Is clinical leadership important to advanced stomal therapy nursing practice?

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• The stomal therapy nurse must at all times maintain the highest standards of nursing care and professional conduct.

• The stomal therapy nurse will provide needed services to persons irrespective of their race, colour, creed, sex, sexual preference, age and political or social status.

• The stomal therapy nurse must respect the beliefs, values and customs of the individual and maintain his/her right to privacy by maintaining confidentiality, sharing with others only information relevant to that person’s care.

• The stomal therapy nurse will not participate in unethical practice.

• The stomal therapy nurse must maintain competency by keeping abreast of new developments in the theory and practice of stoma care and related fields.

• The stomal therapy nurse will participate actively in professional, inter-professional and community endeavours in order to meet the highest professional standards.

• No full member shall be in the employment of a company or self-employed in the manufacture or sale of products, prostheses or pharmaceuticals where it could be perceived that the use or selling of products prostheses or pharmaceuticals could disadvantage or contradict the personal preference of clients or be construed to result in unethical conflict of interest.

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A new year has begun and, for some, not as happy or safe as others. Our thoughts and good wishes are extended to all those affected by the floods in all states, but particularly to people in Queensland.

At the end of November 2010, I received a letter from the Government Department of Health and Ageing. It informed me of the dissolution of the current Stoma Products Appliance Panel. The restructuring of the panel will include two stomal therapy nurses – previously there were three.

Carmen Smith and Diana Hayes (current members) will remain as representatives of the panel until the National Executive is able to provide two new nominees. Hopefully by the time this edition of the journal is printed, the decision will be made.

Congratulations to all stomal therapy nurses who have completed their recredentialling, credentialling and continuing professional development portfolio.

Many of our colleagues are involved in activities that deserve to be recognised. Margaret Fraser, the National Executive Secretary, is one of these people. Margaret has been involved with the Coburg Rotary Club for 10 years and was presented with the Paul Harris Fellow award. This is a special tribute to a person whose life demonstrates a shared purpose with the objectives of the Rotary Foundation. Previously, her father, Warwick Fraser, was the first – with his friend Ivan – to receive the same award from the Kerang Rotary Club.

The Paul Harris Fellow is given in appreciation of tangible and significant assistance given for the furtherance of better understanding and friendly relations among peoples of the world. It is named after the founder of Rotary, Paul Harris, a Chicago lawyer who started Rotary International with three business associates in 1905.

Congratulations Margaret.
Well, what an end to 2010 and a start to 2011, particularly to some areas of Queensland and Victoria. My heart goes out to all those who have been affected in any way by the floods and cyclones. Fortunately, the only problem we had in Hervey Bay was an emptying of the shelves in the supermarkets. In the first instance this was caused by ‘panic buying’. I had patients coming in to my clinic all morning on the first day telling me about the queues in the supermarket and petrol stations. It seems the first items to completely go from the shelves were milk, bread and toilet rolls!

What struck a lot of people was the way everyone banded together to help the flood victims and we saw headlines such as:

More than 12,000 rubber-gloved volunteers hauled sodden debris from soaked homes, shovelled muck and swept and mopped muddy floors in some of the 30,000 homes and businesses that were flooded in Brisbane.

More than 22,000 registered volunteers in Brisbane lent a hand, mopping up mud and clearing ruined furniture from flooded homes.

In the health service we talk about multidisciplinary teamwork; wasn’t this a good example? There were politicians working alongside students, housewives, doctors, plumbers and others... everyone had a common goal and people brought their own unique skills and equipment to achieve what seemed like an impossible task.

So what is the definition of teamwork?

Teamwork is the actions of individuals, brought together for a common purpose or goal, which subordinate the needs of the individual to the needs of the group. In essence, each person on the team puts aside his or her individual needs to work towards the larger group objective. The interactions among the members and the work they complete is called teamwork.

Parker suggests that:

... an effective team also creates an enjoyable experience for its members, who look forward to team meetings and feel a real sense of progress and accomplishment.

Hopefully the volunteers who were such an important part of the team in Brisbane felt a sense of accomplishment, but I am sure a lot more team meetings will be held to look beyond the initial mess to far more complex issues of not only having to structurally rebuild roads, houses and so on, but also at the health issues of those people who have lost material possessions, those that have lost family/friends and the effect some of the scenes have had on the rescuers.

This experience has made me think more about how within the health service we talk about the multidisciplinary team as those members usually directly involved with patient health care, such as the patients, doctors, nurses and allied health staff. But how would our organisation function without our relationships with other teams including the operational services, staff who are forever having to empty waste bins, which are always full after my busy clinic, administrative staff who try to keep me on track, not to book my clinics over 200%. Colonna states that, “no man is an island and neither is the successful team”.

Gettin’ good players is easy. Gettin’ ’em to play together is the hard part (Casey Stengel).

REFERENCES

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Australia: 1800 006 609
Is clinical leadership important to advanced stomal therapy nursing practice?

Sally Langford-Edmonds

The advanced stomal therapy nurse specialist provides clinical leadership that facilitates the ongoing development and evaluation of clinical practice within the organisation.

This statement, found in a recent job advertisement as part of the position summary for an advanced stomal therapy nurse specialist, indicates that clinical leadership is a very relevant professional issue for stomal therapy nurses. So what is clinical leadership, why do we need it, how do we achieve it and where does it direct stomal therapy nursing?

Any person who gives the impression of being an authority and is accountable for providing care to others could be considered a leader. Leadership skills are required by all nurses from the novice establishing their career to the expert in top management positions. A clinical leader is a person who is involved in direct patient care and who influences, guides direction, opinion and course of action, therefore increasing efficiency. Leadership is not necessarily reliant on skill and responsibilities but is more about the attitude that enlightens performance. A good leader will consistently present advanced practice that will impact on others, with enduring benefits to all those involved by inspiring others to plan, lead, control and organise their actions.

From the literature reviewed there has been much discussion about leadership theory that describes leadership styles, the effect of the situation they may find themselves in, and how they apply themselves to the role. A person’s leadership style will be greatly influenced by the environment and effect of the work group they are involved in. Leadership involves the process of persuading and influencing others to achieve a goal using a broad range of skills. It is the ability of the leader to integrate these skills that will assist them to become an effective leader. The three primary leadership styles that have been identified through literature review are:

- **Authoritarian**: where the leader sets the goal, not allowing others to participate in the decision-making, with adherence to rules, regulation and policies.

- **Democratic**: allows others to participate in the decision-making and actively encourages participation so that all parties involved feel committed to the goal.

- **Laissez-faire**: where members are left to devise their own process in achieving goals, which can be risky.

The uses of these styles are not necessarily static and are most successful when utilised according to the situation and task at hand. How a leader interacts will also be influential in the relationship and outcomes. These interactions have been defined as transactional and transformational leadership skills. Transactional leadership involves skills required in the effective day-to-day running of a team where team members’ rewards are exchanged for accomplishing tasks and good worker relations. Transformational leadership involves skills that integrate how a team works together and the innovation of their approach to the work. It is more focused on the processes that motivate team members to perform to their full potential by influencing change and providing a sense of direction. Leaders should remain part of the team, sharing the work, exploring obstacles, identifying inconsistencies as they occur, while maintaining a collaborative approach to resolve them. This will enable leaders to remain close to the business at hand, while being able to understand the members’ perspective.

The need for successful leadership is well documented and it has been said that more problems are caused by inadequate leadership than any other single factor, yet without a skilled leader, effective teamwork and progress cannot be achieved. Mackey made a humorous though pertinent point when discussing this, referring to Jim Collins’ analogy of a Level 5 leader:

... is able to get the right people on the bus, the wrong people off the bus, and the right people in the right seats – and then figure out where to drive it ... It’s been my experience as both a WOCN leader and in my clinical practice that teams/committees get off track because the wrong people are sitting in the wrong seats or the right people are sitting on the wrong seats. Much time is wasted as the teams/committees try to drive the bus before they figure out who is the driver and where they are going. Anyone can steer the bus, but it takes a leader to map out the trip and identify the detours, road blocks, and even the speed bumps to reach their destination safely and in the time allotted.

So, when answering why we need clinical leadership, it is important to note that as leaders it is our responsibility to influence the advancement of nursing, and provide support...
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and leadership to nurses (especially stomal therapy nurses) to deliver quality nursing practice, therefore influencing the future of our tri-speciality. When deciphering the literature in how are we going to achieve clinical leadership in relation to advanced stomal therapy nursing practice we can firstly refer back to the Australian Association of Stomal Therapy Nurses Inc. (AASN) four value statements. These value statements provide significant guidelines for stomal therapy nursing practice and hence where our practitioners need to lead as well as be led.

Quality: One of the core values of our Association means that we believe in high standards and making the most of our abilities. It encompasses all activities, including clinical research, management, education and administrative duties. We strive for excellence in everything we do and, in so doing, promote our profession.

Respect: Reflects our deep consideration for our patients, colleagues and all with whom we as stomal therapy nurses, come in contact.

