The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

- **Meet The Insides Company**
- **Low Anterior Resection Syndrome (LARS)**
- **Everything Comes Right In The End**

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The Outlet

New Zealand Stomal Therapy Nurses

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Chairperson's Report

LEEANN THOM

Welcome to the first edition of the Outlet for 2020. We are now well into the New Year. I hope you have all had the chance to unwind, relax and spend time with family and friends over the festive season.

2020 is going to be an exciting year for the College. The Tripartite meeting is now only eight months away and the tentative programme has been released. With the range of topics, local and international speakers, and an amazing venue, it is going to be an event not to be missed. Make sure you get your registrations in.

We are still looking for nurse presenters for the Tripartite conference. We would love to hear about any research nurses have been doing, case studies, or topics of interest. Abstracts need to be submitted by the end of March so you will need to act soon. Abstracts can be submitted on the Tripartite website. Just imagine how impressive having presented at an international conference will look on your CV.

The college will be holding its BGM at conference and will be looking for new members for the committee. It would be great to see some new faces on the committee, or equally nurses with previous committee experience. I would urge everyone to consider putting themselves forward for nomination at the next BGM. It is a unique opportunity to make a difference to the future of nursing. I personally have found being part of the committee extremely rewarding.

As part of the Tripartite conference the committee has arranged a Wednesday evening event to be held at the Bellini bar on the Princess wharf of Auckland Harbor. Themed a night of "Glitz and Glamour" it will be a chance to catch up, dress up, dance and generally just let your hair down. We know how nurses love to socialize and conference just would not be the same without an evening event. It is very reasonably priced for a great night out. We hope to see you all there.

For many years previous committees have been discussing the need to develop a knowledge and skills framework for stomaltherapy. It is a large undertaking for a small committee so the current committee made the decision to contract the job out. The document is now nearing completion and will be sent out to the membership in the near future for feedback We then hope to have the final draft ready for voting on at the BGM in November.

This year we have again been unable to award the Bernadette Hart award after receiving no applications. I would like to take this opportunity to remind you that the award is available to members with applications closing annually on the 30th of November. We hope this year to see lots of applications.

My warmest regards to you all, what you do makes such a positive difference to all the lives you touch.

Leeann Thom, Chairperson NZNOCSTN

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Editor's Report

ANGELA AND DAWN

Welcome to the first edition of 2020. We hope that all of you had a chance to have some time off over the last few months to recharge your batteries for another busy year ahead.

We know we have said it before but many of you have undertaken study and completed essays that can be submitted to "The Outlet" for publication. So please send us those essays. Without them there is no journal! There is a lot of great work being done out there. It is also about sharing our stories, our case studies. As nurses this is part of our professional responsibility to share our success and failures so we can all learn from each other.

Please also consider taking up the educational funds on offer. The companies provide these scholarships to assist us. Funding can be such a huge issue when trying to attend conferences. It seems like a lost opportunity that these scholarships are not utilised more. The Bernadette Hart Award (policy and application at the back of the journal) is another option.

November will soon be here before we know it. The Tripartite conference is coming together nicely. Abstracts are being called for, see bottom of this page. The "Glitz and Glamour" evening at the Hilton will be a great night out.

We hope you enjoy the journal.

Angela and Dawn

Want to be a nurse presenter at the Tripartite Colorectal Meeting 2020?

The committee of NZNO College of Stomal Therapy Nursing is pleased to open the call for abstracts for the 2020 Colorectal Meeting

Looking Forward, Looking After | Ma Muriki Mua

9-12 November, Aotea Centre, Auckland, New Zealand.

Presentations to be 20 minutes in length, this includes time for discussion. A great opportunity to share your knowledge and expertise.

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NZ NURSES ORGANISATION COLLEGE OF STOMAL THERAPY NURSING

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Profile Page - Sandy Izard

CLINICAL NURSE SPECIALIST, OSTOMY, WAITEMATA DISTRICT HEATH BOARD

I have worked as a D/N in West Auckland since 1979. In 1994 attended Waiariki Poly tech in Rotorua and qualified as a stomal therapist From 1995 I had a joint role as a District nurse /stomal therapist.

