

JCN Roadshow booklet

2015



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Learning something new every day

Nelson Mandela said that 'education is the most powerful weapon you can use to change the world', and while the world might be slightly out of reach for most of us, here at the JCN we do believe that remaining interested in our working



environment and making a little difference everyday can help to change practice, and even the culture of our workplaces. Education doesn't necessarily have to come from great institutions or eminent professors — it can be found in the skill of our colleagues or by listening to patients' previous care experiences.

Education has been very important to the development of JCN's philosophy. Education provides nurses with the tools to develop, which means that patients benefit. Without regular education, poor practice and entrenched ideas can proliferate, which can result in ritualistic practice that means patients can be forgotten. Perhaps one of the most recent examples was the Liverpool Care Pathway, where clinicians of all persuasions had been relying on what they thought they knew, rather than learning new skills and questioning practice. This is where regular education can change lives.

JCN's commitment to education is clear in the free journals we produce; the free access to our website; and most obviously in our roadshows. These national events offer an opportunity for community nurses to try out the latest products, treatments and techniques. Delegates also get the chance to attend a selection of certificated study sessions that focus on important areas of their caseload. This booklet aims to give a snapshot of one day at a JCN roadshow and we hope that it may encourage you to come along in the future (check our website for details www.jcn.co.uk/events). As with all our educational offerings the JCN roadshows are free and we hope that their quality demonstrates our ongoing commitment to nursing educating.

Jason Beckford-Ball, editor,
Journal of Community Nursing

Managing director

Nicola Rusling
nicola@woundcarepeople.co.uk

Publisher

Binkie Mais
binkie@jcn.co.uk

Editor

Jason Beckford-Ball
jason@jcn.co.uk

Business manager

Alec O'Dare
alec@woundcarepeople.co.uk
07535 282827

© Wound Care People Limited 2015

First Floor, Unit G, Wixford Park, George's Elm Lane, Bidford on Avon, Alcester, B50 4JS

t: +44(0) 1451 870310 e: binkie@jcn.co.uk

<http://www.journalofpracticenursing.co.uk>

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Julie Trudgian, lead nurse tissue viability, Royal Cornwall Hospitals NHS Trust

Simplifying the wound-healing matrix

This session looked at chronic wounds and why they sometimes fail to heal, with particular emphasis on the role of the nurse in stimulating the biochemical process that provides the right environment for healing.

The main aim of the session was to explore how familiar the delegate's were with the following elements:

- ▶ The wound-healing process:
- ▶ How dressings can impact on wound healing
- ▶ How to choose the best dressing for the wound.

The session began with some questions to gauge the extent of the delegates' knowledge. Questions included:

- ▶ What is your profession?
- ▶ What is the most important cell during the proliferative phase of healing?
- ▶ Do you believe that wound dressings can influence healing?
- ▶ What factor do you look for when choosing a wound dressing?

After the initial question-and-answer session helped to establish the extent of the delegate's knowledge, the session moved on to a discussion of the mechanics of wound healing.

NORMAL WOUND HEALING

Wound healing is a natural process with many overlapping stages as defined by Calvin (1998):

'A dynamic, natural and efficient process that involves the overlapping of

various healing stages, with a continual sequence of regulatory mechanisms that bring about the ultimate healing of the wound.'

The session outlined how construction work can be a useful metaphor for the wound-healing process, with the immediate aftermath of a wound requiring an emergency response (haemostasis); working through demolition (inflammation); to rebuilding and interior design (proliferation and maturation) (Asmussen and Sollner, 1993) (see *Table 1*).

The session outlined how construction work can be a useful metaphor for the wound-healing process...'

Particularly crucial to the proliferative phase of healing are the fibroblasts. These are known as the 'workhorses' of wound repair and produce components of the

extracellular matrix, including collagen and fibronectin, to help form new granulation tissue. Fibroblasts appear in large numbers three days post injury and reach peak levels at day seven, with their main function being to form new connective tissue.

Specialised fibroblasts (myofibroblasts) draw the edges of the wound together (contraction), which reduces the size of the wound, lessens the potential for infection, and speeds healing.

WHY DO WOUNDS NOT HEAL?

When delegates were asked why wounds sometimes become chronic they gave a range of responses, including 'poor nutrition', 'infection' and 'comorbidities', all of which can be a factor in impeding healing.

Healing is a local process that takes place within the wound bed, but it is also influenced by systemic and environmental factors (*Figure 1*).

Table 1: The normal wound-healing process

Phase	Time	Cells	Building function
Haemostasis	Immediate	Platelets	Emergency services
Inflammation	Day 1-4	Neutrophils	Demolition team
Proliferation	Days 4-12	Macrophages	Project manager
		Fibroblasts	Scaffolding team
		Keratinocytes	Roofers
Maturation		Fibrocytes	Interior designer



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Figure 1. Reasons for delayed healing.