Commitment: Is not just about our relationships with our patients and colleagues; it is about our relationship with our Association. Stomal therapy nurses believe in the importance of support, encouragement and mentorship, in addition to sharing knowledge and experience. Commitment also entails being dedicated and loyal and demonstrating allegiance to our professional body.

Innovation: We recognise the importance of new and fresh ideas and support all our members in their pursuit of innovation and professional excellence.

Clinical leadership and leadership preparedness will vary with every individual and will depend on multiple of factors such as individual leadership style, internal environment, external environment, experience and understanding. The main focus really depends on their motivation to lead, which I believe comes from within. If the desire is there, the skills can be taught, but not all leaders are naturals. So how do nurses gain the level of skill to become a clinical leader? We all start from the beginning, but that starting point will vary among all of us. Our journeys as nurses are all different. We bring into the profession a variety of backgrounds and experiences. Our nursing education will vary with our separate entry and exit points. The variety is really endless, but through these many stages we will progress from novice to expert and these progressions will alter and be repeated as our experiences and career proceed.

There is a wealth of untapped knowledge that is embedded in clinical practice and the ‘know-how’ of the expert nurse. This is especially true for the advanced stomal therapy nurse specialist whose special knowledge and skills need to be shared. The distribution of this knowledge will depend on the learning process. How the learning is approached will depend on the learner and teacher. Andragogy, the art and science of helping adults learn, which is what Knowles’ andragogical model was constructed around, provides some very sound assumptions.

1. The need to know. Adults need to know why they need to learn something before undertaking to learn it.

2. The learner’s self-concept. Adults have a self-concept of being responsible for their own decisions, for their own lives.

3. The role of the learners’ experience. Adults come into an educational activity with both a greater volume and a different quality of experience from youths.

4. Readiness to learn. Adults become ready to learn those things they need to know and be able to do in order to cope effectively with their real life situations.

5. Orientation to learn. Adults are life-centred in their orientation to learn.

6. Motivation. While adults are responsive to some external motivators, the most potent motivators are internal pressures.

The main opportunities the advanced stomal therapy nurse gets to pass on or advance their ‘know-how’ and specialist embedded clinical knowledge is through the learning process. Busen and Engebretson make the statement that many:

... advanced practice nurses (APNs) are matched with clinicians, researchers, and/or educators who model expertise in a given specialty area. Because of the clinical nature of the APN, nurses frequently supervise novice practitioners or, conversely, are seeking experts to provide guidance through mentoring.

This role of supervision, which we commonly see in nursing clinical practice, is referred to often as precepting. This term describes the learning relationship between a student clinician and the more skilled clinician, whose responsibility it is to supervise and appraise the student’s clinical practice. Ideally the preceptor will direct the students’ clinical experience by facilitating exhibiting characteristics and providing opportunities that will lead to clinical competency. These characteristics could be role modelling, promoting role socialisation, encouraging independence and encouraging self-confidence. Mentoring is another term used to describe the relationship in professional development, where an experienced individual takes an active role to nurture on a one-to-one, personal basis, a junior person or protégé. An individual may have more than one mentor. The AASTN value statements clearly exhibit the worth of precepting and mentorship role for the advanced stomal therapy nurse.

Clinical leadership is achieved through more than practical experience alone; there is also the theoretical component and this will need to be learnt in a more formalised form of education. This formalised education can be achieved in many ways through in-service, conferences, research, general reading and as a component of formalised coursework or specifically.
designed study. One such specifically designed course probably directed at higher level leadership is the Australian Clinical Leadership course. The overview for this course describes it as a:

... two-tiered professional development programme for health care professionals... focuses on the development of professionals functioning at both the operational aspects of health care and the implementation and delivery aspect of health care... The Clinical Leadership Programme provides credible, well-researched and evaluated vehicle to assist participants develop leadership qualities which translate into safe quality health care practice.

The varied health environments in which we find ourselves as stomal therapy nurses are constantly changing and present fresh challenges that a clinical leader must work in. Leadership allows others to achieve vast results when faced with constant change and challenges. These skills are most important for nurses who lead care so that they are able to move between leading and alternately following as experiences present themselves. The competency standards for the Stomal Therapy Nurse Professional Role and Development Standard and Education and Health Promotion Standard reflect the importance of clinical leadership in advanced stomal therapy nursing practice. These standards illustrate that clinical leadership is critical to enable stomal therapy nurses to provide a high level of nursing practice that assists individuals, significant others, communities and colleagues to achieve optimal levels of wellness and professional growth, through health education and promotion, evaluation, reflection, continuing education, professional development and research.

REFERENCES
The history of stomas

Henk Van Rooyen • FRCS

This is the first of a series of articles which will look at the history of stomas from ancient times, the different types of stomas, reasons for formation and management of complications that can occur.

“YOU WILL NEED A STOMA”

He was the guard at the ship entrance in the harbour. On his way to work he used to buy the first of three different editions of newspaper. During the day a soaked one would regularly be replaced with a fresh edition. He had a stoma and the paper constituted his “stoma bag”.

She called it George “…Like all the men in my life, it only gives me trouble”, she said with a twinkle in the eye, referring to her stoma, the result of diverticulitis. She wanted it closed but, while interfering with her life, it has never caused her any real distress.

Stomas come from ancient times and will still be with us for years to come.

“Stoma” originates from Greek, meaning mouth or opening. One of the earliest descriptions of intestinal involvement is found in the Biblical context of Judges 3:21–23 where Ehud attacks Eglon, king of Moab:

Then Ehud reached with his left hand, took the dagger from his right thigh, and thrust it into his belly. Even the hilt when in after the blade, and the fat closed over the blade, for he did not draw the dagger out of his belly; and his entrails came out.

In ancient times, stoma formation has been associated with trauma rather than medical emergencies and more closely related to the historic Greek battlefields. Descriptions can be found in many published articles and textbooks and on the modern internet.

Praxagoras, from the island of Kos, is known for the theory of the “four humors controlling life” (blood, phlegm, yellow bile and black bile) and the earliest description of the vascular circulation. Although much of his writings were collected at Alexandria’s university library and subsequently destroyed by barbarian conquerors, the literature has it that in 350 BC he created a stoma for intestinal injuries.

The famous Hippocrates and later also Celsus theorised about the observed fatality of intestinal injuries but had no solution come forth. A later physician, Galen, was surgeon to Emperor Aurelius and overseer for a school of gladiators. His experience with stab wounds to the torso and abdomen led to his belief that little could be done for small bowel perforations and that injury to the colon was the preferred one.

The concept of stoma formation was hampered by the lack of understanding of the significance of intestinal spilling, the value of a stomal outlet, ignorance about the technique and the fear of sepsis associated with intestinal injury. Much of these fears would still be in place at the start of World War I – military surgeons in any case regarded major surgery near the Front as not practical. The history of medical emergencies was slightly different.

Up to the 17th century injuries to the intestine were usually treated with suturing of the abdominal wound alone. This naturally resulted in a very high mortality; the ones surviving were those who would develop a spontaneous fistula through the wound. This observation ultimately kindled the understanding that a created fistula or stoma could provide an outlet and answer. Military surgeons faced more challenges when artillery arrived for the first time at the battlefields during the 14th century. Although the concept of stoma gradually moved forward, still at the time of WWI it would be reserved for the more serious and extensive intestinal injuries.

Medical abdominal emergencies moved forward more rapidly. This evolved mainly around obstructions and gangrenous, inflammatory conditions. Some dubious solutions for obstruction were practised, such as riding on horseback or the swallowing of a heavy metal like mercury to relieve blockage by its sheer weight. Although some patients would succumb to mercury poisoning, a particular one eventually developed a successful stoma, only to demise with a gangrenous intestinal perforation caused by the weight of the metal compound.

At the time understanding obstruction was also difficult. King Stephen of England demised in 1154 from a disease named “iliac passion”, a disorder in which “a desire cometh upon a sick man for discharging his bowels, and he is not able to do so when he is out in the outhouse”. Queen Caroline, the wife of King George II, developed a strangulated umbilical hernia in 1736. After seven days, the gangrenous gut ruptured with spontaneous discharge; however, too late to prevent her death three days later. Margaret White, patient of the British surgeon William Cheselden (1688–1752), was more fortunate. Following an episode of severe vomiting she ruptured her abdominal wall, causing incarceration of the gut. Cheselden removed a gangrenous portion, leaving a healthy length protruding from the umbilicus. This matured and she survived for several years.

Several unprecedented attempts towards a stoma followed, but one of the classical descriptions is of an infant born with anal atresia, given an inguinal colostomy by the French surgeon, Duret, in 1793. The patient lived with this ostomy for the next 45 years. Now the place of a stoma was slowly being realised, but
progress was still hampered by the lack of anaesthesia and the high incidence of sepsis. In view of the latter, a lumbar stoma was created to avoid entering the peritoneal cavity altogether, as well as placement of inguinal stomas as closest proximity to the affected gut. The Danish surgeon, Hendrik Callisen (1740–1824) was a great proponent of the former and dedicated a section to this in his surgical handbook. The French surgeon, Amussat, created the first lumbar colostomy in 1839. Both types were difficult to manage and did not contribute to the popularity of the procedure. It needed WWI to refine the technique and define the place.