At this stage a colleague Pat Beckett worked in the same role and we split the geographical area in half. As the number of people with stomas increased this dual role became challenging. Finally in 2009 the money was found to make it a CNS role and this has been my job ever since. I was able to drop the D/n work and concentrate on the stoma work alone.

In 1999 Lesley Horsburgh from Christchurch and I went to Nepal to follow up on a programme to train nurses in Stomal therapy initiated by Robert Paton in 1996 We were there for about 2 weeks and it was certainly a good chance to value what is available here and to admire how staff and people cope with limited resources . It was also great to see they had managed to have 2 nurses qualified as Stomal Therapists.

In 2004 I was part of the committee that put on the Australasian Conference in Rotorua which resulted in a great conference. I have enjoyed the challenges this role has provided and have valued the unjudgmental support of the other stomal therapists. They are a great and very special group of nurses

As you are aware there are new developments in stoma appliances all the time and it is amazing to reflect back on the products I started with such as convex inserts prior to convex appliances .The development of different barriers and arrival of soft cx pouches All these have helped greatly to give our patients a hopefully secure journey with their stoma It is a role which does provide some humour and also times when you are at your wit's end trying to stop a pouch from leaking and restoring confidence to the patients We have all being there I will miss the interesting times my working life has provided and the friendship and support of my colleagues but I am looking forward to a new chapter in my life.

Quality Of Life Case Study

Jackie Hutchings, Stomal Therapy Nurse, Christchurch, New Zealand

Dansac Education

This case study represents my experience in using Dansac NovaLife TRE soft convex barrier with this specific patient and may not necessarily be replicated.

Patient Overview

The patient is a 75 year female who lives on her own. She presented with complications to her colostomy following an abdominoperineal resection of her rectum.

Patient History

The patient was diagnosed with cervical cancer and underwent a hysterectomy in her late thirties. Some years later she developed non-Hodgkin's lymphoma (NHL) and was treated with various cycles of chemotherapy and immuno-modulator therapies. This NHL occurrence was attributed to her previous radiation treatments.

Since then, the patient has had a history of bowel obstruction due to radiation strictures. She suffered repeatedly with abdominal pain and vomiting and was frequently admitted to hospital. Earlier this year, she was scheduled for a Hartmann's procedure. However, before this procedure took place, she was diagnosed with an invasive adenocarcinoma of her rectum and had an abdominoperineal resection of her rectum.

Intervention

When the patient was referred to me post-surgery, her colostomy was pink and healthy and had slightly retracted. It measured approximately 50mm wide by 35mm height. The patient had accepted her stoma as she had time to prepare and she had a positive outlook on life. Different brands of bags were being evaluated and she was coping well with bag changes.

At the next review, one week later, I noticed that the patient's stoma was sloughy at the upper edge with a slight dehiscence at 3 and 9 o'clock at the mucocutaneous junction. She was also treated for oral and peristomal candida.

Over the following month the patient's stoma decreased in size to measure approximately 35mm wide and 30mm height and the dehisced areas granulated in (photo 1).

Photo 1: Prior to trialing Dansac NovaLife TRE soft convex pouch and TRE seal.

Photo 2: Post discharge from hospital showing marked improvement after 3 days.

However, during this time, the patient's perineal wound broke down and she was admitted to hospital for 7 days for treatment. Negative pressure wound therapy was applied and subsequently managed by the district nurses. The patient was anxious about being back in hospital and worried about who would care for her dog.

I noticed that small granulomas were forming at the stoma edge causing her pain and distress. She had a watery output and her mood was low. As a result, I decided to trial the TRE seal (072-48) with the Dansac NovaLife TRE soft convex pouch (3081-44) to see if this would help improve her skin health as part of an overall care plan. When she initially started using TRE seal she complained of pain around her stoma but this soon settled and a week later her peristomal skin showed significant improvement.

The patient, however, had difficulty remembering the poor condition of her peristomal skin when first admitted, and was feeling low and despondent. By showing her photographic evidence of her stoma, I was able to visually demonstrate the skin's improvement and her mood rapidly improved.

