Tissue Issue

New Zealand Wound Care Society

New Zealand Wound Care Society Newsletter — Issue 18 — November 2012

Welcome

Welcome to the November *Tissue Issue*. Thanks to all our contributors and special mention to Convatec for sponsoring this edition. Printing, production and postage of Tissue Issue is expensive and company sponsorship is invaluable in enabling this to happen.

Hope you enjoy this edition. As always I would love to hear from you with any news, views and articles for future editions.

Carol Tweed (Editor)

President's Report

Firstly my apologies for being somewhat out of touch over the past few months. It has been a busy and quite hectic time for me and my family as I take on a new job and we resettle in the Waikato. I have been in my new job as Director of Nursing at Hospice Waikato since late August, but that has been interspersed with the World Union of Wound Healing Societies congress, consultation meetings around New Zealand as part of a project for my previous job, and of course finding a house and moving my family up from Wellington!

In August I attended the College of Primary Health Care Nurses NZNO Inaugural Conference at the Claudelands Conference and Exhibition Centre in Hamilton. We had an NZWCS stand in the trade exhibition and many delegates stopped by to peruse our publications and ask about becoming members. I also presented as did Julie Betts (on the VLUG), and Jan Rice as a Keynote speaker was also promoting our organisation and the new Venous Leg Ulcer and Pressure Injury Guidelines. Thanks to Julie Betts and Maria Schollum for their help in running the NZWCS stand.

Shortly after moving to Hamilton I travelled to Yokohama, Japan for the World Union of Wound Healing Societies (WUWHS) congress from September 2–6. At the congress I helped set up and man the joint AWMA/NZWCS stand to promote our bid for the 2016 WUWHS congress.

Unfortunately we were unsuccessful in our bid, with the next congress going to Italy to be held in Florence. Overall the congress was quite good, although the huge number and variety of concurrent sessions made it difficult to get to everything of interest, and the congress was spread over two very large venues making it difficult to get around. The trade exhibition was very large with a wide array of companies and products, but due to its location was very poorly attended by delegates. For me some of the more interesting topics were promoting patient wellness and reducing the impact of wounds on patients and health resources, advances in negative pressure wound therapy and developments in pressure injury/ulcer care, particularly new research on using dressings to prevent pressure injuries. Many of the symposia were sponsored by companies, which unfortunately resulted in useful and relevant information being highly commercialised.

Inside this issue

Editor of Tissue Issue

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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

The 2013 NZWCS conference planning is progressing well with the website now live, a draft programme developed and keynote speakers confirmed. The Committee is now in the process of approaching local speakers to deliver plenary sessions and workshops. Abstract submissions are open so please visit the website (http://www.akblimited.co.nz/nzwcs) and spread the word around your colleagues and local organisations.

We need to start thinking about who might be interested and able to take on the role of President of the Society from the next AGM, as I will not be standing for re-election in 2013. I would encourage you all to start thinking about and discussing potential nominees, as we need to be prepared for the AGM. Best wishes to you all.

Wayne Naylor (President)

Wellington Regional Study Day — Evidence Based Wound Care. 28th July 2012

Report by Paula McKinnel — CNS Wound Care. Capital and Coast DHB

The passion for wound care is just amazing. Nearly 90 people gave up a beautiful weekend in late July for updated and new knowledge of evidence based wound care. Delegates came as far north as Auckland and as far south as Blenheim.

The day had a focus on the new pressure injury and venous leg ulcer guidelines and evidence based wound care. The feedback from the day was very positive giving delegates the opportunity to be updated on the new guidelines and evidence of them being used in practice. The delegates also enjoyed the opportunity to network and visit the trade exhibition for new products and services. We had a breath of speakers, local, national and international.

Pip Rutherford (NP Hawkes Bay) and Associate Professor Michael Woodward (Australia), had the challenge of presenting the guidelines and highlighted ways forward in implementing these in the workplace. This was well received by the delegates and created much discussion at break times.

Kate Gray presented 'Partnership Perspective' through a variety of case studies and the approaches to 'partnership' in wound care, which left us in no doubt on reflecting on our interpretation of what this meant to our own practice areas and the importance of patient quality of life.

(Note from editor . . . this reference is: International Consensus. Optimising wellbeing in people living with a wound. An expert working group review. *Wounds International, 2012*.
Free at www.woundsinternational.com).

