AUTUMN 2012 | AUTOMNE 2012
Vol.10 No.4 | Vol.10 numéro 4
CAN $9.95 | 9,95 $ CAN

Wound Care

Soins des plaies

The Official Publication of the Canadian Association of Wound Care
La revue officielle de l'Association canadienne du soin des plaies

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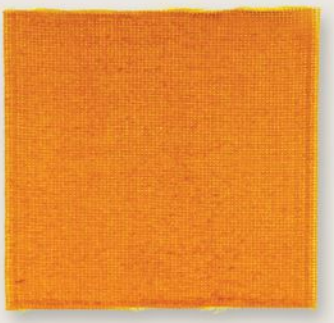

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Wound Care Soins des plaies

Autumn 2012 / Automne 2012
Volume 10, Number 4
Volume 10, Numéro 4
ISSN 1708-6884

Publication Management/
Gestion de la publication
BCS Communications Ltd.
255 Duncan Mill Road, Suite 803
Toronto, ON M3B 3H9

Wound Care Canada is published by BCS Communications Ltd., on behalf of the Canadian Association of Wound Care. Canada's first publication devoted entirely to wound care, *Wound Care Canada* addresses the needs of clinicians, patients, caregivers and industry.

Canadian Publication Mail
Sales Product Agreement
No. 40065546

Return mail to:
642 King Street West,
Suite 224, Toronto, ON M5V 1M7

Wound Care Canada is printed on acid-free paper that contains a minimum of 20 per cent post-consumer fibre.

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The Canadian Association of Wound Care is a non-profit organization of health-care professionals, industry participants, patients and caregivers dedicated to the advancement of wound care in Canada.

The CAWC was formed in 1995, and its official meeting is the CAWC annual conference held in Canada each year. The association's efforts are focused on five key areas: public policy, clinical practice, education, research and connecting with the international wound care community. The CAWC works to significantly improve patient care, clinical outcomes and the professional satisfaction of wound-care clinicians.

L'Association canadienne du soin des plaies est un organisme sans but lucratif regroupant des professionnels de la santé, des gens de l'industrie, des patients et des membres du personnel soignant fortement intéressés à l'avancement des connaissances pour le soin des plaies au Canada.

Fondée en 1995, l'ACSP organise, chaque année, au Canada, un congrès qui lui tient lieu de réunion officielle, le Congrès annuel de l'ACSP. L'association consacre ses efforts dans cinq domaines particuliers : les politiques gouvernementales, la pratique clinique, la formation, la recherche et la création de liens avec la communauté internationale directement impliquée dans le soin des plaies. L'Association canadienne du soin des plaies vise une amélioration significative du soin donné au patient, des résultats cliniques et de la satisfaction professionnelle des spécialistes en soin des plaies.

A Brighter Educational Future with the CAWC

The Canadian Association of Wound Care (CAWC) currently has many educational and informational offerings. However, with today's focus on technology and the internet for the dissemination of information, the CAWC – through collaboration with many strategic partners – intends to step it up a notch. Our intent as an organization is to provide state-of-the-art educational and informational platforms that deliver first-class resources to Canadian caregivers.

A number of partner organizations are currently working with the CAWC to develop these important resources. The Ontario Hospital Association is currently partnered to aid in the development of an online version of the L1 component of our L-series educational program. This will form the basis of a general practitioner training program and a modular approach to wound care education.

iMD is a Canadian company partnered with the CAWC to develop wound care resources within their innovative clinician-focused medical information platform, which is placed in clinicians' offices across Canada.

Best Life Rewarded has partnered with the CAWC to provide health information to those suffering from diabetic foot ulcers. Similarly the CAWC has partnered with the Canadian Diabetes Association to provide resources useful to those with or treating diabetic foot disease.

"Such partnerships are only the beginning of a new and better CAWC," says Douglas Queen, Publisher of *Wound Care Canada*.

Wound Care Canada: Digital Edition

Wound Care Canada has gone green! Beginning with the Summer 2012 issue, only CAWC members receive printed copies of the magazine. Non-members can read the digital version of the magazine; however, if you are a non-member and wish to receive a printed copy, you can join the CAWC – receipt of each quarterly printed issue remains a benefit of membership.

However, we encourage both members and non-members alike to enjoy our new digital online version, which can be accessed at www.woundcarecanada.ca, or through the association's website. The entire digital version of each issue, or sections within, can be emailed to colleagues or to any other portable device for future reference.

CAWC Conference 2012 – London, Ontario

If you're reading this issue of *Wound Care Canada*, and are still undecided about attending the 2012 annual conference in London, Ontario, take a look at some of the highlights that you won't want to miss!

An exciting opening: Meg Soper, our keynote speaker, will entertain, motivate and challenge you to reach your goals. Meg, an RN, uses humour to communicate important messages that you can take back to your own practice.

Something different and fun: This year we are organizing a wound care scavenger hunt. Get a team together or work solo and find the answers to some challenging questions. The hunt will take place throughout Friday and Saturday and will involve all aspects of the conference. Submit your entry and attend our Saturday night party to see the winner of our exciting prize.

Post-conference workshops: These workshops offer you the opportunity to learn important skills to help you serve your patients better. The post-conference sessions offered this year are:

- Case-based dressing workshop
- Total contact casting for neuropathic foot ulcers
- Pressure ulcer prevention in spinal cord injury
- Writing for publication
- Blogging 101.

The Times, They are a-Changin' at the CAWC

You may have heard it through the grapevine … indeed, you may have already seen some of the evolving changes, but the CAWC is changing in a big way. After nearly 2 decades of delivering first-class educational and informational resources for wound care professionals across Canada, the CAWC is recognized as the go-to point for all aspects of wound care.

However, noted Douglas Queen, Publisher of *Wound Care Canada*, "It is time for further evolution, to position the CAWC for the next 2 decades of excellence and first-class delivery of wound care education."

Douglas Queen: "THE CAWC embarked on this new journey in 2012, and it will come to the fore in 2013 and beyond."

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Power:
How to Use it in Evidence-Based Practice

Utilisation de la puissance
dans la pratique fondée sur les données probantes

BY / PAR
SANDRA ENGBERG PHD RN CRNP FAAN
AND / ET
ELIZABETH A. SCHLENK PHD RN

Introduction

In this fictitious study, the investigators compared the time to healing of stage 3 pressure ulcers in subjects treated with the new dressing (XYZ dressing). Fifty patients were recruited into the study and randomly assigned to the new dressing or a usual care control group. The investigators reported that there was no significant difference in the time to wound healing in the XYZ and control groups (p=0.15). They concluded that the new dressing was no more effective than usual care (the dressing currently used on the unit). Should you accept their conclusion?

In answering this question, that is, deciding whether there was really no difference in the effectiveness of the 2 dressings, you need to determine if the study was adequately powered. Within the context of research, power is the ability of a statistical test to detect a difference when one exists in the target population.[1] The target population is the entire group of persons in which you are interested in applying the findings of a study. The goal of research is to use data from a sample to make inferences about the target population, while minimizing the likelihood of making erroneous conclusions about that population.[2]

Statistical tests such as the *t* test, analysis of variance or regression are used to test a hypothesis in a sample of the target population. Typically, 2 hypotheses are considered. One is the null hypothesis, the hypothesis that there is no difference. Testing for statistical significance is based on the null hypothesis.[3] In a study com-

Sandra Engberg and **Elizabeth A. Schlenk** are with the University of Pittsburgh School of Nursing in Pittsburgh, Pennsylvania.

Sandra Engberg et **Elizabeth A. Schlenk** sont de l'École des sciences infirmières de l'Université de Pittsburgh, à Pittsburgh, en Pennsylvanie.

Introduction

Prenons pour exemple une étude fictive, au cours de laquelle les investigateurs ont déterminé le délai de cicatrisation des plaies de pression de stade 3 chez des sujets traités au moyen d'un nouveau pansement (pansement XYZ). Cinquante patients ont été inscrits à l'étude et répartis au hasard entre deux groupes : un groupe traité au moyen du nouveau pansement et un groupe témoin recevant les soins habituels. Les investigateurs n'ont pas observé de différence significative entre les deux groupes pour ce qui est du délai de cicatrisation des plaies ($p = 0,15$). Ils ont conclu que le nouveau pansement n'était pas plus efficace que les soins habituels (le pansement actuellement utilisé au service). Devez-vous accepter leur conclusion?

Pour répondre à cette question, c'est-à-dire pour savoir s'il n'y avait vraiment pas de différence d'efficacité entre les deux pansements, il faut déterminer si l'étude avait la puissance voulue. Dans le contexte d'un projet de recherche, la puissance désigne la capacité d'un test statistique de détecter une différence quand il y en a une dans la population cible[1]. La population cible est l'ensemble des personnes auxquelles on désire appliquer les résultats d'une étude. Le but d'un projet de recherche est d'utiliser les données provenant d'un échantillon pour tirer des conclusions sur la population cible, tout en réduisant au minimum la possibilité que ces conclusions soient erronées[2].

Les tests statistiques, comme le test t et l'analyse de la variance ou de la régression, sont utilisés pour véri-

This article was originally published in the *Journal of Wound Ostomy and Continence Nursing*. It is reprinted here because it is well-written, understandable, comprehensive and relevant to *Wound Care Canada* readers. It is a natural progression in the series of columns entitled "Understanding the Scientific Literature" as it explains power in terms of concepts that have been covered in columns published this year. This article indicates why clinicians need to understand the statistical power of a research project and why they need to see a power calculation or sample size determination when reading an article, particularly if no effect has been detected.

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paring characteristics in 2 groups, the null hypothesis would be that there is no difference in the characteristic(s) of interest in the groups. In a study examining an intervention, the null hypothesis would be that there is no difference in the outcome before and after the intervention (i.e. a 1-group study) or no difference in the outcome between the treatment and control groups. The second hypothesis is the alternative hypothesis, the hypothesis that there is a difference, for example, a difference in characteristic(s) in the groups or in the outcome following an intervention. In the fictitious study, the null hypothesis is that there is no difference in the time to wound healing between the group receiving XYZ dressing and the control group and the alternative hypothesis is that there is a difference in the time to wound healing between the 2 groups.

When researchers interpret the results of statistical tests in their studies, they can make 2 different types of errors: a type I or type II error (Table 1). A type I error occurs when investigators conclude, based on the *p* value, that there was a significant relationship or treatment effect between their groups when none exists in the target population (i.e. the null hypothesis is true). Investigators control the probability of making a type I error when they select the alpha (α) that they will utilize to determine whether the results of their statistical tests are significant. Typically, α is set at 0.05, which means that the investigators are willing to accept a 5% probability (1 chance in 20) that they made a type I error.

The other type of error is a type II or beta (β) error. A type II error is made when the investigators, based on a nonsignificant *p* value, accept the null hypothesis that there was no relationship or no treatment effect when one exists in the target population. Power ($1 - \beta$) is the probability that if a difference exists in the target population it will be detected by the statistical test performed. If, for example, β is set at 0.10, the investigators are willing to accept a 10% chance of not detecting a significant effect if it exists. This β of 0.10 means that the power to detect a treatment effect is 90%.

Ideally, investigators would like the probability of making both type I (α) and type II (β) errors to be 0,

fier une hypothèse dans un échantillon de la population cible. Règle générale, on envisage deux hypothèses. L'une d'entre elles est l'hypothèse nulle, selon laquelle il n'y a pas de différence. La vérification de la signification statistique est fondée sur l'hypothèse nulle[3]. Dans une étude qui compare les caractéristiques dans deux groupes, l'hypothèse nulle serait qu'il n'y a pas de différence entre les groupes pour ce qui est de la ou des caractéristiques d'intérêt. Dans une étude qui porte sur une intervention, l'hypothèse nulle serait que l'intervention ne modifie pas le devenir des patients (étude sur un seul groupe) ou qu'il n'y a pas de différence pour ce qui est du devenir des patients entre le groupe traité et le groupe témoin. La seconde hypothèse est l'hypothèse alternative, selon laquelle il y a une différence entre les groupes, par exemple quant à la ou aux caractéristiques ou quant au devenir des patients après une intervention. Dans l'étude fictive ci-dessus, l'hypothèse nulle est qu'il n'y a pas de différence quant au délai de cicatrisation des plaies entre le groupe traité au moyen du pansement XYZ et le groupe témoin, et l'hypothèse alternative est qu'il y a une différence quant au délai de cicatrisation des plaies entre les deux groupes.

Quand les investigateurs interprètent les résultats des tests statistiques sur leurs études, ils peuvent faire deux types d'erreur : une erreur de type I ou une erreur de type II (voir tableau 1). On parle d'erreur de type I quand les investigateurs concluent, sur la foi de la valeur p, que la comparaison entre les groupes a fait ressortir une relation ou un effet thérapeutique significatif quand il n'y en a en réalité pas dans la population cible (soit hypothèse nulle vraie). Les investigateurs limitent la probabilité d'erreur de type I quand ils choisissent le seuil alpha (α) qu'ils utiliseront pour déterminer si les résultats des tests statistiques sont significatifs. En général, le seuil α est fixé à 0,05, ce qui signifie que les investigateurs sont prêts à accepter une probabilité de 5 % (1 chance sur 20) d'erreur de type I.

L'autre type d'erreur est l'erreur de type II, ou erreur bêta (β). On parle d'erreur de type II quand les investigateurs, sur la foi d'une valeur p non significative, acceptent l'hypothèse nulle, selon laquelle il n'y a pas de relation ou d'effet thérapeutique quand il y en a en réalité un dans la population cible. La puissance ($1 - \beta$)

Le présent article a d'abord été publié dans le *Journal of Wound Ostomy and Continence Nursing*. Il est reproduit ici parce qu'il est bien écrit, compréhensible et pertinent pour les lecteurs de *Soins des plaies Canada*. C'est en outre un prolongement logique de la série d'articles intitulée *Compréhension de la littérature scientifique*, car il explique la puissance à la lumière des concepts qui ont été exposés dans les articles publiés jusqu'ici cette année. Le présent article explique pourquoi les cliniciens doivent comprendre la puissance statistique d'un projet de recherche et pourquoi il est important qu'un compte rendu présente la méthode de calcul de la puissance ou de détermination de la taille de l'échantillon, surtout quand aucun effet n'a été observé.

