

Management of Painful Wounds

Stepping Up to the Challenge



New Zealand Wound Care Society 9th National Conference
Choices, Changes & Challenges

Dunedin 23rd – 25th May 2019 Invited Speaker Wendy White



Pain....we've all been there

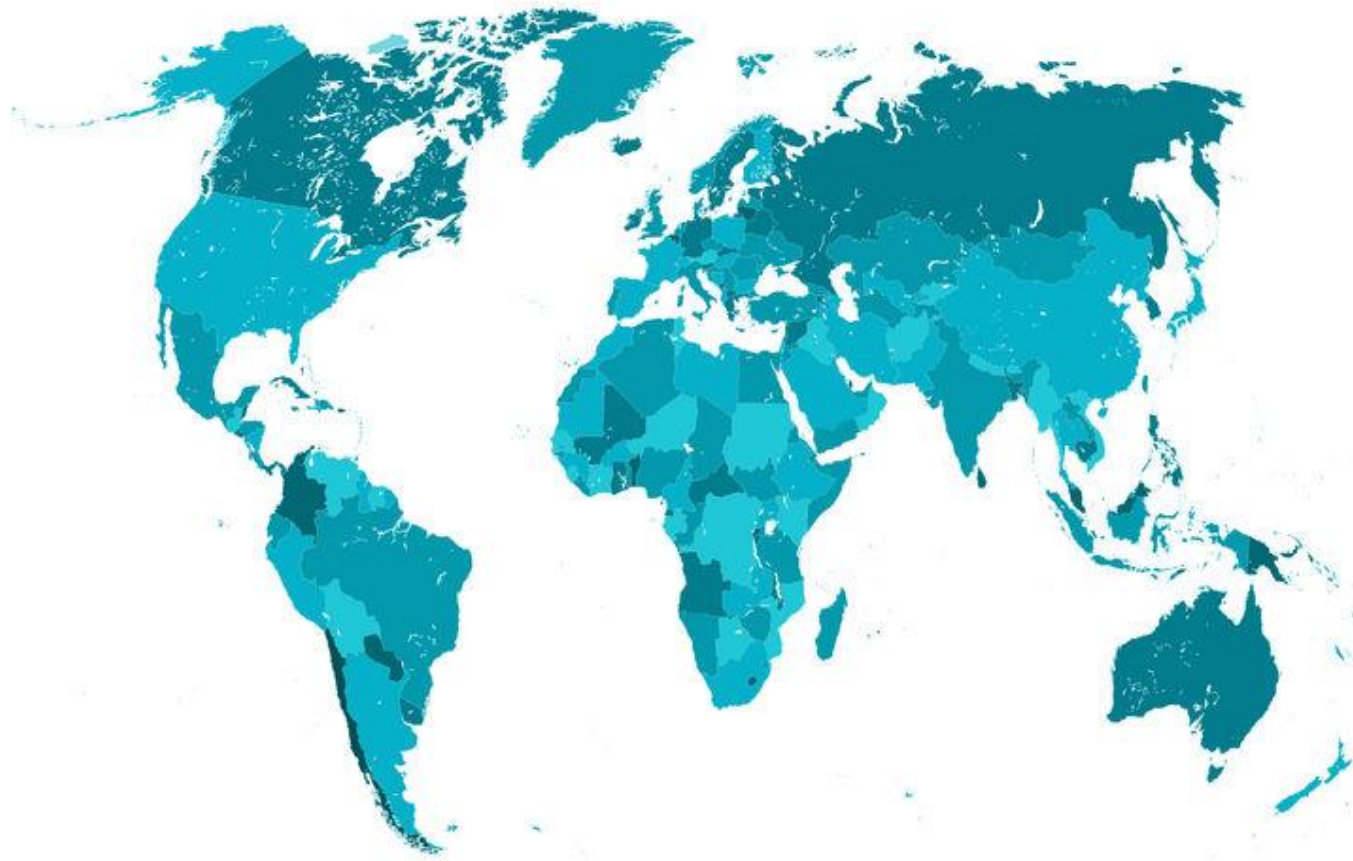


PAIN: Universal Human Reality

‘ an unpleasant
sensory & emotional experience
associated with actual or potential tissue damage,
or described in terms of such damage’

PAIN: Individual Experience
BIOPSYCHOSOCIAL

Access to pain management
is a fundamental
‘Human Right’



2010 DECLARATION Montreal IASP



Pain

Chronic Wounds

WOUND RELATED PAIN (WRP)

1995
Hollingsworth
Nurses
assessment
WRP

Krasner 1995
Chronic pain model

C. Lindholm 2001
Pain leg ulcers

2002
EWMA
1st
Position doc
Pain dressing
change

2004
WUWHS
1st
Consensus Doc
Minimising pain

2003 WBP
Schultz et al

2008
WUWHS
Implementation
WRP

*Price et al
2008
International

2008 WUWHS
Infection Harding et al
2011/2012 WBP RV
Sibbald
Leaper et al
2010 BBWC
Wolcott et al

Decade+
Pain stress pain
Upton ++

Anticipatory pain
Woo

EMLA topical
* Purcell 2018

2016 Infection
IWII
2017 Biofilm
Consensus

World 'Village'

>24yr Timeline

Session Overview

Pain Chronic Wounds

- **Set the scene**
 - Review physiology & pathophysiology of pain (**NeP & Non NeP**)
 - Define & discuss **mechanisms of acute & chronic pain** in wounds
- **Mixed pain in wound management – do we have a problem?**
 - Overview **key findings WRP** in community setting
- **So what? - consequences wound related pain**
 - **Examine link** between pain, / anticipatory pain, stress, distress, negative emotions & healing
- **WRP Assessment & Management Strategies – Time action**
 - Validated **self reporting & observational** tools
 - Pharmacological & non pharmacological interventions overview



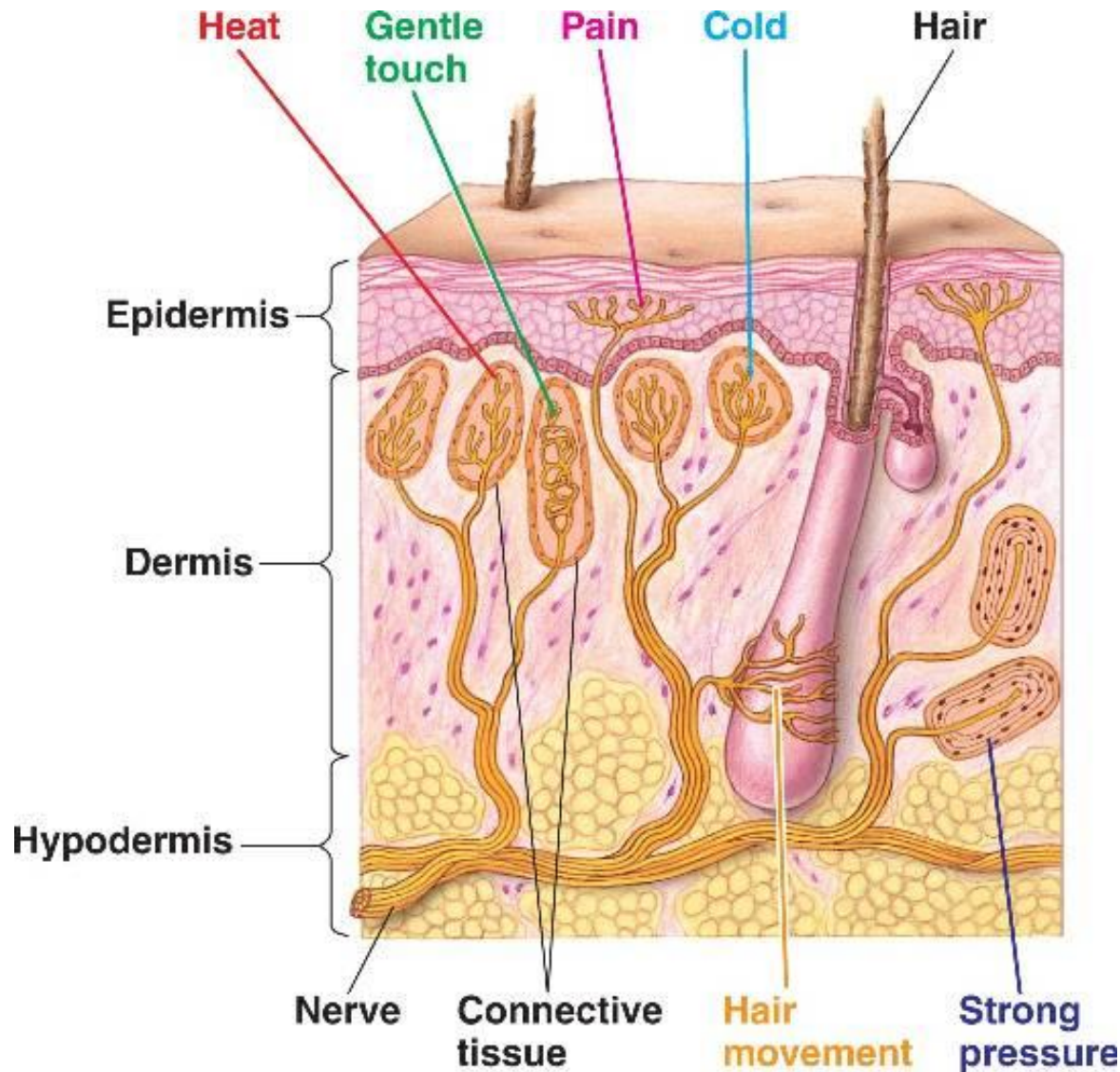
Pain

Mechanisms

‘The current understanding of *wound pain* is primarily drawn from the literature relating to other conditions and the physiology of acute and chronic pain’ p11 (Fleck 2007)

Skin – Sensory & Protection Function

Receptors - *Nociceptors*



Peripheral Nerves

- **Large** (heavily myelinated)

- A-alpha (motor strength)
- A-beta (vibration and touch)

- **Medium** (myelinated)

- A-gamma (info to muscle spindles)



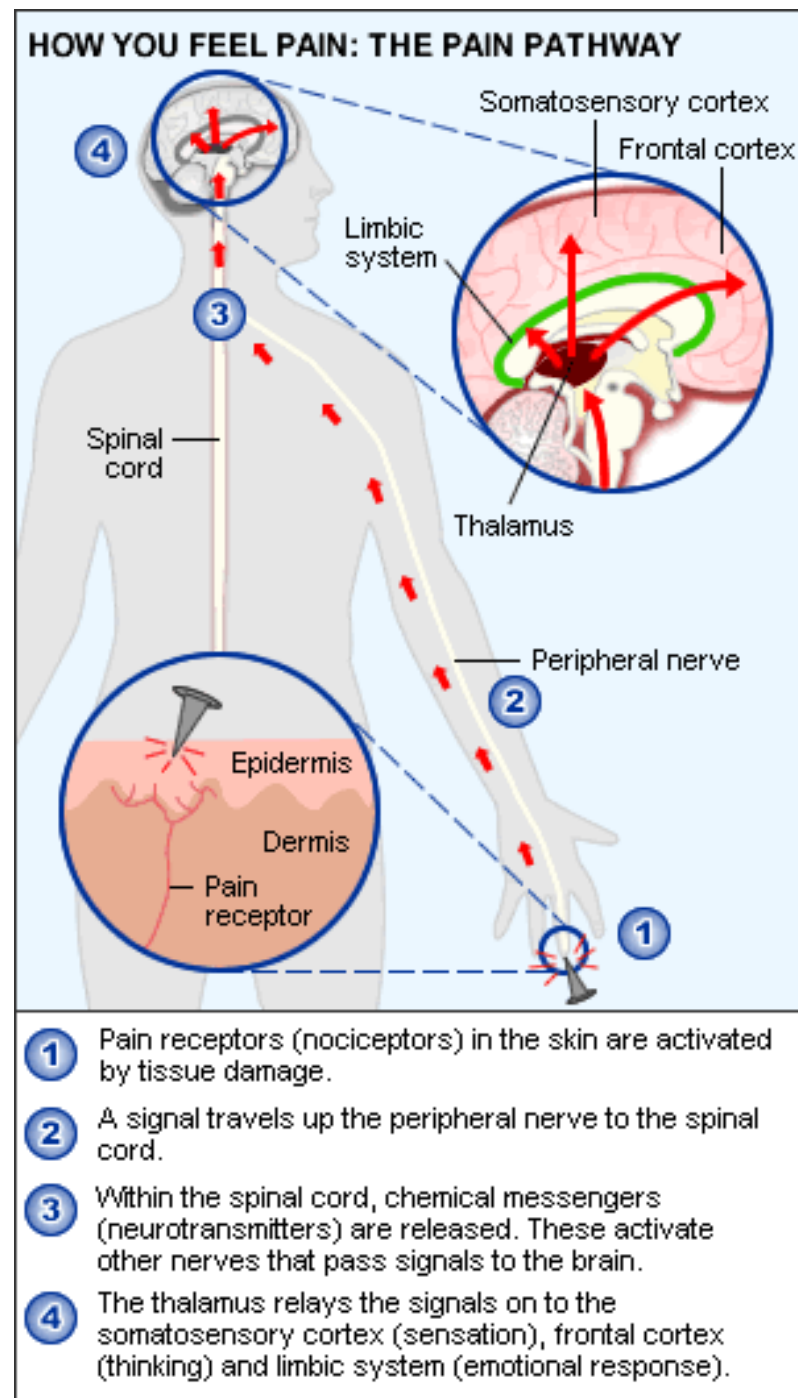
- **Small** (myelinated and non myelinated)

- A-delta (m)
- C (non)
 - Innervate skin (somatic)
 - Involuntary muscle

– Mediate pain, thermal sensation and autonomic

Nervous System (CNS + Peripheral)

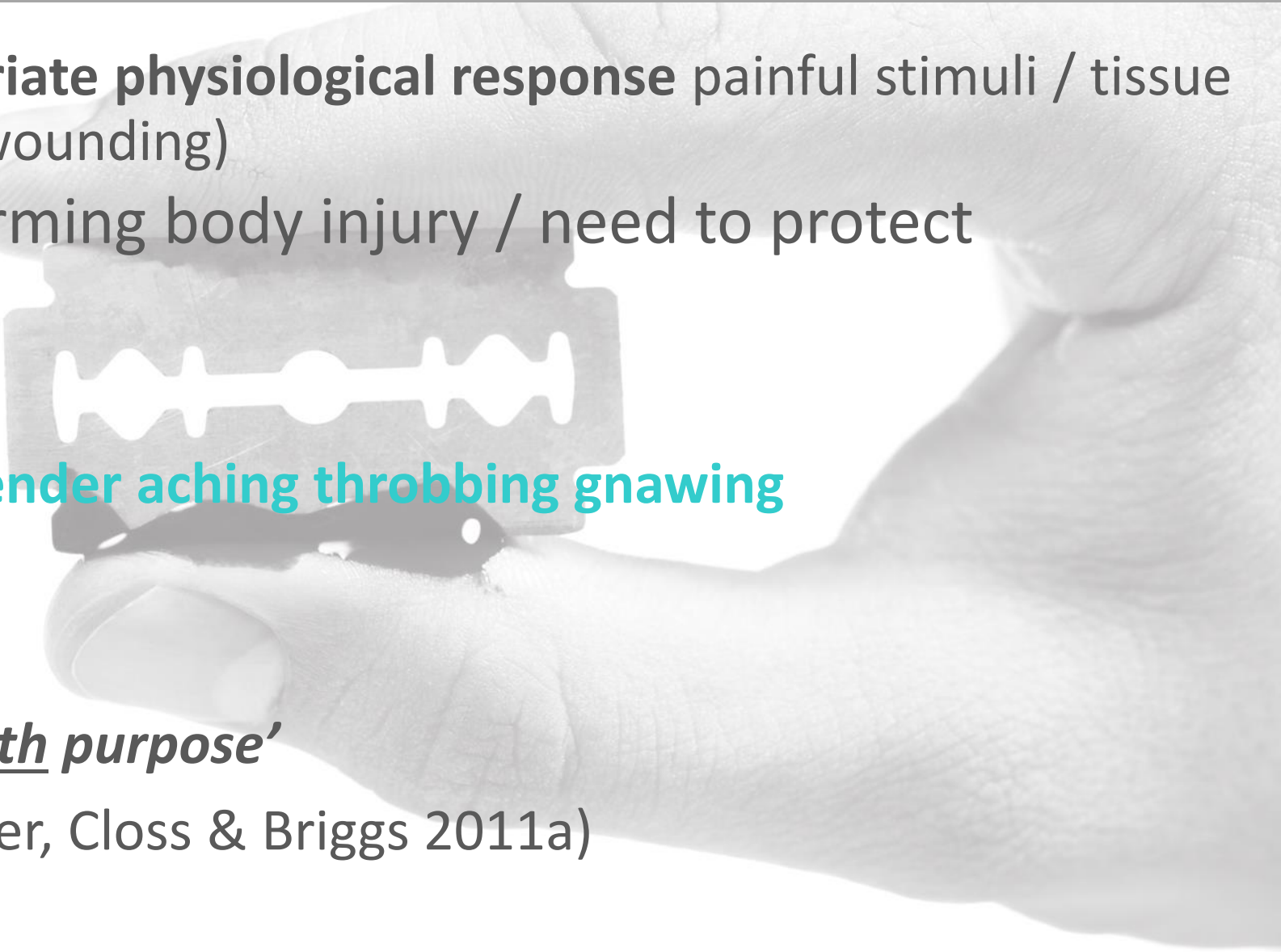
- Tissue damage activates pain receptors
- Peripheral nerves transmit signal spinal cord
- Neurotransmitters pass signal brain
- Thalamus relays to:
 - Somatosensory cortex
(SENSATION)
 - Frontal cortex
(THINKING)
 - Limbic system
(EMOTIONAL RESPONSE)



