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President’s message
Celebrating our diversity

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Dear WCET Members,

This is our last WCET Journal issue for 2015. In just a few short months we will be holding our 21st Biennial Congress in Cape Town, South Africa.

I am excited each time a congress date draws near. I think back on the congresses I have had the opportunity to attend. My first WCET Congress was the 11th Congress in 1996 held in Jerusalem, Israel. I did not know what to expect. This congress created the opportunity for me to meet fellow nurses from countries around the world and to experience the history, culture and important religious places of Israel. The opening ceremony with the parade of International Delegates was awe-inspiring. Our founder, Norma Gill, attended this congress. Meeting her was a highlight of the trip; I will never forget her enthusiasm and devotion to enterostomal therapy.

The presentations by nurses about their work were captivating. Presenters came from both resource-abundant and resource-limited countries. I learned a great deal from both perspectives. The posters were interesting and well done.

The most important thing that I took away from my first congress and every congress since then is a sense of connection with my international brother and sister ETs. I can sum up one of the benefits of WCET with one word: Diversity. We live in different countries, work in different health care systems, speak different languages and practise different faiths. But, in the end, we are all united in our knowledge, skills and abilities and our desire to provide needed care to the patients who need our help.

Speaking of diversity, I hope that many of our members were able to go online and experience our first WCET webinar, entitled: ‘How Patients’ and Nurses’ Diverse Cultures Affect Nursing Care’, presented in English and Spanish by Larry Purnell PhD, RN, FAAN. If you haven’t listened to this program, members can log on free on the WCET website.

So that you can learn more about culture and its importance to our specialty practice, Dr. Purnell will also be a keynote speaker at our Congress in Cape Town.

Congresses are such a great way to celebrate our diversity. I hope that many of you are able to attend the congress in Cape Town. The scientific program features many experts on a variety of topics as well as poster presenters from around the world. The environment in Cape Town is absolutely beautiful. The social program will be delightful I am sure.

Cape Town, the ‘Mother City’ is calling us! Come and celebrate our diversity!

CÉLÉBRONS NOTRE DIVERSITÉ

Chers Membres du WCET,


Chaque fois qu’une date de congrès s’approche, je suis impatiente. Je pense aux congrès passés auxquels j’ai eu la chance d’assister. Mon premier congrès du WCET fut celui de sa 11ème édition qui s’est tenu à Jérusalem en Israël, en 1996 et je ne savais pas à quoi m’attendre.

Ce congrès avait été pour moi une occasion de rencontrer des infirmières venant de différents pays du monde entier et d’expérimenter l’importance de l’histoire, la culture et de la religion en Israël. La cérémonie d’ouverture avec la parade des nations des Délégués Internationaux fut des plus inspirantes. Norma Gill, la fondatrice de notre spécialité, assistait à ce congrès et la rencontrer fut une expérience majeure de ce voyage; je n’oublierais jamais son enthousiasme et sa dévotion pour l’entérostoma-thérapie.


L’élément le plus important que j’ai ramené de mon premier congrès, et de chaque congrès qui a suivi, est ce sens de la connexion effectuée avec mes frères et sœurs ETs au niveau international. Je pourrais résumer un des bénéfices du WCET en un mot: Diversité. Nous vivons dans différents pays, aux systèmes de santé différents; nous parlons différentes langues et pratiquons des religions différentes. Mais à la fin, nous sommes tous et toutes unies par nos connaissances, nos compétences, nos habilitées et notre désir de prodiguer les soins nécessaires aux patients qui ont besoin de notre soutien.
En parlant de diversité, j’espère que nombre de nos membres ont pu expérimenter notre premier séminaire en ligne du WCET intitulé: «Comment la diversité culturelle des patients et des infirmières influence les soins», présenté en Anglais et Espagnol par Larry Purnell PhD, RN, FAAN. Si vous n’avez pas encore pu écouter ce programme, vous pouvez vous connecter gratuitement sur le site du WCET. Ainsi, vous pourrez en apprendre plus sur la culture et son importance dans la pratique de notre spécialité. Dr Purnell sera aussi un orateur invité lors d’une session plénière de notre congrès au Cap.


