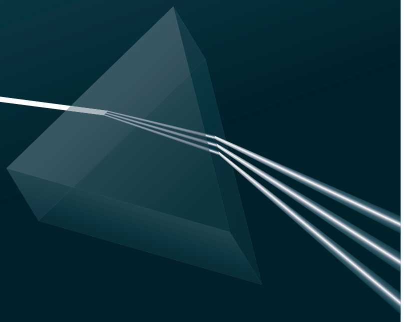


European **Wound, Ostomy** and **Continence** Supplement

November 2020

In association with Gastrointestinal Nursing

European Council of Enterostomal Therapy ECET

EDITOR Benjamin Wakefield
ADVERTISING MANAGER Nicholas Barlow
GROUP CLASSIFIED MANAGER Daniel Doherty
CIRCULATION DIRECTOR Sally Boettcher
PRODUCTION MANAGER Kyri Apostolou
ASSOCIATE PUBLISHER Sophie Gardner
PUBLISHING DIRECTOR Andrew Iafrati
MANAGING DIRECTOR Anthony Kerr
CHIEF EXECUTIVE OFFICER Ben Allen

Editorial enquiries: benjamin.wakefield@markallengroup.com
Commercial enquiries: nicholas.barlow@markallengroup.com

UK PERSONAL SUBSCRIPTION RATES

Quarterly direct debit	£25
Annual direct debit	£100
Annual credit card	£105
2-Year annual credit card	£179
3-Year annual credit card	£252

Subscribe online: www.magsubscriptions.com
Subscribe by phone: +44 (0) 1722 716997
Institutional pricing: institutions@markallengroup.com

MA HEALTHCARE
A MARK ALLEN GROUP COMPANY
www.markallengroup.com

Gastrointestinal Nursing is published by
MA Healthcare Ltd, St Jude's Church,
Dulwich Road, London SE24 0PB
Tel: +44 (0)20 7738 5454
Website: www.gastrointestinalnursing.co.uk

MAG ONLINE LIBRARY

ISSN 1479-5248
Printed by Pensord Press Ltd,
Blackwood, NP12 2YA

Speaking the same language

It is an editor's job to ensure healthcare publications use language that is clear, consistent and unbiased. This can be a particular challenge in stoma care, where the terminology used varies considerably.

Starting from the top, stoma care is known outside of the UK as enterostomal therapy, or as part of wound, ostomy and continence nursing. This variance in drives a wedge between health professionals working in practically the same specialism. For example, when much peer-to-peer learning and professional development involves finding keywords on search engines, those looking for articles on 'stoma care' may miss those on 'enterostomal therapy'. The European Wound, Ostomy and Continence Supplement was launched, in part, to cross these artificial divisions, but finding a common language remains a challenge.

For those receiving this care, perhaps the least stigmatising term is 'person living with a stoma', but it is too unwieldy for regular use. 'Ostomate' is often used, perhaps because the '-mate' part sounds friendly, although a few ostomates have reported finding it a strange and alienating label. Thankfully, it seems to have largely replaced 'ostomist', which sounds more like a political affiliation. Although a stoma is a consequence of surgery, it is important to not pathologise it. As with a chronic illness, a stoma is something that many people with have to live with for the rest of their lives. However, the stigma around stomas makes it especially important that ostomates are encouraged to not think of themselves as ill or permanently medicalised. Instead, the aim should be to normalise a stoma as a healthy, functioning part of the body. In linguistic terms, this means that an ostomate should only be described as a 'patient' when they are directly receiving care.

'Stoma products' is the accepted umbrella term for all devices used by ostomates. The most important are 'appliances', as they are generally referred to in professional circles. However, nothing about this term describes the appliance's function, and it may as well refer to a fridge or toaster. 'Appliance' does not seem to be used by ostomates, which suggests an alienating gap between the language used by those giving and receiving care. When ostomates write for *StomaTips*, they generally talk about their 'bag'. While clear and descriptive, there is something undignified and stigmatising about 'bag', suggestive of refuse sacks, and nurses never seem to use it. The term that appears in *StomaTips* is 'pouch', which is simple and descriptive, but with a pleasant sound and associations, like a kangaroo cradling a joey. As 'pouch' is used and understood by ostomates and nurses alike, it is a contender to replace 'appliance' in professional use. However, specialist pouch nurses have expressed concern that this would create confusion with internal or ileoanal pouches.

The Bladder, Bowel and Stoma Handbook shows the bewildering variety of terms used to describe these products by their manufacturers. The adhesive part of an appliance is referred to as everything from 'baseplate' and 'skin barrier' to the unfortunate 'flange'. Every stoma product that is not an appliance is generally termed an 'accessory', but the way that specific kinds of accessory are classified can be highly inconsistent and confusing.

There has been an attempt to standardise descriptors of complications (or are they 'conditions' or 'problems'?) that affect peristomal skin. The terms moisture-associated skin damage (MASD) and medical adhesive-related skin injury (MARSI) describe the cause of the complication and thus clearly signpost to how they can be resolved. Starting with the same two letters is not ideal, but these terms are a step in the right direction.

Anyone interested in designing and distributing a survey on the real-life language used by ostomates and stoma nurses should email the editor at gin@markallengroup.com. **GN**

Benjamin Wakefield Editor

Today's challenges, tomorrow's opportunities

Renata Batas, PR and Publications,
European Council of Enterostomal Therapy (ECET)

Back in February 2020, when COVID-19 was first reaching Europe, many of us thought it would be over within a few months. As I write this towards the end of the year, we are all still having to cope with the pandemic, which has had a great impact on the work of wound, ostomy and continence (WOC) nurses and the lives of our patients.

However, as the pandemic has progressed, nurses have gained the experience to protect themselves and others. WOC nurses are still struggling with restrictions on physically assessing and treating chronic wounds and ostomy and continence problems. Many colleagues have shared how they have communicated with their patients via emails and telephone or video calls. Others have braved the dangers of the pandemic to physically visit and provide essential care to patients with a new or especially problematic wound, stoma or continence issue; in such situations, nurses must take into account all preventive measures and properly use personal protective equipment.

The persistence of the pandemic means that all the usual face-to-face conferences and other events across Europe scheduled for 2020 have been cancelled, delayed or moved to a remote format. Many WOC nurses have shown technical skill using different applications for virtual meetings, including many small educational webinars organised by different nursing associations, which takes considerable investment of time, equipment and staff. Other organisations have circulated educational material and relevant information to their members by e-mail or via their websites. This has led clinics to upgrade the communication technology available to staff and patients, which should remain in place to use even once the pandemic is over. Fundamentally, these measures have been an important part of minimising the spread of COVID-19.

The board of the European Council of Enterostomal Therapy (ECET) is keen to stay in contact with all its members, across Europe and worldwide. The board has been holding online meetings to discuss future projects, including the next biennial meeting, and to plan how to deliver them in the context of the pandemic. The 15th ECET conference is planned for 7–9 July 2021, in collaboration with the European Wound Management Association (EWMA), Journées Cicatrisations and the French Association of Enterostomal Therapists (AFET). The conference is set to take place in person in Paris—one of the most beautiful cities in the world and one that should be easy to access from all destinations.

The theme for 2021 is 'Global pandemic and caring for people with ostomy, incontinence and wound healing disorders'. The programme will address the extremely unusual experiences shared by health professionals all over the world since last winter—and no doubt for many months to come. Participants will speak about what has been and can be done to overcome the challenges of the pandemic, with its steep learning curves, and move on to treating patients and educating relatives.

Something WOC nurses have missed during the pandemic has been face-to-face presentations of new ostomy, wound and continence care products. The conference will present opportunities to view and physically examine these products and build personal relationships with industry representatives, which will always be more informative than merely viewing pictures and product information online. The ECET team believes that, after a challenging and uncertain year of social distancing, lockdowns and online meetings, WOC nurses will have a greater need than ever to meet each other in the real world. It will be a welcome and rewarding chance to share experiences and knowledge, and the ECET will do everything possible to create a safe environment that reflects the reality of summer 2021. The ECET board looks forward to welcoming you all in Paris.

In the meantime, the ECET has released the fourth edition of the European Wound Ostomy and Continence Supplement, with new articles about wound, ostomy and continence care that should offer useful information for daily practice. ECET members can access all editions of the supplement on the ECET website. **GN**

European
Council of
Enterostomal
Therapy
ECET

Clinical digest

Renata Batas, Enterostomal Therapist at Community Health Centre Ljubljana, Slovenia, provides a brief overview of recently published articles on wound, ostomy and continence care

New lessons on peristomal skin complications from the ADVOCATE trial

Salvadalena G, Colwell JC, Skountrianos G, Pittman J. Lessons learned about peristomal skin complications: secondary analysis of the ADVOCATE trial. Journal Wound Ostomy Continence Nurs. 2020; 47(4):357–363. https://doi.org/10.1097/WON.0000000000000666

Peristomal skin complications (PSCs) are defined as inflammation or damage to the skin surrounding an abdominal stoma that is covered by the adhesive portion of the stoma appliance. They can be caused by chemical, mechanical, infectious and systemic health conditions.

The ADVOCATE trial was a randomised controlled study of PSCs in 153 adult ostomates, using a ceramide-infused skin barrier or a standard skin barrier. Participants were enrolled from 25 sites from the US, Canada and Europe and seen in hospital and outpatient care settings. At baseline, participants all had healthy peristomal skin, free of PSCs, and were followed for up to 12 weeks. At each visit, the stoma and peristomal skin were assessed using the Ostomy Skin Tool, used for visual evaluation of the presence and extent of discolouration, erosion and tissue overgrowth (DET). Photographs were used to verify visual assessments among the sites and for quality assurance. Participants with a DET score above baseline were defined as having a PSC. The incidence of PSCs was 47.7% overall, 40.5% in the ceramide-infused skin barrier group and 55.4% in the control group (p=0.069). The rate of PSC was lower in the group using the ceramide-infused skin barrier than the control group (40.5% vs 55.4%).

This secondary analysis of data from the ADVOCATE trial aimed to: (1) compare pertinent demographic and clinical characteristics of participants with (n=73) and without (n=80) PSCs; (2) describe the PSCs and how they were clinically managed; and (3) examine the relationship between possible risk factors for and the occurrence and severity of PSCs. Group comparisons were made via t tests for continuous variables, χ^2 tests or Fisher exact tests for categorical variables and generalsed linear models for identification of risk factors.

The results showed no statistical differences in the measured participants' demographic and clinical characteristics, including reasons for ostomy surgery, between the groups. In both groups, the majority of stomas were round or oval in shape, with a mean diameter of 33 mm. The majority of the PSCs were mild or moderate in nature, though more severe in ileostomates, and the three most common types were irritant dermatitis (50.7%), maceration (20.5 %) and mechanical trauma (16.4%).

Two risk factors were associated with an increased likelihood of experiencing a PSC: duration with a stoma and peristomal skin creases/fat folds. PSCs occurred at a mean of 64 days after stoma surgery (SD=29.8; range 16–132) and were likely to be less severe as this duration increased. Skin creases were present in 20% of all subjects and 26% of those with a PSC when it occurred, with a greater prevalence in ileostomates. In addition, more than half (53%) of those with skin creases and a PSC were using convex appliances.

PSCs were managed using stoma accessories, including barrier rings/seals, skin barrier powders, stoma pastes or paste strips.

The authors recommended that patient follow-up be on a structured schedule beyond the first few weeks after surgery, because the likelihood of PSC occurrence increases over time. This approach may help improve outcomes, particularly for those with an ileostomy and challenging skin contours.

Urinary incontinence is prevalent in elite athletes of both sexes

Rodríguez-López ES, Calvo-Moreno SO, Basas-García Á et al. Prevalence of urinary incontinence among elite athletes of both sexes. J Sci Med Sport. 2020; online. https://doi.org/10.1016/j.jsams.2020.09.017

Urinary incontinence (UI) is defined as the involuntary leakage of urine. UI affects both sexes, although a higher prevalence has been reported in women than men (51.1% versus 13.9%). Three types of UI are known: stress, urge and mixed. Stress is the most prevalent form of UI in women (3–58.4%) and is defined as involuntary loss of urine on effort or physical exertion, or on sneezing or coughing. It is usually attributed to weakened musculature of the pelvic floor.

This cross-sectional observational aimed to determine the prevalence of UI among elite athletes and to compare prevalence between sexes and across different sports modalities. It included 754 elite athletes (455 women or girls and 299 men or boys) in Spain from December 2018 to May 2019. A questionnaire was used to collect self-reported anthropometric measures, medical history and sport-related data, as well as three UI-specific tools: the International Consultation on Incontinence Questionnaire-UI Short-Form (ICIQ-UI SF), the Three Incontinence Questions (3IQ) and the Incontinence Severity Index (ISI).

