

WoundsUK Award FOR EXCELLENCE Winners

Here we are celebrating the winners of best abstracts at last year's Wounds UK Annual Conference in Harrogate. The theme of the conference was "Data, Science & Practice" and over 250 posters were submitted and the overall winners of the Wounds UK Award for Excellence were Stefanie Mahan and Verity Ashcroft for their work on moisture-associated skin lesions. This is a notoriously challenging wound type to manage but their work clearly demonstrates that with focussed interventions it is very possible to reduce the harm caused to patients.

Overall winners: Skin Integrity

Stefanie Mahan, Tissue Viability Specialist Nurse, Pressure Ulcer Prevention Service, Mid Cheshire Hospitals NHS Foundation Trust, Crewe and **Verity Ashcroft**, Tissue Viability Link Nurse, Care of the Elderly, Mid Cheshire Hospitals NHS Foundation Trust, Leighton Hospital, Crewe

Category: Skin Integrity: Effective change management strategy to reduce the incidence of moisture lesions across an acute trust

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Winner: Assessment and Diagnosis




Julie Green, Director of Postgraduate Studies, Senior Lecturer in Nursing, Keele University School of Nursing and Midwifery, Clinical Education Centre, University Hospitals of North Midlands NHS Trust, Royal Stoke University Hospital, Stoke-on-Trent

Category: Assessment and Diagnosis: What matters to me? The patient voice in wound care



WHAT MATTERS TO ME? THE PATIENT VOICE IN WOUND CARE.

Dr Julie Green
Keele University School of Nursing and Midwifery.
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Quality of Life Wound Checklist

Name: _____ Date: _____

* A reward or gift. Your ability is linked to the star that may be taking some time to load. Please answer these questions about how you are coping with your wound.

- Can you walk as well as you did before you had your wound?
- Can you get on an easily on before you had your wound?
- Do you eat well?
- Are you able to shower or bath?
- Are you able to wear clothes and shoes that you want to?
- Do you get a good night's sleep?
- Please circle the picture to show if you sleep in a bed or in a chair.
- Please circle a number to show how your pain has been recently.
- What medication do you take for your pain?
- Where do you get your support from?
- How do you rate your overall quality of life? Please circle the number to show your answer.

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Background to the intervention:

This simple checklist was designed to address quality of life issues for patients with wounds of any aetiology. The checklist is designed for self-completion, in advance of a consultation. Use of the checklist aims to refocus the consultation on the areas of daily life that the wound has an impact on.

The Wound Checklist:

The CQUIN requirement for each patient with a wound to have a complete assessment (NHS, 2017) has prompted the development of a checklist that is suitable for self-completion, by patient or carer and includes simple, self-assessed pain and quality of life scores. This new 'Wound Checklist' has been developed with support from an advocacy service, 'Reach', to ensure utility for all patient groups.


A four week evaluation has demonstrated that the checklist is simple to complete and does not extend consultation time, whilst providing the consulting nurse with valuable information about the impact of the patient's wound on the patient's quality of life.

Reference:
NHS England (2017) Commissioning for Quality and Innovation. Guidance 2017-2019. www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Winner: Diabetic Foot

Maria Goldsmith,
Specialist Podiatrist Guy's
and St Thomas' NHS
Foundation Trust

Category: Diabetic Foot: An explorative study to determine the psychosocial issues and existing support provision for patients following their first admission to hospital for management of (severe) diabetic foot ulceration




Cardiff University
HEALTHY SOCIETY
CARDIFF

An explorative study to determine the psychosocial issues and existing support provision for patients following their first admission to hospital for management of (severe) diabetic foot ulceration

Maria Goldsmith¹ and Samantha Holloway², Cardiff University

¹ Specialist Podiatrist Guy's and St Thomas' NHS Foundation Trust, PgDip Wound Healing and Tissue Repair
² Programme Director, MSc Wound Healing and Tissue Repair



Guy's and St Thomas' NHS
FOUNDATION TRUST

1. Background and gaps

- Healing of diabetic foot ulceration (DFU) is dependent on restrictive treatments for unpredictable and undefined periods (Ciolek et al. 2017).
- The prevalence of diabetes distress and depression is highly prevalent in international diabetes populations (Nicolucci et al. 2013).
- Psychosocial issues such as lack of control and social isolation have been frequently reported by chronic DFU populations (Fox 2005; Livingstone et al. 2011; Delea et al. 2015)
- The psychosocial issues of patients with a new diagnosis of DFU had not been previously evaluated and previous studies have lacked scientific rigour due to lack of reporting of reflexivity, data saturation and analysis procedure.

