



# Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

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## BP Blogger

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Check out this related back issue - SKIN CARE May 2007

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More information on This and Other Best Practices

- **Contact your Regional LTC Best Practices Coordinator.** They can help you with Best Practices Info for LTC. **Find them at:**
- [www.rnao.org](http://www.rnao.org)  
Click on Nursing Best Practice Guidelines and select LTC BP Initiative
- [www.shrtn.on.ca](http://www.shrtn.on.ca)  
Click on Seniors Health
- **Check out Long Term Care Resources at [www.rgpc.ca](http://www.rgpc.ca)**
- **Surf the Web** for BPGs, resources and sites are listed on pg 2.
- Review back issues of the BP Blogger for related topics [www.rgpc.ca](http://www.rgpc.ca)



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### Myth Busting: Wound Issue

Many chronic conditions compromise skin integrity including diabetes, arterial and venous hypertension, peripheral vascular disease (PVD), and poor mobility. 70% of all wounds occur among older adults. Many changes occur in the aged skin including reduced water content, less fatty tissue, small blood vessel changes, and thinning and drying of skin. The most common wounds are pressure ulcers (bedsores), vascular and neuropathic wounds.

#### Myth 1: Most wounds aren't that serious

An open wound is place for bacteria to enter and infection to start. If left untreated, it can lead to **sepsis** (blood infection). **Sepsis** is serious and can be life-threatening requiring antibiotics. People with diabetes, PVD or poor circulation are at risk of developing wounds on their toes and heels. Foot wounds, when left untreated, may become gangrenous and lead to amputation. Statistically, once a lower limb is amputated due to disease (eg, diabetes), within 3 years, the second limb may be amputated. Always make sure wounds are assessed, appropriately treated and medical conditions are treated.

#### Quick MEC Assessment for Wound Risk (Kohr 2009)

Answer the following questions:

- M:** is the resident MOBILE?      yes/no
- E:** is the resident EATING?      yes/no
- C:** is the resident CONTINENT?      yes/no

If you answered NO to MEC or were unsure:

1. Check for red areas on pressure points
2. Keep heels and buttocks from being "planted" in bed or chair
3. Use gentle touch when moving the resident
4. Inspect mouth and provide oral care
5. Ask for a referral to the dietitian
6. Document and communicate your plan of care
7. Reassess using MEC on a regular basis (every 3 months)

#### Myth 2: All wounds can heal



Unfortunately, not all wounds heal. Health issues such as poor circulation or malnutrition interfere with wounds healing. Residents

"at the end of their life" are in a situation of

#### How to Tell If the Wound is Infected Signs of Infection

Does it . . . . ?

1. **Hurt**  
(new pain, aching, throbbing, burning, etc)
2. **Smell**  
(bad odour, room smells, etc)
3. **Drip**  
(oozing, leaking, or pus drainage)
4. **Heat**  
(feel hot to touch compared to other skin)

(Kohr 2009)

progressive organ failure including skin failure. Their declining health means that wounds most likely won't heal. Palliative wound care can be helpful to manage symptoms, such as wound pain, drainage and odour. Some wounds despite all efforts become chronic wounds and may improve or recur but never fully heal. These chronic wounds are also known as maintenance wounds which means the resident will be living with the wound in its chronic state for many years. Although these chronic or maintenance-type of wounds can be non-healing, it still means that treatments are available to help manage

these wounds. These treatments and approaches need to deal with the wound's main issues such as controlling odour, drainage, or reducing pain.



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[www.rgpc.ca](http://www.rgpc.ca) or [www.shrtn.on.ca](http://www.shrtn.on.ca)

## Myth 4: The more you change a dressing, the better it is

dressing frequently especially when the dressing is intact, there is no infection, drainage or other negative wound changes and the resident's nutrition and wound pain and pressure relief are in place. Chronic wounds do

### When to Swab a Wound (RNAO, 2005)

#### Only if:

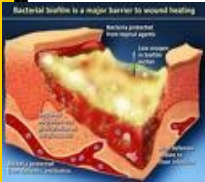
- The wound is getting bigger, not healing, obvious increase in depth;
- when current topical antimicrobial treatment doesn't seem to be working,
- treatment options are pointing to starting systemic antibiotics. Before antibiotics are started, determine the bacteria that is causing the infection so that the appropriate systemic antibiotics can be given.

### How to Swab a Wound

1. Clean the wound with normal saline or sterile water.
2. Look for the cleanest spot in the wound. Ideally a little patch (1cm square) of granulating tissue.
3. Press firmly with the swab tip and rotate it in the exudates that comes up to the surface from beneath the wound when pressed with the swab tip.
4. If the wound is dry, ask yourself...is it infected. If yes and it's dry, consider debridement of the wound.

If you only swab across the top of the wound, you are getting bacteria that is superficial and creates inconclusive results.

