use to gaining 179g per week while on chyme reinfusion therapy

Sai had an excellent post-operative recovery and had his first bowel movement one day post-operatively

Read the full case study here:

https://www.theinsides.co/case-studies/neo-case-study-robust-growth-and-weight-gain

DISCUSSION

The findings from this study underscore the potential of The Insides Neo device to revolutionise neonatal care for patients with double enterostomies. The device addresses several limitations of manual CRT, such as the complexity and time burden on nursing staff, and the need for modifications to stoma appliances.

By automating CRT, the device not only enhances the safety and efficacy of the therapy but also significantly improves the workflow in NICUs. Comparing the assembly of components and equipment required between manual CRT and automated CRT with the device is significant. Manual CRT is set up in motion where set-up of The Insides Neo can be completed ahead of time in anticipation of a stoma appliance change and dramatically reduces nursing time.

The study's results are particularly significant in the context of reducing dependency on PN, which is associated with high costs and risks such as sepsis, venous thrombosis, and liver impairment1,2,5,10. The efficacy of the device to continue to facilitate weaning from PN while supporting substantial weight gain represents a critical advancement in neonatal care.

Furthermore, the device's impact on post-operative outcomes is noteworthy. The advanced maturation of the distal intestine observed in neonates receiving CRT led to improved surgical outcomes, with a rapid return of bowel function and no cases of ileus post-reversal. These findings suggest that the device not only supports immediate clinical goals but also contributes to long-term health outcomes for these vulnerable patients.

FUTURE DIRECTIONS

While the study provides compelling evidence for the efficacy and safety of The Insides Neo device, further research is warranted to explore its long-term impact on patient outcomes. Additionally, larger studies with more diverse patient populations could provide a more comprehensive understanding of the device's benefits and limitations. Investigations into cost-effectiveness and potential applications in other patient groups, such as older children, could further expand the utility of this innovative technology.

CONCLUSION

This study successfully demonstrated the efficacy, safety, and tolerability of The Insides Neo device in performing CRT in neonates with double enterostomies. The device represents a significant advancement in the management of neonatal intestinal failure, offering a standardised, efficient, and user-friendly solution for CRT. The positive clinical outcomes, coupled with the improved nursing workflows, suggest that this device has the potential to become a standard of care in NICUs worldwide.

The innovation and clinical validation presented in this study pave the way for broader adoption of CRT, ultimately improving the care and outcomes for neonatal patients with enterostomies.

KEY FINDINGS

1. Significant Improvement in Weight Gain: The study highlighted a dramatic increase in weight gain among neonates using the device, which is critical for their overall health and recovery.
2. Reduction in PN Dependency: The ability to wean neonates off parenteral nutrition was a significant outcome, reducing associated risks and costs.
3. Positive Nursing Feedback: The device was well-received by nursing staff, who found it easy to use and time-saving compared to manual CRT methods.
4. No Device-Related Adverse Events: The study reported no adverse events related to the device, underscoring its safety in a vulnerable population.
5. Improved Post-Operative Outcomes: The device contributed to better surgical outcomes, including faster return of bowel function and reduced post-operative complications.

REFERENCES

1. Ludlow E, Harrington T, Davidson R, Davidson J, Aikins K, O'Grady G, Bissett I. Evaluating the efficacy and safety of neonatal chyme reinfusion therapy: A feasibility study using a novel medical device. Clin Nutr 2024; 43. 2253-2260. doi: 10.1016/j.clnu.2024.08.016
2. Gutierrez M, Kang KH, Jaksic T. Neonatal short bowel syndrome Semin Fetal Neonatal Med 2011; 16(3) 157-163. doi: 10.1016/j.siny.2011.02.001
3. Goulet O, Olieman J, Ksiazyk J, Spolidoro J, Tibboe D, Köhler H. et al. Neonatal short bowel syndrome as a model of intestinal failure: physiological background for enteral feeding Clin Nutr 2013; 32(2) 162-171. doi: 10.1016/j.clnu.2012.09.007
4. Wong KKY, Lan LCL, Lin SCL, Chan AWS. & Tam PKH. Mucous fistula refeeding in premature neonates with enterostomies J Pediatr Gastroenterol Nutr 2004; 39(1), 43-45 doi: 10.1097/00005176-200407000-00009.
5. Georgeson KE. & Breaux CW. Outcome and intestinal adaptation in neonatal short-bowel syndrome J Pediatr Surg 1992; 27(3), 348-350. doi: 10.1016/0022-3468(92)90859-6
6. Wales P. & Christison-Lagay E. Short bowel syndrome: epidemiology and etiology Semin Pediatr Surg 2010; 19(1), 3-9. doi: 10.1053/j.sempedsurg.2009.11.001.
7. Bhat S, Cameron NR, Sharma P, Bissett I & O'Grady G. Chyme recycling in the management of small bowel double enterostomy in pediatric and neonatal populations: A systematic review. Clinical Nutrition 2020; 37(June): 1-8. doi.org/10.1016/j.clnesp.2020.03.013
8. Stoop T, van Bodegraven E, Ten Haaft B, van Etten-Jamaludin F, van Zundert S, Lambe C, Tabbers M & Goter R. Systematic review on management of high-output enterostomy in children: An urgent call for evidence. JPGN 2023; 78. 188-196. doi.org/ 10.1002/jpn3.12043
9. Dogra R, Chhabra M & Chibber P. Distal enteral feeding can replace total parenteral feeding to support nutrition in patients with high-output stoma (Jejunostomy) – A case series. Clinical Nutrition ESPEN 2023; 57. 537-541. doi.org/10.1016/j.clnesp.2023.07.079
10. Lee E, Kim E, Shin S, Jung Y, Song I, Kim Y, Kim H, Choi Y, Moon K & Kim B. Efficacy and safety of mucous fistula refeeding in preterm infants: an exploratory randomized controlled trial. BMC 2023; 23(137). 1-9. doi.org/10.1186/s12887-023-03950-1