Conclusion

The patient continues to use the Dansac NovaLife TRE soft convex pouch and TRE seal (photo 2). Currently, she only needs to change the bags every 2 days and feels very confident with the drainable bag which is what she wanted to use. She is able to maintain an active lifestyle and has a positive outlook.

Key Learnings

- Be aware of the patient's quality of life and how this can be improved
- Taking photos (with the patient's permission) can be helpful to demonstrate clinical improvement to the patient and maintain a positive focus and treatment compliance

> **"The patient is able to maintain an active lifestyle and has a positive outlook."**

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Ostomy Care

Healthy skin. Positive outcomes.

A clinical pathway to address a health challenge: Low anterior resection syndrome (LARS)

RACHEL MOUSLEY, COLORECTAL CLINICAL NURSE SPECIALIST, WAITEMATA DISTRICT HEALTH BOARD

ABSTRACT

The purpose of this report is to demonstrate the recommendations to providing a multi-step approach for people having a closure of an ileostomy following rectal surgery for cancer in response to low anterior resection syndrome (LARS) as a health challenge.

In order to effectively address these recommendations, the colorectal service at Waitemata District Health Board (WDHB) is establishing a standardised clinical pathway to provide a supportive peri operative journey. In conjunction with this, clinical documentation to enhance pre-operative information provision, consistent comprehensive bowel function assessment and management strategy tools are being developed.

The report will provide an overview of the quality improvement project led by one of the colorectal clinical nurse specialists to address the complex needs of this group of patients. The project was completed as work towards a Master of Nursing programme at Massey University. The project aimed to identify the holistic needs for this group of patients, identify any gaps in supportive care and to identify opportunities for quality improvement applying evidence-based practice.

INTRODUCTION

The emphasis in cancer patient pathways is to detect and cure the cancer as early as possible where able. Although preserving normal bodily function is a goal in treatment, bodily function may be compromised to achieve the best cancer free result. Technological advances and knowledge have helped increase the survival rates of colorectal cancer patients following treatment (1). Sphincter preserving treatment with low and ultra-low anterior resection with low anastomoses often defunctioned with a loop ileostomy, are allowing patients to avoid life with a permanent colostomy after rectal cancer surgery (2). A diverting ileostomy is used to reduce complications from an anastomotic leak (3). The estimated stoma rate for people having rectal surgery in New Zealand (NZ) between 2013-2016 was 88 percent with 54 percent receiving preoperative radiotherapy treatment (4).

Reversing the ostomy once the patient has recovered from rectal cancer treatment is thought to improve patient's quality of life, but this is yet to be proven (5). The functional outcomes of surgery can be poor for many of these patients and is recognised as under-reported (6). Bowel function following the reversal of the stoma can be unpredictable causing lack of control in people's lives; creating debilitating social limitations and impacting quality of life (7). It is not fully understood (8) but bowel function is thought to be altered for 60 to 90% of these patients (7; 9; 10). The severity and duration vary (1) with 25% having ongoing symptoms for more than 12 months (11).

LOW ANTERIOR RESECTION SYNDROME (LARS)

The reversal of the ileostomy is often regarded as the completion of rectal cancer treatment (12), but the reality is that there can be significant changes to bowel function. Long term studies have observed symptoms persisting over ten years post-operatively (13 & 7). The symptoms associated with these bowel function changes are known as low anterior resection syndrome (LARS). LARS is gaining increasing acknowledgment for creating functional, psychological and social problems that require focused assessment and management post reversal of stoma (12). Quality of life has also become an increasingly important outcome requiring specific assessment and evaluation (14).

The aetiology and risk factors of LARS is thought to be multifactorial with worse outcome associated to low tumours (due to the potential of sphincter injury during the construction of the anastomosis), alterations in anorectal physiology, pelvic sepsis following anastomotic leak and those patients undergoing neoadjuvant and adjuvant radiotherapy and chemotherapy (11). There are a variety of symptoms used in the literature to describe and define LARS. These symptoms include sense of urgency, incontinence for liquid stool and frequency of bowel movements, faecal and gas incontinence, clustering of stools, constipation and difficulty emptying.

LARS can impact sexuality, confidence and ability to participate in day to day activities including returning to work; which can contribute to economic wellbeing and ultimately quality of life (15). LARS has the potential to create isolation, stigmatisation, shame and embarrassment (16). Nurses must advocate for the specific needs of patients by directing health policy and service design decision-making.