The mean age of participants was 23.04 (±7.16) years, and 60.3% were women or girls. Of the athletes, 33% first experienced UI at a mean age of 23.75 (±7.74) years (according to the ICIQ-UI SF). Prevalence was 45.1% in females compared with 14.7% in males (p<0.001). Of cases of UI, 59.9% were related to stress, and 30.9% were described as moderate-to-severe (according to the ISI), and UI-related quality of life was scored 4.35 (±2.98) out of 10 (according to the ICIQ-UI SF). Participants reported experiencing UI while training (22.7%), jumping (40.5%) and running (19.6%) and in other situations (20.2%).

Females showed a 5.45-times greater risk of having UI (95% CI=3.55–8.35), six-times higher risk of urinary infection and two-times higher risk of constipation, compared with males. Athletes had higher odds of UI if they had constipation (OR=2.69) or a history of urinary infection (OR=2.21). UI was reported by almost 50% of the female athletes and 20% of the male athletes at a relatively early age (20–30 years). Urinary incontinence has been scarcely addressed in men and even less in sport. Thus, UI should be considered a clinical condition that affects athletes of both sexes.

In the study, over 38 different sports were recorded. The greatest prevalence of UI was in rugby, where 80% of players reported urine leakage. The second largest incidence of UI was observed in swimmers. UI can have a negative impact on the quality of life in female athletes. Given the impact of UI on the day-to-day life of an elite athlete, having UI is likely to compromise performance.

The findings of urine leakage when running, jumping and in other situations support the hypothesis that UI is related to an increase in the forces directed toward the pelvic floor during physical activity. This reinforces the importance of including pelvic-floor muscle exercises in an athlete's training regimen to prevent and manage UI effectively.

COVID-19 patients are prone to medical device-related pressure injuries

Martel T, Orgill DP. Medical device-related pressure injuries during the COVID-19 pandemic. J Wound Ostomy Continence Nurs. 2020; 47(5):430–434. https://doi.org/10.1097/won.0000000000000689

Pressure injuries increase morbidity and mortality, causing 60 000 patient deaths per year in the US. Patients who develop a pressure injury have a higher mortality (1.9% vs 1.8%) and a longer stay in hospital (by 4–6 days) compared with those who do not. Pressure injury also increases the cost of hospitalisation by around $50 000–$60 000 USD per admission.

Patients with COVID-19, with the accompanying severe acute respiratory syndrome (SARS-CoV), are at particular risk for development of pressure injuries. Medical device-related pressure injuries (MDRPIs) represent more than 30% of all hospital-acquired pressure injuries. The prolonged intubation and prone positioning of COVID-19 patients has put a large population of patients at risk of MDRPI in the pandemic.

Researchers at an academic medical centre reviewed their experience with MDRPIs during the 2020 COVID-19 pandemic. From 1 April to 31 May 2020, a spike was noted in the incidence of MDRPIs, the average daily intensive care unit census increased by 27.5%; and 30 hospital-acquired pressure injuries (HAPIs) were reported. This was a 275% increase from the prior 2-month period (February and March 2020), which had seen eight reportable pressure injuries; four of these were MDRPIs, three of which were related to the use of respiratory care devices. Data analysis revealed that 73% of reported pressure injuries were associated with a positive COVID-19 diagnosis. Initial evidence strongly suggested this resulted from prone positioning. Prone positioning is associated with increased survival rates in patients with SARS-CoV, but it has been linked with a three-fold increase in pressure-related injuries when compared with supine positioning. Prone position exerts compressive and shear forces from tubes exiting the mouth and nose on adjacent facial structures, increasing the risk for pressure injury.

The facility saw a rapid influx of this acute patient population, which required a rapid multidisciplinary response to minimise skin injury. A prone-positioning team, including physical therapists, was convened to assist with the workload required to position this patient population. The prone team positioned and repositioned patients more than 500 times during this period, with four-to-six people required to complete the reposition each time. Wound, ostomy and continence (WOC) nurses collaborated with the prone team to develop a pressure injury plan for all patients placed in the prone position for prolonged periods of time. This plan included developing a positioning and product guide for the prone team and the nursing staff.

Treatment and offloading of MDRPIs in these patients were limited. This was made especially difficult by the necessity of continued use of medical devices. Effective dressings applications were limited, due to the warm humid microclimate and location of pressure injuries. Moreover, debridement of necrotic pressure injuries in the acute care setting was not typically completed.

The experiences with MDRPIs during this time led the WOC team to begin development of a quality-improvement project aimed at enhancing management of high-risk respiratory illness patients requiring intubation and prone positioning. They identified potential areas of improvement, and the new programme included an evaluation of staff learning needs, along with the use of preventive dressings, endotracheal securement devices, pressure redistribution surfaces and the option of virtual inpatient wound consultation.

Convex stoma appliances with Manuka honey can improve and maintain peristomal skin integrity

Evans M, White P. Selecting convexity to improve and maintain peristomal skin integrity. Br J Nurs. 2020; 29(16):S8–S14. https://doi.org/10.12968/bjon.2020.29.16.S8

The majority of problems experienced by ostomates relate to peristomal skin complications (PSCs) and appliance leakage. Stoma care should aim to keep peristomal skin intact and free from soreness. Leakage can result in skin becoming irritated, damaged and painful, with a severe impact on psychological wellbeing and overall quality of life.

One cause of leakage is a retracted or flush stoma. Flush and retracted stomas can become apparent in the early postoperative period and may result from obesity or poor surgical technique or stoma siting. In these cases, convex stoma appliances can be an effective tool to establish and maintain a secure and predictable seal. There is a wide range of convex appliances available, allowing solutions for preventing and managing PSCs to be tailored case by case. It is important for stoma care nurses to understand why, when and how these convex appliances should be used; however, it can be difficult to decide which type of convexity is appropriate for an individual patient.

A study was undertaken to compare the results of convex hydrocolloid adhesive flanges with and without Manuka honey. The multicentre study was undertaken across 21 NHS organisations in the UK. It included ostomates who were established users of convex appliances and already used either a shallow/soft or moderate/light convex appliance. All participants had been diagnosed with a PSC following assessment of their peristomal skin by a stoma care nurse, either for regular review or to address a problem. Following this, they had each been offered a convex flange with Manuka honey to try.

Of 31 ostomates, 68% were female and all were aged over 51 years. Of particpants, 74% were ileostomates, 16% were colostomates and 10% were urostomates, and their stomas were flush to the skin (55%), protruding (29%) or retracted (16%).

Participants were followed up over a 6-month period, guided by local policy and assessment of needs. Within 2 weeks of introducing the new appliances, 45% were reviewed by their stoma care nurses. Peristomal skin improvement was observed and verified by independent stoma care nurses.

Convex appliances with Manuka honey appeared to improve clinical outcomes. Users had reduced need to use accessory products. Of users, 93% reported that the appliance met their needs as a result of improved performance; 87.5% reported improvement in their peristomal skin; 46% had seen improvement by day 4; 90% thought the Manuka honey was beneficial; and 55% reported a longer wear time compared with their previous convex appliance. Stoma care nurses reported that 83% of patients experienced fewer leakage episodes and 90% had improved peristomal skin.

Both nurses and patients reported that PSCs were significantly reduced following the introduction of the Manuka honey convex appliance. Therefore, the authors concluded that medical-grade Manuka honey could play an important role in preventing and treating PSCs. **GN**

The fit is the difference

between staying in and working out

Think fit first.

The right fit is key to giving patients security and it is crucial for preventing a circle of leakage and skin issues.[1-2] At Coloplast, we believe that there are 5 fit challenges to overcome for an appliance to fit right. The SenSura® Mio range has been designed to overcome all of them.

Contact your Coloplast representative for more information.

1. Rolstad, B. S. & Erwin-TothP. L. PeristomalSkin Complications: Prevention and Management. Ostomy Wound Manage. 2004;50(9):68-77.
2. Colwell, J. C. et al. International Concensus Results. Development of Practice Guidelines for Assessment of Peristomal Body and Stoma Profiles, Patient Engagement, and Patient Follow-up. Journal of Wound, Ostomy and Continence Nursing: November/December 2019 - Volume 46 - Issue 6 - p 497-504.

Coloplast

SenSura® Mio

Teaching student nurses during a pandemic

Milagrosa Olmedo Alguacil, Dean, and **Concepción Capilla Díaz,** Assistant Professor, both at the University of Granad Faculty of Health Sciences, discuss nursing education

On 14 March 2020, nursing degrees across Spain were upended by royal decree. Decree 463 instituted a lockdown to slow the spread of COVID-19, issued in response to the declaration of a public health emergency by the World Health Organization 3 days earlier (Spanish Government, 2020). The lockdown meant that everything in Spanish universities would have to change, and all lecturers were suddenly forced to teach their students at a distance.

Before the pandemic, virtual teaching processes had been spreading across Spanish universities, aided by the development of the European Higher Education Area (2020). The greatest uptake was in remote institutions, such as the National Distance Education University (UNED), but some traditional faculties were incorporating virtual methods to strengthen face-to-face courses. With plenty of time to prepare, progressive virtualisation presents few problems.

However, having to convert ongoing face-to-face courses into a virtual format all at once is much more difficult. Lecturers had to start using teaching methods that they had little or no experience with, which created unexpected results. Moreover, the investments needed to support this kind of teaching had not yet been considered in general budgets. Meanwhile, lecturers were left without access to familiar tools. For example, in nursing degrees, it has long been considered essential to provide simulation rooms, where student nurses could practise a variety of care activities on dummies, which were often connected to replicas of devices used in primary and secondary care clinics.

Lecturers have had to ask themselves what alternatives were available that would allow students to complete their clinical training without attending health centres or simulation rooms. Generally, virtual training has been the only option. This can draw on the augmented reality techniques that were already used in some face-to-face courses and are usually very well received by students. Lecturers can also use specialist tools for sharing information that allow students to become active creators of their own knowledge.

Graf (2020) has emphasised the importance of simulation rooms, suggesting that these exercises are necessary for nursing students to be able to adapt to the changing demands of the clinical environment and keep up to date with technology and practice. Successful nursing programmes require a combination of theoretical framework and practical experience.

When the lockdown was decreed, clinical training was cancelled throughout all Spanish Universities. However, a Ministry of Health (2020) order on 15 March authorised the hiring of nursing students in their 4th year as health support workers under the supervision of a qualified health professional. This would form part of their curriculum and be considered part of their training. However, this did not apply to all nursing students. For example, in some Spanish universities, nursing students finish their training in the 3rd year and do not have the opportunity to change their contract to add this period of training.

Lecturers are having to ask how and when the pandemic measures will change or be brought to an end. Those running courses that started in September have been given no indication of when the present restrictions might be lifted, and they are having to be put up with indefinitely. In the present scenario, previously face-to-face courses are online-only, and most exams and final degree dissertations will be conducted via streaming.

This raises questions about the quality of this learning, as well as whether health professions are ready to be taught virtually. It is unclear whether students will appreciate the bioethical framework behind this scenario.

Much has been written about new ways of learning for stoma care and other nursing disciplines (Capilla-Díaz, 2019), and now is the time to put them into practice. A pandemic requires health and education institutions to be flexible enough to adapt ways of care to meet the changing needs of individuals and communities. Health professionals and teaching staff need to be ready for new scenarios, as no one knows what will happen next. **GN**

Capilla-Díaz C. New approaches in stoma care nursing. Gastrointestinal Nursing. 2020; 17(9):S3. https://doi.org/10.12968/gasn.2019.17.sup9.s3

Graf AC, Jacob E, Twigg D, Nattabi B. Contemporary nursing graduates' transition to practice: a critical review of transition models. J Clin Nurs. 2020; online:1–11. https://doi.org/10.1111/jocn.15234

Spanish Government. Royal decree 463. 2020. www.boe.es/buscar/act.php?id=BOE-A-2020-3692 (accessed 11 November 2020)

European Higher Education Area. Website. 2020. www.ehea.info (accessed 11 November 2020)

Webinar Series

talkingstomacare.com

coloplast.co.uk

Developing ostomy, continence, urology and wound c
services, that make life easier for people with intimate

View our products and order your free samples

Learn about and request samples of our most innovative products for female and male incontinence, colostomies, ileostomies, urostomies and supporting products for ostomy care

Search and order free samples

Ostomy Self-assessment Tools

If you experience ostomy leakage or sore skin around your stoma, use the Ostomy Self-assessment Tools find advice and solutions, learn about good stoma care routines and check your body profile.

