Multi-disciplinary wound care – different perspectives, different priorities, one aim.

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Introduction

The complexities of leg ulcer management rely on a multi-disciplinary approach to the care of patients with lower limb ulceration (Anderson 2007).

Communication and a certain degree of standardisation are essential to ensure that the patient receives continuity of treatment throughout his pathway of care. This case study demonstrates some of the problems experienced by a patient with painful leg ulceration and highlights challenges faced by the multi-disciplinary team to deliver symptom relief whilst providing an optimum healing environment.

Patient X a 71yrs male retired GP, initially presented to the leg ulcer nurse via referral from the Accident and Emergency department. Mr X had multiple areas of ulceration to the left lower leg, the largest area being 6 x 6cms to the posterior upper third lower leg. All areas of ulceration had 100% thick yellow slough to the wound base with high exudate, previously managed by community nurses requiring daily dressings with opioid pain control.

Mr X, was able to give an extensive and detailed perspective of his leg ulceration, a further perspective was gained following discussion with community nurses. Assessment identified approximately year long history of bilateral leg ulceration previously treated with compression bandaging and various wound care dressings. Past medical history attributing to delayed healing included type 2 diabetes, myocardial infarction, cardiac bypass, chronic renal failure and iron deficiency anaemia. Ankle brachial pressure index greater than 1.0 (suitable for compression therapy with caution due to diabetes, however patient had warm pink well perfused feet with good sensation). Initial impression indicated that the underlying aetiology was venous, complicated by previously described medical history and infection. Mr X was admitted to an acute medical ward.

Method

As a primary dressing ActiFormCool® sheet hydrogel was applied to all ulcerated areas initially with reduced compression bandaging (due to diabetes and pain). Case studies have demonstrated the effectiveness of this dressing for wound pain relief and to manage slough and exudate in order for the wound to heal (Young, Hampton 2005) (Hofman 2005).

Improvements were monitored by photographs, wound management and Visual Analogue pain scale.

Results

Following first dressing change frequency changed from daily to twice weekly. After the first week dressing change required only weekly renewal and the patient reported pain relief from the moment of application of ActiFormCool®. A week after application analgesia was reduced significantly. The patient described dressing change as “no unpleasant feeling on application or removal”. Ward staff felt that dressings were easy to apply and remove. Containment of exudate reduced odour and risk of contamination to the ward environment. Wound assessment showed reduction of slough exposing areas of granulation following the first week of application with 90% granulation after 2 weeks.

On discharge ActiFormCool® was continued by the dermatology day unit and in the community.

Discussion

Patients admitted to the acute ward often have multiple needs other than that of only leg ulceration. It is the role of the leg ulcer nurse to assess, plan and implement care for these inpatients to ensure that leg ulcer wounds are managed effectively along side their acute condition. Selection of an appropriate wound dressing needs to be acceptable to the patient, but also provide an optimal wound healing environment. The dressing should manage exudate but maintain a moist, infection free environment.

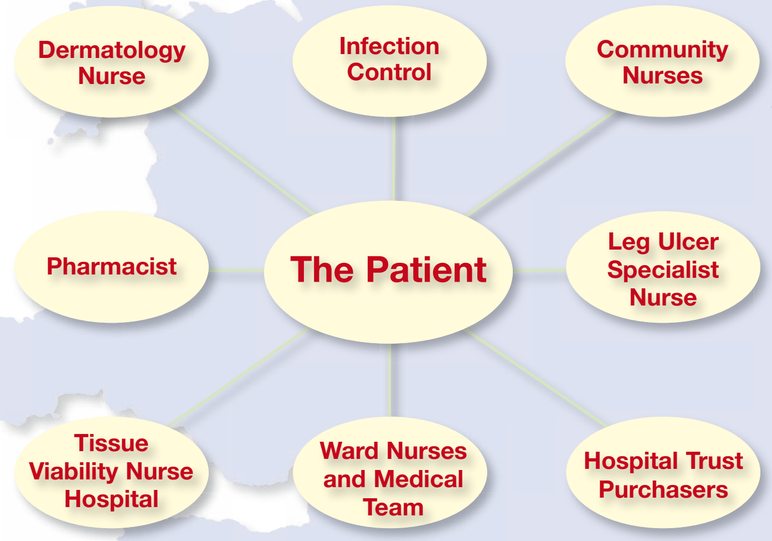
The dressing choice also needs to be accessible to the ward team, easy to apply and remove, but also be cost effective. This is particularly important as patients are often transferred to different departments within the trust. Discharge planning must provide a safe and continued transition back into the community. ActiFormCool® appears, from this short case study to cover all these perspectives allowing continuity of care and optimal wound healing. ActiFormCool® dressing improved the patient’s pain, managed wound exudate and reduced frequency of dressing change. Additionally, less experienced ward staff nurses felt confident in its application and removal. There was significant wound healing during Mr X hospital admission.

