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

I would like to give this edition the subtitle “Doing great things in difficult times”, which has been inspired by the team of nurses and physicians in Flin Flon General Hospital who successfully tackled a very large wound caused by lymphedema. Kristi Burke has written from her heart on how the onset of COVID-19 inspired her team to collaborate, and become empowered through education and acquisition of solid wound assessment and management skills.

Now more than ever we need to work in collaborative practice, which according to the World Health Organization, is “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.” This is truly what happened in Flin Flon.

Interprofessional practice requires health care professionals to be mindful of their own scope of practice, and to that end, wound care has policy and evidence informed practice tools for guidance.

I encourage everyone to review the Wound Care Policy (WRHA 110.000.320) as it relates to wound care competencies, consultation with Advanced Wound Care Clinicians and specialists. Time is very precious and in short supply, so using the Wound Bed Preparation Paradigm to inform dressing selection and using an advanced wound care dressing that can stay on for several days where possible, will decrease your workload.

Get to know your Advanced Wound Care Clinicians and consult with them (after you have a wound assessment completed). This edition features bios on Adrienne Pearson and Tara Schmitz-Forsyth of Seven Oaks General Hospital and Riverview Health Centre respectively.

Stay safe and keep in touch.
Jane McSwiggan, MSc., OT Reg. (MB), IIWCC,
Education and Research Coordinator, Wound Care, WRHA

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

Practice Corner: Scope of practice for nurses and wound care

The three nursing colleges have collaborated to provide a statement regarding wound care and scope of practice for nurses. Autonomously performing a wide range of nursing interventions that promote, maintain, and restore health, including wound assessment and intervention are entry-level competencies for LPNs, RNs, and RPNs (nurses) in Manitoba. Nurses in Manitoba have the foundational knowledge required to undertake further education in the care of more complex wounds. Nurses must be qualified and competent in their area of practice. All three nursing regulators have expectations that nurses are compliant with employer policies and expectations for education.

Deb Elias RN MN FRE Chief of Quality Practice, College of Registered Nurses of Manitoba

Brenda Wohlgemuth LPN BA Consultant, Education Program Evaluation, College of Licensed Practical Nurses of Manitoba

Ryan Shymko, RPN BA MA Practice Consultant/Deputy Registrar, College of Registered Psychiatric Nurses of Manitoba

Wound Care Resources

Did you know? The Evidence Informed Practice Tools - Clinical Practice Guidelines for Wound Care can be found on the WRHA website at:

- https://professionals.wrha.mb.ca/old/extranet/eipt/EIPT-013.php

We are aware that some need updating, so other great resources are:

- **Skin and Wound Community of Practice (BC)**

  https://www.clwk.ca/communities-of-practice/skin-wound-community-of-practice/

- **Wounds Canada**

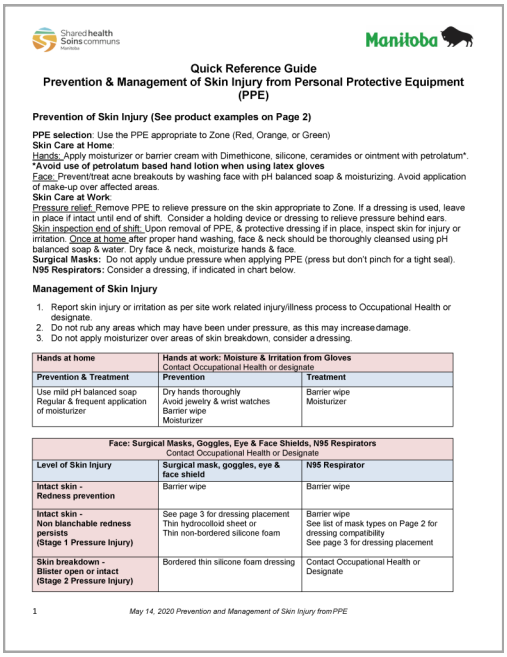
  https://www.woundscanada.ca/index.php?option=com_content&view=article&id=110&catid=12&Itemid=724

  https://www.woundscanada.ca/health-care-professional/education-health-care-professional/webinars