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Building Cultural Connections with Healthcare Professionals in Aotearoa (New Zealand) from a Wound Clinical Nurse Specialist Perspective

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ABSTRACT

Cultural safety should be integrated into healthcare professional practice to provide holistic care to our patients and meet our cultural safety competencies, but often we are challenged on how to implement or articulate this. This article discusses an approach of how, in Aotearoa (New Zealand), we have connected with a diverse group of healthcare professionals, including Māori and Pasifika teams, to strengthen our cultural connections and enhance our cultural awareness to ultimately improve service care and delivery.

Mandy Pagan

INTRODUCTION

In Aotearoa (New Zealand) health disparities and inequalities for Māori and Pacific populations are widely known and published [1–3]. These inequalities have been attributed to personal, social, economic and environmental factors such as access to employment, income, health, and educational opportunities, and for Māori the generational effect of colonisation [1]. As a consequence this can lead to smoking, alcohol, and drug use; poor nutrition and living in overcrowded unhealthy homes [1,2]. In Aotearoa health disparities affect the young to old; 2013-2015 data for 0 to 74 aged group indicated Māori and Pacific presented with higher avoidable deaths and had a lower life expectancy compared to non- Māori and non-Pacific people(1). In addition, Māori have double the death rate from ischaemic heart disease, chronic lower respiratory diseases and all cancers combined [3].

As healthcare professionals (HCPs) challenging racism and recognising cultural health inequities and how they have resulted, can empower us to practice in a culturally sensitive and safe way. In Aotearoa cultural safety is assessed or measured through clinical and cultural competencies developed by the professionals governing body [4,5]. Like myself, Pākehā (white inhabitants of Aotearoa), or non-Māori, can find it challenging to evidence this within clinical practice.

BACKGROUND

The signing of the Treaty of Waitangi (Te Tiriti O Waitangi) in Aotearoa in 1840 between the British Crown and Māori (indigenous peoples) is considered a founding document for Aotearoa to protect Māori culture and enable British governance [6]. Though the Treaty interpretation contrasts between the Māori and English version it is considered a taonga (treasure) and referenced widely within government documents [6–8].

Our Nursing Council defines culture as “Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability”[5]. All nurses working in Aotearoa are required to meet the Nursing Council Code of Conduct and kawa whakaruruhau (cultural safety) standards [5]. The Council reminds us that practicing and demonstrating cultural safe practice is based on the recipients’ experiences and not on the HCPs interpretation[5].

In 2005 I was appointed as Wound Clinical Nurse Specialist. This newly developed role required the development of a service quality improvement plan. In accordance with the registered nurse competencies [9] I included statements on the Treaty and kawa whakaruruhau but when presented to our Māori Health Manager he challenged me to how I would place this into practice. I requested his guidance, and he suggested I develop a ‘Cultural Focus Group’ with other health professionals to support and learn from our Māori health colleagues and develop whakawhanaungatanga (relationship building). With my managers support I developed the draft terms of reference that included the meeting location/s, day, time, frequency, quorum required, membership, chair, secretary roles and who the group is accountable to. In addition, the groups' purpose is to share learnings, provide guidance, and improve cultural practices across primary and secondary care settings whilst incorporating the Treaty of Waitangi Principles of partnership, participation, and protection [6-8]. The members responsibilities are to identify service inequalities for Māori and Pacific people to facilitate cultural awareness and safety, to address racism and encourage reflective practice and critical thinking in a supportive environment. Members are expected to communicate relevant learnings and information with their colleagues.

The terms of reference were reviewed and approved by relevant managers and group members.

The first hui (meeting) was held in September 2005, in the hospitals Māori Health Unit, and included our hospital's Māori and Pasifika nursing teams and their clinical manager and an external Māori health provider known to me. This first meeting regarded the group purpose as important and to invite more external HCPs. Since then, membership has grown across primary and secondary sectors including Māori and Pacific healthcare providers, kaiāwhina (non-regulated health and disability workers), cancer co-ordinators, podiatrist, social workers, prison nurses, educators, nurse practitioners, and clinical nurse specialists (e.g. sexual health, diabetes, colo-rectal). As secretary I record the meeting minutes and circulate these with relevant information and resources to members to share with their teams and networks. Huis are held up to four times a year, for one to one-and-half hours; venues are changed with members hosting these which has enabled attendance and introduction of new members, nurturing whakawhanaungatanga (relationship building), and learning about the respective organisation.