Future discussions will look more closely at the different types of stomas, mainly colostomy, ileostomy and urostomy. Also we will consider some of the diseases associated with ostomies and how to create and manage the difficult ones.

Until next time.

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**Australian Association of Stomal Therapy Nurses Inc.**

**Education and Professional Development Subcommittee**

**POSITION STATEMENT**

Scope of nursing practice for stomal therapy nurses

It is recognised that stomal therapy nurses practise in a variety of settings and must operate in accordance with their scope of practice as determined by their relevant state registering body.

**Stoma Appliance Scheme: updated schedules**

Available from the Department of Health website


If the page does not show immediately, use the [www.health.gov.au search system](http://www.health.gov.au) and you will find it by typing in **stoma appliance scheme**
Journey to the G spot

Prophylactic gastrostomy insertion for oropharyngeal cancer

Margot Hickman RN, STN, CNC • Gastrostomy Care, Royal Hobart Hospital, Hobart, TAS

ABSTRACT

Many patients undergoing treatment for oropharyngeal cancers require a percutaneous endoscopic gastrostomy (PEG) prior to radiation therapy. This case study follows the journey of a 46-year-old man diagnosed with squamous cell carcinoma at the base of his tongue, including initial consultation with discussions on benefits of a PEG tube, the procedure for insertion, postoperative PEG care and complications which may occur including hypergranulation. Dental care is important in patients with oropharyngeal cancers and especially when having radiation therapy. Mucositis was another complication that occurred during treatment and the management of this is discussed together with recommendations for oral hygiene.

INTRODUCTION

Peter* is a 46-year-old man diagnosed with squamous cell carcinoma (SCC) at the base of his tongue. The first indication was a lump on the right side of his neck, present for three years before he sought consultation with his general practitioner (GP). During this three-year period, he suffered from three separate dental abscesses and presumed that the lump, which fluctuated in size, was connected with his dental infections.

In September/October 2008 he had a bad attack of influenza and following this the lump did not “go back down”. Still thinking it was a gland affected by his flu symptoms, it was another four months before he sought a consultation with his GP.

In March, at the ENT clinic, flexible fibroscopy showed an asymmetry of the hypertrophic tissue at the base of tongue.

12 February 2009: GP requested a fine needle aspiration under X-ray control. Ultrasound of the neck showed the lymph node to be intensely vascular and suggestive of some necrosis within the node.

19 February 2009: Fine needle aspiration revealed signs of malignancy and excision of the node was recommended.

26 February 2009: X-ray computed tomography (CT) of the brain and neck was requested by the oncology/head and neck team.

27 February 2009: CT completed and report noted that:

*The brain appears normal.*

There is a lesion in the inferior maxillary sinus bilaterally, which may reflect mucous retention with the possibility of a cyst/polyp. There is a large abnormal lymph node on the right side of the neck, with smaller nodes on the left and in the right posterior triangle. There is an abnormal appearance to the base of the tongue suspicious of primary tongue base carcinoma. Direct visualisation and biopsy is recommended.

In March, at the ENT clinic, flexible fibroscopy showed an asymmetry of the hypertrophic tissue at the base of tongue.

SCHOOL ISSUES

Peter has smoked 60 cigarettes a day for a number of years, indeed his first waking thought and action is to reach for and light a cigarette, then after a first of many daily coffees another cigarette. He runs his own successful car mechanic business and to maintain his 192 cm, 120 kg frame he consumes “take away” food between coffees and cigarettes. He is in a long-term de-facto relationship and has three children. His partner, who is very supportive, runs a family owned take away food business.

THE JOURNEY BEGINS

Investigations

Peter consulted his GP in the first week of February 2009 regarding the lump in his neck.

12 February 2009: GP requested a fine needle aspiration under X-ray control. Ultrasound of the neck showed the lymph node...
They said it couldn’t be done.
So we did it.

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the teeth on the medial and distal 4/4s and distal 4/5. The remainder of teeth showed no evidence of cavities.

April 2009: Two teeth were removed under general anaesthetic.

**DENTAL CARE**

Dental care is important in people with this diagnosis. Any tooth caries increase the risk of infection from mucositis, which is inevitable whilst undergoing radiation treatment. In some cases this can cause treatment to be ceased leading to a negative outcome for the patient. Post-treatment extractions are avoided due to the risk of radiation necrosis. Poor vascularity of the mandible compromises healing after radiation therapy. Therefore, any tooth which promises to be a potential threat in the future is removed before treatment commences.

15 April 2009: At a planning appointment a simulated CT scan was done to locate the tumour. Tattoo marking was done and a face mask was made. This aims to protect all areas of the head and neck not marked from radiation rays.

**FIRST MEETING**

A 30–40 minute meeting was arranged to follow a planning consultation so as to avoid an extra hospital appointment. Apart from making personal contact, during this meeting, the PEG feeding tube was explained and shown to Peter and his partner. A simple explanation was given, which included the need for the PEG tube, the insertion method and what to expect after the initial insertion. Feeding methods were mentioned, as was hygiene, but not too much detail was given at this point since a ‘hands-on’ demonstration after PEG tube insertion has proven to be more beneficial. Too much information at this initial meeting can be counterproductive. A booklet in ‘people’ speak (developed by the author) was also provided, since not all relevant information is retained at the first meeting. Questions that Peter and his partner thought of were answered and a phone contact number provided for any further questions they may think of after their first meeting. These meetings can be very emotional and the availability of the clinic support network cannot be stressed too strongly. The decision to have PEG tube placement has to be made by the patient and family based on the following advantages it will bring during and immediately after treatment.

**ADVANTAGES OF A PEG TUBE**

- It will aid in maintaining adequate nutrition and hydration.
- It will alleviate the concern that may be caused by not being able to swallow.
- Medication can be administered via the tube.
- It will negate the need for hospital admissions for nutritional problems.
- It will help maintain body strength and wellbeing whilst undergoing treatment.
- It will aid in the protection of other vital body functions whilst under extreme stress.

Discussion of these positives was included in this very important first education session, along with the assurance that this is a means of supplementing oral intake. Some oral intake is strongly encouraged throughout the treatment, even in the most difficult of circumstances, as it helps maintain some oropharyngeal motility which, in turn, will see an early return to a normal swallowing reflex after treatment.

Much emphasis is placed on the fact that insertion of the PEG tube is only another way of eating for as long as it is needed and that when the patient is ready, tube removal is done within a few days if medical conditions allow.

**NUTRITION AND HYDRATION**

Most people take adequate nutrition and hydration for granted and do not usually give much thought to the normal and mostly pleasurable act of eating. In Peter’s case, and indeed all cases of head/neck cancer undergoing treatment, this normal occurrence becomes compromised within two to three weeks.

An alternative to doing daily battle with total oral intake is the insertion of a percutaneous endoscopic gastrostomy (PEG) tube. A PEG referral form was designed by the author a few years ago for ease of collating and evaluating necessary information. On receipt of this request, a meeting is arranged with the patient and family or carer; in this case it was with Peter and his partner.

**Figure 1. Mask in preparation for radiotherapy.**
This is a lot of information for any person to consider. Patients are told that a decision about whether to proceed with a PEG tube insertion need not be made immediately; indeed, discussion within the family is encouraged before a decision is reached. However, most people will decide (usually in the affirmative) at this meeting. A date is then booked in the endoscopy department for insertion of a gastrostomy feeding tube.

If, as was the case with Peter and most other head and neck cancer patients, some preceding investigations had been undertaken (such as direct laryngoscopy and biopsy) these will negate the necessity for a repeat anaesthetic pre-assessment. Any patient who has not undergone any procedure under anaesthetic during the preceding six months will require anaesthetic pre-assessment, since maintaining an adequate airway due to tumour invasion may be a problem and any other comorbidity needs to be known before any such procedure takes place.

**PEG TUBE INSERTION**

PEG tube insertion is ideally performed seven to 10 days before commencing treatment. This allows the gastrostomy stoma adequate healing time before treatment commences. The first six days of treatment is a combination of chemotherapy and daily radiotherapy. The chemotherapy is called sensitising chemotherapy, which enables the effect of the radiation on the body to be at its optimal level at the designated area.

20 April 2010: Peter was admitted to the day surgery unit endoscopy department, having fasted from 12mn. Cephazolin 1Gm was administered intravenously (IV) 30 minutes before the procedure commenced as a prophylaxis to prevent infection. One litre of Hartman’s solution was administered intravenously and Peter was sedated.

**PROCEDURE**

The procedure is generally carried out by two operators. A gastroscope is inserted into the mouth and gently manoeuvred down the oesophagus into the stomach. This is observed on a video monitor (as is the rest of the procedure). The stomach is inflated with air, which pushes its walls up against the abdominal wall. A diagnostic examination of the oesophagus, stomach and duodenum is done to exclude any outlet obstruction or stomach disease, which could contraindicate PEG tube insertion. The light at the tip of the gastroscope is seen shining through the abdominal wall; this is called transillumination and at this juncture the site most suitable for each individual case is selected by finger indentation on the stomach wall by the abdominal operator directly over the light as viewed through the endoscope (on the video screen).