Internationally there is a lack in conservative, well-studied interventions for LARS symptom management posing a challenge to health professionals. The number of patients in NZ that are affected by LARS has not yet been studied. Data sources accessed and available on LARS are limited to a broad perspective of health and disease and do not focus on outlooks that are important to NZ which is significant to our Māori and migrant population. This is limited in attempting to address Māori and other specific cultural health needs rather than simply doing so in the context of the overall population.

DATA COLLECTION

Clinical practice for LARS patients varies with a wide-ranging approach to management due to lack of formal process, assessment or management strategy tools. Differences in knowledge, experience, preference and habits create further variance. Literature also tells us there is a considerable lag between research and implementation. To examine and capture clinical practice within WDHB (as a baseline measurement to enable future measurement of changes to practice) an online survey was designed to ask the colorectal surgical team several questions regarding clinical practice for management of LARS.

The survey identified that 50% of the team reviewed patients with severe LARS symptoms in clinic on a twelve-monthly basis, compared to 37.5% reviewing patients six monthly and 12.5% six-weekly. This provided baseline data to direct opportunities for quality improvement to establish the standardisation of practice as it demonstrated inconsistencies in clinical practices and inequality for patients. One focus of the project is addressing these inconsistencies in accessing supportive care; whilst also standardising management strategies dependent on patients' symptoms.

An online survey was also sent to patients asking about the information provision they had received during their peri operative journey and whether this was useful. It asked them how useful the information was that they received before their operation, on discharge from hospital and in the surgical follow up clinic. It was important to ask the patients about their experience to identify from their perspective if information they received was useful. What further information they would have liked to know and if there were any suggestions on how the service could be improved.

The survey used both open and closed questions. People shared experiences of feeling isolated, unable to return to work for fear of running to the toilet constantly and not wishing to attend social events due to their embarrassing symptoms. The survey identified that 40% of patients felt that the information they received in the follow up clinic was inadequate regarding bowel function issues. This demonstrates opportunity for quality improvement in information provision which can contribute to decision making, ability to cope, improves communication and reduces anxieties and mood disturbances.

The colorectal team and patient surveys were used to check consistencies in clinical practice and gain perspective from patients into the needs of the group. The metrics to define the success of this quality improvement consist of auditing at regular periods of time to capture clinical practice after changes are implemented and reviewing the patient's perception of the adequacy in their information provision. Use of well-designed context based online surveys can create desirable data collection within limitations of time and cost and within any other restrictions. A well-designed survey requires a known and controlled degree of reliability and should provide information that will be useful and utilised (17). The use of surveys will evolve as the project develops to reflect the information that is being sought.

LITERATURE REVIEW

To explore the gold standards of LARS management a literature review was completed to synthesise the research available and identify applicable recommendations to clinical practice based on evidence. The recommendations for clinical practice from the literature review were complex and significant. Unfortunately, there is a lack of evidence-based management of LARS and more randomized controlled trials are needed (18). However, the literature recognised that a multi-step peri operative journey is required for this group of patients.

Van der Heijden et al. (2018) and Dulskas et al. (2018) recommend pre-operative education to raise awareness of the normal post-operative outcomes such as LARS, identifying strategies to optimise social support, and providing information on management options. Screening for symptoms of LARS post operatively has been suggested by Thomas et al. (2019) as a tool to evaluate presence and impact of symptoms. Bazzell et al. (2016) recognised patients would like more education at time of discharge. Most notably throughout the literature was a key theme; improving patient focused follow up, for symptom management which correlated well to survey feedback received from patients.

COLORECTAL CLINICAL NURSE SPECIALIST LED CLINICS

The New Zealand Nursing Organisation (NZNO) 2020 and beyond, vision for nursing, identifies nurse-led clinics and collaborative, interdisciplinary approaches to health care for meeting future population health needs (21). Providing adequate follow up that meets the holistic complex physical and emotional needs of patients, whilst ensuring optimum cancer surveillance requires specific attention and action. Clinical pathways are a good way to improve patient experience by providing an instrument to coordinate care from the multidisciplinary team, reduce variation in clinical practice, and ultimately improve patient outcomes.

