

Proceedings Report

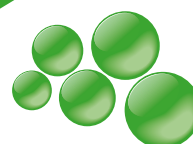
3rd Congress of World Union of Wound Healing Societies

Toronto, June 2008

Mölnlycke Health Care
wound **academy**

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One problem, one voice, presenting the wound care evidence base

Rather like the Olympics, the World Union of Wound Healing Societies (WUWHS) meets every four years and brings together the best from each discipline.

The 3rd Congress of the World Union of Wound Healing Societies (WUWHS) saw over 3000 delegates, presenters, publishers and industry exhibitors celebrate the successes of the Union that have been realised since its inception in 2000. This meeting also threw down a number of challenges to practitioners world-wide, more of which later.

The WUWHS exists to enhance the lives of persons with wounds world-wide through improving standards, facilitating access to wound care, educating professionals, appraising evidence and facilitating best practice. Working groups comprising multi-professional staff from a variety of countries, undertake this work in the time between Congress meetings, with results and progress presented and discussed at the meeting and via the publication of WUWHS best practice documents. Working in this way ensures that all countries' interests and requirements are represented and that the information and documents developed are truly applicable to as many practitioners as possible. Such a working model also facilitates the sharing of practice between countries and enables those that are more sophisticated in wound care to help those who still have some way to go.

The theme of the 2008 meeting was 'One problem, one voice', *presenting the wound care evidence base*, which today is far more robust than even at the last congress, four years ago. This evidence, expert knowledge and work undertaken since the 2004 event have been brought together in a brilliant new web-based initiative, 'WoundPedia'¹. This excellent site will of course, not be static - as new evidence is presented, it will be available on the website to all practitioners (well at least all those with internet access!). In addition, four new 'Principles of Best Practice' consensus documents have been produced and were circulated at the congress:

- Minimising pain at dressing-related procedures: 'Implementation of pain relieving strategies'²
- Vacuum assisted closure: recommendations for use³
- Compression in venous leg ulcers⁴
- Diagnostics and wounds⁵

As the WUWHS only takes place every 4 years, there is obviously a lot of information to be disseminated and networking to be done. The organisers cleverly 'streamed and themed' the content to cover pressure ulcers, leg ulcers, acute wounds, and complex wounds to name but a few. Theory and practice issues were presented and thoroughly discussed both within the conference centre and in the many refreshment venues across Toronto. Interestingly, and appropriately, reimbursement was covered. This is a major issue for all practitioners whatever country they hail from and whatever system is used and one that the WUWHS has been formally exploring since 2004. Of course, reimbursement issues cannot be fully addressed without appropriate research around quality of life and health economics, and this is still sadly lacking.

As is fitting for such a comprehensive programme, many types of wounds were discussed, along with scarring, infection and pain. Some of the most pertinent points are highlighted below.

Wound infection

Naturally all types of wounds have the potential to become infected. However, burns and diabetic foot ulcers carry several high risk factors. In burns for example, it was suggested that both age and total body surface area burned are high risk factors for infection. In these patients, sepsis, presenting as for example, pneumonia, pyelonephritis or systemic catastrophe, accounts for up to 60% of deaths.

In many cases, even with the use of antimicrobials, burn eschar can be colonised by day 5 post-burn. Biofilms also are difficult to eradicate in such patients, although the risk is reduced if development can be decreased with early excision/debridement of the burn and autografting to prevent bacteria entering the deep tissues.

Infection and peripheral arterial disease increases the ratio for non-healing of wounds, particularly with associated diabetes. Neuro-ischaemia and neuropathy can be associated with rapidly developing infection. Diagnosis of infection is primarily a bedside skill, with smell, crepitus and pain being good indicators and the laboratory tests support or refute the hypothesis.

Chronic wound infection is more difficult to diagnose. The ability to probe to bone can indicate deep infection, but by the same token, not being able to get that far doesn't exclude osteomyelitis. X-ray can confirm this.

Scarring

Scarring is caused by the reaction of fibroblast tissues to force and occurs in all wounds except the very superficial or small. However, the critical depth of injury that will cause scarring has yet to be determined. In addition, sutures and denervation or innervation can affect scarring, the latter in animal models delays healing.