Local anaesthetic is introduced approximately 1 cm along this pathway, Lignocaine 2% with Adrenaline 5 ml mixed with Marcain 0.5% with Adrenaline since the addition of Marcain extends the analgesic effect. A wide bore needle with an outer plastic sheath is plunged directly into the stomach. A snare, which is introduced down a channel in the gastroscope, is opened over the needle and sheath and gently closed to fit snugly around them. The needle is then withdrawn, leaving the sheath in situ and a plastic guide wire loop is threaded through the sheath by the abdominal operator. The snare is eased along to grasp the guide wire loop and all is withdrawn from the patient’s mouth including the gastroscope. The guide wire loop now extends from the mouth, down the oesophagus into the stomach and out of the abdominal wall through the plastic sheath where it was originally introduced.

The gastrostomy tube has a solid pointed end with a wire loop attached. This is joined through the guide wire loop and
pulled firmly and smoothly by the abdominal operator whilst supporting the abdominal wall with the other hand. Thus the gastrostomy feeding tube is drawn down into the mouth and through the abdominal wall. An external bolster is placed over the external part of the tube, the tube is cut (approximately 25 cm length) and a feeding adaptor is fitted.

It is recommended that correct internal placement be confirmed by reintroducing the gastroscope and at this hospital a photograph is taken and filed in the patient’s notes.

A low-adherent, highly absorbent dressing is applied around the PEG site and changed daily. The stoma may be left dressing free after four to five days.

POSTOPERATIVE CARE

IV fluids are administered and ordered for 12 hours. The feeding tube may be used, if needed, four hours after insertion.

Postoperative analgesia and anti-etic are also prescribed as the area can prove to be painful for 24–48 hours.

A PEG tube instruction sheet below (developed by the author) is sent back to the ward with each patient, with the patient’s sticker attached and the number at the bolster level is documented.

Peter was admitted overnight (as is the norm for all PEG tube insertion patients) to monitor and control any pain, discomfort or bleeding issues.

21 April 2010: A postoperative visit found Peter eager to go home. His discomfort had been well controlled after an initial dose of IV Panadol 1 Gm administered in the recovery ward and a dose of subcutaneous Morphine overnight. Peter’s dressing was changed; the stoma was cleaned with sterile water and monitored for skin redness and excessive ooze. The tube was then rotated 360 degrees and Peter was informed to do this on a daily basis: This rotation causes no pain, and is easy to do in the shower.

Tube rotation promotes granulation of the tract, helps keep the tract free from debris and helps prevent stricture formation. Daily rotation is done for the life of the tube and any replacement that may follow.

Peter and his partner were educated about venting, flushing and feeding and both participated in a trial run of these and passed with flying colours. A dietician was involved from this point. The nurse and dietician work together as a team to promote as healthy a passage through the impending treatment as possible.

Peter is discharged, to be followed up by phone the next morning and afterwards at the commencement of his treatment in six days time. On departure, Peter very proudly announced that he had given up smoking and did not intend starting again.

SIX DAYS LATER

We met again in the oncology outpatients clinic where Peter’s one week in-patient stay began. He had a day in the outpatients department before being admitted to the oncology ward as an in-patient for the next six days. During this time Peter had chemotherapy treatment and daily radiation therapy, the chemotherapy being what is known as sensitising chemotherapy, to maximise the uptake of the radiation to the appropriate area. His PEG site was red and sore, a swab of the stoma was taken (swabbing down the stoma not around it) and his tongue checked! He had a white tongue and an itchy PEG site. Because thrush is a systemic affliction, if it is on the tongue it is also found around the PEG site. Mycostatin drops and ointment for topical application were suggested and written up. The swab grew *Staphylococcus aureus*, but antibiotic therapy was not deemed necessary.
Discretion is vital for people living with a stoma

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The next day a visit to Peter on the ward found his stoma site much improved and the itch had gone. He had also started on nicotine patches and was more relaxed and coping well. His six-day stay in hospital was uneventful and he managed his confinement well.

A week later at his daily attendance for radiation treatment his stoma continued to mature slowly and some serous exudate was noted. Because dressings should be avoided if at all possible, Stomahesive powder was applied and supplied to Peter to use daily. This worked its “magic” and a beautiful dry clean stoma was achieved in a few days.

For the next six weeks the norm for all patients are daily or weekly visits from the PEG nurse and the dietician to monitor and hopefully prevent too much weight loss. This not only keeps them out of hospital but ensures maximum wellbeing during a very horrible treatment.

SIX WEEKS AFTER PEG TUBE INSERTION

During a routine clinic visit six weeks after PEG tube insertion, granulation tissue, albeit a minimal amount, was noted at the stoma. If left untreated, granulation tissue can continue to grow causing discomfort, bleeding and possible infection (an increased risk due to the treatment involved). Silver nitrate was applied to cauterise the area, making sure that the base of the granulation is treated as well as the top. The area was sprayed with local anaesthetic as this assists in patient comfort.

During the course of this very demanding treatment, mouthwashes, gargles, lozenges and gel can all be tried and will work to some degree for all cases but these aids are just palliative and will not affect a cure of the condition. Mouth hygiene is now of extreme importance, not only to minimise the discomfort but also to prevent systemic spread of the potential deadly flora harboured by the oral cavity, especially on a much weakened body defence.

Peter had great difficulty sleeping. He could not lie down because of his inability to swallow a much thickened volume of saliva due to his gross mucositis. Prescribed antibiotics were not as effective as one might hope and although sleeping tablets helped life was tough!! Reassurance was given that there really is an end to this, and indeed when seen in the PEG clinic one month later, although Peter’s tongue still felt and looked very thick and ulcerated, there was a huge improvement in his gums and oral mucosa. His oral intake was very slowly improving and his PEG tube remained his main method of sustenance. Minimal granulation tissue was seen and again was treated with silver nitrate sticks.

A dietician was also present in the PEG clinic and Peter’s weight was monitored and more suggestions for oral intake were made. A further PEG clinic appointment was made for two months’ time.

TWO MONTHS LATER – TUBE REMOVAL

Two months later, a smiling happy Peter presented for his PEG clinic appointment. Although his mouth was still uncomfortable, it was so much better and he was regaining his taste and eating well. He now felt ready to have his “extra mouth” removed.

Local anaesthetic gel was applied and worked down the tract with the tube. A firm pull with one hand, with firm abdominal counter pressure applied with the other hand, and out comes the tube. Yes, this is uncomfortable but keep the patient talking and by the time “Ouch” is exclaimed it is all over. A dry dressing comprising five gauze swabs and three or four pieces of combine was fixed firmly over the stoma and remained in situ for 24 hours before removing. A waterproof dressing was applied.
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Please tell your patients to always read the label and use only as directed. If their symptoms persist, tell them to see their doctor or health professional.
before showering and this should be done before each shower for approximately two weeks. Daily dressings of a non-adherent but absorbent dressing is adequate after day two.

After two weeks a phone consultation was made regarding healing of the stoma site. In Peter’s case no problems had occurred and the stoma had healed well. Appointments were made at the oncology head and neck clinic for one month, two months and then three months to monitor progress. Unfortunately, in some cases these visits are needed to monitor reoccurrence of the tumour.

SIX MONTHS LATER

At the head and neck clinic Peter continued to progress, although his mouth and tongue still bothered him at times. His tongue felt thick and gum infections were common. He was eating well, eating normal food and back at work full-time. In fact, life was very nearly just as it had been before and … yes, Peter is smoking again!

* Name changed to protect the patient’s identity.

REFERENCES:

Visit the AASTN website
www.stomaltherapy.com
Specialist nurses in the spotlight: A case study about credentialling

Ms Lorraine Gray MSc, BA (Soc Sc), STN (ret) • Western Australian Member, Education and Professional Development Subcommittee Australian Association of Stomal Therapy Nurses Inc.

Following the Specialist Cancer Nurses Scoping Project¹, undertaken by Professor Shaw and his associates from the University of Sydney and submitted to the Cancer Nurses Society of Australia in April 2009, and the Fellowship article by Sandy Middleton and her associates², published in the Collegian in December 2009, it is time to offer a further perspective within the Australian nursing environment. This article outlines the credentialling model developed and implemented in 2000 by the Australian Association of Stomal Therapy Nurses Inc. (AASTN) for recognition of its specialist nurses, and follows the format used by Shaw³.

BACKGROUND

In 1998, the Education Subcommittee of the AASTN undertook to develop a credentialling process to enable recognition of advanced practice nurses in this speciality area. At this time, discussions were being held at peak nursing body meetings and various conferences and there was some progress towards the development of guidelines within the (then) national nurses organisations, of which the AASTN was a member. These preliminary documents provided an initial framework. However, information was also sourced from Australia, New Zealand, America and Britain. After much debate, the AASTN decided to develop its own peer-review-based process suitable for the number of its members (approximately 340 in 2000), the vast majority of whom work as sole practitioners within a multidisciplinary team with limited or no opportunity for direct peer review.