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allowing them to be confident that their sample findings reflect reality in the target population. Unfortunately, achieving this goal generally requires a larger sample than can be feasibly recruited.[3] Although there are exceptions, in most situations type II errors (e.g. erroneously concluding that an intervention is not effective when in reality it is) are considered less critical than type I errors (e.g. erroneously concluding that the intervention is effective when it is not). For this reason, a type II error rate of 0.20 is often considered acceptable.

Power and sample size

Power is an important consideration when studies are designed to examine the relationships between variables (e.g. characteristics associated with wound healing) or the impact of an intervention. Power is a function of the level of significance (α), effect size and sample size.[4] Power is inversely related to the level of statistical significance used to avoid making a type I error. While a small α level such as 0.01 or 0.001 decreases the likelihood of making a type I error, it also decreases the power to detect significant effects when they do exist.

Effect size refers to the strength of the relationship or treatment effect that the investigators want to be able to detect. The effect size can be estimated from the findings of published studies or from previous pilot work that the investigators have done, or it can be based on the minimum clinical difference that is thought to be worth detecting. The effect size that investigators want to detect is directly related to power. The power to detect large treatment effects or differences between groups is greater than the power to detect small differences.

The other factor that determines power is the sample size of a study. Sample size is directly related to the power to detect significant differences that exist in the target population. Sample size is the factor that investigators can most readily manipulate to ensure that a study is adequately powered to detect differences in the target population. If the sample size is too

TABLE 1

Correct and incorrect decisions about the target population

	In the target population	
In the sample	**Alternate hypothesis is true**	**Null hypothesis is true**
Alternate hypothesis is true	Accurate results	Type I error
Null hypothesis is true	Type II error	Accurate results

est la probabilité qu'une différence soit décelée dans la population cible au moyen du test statistique quand une telle différence existe. Par exemple, un seuil β de 0,10 signifie que les investigateurs sont prêts à accepter une probabilité de 10 % de ne pas déceler d'effet significatif, si un tel effet existe. Un seuil β de 0,10 veut dire que la puissance de détection d'un effet thérapeutique est de 90 %.

Idéalement, les investigateurs aimeraient que la probabilité d'erreur tant de type I (α) que de type II (β) soit de 0, ce qui leur donnerait la certitude que les résultats obtenus dans l'échantillon reflètent la réalité dans la population cible. Malheureusement, pour y parvenir, il faut en général un échantillon dont la taille n'est pas réaliste[3]. Bien qu'il y ait des exceptions, dans la plupart des cas, les erreurs de type II (p. ex. conclure à tort qu'une intervention n'est pas efficace quand elle l'est en réalité) sont considérées moins critiques que les erreurs de type I (p. ex. conclure à tort qu'une intervention est efficace quand elle ne l'est pas en réalité). C'est pourquoi un taux d'erreur de type II de 0,20 est souvent jugé acceptable.

Puissance et taille de l'échantillon

La puissance est une importante considération quand les études ont pour but d'examiner les relations entre des variables (p. ex. les caractéristiques associées à la cicatrisation des plaies) ou l'impact d'une intervention. La puissance dépend du seuil de signification (α), de l'ampleur de l'effet et de la taille de l'échantillon[4]. La puissance est inversement proportionnelle au seuil de signification statistique utilisé pour éviter de faire une erreur de type I. Un seuil α faible, tel que 0,01 ou 0,001, réduit la probabilité d'erreur de type I, mais il réduit aussi la puissance de détection d'effets significatifs quand ils sont présents.

L'ampleur de l'effet désigne l'importance de la relation ou de l'effet thérapeutique que les investigateurs veulent pouvoir détecter. On peut estimer l'ampleur de l'effet à partir des résultats d'études publiées ou d'études pilotes menées antérieurement par les investigateurs, ou en se fondant sur la différence clinique minimale dont la détection est considérée comme valable. L'ampleur de l'effet que les investigateurs désirent détecter est directement liée à la puissance. La puissance de détection d'importants effets thérapeutiques ou de grandes différences entre des groupes est plus grande que la puissance de détection de petites différences.

L'autre facteur qui détermine la puissance est la taille de l'échantillon d'une étude. La taille de l'échantillon est directement liée à la puissance de détection de différences significatives qui existent dans la population cible. La taille de l'échantillon est le facteur que les investigateurs peuvent le plus facilement modifier

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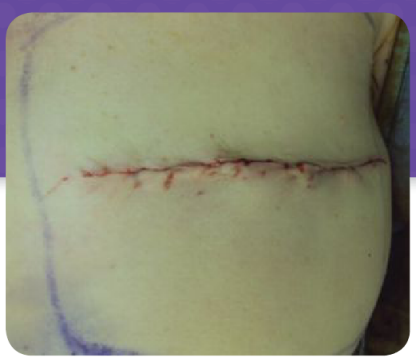
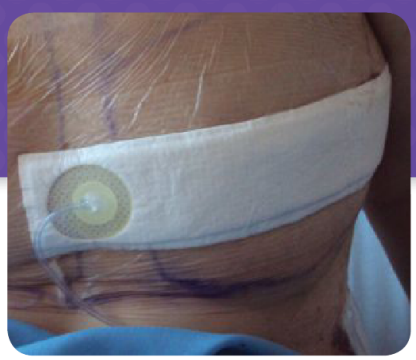
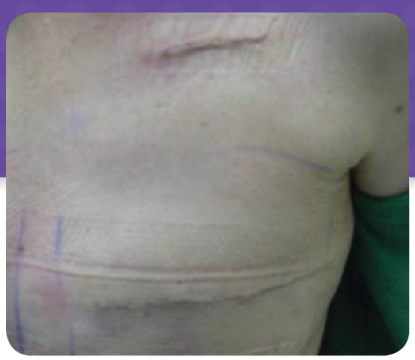


Post surgical wound following breast reconstruction. The wound measured 15cm in length and 0.5cm in width. Note the closed incision is raised above the level of surrounding skin.



Patient with dressing in place on first assessment (day 1).



Post surgical wound after PICO removal day 11. Note some indentation from the PICO dressing but otherwise healthy surrounding skin. The surgical incision is closed, there is no exudate and the incision is flat. Compare with the tunnelled IV site wound of same age which remains raised.

1. CSR/CT09/02 A prospective, open, non-comparative, multi-centre study to evaluate the functionality and dressing performance of a new negative pressure enhanced dressing in acute wounds.
2. Data on File 1104011 Assessment of simplified NPWT device in pre-clinical blood flow studies.
3. Data on File. Economic Analysis, Andriy Moshyk.

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small, the differences in the target population might not be detected, whereas if the sample size is too big, the investigators may spend more time and money than needed to detect differences in the target population. Thus, a research plan should include a power calculation to determine how many subjects are needed to detect the desired effect size in the target population. When the findings of a research study are published, the results of the power calculation should be reported.

Power in evidence-based practice

When you are considering research studies as potential evidence for clinical practice, it is important to determine whether a power calculation was reported. Power calculations are particularly important when the findings of interest were "not significant." Without knowing if the study was adequately powered, you cannot be sure if nonsignificant findings reflect reality in the target population or if they are the result of a type II error. If a power calculation was performed to determine the sample size needed, it will be reported in the "Methods" section of the article.

If the findings of a study were not significant, it is also important to confirm that the study met the stated sample size goal. The following example of a power analysis is from a study comparing the impact of medical-grade honey to usual care on wound-healing rates in wounds healing by secondary intention.[5]

> *It was estimated that 50% of patients treated with conventional dressings would achieve healing by 24 weeks. To detect a 20% greater healing rate in the honey treated group with 80% power and at the 5% statistical significance level, each group required 93 patients. A target recruitment of 200 patients was therefore needed to allow for potential dropouts.*

Based on the reported power analysis, the study needed to recruit 186 subjects (93 per group) in order to have an 80% probability of avoiding a type II error. The study was powered to detect a 20% difference in healing rates between the 2 groups (effect size). When data collected in this study were analyzed, there was not a significant difference in the healing rates in the 2 groups. Before you conclude that the honey is no more effective than conventional care in shortening the time to wound healing, you need to compare the final sample size to the number of subjects who, the power calculation indicated, were needed to detect the desired effect size. A study with nonsignificant findings can only be considered adequately powered if it meets

pour s'assurer que leur étude a la puissance voulue pour détecter des différences dans la population cible. Si l'échantillon est de trop petite taille, les différences dans la population cible pourraient ne pas être détectées, tandis que si l'échantillon est de trop grande taille, les investigateurs pourraient consacrer trop de temps et d'argent à la détection de différences dans la population cible. Par conséquent, le plan de recherche doit prévoir un calcul de la puissance qui permet de déterminer le nombre de sujets nécessaire à la détection de l'ampleur de l'effet désirée dans la population cible. Les résultats du calcul de la puissance doivent figurer dans le compte rendu d'une étude de recherche.

Puissance et pratique fondée sur les données probantes

Quand on considère une étude de recherche pour déterminer si elle pourrait être une source de données probantes pour la pratique clinique, il est important de déterminer si le compte rendu présente le calcul de la puissance. Le calcul de la puissance est particulièrement important quand les résultats d'intérêt ne sont pas significatifs. En effet, quand on ignore si l'étude avait la puissance voulue, on ne peut déterminer avec certitude si des résultats non significatifs sont le reflet de la réalité dans la population cible ou s'ils sont le fruit d'une erreur de type II.

Si les résultats d'une étude ne sont pas significatifs, il est aussi important de confirmer si l'étude a atteint l'objectif fixé en ce qui a trait à la taille de l'échantillon. L'exemple ci-dessous d'analyse de la puissance est tiré d'une étude comparant le miel de qualité médicale aux soins habituels du point de vue de l'effet sur les taux de cicatrisation des plaies dans les cas de cicatrisation des plaies par deuxième intention[5].

> *On a estimé que chez 50 % des patients traités au moyen de pansements classiques, le délai de cicatrisation des plaies serait de 24 semaines. Pour détecter un taux de cicatrisation 20 % plus élevé dans le groupe traité par le miel avec une puissance de 80 % et un seuil de signification statistique de 5 %, il fallait 93 patients dans chaque groupe. On a donc fixé un objectif de recrutement de 200 patients, au cas où des patients se retireraient de l'étude. (p. 568)*

Selon l'analyse de la puissance présentée, 186 patients (93 par groupe) devaient participer à l'étude pour que la probabilité qu'il n'y ait pas d'erreur de type II soit de 80 %. L'étude avait la puissance voulue pour détecter une différence de 20 % entre les deux groupes quant aux taux de cicatrisation (ampleur de l'effet). L'analyse

its sample size goal. In this study, they were able to recruit only 105 subjects instead of the projected 186, which must be considered when the findings are interpreted. One possible explanation for the nonsignificant findings is that the study was not adequately powered to detect a significant treatment effect.

Conclusions

Power, the ability of statistical testing to detect significant differences that exist in the target population, is an important concept for investigators designing studies and for clinicians utilizing research findings in evidence-based practice. Investigators need to do a power calculation to make sure that their studies are adequately powered to detect clinically meaningful differences in the target population. When clinicians consider research studies as potential evidence for clinical practice and study findings are not significant, it is important to determine whether a power calculation was reported and to confirm that the study met the stated sample size goal. Unless a study was adequately powered, clinicians cannot be sure if nonsignificant findings reflect reality in the target population or if they are the result of a type II error.

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TABLEAU 1

Bonne et mauvaise conclusions sur la population cible

	Dans la population cible	
Dans l'échantillon	**L'hypothèse alternative est vraie**	**L'hypothèse nulle est vraie**
L'hypothèse alternative est vraie	Résultats exacts	Erreur de type I
L'hypothèse nulle est vraie	Erreur de type II	Résultats exacts

des données recueillies au cours de l'étude a révélé qu'il n'y avait pas de différence significative entre les deux groupes quant au taux de cicatrisation. Toutefois, avant de conclure que le miel n'est pas plus efficace que les soins classiques pour réduire le délai de cicatrisation des plaies, il faut comparer la taille de l'échantillon final au nombre de sujets qui, selon le calcul de la puissance, était nécessaire pour détecter l'ampleur de l'effet désirée. En effet, on ne peut considérer qu'une étude dont les résultats ne sont pas significatifs a la puissance voulue que si l'objectif en ce qui a trait à la taille de l'échantillon a été atteint. Les investigateurs de l'étude qui nous intéresse n'ont pu recruter que 105 sujets au lieu des 186 prévus, ce dont il faut tenir compte pour interpréter les résultats, car les résultats pourraient avoir été non significatifs entre autres parce que l'étude n'avait pas la puissance voulue pour détecter un effet thérapeutique significatif.

Conclusions

La puissance, soit la capacité d'un test statistique de détecter les différences significatives qui existent dans la population cible, est un important concept pour les investigateurs qui conçoivent des études et pour les cliniciens qui utilisent les résultats des études dans la pratique fondée sur les données probantes. Les investigateurs doivent calculer la puissance pour s'assurer que leurs études ont la puissance voulue pour détecter des différences cliniquement significatives dans la population cible. Quand les cliniciens considèrent une étude de recherche dont les résultats ne sont pas significatifs pour déterminer si elle pourrait être une source de données probantes pour la pratique clinique, ils doivent déterminer si le compte rendu présente le calcul de la puissance et si l'objectif fixé en ce qui a trait à la taille de l'échantillon a été atteint. À moins qu'une étude ait la puissance voulue, les cliniciens ne peuvent déterminer avec certitude si des résultats non significatifs sont le reflet de la réalité dans la population cible ou s'ils sont le fruit d'une erreur de type II.