Pain Mechanism:

Nociceptive (non NeP)

- **Appropriate physiological response** painful stimuli / tissue injury (wounding)
 - Informing body injury / need to protect
- **Sharp tender aching throbbing gnawing**
- ***'Pain with purpose'***
(Taverner, Closs & Briggs 2011a)





Pain Mechanism:

Neuropathic (NeP)

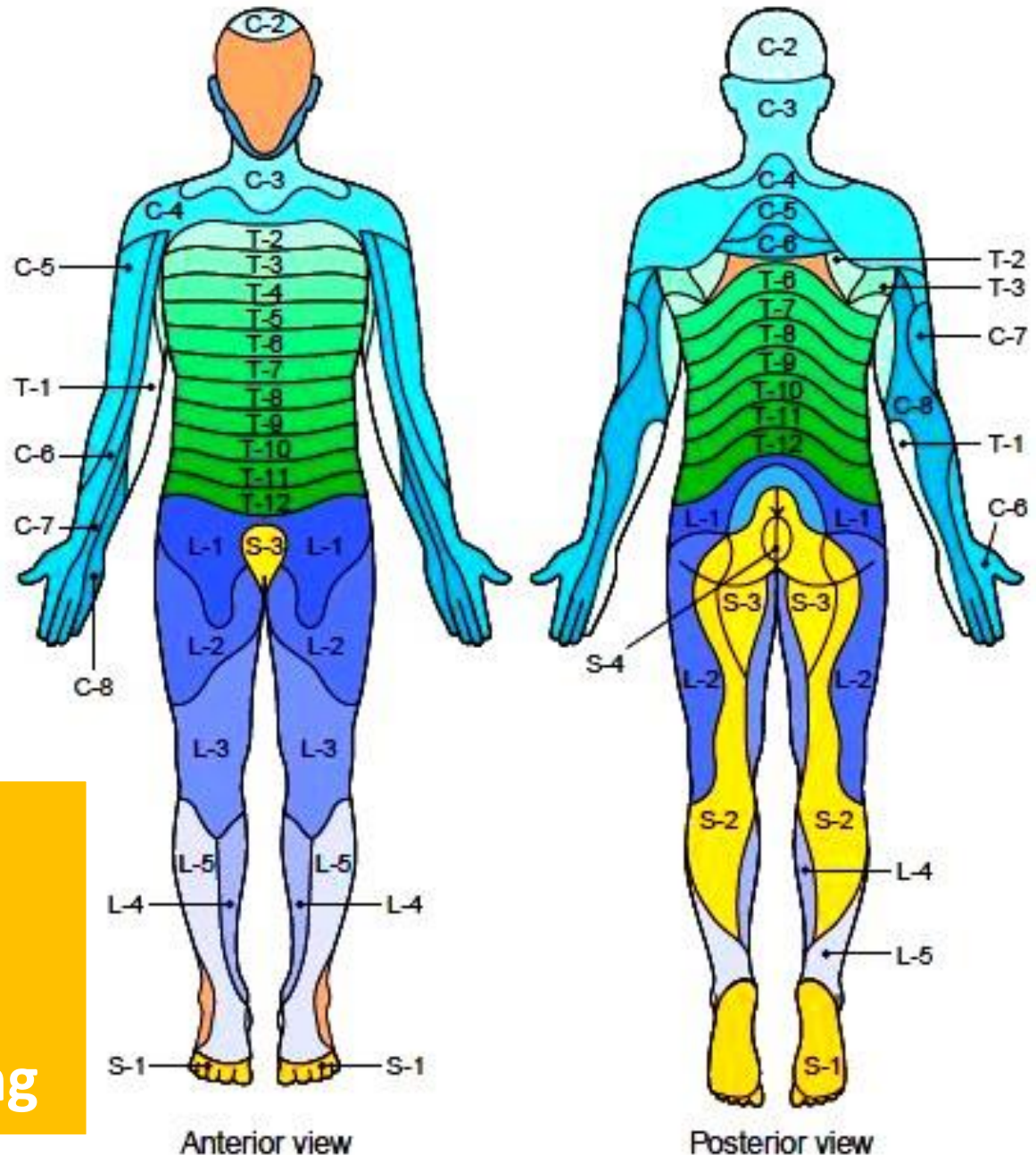
- **Maladaptive response somatosensory system (P&C NS)**
to the primary pathology

TRAUMA / SURGERY / DISEASE / CNS SENSITISATION

- **Positive (painful): *Dysesthesia***
burning, shooting, stabbing (lancinating), **stinging**
- **Negative(non painful): *Paraesthesia***
numbness, tingling, pins & needles, prickling
- ***‘Pain without purpose’*** Taverner et al 2011a

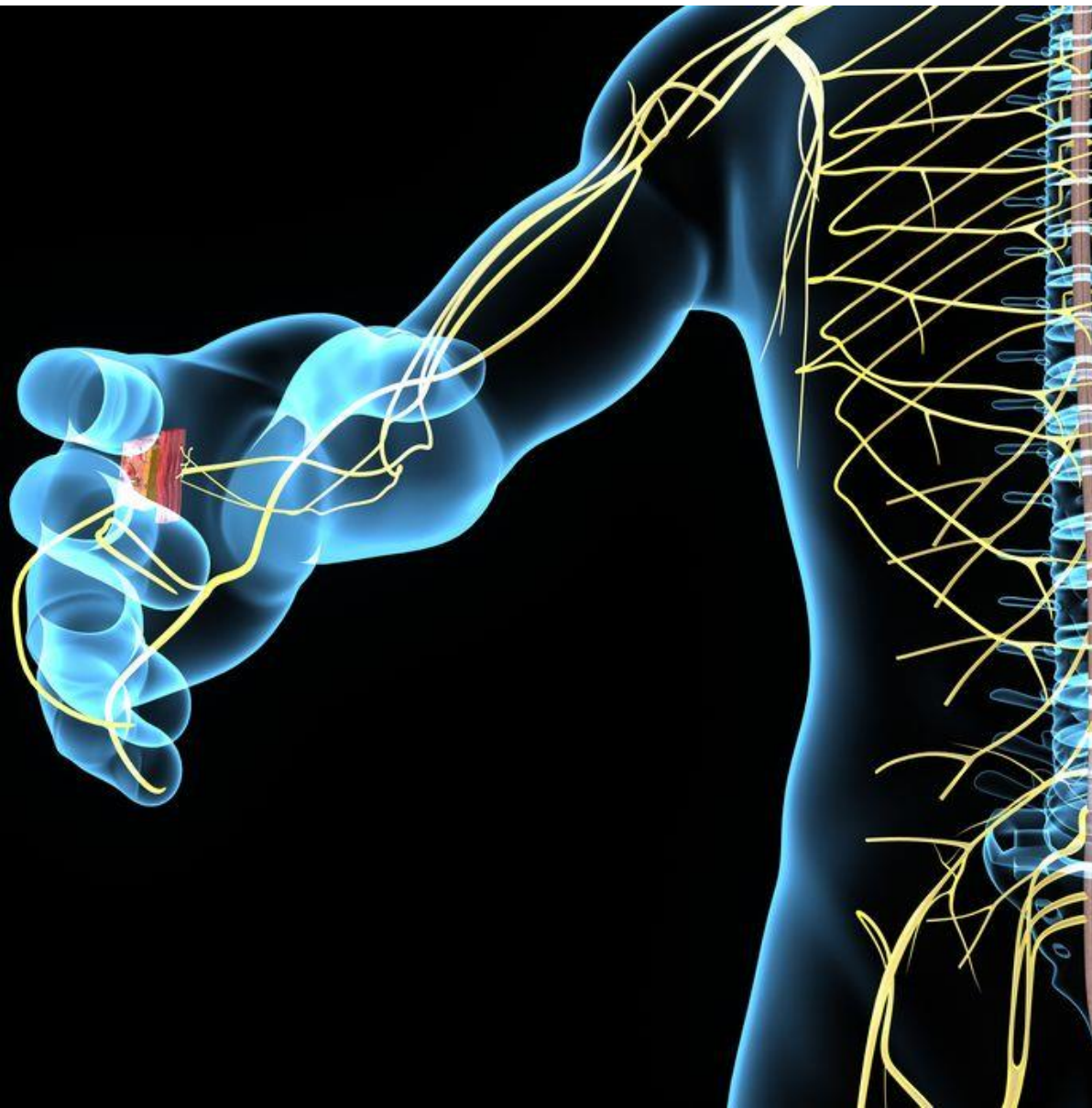


Neuro-anatomically logical



Constant
Intermittent
Paroxysmal
Nocturnal worsening

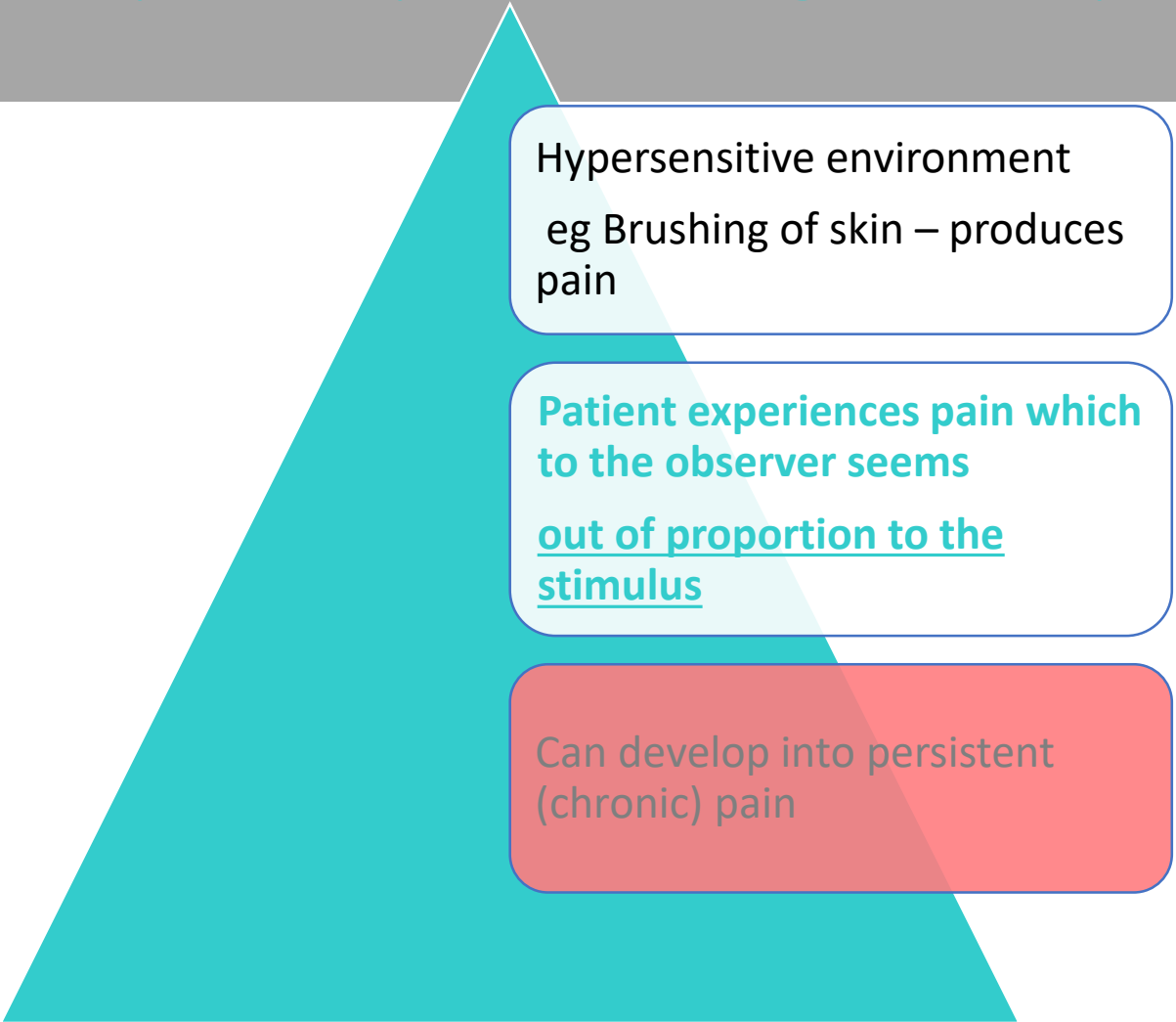
Hyperalgesia



- Normal
 - c – nociceptors ‘silent’ when not stimulated
- Pathophysiology
 - **Post acute injury or during ongoing inflammation**
 - C – nociceptors become **sensitised**
 - Release **pain and inflammatory mediators**
 - Can lead to small stimuli being perceived as painful
- Primary hyperalgesia—**in the wound**
- Secondary hyperalgesia—**surrounding skin**

Allodynia

Any sensory stimulus registers as pain



Hypersensitive environment
eg Brushing of skin – produces pain

Patient experiences pain which to the observer seems
out of proportion to the stimulus

Can develop into persistent (chronic) pain

'Wind Up' Pain

Sustained [repeated]

- Increased c – nociceptor activity

Alters response of CNS - inputs from periphery

- **Progressive increase intensity of perceived pain**

Wind up pain can be exaggerated in persistent (chronic) pain

EWMA Position Document. Pain at wound dressing changes. www.ewma.org

Popescu A, Sal Salcido R. [2004] Wound Pain: A challenge for patient and wound care specialist. *Advances in Skin and Wound Care*. 17[1]: 14-20