The AASTN envisaged the process as an opportunity to promote safe, quality care and outcomes for consumers, which were provided by appropriately qualified and professionally supported nurses.

CRITERIA FOR CREDENTIALLING

To be eligible to undertake the process, a stomal therapy nurse (STN) must:

- Be a qualified STN, having undertaken a Stomal Therapy Nursing Education Programme (STNEP), which has met national guidelines and was thus recognised by the AASTN.
- Be a full financial member of the AASTN.
- Have two years’ recent practice experience in stomal therapy nursing to demonstrate and maintain clinical competence. This was not necessarily in a dedicated or designated stomal therapy nursing role, provided the appropriate clinical competencies could be met.
- Complete at least one year of continuing professional development (CPD) demonstrating 100 points of CPD each year. A point allocation proforma was developed within a portfolio of a wide range of appropriate activities, including professional leadership and involvement, education and innovation, accountability, preceptoring, mentoring and research (Figure 1).

CREDENTIALLING PROCESS REQUIREMENTS

- Annual submission of a CPD record (as above) to the Credentialling Officer, with supporting documentation if indicated.
- Undertaking a written examination consisting of multiple-choice and short-answer questions, plus a case study covering stoma management (35%), wound management (35%), continence management (15%) and professional issues (15%), with an 80% mastery for successful completion.
- Verbal and written feedback to the applicant after marking of the examination paper.
- Ongoing CPD with demonstration of 100 points annually to support lifelong learning.

The new process was ready for implementation in 2000. A number of experienced STNs were invited to participate in the examination and CPD for that year. Eight STNs were credentialled by the end of 2000. Three further STNs applied for CPD recognition as a stand-alone process. Subsequently, between three and eight credential applications have been received annually.

A reference list and suggested articles are offered as preparatory guidance to applicants, and the exam has an open-book format. The whole process is free to members and is entirely voluntary, in line with the philosophy of credentialling. A certificate of achievement is awarded to successful participants.

Duration and renewal of credential

The duration of the credential was initially three years. After evaluation and feedback from participants, and in line with other organisations, the duration was extended to five years in 2008. In the year the credential expires, the STN is invited to renew their credential by submission of a reflective journal.

RE-CREDENTIALLING PROCESS

Each STN must submit a written reflective journal identifying the demonstration of their competence in all aspects of the Standards...
The national AASTN Executive Committee underwrites the financial requirements of the subcommittee (annual travel and accommodation in October, stationery and postage). State branches have underwritten a significant portion of the financial requirements of their subcommittee representatives when they attend the other biannual meeting in March, often in conjunction with the AASTN’s conference.

UPTAKE

There have been 50 STNs credentialed over the 10 years of operation. Eighteen of these have been recredentialled once, and 15 have undertaken the recredentialling process for a second time. Currently, only 39 STNs remain credentialed from an entire membership of 403 eligible members (9.6%), because 11 have retired since being credentialed, reflecting the level of senior leaders who were committed to demonstrating support for the process.

Five newly credentialled members are included in this number for 2010.

The CPD numbers increased from the initial 11 in 2000 to 113 in 2009. This was equivalent to 28% of the membership participating in the AASTN process, whilst other STNs are recording their activities to meet their registration requirements only. Numbers for 2010 are a rather disappointing 94.

Between 16 and 21 new CPD applications have been received each year for this single component.

LINKS TO PRACTICE/RENUMERATION

Despite various attempts in different Australian states to obtain recognition of the additional professional commitment required to become credentialled, there is currently no link between the credential and remuneration. In an effort to lift the awareness and profile of credentialling within the nursing hierarchy, employers are sent a letter of congratulations for employing an STN who has shown professional commitment in meeting the criteria to become credentialled. Employers include citation of this credential as part of their agency’s accreditation.

REVIEW

The commitment of the subcommittee members to develop a unique process of professional recognition for the AASTN has required time and confidence that they knew the needs and circumstances of AASTN members better than an ‘outsider’ could; hence the determination to carry out the work involved themselves. This continues to be the case.

The process now requires dedicated time from the Credentialing Officer for administration of the credentialling process and CPD requirements intermittently through the year. High activity periods occur around the time of the examination (set for September) and at the end of the year when CPD portfolios arrive. Education and professional development meeting time is allocated to developing, reviewing or revising examination questions and working documents and to examination marking.

Members of the subcommittee are requested to submit questions for the examination bank annually. Time is also dedicated by
the Examination Officer for compilation of the examination and marking key, and question bank review.

FUTURE

By credentialling one’s own members a profession demonstrates a very high level of self-regulation and self-promotion in comparison with those that do or cannot.2

Members of the AASTN certainly consider they have shown a high level of commitment to their professional development and promotion. The AASTN Executive is committed to maintaining the process as it has evolved, and is making headway in having a greater proportion of members participate. State branches also need to encourage their experienced STNs to lead the way, and all members can participate in CPD.

The Coalition of National Nursing Organisations, as one peak professional body, is still working towards a national approach on credentialling for other groups of specialist nurses. The process allows members and consumers to identify leaders within the speciality. Research is required to evaluate the difference this process makes to care outcomes and to the STNs involved. This may be the next project for the subcommittee as they consolidate and expand the credentialling process for appropriately qualified and professionally supported nurses.

ACKNOWLEDGEMENTS

Additional text contributions were received from:

Cynthia Smyth – Past Chairperson of the AASTN Education Subcommittee who was instrumental in initiating the credentialling discussion within the AASTN in 1998 and who guided the subsequent development and implementation of our model until her retirement in 2009.

Fiona Bolton – Current Chairperson of the (now) AASTN Education and Professional Development Subcommittee fionabolton65@optusnet.com.au

Sue Delanty – AASTN Credentialling Officer sue.delanty@dhhs.tas.gov.au

Merle Boereê – Recredentialled STN Merle.Boeree@health.sa.gov.au

REFERENCES


Continuing professional development (CPD)

A new portfolio is here

Congratulations to all those who have achieved their 100 points for 2010. Your certificate will be with you shortly, if it has not already arrived.

For 2011, the Education and Professional Development Subcommittee (E&PDS) has significantly updated the AASTN CPD portfolio (available on the website) with the National Registration Board’s (NRB) CPD requirements in mind. When you have a look at it, you will find that you will be able to use the AASTN portfolio for either body’s audit, as there is guidance about what is needed and space for the conversion of points into hours. Hopefully, this will streamline the evidence required for the NRB’s mandatory process, although there is need for verifying signatures on a hard copy. We welcome your feedback on how useful and easy (or otherwise) you find this new portfolio.

Please encourage your colleagues to participate in CPD, even if they prefer to use their own portfolio system. We hope to see nearly 100% of members participating – we have a little way to go yet, with roughly 28% involved at the end of 2010.

For those of you who think you will have some difficulty making 100 points because of the following:

- You are not full-time in stoma management – remember the STN role encompasses wound and continence management, so if you predominantly work in these areas, that’s just as valid. So is research and nurse education.
- You don’t do any committee work – 100 points may be easier to achieve if you are on a committee, but there are lots of other ways to show you are still contributing to your own development: that’s what lifelong learning is all about.
- Your role does not entail giving talks or precepting nursing students – an offer to be involved or doing something extra for work is always appreciated – you never know, you might even get to like public speaking!
- Any other reason (even if it not having enough time or know-how to do it all) – speak to your E&PDS member for support.

DON’T JUST IGNORE CPD – IT WON’T GO AWAY!

The following ideas may help, and the time is NOW. In addition to the data on the CPD portfolio, have you considered any of the following:

- Print off the CPD record (the AASTN one or another of your own devising) for display on your office noticeboard where it is readily visible and easily accessible. You will need various signatures confirming your recordings, so keep it readily available.
- Place a loose-leaf folder at the front of the top drawer of your filing cabinet for hard copies of evidence (committee membership, invitations to present an in-service/tutorial/workshop/study day topic/ostomy association presentation/parents’ and teachers’ meeting presentation on assisting children cope with their stomas or continence issues at school/participate in a newsletter development). Keep these in order as they are done, so that you will not have to resort them prior to posting.
- Create a separate folder in your email for any of the above invitations/activities that come via email so that they are easily retrieved and printed off as evidence for submission.
- Complete an online educational module, for example, WoundsWest (it is free and easy to do and the certificate comes in the mail).
- Visit pertinent/relevant websites and providing feedback to JSTA on where educational materials for STNs, patients, nursing staff or doctors can be found.
- Provide feedback to those websites relating to their educational material.
- Identify errors or issues in textbooks and write to the author or publisher.
- Prepare a written submission to your agency’s staff newsletter, accreditation panel, or a journal about STN activities/Stomal Therapy Awareness Week and so on. Even if it is not published, add it to your file, as you have had to research the data and thus have expanded your knowledge.
- Attend your local ostomy association meetings and contribute to their newsletter or magazine.
- Attend and contribute to meetings in your agency related to policies, procedures or competencies, whether directly STN-related or not.
- Record your participation in your agency’s mandatory competency requirements – these are all part of your CPD.
- Review that new book on professional issues/breast care/continence/ostomy and wound management you received or bought – you will have done this informally, but why not convert this into a ‘formal’ review and submit it to the JSTA for everyone’s education.
- Contact a new STN, either in Australia or overseas and act as a mentor.
- Identify in writing that ‘niggling problem’ you confront regularly and actually spend a little time considering how to solve it. Tell the rest of us about it in a short Item of Interest in your state’s newsletter, meeting, educational event and the JSTA and ask for suggestions or feedback.
- Offer to host a Big Morning Tea for the Cancer Council.
• Participate in formal product trials, or record your own reflections on various products, sufficient to make a change in your practice. Tell others about it.