Références (voir page 11)

Reducing the Pressure of Pressure Ulcers:

Trillium Health Centre's Focus on New Solutions to an Old Problem

By Karen Witkowski
RegN BScN
and
Alexander Ribeiro
BComm IIWCC

Abstract

The development of a pressure ulcer and the resultant wound care are considered a needless harm as ulcers are often avoidable if adequate detection and prevention measures are applied. In Ontario, it is estimated that excess costs of $481 million annually are attributable to adverse events, representing 2.8% of the province's total hospital expenditure. Trillium Health Centre, one of Canada's largest academically affiliated tertiary care hospitals, constantly strives to improve safety, quality of care and the overall patient experience through the translation of best evidence into practice. This article outlines Trillium's success in reducing its organization-wide 2009 pressure ulcer prevalence of 17.9% and incidence of 14.8% to 9.6% and 5.2%, respectively, in 2011. Improvements were based on the collaborative practice of an interprofessional team, a corporate partnership with 3M and commitment across Trillium's community. The strategic focus and use of in-house knowledge and expertise were key factors in this skin and wound care initiative. Distinct from many other initiatives, partnerships were built around strengthening the structures, processes and outcomes within Trillium. This methodology promotes knowledge translation and ensures the sustained application of learned tools and techniques throughout the organization.

Introduction

The costs of wound care to both patients and healthcare organizations continue to mount due to the complexity and acuity of hospitalized patients, the aging population and the escalating incidences of diabetes in young adults. The impact of chronic wounds – with respect to infection, mortality, quality of life, limb amputation, pain and healthcare costs – means that the assessment, protection and support of skin integrity should be priorities.

The development of a pressure ulcer is considered needless harm, as it is often avoidable if adequate detection and prevention measures are applied. Pressure ulcers cause pain and suffering, and can delay recovery and return to activities of daily living. They increase the likelihood of infection and lengthen hospital stays. An estimated 900,000 patients develop a pressure ulcer each year,[1] with 60,000 patients dying from complications of facility-acquired pressure ulcers.[1] In 2000 and 2001, pressure ulcers were cited as 1 of the top 3 in-hospital errors that led to patient deaths.[2] In 2010, Wardle calculated that hospitals yield a provincial estimate of $481 million in annual excess costs attributable to adverse events, representing 2.8% of Ontario's total hospital expenditure.[3] The excess cost associated with a pressure ulcer was estimated at $66,412 for each occurrence.[3]

The Ontario Case Costing Initiative database includes patient-specific cost data for all inpatient discharges and ambulatory surgeries from a sample of Ontario acute care hospitals. These data show that a patient with a Stage III pressure ulcer has an average length of hospital stay of 18.8 days, with an estimated total cost to treat of $19,213. The respective figures are 27.7 days and $29,208 for Stage IV pressure ulcers, and 73.1 days and $85,436 for Stage X pressure ulcers

What is a pressure ulcer?

A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence. It occurs as a result of pressure, or pressure in combination with shear, friction or moisture.

Karen Witkowski is a nurse clinician/enterostomal therapist at the Trillium Health Centre, Mississauga, Ontario.

Alexander Ribeiro is with 3M Health Care, London, Ontario.

with bone and necrotic tissue involvement. Patients with pressure ulcers had the highest unadjusted total 90-day costs ($117,578) and the highest 90-day readmission costs ($3,127).[3]

Trillium Health Centre is one of Canada's largest academically affiliated tertiary care hospitals, providing acute, rehabilitation and complex continuing care services. Created in 1998 and operating sites in Mississauga and West Toronto, Trillium has a primary catchment area of more than 1 million people. Trillium has more than 800 inpatient beds and served the healthcare needs of more than 700,000 people in 2009 alone. Trillium constantly strives to improve safety, quality of care and the overall patient experience through the application and translation of best evidence into practice.

Trillium succeeded in reducing its organization-wide 2009 pressure ulcer prevalence of 17.9% and incidence of 14.8% to 9.6% and 5.2%, respectively, in 2011. Improvements were based on the collaborative practice of an interprofessional team, a strategic commitment across Trillium's community and a corporate partnership with 3M. Since 2002, Trillium and 3M have partnered in projects to share knowledge and expertise in evaluating and improving targeted healthcare processes and services.

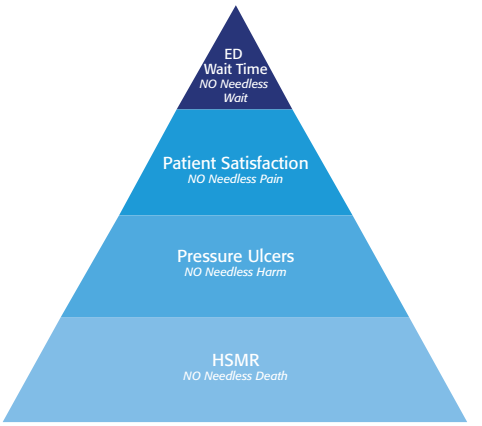
In 2007, Trillium made the decision to focus on skin and wound care in relation to pressure ulcers. A nurse clinician/enterostomal therapist (ostomy/skin and wound) was hired to develop a skin, wound and ostomy program. This incentive received further support when the incidence of hospital-acquired pressure ulcers was identified as a "big dot" measure. Specifically, suspected deep-tissue injury Stages II–IV and unstageable were targeted for improvement.

"Big dot" measures

The Ontario Excellent Care for All Act assigns responsibility for quality of care and improving the patient experience to hospital boards.[4,5] Using the Institute for Healthcare Improvement's "No Needless List,"[6–8] Trillium identified 4 comprehensive "big dot" quality indicators to focus improvement efforts from the board to the front line. Big dots are whole-system/institution-wide outcome-driven measures used to evaluate overall performance and the effectiveness of an organization's strategies. A big dot is a measure of the overall success of specific processes. For each big dot, a corollary "driver diagram" was developed, aimed at helping the board understand and measure the organization's quality-improvement plans, efforts and results. Trillium's 4 specialized driver diagrams are key elements in its knowledge translation and institutional-change efforts aimed at facilitating quality improvement.

FIGURE 1

Big dot indicators and corresponding measures



Trillium's Quality by Design Framework positions the 4 big dots – no needless death, harm, pain and wait – in ascending order of importance to patients (Figure 1). In the driver diagram's structure, measurable outcomes depict the projects that influence drivers, which in turn achieve the aim to move the big dot. This means that the driver diagram links individual and team performance to results, shows the areas that need more attention or resources and, in areas of sustained high-performance levels, sheds light on where to maintain efforts. The second big dot indicator, "no needless harm," focuses on measuring the incidence of hospital-acquired pressure ulcers (specifically, suspected deep-tissue injury Stages II–IV and unstageable). The driver diagram for this big dot received approval in March 2010.

"No needless harm" focuses on measuring the incidence of hospital-acquired pressure ulcers through risk assessment, minimization of moisture and incontinency, minimization of pressure, transparency of information, implementation of nutritional support, mobilization, best practice skin and wound care, health-provider knowledge in pressure ulcer prevention and management, and patient and family education. These drivers roll up into the 3 categories of detection, prevention and mitigation.

Methods

In 2009, a benchmark survey was conducted that revealed a hospital-acquired pressure ulcer incidence of 14.8% among acute care patients; the national pressure ulcer prevalence was 12.3%. That same year, Trillium's Skin and Wound Committee oversaw the

Prevalence of pressure ulcers

Prevalence is defined as a cross-sectional count of the number of cases at a specific point in time, or the number of persons with pressure ulcers who exist in a patient population at a particular moment in time.[13]

Incidence of pressure ulcers

Incidence is defined as the number of persons who develop a new pressure ulcer within a particular time period in a particular population.[13]

development and implementation of a proactive, hospital-wide pressure ulcer prevention and treatment program. The ultimate long-term goal of the Skin and Wound Care Program is to deliver consistent, sustainable, evidence-based wound care, thereby improving patient outcomes and reducing costs. To improve outcomes for patients with wounds, education for clinicians providing wound care is essential. The Advanced Wound Care Program had the key objective of developing a supplemental wound care education program. The overall goals were to maintain or improve patient wound care outcomes, achieve cost reductions and increase nursing-staff knowledge and satisfaction. The advanced wound care product standardization process, coupled with a comprehensive educational program, has allowed Trillium to achieve significant cost savings without sacrificing access to care.

The principal elements that were operationalized to realize these goals included: engagement and education of staff, patients and families; establishment of structures and processes to enable the skin and wound program; and development and implementation of a partnership model.

Quality boards displaying safety crosses

Coinciding with the introduction of driver diagrams, individual patient units implemented quality boards with safety crosses to display key quality metrics (e.g. hospital-acquired pressure ulcers, patient falls, *Clostridium difficile* infections, and surgical-site infections). Modelled on the UK's Releasing Time to Care program, the safety crosses employ a unique 4-quadrant design. The quality boards are displayed on each unit in high-traffic areas, usually by the nursing station, so they are immediately visible to staff, patients and families. Information is updated on a daily basis. For ease of interpretation, it is displayed on a graph and pictorially on colour-coded charts.

Engagement

The engagement elements included the following:

- Active engagement of physicians and allied health professionals in the prevention of as well as intervention with pressure ulcers.
- Consultation and involvement of Trillium's dietitians in wound healing, with the implementation of the Med Pass Program on key nursing units. Med Pass provides patients with nutrient-rich drinks to accompany their medications.
- The addition of a 0.5 full-time-equivalent nurse clinician/enterostomal therapist.
- Focused attention on high-risk areas, including the critical care, emergency and medical units.
- Identification and education of skin and wound "champions" within the medical health system.
- Daily unit-based nursing huddles that include discussion around patient care, skin care issues, ulcer prevention and any newly acquired pressure ulcers on the individual units.
- Quality boards that display safety crosses (see sidebar) capture and document unit-acquired pressure ulcers as well as unit-acquired nosocomial infections and falls.

Education

Monthly education sessions were initiated at level I (basic) and level II (advanced). Topics included risk assessment and prevention, instruction on mobility and toileting, pressure ulcer staging, wound documentation and intervention strategies (including appropriate product use).

E-learning modules were made available through 3M. These interactive modules are designed to augment existing educational sessions. The modules have been used not only by nursing staff, but also by members of the multidisciplinary team.

In addition:

- advanced skin and wound education sessions were held for advanced practice leaders;
- educational materials were developed outlining methods to maintain healthy skin while in a hospital environment, and made available to nursing staff, patients and family members; and
- documentation sessions were conducted using case studies.

Supporting structures and processes

A preventive heel ulcer program was implemented, and downloading heel boots were purchased for at-risk patients. The Prevalon heel-protector boot by Sage was introduced to the nursing units in January 2010, with

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the goal of eradicating hospital-acquired heel ulcers. If used correctly, the boot completely eliminates heel pressure. An algorithm was also designed to help nurses identify patients at risk for developing heel ulcers.

Several other tools and initiatives were also implemented:

- re-addressing "aids" (e.g. pillows, foam wedges, seating cushions, pressure-relieving mattresses) within the hospital, including in the emergency department;
- a hospital-wide preventive bed-maintenance program and mattress replacement (in progress);
- incontinence/immobility review;
- digital wound photography embedded within patient's medical record, enabling accurate and consistent documentation of wound-healing status;
- notification to the nurse clinician/enterostomal therapy nurses of "at-risk" patients, documentation of preventive skin care strategies and identification of patients with newly acquired pressure ulcers;
- annual product review, evaluation and usage reports of the advanced skin and wound care line; and
- annual organization-wide prevalence study and more frequent "mini-prevalence" studies in selected high-risk areas.

Partnership model with vendor

Many healthcare facilities struggle with making their available resources meet the growing healthcare needs of their communities. Trillium was faced with escalating costs for wound care products, approaching $500,000 annually. This was due in part to the availability of multiple lines of wound care products, coupled with a lack of wound care education. Clinicians were confused as to which wound care product to employ, often leading to overuse and misuse. Many studies and best practice guidelines have shown that a standardized approach to wound care can lead to cost savings for healthcare facilities.[4,9–12] Standardization should be evidence-based and take into account the objectives and desires of multiple stakeholders, including clinicians.

A partnership with 3M was established to facilitate activities such as product reviews, customized posters, educational "lunch and learn" sessions and e-learning modules. These interventions ensured a consistent and appropriate approach to skin and wound care, and standardized product use throughout the facility. Successes (both clinical and economic) of the standardization process included the collaborative partnership approach to product needs assessments, product analysis with purchasers and vendors, and the partnership with the chosen vendor supporting education.

A comprehensive and rigorous product review project was completed as part of the partnership model, aimed at streamlining and simplifying choices without eliminating product classifications. The use of wound care products was audited on each unit and significantly streamlined. Wound care products were then meticulously matched to specialty-area needs. This alone resulted in significant cost savings and reduced inventory.

Results

Engagement and education

Education for clinicians providing wound care is essential to improve patient outcomes. Education and care plans at Trillium are evidence-based and incorporate best practice standards. More than 20 nurses have been identified as skin and wound "champions" for the medical health system. They meet every month for 4 hours to address, identify and strategize issues and concerns on their individual units. Their primary roles as "change champions" are to help their colleagues in the transfer of knowledge to the bedside and ensure best practices are being followed as they relate to skin and wound care. To engage and educate healthcare professionals, biannual skin and wound newsletters are distributed; furthermore, "Skin and Wound Week" was celebrated in November 2011.

The results of best practice education include:

- skin and wound assessment with documentation in the emergency department;
- skin assessment and documentation upon admission and daily thereafter;
- risk assessment (Braden) and documentation within 24 hours of admission and every Sunday thereafter, or sooner if a patient's condition changes; and
- implementation and documentation of preventive skin care measures for patients who score 15 or less on the Braden scale.

Supporting structures and processes

In all non-critical care units, wound care documentation occurs online using a new wound documentation tool. Full documentation using the same tool is completed weekly. Roll-out of online documentation in critical care units is currently in progress.

A wound care plan designed for the Kardex has been developed by nursing staff and is available to the nursing units. Wound care planning is essential for wound care consistency.

