

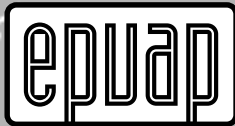
Mission Statement The European Pressure Ulcer Advisory Panel's objective is to provide the relief of persons suffering from, or at risk of pressure ulcers, in particular through research and the education of the public.

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EUROPE, A NEW CHALLENGE FOR THE EPUAP



Denis Colin

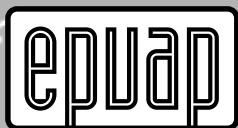
A few weeks ago ten new countries joined the European Union. One of these was Hungary and many EPUAP members will fondly remember the great success of the EPUAP Budapest meeting in 2002 and the enthusiasm of our Hungarian hosts. The recent political event and our experience of an enlarged and successful Europe lead me to a vision, which could also be a true challenge. Do we not have the responsibility, as EPUAP, to welcome all the new countries? The first step is to establish some formal links through an active partnership between 'old' and 'new' European members. We could then assess the health impact of pressure ulcers in these countries, using some well-known standards. We also have to compare our guidelines, our educational programmes and our research skills in this pressure ulcer managements field. This approach seems fundamental to me and there is no doubt that it will be a unique opportunity to learn from each other. We certainly will improve our daily practice, as clinicians, teachers and researchers. We could then summarize our findings, revise our guidelines in order to form new consensus based guidelines, and finally disseminate these. We could also define a pan-European research programme led by a EPUAP committee responsible for the promotion and evaluation of the scientific programme.

But let us consider taking this one step further. The EPUAP, due to its human, technical and scientific experience, has a role to play in persuading Europe (European Union health administration) to adopt a political view that prioritises pressure ulcer management and to release the funds necessary to better prevent and treat pressure ulcers.

Also, in my opinion, it is the EPUAP's responsibility to help ensure fair and equal treatment regarding pressure ulcer management throughout all European countries, regardless of their wealth. I see no reason that an aging patient in Poland or Lithuania would not have the equal right to the protocols and guidelines for pressure ulcer management as the French, English or Italian patients.

Denis Colin

President



EDITORIAL



Dr Michael Clark

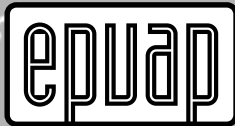
WE are now rapidly approaching the wound event of 2004 – the meeting of the World Union of Wound Healing Societies to be held in Paris this July. The European Pressure Ulcer Advisory Panel is proud to be a co-host of this event and there will be a wealth of new pressure ulcer information presented over the week long meeting. The EPUAP look forward to welcoming you to Paris this July for what will be undoubtedly a rewarding, though probably exhausting week. In this issue we have the latest news from the organiser of the WUWHS event, Luc Téot and would like to thank Luc for taking time away from the preparations to provide EPUAP members with an update of the Paris meeting.

There has already been a pressure ulcer meeting in Paris this year! The PERSE association held its annual training day half-way up the Eiffel tower on 1 April. We have reproduced some photos from this event in this issue of the *Review* given that the EPUAP was strongly represented by Denis Colin (France), Carol Dealey (UK), Jeen Haalboom (the Netherlands), Christina Lindholm (Sweden) and Tom Defloor (Belgium). I was also present at the meeting but with my distinct fear of high places it was a great relief to step out of the elevator and into the conference hall! The meeting was a great success with over 170 delegates and several exhibitors. However, no-one could quite believe it when you said you were going to be speaking up the Eiffel Tower on 1 April – surely this was our President's way of teasing several EPUAP trustees? The reality was this year marked the third meeting of PERSE within one of the great symbols of France – a magnificent venue for an excellent gathering upon pressure ulcers.

Next year the EPUAP annual meeting will be held in Aberdeen in the North-East of Scotland. The dates of the meeting are 5–7 May 2005 and the event will be preceded by a national tissue viability event hosted by the UK Tissue Viability Society on 4 May. It is a great pleasure to be able to plan an EPUAP open meeting to be held within my home town – this issue of the *EPUAP Review* contains the preliminary programme for this event. We are confident that the programme and social events will match the great success of our recent meetings in Budapest and Tampere. There is no doubt that our Scots colleagues will richly entertain us during our stay in Scotland – and I look forward to seeing as many EPUAP colleagues as possible in traditional Scottish dress!

See you in Paris.

Michael Clark
Editor



THE WORLD UNION OF WOUND HEALING SOCIETIES



Luc Téot

THE Second World Union of Wound Healing Societies meeting will be held in Paris from 8–13 July 2004. This congress will be the official and unique congress in 2004 for the most important Scientific Societies in wound healing including EPUAP, ETRS, EWMA and the French Wound Healing Society. Other well known international groups like the Association for Advancement of Wound Care (AAWC), the Canadian Association of Wound Care (CAWC), the Japanese Society of Pressure Ulcers, and the National Pressure Ulcer Advisory Panel will be ‘Privileged Partners’ at this World Congress. A large participation of all scientific groups or societies interested in wound healing, burns, pressure sores, leg ulcers, diabetic foot problems and trauma coming from all over the world has already been accomplished. More than 1100 free paper and poster abstracts are under review.

By bringing together disparate specialities, such as dermatology, plastic and reconstructive surgery, rehabilitation, geriatrics and burns, this meeting represents an achievement offering a world-wide vision of this emerging field and discipline of wound healing. The World Union of Wound Healing Societies (founded in 2000, in Melbourne) has reached a level of organization that has allowed it to develop commissions and working parties on education, third world assistance, publications, research and organization of care.

What are the main goals to be achieved in Paris in 2004:

- Presenting new world-wide research and make this accessible to all practitioners.
- Extending our knowledge in the care of wounds, by exchanging techniques and practices from new dressings to traditional medicine, in order to produce valid international guidelines.
- Establishing ethical policies concerning the development of new techniques like cell cultures, embryo cultures and gene therapy in wound healing.
- Ensuring reimbursement of products and to this goal a large panel of invited European Politicians will meet practitioners to develop common strategies.
- Education will be provided through teaching courses in order to develop educational programs that can be used anywhere in the world.
- More than 5000 healthcare professionals are expected to attend this unique meeting. We are looking forward to meeting you there!

Luc Téot

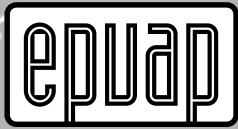
Deputy Chairman of the second WUWHS



CIVIC AWARD FOR JEEN HAALBOOM

JEEN HAALBOOM, a past President of EPUAP was recently honoured in the Netherlands with the award of Knight in the Order of the Dutch Lion, the highest civilian decoration possible in the Netherlands, because of his involvement with pressure ulcers. EPUAP wishes to congratulate Jeen on this prestigious award and photographs from the ceremony are shown below.

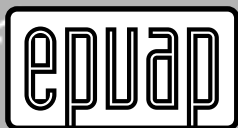




PARIS MEETING APRIL 2004

ON 1 April 2004, PERSE (the national French pressure ulcer organization) held its annual meeting in a conference room mid-way up the Eiffel tower in Paris. Here are some moments from this excellent gathering; further details on PERSE and its activities can be found at: <http://www.escarre.fr/>





FUTURE MEETINGS

Dr George Cherry



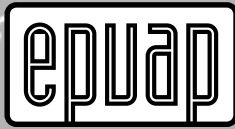
AT the Second World Union of Wound Healing Societies Meeting in Paris in July the European Pressure Ulcer Advisory Panel will have a booth. We welcome our members and delegates to visit us. The programme looks exciting and pressure ulcers are one of the main topics with many speakers from the EPUAP. As you know the EPUAP one of the four co-hosting societies at the meeting in Paris which will serve as our annual meeting for 2004. The members' annual general meeting of the EPUAP will be held on Sunday between 4.30 –5.30 pm. Members will receive a meeting agenda for the AGM and this will also be available at our booth in Paris as well as the AGM meeting's location in the Palais des Congres.

Next year our annual meeting, in which the theme is 'Pressure ulcers – back to basics – the fundamental principles', will be held on 5–7 May in Aberdeen, Scotland. The provisional programme is in this issue of the *Review* as well as the registration form. Please keep in mind that the deadline for abstracts is 28 February 2005.

Members of the EPUAP Business Office look forward to seeing you in Paris in July as well as next year in Scotland.

Dr George W. Cherry





LIVING WITH A PRESSURE ULCER: A STUDY PROGRESS REPORT

Prepared by Carol Dealey on behalf of the Research Team

IN 2003 the EPUAP trustees decided to support a pilot study into the experience of patients with pressure ulcers. The following report summarises the background to this project along with the progress made to date.

Research Team

Dr Sue Bale (UK)
Dr Denis Colin (France)
Carol Dealey (Project Leader, UK)
Dr Tom Defloor (Belgium)
Alison Hopkins (UK)
Fran Worboys (UK)

This pilot project is being funded by the EPUAP. The purpose of this report is to bring members up to date with our progress.

