A grade 4 pressure ulcer cared for in a nursing home

Denise McDonagh, Tissue Viability and Infection Control Nurse, Craigavon and Banbridge Community H&SS Trust, Northern Ireland

Pressure ulcers are a major health problem causing a substantial amount of suffering which leads to a reduction in the quality of life for patients and their carers (Franks et al, 1999).

The clinical challenge
- Manage bioburden imbalance
- Debride slough and necrotic tissue
- Reduce pain at dressing change
- Manage exudate and odour.

Assessment of the patient and the wound
Mrs B is a 92-year-old woman being cared for in a nursing home. Her medical history included arterial insufficiency, urinary and faecal incontinence, and immobility.

Mrs B was referred to the Tissue Viability Nurse (TVN) for advice on the management of a grade 4 pressure ulcer of 4 months duration (Figure 1). The wound was situated in the ischial tuberosity region, and on initial assessment measured 6cm long x 4.5cm wide x 5cm deep. The wound bed presented with 90% slough and 10% necrotic tissue and was extremely malodorous, producing high levels of serosanguinous exudate. The surrounding skin was erythematous and the discoloured wound base indicated the presence of infection (Cutting and Harding, 1994). Dressing changes were painful for the patient.

Wound management
Mrs B commenced on flucloxacinil 500mg and metronidazole 400mg both three times daily to treat the presenting infection. The antibiotic regimen was followed for 7 days. A wound swab was sent to microbiology for culture and sensitivity to isolate the causative pathogen(s). The wound swab results identified sensitivity to isolate the causative pathogen(s). The swab was sent to microbiology for culture and sensitivity to isolate the causative pathogen(s).

The wound now presented with approximately 98% healthy red granulation tissue and 2% sloughy tissue. The exudate levels remained high however, odour was no longer a problem and surrounding tissue was normal in appearance. Mrs B did not appear to experience any pain during dressing changes while using this regime. Dressing changes continued to be carried out daily; however, the Carboflex® dressing was no longer required as the odour had resolved. At 5 weeks there was a marked reduction in the size of the wound: 3cm long x 2cm wide x 2.5cm deep. Exudate level was now reduced, and the base of the wound was granulating and contracting. There remained a small amount of slough which was resolving slowly and the edges were epithelialising (Figure 3). Dressing changes were reduced to alternate days. At week 8 the wound was completely healed. After a further 3 months the scar had flattened and the skin appearance was returning to normal (Figure 4).

Discussion
This case study illustrates the challenges of nursing an elderly patient with a pressure ulcer in a nursing home. Selection of appropriate dressings was guided by an holistic assessment of the patient. Mrs B’s treatment regime using a hydrofiber® dressing with ionic silver (Aquacel® Ag) along with systemic antibiotics were successful in reducing the bacterial burden and enhancing wound healing.

By working in collaboration with the TVN, the nursing home staff achieved complete healing of a grade 4 pressure ulcer and greatly improved Mrs B’s quality of life.


Wounds UK

Figure 1. On assessment: pressure ulcer of 4 months duration.

Figure 2. Reassessment after 26 days.

Figure 3. Reassessment at 9 weeks.

Figure 4. Wound healed, scar flattened.