A cost savings was recognized when the skin and wound care product line was first standardized. In the third usage report, an overuse of 3 products was identified and eliminated for additional significant cost savings. Annual usage reports are completed to determine the appropriate use of products and identify

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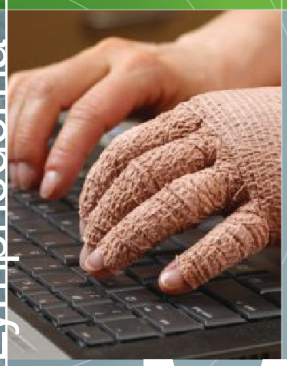

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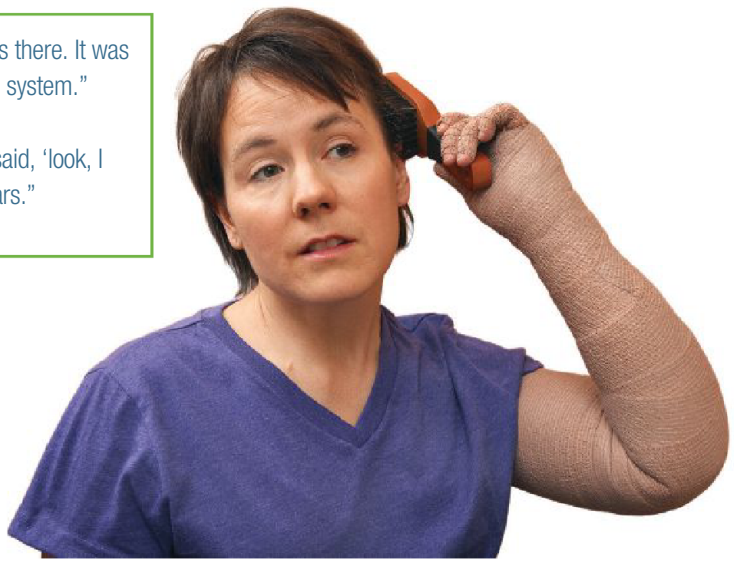

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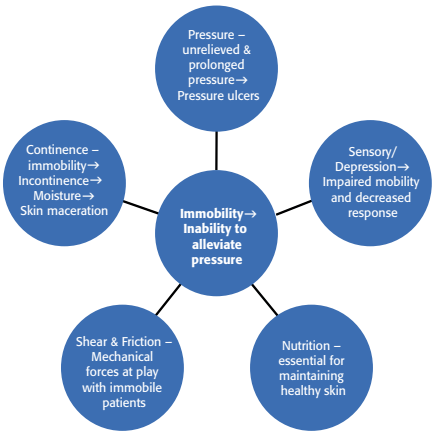
FIGURE 2

Immobility risks and issues



areas where overuse or misuse are occurring.

Implementation of the preventive heel ulcer program resulted in a dramatic reduction in heel ulcer prevalence, from 57 patients in 2009 (431 patients surveyed) to 15 patients in 2010 (424 patients surveyed) and 5 patients in 2011 (460 patients surveyed).

In 2010, corporate funding was released to review and update all the surfaces and frames in the critical care environment. A proposal is being submitted to address a hospital-wide bed maintenance program.

Mobility and continence remain 2 major concerns for the aging Trillium population. Of the 424 patients assessed during the 2010 prevalence survey, 114 patients were between the ages of 70 and 79 years, and 124 patients were between the ages of 80 and 90 years. Overall, 80 patients were incontinent of urine, 84 required the use of a bladder catheter and 92 were incontinent of stool. The prevalence survey identified a significant overuse of briefs, plastic underpads and multiple layering. A total of 205 patients were classified as non-self-ambulating. Immobility dramatically impacts on nutrition, cognition, continence, pressure, shear and friction, all of which can lead to pressure ulcer development. Immobility risks and issues have been identified and shared with the Trillium staff and community. The message is clear: Patients need to mobilize! (Figure 2)

Annual prevalence

Annual prevalence surveys allow progress to be determined. In 2009, Trillium's pressure ulcer prevalence (excluding Stage I) was 17.9%, well above the national average of 12.3%. However, as a direct result of the above interventions the prevalence rate (excluding Stage I) was reduced to 11.8% in 2010, while the incidence of facility-acquired pressure ulcers (excluding Stage I) decreased from 14.8% in 2009 to 7.6% in 2010. In 2011, prevalence (excluding Stage I) was reduced to 9.6% and the incidence of facility-acquired pressure ulcers (excluding Stage I) to 5.2%. Figure 3 charts the incidence of hospital-acquired pressure ulcers, showing a clear downward trend.

Summary and conclusions

A facility-acquired pressure ulcer is an adverse event that results in harm to the patient and added costs for the healthcare system. Every organization and healthcare provider must take responsibility for ensuring that pressure ulcer prevention is a priority. At Trillium, the introduction and use of driver diagrams has enabled the organization to focus its quality efforts and simultaneously unite the contributions of patients, staff, physicians, management and the board toward the common goal of improving the health of the community. Driver diagrams support both accountability and transparency, while being an effective means of fostering staff engagement in quality initiatives.

Trillium's nurse clinician/enterostomal therapist attributes a good part of the success of the Skin and Wound Program to the creation and deployment of the "no needless harm" driver diagram: "Our ultimate goal in terms of hospital-acquired pressures ulcers – our big dot – is 0%," she says. "The 'no needless harm' driver

FIGURE 3

Prevalence of hospital-acquired pressure ulcers

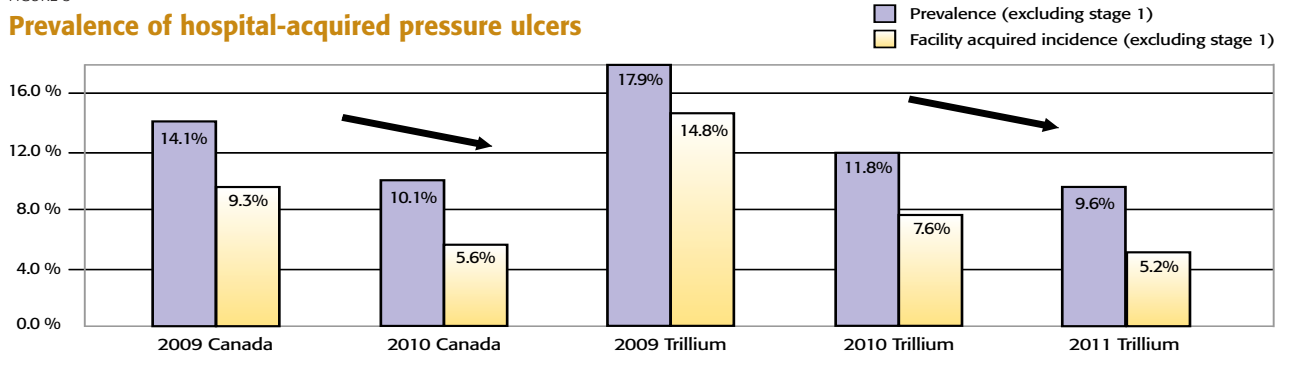


diagram means our goals are visible to staff, senior management and the board. We now know where we are and where we need to go."

The result of the most recent prevalence survey substantiates further progress to eliminating hospital-acquired pressure ulcers at Trillium. This survey, conducted in early 2011, revealed a 9.6% prevalence and 5.2% incidence (both excluding Stage 1). These results verify the successful spread and sustainability of the multiple efforts targeted at reducing hospital-acquired pressure ulcers. Trillium is committed to safe and effective high-quality care. While the successes to date are encouraging, the organization remains committed to achieving its ultimate goal of eliminating pressure ulcers by setting a hospital-acquired pressure ulcer target of rate of 4.5% for 2012.

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Wound Care Management:
Optimizing the D in DIME

BY
PATRICIA COUTTS RN IIWC

KEVIN Y. WOO PHD RN ACNP GNC(C) FAPWCA

DAVID H. KEAST MSC MD FCFP

R. GARY SIBBALD BSC MD FRCPC (MED DERM) MACP FAAD MAPWCA

Introduction

The healing of acute wounds follows a fairly predictable sequence of overlapping stages, including inflammation, proliferation, re-epithelialization and remodelling.[1] Unlike acute wounds, however, chronic wounds such as pressure ulcers, venous leg ulcers and diabetic foot ulcers do not always follow this predictable pattern because of disruption to 1 or more elements of the healing process.

The treatment of chronic wounds requires a systematic approach under the fundamentals of wound bed preparation (preparation and optimization of the wound bed for functional healing).[1] Within this framework, it is important to treat the cause and address patient-centred concerns before addressing local wound care.

Local wound management consists of the mnemonic DIME[2]:

- **D**ebridement;
- **I**nfection (reduction of bacterial bioburden) or abnormal prolonged inflammation;
- **M**oisture balance; and
- **E**dge effect of the stalled chronic wound.

This article focuses on the D: Debridement.

Role of debridement

Debridement is integral to wound bed preparation by removing devitalized tissue, foreign material, phenotypically abnormal or dysfunctional cells (cellular burden) and bacteria sequestrum. Providing the wound has the potential to progress toward healing, debridement has been demonstrated to stimulate the healing cascade, advancing wounds that are trapped in the inflammatory phase[3] through to the granulation phase and then on to epithelialization and healing. Optimizing the debridement process will promote effective and rapid healing of chronic wounds and can affect the cost of treatment.

Debridement of necrotic tissues in chronic wounds can be achieved with a number of methods, described as surgical (conservative sharp [forceps, curette to pick or scrape off necrotic tissue] and surgical sharp [scalpel cut to viable tissue]), autolytic (patient's endogenous collagenase), biologic (maggots), mechanical (wet-to-dry dressings, other devices) and enzymatic (collagenase).[4]

Methods of debridement can be deployed as a single therapeutic modality or serially combined to optimize the debridement process. Indeed, the different inherent conditions and nature of each patient's wound will require individualization of therapy. A variety of factors should be considered when choosing a debridement method or a combination of treatment modalities in order to achieve optimal clinical outcomes, including the patient's condition, goals of care, ulcer/peri-ulcer status, type of wound, quantity and location of necrotic tissue, presence of infection, the healthcare setting and professional accessibility or capability.

Costs

A recent analysis determined the costs associated with each type of debridement method,[5] with the aim of informing clinicians and policymakers not only of the direct and indirect costs associated with these therapies, but also the impact they can have on the healthcare system. The study determined the direct and indirect costs associated with the various debridement methods available to achieve a clean wound base for healing in Canada. It was based on a hypothetical patient in need of debridement of a chronic, stalled wound. The size of the wound was assumed to suit a 10×10 cm dressing and the time of therapy was defined as the time to a clean wound bed. The average time taken to achieve a clean wound bed was determined by the experiences of various wound care clinics and published literature.

Direct and indirect costs associated with wound management included healthcare personnel time (e.g. physicians, nurses, support workers), supplies (e.g. dressing, equipment, medical-grade maggots, collagenase), complications associated with the treatment (e.g. pain, infection, management of complications), operating room costs, transportation (e.g. transfers for care) and out-of-pocket expenses (e.g. parking). These were estimated based on existing

Patricia Coutts is Wound Care and Clinical Trials Co-ordinator, Dr. R. Gary Sibbald Dermatology Practice, Mississauga, Ontario

Kevin Woo is a Clinical Researcher and Nurse Practitioner, Wound Care Program, Women's College Hospital, Toronto, Ontario

David Keast is a Clinical Adjunct Professor of Family Medicine, University of Western Ontario, London, Ontario

R. Gary Sibbald is Professor, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario

data from federal, provincial and regional sources. In addition, all resources were stratified into 1 of 3 categories: namely daily resources, regularly scheduled resources and one-time resources.

The costs associated with the various debridement methods with the base case time to a clean wound bed are shown in Table 1. Surgical sharp and conservative sharp debridement were found to be the least costly methods, while biologic and mechanical debridement methods were the most costly. Of the remaining 2 approaches, autolytic treatment was more expensive than enzymatic treatment, with the cost differential driven primarily by the time needed to achieve a clean wound bed. A sensitivity analysis demonstrated that reducing or increasing the time to a clean wound bed by 1 week yielded similar cost rankings (Table 1).

Optimizing debridement

Optimizing the effects of debridement involves choosing the most clinically appropriate and cost-effective method for each situation. Patient status, wound condition and accessibility to trained healthcare personnel should all factor heavily in the decision process. Surgical debridement (sharp and conservative sharp) is the fastest and least expensive methodology, but must be performed by specially trained, competent, qualified and licensed healthcare professionals in an appropriate setting.

Surgical debridement is recommended in the presence of advancing cellulitis, crepitus, fluctuance and sepsis secondary to ulcer-related infection. However, sharp debridement is not appropriate for all patients and should be used with caution in the presence of immune incompetence, a compromised vascular supply to the limb or lack of antibacterial coverage in systemic sepsis. Relative contraindications include anticoagulant therapy and bleeding disorders. Individuals with stage III or IV pressure ulcers with undermining, tunnelling, sinus tracts or extensive necrotic tissue that cannot be easily removed by other debridement methods should be recommended for surgical evaluation.

Non-healable or maintenance wounds (where the cause of the wound has not been corrected because of patient or healthcare system factors) may benefit from conservative debridement of slough, but should not undergo active surgical debridement where there are patient contraindications or access to skilled professionals is lacking.

Until recently, debridement between surgical procedures was achieved with the use of moist dressings or autolysis, which allows the body's own collagenase to break down denatured strands of collagen. The introduction into the Canadian market of a collagenase ointment has the potential to speed the process of debridement following surgical intervention and further reduce the costs of therapy. Collagenase ointment can be used as an adjuvant therapy to sharp debridement or as a first-line therapy where sharp debridement is not appropriate. It is important to perform continuous debridement on a chronic pressure ulcer until the wound bed is covered with granulation tissue and free of necrotic tissue.