Go to the Trouble Shooter

Bowel Care

you have bladder or bowel issues, help is at hand

more about Bladder & Bowel issues

Talking stoma care:

overcoming everyday challenges

In conversation, exploring innovative insights and solutions to common challenges in stoma care practice.

21st October 2020 • 2nd December 2020 • 20th January 2021
24th March 2021 • 8th June 2021 • 9th September 2021

Organised by

Gastrointestinal Nursing

Coloplast

Coloplast® Professional

Complications in colostomy patients: analysis and assessment of risk factors

Abstract

Background: The increasing prevalence of people living with a colostomy (and a stoma in general) has made understanding, assessing and managing stomal complications an increasingly important objective. **Aims:** The aim of this study was to analyse the onset of stomal complications in relation to comorbidities to evaluate any predisposing pathologies. **Methods:** This retrospective analysis was conducted on the patient records of colostomates admitted to a hospital in Milan, Italy, from 2015 to 2018. **Findings:** The analysis showed that 54% of patients presented with more than one complication. The most common were peristomal skin lesions (42%) and oedema (25%). The disease that showed the highest correlation with stomal complications was heart disease (23%). **Conclusions:** Despite a limited sample size of 101 patients, this study demonstrated a correlation between stomal complications and heart disease. Nurses should pay particular attention to ostomates with cardiovascular issues.

Francesco Carlo Denti, Enterostomal Therapy Nurse; **Andrea Maglio**, Enterostomal Therapy Nurse; **Davide Brambilla**, Registered Nurse; **Vitalba Scaduto**, Registered Nurse, all at San Raffaele Hospital, Milan, Italy

ambulatorio.stomizzati@hsr.it

Key words

- Colostomy
- Complications
- Incidence
- Related diseases
- Retrospective study

This article has been subject to double-blind peer review

Many colorectal surgical procedures result in stoma formation, and an increasing number of abdominal operations involve the creation of a colostomy (Koc et al, 2017).

Abdominal stomas often present with physical complications or problems. The appearance of stomal and peristomal complications has a significant impact on quality of life. This makes it necessary to assess for, classify and document peristomal complications whenever an ostomate attends the hospital or at outpatient follow-up.

The incidence of complications is difficult to determine, especially in Italy, where the care provided to the stoma patients varies across the counties and is not homogeneous. However, studies have described the present situation as lacking.

Despite advances in surgical techniques and stoma care products over the past several decades, stomal and peristomal complications remain prevalent. Many international studies have reported incidence rates for stomal complications of 3–82% (Kwiatt and Kawata, 2013; Salvadalena, 2013; Ambe et al, 2018; Malik et al, 2018). These complications, which may arise immediately after surgery or after a year or more (Carlsson et al, 2016), affect not only the patient's quality of life, but also healthcare economics (Koc et al, 2017). To date, despite surgical and care improvements, little has changed regarding the incidence of stomal complications (Kwiatt and Kawata, 2013).

Skin lesions can be evaluated using a number of scales, such as the Study of Peristomal Skin Lesions (SPSL) scale (*Figure 1*)—or Studio sulle alterazioni cutanee peristomali (SACS) in Italian. The SPSL scale is a validated tool that allows for uniform definition of stomal skin lesions (Bosio et al, 2006). It grades the lesion's severity according to five categories (L1, L2, L3, L4 and LX) and locates its topographic position within one or all of the four quadrants around the stoma (T-I to T-V), based on the topography of breast lesions (Bosio et al, 2006).

The literature suggests that a number of factors determine the occurrence of stomal complications. The main aetiological factors include the type and position of the stoma; the type of intervention; the presence of

Lesion type

L1	**Hyperemic lesion:** peristomal redness with intact skin
L2	**Erosive lesion:** open lesion not extending into subcutaneous tissue, with partial-thickness skin loss
L3	**Ulcerative lesion:** open lesion extending into subcutaneous tissue and below, with full-thickness skin loss
L4	**Ulcerative lesion:** full thicknesses skin loss with non-viable; dead tissue (necrotic, fibrinous)
LX	**Proliferative lesion:** abnormal growths present (hyperplasia, granulomas)

Topographic location

T-I	Right upper peristomal quadrant: 9–12 o'clock
T-II	Left upper peristomal quadrant: 12–3 o'clock
T-III	Left lower peristomal quadrant: 3–6 o'clock
T-IV	Right lower peristomal quadrant: 6–9 o'clock
T-V	All peristomal quadrants

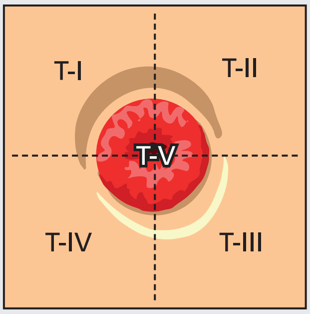


Figure 1. Study of Peristomal Skin Lesions (SPSL) scale

comorbidities, obesity or malnutrition; and the use of corticosteroids (Kwiatt and Kawata, 2013; Andersen et al, 2018). However, other studies have questioned these risk factors and identified other factors such as smoking, diabetes and a history of treatment for malignant disease, as the main factors that influence the occurrence of stomal complications (Nastro et al, 2010; Koc et al, 2017).

It has also been suggested that the risk of stomal complications can be mitigated by certain key factors. These include pre-operative involvement of a specialist stoma care nurse, such as an enterostomal therapy nurse or wound, ostomy and continence nurse. The stoma nurse is able to take charge of the patient and provide pre-operative education to promote the patient's stoma care skills and positive capacity to cope with the changes brought about by the intervention (Stoffels et al, 2018). The nurse can also participate in preoperative planning, including stoma-site marking, where the stoma nurse chooses the most suitable site on the patient's abdomen for the ostomy to be created, as a correctly positioned and well-formed stoma improves the patient's quality of life and ability to adapt to the change (Pittman et al, 2008; Mahjoubi et al, 2010; Person et al, 2012).

The aim of the present study was to analyse the onset of stomal and peristomal complications and skin lesions, to identify any predisposing pathologies.

Methods

This retrospective study was conducted by collecting and analysing the medical records of consecutive patients with a colostomy admitted to the general and emergency surgery department of San Raffaele Hospital in Milan, Italy, over the period from July 2015 to December 2018. This included both elective and emergency operations, as well as both end loop colostomies and transverse loop colostomies. The records of ileostomates and urostomates were excluded, because the study aimed to focus on colostomates exclusively.

Data were collected on the onset of every type of stomal complication, as well as the severity and location of skin lesions, classified using the SPSL scale. Using statistical software, these factors were compared with data on:

- Demographic factors (sex and age)
- Administration of chemotherapy and/or neoadjuvant radiotherapy
- Use of pre-operative abdominal marking
- Presence of comorbidities
- Type of intervention (emergency or elective).

Results

The medical records of 101 patients (12 from 2015, 24 from 2016, 46 from 2017 and 19 from 2018) (*Figure 2*) were analysed. Of the sample, 57% were men and 43% were women, and

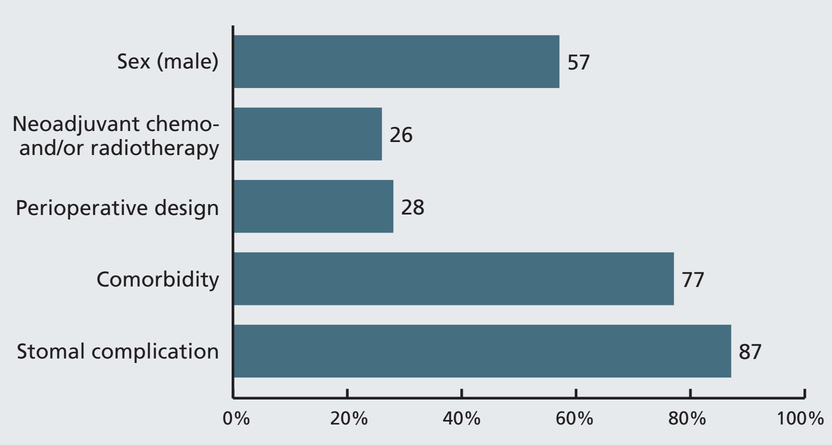
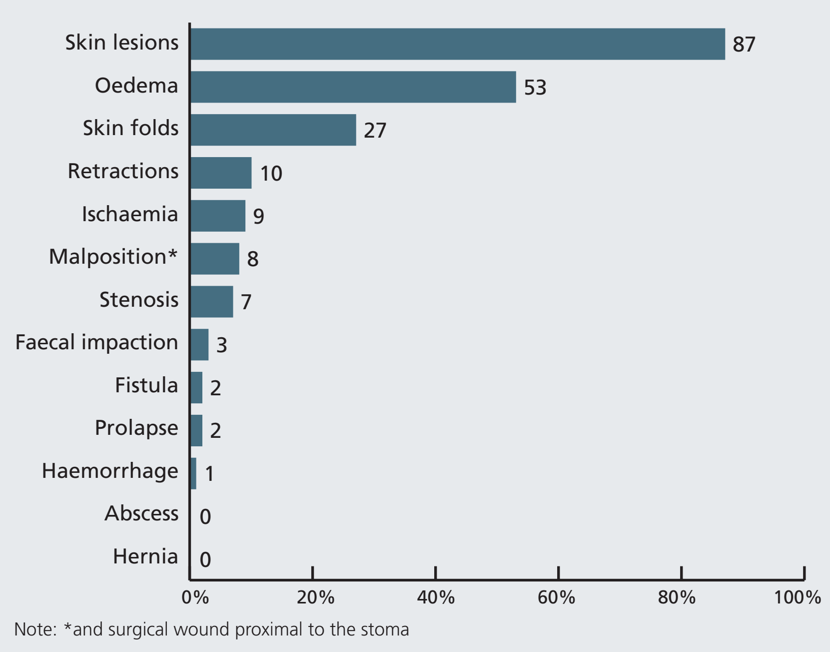


Figure 2. Demographic and clinical variables, % (n=101)

the average age of the patients involved was 71 years (range, 31–96 years). Of patients, 25% underwent radiotherapy and/or neoadjuvant chemotherapy. Pre-operative stoma-site marking was performed on 28% of patients, including 86% of those undergoing elective surgery, but only 14% of those undergoing emergency surgery. Of all patients, 78% had at least one comorbidity at the time of surgery.

Of the sample, 89% presented at least one stomal complication during hospitalisation, while 54% had more than one complication. There were 211 complications recorded. This averaged 2.1 complications per patient. This statistic was lower in the period from 2015 to 2017 (1.9) than in 2018 (2.6). The 28% of patients who had received pre-operative stoma-site marking had a complication rate of 27%. Of these complications, 39% were related to the onset of oedema, poor management of the stoma appliance or skin problems, and therefore not directly related to the pre-operative stoma-site marking, in accordance with the findings of Baykara et al (2014).

The specific complications identified are given in *Figure 3*. The most frequent complications were skin lesions, oedema and skin folds, affecting 87%, 53% and 27% of patients, respectively. Of the skin lesions, 39% were classified on the SPSL scale as L1 (*Figure 4*).



Note: *and surgical wound proximal to the stoma

Figure 3. Patients experiencing specific stomal complications, % (n=101)

Discussion

In the present study, factors that predispose colostomates to stomal and peristomal complications were analysed. The complications were more common among the 25 patients in the age group between 81 and 90 years, with an average of 2.4 complications per patient. Sex was not a significant factor, with men experiencing an average of 2.1 complications and women experiencing an average of 2.7 complications. Similarly, neoadjuvant radiotherapy and/or chemotherapy were not predisposing factors either, as the 20% of patients who developed these presented with 18% of the total complications, which was in line with the findings of Koc et al (2017).

Data analysis showed that, overall, skin lesions were more frequent in patients with heart disease (22%), urological disease (11%), vascular disease (11%) and diabetes (11%). No specific association was found between the classification of skin lesions on the SACS scale and any predisposing factors.

Among those who developed oedema, 25% had heart disease, 14% had diabetes, 10% had vascular disease and 10% had urological disease. In the case of skin folds, the main related diseases were heart disease (21%), urological disease (11%), vascular disease (11%) and diabetes (7%). Finally, among those who developed retraction, 32% had heart disease, 11% had diabetes, 11% had urological diseases and 11% had BMI outside the normal range.