Prevention & Management of Skin Injury from PPE

This **Quick Reference Guide** (link below) was developed by Kari Mann, CNS for Skin and Wound at HSC Winnipeg, and Jane McSwiggan Education and Research Coordinator, WRHA, in response to the development of staff skin injuries from the use of personal protective equipment (PPE) being worn on the face and irritation to hands from gloves.

https://sharedhealthmb.ca/files/covid-19-ppe-skin-injury-qrg.pdf



Quick Reference Guide
Prevention & Management of Skin Injury from Personal Protective Equipment (PPE)

Prevention of Skin Injury (See product examples on Page 2)

PPE selection: Use the PPE appropriate to Zone (Red, Orange, or Green)
Skin Care at Home:
Hands: Apply moisturizer or barrier cream with Dimethicone, silicone, ceramides or ointment with petrolatum*.
***Avoid use of petrolatum based hand lotion when using latex gloves**
Face: Prevent/treat acne breakouts by washing face with pH balanced soap & moisturizing. Avoid application of make-up over affected areas.
Skin Care at Work:
Pressure relief: Remove PPE to relieve pressure on the skin appropriate to Zone. If a dressing is used, leave in place if intact until end of shift. Consider a holding device or dressing to relieve pressure behind ears.
Skin inspection end of shift: Upon removal of PPE, & protective dressing if in place, inspect skin for injury or irritation. Once at home after proper hand washing, face & neck should be thoroughly cleansed using pH balanced soap & water. Dry face & neck, moisturize hands & face.
Surgical Masks: Do not apply undue pressure when applying PPE (press but don't pinch for a tight seal).
N95 Respirators: Consider a dressing, if indicated in chart below.

Management of Skin Injury

1. Report skin injury or irritation as per site work related injury/illness process to Occupational Health or designate.
2. Do not rub any areas which may have been under pressure, as this may increase damage.
3. Do not apply moisturizer over areas of skin breakdown, consider a dressing.

Hands at home	Hands at work: Moisture & Irritation from Gloves Contact Occupational Health or designate	
Prevention & Treatment	**Prevention**	**Treatment**
Use mild pH balanced soap Regular & frequent application of moisturizer	Dry hands thoroughly Avoid jewelry & wrist watches Barrier wipe Moisturizer	Barrier wipe Moisturizer

Face: Surgical Masks, Goggles, Eye & Face Shields, N95 Respirators Contact Occupational Health or Designate		
Level of Skin Injury	**Surgical mask, goggles, eye & face shield**	**N95 Respirator**
Intact skin - Redness prevention	Barrier wipe	Barrier wipe
Intact skin - Non blanchable redness persists (Stage 1 Pressure Injury)	See page 3 for dressing placement Thin hydrocolloid sheet or Thin non-bordered silicone foam	Barrier wipe See list of mask types on Page 2 for dressing compatibility See page 3 for dressing placement
Skin breakdown - Blister open or intact (Stage 2 Pressure Injury)	Bordered thin silicone foam dressing	Contact Occupational Health or Designate

1 *May 14, 2020 Prevention and Management of Skin Injury from PPE*

In consultation with Occupational Health and Safely, it was determined that N95 respirators could be fit tested with thin and flexible interface dressings which easily conform to the face, to see if a seal can be achieved. Please review the **Quick Reference Guide** carefully for the list of N95 respirators have been fit tested quantitatively using Portacount Pro Plus model 8038. It is important to note that a if respirator did not seal with a dressing it also did not seal without a dressing therefore a different model of respirator hasto be fitted.

Please click the link below to view the poster **PPE - Tips for Prevention of Skin Injury**.

https://sharedhealthmb.ca/files/covid-19-ppe-skin-injury-poster.pdf

Important

- Contact Occupational Health Designate for work related skin conditions
- Check the seal each time an N95 respirator is applied by performing a user seal check.

