The management of a category 4 pressure ulcer using ActivHeal® AquaFiber Ag

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**Background**

Wound infection is without doubt the most troubling of all wound complications and is a major cause of delayed healing and may produce symptoms, such as malodour and pain, which distress patients and are a challenge for clinicians to manage (Newton, 2011). Wound infection occurs as a result of an imbalance between the patient’s immune system, the type of bacteria and the conditions within the wound itself (International Wound Infection Institute [IWII], 2016). Accurate wound assessment is essential to ensure early detection of changes within the wound and the surrounding skin, which may indicate a rise in bacterial levels (IWII, 2016). There are classic signs and symptoms that are easily identifiable as wound infection. Localised infection is often characterised by the classic signs and symptoms of inflammation, pain, heat, swelling, redness and loss of function (IWII, 2016). For healing to proceed it is important to prevent the establishment of localised infection and spreading infection. This may involve the prevention of progression to colonisation or the management of an established localised infection (World Union Wound Healing Society [WHWHS], 2016)

**Method**

A 86 year old female was admitted to a residential care home, following a total hip replacement after falling and fracturing her hip and the development of a category 3 pressure ulcer. The patient had previously been cared for at home however she had become less mobile and incontinent of urine and a category 3 pressure ulcer on the sacrum developed. Once in the care home the patient was nursed on an alternating mattress and received 2 hourly repositioning. A referral was made to tissue viability as the pressure ulcer had deteriorated to a category 4 pressure ulcer to the sacrum. A full assessment was undertaken with a long wound swab.

**Results**

Initial assessment, the ulcer measured 3.7cm x 3.2cm with a depth of 2cm and the wound undermined downwards by 3.5cm. The pressure ulcer had 50% slough and 50% granulation tissue and high exudate levels. The pressure ulcer was showing clinical signs of infection of erythema, abnormal discharge and increased levels of exudate along with a visual analogue score for pain at 10 (10= worst pain imaginable).

A wound swab was taken and sent for culture and sensitivity. The wound swab showed heavy growth of both mixed anaerobes and proteus species, and antibiotics were prescribed. Despite this, the wound no longer contained sloughy tissue but had 95% granulation tissue and 5% epithelial tissue. Exudate levels remained high but all the clinical signs of infection were no longer apparent. The patients pain level had also reduced to 6 using a visual analogue scale. The wounds was healthy and no longer macerated. (Figure 2)

The wound swabs showed heavy growth of mixed anaerobes and proteus species sensitive to Metronidazole therefore the patient was commenced on a 7 day course of Antibiotics. The same dressing regime continued.

**Conclusion**

The ActivHeal Ag dressing was found to be an appropriate dressing in the management of the infected category 4 pressure ulcer with high exudate levels. The dressing produced very positive patient outcomes. The correct dressing choice in this case enabled the patient to be managed quickly and effectively without an overly long treatment time and assisted in the management of clinical indications of exudate management and to reduce wound bioburden along with being safe and acceptable to the patient. The patients pain score reduced throughout the use of the dressing. The case study illustrates the importance of a holistic approach when caring for a patient with a challenging wound and ensuring that the correct diagnosis is made based upon a thorough assessment ensuring good clinical outcomes for the patient.

**References**