The first-line use of mechanical, autolytic, enzymatic or biologic methods of debridement is appropriate where there is less urgent clinical need for drainage or removal of necrotic tissue. In this instance, enzymatic therapy is associated with lower costs than the other methods of debridement. Daily assessment of the wound for signs of erythema, tenderness, edema, purulence, fluctuance and malodour (i.e. signs of infection) is important to ensure appropriate management. Careful consideration of patient parameters is required to tailor the debridement method to individual patient needs and ensure optimal clinical as well as economic outcomes.

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TABLE 1

Debridement methods and costs

Method	Base case		Cost	
	Time to a clean wound bed (model prediction, weeks)	Cost ($)	Time to a clean wound bed ↓ by 1 week ($)	Time to a clean wound bed ↑ by 1 week ($)
Surgical sharp	3	1,039	949	1,129
Conservative sharp	6	1,120	1,014	1,225
Enzymatic	4	1,265	1,152	1,378
Autolytic	10	1,505	1,379	1,630
Mechanical	6	1,841	1,604	2,078
Biologic	3	2,151	1,517	2,785

Challenges Facing Interprofessional Teams:

Tips for Effective Teamwork

BY
Afsaneh Alavi MD FRCPC(Derm)
Laurie Goodman RN BA IIWCC
Patricia Coutts RN IIWCC

Introduction

There are many reasons why teamwork in medicine is effective and beneficial. Over the past few years, healthcare professionals have experienced the benefits of interprofessional teams and have become more eager to work together in providing patient care. Patients prefer to be managed by a team because it gives them a sense of confidence and instills the belief they are receiving optimal care. When healthcare professionals with different areas of expertise work together as a team to identify a patient's problems, the treatment is likely to be more effective.[1]

Healthcare professionals who practise as a team are better able to balance responsibilities and workload, particularly in challenging cases. It is imperative that healthcare professionals share their knowledge and unique expertise with each other. Such a collaborative environment provides a good resource that can be integrated and applied into shared patient care plans. Teamwork provides friendship and support for an entire group, and since teamwork facilitates being dynamic, the quality of care will be increased.

Development stages of teams

As described by Tuckman in 1965, every team develops through different stages: forming, storming, norming and performing.[2] In the *forming* stage, team members begin to get to know each other but lack sufficient confidence to work together. At this stage the group is analogous to a person who wants to swim but is standing at the side of the pool, cautiously dipping a toe into the water.

The second stage is *storming*. This is considered the most challenging phase for individuals and leadership. The attitude of every team member is crucial. If the team has a positive forming stage, including effective selection, clear objectives and outlines, then the challenges brought about during the storming phase can be easily overcome. By resolving conflicts and challenges, the group members begin to know each other and to realize their responsibilities and the amount of work ahead. They are analogous to swimmers who jump into the water and splash around until they learn how to float.

During the *norming* period, team members become accustomed to working with each other, accepting responsibilities and helping other members – analogous to swimmers floating together smoothly. Team members now work effectively as a team as they enter the final stage, known as *performing*.

Challenges facing healthcare teams

Healthcare teams encounter significant challenges when working with individual patients and their circle of care. This holds true regardless of where care is provided, be it in a private office, clinic, community, hospital or long-term care setting. Some difficulties are common, while others are unique to the specific culture and healthcare system.

Not only does the healthcare system require changes to facilitate teamwork, but also individual staff from various disciplines should develop the knowledge and skills required to create a shared vision and collaborate. It is crucial to be able to work with those from different disciplines.

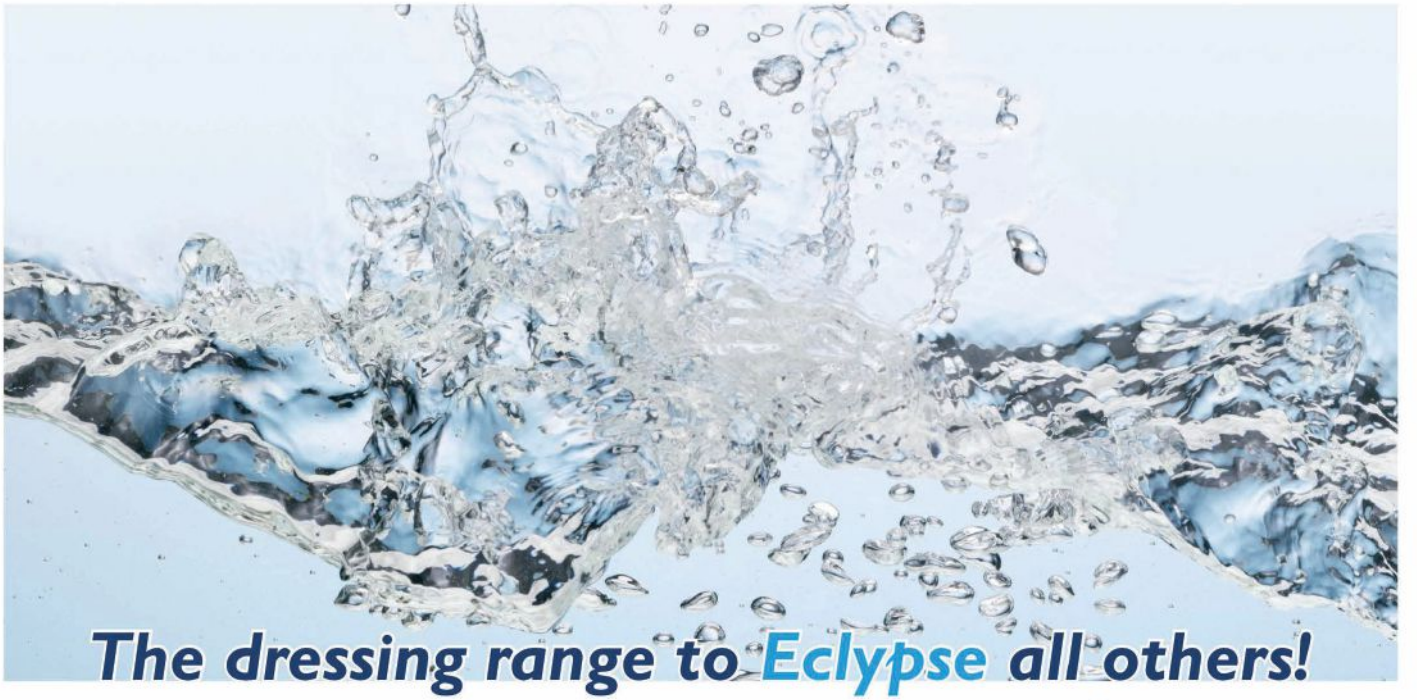
According to Krasner and colleagues, the concept of a trans-professional team means that team members do not think within the confines of their own individual disciplines or professions.[1] Team members may perform the function of another, but within the boundaries of their own professional scope of practice. Trans-professional teams can minimize delays in care delivery while optimizing patient care. Each team member works together for the common goal – to provide the best care for the patient. The following 12 recommendations provide practical ways of overcoming barriers to effective teamwork.

1. **Promote group interaction.** Clear communication is key for any group to function, and establishing a weekly or monthly meeting can be an effective way to achieve this goal. The facilitator or leader of

Afsaneh Alavi is with the Department of Medicine (Dermatology) at the University of Toronto, Toronto, Ontario

Laurie Goodman is a nurse clinician, skin and wound care, with Credit Valley Hospital, Mississauga, Ontario

Patricia Coutts is Wound Care and Clinical Trials Co-ordinator, Dr. R. Gary Sibbald Dermatology Practice, Mississauga, Ontario



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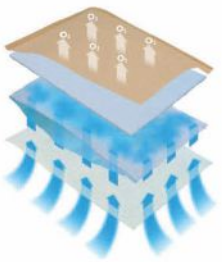

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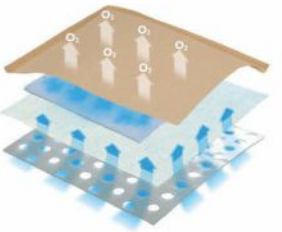

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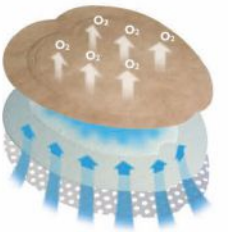

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Eclypse Adherent®	10cm x 20cm	CR3883	10
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Eclypse Adherent Sacral®	22cm x 23cm	CR3986	10
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the group must be a good listener, as communication provides a positive working relationship. In addition, documentation methods should be similar within the team to prevent duplication and enable team members to cover each other's work in case of absence.

2. **Encourage mutual flexibility**, adaptability, openness and willingness to share in the workload and leadership.
3. **Define the goals** and objectives of the team. Each individual might have different aims – some join a team for education, others for income and some for publication — but all team members should work in the same direction toward common goals.
4. **Empower the members** and request their opinions in group decision-making sessions, so they feel they belong to the group.
5. **Identify anxieties** and try to resolve them.
6. **Encourage some independence** and self-directedness of team members by avoiding excessive interference.
7. **Create an atmosphere conducive to effective team functioning.**
8. **Balance the responsibilities** within the team. It is very important to avoid providing too much external input to the team, as they may find it exhausting. Some team members may dominate quieter ones, which can detract from the overall effectiveness.
9. **Prevent barriers** or silos by avoiding the formation of smaller groups within the larger team.
10. **Consider professional adulthood a requirement.** Addressed by Laidler in 1991, professional adulthood is important to crossing professional boundaries.[3] Staff should feel confident with their roles and professional identities, so that team members do not feel uncomfortable in helping others or taking on certain parts of other roles. This also prevents jealousy within the team.
11. **Provide a supportive and safe environment** for working together on the same playing field. Flattened team structures are more effective, so avoid establishing a hierarchy.
12. **Provide mutual respect** for all members and acknowledge the unique contributions and successes of each.

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The Perfect Storm

Summary of a National Wound Care Stakeholder Round-table

La tempête parfaite

Résumé d'une table ronde nationale d'intervenants du domaine des soins des plaies

Wounds are an under-recognized health issue in Canada. While hospital, home and community care managers know that wound care is a major challenge, few are aware that wounds cost the Canadian healthcare system $3.9 billion annually or approximately 3% of total healthcare expenditures. Some estimates suggest this cost may grow by 30% in the next decade as a consequence of changing demographics and the incidence of diabetes. Wounds, increasingly being referred to as the hidden epidemic, have serious patient consequences including intractable pain, infectious complications, hospitalization, reduced quality of life, depression and increased risk of death.

In June 2012, 35 key opinion leaders representing Canadian healthcare met to start a conversation about achieving efficiencies in wound prevention and care that will transform service delivery and improve value for money.

Delegates first heard from a number of experts and then proceeded to participate in a series of facilitated discussions. They reported the following:

Wound care statistics

- It is estimated that 30 to 50% of all healthcare involves wounds
- In a typical acute care hospital, 20 to 50% of beds are occupied by patients with a wound
- 34 to 37% of persons receiving community care have a chronic wound
- In the community, 25 to 75% of nurse time is spent on wound-related care, with 70% of all wounds being treated in this setting
- At $3.9 billion per year, the cost of wound care exceeds that for stroke

Au Canada, on sous-estime le problème de santé que représentent les plaies. Les gestionnaires des soins de santé hospitaliers, communautaires et à domicile savent que les soins des plaies posent un grand défi, mais peu d'entre eux savent que les plaies coûtent chaque année 3,9 milliards de dollars au système canadien de soins de santé, ce qui représente environ 3 % du total des dépenses en santé. Selon certaines estimations, le coût des plaies pourrait augmenter de 30 % au cours des dix prochaines années en raison des changements démographiques et de l'incidence du diabète. Les plaies, qu'on qualifie de plus en plus souvent d'épidémie cachée, ont de graves conséquences pour les patients, dont douleur irréductible, complications infectieuses, hospitalisations, réduction de la qualité de vie, dépression et risque de décès accru.

En juin 2012, 35 des principaux leaders d'opinion canadiens du domaine des soins de santé se sont réunis pour entamer une conversation sur l'amélioration de l'efficience de la prévention et des soins des plaies afin de transformer la prestation des services et d'améliorer l'optimisation des ressources.

Après avoir entendu des experts, les délégués ont pris part à une série de discussions animées par un modérateur. Ils ont fait les observations suivantes :

- il n'y a pas de normes de soins locales, régionales, provinciales et nationales;
- les efforts visant à faire adopter les innovations touchant les produits, procédés et programmes sont fragmentés et les évaluations des technologies de la santé ne sont pas assez rapides;
- la somme de 3,9 milliards de dollars est amplement suffisante si les ressources sont plus efficacement affectées; et

"Governments must take responsibility and lead on these issues. They must adjust their thinking to recognize that spending on health-care now is a real and necessary investment that is far less of a burden than the untallied cost of inaction...how their inaction is crippling their health systems and ruining their economic development."

– World Health Organization, 2011

- a lack of local, regional, provincial and national standards of care;
- fragmented efforts to introduce product, process and program innovation including timeliness of health technology assessments;
- that $3.9 billion is more than adequate—it's about spending these resources more effectively; and
- there are currently no national data to support the development and measurement of key performance indicators of outcomes and quality.

The conclusion the group reached is that Canada can and must do a better job by leveraging our strengths from coast to coast. Canada has the necessary assets to not only provide pan-Canadian leadership on wound management but also to potentially take a global leadership role.

Round-table delegates identified several systemic barriers to effective wound care:

- Lack of systematic focus on patient/family in wound care research and delivery of wound care.
- Lack of accountability in benchmarking and reporting on wound care services and costs.
- Lack of quality measures leading to an inability to assess value for money.
- Lack of equitable access to services and supplies (notably in First Nations populations).
- Lack of focus on wound care as a distinct professional specialty.
- Lack of professional and public education.

Thankfully, awareness of the wound care crisis has been growing, and stakeholders have responded with a number of regional and local initiatives. Within its healthcare portfolio, the Ontario Centres of Excellence program is currently supporting several projects in the wound care area. Making wound care a priority has led a Local Health Integration Network in Ontario to realize substantial savings, and a Sherbrooke, Quebec, initiative has effectively introduced a telemedicine initiative to support wound care in rural areas.