World Wide Pressure Injury Prevention Day: November 19th

Join a challenge to all our teams from Marlene Varga Clinical Nurse Specialist, Pressure Injury Prevention, at Covenant Health in Edmonton to wear a red shirt on November 19th.

See National Pressure Injury Advisory Panel (NPIAP) website for Pressure Injury Resources:

https://npiap.com/page/Resources

Our Wound Care Journey in Northern Manitoba

By: Kristi Burke, RN, Best Practice Educator for Acute Care, Flin Flon General Hospital, Northern Health Region

As a 'seasoned' nurse, wound care was, dare I say, just a regular part of our nursing care. You remove a dressing, assess the wound, cleanse with normal saline, and apply a new dressing as ordered. This was the usual routine for years. The odd time an educational opportunity came up regarding wound care, but it did not change our practice.

The structure of nursing back then, in this small northern hospital, was also not as it is today. There were no Best Practice Educators or Clinical Resource Nurses to equip frontline nurses with the information and tools they needed to stay up to date with ever evolving wound care. It was also a rare occurrence that someone had a colleague in the city to consult with regarding wounds.

Things changed for us in the spring of this year. We were faced with a very complex wound that challenged our 'usual' practice of wound care. A client was admitted to us with a very large, chronic lower leg ulcer that was in quite an exacerbated state. The nursing staff, old and new, had never seen anything like this before. By the time I got involved in the care, the charge nurse of the medical floor had reached out to the Education and Research Coordinator –Wound Care, Jane McSwiggan in Winnipeg. The client had already finished a course of IV antibiotics but unfortunately there was no real change in the wound yet.

Ironically, due to COVID-19, we were able to communicate as a team, including the physician, via Microsoft Teams, in addition to email and telephone calls. With the client's permission, we were also able to do Facetime calls. This way we collaborated at dressing changes and the client was able to be part of the conversation, and part of learning and planning of her care. Jane assisted the nursing staff, especially myself, in applying best practice to wounds.

The most important step to wound care that has helped change our practice is: what type of wound is it and what is the cause of the wound? **“You cannot effectively treat the wound if you do not know the cause of the wound”**. That statement will forever be engrained in my nursing brain. I have used that statement numerous times now when asked to help address new wounds. Not only to keep my train of thought in the right direction, but to get the frontline nurses engaged in the critical thinking of wound care.

It was obvious to all that the client had severe lymphedema of the legs. But now we were able to connect that this lymphedema caused impaired circulation which in turn was causing this chronic leg ulcer. Our priority was to now treat the lymphedema. Jane was able to put us in touch with Martina Reddick, RN and Lymphedema Specialist, as well as our 3M industry partner, Lynne Perkins. Those additional contacts were vital going forth, and they were also with us to the end of our journey with this client.

The next big step was to get nursing staff trained in Coban 2 compression dressing application. In the past,this training was done in person/hands on. But in the middle of a pandemic we had to figure out how to get this training available to the staff in northern Manitoba.

With the coordination of Jane and Lynne Perkins who is the one that usually comes to do the training in person, we were able to arrange several sessions virtually for staff to attend. Nurses were able to hear the presentation, watch videos, and take part in conversation and ask questions. Coban 2 sample products were shipped to us for staff to be able to do the hands on practice of applying the compression wraps. With some fancy positioning of the cameras and the staff Jane and Lynne were able to witness the staff performing this. I was present at every session as well to help guide the staff during the hands on practice. I feel that this set up was a success and feedback from staff was positive.

...continued on next page.

Our Wound Care Journey in Northern Manitoba Cont.

With the Coban 2 compression wrap skill set now in our tool box we were able to begin 'treating the cause' of this chronic lower leg ulcer. We were seeing improvements with wrapping the affected leg and were able to convince the client to have both legs wrapped to treat her lymphedema.

