Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Wound up for Wounds

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In this issue:

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Wound up for Wounds

Wound up (verb. To be excited) for Wounds (noun. Injuries to living tissue)

Welcome to the November edition of *Wound Up for Wounds.*

The last edition was in February and unfortunately with the publication ban during the provincial election campaign, it was not possible to publish any editions over the summer.

In the February newsletter we presented a wound and had the reader assess it using the Wound Bed Preparation Paradigm, and in this edition we look into options for managing it. This edition looks at critical incident reporting, and we congratulate the newly minted Wound Care Champions at SOGH.

We are delighted to reproduce the message from the President of the International Skin Tear Advisory Panel (ISTAP), Karen Campbell, from Western University about ISTAP's vision of a "world without skin tears". Karen's communiqué also presents the standardized and globally adopted skin tear classification system.

November 20th is World Wide Pressure Injury Prevention Day which coincides with the Prevalence and Incidence study of Pressure Injuries. Thanks in advance to study leaders and team members.

Special thanks to Kristine Schellenberg, RN MN, GNC©, Clinical Nurse Specialist, WRHA Long Term Care Program, for editorial assistance.

Jane McSwiggan, MSc., OT Reg. (MB), IIWCC,
Education and research coordinator, Wound Care

CARING FOR HEALTH

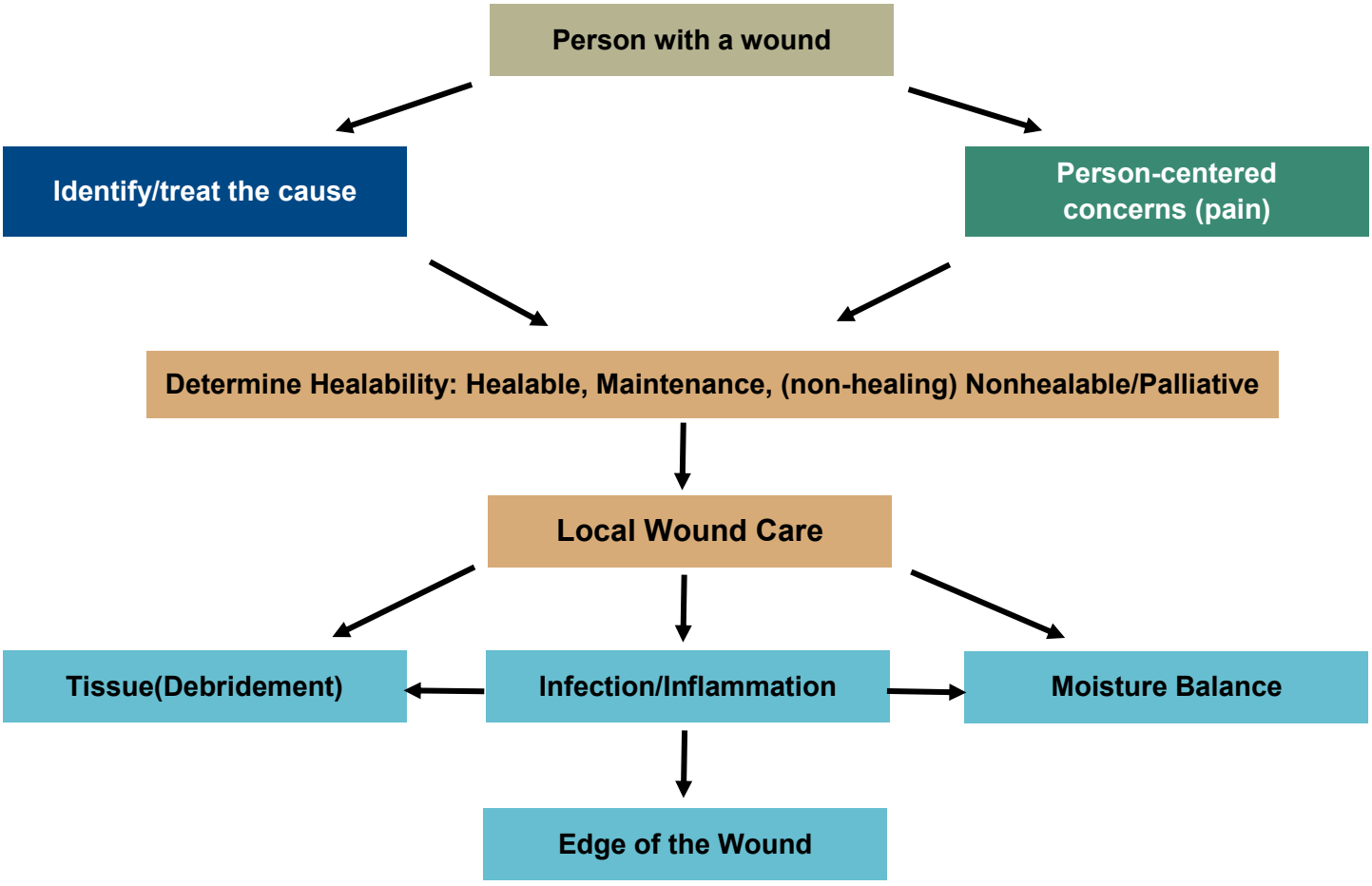
Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Did you know?