Le Cap, la «Cité Mère» nous appelle! Venez et célébrons notre diversité!

Norma N Gill Foundation
Roll of Honour Members 2015

The following persons have given financial support to help promote stomal therapy throughout the world. This will enable the realisation of Norma’s vision. The Committee would like to acknowledge their sincere appreciation.

Sponsored a member:
- Fiona Bolton — Australia
- Maria Caliri — Brazil
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- Dorothy Benz — USA
- Helen Richards — Australia
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- Molly Holt — USA
- Vashti Livingston — USA
- Patricia Sinasac — Australia
- Jacqueline Geddis — Canada
- Judy Wells — Australia
- Qin Zhou — China

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We would like to keep WCET members as well as the ostomy, wound and continence community up to date with news and special announcements from our organisation.

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Editorial

Following in the footsteps: JWCET at 35

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December is the 35th anniversary of the Journal of the World Council of Enterostomal Therapists (JWCET). The JWCET has gone through multiple formatting changes over the years, but has continued to provide quality research and articles from around the world.

Norma N Gill was the first Editor and her legacy lives on in our organisation and our journal. Norma N Gill was born in Akron, Ohio, USA. Until I read the festschrift book several years ago, I didn’t know that Akron was her birthplace. Interestingly enough, I was born in Akron, Ohio, but beyond knowing about the Cleveland Clinic ET program, I knew nothing about Norma N Gill as a person. However, indirectly I certainly benefited from Norma’s knowledge. I obtained my BSN at the University of Akron and my MSN at Kent State University, and Norma was a consultant for the Akron hospitals where I worked. My mentors did know her and emulated Norma’s need to teach and share information. She was a bigger influence than I ever realised and I was very fortunate. It is ironic that in our 35th anniversary year I have followed her as journal editor.

As the Executive Editor of JWCET, I also follow the previous journal editors and leaders of our organisation, and try to provide articles that are educational as well as research-based, that can be used by everyone. This is a time-consuming task. The use of the internet means I can contact people quickly, regardless of time zones, but it also means endless frustration when a computer crashes, service is interrupted or software issues occur.

On the plus side, I get to know dedicated nurses from all over the world and learn from all of them. I try to have articles in multiple languages and have wonderful executive and editorial board members that help me with reviews and translations. Some editions have more ostomy or wound or continence articles. While I strive for a balance in content, I am limited by what has been submitted. Therefore, I encourage all of you to think about your work and consider writing for the journal. If you have an idea but don’t know where to start, bring those ideas to the Congress and come to the beginning writer session. Get your friends and co-workers together and think of a topic. It is more fun to write with a group and you push each other to get it done. We all started somewhere and that first case study or article is the hardest. I am no different. I work better with deadlines and friendly encouragement. Usually my friends will review work for me and give me feedback and suggestions.

Let’s all take a moment to realise we can further Norma’s mission and bring quality to patient care worldwide. We can transcend cultural, religious, or political differences and help each other, and our patients. Thank you for your commitment to WCET and to our journal. Keep up the great work.

Norma N Gill Foundation

❖ Roll of Honour Organisations 2014–2015 ❖

The following organisations have very generously given donations to the Foundation to help fund NNGF scholarships so furthering Norma’s vision

- Australian Association of Stomal Therapy Nurses (AASNT)
- South African Stoma Nurses Association (SASA)
- Mid-East WOCN Chapter
- FOW-USA
- Indonesian Enterostomal Therapy Nurses Association (IENETNA)
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For more information, please call FREEPHONE 0800 028 8014 (UK) or 1-800 408508 (Ireland). Overseas customers can contact our International Customer Services Team: Tel: +44 (0) 121 333 2000 or email international@salts.co.uk

www.salts.co.uk
NOTE:

Parts of this manuscript are taken from previous writings by Dr Ayello in the NNGF book and WCET Journal editorials.

Long before the internet, an association’s journal paved the way for members and others in their specialty to communicate sooner in print their ideas and research. Journals serve as a way of “putting down in writing” the best thinking and work of authors, disseminating it to a wider number of people than just “word of mouth (oral records)” can do, and preserving that record of thought for others to refer to it over time. It is more than just raising awareness of a topic and sharing information. The process also includes critical review of the work, which in publishing terms is called “peer review”. After a manuscript is published, the discussion that is generated from reading journal articles by examining different aspects of a care practice or perhaps addressing a controversial point of view is invaluable as it influences the ongoing professional practice reflection that nurses need to keep their practice current and evidence-based.