The hui agenda includes opening and closing with a karakia (prayer) and/or waiata (song), this has improved our use and pronunciation of te reo Māori (Māori language) with guest speakers or members sharing their learning from attended seminars or conferences. Each member shares a report of their current work, practice advancements, successes, and practice needs. In addition, relevant educational huis, health screening and promotion clinics, cultural initiatives, government documents and research are shared utilising the Māori Health and Pacific Health Review, these on-line free publications provide extracts of Māori and Indigenous health research from Aotearoa and internationally that identify health disparities and initiatives that raise group discussion and learning[10,11]. Members have introduced cultural models of care, such as the Dr Mason Durie's 'Te Whare Tapa Whā Māori Mental Health and Well-being' model [12]. This model of care presents the concept of a four-side whare (house) with the whenua (land) forming the foundation. The four-dimensions depict Tinana (body), Wairua (spirit), Whānau (extended family network) and Hinengaro (mind) that must be in equilibrium to maintain the person's and whānau wellbeing [12]. I have applied this model of care when working with Māori, and non- Māori, to aid a holistic assessment and develop therapeutic patient and whānau relationships.

The group provides an excellent forum to share resources, debrief, brainstorm, and troubleshoot in a safe and supportive environment. This has cemented close relationships and social connections between members. This is especially important when tragic or celebratory events have occurred with members showing aroha (love, compassion) and manaakitanga (kindness, generosity, caring for others). A noteworthy example is when Sandra Vaeluaga Borland was named Member of the New Zealand Order of Merit for the Queen's Birthday Honours for her services to the Pasifika community and to nursing [13]. Over the years members have also assisted colleagues clinically assisting at community days and clinics to reach underprivileged people providing services such as cervical screening and diabetes education. Another initiative is assisting our Pasifika nurses by promoting and contributing to the annual Christmas food drives for families in need.

The group effect is far outreaching with new members being welcomed onto the group often from word-of-mouth. This is especially important for HCPs working in challenging or isolating roles such as our prison nurses, and the formation of new roles over the years, such as our Cancer Coordinator who has connected with our Māori and Pacifica nurse teams to reduce barriers to access timely cancer support and treatments.

In 1987 the Māori Language Act declared te reo Māori to be an official language of Aotearoa[14]. Using te reo Māori every day is a way we can show our support, to connect, grow and protect this beautiful language. I use te reo Māori in my greetings with colleagues and patients, email correspondence and when answering my personal and work phone. From this simple act others have been encouraged to use te reo Māori. Encouragingly, group members have also introduced morning karakia and waiata into their work environments encouraging HCP connections and further use of te reo Māori. .

MEMBER COMMENTS

"The Group provides a place of safety to learn, discuss and care for our professional colleagues within this group" *Rachel*

'Ma te whiritahi, ka whakatutuki ai nga pumanawa a tangata' (Together weaving the realisation of potential) *Charleen*

"The word 'safe' reflects what the Group means to me" *Nadine*

"A safe environment to build authentic relationships that support each other and share knowledge that enhances our professional practice" *Sandy*

"I work in isolation so the contacts I have developed have been invaluable to promote my service and grow my support network" *Sue*

CONCLUSION

As HCP we can work individually and collectively to address health inequalities, racism, discrimination, and meet our cultural competencies in creative ways. Many HCPs are time-poor but the importance of whakawhanaungatanga (building relationships) using face-to-face huis should not be underestimated to enhance our growth, improve our resilience and cultural awareness collectively. On reflection my early intentions of including cultural elements into my quality plan was "lip service" and lacked actions to provide culturally appropriate outcomes, I will be forever grateful for being challenged to develop the Cultural Focus Group. The group, now running for 19-years, is an accomplishment and testament to its importance to members. Personally, for me the group has enhanced my cultural understanding, empathy, and growth, and facilitated strong collegial bonds that challenge me to improve my practice in a culturally sensitive and responsive way. Take up the wero (challenge) and consider what small changes you can perform to acknowledge your indigenous people and facilitate cultural relationships and awareness in your work environments.

MAHITAHI (COLLABORATION)

E hara taku toa

i te toa takitahi,

he toa takitini

My strength is not as an individual, but as a collective [15]

ACKNOWLEDGEMENTS

My amazing and courageous 'Cultural Focus Group' colleagues who continue to inspire and guide me.