Cancer is a key area of focus by the Government (22). NZ has a faster cancer treatment (FCT) programme as part of the NZ national cancer pathway with targeted reduction in waiting times for appointments, tests and treatment and standardised care pathways for all patients across the country. The NZ National Colorectal Cancer Guidelines mandate cancer surveillance clinic follow-up at six months, 12 months and then yearly until five years post-operatively (23). To support this group of patient's individuals may require more frequent follow up dependent on severity of symptoms.

Colorectal clinical nurse specialist led clinics are cost effective, beneficial to patient outcome and help reduce the pressure of the consultant-led colorectal outpatient clinics. LARS management requires a comprehensive multi step support process for patients including optimal pre-operative preparation, to foster realistic

expectations and promote adaptation to bowel function changes. Supportive holistic follow up care following stoma reversal for bowel function management. Providing regular access to advice from a health professional creates the opportunity to capture range in health literacy and reduce assumptions in patient self-management capabilities. It also demonstrates understanding, empathy and patient value towards the impact of bowel function issues as an ongoing health challenge for some people.

Cancer care can create competing work priorities for health care teams. The reality of developing processes and documentation for a large organisation with economic restrictions mean that the speed at which things happen may be slow paced. Despite the financial constraint and escalating demand for healthcare part of the NZ cancer care framework focuses on improving timely physical, psychological and social support follow up care. Recommending access to easily understood and nationally consistent information resources (22).

Optimising health outcomes is an obligation of a speciality service to ensure the rights of consumers are met (24). Changes to practice are often dynamic and complex, across hierarchy systems, processes and teams. Leading change requires understanding of diffusion and innovation through social systems (25). The Plan Do Study Act (PDSA) cycle is a systematic integrated quality improvement implementation model that has been utilised throughout the clinical project to provide structure and testing to improve changes in systems, policies and processes (26). Capturing clinical practice through auditing after changes are implemented will identify if changes are improving patient outcomes and meeting the objectives of the project.

As part of the quality improvement, a simple to follow algorithm flow chart that provides a systematic, structured clinical pathway for the peri operative journey has been created. This demonstrates the proposed peri operative journey following the key recommendations from the literature. It is important to remember that changes to practice need to be attainable, sustainable and gain the support and buy in from colleagues and the wider organisation. Gaining support for the quality improvement was important for sustainability of the project, to divert resources including time and money towards the initiation and implementation of the change process. It was also important in establishing key members of the team to help drive the adaptions of clinical practice.

Documentation for a nurse led clinic requires focused bowel function assessment. The tools that will be utilised include a bowel function diary, a food diary and use of a Bristol Stool Chart. The LARS score assessment tool will be used in conjunction with these (see appendix 1). It is a five item, self-administered questionnaire and measures the five most important symptoms identified by patients. It was validated internationally by Juul et al. (2014). The symptoms are assigned a score from zero to 42 based on the association with their impact on quality of life. The tool groups patients' symptoms into three categories; no LARS, mild LARS or major LARS.

The assessment scores will help categorise patients and guide frequency of follow up and direct the use of an evidenced based management tool. An important piece of data collection moving forward for the team will be identifying how many patients are affected by LARS within the WDHB. The LARS score tool will be used to collect this data at selected set time frames utilising the three categories. The development of a management algorithm for bowel function symptoms is also required to promote consistency in clinical practices by the colorectal team using the LARS score to distinguish the severity of symptoms.

Waitemata has a large migrant population with over a third (37%) of residents born overseas (compared to 25% nationally) (27). It is important to address barriers to accessing mainstream healthcare such as geographical, financial or cultural restrictions and inequalities. Currently interpreters are used to translate information between patient, family, care givers and staff. As WDHB has a diverse population developing resources and tools in commonly used languages in the Waitemata community will be a desirable goal for this project in the future.

