Tissue Issue

New Zealand Wound Care Society

New Zealand Wound Care Society Newsletter

Issue 14 — July 2011

Hello everyone!

As the new editor for Tissue Issue, I warmly welcome you to the July issue. Many thanks go to the Nelson & Marlborough branch for providing all the fantastic and high quality educational material for this edition.

This brings me on to future issues and a request. I would love to continue to fill these pages with articles and features that are relevant and pertinent to your practice. It might be a case study, a short piece on reflective patient care and how it changed your practice, a humorous story to share or a summary of published research. That means I need contributions PLEASE!! You all have expertise and experience that can be shared to help others. No matter what writing skills you have, any contributions will be gladly accepted. I'm very happy to help get anything written up and don't forget — pictures can tell a thousand words. So, don't delay! You can e-mail me any material or suggestions on how you think Tissue Issue could improve: caroltweed@xtra.co.nz

Carol Tweed — Wellington

President's Report

Firstly, a big thank you to all those who dialled in for the 2011 AGM, I believe we had one of the highest attendances recorded for a teleconference AGM for the Society. This is really important as the AGM is where you the members get to hear more about the NZWCS internal workings and get an opportunity to have a say on what the Society is doing. The other important aspect of the AGM is of course voting in new National Committee members and Area Coordinators. Again I would like to thank everyone for showing confidence in my leadership by re-electing me as President. I hope the next two years will see the Society continuing to grow its presence in NZ and internationally, as well as looking at innovative ways of increasing member benefits.

I would like to welcome all the new and returning National Committee members and Area Coordinators. It is really great to see that all areas are now represented on the Committee; this means each area can contribute to national level decisions and also communicate back to local members. I am also very pleased to welcome Carol Tweed as the new Tissue Issue Editor. This is a voluntary position that compiles the TI content and liaises with the designer, printer and commercial sponsors. So far this year we have had great support from specific Society Areas for TI content; Waikato for issue 13 and Nelson/ Marlborough for this issue.

An important decision made at the AGM was to raise membership fees in a staged approach over the next two years. This will allow the Society to generate enough income from memberships to cover the day-to-day expenses of running the Society, including membership of AWMA and the Wound Practice & Research and EWMA journals. It will also free up any funds generated from events, such as our national conference, so they can be used for project work and to increase member benefits.

Inside this issue

Editor of Tissue Issue

Carol Tweed

caroltweed@xtra.co.nz

What is the New Zealand Wound Care Society?

The NZWCS is a voluntary organisation made up of health care professionals from a variety of disciplines who share a common interest in wound management. As an organisation it gives its members an opportunity to share experience, expertise and knowledge providing a forum to network with other members throughout the country.

Currently there are fourteen branches New Zealand-wide. Each has an area coordinator and a national committee member. The area coordinator is responsible for coordinating meetings and seminars for the local branch members, while the national committee member represents each branch at a national level. In some areas these duties are undertaken by the same volunteer.

For more information & membership forms visit: www.nzwcs.org.nz

I am pleased to be able to announce the recipients of the inaugural NZWCS Research Grant. Following review of applications by a Scientific Advisory Committee, comprising a NZWCS National Committee member, two nursing academic researchers and myself, Dr Chris Hendry and her team at the New Zealand Institute of Community Health Care were awarded a grant for $9,940. The grant will allow the researchers to evaluate two years of clinical data from a nurse led specialist wound management service to identify risk factors for delayed healing and associated treatment strategies.

Best wishes

Wayne Naylor, President, NZWCS

Case study: Cavity wound management

A 77 year old patient, Mr H, sustained an injury falling from a height onto a garden stake initially causing a massive closed haematoma to his left thigh and extensive bruising to his left buttock. Mr H had been suffering balance problems related to medication, hence his fall.