REFERENCES

1. Walsh M, Grey C. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand-a decomposition analysis. NZMJ [Internet]. 2019;132:1492. Available from: www.nzma.org.nz/journal.
2. Brown H, Bryder L. Universal healthcare for all? Māori health inequalities in Aotearoa New Zealand, 1975–2000. Soc Sci Med. 2023 Feb 1;319:1–8.
3. New Zealand, Wellington. Ministry of Health. Pae Tū: Hauora Māori Strategy, 2023
4. Shaw S, Tudor K. Effective and respectful interaction with Māori: How the regulators of health professionals are responding to the Health Practitioners Competence Assurance Amendment Act 2019. New Zealand Medical Journal [Internet]. 2023;136(1569). Available from: https://journal.nzma.org.nz/
5. Nursing Council of New Zealand. Guidelines for cultural safety, the Treaty of Waitangi and Māori health in nursing education and practice. Nursing Council of New Zealand; 2011.
6. Office of Treaty Settlements. Healing the past, building a future. A Guide to Treaty of Waitangi Claims and Negotiations with the Crown. 2018.
7. Came H, Mccreanor T, Manson L, Nuku K. Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. NZMJ [Internet]. 2019;132:1492. Available from: www.nzma.org.nz/journal.
8. Wilson L, Wilkinson A, Tikao K. Health professional perspectives on translation of cultural safety concepts into practice: A scoping study. Front Rehabil Sci. 2022 Jul 28;3:891571. doi: 10.3389/fresc.2022.891571.
9. Nursing Council of New Zealand. Competencies for Registered Nurses [Internet]. Nursing Council of New Zealand; 2022. Available from: file:///C:/Users/pagan/OneDrive/Documents/NZWCS/Cultural%20Article/NCNZ006-Competencies-Registered-Nurses-15-08-2022v0.1pdf.pdf.
10. Tukuitonga C. Research Review: Pacific Health. [cited 2024 Jan 30]. Pacific Health Review. Available from: https://www.pacifichealthreview.co.nz/
11. Harwood M. Research Review: Māori Health. [cited 2024 Jan 30]. Māori Health Review. Available from: https://www.maorihealthreview.co.nz/
12. Wilson D, Moloney E, Parr JM, Aspinall C, Slark J. Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. J Clin Nurs. 2021 Dec 1;30(23–24):3539–55.
13. Ahmed U. Stuff. Southlander undeterred by hardships recognised in Queen's Birthday Honours. 2022 Jun 6.
14. New Zealand Government. Maori Language Act 1987 [Internet]. 2016. Available from: https://www.legislation.govt.nz/act/public/1987/0176/latest/whole.html#whole.
15. Alsop P, Kupenga TR. Mauri Ora Wisdom from the Maori World. Nelson, New Zealand: Potton & Burton; 2016. 1–160.

LeeAnne, CeraPlus™ Product User

Patient Perspective — Shontelle's Journey

BY SHONTELLE FAWKNER[1,3]

My name is Shontelle Fawkner, I'm 36 years old and live in Riverhead with my Husband Dan and our two children, Lucy who is 4 and Oliver who is 3 ½ months old. When my Stoma Nurse Specialist asked me if I would be interested in talking about my experience at the conference, my first thought was absolutely not, I don't like public speaking and I didn't think I could do it. Then after some consideration, I thought maybe hearing my experience might help someone and if so that would be somewhat cool. I was a bit nervous.

In July last year while 23 weeks pregnant I had a laparoscopic subtotal colectomy with end ileostomy.

Dan and I welcomed Lucy in November 2019 and I was very fortunate to have a stress-free pregnancy. It was not until there were signs of pre-eclampsia at 39 weeks that I was induced and we welcomed a healthy 8lb 5oz baby, a very quick labour that took place on the toilet floor at a Tertiary Hospital. My husband and midwife missed it but the wonderful hospital team took great care of us until everyone arrived and were shocked to find Lucy was already here. This was an insight into Lucy's personality… she waits for no one.

After a few years of enjoying Lucy we decided it would be nice to have a sibling for her to boss around, and in February last year I became pregnant with Oliver, we were very excited. They say second/subsequent pregnancies are generally easier…well that could not be further from the truth in my case.

The early weeks were relatively normal, the usual nausea and fatigue set in but I had a very active 3-year-old to keep me on my toes. At 11 weeks I noticed some blood in my stool and at first, I thought it is probably just one of the joys of pregnancy, constipation or maybe even a haemorrhoid. I thought I would give it a couple of days and see if it goes away…the typical "she'll be right" kiwi attitude, combined with the "that's too embarrassing to go to the doctors for". After giving it a few days and no changes, I booked an appointment with my GP, something I probably would not have done but being pregnant and having someone else to think about I did not want to muck around.

I told my GP about the blood and how I had been feeling quite nauseous and fatigued but I was 11 weeks pregnant, which is very normal. He also thought it is probably just some constipation so prescribed some sachets to help things move along but he also sent me for a couple of tests just to be safe.

The test results showed some slight inflammation so my GP told me he would send a referral to the DHB. This was mid-May last year; never would I have imagined that just over two months later I would be recovering from a major surgery.

It was all new to me, other than having my tonsils out as a child and having my children I (gratefully) had never had to go to through the health system. Aside from being a curvy girl, I have always led a pretty healthy, active and "normal" life. I rarely got sick; I was a regular at the gym and F45 and actively took part in social sports.

Weeks went by and I was feeling worse, the frequency of going to the bathroom was increasing, as was the amount of blood. I saw my GP again and described my symptoms and he prescribed a course of prednisone. I felt a little better but not for long. I asked if he could refer me to a private clinic, and after an appointment my symptoms matched those of ulcerative colitis and I had a flexible sigmoidoscopy to confirm.

I was diagnosed with moderate UC in June and I commenced another course of Prednisone as well as Asacol, some ondansetron to help with the nausea and continued to take my pregnancy medications of ferritin and potassium iodate. I had a follow up appointment with the clinical nurse specialist for inflammatory bowel disease a few weeks later and I really wasn't doing well. I was going to the bathroom 10+ times a day, always with blood, I just felt so awful and so drained. It was during this appointment that it was decided I would go over to nearest Tertiary Hospital to start some IV steroids. The obstetrics team were also monitoring me and with the high level of steroids, I had to monitor my blood sugar levels closely. With still no improvement we tried an Infliximab infusion and after a couple of days things did start to improve, the markers were coming down, toilet visits were decreasing and things were looking positive, so much so that the Gastro team said I could go home on the proviso that if I started feeling unwell again or developed a fever that I had to come back in. After 7 nights in hospital I was discharged and told to continue with my medications, I was so happy to get home to see my family, especially Lucy who I was missing so much and looking forward to a sleep in my own bed. The first night was rough but I put it down to a week a of not much sleep and a lot of medication.