The same risk factors were presented among those with the less frequent complications

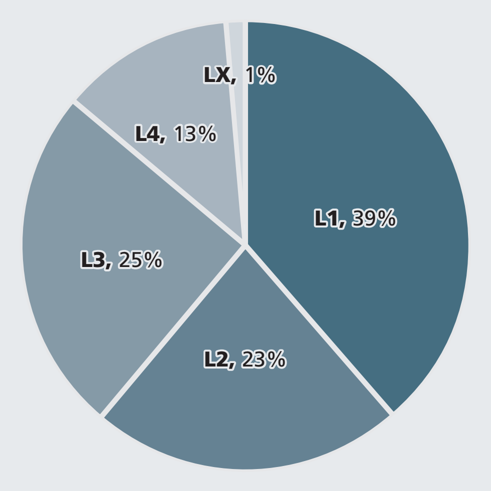


Figure 4. Skin lesion classification (n=88)

(n=32, 15%) because the greatest correlation was observed with heart disease, which is in line with the values described above.

As this study was limited to the observation of a sample of patients admitted to hospital, it is not possible through this work to define which factors, if any, predispose colostomates to stomal and peristomal the complications in the long term.

Limitations

The sample analysed was limited to 101 patients, as the pool of data was confined to the medical records from a single hospital ward. Data on a number of potentially relevant factors were not available in the hospital records to compare with the incidence of stomal complications. These included:

- History of smoking or drug use
- Indication for stoma formation
- Temporary or permanent nature of the stoma
- Presence of obstruction and/or dysfunction
- Use of resection with anastomosis
- Surgical techniques used to form the stoma (Koc et al, 2017).

Meanwhile, the retrospective nature of the data may have introduced inherent flaws unknown to the researchers. Using medical records alone did not allow for long-term analysis of risk factors.

Conclusions

In this study of 101 colostomates over 3 years, 211 stomal complications were observed. The most significant predisposing factor proved to be heart disease, which is in line with the literature. Meanwhile, the most notable preventive factor was pre-operative stoma-site marking, especially in patients with late-onset stomal complications, which is in accordance with the findings of Arolfo et al (2018).

The findings support the need for structured, multidisciplinary OW interviews with patients. These meetings are an opportunity to personalise pathways of care and education according to the patient's need (Khalilzadeh et al, 2019). They are also a chance to reassure and educate the patient to reduce the risk of complications after surgery and improve their quality of life (Registered Nurses' Association of Ontario, 2009). Once a patient has a stoma formed, they should be provided with instructions on how to recognise complications and guidance on why they should return to the ostomy clinic for regular follow-up visits (Salvadalena, 2013).

More complete and specific conclusions could be drawn from similar studies with a larger sample, from wider a variety of centres. Researchers would also be able to investigate the risk factors mentioned in the limitations that could not be considered in this study. It may also be useful to further study stoma patients with heart, vascular, urological, diabetic and BMI-related diseases, in order to provide tailored advice and interventions to reduce risks. **GN**

CPD reflective questions

- What are the most prevalent stomal complications?
- What factors can predispose an ostomate to stomal complications?
- How effective is preoperative stoma-site marking as preventive measure for stomal complications?

Declaration of interest *None*

Ambe PC, Kurz NR, Nitschke C, Odeh SF, Möslein G, Zirngibl H. Intestinal ostomy. Dtsch Arztebl Int. 2018; 115(11):182–187. https://doi.org/10.3238/arztebl.2018.0182

Andersen RM, Klausen TW, Danielsen AK et al. Incidence and risk factors for parastomal bulging in patients with ileostomy or colostomy: a register-based study using data from the Danish Stoma Database Capital Region. Colorectal Dis. 2018; 20(4):331–340. https://doi.org/10.1111/codi.13907

Arolfo S, Borgiotto C, Bosio G, Mistrangelo M, Allaix ME, Morino M. Preoperative stoma site marking: a simple practice to reduce stoma-related complications. Tech Coloproctol. 2018; 22(9):683–687. https://doi.org/10.1007/s10151-018-1857-3

Baykara ZG, Demir SG, Karadag A et al. A multicenter, retrospective study to evaluate the effect of preoperative stoma site marking on stomal and peristomal complications. Ostomy Wound Manage. 2014; 60(5):16–26

Bosio G, Pisani F, Fonti A et al. Multicentre observational study on peristomal skin disorders: a proposal classification [article in Italian]. G Chir. 2006; 27(6–7):251–254

Carlsson E, Fingren J, Hallén AM, Petersén C, Lindholm E. The prevalence of ostomy-related complications 1 year after ostomy surgery: a prospective, descriptive, clinical study. Ostomy Wound Manage. 2016; 62(10):34–48

Khalilzadeh GM, Tirgari B, Roudi Rashtabadi O, Shahesmaeili A. Studying the effect of structured ostomy care training on quality of life and anxiety of patients with permanent ostomy. Int Wound J. 2019; 16(6):1383–1390. https://doi.org/10.1111/iwj.13201

Koc U, Karaman K, Gomceli I et al. A retrospective analysis of factors affecting early stoma complications. Ostomy Wound Manage. 2017; 63(1):28–32

Kwiatt M, Kawata M. Avoidance and management of stomal complications. Clin Colon Rectal Surg. 2013; 26(02):112–121. https://doi.org/10.1055/s-0033-1348050

Mahjoubi B, Kiani Goodarzi K, Mohammad-Sadeghi H. Quality of life in stoma patients: appropriate and inappropriate stoma site. World J Surg. 2010; 34(1):147–52

Malik TAM, Lee MJ, Harikrishnan AB. The incidence of stoma related morbidity – a systematic review of randomised controlled trials. Ann R Coll Surg Engl. 2018; 100(7):501–508. https://doi.org/10.1308/rcsann.2018.0126

Nastro P, Knowles CH, McGrath A, Heyman B, Porrett TRC, Lunniss PJ. Complications of intestinal stomas. Br J Surg. 2010; 97(12):1885–1889. https://doi.org/10.1002/bjs.7259

Person B, Ifargan R, Lachter J, Duek SD, Kluger Y, Assalia A. The impact of preoperative stoma site marking on the incidence of complications, quality of life, and patient's independence. Dis Colon Rectum. 2012; 55(7):783–787. https://doi.org/10.1097/DCR.0b013e31825763f0

Pittman J., Rawl SM, Schmidt CM, Grant M, Ko CY, Wendel C, Krouse RS. Demographic and clinical factors related to ostomy complications and quality of life in veterans with an ostomy. J Wound Ostomy Continence. 2008; 35(5):493–503

Registered Nurses' Association of Ontario. Ostomy care and management. 2009. https://rnao.ca/sites/rnao-ca/files/ostomy_care__management.pdf (accessed 13 October 2020)

Salvadalena GD. The incidence of stoma and peristomal complications during the first 3 months after ostomy creation. J Wound Ostomy Continence Nurs. 2013; 40(4):400–406. https://doi.org/10.1097/WON.0b013e318295a12b

Stoffels B, Sommer N, Berteld C, Vilz T, von Websky M, Kalff J, Pantelis D. Late complications of permanent intestinal stoma [article in German]. Zentralblatt für Chirurgie. 2018; 143(06):603–608. https://doi.org/10.1055/a-0649-1230


STOMA Tips


PRACTICAL ADVICE AND INSPIRATION FOR A CONFIDENT, INDEPENDENT LIFE
STOMA Tips
In association with:
BJN
PRACTICAL ADVICE AND INSPIRATION FOR A CONFIDENT, INDEPENDENT LIFE
STOMA Tips
Choosing the right appliances and accessories
What to wear after stoma surgery
Stag with a stoma
Eating more of what you want
In association with
BJN
Gastrointestinal Nursing

Chronic pilonidal sinus wounds: regular cleaning and early laser depilation are key interventions to successful healing

Abstract

Pilonidal sinus wounds are notoriously slow to heal and have a high risk of infection due to proximity to the anus, the moist environment of the natal cleft and friction of buttock cheeks. Since the first pilonidal sinus disease (PSD) protocol was issued to the US army in 1955, care for PSD has focused on the principles of wound care following surgical excision with secondary or modified closure, including cleaning of the wound, hair removal and daily dressings. These principles remain valid today, although advances in the choice of dressings and laser therapies for long-term hair management allow patients more independence and less frequent dressings. At present, there are no standard guidelines for wound care following pilonidal sinus (PS) surgery. This article recommends thorough wound cleaning, starting laser depilation early and individualised patient education to accelerate wound healing and reduce recurrence. Collaboration between specialists in a multidisciplinary team is essential.

Liliana Marza, Laser Nurse Specialist, Skin55 Dermatology, London

liliana@laserskintreatment.co.uk

Key words

- Laser depilation
- Laser hair removal
- Pilonidal cyst
- Pilonidal sinus
- Wound recurrence

This article has been subject to double-blind peer review

Pilonidal sinus disease (PSD) is an inflammatory condition, located mainly in the inter-gluteal area. The incidence has increased across the world, and, in Germany, 100 in 100 000 people are affected (Doll et al, 2019). PSD affects mainly young males with increased bodily hair and has a significant impact emotionally, economically and on the quality of life of the patient and their family.

Many patients are too embarrassed to seek medical advice until the condition becomes acute and are often first seen as an emergency, needing urgent incision and drainage of an abscess (Marza, 2019). When the inflammation subsides, excision of the sinus is usually recommended. The resulting midline wound may be left to heal by primary or secondary intention. In more complex surgery, lateral extensions may be present. Healing time depends on the surgical technique, but the principles of wound care remain the same.

Pilonidal sinus (PS) wounds are slow to heal, given the anatomical location. Although these wounds are expected to close within 2–6 months, they may sometimes take 1–2 years or even longer to completely heal (Harris et al, 2016). Delayed wound healing increases the risk of hair penetrating into subcutaneous tissue, which may cause recurrence of the sinus (Doll et al, 2007).

The care of the wound following surgery is performed by a variety of health professionals—and sometimes by family members—often with varying levels of understanding of this complex condition. A qualitative study by McCaughan et al (2018) showed that it is common for patients to have unrealistic expectations of the rate of healing, as well as that this is in conflict with the expectations of the clinicians. Reassurance, consistent information and continuity of care help create a bond of trust between the patient, family and healthcare team, as well as reduce anxiety at a challenging time for the patient.

Although there is no standard guideline for PS wound care, valid principles can still be drawn from the PS protocol issued in the 1950s by the

US Army Medical Division (1955) for US soldiers stationed in Europe.

These principles are regular cleaning of the wound, removal of hair and use of dressings that are appropriate to the stage of the wound healing. It is the responsibility of the team of health professionals to develop a plan that fits each individual's specific needs and ensure consistent care appropriate to the local setting and availability.

This article describes principles of wound care following PS surgery and recommends regular wound cleaning and early laser depilation of the natal cleft to enhance healing and avoid further complications.

Wound management

The main aim of PS wound management is to ensure the wound closes from the base up and prevent premature closure of the wound entrance (Newton, 2016). PS patients are usually young and physically active, and they often need reassurance that the wound will improve and they will be able to return to their normal lifestyle. Delays in wound healing have a negative impact on patients' confidence and can make them feel isolated among an endless cycle of wound care visits, while living with the constant fear of recurrence of the sinus (McCaughan et al, 2018).

Wound assessment

Wound assessment requires a holistic approach, involving taking the patient's medical history and examining the wound, its edge and the surrounding area. At every visit, the wound must be assessed for size, depth and colour, as well as the presence of discharge, odour, debris and accumulated hair (*Table 1*). The data should be recorded for comparison at future appointments to assess progress. Particular note should be made of bridging, pocketing and early epithelialisation. The size and depth may be measured with a probe or thin catheter and a disposable paper ruler.

Photographs can aid the monitoring of wound progress. Consent must be taken before capturing images of the patient. For optimal visualisation of the perianal area and to reduce tensing of the buttocks, it is recommended that patients lie in the 'jackknife' position. This involves lying prone, with one or two pillows under the pelvis.

Table 1. Assessment of pilonidal sinus wounds

Area	Specifics
Symptoms	Discomfort, discharge, irritation
Wound measurement	Length, width, depth
Wound presentation	Colour, odour, bleeding/discharge, hairs/debris, bridging/pocketing, epithelialisation, hyper granulation
Periwound skin	Colour, fragility, exfoliation, folliculitis
Intergluteal area	Hair density/coarseness, depth

A reduction in wound surface by 20–30% after 3–4 weeks of treatment is a good predictor of timely healing (South West Regional Wound Care Program, 2015). If the wound is not closing as expected, it must be reassessed for presence of infection and/or hairs.