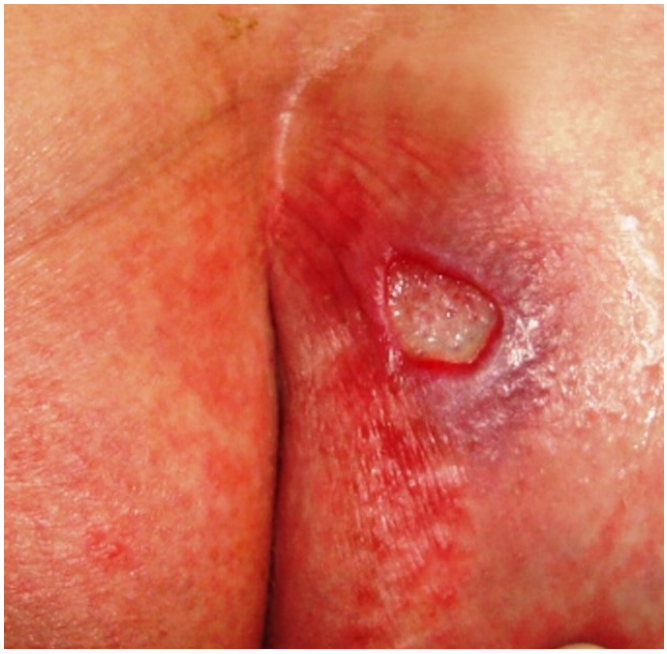
- In Manitoba, stages 3, 4 and unstageable pressure injuries are critical incidents if they meet the criteria.
- Please report using RL6 or call the Critical Incident Reporting and Support Line (24 hours) at 204-788-8222.
- Further information: http://home.wrha.mb.ca/quality/afterreported.php

Wound Bed Preparation: Your Ticket to Success

Wound bed preparation has several steps in the assessment of the wound shown on the next page.



Adapted from: Sibbald, R.G., Elliott, J.A., Ayello, E.A., & Somayaji, R. (2015)



Treat the cause

Is the cause of the wound known, is it treatable?

The periwound skin has erythema. Is it Moisture Associated Skin Damage (MASD), heat related, contact dermatitis, or fungus?

Was wound preventable or not?

This is a Stage 3 Pressure Injury, which could have evolved from a deep tissue injury. Was the person sitting on a deflated or upside-down cushion, or did the skin breakdown due to a deterioration in their condition (e.g. influenza or GI outbreak, exacerbation of existing condition, surgery)? Is there something else identified as the cause?