Assessment

Because there are so many reasons why wounds may not heal, a proper holistic assessment that considers all areas of the patient's life, including physical and psychological wellbeing, is crucial — without a complete assessment it is impossible for the nurse to identify the particular causative and contributory factors that may be influencing wound healing.

For example, if a patient with significant oedema and a lower-limb leg ulcer spends a lot of the day sitting in a chair watching the television, this will have an impact on the potential for healing, but the nurse will only discover this during a conversation about lifestyle.

Similarly, comorbidities such as diabetes or chronic heart failure, may seriously affect a wound's capacity for healing, but this will only be revealed by a detailed examination of the patient's medical history.

THE MAIN GOALS OF HEALING

When the holistic assessment has been completed, it is time to turn the attention to healing. In wound care the main goals of healing are:

- ▶ Resolving infection
- ▶ Removing excess slough and dead tissue from the wound
- ▶ Managing exudate
- ▶ Managing underlying systemic

illness which may be delaying healing

- ▶ Managing systemic illnesses that influence healing
- ▶ Promoting wound contraction.

Case 1

In this case the female patient presented with vasculitis on both lower legs. The underlying haemolytic disorder put her at increased risk of infection and both feet had broken down resulting in painful wounds over the Achilles tendons. This meant that she could not walk independently and was not sleeping.

From a nursing management perspective the patient required pain control, a plan to deal with exudate, and desloughing of the wound bed. From a dressing-selection point of view, a product was needed that would promote healing and provide pain-free wear time and removal.

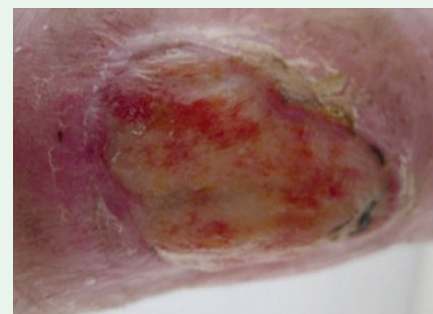
Support was also sought from the dermatologist, haematologist, physiotherapist and occupational therapist. The author chose to use UrgoClean® (Urgo Medical) for its desloughing properties and its ability to stimulate the activity of fibroblasts in the wound bed. An adhesive foam dressing was used as a secondary dressing.

The session also highlighted the role of exudate, with healing requiring a moist wound bed, which is neither too wet nor too dry as both will affect healing.

Dressing selection

One of the main treatments for any type of wound is an appropriate dressing, but with so many dressings available the choice can be daunting. Below are some basic principles that nurses should remember when approaching dressing selection:

- ▶ Evidence: is the dressing supported by research evidence or in guidance from bodies such as the National Institute for Health and Care Excellence (NICE)?
- ▶ Past dressing experience: which types of dressings have worked for previous patients
- ▶ Aim of treatment: is the treatment goal to absorb exudate (higher absorbency dressing), fight infection



At the end of the treatment period, the level of slough had been reduced and the volume of exudate from the wound controlled. There was fresh granulation tissue covering the tendon and the wound began to heal rapidly. The patient also reported that her pain and quality of life had improved.

(antimicrobial dressing), or provide protection for the wound bed (film dressing)? All of these considerations, and many more, may influence dressing choice

- ▶ Professional accountability/the law: does the nurse have the correct knowledge and experience to make an informed decision? Remember, it is always a good idea to consult with a colleague if unsure
- ▶ Wound classification: is the wound a pressure ulcer or a venous leg ulcer? Is it highly exuding or infected? Arriving at the correct wound classification will help with accurate dressing choice
- ▶ Cost: one of consequences of the explosion in wound care technology has been the range of products now available. Nurses may be limited by their local formulary, but it is important to bear in mind the cost of different dressings
- ▶ The law: nurses are responsible for their own practice and any decisions made. Nurses must ensure that they are acting within their knowledge base and that they document all treatment decisions or changes in wound status.

STIMULATING HEALING

It is important to identify any factors that are preventing patients from healing themselves. This can be done by exploring the 'pathway' of their condition and treatment to date and identifying factors that may be blocking the healing process.

Nurses should aim to stimulate healing from the point of injury, with dressings that can address the presentation of the wound and are specifically designed to create the optimum conditions for healing from first application.

Finding the right evidence

How does the nurse know when he or she has chosen the right dressing for the right patient? Randomised controlled trials (RCTs) are the best source of evidence, however, there are few of these available in tissue viability, partly due to the difficulty of achieving consistent sample groups.

Alternatively, case studies can also provide evidence. Good case studies should consider all variables affecting healing and provide visible evidence of the experience of a patient with a wound.

Case studies

Some clinical case studies from the author's practice illustrate the points made above about providing the best environment possible to encourage wound healing (see case study boxes).

CONCLUSION

As seen in the presentation above, no matter what the presenting

symptoms and underlying factors involved in the presentation of a wound, holistic assessment, evidence-based dressing selection and optimising the action of fibroblasts to stimulate healing can result in better outcomes for patients and more cost-effective wound care. **JCN**

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Case 2

This case featured a 47-year-old man who presented with a leg injury sustained in a road traffic accident. This left him with a lower leg fracture that had healed following the application of an external fixator.