His complex medical history determined how his wound would be managed:

1. Ischaemic heart disease CABG x3
2. Persistent atrial fibrillation (temporary success with pulmonary vein cryoablation).
3. CHF
4. Previous amiodarone induced thyrotoxicosis with subsequent border line hypothyroidism
5. Hypertension
6. Ex-smoker 40years ago
7. Left total knee replacement 2006.

The GP surgery was managing the wound using simple dressings ...until the closed necrotic eschar started to leak old blood!! It was at this point that Mr H was referred (Figure 1).

Management was by sharp debridement of the necrotic eschar to enable the removal of old haematoma and allow the wound bed to start granulating. Once the eschar was removed it was then possible to gently pack the cavity and undermining margins, which extended for 4–5cms (Figure 2). This was achieved using a Mesalt ribbon dressing and a secondary dressing of DryMax (now called Relevo).

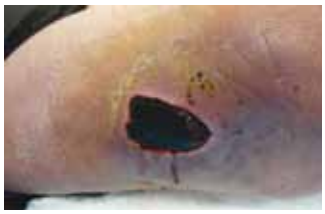

Figure 1: Wound covered with necroti c eschar

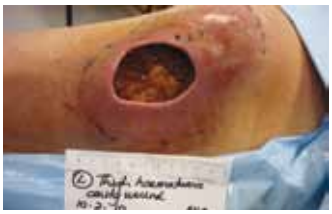

Figure 2: Cavity wound followng eschar debridment and old haematoma removal

As soon as the majority of the old haematoma was removed with Mesalt and the dressing was starting to stick to the wound bed, it was time to change the packing product to Aquacel Ag (Figure 3). The Aquacel Ag was fashioned to fit the wound bed to prevent the nurses trying to remove the dressing off the epithelialising margins (it is important to leave the dressing undisturbed). Plain Aquacel was then extended over the peri wound area to prevent maceration. A hydrocolloid was applied as a secondary dressing.

In the final stages of healing (Figure 4), a hydrocolloid was used as the primary dressing. Advice was given for scar management once the wound was fully healed (Figure 5).

Due to the conservative management of the wound it took 4 months to heal as the surgeon was not prepared to surgically debride or use VAC therapy due to Mr H's anti-coagulant therapy.

Susie Wendelborn

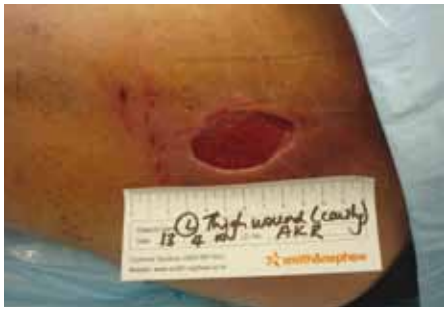

Figure 3: the healing cavity wound

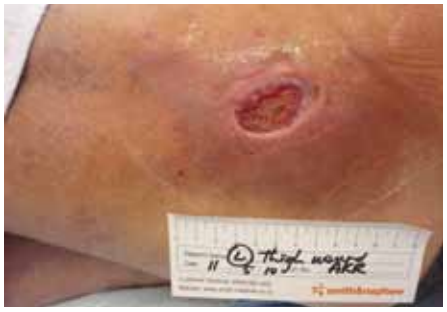

Figure 4: The wound almost completely healed

Figure 5: The final healed wound

A palliative wound case

Malignant wounds that have no potential to heal present a distinct profile of management challenges. Priorities may vary between individuals depending on performance status and general well-being, but the focus of wound management often requires meticulous care with dressing selection to manage high exudate, malodour and a tendency to bleed.

Such was the case for Bill, a 71 year old who had not seen a doctor for 17 years, after declining excision of a squamous cell carcinoma of his leg in 1993. When Bill did seek medical care in 2010 he had a malodorous, heavily exudating fungating lower leg ulcer measuring 20 cm x 15 cm (Figues 1 and 2). His leg also had contractures and he could no longer weight bear. Bill had a haemoglobin of 60g/l and was in functional hypoxia related to chronic blood loss anaemia.