Periwound cleaning

The first step to be carried out is periwound cleaning. This should make use of a cleaning solution suitable for the condition of the wound, taking into account local availability and the patient's allergies and sensitivities. A number of antiseptic solutions for wound cleansing have been proposed, and polyhexamethylene biguanide (PHMB) has been found to be less irritating to the skin than chlorhexidine and povidone iodine and can also be used to reduce bacteria in the wound (Brown, 2017). An inexpensive, easily available alternative antimicrobial cleanser is acetic acid, which is effective and is useful against *Staphylococcus aureus*, MRSA, *Pseudonomas aeruginosa* and other gram-negative bacteria (Mangkorntongsakul, 2019). Care must be taken to remove the antiseptic from the skin and minimise risk of developing contact dermatitis.

Wound irrigation

Following periwound cleaning, wound irrigation by a steady stream of solution across the open wound surface facilitates removal of debris and permits better visual examination of the wound. It should be carried out before each dressing change and at every assessment (Gabriel, 2017). Wounds can be irrigated using normal saline, potable tap water or antiseptic solutions, such as PHMB, in infected wounds (Brown, 2017). Wound irrigation can promote healing from the inside outward and may prevent premature bridging and development of an abscess pocket or infected sinus tract.

Hairs and debris

Hairs and debris must be removed meticulously. The author uses a magnifying glass and non-toothed fine forceps to remove hairs from the wound and electrical clipper with a disposable head to remove periwound hairs (*Figure 1*). Although electrical clippers do not perform as short a haircut as razors, they are preferable, as they reduce the risk of razor micro-cuts and it is recommended by the surgical site infection guidelines from the National Institute for Health and Care Excellence (2019).

Liliana Marza

Figure 1. Fine forceps, wound probe and electrical clipper with a disposable head

Table 2. Indications of infection in deep or superficial wounds

Wound depth	Acronym
Deep wounds	**S:** Size increasing in the base **T:** Temperature on the side of wound is increased **O:** Os (Latin for bone) Bone can be probed **N:** New breakdown areas in the base of wound **E:** Exudate increased **E:** Erythema on the surrounding skin (cellulitis) **S:** Smell indicative of bacteria or anaerobes
Superficial wounds	**N:** Non-healing **E:** Exudate increased **R:** Red bright, friable granulation **D:** Dead yellow slough on the wound surface **S:** Smell indicative of bacteria or anaerobes

Source: Woo and Sibbald (2009)

Wound dressing

The aim of management of a PS wound is to ensure healing from base up, avoiding infection and early epithelialisation. The selection of a suitable dressing depends on the stage of the wound, volume of exudate, comfort for patient and cost (Harris et al, 2016). If the wound is not infected and has a high volume of exudate, an alginate dressing (e.g. Sorbsan, Kaltostat) or Hydrofibers (e.g. Aquacel) may be chosen. Where a sinus wound is contaminated, antimicrobial dressing (silver, iodine or honey) are most often used. Dressings need to be packed lightly, and use of a secondary dressing, such as a non-adherent dressing or absorbent pad, is often required (Newton, 2016).

Some wounds may benefit from vacuum assisted closure (VAC) therapy, although this may be uncomfortable, particularly at change of dressings. The healthcare team must devise a pain management plan for each stage of the wound, taking into account the patient's particular needs.

Delayed wound healing

The healing of PS wounds is often delayed. A Canadian literature review by Harris et al (2012) concluded that there were two main reasons for this delay in wound healing: failure to recognise infection and failure to remove hairs from the wound and the surrounding area.

Failure to recognise infection

Clinical signs that may indicate an infection have been described by Woo and Sibbald (2009) and are known by the mnemonics STONEES for deep wound infections and NERDS for surface infections (*Table 2*). The presence of three or more signs indicate an infection, and a culture swab is recommended to determine the appropriate antimicrobial agent.

Failure to remove hairs from the wound

The periwound skin in the natal cleft often contains bacteria (including Staphylococci), and the wound can trap hairs. These hairs act as a foreign body, causing inflammation and impeding healing (*Figure 2*).

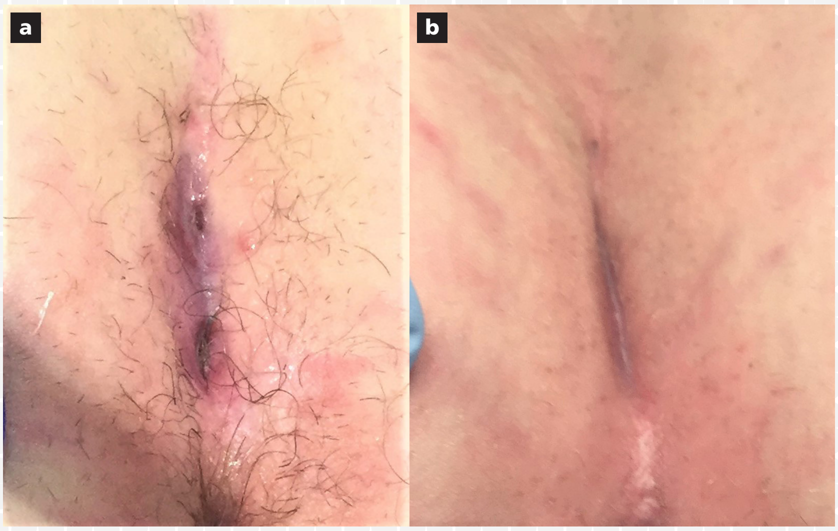
The need to eliminate a source of inflammation/infection cannot be overstated (Harris et al, 2012). In the author's 20 years' experience of dealing with PS delayed wounds, meticulous removal of loose hairs from the wound and a series of laser depilation of the periwound hairs have resulted in no further intervention being needed (*Figure 3*).

Hypergranulation

One of the most common complications that can cause a delay in wound healing is hypergranulation, which results from the presence of a foreign body, infection, excess moisture and/or friction (Lloyd Jones, 2014). Hypergranulation grows beyond the top of the wound surface and can have a cauliflower-like appearance (*Figure 4a*) (Johnson, 2007). Numerous treatments are available, although there is no standard guideline on the best approach (*Figure 4b*). Silver nitrate used to be the first choice for small areas, as it has immediate effect; however, silver nitrate has become less favoured, as it may delay healing by reverting the wound to the inflammatory stage of healing (Johnson, 2007). Dressings (e.g. silver or iodine) may be used, but they can prolong the healing time by up to 6 weeks (Johnson, 2007). Meanwhile, topical corticosteroids, such as Trimovate (Ennogen) or Terra-Cortril (Intrapharm) ointment, give quick results, but they are used off licence and must be prescribed by a medical consultant (Cooper, 2007). The use of fludroxycortide tape, sold as Haelan (Packpharm), has become popular (Oldfield, 2009). To reduce the risk of hypergranulation, it is imperative that the wound is carefully assessed for early signs of infection and that hairs are removed from inside the wound and the surrounding surface.

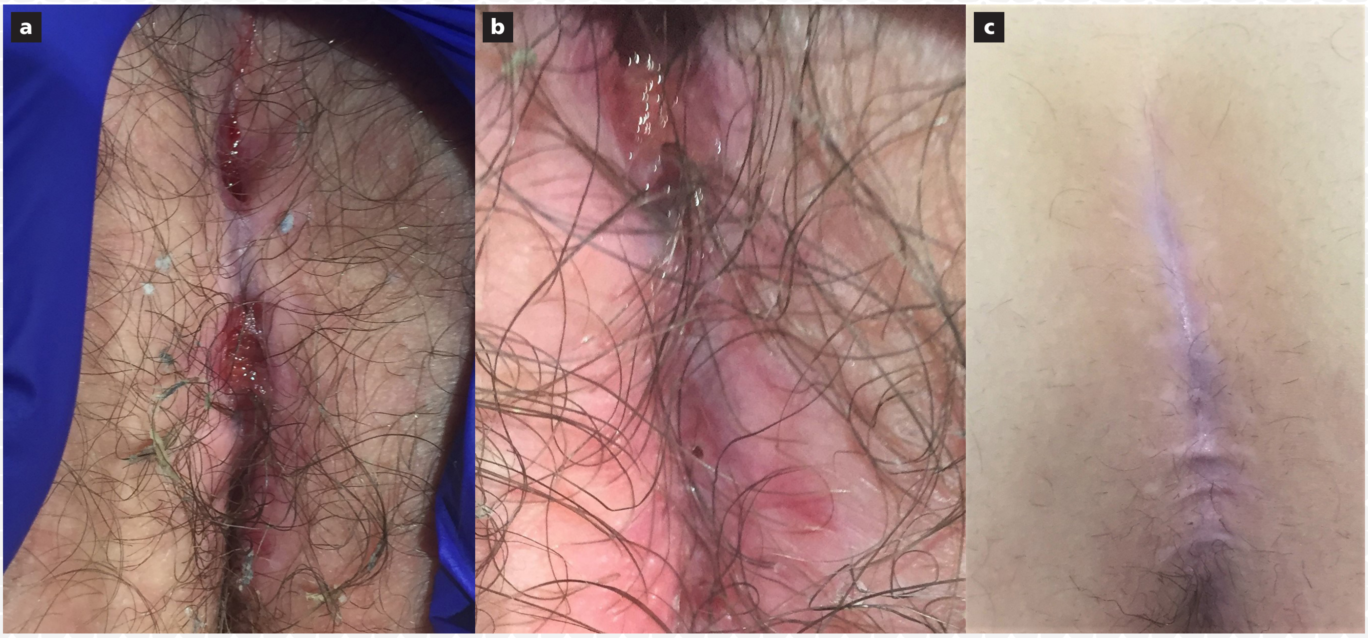
Laser depilation for long-term hair removal

Laser hair depilation has been around for many years. It has been used to treat a number of medical conditions, such as hirsutism, folliculitis, ingrown hairs and hidradenitis suppurativa, as well as PS.



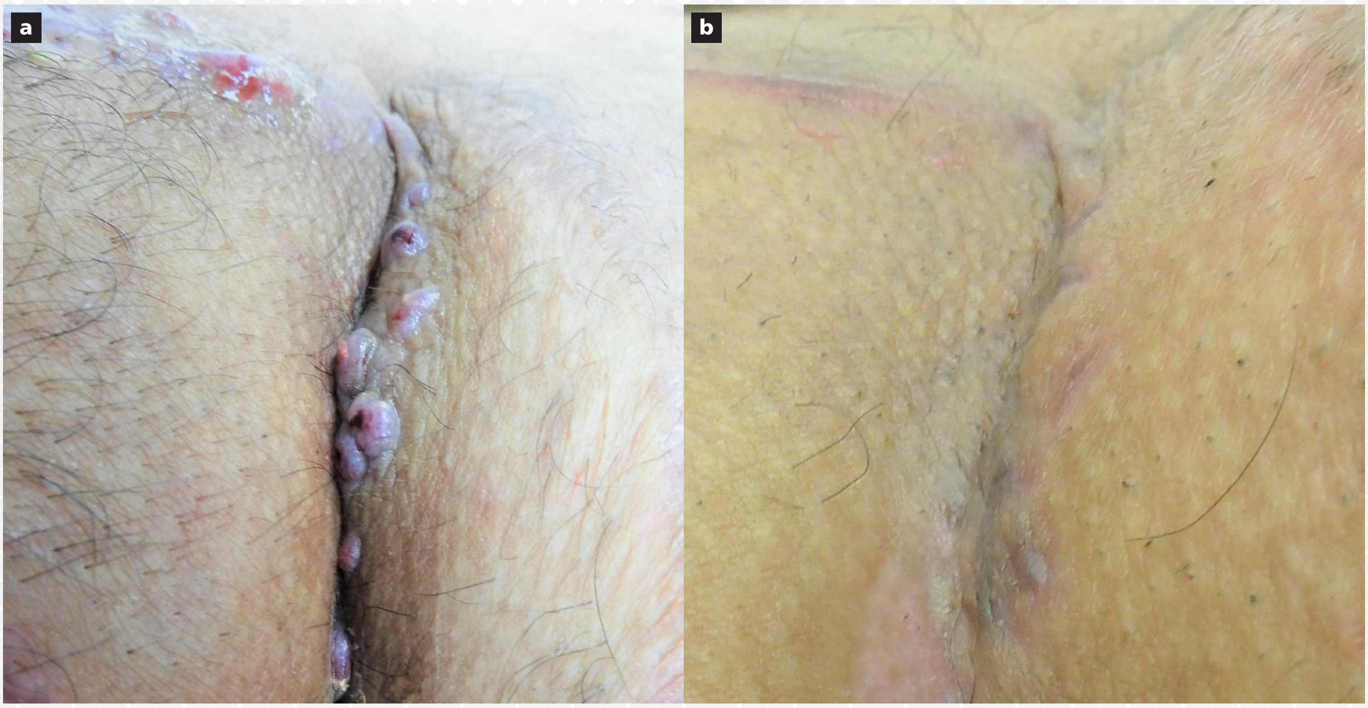
Liliana Marza

Figure 2. Non-healing wound with foul odour and discharge 4 months after surgery (a) and wound healed after cleaning and one laser depilation (b)



Liliana Marza

Figure 3. Communicating unhealed sinus 4 months after pilonidal sinus excision and before laser depilation (a), coarse hairs entering the sinus and visible pits (b) and wound healed following a series of laser depilations (c)



Liliana Marza

Figure 4. Hypergranulation following complex pilonidal sinus surgery (a) and wound healed following debridement and laser depilation (b)

Benedetto and Lewis (2005) have stated that excess hair growing in and around the gluteal cleft increases the risk of the occurrence of PSD, and the frequency and severity of recurrences are directly related to the density of the hair present on the buttocks. Loose hairs are sucked into the pilonidal sinus by friction and movement of the buttocks and then act as a foreign body, stimulating inflammation and infection (McCallum et al, 2008).

