

EARNING THE PATIENT'S TRUST TO FACILITATE HEALING

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Wound history

A 79-year-old widowed female with a previously unremarkable medical history; asthma, essential hypertension and senile macular degeneration sustained a laceration to her right elbow and extensive bruising to the right inner aspect of her leg following a fall, after experiencing a 'dizzy spell'. The District Nursing (DN) team dressed the laceration and assessed the bruising. Whilst the laceration healed, within 4 days there was extensive bruising and two intact blisters on the patient's right leg. At this time the patient suffered a collapse and palpitations. She was admitted to hospital and diagnosed with atrial fibrillation. She was fitted with a pacemaker 8 days later. During an admission period of 18 days she was treated for cellulitis of her right leg. There was no referral to the DN team on discharge, however, after 12 days the patient called the DN team requesting a visit to dress her leg as it was 'leaking'.

Wound assessment

Previous experience of poor care and service from the NHS meant it was vital the patient's trust was rapidly gained. The patient wanted an uncomplicated dressing regime and requested that her leg be dressed only with a surgical pad and a cotton retaining bandage, as she felt unable to tolerate any other type of dressing because of the pain and discomfort.

A thorough assessment of the wound was completed: the patient was found to have a ruptured haematoma, which had become necrosed and sloughy with haemoserous exudate. The wound measured 9cms wide by 8cms long, wound depth could not be determined. The two main considerations in devising a plan of care were that the patient was keen to keep the dressing regime uncomplicated and was against sharp debridement. By addressing these issues we aimed to gain the patient's trust.

Earning the patient's trust

The concept of wound healing and how it could best be achieved was explained to the patient, and a plan of care that was acceptable to the patient was drawn up. The plan of care was as follows:

- Daily visits, initially
- Wound cleansed with either sterile saline or cooled boiled water (patient's request)
- Barrier film to be applied to wound margins and surrounding skin
- 50/50 ointment (50% liquid paraffin and 50% white soft paraffin) to be applied to intact skin
- Flaminal® Hydro to be applied to wound, as instructed by manufacturer
- Foam dressing to cover wound area
- Plain surgical pad to cover foam dressing
- Dressings to be held in place with cotton conforming bandage
- The wound was to be photographed every Monday with the patients consent to be obtained each time
- A wound chart was to be filled in at every visit to provide a detailed record of wound condition and progress.

Wound treatment with Flaminal®

Within 24 hours the patient reported less discomfort and a softening of the necrosis was noted. By day 4, granulation tissue was visible. By day 25 the level of slough in the wound had decreased significantly and Flaminal® Forte replaced Flaminal® Hydro in the dressing regime. Daily visits continued until day 104 and then, with the patient's agreement, the frequency was reduced to alternate days. The wound was noted to have healed on day 115 and, 8 months on, is still healed. At no point during the wound healing process did the wound demonstrate any evidence of an infection.

Day	Pain level 1 = Mild 2 = Moderate 3 = Severe	Wound size (Width x length)	Type of tissue present N = Necrosis S = Slough G = Granulation E = Epithelial	Level of exudate + = Slight ++ = Moderate +++ = Severe
11	1 – 2	9cm x 8cm	S G	++
18	2	9cm x 8cm	S G	++
25*	1	8cm x 7cm	S G E	++
67	1	4cm x 5cm	G E	+
81	0	3cm x 4cm	G E	+
109	0	1.5cm x 2.5cm	G E	Minimal

* Flaminal® Forte replaced Flaminal® Hydro in the dressing regime

Day 11



Day 18



Day 25



Day 67



Day 81



Day 109



Discussion

The DN team was unfamiliar with Flaminal®, a novel alginate antimicrobial dressing with exudate control. However, the team had to devise a plan of care that was acceptable to the patient and to the team. Published data on Flaminal® suggested that it would be highly suitable for the management of this wound^{1,2}. Throughout the wound healing process the patient kept her trust in the DN team and continued with the agreed plan of care. What may be considered noteworthy is that during this time there was no evidence of an infection. Flaminal® Hydro and Flaminal® Forte have since been used by the DN team on a range of wounds including pressure sores, leg ulcers and MRSA positive wounds. Faster healing times have been observed when Flaminal® has been used with a foam dressing which has an adhesive border.

Conclusion

This case study showed how a large, traumatic and complex wound healed with a simple, uncomplicated regime (alginate gel dressing and secondary dressing). Daily visits for such a sustained period of time are clearly not recommended in many cases, however, in this case they proved to be highly beneficial for the patient and the team, allowing a strong relationship based on trust and mutual respect to be developed. Flaminal® has been shown to be antimicrobial, simple to use, absorb exudate and be acceptable to the patient by minimising pain.

Reference List

1. De Smet, K, van den Plas, D, Lens, D, and Sollie, P. Pre-clinical Evaluation of a New Antimicrobial Enzyme for the Control of Wound Bioburden. *Wounds* 21(3), 65-73. 3-3-2009.
2. Vandenbulcke K, Horvat LI, De MM et al. Evaluation of the antibacterial activity and toxicity of 2 new hydrogels: a pilot study. *Int J Low Extrem. Wounds* 2006;5:109-14.