THE EFFECT OF A NEW DEBRIDEMENT TECHNIQUE ON PATIENT WELLBEING

There have been a number of documents published during the past few years focusing on the importance of the patient experience of NHS care (Department of Health [DH], 2011a, 2011b; Wounds International 2012), and the significance of the whole patient journey.

Treating patients with compassion, dignity and respect is fundamental in any specialty and wound management is no exception. Therefore, it is increasingly under the spotlight of the DH, given the high impact on patient-reported experience of care and the escalating associated financial burden.

In February 2012, the National Institute for Health and Clinical Excellence (NICE) published a new quality standard on patient experience in adult NHS services. The document stated that high-quality care should be both effective and safe, and contained 14 quality statements to this effect, all of which can be aligned to wound care (Table 1).

Eaton (2012) commented that the aim of the guidance was to create ‘sustainable change’ that will result in an ‘NHS cultural shift’ towards a truly patient-centred service.

WELLBEING
The NHS Operating Framework (DH, 2011a) advocated that quality and outcomes should drive everything that clinicians do. The framework was designed to act as a catalyst for driving quality improvements. Domain 4 of the framework — ‘ensuring that people have a positive experience of care’ — is focused on a number of areas, including improving people’s experience of A&E services and responsiveness to patients’ personal needs. Pain management, particularly related to wound debridement, and ongoing care will certainly impact on the individual’s experience of those services and will be reflected in outcome data.

As the population ages, and the management of tissue viability develops heightened focus, this will be further reflected in the outcome domains of the future.

A positive experience of care can also be reflected in optimising wellbeing. While health professionals may focus on wound healing as a key outcome, the priorities of the person challenged by the ‘wound experience’ may be reducing pain and malodour, or finding a dressing that is comfortable.

One international consensus group looking at factors affecting wellbeing suggested that odour and excessive exudate can lead to feelings of low self-esteem (Wounds international, 2012). Evidence suggests that reducing the wound bioburden and the amount of devitalised tissue in the wound bed can also reduce malodour and excess exudate (Wolcott et al, 2009), which can be effectively achieved through debridement.

PREPARING THE WOUND BED — INNOVATIVE DEBRIDEMENT TECHNIQUES
Debridement of devitalised tissue in the wound bed has been described as fundamental to healing in many wound types (Hofman, 2007; Gray et al, 2011; Vowden and Vowden, 2011). Indeed Fletcher (2010) states that every patient with a wound is entitled to a good minimum standard of care.

Debridement has been described as the removal of non-viable tissue from the wound bed to encourage wound healing, and is, therefore, an essential component
Historical methods of debridement include:

- **Autolytic**
- **Enzymatic**
- **Mechanical**
- **Surgical**
- **Sharp**
- **Biosurgical options.**

**Ultrasound**

As mentioned above, ultrasound technology has recently been applied in wound management—the procedure uses low frequency ultrasound to help debride layers of necrosis and foster healing. Ultrasound is defined as a mechanical vibration transmitted at a frequency above the upper limit of human hearing (Sussman and Dysom, 2001) to debride recalcitrant wounds.

Ultrasound debridement technology delivers ultrasound either in direct contact with the wound bed or via an atomised solution. Most devices include a built-in irrigation system and are supplied with a variety of probes for different wound types. This method of debridement can be immediate and selective and can be used over a period of time, however, financial investment and specialist training can inhibit the use of this modality.

**Hydrosurgery**

The hydrosurgical method of debridement uses a high energy saline beam to precisely remove devitalised tissue. The high pressure jet of sterile saline travels parallel to the wound surface, enabling the practitioner to cut and remove tissue while irrigating the wound bed.

This option can provide rapid removal of dead tissue and may be used in a variety of settings (Gurunisoglu and Glasgow, 2009). Again, the unit cost of the therapy can be high and it must be facilitated by a specially trained practitioner.

