Regional roadshows: providing outreach specialist education

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ABSTRACT

This paper describes how we optimised the care of our complex paediatric patients by providing on site face-to-face education to regional and rural nurses. The provision of this education has provided us with many benefits, including improved communication between regional and rural centres and our specialist unit, upskilling and increased interest in our patients, and improved patient care.

BACKGROUND AND NEEDS ASSESSMENT

Our nurse led service is the only dedicated paediatric stomal therapy nursing service in the state and provides support and care to over 1000 children with bowel and bladder stomas, surgically placed gastrostomies, continence concerns, complex wounds, and pressure injuries. Such a diverse service profile means the team of stomal therapists and nurses is (like most stomal therapy services), constantly on their toes. Much of the workload comes from supporting families in regional areas and is often achieved by utilising email and phone calls as a way of assessing and managing our ostomates from afar. Families often report difficulties in finding appropriate local support, as the stomal therapists and nurses are often well-experienced with adult patients as opposed to the paediatric population.

The differences between adult and paediatric stoma care are diverse.[1] Paediatric patients with bowel stomas often only require them temporarily for a matter of months, constipation and faecal incontinence is often managed with appendicostomies or chaits, and rather than ileal conduits or suprapubic catheters (SPCs), stomal therapists frequently manage Mitrofanoffs and teach children as young as 5years old how to catheterise. Add in the complexities of dislodged tubes during play time, real or perceived social inequalities requiring additional support to manage continence at school,[2] and the fear and anxiety that children and parents may face, families often want to have a local nurse or stomal therapist they can turn to for advice.[3]

Like many services that assisted in managing complex care, the service was further impacted by COVID-19. Throughout the pandemic, our stomal therapy nursing service had limited opportunities to provide education, particularly face-to-face. Once the state borders and restrictions began to be lifted, we noted a lot more families, nurses and fellow stomal therapists asking about face-to-face education and reviews. Families reported they finally felt 'safe' to go into hospitals for reviews, and previously ignored issues were beginning to come out of the woodwork. The stomal therapy team brainstormed how to best support our regional nursing services and, in turn, support our regional families. Initial discussions were centred around an education day at the tertiary hospital we were employed with.

From conversing with parents and stomal nurses, we were aware that many regional hospitals were experiencing short staffing, which would likely impact on their ability to travel for education. We then discussed potentially visiting different hospital services within the state, and realised that by doing so, we could tailor our education to suit individual needs, and offer shared reviews of our paediatric patients with their local nurses. Overall, the purpose of our visit was providing face-to-face education to upskill nurses, develop professional relationships, and to identify how our tertiary hospital could provide better support for regional hospitals and our patients.

EDUCATION PROVIDED

Our service developed a proposal and was fortunate enough to obtain funding through our hospital's paediatric education program. We established a plan to visit five regional sites within the state and began to get in touch with local stomal therapists, nurse educators and clinical nurses. Knowing who to contact took some trial and error but using the AASTN website as a guide was a great starting point. The feedback we received was incredibly positive and all our local regional nurses were more than happy to provide practical support like arranging conference rooms and putting us in touch with nurse educators and paediatric nurses who might be interested in attending. We then were able to work with each individual health service to tailor our support to suit their hospital needs. We offered patients the opportunity to have reviews at their local hospitals which allowed for shared care to commence. Each member of our team decided on a location and took on the responsibility of communication, planning and coordinating individual visits.

Just as we began to feel organised, our own staffing issues arose. Like all workplaces, our small team were struck down with COVID – one week after the other! The impacts of leave were significant on our workload, and the practical elements of planning the trip were often put on hold to ensure we could still safely deliver patient care. Being able to dedicate a small amount of time each day, even just 10 minutes, to discuss our progress and determine outstanding tasks was incredibly useful. We got in touch with company representatives who kindly provided us with some fantastic resources that we would use for hands on education. Our luggage was full of product samples, information brochures, medical models and a variety of stomal therapy devices to demonstrate to our colleagues in each regional location.

On the day of our tailor-made presentations, each of us were greeted warmly by our stomal therapists and nursing staff at their home hospitals. Each presentation covered a wide variety of topics including paediatric bladder and bowel stomas, surgical

gastrostomies, complex wounds, pressure injury management, general urology and Malone Antegrade Colonic Enemas (MACE). To ensure we were able to gauge the effectiveness of the education, we developed a simple online form and rating system to obtain quantitative data and also provided open questions for respondents to provide qualitative data. A QR code was provided to participants prior to the presentation and, following the completion of all the presentations, a post survey was also sent. The questions asked the participants (a combination of stomal therapists and nurses) to rate their confidence in assessing and troubleshooting bowel stomas, appendicovesicostomies, appendicostomies/caecostomies, chaits, complex wounds, pressure injuries, and surgically placed gastrostomies on a scale of '1' (not confident at all, no knowledge) to '5' (confidently manage independently, good knowledge base). We included the question 'What paediatric stomal therapy topic would you benefit most from?' to allow participants to answer in their own words. We did have some technical issues, with some staff being unable to log in and complete the survey when using the QR code.

FEEDBACK

A total of 30 respondents provided initial feedback. The area that staff reported the least amount of confidence was assessing and troubleshooting appendicovesicostomies, with the average self-reported score of 1.7. Only marginally higher was the confidence for managing appendicostomies, caecostomies and chaits at 1.72. More common stomas such as surgically placed gastrostomies and bowel stomas were reported at scores of 2.5 and 2.6 respectively. The area the respondents felt most confident was the assessment and management of complex wounds (3.1) and the assessing, staging and management of pressure injuries (3.33).

Of the 30 responses from the pre-presentation scores, only 10 responses were received from the post-presentation. Unfortunately, the limited responses meant that no formal comparisons could be made. The data received did demonstrate an overall improvement in confidence assessing and managing paediatric stomas (Table 1). Participants reported that learning about chait caecostomy catheters was the most beneficial, with six of the ten respondents stating that chait education was the most beneficial topic to learn about. When asked to provide feedback or suggest improvements, general feedback was favourable, with respondents reporting the workshop was 'beneficial', 'great' and 'excellent' although more hands-on activities such as practising changing chaits and learning about appliances was suggested for future sessions.

Table 1. Outcome scores from pre- and post-education surveys where 0 is 'not at all confident' and 5 is 'confident to manage independently'

	Baseline (n=30) Mean	Post-education (n=10) Mean
Troubleshooting appendicovesicostomies	1.7	*
Managing appendicostomies, caecostomy and chaits	1.72	3.56
Managing gastrostomies	2.5	4.0
Managing bowel stomas	2.6	3.9
Assessment and management of complex wounds	3.1	4.1
Assessing, staging and management of pressure injuries	3.33	4.0

*No data was available

CONCLUSION

Knowing that nurses and stomal therapists had increased confidence managing paediatric stomas is rewarding, and the feedback provided will hopefully help us provide improved education next year. A stomal therapist recently reported she was able to change her practice and use a flexible guidewire to change a chait which resulted in an easier, and less traumatic change for her patient.

More than just education, the experience allowed us the opportunity to get to know our regional nurses. The support they provide our families, often with limited resources, is incredible and our families frequently echo this sentiment. We have since had regular contact with the stomal therapists and nurses we met whilst 'on tour' and have been able to transition care of at least eight children to their local hospital for regular appendicostomy management which has reduced the need for unnecessary and costly travel to the tertiary hospital setting. As a stomal therapist, having a support network of experienced nurses and stomal therapists across the state is an invaluable resource.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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