However, the patient developed a chronic leg ulcer, even though osteomyelitis was ruled out twice and there was no venous or arterial disease (this was confirmed by Duplex scanning).

The patient experienced repeated infections, which were treated with manuka honey, before finally being diagnosed with leukocytoclastic vasculitis (a disorder of the skin caused by small-vessel vasculitis, or inflammation in the blood vessels).

A management plan was drawn up with the patient in an attempt to heal the wound. This involved a multidisciplinary team approach, including input from the dermatology team, a haematologist, the tissue viability specialist, and the orthopaedic team.

A biopsy was performed to determine the cause of new areas of necrosis and the vasculitis was treated with steroids.



The new areas of necrosis were possibly due to an increase in bacterial burden, therefore the team decided to use Urgotul SSD® (Urgo Medical), for its antibacterial action, long wear time and ability to stimulate fibroblast activity in the wound bed.

Despite the fact that this wound was chronic, it went on to heal completely within three months of starting treatment with Urgo SSD. The patient was able to manage the wound independently and was pleased with the action of the dressing and healing outcome.



Simon Barrett, tissue viability nurse consultant

Debridement as part of the wound assessment process

This session examined the benefits of debridement and how it can help nurses to better view the wound bed, thereby increasing the chances of accurate assessment and, in turn, appropriate treatment.

WHAT IS DEBRIDEMENT?

The session began by offering the audience a definition of debridement, namely that it involves the removal of devitalised tissue from the wound and surrounding skin (*Figure 1*). This includes removal of hyperkeratosis and devitalised tissue and as such debridement forms part of the wound bed preparation process.

Like any other element of treatment, it is important that nurses who practise debridement are aware of the variations in method, as well as the limitations of their own skill and competency.

Debridement is considered to be a beneficial component of wound



Figure 1. A heel wound showing significant devitalised tissue.

management because (National Institute for Health and Care excellence [NICE], 2014):

- ▶ Devitalised tissue within the wound may mask or mimic signs of infection and act as a physical barrier to healing
- ▶ Debridement helps to remove wound debris, sloughy tissue and exudate, making it easier to see the condition of the wound bed.

Devitalised tissue

Devitalised tissue can be caused by:

- ▶ Infection (seen as inflammation)
- ▶ Toxins (seen as inflammation)
- ▶ Trauma/injury
- ▶ Reduced blood flow, resulting in death of tissue.

‘As with any other treatment, it is important that the nurse has carried out a structured assessment before debridement is performed.’

It is important that clinicians aim to remove devitalised tissue as quickly and efficiently as possible, when it is safe to do so and after an holistic assessment. Wound debridement should be an integral element of good wound care, as outlined in the best practice statement, *Optimising Wound Care* (Wounds UK, 2008).

However, as with any other treatment it is important that nurses carry out a structured assessment before debridement is performed (*Figure 2*).

GETTING STARTED

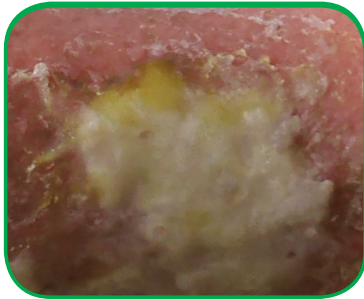
The session went on to outline that debridement should not just be the realm of the specialist — it is a technique that can be used by all clinicians providing they have attained an appropriate level of competency.

It is also important that the method of debridement selected meets the needs of the patient and is not limited by the nurse’s skills (Gray et al, 2011), for example, if a patient really requires surgical debridement but the nurse is not qualified to provide this, he or she should consider referral to the local specialist team, rather than persevering with a ‘softer’ form of debridement that may not benefit the patient long-term.

The session also highlighted that before debridement is considered, nurses should bear the following points in mind:

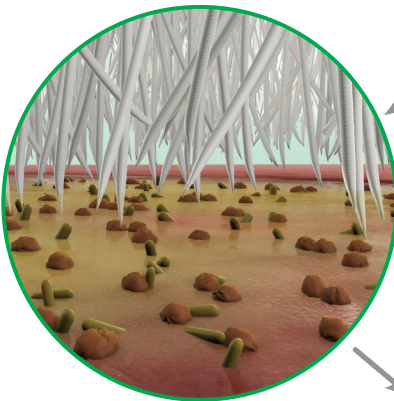
- ▶ What is the aim of debridement, i.e. to promote healing or provide symptom control?
- ▶ How quickly is debridement required and which method will best achieve this? For instance, autolytic debridement with dressings will take a lot longer than sharp debridement, but may involve less trauma
- ▶ How best to debride, e.g. is there hard, necrotic tissue that requires surgical intervention, or could a gentler method such as softening with a hydrogel dressing be considered first?