What contributes to the wound?

- Medical history, medications, nutrition age
- Mobility (ambulation, transfers, bed mobility)
- Incontinent of urine, bowel, or both, and issues with incontinence product, or with changing?
- Are there challenges to off-loading pressure?
- Does the dressing stay on?
- Are the supplies available?

Person-Centred Concerns

What is important to this individual and what do they value in quality of life? (e.g. are they a very social individual and like to sit from morning to evening with no rest, or do they only like to lie on their back and will always move to this position despite attempts to off-load the pressure?)

Has a pain assessment been done, is pain being managed, is it being monitored? How is the pain during dressings/wound cleansing?

Have we consulted OT, PT, and dietitian?

Wound healing requires:

Healability

Is the wound healable? If not healable, the goal would be focused on quality of life which would include managing pain, reducing risk for infection, and not have wound deteriorate further.

Local Wound Care (Wound Assessment)

Tissue: 10% granulation, 90% slough

Debridement: Slough needs to be debrided

Infection/Inflammation: Look for signs of superficial (3 or more NERDS) or deep/ surrounding infection (3 or more STONEES)

Non-healing
Exudate
Red friable tissue
Debris
Smell

Size increasing
Temperature elevation
Os (probes to bone)
New areas of breakdown
Exudate
Edema, Erythema
Smell

Moisture Balance:

- Is the wound highly exudating?
- Can moisture be managed?
- Do multiple layers under the person create moisture and/or heat?

Edge of Wound:
The wound edges are attached and currently there is no depth, undermining, or tunneling.

What are options for dressing this wound?

As with all things wound-wise, the answer is found in your wound assessment.

Tissue type and debridement (T/D):

Assessment found 90% slough and 10% granulation tissue. In a healable wound the slough needs to be debrided to create a clean wound bed.

- Irrigation to cleanse wound
- Autolytic debridement using a dressing

Infection/Inflammation:

NERDS vs. STONEES, will tell you whether there is a superficial or a deep and surrounding wound infection. Do you need a topical antimicrobial or a topical antimicrobial and a systemic antibiotic?

Moisture Balance:

You are aiming for a wound that has the same level of moisture as your eye

- If slough is dry and little exudate, may consider a hydrogel* to help moisten the slough and promote debridement (monitor regularly to ensure does not get macerated).
- If there is no local infection, but moisture needs to be managed, then using a hydrophilic* dressing may be a good option (as long as no allergy to zinc).
- If the wound is too moist or has a local infection, then an topical antimicrobial* applied to the slough would help with moisture management and manage the local wound infection.

Edge of the wound:

Examine the periwound, and use caution in the choice of a cover dressing, to ensure that further trauma or pain is not caused.

- The wound edges are attached and currently there is no depth, undermining, or tunneling at this point, so we know that packing is not needed
- Choosing the right cover dressing will depend on amount of exudate, so bordered foam* is one of the considerations.

WRHA formulary trade-names of products with *

Hydrogel: Intrasite™ gel

Hydrophilic: Triad™

Antimicrobial: Bactigras™ INADINE™ : Iodosorb™:

Note Acticoat ™ is also an antimicrobial dressing, it should be used in consultation with an Advanced Wound Care Clinician

Bordered Foam: Mepilex® Border; Tielle™ adhesive foam dressings (use with caution on fragile skin)

Lanyard card for wound assessment

(Print, cut out and laminate)

Wound Assessment		NERDS
Identify/Treat the cause		(≥3 antimicrobial dressing, no swab)
Person-centred concerns & pain		**N**on healing wound
Healable, Maintenance, Non-Healable?		**E**xudative wound
T/D:	Type of tissue?	**R**ed, friable granulation tissue
	Need for debridement?	**D**ebris (slough/eschar)
I:	Infection/Inflammation	**S**mell or unpleasant odour
	NERDS or STONEES?	**STONEES**
M:	Moisture Balance, not too wet, not too dry	(≥3 antimicrobial dressing, swab, abx)
E:	Edge of wound & peri-wound skin	**S**ize is bigger
		Temperature is Increased
		Os (probes to bone)
		New or satellite areas of breakdown
		Exudate,
		Erythema, edema
		Smell or unpleasant odour