Background to the study

Little is known of the impact of pressure ulcers on an individual's quality of life. Langemo *et al* (2000) undertook a phenomenological study in which they reported that pressure ulcers have a profound impact on the lives of the sufferers. The authors suggest that a larger study is required to obtain a greater understanding of the patient's experience of living with a pressure ulcer. Their sample size was small (eight respondents), all of whom were under the age of 55 years. Fox (2002) also undertook a phenomenological study of the experience of five patients who had had grade 4 pressure ulcers that were healed or nearly healed. Again the patients were relatively young with an age range of 30–64 years. This is by no means representative of patients with pressure ulcers as a whole as the majority have been found to be over 65 years of age in a number of surveys. For example, Whittington *et al* (2000) surveyed 17,560 acute patients and found an incidence rate of 7%, of these 73% were over 65 years in age. Also the majority of patients in Langemo *et al*'s study (5/8) had spinal cord injury (SCI) and it was difficult to separate the impact of SCI from the impact of the pressure ulcer (Langemo *et al*, 2000).

Research Question

What is the lived experience of patients with pressure ulcers?

Study Plan

An initial pilot study will be undertaken in order to identify any weaknesses within the research protocol, especially the issue of having a number of people conducting the interviews and issues of translation from one language to another. The information obtained will be used to support a grant application for the main study. In the main study, healthcare professionals from countries across Europe who care for patients with pressure ulcers will be invited to participate. Each healthcare professional will undertake to interview between 3–5 patients who meet the study inclusion criteria. Prior to undertaking the interviews, each participant will receive standardised training on the study protocol and interview skills. All data generated from the interviews will be sent to a central data collection point for analysis.

Methods

Overall study design

The methodology to be used for this study is phenomenology. This is a philosophy initially developed by Brentano (1838–1917) and Stumpf (1848–1936) who saw it as a way to describe human experience as it is lived (Jones, 2001). Thus, phenomenology seeks to study the nature of phenomena as people experience them, rather than find causal relationships (Parse, Coyne and Smith, 1985). The ideas developed by Brentano and Stumpf have subsequently been developed by a number of theorists.

A phenomenological approach allows the exploration of an individual's perception or account of an event (Smith 1995). The unstructured interview is a common tool for generating phenomenological data and it assumes that realities beyond the interview can be expressed. However, it is important to recognise that the language of interviews can fracture the individual's story (Miller and Glassner 1997), thus care must be taken with the development of the interview schedule and the technique used. Probing techniques will be employed to ensure mutual understanding of meaning.

This study will generate rich data and the chosen analytic technique will support the researchers' beliefs that the unstructured interview will reflect on the individual's inner world. Thus for analysis, this study will use Interpretative Phenomenological Analysis (IPA) as described by Smith, Jarman and Osborn (1999). The structure offered by IPA

will enable the identification of themes and connections, searching for patterns and tensions.

There are a variety of philosophical approaches to phenomenology. This study will utilize the Heideggerian hermeneutics branch where the goal is to study how people interpret their lives and make meaning of what they experience (Cohen *et al* 2000). Unlike the Husserl branch of phenomenology, Heideggerian philosophy accepts that the data generated by the participant is fused with the experience of the researcher. This means that the views of the researcher cannot be bracketed off, thereby recognising that no researcher can come to the study with suspended preconceptions. Thus within Heideggerian philosophy the researcher is an active participant ensuring the importance of the role of reflexivity within the analysis.

The status of the literature review also reflects this philosophy. It is a common misconception that the researcher should not begin the study with the literature review (Cohen *et al* 2000). This is linked to the Husserlian view on bracketing, attempting to prevent contamination of the analysis by the researcher. Within the Heideggerian approach, the role of the researcher and importantly their knowledge and experience, are accounted for. In addition, the research question should arise from a personal or professional question about the phenomena and/or develop from previous research in order to fill gaps in our knowledge.

In order that the study will uncover the participants view on their world, unstructured interviews will be used. This method assumes that what the participant says has some significance to them and that there is a link between this and their beliefs (Smith 1995). Jasper (1994) suggests that the researcher requires very specific interview skills in order to prevent the data from being contaminated, for example, by asking leading questions. It is crucial that the participant is allowed to tell their story in their own way. The interviewer can easily fracture this by the inappropriate use of questions or inattentive listening. The skilled use of prompts is essential if shared meanings are to be obtained from the interview process. Prompts allow exploration and clarification if used sympathetically.

Carpenter (1995) has described some of the terms used in phenomenological research: essences, intuiting and reduction. Essences are the elements or basic units of any phenomena. They can be used to build an understanding of a phenomenon. Intuiting is the process of developing an accurate interpretation of the phenomenon that is being investigated. Reduction is the process of isolating the essences of a phenomenon from any preconceived ideas. The researcher must bracket any existing knowledge, that is, put it to one side, in order to remain neutral with respect of beliefs about a phenomenon. As a result, the essential truths of a phenomenon, and not someone's beliefs about it can be presented. Such skills include the use of reflection, clarification and conveyance of interest. She further discusses the benefits of practising interview and discussion techniques.

As with any research, academic rigour is essential to the credibility of the findings. Rose *et al* (1995) have discussed rigour in phenomenology in terms of credibility and consistency. Credibility or trustworthiness are alternative terms for validity within qualitative research and, within phenomenology, relates to whether the researcher has truly pre-

sented the essences of a phenomenon. As discussed previously, the researcher cannot be a neutral observer, but is an explicit part of knowledge production (Flick 1998). Reflexivity and self-awareness can be exploited and used as insight (Lipson 1991), thereby reducing subjectivity.

Two main concerns with a multi-centre, pan-European phenomenological study, are the issues of consistency and translation. These have been addressed through the training of the researchers and the provision of a central analysis for the data. Training includes both the philosophical underpinning of the study and the use of the unstructured interview technique. Where English is the target language, the researcher verifies the translated transcripts for accuracy. Finally, the themes arising from the texts are verified with the researchers.

IPA also offers a structure that reveals the analytic process, a transparency that adds to the credibility of this study.

Study Sample

A purposive sample of patients will be recruited. Patients will be included in the study if they meet the following criteria:

- An existing grade 3 or 4 pressure ulcer of greater than one month in longevity.
- The patient is able to talk about the experience of living with a pressure ulcer in the same language as the interviewer.
- The patient is over 65 years of age

It was considered that if a pressure ulcer healed within a month it was not likely to have a major impact on the life of the sufferer, although it must also be recognised that many pressure ulcers of this severity are likely to take much longer than a month to heal.

Data Collection

The patient interview will be conducted in a private setting and the interview audiotaped and transcribed verbatim. Basic demographic data (Appendix 1) will be collected followed by a semi-structured interview using the interview schedule in Appendix 2.

Data Analysis

The demographic information will be analysed using frequencies and compared with data collected in the pilot European Pressure Ulcer survey undertaken by EPUAP to determine if the sample is reasonably representative of the known data on patients with pressure ulcers. Analysis of the interviews will follow the framework offered by Interpretative Phenomenological Analysis (IPA) and will introduce system and rigour. The analysis has four stages:

1. The transcript is read several times. Comments, insights, possible interpretations are documented down the left hand margin. The right hand margin is used to document emerging themes and key words that may capture the essence of the paragraph. They can be directly from the discourse or from theoretical concepts.
2. Review of the emerging themes for connections, creating some order. Some may be sub-ordinate, others core themes. Their place within the text must be documented.
3. A table of themes is developed accompanied by quotes from the text.

4. This analysis is continued with the other interview texts and thus IPA is a cyclical process. Previous analysis can inform on the next, but themes will not be dropped. Any new themes will be taken to the previous text to ascertain their relevance.

Ethical Issues

Ethics approval for this study will be sought according to the regulations in each participating country.

Progress to date – the Pilot Study

A pilot study has been undertaken at the following centres: University Hospital Birmingham NHS Trust, Wound Healing Research Unit, Cardiff and Tower Hamlets PCT, UK; University of Gent, Belgium. Each centre has recruited 2 patients and the transcripts are being analysed. The steering group will be meeting in May to discuss the findings and prepare a report for EPUAP Trustees and for presentation in 2004 at the World Conference.

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Appendix 1

Demographic Data

- Patient age, gender and diagnosis.
- Where pressure ulcer developed, e.g., hospital.
- Pressure ulcer grade, position, longevity, past and current treatment including pressure redistributing equipment.

Appendix 2

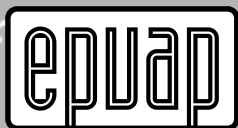
Semi-structured Interview Schedule

Title: *Living with a pressure ulcer*

A loose framework will be followed but will be tailored to the individual's response. The interviewee may answer some questions without being asked, so not all the questions will be relevant.

Suggested prompts: "Tell me more", "Can you explain that to me?", "Can you give me an example of that/ what you mean?", etc.

- You are part of this study because you have a pressure sore. Is this the word you would use, or would you use another term? (terminology, shared meaning)
- Let us start by you telling me briefly about yourself. (gentle introduction)
- What is it like having a pressure ulcer? (lived experience. Listen for and clarify pain, treatment, relationships, social, equipment issues)
- Do you know what your pressure ulcer/sore looks like?
- How would you describe it?
- What is the treatment like? How long does it take? [how it feels when examined]
- How does it make you feel about yourself? or Does having a sore make you feel any different?
- Has it made any difference to you? [if Yes, in what way, describe further – if No, why not]
- Do you know how it happened/occurred? [how does that make you feel?]
- Is it (the sore) something you would talk about with anyone?
- Have you had any sort of information on it?
- What do you think will help it to heal?
- Could you suggest 3 things/ anything that would improve your experience here?
- Can you tell me whether you think anything will change for you once you go home? (equipment, planning, daily life, relationships)
- This study is about understanding people's experience of living with pressure ulcers. Is there anything that I have not asked you but it would be useful for me to know?