Bill consistently declined limb amputation and assessment for palliative radiotherapy, but did accept blood transfusions when his symptoms indicated, and is now comfortable in residential care with a palliative wound care plan.

Dressings are minimised to three times weekly. Odour and bleeding tendency are managed using a topical preparation of ionic cream with 0.5ml coal tar LPC

Figure 1: Fungating squamous cell carcinoma right leg

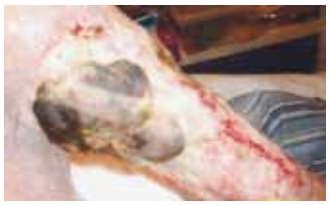

Figure 2: Fungating squamous cell carcinoma right leg (lateral view)

liquid, into which metronidazole and tranexamic acid tablets are crushed. This preparation is fully subsidised and prepared in 500g pots, which allow liberal application without causing the increased exudate and maceration that can occur with a hydrogel as a mixture base. Cuticerin is applied as a non-adherent layer and covered with Drymax, a highly absorbent secondary dressing containing cellulose and super polymers that comes in a 20 x 22 cm size, secured with crepe bandage.

This focused approach to palliation has achieved the primary goal of odour and exudate control, with reduction in bleeding episodes while the wound itself predictably continues to extend and grow, with less distress for the patient.

Cushla Arnot

Don't diagnose without all the information

Recently I was asked to do a Doppler assessment on a patient who had been referred with an ulcer that needed to be healed before her knee surgery. In the verbal hand over the nurse commented, "It's obviously arterial, could you do a Doppler?"

On examination the ulcer was punched out, pale, had a shiny taut appearance around the wound and was situated on the top of her foot.

However, once I completed the NZWCS Leg Ulcer Assessment Form, a very different picture emerged. The lady had had a major injury to her foot as a teenager with significant grafting, which had resulted in her foot lacking in normal subcutaneous tissue and a stretched pale appearance. She had also developed osteo-arthritis and now required replacements to both knee joints.

Her gait was very flat footed on her wounded side and she had very limited calf muscle pump when walking. She was unable to walk any significant distance, so I couldn't assess any claudication although she has a full flight of stairs at home and reported no calf pain using them.

I could find no evidence of blanching on elevation or dependent rubor and she had good capillary refill.

She told me she had had a ganglion on the top of that foot for some time but had accidentally dropped a pumpkin on it and this had burst the ganglion, causing the ulcer which was now not healing.

So, although this wound was in the area predominantly attributed to arterial ulcers, it had been a traumatic event originally. Her remaining history included high blood pressure controlled on medication, varicose veins and she was taking Prednisone for her osteo-arthritis. Her ABPI was 1.1 on both legs. Well, not an arterial ulcer, so there was hope!

We commenced her on compression bandaging at 40mmHg using the Coban 2 system. On initial assessment, the ulcer measured 8 x 8mm, and by the time of her surgery had reduced to 2 x 2mm. While in hospital on bed rest after her surgery, the wound has completely healed.

Raewyn Kaihe
District Nursing Services Co-ordinator, Motueka

Holistic Wound Care Conference

HOLISTIC WOUND CARE
NEW ZEALAND WOUND CARE SOCIETY CONFERENCE 2011 DUNEDIN

Date: November 2–4, 2011
Location: Forsyth Barr Stadium, Dunedin
Keynote Speakers: Professor Keith Harding (United Kingdom), Sue Templeton (Australia), Associate Professor Bill McGuiness (Australia)

Early Bird registration closes 1 September 2011
Further details on the NZWCS conference webpage:
http://www.nzwcs.org.nz/conf-2011.html

Journal Article Reviews

Bergstrom, K. (2010). Assessment and management of fungating wounds. *Journal of Wound Ostomy and Continence Nursing*, 38(1): 31–37.

This article provides an easy to read overview of the epidemiology of fungating wounds including assessment and options for management. The author challenges wound care nurses to "initiate and participate in interdisciplinary studies addressing these challenging wounds."