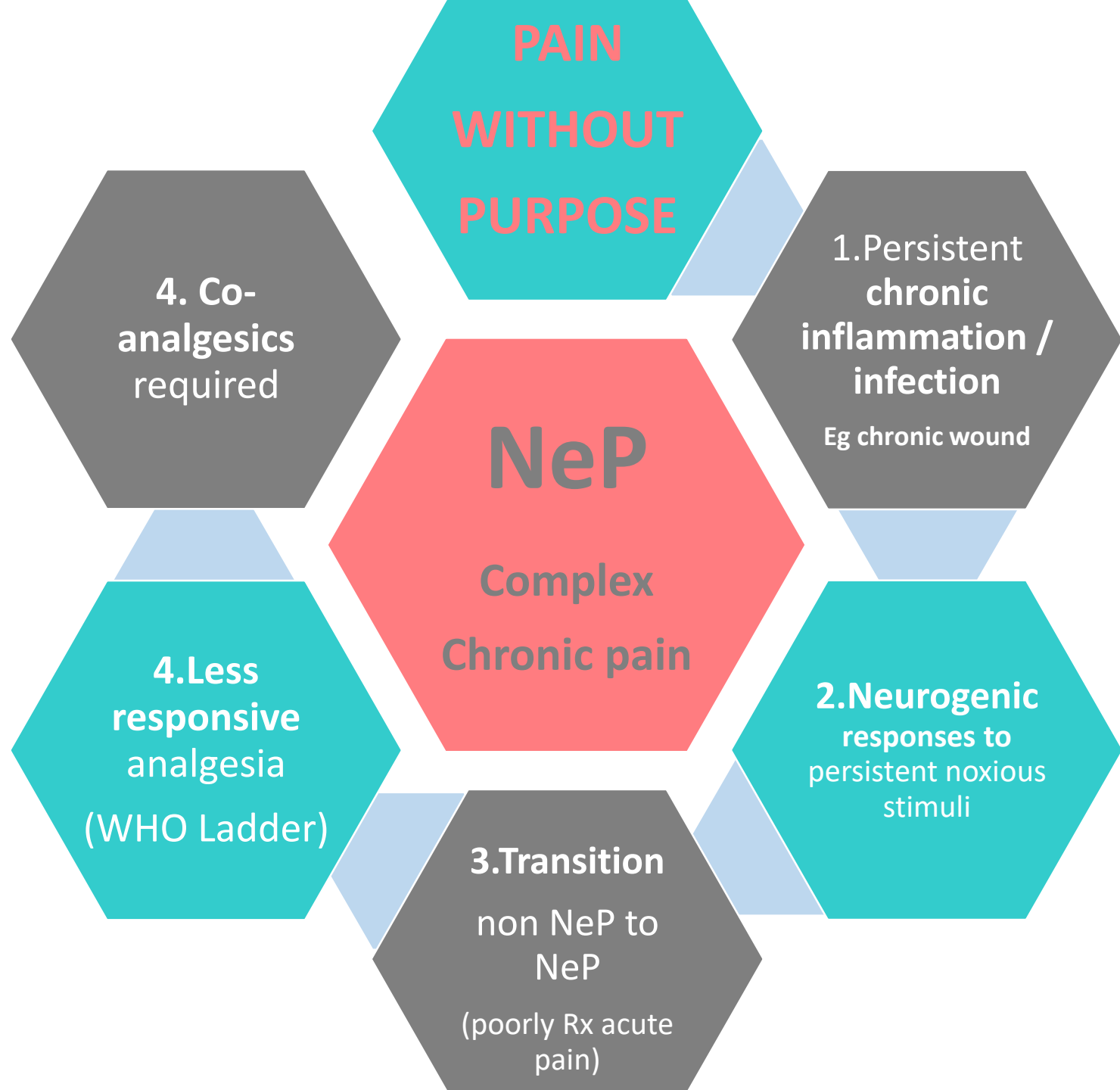
Procedural Pain

‘Noxious barrage of CNS can cause sensitisation when increased excitability of the neuron can cause a response in the neural receptive field that previously was unresponsive...

this can lead to persistent pain...

Thus no noxious stimulus should be considered benign,
as the stimulus may effect the CNS in an adverse way’
p426

What we do / don't do at dressing change (procedure) IS IMPORTANT!



Chronic Pain Sequela



NeP
under
recognised*

NeP
poorly
managed*

Suffering
Disability
Debilitating**

*Bouhassira & Attal 2011 / Taverner 2011

**Closs Staples Reid Bennett Briggs 2007

Common Descriptors NeP Literature

Debilitating


(latin: *debilis* 'weak')

Disabling

(cripples, incapacitates)



Insomnia, Depression, Suicidal ideation



NeP
important
public health issue
&
burden

Haanpaa et al 2011; **Taverner 2011; Matsuki & Upton 2013**



Impact Pain

Chronic wounds

WRP described common symptom

Chronic Wounds



BACKGROUND:

Pain at rest [Day / Night All the time]

INCIDENT:

Day to day activities / movement

PROCEDURAL:

Dressing related procedure

Operative:

Biopsy / debridement

PERSON

Pain related to Wound

All wounds / venous leg ulcers

- Never / rarely 32.2% / 26%
- Quite often 31.1% / 31%
- Most / all time 36.6% / 42.7%

Venous & arterial ulcers more frequent pain [p=0.002]

Location of WRP

All wounds / venous leg ulcers

- In wound 53.6% / 52%
- In wound & skin 1.3 / 1.4%
- Surrounding skin 25.5% / 28.7%
- Skin & elsewhere 0.33% / 0.1%
- Radiating elsewhere 18.9% / 17.1%

Pain related to Dressing Change

All wounds / venous leg ulcers

- Never / rarely 45.3% / 39%
- Quite often 21.9% / 25%
- Most / all time 31.9% / 35.6%

Venous, arterial & mixed associated
more frequent pain at dressing change [$p<0.001$]

Time Pain Resolve Post Dressing

All wounds / venous leg ulcers

- Less than 1hr 42.5% / 46.9%
- 1-2hrs 23.3 / 30.2%
- 3-5hrs 9.9% / 13.2%
- More than 5hrs 8% / 9.5%

*'I've had shooting pains so strong
that I'd almost describe it as having a knife
or an axe in the ulcer.*

*I've had pains that were so intense
that I've cried out loud and startled my
family.*

(54-year-old man, ulcer duration: eight months.)

ACUTE PAIN

‘Temporary’

CHRONIC PAIN

‘Persistent’

Psychological Stressors

- Acute 'time limited':
 - Public speaking
- Brief:
 - Exams
- Event sequence:
 - Death spouse / disaster
- **Chronic:**
 - Living with persistent pain
- Distant:
 - Past abuse / combat exposure



Negative Lived Experience

The impact of chronic unrelenting pain can be devastating,
eroding the individuals QoL*
and constituting a significant amount of stress.

Increased stress has been demonstrated
to lower pain threshold,
and decrease tolerance.

The result is a vicious cycle of pain, stress / anxiety,
anticipation and worsening of pain.



Past negative
experiences

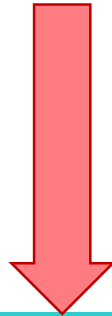
Anticipatory Pain

Woo (2008)

Past painful experiences



Higher anxiety levels pre dressing change



Higher pain intensity scores during wound care

Pain

Major Feature Chronic Wounds

- Most 'distressing'

[Price et al 2007, Hopkins 2004, Wilson 2004, Nemeth et al 2003]

- Fear, worry, frustration, anger
(negative emotions)



Price, P. Fogh, K. et al. 2007. Managing painful chronic wounds: the Wound Pain Management Model. *International Wound Journal*;4[S1];4-15
Hopkins, A. Disrupted lives: investigating coping strategies for non healing leg ulcers. *British Journal Nursing*.;13:556-63
Wilson, A. 2004. Quality of life and leg ulceration from their perspective. *British Journal of Nursing*;13:S17-20
Nemeth, K. Harrison, M et al 2003. Pain in pure and mixed aetiology venous leg ulcers: a 2 phase point prevalence study. *Journal of Wound Care*;12:336-40

STRESS: DISTRESS: DEPRESSION

- **Distress:**

- Persistent stress that is **not resolved** through coping or adaptation

- May lead:

- **Anxiety**
- **Depression** [withdrawal]



Physiological Response to Stress

- Increase activity **sympathetic nervous** system
- Increased levels of **epinephrine** and **nor-epinephrine**
 - **Vasoconstriction**
 - Increased cardiac effort
 - Inhibition GIT
 - Increased glycolysis in muscles.



Pain = Physical / Emotional STRESSOR

- Hypothalamic – pituitary – adrenal axis
 - Feedback loop deactivated
 - **Production excess cortisol**
- **Dysfunction immune system**
 - **Suppression** = reduced PIC / enzymes
 - **Sustained suppression** = excessive immune response / tissue breakdown
- **Delay healing / Infection**

Cortisol & Gate Control Theory

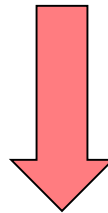
- Peripheral and central nervous system
 - **Brain processes perception pain**
 - Nociceptive signals – ‘gate’ spinal chord
- Some peripheral stimulation close gate
 - ‘Rubbing’
 - Distraction
 - Music, guided visual imagery, tapping
- Chemicals open gate
 - **Stress hormones - cortisol**

Consequences Excess Cortisol

(Kiecolt-Glaser 1998)

- **Depression immune** function
- Changes levels of inflammatory cytokines [wound healing]

**PAIN INDUCED
PSYCHOLOGICAL STRESS**



‘There is substantial data
to suggest that
**stress-induced disruption of
neuroendocrine equilibrium**
is detrimental to health,
*with the strongest evidence
to date
in wound healing.*’

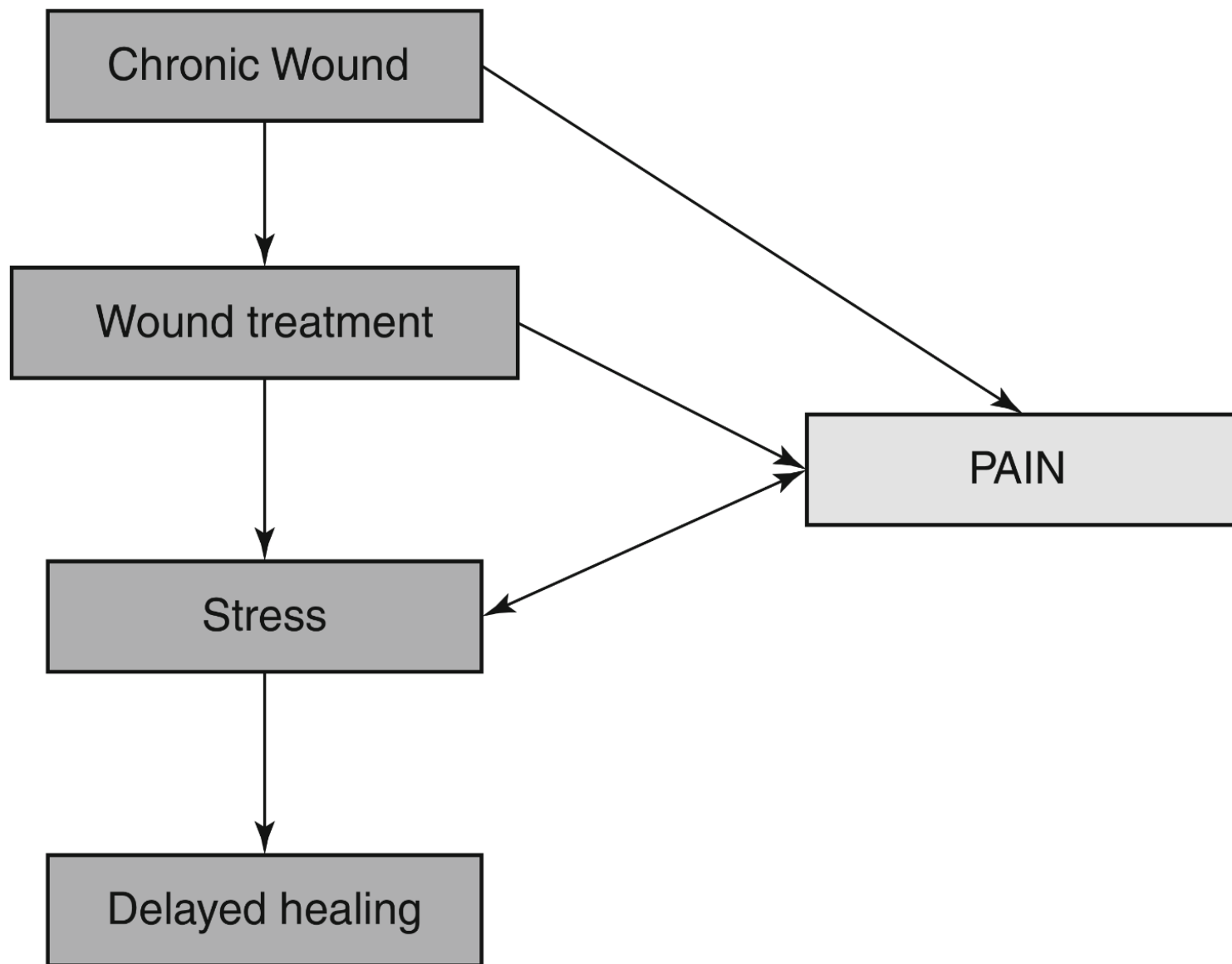


FIGURE 3.1 A model illustrating link between psychological stress, pain and chronic wound healing

Upton & Upton (2015)

Pain — Stress - Pain

Impact Person

- Pain psychological *stressor*

(Upton, Solowiej; Woo 2012; Matsuki, Upton 2013)

- Negatively impacting person

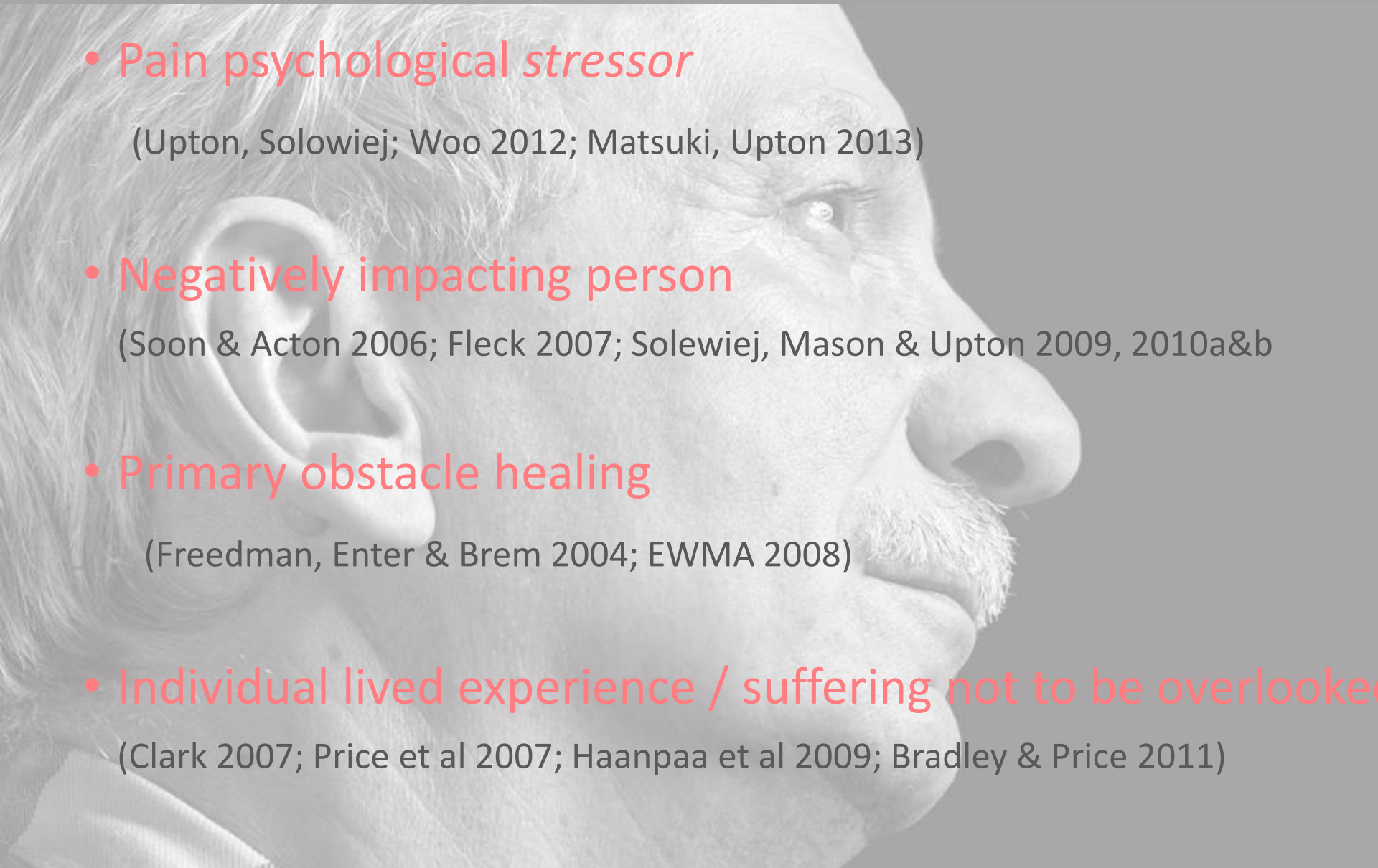
(Soon & Acton 2006; Fleck 2007; Solowiej, Mason & Upton 2009, 2010a&b)

- Primary obstacle healing

(Freedman, Enter & Brem 2004; EWMA 2008)

- Individual lived experience / suffering not to be overlooked

(Clark 2007; Price et al 2007; Haanpaa et al 2009; Bradley & Price 2011)



SO ...