Wounds Canada Spring Conference is in Calgary at the Calgary Plaza Hotel and Conference Centre, April 3-4, 2020. Early bird registration is already open

Congratulations to Seven Oaks General Hospital Wound Care Champions

By Adrienne Pearson RN, BN, ET, SOGH Skin and Wound Consultant, Inpatients

From left to right: Henni Dyck (Program Director Renal Health), Gloria Duncalfe, Kirsten Morris, Nicolle Orsulak (Renal Program Champions), Lori McKenzie (Skin and Wound Consultant, Renal Health), Carol Hapko (Family Medicine), Adrienne Pearson (Skin and Wound Consultant, Family Medicine), Gail Marcaida, Mike Rattai-not pictured (Family Medicine staff).

SOGH would like to congratulate Gloria Duncalfe, Kirsten Morris, Nicolle Orsulak, Carol Hapko, Gail Marcaida and Mike Rattai who have completed their Wound Care Champion Mentorship.

In the fall of 2018 SOGH refreshed its Wound Care Champion Program. The recruitment process was initiated with an information session entitled “Become a Wound Care Champion”. Feedback from this session guided the decision to host WRHA “Practice Days: Wound Assessment and Dressing Selection” and three of the WRHA Level 2 Wound Care Courses in our facility. Interested staff completed a mentorship agreement with the wound and skin consultants. The Agreement included mentoring objectives and a plan of activities to achieve their personal learning goals.

On October 17th the champions were awarded certificates and pins to celebrate their completion of the Wound Care Champion Mentorship Program. These champions are excellent resources for their peers and advocates for optimal wound management.

The intent of the mentorship experience is to assist the potential champions with identifying and guiding their self-directed educational experience with wound care. Participants engaged in various hands-on experiences and interactions with the skin and wound consultants at SOGH. The average mentorship was approximately one year in length. Graduates conveyed very positive comments as a result of their mentorship, expressing an increase in their confidence level regarding wound assessment and management.

Moving forward we plan to build further capacity through mentoring additional Wound Care Champions, with an eye to ensuring wound care champions are available resources in each of our clinical programs. If you would like further information or assistance with establishing a Wound Care Champion Program in your facility please contact Adrienne Pearson at (204) 632-3108 apearson2@sogh.mb.ca or Lori McKenzie at (204) 632- 3567 lmckenzie@sogh.mb.ca

Delving into Critical Incidents (CI) and Wounds

Policy and Procedures
The WRHA policy titled *Critical Incident Reporting and Management* (10.50.040) addresses critical incidents and how to report them. The policy fulfills the responsibilities as outlined in the Regional Health Authorities Amendment Act, the Manitoba Evidence Amendment Act and the Manitoba Health policy pertaining to critical incidents and disclosure of critical incidents.

Definition
A critical incident is an unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that:

- is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital, or unusual extension of a hospital stay, and;
- does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

Examples of critical incidents

- A wrong-side surgery
- A wrong medication administered causing death
- A stage 3, 4 or unstageable pressure ulcer

Reporting a Critical Incident
Staff with access to RL6: Risk may report a Critical Incident through RL.
Anyone may report a Critical Incident by calling the WRHA Critical Incident Reporting and Support Line (CIRSL), 24 hours a day, 7 days a week at 788-8222**.** Callers who choose to may report anonymously.

What happens after I report a critical incident?

- By law, a facility, program or area representative will ensure that appropriate disclosure to the patient and/or family members occurs.
- An individual will be designated to provide ongoing contact and support for the patient and family members as appropriate
- A Critical Incident Review Committee (CIRC) is named to review the critical incident and make recommendations as appropriate, in concert with the site/program leadership.
- A written report of the CIRC review is provided to the senior leader of the facility, program or area, as well as to Manitoba Health.