Diagnostic tools

The first man (or woman!) to invent a diagnostic tool that tells us exactly what microbes are in a wound, their number and their absolute sensitivity will be hailed as a hero of the wound care world. If they could throw in a bit that indicates the exact stage of healing the wound is at, and the MMP, TIMP, VEGF and status, then surely a Nobel prize is in order!

Unfortunately, while such a tool may still exist only in the world of Star Trek as yet, great strides have been made in this field, particularly in relation to recalcitrant wounds. The current arsenal of tests available include; physical, observational, biological and chemical and biochemical. None identify the cause of delayed healing despite the potential that this would have to improve wound management. However, development of a comprehensive diagnostic tool would be likely to attract funding as if it was used appropriately and in conjunction with other tools and management approaches, it would revolutionise wound-care expenditure by enabling more appropriate diagnosis, intervention and evaluation.

Several potential markers are being explored for use in wound diagnostics⁵. These include:

- Bacterial load/biofilms
- Cytokine release in response to specific microbial antigens
- Growth factors and hormones
- Inflammatory mediators
- pH of wound fluid
- Immunohistochemical markers

So, there are challenges for practitioners and industry in this field. Any tool for use in the clinical area will need to be simple to use, produce clear and meaningful results, and be cost-effective to develop and use. But practitioners want to improve their care, patients want a well-managed wound and purchasers want both, using as few resources as possible. Those developing these tools have to keep a lot of people happy!



Wound pain

Pain has been high on the WUWHS agenda since its inception. In 2004, the WUWHS published the first 'best practice' statement on wound-related pain. In the intervening four years, practitioners have been working together and working with industry to develop assessment and intervention strategies to address this major issue. For example, Woo and colleagues have undertaken a number of studies exploring the psychological issues that may determine perception and tolerance of pain, Patricia Price led a multi-national survey, eliciting over 2000 patients views on wound-related pain, be it at dressing change or other times. Mölnlycke Health Care of course, have been working closely with the WUWHS expert working group on this topic and produced an excellent and lively symposium on the first day of the conference. This symposium, chaired by Professor Keith Harding and Diane Krasner, entitled 'Minimising Pain at Dressing-Related Procedures' featured both research and practice aspects, from the early studies of patient pain through to the launch of a new pain assessment tool that has been piloted and implemented in a large Australian hospital with excellent results. The speakers, Professor Patricia Price, Christina Lindholm, Wendy White, Diane Krasner, Gary Sibbald and Kevin Woo, presented the work they had undertaken on this topic.

Unfortunately, due to space constraints, we are unable to reproduce it here in full, so here are the edited highlights.

Minimising pain at dressing-related procedures

Introduction

Professor Keith Harding, Director, Dept. of Wound Healing, School of Medicine, Cardiff University

One of the first studies undertaken into the understanding of patient pain was by Hollinworth in 1995⁶. In the intervening 13 years, many other studies have demonstrated that wound-related pain is a very real issue for patients and that in most cases it is; not assessed, assessed but poorly understood or poorly assessed and therefore poorly managed. Despite such evidence of the existence of wound-related pain and at dressing-related procedures and guidance documents^{7,8}, as is demonstrated by Price et al⁹, still it is inappropriately addressed.

Professor Harding suggested why this may be the case:

Is pain an underestimated problem?

Evidence from patients suggests that pain is underestimated by practitioners: is it because we believe for example, that deep wounds are not painful due to destruction of nerve endings, or that pain only occurs at dressing change, not before or after?

Is it a lower priority than other wound care issues?

Perhaps exudate management and healing are our clinical priorities (but are not necessarily of priority to the patient). Perhaps it is lower in priority than the need to save on time and resources. But perhaps it is a lack of understanding about wound-related pain.

Are we afraid of asking about pain?

It can be difficult to hear about our patient's pain, especially if we feel powerless to help. Perhaps we don't like to hear that our efforts to cure are actually exacerbating the problem.

This aim of this symposium therefore was to provide delegates with both theoretical and practical perspectives and approaches to help improve assessment and management of wound-related pain.