PAIN

REALLY Matters



Mixed Pain

Chronic wounds

Research Question

In a primary health care setting,
**what is the prevalence of
neuropathic (NeP) vs non NeP
wound related pain (WRP)**
in persons
presenting with
acute or chronic wounds?

Primary Outcomes

To identify & describe:

1. the **presence, quality and quantity of WRP**

2. the **proportion of NeP** vs non NeP

in **consenting adults,**
with **acute or chronic wounds,**
managed in a **primary health care setting**

Screening NeP

Douleur Neuropathique en 4 Questions

DN4 (Bouhassira et al 2005)

- **7 sensory descriptors + 3 sensory examination**
 - (Touch, prick, brush) – *in painful area*
 - **4/10** positive screen NeP characteristics

****DN4-Interview**

- **7 sensory descriptors only**
 - **3/10** positive screen

DN4 Questionnaire

Please complete this questionnaire by ticking one answer for each item in the 4 questions below:

INTERVIEW OF THE PATIENT

Question 1: Does the pain have one or more of the following characteristics?

- 1 – Burning
- 2 – Painful cold
- 3 – Electric shocks

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Question 2: Is the pain associated with one or more of the following symptoms in the same area?

- 4 – Tingling
- 5 – Pins and needles
- 6 – Numbness
- 7 – Itching

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

3/7 + screen NeP

EXAMINATION OF THE PATIENT

Question 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

- 8 – Hypoesthesia to touch
- 9 – Hypoesthesia to prick

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Question 4: In the painful area, can the pain be caused or increased by:

- 10 – Brushing

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

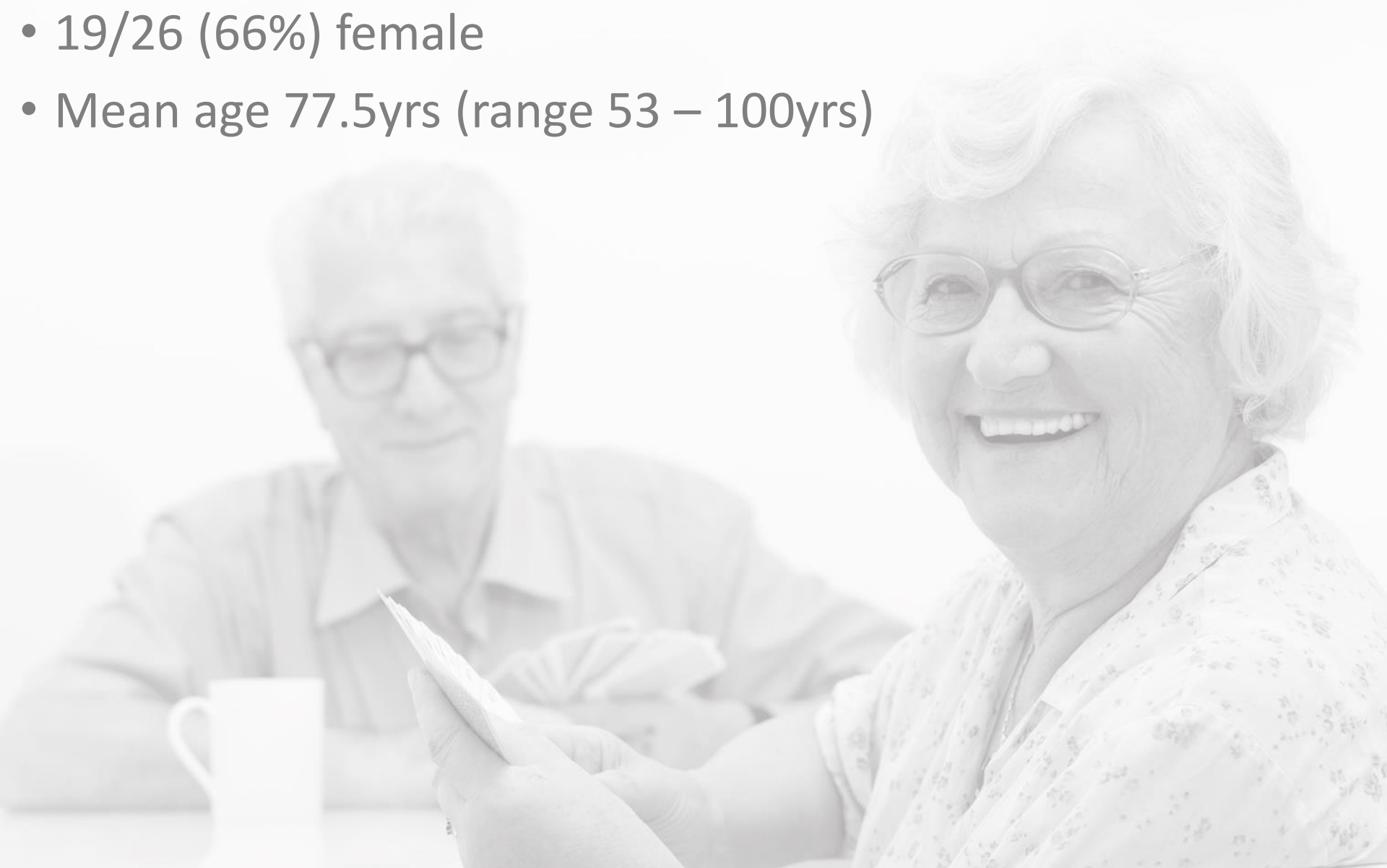
The total score is calculated as the sum of the 10 items and the cut-off value for the diagnosis of neuropathic pain is a total score of 4/10.

Total
<input type="text"/>

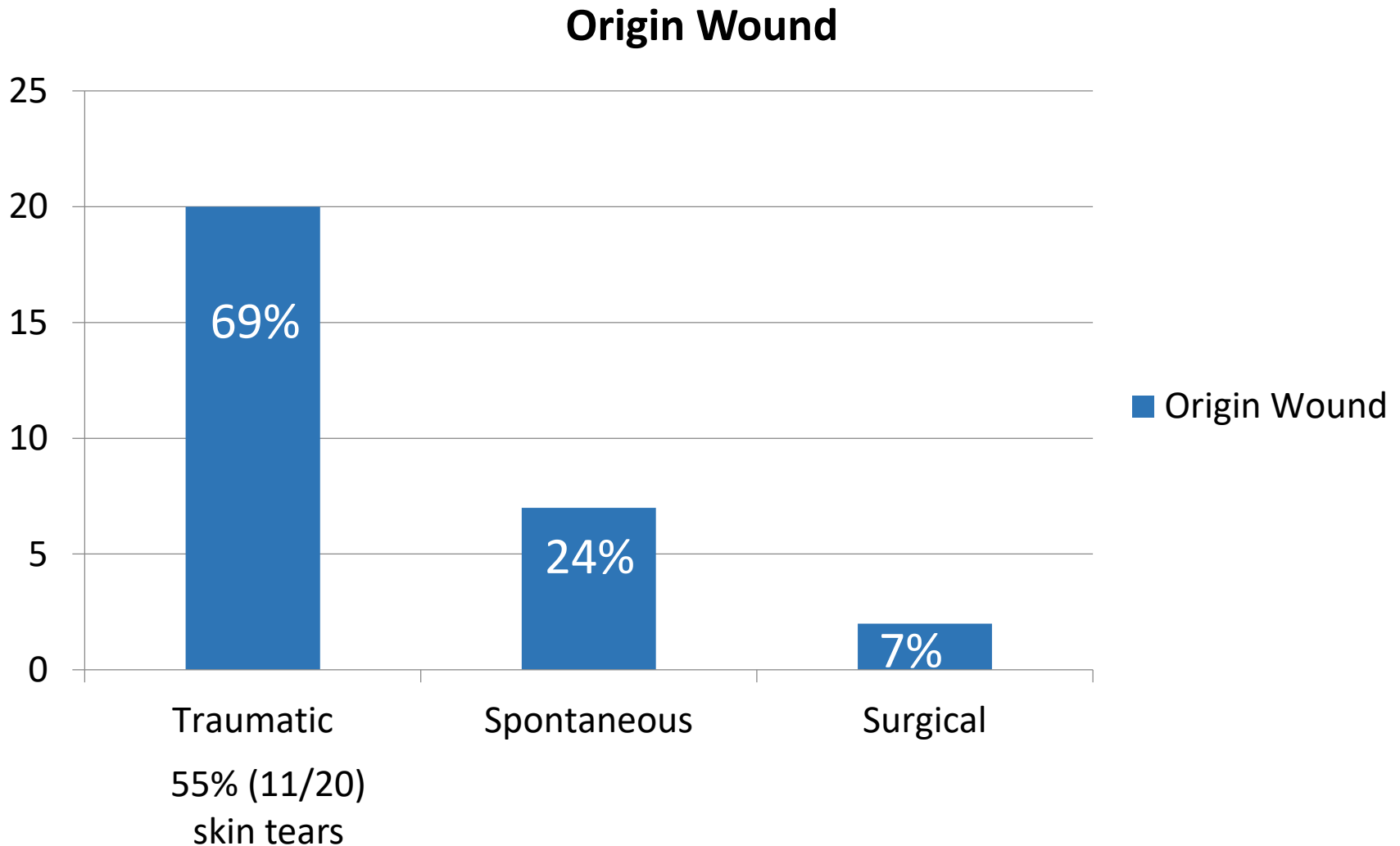
Bouhassira D, Attal N, Alchaar H, et al. "Comparison of pain syndromes associated with nervous or somatic lesions and development of a new neuropathic pain diagnostic questionnaire (DN4)." Pain 114.1-2 (2005): 29-36.

Participant Demographics

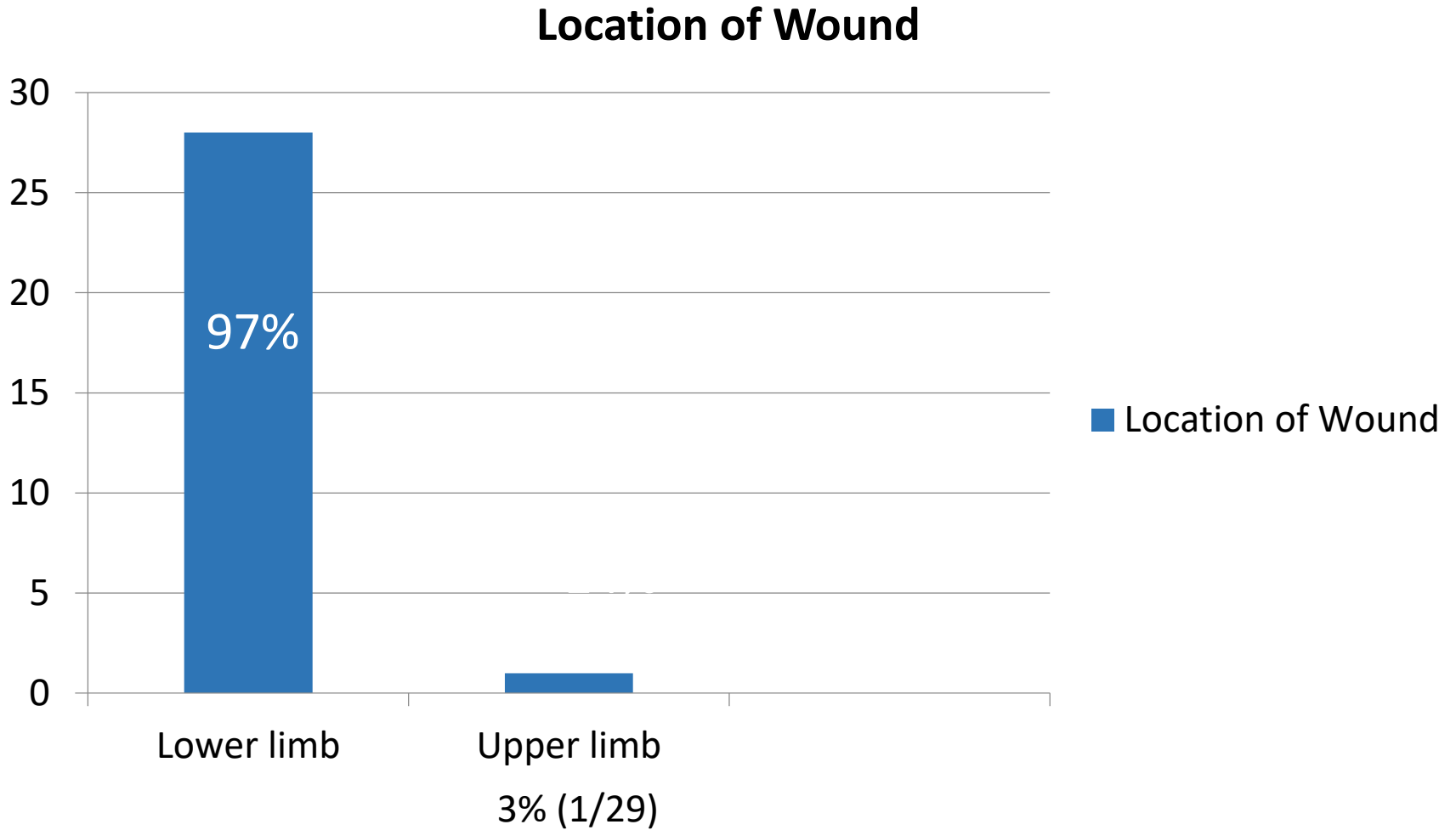
- 19/26 (66%) female
- Mean age 77.5yrs (range 53 – 100yrs)