CONCLUSION

This report demonstrates the quality improvement initiative commenced to address the health challenges of LARS patients within WDHB. The recommendations identify the role of a multi-step approach for patients having a stoma reversal following rectal cancer surgery. Clinical pathways are a good way to improve patient experience by providing an instrument to coordinate care from the MDT, reduce variation in clinical practice, and ultimately improve patient outcomes. Firstly, the aim is to optimise pre-operative preparation with information provision, promote realistic expectations and understanding of why bowel function changes. Secondly, to provide adequate follow up that meets the holistic complex physical and emotional needs of patients whilst ensuring optimum cancer surveillance.

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Appendix1: LARS Score Questionnaire

The aim of this questionnaire is to assess your bowel function. Please tick only one box for each question. It may be difficult to select only one answer, as we know that for some patients symptoms vary from day to day. We would kindly ask you to choose one answer which best describes your daily life. If you have recently had an infection affecting your bowel function, please do not take this into account and focus on answering questions to reflect your usual daily bowel function.

Q.1 : Do you ever have occasions when you cannot control your flatus (wind)?

□	No, never	0
□	Yes, less than once per week	4
□	Yes, at least once per week	7

Q.2 : Do you ever have any accidental leakage of liquid stool?

□	No, never	0
□	Yes, less than once per week	3
□	Yes, at least once per week	3

Q.3 : How often do you open your bowels?

□	More than 7 times per day (24 hours)	4
□	4-7 times per day (24 hours)	2
□	1-3 times per day (24 hours)	0
□	Less than once per day (24 hours)	5

Q.4 : Do you ever have to open your bowels again within one hour of the last bowel opening?

□	No, never	0
□	Yes, less than once per week	9
□	Yes, at least once per week	11

Q.5 : Do you ever have such a strong urge to open your bowels that you have to rush to the toilet?

□	No, never	0
□	Yes, less than once per week	11
□	Yes, at least once per week	16

The allocated points per question are indicated in the right hand column, the score from each of the five answers is added together to give a final score between 0-42.

Interpretation: 0-20 = No LARS 21-29 = Minor LARS 30-42 = Major LARS

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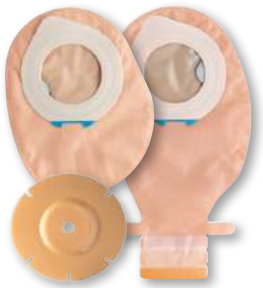

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Everything Comes Right in the End

BRONNEY LAURIE, STOMAL THERAPIST, SOUTH CANTERBURY DISTRICT HEALTH BOARD

The following is a case study of a 52 year old gentleman and his journey whilst under my service.

Craig has congenital rubella syndrome, he is deaf and mute. He has a visual impairment, an intellectual impairment and autism. He lived on a farm based facility that he loved, he helped out around the lifestyle block, had friends and carers that knew him well - it was his home.

Craig has a past history of multiple admissions for conservative management of small bowel obstructions due to foreign body ingestion. He presented once again with vomiting and abdominal distension and was admitted for conservative management. Serial X-rays over 5 days showed the foreign bodies were not progressing and Craig was taken to theatre for a laparotomy and enterotomy of the small bowel; four flat river stones were removed. He was discharged home a few days later.

Unfortunately three weeks later he was once again admitted with vomiting and abdominal distension. An abdominal X-ray revealed five river stones within the bowel with small bowel distension. He was taken to theatre for a laparotomy. Due to multiple previous laparotomies the bowel was found to be frozen with multiple adhesions and surgery was difficult. Two further rivers stones were removed and a jejunostomy was sited with the hope that the remaining river stones present further up would come through the stoma. He was commenced on TPN and kept NBM.

The remaining three stones, sited in the right lower quadrant were monitored with serial abdominal X-rays. However this showed very marginal movement and consequently Craig was taken back to theatre for a colonoscopy via the stoma and two stones were removed. Five days later he had another colonoscopy to remove the remaining stone. Incidentally it was also discovered at that time that Craig had eaten the green tops of the mouth sponges used in the ward.

I met Craig once he had been discharged from hospital, because he had to be closely monitored in regard to the fact that he would eat anything Craig had been moved from his home on the farm to a secure home in town. This in its self was a major transition; he had freedom on the farm and a routine that was familiar to him. Now he was with new staff and residents that he had never met before and it was difficult to know if he understood why this was happening. Craig knew some sign language and he had a book with the signs that he knew to help with communication. He also had his regular carer from the farm calling in to assist when necessary as they had a strong bond and understanding of one another.