For more information about critical incidents see the WRHA website at http://www.wrha.mb.ca/healthinfo/patientsafety/criticalincident/index.php.

Additional Information

Having trouble signing up for wound care courses?

Staff with LMS access

Log into the Learning Management System (LMS) from any computer or device at https://manitoba-ehealth.learnflex.net.

If needed, create a new account by clicking “new User”.

Enter “**WOUND CARE**” in the global search bar.

- Level 1 is a bundle of 8 modules available online;
- Level 2 and other courses are delivered in the classroom setting.

Staff without LMS access

Contact Cindy Hoff at choff@wrha.mb.ca or 204-926-7047 to register.

Have a question?

Contact Jane McSwiggan, Education and Research Coordinator-Wound Care at jmcswiggan@wrha.mb.ca.

Upcoming Wound Care Courses

The slate of courses for 2020 is being developed, check LMS by end of November.

ISTAP COMMUNIQUÉ

Message from the ISTAP President

The year 2020 will be important in the life of ISTAP in fulfilling our vision of a “world without skin tears”. We have established a formal governance structure, set up working committees to conduct the work of the board and are working on initiatives to improve the global awareness of skin tears. The ISTAP Board meets regularly in order to discuss our objectives and to evaluate our progress vis a vis our strategic plan. The ISTAP Board works diligently to make decisions about ISTAP’s key priorities and to find answers to other important questions related to ISTAP’s mission and operations.

It is satisfying to note that the number of healthcare professionals who have registered to join ISTAP continues to grow around the world. In order to keep you up to date, we have developed this electronic ISTAP Communique in order to keep you informed of key highlights related to skin tears in relation to education, research, participation at events and related news. We are working on “Building Blocks for the Future”. Now we need to take these blocks and build upon them with new opportunities and take the ISTAP to the next level. I look forward to working on this endeavor with all of you.

Karen Campbell, PhD, MScN, BScN, NSWOC, RN

President, ISTAP

Adjunct Professor, MClScWH, Western University, London, Ontario

Global Validity and Reliability Testing of the ISTAP Skin Tear Classification System

As skin tears are frequently misdiagnosed and underreported, a standardized and globally adopted skin tear classification system, with supporting evidence for diagnostic validity and reliability, is required to allow assessment and reporting in a consistent way. In cooperation with the ISTAP, the Skin Integrity Research Group (SKINT) conducted a two-phase study to evaluate the validity and reliability of the ISTAP Classification System internationally. Phase 1 was a study to validate the content of the ISTAP Classification System through expert consultation in a two-round Delphi procedure involving 17 experts from 11 countries. A definition for the concept of a “skin flap” in the area of skin tears was developed and added to the initial ISTAP Classification System consisting of three skin tear types. Phase 2 included a psychometric evaluation of the instrument using an online survey with 24 skin tear photographs in a convenience sample of 1601 healthcare professionals from 44 countries. The overall agreement with the reference standard was 0.79 (95% CI 0.79-0.80) and sensitivity ranged from 0.74 (95% CI 0.73-0.75) to 0.88 (95% CI 0.87-0.88). The inter-rater reliability was 0.57 (95% CI 0.57-0.57). The Cohen’s Kappa measuring intra-rater reliability was 0.74 (95% CI 0.73-0.75).

The global validation of the ISTAP Classification System is a major step forward towards a more systematic assessment and reporting of skin tears in clinical practice and research. The ISTAP Classification System seems to be a valid, reliable, and easy-to-use tool for classifying skin tears according to their severity level. The ISTAP tool is available in 15 languages, which may enhance global implementation (https://www.skintghent.be/en/onderzoek/Tools/4/skin-tears).

Please keep an eye on the ISTAP website to learn more about the publication!

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