Wound Demographics



Wound Demographics



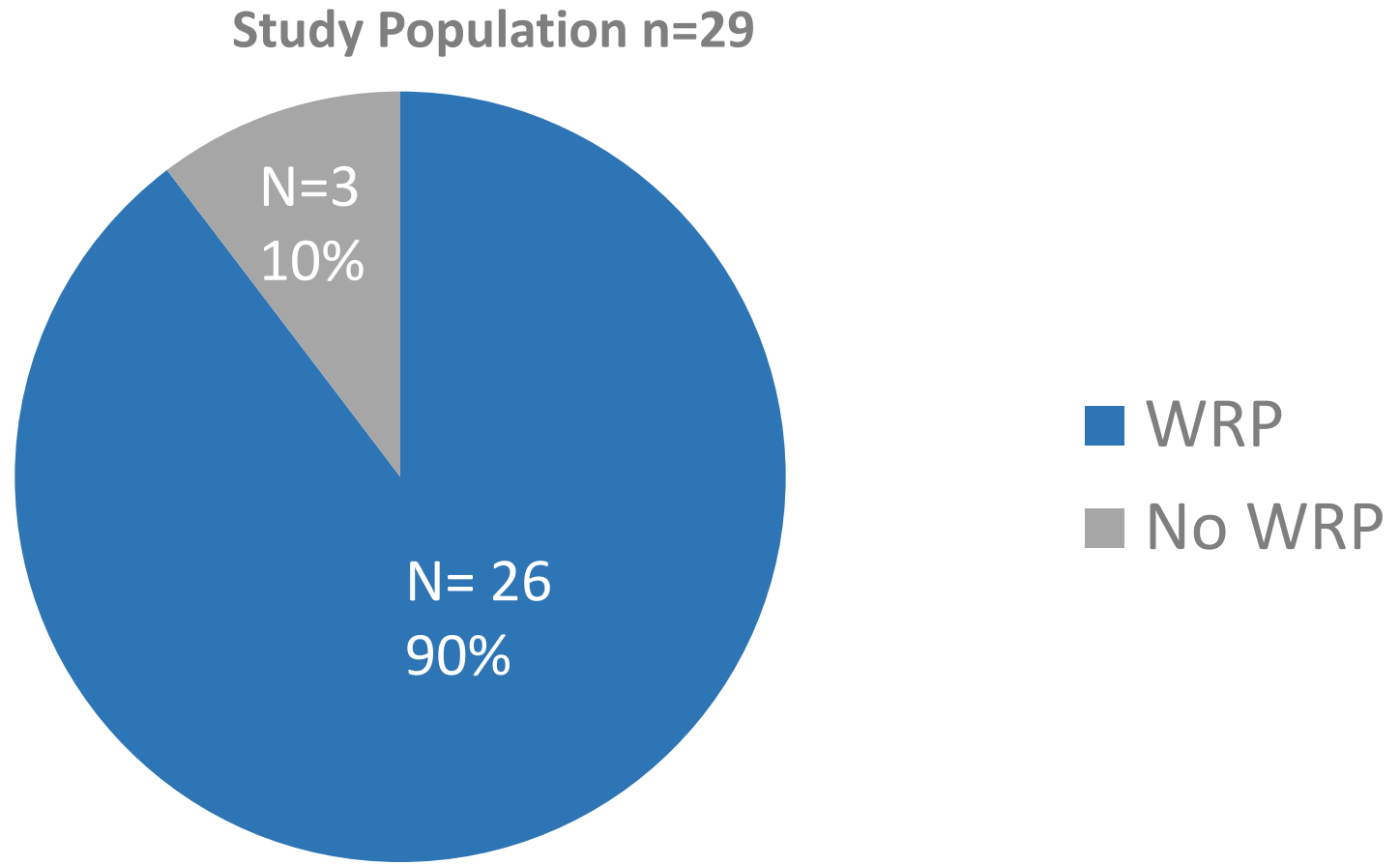
Wound Demographics



Mean duration 12.2 weeks (range 1-112 weeks)

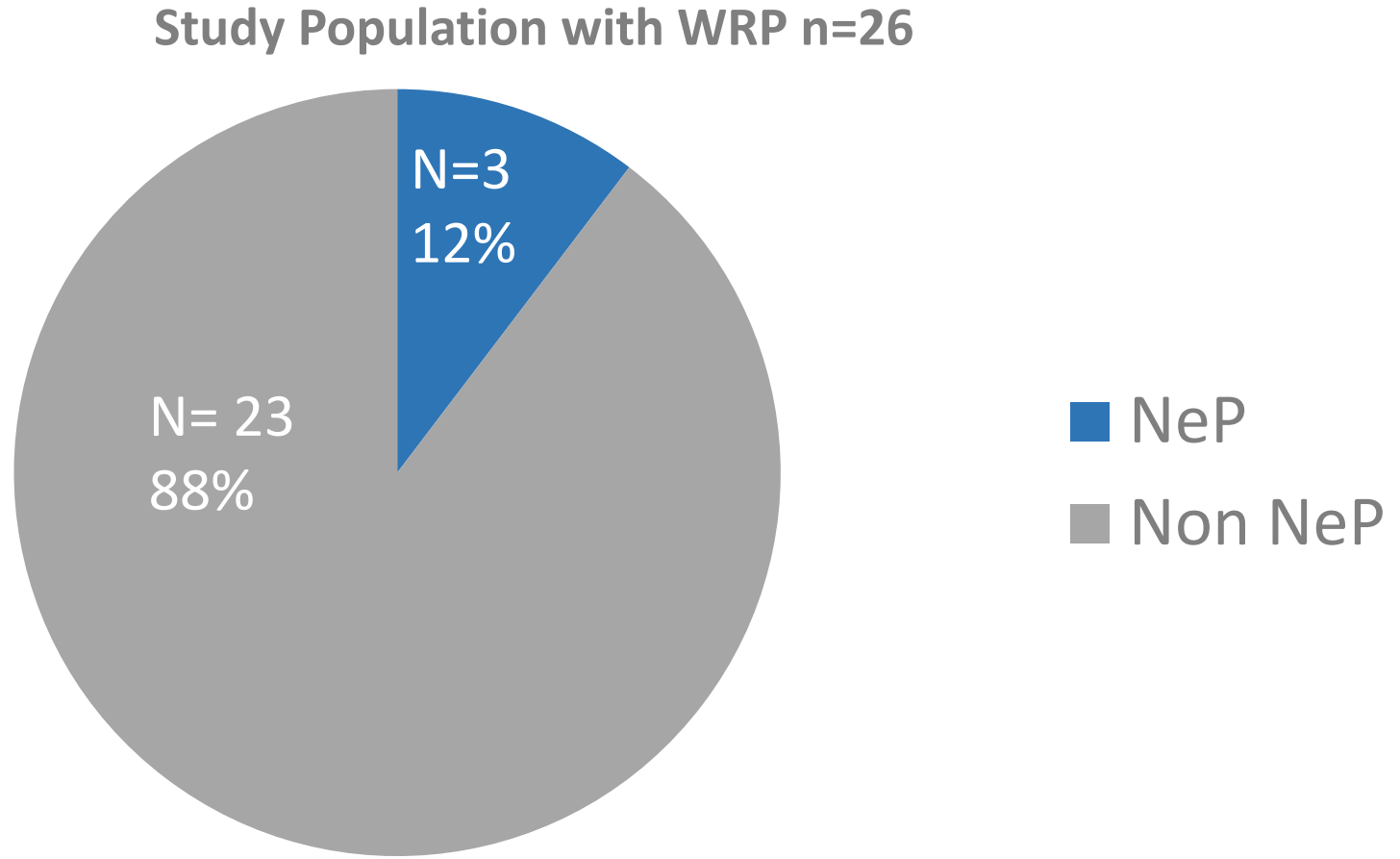
79% (23/29 wounds) present 6 weeks or more

Presence WRP



WRP mean worst pain severity score = 5.6 / 10 (moderate pain)

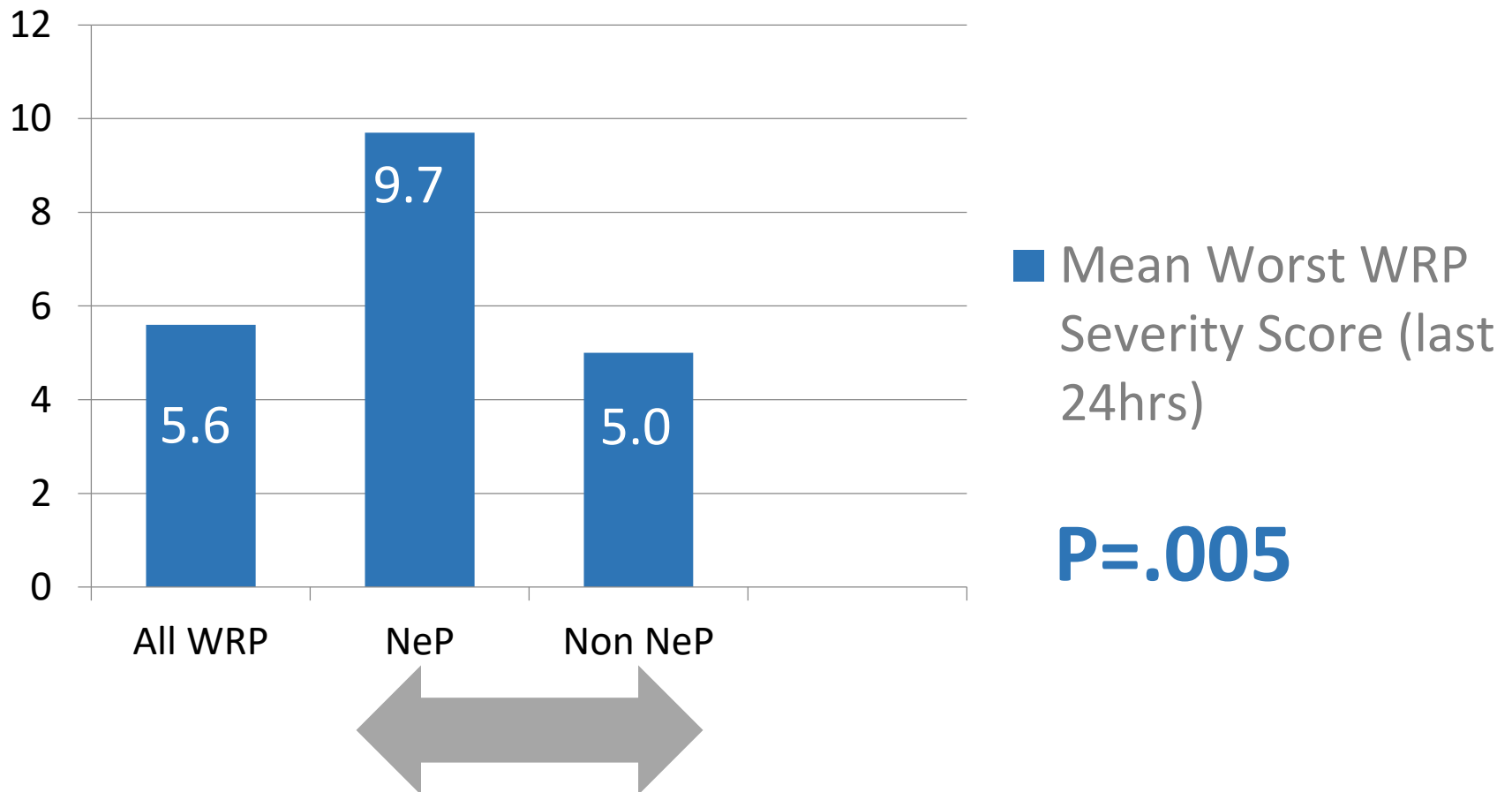
Proportion NeP vs Non NeP



NeP mean worst pain severity score = 9.7 / 10 (severe pain)

WRP Quantity: Severity

Study Population with WRP n=26
NeP n=3 / Non NeP n=23



WRP Location

Non NeP

NeP

Away

30%

N=7

39%

N=9

In
Wound

74%

N=17

Away

100%

N=3

100%

N=3

In
Wound

67%

N=2

(Away wound) **p = 0.046** (In all 3 locations) **p= 0.052**

WRP Quality: Descriptors

Gnawing
Aching
Throbbing
Tender
Sharp

NeP reported mean **9.3 / 11** descriptors

Non NeP reported **2.8 / 11** descriptors

p = 0.001 (mixed pain)

Crawling
Burning
Stinging
Shooting
Tingling
Stabbing

NeP reported mean **5.3 / 6** NeP descriptors

Non NeP reported mean **1.3 / 6** NeP descriptors

p=.001

NeP
↓

In this pilot study.....

- **WRP common symptom 90%**
 - Older person
 - Lower limb trauma / slow healing leg ulceration
 - Moderate levels WRP
- **12% those with WRP screened + NeP**
 - Severe levels WRP
- **Significant difference NeP vs non NeP**
 - Mean pain quality (severity) scores (worst 24hrs)
 - Mean no. of descriptors (quality - mixed pain experience)
 - Location WRP (away wound / all 3 locations)

Purcell (2012/17/18)

Leg ulcer pain >4

5% EMLA (2.5% lignocaine / 2.5% prilocaine)

50% MIXED PAIN BASELINE

Dressing change

Intervention pain scores

3.39.vs 4.82 control

Post dressing change

2.71 vs 3.92



Time for Action

*Chronic wound
pain*

Assume every wound painful, every person wound is in pain
(WUWHS 2004)