Now that we were well on our way with step #1 of wound care, treat the cause, it was time to refocus on the wound again. **We learned that as the wound changes, so will the purpose of the dressing.** Using the knowledge that we had gained, reference tools we acquired, and the input from our contacts, we were able to deal with the exudate, odor, maceration of surrounding skin, eschar, slough, etc. by reassessing the wound and responding to the changes in the wound.

As health care providers, our goal of care is to see positive outcomes as a result of the interventions we perform. As much as we would like them to be instant results, we know this is not always the case. It was quite impressive how the staff were able to grasp the concept of how long our journey was going to be in healing this wound. They were all instrumental in educating the client about the care of her wound and keeping her motivated on her long journey with us.

The client was with us for just over three months. In that time we were able to help her achieve a weight loss of over 100lbs, reduce the lymphedema to both her lower legs drastically, and heal the wound down to 1/4 of its original size. Once getting her to that point she was able to be transferred back home to her community where home care continued to deal with the lymphedema and the wound.

Things in our small town, northern hospital look completely different now than they did years ago.

The implementation of Clinical Resource Nurses for each ward, and now a Best Practice Educator for the hospital results in staff having more support with challenges in patient care. As Best Practice Educator, I want to make sure the nursing staff have the tools and resources they need to be confident and successful. And now with my new found passion for wound care, I want make sure staff have what they need to give the best wound care possible.

Resource binders have been created for each ward, opportunities for webinars and presentations have been shared, and articles on wound care have been sent to them to read. All nurses have been strongly encouraged to complete the Level 1 Wound Care, available to us via Digital Health LMS. Then more opportunities for them to obtain the Level 2 certification will be arranged.

A more diverse array of dressing products have been ordered so the staff are able to deal with any wound.

The most important tool we now have is our valuable contacts in Winnipeg. The ability to reach out to wound care experts was the first crucial step to changing our course of wound care. Wound care in our remote, northern hospital has now been forever changed. A huge thank you goes out to Jane McSwiggan for being part of that change. With her facilitation, guidance, and advice, the nursing staff, as well as myself, are now a little more confident in approaching wound care.

And the journey continues…….

Note from Jane

Thank you so much Kristi for your kind words. The practice change that your team embraced occurred because of the team's commitment to excellence patient care and the fact that you stopped at nothing to make that happen. There were so many moments in the care of this client that were pivotal:

1. We had to design a treatment regime that did not require frequent dressing changes as Coban 2 had to be applied each time the wound was dressed. The client had a large and heavy limbs with skin lobules and folds so it was a very labour intensive process. It was important to ensure that there were no staff injuries during dressing changes and application of Coban 2.
2. Nurses and physicians learned that the overwhelming amounts of slough and eschar that the wound was producing were a function of the healing process and occurring in a setting of perfusion therefore we were able to guide the physicians to employ sharp debridement techniques.
3. The client had to be involved at all stages of the process and at times we needed to be somewhat strategic when she became discouraged. Martina Reddick's involvement and ability to speak to the client directly over FaceTime became one of those strategies as we drew upon her immense experience in treating Lymphedema to be a cheerleader for the client and the team.
4. Increases in exudate and slough do not mean that the wound has a deep and surrounding infection. I would echo Kristi in saying that this wound was not showing signs of cellulitis, but increases in slough mistaken for pus and exudate prompted a request to swab the wound (when Kristi was not there to catch it). As you can imagine the swab of the slough was not very helpful. Unfortunately for the patient the discussion about wound infection was very upsetting, and required a great deal of effort by Kristi and her colleagues to reestablish the patient's trust in the team's ability to heal her wound. We went back to the basics of assessment of infection using NERDS and STONEES, to find that it was a NERDS (superficially infected) wound, which was treated by adding back a regime of Cadexomer Iodine and absorbent secondary dressings.

The team in Flin Flon are absolute rock stars, they consult when they don't know the answer and over the last few months I have had them liaise with other Advanced Wound Care Clinicians with wounds that I do not have the skill to advise on. It has been an absolute pleasure to see this team grow and flourish.