2. Method

- Interpretative qualitative study of 6 participants with diabetes mellitus and a new diagnosis of a DFU at hospital admission, within the preceding 6 weeks
- Semi-structured interviews using guide
- Reflective journal

6 phase thematic analysis assisted by NVivo11 (Braun and Clarke 2006)

3. Results

Themes	Subthemes
Health care beliefs	Identity
	Cause
	Timeline
	Consequences
Coping strategies	Adaptive coping
	Maladaptive coping
The dirty service	Perceived support
	Naivety of diabetic foot disease
Social support	Positive
	Negative

4. Discussion

- Participants regarded their DFU as "acute", i.e. they believed their ulcer would heal
- Participants reported lack of information about the rehabilitation process
- Perceived controllability of their DFU was transitional over time i.e. powerful other to internal
- All participants reported some healthy strategies for coping and regarded the DFU MDT as highly trusted

"They talked me through it all, told me what was happening, why it had happened to me."

"In that little timeframe from blister to black toe in 36 hours."


"I presume I could also get another infection in the bit that's healing but I don't know about that."

"I feel like I was one of the lucky ones."

"When I said it could be an amputation possibly, the first thing I remember Mum saying is, you won't be able to do your normal job."

"I'm rehabilitating myself gradually, get back to moving about as before."

"I feel that I've been cheated a bit on the aftercare"




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Winner: Pressure Ulcer

Dr Amy Ferris, Medical Registrar, University Hospital of Wales, Clinical Research Fellow, Welsh Wound Innovation Centre


Category: Pressure Ulcer: Are pressure ulcers an inevitable part of the dying process in palliative patients? A systematic review of the evidence.



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cymdeithas Ffio
Cardiff and Vale
University Health Board

Are pressure ulcers an inevitable part of the dying process in palliative patients; a systematic review of the evidence.

Dr Amy Ferris, Dr Annie Price, Professor Keith Harding



**WELSH WOUND INNOVATION CENTRE
ARLWOSSOD
GLWYFAU CYMRU**

Background

Pressure ulcers are defined as an area of tissue loss secondary to pressure or shear, usually over a bony prominence. They convey significant morbidity for patients as well as financial cost for the NHS. NICE describe pressure ulcers as "often preventable" but what does this mean? Multi-organ failure is recognised as a pre-terminal event and now "skin failure" - a state of compromised tissue integrity affecting skin cell survival at a time of physiologic stress" and "Skin Changes at Life's End" - physiologic changes that occur as a result of the dying process affecting skin and soft tissues" are becoming increasingly recognised.

This systematic review was conducted to assess whether pressure ulcers can in fact be an inevitable part of the dying process for some patients.

Method

Registered with PROSPERO database (ID CRD42017078211)
Used "Preferred Reporting Item for Systematic Reviews and Meta-Analysis" (PRISMA) proforma (Figure 1)
Searches conducted in MEDLINE (1949-22/9/2017), EMBASE (1956-22/9/2017), CINAHL (1937-22/9/2017) and the Cochrane Library to identify relevant original articles (experimental and epidemiological studies) evaluating patients who were both receiving palliative care and identified as having pressure ulcers, looked after in both community and inpatient settings.
Excluded: Review and commentary articles; meta-analyses and consensus documents, case series describing fewer than 5 cases or with poor-quality data, articles unrelated to the terminal phase of illness or describing wounds other than pressure ulcers.
Articles screened and data extracted by 2 independent reviewers (AF and AP), then compiled into Microsoft Excel spreadsheet for analysis.
For data with a p-value provided we have only included the statistically significant results (p<0.05).

Results

12 articles (63,907 patients) were selected for analysis (Figure 1); retrospective cohort studies (n=5), prospective cohort studies (n=1), retrospective case control studies (n=2) and audit (n=1). Prevalence of pressure ulcers 12.4% (range 9.9-54.7%), incidence 11.3% (range 0-37.5%). Prevalence in the nursing homes is significantly higher than for other care settings (Figure 1) 9 articles examined risk factors for pressure ulcer development (Figure 2). Worsening physical performance or immobility was the most frequently cited risk factor for pressure ulcer development, followed by Waterlow score and advancing age and prolonged duration of stay.¹⁻⁹

4 articles included information on the temporal relationship between ulcer formation and death but different reporting methods makes direct comparisons between articles challenging. Hanson (1991) found a mean of 82% of pressure ulcers developed within 2 weeks of death.¹¹ Hendrichova et al. (2010) found that 53.9% of new ulcers developed within 6 days of death.¹² Kayser-Jones et al. (2008) identified a mean of 66.8 days from pressure ulcer formation to death.¹³ Henoch and Gustafsson(2003) recorded a median of 12 days from ulcer formation to death (range 1-59 days).¹⁰

Limitations

Due to the ethical limitations of performing trials in dying patients, there is a lack of randomised control trial or robust case control data for pressure ulcer formation or prevention in this population and data was not of a quality to enable meta-analysis. The population groups themselves were also very heterogeneous making it difficult to draw overall conclusions.