• Create a poster/photographic presentation for your ward, ostomy association or agency for graduate nurses or patients.

• Write up that case study you found different or challenging for publication.

• Research the professional question posed in Part 2 below.

This is not an exhaustive list, but are some of the ideas gleaned from other STNs who have commented on and experienced some of the same issues about reaching 100 points.

Still think you can’t? Discuss your predicament with an E&PDS member. You will find their contact details on our website at: www.stomaltherapy.com

SENDING YOUR PORTFOLIO FOR EVALUATION

1. Please post your package in time to meet the deadline of 31 December. Remember, it can be mailed before this if you have reached 100 points.

2. Include your full address and state on the front of your portfolio.

3. Attach evidence in order, corresponding with the relevant, dated, portfolio entry.

4. Talk to your state education representatives if you have any issues before sending – don’t just slap this professional record together.

5. For credentialled STNs, the annual CPD is required to maintain your credentialled status.

6. In case of personal issues/problems, for example, extended maternity leave, a bad car accident necessitating being off work and so on, please advise Sue that you will not be submitting this year – she will then not have to chase you for a submission.

PART TWO

The E&PDS would also like to add a further opportunity for you to earn 10 points by researching and answering the following professional issue question. Submit your answer with your portfolio.

A professional issue (CPD – 10 points)
The nature of nursing has the potential to predispose nurses to develop stress and possibly burn-out. STNs are not immune to this phenomenon, despite the job satisfaction most enjoy.

(a) Briefly discuss burn-out in relation to the practice of stomal therapy nursing.

(b) List factors and/or characteristics that are considered to protect a nurse from developing stress and/or burn-out in order to promote professional nursing caring.

BIBLIOGRAPHY


CONCLUSION

Members of the E&PDS are very willing to discuss your circumstances and try to assist with options for your participation in the AASTN CPD process. We believe all STNs are trying to keep up-to-date in a variety of ways, and as a professional organisation, support these efforts. Let us know whether these tips have helped, and please offer any more from your own experiences. Happy “Developing”.

Lorrie Gray
On behalf of the AASTN Inc. E&PDS

Smith & Nephew Stomal Therapy Education Grant

The Smith & Nephew Stomal Therapy Education Grant is awarded annually to financially assist a registered nurse who is currently undertaking or has applied to undertake a recognised AASTN Stomal Therapy Nursing Education Programme. The award is administered by the AASTN Executive but presented by Smith & Nephew. The value of the scholarship is $1,000.

SELECTION CRITERIA AND GUIDELINES

The applicant is to submit to the AASTN Secretary by 31 July 2011:

• A completed official application form which is to be obtained from the Secretary.

• Proof that the candidate has been accepted, is undertaking, or has completed a recognised AASTN Stomal Therapy Nursing Education Programme within the period January to December in the year of application.

• A current curriculum vitae.

• Written confirmation from the applicant’s employer that the candidate is able to utilise their stomal therapy nursing skills on completion of the course.

Incomplete applications will not be considered.

The AASTN Executive will announce the successful candidate within six weeks of the closing date.
Top honours for one of our Life Members
Sister Mary Kelly OAM

Sister Mary Kelly has been awarded a Medal of the Order of Australia for her long-running service to nursing, stomal therapy and palliative care support in Bunbury and the Western Australia (WA) South West.

Many of you who have been AASTN members for a while will remember her as the quiet nun who was always ready to be involved, have fun and who contributed much to stomal therapy, the AASTN, both in WA and nationally, but also internationally.

She came from Ireland to Perth as a 21-year-old nun in 1953 and completed nurse training at St John of God Health Care before shifting to Bunbury in 1976. She had been in town for less than a year when she was approached by local surgeons to take on the role of a stomal therapy nurse. Sister Kelly said:

"There was absolutely no care for patients with stomas from Perth right through the South West."

With very little experience driving a car, Sister Kelly found herself clocking up thousands of kilometres providing support for stoma patients both in hospital and the community. She said:

"It was no easy feat, but then angels came to the rescue in the form of the Brunswick Lions Club. They heard of the work I was doing and bought me a car, and eventually my travelling expenses were funded by about 19 different South West Lions clubs."

Sister Mary had an uncanny gift for getting people involved with her – surgeons, patients, colleagues, volunteers and organisations. Fund-raising was a special and successful part of her activities.

Sister Kelly said Bunbury was a new area at the time and it was a daunting challenge, but she was pushed by a determination to provide nursing care to those who needed it in her developing, far-flung, community-based, stomal therapy nursing practice.

Sister Mary Kelly was also an important part of the establishment of palliative care in Bunbury in the 1990s. She explained:

"Palliative care was a new area of nursing at the time – the combination of physical, spiritual and psychological care – we were breaking new ground."

Sister Kelly travelled overseas extensively to attend medical conferences and present papers on her work. She also contributed papers to many national AASTN and WCET conferences.

Typical of Sister Mary, when asked if she would coordinate the day-to-day running of one of the WA Stomal Therapy Nursing Education Programmes, Sister Mary was horrified. She “wouldn’t know enough, wouldn’t be able to stand up there and teach a whole group, wouldn’t be able to keep the doctors organised” and similar protests, but was prevailed upon to accept the challenge. As with all challenges she faced, she made a superb job of the whole experience, and another group of fledgling STNs was launched, having been inspired by this warm, caring and special nurse leader.

Sister Kelly is now retired in Perth and said she still provides support to friends when they need it. She said:

"My years of nursing in Bunbury and the South West were so rewarding – I received as much as I gave to my patients, it was a great honour to be involved."

Australia has certainly benefited greatly from having Sister Mary Kelly live and work here, especially with her abiding passion for stomal therapy nursing and the people to whom she has devoted her skill and compassion.

We congratulate her on this special public recognition of her contribution to so many.

ACKNOWLEDGEMENTS
Shanelle Miller
Bunbury Mail
Keryln Carville

AASTN OVERSEAS TRAVEL GRANT

The Australian Association of Stomal Therapy Nurses Overseas Travel Grant is open to applications in the year 2009. The grant to the value of $2,000 is awarded biennially to assist an active AASTN full member to travel overseas in order to participate in research, conferences or other worthy projects.

SELECTION CRITERIA AND GUIDELINES
The applicant is to submit to the AASTN Secretary by 31 October 2011:

• A completed official application form, which is to be obtained from the secretary.
• A letter of endorsement from the candidate’s state branch verifying their status as a full member, active within the branch.
• A letter of endorsement from the candidate’s employer verifying the candidate’s commitment to excellence in the field of stomal therapy nursing.
• A current curriculum vitae.
• A commitment by the candidate to continue working for at least 6 months after their return. A medical certificate must be supplied to the AASTN Executive if the applicant is unable to fulfil this contract due to illness or other circumstances.

In addition, the successful candidate will submit to the AASTN Executive a report for publication that acknowledges the award within 3 months of their return.

The project must be commenced within 2 years of the award. Receipt of a grant automatically excludes members from re-applying for 5 years. The successful candidate will be notified within 6 weeks following the closing date.
Australian Council of Stoma Associations Inc. (ACSA)

The changing face of the International Ostomy Association (IOA)

Peter McQueen • President, ACSA

Major reforms of the IOA took place at the IOA conference at Frankfurt, Germany, in November 2010, with the international body moving from a globally focused organisation to a regional-based organisation. The change in direction will enable the regional organisations to take over the development, control and financing of support programmes in their respective regions, instead of relying upon the international body controlling these activities.

The three regions are: Europe, The Americas (comprising North and South America) and the Asia South Pacific (ASPOA) comprising the Asian and South Pacific regions from the old organisation. Australia currently is an Associate member of ASPOA; this status allows us a voice but no vote at regional conferences. There is a motion to be put to the member associations of ACSA that Australia apply for full membership of the new region and this will be decided by postal (electronic) vote in January 2010. If adopted, it will allow Australia to become more involved in regional activities and further develop the support activities of the Australia Fund. The regions office bearers are: President, Mr Michi Takaishi (Japan), Vice-President, Mr Barry Maughan (New Zealand), Secretary, Mr Ronaldo Loro (Philippines) and Treasurer, Mr Richard McNair, (New Zealand).

The IOA will have a Central Coordination Committee (CCC) to coordinate current support programmes that are under way. World Ostomy Day, liaison with international organisations such as the WCET and appliance manufacturers. This committee will have two representatives from each region and its chairperson will be elected from that committee and will rotate between each region every two years.