The carers had never seen a stoma and had no education in regard to its management. Craig could not change the pouch; he did empty it and was very aware and particular about doing this. The carers were very apprehensive in regard to changing the pouch or touching the stoma. I visited knowing that it would take time and patience to engage them as necessary and have a plan put in place that all were happy with.

On arrival to the home there was a great deal of stress as Craig's pouches were regularly leaking and causing issues with everyone concerned. The carers thought this was the 'norm' and thought they would never manage. For Craig this meant that he was constantly messing his clothing and bedding through no fault of his own. The peristomal skin was so raw and excoriated that it was bleeding, the excoriation was the size of the flange and on the skin outside the pouch as well. The stoma was flush with the abdomen, when Craig moved and sat up or bent over the stoma was sitting a crease at 3'o'clock and 9'o'clock. The shallow convexity pouch being used was popping off and not adhering due to the condition of the peristomal skin, the bowel motion was also very loose. Lopermide was being administered, we increased this slightly and it was titrated as necessary.

Our first meeting was extremely challenging, any stoma cares for Craig were very painful. He had actually been discharged home on pain relief due to pain from the stoma, I knew if we could prevent leakage and excoriation this would quickly resolve. Due to the pain he was very reluctant to let me remove the pouch or perform any cares. His carer was present and she thankfully was able to settle him enough so that I could look and see what was going.

Trust was so important as I needed to ensure that Craig and I developed a relationship so that I could ensure that stoma cares became a part of his normal everyday life and would cause no undue stress. Eye contact was important and I spoke to him although he couldn't hear me, I took my time and showed him what I was doing. He did make some loud noises that I interpreted were due to the pain. The usual skin cares were performed and I used paste in the two creases.

I decided to trial the Salts Soft Convexity drainable pouch XND1352 with the large flange; I hoped that this would adhere well into the creases and move with his body so it would not

Everything Comes Right in the End

BRONNEY LAURIE, STOMAL THERAPIST, SOUTH CANTERBURY DISTRICT HEALTH BOARD

'pop' off. Craig picked up very quickly how to use the drainable end with no problems, this was important as he was taking ownership of the stoma as much as was possible for him at that time. I needed to introduce a pouch that was going to last more than a few hours, if we made at least 24 hours I would have been happy.

Ideally the pouch would say in place for a few days at a time and be changed in a regular routine as routine was very important to Craig. I noted on my visits that Craig was very particular, his room was tidy, everything was in its place, he had a drawer for his stoma products and they were perfectly set out and he was very quick to put something back into its right place if I got it wrong.

Over the next few days I visited daily and was so pleased that we were having success with the pouch remaining in place. . The picture included with this case study was actually taken whilst Craig was lying down and a number of days after my first assessment when it had begun to improve. The Salts XND1352 was the perfect choice for Craig; the soft convexity and larger base plate provided the tack and adhesion that extended the wear time to two days. Reducing the amount of pouch changes and the aloe extracts in the Salts hydrocolloid directly impacted on Craig's peristomal skin and the healing process. Craig always expected pain when the pouch was removed so even though the peristomal skin continued to heal, removing the pouch remained slightly challenging. I arrived at the same time each day and Craig would see me and go straight to his room where everything was laid out ready by Craig himself.

The pouches were staying in place for 48 hours until physically removed, this was life changing for Craig. Before hand any contact with the stoma had caused pain and stress. Now the pain was non- existent as the peristomal skin was much improved and healed. The carers were now able to manage pouch changes with confidence and they continued with the routine we had put into place. The pouch remaining adhered meant that Craig could now go out with other residents and enjoy activities that he had been missing out for fear the pouch would 'explode'.

I personally could not imagine what it is like to live in Craig's world and what his view of it must be. It was a privilege to be involved in his care and being able to provide a service that contributed to improving a situation that had been causing a great deal of stress. I often reflect on my patients, their families and carers and their journey. The vulnerability of the patients that I have worked with and their willingness to open up and share their lives with me has been paramount to my improving my practice. These patients come to us depending on our professionalism and should not have to accept anything less. How they manage every day is often astonishing.