A MULTI-CENTRE QUALITATIVE OBSERVATIONAL STUDY TO DEFINE THE NURSING PRACTICES THAT CONSTITUTE PRESSURE ULCER PREVENTION AND TREATMENT

Authors:

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Clare Williams (*Senior Nurse Tissue Viability, NE Wales NHS Trust*)

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Barbara Pritchard (*Tissue Viability Nurse, NE Wales NHS Trust*)

Introduction

The prevalence of pressure ulcers in acute hospital settings varies from 8% – 22 % (Clark *et al* 2004). Therefore it is of utmost importance that individuals who are deemed to be at risk are assessed and subsequently receive preventative care. If an individual has a pressure ulcer then the treatment they receive should prevent further damage and aid the healing process.

National guidelines (England and Wales) have been produced on the topic of pressure ulcer prevention and management (for example NICE 2001). The Tissue Viability Nurses from three trusts have adapted these guidelines to meet local needs, resulting in uniformity of practice across North Wales. However the impact of the guidelines is difficult to measure as no baseline of current practice has been established. In addition the proposed theme for the EPUAP conference in Budapest 2002 'Have we made a difference?' had stimulated a review of nursing practice. Therefore the Tissue Viability Nurse's have completed an observational study across the three trusts in order to define current nursing practice in relation to pressure ulcer prevention and treatment. The findings were verified by identifying which nursing practices are deemed to be pressure ulcer preventing or pressure ulcer treating in nature using a Delphi technique with the members of The European Pressure Ulcer Advisory Panel. It was hoped that the work would produce definitive criteria of what constituted nursing practice in relation to pressure ulcer prevention and treatment; it was the first time this has been completed in the United Kingdom since 1992.

The investigation sought to replicate an earlier observational study (Clark *et al* 1992). In which the authors produced a list of nursing practices that were deemed to be

pressure ulcer preventing and treating in nature. The purpose of the replication is to identify whether, and how, nursing practices relating to pressure ulcer prevention and treatment have altered over the last ten years.

Aim and objectives of the study

The aim of the study was to define a set of clinical nursing practices that together comprise pressure ulcer prevention and treatment. The objectives of the study are as follows:

- To complete periods of non-participative unstructured observation within the medical directorates of the three North Wales Acute Trusts.
- To document all nursing practices observed and following discussion produce a set of nursing practices that are deemed to be pressure ulcer preventing or treating in nature.
- To obtain verification that the nursing practices observed relate to pressure ulcer prevention and treatment in the UK and mainland Europe.

Methodology

Prior to commencement of the study ethical approval was obtained from all three Trusts. Observation is a research method in which the investigator systematically watches, listens to and records phenomena of interest. In this study the researchers adopted a non-participant role to ensure they concentrated on recording all nursing practices. They completed a series of over one hundred episodes of four-hourly observations in the medical wards within the three acute Trusts in North Wales. The medical units were chosen due to the nature of the patient population with a large majority of patients being deemed as at risk of developing pressure damage according to their pressure ulcer risk assessment score. Each Tissue Viability Nurse sat within one six-bedded area on a medical ward and recorded all nursing practice. The observations were unstructured to prevent any preconceptions influencing the data collection process. The periods of observation were divided to cover the majority of the patients day; 7am – 11am, 11am – 1pm, 1pm – 3pm, 3 pm – 7pm and 7pm – 11pm. Following each period of observation the data from all three trusts was col-

lated centrally at one site and a bank of nursing practices developed. Following the format utilised by Clark *et al* (1992) the initial observations of all observed nursing practices were recorded. When the equation $1 - (\text{number of activities seen once} / \text{total number of activities}) \geq 0.95$ (Clark *et al* 1992) was satisfied, observations of practice ceased as it was considered that a complete behavioral catalogue has been established.

Analysis

The purpose of the study was to define nursing practice relating to pressure ulcer prevention and treatment. Given the observational design of the study no formal statistical analysis was undertaken. The data naturally classified itself into six categories (toileting, hygiene, nutrition, positioning, skin care and miscellaneous). This was then transcribed into formic layout which is a tick box form that can be analysed using a computer programme thus easing the examination of the data. The forms were sent along with a covering letter explaining the rationale for the study to the 391 members of The European Pressure Ulcer Advisory Panel as at June 2003.

The members were asked to allocate the observed practices into one of four categories; pressure ulcer prevention/pressure ulcer treatment, general nursing care, a combination of pressure ulcer prevention/treatment and general nursing care or unsure. The respondent had the option of choosing unsure if they did not understand the nature of the activity. Pressure ulcer preventing was defined as a nursing activity that prevents tissue damage to the skin resulting from pressure, shear or friction. Pressure ulcer treatment was defined as nursing activity that relieves or reduces the effect of pressure, shear or friction on areas of establishes damaged or to promote healing of damaged tissue. Additional definitions were provided if the terminology was potentially confusing e.g. toileting.

Of the 391 forms distributed 86 were returned, one return was a refusal to participate as the respondent did not think the work would contribute to the body of knowledge on the subject and one individual received the form too late to participate in the study.

Results

Of the 86 respondents 78% were nurses, 19% non-nurses and 3% did not state their profession. The distribution of the respondents is displayed in the following table.

Country of origin	Number of respondents
England	43
Ireland	8
Holland	7
Italy	5
Wales	4
France, Scotland, USA	3 (per country)
Germany, Portugal	2 (per country)
Austria, Belgium, Estonia	1 (per country)
Norway, Sweden, not-stated	1 (per country)

In the majority of the results the activities were evenly spread across the three main categories. The following results represent categories in which over sixty-five percent of EPUAP members were in agreement with the categorization of the activity.

In the toileting category 64% of the respondents identified toileting with movement as part of general nursing care. In the hygiene category: oral hygiene and giving the patient a preparatory wash in which the nurse prepares the environment and the patient washes themselves were categorized as general nursing care.

Within the nutritional category the highest level of agreement (61%) was in allocating the giving of nutritional supplements as a combination of general nursing care and pressure ulcer preventing and treating activity. Six activities in the miscellaneous section were categorized as general nursing care; administration of medicines (68%), assisting medical staff with a procedure (66%), care of the nauseous patient/patient producing sputum (74%), care of the deceased patient (79%), administration of oxygen/suction (68%), taking a blood sample (65%). The activities that included repositioning and the use of pressure relieving/redistributing support surfaces were categorized as a combination of general nursing care and pressure ulcer prevention/treating (50 – 68%). However, this section contained the highest number of responses (7 – 33%) categorizing activities as specifically pressure ulcer preventing/treating. The final section on skin care the application of emollients/barrier products was categorized by 57% of the respondents as a combination of pressure ulcer preventing/treating and general nursing care as was the application of wound dressings (52%).

Limitations

The nursing care that was observed was undoubtedly influenced by the pressure ulcer risk status of the patients along with ward activity, staff patient ratios and patient dependency levels. The variations in care may have been influenced by the knowledge and experience of staff being observed. At times some of the observations were lost due to nursing actions that took place out of sight of the researcher.

It was not possible to control these variables but an attempt to reduce their potential impact was made by time-sampling thus varying the time-periods of the observations to cover the morning, afternoon and evening shift patterns. An attempt to reduce observer bias was undertaken by recording actual observations rather than perceived or inferred events.

The observers were the Tissue Viability Nurses for the areas being observed and the Hawthorn effect of this situation also has to be acknowledged.

Discussion

None of Clark *et al*'s 14 criteria that were deemed to be solely pressure ulcer preventing or treating were categorized as such in this study, four of the previously recorded activities were never seen as such in the current study, patient being made comfortable, application of sheepskin boots or pad to the heel or sacral area, use of donut devices

to raise heels off the support surface, inspection of plaster of Paris. The first category was not identified in this study as the components of making a patient comfortable were broken down and the detail recorded, the latter activity was probably due to the observations taking part on medical and not orthopaedic wards.

The remaining activities that were categorized in the earlier study as pressure ulcer preventing or treating were viewed as a combination of pressure ulcer prevention, treatment and general nursing care.

It appears that the specific part played by nursing care in pressure ulcer prevention and treatment has become subsumed with general nursing care and not viewed as an entity in itself. Therefore can this loss of identity be seen as progression towards holistic care or a regression due to its loss of status? If pressure ulcer prevention and treatment are not obviously demonstrated to the observer then how is the importance of its role to be identified and performed by nursing staff. It also would thwart the auditing of pressure ulcer prevention guidelines as the specific components of care would be difficult to identify. Worryingly the loss of pressure ulcer prevention and treatment may be more due to an absence of care rather than it being subsumed into general nursing care. If staff are not educated and aware of the value of pressure ulcer prevention and treatment its significance may be lost and thus eventually this aspect of care omitted.

