

Safe debridement at home - a case study

Liliana Girip, Community Staff Nurse and Anne McLoughlin, Community Staff Nurse, Oxleas NHS Foundation Trust.



Picture 1: Before treatment with the mechanical debridement pad showing extensive slough



Picture 2: Medial aspect following debridement in one treatment session



Picture 3: Lateral aspect following debridement

Introduction

Safe, rapid and effective debridement at home has been limited for many years and has normally required a Specialist Nurse referral and a probable hospital admission for treatment. The main debridement option available at home performed by generalist nurses has been autolytic debridement, but this does not usually lead to rapid debridement and has some disadvantages (Wounds UK, 2013).

This is the case study of Miss W, a 63 year old lady with cerebral palsy, a venous leg ulcer, recurrent cellulitis and chronic eczema during the past three years.

In 2012 she attended A&E and had been hospitalised with cellulitis. She presented to the District Nurses in August 2012 with improving cellulitis, but still experiencing copious exudate, excoriation, pain, gross oedema and lymphorrhoea.

Miss W recently moved to the area and lived alone in sheltered accommodation. She was previously an independent and active lady who enjoyed going to the gym and socialising with other residents.

Miss W was anxious and very concerned regarding the slow progress of her leg ulcer and surrounding skin, the odour and the increased pain that she was experiencing, resulting in loss of independence, reduced mobility, isolation, altered body image and low self-esteem. As a result of this Miss W stopped going to bed and slept in the chair.

Method

Following a holistic assessment the main aim identified was debridement of the wound and surrounding skin (Picture 1). It was hoped that debridement would help towards reducing pain, exudate, and bacterial load and so with compression bandaging, reduce oedema and lymphorrhoea.

Approval was gained from the local Tissue Viability Nurses and, following an explanation of the other debridement treatment options to the patient, consent was given to evaluate a new mechanical debridement pad*. Digital images were taken pre and post treatment. The mechanical debridement pad was used for one treatment

session, including several intervals of rest. The outcome was complete removal of slough as shown in the medial and lateral views in Pictures 2 and 3.

Results

Debridement of the wound and skin was successfully completed in this one session. Miss W's holistic care continued to be managed with skin care and compression bandaging, including patient education on skin care and leg elevation at rest.

Conclusion

Miss W progressed quickly, with the leg ulcer healing in eight weeks. To her delight, her quality of life improved significantly and she was able to sleep in her bed and resumed her visits to the gym. She was relieved that this safe debridement treatment, used at home, prevented her having another hospital admission.

Using this new mechanical debridement pad proactively in a patient's home could help to reduce the cost of treatment, avoid hospital admission, reduce possible risks associated with surgical debridement, and ultimately reduce stress and anxiety for the patient - as it did in this case study.

It is an ideal debridement method for use by District Nurses and enables them to perform safe, rapid debridement at the bedside with minimal education and training required. It also means that the District Nurses can adopt International Best Practice, as outlined in the new European Wound Management Association (EWMA) Debridement Consensus Document (Strohal et al, 2013).

References

Effective debridement in a changing NHS: a UK consensus. London: Wounds UK, 2013. Available from: www.wounds-uk.com
Strohal, R., Apelqvist, J., Dissemond, J., et al. EWMA Document: Debridement. J Wound Care. 2013; 22 (suppl.): S1-S52