Wounds Canada Halifax Spring 2019 Conference:

We're All in This Together

April 12–13, 2019, Halifax Convention Centre, Halifax, NS

Session Summaries

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Wounds Canada held its spring 2019 conference in Halifax, NS, April 12 to 13. Local volunteers attended sessions and prepared the summaries that follow, which include highlights and practice pearls from expert speakers.

ACROSS THE SECTORS: WOUND CARE REALITIES AND DISPARITIES

Presenters: Mary-Ellen Gurnham, Kimberly Lacey, Suzanne D'Entremont, Lynne Kavanagh

This session reviewed and discussed the extent and quality of evidence related to the prevention and management of wounds, and practical, patient-centred and cost-effective approaches to wound care. Speakers also discussed how clinical decisions affect policy and vice versa.

Nova Scotia recently amalgamated its nine health districts, and the province's vision is for standardized delivery of evidence-based best practices in wound prevention and management across Nova Scotia's entire health-care system.

According to its goals, this province-wide approach must be:

- collaborative (establishing strong and lasting relationships)
- built on previous efforts (learning from other successes)
- adoptive and adaptive (adopting best practice guidelines and recommendations, adapting them to the local context)
- interconnected (bringing together policy, edu-

cation and clinical resources to drive practice change)

It was emphasized that while programs can provide facilitation and leadership, it takes the efforts of every clinician and administrator to create a truly unified, provincial approach. A cultural shift is required to see separate practice areas as part of one integrated team.

The presenters conducted a room poll asking attendees to identify the two biggest barriers to best practice. The answer? Human resources and funding.

Highlighted were a number of disparities in care across the region and either how the province is addressing them or what barriers exist to handling them.

Disparity: Shortage of human resources across all sectors

Provincial response: Providing ongoing assessment of service delivery to inform future directions within the provincial framework

Disparity: Lack of coordination in terms of geography, facility type and across teams

Provincial response: Standardizing resources and tools for clinical practice and communication among clinicians and patients, and exploring ways to improve coordination of care across sectors.

Disparities: Lack of standardized education, organizational changes, competing priorities (limited time committed to education), complexity of care, difficulty keeping pace with changes (e.g., ongoing research means new programs can be out of date even before they are launched).

Barriers and opportunities:

- Education doesn't always translate into practice when policies are in place that prohibit change or critical thinking by frontline providers.
- Accountability is needed to support best practice.
- Need a way to access decision-makers in organizations to pass on valuable learning.
- Integrated teams should be educated together, so members can see the value of all roles, where they fit in, and the importance of communication.

Disparity: Cost of care
It is difficult to collect cost data without standard reporting or standardized documentation. Often what little information is collected is not collated.

Provincial response: Exploring feasibility of data-collection framework using technology, and working on a pilot in the Eastern Zone

Disparity: Funding
The province needs to invest so it can see future savings, but all sectors are competing for money. It is important to ensure changes in one sector don't negatively impact another.

Barriers:

- Lack of data makes it difficult to advocate for policy change.
- When everyone owns it (wound prevention and care) but nobody owns it, there is no accountability.

A room poll asked the following: What has been most effective for practice change? Answer: Practice enablers/resources, education. (Note that there was little response to process change or policy.) Enablers allow nurses to do something today.

The presenters highlighted two recent success stories that provide models for moving forward:

- Cost-effectiveness was demonstrated for total contact casts (TCCs) for diabetic foot ulcers (DFUs). DFUs precede 85% of lower-extremity amputation. The business case around this statistic shows that home care for 30 weeks is $3,176 more expensive than a TCC for 12 weeks.
- The Northwood Wound Care Program (2012) in Nova Scotia was successful. See the article Developing a Wound Care Program in Long-term Care: Changing the Focus from Products to Prevention in *Wound Care Canada* (vol. 16, no. 2, Winter 2018) for a detailed overview of how changes implemented resulted in improvements in a number of areas.

WHEN WOUNDS DON'T HEAL

Presenters: Pat Coutts and Justin Paletz

This session took the standing-room only audience through several case studies and reviewed the differences between healing and non-healing wounds.

