ACHIEVING WOUND HEALING WITH THE PATIENT AS A CENTRAL MEMBER OF THE TEAM

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Introduction
Pressure ulcers (PUs) are areas of superficial or deep-tissue damage caused by pressure, shear, friction or a combination of these factors. They are often associated with immobilisation and malnutrition, whilst old age, diabetes, venous insufficiency, malignancy and medication may contribute to delayed healing. According to the NICE guidelines, the ulcer should be debrided, if necessary, and the optimum wound healing environment should be created by using modern dressings. This communication describes the management of bilateral pressure ulcers with a patient-centred treatment approach.

Patient history
The patient, Mrs M, was a 52 year old woman who was admitted to hospital with lethargy, confusion and decreased oral intake. She had bilateral heel sores. Mrs M had type 2 diabetes mellitus, controlled by diet, and she was clinically obese with limited mobility. She had previously suffered renal failure and had recently been admitted for community acquired pneumonia.

Wound history
The bilateral heel sores were reviewed by the tissue viability team and found to be complicated by osteomyelitis. The left heel ulcer measured 4x3cm, depth 0.75cm. The wound was covered with 60% slough and 40% granulation tissue. The right heel ulcer measured 7x6cm, depth 1cm. The wound had 99% slough although dry around the edges and close up: 5% granulation tissue. Both ulcers were classified as grade 4.

The left heel was managed with honey tulle and Allevyn adhesive. Sharp debridement was employed for the right heel, with the patient’s consent, to remove the slough and then dressed with Purilon Gel and Allevyn heel. Maggot therapy was ordered. After 5 days, the left heel had 25% slough and 75% granulation tissue. The right heel demonstrated softening of the slough which was lifting. The right heel was cleaned and bioform maggot therapy applied and left for 4 days.

Mrs M was moved from a high dependency bed to general medicine where the staff undertook care of the wounds under tissue viability supervision. For 2 weeks maggot therapy and the VAC system were used with limited success. Mrs M did not like either of these treatment regimes, however she consented to try them once the potential benefits had been explained. The ulcers had not healed and after much consideration Kerraboot® was chosen for the management of the ulcers. Kerraboot® was new to Mrs M and other members of the team. This presented a great opportunity for the team to learn about a different type of wound healing product.

Kerraboot®
Kerraboot® is a boot-like dressing that creates and maintains a moist healing environment around the wound surface and allows free drainage of exudates away from wound (Harvey, 2006). It facilitates debridement through autolysis. Advantages of Kerraboot® are that it can be applied to wound at any stage of healing, does not require special training, nor does it require a secondary dressing.

Results
Day 0 - Pressure ulcers before commencing Kerraboot®
☐ Heel pulse palpable
☐ Wound debrided
☐ Wound sloughy
☐ Some exposed bone and tendon in base of wound

Day 14 – Kerraboot® being changed daily – staff very pleased with the product and results to date
☐ Minimal granulation tissue visible around edge of wound
☐ Heel pulse palpable
☐ Wound debrided to granulating base

Day 21 – Patient was discharged into the community
☐ Minimal granulation tissue
☐ Wound is clean and granulating

Discussion
The importance of a holistic, patient-centred approach, as opposed to an impersonal, wound-related approach, has now become the norm. Mrs M was made a central member of the team and was fully involved in creating her unique treatment plan. The treatment options were discussed and, in spite of her reservations on the use of maggot therapy and VAC therapy, Mrs M listened to and accepted the advice of the healthcare professionals. Following the failure of these options to facilitate healing, the treatment plan was carefully revised and Kerraboot® was selected to manage the ulcers.

Having debrided the wound, Kerraboot® created and maintained a healing environment. In keeping the wound moist and warm, Kerraboot® promoted the growth of granulation tissue. It was considered to be quick and easy to apply, without causing any pain to the patient. Compared to maggot therapy and VAC therapy, Kerraboot® was highly acceptable to the patient.

Conclusion
This communication demonstrates the importance of getting to know your patient and inviting your patient to be a fully participating partner on the team to ensure full compliance and achieve full wound healing.

Key points
☐ Building relationships is central to nursing work
☐ The patient should be a fully participating partner on the team
☐ Kerraboot® may rapidly facilitate healing, it is quick and easy to apply and remove, with minimal discomfort to the patient

Reference List
Ref Type: Journal