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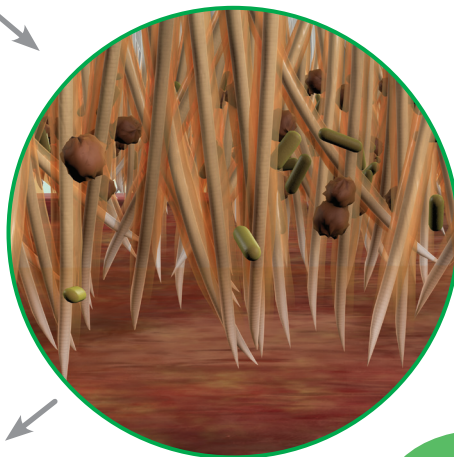
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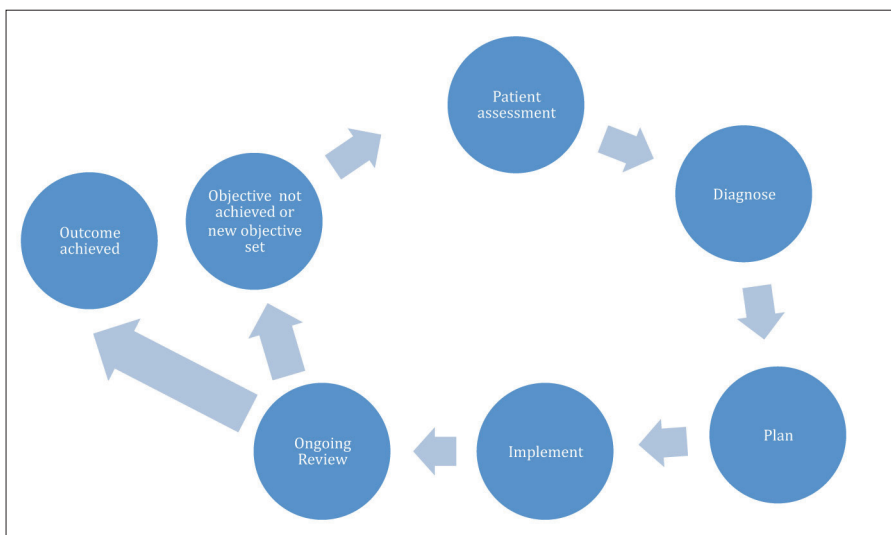


Figure 2. A structured approach to assessment, diagnosis and management is vital in any type of wound (Gray et al, 2011).

Asking this type of question will help nurses decide whether or not to debride, and by which method.

DRESSING/DEVICE SELECTION

The particular debridement technique chosen will depend on a number of variables, including:

- ▶ Patient need: does he or she have a wound that needs debriding quickly (with mechanical or sharp debridement); or if the patient is not fit for surgery or refuses larval therapy for example, could a slower method such as autolytic debridement be used (Gray et al, 2011)?
- ▶ Nurse skill/competency: does the nurse have the necessary skills to perform debridement or will he or she need to refer on?
- ▶ The organisation's formulary: what products are available?

Which type of debridement?

The type of debridement used will depend on many factors including:

- ▶ Skill: do nurses have the skill to use sharp debridement, for instance, or will they need to use a slower method such as autolysis?
- ▶ Resources: for example, is there nursing time available for autolytic debridement, which can involve multiple dressing changes?
- ▶ Cost and effect: is the proposed method of debridement the most cost-effective, i.e. will a one-off session of mechanical debridement be cheaper than a

- ▶ programme of larval therapy?
- ▶ Frequency: how often is debridement required, e.g. as a one-off session of mechanical/sharp debridement; or as a longer programme of autolytic debridement?

Types of debridement

The most common methods of debridement are:

- ▶ Autolytic
- ▶ Larval
- ▶ Mechanical
- ▶ Hydrosurgical
- ▶ Ultrasound
- ▶ Sharp
- ▶ Surgical.

Autolytic

Autolytic debridement is effectively the use of the body's own enzymes to soften and eventually remove devitalised tissue. This is done by covering the wound with a dressing that promotes a moist wound-healing environment, usually a hydrogel, hydrofiber or hydrocolloid.

As highlighted in this session, the main benefits of autolytic debridement are that there is little pain involved and it is a versatile and easy technique with nurses being easily trained in how to apply dressings and check for the softening of necrotic tissue.

Autolytic debridement is also a useful technique to soften devitalised tissue in preparation for the use of larvae or mechanical debridement with a monofilament fibre debridement pad

(see below for the use of Debrisoft® [Activa Healthcare]).

The fact that autolytic debridement can involve numerous dressing changes as the necrotic tissue softens and is absorbed into the dressing, also means that it can be costly in terms of the amount of dressings used and nursing time. Autolytic debridement is also associated with anaerobic odour (produced as the tissue is slowly broken down), as well as maceration of the surrounding skin (caused by the increase in moisture resulting from softening tissue).

Larval therapy

This debridement technique involves larvae being applied to the wound either in a sealed mesh bag, or 'free-range'. The larvae secrete an enzyme that semi-liquefies the necrotic tissue, thereby allowing it to be ingested.