Although not an intended outcome of the study, a consensus of opinion between the researchers was that the majority of hands-on basic nursing care was delivered by unqualified and student nurses. In this instance basic nursing care relates to washing, toileting, feeding and repositioning. Secondly, the observers were aware of long periods of time when the bays were without any nurse presence at all. However, it has to be noted that these were informal observations and were not formally documented as part of the original study. Nonetheless, it highlights the need for a more formal study to be undertaken investigating what nurses do.

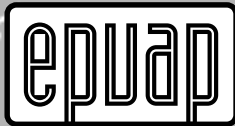
Conclusion

The nursing activities that are involved in pressure ulcer prevention and treatment appear to have changed little over the last twelve years. However the mechanism of care delivery appears to have moved from specific pressure ulcer care to being subsumed within general nursing care. EPUAP and national bodies have produced guidelines for the prevention and management of pressure ulcers. The researchers thought that during the periods of non-participative observation they would see visual evidence of their implementation, however a dearth of pressure ulcer care was observed. The value of the study was in experiencing the clinical reality rather than the perceived version of what constitutes clinical practice and the researchers would urge other clinicians to repeat the study in their own areas and thus validate the findings to date.

The authors would like to acknowledge the advice given by Dr Michael Clark and the support from the EPUAP office.

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7TH EPUAP OPEN MEETING, TAMPERE, FINLAND

Pressure Ulcer Prevention and Management, Poster Abstracts, September 2003

(continued from Volume 5, Issue 3, 2003)

THE EFFECTS OF THE THIRTY-DEGREE TILT POSITION ON THE SHAPE OF PRESSURE ULCERS

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Introduction

In Japan, the 30-degree tilt position has been recommended as a technique for preventing and curing pressure ulcers since it avoids compression or friction on some particular sites on the body's surface. However, it has been observed that this positioning sometimes leads to the exacerbation of pressure ulcers. This suggests that a change in body position can affect the shape of pressure ulcers. In this study, we examined the shape of pressure ulcers in relationship to changes in body position.

Method:

The subjects of this study were nine patients with pressure ulcers who gave informed consent to the study. Four patients had pressure ulcers in the coccyx region, three patients in the sacral region, and one patient in the posterior iliac region. Undermining had formed in six of the patients. According to NPUAP classification, two patients were Stage II, one patient was Stage III, and six patients were Stage IV.

Procedure:

The subjects were oriented in the 90-degree lateral position; we traced the wound's visible perimeter as well as outlined the undermining area around the wound. We then transferred the tracing to a clear overhead projector sheet. Next, the subjects were oriented in the 30-degree tilt position; and repeated the same procedure. Changes in the surrounding skin, the wound's surface area, shape, amount of dislocation (in the wound and undermining area) of the pressure ulcers were compared between the two positions. The differences were tested using the Mann-Whitney test.

Results:

Four of the nine patients showed a change in pressure ulcers shape, and compression at the wound edges. There was a significantly greater dislocation along the transverse

plane (the amount of dislocation from the bilateral iliac bone side towards the wound edge) when these four patients assumed the 30-degree tilt position ($P = 0.03$) and a significantly smaller ratio of the cranial side and the distal side length of circumference of the wound ($P = 0.03$ and 0.04). Undermining dislocation was 6.87 mm for the patients with changes in wound shape and 1.45 mm for the patients who had no changes in wound shape.

Summary:

Compression of the wounds during the 30-degree tilt position attributes considerable changes in wound shape from the bilateral iliac bone sides towards the wound edge. This is probably an outcome of the pressure which pushed the buttock skin from the bed plane in the direction of the ceiling. In addition, the characteristically loose skin on the buttocks of elderly Japanese subjects probably leads the wound to close. The amount of undermining dislocation observed during the 30-degree tilt position is thought to delay the healing process due to the inability of granulation tissue to form. These results suggest that the 30-degree tilt position has limitations and is not recommended as a technique for orienting the bodies of patients who have pressure and loose buttock skin.

A CROSSOVER STUDY EVALUATING AN ADHESIVE FOAM DRESSING FOR HEEL ULCERS

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Introduction:

Pressure ulcers are a significant health problem with at least 1.7 million people developing ulcers annually. Heel ulcers are difficult to dress with ordinarily shaped foam dressings. Two types of anatomically shaped dressings for moist wound healing of the heel are available on the market: Biatain Heel Dressing (Coloplast A/S) and Allevyn® Heel (Smith & Nephew). The two dressings are indicated for use in moderately to highly exuding ulcers.

The purpose of this study was to investigate the two dressings in relation to cost-in-use, health related quality of life

(HRQoL) and patient/investigator preference in patients with stage 2 or 3 heel pressure ulcers.

Methods:

12 patients were included in this open, block-randomized, prospective, crossover study. At inclusion more than 50 % of the ulcer area was covered with granulation tissue. Each patient was treated with both dressings, i.e. the type of dressings was consecutively switched at each dressing change to avoid bias in exudates levels. Data was recorded on 10 dressing changes per patient.

Results:

73% of the patients preferred to use Biatain Heel Dressing and the investigator preferred Biatain Heel Dressing in 64% of the cases. Patients considered Biatain Heel Dressing to have a positive influence on wound pain in 88% of the cases; no negative influence was reported. In 98 % of the cases patients experienced no or mild pain during dressing application when using Biatain Heel Dressing.

Exudate handling capacity and pressure relieving effect were good for both dressings. Patients regarded the odour controlling ability of Biatain Heel Dressing to be superior to that of Allevyn® Heel.

The mean wear-time was 63.5 hrs for Biatain Heel Dressing and 57.1 hrs for Allevyn® Heel. Preliminary cost-in-use results estimate direct cost of treatment to _ 30.4 and _33.4 per week for Biatain Heel Dressing and Allevyn® Heel, respectively.

Summary:

The results indicate that both dressings perform well, however, both the majority of patients and health care professionals preferred to use Biatain Heel Dressing. Results on wear-time and the dressings' apparent influence on pain may support this. Final study results are under preparation and will be presented.

NURSES' PERCEPTIONS IN ASSESSMENT OF PRESSURE ULCER

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Introduction:

Pressure ulcers are common in many healthcare settings. As most pressure ulcers could be prevented it is important to have prevention and educational strategies. EPUAP guidelines stress that risk assessment tool should be complementary to clinical judgement of pressure ulcers.

The aim of the study was to examine nurses' perceptions of assessment of pressure ulcer, to what extent assessment tools are used and nurses' perceptions regarding tools.

Method:

Data were collected with the use of questionnaire distributed to 89 nurses in communities (response rate 71%) and 116 nurses in three hospitals (response rate 65%), all in one county in Sweden.

Result:

An assessment in order to identify patients at risk for pressure ulcers was always made by 43% and occasionally by 56%. Less than one third of the nurses knew about assessment tools and very few used them. Perceived advantages with assessment tools were early discovery of risk patients and early interventions. They also supported nurses in carrying out a uniform assessment. Disadvantages mentioned were that they could be misleading and time-consuming. Regarding patients at risk nurses usually document the location of the pressure ulcers (99%), intact skin (58%) and patients' perception of pressure ulcer 33%. More than half of the nurses (54%) said that there were no written guidelines.

Summary:

The findings of the study indicate that nurses do not always have a systematic, evidence based approach in pressure ulcer assessment. Even though assessment tools are rarely used, nurses could identify important advantages in using them in clinical care.

WHAT TYPES OF INSTITUTIONS SHOULD PARTICULARLY IMPROVE PRESSURE ULCER CARE IN LONG-TERM INSTITUTIONAL CARE (LTIC), IN FINLAND

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Pressure ulcers (PU) are an unwanted but persistent condition in long-term institutional care (LTIC) for the elderly. Prevalence of sores vary from 3 – 35 % depending on definition and time of assessment in relation to length of stay. In Finland, a voluntary collaborative project to implement Resident Assessment Instrument (RAI) in LTIC was launched in 2000. The aim of the project was to improve quality of care through individual care-planning, set national thresholds for quality of care and compare outcomes at ward level using internet. In 2002, nineteen communities with more than 200 wards participated. Assessments of 5456 individuals, mean age 82 years and females 74 %, were performed semi-annually. The sample comprised appr. 17% of the LTIC residents in Finland. All types of institutions participated. Prevalence for grade 1–4 pressure ulcers was determined in order to find out what types of institutions should most improve their performance in preventing and managing pressure ulcers.

Data collecting method was Minimum Data Set 2,0 (copyright interRAI). Statistical methods were chisquare for dichotomic and test for continuous variables. Logistic regression analysis for those variables significantly associated with PU was performed

Results:

PU were most often found in hospital based LTC caring residents with highest functional dependency, in nursing homes with medium functional dependency, the occurrence of PU was 9,9 % whereas in assisted living with lightest case-mix the corresponding figure was 7. Final regression analysis showed that diagnoses often seen in relation with PU

stayed significant: Diabetes Mellitus (OR 1,33 95% CI 1,03–1,73), deep vein thrombosis (OR 1,89 95% CI 1,01–3,52) peripheral arterial disease (OR 2,18 95% CI 1,45–3,28) paraplegia (OR 10,2 95% CI 3,40–30,5) pneumonia (OR 3,43 95% CI 1,80–6,52). Increasing pain (OR 1,45 95% CI 1,29–1,63) together with increasing dependency (ADL=6, scale 0–6, where 6 = total dependency: OR 4,2 95% CI 2,09–8,50) were also associated with PU, whereas grades of dementia remained insignificant. Compared to hospital-based institutions, nursing-homes showed increased risk for PU (OR 1,39 95% CI 1,11–1,73) whereas assisted living remained not significant.