Pain at dressing change in patients with chronic wounds: a multinational survey

Professor Patricia Price, Research & Education Director, Dept. of Wound Healing, School of Medicine, Cardiff University

Statements such as 'tremendous pain, I crawl on all fours' and "When in severe pain I do not want to say anything or talk to my family" surely would shock health care professionals. Yet these were expressed in an international survey that assessed patients' perceptions of their wound pain.

This cross-sectional study sought the views of 2018 patients in 15 countries to

explore the extent of problems related to pain and dressing-related procedures from patient perspective and to compare pain experiences between wound types across a range of countries⁹.

A summary of the study can be found in the Abstracts section of the September 2008 edition of the Wound Academy Bulletin. However, some of the key points found are worth highlighting:

- 69% of patients experienced ulcer-related pain 'quite often', 'most of the time' or 'all of the time'
- 40% of patients indicated that pain at dressing change was the worst part of living with a wound
- Over all wound types, 54% of patients experienced pain at dressing change ranging from 'quite often' to 'all of the time'
- 23% said touching or handling of the wound was the most painful part of dressing change
- 75% agree or strongly agree that they would like to be involved in the process of dressing change
- 60% reported that it took longer than 1 hour for this pain to resolve
- Pain was considered the biggest problem of all wound symptoms
- The highest median (pain) score was found in patients with mixed ulcers and burn wounds

The researchers concluded that chronic wound pain, particularly as part of dressing related procedures, is common, although further analysis is necessary to understand the role of cultural diversity. More importantly, the information from this study provides practitioners with the first step to incorporating wound pain practice within a model of culturally competent wound care.

Pain on dressing removal

Diane Krasner, Special projects Nurse, York, Pennsylvania, USA

Another multinational qualitative study assessed the patient perspective of pain at dressing removal (traditional adhesive dressings and dressings with Safetac[®] technology (Mölnlycke Health Care) in 3034 patients with a variety of wound types¹⁰.

Results showed that 77% of participants experienced high, moderate or slight wound or peri-wound trauma at their first visit with adhesive dressings. 50% of participants experienced no wound/peri-wound trauma at the second visit with dressing with Safetac. In addition, there was a significant ($p=0.01$) reduction in pain levels associated with dressings with Safetac technology compared to the advanced dressings with traditional adhesives.

So, using dressings with Safetac can help to minimise pain and peri-wound trauma at dressing change. Other strategies to consider include:

- Analgesia
- Time-outs
- Imagery or Music
- Diversion
- Interactive Dialogue
- Deep Breathing
- Touch

Why assessment of pain is important

Professor Christina Lindholm, Högskolan Kristianstad, Stockholm, Sweden

Aside from wound pain causing suffering to the patient and the physical effects it can have on wound healing, it is important to assess pain for the sake of the practitioner-patient relationship. Nurses particularly are challenged and frustrated when patients are in pain. Indeed, as the International Council of Nurses states, 'Nurses work with patients and their families to identify the source of pain and to relieve it.'

So, we need to use a structured assessment tool and then relieve pain according to its type. Such a tool should be part of a holistic assessment and cover:

- Type – acute, chronic, nociceptive, neuropathic
- Intensity – stabbing, pulling, aching

- Variations during times of the day
- Constant or just at dressing change

As will be seen in the next section, such a tool has been developed and implemented.

Wound-related pain assessment tool

Wendy White, Clinical Nurse Consultant/Educator, (private practice), Lake Haven, NSW Australia

All too often, the priorities of the clinician are contrary to those of the patient. For example, in wound care, we may be more concerned with time to healing or limb preservation, whereas the patient's concern is the pain and their quality of life.

To this end, Mölnlycke developed a pain assessment tool that was piloted, revised and then implemented in an Australian hospital. The tool guides the practitioner through the stages and processes required for a contemporaneous, comprehensive assessment (A copy of the tool can be found at the end of this supplement and is available at www.molnlycke.co.uk).

Initial

Full pain history - building picture [acute vs chronic pain]
 Background - incident, procedural, operative pain
 Body map – location [patient may have multiple pain sites]
 Pain intensity – using a validated pain scale
 Patient feelings, perceptions, expectations

Ongoing

Before, during and after dressing procedure [score]

Review assessment

Assess / evaluate treatment strategies and progress

The tool has a body map to indicate wound location and areas of pain, with statements related to pain for the patient to score themselves against. Infection can also be noted. Each score is 'plotted' thus facilitating the evaluation of the effectiveness of intervention strategies.