The author discusses the importance of assessment and highlights that treatment should be developed with a multidisciplinary approach to meet the individual's own goals and wishes. The article focuses on varying treatment options for pain, exudate, odour, bleeding, peri-wound skin irritation and psychosocial support.

The author advocates that wound care nurses should have an active role in assessment and management to control the distressing symptoms of fungating wounds. As well as acting as advocates and providing education for patients, the nurse "should generate and participate in further research about fungating wounds". For my own practise the article provided further treatment and management options for patients with fungating wounds and highlighted the need to be creative with available products.

Sue Rossiter

Vanderwee, K., Defloor, T., Beeckman, D. et al (2011). Assessing the adequacy of pressure ulcer prevention in hospitals: a nationwide prevalence survey. *BMJ Quality & Safety*, 20(3): 260–267.

A nationwide study was undertaken in Belgium to identify prevalence and adequacy of pressure ulcer preventative interventions. One hundred and forty-three hospitals were invited to participate of whom 68% (n=84) agreed.

A standardised methodology using the European Pressure Ulcer Advisory Panel (EPUAP) minimum data set was used encompassing general data, patient data, risk assessment using the Braden risk assessment tool, skin observation and prevention. Pressure ulcers were categorised using international pressure ulcer guideline definitions. To improve inter-rater reliability, supervisors undertook training sessions and they provided on-going teaching to multiple groups of 2 nursing staff who subsequently inspected every patient's skin as part of the data collection. All data collection occurred over a 10 day period in April 2008. The total sample comprised almost 20,000 patients of whom 60% were over the age of 70 and 25% at risk of PU development according to the Braden scale.

Overall only 10.8% of the patients at risk received fully adequate prevention (defined as preventative measures — equipment and repositioning — for both bed and chair nursing). Conversely, more than 70% of patients not at risk received some preventative measures, which could be considered inefficient and unnecessary. The sacrum and heels were the most commonly affected areas for pressure ulcers. The overall prevalence was 12.1% for categories I–IV, for categories II–IV, prevalence was 7%.

The authors suggest that if preventative measures were to improve, the prevalence of pressure ulcers may decrease. The challenge for hospitals is to effectively disseminate and implement pressure ulcer guidelines and to address barriers.

Carol Tweed

Pan Pacific Ulcer Forum, Venous Leg Ulcer Forum

Date: October 15–17, 2011
Location: Canberra, ACT, Australia
Venue: Rydges Lakeside
Fees: NZWCS members receive the AWMA member discount for registration fees
Further information: www.panpacificulcerforums.com.au

NZWCS National Committee & Area Coordinators

Wayne Naylor — President
Pam Mitchell — Vice President

Northland/Auckland: Prue Lennox — Committee Member & Area Coordinator

Waikato: Julie Betts — Committee Member, Angela Carter & Anna Campbell — Area Coordinators

Rotorua/Taupo/Bay of Plenty: Diane Hishon — Committee Member, Lyn Dalton & Karen Tonge — Area Coordinators

Hawke's Bay: Leonie Smith — Committee Member & Area Coordinator

Manawatu/Whanganui: Desley Johnson—Committee Member, Denise Shailer — Area Coordinator

New Plymouth/Taranaki: Chris Gruys — Committee Member & Area Coordinator

Emil Schmidt — Treasurer
Jeannette Henderson — Administrator

Wellington: Paula McKinnel — Committee Member, San Gerryts — Area Coordinator

Nelson/Motueka: Susie Wendelborn— Committee Member, Sue Rossiter — Area Coordinator

Canterbury: Val Sandston — Committee Member, Karyn Ballance — Area Coordinator

Otago: Rebecca Aburn — Committee Member & Area Coordinator

Southland: Mandy Pagan — Committee Member, Joanna Hunter — Area Coordinator

See the NZWCS website Committee and Coordinators page for contact details of the National Committee members and Area Coordinators.