Summary:

The results demonstrate the particular need for nursing-homes, with medium-dependency residents, to focus on recognising and managing pressure ulcers.

THE EFFICACY OF COLLAGENASE IN THE MANAGEMENT OF WOUNDS OF PATIENTS IN A HOSPITAL SETTING

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Introduction:

Wound Bed preparation (WBP) is aimed at promoting closure by preparing the wound bed. Debridement is an important part of WBP. The purpose of this study was to evaluate clinical efficacy of collagenase* and its handling properties in the management of various wounds, treated in a clinical setting. Enzymatic debridement with collagenase is shown to be easy, selective, without causing bleeding, pain and damaging healthy skin.

Methods:

Dressing changes took place once per day, depending on the amount of exudate and condition of the wound a secondary dressing was chosen according to the discretion of the clinician. Data was collected by means of a questionnaire, looking at among others, clinical efficacy of collagenase e.g. time to complete debridement, aetiology-, size/depth of the wound, evolution of the condition of the wound bed, exudate production, pain, dressing comfort, handling of the dressing regime. The trial continued until complete debridement was achieved, the wound had closed, the patient was withdrawn, or an adverse incident was reported.

Results:

N = 30 wounds were included in the evaluation. Upon initial the total mean wound size was 12 x 8 cm, mean wound depth was 0.8 cm. At the end of the study the total mean wound size was 8 x 5 cm, mean wound depth was 0.1 cm. Upon initial the total percentage of black necrotic tissue present was 70%, the percentage of sloughy tissue present was 20%. At the end of the study the amount of black necrotic tissue present was reduced to 20% and the amount of sloughy tissue present was 5%. The average time to complete debridement for the evaluated wounds was seven days, with a range of ± 3 days. Collagenase was easy to ap-

ply and to remove and the patients reported no – or little pain upon dressing application, wearing the dressing and dressing removal.

Conclusion:

Collagenase was demonstrated to support the removal of non viable tissue in patients with wounds treated in a clinical setting, the product was well tolerated by the patients and easy to handle for the clinicians.

* Iruxol is a product of Smith & Nephew Medical Ltd

CUSHIONING EFFECTS OF WOUND DRESSINGS: NEW FINDINGS

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Pressure ulcers/sores on the body are caused by consistent pressure application by opposing surfaces over the skin covering bony prominences, resulting in reduced blood flow, soft tissue necrosis and consequent ulcer development. These wounds are known to particularly affect certain patient groups, such as elderly, immobile or diabetic patients.

In order to better assess the cushioning effects of wound dressings, a laboratory-based pressure monitoring model has been developed and employed to study the cushioning-effect applied by hydrated dressings *in vitro*. This test has been designed to closely mimic the clinical situation.

Whilst much previous research has focussed on pressure relieving devices and mattresses, relatively little work has been presented on the effect of wound dressings on interface pressure. The presented pressure mapping data demonstrates differences in cushioning effectiveness between wound dressing types. The data also demonstrates how cushioning effectiveness can be altered by increased exudate absorption over a dressing's wear time. Previous thinking on the cushioning effects of foam dressings is reviewed.

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RANDOMIZED CLINICAL TRIAL COMPARING THE EFFECT OF A SILVER CHARCOAL DRESSING (Actisorb + 25)¹ IN THE MANAGEMENT OF BACTERIAL LOAD IN PRESSURE ULCERS WITHOUT SIGNS OF CLINICAL INFECTION, VERSUS CLEANSING AND DEBRIDEMENT RECOMMENDATIONS OF THE AMERICAN AGENCY FOR HEALTH CARE POLICY RESEARCH CLINICAL PRACTICE GUIDELINE ABOUT THE TREATMENT OF PRESSURE ULCERS.

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Unitat Interdisciplinària de Ferides Cròniques, Consorci Sanitari de Terrassa and Grupo Nacional para el Estudio y

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Introduction:

According with the recommendations of the American Agency for Health Care Policy Research Clinical Practice Guideline about the Treatment of Pressure Ulcers (1994), adequate cleansing and debridement prevents bacterial colonisation from proceeding to the point of clinical infection. Current knowledge and available resources have changed since 1994, as the role of bacterial load instead besides local infection has been correlated with wound healing delay; another fact is the development of silver dressings with the capacity of managing bacterial load

Patients and methods:

We designed a randomized clinical trial in which we included stage III and IV pressure ulcers without clinical signs of infection which were randomly assigned to two arms of treatment:

- Cleansing and debridement + moist environment dressings (hydrogel and/or polymeric foam) in a period of two weeks
- Cleansing and debridement + a charcoal dressing (Actisorb+ 25) + moist environment dressings (hydrogel and/or polymeric foam) in a period of two weeks.

Simultaneous swab and aspiration cultures were done at day 0 and day 14. In a subgroup of patients we did another culture at day 28, in this case ulcers from group case or control were treated this two weeks only with adequate cleansing and debridement .

Actisorb is an antimicrobial carchoal dressing containing silver firmly bound to carbon fibres. Clinical signs of infection were established according with a tool developed by the Gerontological Nursing Intervention Center of the University of Iowa College of Nursing.² We considered a positive bacterial load managing when bacterial levels were equal or less than base readings.

Results:

We have included 99 pressure ulcers, 46 in the Actisorb group and 53 in the control group. A subgroup of eighteen pressure ulcers (six in the intervention group and twelve in the control one) were sampled at week 4.

Results in all the pressure ulcers included in the survey:

	Group Actisorb	Group Control	
Positive Bacterial load managing at 2 weeks	36 (78.3%)	32 (60.4%)	P: 0.056
Positive Bacterial load managing at 4 weeks	5 (83.3%)	2 (16.7%)	P: 0.06

Twenty pressure ulcers included in our survey were infected according to quantitative bacterial data) although they did not present signs of clinical infection when included in the survey. A subgroup of six infected pressure ulcers (two in the intervention group and four in the control one) were sampled at week 4.

Results in the pressure ulcers with infection included in the survey:

	Group Actisorb	Group Control	
Positive Bacterial load managing at 2 weeks	8 (88.9%)	2 (22.2%)	P: 0.002
Positive Bacterial load managing at 4 weeks	2 (100%)	0	

Discussion:

The systematic use of Actisorb in a period of two weeks of cleansing and debridement is much effective than the recommendation of adequate cleansing and debridement in order to manage bacterial load in pressure ulcers. Two weeks after the intervention, pressure ulcers treated with Actisorb remain with a better level of bacterial load management.

Our research suggest us several questions about the accuracy of clinical signs and symptoms of localized infection in chronic wounds as we found about 20% of pressure ulcers infected. Further research in this area is essential for a deep understanding of this concepts in pressure ulcers.

Although the goal of our trial was not initially to test the effectivity of the treatment of infection, our results suggest that the use of Actisorb in the management of bacterial load in infected wounds is much better than the recommendation of providing and adequate cleansing and debridement before considering the use of topical antibiotics.

According to our results the use of Actisorb is better option for the management of bacterial load as well for the treatment of infected pressure ulcers than the traditional recommendation of cleansing and debriding before the use of topical antibiotics. This fact is very important under the point of view of cost/effectiveness of the treatment of pressure ulcers as well as in the way for a rational use of antibiotics.

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This research has been done with an unrestricted research grant from Johnson & Johnson, Spain.

RANDOMIZED CLINICAL TRIAL ABOUT THE SYSTEMATIC USE OF MEPENTOL®, A TOPICAL PRODUCT OF HYPEROXIGENATED FAT ACIDS AND HERBAL EXTRACTS, IN THE PREVENTION OF PRESSURE ULCERS IN HEELS

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Introduction:

Pressure ulcers (PU) are the result of the effect in capillary circulation of the compression made by a force that affect

the tissues between the skin and a body prominence. This compression forces may affect tissues in three ways, damage in skin due to mechanical forces, damage in skin tissues due to reperfusion injuries and damage in the skin due to necrotic processes. Hyper-oxygenated fatty acids (HFA) are a topical product useful in the prevention of PU and in the treatment of stage I PU as they have effect in the improvement of local microcirculation as well as in barrier properties of the skin.

Subject and method:

We have designed a randomized clinical trial in order to test the effectivity of the systematic application of Mepentol[®], an hyper-oxygenated fatty acids solution with *Equisetum arvense* and *Hypericum perforatum* in the prevention of pressure ulcers in patients at medium to high risk of pressure ulcers in two nursing homes, Centro de Saude da Pampilhosa da Serra and Santa Casa da Misericordia, Pampilhosa da Serra (Portugal). One-hundred patients will be included in two arms of intervention:

- Conventional measures for preventing pressure ulcers defined in the protocol of two nursing homes (control)
- The same measures as control group plus the use of Mepentol applied in the heels twice a day (case)

Patients will be treated in a period of six weeks. Incidence of pressure ulcers according with GNEAUPP, NPUAP and EPUAP guidelines will be used as main outcome measurement in conjunction with a range of heel skin characteristics.