Thank you to Martina Reddick who was available for advice and support to the staff and to Lynne Perkins from 3M who ensured that there was product quickly available for treatment and who ran the education sessions for compression wrapping.

New Tools for your Toolkit

Evidence Informed Practice Tool

Preventing Medical Treatment Related Skin and Tissue Injuries in Adults and Children

https://professionals.wrha.mb.ca/old/extranet/eipt/files/EIPT-071.pdf

Pressure Injury Prevention Infographic

Thank you to Jenessa and Judy for creating an infographic to increase awareness about prevention of Pressure Injuries. https://professionals.wrha.mb.ca/files/collaborative-care-pressure-injury-prevention-day.pdf

Meet your Advanced Wound Care Clinicians

Adrienne Pearson, RN,BN, ET, CLT

Adrienne Pearson, RN,BN, ET, CLT
Seven Oaks General Hospital

I have been a Skin & Wound Consultant at Seven Oaks General Hospital (SOGH) since 2012. In 2010 I became a certified Enterostomal Therapist, with training in Ostomy, Continence and Wound management. I am certified in Conservative Sharp Wound Debridement and this spring I obtained my Certification in Lymphedema Therapy. I am an active member of the Regional Wound Care Team.

My role at SOGH has been most fulfilling in providing excellence in wound management, as well as educating and mentoring staff members. I am pleased that SOGH is making great gains in our Wound Care Champion Program. This is a rewarding mentorship and training program, which allows me to mentor health care professionals and provide them with advanced knowledge and skill in wound prevention and management. We have had OT's and nursing participate in the program so far, with excellent feedback and benefit to our patient sand staff.

This spring, I was awarded the Seven Oaks Health Promotion and Wellness Bursary, in part to enhance current practices in lymphedema management. I believe this new training will have benefits for clients, their quality of life, as well as being a resource for our region regarding best practice management and risk reduction for lymphedema. This training has already had positive impacts and benefits for patients affected by lymphedema, at SOGH.

I intend to use my specialized lymphedema training to impact change and awareness regarding lymphedema management. My hope for the future is to advocate for increased provincial funding for lymphedema management in Manitoba.

Tara Schmitz Forsyth RN MN CVAA©

Tara Schmitz Forsyth RN MN CVAA©
Riverview Health Centre

Tara is a Clinical Nurse Specialist at Riverview Health Centre, and has been in the role for just over a year. In 2012, her interest in wounds led her to become curious about Advanced Practice Nursing and she decided to enroll in the Master of Nursing Program at Athabasca University with a focus on the CNS role. She earned her Master of Nursing degree in 2018. Tara has two clinical passions; vascular access and wounds. She spent 13 years working in a Home Care program that fostered these interests. She is certified in advanced debridement and is the Co-Chair of a Regional Committee tasked to develop an education program supporting the development of debridement theory and skill. Tara is part of a small regional team of wound care professionals focused on education for limb salvage in the diabetic patient. The team has been invited to support learning opportunities to both emergency physicians and this year to family practice physicians. In her current role as a CNS, she has developed interests in the care of palliative wounds and pressure injury prevention. Tara was one of two regional wound care scholarship recipients this year and is excited to have just registered for the International Interprofessional Wound Care Course.

Introducing Jenessa and Judy: Student Occupational Therapists

I (Jane) have the great pleasure of being an educator for Jenessa Spencer and Judy Dang who are second year student Occupational Therapists. Like many others, Jenessa and Judy faced several challenges since the pandemic began in March 2020. They quickly adjusted to Zoom lectures, learned that Zoom fatigue was unpleasant and had to confront a lot of uncertainties with the continuation of their program. In addition, they learned that their Intermediate 1 fieldwork placements from May to June were being postponed to a later date as the pandemic was still in its infancy. During this time, they adjusted to second year course material and learned new skills from their faculty.

