

“21 days in the life of Edna”

Author: Sian Fumarola RGN; BSc Hon; Cert H. ed; Cert counselling Tissue Viability Clinical Nurse Specialist.

University Hospital of North Staffordshire 
NHS Trust

Introduction

Wounds that have occurred or deteriorated as a result of delayed intervention pose difficult treatment challenges for clinicians due to tissue changes, pain and distress. Skin damage can occur as a result of direct pressure from external forces, friction or shear in which the skin is damaged from a bony prominence rubbing against the skin from within (Beldon 2006). Movement and release of the source of pressure relieves the symptoms and prevents further damage. In some cases this is not possible leading to rapid tissue damage often affecting underlying structures. This is particularly problematic for immuno-compromised patients who are also at risk of developing infection (Armitage 2006).

The Case Study

The patient in this case study suffered pressure damage as a result of sustained pressure over bony prominences whilst she was unconscious after a fall at home.

Edna is a 72 years old lady who suffers from chronic myeloid leukaemia. Following a hospital out patients visit she lost consciousness at home and collapsed to the floor where she spent several hours before being discovered by her daughter.

She was admitted to secondary care where she was assessed and found to have extensive bilateral tissue injury (grade 3 EPUAP) to her knees as a result of unrelieved pressure while lying on the floor. The plastic surgeons and tissue viability nurse specialist jointly assessed the tissue injury and agreed that conservative management was the preferred treatment option.

Edna was an independent lady and very frustrated that she was unable to mobilize due to the discomfort of the bulky dressings secured by bandages. She was eager to return home as soon as possible.

Due to her immuno-compromised condition, the nurse was concerned about possible infection, but because of the pain that Edna was already suffering, she was reluctant to use an antimicrobial dressing (silver), or topical antibiotics that may add to the pain in her wounds (Armitage 2006). It was decided to use ActiFormCool® ionic sheet hydrogel dressings (Activa Healthcare) that would provide the moisture necessary to facilitate

debridement of devitalised tissue without causing damage to the surrounding skin (Hampton 2005). In addition the dressing would address the wound pain that Edna was experiencing (Hofman 2006), and be comfortable enough for her to move her knees freely.

The dressings were applied to the wounds, covered with film dressings, and changed every 2 days. The objective was to promote autolytic debridement and reduce pain and discomfort. Edna found the dressings comfortable to wear and pain free at dressing change. She was mobilizing independently half an hour after the initial application.

Following 9 days of treatment the wounds were fully debrided, and on day 14 she transferred to the plastics department for a skin graft. On day 21 she was discharged home.

The poster depicts a series of photographs following the stages of debridement and makes comment on Edna’s experience of the process and clinical outcome.

Conclusion

Wound care is a science, but the real issues of pain relief and patient needs should be an important consideration when using the correct product. In this case the specialist nurse made the decision to use a non-antimicrobial dressing that would facilitate debridement of the necrotic tissue, encourage granulation and relieve the pain. This meant that there was no need to use several different products to achieve the overall result even though the patient was in a potential at risk condition. The experience of the nurse, correct assessment, and careful monitoring of the patient led the nurse to choose ActiFormCool® as a simple solution that achieved the best outcome for Edna.

References

Beldon P (2006) Pressure ulcers: Prevention and management. Wound Essentials 1: 68-76
Hampton S (2004) A small study in healing rates and symptom control using a new sheet hydrogel dressing. JWC 13; 4
Hofman D (2006) A wound dressing that may relieve pain. Poster presentation at EWMA conference, Stuttgart



Left knee on admission - necrotic tissue - wound measurement 11cm x 11cm



Day 5 - less necrotic tissue - wound measurement 10cm x 10cm - granulation appearing



Day 9 - shallower and completely clean



Right knee on admission



ActiFormCool® in situ



Day 9 - clean and granulating