The management of maceration in a Nursing Home environment

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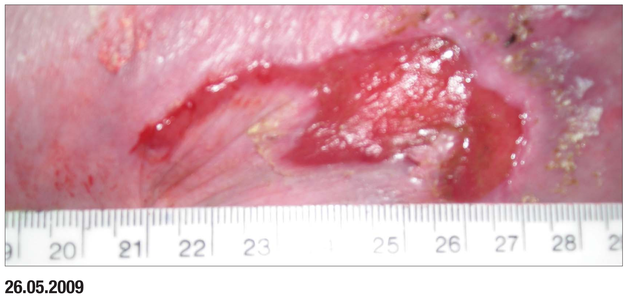

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Introduction

The role of nursing homes has expanded in recent years due to the increasing size of the elderly population (Phillips et al, 2009). In this case study the author will demonstrate the role of the group nursing home Tissue Viability Nurse in the management and treatment of a complex exuding wound.

Wound exudate management can prove a challenging barrier for the healthcare professional when trying to promote wound healing. It is suggested that maceration is an under-recognised problem that causes delayed healing (White and Cutting, 2003). This can result in multi frequency dressing applications, leading to increased cost and nursing time. With increased exudate comes the risk of pain, infection, increased odour and maceration. All of these factors can lead to a decreased quality of life for the patient.

Mrs A was a 72 year old paraplegic lady who had been living in the nursing home for the previous 3 years and been admitted to the home with a grade 4 pressure sore/cavity in her coccyx area. Mrs A had a known sensitivity to adhesive dressings. Combined with the large amounts of exudate produced from the cavity, Mrs A developed several red and broken areas to her surrounding areas of skin.

Management of exudate had previously included three different versions of VAC therapy; however this had been unsuccessful due to the reaction from their adhesiveness. All appropriate formulary dressings had also been used, again with little effect.

Method

Due to the location of the wound there was an increased risk of infection. Therefore it was felt that an antimicrobial dressing to pack the cavity with a highly absorbent secondary dressing would be appropriate. Mrs A was initially treated with Suprasorb® A+Ag (Alginate with silver) rope to pack the cavity, with Flivasorb® as a secondary dressing to absorb and contain the excess exudate. The Flivasorb® was held in place by the use of Mrs A's underwear to reduce the risk of any sensitivity due to any adhesiveness. Dressings were changed 2-3 times daily.

Following two admissions to hospital with pneumonia, Mrs A returned to the home and commenced Suprasorb® X+PHMB (Polyhexamethylene biguanide) to pack the cavity and Flivasorb® again to absorb and contain the excess exudate. PHMB is a biocellulose HydroBalance dressing combined with an effective broad spectrum antimicrobial.

Results

Over a six month period, Mrs A's wounds improved considerably. The cavity decreased in size from 6.5cm x 2cm x 4cm in depth to 3cm x 2cm x 0.5cm depth.

Due to the supersabsorber particles within the Flivasorb® enabling exudate to be absorbed and locked away, Mrs A's dressing changes reduced from 2-3 times daily to once every three days. There was also a significant reduction in redness and broken areas to surrounding skin due to the high absorbing capacity and the flexible wound contact layer, enabling the prevention of any wound adhesion.

Discussion

The treatment of highly exuding wounds can be time consuming and distressing for the patient. The need to maintain an optimum wound healing environment is essential and therefore the correct absorbent dressing is paramount. Grocott (1998) argues that exudate management depends critically on the appropriate dressing selection, its fit and optimum absorption.

The use of Flivasorb® on a highly exuding wound has significantly changed the management of care given to Mrs A, resulting in less dressing changes, less nursing time, less use of dressing varieties and improved quality of life.

Conclusion

Mrs A is no longer bed bound; She gets out of bed every morning and at other times during the day. She has an electric scooter and now enjoys going out and having lunch with friends. She also appears much more cheerful in herself and is now eating and drinking better. Her quality of life has greatly improved.

References

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