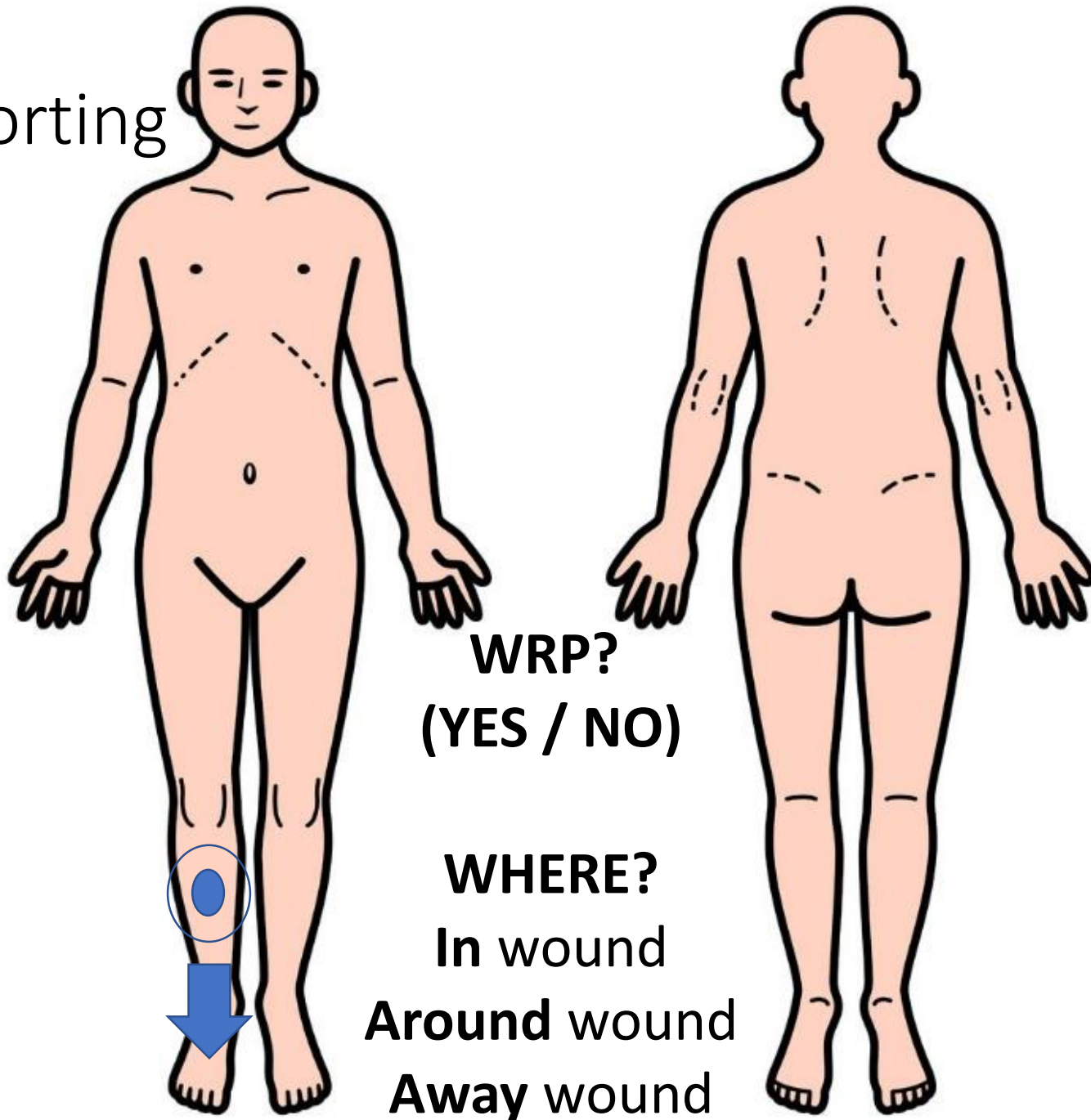


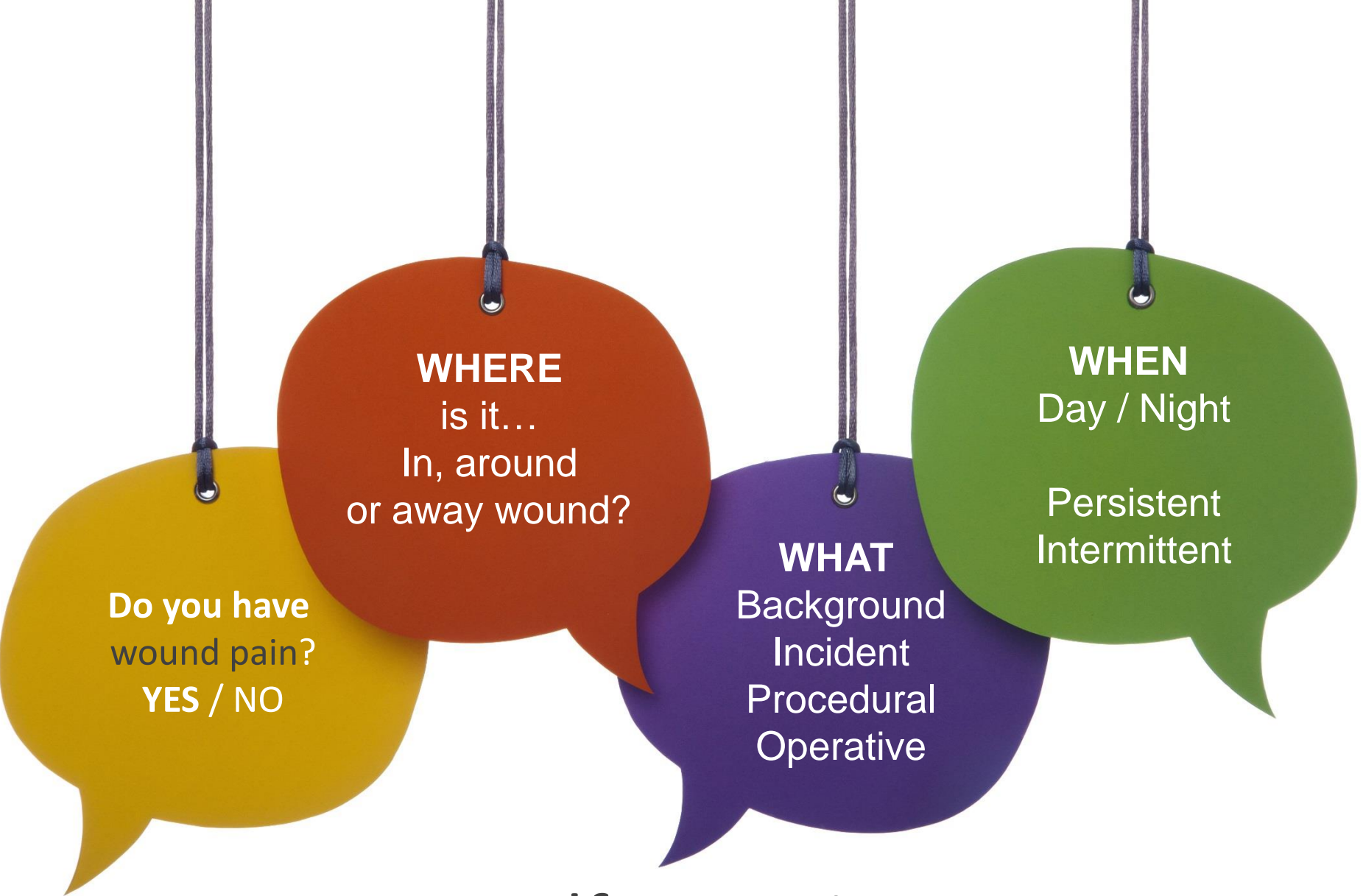
Management WRP important person – more than HCP
Sibbald et al 2006; Tarvener et al 2011b

Consistent, Careful, Regular

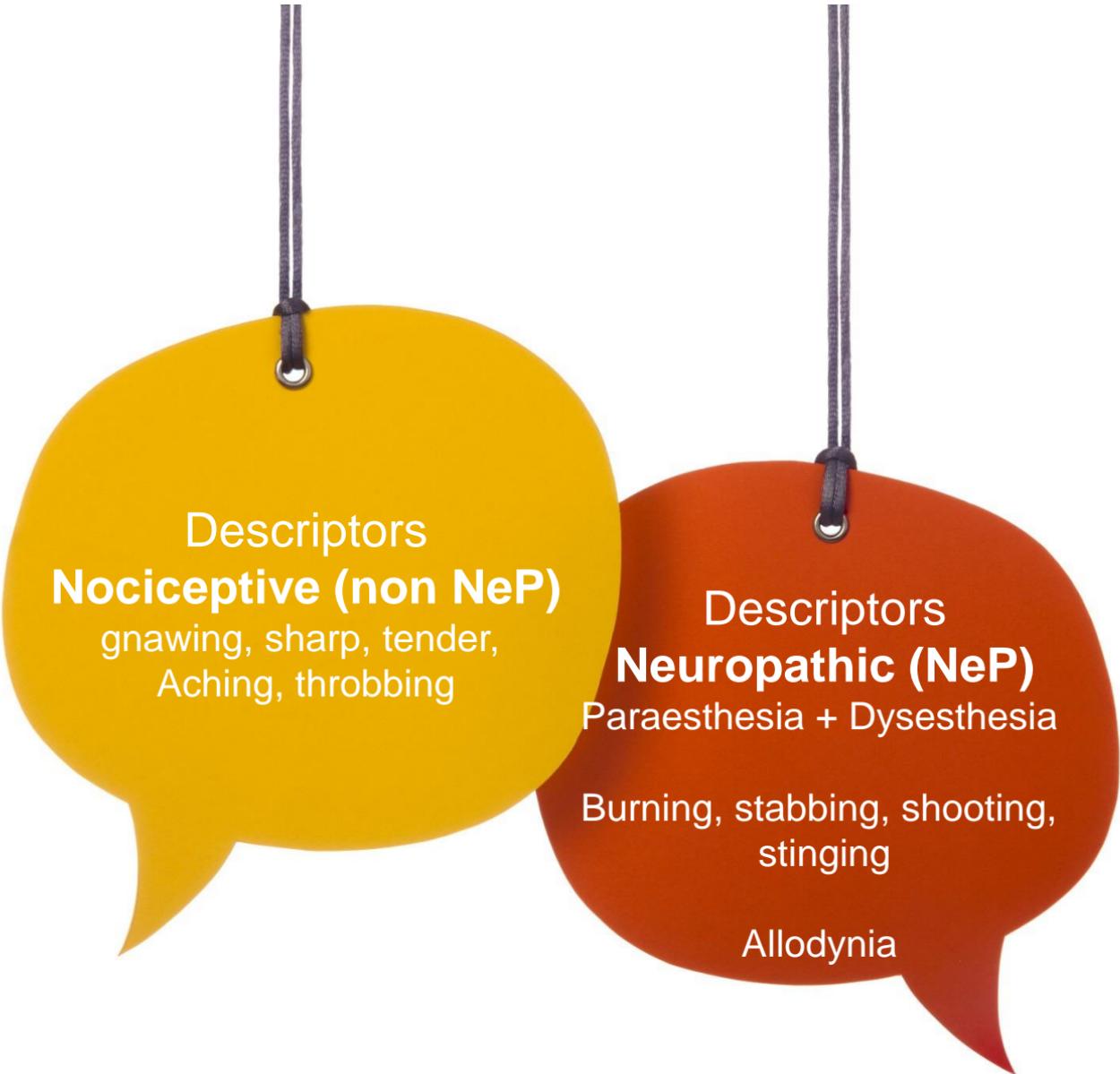
- **Monitor over time** (Woo, Harding, Price et al 2008)
 - Baseline / changes - TRENDS
- **Validated tools**
 - Self reporting (Gold Standard)
 - Observation (unable self report)
 - Unidimensional eg severity
 - Multi dimensional (WUWHS 2004/08)

Self Reporting





Self reporting
Questions relating wounds



Descriptors
Nociceptive (non NeP)

gnawing, sharp, tender,
Aching, throbbing

Descriptors
Neuropathic (NeP)

Paraesthesia + Dysesthesia

Burning, stabbing, shooting,
stinging

Allodynia

Self reporting

DN4 Questionnaire

Please complete this questionnaire by ticking one answer for each item in the 4 questions below:

INTERVIEW OF THE PATIENT

3/7 + screen NeP

Question 1: Does the pain have one or more of the following characteristics?

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- 3 – Electric shocks

Yes	No
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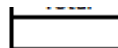
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- 4 – Tingling
- 5 – Pins and needles
- 6 – Numbness
- 7 – Itching

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

DN4
INTERVIEW

DN4



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4/10 + screen NeP

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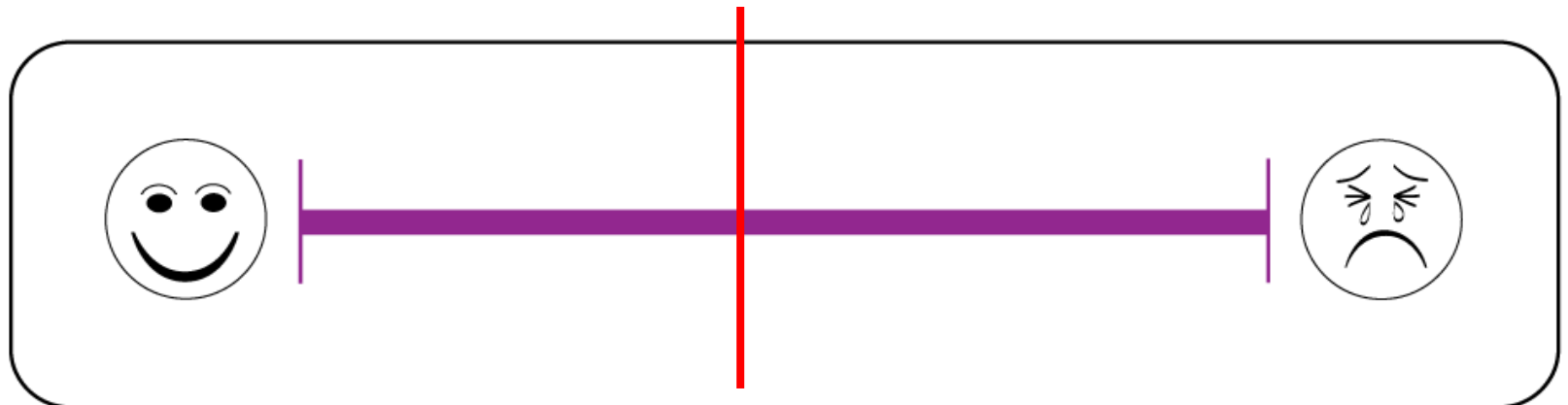
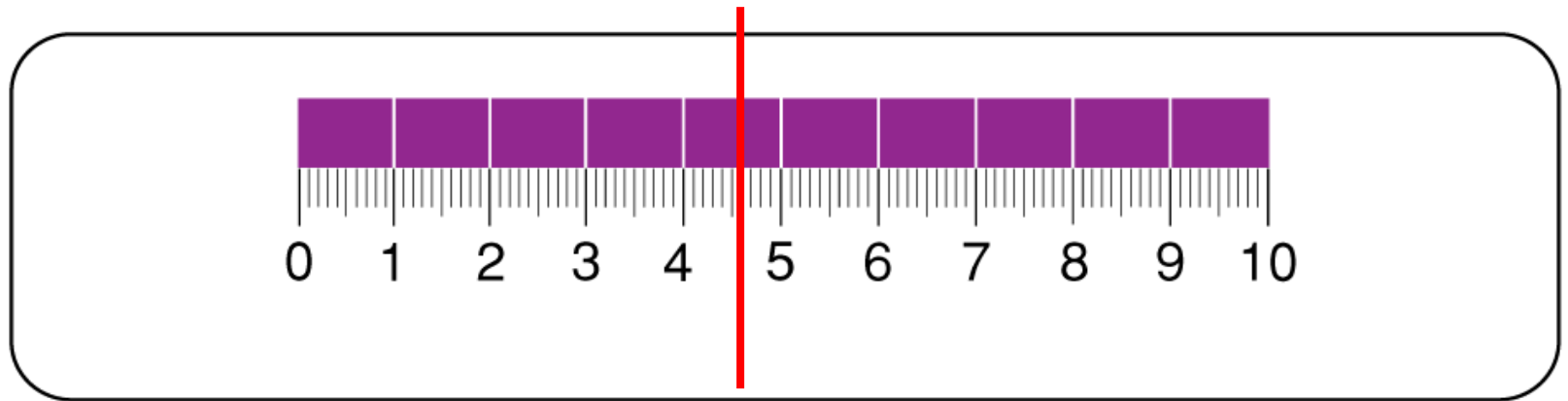
DN4
INTERVIEW

DN4



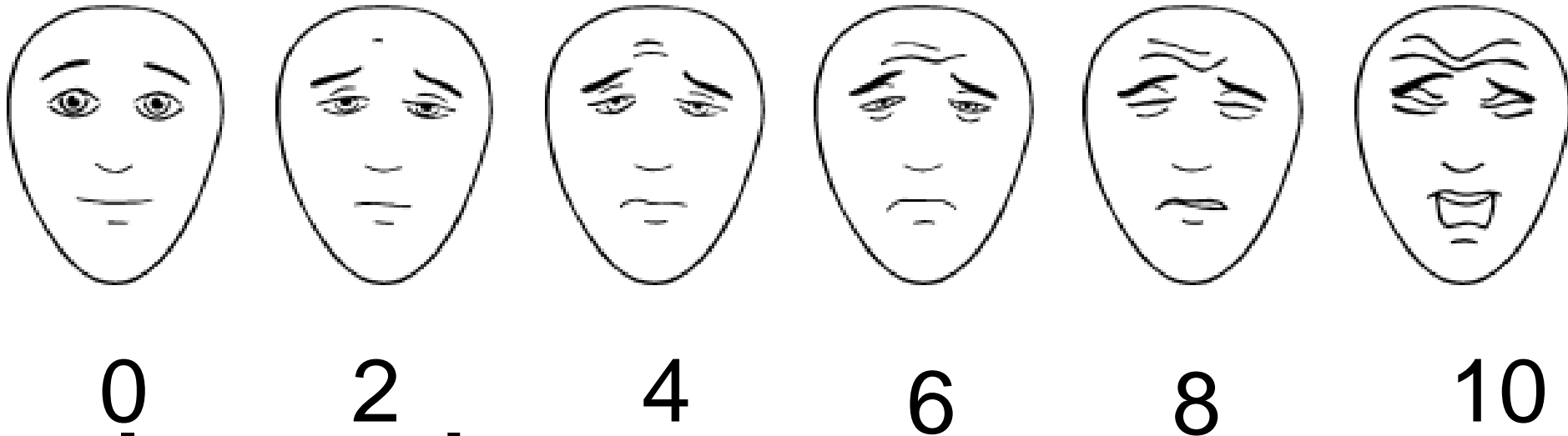
Self reporting WUWHS 2004/2007

Self Reporting:
Visual Analogue Scale
Numerical Rating Scale (NRS)



Self Reporting Faces Pain Scale [Revised] FPS-R

Point to the face that shows how much you hurt right now?