It was my honour to serve as the Executive Editor of the WCET Journal (JWCET) for 10 years. When I took over the journal in May 2004 in Brazil after a thorough orientation from the then editor, Julia Thompson, I was struck with the sense of history and the importance this journal has played for the World Council of Enterostomal Therapists. I have been a professional editor for over 25 years, but I can tell you that being the Executive Editor for the JWCET is a unique and difficult job. You see what is different about our journal is that we assist first-time authors to get their manuscripts published. We are happy to help with manuscript editing that most journals would not do. Also special about our journal is that we publish manuscripts both in English and other languages. This was a challenge for me, as I do not speak another language. It was also a constant battle with my computer spell-check, which wanted to change the Australian spelling to American spelling. Sometimes, in some manuscripts, I would find a combination of words, some in Australian spelling and others in American spelling; it took a lot of work to fix this and make it consistent. The journal can only publish what is received, so authors were encouraged to write manuscripts on all three areas of our specialty, so a good balance of articles on ostomy, wounds and continence care could be published. So, please write, the JWCET is always looking for quality manuscripts.

Over the years, many of you have stepped forward and helped me with translations and, most importantly, been patient with me in making sure we get the content right. Thank you Michelle Lee Wai-Kuen, Chi Keung Peter Lai, Louise Forest-Lalande, Laurent Chabal, Heidi Campos, to name a few who I could always count on to say “yes” to requests for translations.

For me personally, the long hours of recruiting manuscripts, sending them out for peer review, sending authors the suggested revisions and then working with our publisher to do the copy editing and proofs so each issue could arrive to each member was worth it. You would take the time to tell me that an article we published helped you with a patient’s care when you were trying to come up with a better intervention. Perhaps this is why the “Stories from the bedside” continues to be one of the most popular features of the journal.

Our history tells us that Norma N Gill, ET, was the first Editor of the JWCET. Her first editorial can be found in Box 1. Her words are just as inspiring now as when she first published them in 1982. The original journal was 12 cream-coloured, unbound pages including the front and back covers. As written in my editorial in 2010:

It included two short, one page articles. One was on assessing behaviour for patient teaching by an ET nurse from Australia and the other was about stoma rehabilitation in Japan. The rest of the contents included announcements about activities around the WCET world, a sample of a conventional ileostomy card for patients to carry, and information about various committees and conferences [since then the cards have been updated and can now be downloaded from the WCET website, isn’t technology great?]. The list of International Delegates (ID) contained the names of 28 IDs from the following locations: Australia, Belgium, Brazil, Canada, Denmark, Egypt, France, Finland, Holland, India, Ireland, Israel, Italy, Japan, Mexico, New Zealand, Norway, Puerto Rico, Singapore, South Africa,
Sweden, Switzerland, United Kingdom, United States, West Germany, Yugoslavia and Zimbabwe. The application for membership listed the “dues” as ten pounds sterling or twenty dollars US, with lapsed members having a reinstatement fee of £20, which thirty years later is similar to the £25 that our WCET members pay for membership.2

A journal is more than a reliable source of information for association members. It announces to the world, that keeping up with the latest clinical information is an important attribute that our WCET members value and others can find in the JWCET. By publishing peer-reviewed research on both current and emerging topics in ostomy, wound, and continence care, the JWCET provides leadership in building the evidence base for our practice.

Judging from the feedback that you, our members, provide in our membership survey, the journal continues to do a great service in providing you what you want: a mixture of scientific articles and clinical topics that you can easily translate into your everyday practice. We have and will continue to listen to you; keep your comments about what you like, don’t like, but most of all your manuscripts coming to us.

While the pioneers who created the JWCET were interested in fostering communication among WCET members, it was also with great foresight that these founders insisted that the JWCET be an association-owned journal. This is important because WCET controls the content of what is published in the journal, owns the copyright on the articles published, and benefits financially from any profits realised after production and mailing costs. The JWCET is a stable publication as it has had the same publisher for over 20 years.