For a number of reasons larval therapy is not a technique that is suitable for all patients, for example:

- ▶ The position of the wound may make it difficult to apply the maggots — if applied to sacral wounds for example, the person may crush the maggots when sitting or lying down
- ▶ Dry wounds with hard eschar that may not liquefy.

Larval therapy is a skilled method of debridement, but it can be applied by nurses who have received specialist training. It is also important to balance the fact that larval therapy may be more expensive than some other debridement methods, but involves a shorter treatment period.

Mechanical

Although rarely used in the UK now, the so-called 'wet-to-dry' technique was once a popular debridement method and involved using a dressing to 'dry-out' the top layer of the wound, which adhered to the dressing. This top layer of the wound then 'came away' when the dressing was subsequently removed. Not only was this method potentially painful and traumatic, it was also non-selective, removing healthy and unhealthy tissue.

However, newer products have been introduced. The Debrisoft monofilament fibre debridement pad makes mechanical debridement easier and atraumatic.

WHAT IS DEBRISOFT?

Debrisoft is a single-use debridement pad with patented monofilament fibre technology. Each pad has 18 million monofilament fibres cut to a specific angle and length. The fibres quickly lift up debris, superficial slough and exudate and bind it within the pad. Debrisoft removes the barriers to healing and leaves the area clear and promotes the development of healthy tissue. The pad is soft and conformable and will not damage any new granulation or epithelial cells.

This means that Debrisoft is a safe and effective method of debriding wounds that contain superficial slough and debris, including leg ulcers, pressure ulcers, diabetic foot ulcers, trauma wounds and postoperative wounds healing by secondary intention. Debrisoft is also very effective in the removal of hyperkeratosis from the skin.

However, above all Debrisoft is easy to use, making it convenient for both specialist and general nurses, patients and carers to use when cleaning a wound, enabling improved wound assessment. Debrisoft is a debridement tool which can be used for the cleaning and debridement of wounds and skin at each dressing change. It normally takes just a few minutes and in some cases may only need to be used once. It can be used in a variety of settings including the patients own home and where appropriate may be used by the patient which encourages self-care.

With increasing amounts of care being provided in or nearer to patients' homes (Department of Health [DH], 2009), Debrisoft can play a crucial role in enabling patients to access best practice wound assessment from generalist nurses, rather than requiring a specialist.

In simple terms, Debrisoft offers clinicians a new way to gently

debride the wound bed, aiding visualisation and therefore accurate assessment. The soft fleecy side of the pad should be fully moistened with 20–40ml (1–2 egg cupfuls) of tap water or saline. With gentle pressure, as if exfoliating, use the soft fleecy side of the moistened Debrisoft in a circular motion on the wound or in long sweeping strokes on the skin.

This cleansing and debriding action helps to quickly reveal the condition of the wound bed and surrounding skin, effectively lifting, binding and removing dead tissue and other factors that may obscure the state of the wound, such as devitalised tissue and wound debris (Collarte and Lara, 2011).

CONCLUSION

This session set out to examine how debridement is crucial to accurate wound assessment, allowing the nurse to properly view the wound, as well as removing necrotic tissue that may encourage infection.

As mentioned above it is important that nurses debride according to their competency, and

should not be afraid to refer on if unsure about this. There are a range of different debridement methods available and it is incumbent upon nurses to keep their knowledge of these up to date to provide patients with the best available evidence-based care. **JCN**

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Debrisoft before and after

Below are a number of clinical photographs showing wounds before (*left*), and after (*right*) the use of Debrisoft.



Learning zone: managing high exudate volumes

High levels of exudate in a patient's wound can be problematic for a number of reasons, including maceration of the periwound skin, malodour and problems with dressing choice due to absorbency.

This JCN Learning Zone sought to provide guidance for nurses on a number of exudate-related issues that can arise including:

- ▶ Understanding what exudate is
- ▶ The role of exudate in wound-healing process
- ▶ How exudate is often a problem in wound care
- ▶ The difference between absorption and retention
- ▶ Importance of appropriate dressing selection.

WHAT IS EXUDATE?

- ▶ Exudate contains water, electrolytes, nutrients, inflammatory mediators, protein digesting enzymes, growth factors and waste products
- ▶ Exudate also contains cells such as neutrophils, macrophages and platelets

Wounds that can be affected by high exudate

Some wounds are particularly prone to high exudate volumes:



- ▶ Exudate can contain microorganisms (this does not necessarily mean the wound itself is infected).

Exudate is essential for moist wound healing, providing vital growth and immune factors, supporting cell migration across the wound bed, releasing nutrients for cells, and promoting cell proliferation.

WHAT ARE THE CHALLENGES?

A wound that is producing high volumes of exudate can result in some specific treatment challenges:

- ▶ Malodour
- ▶ Wound enlargement
- ▶ Protein loss/fluid electrolyte imbalance
- ▶ Local wound infection
- ▶ Delayed healing
- ▶ Soiled clothing and bedding.