All of the articles studied included patients classified as "palliative", however this broad term does not necessarily mean that patients were in the last days of their life when they were studied, making it harder to draw conclusions reliably.

Risk factors highlighted in this review were described as being statistically significant in the original articles, however statistical methods were rarely described in detail and statistical significance does not necessarily convey clinical significance.

Discussion

This review identified an overall prevalence rate of 12.4% for pressure ulcers in patients receiving palliative care. This is higher than the prevalence of 4.7% quoted by NICE in 2013 (compiled from 186000 sets of patient data) and higher than the data recorded by Clark et al (2017) in a national audit of Welsh hospitals identifying an inpatient prevalence of 8.9%.¹⁴ This suggests that the palliative population are more likely to experience pressure ulcers when compared with the general population.

Prevalence was higher in nursing home residents vs. patients cared for in their home or in hospital (Figure 2). This could be due to nursing home residents generally having higher care needs and reduced independence and mobility increasing the risk of ulcer formation.

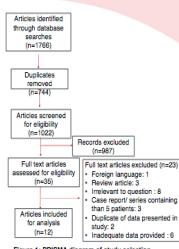
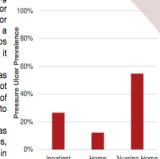
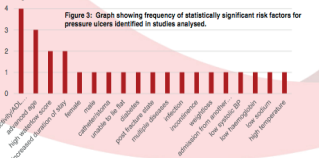
The varied lists of risk factors for pressure ulcer formation identified in this review highlight how challenging it can be to draw conclusions from observational research for complex individuals with multiple pathologies. Poor physical activity, advancing age, duration of stay and Waterlow Score were the factors identified as being most significant in this population (Figure 3). It is worth considering whether these risk factors are actually features of a dying patient rather than risks for an ulcer, and demonstrate a patient entering multi-organ failure, with skin failure as an element of this dying process.

The NIPAP advice that in those who are actively dying, "prevention and treatment of pressure ulcers may be superseded by the need to promote comfort by minimising turning and repositioning".¹⁵ However, identifying the time when a patient is actively dying can be challenging to even the most experienced clinicians. Conversely pressure ulcers themselves can cause significant pain and distress so their avoidance in patients for whom comfort is a priority is important. A better understanding of these processes would allow clinicians to help their patients make informed choices about their pressure relief, continence care and use of pressure relieving devices at the end of life.

Conclusions


As patients approach the end of their life, treatment goals change from curative and life prolonging to comfort and supportive care, even if this may make death more likely as a consequence (the doctrine of double effect). This should include wound management, and modifying approaches to dressing changes, wound debridement, continence care, pressure relieving equipment and turning, amongst others factors, may be necessary. This review has shown that pressure ulcer prevalence is higher in palliative patients compared with the general population, especially for those in nursing homes, although the reason for this is not clear. While these findings should not be used as an excuse for poor practice, we suggest that pressure ulcer formation in this population may not always reflect the standard of care, and may instead be a feature of complex circumstances, some of which are not modifiable.

As such skin failure, as with other organ failures, may be an inevitable part of the dying process for some patients.

"Health & Wealth for Wales"

Contact Details: Dr Amy Ferris, amy.ferris@dydnpn.com.uk +44 2920 743870



Winner: Infection

James Masters (on behalf WHISH study team), Clinical Research Fellow in Trauma and Orthopaedics, University of Oxford

Category: Infection: Randomised controlled feasibility trial of standard wound management versus negative-pressure wound therapy in the treatment of adult patients having surgical incisions for hip fractures



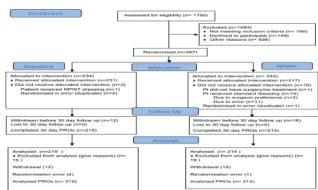
Randomised controlled feasibility trial of standard wound management versus negative-pressure wound therapy in the treatment of adult patients having surgical incisions for hip fractures

JPM Masters, J Achten, B Shirkey, J Cook, M Dritsaki, L Sansom, M L Costa on behalf WHISH study team

Aims
We aimed to conduct a randomised feasibility trial of incisional negative pressure wound therapy (iNPWT) versus standard dressing following hip fracture surgery. The primary objective was to quantify differences in the rate of SSI 30 days after hip fracture surgery in standard dressings and iNPWT.