By night three, however the fevers had come back with a vengeance so we knew it meant a trip back to ED. My inflammatory numbers had skyrocketed again and I was admitted back to the gastro ward. The Gastro team were worried about the possibility of toxic megacolon so I was sent for an X-Ray and a large rescue dose of Infliximab was given. I also had another Flexi sigmoidoscopy and once it was done, I could just tell from the tone of the doctors voice that it wasn't looking good, he said it was severe. I was told that the surgical team would come by to have a chat about what the next steps might be if I did not respond to the Infliximab infusion. I had never had any UC symptoms before and there is no history of IBD in my family. The only explanation as to why this was happening is that Pregnancy can do strange things.

It was all very scary and very overwhelming, I was hoping that the Infliximab would be able to get on top of things time, I really did not want to have surgery especially as it was explained to me that being under 25 weeks gestation there is no attempt to save the baby if something goes wrong. It was all a lot to process. When the surgeons came to see me and explain what surgery would look like it highlighted how very little I knew about how the human body works, I did not even know what a stoma was.

In the meantime the rescue dose of infliximab started to work, numbers were coming down but unfortunately it was the same pattern as last time, a few days later the fevers returned and I went downhill. The doctors came in to see me to give me the news that with the infusions unable to get a handle on the inflammation, surgery had become the less risk option, this level of inflammation in the body is dangerous and the decision was made to go ahead with surgery.

Surgery day and I was wheeled off early in the morning, as I lay down in the waiting room listening to all chatter, the doctors behind the other curtains, asking the patient next to me to confirm it was their left knee to be operated on, I was feeling all sorts of emotions, sad, scared, worried and just praying that everything would be ok.

When I woke up from the quickest 6-hour sleep of my life, of course the first thing on my mind was the baby. The team in recovery checked everything and it all looked good, once stable I was back up to the ward and so happy to see the faces of my loved ones all eagerly waiting for me to return. What was a super short day for me was the opposite for my family, waiting hours and hours to get the phone call that everything went well.

The week spent in hospital following the surgery was tough. Not only physically trying to move around when things were very tender but also as someone who doesn't like the sight of anything medical or surgical – I can't even watch a medical show on TV – I could hardly to look at my stoma, the thought of having to clean it and do bag changes was very daunting.

Close to a week post op and it was time to sit my bag change exam, I was nervous, and to be honest I failed dismally, I almost passed out. I asked if I could try again the next day and it went much better. I spent a total of 22 days in Hospital and when I was being discharged, I was experiencing a very strange feeling of being so excited to go home but at the same time not wanting to be discharged in case I got sick again. The thought of not having the doctors and nurses nearby made me feel quite anxious, as did having to manage the stoma on my own.

The Stoma Nurse Specialist came to see me at home and has been so helpful, always available to answer my questions and provide advice. We chatted about all things stoma and also what foods to eat and not to eat.

Now if ever there is a silver lining it has to be the post ileostomy diet…never in my life have I been told I should eat white bread, white rice, pasta, mashed potatoes and salty chips…this I could get on board with. I did have some input from the hospital dieticians as we were trying to find the balance between stoma friendly foods and ensuring good nutrition for me and my growing baby.

I slowly adjusted to my new normal however as the pregnancy progressed, I started to experience some prolapse. The Stoma Nurse Specialist and I had talked about there being quite a high chance of prolapse given my tummy would be growing, and the first few times I was able to manage at home it by laying down and a cold compress. But it got to a point where I couldn't be up and about for long before it prolapsed and one day it prolapsed so much that I didn't know what to do so I headed to the ED. I was admitted to the Tertiary hospital again. I was in quite a lot of pain, I was vomiting and my output was very bloody. After the stoma was put back in place, I was taught how to manage it going forward. The stoma nurse specialist also got me a tummy band to help.

After a couple of nights in hospital I was discharged again and over the next couple of months I think I experienced most of the common "things" associated with a stoma. A slight blockage that I put down to way too much Whittakers Coconut Chocolate. I wasn't having any output, had abdominal pains and had vomited a couple of times, I got in the shower to see if that would make me feel better and maybe the warm water did something because let's just say it unblocked. Unfortunately Lucy walked in to the bathroom at about the same time and said oh my gosh mum did you just do a poo in the shower. Now all I could think about was the fact that she was probably going to announce this at kindy the next day, Dad did kindy drop off for the next few days just to be safe.

As the warmer weather came I also had a few issues with the skin around my stoma. I have sensitive skin in general and it was becoming quite red, itchy and my bags were not sticking well. I had been using a soft convex bag without problem and the prolapse had settled down too. After talking with the Stoma Nurse Specialist, we tried another type of bag, one that was flat and has some manuka honey in it and my skin started to improve. I'm now back to the convex bag and a seal and have found this works best for me right now.

Lastly and for me the most dreaded…Leaks or bag blowouts. Touch wood, I have been quite lucky with this and it has only happened a couple of times. The first time it happened I was at home, I had leant against the kitchen bench and then I felt it. For a second I thought my waters had broken but no, it was a bag blowout and it was not water running down my leg…Sometimes if you don't laugh you'll cry right?!