## Myth 3: Chronic wounds don't hurt



Research confirms that people find dressing changes to be an extremely painful experience. Don't "yank it off" as this action can cause more damage to the wound and the surrounding skin. Every time the adhesive of is pulled off, it takes some top layer skin cells with it. It's a "big deal" for aged skin which has less moisture, is more fragile and leads to skin stripping and tearing which in turn provides unwanted bacteria an entry point. Avoid using adhesives, and if needed, make sure removal is done with a "lateral pull" to support the skin and break the adhesive bond. Barrier sprays and wipes provide skin protection.

### Pressure Points

Body areas susceptible to skin breakdown and development of wounds

With prolonged sitting or lying in one position, the skin over bony areas is at greater risk of breaking down and developing into a wound. Common body areas are:

Sacrum (tailbone)	Elbows
Heals	Spine
Buttocks (sitting)	Ankle bones
Head: back of head, ears and nose	



There is no scientific rationale for removing a need dressings and currently available dressings (foams, hydrocolloids, hydrofibres,) are designed to be left on intact UNLESS the dressing is saturated or coming off. These newer dressings are designed to support moist environment ("moist like your eyeball") that will heal wounds faster and better than dressings using gauze, tape and changed 1 to 4 times a day. Removing a dressing cools off the wound, rips off fragile new tissue causes pain, slows healing and skin trauma around the wound.. Leave the dressing alone and remember to focus on what the causes are for the wound.

## What Does STAGING Wounds Really Mean?

Stages for Pressure Ulcers were developed by the National Pressure Ulcer Advisory Panel (NPUAP) and have been endorsed within many practice guidelines, BUT what do they really mean?

Staging tells us about the DEPTH of the tissue destruction within the wound

<b>Stage I</b>	Is a reddened area that stays red even when the pressure is relieved
<b>Stage II</b>	Is a shallow open ulcer with a red pink wound bed, into but not through the dermis; can also be an intact or open fluid filled blister
<b>Stage III</b>	Has full thickness tissue loss. No tendon/muscle/bone visible, but often subcutaneous fat is evident. Slough may be present but can still visualize depth of wound/tissue loss. Undermining or tunnelling may be present.
<b>Stage IV</b>	Is an open wound where the base of the wound can't be seen because of fibrinous yellow/gray slough or black leathery "eschar" scab
<b>Suspected Deep Tissue Injury</b>	Is a wound that is a dark purplish area that appears bruised over a body pressure point area. The most common area is over the sacrum (tailbone)

### Don't Back Stage a wound!

Staging is useful to describe the state of a wound, but be careful not to "back-stage" a wound. For example, a wound that is healing or closing/shrinking is considered a "healing Stage III pressure ulcer" not a Stage II.

Check out these Best Practices & Guidelines Answers to the Myths came from them. Find out more!

### Canadian:

**Registered Nurses Association of Ontario - Nursing Best Practice Guidelines (RNAO):** [www.rnao.org](http://www.rnao.org)

- Risk assessment & prevention of pressure ulcers. Toronto, ON: (Revised 2005).
- Assessment & management of stage I to IV pressure ulcers. Toronto, ON: (Revised 2007).
- Risk assessment & management of venous leg ulcers. Toronto, ON: (Revised 2007).
- Assessment & management of foot ulcers in people with diabetes. Toronto, ON: (2005).

**Canadian Association of Wound Care Best Practice Recommendations(CAWC):** [www.cawc.net](http://www.cawc.net)

- Sibbald, RG, Orsted, HL, Coutts, PM and Keast, DH (Update 2006). Best Practice Recommendations for Preparing the Wound Bed. *Wound Care Canada; 4(1) special issue.*
- Orsted, H, Searles, G, Rowell, H. Et al. (Update 2006) *Best Practices for the Prevention and Treatment of Diabetic Foot Ulcers. Wound Care Canada; 4(1) special issue.*
- Keast, K, Parslow, N, Houghton, P et al. (Update 2006). *Best Practices for the Prevention and Treatment of Pressure Ulcers. Wound Care Canada; 4(1) special issue.*
- Burrows, C, Miller, R, Townsend, D; et al. (2001). *Best Practices for the Prevention and Treatment of Venous Leg Ulcers. Wound Care Canada; 4(1) special issue.*

[www.lhsc.on.ca/wound](http://www.lhsc.on.ca/wound)

### Other:

**American Medical Directors Association (AMDA):** Pressure ulcers in the long-term care setting. Columbia, Md: (2008).

**National Pressure Ulcer Advisory Panel (NPUAP):** [www.npuap.org](http://www.npuap.org) PUSH - A validated pressure ulcer healing scale

Gist S, et al. (2009) Wound care in the geriatric client. *Interventions in Aging.* 4(1):269-87.

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