Instructions

‘These faces show how much something can hurt. This face [left] shows no pain [or hurt]. The faces show more and more pain [point to each from left to right] up to this one [right] It shows very much pain.

Point to the face that shows **how much you hurt right now**’

Bieri, D. et al . 1990. The Faces Pain Scale for the self assessment of the severity of pain experienced by children: development, initial validation and preliminary investigation for the ratio scale properties. Pain;41[2]:139-150

Faces Pain Scale - Revised: von Baeyer, van Korlaar, Spafford, Goodenough (2001). (2007)

<http://painsourcebook.ca/pdfs/pps92.pdf>

BEFORE DURING AFTER DRESSING CHANGE

PRE 1.5 / DURING 7 / POST 5

BEST 1.5

WORST 8

WHAT ARE NUMBERS TELLING US?

Moderate pain > 4 [0-10] or > 40% other scoring

‘Time out’

Top up medication

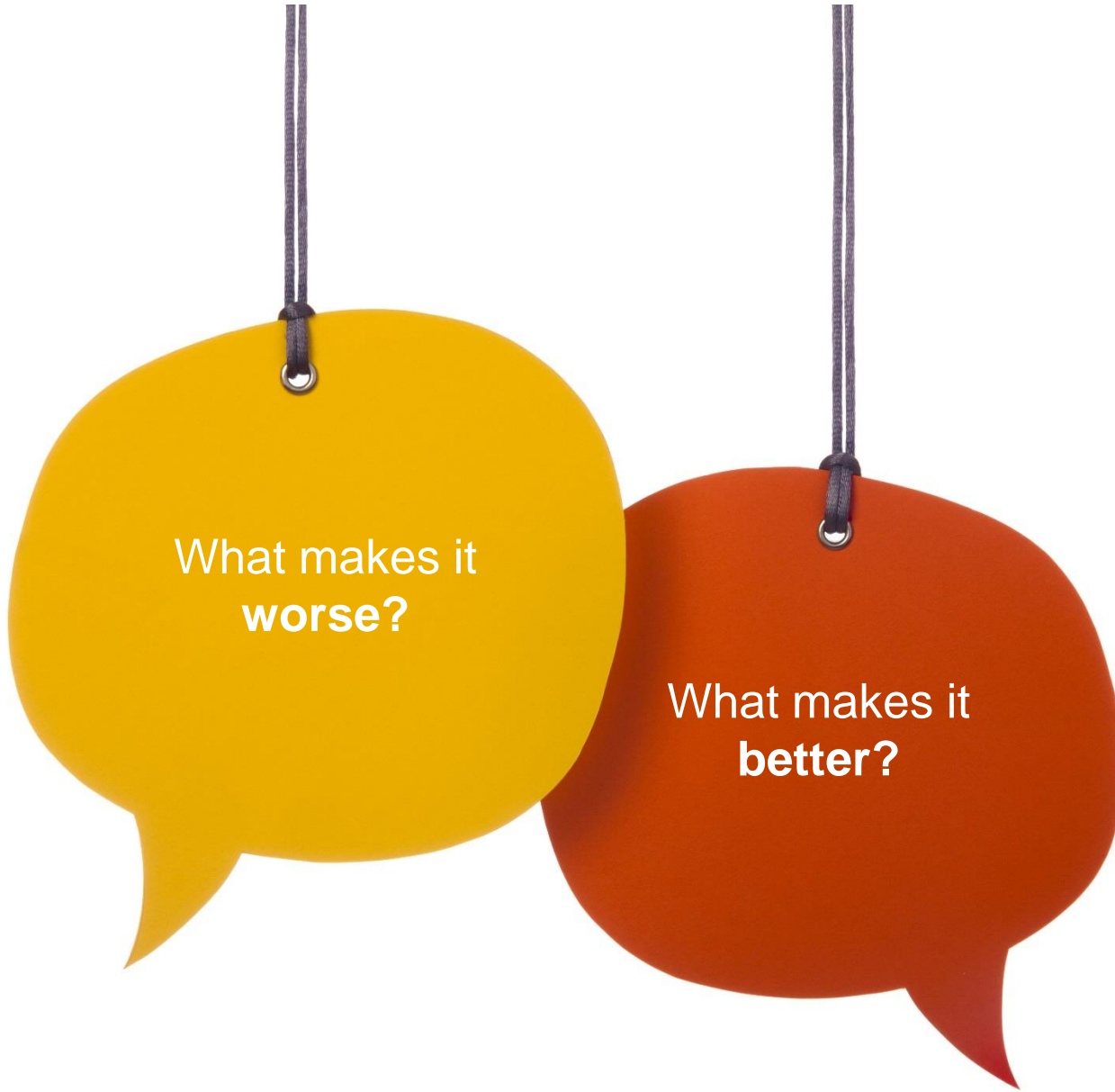
Review existing analgesic regime

Review dressing choice and procedures



0.	1.	2.	3.	4 - 5.	6.	7 - 9.	10.
No	Mild	Mod.	Mod.	More	Severe	Intensely	Most
			Analgesia	severe		severe	Severe pain

Antisocial



What makes it
worse?

What makes it
better?

Self reporting

**‘...a critical aspect
of wound pain assessment
is accepting or believing
what the patient says.’**

Observational:

When Self Reporting Not Possible

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident:

Name and designation of person completing the scale:

Date: **Time:**

Latest pain relief given was.....**at**.....**hrs.**

Q1. Vocalisation
eg. whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3 **Q1** ☐

Q2. Facial expression
eg: looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3 **Q2** ☐

Q3. Change in body language
eg: fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 **Q3** ☐

Q4. Behavioural Change
eg: increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3 **Q4** ☐

Q5. Physiological change
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 **Q5** ☐

Q6. Physical changes
eg: skin tears, pressure areas, arthritis, contractures, previous injuries.
Absent 0 Mild 1 Moderate 2 Severe 3 **Q6** ☐

Add scores for 1 – 6 and record here **Total Pain Score**

Now tick the box that matches the Total Pain Score ☐ ☐ ☐ ☐

Finally, tick the box which matches the type of pain ☐ ☐ ☐

Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

Abbey, J; De Bellis, A; Pillar, N; Eistenman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002
(This document may be reproduced with this acknowledgment retained)

28 TOOLS!

Pain Assessment IN Advanced Dementia PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing Short period of hyperventilation	Noisy labored breathing Long period of hyperventilation Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan Low level speech with a negative or disapproving quality	Repeated troubled calling out Loud moaning or groaning Crying	
Facial Expression	Smiling, or inexpressive	Sad Frightened Frown	Facial grimacing	
Body Language	Relaxed	Tense Distressed pacing Fidgeting	Rigid Fists clenched, knees pulled up Pulling or pushing away Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	

This material prepared by the Geriatric Research Education Clinical Center, is provided by the Illinois Foundation for Quality Health Care, the Medicare Quality Improvement Organization for Illinois, was prepared by Med/Soc, under contract with the Center for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents generated do not necessarily reflect CMS policy.

Non Verbal Pain Indicators

Edwards et al 2005

- Vocal expressions
- Facial
- Bracing
- Restlessness
- Rubbing

Behavioural

- Breathing, heart rate, blinking increase
- Muscle tension, sweating palms
- Dry mouth, tense voice
- Pale skin / cold sweat

(Upton & Solowiej 2010)

How
wound symptoms
(including pain)
impact on their life?

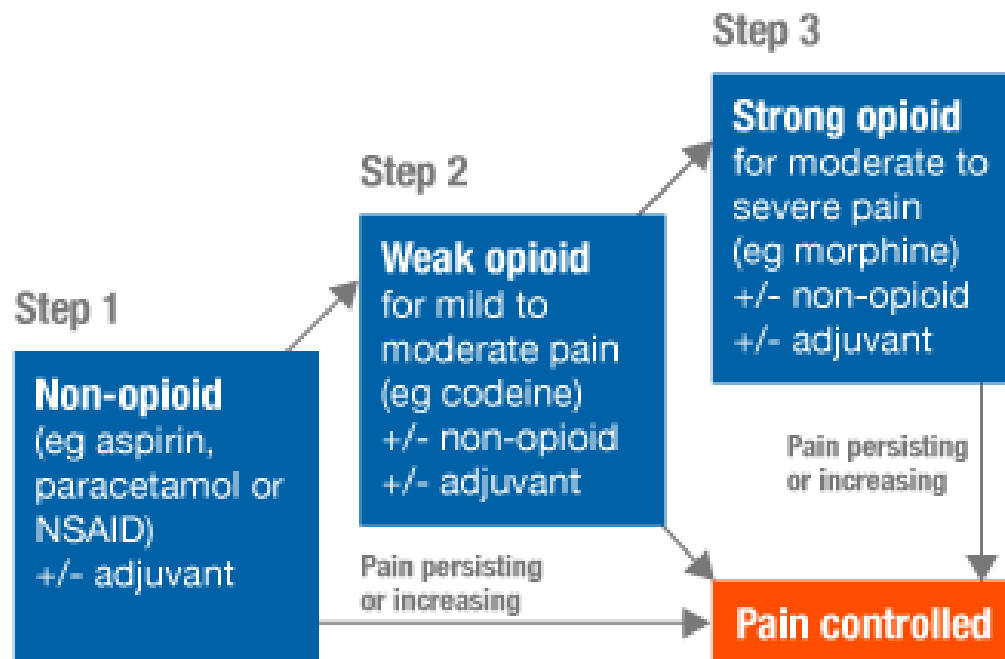
Self reporting

Can't Manage What Don't Measure



Strategy's
to prevent & minimise pain

Pharmacological Interventions WHO Ladder (1985)



2019

Global Year Against Pain in the Most Vulnerable (IASP)
RESOURCE

Evidence Based Recommendations (1)

Pharmacological Management NeP

NeuPSIG / IASP (2007 / 2010 update)

- **1st line (one or more)**

- Secondary-amine **TCA** (nortriptyline/desipramine)
- **SSNRI** (duloxetine / venlafaxine)
- **Calcium-channel blocker** (gabapentin / pregablin)
- Focal (topical lidocaine) in combo
- Acute/cancer/severe / titration
 - Opioid / tramadol combo with one 1st line

Cruccu, Truini
(2017)
REVIEW ALL
GUIDELINES

Evidence Based Recommendations (2)

Pharmacological Management NeP

NeuPSIG / IASP (2007 / 2010 update)

- **Reassess pain regularly**
 - Pain <3/10 – continue
 - Pain >4/10 (6-8 weeks) add another 1st line
 - If <30% reduction – switch another 1st line
- Consider 2nd and 3rd line if all fails
 - Tramadol / Opioid
 - Other AD / AC / low dose capsaicin

Every Decision Has Impact

Acknowledge & appreciate SIGNIFICANCE pain experience

(Gandhi 2010)

Person

- **Assessment*****
(ongoing / referral)
- Therapeutic relationship HCP

Kohr Gibson 2008 / Jong et al 2007)

- Team approach (person)
- Individualised care
- (non pharmacological – distraction (VR, talking, singing, music) relaxation, imagery, cutaneous stimulation)

Pharmacological

- Background
- Breakthrough
- Procedural

WHO ladder

Analgesia

Co-analgesics

Interdisciplinary team

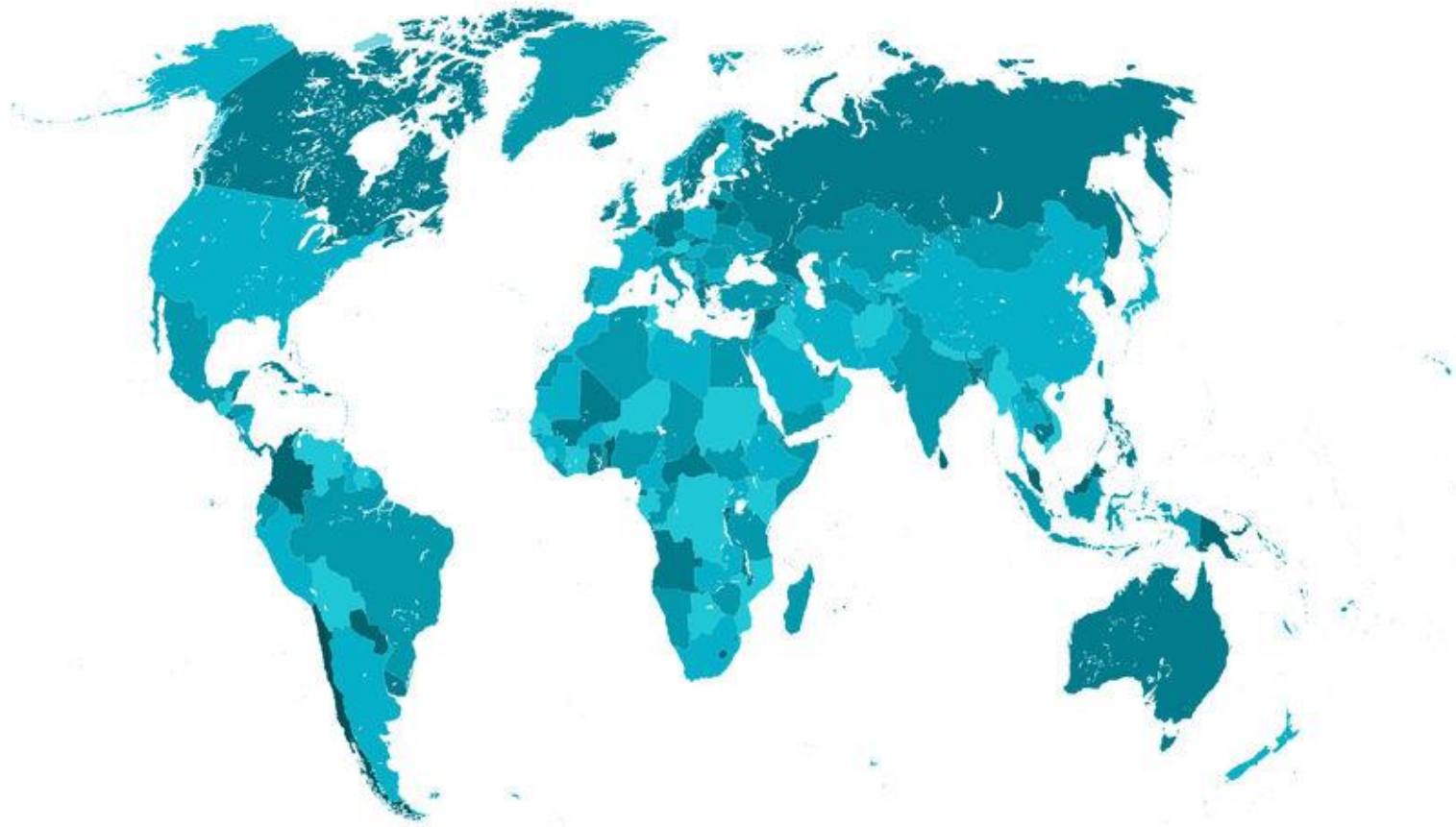
Wound Care

(Triggers / relievers)

- Plan 'time out'
- Handle gently
- Exposure
- Cleansing / debridement (BBWC)
- Product selection
 - Safe / do no harm
 - Comfort (wear / removal)
 - Atraumatic dressings
 - Protect periwound / bed
 - Absorbency / wear time
 - Antimicrobial
 - Modulators inflammation
 - Topical anti-inflammatory
 - Topical anaesthetic

Remember the impact we have their experience

Access to pain management is a fundamental 'Human Right'



2010 DECLARATION Montreal IASP

Recognition / Acknowledgement

Significant
impact on
LIFE*

MEETING
rights / needs

Bio psycho
social Spiritual

CORE

to

Health Care Ethics



'Create an environment in which people can heal' Douglas 2010

Concept not new in wound management

Person Focused Wound Care

Sibbald et al 2001 (18yrs)