Numerous small-scale reports have shown the benefit of laser hair depilation for PS, leading to repeated calls for larger studies. A group of surgeons, led by Minneci et al (2018), were prompted by the 'very encouraging results' of their initial pilot study to carry out a large, prospective, controlled trial of laser epilation for PS to give a definite answer. Their historical data showed a 20% recurrence rate, but none of the 13 patients involved in the pilot study developed recurrence following laser depilation within 1 year.

At present, most surgeons recommend hair removal as a preventative measure for recurrence. The advice varies from shaving to using epilation creams to laser depilation. Electrolysis is not suitable for large areas, as it is time-consuming. Shaving and applying depilatory creams in the intergluteal area are inconvenient, require assistance and, in the long-term, lead to poor compliance and consequent recurrence (Hayes Inc, 2014). In addition, new haircuts increase the risk of hairs penetrating in the intergluteal area. Ghnnam and Hafez (2011) recommended that, for every patient with PSD, laser depilation be started before surgery and continued every 6 weeks for between six and eight sessions. A series of treatments are required to transform coarse hairs into fine hairs that do not cause recurrence of the PSD.

All types of light-based technology and laser hair-removal systems are suitable for reduction of hair growth. The choice of the type of laser used should take into consideration the patient's skin type, hair coarseness and pain tolerance (Marza, 2013). Blonde hairs, which lack melanin, do not respond to laser treatment. A series of treatments are well tolerated and are safe in the hands of laser specialists with an interest in this medical condition. Appropriate wound cleaning just before depilation is of paramount importance.

Compared with surgical treatment of recurrences, laser depilation is an efficient and cost-effective method of preventing recurrence and reducing morbidity (Almajid et al, 2017). As a result, a number of NHS clinical commissioning groups are now funding laser depilation of PSD, as are medical insurance companies, recognising the cost-effectiveness of such treatments (Marza, 2019).

The author has noted a tendency in recent years for more surgeons not to undertake repeat surgery until the periwound area has been laser depilated. The author recommends starting laser depilation early, as soon as the surgeon has reviewed the surgical wound at 4–6 weeks, to avoid hairs becoming embedded in the wound (*Figure 5*). It is advisable to review the patient every year thereafter, to ensure that the wound has stayed healed and the hair burden remains reduced.

Patient education

Patient education plays an important role in ensuring that the wound heals and reducing the risk of recurrence. Particular advice needs to be given according to each patient's individual circumstances and stage of the wound healing. What is practical will depend on the patient's occupation and level of support at home from family and carers. Dressings are very difficult to manage without support, and, the simpler the procedure, the more likely the patient is to adhere to treatment. Patients should be given verbal and written information (*Table 3*), including the rationale for the advice given.

Multidisciplinary collaboration

PSD should ideally be managed by a multidisciplinary team, with an agreed set of protocols and a treatment plan for every individual. Important members of the team include a surgeon with a specialist interest in PSD, a dedicated wound care nurse, a laser specialist and community support from primary care. Ideally, patients should be seen by the team as a whole so that they can understand the long-term plan of treatment and be reassured that the support they require is available. While it may be difficult to assemble such a dedicated team in every centre, the principles of multidisciplinary care should be maintained by effective communication between specialities.

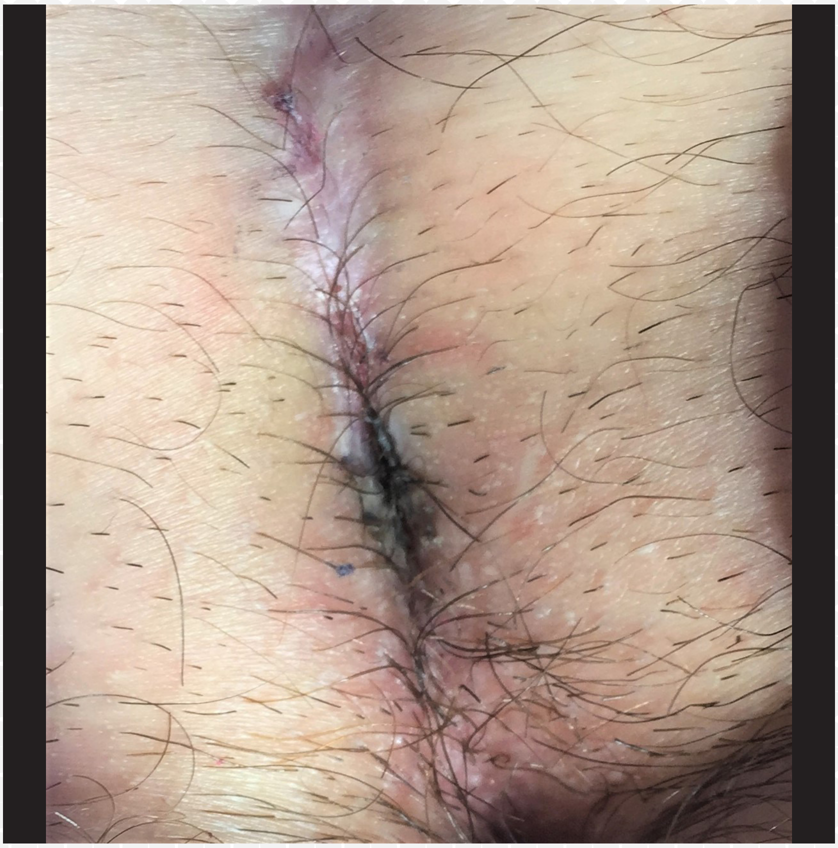

Liliana Marza

Figure 5. Embedded hairs in the wound and skin breaking 3 years after pilonidal sinus excision, causing pain and irritation every few weeks

Table 3. Lifestyle activities recommended and to be avoided to reduce recurrence of pilonidal sinus wounds

Area	Encouraged	To be avoided
Activity	Gentle walk, exercise	Squatting, cycling, riding, heavy weightlifting, impact sports; driving or sitting for long period of times
Diet and weight	Balanced, high-fibre foods; weight loss (if overweight)	Increase in weight/obesity; constipation
Clothing	Cotton underwear	Lint-shedding pants, thongs
Hygiene	Showering wound area (or using wet wipes) after opening bowels; leaning forward when washing occipital hair and following haircuts to avoid loose hairs accumulating in gluteal cleft; keeping perianal area dry by light patting +/- hairdryer on low setting	Loose hairs accumulating in the gluteal cleft; sweat and moisture in the inter-gluteal area
Hairs	Long-term intergluteal hair removal and yearly review	Coarse periwound hairs

Conclusions

Poor wound care following surgery increases the risk of PSD recurrence. All hair in the wound should be removed at every assessment, and patients should be educated to wash the intergluteal area carefully, particularly after haircuts, to prevent re-accumulation and to keep the perianal area dry. An appropriate dressing must be chosen for each stage of wound healing. Laser depilation of the periwound area should be started as soon as the surgeon has reviewed the wound. Even one laser depilation can enhance wound healing, although a series of laser treatments is advocated to make the hairs finer

CPD reflective questions

- List three wound care principles following pilonidal sinus (PS) excision with secondary closure
- What are the two main reasons for delayed healing following PS surgery?
- How does the presence of hair impede PS wound healing?
- What interventions should be carried out at each wound assessment?

and reduce the risk of PS recurrence. It is essential to give the patient consistent information by the multidisciplinary healthcare team to improve the outcome of this troublesome condition and reassure patients that they are receiving the best care. **GN**

__Declaration of interest__ None. Liliana Marza is an independent laser practitioner in private practice at Skin55 Dermatological Centre, London

Almajid F, Alabdrabalnabi A, Almulhim K. The risk of recurrence of pilonidal disease after surgical management. Saudi Med J. 2017; 38(1):70–74. https://doi.org/10.15537/smj.2017.1.15892

Benedetto A, Lewis AT. Pilonidal sinus disease treated by depilation using an 800 nm diode laser and review of the literature. Dermatol Surg. 2005; 31(5):587–591. https://doi.org/10.1097/00042728-200505000-00020

Brown AM. Caring for pilonidal sinus wounds and fistulas: a practical management guide. J Community Nurs. 2017; 31(6):44–47. www.jcn.co.uk/journal/12-2017/wound-care/1986-caring-for-pilonidal-sinus-wounds-and-fistulas--a-practical-management-guide/ (

Cooper R. Steroid therapy in wound healing (abstract from EWMA Conference, Glasgow, 2007). 2007. www.wcauk.org/uploads/files/documents/resources/educational-booklets/booklet_overgranulation.pdf (accessed 19 October 2020)

Doll D, Krueger CM, Schrank S, Dettmann H, Petersen S, Duesel W. Timeline of recurrence after primary and secondary pilonidal sinus surgery. Dis Colon Rectum. 2007; 50(11):1928–1934. https://doi.org/10.1007/s10350-007-9031-4

Doll D, Orlik A, Maier K et al. Impact of geography and surgical approach on recurrence in global pilonidal sinus disease. Sci Rep. 2019; 9(1):15111. https://doi.org/10.1038/s41598-019-51159-z

Gabriel A. Wound irrigation. Medscape. 2017. https://emedicine.medscape.com/article/1895071-overview (accessed 30 May 2020)

Ghnnam W, Hafez D. Laser hair removal as adjunct to surgery for pilonidal sinus: our initial experience. J Cutan Aesthet Surg. 2011; 4(3):192–195. https://pubmed.ncbi.nlm.nih.gov/22279385/. https://doi.org/10.4103/0974-2077.91251

Harris C, Sibbald RG, Mufti A, Somayaji R. Pilonidal sinus disease. Adv Skin Wound Care. 2016; 29(10):469–478. https://doi.org/10.1097/01.ASW.0000491324.29246.96

Harris CL, Laforet K, Sibbald RG, Bishop R. Twelve common mistakes in pilonidal sinus care. Adv Skin Wound Care. 2012; 25(7):324–332. https://doi.org/10.1097/01.ASW.0000416004.70465.8a

Hayes Inc. Laser hair removal for prevention of pilonidal sinus recurrence. 2014. www.crd.york.ac.uk/crdweb/showrecord.asp?linkfrom=oai&id=32014000490&linkfrom=oai&id=32014000490 (accessed 7 June 2020)

Johnson S. Haelan tape for the treatment of overgranulation tissue. Wounds UK. 2007; 3(3):70–74

Lloyd-Jones M. How does hypergranulation tissue work? Wound Essentials. 2014; 77(1):8–13

Marza L. Reducing the recurrence of pilonidal sinus disease. Nurs Times. 2013; 109(25):22–24

Marza L. Pilonidal sinus disease: a multidisciplinary approach. Trends Urol Men Health. 2019; 10(1):17–20. https://doi.org/10.1002/tre.673

Mangkorntongsakul V. Wound cleansers. 2019. https://dermnetnz.org/topics/wound-cleansers/ (accessed 19 October 2020)

McCallum IJD, King PM, Bruce J. Healing by primary closure versus open healing after surgery for pilonidal sinus: systematic review and meta-analysis. BMJ. 2008; 336(7649):868–871. https://doi.org/10.1136/bmj.39517.808160.BE