The presenters referenced the Wounds Canada Wound Prevention and Management Cycle (WPMC), with a focus on wound assessment and involving the patient and family as much as possible. They stressed that clinicians should be aware of pain during assessments and that some patients anticipate pain with difficult dressing removal. Clinicians should develop a plan of care around monitoring and controlling a patient's pain.

Also discussed were intrinsic and extrinsic factors that affect wound healing, and presenters emphasized the importance of establishing goals of care with a patient based on whether the wound is healing, non-healing or non-healable.

Since cancer can be a factor in a wound not healing, there followed a review of the three most common skin cancers in North America, the risk factors and what to do when a biopsy confirms cancer.

Presenters discussed clinical clues to melanoma, and a number of pictures illustrated what to look for in a questionable malignant ulceration. If suspicious, the clinician should refer the patient for biopsy. When the pathology reveals a skin cancer, the patient must be referred on for excision (depending on the goals of care). Delay in diagnosis can be detrimental for the patient. Clinicians should be mindful of the risk factors for skin cancer and consider it as a possible cause for these non-healing ulcers. The discussion encouraged the audience members to reflect on their own practices and potential patients who may have a skin cancer.

Key Points

- Not all wounds are healable. Be a detective and investigate what is causing the wound.

- Know potential team members in your facility and community.
- Make care goals simple and easy for the patient and family.
- Consider "malignancy" for non-healing wounds. If suspicious, ask for a biopsy. Early detection and diagnosis are key. Delays in diagnosis have a negative impact on outcomes for patients.
- Consider next steps when pathology reports a malignant ulcer and review goals of care.

PRESSURE INJURIES

Presenters: Sheila Moffatt, Natalie Cheng, Caroline Kelly

Here are some of the key points shared during this session:

- In Nova Scotia, a province-wide pressure injury prevalence study is completed each fall in acute-care facilities.
- Each year the United States sees an average of 17,000 lawsuits related to pressure injuries, with an average settlement of $250,000. This is coming to Canada, and we have recently seen lawsuit actions in Nova Scotia for pressure injuries.
- "Deep tissue injury" will be a new stage added to the pressure injury staging categories.
- Promotion and implementation of best practice is carried out using the Wounds Canada Wound Prevention and Management Cycle (WPMC).
- A barrier to prevention in Nova Scotia is the lack of funding for effective offloading equipment.
- Pressure reduction is now termed *pressure redistribution*.
- Ideally wheelchair repositioning should take place every 15 to 30 minutes if the patient can do this independently. If the person requires assistance from staff, repositioning should be done every hour while the patient is sitting.
- Team care is required for the effective prevention and management of pressure injuries. Health-care providers need to empower the patient, who is the key person on the team.

SKIN FRAILTY: PREDICTION, PREVENTION AND MANAGEMENT AT THE EXTREMES OF LIFE

Presenters: Kerri Coulson, Janet Kuhnke, Sheila Moffatt, Emily Woodgate

Emily Woodgate discussed preemie and newborn skin and its susceptibility to absorption and damage due to the skin not having its full protection capability until approximately age three.

Kerri Coulson presented information about the causes and management of moisture-associated skin damage (MASD). Key recommendations included ensuring the use of pH neutral soaps, being gentle when cleansing, moisturizing and using a barrier product, and properly charting the intervention(s). Interigo was identified as associated with skin-on-skin touching (the "jiggly and rubbing bits"). Periwound MASD and peristomal MASD were also discussed.

Sheila Moffatt discussed aging skin in special populations and used case studies to illustrate the causes of skin damage. One case outlined the situation of a spina bifida patient with heel ulceration through to the bone. After a clinician took a history and investigated to determine the cause, it was discovered that the foot pedals on the patient's wheelchair had been adjusted. It was

stressed that a specialist occupational therapist should be engaged to make this type of adjustment.

The concept of a "patient care village" was discussed, where staff involved with the patient work collaboratively to produce a more efficient and better outcome for the patients.

Janet Kuhnke led an engaging session, involving Q and A, that looked at three different cases, preterm, term and older adult, and highlighted the skin frailty issues at these ages.

She encouraged the use of online resources and stressed the importance of using validated assessment tools.