Since having the surgery, the UC side of things have improved immensely, the weeks following surgery aside from feeling tender, I felt so much better in myself, to have that yucky inflammation out of my body was great, and now it was time to focus on getting better and to finish growing this baby. I did experience a flare up of proctitis and was prescribed Pentasa suppositories and since having Ollie I still have small amounts of blood and mucous but I was told that could happen.

I obviously would not choose to have had this happen during pregnancy (well if I could, I would not choose it at all) but in a way Pregnancy was a distraction. I was so focused on this little baby being ok that I just got on with it and all of my energy was put into getting him here safely. I was under Obstetrics care for the remainder of the pregnancy and with baby's growth tracking on the smaller side; I had frequent scans and monitoring. At the 38-week check-up, the decision was made to induce and we welcomed our beautiful baby boy on the 17th of November via vaginal delivery, 6lb 9oz of pure perfection. In the lead up to the delivery, I have to say I was less worried about the actual labour and more about what my stoma was going to do and if it would prolapse. It did not, and I have not had any prolapse since. The stoma is a little larger and protrudes a little more post-partum, but still does what it needs to do.

SOME THINGS THIS EXPERIENCE HAS SHOWN ME:

I am very resilient, I try not to let the things thrown at me get me down, of course I have wobbly days but then I remind myself I have so much to be grateful for. It has been important to try to take things one day at a time, adjust to my new normal. I cannot do anything to change it so there isn't much point dwelling on it.

I also have one amazing village, my family, and my friends. The time spent in hospital really showed me how much love and support I have around me. All the people who came and sat at my bedside, cooked a meal, helped with Lucy, sent their well wishes, I feel very blessed. Special mention to my Mum Tracey who I get a lot of my strength from and who gave Lucy those cuddles only a mum can give when I wasn't there to. I could not have gone through any of this without my husband Dan, he is the real MVP. He is the calming voice I need when it all gets a bit too much, nothing seems to phase him…and he has seen some things on this journey…It is safe to say there isn't much mystery left in our relationship.

I am very impressed at the level of care I have received, nurses, support staff, doctors, and the community teams, my Stoma Nurse Specialist in particular has been instrumental in getting me through this journey so far, it was all a complete unknown and a huge learning curve.

I see the surgical team in a couple of weeks' time to discuss the next stage, the J-Pouch formation. I have read mixed reviews about having a J-Pouch but for me at my age and having a young family to keep up with, a little more normality would be nice. While having further surgery(s) is scary I think I would regret not doing it.

2023 was the worst year of my life so far but it also has to be one of the best, to have Oliver here with us (when at times I really did not know if that would be the case) is something special. Our little family is complete and now the real fun begins.

Thanks to Shontelle for presenting her experience and journey with her stoma at the 2024 Collage of Stomal Therapy conference, Auckland.

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.

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The NZNOCSTN retains copyright for material published in The Outlet. Authors wanting to republish material elsewhere are free to do so provided prior permission ivs 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

Awards & Grants

Available to ALL members of NZNOCSTN.

Review full information on NZNOCSTN web site.

Bernadette Hart Award

Section members may make application annually for the Bernadette Hart Award. The award is for conference or course costs. See full history of award on NZNOCSTN web site.

Applications close on 30 November annually.

Policy for Bernadette Hart Award

PROCESS

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

CRITERIA

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

FEEDBACK

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

and/or

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

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30 NOVEMBER (ANNUALLY)

SEND APPLICATION TO:

Email: emma.ludlow@middlemore.co.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: ______________________________

Address: ______________________________

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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

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EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration)
$ ______________

Transport: $ ______________

Accommodation: $ ______________

Other: $ ______________

Funding granted/Sourced from other Organisations

Organisation:

______________ $ ______________

______________ $ ______________

______________ $ ______________

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

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Have you been a previous recipient of the Bernadette Hart award within the last 5 years? ○ No

○ Yes (date) ______________________________

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

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

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

Signed: ______________________________

Date: ______________

Te Whatu Ora Health New Zealand

STOMAL THERAPY SERVICES CONTACT DETAILS – FEB 2024

NOTE

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

Te Tai Tokerau – Northland

Referral Email	districtnursing.whangareireferrals@northlanddhb.org.nz
Generic Stoma Email	stomaltherapynurses@northlanddhb.org.nz
Rachel Pasley **Stomal Therapy Nurse** Whangarei Hospital	**Phone:** 09 430 4101 ext: 60960 **Cell:** 021 363 057 **Email:** rachel.pasley@northlanddhb.org.nz
Carla Butler **Ostomy Nurse** Whangarei Hospital	**Cell:** 021 876 914 **Email:** carla.butler@nothlanddhb.org.nz

Waitemata

Referral Email	OlderAdultsHomeHealth@Waitematadhb.govt.nz
Toko Kaneko **Ostomy Nurse** North Shore	**Phone:** 09 486 8945 ex: 47557 **Email:** satoko.kaneko@waitematadhb.govt.nz
Preeti Charan **Stomal Therapy Nurse** Waitakere	**Phone:** 09 837 8828 ex: 46342 **Email:** preeti.charan@waitematadhb.govt.nz
Marie Buchanan **Stomal Therapy Nurse** Whangaparoa/Rodney	**Phone:** 021 1945 875 **Email:** marie.buchanan@waitematadhb.govt.nz
Angela Makwana **Stoma Therapist Nurse** North Shore Hospital – inpatients only	**Phone:** 09 486 8920 ex: 44125 **Cell:** 021 533 685 **Email:** angela.makwana@waitematadhb.govt.nz

