

Achieving Optimum Wound Management in Challenging Situations



- We will cover:
 - Patients at high risk of wound infection
 - Identifying the underlying causes of wound exudate/fluid
 - Prevention of peri-wound trauma and maceration
 - Addressing wound pain
 - Developing partnerships with our patients



High Risk Wound Infection

- What increases an individual with a wounds risk of infection?:
 - Medical
 - Social
 - Environmental
 - Psychological



Medical



- Has the patient got an underlying medical condition which increases their risk of infection:
- Full assessment and commence treatment for underlying medical pathophysiology
- Interventions should not be based primarily on the wound but the patient as a whole:
- All based on the expertise of the multi-disciplinary team.



Social factors which increase infection risk



- Poor hygiene, both personal and environmental
 - Inadequate nutrition
 - Drug and or alcohol abuse
 - Mental health issues
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- How do we treat this man, can we treat all his issues, certainly not at once prioritise risk:



Environmental Risk Factors



- Housing conditions – poor housing conditions, where bacteria can proliferate may pose a risk to the patient
- Geographical isolation – difficulty in gaining access to services, carrying out dressing on their own
- Poor dietary intake.



Psychological factors affecting Infection



- Poor self-care standards
- Mental health issues: depression, aggression or withdrawal, often leads to social isolation and suspicion for those trying to provide support and care
- Lack of awareness or understanding of disease process and associated complications
- Pain can influence this.



Factors influencing infection risk

- Medical, social, environmental and psychological factors which increase infection risk are never in isolation of each other but are usually a combined factor.
- Places emphasis on both an holistic assessment of the patient and their wound but also the importance and benefits of the multidisciplinary team.



Wound Exudate - Acute V Chronic

- *Is exudate good or bad for a wound?*
 - *Good exudate*: An acute wound's exudate is stimulated at the inflammatory phase and therefore is rich in growth factors to stimulate wound healing, however
 - *Bad exudate*: Chronic wound exudate is different because it is likely to contain bacteria, dead white cells and tissue degrading enzymes which facilitate autolytic debridement.



What is Wound Exudate

- Wound exudate has a key role to play in wound healing:
 - This presence of fluid in the surrounding tissues contributes to localised pain, heat and swelling.
 - Can be difficult to manage, often requiring frequent review and multiple treatments
 - Poorly managed can cause maceration, pain, and distress to the patient.



Factors affecting exudate

- When assessing a wound which has exudate key questions have to be asked and answered before treatment can commence
 - Q 1- Is this exudate part of the wounds normal healing process?
 - Q 2 – Does the presence of exudate indicate an infection?
 - Q 3 - Does the patient suffer from oedema and or lymphoedema?
 - Q 4 – Is there any indication of fistula or sinus development in this wound
- The answers to these questions will prove the basis for your treatment, management and review process for the wound in question



Is this exudate part of the wounds normal healing process?



No or little exudate present in a wound indicates:

1. has it been left exposed to the air?
2. has an appropriate dressing been applied?:
 - does it promote moist wound healing?
 - is it designed to absorb more exudate than the wound is producing?
3. Environmental factors – is the room too warm causing the dressing to dry out.



Does the presence of exudate indicate an infection?



Left wound presents with classic signs of infection:

- Wound bed covered in yellow/green tissue
- Granulation tissue very pale.
- Exudate thick viscosity
- Causing severe excoriation and maceration to surrounding tissue. Clearly macerated where exudate has leaked onto surrounding skin



Does the patient suffer from oedema and or lymphoedema?



- Chronic oedema should be assessed to determine the underlying cause.
- Significantly impacts on quality of life
- Treatment is based on holistic and multidisciplinary assessment
- Plan of care involves:



Is there any indication of fistula or sinus development in this wound



- Exudate from sinus and fistula's can be very difficult to manage due to excessively large volumes
- Dressings which are highly absorbent and provide moisture vapour permeability are often chosen to try and reduce exudate and any associated complications.
- If very high exudate volumes may have to consider, wound managers, Topical Negative Pressure.



Peri-wound trauma and maceration

- Peri-wound trauma and maceration, may occur due to:
 - Excoriation due to irritant effects of contaminants
 - Use of inappropriate dressings or incorrect wear time.
 - Excess exudate of wound fluid
 - Presence of infection
 - Failure to protect the skin



Excoriation

- Acute phase
 - Itch
 - Pain
 - Burning
 - Erythema
 - Clustered papulovesicles
 - Wet weeping skin
- Chronic phase
 - Dryness
 - Lichenification
 - Fissures

Occurs within a few hours of exposure to irritant, becomes chronic after repeated insults



Excoriation

- To treat excoriation we have to identify the irritant causing it;
 - Wound exudate
 - Bacterial invasion
 - Incontinence
- Focus should then be concerned with the treatment of the cause



Skin Stripping

- The stripping of the epidermis, dermis is usually caused by the removal of an adhesive agent.
- Is this the fault of the dressing?



Infected - maceration

- Aim to treat infection with antibiotic therapy.
- Treat with topical antimicrobial if appropriate to prevent increase in bacterial load and prevent further re-infection
- Maintain integrity through topical moisturiser
- Select dressing capable of handling large volume of exudate
- Change according to fluid volumes



Pain

“an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage”

Merskey and Bogduk, 1994



Pain prior to dressing change

- Complete a full history of the patients global pain addressing issues
- Pharmacological interventions should be considered.
- Find a treatment most appropriate for your patients need.
- Ensure administered prior to dressing – time to allow it to work
- Assess effect.



Pain at Dressing Change

- Pain at dressing change occurs due to trauma of the wound bed or peri-wound area.
- Analgesia may be administered but should be given time to work and effect monitored
- Dressing selection should be based on non-adherence, levels of exudate, type of tissue present and treatment objectives



Pain between dressing changes

- Pharmacological interventions should be considered.
- Find a treatment most appropriate for your patients need.
- Assess effect.
- Wound management-
- Involve patient in the decision making, where possible and appropriate



Patient Partnerships

- None of the previous is treatable or manageable if we do not have a relationship with the patient.
- Listen to what concerns them the most
- Accept treatments based on their concerns
- Discuss treatments and options
- Involve other family members if felt appropriate.



Patient Relationships



Conclusion

- Infection, exudate, peri-wound trauma and pain are never treated in isolation of each other
- All wounds are multi-factorial and so is the patient
- Treatment is based on joint working partnerships between you the clinician, you as part of a multi-disciplinary team and the patient, prioritising and working in partnership.
- Finally, Wounds generally are never easy, often complex, sometimes frustrating but always fascinating.