Skin Colour Awareness and Skin Assessment

Jenessa Spencer

To be honest, prior to this placement I had not spent a lot of time thinking about different kinds of wounds or pressure injuries, unless brought up in class when discussing wheelchair seating. This placement with Jane McSwiggan, has opened my eyes to the prevalence of pressure injuries, and the other numerous kinds of wounds that patients may develop.

In discussing pressure injury assessment, prevention and treatment with Jane, the topic of skin colour arose and the challenges of recognizing pressure injuries as skin tone becomes darker. These challenges are often specific to stage 1 and deep tissue pressure injuries, as pressure injuries on darker skin present differently when there is no open wound.

There are very few resources available for assessing patients with darker skin tones for stage 1 and deep pressure injuries, therefore I developed a set of images and tips for techniques on assessing and staging these injuries.

Jenessa Spencer

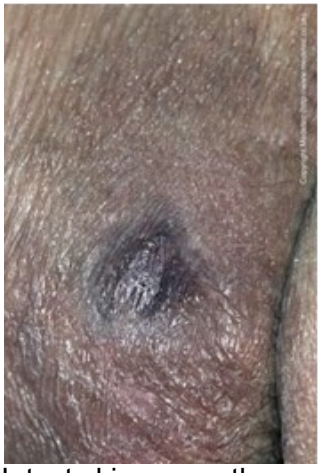
Second year Master of Occupational Therapy Student, U of M

Skin Colour and Assessment Tips	
Education	**Lighting**
Refer to images of stage 1 and deep tissue pressure injuries characteristics on darker skin tones.	Use adequate room lighting. Use pen lights, or handheld mirrors with lights for increased lighting.

Look	**Listen**	**Feel**
Conduct a thorough assessment by doing a full body skin inspection Remember to check in between folds and creases.	Listen to your patients, residents or clients' complaints of pain or discomfort which may be a sign of pressure injury development	Feel skin for bogginess, induration and warmth, as it is uncommon that darker skin tones will blanch. Stage 1 and deep tissue pressure injuries are often painful - make sure to ask about pain on assessment

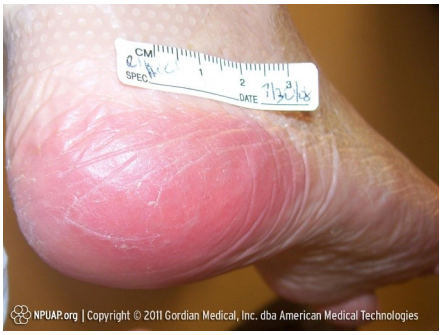
Assessment Characteristics for Darkly Pigmented Skin vs. Lightly Pigmented Skin

Stage 1 Pressure Injury



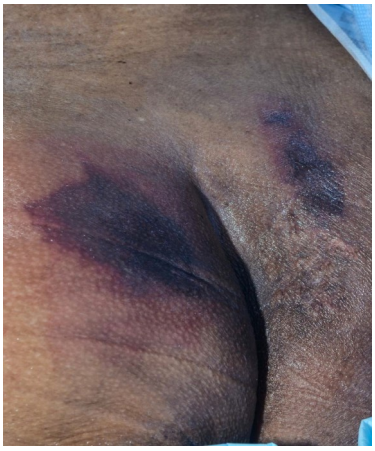
- Intact skin, no erythema
- Appears as purple/bluish discolouration
- Assess for:
  - ◊ localized heat/coolness
  - ◊ edema
  - ◊ induration (firmness)
  - ◊ pain
- Offload area