Preliminary results:

We have now included 29 patients, 16 in the Mepentol group and 13 in the control one. We hope to have the 50 + 50 patients included at the end of June. The incidence of pressure ulcers in the Mepentol group is zero while the incidence in the case group is 23.1 % (P = 0,042)

Preliminary discussion:

Our preliminary results are in accordance with the experimental and clinical evidences about the effectivity of Mepentol in the prevention of pressure ulcers and the treatment of Stage I pressure ulcers. Mepentol is an easy to use and cost/effective measure for the prevention of pressure ulcers in patients at risk of developing pressure ulcers.

This research has been done with an unrestricted research grant from Laboratorios Bama Geve.

THE IMPACT OF A NEW CAVILON SKIN CARE PROTOCOL FOR PATIENTS CARED FOR IN NURSING HOMES IN THE UK

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Introduction:

Patients cared for in Nursing Homes are vulnerable to skin problems, particularly pressure ulcers and incontinence dermatitis. This study is concerned with skin care in elderly, incontinent patients cared for in Nursing Homes. It explores the extent to which a new skin care protocol could be implemented, and its effects on patients' skin condition, and staff time.

Methods:

A longitudinal, pre and post intervention study design was employed in this study. Data were collected on current skin conditions and skin care procedures, prior to, and following the introduction of a new skin care protocol. A supportive education programme was delivered to staff. Nurses and carers were observed as they undertook skin care following episodes of incontinence. The time taken, products and amounts used were recorded. The presence and severity of incontinence dermatitis was recorded, together with the presence and severity of pressure ulceration. The new sacral skin care protocol comprises using a skin cleanser, a barrier cream and a barrier film* supplied by 3M Health Care.

All patients with incontinence, and all staff working in six Nursing Homes were included in this study. Two Nursing Homes were randomly selected to participate in detailed skin assessments, and documentation of skin care procedures and product usage.

Results:

164 patients were included in the detailed assessments, 79 pre-intervention, 85 post-intervention. 49 were male (29.9%) and 115 female (70.1%). Only 3% of patients were under 70 years of age, with 72% over 80 years of age. These patient profiles were very similar at both time points, indicating a frail, elderly population of patients. Pre-intervention 29.1% were incontinent of urine only, 64.6% were doubly incontinent and 6.3% were catheterised. Post-intervention 29.4% had urinary incontinence, 65.9% were doubly incontinent, and 4.7% were catheterised.

Staff adhered well to the new skin care protocol; during the observations, the care for only one patient did not follow the protocol. Skin condition was maintained or improved using the new skin care protocol. The presence of a pressure ulcer did not significantly differ between time points although the grade of ulcer was found to change significantly between time points ($p = 0.005$). The presence of Grade 1 (EPUAP) pressure ulcers was found to significantly decrease over time ($p = 0.041$). The presence of incontinence dermatitis was found to be significantly lower after introducing the skin care protocol ($p = 0.021$).

There was significant reduction in time taken to deliver skin care post-intervention ($p < 0.001$). There was a mean time saving of 5 minutes and 44 seconds, per patient per procedure. If the procedure is carried out an average of 8.5 times (ten and seven times in the two nursing homes used) this gives a time saving of 45 minutes and 55 seconds per patient, per day using the new skin care protocol.

Summary:

Staff adherence to the new skin care protocol was good, with only one observed episode when the protocol was not followed, suggesting a high degree of success in its implementation. In this study we demonstrated that the introduction of a new skin care protocol, supported by an educational programme, maintained or improved patients' skin condition, and significantly reduced the time involved in delivering nursing care.

* 3M 'Cavilon' Durable Barrier Cream and 3M 'Cavilon' No Sting Barrier Film and a proprietary skin cleanser were supplied by 3M Health Care.

REVIEW OF THE EVIDENCE . . . ONE SUPPORT SURFACE FOR PREVENTION & TREATMENT

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Educational Services Administrator, Gaymar Industries, Inc.

Jeanne Perla, PhD RN, Medical Research Scientist

Introduction:

Pressure and treatment of pressure ulcers is an important health care initiative. Patients can be spared the pain and suffering of pressure ulcers and patients and caregivers can avoid the financial burden of costly medical equipment, by the wise care management of patient populations at risk for and being treated for pressure ulcers. The clinical experience can best be shared by documentation in the literature. It is the responsibility of every clinician to publish their experiences for the wound care community. The evidence can be critically analyzed and used by other clinicians in making the most appropriate decisions for quality outcomes management.

Methods:

Literature review of evidence related to the clinical outcomes of using a static air overlay (Sof-Care® Air Overlay). Search of the literature in Pub Med (1980 to the present) limited to English, human subjects only. Guideline for strength of evidence was proposed by the Agency for Health Care Policy and Research (now the AHRQ) in Clinical Practice Guidelines #3 and #15. Level A = Good research-based evidence; Level B = Fair research-based evidence; Level C = Expert Opinion. Content of articles is reviewed for outcomes related to use of static air overlay.

Results:

A search of the literature reveals a total of eleven articles on this static air overlay (Sof-Care® Air Overlay). Three articles are clinical trials, eight articles are descriptive studies on clinical and financial outcomes of resource allocation. According to criteria for strength of evidence, Level A = three articles and Level B = eight articles. There are no level C articles. Review of outcomes (results) supports the use of this static air overlay (Sof-Care® Air Overlay) for management of pressure ulcers.

Summary:

The literature search reveals that over the past two decades there is A and B Level evidence to support the use of the Sof-Care® Air Cushion. Clinical and financial outcomes reflect the benefits of using the Sof-Care® Air Cushion. Review of these eleven articles indicates results that support the use of this static air overlay for both prevention and treatment of pressure ulcers. It is suggested that further research using this static air overlay (Sof-Care® Air Overlay) be initiated with the goal of increasing the database of evidence related to outcomes management for prevention and treatment of pressure ulcers.

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A NEW APPROACH TO THE MANAGEMENT OF A POST-SURGICAL WOUND IN A NEUROPATHIC DIABETIC FOOT WOUND (The Belfast Sandwich) The place of a dressing sandwich of a protease modulating product, a silicone non-adherent and a hydro-fibre

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Wound description:

The wound was a post surgical wound resulting from surgical removal of infected bone and soft tissue drainage. This had resulted from diabetic foot ulceration complicated by sepsis.

Medical history:

Diabetes mellitus had been diagnosed 20 years previously. Mass was 97 kg height was 1.85m BMI was 28.34 Medication was Metformin 500 mg tid The last measured HbA1s were in the range above 11 indicating poor control.
 Day 1 – Details of circulatory status and sensory evaluation are recorded.

Wound presentation:

The patient was admitted to hospital following review at the joint podiatry/vascular surgical clinic.
 Day 7 – Following arteriogram and duplex arteriography a sub-intimal angioplasty was completed and surgical removal of the first digit.
 Day 10 – The post surgical wound was dressed with Inadine Sterile gauze and surgipad.
 Day 13 – Dressing regime was altered to “The Belfast Sandwich” of Promogran Mepitel and Multi-layer Aquacel.
 This regime was employed from this stage until wound resolution at day 161. This case study charts the wound progress in more detail chronologically.

Case learning:

Dressing choice can have a profound influence on the outcome of diabetic foot ulceration. This case illustrates how occlusive dressing contributed to maceration in a diabetic foot ulcer complicated by some element of infection.

THE PREVALENCE OF DIABETES MELLITUS IN A POPULATION RECEIVING PODIATRIC CARE BY A COMMUNITY HEALTH CARE PROVIDER: AN ANALYSIS OF THE RESOURCE DEMANDS OF DIABETIC FOOT ULCERATION FOR PODIATRIC CARE

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Aims:

The aim of the study was to determine the level of diabetes in the caseload of a community health care provider, the frequency of diabetic foot ulceration and the resource demands of diabetic foot screening and ulceration management.

Methods:

Information on clinical time, task description and primary and secondary reason for referral to community podiatrist were recorded on a database. Information pertaining to the level of diabetes in this population was analysed over a period of one year. Diabetic foot ulceration was studied in a two-week period. The information from the database was retrieved using of a standard query language.

Results:

The population of the community trust was 328,850. The population receiving podiatric care was 34,595. The percentage of the population that received podiatric care that was registered diabetic was 19.63% Non-insulin requiring diabetes 5428 (1.65% of community trust population) Insulin requiring diabetes total was 1363 (4.1% of community trust). Total contact time by podiatrists was 1539,389 minutes on an annual basis. The total contact time by podiatrists for diabetic foot care was 497,049 minutes (32% of all podiatric care time)

Summary:

Multi-disciplinary management of diabetic foot disease has been shown to decrease the level of amputation. The level of diabetes (19%) in a community care provider responsible for foot care is high. Diabetes accounts for a disproportionate demand on clinical resources in podiatric care. Access to community podiatric care was determined by level of priority. Diabetes ensured a high level of priority.

This reflects the importance the trust attaches to the provision of screening and managing diabetic foot ulceration. The future predicted rise in the level of diabetes needs planning and structuring in health care delivery to ensure future adequate service delivery.