McCaughan D, Sheard L, Cullum N, Dumville J, Chetter I. Patients' perceptions and experiences of living with a surgical wound healing by secondary intention: a qualitative study. Int J Nurs Stud. 2018; 77:29–38. https://doi.org/10.1016/j.ijnurstu.2017.09.015

Minneci PC, Halleran DR, Lawrence AE, Fischer BA, Cooper JN, Deans KJ. Laser hair depilation for the prevention of disease recurrence in adolescents and young adults with pilonidal disease: study protocol for a randomized controlled trial. Trials. 2018; 19(1):599. https://doi.org/10.1186/s13063-018-2987-7

National Institute for Health and Care Excellence. Surgical site infections prevention and treatment. (NG125). 2019. www.nice.org.uk/guidance/ng125/resources/surgical-site-infections-prevention-and-treatment-pdf-66141660564421 (accessed 11 June 2020)

Newton H. Ten top facts about managing sinus wounds. Wound Essentials. 2016; 11(1):8–12

Oldfield A. The use of Haelan tape in the management of an overgranulated, dehisced surgical wound. Wounds UK. 2009; 5(2):80–81. www.woundsinternational.com/resources/details/the-use-of-haelan-tape-in-the-management-of-an-overgranulated-dehisced-surgical-wound (accessed 19 October 2020)

South West Regional Wound Care Program. Pilonidal sinus management guide. 2015. https://swrwoundcareprogram.ca/uploads/contentdocuments/pilonidalsinusmanagementguideline.pdf (accessed 19 October 2020)

US Army Medical Division. Pilonidal disease. Med Bull (NY). 1955; 12(12):291–292

Woo KY, Sibbald RG. A cross-sectional validation study of using NERDS and STONEES to assess bacterial burden. Ostomy Wound Manage. 2009; 55(8):40–48

Lesbian, gay, bisexual and transgender (LGBT) inclusion in nursing services: a reflective case study from stoma care

Abstract

Speaking with a female patient and her same-sex partner about their experiences of colorectal cancer and ileostomy surgery led to reflection on how specialist nursing care could be made more inclusive of the needs of lesbian, gay, bisexual and transgender (LGBT) people. The LGBT community includes people who are attracted to the same sex and/or identify as a different gender to the one they were assigned at birth. LGBT people in the UK have experienced a long history of discrimination and only begun to win legal protections over the past two decades, an experience that still affects the older generation especially. Compared with the general population, LGBT people are more likely to report poor health status, experience mental health issues and engage in risky behaviours; however, many are reluctant to attend healthcare services due to fear of discrimination. UK LGBT rights charity charity Stonewall surveys have revealed some discriminatory attitudes and widespread unconscious bias among health and social care staff. For health professionals, it can be a challenge to use the correct terminology to avoid causing offence, and there is a largely unmet need for inclusion training to improve their understanding and confidence to speak with patients about sexual preference and gender identity. However, confident LGBT inclusivity can be achieved with simple communication skills, such as equal treatment for same-sex partners, acknowledgement of post-transition names and pronouns and discretion in documentation, as well as awareness of verbal and non-verbal cues. Clinic environments can be made more LGBT-friendly with gender-neutral toilets, as well as wearable LGBT symbols, inclusive imagery and posters and literature that promotes LGBT rights, inclusion and support groups. Specialist nurses can act as role models and advocates for LGBT patients and colleagues in their area through small but impactful actions.

Pip Chandler, Coloplast Nurse Manager Wales and West, Coloplast Nursing Service, UK

gbpca@coloplast.com

Specialist nurses typically provide care for all sections of society, working with patients whose identities vary in terms of ethnicity and cultural background; socio-economic class; and sexual or gender identity. At all times, registered nurses have a duty to keep patients safe, preserve their dignity and place their interests at the core of service provision. This requires nurses to be able to recognise, assess and respond to the specific needs of each individual patient (*Box 1*). An important element of this is equality of treatment for people of different demographic characteristics working in and using healthcare services.

Equality is a major focus of the regulatory work carried out by the Care Quality Commission (2012; 2019), and the Nursing and Midwifery Council (2019) code of conduct requires nurses to ensure that their services are provided in an impartial manner. Achieving this requires nurses to regularly update their knowledge on relevant issues of equality, as well as teach themselves to recognise their own unconscious biases. This article presents a case study of the author's experience of providing stoma care for a patient who identified as homosexual and part of the broader lesbian, gay, bisexual and transgender (LGBT) community. Following the author's discussions with this patient, it also presents their reflections on how nurses (in general and in stoma care in particular) can do their best to understand and provide equitable care for LGBT patients.

Case study

Jane was a 42-year old woman in a long-term same-sex relationship. In 2018, Jane was diagnosed with bowel cancer, for which she underwent a course of radiotherapy and chemotherapy. In 2019, she underwent an anterior resection, resulting in the formation of a covering loop ileostomy, and she spent 4 days in hospital before discharge. While working as Jane's stoma care nurse, the author spoke with her and her partner, Sue, about their experience.

From the beginning, Sue described feeling isolated and frightened by Jane's cancer diagnosis, saying that she did not know where to turn. Her first reaction had been to tackle it via 'Dr Google', as well spending more time on online forums for LGBT people. However, she felt that this had served only to increase her sense of anxiety and loneliness.

In the preoperative period, Jane felt personally able to be open to the nursing staff about her sexual identity, which she felt was the result of growing up in an environment where she always felt comfortable about her sense of self. She also felt that they had received 'equality' in the care provided by the nursing staff, as the nurses had spent time with and shown interest in them.

However, Jane did not think she had either felt a sense of 'safety' or been able to build a rapport with the ward staff, which meant that she did not trust that they were open to discussions of more personal issues. She suggested that this may have resulted from the time pressure on surgical inpatients.

Meanwhile, Sue recalled feeling that they did not have 'permission' to talk about either the physical aspects of stoma care or the emotional impacts the diagnosis was having on them as a couple. She wondered 'Why is it that we could talk about poo, but our sexuality felt like too big an issue?', and she said that 'It would have been great if I could have seen that at least one member of staff was supportive of the LBGT community'.

Jane reported being particularly concerned about what she would be able to wear once she had a stoma, and this was a major worry in the first few days and weeks after surgery. However, she did note that this was likely an issue in common with heterosexual women.

Once Jane was home, she was able to spend time with her stoma nurse asking questions and discussing ways to manage her stoma and address concerns around intimacy. Jane reported feeling very lucky to discover that stoma formation had no major impact on her own sexual activity.

From speaking with other LGBT ostomates online, Jane and Sue both identified an unmet need for specialist support for people in their position, and this was one of the main topics of discussion on such forums. Stoma formation can be a devastating and isolating experience for anyone, and people with a minority sexual identity may be especially reliant on online communities for companionship and advice.

Supporting Jane and Sue led the author to a period of self-reflection on the care that they had received, as well as an awareness of the need to raise LGBT issues among stoma care nurses. This included undertaking research on LGBT issues in stoma care, in the literature, in patient leaflets and online. On patient support forums, there appeared to be some information about sexual health, which often emphasised that a stoma should not be used for penetrative sex, underlining that the stoma itself has no nerve endings and is formed from delicate mucosa. There seemed to be less emphasis on the needs of women than those of men, and especially of female same-sex couples.

Key words

- Diversity training
- Gender identity
- Health inequalities
- Sexual orientation
- Sexuality

This article has been subject to double-blind peer review

Box 1. Prioritising people

Nurses and midwives must ensure that those who are receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged. In order to treat people as individuals and uphold their dignity, nurses and midwives must:

- Treat people with kindness, respect and compassion
- Make sure they deliver the fundamentals of care effectively
- Avoid making assumptions and recognise diversity and individual choice
- Make sure that any treatment, assistance or care for which they are responsible is delivered without undue delay
- Respect and uphold people's human rights.

Source: Nursing and Midwifery Council (2019)

The LGBT community

LGBT is an umbrella term, inclusive of people who are attracted to the same sex (lesbian and gay) or both sexes (bisexual) and people who identify as a different gender to the one they were assigned at birth (transgender) (Fish and Williamson, 2018). The term is inclusive of a wide variety of people who do not conform to traditional gender and sexual boundaries, which may be reflected with additional initials, such as queer or intersex (e.g. LGBTQI+). Many LGBT people consider themselves united by a broad community of shared interests and cultural practices; however, its individual members are highly diverse in terms of culture, ethnicity and socio-economic status, as well as sexual and gender identity (Royal College of Nursing (RCN), 2016).

According to the Office for National Statistics (2017), 6.6% of the UK population have a sexual preference that is not heterosexual. Meanwhile, a study by Mercer et al (2013) found the number of people in the UK identifying as lesbian, gay or bisexual to be 2%, although this proportion rose to 7% of those 16–24 years old. The same study also found the number of people identifying as 'other' (neither homosexual nor heterosexual) to be 0.6%, an increase from 0.3% in 2012, while a further 4.1% did not answer the question. Meanwhile, Stonewall (2020a) puts the best estimate of the number of transgender and nonbinary people as around 1% of the population, which would be over half a million people in the UK.

Legal history

LGBT people in the UK have faced a long history of social discrimination and inequality (Stonewall, 2020b). Sex between men was only decriminalised in 1967 in England, 1980 in Scotland and 1982 in Northern Ireland. It was not until 1991 that the armed forces ceased criminal prosecutions against gay men and 2001 that the age of consent was equalised for gay men. Section 28, a law banning 'the teaching of the acceptability of homosexuality', was introduced as late as 1989 and only repealed in 2003. This repeal was followed by a succession of laws establishing legal rights for LGBT people, including the Gender Recognition Act 2004 and Marriage (Same-Sex Couples) Act 2013. LGBT people using health services are now protected by the Equality Act 2010, which prohibits discrimination based on gender reassignment or sexual orientation, as well as age, disability or sex.

According to Age UK (2019), many older LGBT people still live with the effects of having grown up under the fear of abuse or criminal prosecution, with the real fear of being forced to undergo electric shock therapy or chemical castration to 'cure' them of their desires. Some in this older generation may still be in the habit of masking their sexuality, hiding visible signs of their LGBT identity and avoiding public displays of affection, such as kissing or holding hands, with partners. Those living with dementia may find it harder to move past these fearful memories and recognise more recently established rights and protections (Harper, 2019).

Health inequalities

Because a person's sexual orientation and gender identity are a significant factor in their behaviour and sense of self, this would logically impact on their physical and mental wellbeing. On average, LGBT people have a poorer self-rated health status than the wider population and are more likely to have conditions that impact on their long-term health (International Longevity Centre UK, 2019). In terms of mental health, LGBT people are at greater risk of depression, anxiety, eating disorders and attempting suicide, and they are more likely to demonstrate more risky behaviours, such as smoking, alcohol, drug use and high sexual activity (Stover et al, 2014; Public Health England, 2015). These issues are summarised in a report by Stonewall (2018) (*Box 2*).

These unequal outcomes are likely driven by reluctance to seek care, driven by a fear

Box 2. Health status of LGBT people in the UK

- 52% said they've experienced depression in the past year
- 13% LGBT people aged 18–24 said they have attempted to take their own life in the past year
- 46% of trans people have thought about taking their own life in the past year; 31% of LGB people who aren't trans said the same
- 41% of non-binary people said they harmed themselves in the past year, compared with 20% of LGBT women and 12 % of GBT men
- 16% said they drank alcohol almost every day over the past year
- 13% of those aged 18–24 years took drugs at least once a month

Source: Stonewall (2018)

of potentially being stigmatised by health professionals (Doran et al, 2018). For example, Stover et al (2014) found that 14% of LGBT people avoided seeking treatment for fear of discrimination because of their sexual identity, and the Stonewall (2018) report found that 19% of homosexual people (rising to 40% of bisexual men and 29% of bisexual women) were not open to healthcare professionals about their sexual orientation.

Professional attitudes

The Stonewall (2018) report also suggested that there is some basis for this fear of discrimination, with 13% of LGBT people reporting having experienced some form of unequal treatment from healthcare staff because they identified as LGBT (*Box 3*). This is reflected in a study by Healthwatch Nottingham (2017), in which a third of LGBT people using health services felt that their sexual orientation had an impact on their experience of care, and 80% of these perceived this impact to be negative. Among the main contributors to these negative experiences were health professionals making assumptions about a patient's sexual orientation or gender identity (Fish and Williamson, 2018). Such assumptions often result in actions that are not intended to hurt but do cumulatively have a negative effect, sometimes termed 'microaggressions' (Sue, 2010).