Stage 1 Pressure Injury



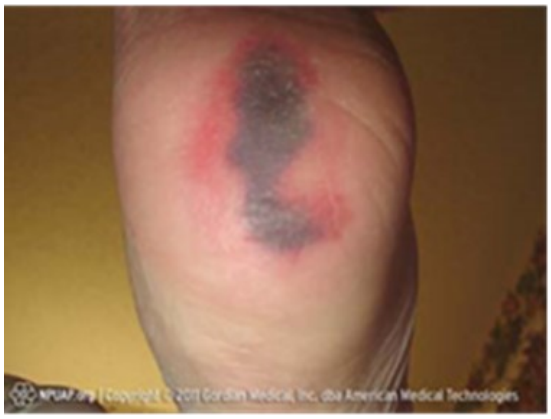
- Intact skin with erythema
- Skin does not blanch with applied pressure
- Assess for:
  - ◊ localized heat/coolness
  - ◊ edema
  - ◊ induration (firmness)
  - ◊ Pain
- Offload area

Deep Tissue Pressure Injury



- Persistent maroon/purple discolouration
- Assess for:
  - ◊ Edema
  - ◊ Firm or boggy consistency, differing from surrounding skin
  - ◊ Warm or cool temperature, differing from surrounding skin
  - ◊ Blood filled blister (intact or ruptured)
- Offload area
- Identify stage if wound evolves

Deep Tissue Pressure Injury



- Persistent, non-blanchable area of redness
- Assess for:
  - ◊ Edema
  - ◊ Firm or boggy consistency, differing from surrounding skin
  - ◊ Warm or cool temperature, differing from surrounding skin
  - ◊ Blood filled blister (intact or ruptured)
- Offload area
- Identify stage if wound evolves

Introducing Jenessa and Judy: Student OTs cont.

Opportunities for Growth

Judy Dang

Judy Dang

Second year Master of Occupational Therapy Student, U of M

As a second-year student occupational therapist at the University of Manitoba, I am pleased to work alongside Jenessa Spencer and Jane McSwiggan for the six next weeks for our intermediate one fieldwork placement. Before starting fieldwork, I was informed my original fieldwork placement could no longer take me in as a student. Fortunately, Jane was able to provide Jenessa and I with a wonderful placement. This is a unique experience from the traditional role of occupational therapy I have experienced in the past. I am learning about her role within the corporate setting at the WRHA in the Nursing Initiatives portfolio.

The unexpected placement change has encouraged me to transform these difficult times into opportunities for growth. Quickly switching into different placements has enhanced my ability to be flexible. In addition, it also has provided me more opportunities to work with stakeholders such as Quality Improvement and Patient Safety (QIPS).

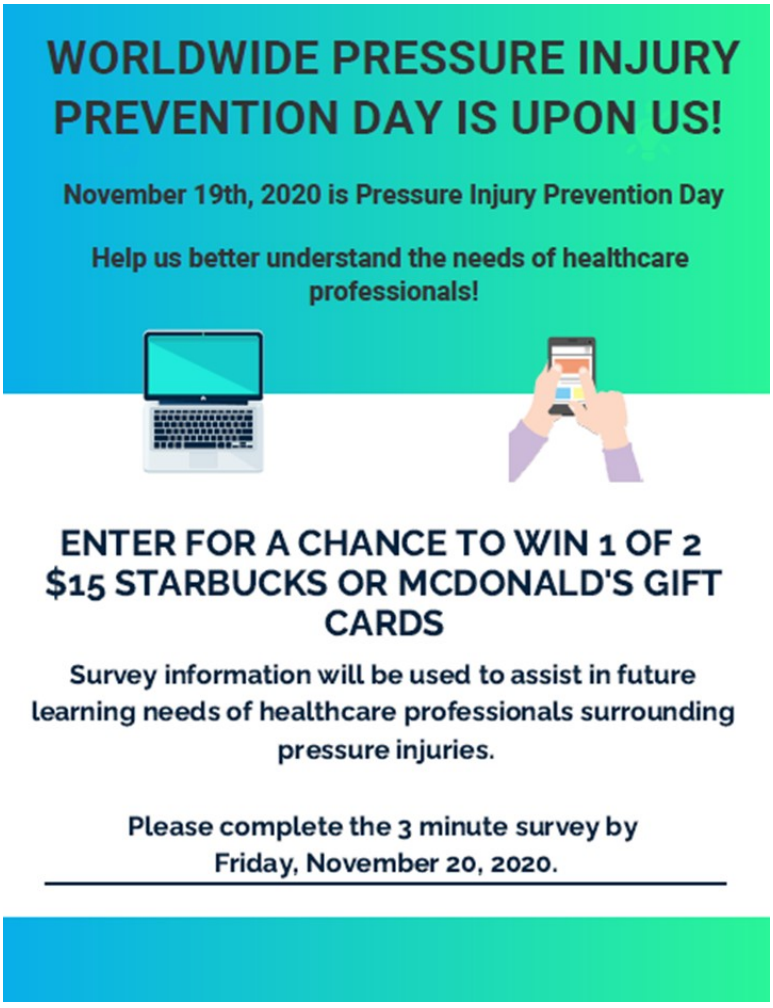
The discussions with QIPS revolve around prevention of pressure injuries, as there has been an increase of complex and sicker patients in the healthcare system and, unfortunately, more skin injuries especially related to medical devices such as cast boots and knee immobilizers.