WHY IS EXUDATE A PROBLEM?

Chronic exudate has been described as a wounding agent in its own right and it must be managed effectively to create the optimal wound-healing environment. The periwound area is also vulnerable to the excess moisture caused by exudate and this needs to be managed to avoid maceration.

WHAT ROLE DOES DRESSING CHOICE PLAY?

It is important to choose a dressing that can cope with the amount of exudate being produced by the wound. This means choosing a dressing that can absorb exudate, prevent leakage onto the periwound area and stay on the wound for a sufficient length of time to be effective.

IS THE DRESSING WORKING?

It can be hard to know if the correct dressing to manage the amount of exudate being produced by a wound has been chosen. However, there are some classic signs that a dressing may not be coping:

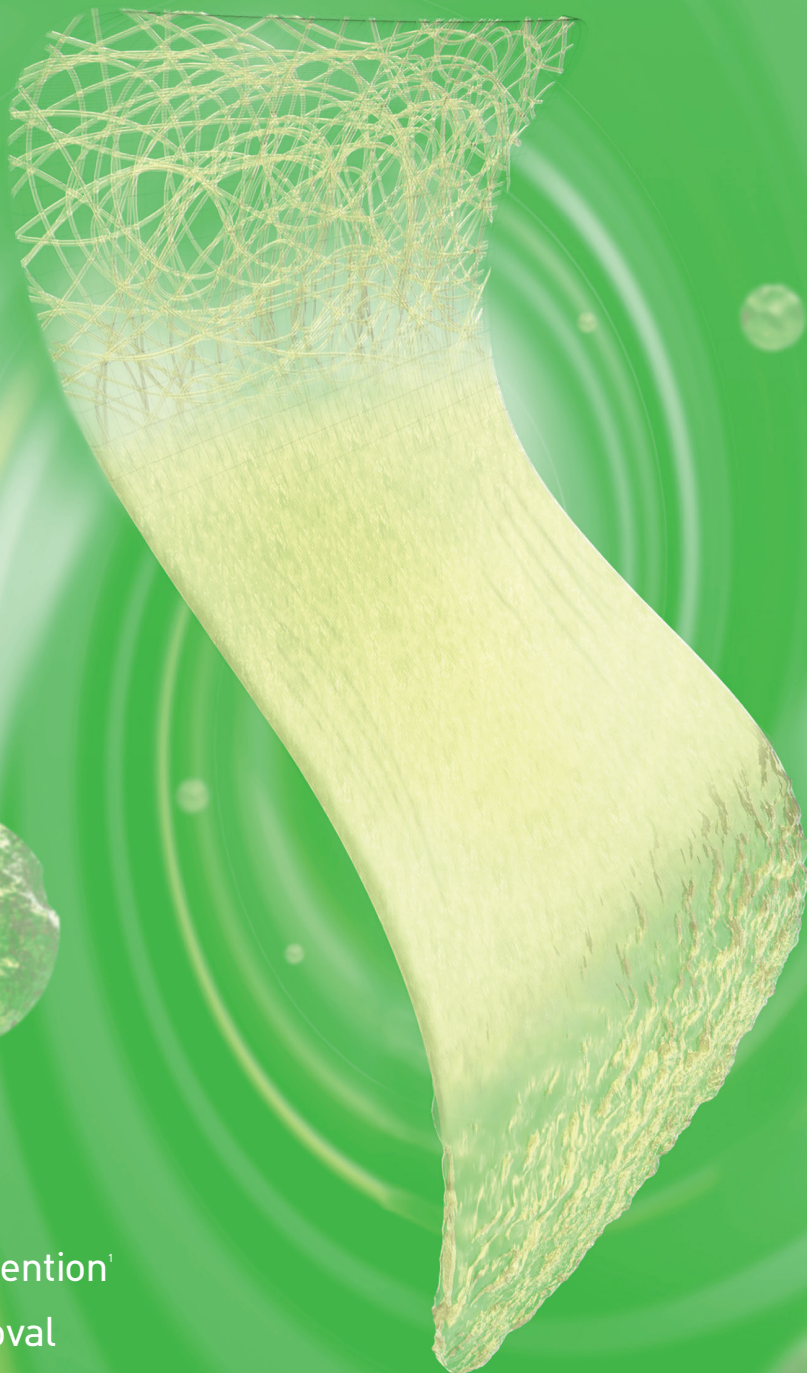
- ▶ Patient's quality of life does not improve
- ▶ The wound margins extend
- ▶ Wound bed shows signs of increasing bacterial load
- ▶ There is soiling outside dressing on periwound skin
- ▶ Frequent dressing changes
- ▶ Odour is not controlled
- ▶ Wound pain continues.

CONCLUSION

Understanding the exudate management properties of wound dressings and the recommended wear time is essential when caring for patients with highly exuding wounds. This will help to prevent complications such as skin reactions, maceration and delayed healing.