As can be seen above, the IOA will be a vastly different organisation to what it has been in the past. We hope the reforms will make it a much more relevant organisation, with the regions accepting a much larger role in programme development and management.

On the local front, the much awaited review of the Stoma Appliance Scheme (SAS) has been finalised with the Department of Health and Ageing response released in December. As per the terms of reference, it concentrated on pricing issues and listing protocols. A major overhaul of the Stoma Products Assessment Panel (SPAP) has been recommended to implement the protocols put forward. Appliance allowances will remain the same and ostomy associations’ responsibilities under the SAS guidelines will not change.

If you have any questions concerning ACSA or its activities, I can be contacted on email peter_mcqueen@optusnet.com.au

Colorectal Surgical Society of Australia and New Zealand (CSSANZ) Scholarship for Stomal Therapy Nurses

PURPOSE
To foster and further develop the relationship between the Australian Association of Stomal Therapy Nurses Inc. (AASTN Inc.) and CSSANZ, the CSSANZ will present a scholarship for a novice stoma therapy nurse (Stomal Therapy Nursing Education Programme completed within the previous three years) to attend their annual Spring Meeting. This is an annual award and will be presented at the AASTN Inc. Annual General Meeting.

AWARD VALUE
This scholarship will cover registration to the annual CSSANZ Spring Meeting, economy class airfare and $500 towards accommodation.

ELIGIBILITY CRITERIA
Applicants must:
• Be a full member of the AASTN Inc.
• Be currently registered in the state where they are working and utilising their stoma therapy nursing skills.
• Have completed an AASTN Inc. recognised Stomal Therapy Nursing Education Programme within the previous three years.
• Be able to attend the Spring Meeting in or outside Australia.

The decision of the judges is final and based on the following criteria:

• Suitability for publication following the JSTA Guidelines for Authors found in the current JSTA.

If you have any questions concerning ACSA or its activities, I can be contacted on email peter_mcqueen@optusnet.com.au

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Happy New Year to you all and what a year it has been so far, with huge floods in at least three states, horrific fires in WA and rain, rain, rain covering most of the eastern states!

As I write this report I am almost completely surrounded by water due to the incredible floods we have experienced in Brisbane where I live and also throughout the whole of Queensland. Thankfully no water is in my street but I am on the top of a hill looking over a lake which once were paddocks at the back. Friends not far from here had to leave their houses quickly to avoid being swept away by the force of the raging Brisbane River. A number of people were housed in people’s homes including ours that they had never met along with their animals and possessions but in true Aussie spirit were made to feel welcome and offered the hand of friendship and love. When the waters recede, the clean-up will begin and I am sure there will be thousands of people who will assist with this mammoth task.

In April 2012, we will extend that hand of friendship to colleagues around the world as we welcome them to the WCET congress in Adelaide. Our congress committee is continuing the planning of this event to ensure that we all experience very interesting and informative papers but also ensure our guests are treated to some of the Australian hospitality for which we are renown.

A number of us will be meeting in July at the joint AASTN/Tripartite conference in Cairns, which will be a unique event as we join with our colorectal colleagues. During this event we will have a WCET meeting where our congress Chairperson, Fiona Bolton will give us an update of the planning for the 2012 Congress. Please look for this meeting time and date in your programme as I urge all WCET members to attend. If you are not a member of WCET, you can join by going to the website at: www.wcetn.org and clicking on the new member tab.

Thank you to all those who have renewed their membership, but if you forgotten to do this, it is not too late to pay your fees now.

I look forward to seeing you in Cairns to experience this unique event where we share the stage with surgeons and STNs from many parts of the world. I know we have an organising committee for this event who will do us proud, so put your support behind them and join me in Cairns from 3 to 7 July.

On a personal note, I would like to include with this report a photo of my new grandson, Fergus Jonathan Smith, who was born on 10 December 2010, a wonderful Christmas present for me as well as my daughter Joanne, son-in-law Andrew and granddaughter Rosie. As his Nana, I think he is a beautiful baby but will let you judge that for yourself.
The following report is from the CoNNO meeting held at the College of Nursing, Sydney, on 8 October 2010. Presentations and issues discussed included:

**Invited presenters**

Prof. Mary Chiarella representing Workforce Australia (HWA) discussed the National Approach to Health Workforce Reform. This is an initiative of the Council of Australian Governments (COAG) and was recently established to meet the future challenges of providing a health workforce that responds to the needs of the Australian community.

HWA will develop policies and programmes across four main areas: workforce planning, policy and research; clinical education; innovation and reform of the health workforce; and the recruitment and retention of international health professionals. HWA will also consider the adequacy and availability of the workforce data. Further information can be found at: www.hwa.gov.au

Ann Morrison, Executive Officer of the Nursing and Midwifery Board of Australia discussed the function of the Australian Health Practitioner Regulation Agency (AHPRA) and the National Registration and Accreditation Scheme. AHPRA is the organisation for the registration and accreditation of 10 health professions including nursing, across Australia. AHPRA’s operations are governed by the Health Practitioner Regulation National Law Act 2009 that came into effect on 1 July 2010. Further information can be found at: www.nursingmidwiferyboard.gov.au

Amanda Adrian from the Australian Nursing and Midwifery Council (ANMC) discussed one of their primary functions being the accreditation of nursing and midwifery courses in Australia. The ANMC is disseminating expressions of interest for credible clinicians and academics to join either the ANMC Accreditation Committees or the ANMC Schedule of Accreditation Assessors. Further information and application forms are available from: www.anmc.org.au

Dr Leonie Katekar, Director of the Clinical Unit and Kathy Dallest, Clinical Safety Programme Manager of the National E-health Transition Authority (NEHTA) discussed the functions of the clinical unit and their aims to improve the quality and safe delivery of health care in Australia. Further information can be found at: www.nehta.gov.au

**CoNNO Council**

In the recent CoNNO Council elections, over 60% of member organisations voted. The five successful nominees were:

Kim Ryan (Australian College of Mental Health Nurses)
Tracey Osmond (College of Nursing)
Lyn Hinspeter (CRANAplus)
Debra Cerasa (Royal College of Nursing Australia)
Maryanne Craker (National Enrolled Nurse Association of Australia)

**Resignations from the CoNNO**

Geriacthion has withdrawn their membership from CoNNO as this group is dissolving.

**Member organisation reports and minutes**

Member organisation reports, a copy of the meeting minutes and the presentations can be accessed via the CoNNO website at: www.conno.org.au

Nursing Informatics Australia has asked if any CoNNO member groups have members interested in developing nursing terminology for Australia for inclusion into health information systems. If so, please email Joanne Foster on: j.foster@qut.edu.au

**CoNNO website**

The update of the website is still in progress. CoNNO is requesting that member groups forward any photos that demonstrate the diversity of nursing in Australia.

**Mentorship survey**

Recently CoNNO sent to all membership groups a Mentorship survey. There were 16 replies and, once collated, a report will be forwarded.

**Credentialling project**

As a number of the member groups either has a credentialling process available for their members or is considering developing a process, CoNNO has received limited funding from DOHA to undertake a project relating to credentialling. Although the basis of the project is in its infancy, it may look into whether there should be a standardised credentialling process and if there are any benefits of credentialling/does it help? It was mentioned also of the variations in the word “credentialled” that are utilised for example accredited and certified.

**Next CoNNO meeting**

The dates for the meetings in 2011 have changed to March in Melbourne and August in Sydney. This change occurred as many member groups had conferences which coincided with the current months. The actual dates are to be determined by the Council.
New South Wales

Our last meeting for 2010 on Friday 3 December, followed by Christmas Dinner at nearby Newtown Vegetarian Restaurant, was well attended. At the meeting, scholarships to six nurses undertaking the Stomal Therapy Course through the College of Nursing were presented. The scholarships were kindly given this year by ONL (Ostomy NSW Limited) and the NSW Chamber of Fruit and Vegetable Industries to the value of $10,000. The successful applicants were Lara Riley, Daniela Marjanovic, Colleen Mendes, Sarah O’S hannassy, Alison Carlin and Elise Tucker. The branch congratulates them and wishes them well in their course.

We welcome a new member to the AASTN NSW Branch – Robyn Paterson.

The South Coast study day in November, organised by Julia Kittscha, Margaret McCabe and Helen Richards, was very successful. There were 82 registrants, with excellent evaluation forms returned.

Our educational session at our first February meeting will be Problem Solving with stoma problems coordinated by Heather Hill.

Our second-monthly meetings continue, with good attendance numbers. All meetings are held at Royal Prince Alfred Hospital, Camperdown, Level 9 East Ambulatory Care. Teleconferencing is a very good option for members who are unable to physically attend the meetings. If you are an AASTN member and do not get to our branch minutes, please contact me for information on how to teleconference on 9515 8990.

Meetings for 2011 are Tuesdays 1 February, 5 April, 7 June, 2 August, 4 October and Friday 2 December. I encourage any branch members to attend these meetings, where you will be able to network with other STNs in similar vocational positions, contribute to group discussions about current treatments and trends and contribute to group fundraising. Active involvement brings eligibility for financial assistant to attend national conferences and interesting educational sessions.