A dynamic presentation from our local dermatologist Dr Lisa Judd on 'red, weepy, scaly legs' answered much more than that for us in the hour she was with us.

I'm sure there was a few of us who wished she was also available at lunch time to enable us to quiz her some more. Dietician Jo Stewart presented the new evidence of nutrition in wound healing and outlined the changes in the prescribing of nutritional supplements. Clare Jones (CNS Acute Community Care, C&C DHB) shared with us the Cellulitis Pathway initiative lead by the Community and Emergency Dept, through the development phase, the results so far and the future ahead.

Associate Professor Michael Woodward had the final word for the day and presented on the care of the older person with wounds, which included the risks of polypharmacy and how drugs effect wound healing. It was encouraging to hear that just because you are old does not mean you don't heal, but that healing generally occurs more slowly and is dependent on the co-morbidities.

I'd like to thank all the companies (Smith & Nephew, Covidien, Arjohuntleigh, ConvaTec, Monolycke, DME, 3M & USL) for their continual support in the education of wound care and giving up their time on such a beautiful Wellington day. A special thank you to Covidien for sponsoring Associate Professor Michael Woodward from Australia, to present for us. Also big thanks to:

- All our speakers for volunteering their time to speak and sharing such a breath of knowledge.
- To the delegates, who dedicated their time to spending a Saturday learning more to wound care practice.
- Lastly to San Gerryts (Wellington NZWCS co-ordinator) and team for putting together another successful study day.

Inviting all continence and wound care nurses to join the Stomal Therapy Section

The NZNO Stomal Therapy section would love you to join us as we progress towards NZNO College status. We are keen to increase our membership and would appreciate your knowledge and expertise, as stomal therapy combines aspects of wound care and continence, and many of our Stomal Therapy members also work as Wound Care Nurses or Continence Advisors. It therefore seems like a natural liaison.

Benefits for you would include:

- being part of a small and friendly group of professional nurses
- receiving and being able to contribute to our excellent journal four times a year
- having the opportunity to have your say and influence nursing with representation at regional and national level, advising the decisions of policy-makers
- learning, networking and enjoying yourself at our biennial Stomal Therapy Conference
- free membership
- the opportunity to receive awards and scholarships.
- being assured your support industrial strength and professional development, get the most from your union!

To join our section email Jackie Hutchins @ wayne.hutchings1@clear.net.nz

Case study: Management of a lower leg haematoma wound.

Anne Stone — CNS (Wound Care). Whanganui DHB

This case study outlines the management of a lower leg haematoma with complications which occurred because of delayed intervention. Recommended wound management for lower leg haematomas includes early evacuation of the haematoma to salvage tissue, high or low compression therapy (dependent upon suitability of patient to tolerate) to re-adhere skin, reduce risk of reformation of the haematoma, reduce trauma and reduce necrosis. *(Pagan 2011)*

An 85 year old lady, Mrs. B, sustained injuries when both her shins were caught in the car door. Mrs B was taken to the Accident and Medical Clinic where she was treated and advised to see her GP for on-going wound care. There was a skin tear on the left shin and a haematoma on the right shin. Mrs. Bs' daughter in law phoned the CNS in Wound Care voicing concerns about the severity of the wounds. After consultation with Mrs.B's GP it was arranged for the patient to be assessed in her home by the CNS in wound care. At this point she had been seeing her GP for one week post injury.

It is essential to recognise systemic and environmental factors that affect wound healing and treat these alongside local wound factors. A way to diagnose and manage these factors is using the mnemonic HEIDI (history, examination, investigation, diagnosis, intervention).

History

Medical — hypertension, angina, transient ischaemic attacks, heart failure, ischaemic heart disease, and osteoarthritis. The patient lived alone in her own home and was independent in her personal cares. When outside she used a walker to assist mobilisation.

Wound history — a previous skin tear on the lower leg took months to heal. Medication: Aspirin (anticoagulant), Flucloxacillin and Paracetamol.

Examination

The left leg had a skin tear with an intact skin flap (6cm x 4cm). This needed no intervention and the area was monitored.

Right leg — the assessment of the skin and limb provides information to help with diagnosis and planning of the intervention(s). Wound bed preparation is essential for healing. For the wound assessment the "TIME" principle was used.

Tissue: The haematoma measured 12cm long by 8cm wide. The depth could not be ascertained due to congealed blood over the area. The tissue was non-viable.