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References 1. SMTL method TM-404 for Free Swell Absorbition and Retention. Test performed at SMTL, UK. Laboratory report 20140806-001.

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HEALTH CARE**

Learning zone: understanding MRSA



S*taphylococcus aureus* is a gram-positive bacterium found on the skin and nasal carriage. Meticillin-resistant *S. aureus* (MRSA) is a strain that has developed antibiotic resistance and often occurs in patients who have had direct or indirect contact with hospitals, care homes or other healthcare facilities. MRSA causes a variety of serious healthcare-associated infections, including in wounds.

It is important for nurses to understand what a healthcare-acquired infection is and to identify the difference between hospital- and community-acquired infections. Similarly, it is vital to be able to determine how MRSA can be identified and managed. This Learning Zone sought to equip nurses with the knowledge to educate patients on their role in the prevention of the spread of MRSA and to understand the role of decolonisation products in the community.

WHAT IS AN HCAI?



Healthcare-associated infections (HCAIs) can develop after interventions such as medical or surgical treatment, or from being in contact with the healthcare environment, such as from medical equipment. The term HCAI covers a wide range of infections including MRSA, meticillin-sensitive *Staphylococcus aureus* (MSSA) and *Clostridium difficile*. HCAIs are a serious risk to the health of patients, including those with wounds, causing significant morbidity and mortality for those infected. As a result, infection prevention and control is a key priority for community nurses and other clinicians.

WHO IS MOST AT RISK?



A variety of people are at-risk from MRSA and it is important that community nurses are aware of these high-risk individuals:

- ▶ Patients with a known history of MRSA
- ▶ Patients from areas / facilities known to have a high MRSA prevalence
- ▶ Dialysis patients
- ▶ Patients that have been hospitalised in the past 12 months
- ▶ Patients who have come into contact with MRSA carriers while hospitalised
- ▶ Patients with chronic skin lesions (e.g. ulcers, chronic wounds, deep soft tissue infection)
- ▶ Patients in nursing care who are immobile, have disrupted feeding or swallowing patterns, or who are incontinent
- ▶ Patients with a catheter in situ (e.g. urinary catheter, PEG tube or tracheal cannula)
- ▶ Patients who have received antibiotic therapy in the past six months.

DECOLONISATION



If a community patient is identified as a carrier of MRSA, a decolonisation procedure will be required before admission to hospital or nursing home etc, to help avoid further spread.

This will involve the patient performing few important measures, including:

- ▶ Using a prescribed antibacterial wash/shampoo, usually for a period of five days
- ▶ Using a prescribed nasal gel in conjunction with the wash and shampoo
- ▶ Changing clothes, bedding, pillowcases and towels on a daily basis
- ▶ Washing with single-use toiletries.

Identifying the signs of MRSA infection

It is important that nurses are able to identify a patient with an MRSA infection and which type it is.

Skin and soft tissue



- ▶ Appears as a small red bump pimple or boil
- ▶ Skin area may be tender or swollen
- ▶ Skin often becomes warm to the touch
- ▶ Patient may begin to run a fever
- ▶ Infections are often mild, but can become deeper and more serious.

Invasive



Often begins as a skin or soft tissue infection around the site of a wound leading to shortness of breath, fever, chills and often the development of an abscess. In severe cases this can lead to:

- ▶ Bloodstream infections
- ▶ Pneumonia
- ▶ Death.

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Learning zone: How to use Debrisoft

WHAT IS DEBRISOFT?

Debrisoft is a single-use debridement pad with patented monofilament fibre technology. Each pad has 18 million monofilament fibres cut to a specific angle and length. The fibres quickly lift up debris, superficial slough and exudate and bind it within the pad. Debrisoft removes the barriers to healing and leaves the area clear and promotes the development of healthy tissue. The pad is soft and conformable and will not damage any new granulation or epithelial cells.

LEARNING ZONE: HOW DO I USE DEBRISOFT?

Debrisoft removes debris and superficial slough from wounds or skin. Unlike some other methods of debridement, Debrisoft's unique mode of action actually lifts material out of the wound bed and binds it within the Debrisoft pad, promoting healing. Debrisoft can be used

Wounds before and after use of with Debrisoft



across all clinical settings for the debriding and cleansing of chronic wounds, e.g. pressure ulcers and leg ulcers. It is also suitable for acute wounds, hyperkeratosis and periwound skin. Debrisoft can remove suspected biofilms (Wiegand et al, 2014; poster presentation, Wounds UK, Harrogate) and is referred to as 'a Biofilm-buster' by clinician Simon Barrett.

WHAT DOES THE NICE GUIDANCE SAY?

The National Institute for Health and Care Excellence (NICE) has released guidance recommending the use of Debrisoft to improve the treatment of acute and chronic wounds (www.nice.org.uk/guidance/mtg17).