Such tools with score and scales can record trends in pain intensity before, during and after procedure and when used together with appropriate assessment strategies, can provide a broad understanding of the patient's experience.

Evidenced, informed practice: Consensus document

Kevin Woo

*Lecturer, Dept. of Public Health Sciences, University of Toronto;
 Clinical Scientist / Chronic Wound Specialist; Wound Healing Clinic,
 Women's College Hospital, Toronto*

Dr. R Gary Sibbald

*Professor of Public Health Sciences & Medicine, University of Toronto
 Director of Medical Education and Wound Healing Clinic,
 Women's College Hospital, Toronto*

The culmination of the symposium was the presentation and launch of the latest WUWHS Principles of Best Practice document, 'Minimising pain at dressing-related procedures: implementation of pain relieving strategies'⁵. The purpose of the document is to:

- Update healthcare professional knowledge concerning wound-related pain
- Formulate appropriate assessment of and documentation for wound-related pain
- Appraise treatment strategies to reduce pain at dressing-related procedures
- Incorporate the importance of pain management to promote optimal wound healing
- Recommend practical tools to implement practice change

Ten consensus statements were agreed as guidance for practice:

1. Identify and treat the cause of the chronic wound and address concerns expressed by the patient, including a pain assessment at each visit.
2. Evaluate and document pain intensity/characteristics on a regular basis (before, during, and after dressing change)
3. Cleanse wounds gently with warm saline or water. Avoid the use of abrasive wipes and cold solutions
4. Select an appropriate method of wound debridement for each wound and include the potential for causing wound related pain.
5. Choose dressings that minimize trauma/pain with application and removal.
6a. Treat infections that may cause wound-related pain and inhibit healing
6b. Treat local factors that may induce wound related pain (e.g. inflammation, trauma)
7. Select an appropriate dressing to minimize wound related pain based on wear time, moisture balance, and peri-wound maceration
8. Evaluate each patient's need for pharmacological (topical /systemic agents) and non-pharmacological strategies to minimize wound related pain
9. Involve and empower patients to optimize pain control
10. Healthcare providers should ensure wound-related pain control for every patient

Conclusion

The symposium challenged practitioners to reflect on their practice with regard to wound pain and dressing-related pain. However, it also provided practical and theoretical strategies for implementing such changes in practice and thus improving the patient experience.

Your next steps are easy!

- Obtain and review a copy of the consensus document
- Share it with your colleagues
- Document current practice
- Integrate pain evaluation tools
- Evaluate results of evidence informed pain management