Method
This is a multicentre two arm non-blinded randomised feasibility study embedded within a prospective cohort. Eligible patients were over 65 years of age undergoing surgery for hip fracture. Patients were allocated to iNPWT or standard care. Patients with and without capacity were included and Oxford C Research Ethics Committee granted ethical approval on 28/04/2017, 17/SC/0207.

Results



Characteristic	Total N=62
Age (mean)	83.57
Gender (F/M)	32/5:137
ASA 1-2	114
ASA 3-4	328
Mean prep AMTS (SD)	7.69 (3.28)
Own home	381
Residential care	35
Nursing home	46

	Number	Total (%)	95% CI (%)
Primary Outcome CDC SSI	18 (4.2%)	432	2.5-6.5
Complications reported	19 (4.4%)	432	2.7-6.8
Dieter diagnosed wound infection	10 (2.3%)		
Antibiotics for wound infection	16 (3.7%)		
Further surgery	2 (0.5%)		
Further surgery - day	3 (1.0%)		
Debridement	7 (2.0%)		

Conclusion This study identified a significantly higher rate of surgical site infection in hip fracture patients than is currently reported by national surveillance procedures (7%) with several associated parameters for infection such as treatment with antibiotics and further surgery. This finding has implications for understanding and treating this important complication.



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Winner: Leg Ulcers

Stephen Barker, Medical Director, SFH Oxford Ltd

Category: Infection: Anatomically Focused Compression May Help Improve Venous Leg Ulcer (VLU) Management Outcomes?

Anatomically Focused Compression May Help Improve Venous Leg Ulcer (VLU) Management Outcomes?

Introduction:

The principal underlying cause of VLU is sustained venous hypertension with associated valvular incompetence, often sited in the perforating (or communicating) veins above the medial malleolus. The widely accepted 'gold standard' for treatment, to achieve healing, is to apply graduated compression to improve 'calf muscle pump' performance, enhancing venous return, achieved by either compression bandages, or compression hosiery. In published RCTs, healing rates are similar (Ashby 2014). The overall use of compression hosiery is increasing in the UK, but to get good outcomes, high compression levels are considered necessary. Furthermore, patients in Class III hosiery have the longest times between healing and recurrence (compared to those using Class II products), but the non-concordance rate is extremely high (42% - Anderson, 2014).

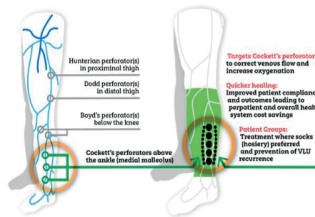
The common perforating veins (from superficial to deep) are referred to as Cockett's perforators, sited at ~5, ~10 and ~15cm above the medial malleolus, usually on the more postero-medial aspect of the lower calf. [Other perforating veins can or do exist.] By designing hosiery to ensure that the required high compression is applied specifically, focused, to the anatomical area of the lower leg where most leg ulcers form, generally around these underlying perforating veins and to provide an overall background of (lower) graduated compression to the rest of the lower leg, should help reduce overall oedema (as a result of sustained venous and lymphatic stasis) and aid venous return whilst simultaneously, improving concordance rates through having an easier to don product that causes significantly less overall discomfort.

Recently, this has been achieved through use of anatomically focused arrays of pads, fashioned from a newly created ink polymer, applied to the inner aspect of newly created, graduated compression hosiery.

Initially, this concept has been tested on healthy (athletic) volunteers during progressively more intense exercise, to evaluate the effects of applying additional compression specifically targeting the area around the perforating veins on both systemic cardio-respiratory and peripheral vascular responses.

Method:

- **Participants;**
- 12 recreational club runners
- **Experimental Procedures;**
- Randomised trial design with two conditions: "STO" (wearing knee-high compression pad stockings) and "PLAC" (placebo; wearing standard knee-high running socks)
- Each trial involved performance assessments taken during progressively more intense (incremental) running (>1km/h stage), on a treadmill, at 1% incline raises. Each stage was 4.5min running and 30s rest. The protocol was designed to produce exhaustion within 30min
- **Experimental Measures;**
- Running time to exhaustion was used as the main marker of exercise performance
- Standard cardio-respiratory measures (oxygen uptake, heart rate and max' heart rate)
- Haemoglobin indices (HbO₂, Hb) measured continuously with Near Infrared Spectroscopy technique (NIRS) from calf (compressed) and thigh (non-compressed) tissue



Results:

Specifically, in rest periods between exercise stages, significantly steeper slopes for calf tissue re-oxygenation and ΔHb decreases were noted in the STO trial compared to PLAC trial. [This finding corroborates, but exceeds, a previously observed increased calf tissue oxygenation in recovery following an exhaustive run when wearing graduated compression sleeves (Menetrier et al. 2010)].