Te Kota Tumai – Auckland

Referral Email	communityservices@adhb.govt.nz
Generic Stoma Email	ostomyservices@adhb.govt.nz
Mary Vendetti **Stomal Therapy Nurse**	**Phone:** 0800 631 1234 **Email:** maryv@adhb.govt.nz
Lorraine Andrews **Stomal Therapy Nurse**	**Email:** lorrainean@adhb.govt.nz

Counties Manakau

Referral Email	community.central@middlemore.co.nz
Generic Stoma Email	communityostomycns@middlemore.co.nz
Erica Crosby **Stomal Therapy Nurse**	**Cell:** 021 2279 229 **Email:** crosbye@middlemore.co.nz
Teri Norton **Ostomy Nurse**	**Cell:** 021 516 903 **Email:** terri.norton@middlemore.co.nz
Anna McLean **Ostomy Nurse**	**Cell:** 021 316 570 **Email:** anna.crisp@middlemore.co.nz
Pravin Deo **Stomal Therapy Nurse** Middlemore Hospital inpatient only	**Cell:** 021 926 740 **Email:** pravin.deo@middlemore.co.nz

Waikato

Referral and Generic Stoma Email	Stomanurses@waikatodhb.health.nz
Carol Lee **Stomal Therapy Nurse** Waikato Hospital	**Cell:** 021 241 4360 **Email:** carol.lee@waikatodhb.health.nz
Nicole Prosser **Ostomy Nurse**	**Cell:** 027 223 0439 **Email:** nicole.prosser@waikatodhb.health.nz

Lakes

Referral Email	DNS.Rotorua@lakesdhb.govt.nz
Gillian Bedford **Stomal Therapist Nurse** Rotorua Hospital	**Phone:** 07 349 7955 ext: 8111 **Cell:** 027 605 6464 **Fax:** 07 349 7939 **Email:** gillian.bedford@lakesdhb.govt.nz

Hauora a Toi – Bay of Plenty

Referral Email	admin@bopccc.org.nz
Helen Collins **Clinical Nurse Specialist:** Bay of Plenty DHB	**Phone:** 07 579 8652 **Cell:** 027 7038 227 **Email:** helen.collins@bopdhb.govt.nz
Ashita Narayan **Clinical Nurse specialist colorectal** Bay of Plenty DHB	**Cell:** 027 263 0224 **Email:** ashita.narayan@bopdhb.govt.nz
Sandra Underwood, Allison Henderson, Jules Smith, Liz Thompson **Stoma Therapy Nurses**	**Phone:** 07 579 8757 **Fax:** 07 571 6046

Health NZ Tairawhiti

Referral and Generic Stoma Email	Ostomy.ContinenceTeam@tdh.org.nz
Anna Veitch **Ostomy Nurse**	**Phone:** 06 869 0500 ext: 8135 **Cell:** 027 226 3158 **Fax:** 06 869 0554 **Email:** Anna.Veitch@tdh.org.nz
Kate Petro **Ostomy Nurse**	**Cell:** 021 784 586 **Email:** Kate.Petro@tdh.org.nz
Hannah Serafini-lewin **RN Stomal Therapist**	**Email:** hannah.serafini.lewin@tdh.org.nz

Taranaki

Referral and Generic Stoma Email	stomaltherapists@tdhb.org.nz
Lily Murray **Stoma Therapy Nurse** New Plymouth Hospital	**Phone:** 06 753 7797 ext: 8793 **Cell:** 027 249 8716
Robyn Hardy **Stoma Therapy Nurse**	**Phone:** 06 753 7797 ext: 8564 **Cell:** 027 265 5092

Whanganui

Referral Email	nicky.bates@wdhb.org.nz referral.centre@wdhb.org.nz
Nicky Bates **Stomal Therapy Nurse** Wanganui Hospital	**Phone:** 06 348 1301 **Cell:** 027 3344 272 **Email:** nicky.bates@wdhb.org.nz

Mid Central District

Referral Email	districtnursingreferrals@midcentraldhb.govt.nz
Generic Stoma Email	CNS4CRC@midcentraldhb.govt.nz
Lawrence Mutale **Stomal Therapy Nurse** Palmerston North Hospital	**Phone:** 06 350 8073 **Cell:** 027 272 7592 **Email:** lawrence.mutale@midcentraldhb.govt.nz
Adrienne McGrail **Ostomy Nurse**	**Phone:** 06 350 8072 **Cell:** 027 272 7592 **Email:** adrienne.mcgrail@midcentraldhb.govt.nz

Te Mataua Maui – Hawkes Bay

Referral and Generic Stoma Email	ostomyservice@hbdhb.govt.nz
Maree Warne **Stomal Therapy Nurse** Hawkes Bay Fallen Soldiers' Memorial Hospital	**Phone:** 06 878 1635 **Cell:** 027 2406 092 **Email:** ostomyservice@hbdhb.govt.nz
Trish White **Ostomy Nurse**	**Phone:** 06 878 1635 **Cell:** 027 2406 092 **Email:** ostomyservice@hbdhb.govt.nz
Anja Read **Ostomy Nurse**	**Phone:** 06 878 1635 **Cell:** 027 2406 092 **Email:** ostomyservice@hbdhb.govt.nz