References

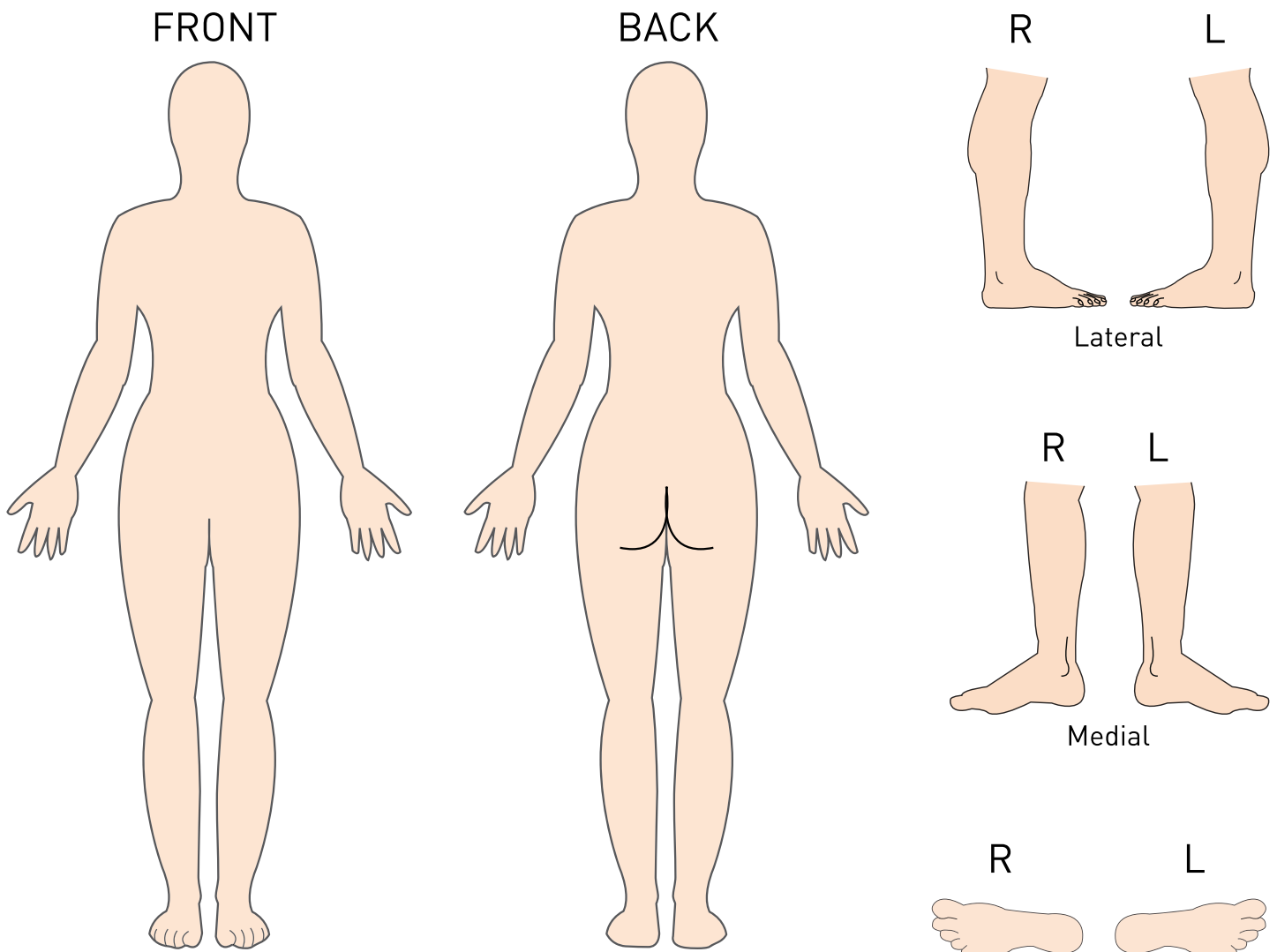
1. <http://www.woundpedia.com>
2. Principles of best practice: Minimising pain at wound dressing-related procedures. A consensus document. Toronto, Canada. © WoundPedia Inc 2007. Available at www.Molnlycke.com
3. World Union of Wound Healing Societies (WUWHS). Principles of best practice: Vacuum assisted closure: recommendations for use. A consensus document. London: MEP Ltd, 2008
4. World Union of Wound Healing Societies (WUWHS). Principles of best practice: Compression in venous leg ulcers: A consensus document. London: MEP Ltd, 2008
5. World Union of Wound Healing Societies (WUWHS). Principles of best practice: Diagnostics and wounds: A consensus document. London: MEP Ltd, 2008
6. Hollinworth, H. Nurses' assessment and management of pain at wound dressing changes. *J Wound Care*. 1995 Feb;4(2):77-83.
7. European Wound Management Association. Pain at Wound Dressing Changes. London, UK: Medical Education Partnerships LTD, 2002.
8. World Union of Wound Healing Societies. Principles of Best Practice: Minimising Pain at Wound Dressing-Related Procedures: A Consensus Document. London, UK: Medical Education Partnerships LTD, 2004.
9. Price, P.E, Fagervick-Morton, H., Mudge, E. J., *et al*. Dressing-related pain in patients with chronic wounds: an international patient perspective. *Int Wound J* 2008;5 159-171
10. White R. A multinational survey of the assessment of pain when removing dressings *Wounds UK* 2008, 4(1), 26-37

WOUND-RELATED PAIN AT DRESSING CHANGE ASSESSMENT TOOL

Date Surname DOB Initials

Medical record Wound type

1. Indicate location of wound/s and number on the body map and leg/foot pictures



2. Do you experience pain or discomfort related to your wound/s?

Yes

No

If yes, complete the questions on the next page.