Cheers,
Jenny Rex

Wollongong Stomal Therapy Study day 6 November 2010 report: The ins and outs of stomas

A very successful study day was held in Shellharbour with 82 delegates in November 2010. The day was organised by Julia Kittscha (STN Wollongong Hospital), Helen Richards (STN Figtree Private Hospital) and Margaret McCabe (STN Shoalhaven). Nurses of all levels from many different specialities came to the day, including nursing homes, acute care and community health. The aims of the day were to provide education relating to surgical and oncological treatment of colorectal cancer as well as stoma management, paediatrics and laxatives. The inspiration of the day was brought to us by Kate O’Reilly, who talked about her roller-coaster ride with fistulising crohns disease ending up with a permanent ileostomy. We were well supported by our trade who provided displays encompassing all aspects of stoma care. A staggering 75 evaluation forms were completed. Ninety six per cent of the respondents thought the day would positively impact on their practice, with 92% interested in attending future days. With such great feedback, watch this space because there will be more days later this year!

Queensland

We are all trying to cope with the incredible destruction and flooding over most of Queensland over the last two weeks. The rain has been incredible and there has been little sunshine. I don’t think we will ever forget the images from Toowoomba and Grantham this week. We hope that all our colleagues are safe. A big thank you to the companies and associations that are supporting our clients wherever they can. Hopefully we will see the sunshine in Cairns in July.

A good time and great food was had by all who attended the STN Christmas lunch breakup. It was held at the Greek Club. It was also time to celebrate with Clarrie Bond as she has decided to retire. Clarrie has worked in theBeenleigh Community Services for many years and her expertise will be missed. We wish her well in joining the grey nomads.

Nicolle Bowden, STN from the Mater Children’s Hospital, had a very traumatic accident on 25 November 2010. She has a long process to recovery and all our thoughts and prayers are with her and her family.

Sadly Lena Stillman passed away in January 2011. She was a well respected STN at the Royal Brisbane Hospital before Val Wright. Lena was a pioneer in stomal therapy nursing and her knowledge and professionalism to our chosen career is well recognised. Lena was also a Life Member of the AASTN.

On the bright side, Brenda Sando is a proud grandmother for the second time. Fergus was born on 10 December 2010 and all are doing well.

We are all looking forward to attending the conference in Cairns in July. We wish the Victoria branch every success for the upcoming conference.

Cheers,
Helleen Purdy

South Australia

The Christmas season is over and the new year is fast receding and it is now time to review the last quarter of 2010 for STNs in South Australia.
In retrospect, the most significant event of this time would be the awarding of the Shelley Simper Award to a deserving South Australian STN. This award is named after an STN who worked at the Flinders Medical Centre and died at a young age of cancer. The award is bestowed biannually to an STN who best reflects the spirit of stomal therapy.

This year’s winner is Merle Boereê, who has worked for many years at the Royal Adelaide Hospital in the Stomal Therapy Department. Merle has devoted many hours to education in South Australia and is a mentor and teacher to many of the STNs in this state. She is a deserving winner and we congratulate her warmly for her achievements.

The year 2010 ended in the usual flurry of festive activity with the annual Christmas dinner being held at the Caledonian Hotel in North Adelaide. About 30 STNs and trade representatives attended to see out the year and celebrate with colleagues. The food and company were good and the occasion was enjoyed by all.

On 7 December, the South Australian Nurses for Continence Interest Group also held an end of year dinner at New Generation. Although the weather was very forbidding, which prevented some of the country-based nurses attending, there was a reasonable audience. The speakers included firstly Dr Mary Palmer, an American nurse with an interest in aged care and incontinence, who spoke about elements of functional decline. Dr Jan Paterson from Flinders University, SA, also updated the group on some of the recent changes in pelvic floor muscle training exercise regimes. Several STNs attended the occasion, which was well received by all.

Another less festive event that occurred in South Australia at the end of 2010 was the completion of the first module for a group of would-be STNs in October. The group included several country nurses who were expanding their knowledge and will be a great resource for ostomates in these regions. February will also see a similar week being held and then those who wish to continue the whole course will amalgamate and complete the course.

So the year 2011 promises to be another busy year for South Australian STNs as many continue to plan for the 2012 WCET Congress in Adelaide. Much of the state group activity will be centred around planning for this and may overshadow many other events. I am sure that the end result will be worth the effort spent in formulating the occasion.

Lynda Staruchowicz

Tasmania

The year 2010 finished with a bang in Tasmania with one of our members getting married and two attending graduation ceremonies. Teena Cornwall married Evan Carydakis on 27 November at Marion’s Vineyard in the heart of the beautiful Tamar Valley. The bride was stunning, as we knew she would be. From all of us, we wish Teena and Evan a bright and happy future together. Tracey Beattie and Carolynne Partridge graduated from the University of Tasmania with a Master in Clinical Nursing. Congratulations Tracey and Carolynne on your well-earned achievements.

The Tasmanian branch of the AASTN started 2011 with our AGM, held on 5 January at the Royal Hobart Hospital. Following the AGM, the Tasmanian branch committee members are as follows:
- President/State Rep – Andrea Hicks
- Secretary – Teena Cornwall
- Treasurer – Carolynne Partridge
- Conference Chairperson – Sonia Hicks
- AASTN E&PD Subcommittee Member – Sue Delanty

I have taken on the role of President, allowing Sonia Hicks to concentrate on her new role as Conference Chairperson, having commenced planning for our 2013 conference. Sonia will also remain as our Ostomy Tasmania liaison, as she has a well-established and successful working relationship with the wonderful staff at Ostomy Tasmania. I would also like to take this opportunity to thank Tracey Beattie for her fabulous contribution as state representative over the last two years. Also requiring recognition is Sue Delanty, who has been working tirelessly on evaluating CPD portfolio. Thank you Sue. We want you to know we appreciate the work you do for STNs/nursing in Tasmania; it does not go unnoticed.

In 2011 we have regular teleconference and face-to-face meetings organised. Margot Hickman is planning to have a Kimberly-Clark-sponsored PEG seminar in Launceston. The date has not yet been finalised, but it will probably be in July. This seminar will be advertised on the AASTN website.

The Royal Hobart Hospital STNs, Sonia Hicks and Vanessa Rhodes are very pleased to announce that their hard work has been recognised and their staffing level will be increased, reflecting the increased need for the service they provide. Their position hours will be increased from 1.0 FTE to 1.4 early in 2011.

On behalf of us all in Tasmania, kindest regards,

Andrea Hicks

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Andrea Hicks
Tuesday 29 November
6 pm for 6:30 pm – Nurses Memorial Centre
Pre-Christmas drinks and nibbles.

A meeting was held in Melbourne, in December, by the representatives of the health department, in regard to the Stoma Appliance Scheme. A good representation of STNs attended this meeting, to give their opinions on this matter. We are still awaiting the outcome of this discussion.

Patricia McKenzie

Western Australia

After having our first committee meeting for 2011, it would seem that the year is off to a flying start. Planning began for the scheduled clinical updates and proposed topics. The professional study day was so successful last year that a subcommittee is being proposed to enable forward planning for hopefully another successful day. As the Conference looms closer people are making plans to attend and there is quite a bit of excitement around this. For all our Queenslanders during the devastating floods, we wish you all the strength to begin again. We cannot forget those in the areas of Victoria that are now experiencing flooding. We hope that all of you stay safe and strong.

Regards,

Leigh Davies

Stoma Appliance Scheme
Friday 17 December 2010

Diana Hayes • Outgoing SPAP Liaison / AASTN

The Stoma Products Assessment Panel (SPAP) will be formerly dissolved on December 31, 2010. I attended the meeting on Thursday December 16 2010 at 1430, representing AASTN. This foundational meeting was held in the Department of Health & Ageing Victorian Office, 595 Collins Street Melbourne. The meeting was open to all stakeholders involved in the Stoma Assessment Scheme.

The main features of the meeting have been summarised as:

Problems with the current SPAP system are:
- The Department of Health & Ageing chairs the SPAP meetings
- There may be conflicts of interest between the industry and ACSA
- The MTAA representative has voting rights when this individual does not represent all companies in this industry

The re-structuring of SPAP will therefore comprise the following:
- New SPAP membership to be finalised in February 2011
- Increased rigor using an evidenced-based approach
- Consistency in pricing
- Chair will be an independent not government-employed
- There will be (at least) two Stomal Therapy Nurses who will need to nominate via the AASTN
- There will be (at least) two academics who are expert in reviewing and interpreting clinical evidence
- There will be (at least) one individual who can expertly review economic analyses and valuation
- One consumer representative
- One industry rep (non-voting)
- One ACSA rep (non-voting)

There will be four SPAP meetings per year. The most significant aspect that transpired from the meeting was the need for transparency. The SAS process needs to be transparent. The scheme also needs to be sustainable. Therefore, the target savings for the scheme is $13,000,000.
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