

A DAY IN THE LIFE: WOUND MANAGEMENT IN PALLIATIVE CARE

Wound care involving patients in palliative care requires a different approach to standard wound care with many of those encountered presenting with very compromised skin. Here, the workings of a hospice are shared with a typical day at the hospice also presented.

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At Kirkwood Hospice, we use a variety of different dressings to dress different wounds. While the majority of wounds we encounter are pressure ulcers and moisture lesions, we are also experienced in dressing fungating wounds, leg ulcers, skin tears and lymphorrhea.

Through study days and tissue viability link nurse meetings, we keep up to date with recommended practice. At a recent study evening led by a tissue viability nurse, the recommendation of hydrocolloids to treat, in particular, category I and II pressure ulcers, was made. While as a nursing team we know the indications for hydrocolloids (Wounds International, 2011), we do not routinely use them to treat category I and II pressure ulcers.

What we soon discovered was that while hydrocolloids might be recommended in general practice, our personal experience in the hospice is that they are often not particularly compatible with our typical patient, for example, many of our patients have cachexia and the sticky nature of hydrocolloids can prove to be problematic when removing them, as they adhere to skin, which is usually very thin and fragile and, therefore,

makes the skin even more vulnerable to damage.

While the recommended length of use for hydrocolloids is 3–5 days (World Wide Wounds, 1998), hospice policy dictates that all wounds should be reassessed at least once in a 24-hour period (unless there is a specific indication to leave a wound dressing in place for a prolonged period). This is particularly important for patients with category I and II pressure ulcers, as their rapidly deteriorating condition means their skin has the potential to deteriorate rapidly as well. Through regular assessment of wounds, we can pinpoint exactly when a wound has deteriorated and keep our documentation up to date to allow for effective and accurate root cause analysis. Peeling back and, if necessary, changing a dressing daily, if the dressing is adhering tightly to the skin has the potential to do more harm than good.

Upon assessing a wound recently, which had begun as a category I pressure ulcer and dressed with a hydrocolloid dressing, the wound was found to have deteriorated to a category III as there was slough present. It is not possible to say for certain what caused this deterioration, as the patient in question was older,

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cachexic, had weeks to live and was mainly nursed in bed; all of which are high-risk factors for developing pressure ulcers (Waterlow, 2005). However, we have found at the hospice that, in the past, hydrocolloids have made wounds on many of our patients 'soggy', which has caused further deterioration in skin condition.

While these findings are anecdotal, it is something that we are very mindful of at the hospice, at a time when our patients' skin is already very compromised. Hydrocolloids by nature provide a moist environment to enable wound healing, however, the general feeling at the hospice is that our patients have very specific problems and needs, and do not always necessarily fit the general advice that is currently available.

At the hospice, the main dressing that we use to treat pressure ulcers is Mepilex® and Mepilex Border® (both Mölnlycke Health Care). We find them to be a gentle and absorbent dressing, which, when using the bordered variety, stick effectively, but gently, to skin. Other dressing options we have are silver dressings for critically colonised and infected wounds (in particular, Aquacel® Ag, ConvaTec), and highly absorbent dressings, such as Flivisorb® (Activa Healthcare) (useful, for example, for high levels of lymphorrhoea). Dermal pads (Aderma) are also useful for the management of category I pressure ulcers or areas that we deem to have the potential to develop into a pressure ulcer.

For example, a patient we had recently had category 1 pressure damage to both heels. His skin was red and non-blanching, and he was nursed in bed and, therefore, at clear risk of the skin on his heels breaking down. By using Aderma Dermal heel pads (along with a regular repositioning regime), we successfully protected the heels and prevented the patient from suffering unnecessary pain, discomfort and potential infection.

In terms of cost, a 7 x 7.5 cm Mepilex border dressing is £1.39 per dressing — the specially designed sacrum dressing even more so at £3.34. A standard square of Aderma® (Smith & Nephew) dermal pad costs approximately £8. This is clearly expensive, however, we have found them to be effective at the hospice at preventing skin deterioration, and as they are also washable and, therefore, reusable (for the same patient), they are considered a worthwhile expense. The hospice acquires these dressings through the NHS at a discounted rate, however, the wound care team at the hospice is planning to assess the use and cost of such dressings and establish whether there are other dressings that are cheaper but still as effective.

We are also trying to rationalise our dressing selection, as we currently have several different brands that effectively do the same job. It would be more economical for the hospice, and would also make dressing selection easier for staff. An example of the hospice successfully rationalising a product is our use of emollients. At one point, a few years ago, we had several different creams in stock to moisturise skin and treat excoriation and moisture lesions. Our emollient of choice now is Epaderm® (Mölnlycke Health Care), while Cavilon® (3M) is used in the treatment and prevention of moisture lesions. This system ensures we know exactly what to use for specific conditions, and we are particularly good at moisturising skin to ensure it stays in the best condition possible.

While our aim is to rationalise our core stock, we will obviously continue to treat each patient individually and assess them on their own specific needs. If they require a specialised dressing that we do not routinely stock, we will order it in for them. **WE**

References

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A day in the life of wound care management at Kirkwood Hospice

7am Start of early shift. Look at patients wound care requirements, so any required actions can be planned for and prioritised, for example: which patients have dressings that need changing, and who is due a general skin assessment to check there haven't been any changes in skin condition (required at least once every 24 hours)

10am An excellent time to assess a patient's skin is while assisting them with their hygiene needs. If it isn't a staff nurse doing this, the auxiliary nurses are competent in recognising abnormal skin changes and report these to the staff nurse on duty.

1pm A patient has been admitted during the morning, with a fungating tumour to his rectum. The wound is assessed for size, exudate levels, level of discomfort to patient and signs of infection. The full assessment is documented, along with a diagram of where the wound is, and a thorough care plan indicating cleansing methods, dressing type and size, and required frequency of change. Stock is also checked for availability of appropriate dressings and more ordered if necessary. This thorough documentation gives clear guidance to other members of staff on the next shift and on subsequent days, so they have a clear guide as to the original condition of the wound (therefore, enabling any changes to be recognised), and what is needed to dress it.