WOUND HEALING WITH BIATAIN™ DRESSING AFTER OPEN TRANSMETATARSAL AMPUTATION

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Introduction:

Diabetes continues to be the most common underlying cause of lower extremity amputation (LEA) in Europe and in the United States. Infected diabetic pressure foot ulcers are a significant risk factor in the causal pathway to amputation. This includes soft-tissue infection with severe tissue destruction. Lack of wound healing, systemic sepsis, or unresolved infection can lead to extensive tissue necrosis and gangrene requiring transmetatarsal amputation to prevent

more proximal limb loss. Adequate debridement may be required at some level as a means of removing all infected material.

Methods:

Postoperative wound healing is quite difficult. When the exudate production from operative wound is considerable, the author suggests performing often wound dressings in order to control the infection. Exudate absorption is very essential to wound healing. The author offers the usage of Biatain™ dressing and mobilizing plantar flap towards the back of the foot as a fine wound healing technique. The first day after the operation a lavage and a non adhesive Biatain™ dressing is needed. The first week the wound treatment performed every day. It consists of daily lavage and dressings with non adhesive Biatain™. In many cases, a debridement is recommendable too. After few days when the exudates decrease and vital tissues appear, there is a need for a slow rotation of the plantar flap towards the back of foot with a soft plaster side to side.

Results:

This method presented seven inpatients, the results were healing, and forming a well-shaped stump in five of the cases /71.43%/. Unfortunately for the rest of them were performed high amputations in the second stage. This was due to the major changes in the blood vessels of the lower limb and the progressing of the infection.

Summary:

Author recommends the wound healing technique with Biatain™ as a method of choice after transmetatarsal amputation due to diabetic pressure foot ulcer.

INDICATION OF PLASTIC SURGERY IN PRESSURE SORE TREATMENT

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Object:

Based on surgery experience on over 500 patients with pressure sores (decubitus) over 8 years, the authors are trying to define indication rules for admission of pressure sore patients to plastic surgery.

Method:

Following procedures and results in treatment of patients in the reconstruction surgery department of the Clinic of burns and reconstruction surgery.

Results:

More than 70 patients with pressure sores (decubitus) are admitted to hospital each year.

More than 80% decubitus are located in pelvic region.

More than 90% patients have medullary disorder.

Average age of patients is 47.3 years, 90% of them are men.

Average length of hospital stay is 24.7 days, 80% patients leave our clinic completely healed.

Local, muscular and musculoskeletal flaps are used for treat-

ment most often, skin transplants and conservative therapy are used less often.

Conclusion:

III and IV degree pressure sores are an indication for plastic surgery. The first phase – total necrectomy – is very important. In flap selection it is necessary to follow these two rules:

- a) predilection region for flaps selection and
- b) flap size sufficient for possible future treatment of relapses

General state of patient (somatic, mental) is also an important indicator for surgery. Post-op care, rehabilitation and routine follow ups are an essential part of treatment.

AN INVESTIGATION INTO THE RELATIONSHIP BETWEEN NEGATIVE PRESSURE, WOUND HEALING AND THE PROBLEMS OF SKIN DAMAGE ASSOCIATED WITH WOUND FLUID

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Summary:

Negative pressure has become valuable part of wound care and requires evidence based information on its application in different types of wounds. This study reviews the most appropriate place for negative therapy in wound care and develops a standard for use.

Introduction:

Wounds present a major healing challenge to all health care providers and wound management can be expensive for the NHS. In recent years, negative pressure therapy has become increasingly used in healing wounds. Although there is evidence that points to a faster healing rate with negative therapy than other methods, very little information or evidence has been provided on the type of wounds that are ideal for negative pressure. This study will review cases where vacuum therapy has been part of the care and will use the information to develop a protocol for its future use.

Methods:

The researcher interviewed nurses from around the UK. Each nurse was asked to provide structured information on each patient, how the product was applied in order to determine healing outcomes. Patients were not named in the study.

Results:

The results demonstrated significant benefits in skin grafts, pressure ulcers, extravasation, some leg ulcers and dehisced wounds. There was also a reduction found in skin maceration. Some wounds could be difficult to occlude due to the shape or position of the wound. Nurses have devised clever methods of retaining the negative pressure and this is reported within the results.

Conclusion:

This study provided background information on which wounds responded well to negative pressure and described

how that information was used to develop protocols for the use of the therapy.

DIGITAL DOCUMENTATION SYSTEM WITH INTEGRATED DATA-ANALYSIS

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Introduction:

Software was developed to address the need for digital patient records; it incorporates the total care process, progressing technical integration. The areas focussed on are individual departments and hospitals, care facilities, clinics and private practices. Moreover pressure ulcer registration may be mandatory from both a legal and quality control perspective. The system was used for individual pressure ulcer patient data registration as well as data base development to analyse evolution of therapy.

Method:

This paper reports on experience with the system, looking at pressure ulcer patients, in German speaking countries such as Switzerland and Austria. The following steps of the process are described: New submission of a patient with a pressure ulcer, clinical pathway, ulcer assessment, patient history, ulcer management regime, methods, materials, documentation on time path and data analysis.

Results:

An algorithm enables analysis of the conducted care. With this, not only the costs of a single treatment were evaluated, but also single treatment regimen was compared and outcomes analysed.

Conclusions:

This German-Swiss developed system is shown to enable less time consuming documentation, enabling enhancement of quality of care. The integrated data analysis system is demonstrated to be instrumental in the structural pressure ulcer data gathering and assessment of outcomes.

THE MANAGEMENT OF HARD TO HEAL PRESSURE ULCERS OF PATIENTS IN A HOSPITAL SETTING

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Introduction:

Although the biological response to wound healing of individual patients with hard to heal wounds is not yet fully known, a recent introduced collagen* may support wound healing in these patients. The product is reported to aid cell proliferation and chemotaxis. This paper reports on 6 controlled case studies of patients with multiple hard to heal pressure ulcers.

Methods:

Patients, who had two hard to heal ulcers were included in the study. If required, wound bed preparation was conducted using collagenase†. When the wound was completely debrided, collagen was applied. The product is composed of collagen and oxidised regenerated cellulose matrix and is reported to activate proteases present in chronic wound fluid, protecting PDGF. Dressing changes take place, depending on the amount of exudate and condition of the ulcer, a secondary dressing is chosen to the discretion of the clinician. Data was collected by means of a questionnaire, looking at among others, clinical efficacy, e.g., time to wound closure, etiology – size/depth of the wound, evolution of the condition in the wound bed, exudate production, pain, dressing comfort, handling of the dressing regime. The study continued until the wound had closed, the patient was withdrawn, or an adverse incident was reported.

Results:

N = 10 ulcers (five patients) were included in the evaluation. Upon trial commencement the total mean wound size was 14 x 8.7 cm, mean wound depth was 1.8 cm. Upon trial commencement the total percentage of black necrotic tissue present was 22%, the percentage of sloughy tissue present was 42%. The average time to complete wound closure was 16 weeks. The products under evaluation were easy to apply and to remove, the patients reported no pain or little pain upon dressing application, wearing the dressing and dressing removal.

Conclusion:

The results of this small study suggest collagenase to support the removal of non viable tissue and collagen to support healthy tissue granulation in patients with hard to heal ulcers, treated in a clinical setting.

* Trademark of Johnson & Johnson

† Trademark of Smith & Nephew

INFECTION CONTROL PRACTICES RELATING TO CHRONIC WOUNDS

*Phil Bowler, Joy Schank and Barbara Bates-Jensen,
ConvaTec Global Development Centre, Deeside, UK*

Pressure ulcers are invariably colonized with a wide variety of microorganisms, predominantly aerobic and anaerobic bacteria, that may compromise healing and cause infection. The majority of wound bacteria originate from the mouth and gut, although commensal floras of the peri-wound skin are also frequent colonizers. Since wound microflora originate from a variety of sources, a complex microbial ecosystem is often evident that may comprise potentially pathogenic aerobes and anaerobes, as well as antibiotic-resistant bacteria. Such microbial ecosystems present a risk to both the wound (in terms of delayed healing and infection) and cross-contamination, and hence the control and containment of the microbial population is essential.

Some moisture-retentive dressings such as hydrocolloids and polyurethane films have been shown to physically prevent the dissemination of wound pathogens and hence they have an important role to play in infection control. More recently, antimicrobial dressings have been claimed to pro-

vide similar protection by creating an antimicrobial barrier between the wound and the environment. One such dressing, AQUACEL Ag Hydrofiber®, combines the antimicrobial efficacy of ionic silver with excellent fluid absorption properties.

Scientific and clinical studies are presented that demonstrate the benefits of AQUACEL Ag Hydrofiber® dressing in managing exuding pressure ulcers that are at risk of infection.

SUSTAINED ACTIVITY OF AN ANTI-MICROBIAL HYDROFIBER® DRESSING AGAINST ANTIBIOTIC-RESISTANT WOUND PATHOGENS

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ConvaTec Global Development Centre, Deeside, UK*

Introduction:

Pressure ulcers are commonly colonised with a wide variety of microorganisms, predominantly aerobic and anaerobic bacteria, that may compromise healing and cause infection. Topical antimicrobial agents are often used to reduce microbial load and virulence expression in wounds and hence improve conditions for healing.