Discussion:

Initially, these new, padded, graduated compression stockings have been developed for the sports market - to aid training, performance and recovery. By applying a focused, optimised compression level (determined at 24-25mmHg at the ankle), the stockings can assist the 'calf muscle pump', significantly improving venous return and simultaneously, as shown, tissue oxygenation in the lower limb. The initial data is positive and anecdotally, very many elite athletes have noticed improvements in performance times, less tiredness and far quicker recovery. The question is, can these beneficial haemodynamic effects be transferable to the treatment of venous leg ulcers? The functional objectives are similar: The superficial veins (and lymphatics) below the skin, but above the fascia of the lower leg, are connected to the deep veins inside the calf muscle principally by Cockett's perforating veins. When the one-way valves in the deep and/or Cockett's perforating veins are damaged (most often through previous deep vein thrombosis - DVT), the higher venous pressure generated is transferred back to the superficial veins which causes ultimately, the skin to become of poor quality, receive less tissue oxygenation and eventually breakdown, whereby an ulcer then forms. Management of these superficial and Cockett's perforating veins is a key objective for any compression treatment. The application of anatomically targeted, higher compression-creating pads to these specific structures, within an overall easier to apply graduated compression stocking, could help improve outcomes and especially, improve concordance rates.

Conclusion:

The data, so far, is on healthy (athletic) volunteers and shows a positive effect (re: tissue oxygenation) for these anatomically focused compression pads and by applying targeted high compression to make application easier and overall discomfort less. Further research is required to confirm this in patients with VLU.

References:

Ashby RL, Gabe R, Ali S, et al. VENUS IV (Venous Leg Ulcer Study IV) - compression hosiery compared with compression bandaging in the treatment of venous leg ulcers. Health Technol Assess (2014) 18(11):1-10. doi:10.3391/ht.a.18.11.1

Anderson and Smith G. 2014. Compression Made Easy. Wounds UK. Vol 10 (3).

Menetrier A, Mourot L, Bouhaddi M, et al. Int J Sports Med 2011; 32 (11): 864-8.

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To submit your abstract please use the following link www.surveymonkey.co.uk/r/WUKH19

E-POSTER VIEWING

The e-poster exhibition is the perfect forum for wound care clinicians to exhibit their work at the largest UK wound care conference. All e-poster exhibitors receive a discounted attendance rate at the event.

All e-posters will be displayed on large screens, with posters scrolling repeatedly. Each screen will display a category; where there are a very large number of e-posters in a category, more than one display screen will be provided. Where there are two categories with lesser e-poster numbers, these will be combined into one screen.

VIEWING ON DEMAND

Wounds UK will also provide large screens where delegates are able to select any poster they wish to view.

POST-CONFERENCE

All e-posters will remain available to view online after the conference closes.

DEADLINE

Deadline for submissions is **1 AUGUST 2019**

All successful entries will be notified by **27 SEPTEMBER 2019**

Please contact the events team on info@omniamed.com or **020 3735 8244** if you have any questions or require further information

WoundsUK Award 2019 FOR EXCELLENCE

Call for abstracts

Wounds UK are pleased to announce the call for abstracts for the 2019 Wounds UK Annual Conference, held at the Harrogate International Convention Centre 4-6 November.

Entries for the e-poster exhibition require you to submit an abstract. Every entry received will automatically be considered for the Wounds UK Award for Excellence 2019.

All abstracts will be reviewed by our judging panel, who will be looking to accept submissions that display high levels of innovation, relevance to current and/or best practice and provide high-quality research/evidence.

THE WINNER OF THE WOUNDS UK AWARD FOR EXCELLENCE WILL RECEIVE A FREE 3-DAY DELEGATE PASS WITH ENTRANCE TO THE GALA DINNER

This year's categories are:
CASE STUDY, COST, DIABETIC FOOT, INFECTION, PHD PRESENTATION, PRACTICE, RESEARCH, SCIENCE, SKIN INTEGRITY, OTHER

TO SUBMIT YOUR ABSTRACT, PLEASE USE THE FOLLOWING LINK WWW.SURVEYMONKEY.CO.UK/R/WUKH19

Poster presentations will be presented on electronic poster displays only, no hard copies will be on display