Wairarapa

Referral Email	Christina.Cameron@wairarapa.dhb.org.nz
Christina Cameron **Stomal Therapy Nurse** Wairarapa Hospital Masterton	**Phone:** 06 946 9800 ext 5701 **Cellphone:** 027 6875 235 **Email:** Christina.Cameron@wairarapa.dhb.org.nz

Hutt Valley

Referral Email	dnadmin@huttvalleydhb.govt.nz
Vicky Beban **Stomal Therapy Nurse** Hutt Hospital	**Phone:** 04 570 9148 **Cell:** 027 221 4247 **Fax:** 04 570 9210 **Email:** vicky.beban@huttvalleydhb.org.nz
Holly Kennedy **Stomal Therapy Nurse**	**Cell:** 027 405 7767 **Email:** holly.kennedy@huttvalleydhb.org.nz

Capital Coast

Referral Email	stomanurses@ccdhb.org.nz
Rochelle Pryce **Stomal Therapy Nurse**	**Cell:** 027 2263 259 **Email:** rochelle.pryce@ccdhb.org.nz
Stephanie Faulknor **Ostomy Nurse**	**Cell:** 027 2348 283 **Email:** stephanie.faulknor@ccdhb.org.nz
Hannah Knox **Ostomy Nurse**	**Cell:** 027 281 0942 **Email:** hannah.knox@ccdhb.org.nz

Nelson – Marlborough

Referral Email	DistrictNursesNelsonClinicalCoordinator@nmdhb.govt.nz
Nelson	
Cathy Enright **Ostomy Nurse**	**Cell:** 022 011 6323 **Email:** cathy.enright@nmdhb.govt.nz
Blenheim	
Sharryn Cook **Clinical Nurse Specialist Stomal Therapy**	**Cellphone:** 022 013 6582 **Email:** sharryn.cook@nmdhb.govt.nz

Te Taia Poutini – West Coast

Referral Email	greydn@wcdhb.health.nz

Greymouth

Kat Neiman **Stomal Therapy Nurse**	**Phone:** 03 769 7721 **Email:** Katrina.neiman@westcoastdhb.health.nz

Westport

Cody Frewin **Ostomy Nurse**	**Phone:** 03 789 7678 or 03 788 9030 Extn 8716 **Email:** bullerdn@westcoastdhb.health.nz

Reefton

Margaret Prince **Ostomy Nurse**	**Phone:** 03 769 7432 **Cellphone:** 027 244 8147 **Fax:** 03 732 8785 **Email:** reeftondn@westcoastdhb.health.nz

Hokitika

Annie Hughes **Ostomy Nurse**	**Phone:** 03 756 9906 **Fax:** 03 755 5058 **Email:** hokidn@westcoastdhb.health.nz

Waitaha – Canterbury

Referral and Generic Stoma Email	stomal@nursemaude.org.nz
Jenny Roberts **Stomal Therapy Nurse**	**Email:** jenny.roberts@nursemaude.org.nz
Fran Horan **Stomal Therapy Nurse**	**Email:** frances.horan@nursemaude.or.nz
Marian Lippiatt **Ostomy Nurse**	**Email:** Marian.lippiatt@nursemaude.org.nz
Rachel Bates **Ostomy Nurse**	**Email:** Rachel.Bates@nursemaude.org.nz
Jennifer Rowlands **Stomal Therapy Nurse**	**Email:** Jennifer.rowlands@nursemaude.org.nz
Jade Lippiatt **Ostomy Nurse**	**Email:** jade.lippiatt-abbot@nursemaude.org.nz

Ashburton

Referral Email	belinda.ohara2@cdhb.health.nz
Belinda O'hara **Ostomy Nurse**	**Phone:** 03 307 8465 ext: 28879 **Cell:** 027 531 8691 **Email:** belinda.ohara2@cdhb.health.nz

South Canterbury

Referral and Generic Stoma Email	dnstomal@scdhb.health.nz
Bronney Laurie **Stomal Therapy Nurse Community** Timaru Mon & Fri	**Phone:** 03 687 2310 **Cell:** 027 273 4809
Coralie Bellingham **Stoma Therapy Nurse Community** Timaru Wed & Thu	**Phone:** 03 687 2310 **Cell:** 027 273 4809

Dunedin/Otago District

Referral and Generic Stoma Email	stomal.therapyotago@southerndhb.govt.nz
Leeann Thom **Stomal Therapy Nurse** Dunedin	**Phone:** 03 476 9724 **Fax:** 03 476 9727
Jillian Woodall **Ostomy Nurse**	
Ruth Macindoe **Ostomy Nurse**	
Anna Wallace **Ostomy Nurse**	

Southland/Invercargil

Referral and Generic Stoma Email	StomaNursesInv@southerndhb.govt.nz
Nicola Braven **Stomal Therapy Nurse** Invercargill	**Phone:** 03 214 5783 **Cell:** 027 294 7531 **Email:** nicola.braven@southerndhb.govt.nz
Wendy McStay **Ostomy Nurse**	**Phone:** 03 214 5783 **Cell:** 027 294 7531 **Email:** wendy.mcstay@southerndhb.govt.nz

NZ NURSES ORGANISATION
COLLEGE OF STOMAL THERAPY NURSING

The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

NGĀ MIHI NUI