Infection: There was pain, heat, swelling and redness to the wound and surrounding skin indicating there was infection present in the haematoma and surrounding skin (cellulitis). The haematoma was providing an ideal medium for bacteria to flourish.

Moisture: There was slight dark blood stained exudate

Edges: The right lower leg was oedematous. There was bruising on the surrounding skin, also swelling above the haematoma indicating deeper damage and redness and heat indicating infection (*Figure 1* pre-debridement).

The patient was experiencing pain from the wound which she described as throbbing and burning; this was assessed as a level 5 when at rest and 7 when mobilising.

Investigations: Microbiology — the wound swab result showed *Staphlococcus* aureus.

Vascular assessment — A hand held Doppler was unable to pick up a very good sound in the feet. There was a good capillary refill. The findings and patient history indicated arterial disease. This was suggestive that high compression bandaging wasn't a safe option to reduce oedema and aid healing.

Diagnosis: There was a haematoma to the right lower leg and the left leg had a category 1b skin tear (STAR classification). The patient had multiple systemic pathologies resulting in reduced arterial flow to the lower legs that were likely to delay or prevent wound healing.

Interventions:

Nursing objectives were identified as:

- To provide an appropriate wound healing environment
- To decrease bacterial burden

Following assessment by the CNS, Mrs B was taken to the ED for commencement of IV antibiotics. Venous access was obtained, first dose given in ED and thereafter continued by the District Nurses at home. Because there hadn't been early evacuation of the haematoma, pain, infection and tissue necrosis had occurred with potential for the wound to become chronic. Sharp debridement was indicated to reduce the bacterial burden to assist in infection management, to allow visualisation of the wound bed and to allow healing; however because of concurrent anticoagulant therapy, conservative debridement took place whereby dead skin and congealed blood were gently removed from the surface.

This was undertaken by the CNS in the patient's home once antibiotic therapy had commenced. The procedure was explained to the patient and consent obtained. Paracetamol was administered and EMLA applied to the wound area 30 minutes prior to the procedure.

The patient did not experience any increase in pain during the procedure. Despite debridement there was still haematoma visible undermining to about 3cm. Autolytic debridement was supported using Intra-site Gel and Iodosorb to assist removal of the remaining haematoma, reduce bioburden and additionally to prevent any trauma or pain during dressing change.

A low adherent primary dressings and an absorbent secondary dressing were applied.

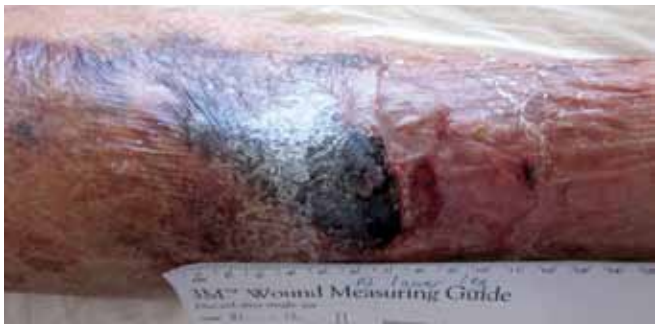

Figure 1: Pre-debridement

To reduce oedema Surepress padding was applied to further protect the skin and provide absorption. This was followed by application of a Setocrepe bandage toes to below knee. The patient was also asked to elevate the legs during the day.

The District Nurses re-assessed the wound, cleansed and reapplied dressings every 2 days in the community.

Evaluation: After 5 days of IV antibiotics the patient continued on oral therapy for a further 2 weeks. Pain was managed by regular administration of paracetamol which was assessed to be effective. The haematoma was gradually evacuated over this time period, the pain subsided and the oedema in the right leg and swelling above the wound reduced (*Figure 2* one week post debridement). The skin tear on the left leg healed in 2 weeks. The haematoma wound healed in 4 weeks.

Considering the patient's co-morbidities and complications from the haematoma, it was amazing the wound healed in that time. The patient's concordance with therapy, CNS intervention and the District Nurses care enabled the wound to heal in a short time frame preventing a chronic wound developing.

Conclusion: Faster wound healing was achieved following debridement. Appropriate management of lower leg haematomas immediately post trauma can prevent complications occurring.

References:

Carville, K et al (2007) STAR: A consensus for skin tear classification. Primary Intention; 15(1)18–28.

Pagan, M. Hunter, J (2011). Lower Leg Haematomas: Potential for complications in older people. Wound Practice & Research;19(1):21–28

Figure 2: One week post debridement