Signature

This pain assessment tool has been adapted by the International Pain Advisory Panel¹

¹Helen Hollinworth 2005. Pain at wound dressing-related procedures: a template for assessment. www.worldwidewounds.com



WOUND-RELATED PAIN AT DRESSING CHANGE ASSESSMENT TOOL

Date Initials Signature

3. When do you experience wound-related pain? (May mark more than one box if applicable)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Pain at rest (Background) | <input type="checkbox"/> During day | <input type="checkbox"/> During night |
| <input type="checkbox"/> Pain during day-to-day activities (Incident) | <input type="checkbox"/> Pain during dressing change (Procedural) | |
| <input type="checkbox"/> Pain during biopsy/debridement (Operative) | <input type="checkbox"/> Pain after dressing change | |

4. Where is the wound-related pain? (May mark more than one box if applicable)

- In the wound In the area surrounding the wound (skin)

Does the pain go anywhere. If yes where does it go?

5. What words would you use to describe your pain? (May mark more than one box if applicable)

- | | | | | | |
|----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Aching | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tender | <input type="checkbox"/> Sharp | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stinging | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other* |

*Give details:

6. At dressing change, what makes the wound-related pain worse (triggers)? (May mark more than one box)

- | | | |
|--|--|---|
| <input type="checkbox"/> Removing dressing | <input type="checkbox"/> Applying dressing | <input type="checkbox"/> Some dressing types* |
| <input type="checkbox"/> Cleansing | <input type="checkbox"/> Touch | <input type="checkbox"/> Other* |

*Give details:

7. At dressing change, what makes the wound-related pain better (relievers)? (May mark more than one box)

- | | | |
|---|--|--|
| <input type="checkbox"/> Removing dressing myself | <input type="checkbox"/> Time-outs or brief rests | <input type="checkbox"/> Certain types of dressings* |
| <input type="checkbox"/> Warm cleansing solutions | <input type="checkbox"/> Pain-relieving medication | <input type="checkbox"/> Other* |

*Give details:

8. Have you been prescribed or are you currently taking pain-relieving medications (tablets, injections, topical applications, patches) for your wound-related pain?

- Yes No

If yes, list name/dose and when last taken/applied/used:

.....

9. Are any of the following activities negatively affected because of the wound-related pain you experience?

- | | | |
|---|---|---------------------------------|
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Activities of daily living | <input type="checkbox"/> Other* |
| <input type="checkbox"/> Leisure activities | <input type="checkbox"/> Sport or exercise | |

*Give details:

10. If the wound-related pain was reduced, which activity would you look forward to the most?

.....

WOUND-RELATED PAIN AT DRESSING CHANGE MONITORING & EVALUATION TOOL

Surname Initials DOB:



Date each dressing change and plot wound-related pain score on the graphs below. Record, monitor and evaluate interventions initiated to minimise wound-related pain at each dressing-related procedure.

		Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date			
		WOUND-RELATED PAIN SCORE		Before 0 = no pain, 10 = worst possible pain														
During 0 = no pain, 10 = worst possible pain																		
After 0 = no pain, 10 = worst possible pain																		
Visit nr																		
Intervention to minimise wound-related pain																		
Sign																		

NB! Once an appropriate pain scale tool is selected (self reporting or observational), continue to use the same tool at each assessment.

Forthcoming dates for your diary:

Leg Club Conference
The Art & Science of Nursing in the 21st Century
October 1-2
Worcester UK

Wounds UK 2008
10-12 November
Harrogate International Centre, Harrogate

**19th Conference of the European Wound
Management Association (EWMA 2009) Healing,
Education, Learning and Preventing in Wound Care**
May 20-22
Helsinki Finland

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Mölnlycke Health Care, The Arenson Centre, Arenson Way, Dunstable, Bedfordshire LU5 5UL, UK.
Tel. 0800 7311876, Fax 0870 6061888, www.molnlycke.co.uk