Ideally, such topical applications should demonstrate fluid management properties (due to the fact that exudate production increases in microbially compromised wounds) as well as sustained antimicrobial activity such that the dressing can be left undisturbed for a period of days, while providing an optimal environment for healing. An antimicrobial absorbent Hydrofiber® dressing (AQUACEL® Ag) has been designed to meet these requirements.

Methods:

In order to prove sustained antimicrobial activity during a period of maximum wear time, dressing samples were subjected to a variety of antibiotic-resistant bacteria and fungi using a simulated wound fluid model. Numbers of challenge organisms in each test were counted over 14 days, and the simulated wound fluid was re-inoculated with the same organism on days 7 and 10 to mimic clinical conditions.

Results:

AQUACEL® Ag Hydrofiber® dressing was effective in killing a variety of aerobic, anaerobic and antibiotic-resistant micro-organisms, and maintained this activity even when the growth medium was re-inoculated the additional micro-organisms during the study.

Conclusion:

The combined absorbent properties and sustained antimicrobial activity of AQUACEL® Ag Hydrofiber® dressing indicates that this dressing is likely to play an important role in the management of indolent, microbially-challenged and exuding pressure ulcers.



JULY 2004

8 – 13 **2nd World Union of Wound Healing Societies Meeting** · Paris, France
MF Congress, Contact: Mr Bia
8 rue Tronchet, 75008 Paris, France
Tel: +33 140 07 11 21 Fax: +33 140 07 10 94
Web: <http://www.wuwhs.org>

SEPTEMBER 2004

8 **Scottish Wound Care Conference**
Thistle Hotel, Glasgow
Contact: Vi Guyan Conference Administrator
Tel: 01224 582355
Fax: 01224 570296
E-mail: vguyan@aol.com

NOVEMBER 2004

16 – 17 **Wounds UK 2004**
Harrogate International Conference Centre
Orlando, Florida, USA
Contact: www.wounds-uk.com

18 – 20 **ETRS Focus Meeting**
Tissue Repair, Contraction and the Myofibroblast
Nyon, Switzerland
Contact: ETRS Business Office
68 Church Way, Iffley, Oxford, OX4 4EF
Tel: +44 1865 714358
Fax: +44 1865 714373
E-mail: oxfordwound@aol.com

MAY 2005

4 **Tissue Viability Society Meeting**
Aberdeen, Scotland

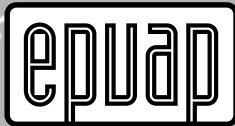
5 – 7 **8th European Pressure Ulcer Advisory Panel Open Meeting**
Aberdeen, Scotland
Further information can be obtained from:
www.epuap.org
or by e-mail from:
oxfordwound@aol.com

SEPTEMBER 2005

15 – 17 **ETRS Meeting**
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Contact: Mr H. Nielsen
E-mail:
congress@congress-consult.com

OCTOBER 2005

2 – 7 **Union Internationale de Phlebology XVth World Congress**
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First announcement

8th European Pressure Ulcer Advisory Panel Open Meeting

May 5-7 2005

Theme: Pressure ulcers; back to basics
– the fundamental principles

Preceded by a one-day Tissue Viability Society Meeting
May 4 2005

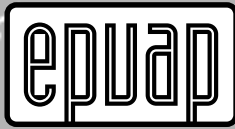


Aberdeen Exhibition and Conference Centre
Aberdeen, Scotland

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**Theme: PRESSURE ULCERS;
BACK TO BASICS – THE FUNDAMENTAL PRINCIPLES**

Aberdeen Exhibition & Conference Centre, Aberdeen, Scotland, 5–7 May 2005

Preceded by a one day Tissue Viability Society Meeting, 4 May 2005

Wednesday 4 May 08.00 Registration
09.00 – 17.00 Fundamental principles and good practice in tissue viability.
Tissue Viability Society

Thursday 5 May **Morning**
07.00 Registration
08.30 – 10.30 KCI sponsored symposium
08.30 – 10.30 Smith & Nephew sponsored symposium
11.00 – 13.00 ConvaTec sponsored symposium
11.00 – 13.00 Johnson & Johnson sponsored symposium

Provisional Scientific and Social Programme

Thursday 5 May 13.00 Opening Ceremony **Jack McConnell** (*First Minister for Scotland*)
13.15 – 14.30 What did we learn in Tampere – why have we gone back to basics?
Denis Colin (*President*)
13.30 – 14.15 Evidence in Pressure Ulcers and current research
Ruud Halfens
14.15 – 14.45 Looking beyond the evidence – don't discount areas where no evidence exists
Mike Clark
14.45 – 15.15 Coffee
15.15 – 16.30 Free papers / workshops
16.30 – 17.15 1958 –1970 Fundamental Aetiology
Michael Kosiak

Social event Scottish Evening with Ceilidh band, Beach Ballroom

Friday 6 May 08.00 – 08.45 Posters and exhibition viewing
08.45 – 09.15 Risk Assessment **Doreen Norton**
09.15 – 09.45 Incidence – A position statement
Tom Defloor
09.45 – 10.45 Free Papers Workshops x 2
10.45 – 11.15 Coffee
11.15 – 12.15 Free Papers Workshops x 2
12.15 – 13.15 Lunch
13.15 – 13.45 AGM
13.45 – 14.15 Implementing guidelines – the challenges
14.15 – 14.30 Nutrition – barriers to the implementation of a specific guideline
Jos Schols and Giuseppi Benati

14.30 – 14.45	Scottish Pressure Ulcer Guidelines – Best Practice
14.45 – 15.30	Implementation at a local level – success / challenges.
15.30 – 16.00	Tea
16.00 – 17.15	Free papers x 2 Workshops x 2
17.15 – 17.45	EPUAP award
17.45	End
	Gala Dinner

Saturday 7 May	09.00 – 09.30	Grading group presentation
	09.30 – 10.15	Pressure ulcers since 2000. EPUAP, NPUAP and Japanese society representatives
	10.15 – 10.45	Coffee
	10.45 – 11.10	Poster prizes
	11.10 – 11.50	The lived experience of pressure ulcers Alison Hopkins
	11.50 – 12.00	Introduction to 2006
	Suggested Themes for 2006	Ethics in care of patients with Pressure ulcers, include care of patients at the end of their life and patients who are elderly.
	12.00	Denis Colin – Close

Workshops	1.	Grading	Tom Defloor x 2 one Thursday
	2.	Difficult Wounds	Jacqui Fletcher x 2 one Thursday
	3.	Assessing / Measuring Pressure Ulcers – call for volunteers	
	4.	Seating Assessment	Steve Sprigle / Fiona Collins
	5.	Advanced Biomechanics	Duncan Bain, Friday session 3
	6.	Basic Biomechanics	Friday session 1

Prizes will be awarded for:	First time speaker – native language
	First time speaker – non-native language

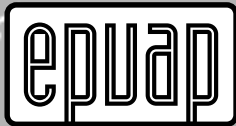
Social Programme	During meeting – All included in registration fee
Thursday 5 May	Scottish evening with Ceilidh band, Beach Ballroom, Aberdeen
Friday 6 May	Gala Dinner and entertainment
Pre and post conference	Tours (including golf, a visit to a Whiskey distillery, and other Scottish beautiful country excursions) will be available at extra cost.

CALL FOR ABSTRACTS

Deadline: 28 February 2005

Instructions:	1	The abstract should be on one A4 page with 2cm margins around page. Longer abstracts will be returned.
	2	Title, authors and institutions should be included
	3	Presenting author should be underlined
	4	Abstracts should be written in the following format: Introduction, Methods, Results, Summary
	5	Please indicate preference for oral or poster presentation
	6	Abstracts will only be accepted by disk or sent by e-mail

E-mail address: EuropeanPressureUlcerAdvisPanel@compuserve.com



REGISTRATION FORM

Name _____

Address _____

Telephone: _____ Fax: _____

E-mail: _____

Registration fee*

Tissue Viability one day meeting £75 120 Euros

Members:

Before 28 February £250 (Approximately 390 Euros)

After 28 February £300 (Approximately 460 Euros)

Non-members:

Before 28 February £300 (Approximately 460 Euros)

After 28 February £350 (Approximately 545 Euros)

*Registration fee: Includes all lunches, coffee, tea, reception and social events. Cheques should be made out to EPUAP in pounds sterling and must be drawn on a British bank.

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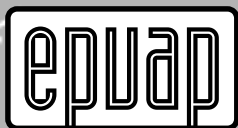
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Please fill in accommodation and tour forms and send to the separate address on the form. Only abstracts and registration forms should be returned to the EPUAP Business Office.



MISSION STATEMENT

The European Pressure Ulcer Advisory Panel's objective is to provide the relief of persons suffering from, or at risk of pressure ulcers, in particular through research and the education of the public. The European Pressure Ulcer Advisory Panel is a registered charity, number 1066856.

MEMBERSHIP APPLICATION

PLEASE PRINT CLEARLY

Name: _____
Title (Prof, Dr, etc) First name Last Name Degrees

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Main fields of interest: _____

Membership fee: £30 per year (September - September)
Which includes Certificate of Membership plus the EPUAP Review

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