A Stonewall and YouGov (2014) report on professional attitudes and beliefs in relation to the LGBT community sampled the views of 3001 health and social care professionals in the UK. Pockets of direct discrimination were identified, with 25% of patient-facing staff having heard colleagues make homophobic, biphobic or transphobic remarks. Meanwhile, many were not aware of LGBT-specific health issues, with 57% of patient-facing practitioners in Wales not considering sexual orientation to be relevant to a patient's health needs.

These reports imply that patient care is not only adversely affected by conscious discriminatory attitudes held by certain members of staff, but also by the internal biases that influence every single person. Internal biases refer to the brain's use of established mental associations to make decisions on certain topics without the person's awareness, intention or control (Harvard University, 2020).

Box 3. Health service experience of LGBT people in the UK

- 13% have experienced some form of unequal treatment from healthcare staff because they are LGBT
- 23% have witnessed discriminatory or negative remarks against LGBT people by healthcare staff; in the previous year alone, 6% of LGBT people (including 20% of trans people) witnessed these remarks
- 5% have been pressured to access services to question or change their sexual orientation when accessing healthcare services
- 19% are not out to any healthcare professional about their sexual orientation when seeking general medical care; this number rises to 40% of bi men and 29% of bi women
- 14% have avoided treatment for fear of discrimination because they are LGBT

Source: Stonewall (2018)

Inclusivity training

Stonewall and YouGov (2014) recommend practical ways to reduce the negative impacts of discriminatory attitudes and/or internal bias, including routine implementation of training, support and guidance designed to raise confidence levels and the understanding among healthcare staff.

According to Stonewall and YouGov (2014), 25% of health and social care staff in the UK (and 36% in Wales) have never been provided with any equality or diversity training by their employer. Meanwhile, only 5% of patient-facing practitioners in Wales stated that they had had training on the health needs of LGBT patients. The author's own professional training had not addressed LGBT-specific needs, which suggests that there is a need for more explicit standards and benchmarks on curriculum content and learning outcomes in nursing education (Higgins et al, 2019). Practitioners themselves report an unmet need for this preparation, with only 13% of 1200 nurses feeling prepared to meet the needs of transgender patients (Stonewall, 2018). It should be the responsibility of employers to provide their staff with sufficient educational resources on issues of equality, diversity and internal bias, including inclusivity training.

Asking patients personal questions is not easy, especially around sexual identity. This was recognised in the Stonewall (2018) report, where the proportion of staff who found it difficult to ask a patient about their sexual orientation (24%) was much higher than for other protected characteristics, including age (2%), religion (3%) and race (5%). This may be because LGBT issues are associated with a complex vocabulary, where it is difficult for people outside that community to stay on top of the correct terminology. This creates a fear that using the wrong language could cause unintended offence (Grundy-Bowers and Read, 2019).

Communication skills

A few simple communication skills should be able to empower nurses to feel confident speaking with LGBT patients about sexual orientation and gender identity.

For example, if an LGBT patient is accompanied by a same-sex partner, they should be treated the same as if they were in any other kind of marriage or relationship. It is important that a clinician's body language acknowledges the legitimacy of same-sex relationships, to avoid experiences such as that of Philippa, a contributor to the Stonewall (2018) report:

> **'I held out my hand to shake, and the nurse did not look at myself or my wife after I introduced who she was, and there was no eye contact throughout the interview. We felt we just wanted to leave.'**

Figure 1. Creating a safe and equitable environment for all

Likewise, with transgender and/or nonbinary people, it is essential to use and respect their chosen name and pronouns (e.g. he/his, she/her, they/their). Intentionally using their pre-transition name (deadnaming) or pronouns (misgendering) is likely to cause offence (Dean, 2016; Healthwatch North Somerset, 2018). However, directly asking them how they prefer to be referred to is likely to be taken kindly, as is correcting a mistake. LGBT people will understand that other people may be unsure of how to identify them in relation to their gender identity or sexual orientation, and it is acceptable to ask which terms they would prefer are used (Diversity Trust, 2018).

It is also important to offer LGBT people the option of discretion. Therefore, nurses completing a patient's documentation should only make a record of their sexual orientation with their prior consent (RCN, 2016).

It may be preferable to avoid the term 'next of kin', because this is traditionally confined to parents, children or spouses in a heterosexual marriage, and LGBT people are more likely to be estranged from or lack these conventional close relationships. Therefore, LGBT people should instead be given the opportunity to name any person who they feel closest to and would like to be informed about their care needs (Age UK, 2019), as well as the chance to name anyone they would specifically not want to have contact with (Glasper, 2016).

These small things can be moments that matter, and they may be remembered by the patient and their loved ones. It is a nurse's duty to be sensitive to the needs of their patients, and this means picking up on their verbal and non-verbal cues. Likewise, nurses should also be mindful of the cues they are giving themselves and ensuring that their own body language is open and impartial. According to Fish and Williamson (2016), this kind of consciousness awareness can make a difference when:

- Framing pre-assessment questions
- Addressing a patient's concerns about diagnosis or treatment
- Discussing the emotional impact with their partner
- Accessing other information, such as making benefits assessments etc
- Making conversation to fill time, such as when pushing a patient in a wheelchair or preparing equipment for treatment.

Inclusive spaces

Part of making a healthcare clinic open and inviting to all is a physical environment that fosters an inclusive culture and helps patients feel emotionally safe. This could be an organisation-wide structural change, such as the addition of unisex toilet facilities (alongside separate male and female toilets) to cater for nonbinary people and others who do not fit into simple male or female categories. However, there are other potential changes that are inexpensive and within each nurse's daily area of influence and can help create a safe and equitable environment for all (*Figure 1*)

The Stonewall and YouGov (2014) report found that 78% of health and social care staff had never seen any posters or literature that were specifically aimed at or inclusive of LGBT people. Therefore, all nurses should be challenged to champion simple, cost-effective displays of LGBT inclusion in their own working areas, such as:

- LGBT-friendly symbols on pins, stickers or lanyards worn by staff, such as rainbow flags and pink triangles, which indicate that an organisation is a safe place for LGBT people (Wilkerson et al, 2011; Grundy-Bowers and Read, 2019)
- Images of transgender people and same-sex couples among the pictures of people used in posters and patient literature, which can help normalise different sexual preferences and gender identities
- Posters and patient literature that promote LGBT rights and inclusion, aimed at patients or staff, which should ideally be made with the input of LGBT stakeholders, and signpost readers to LGBT support groups.

Conclusions

The strength of nurse–patient relationships can have a significant effect on quality of care and therapeutic outcomes (Kornhaber et al, 2016). Specialist nurses should act as role models and advocates for patients and colleagues, which means being prepared to speak up and help to bring about greater equality for everyone using or working in their organisation. Nurses are in a privileged position, being able to champion the rights of some of society's most vulnerable people, and therefore play a fundamental role in supporting the health needs of LGBT patients (Grundy-Bowers and Read, 2019). Every nurse can drive positive change in their clinical environment to improve the experience of LGBT people through small but impactful actions. **GN**

Declaration of interest *Pip Chandler is an employee of Coloplast*

Age UK. Safe to be me: meeting the needs of older lesbian, gay, bisexual and transgender people using health and social care services.2019. www.ageuk.org.uk/our-impact/programmes/safe-to-be-me/ (accessed 21 October 2020)

Care Quality Commission. CQC's Equality objectives for 2019-2021. 2019. www.cqc.org.uk/sites/default/files/20190408_new_equality_objectives_2019-2021_final_web_accessible.pdf (accessed 21 October 2020)

Care Quality Commission. Meeting the needs of lesbian, gay, bisexual and transgender people. 2012. www.cqc.org.uk/news/stories/meeting-needs-lesbian-gay-bisexual-transgender-people (accessed 21 October 2020)

Dean E. Fair care for transgender patients. Nurs Stand. 2016; 31(12):15. https://doi.org/10.7748/ns.31.12.15.s16

Diversity Trust. Trans health & wellbeing research report. 2018. www.diversitytrust.org.uk/research_reports/trans-health-wellbeing-research-report/ (accessed 21 October 2020)

Doran D, Williamson S, Wright KM, Beaver K. "It's not just about prostate cancer, it's about being a gay man": a qualitative study of gay men's experiences of healthcare provision in the UK. Eur J Cancer Care. 2018; 27(6):e12923. https://doi.org/10.1111/ecc.12923

Fish J, Williamson I. Exploring lesbian, gay and bisexual patients' accounts of their experiences of cancer care in the UK. Eur J Cancer Care. 2018; 27(1):e12501. https://doi.org/10.1111/ecc.12501

Glasper A. Ensuring optimal health care for LGBT patients. Br J Nurs. 2016; 25(13):768–769. https://doi.org/10.12968/bjon.2016.25.13.768

Grundy-Bowers M, Read M. Developing cultural competence in caring for LGBTQI+ patients. Nurs Stand. 2019; 35(2):29–34. https://doi.org/10.7748/ns.2019.e11390

Harper P. How healthcare professionals can support older LGBTQ+ people living with dementia. Nursin Older People. 2019; 31(5):16–21. https://doi.org/10.7748/nop.2019.e1115

Harvard University. Project implicit. 2020. https://implicit.harvard.edu/implicit/takeatest.html (accessed 21 October 2020)

Healthwatch Nottingham. Exploring health care experiences of the LGBT+ community. 2017 . https://hwnn.co.uk/wp-content/uploads/2016/12/lgbt-report-final.pdf (accessed 21 October 2020)

Healthwatch North Somerset. Trans health, care and wellbeing report. 2018. www.healthwatchnorthsomerset.co.uk/report/2018-04-30/trans-health-care-and-wellbeing-report (accessed 21 October 2020)

Higgins A, Downes C, Sheaf G et al. Pedagogical principles and methods underpinning education of health and social

CPD reflective questions

- What internal biases might you have regarding lesbian, gay, bisexual and transgender (LGBT) people, and might these impact on the care you provide?
- What changes can you make in your own practice area to make it more inclusive for LGBT patients?
- Do you know of any local LGBT support groups in your area?

care practitioners on experiences and needs of older LGBT+ people: findings from a systematic review. Nurs Educ Pract. 2019; 40:102625. https://doi.org/10.1016/j.nepr.2019.102625

International Longevity Centre UK. Raising the equality flag: health inequalities among older LGBT people in the UK. 2019. https://ilcuk.org.uk/raising-the-equality-flag-health-inequalities-among-older-lgbt-people-in-the-uk/ (accessed 21 October 2020)

Kornhaber R, Walsh K, Duff J, Walker K. Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. J Multidiscip Healthc. 2016; 9:537–546. https://doi.org/10.2147/JMDH.S116957

Mercer CH, Tanton C, Prah P et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). Lancet. 2013; 382(9907):1781–1794. https://doi.org/10.1016/S0140-6736(13)62035-8

Nursing and Midwifery Council. The professional duty of candour. 2019. www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/ (accessed 21 October 2020)

Office for National Statistics. Sexual orientation, UK. 2017. www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018 (accessed 21 October 2020)

Public Health England. Preventing suicide: lesbian, gay, bisexual and trans young people. 2015. www.gov.uk (accessed 21 October 2020)

Royal College of Nursing. Caring for lesbian, gay, bisexual or trans clients or patients. 2016. www.rcn.org.uk/professional-development/publications/pub-005592 (accessed 21 October 2020)

Stonewall, YouGov. Unhealthy attitudes: the treatment of LGBT people within health and social care services. 2014. www.stonewall.org.uk/our-work/campaigns/unhealthy-attitudes (accessed 21 October 2020)

Stonewall. The truth about trans: a Q&A for people who are hungry for real info. 2020a. www.stonewall.org.uk/truth-about-trans (accessed 21 October 2020)

Stonewall. Key dates for lesbian, gay, bi and trans equality. 2020b. www.stonewall.org.uk/about-us/key-dates-lesbian-gay-bi-and-trans-equality (accessed 21 October 2020)

Stonewall. LGBT in Britain: health report. 2018. www.stonewall.org.uk/lgbt-britain-health (accessed 21 October 2020)

Stover CM, Hare P, Johnson M. Healthcare experiences of lesbian, gay, and bisexual college students: recommendations for the clinical nurse specialist. Clin Nurse Spec. 2014; 28(6):349–357. https://doi.org/10.1097/NUR.0000000000000081

Sue DW. Microaggressions in everyday life: race gender and sexual orientation. Hoboken, N.J: Wiley; 2010

Wilkerson JM, Rybicki S, Barber CA, Smolenski DJ. Creating a culturally competent clinical environment for LGBT patients. Journal of Gay & Lesbian Social Services. 2011; 23(3):376–394. https://doi.org/10.1080/10538720.2011.589254