She also emphasized the importance of noting and recording the condition of a patient's skin when sending them to, or receiving them from, another's care. This helps identify when the breakdown likely occurred. The clinician should also ensure that the results from assessments such as the Braden are acted upon in a timely way.

Key Points

Practitioners should be able to do the following:

- Recognize incontinence-associated dermatitis (IAD), moisture-associated skin damage (MASD) and issues at the extremes of age
- Understand the effects of pressure and moisture on the skin
- Learn prevention and management strategies

LOWER LIMB ULCERS

Presenters: Caroline Everett, Barbie Murray, Matt Smith

This session provided information on options for interventions and care in healable ulcers, the importance of foot care in high-risk feet and the use of BPRs for prevention and management of lower leg issues.

Key Points:

- The prevalence of peripheral arterial disease (PAD) in Nova Scotia requires attention. Diabetes and smoking are major factors. Early detection and treatment of PAD are essential for health-related quality of life and limb preservation.
- The management of lower-leg edema is key to preventing ulcers and recurrent infection.
- Regular podiatry care is essential for high-risk feet, ulcer prevention and prevention of lower extremity amputation.

SKIN DISEASES AND INFECTION

Presenters: Lynn Johnston, Rob Tremaine, Paul Bonnar, Barbie Murray

This session helped delegates identify common skin diseases, conditions and disorders, explore the stages of the wound infection continuum, define clinical infections, identify the signs and symptoms of local, spreading and systemic infections, and explore BPRs for information and resources related to the prevention and management of common skin and wound infections.

Several case studies were presented, illustrating stasis dermatitis, vasculitis, pyoderma gangreno-

sum, cellulitis and infected venous leg ulcer.

Speakers emphasized the importance of assessing and reassessing wounds for signs of infection. Delegates were urged to be specific in their investigation and determine if there is local or systemic involvement. Clinicians should ensure they know the history of the wound (acute, chronic, traumatic) to better drive treatment. Red and/or inflamed doesn't always equal infection. Though all wounds are colonized, they aren't necessarily infected. Look for signs of infection, however subtle.

Assessment should include a full review of prior investigations, culture-specific biopsies (and possible subsequent antibiotic change), advanced imaging, a thorough blood screen and an assessment of the current wound status.

When setting goals, confirm the diagnosis, manage the wound, eradicate infection, manage pain and work to prevent recurrence. Assemble a team that includes the patient and family and/or caregivers. Ensure adequate reassessment and modification of the treatment plan while maintaining best practice.

Use care when selecting antibiotics: for mild infections use oral, narrow spectrum, and for severe infections use broad-spectrum oral or IV treatment. Constantly evaluate the outcomes and adjust if necessary.

Key Points:

- Follow best practice guidelines and collaborate to form a patient-driven team and effective plan of care.
- Remember that erythema does not always mean infection.
- Loss of skin integrity increases the risk of wound infection.
- Investigate, if warranted, to confirm the presence and degree of infection.
- Conduct comprehensive and ongoing assessments, which support safe and effective treatment of infection and foster antimicrobial stewardship.
- When there has been no significant response to antibiotics, confirm a clinical diagnosis before repeating antibiotics.
- Consider conducting a biopsy to rule out or diagnose malignancy/PG.
- Treat symptoms until investigations provide more diagnostic information.

ACUTE WOUNDS

Presenters: Leah MacDonald, Jack Rasmussen, Sheila Moffatt

The session reviewed burns, including what occurs at cellular level. It's essential to determine the extent and degree of the burn and to treat based on these factors. Surgical intervention/debridement is recommended for third degree and non-healing, deep second-degree burns. Tangential excision is a procedure that removes a thin layer of burn tissue and preserves the underlying vital supply such as nerves and blood vessels.

Information was presented on the appropriate use of advanced therapies in wound management, as they can be expensive and may be difficult to implement depending on the clinician's skill, the therapy's availability and the clinic's demographics. However, practitioners can consider some therapies, such as hyperbaric oxygen and electrical stimulation, when other conventional therapies have failed.

In all cases, therapies selected must be appropriate for the wound type. For example, one would not use negative pressure wound therapy on a malignant wound, as the risks of bleeding and rapid tumour growth are high.