In response to these issues I have begun conducting projects that include a needs assessment of healthcare professional knowledge related to staging pressure injuries, including educational requirements.

https://www.surveymonkey.com/r/M98VQX5

Please assist me in this process by completing this short survey by Friday November 20th 2020, You could win one of two $15 gift cards to Starbucks or McDonalds by entering the competition.

Based on this information I will be developing tools to enhance knowledge translation regarding pressure injuries in creative ways.



Education Opportunities

November 19, 2020 2:00 – 4:00 pm EST | Register for this session at: https://bit.ly/36TGjUT

Skin and Wound Care Virtual Workshop Series:
Prevention and Management of Pressure Injuries

Speaker:

Laurie Goodman, RN
Toronto, Ontario

Objectives:

- Define pressure injury and identify intrinsic and extrinsic factors that increase a risk for pressure injury development
- Accurately stage pressure injuries using the National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Classifications
- Review of wound bed preparation, signs and symptoms of a wound infection
- Identify categories of wound dressings and professional skin care products that may be used to manage pressure injuries

November 24, 2020 2:00 – 4:00 pm EST | Register for this session at: https://bit.ly/3jDRHrr

Skin and Wound Care Virtual Workshop Series:
Lower Limbs Management

Speaker:

Laurie Goodman, RN
Toronto, Ontario

Objectives:

- Identify and understand risk factors for lower limb ulcers, edema and lymphedema
- Discuss management strategies for Edema and Lower Leg Ulcers
- Identify the form and functions of compression wrapping for management of Lymphedema

November 26, 2020 2:00 – 3:00 pm EST | Register for this session at: https://bit.ly/2GKm0OA

Skin and Wound Care Virtual Workshop Series:
Proactive Wound Care Management: Practicing Proactive Wound Care

Speaker:

Laurie Goodman, RN
Toronto, Ontario

Objectives:

- Examine why the best wound care approach might be a proactive one
- Review the benefits of Negative Pressure Wound Therapy (NPWT) and the published data on early vs late initiation of NPWT
- Explore the role that collagen and Oxidized Regenerated Cellulose (ORC) can play in managing inflammation

WRHA Scholarship Recipients

Congratulations to Tara Schmitz Forsyth from Riverview Health Centre and Nicole Johnson from St. Boniface Hospital who each received a wound care scholarship to attend advanced wound care training. Wishing you the best of luck with your studies!

Wound Care Course Update

We have not been able to offer a Fall/Winter slate of wound care courses due to COVID-19. We are working on ways in which to deliver education, so hope to update everyone soon.

Level 1 wound care is still available online for **Staff with LMS access**

Log into the Learning Management System (LMS) from any computer or device at https://sharedhealthmb.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;

Have a question?

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

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

Wound *Care*

Arterial ulcers need to be fed

Venous ulcers need to be hugged

Diabetic Foot Ulcers need to be protected

- Tej Sahota

Correction

In the February edition, Lynne Perron should have read Lynn Perrin.