The words of John Lennon often come to mind;

Everything comes right in the end…so if its not right…
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Meet the Insides Company:

A NEW ZEALAND MEDICAL TECHNOLOGY INNOVATOR FOCUSSED ON INTESTINAL DISEASE

If you're at the forefront of caring for patients with gastrointestinal diseases, you will know how fraught it can be. Yet no matter how much technology and surgical techniques advance, if there are no resources, there are no resources!

This is the foundation principle that lead to **The Insides Company** (formerly called Surgical Design Studio). The Insides Company was spun out of The University of Auckland and The MedTech Core thanks to Professor Ian Bissett, Associate Professor Greg O'Grady, Associate Professor Andrew Stevenson, Dr. John Davidson, and Rob Davidson.

It all began in 1987 when Professor Bissett completed his surgical training and travelled with his wife and two young children for what turned out to be an 11-year term in Nepal. "It was a very rewarding yet draining experience of solution based, out of the box thinking and 'alternative' resources to help people with many dire gastrointestinal conditions."

While in Nepal, many of Professor Bissett's patient's complications arose due to a lack of resources to combat sepsis, malnutrition, and fluid and electrolyte imbalances that resulted in kidney and or liver damage. Total Parenteral Nutrition (TPN) was not an option due to cost, so Professor Bissett had to turn to the only viable and well researched option that was available to him – reinfusion of a patient's own chyme. This is a labour-intensive task involving sieving chyme through a muslin cloth and syringing the fluid down the distal limb of a patient's gastrointestinal tract. Chyme Reinfusion is not a new procedure however is not the most pleasant activity when performed manually and has therefore not drawn a large crowd of followers. Nonetheless, this was how Professor Bissett saved many lives throughout his time in Nepal.

Upon returning to New Zealand, Professor Bissett further advanced his surgical training and became Professor of Surgery at The University of Auckland in 2002. He continued to incorporate chyme refeeding into his patients care wherever appropriate, however he needed a system to perform the procedure in an acceptable way.

In 2017, Professor Bissett approached colorectal surgeon, and biomedical engineering PhD Associate Professor Greg O'Grady to find a solution. Greg collaborated with biomedical engineer Dr John Davidson and later, senior mechanical engineer Rob Davidson, to design a prototype reinfusion system for chyme.

A proof of concept system was developed utilizing Rob Davidson's specialist expertise in impeller fluid mechanical engineering. A prototype was developed and gained New Zealand Health and Disability Ethics Committee approval to start first human trials. A feasibility study was conducted at Auckland City Hospital with 10 patients in 2018. These patients either had high-output entero-atmospheric fistula or high-output ileostomies requiring TPN or frequent fluid resuscitation. The results of the feasibility study were outstanding: positive weight gain; hydration and nutritional status were restored; and patients gradually weaned off TPN as they transitioned back on to an oral diet. The chyme reinfusion system went through 10 development iterations over the course of the feasibility study, leading to what is commercially available today. The usability of the system coupled with the fact the patient could perform the infusion themselves continue to drive product acceptance and results. The results of the feasibility study have recently been accepted for publication by a leading peer-reviewed journal.

In 2017 the University of Auckland transferred all assets into a limited liability company, now called The Insides Company. The brand reflects the company's mission: to build revolutionary abdominal technology that empowers patients to take control of their condition. The company has continued to grow and in 2019 it products were granted Breakthrough Designation by the US Food and Drug Association. The company then raised $4M with the help of UniServices, Icehouse Ventures, K1W1, and the New Zealand Venture Investment Fund. With this funding the company has been able to recruit a complete operating team and gain the product regulatory approvals for New Zealand, Europe, and the UK.

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Policy for Bernadette Hart Award

Process

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

Criteria

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

Feedback

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

and/or

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

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

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

BERNADETTE HART AWARD APPLICATION FORM

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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: $ _____

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Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

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

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

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

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

Signed: _____ Date: _____

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Writing in The Outlet

PURPOSE

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

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

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

GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

Literature Review
If publishing a research paper.

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

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

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

NB: Written in conjunction with NZNO Kai Tiaki Publishing Guidelines

The Outlet

New Zealand Stomal Therapy Nurses