While promising, these efforts don't go far enough. Canada needs a national wound care strategy that addresses current gaps and needs with clearly defined objectives:

- **Person-centred:** a system that integrates a patient and family perspective.
- **Accountable:** a transparent system that informs stakeholders about costs and performance.
- **Efficient:** a system that tracks and analyzes results to ensure a good return on investment.
- **Equitable:** a system that reaches all irrespective of geography, or socioeconomic or disease status.

Statistiques sur les soins des plaies

- On estime que les plaies donnent lieu à entre 30 et 50 % de tous les soins de santé.
- Dans un hôpital de soins actifs typiques, de 20 à 50 % des lits sont occupés par des patients qui présentent une plaie.
- De 34 à 37 % des personnes qui reçoivent des soins de santé communautaires présentent une plaie chronique.
- En milieu communautaire, où 70 % de toutes les plaies sont traitées, les soins liés aux plaies accaparent de 25 à 75 % du temps du personnel infirmier.
- Le coût des soins des plaies est de 3,9 milliards de dollars par année, ce qui dépasse le coût des accidents vasculaires cérébraux.

- on n'a actuellement pas de données nationales permettant le développement et la mesure d'indicateurs de rendement clés en ce qui a trait aux résultats et à la qualité.

Le groupe a conclu qu'au Canada, on peut et on doit faire davantage en misant sur nos points forts d'un bout à l'autre du pays. Le Canada a les atouts nécessaires non seulement pour assurer un leadership pancanadien en matière de prise en charge des plaies, mais peut-être aussi pour assumer un rôle de chef de file à l'échelle mondiale.

Les délégués de la table ronde ont cerné plusieurs obstacles systémiques aux soins efficaces des plaies :

- la recherche sur les soins des plaies et la prestation de ces soins n'est pas systématiquement axée sur le patient/la famille;
- il n'y a pas d'obligation redditionnelle au chapitre de l'analyse comparative et de l'établissement de rapports sur les services et les coûts liés aux soins des plaies;
- comme il n'y a pas de mesures de la qualité, on ne peut évaluer l'optimisation des ressources;
- l'accès aux services et fournitures n'est pas équitable (surtout dans les Premières Nations);
- on ne met pas l'accent sur les soins des plaies en tant que spécialité professionnelle distincte;
- il n'y a pas d'éducation des professionnels ni du public.

Heureusement, on prend de plus en plus conscience de la crise entourant les soins des plaies et les intervenants ont réagi en prenant un certain nombre d'initiatives régionales et locales. Dans le cadre de son portefeuille des soins de santé, le programme des

When wounds are trapped in the inflammatory phase, debridement is not complete…

Lorsque les plaies sont piégées dans la phase inflammatoire, le débridement n'est pas complet…

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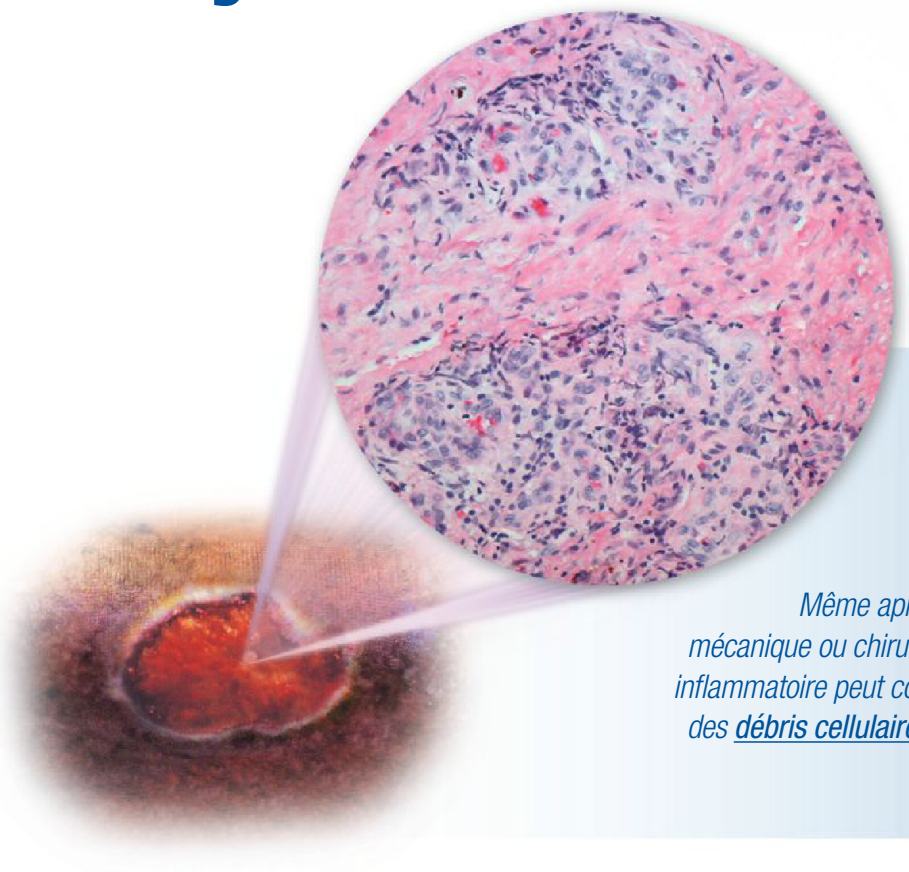

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Occasional slight transient erythema has been noted in surrounding tissue when applied outside the wound. One case of systemic hypersensitivity has been reported after 1 year of treatment with collagenase and cortisone.

Use of Collagenase SANTYL® Ointment should be terminated when debridement is complete and granulation tissue is well established.

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On a noté un érythème occasionnel et léger sur les tissus environnants lorsque l'application de l'onguent dépasse le pourtour de la plaie. Un cas d'hypersensibilité systémique a été rapporté après un an de traitement à la collagénase et à la cortisone.

L'utilisation de l'onguent SANTYL® avec collagénase devrait être cessée lorsque le débridement est complété et que la granulation est bien entamée.

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DESCRIPTION: Santyl® (collagenase) ointment is a sterile topical enzymatic debriding agent that contains 250 units of collagenase per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation of *Clostridium histolyticum*. It possesses the unique ability to selectively digest denatured and undenatured collagen that binds necrotic debris to the wound surface.

CLINICAL PHARMACOLOGY: Santyl® (collagenase) possesses the ability to digest insoluble collagen, undenatured and denatured, by peptide bond cleavage, under physiological conditions of pH and temperature. This ability makes it particularly effective in the removal of detritus from dermal lesions, contributing towards the more rapid formation of granulation tissue and subsequent epithelization of dermal ulcers and severely burned areas. Collagen in healthy tissue or in newly formed granulation tissue is not digested.

INDICATIONS: Santyl® (collagenase) is a sterile ointment indicated for the debridement of dermal ulcers or severely burned areas.

CONTRAINDICATIONS: Application is contraindicated in patients who have shown local or systemic hypersensitivity to collagenase.

WARNINGS: Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

PRECAUTIONS: The enzyme's optimal pH range is 6 to 8. Significantly lower pH conditions have a definitive adverse effect on the enzyme's activity, and appropriate precautions should be carefully taken. The enzymatic activity is also adversely affected by detergents, hexachlorophene and heavy metal ions such as mercury and silver that are used in some antiseptics and by cobalt, magnesium and manganese. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl® (collagenase) ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution followed by sterile normal saline do not interfere with the activity of the enzyme. The ointment should be confined to the area of the lesion in order to avoid the possible risk of irritation or maceration of normal skin; however, the enzyme does not damage newly forming granulation tissue. A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as zinc oxide paste. Since the enzyme is a protein, sensitization may develop with prolonged use.

ADVERSE REACTIONS: Although no allergic sensitivity or toxic reactions have been noted in the recorded clinical investigations to date, one case of systemic manifestations of hypersensitivity has been reported in a patient treated for more than one year with a combination of collagenase and cortisone. Irritation, maceration or erythema has been noted where prolonged contact of normal skin with Santyl® (collagenase) ointment has been allowed, either by application of the ointment to areas of normal skin or by excessive application of ointment to the wound crater with subsequent spread to normal skin when dressings are applied. The reported incidence for this type of reaction was 1.8%.

SYMPTOMS AND TREATMENT OF OVERDOSE: Symptoms: To date, the irritation, maceration or erythema reported on prolonged contact of normal skin with Santyl® (collagenase) ointment constitute the only symptoms of overdosage reported. **Treatment:** Santyl® (collagenase) ointment can be rendered inert by the application of Burow's solution USP (pH 3.6 - 4.4) to the treatment site. If this should be necessary, reapplication should be made only with caution.

DOSAGE AND ADMINISTRATION: For external use only. Santyl® (collagenase) ointment should be applied once daily, or more frequently if the dressing becomes soiled (as from incontinence) in the following manner: **(1)** Prior to application the lesions should be gently cleansed with a gauze pad saturated with sterile normal saline, to remove any film and digested material. If a stronger cleansing solution is required, hydrogen peroxide or Dakin's solution may be used, followed by sterile normal saline. **(2)** Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate antibacterial agent. Should the infection not respond, therapy with Santyl® (collagenase) ointment should be discontinued until remission of the infection. **(3)** Santyl® (collagenase) ointment should be applied (using a tongue depressor or spatula) directly to deep wounds, or when dealing with shallow wounds, to a non-adherent dressing or film dressing which is then applied to the wound. The wound is covered with an appropriate dressing such as a sterile gauze pad and properly secured. **(4)** Use of an occlusive or semi-occlusive dressing may promote softening of eschar, if present. Alternatively, crosshatching thick eschar with a #11 blade is helpful in speeding up debridement then cleanse with sterile saline. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors. **(5)** All excess ointment should be removed each time the dressing is changed. **(6)** Use of Santyl® (collagenase) ointment should be terminated when debridement of necrotic tissue is complete and granulation is well under way.

HOW SUPPLIED: Available in 30 gram tubes of ointment. Sterile until opened. Contains no preservative. Do not store above 25°C.

Product monograph available upon request.

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Onguent 250 unités/g

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DESCRIPTION : Santyl® (collagénase) onguent est un agent de débridement topique stérile enzymatique qui renferme 250 unités de collagénase par gramme de pétrolatum blanc U.S.P. L'enzyme collagénase est dérivée de la fermentation de *Clostridium histolyticum* possédant le pouvoir unique de digérer de manière sélective le collagène aussi bien naturel que dénaturé qui lie les fibres nécrosées à la surface de la plaie.

PHARMACOLOGIE CLINIQUE : Santyl® (collagénase) a la capacité de digérer le collagène insoluble, non dénaturé et dénaturé, par clivage de la liaison peptidique à un pH et à une température physiologiques. Cette caractéristique le rend particulièrement efficace dans l'élimination des déchets des lésions dermiques favorisant ainsi la formation du tissu de granulation et l'épithélialisation ultérieure des zones dermiques ulcérées et gravement brûlées. Le collagène des tissus sains ou du nouveau tissu de granulation n'est pas digéré.

INDICATIONS : Santyl® (collagénase) est un onguent stérile indiqué pour le débridement des zones dermiques ulcérées ou gravement brûlées.

CONTRE-INDICATIONS : L'application est contre-indiquée chez les patients ayant présenté une hypersensibilité locale ou systémique à la collagénase.

MISE EN GARDE : Les patients atteints de conditions débilitantes doivent être surveillés étroitement pour éviter la généralisation des infections bactériennes. Les enzymes de débridement augmenteraient le risque de bactériémie.

PRÉCAUTIONS: Le pH optimal de l'enzyme est de 6 à 8. Un pH nettement inférieur à un effet nettement adverse sur l'action de l'enzyme et des précautions appropriées doivent alors être prises. L'action de l'enzyme est également contrariée par les détergents, l'hexachlorophène et les ions de métaux lourds, comme le mercure et l'argent, présents dans certains antiseptiques, et par le cobalt, le magnésium et le manganèse. Quand on soupçonne l'utilisation de ces produits, la zone affectée doit être soigneusement nettoyée par des lavages répétés avec une solution saline avant l'application de l'onguent Santyl® (collagénase). Les bains contenant des ions de métaux ou des solutions acides comme la solution de Burow doivent être évités en raison de l'ion métal et du faible pH. Les solutions nettoyantes comme l'eau oxygénée ou la solution de Dakin suivie d'une solution stérile saline n'entravent pas l'action de l'enzyme. L'application de l'onguent doit se limiter à la zone affectée pour éviter le risque possible d'irritation ou de macération de la peau saine. Cependant, l'enzyme n'altère pas le nouveau tissu de granulation. Un érythème bénin dans le tissu avoisinant pourrait se produire. Cela peut facilement être évité en protégeant la peau saine avec un produit comme de la pâte d'oxyde de zinc. Compte tenu de la nature protéique de l'enzyme présent dans le médicament, son emploi prolongé pourrait amener une sensibilisation.

EFFETS SECONDAIRES : Bien qu'aucune sensibilité allergique ni réaction toxique n'aient été notées à ce jour dans les compte rendus d'études, on a signalé un cas de manifestations systémiques d'hypersensibilité chez un patient traité pendant plus d'un an avec une association de collagénase et de cortisone. On a noté de l'irritation, de la macération ou de l'érythème dans le cas de contact prolongé de la peau normale avec l'onguent Santyl® (collagénase), soit par application de l'onguent sur les régions normales de la peau, soit par application excessive de l'onguent dans le cratère de la plaie, permettant à celui-ci de s'étendre à la peau normale lors de l'application des pansements. L'incidence signalée de ce type de réaction était de 1,8%.

SYMPTÔMES ET TRAITEMENT DU SURDOSAGE: Symptômes: Jusqu'ici, l'irritation, la macération ou l'érythème signalés en cas de contact prolongé de la peau saine avec l'onguent Santyl® (collagénase) représentent les seuls symptômes signalés de surdosage. **Traitement :** On peut rendre l'onguent Santyl® (collagénase) inerte en appliquant la solution de Burow U.S.P. (pH 3.6-4.4) sur la plaie. La réapplication du produit, si elle est considérée nécessaire, ne se fera qu'avec prudence.