The NICE guidance supports the case that Debrisoft provides multiple patient health benefits, as well as significant cost savings for the NHS. NICE evaluated Debrisoft and found that, compared to using hydrogels, autolytic dressings, irrigating wounds with saline, or gentle cleansing with gauze, Debrisoft:

- ▶ Provides quicker debridement, allowing earlier visibility of the wound bed and, therefore, better management of the wound
- ▶ May reduce pain associated with debridement
- ▶ Enables faster treatment (on average, two to four minutes per wound)
- ▶ Results in less frequent and fewer overall care visits
- ▶ Reduces risk of trauma to healthy tissue and reduces bleeding
- ▶ Reduces overall number of wound dressings used
- ▶ Contributes to overall cost savings compared with current practice.

The conclusion of the NICE guidance committee was that by using Debrisoft on appropriate wounds, these wounds would be 'fully debrided more quickly, with fewer nurse visits needed compared with other debridement methods. In addition, the Debrisoft pad is convenient and easy to use, and is well tolerated by patients'.

NICE estimate that using Debrisoft within the community can save the NHS up to £484 per patient for complete debridement of a wound compared to current standard practice and that using Debrisoft could save the NHS as much as £15 million annually.

TIPS FOR USING DEBRISOFT

- ▶ Open the Debrisoft single-use sterile pack
- ▶ Fully moisten the soft, fleecy side of Debrisoft with 20–40mls of tap water or saline, according to local guidelines
- ▶ With gentle pressure — as if exfoliating — use the soft fleecy side of the moistened Debrisoft in a circular motion on wounds, or in long sweeping strokes on the skin
- ▶ Use a new piece of Debrisoft for each wound or area of skin and dispose of it in normal clinical or household waste
- ▶ Debrisoft can be used on the actual wound bed and will not damage fresh granulation tissue and epithelial cells.

Watch the Debrisoft Difference video at www.debrisoft.co.uk

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Learning zone: choosing made-to- measure hosiery

For blood to be effectively returned to the heart from the lower limb, valves in the veins are essential to prevent the backflow of blood. Damaged valves result in venous hypertension, tissue oedema and possible development of leg ulcers.

Compression hosiery can help by assisting venous return and thereby reversing venous hypertension. It can also treat venous leg ulcers, again by reversing venous hypertension as well as preventing further occurrence of ulceration. Hosiery can also prevent and control the oedema associated with venous conditions.

WHY MADE-TO-MEASURE?

Made-to-measure hosiery can improve patient comfort, concordance and quality of life, which are crucial factors when preventing leg ulcer recurrence. Nurses should consider the following:

- ▶ Will the patient wear the hosiery if it doesn't fit, is uncomfortable or falls down?
- ▶ Will the patient speak up if this is the case?
- ▶ If a patient is comfortable they are much more likely to keep on wearing hosiery.

Made-to-measure hosiery can be cost-effective in terms of value in nurse and patient time and getting the right fit first time, whereas it can take two or three tries to get the

right fit when using 'off-the-shelf' compression hosiery. Using off-the-shelf hosiery can:

- ▶ Impact on case load management
- ▶ Cause inconvenience for the patient
- ▶ Require ongoing measurement as patients' limb sizes can change over time
- ▶ The nurse may need to order different 'off-the-shelf' sizes for each leg.

LIMB ASSESSMENT AND CHOICES

There are various types of made-to-measure hosiery available and nurses need to assess and consult with patients to achieve the best option. Made-to-measure hosiery comes in open- or closed-toe variations as well as below-knee or thigh-length styles.

The choice between open- or closed-toe depends on:

- ▶ Patient preference: giving the patient choice will aid compliance
- ▶ Certain types of treatment, such as podiatry or chiropody, may mean that the patient requires open-toe hosiery.

The choice between below-knee or thigh-length hosiery depends on:

- ▶ Thigh-length hosiery incorporates hold-ups, removing the need for a suspender belt
- ▶ Patient preference
- ▶ Both below-knee or thigh-length are effective at aiding venous return
- ▶ Painful veins behind the knee require thigh-length hosiery.

When assessing for hosiery, it is also important to consider whether patients and carers are able to apply and remove stockings.

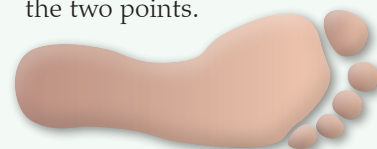
Measuring hints and tips

In order to correctly measure the patient's limbs for made-to-measure hosiery consider the following:

- ▶ Measure when the patient is sat down on a chair with a bend in the knee; or standing-up if measuring for thigh-length hosiery or tights
- ▶ When standing, encourage the patient to plant the feet apart with the weight distributed evenly through both legs
- ▶ Measure the limb systematically
- ▶ Measure at the smallest part of the ankle
- ▶ Measure at the widest point of the calf
- ▶ Measure around the foot including any 'lumps and bumps'.

Tips for measuring foot length

- ▶ Ask the patient to stand on a piece of paper
- ▶ Using a rigid object (i.e. a ruler) mark the level of the toes
- ▶ Next, mark the level of the heel
- ▶ Then measure distance between the two points.





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