Flexible learning in challenging times: development of an e-learning resource for health care students

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Introduction

• Nurses and podiatrists are regularly involved in the care of patients with chronic wounds

• Collaborative practice is an essential component of modern wound care however the reality remains that there is often little collaboration between the two professions

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Barriers to collaborative practice

- Lack of awareness of each others roles
- Professional stereotyping
- Professional identity
- Inconsistent educational strategies
- No exposure to interprofessional education at undergraduate or postgraduate level

(Mandy et al 2005; Xyrichis and Lowton 2007)

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Objectives

The Interactive Web Based Resource will provide an innovative approach to wound care education that will:

- Bridge the theory to practice gap
- Broaden perspectives beyond the student's specialist area
- Highlight the importance of interdisciplinary working and raise awareness of each other's roles.
Problem Based Learning

• Savin-Baden (2000) ‘PBL should mimic practice in so far as it reflects the collegiate way in which practitioners need to operate, identifying their own and others’ expertise and working coherently to solve a problem’

• Aims to develop:
  – Critical thinkers
  – Problem Solvers
  – Questioning students

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Structure

- Core knowledge
- Case study selection
- Resources
- Quizzes

- Activities
- Interactive
Welcome to Challenges in Wound Care, an interactive online teaching and learning tool for practitioners involved in wound care and tissue viability. The tool aims to offer an inter-professional approach to wound care and tissue viability issues encouraging an awareness of professional roles and the need for liaison and referral to ensure optimum patient care and enhance professional practice.

The tool is split into two sections and uses a problem-based learning format with case study scenarios centred on the assessment, diagnosis, and management of various wound care scenarios. The two sections are:

<table>
<thead>
<tr>
<th>Core Knowledge</th>
<th>Clinical Case Studies</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Chronic Oedema</td>
<td>01 Pressure Ulcer</td>
<td>01 Leg Ulcer Differential Diagnosis</td>
</tr>
<tr>
<td>02 Physiology of Wound Healing</td>
<td>02 Surgical Dehisced Wound</td>
<td>02 External Links</td>
</tr>
<tr>
<td>03 Wound Debridement</td>
<td>03 Diabetic Foot Ulcer</td>
<td>04 Venous Ulcer</td>
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<tr>
<td>04 Wound Products</td>
<td></td>
<td>05 Arterial Ulcer</td>
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<tr>
<td>05 Wound Cleansing</td>
<td></td>
<td>06 Mixed Disease Ulceration</td>
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<td>06 Nutrition</td>
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<td>07 Pain</td>
<td></td>
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<tr>
<td>08 Diabetic Foot Ulcers</td>
<td></td>
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<tr>
<td>09 Pressure Ulcer Management</td>
<td></td>
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<tr>
<td>10 Recognising Infection</td>
<td></td>
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<tr>
<td>11 Exudate Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Legal Issues</td>
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</tr>
</tbody>
</table>
There are number of differences between acute and chronic wounds as described by Cutting and Tong (2003) and displayed in the table below:

<table>
<thead>
<tr>
<th>Acute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short duration for healing</td>
<td>Not healed within 6 weeks of formation</td>
</tr>
<tr>
<td>No underlying pathology</td>
<td>Underlying pathology</td>
</tr>
<tr>
<td>Normal inflammatory stage</td>
<td>Prolonged inflammatory stage</td>
</tr>
<tr>
<td>Usually heal without complication</td>
<td>A variety of complications</td>
</tr>
<tr>
<td>Acute wound fluid supports cell proliferation</td>
<td>Chronic wound fluid does not support cell proliferation</td>
</tr>
<tr>
<td>Acute wound fluid does not damage peri-wound skin</td>
<td>Chronic wound fluid damaging to peri-operative skin</td>
</tr>
<tr>
<td>Neutrophil elastase and MMP levels are normal</td>
<td>Neutrophil elastase and MMP levels are high</td>
</tr>
<tr>
<td>Fibronectin intact</td>
<td>Fibronectin degraded</td>
</tr>
<tr>
<td>Normal remodelling of extracellular matrix</td>
<td>Defective remodelling of extracellular matrix</td>
</tr>
<tr>
<td>Normal levels of inflammatory cytokines</td>
<td>Increased levels of pro-inflammatory cytokines</td>
</tr>
</tbody>
</table>

The acronym **TIME** may be used to assess and manage wound bed preparation.

**Tissue Management:** Assess the amount of viable and non-viable tissue. The presence of slough and necrotic tissue can delay healing. Useful to use % to act as an objective marker.

**Infection/inflammation:** Prevention of infection is vital to prevent complications. Signs and symptoms of infection are frequently absent with subtle changes such as increase in exudate may be only indication of infection. Infection is frequently polymicrobial with a rapid onset and osteomyelitis is a frequent complication.

**Moisture Balance:** Assess wound exudate and record.

**Edges of the wound:** Closure of diabetic foot ulcers can be delayed due to necrotic tissue. Skilled sharp debridement is essential to promote healing.

There may be a failure of epithelial advancement due to:

- Callus
- Dried exudate
- Non-viable tissue
- Wound pH
- Growth factor deficiency
- Excess protease activity
- Abnormal cellular matrix components
Blood Vessels

There are three interconnected networks of blood vessels associated with the skin:

1. Capillary network beneath the epidermis – plexus
2. Arterioles and venules in the dermis
3. Larger arteries and veins in the subcutaneous tissue

Functions of the skin

The skin has several functions:

- Protection of internal structures
- Sensory perception
- Regulation of body temperature
- Excretion
- Metabolism
- Absorption
- Immunity
INTRODUCTION

Mobility

Independent and active, Lilly is the main carer for her husband.

Mental status

Lilly has no history of mental illness and is generally very positive and outgoing, although she admits becoming increasingly concerned about her ulceration, not for herself but in terms of who would look after her husband if she required hospitalisation.
Wound assessment

How would you describe these ulcers?

The tissue on Mary’s ulcer is mostly viable with approx 15% of non viable tissue evident (slough) there is evidence of increased bacterial load as the wound bed appears generally inflamed and the exudate was malodorous, there is a definite moisture imbalance as the levels of exudate was high and the edges are non advancing; there was no evidence of new granulation tissue or epithelial growth around the wound edges.
Activity 5
Consider the effects of Matthew’s poor nutritional state on the healing of his wound.

Whereas good nutrition facilitates healing, malnutrition delays, inhibits, and complicates the process (Williams and Lazzer 2009). Nutritional assessment is vital aspect of wound management and if additional nutritional support is needed this is best addressed by utilising the multidisciplinary team including medical, nursing and dietetic staff. Nutritional support is fundamental to patient care and needs vary on an individual patient basis. Recommendations to patients with wounds should be to consume a healthy balanced diet, with sufficient quantities of energy and protein foods.
Q1: Cavity wounds that are left open and not sutured are left to heal by:

- A) Filling
- B) Primary Intention
- C) Secondary intention
- D) Granulation
Summary

- CIWC allows practitioners involved in wound care to develop their fundamental knowledge at a time convenient to them
- Acts as an adjunct to formal teaching
- Presents core knowledge development and proceeds to linking theory to practice – case studies
- Can be further developed for the interactivity element
Thank You