POSOLOGIE ET ADMINISTRATION : Pour usage externe seulement. L'onguent Santyl® (collagénase) doit être appliqué une fois par jour ou plus fréquemment si le pansement se souille (à cause d'incontinence par exemple) de la façon suivante : **(1)** Avant application, les lésions doivent être nettoyées doucement avec une gaze saturée d'une solution stérile saline normale pour enlever toute pellicule et toute matière digérée. Si l'on a besoin d'une solution nettoyante plus puissante, on peut utiliser de l'eau oxygénée ou de la solution de Dakin suivie de solution stérile saline normale. **(2)** En cas d'infection, révélée par la présence de cultures positives, de pus, d'une inflammation ou d'une odeur, il serait souhaitable d'employer un agent antibactérien approprié. Il faut interrompre le traitement au Santyl® (collagénase) jusqu'à rémission de l'infection, si l'infection ne se résorbe pas. **(3)** Appliquer Santyl® (collagénase) directement sur les blessures profondes à l'aide d'un abaisse-langue ou d'une spatule. Pour les plaies superficielles, appliquer l'onguent sur une compresse non adhérente ou un pansement transparent à être déposée sur la plaie; puis recouvrir d'un pansement approprié tel une compresse de gaze stérile adéquatement retenue. **(4)** L'utilisation d'un pansement occlusif ou semi-occlusif peut favoriser le ramollissement de l'escarre, le cas échéant. Ou, si l'on hachure une escarre épaisse à l'aide d'une lame numéro 11, on peut accélérer le débridement. Nettoyer alors avec une solution saline stérile. Il est également souhaitable d'enlever autant de détritus lâches que possible à l'aide de pinces et de ciseaux. **(5)** Enlever tout excès d'onguent à chaque renouvellement du pansement. **(6)** Arrêter les applications de l'onguent Santyl® (collagénase) dès que le tissu nécrosé est suffisamment débridé et que le bourgeonnement est bien entamé.

PRÉSENTATION : Disponible en tubes de 30 grammes d'onguent. Stérile dans l'emballage non ouvert. Aucun agent de conservation. Ne pas entreposer au-dessus de 25°C.

Monographie du produit sur demande.

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• **Sustainable:** a system with built-in processes to ensure efficiencies can be maintained over the long term.

As the solution, the delegates unanimously endorsed the concept of a physical or virtual centre dedicated to reducing the burden of wounds through leadership and innovation with the downstream impact of improving system accountability and sustainability. A Canadian Wound Care Innovation Centre of Excellence would be a hub for exploring all forms of innovation — product, process and program. Specifically, the Centre would:

- enable inter-professional collaboration;
- be a clearinghouse for process, methodology, models, tools and technology;
- serve as a subject-matter focal point and singular voice;
- build and maintain an educated resource pool through training and hands-on experience;
- act as the liaison among industry, institutional and organizational peers; and
- be a central repository for data, research and study materials.

Round-table participants also agreed that a Centre of Excellence would effectively address the gaps and needs they identified, while putting Canada at the leading edge of this evolving area of medicine. Most significantly, the Centre of Excellence would give stakeholders a mechanism for driving R&D, establishing partnerships and improving and sustaining standards of care and educating health professionals and the public.

As a funnel for wound care initiatives, education and standards, the Centre of Excellence would offer an efficient and cost-effective solution to the wound care crisis in Canada.

Next steps

Over the next 12 months, a number of commitments made at the meeting will be actioned. These include submitting a brief to the Council of the Federation's Working Group on Health Innovation and participating in the Federal Government Standing Committee on Finance's pre-budget consultation; initiating discussions and establishing links with partners; securing funding; pursuing opportunities to raise awareness with Canadian media; and developing a partnership model that will strengthen the ability to achieve the goal of a Canadian Wound Innovation Centre of Excellence.

For more information regarding the round-table, please contact Maureen Latocki, Acting Executive Director, Wound Care Alliance Canada, via email at maureen.latocki@woundcarealliance.com.

Centres d'excellence de l'Ontario finance actuellement plusieurs projets dans le domaine des soins des plaies. En faisant des soins des plaies une priorité, un Réseau local d'intégration des services de santé de l'Ontario a fait des économies considérables et un projet a été mené à Sherbrooke (Québec) pour lancer une initiative de télémédecine pour appuyer les soins des plaies dans les régions rurales.

Ces efforts sont prometteurs, mais insuffisants. Le Canada a besoin d'une stratégie nationale en matière de soins des plaies qui comble les lacunes et besoins actuels et dont les objectifs sont clairement définis :

- **accent sur la personne :** intégration de la perspective du patient et de sa famille;
- **reddition de comptes :** un système transparent qui renseigne les intervenants sur les coûts et le rendement;
- **efficience :** un système qui permet de déterminer et d'analyser les résultats pour assurer un bon rendement des investissements;
- **équité :** un système auquel tous ont accès, indépendamment de leur lieu de résidence, de leur statut socio-économique et de leur état clinique;
- **viabilité :** un système qui intègre des processus qui assurent le maintien de l'efficience à long terme.

Comme solution, les délégués ont entériné à l'unanimité le concept d'un centre réel ou virtuel voué à la réduction du fardeau des plaies par l'entremise du leadership et de l'innovation, dont l'impact en aval serait l'amélioration de la reddition de comptes et de la viabilité du système. Un Centre d'excellence canadien en innovation en matière de soins des plaies serait la plaque tournante de l'exploration de toutes les formes d'innovation, soit celles touchant les produits, les procédés et les programmes. Le Centre aurait les fonctions suivantes :

- permettre la collaboration inter-professionnelle;
- être un centre d'échange de procédés, méthodes, modèles, outils et technologies;
- servir de point de contact spécialisé et de voix unique;
- constituer et maintenir une réserve de personnel qualifié par l'entremise de la formation et de l'expérience pratique;
- assurer la liaison entre les pairs de l'industrie, des établissements et des organisations; et
- servir de dépôt central pour les données et les documents de recherche et d'étude.

Les participants de la table ronde ont en outre convenu qu'un Centre d'excellence permettrait de combler efficacement les lacunes et les besoins cernés, tout en plaçant le Canada à l'avant-garde

« Les gouvernements doivent assumer leurs responsabilités et prendre l'initiative pour régler ces problèmes. Ils doivent ajuster leur façon de penser pour reconnaître que les ressources consacrées à la santé maintenant représentent un investissement réel et nécessaire dont le fardeau est nettement inférieur au coût, par ailleurs indéterminé, de l'inaction […] et que leur inaction a des effets désastreux sur leurs systèmes de santé et cause un tort irréparable à leur développement économique. »

– Organisation mondiale de la santé, 2011

Planning committee

Peggy Ahearn, Executive Director,
Canadian Association of Wound Care

Peter Gardner, Member,
MEDEC Wound Care Committee

Cathy Harley, Executive Director,
Canadian Association for Enterostomal Therapy

Maureen Latocki, Acting Executive Director,
Wound Care Alliance Canada

Fabien Paquette, Chair,
MEDEC Wound Care Committee

John Stone, Vice Chair,
MEDEC Wound Care Committee

Laura Teague, President,
Ontario Woundcare Interest Group (OntWIG)

Wound CARE Instrument

Available!

The Canadian Association of Wound Care and the Canadian Association for Enterostomal Therapy collaborated to produce the Wound CARE (Collaborative Appraisal and Recommendations for Education) Instrument.

The Wound CARE Instrument provides a set of standards that support healthcare providers, organizations and health authorities to undertake a comprehensive and collaborative evidence-informed appraisal process before launching a wound management educational event or program.

The Wound CARE Instrument can be used to evaluate existing wound care programs, as well as to develop new programs.

Visit http://cawc.net/index.php/resources/wound-care-instrument/ to download a copy.

Comité de planification

Peggy Ahearn, directrice générale, Association canadienne du soin des plaies

Peter Gardner, membre,
Comité de soin des plaies de MEDEC

Cathy Harley, directrice générale,
Association canadienne des stomothérapeutes

Maureen Latocki, directrice générale intérimaire,
Wound Care Alliance Canada

Fabien Paquette, président,
Comité de soin des plaies de MEDEC

John Stone, vice-président,
Comité de soin des plaies de MEDEC

Laura Teague, présidente,
Ontario Woundcare Interest Group (OntWIG)

de ce domaine en pleine évolution de la médecine. Chose plus importante encore, le Centre d'excellence donnerait aux intervenants un mécanisme pour propulser la recherche et le développement, créer des partenariats, améliorer et maintenir les normes de soins et éduquer les professionnels de la santé et le public.

En canalisant les initiatives, l'éducation et les normes en matière de soins des plaies, un Centre d'excellence serait une solution efficiente et rentable à la crise des soins des plaies au Canada.

Prochaines étapes

Au cours des douze mois à venir, certains des engagements pris à la réunion seront concrétisés, dont les suivants : présenter un mémoire au Groupe de travail sur l'innovation en matière de santé du Conseil de la fédération et participer aux consultations prébudgétaires du Comité permanent des finances du gouvernement fédéral; entamer des discussions et créer des liens avec des partenaires; obtenir le financement nécessaire; exploiter les possibilités de sensibilisation au sein des médias canadiens; et développer un modèle de partenariat qui favorisera l'atteinte de l'objectif du Centre d'excellence canadien en innovation en matière de soins des plaies.

Pour en savoir davantage sur la table ronde, communiquer avec Maureen Latocki, directrice générale intérimaire de Wound Care Alliance Canada, par courriel à l'adresse maureen.latocki@woundcare alliance.com.

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[1] *Data on file at Hydrofera, LLC*
[2] *Ramsey et al., Comparison of the **Effects of Antimicrobial Wound** Dressings on Cell Viability, Proliferation, and Growth Factor **Activity**, SAWC 2008*

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Q&A with the Ontario Woundcare Interest Group

***Wound Care Canada* spoke recently with Laura Teague, President of the Ontario Woundcare Interest Group (OntWIG). Teague is an acute care nurse practitioner at St. Michael's Hospital in Toronto.**

L'Ontario Woundcare Interest Group répond à nos questions

***Soins des plaies Canada* a récemment rencontré madame Laura Teague, présidente de l'Ontario Woundcare Interest Group (OntWIG). Madame Teague est infirmière praticienne en soins actifs à l'Hôpital St. Michael's de Toronto.**

What is OntWIG?

Formed in 2008, OntWIG is an affiliate interest group of the Registered Nurses' Association of Ontario (RNAO). OntWIG is comprised of 250 healthcare professionals, including nurses, registered nurse practitioners, chiropodists, occupational therapists, physiotherapists and physicians from across all sectors (acute, long-term, chronic and community care). The group shares an interest in advancing health policy issues regarding access to wound care specific to the province of Ontario.

What is OntWIG's mission?

Our mission is to lead, promote and influence wound prevention and treatment public policy for all citizens of Ontario. We envision an Ontario healthcare system in which everyone has equal access to optimal wound prevention and treatment, regardless of where they receive care.

What are OntWIG's goals?

We have 3 major goals: The first goal is to lobby the provincial government for a comprehensive wound care strategy that will increase access to optimal evidence-based wound management for patients in Ontario across all healthcare sectors. Embedded in that strategy is not only access to clinical care regardless of a patient's current status within the healthcare system (e.g. acute, long-term or home care) or where he or

Qu'est-ce que l'OntWIG?

Formé en 2008, l'OntWIG est un groupe d'intérêts affilié à l'Association des infirmières et infirmiers autorisés de l'Ontario (RNAO). L'OntWIG regroupe 250 professionnels de la santé, dont des infirmières, des infirmières praticiennes autorisées, des podologues, des ergothérapeutes, des physiothérapeutes et des médecins de tous les secteurs (soins actifs, de longue durée, chroniques et communautaires). Le groupe cherche à mettre de l'avant les questions de politique de santé ayant trait à l'accès aux soins des plaies en Ontario.

Quelle est la mission de l'OntWIG?

Notre mission est d'orienter, faire valoir et influencer les politiques publiques en matière de prévention et de traitement des plaies pour tous les citoyens de l'Ontario. Nous envisageons un système de santé ontarien où tous ont un accès égal aux méthodes optimales de prévention et de traitement des plaies, indépendamment de l'endroit où les soins sont prodigués.

Quels sont les objectifs de l'OntWIG?

Nous avons trois grands objectifs. Le premier est de faire pression sur le gouvernement provincial pour qu'il mette en place une stratégie globale de soins des plaies qui augmentera l'accès des patients ontariens aux pratiques optimales de prise en charge des plaies fondées sur des données probantes dans tous les

she lives, but improvement in communications via electronic records systems and cross-sectoral access to interdisciplinary team members as required.

Our second goal is to break down the "silos" between healthcare sectors – i.e. acute care, long-term care, rehabilitation facilities and home care – which will in turn improve value for money. If care is standardized across all sectors, which requires the requisite funding and education, then optimal wound care can be delivered in all areas and at all levels.

Our third goal is to foster the use of a common language when describing wounds. In this way, we're counting and describing things consistently. The danger in not doing so is that you may under- or overestimate a problem, potentially putting a patient at risk.

What impact has OntWIG had to date?

We are very proud of what we have been able to achieve in 4 years. For example, OntWIG brought forward a formal resolution at the 2011 RNAO annual general meeting: "To advocate to the Ministry of Health and Long-Term Care for a comprehensive, cross-sector, interdisciplinary, provincial wound care strategy, inclusive of sector-wide accountability for pressure ulcer prevention." The resolution was unanimously adopted.

Also in 2011, OntWIG hosted a symposium titled "*Quality, Risk, Accreditation – Toward a Wound Management Strategy*." The meeting brought together a cross-section of 150 wound care stakeholders to share their ideas for tackling the fragmented, uncoordinated and uneven access to and delivery of wound management services across Ontario.