**Autolytic**

Devitalised tissue in the wound bed may increase inflammatory response...
Mr X is a 62-year-old man who underwent an extensive surgical debridement to

and mask or mimics signs of infection (Leaper, 2002; Kammerlander et al, 2005). Autolytic debridement, using occlusive and semi-occlusive dressings to promote rehydration of devitalised tissue, is an option for generalist practitioners, however, this needs to be carefully supervised as it can be dangerous if not monitored correctly and should not be used purely because the clinician does not have the skills to consider other methods. As autolytic debridement takes a long time, the dead tissue can become a focus for infection, thus delaying healing.

More recently, the use of hydro-balanced antimicrobial dressings, such as Suprasorb X + PHMB® (Activa Healthcare) has proved effective in promoting autolytic debridement while controlling the bioburden within the wound, thereby, preventing systemic infection (Fumarola et al, 2010; Mason, 2011).

DEBRISOFT

Although debridement may be the appropriate treatment option, challenges exist in the level of skill required to perform some aspects of mechanical debridement safely, for example, sharp debridement and hydrosurgical debridement.

To address this challenge, a selective method of mechanical debridement has been developed and successfully evaluated in practice in a number of different types of wounds (Gray et al, 2011; Haemmerle et al, 2011; Westgate and Cutting, 2012; Stephen-Haynes, 2012, Fumarola, 2012). Callaghan and Stephen-Haynes (2012) described the treatment of 12 pressure ulcers using the active debridement system and reported rapid, safe and pain-free debridement. The pad resulted in better visualisation of the wound bed, improved management objectives and reduced numbers of district nurse visits. Collarte et al (2012) undertook a 10-patient study evaluating removal of hyperkeratosis from the lower leg. They discovered that Debrisoft aided fast and effective wound and periwound skin debridement without the delay of referring on to specialist teams. Pritchard (2012) described debridement of slough from an extensive leg ulcer, enabling the application of topical antimicrobials to the wound bed and subsequent wound healing.

Haemmerle et al (2011) evaluated the debridement properties of Debrisoft in 11 patients with ulcers to the lower leg. Researchers discovered that the monofilament pad removed almost all of the debris in the wound while leaving healthy granulating tissue intact. Scanning electron microscopy revealed wound debris tightly packed into the monofilaments of the pad.

Reference


the tissue of the lower leg following a necrotising infection (Figure 1). He was managed in an intensive care unit and then in the renal unit, undergoing haemodialysis following sepsis.

Mr X experienced circumferential loss of tissue from below the knee to the ankle and the wound demonstrated extensive slough (Figure 1). It was being managed with negative pressure wound therapy (NPWT) in preparation for skin graft (Figure 2).

Wound cleansing proved problematic because of the extensive area involved. Conventional methods, including irrigation or cleansing with saline and gauze, had proved ineffective. Critical contamination involving Pseudomonas aeruginosa developed, preventing skin grafting.

Due to the poor efficacy of other methods, a decision was taken to use a Debrisoft pad to enable cleansing and debridement of the wound and aid removal of the possible biofilm at dressing change. The pad was moistened with sterile saline and passed over the wound with light pressure to remove slough and wound debris (Figures 3 and 4).

This procedure was repeated at each dressing change (Figure 5). Dressing changes took place two or three times per week depending on the seal achieved with the NPWT. Mr X remained pain free during the procedure and skin graft was successfully applied to the lesion.

CONCLUSION
This article has examined the different types of debridement available and their effect on the wellbeing of the patient with a wound. Some techniques have an adverse impact on the patient, including pain and trauma, as well as requiring expert knowledge from clinicians. Because of this, Debrisoft, a new debridment method that removes devitalised cells, slough and debris from the wound bed, may be useful, as it offers a less painful debridment method, improved visualisation of the wound bed, and can reduce the amount of healthcare professional time required to debride.

DECLARATION
This article has been produced with the support of Activa Healthcare.

Figure 2: The wound being treated with NPWT.

Figure 3: Debrisoft was able to cleanse the wound and gently debride it of debris.

Figure 4: The wound after debridement with Debrisoft.

Figure 5: As the wound progressed, Debrisoft continued to cleanse and debride.