Diagnose
cause

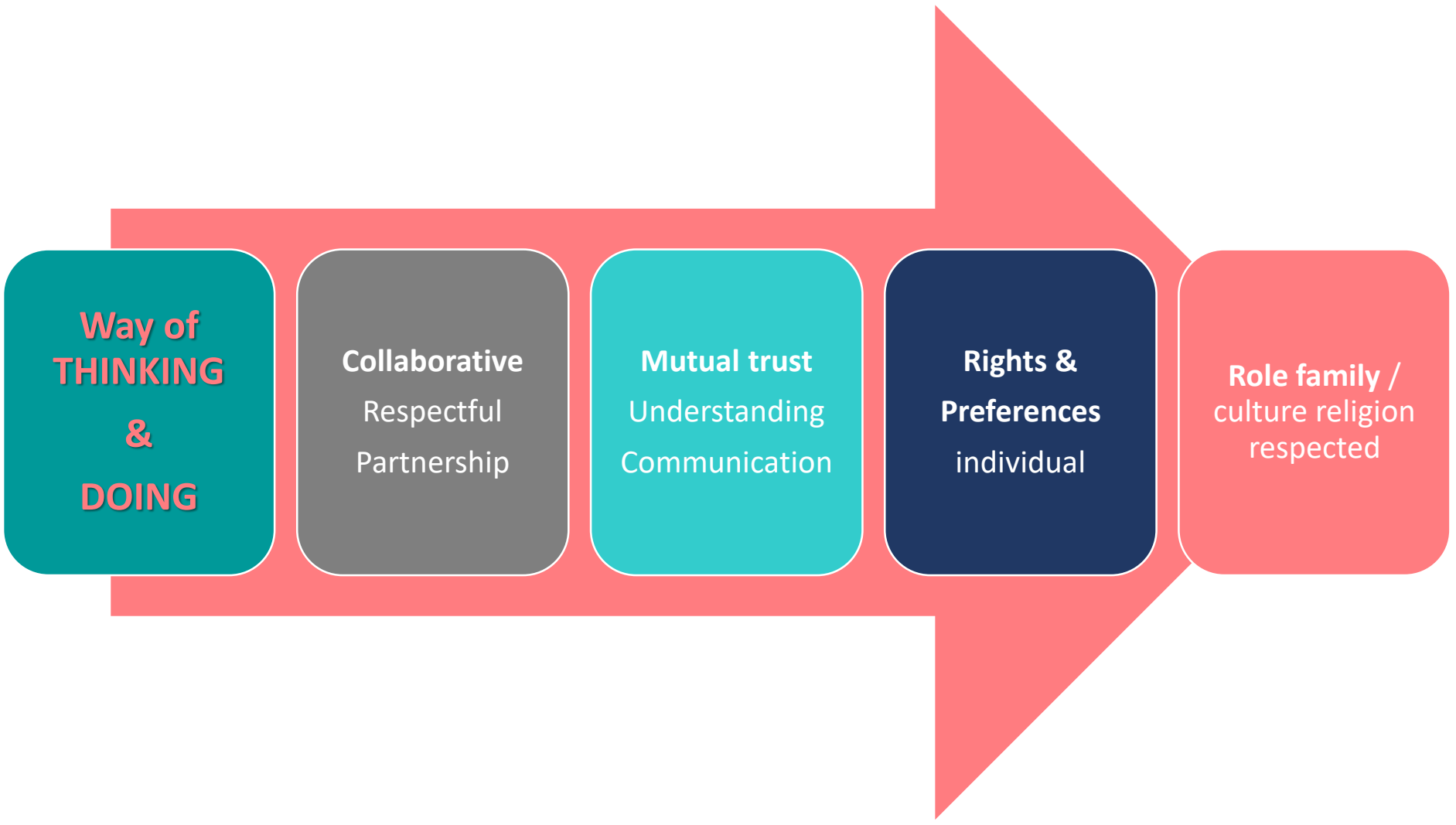
Person issues
/ concerns

Correct
systemic
& local
factors

Patient Centredness
Rhetorical lip service ?

Essential
Attitudes & behaviours
HCP & Organisations

Scholl, et al (2014) An integrative model of patient centredness – a systematic review and concept analysis. PLOS One



**Way of
THINKING
&
DOING**

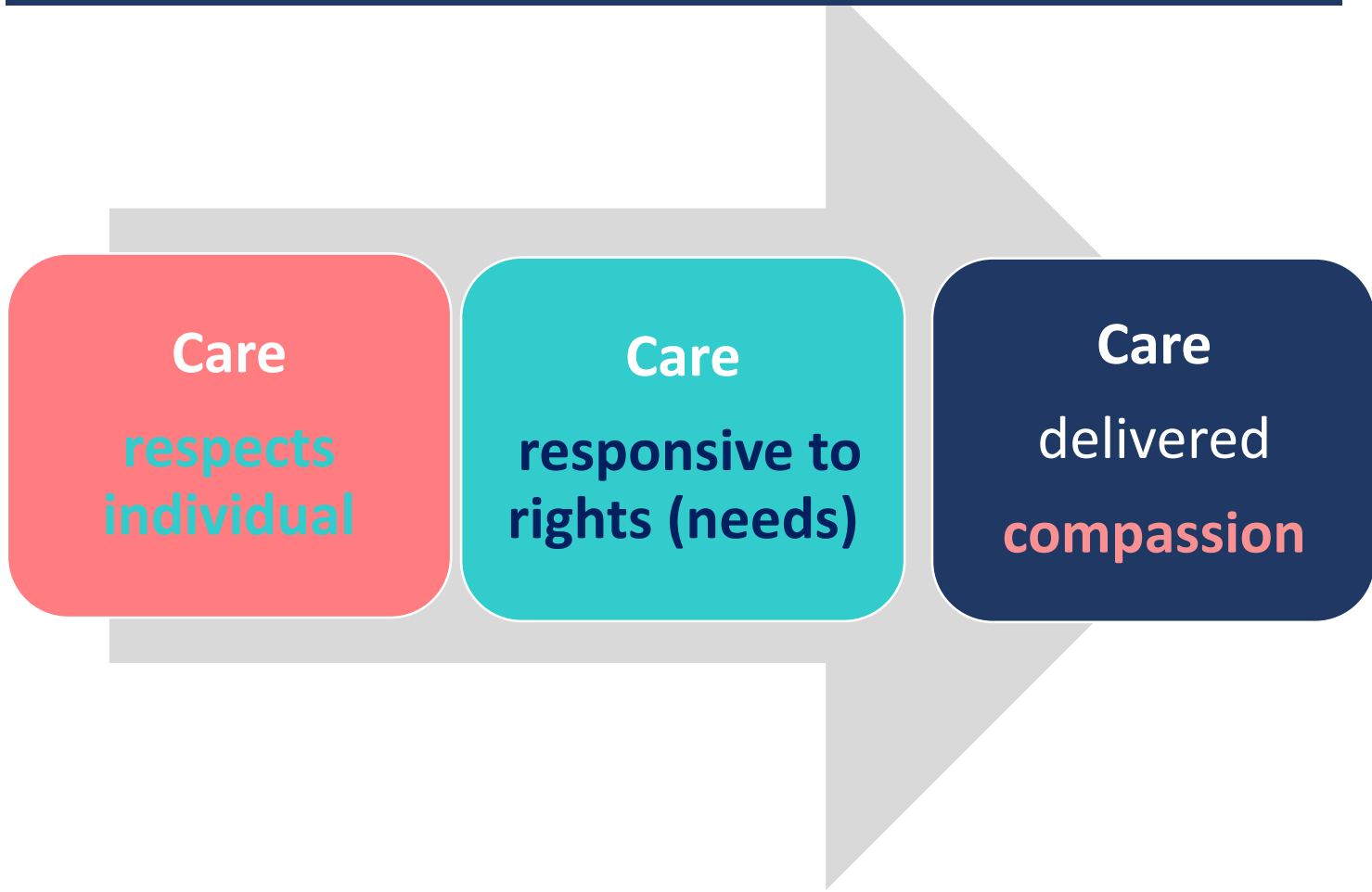
Collaborative
Respectful
Partnership

Mutual trust
Understanding
Communication

**Rights &
Preferences**
individual

Role family /
culture religion
respected

Care...what we do & how we do it



Suffering

Closely related experience

- **Pain**
- Distress, hardship
- Alienation from others
- Cut off from community
- Feeling inferior
- Loss of self
- Loss of dignity

**'Compassion appears as a way to
accomplish the restoration of human connectedness
..and a healthy sense of self'' p1**



HCP

Characteristics

A photograph showing two women. On the left, a woman with blonde curly hair wearing a red cowl-neck sweater is looking towards the right with a concerned expression. On the right, a woman with blonde straight hair wearing a beige t-shirt is sitting down, looking down with her hand to her face, appearing distressed or sad. The woman in red has her hand on the shoulder of the woman in beige. The background is a bright, out-of-focus indoor space.

Sympathy

Being able to FEEL for others

Tierney, S. Bivins, R. Seers, K. (2018). Compassion in nursing: Solution or stereotype?. Nursing Inquiry.

Empathy

A photograph showing a woman with glasses and a blue shirt hugging a person with long brown hair from behind. The person being hugged has their face buried in her chest, suggesting they are distressed or crying. The woman's expression is one of compassion and care.

- ...an affective state of mirroring or **understanding another's emotions**

Trzeciak, S. Roberts, B. Mazzairelli, A. (2017). Compassionomics: Hypothesis and experimental approach. Medical Hypotheses.

- The ability to **understand the concerns** (distress pain suffering) and perspectives of another **and the ability to communicate that understanding**

Lown, B et al (2017) How important is compassionate healthcare to you? A comparison of the perceptions of people in the United States and Ireland. Journal of Research in Nursing.



Be in their shoes

Cole-King, A. Gilbert, P. (2011) Compassionate care: the theory and the reality. *Journal of Holistic HealthCare*.

Compassion – ACTION Based on Empathy

- **...to take action to relieve suffering**

Trzeciak, S. Roberts, B. Mazzei, A. (2017). Compassionomics: Hypothesis and experimental approach. Medical Hypotheses.

- **Being moved by another's suffering and wanting to help ...compelled to take action**

Burridge, L et al (2017). Building compassion literacy: Enabling care in primary health care nursing. Science Direct.

- **Efforts to understand and relieve patient concerns and distress, effective communication, respect & knowledge of the patient & complex network relationships at home / community**

Lown, B et al (2017) How important is compassionate healthcare to you? A comparison of the perceptions of people in the United States and Ireland. Journal of Research in Nursing.

‘... a sensitivity of the distress of
self & others
with a commitment to try to
do something about it and prevent it’

Awareness Attentive Motivation

*“Knowing
healthcare should be practiced
with compassion
did not ensure it was.”*

Compassion Deficit in HealthCare

Lown (2006)

- 50% staff felt compassionate care delivered

Mannion (2014)

'Emerging consensus that caring and compassion are under threat in the frenetic environment of modern healthcare'

- -ve Wellbeing staff / culture of organisations
- **Damage & suffering** (poor clinical outcomes) when absent in care

Compassionate Care – A PROTECTANT!

- HCP observational studies
 - **Maintain empathy human connection – compassionate care**
 - Less burn out, wellbeing resilience
 - **“PROTECTANT”**
 - VIRTUOUS cycle - more effective care / outcomes - better economics
- Contrast tradition thinking

Trzeciak, S. Roberts, B. Mazzei, A. (2017). Compassionomics: Hypothesis and experimental approach. Medical Hypotheses.

- **“Shield”**

Lack of consensus - challenge



Compassion **counteract empathy distress** promote **resilience**

Trzeciak, S. Roberts, B. Mazzairelli, A. (2017). Compassionomics: Hypothesis and experimental approach. Medical Hypotheses.

Less Burn Out

‘Lean in
vs
lean out’

What Persons (& others) Want... **Connection!**

Have humanity & uniqueness acknowledged

“ A gentle **touch**, mindful **listening**
&
being truly present
may be sufficient “.

P 2 Montague et al 2015

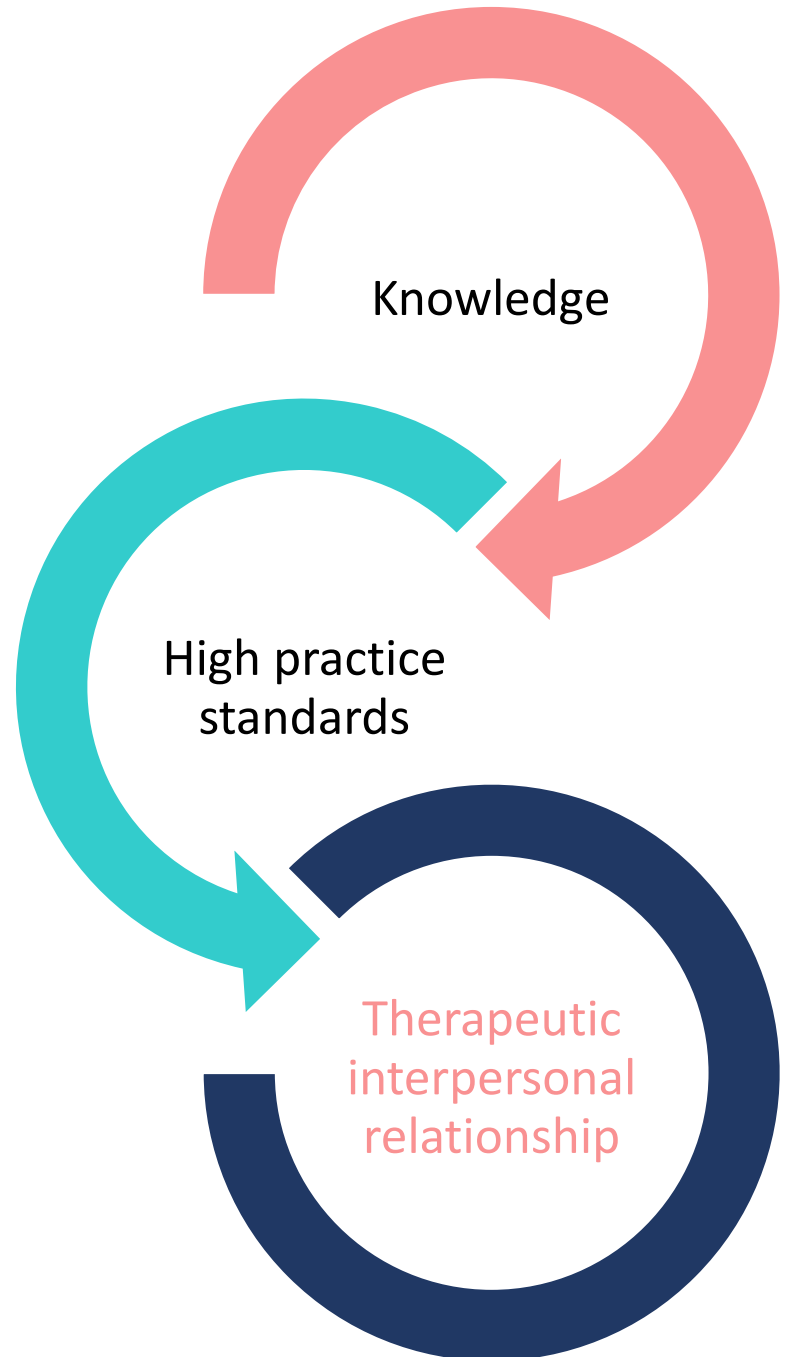
Compassion
makes care more
effective

CAPABLE CARE +
COMPASSIONATE
CARE

Knowledge

High practice
standards

Therapeutic
interpersonal
relationship



“Compassion is not an optional extra,
but far too frequently it is seen as being
much less important than other aspects of care.

There is extraordinary potential
for blending EBM
&
patient centeredness”

Food for thought

Management of Painful Wounds

Stepping Up to the Challenge



New Zealand Wound Care Society 9th National Conference
Choices, Changes & Challenges

Dunedin 23rd – 25th May 2019 Invited Speaker Wendy White



Sharing. Learning. Growing



Wendy White
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