Other successes include OntWIG's collaboration with Accreditation Canada to develop a national standard or required organizational practice for pressure ulcer prevention, which was adopted for implementation in January 2012; and OntWIG's participation in developing the RNAO *Guidelines for the Assessment and Management of Diabetic Foot Ulcers*, which were recently adopted by the Council of the Federation's Working Group on Health Innovation.

This autumn, OntWIG will be releasing the Ontario Wound Care Strategic Framework. It is our desire to see the framework used to start a dialogue among healthcare providers, patients, policymakers and the public about the growing challenge that wound care presents to the sustainability of the Ontario health system and to work collaboratively with the Ontario government and its agencies to achieve our vision: "Fewer wounds, faster healing." The next step will be seeking the support of key stakeholder groups, including CAWC, the Canadian Association for Enterostomal Therapy (CAET) and other professional organizations.

secteurs des soins de santé. Cette stratégie doit non seulement assurer l'accès d'un patient aux soins cliniques indépendamment de son statut au sein du système de soins de santé (p. ex. soins actifs, de longue durée ou à domicile) ou de son lieu de résidence, mais aussi améliorer les communications par l'entremise de systèmes de dossiers électroniques et, au besoin, de l'accès intersectoriel aux membres d'une équipe multidisciplinaire.

Notre deuxième objectif est d'éliminer le cloisonnement entre les secteurs des soins de santé – soit les soins actifs, les soins de longue durée, les établissements de réadaptation et les soins à domicile –, ce qui contribuera à l'optimisation des ressources. Si les soins sont normalisés dans tous les secteurs, ce qui exige financement et éducation, les soins des plaies seront optimaux dans tous les secteurs et à tous les échelons.

Notre troisième objectif est de favoriser l'utilisation d'un langage commun pour la description des plaies. Ainsi, les choses pourront toujours être comptées et décrites de la même de façon. Faute de langage commun, on peut sous- ou surestimer un problème, ce qui peut mettre un patient en danger.

Quel impact l'OntWIG a-t-il eu à ce jour?

Nous sommes très fiers de ce que nous sommes parvenus à faire en quatre ans. Par exemple, l'OntWIG a présenté la résolution en bonne et due forme suivante à l'assemblée générale de 2011 de la RNAO : « Plaider auprès du ministère de la Santé et des Soins de longue durée pour qu'il adopte une stratégie provinciale de soins des plaies globale, intersectorielle et multidisciplinaire – avec obligation de reddition de comptes dans tous les secteurs – en matière de prévention des plaies de pression. » La résolution a été adoptée à l'unanimité.

Également en 2011, l'OntWIG a tenu un symposium intitulé « *Quality, Risk, Accreditation – Toward a Wound Management Strategy* » (Qualité, risque, agrément – vers une stratégie de prise en charge des plaies). Au cours du symposium, un groupe représentatif composé de 150 intervenants du domaine des soins des plaies a échangé des idées sur les mesures à prendre à l'égard de la fragmentation, de l'absence de coordination et de l'inégalité de l'accès aux services de prise en charge des plaies et de la prestation de ces services en Ontario.

Parmi les autres réussites de l'OntWIG, mentionnons la collaboration avec Agrément Canada à l'élaboration de normes nationales ou pratiques organisationnelles obligatoires en matière de prévention des plaies de pression, qui ont été adoptées aux fins de mise en œuvre en janvier 2012, et la participation de l'OntWIG à la préparation des *Guidelines for the Assessment*

L'OntWIG envisage un système de santé ontarien où tous ont un accès égal aux méthodes optimales de prévention et de traitement des plaies, indépendamment de l'endroit où les soins sont prodigués.

OntWIG envisions an Ontario healthcare system in which everyone has equal access to optimal wound prevention and treatment, regardless of where they receive care.

What is the secret to your success?

OntWIG is led by a team of dedicated volunteers who are passionate about improving wound care. We have been successful because of our willingness to work collaboratively with other organizations. A good example is our participation with CAWC, CAET and MEDEC (representing the wound care industry) in a national stakeholder roundtable that brought together representatives from 35 of Canada's most influential healthcare organizations to talk about a pan-Canadian wound management innovation agenda.

How can I join OntWIG?

Membership is open to all healthcare professionals with an interest in wound care. Annual membership ($35 or $20 for students) entitles you to attend the annual symposium and annual general meeting, and participate in workgroups and interprofessional networking opportunities. You will also receive a quarterly newsletter. Contact info@rnao.org or call 1-800-268-7199 for more information.

OntWIG Exeutive Committee

President: Laura Teague RN (EC) MN NP

Membership: Lyndsay Orr PT MCLSc

Communications:
Debbie Hanna-Bull RN BScN MN

Health Policy: Nancy Purdy RN PhD

President-Elect: Karen Laforet RN MClSc-WH IIWCC

Treasurer: Valerie Winberg RN (EC) MScN

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Présidente : Laura Teague, IA (CS), MScInf, IP

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Debbie Hanna-Bull, IA, BScInf., MScInf

Politique en matière de santé :
Nancy Purdy, IA, PhD

Présidente désignée :
Karen Laforet, IA, MScCl-CP, IIWCC

Trésorière : Valerie Winberg, IA (CS), MScInf

and Management of Diabetic Foot Ulcers (Lignes directrices sur l'évaluation et la prise en charge des ulcères du pied diabétique) de la RNAO, qui ont récemment été adoptées par le Groupe de travail sur l'innovation en matière de santé du Conseil de la fédération.

Cet automne, l'OntWIG rendra public un cadre stratégique en matière de soins des plaies en Ontario. Nous désirons que ce cadre serve de point de départ au dialogue entre les fournisseurs de soins, les patients, les décideurs et le public sur les défis croissants que représentent les soins des plaies au chapitre de la viabilité du système ontarien de soins de santé. Nous désirons aussi travailler en collaboration avec le gouvernement ontarien et ses agences afin que notre vision – « Moins de plaies, cicatrisation plus rapide » – se réalise. L'étape suivante consistera à demander l'appui de groupes d'intervenants clés, dont l'ACSP, l'Association canadienne des stomothérapeutes (CAET) et d'autres organisations professionnelles.

Quelle est la clé de votre succès?

L'OntWIG est dirigé par un groupe de bénévoles dévoués qui ont à cœur de contribuer à l'amélioration des soins des plaies. Notre succès vient de notre volonté de travailler en collaboration avec d'autres organisations, dont un bon exemple est notre participation avec l'ACSP, la CAET et MEDEC (qui représente l'industrie des soins des plaies) à une table ronde nationale d'intervenants au cours de laquelle des représentants de 35 des plus influentes organisations canadiennes du domaine des soins de santé ont discuté d'un programme d'innovation pancanadien en matière de prise en charge des plaies.

Comment peut-on devenir membre de l'OntWIG?

Tous les professionnels de la santé qui s'intéressent aux soins des plaies peuvent devenir membres. La cotisation annuelle de 35 $ (20 $ pour les étudiants) permet d'assister au symposium annuel et à l'assemblée générale annuelle, de participer à des groupes de travail et de profiter de possibilités de réseautage interprofessionnel. Les membres reçoivent en outre un bulletin trimestriel. On peut obtenir de plus amples renseignements en envoyant un courriel à l'adresse info@rnao.org ou en composant le 1-800-268-7199.

Tweet Tweet!

You can now find the Canadian Association of Wound Care on Twitter and Facebook. Follow us on Twitter at **http://twitter.com/woundcarecanada** to receive timely updates regarding the Association's wound care education programs and the latest news in wound care. You can also find the Canadian Association of Wound Care on Facebook.

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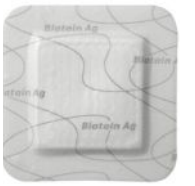

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Living with Lymphedema and its Complications

Ann Hasznosy has lived with lymphedema all her life. Although she has suffered occasional setbacks, she has found that working closely with her healthcare team – with open communication – has helped her maintain well-being. Ann is a 58-year-old retired business owner; she lives with her husband, Art, in Port Colborne, Ontario.

I was born with congenital Milroy disease, which is known today as primary stage 1 lymphedema. My case is different from most others because the disease affects my whole body. While most people with this affliction usually carry the lymphedema in either the upper or the lower extremities, the left side of my face is affected as well as my right arm and left leg. Another difference seems to be that all the traditional palliative therapies used in the treatment of this disease are, in my case, counterproductive.

"If something was a challenge, I felt it could be conquered."
– Ann Hasznosy

Growing up

Despite these challenges, I was very fortunate when growing up. My parents always encouraged me to try whatever I wanted. If something was a challenge, I felt it could be conquered. It wasn't always easy, though, and in some instances modifications had to be made in the way I approached things. However, I was able to play many sports – including basketball, volleyball and baseball – and loved every minute of them. At one point a referee unfamiliar with my condition took the coach aside before a game and told him I would not be allowed to play as I obviously had grievous injuries! It took a lot of explaining and demonstrating that I could indeed handle the rigors of the sport before I was allowed to participate.

One great concern has always been infection. During my teens and twenties, as much as my lymphatic system was already stressed, bumps, bruises, cuts and sores took time to heal but were never really a concern. However, the ravages of time are catching up.

Treatment challenges

Around 2.5 years ago I noticed a spot on my lower left leg that I had hit repeatedly going up and down ladders and that was being bumped by grocery shopping carts. It became very angry-looking and measured

Ann Hasznosy: It is important to keep an open mind.

1.5×1.2×0.5 cm. My family physician sent me to a local wound care facility. With various treatments – including silver alginate, an absorbent silicone foam dressing and a protease-modulating matrix dressing – the wound showed a slight improvement. But after being treated for 3 months, with bandage changes 2 or 3 times a week, the wound had actually increased in size to 2.5×1.6×0.6 cm, with deterioration and increased drainage. The edges of the wound had hypergranulated and would bleed freely. Cultures were taken and it was determined that the wound had become infected. A round of antibiotics was prescribed.

I was referred to Dr. R. Gary Sibbald's wound clinic in Mississauga, Ontario. Dr. Sibbald examined the wound and felt that basal cell carcinoma was involved, which was verified by a biopsy. I am currently being treated with an imiquimod topical cream for superficial basal cell carcinoma. We have encountered a few setbacks along the way. Not knowing exactly how the lymphedemic leg would be affected by this treatment, we have had to adjust treatment frequencies, sometimes

CAWC Institute of Wound Prevention and Management

The CAWC Institute Events Include:

Level 1: Knowledge Learning

Basic wound management knowledge to support a best practice approach to patient care, including: wound healing principles; wound bed preparation; pressure ulcers, venous leg ulcers and diabetic foot ulcers.

Level 2: Skills Learning

Interactive learning and practice of wound care skills, including: local wound care; debridement, infection control and dressing selection; lower leg assessment and compression therapy; foot care and foot wear; pressure, friction and shear management.

Level 3: Attitude Learning

Steps and methods for practicing within a team to develop and sustain prevention strategies, with a focus on pressure ulcer and diabetic foot ulcer awareness and prevention.

2013 L Series Levels 1, 2 & 3

The CAWC will host L Series workshops in the following cities in 2013.

Please visit: http://cawc.net for further information regarding dates and venues.

London, ON

Vancouver, BC

Winnipeg, MB

Toronto, ON
(Spring 2013 and Autumn 2013)

Calgary, AB

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For more information, please contact: Diana Seminara, Event Coordinator, Canadian Association of Wound Care · 416-485-2292 x225 · diana@cawc.net

Register now at www.cawc.net

"My parents always encouraged me to try whatever I wanted."
– Ann Hasznosy

even stopping treatment for a period of time. I have had a few adverse reactions where the wound would appear to be healing, only for the skin to crack open and lymphatic fluid pour out. Hopefully now we are on the right track and improvement will continue. With my condition, any treatment is always a learning experience for everyone involved.

At my first appointment with Dr. Sibbald, there was much discussion around wearing compression socks, not only to aid the healing of my wound, but also to help with the lymphedema itself. I explained that I had tried many different compression therapies, all of which worked for a very short period before starting to aggravate my condition. Therefore, I was unwilling to go down that avenue of treatment. Many discussions later, we came to a mutual understanding that I would apply a "small" amount of compression to my leg by wearing Tubigrip "G" and would monitor the outcome. So far, the results have been positive.

The importance of communication

If I can offer any advice to others who are faced with a similar situation, it is to provide as much background information on your health issues as possible. After all, you are the one living with this condition and you can best explain your situation. The more knowledge is shared, the better for all concerned! If you don't let your healthcare professional know what has worked for you in the past or what therapies you are willing to try, then your interactions can become very frustrating. It is also important to keep an open mind.

For healthcare providers, remember that the patient is your best source of information. Although tests and reports will give you the needed facts and results, your patient's words, recollections, expressions and demeanor are also important. Not all therapies work for all patients. So, if a patient indicates that a certain treatment hasn't worked in the past, then consider exploring new avenues or options.

Finally, for both patients and healthcare professionals: Always listen carefully, communicate clearly and be willing to negotiate, if necessary.

Upcoming events

Mark your calendar for these important international wound care events!

The American Professional Wound Care Association Conference 2013
April 4–7, 2013
Caribe Royale All-Suites
Orlando, Florida
Website: www.apwca.org/apwca2013

26th Annual Wound Healing Society Symposium on Advanced Wound Care
May 1–5, 2013
Colorado Convention Centre
Denver, Colorado
Website: www.woundheal.org/annual-meeting

Canadian Association for Enterostomal Therapy Conference 32nd Annual Conference
May 9–12, 2013
Toronto Marriott Eaton Centre
Toronto, Ontario
Website: www.caet.ca

Wound, Ostomy and Continence Nurses Society 45th Annual Conference
June 22–26, 2013
Seattle, Washington
Website: www.wocn.org/?page=annual_conference

MARK YOUR CALENDAR!

The 19th Annual Canadian Association of Wound Care Conference

From Innovation to Action: The Future of Wound Care is Now

November 7–10, 2013
Sheraton Wall Centre, Vancouver, British Columbia

For further information, please visit www.cawc.net.

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