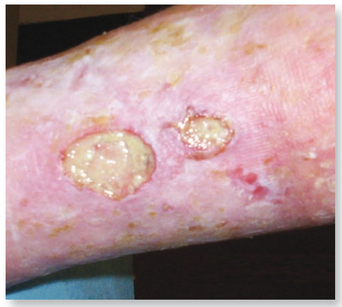
Conclusion

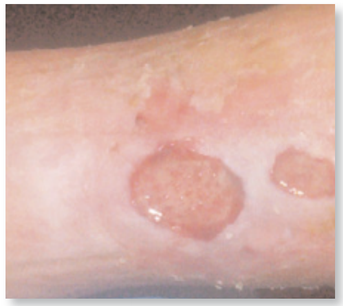
It is the role of the leg ulcer nurse to assess and plan the management of a patient admitted with lower limb ulceration. The effective continuation of planning and implementation is a result of providing dressing choices which are assessable and acceptable to both the patient and all the multi-disciplinary team. This case study shows that ActiFormCool® effectively achieved the multi-disciplinary team’s objectives covering all perspectives of wound care.

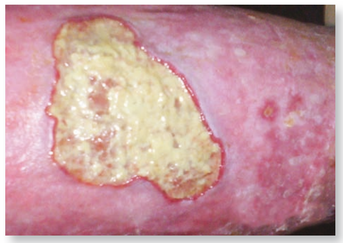
References

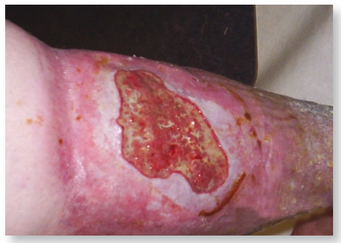
Anderson I (2007) Applying guidelines in clinical practice. Wounds Essentials; 2: 24-33
Hofman D (2005) A dressing which can relieve wound pain? Poster presentation EWMA, Stuttgart 2005 conference
Young S, Hampton S (2005) Pain management in leg ulcers using ActiFormCool. Wounds UK; 1 3: 94-101

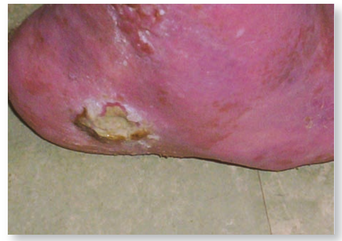


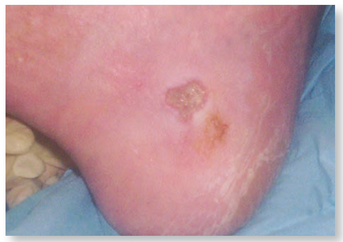

Left lateral on admission 09/10/06


Left lateral lower 1/3 after two weeks 23/10/06


Left posterior on admission 09/10/06


Left posterior calf after two weeks 23/10/06


Left medial ankle on admission 09/10/06


Left medial ankle after two weeks 23/10/06

Perspectives affecting choice of dressings

The Leg Ulcer Nurse
Evidence based, safe application, continuity and optimum wound healing.

The Patient
Pain and odour control, comfort.

The Ward Nurse
Ease of application/removal, availability, exudate control.

The Pharmacist
Availability.

The Trust
Cost effectiveness and length of stay.

Community Nurses/Dermatology Day Unit Nurses
All of above.

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