Industry partners have long played an important role in the creation and sustainability of the journal. When along with Greg Paull, our publisher, we created Journal Sustaining Partners (JSP), we were able to assure the quality of this highly valued membership benefit, the quarterly JWCET. Thank you to our current JSP: Coloplast, Hollister, Dansac, Welland and Calmoseptine. Your loyal support of the JWCET is most appreciated.

Each editor brings their own “personality” to the journal. I would like to think that some of mine resulted in creating the country flags on the International Delegates pages, adding research columns in various issues, helping to position our journal for Medline indexing (we did not get it on our first attempt, but we will keep trying), posting electronic copy of the journal on our website, making the President’s message and Editorial open access on our website so anyone can learn about our organisation and posting a “how to write a manuscript article” also on the WCET website. Thank you for giving me the title of Executive Editor Emeritus; I am truly humbled and honoured by this designation.

In closing, I want to share with you one of my favourite quotes. It is by John F Kennedy, who said: “Change is the law of life and those who look only to the past or present are certain to miss the future”.

Editors live in the future, writing today in anticipation of trends and content that is important for the future of our specialty. We are always working months, sometimes even years ahead of time to bring you an informative journal. So it is with that in mind, that I changed roles and left my volunteer journal position at the Congress in Sweden. The future of the journal is now in the capable hands of a different team. We all need to support our new Executive Journal Editor, Karen Zulkowski, and her Editorial board as they take the journal to new and more exciting places. After all, Norma is watching us and we must be faithful stewards to her journal. Congratulations on 35 years WCET, here’s to the next 35!

REFERENCES

Editorial
Norma N Gill, CET

It is rather scary to suddenly be the Editor of a Journal when this isn’t something that you have done before. My reason for accepting this position was two-fold. It is a challenge. The other part is more serious AND important. It is to try to prod and push all of you to help make it your “mouthpiece” to exchange and gain information.

Each of you can be a reporter in his own right. Feel free to write an article, an idea, a problem and solution, or even a “Letter to the Editor” saying what you like and dislike about the Journal. Also, ask the other medical personnel you know to submit an article of interest.

With the help of Evonne Fowler, Chairman of my Committee, and her committee from different countries, Nortrud Loy and the officers of the organization, we are going to make the WCET Journal the best in content so that when the next editor is appointed, he or she will know what you want in your journal.

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Box 1: First WCET Journal editorial
EDITORIAL
Norma N. Gill, C.E.T.

It is rather scary to suddenly be the Editor of a journal when this isn’t something that you have done before. My reason for accepting this position was twofold. It is a challenge. The other part is more serious and important. It is to try to prod and push all of you to help make your “mouthpiece” to exchange and gain information.

Each one of you can be a reporter in your own right. Feel free to write an article, an idea, a problem and solution, or even a “Letter to the Editor” saying what you like and dislike about the Journal. Also, ask the other medical personnel you know to submit an article of interest.

With the help of Evonne Fowler, Chairman of her Committee and her committee from different countries, Nortrud Loy and the officers of the organization, we are going to make the WCET Journal the best in content so that when the next editor is appointed he or she will know what you want in your Journal.

We will make errors, add, delete, and most of all listen to you to make it happen.

PRESIDENT’S LETTER
Sitting at my desk back in Capetown it is hard to realise that all the planning and travelling of the past month are over! To all of us attending Munich and the fourth meeting of the WCET, the fulfillment and sense of achievement must be great. One hundred forty-eight of us from 18 countries managed to arrive at a series of unlikely venues, including a basement beer hall cum theatre and a non air conditioned hotel room—the temperature in Munich being around the mid eighties the week we were there!—and participate in a lively meeting carried out in a true spirit of enthusiasm by all.

Probably the greatest success was the genuine wish of so many of the members to actively give their support to the future objectives of the WCET by joining in committees and projects. Nearly every group has a truly international flavour, thus our “cross pollination” of ideas and results will cater to everyone’s taste.

What of the present in world stoma care? The realities are very simple—the need for FIRST PRINCIPALS IN GOOD BASIC CARE still holds good. The tendency to worry towards the quasi-medical surgical aspects, rather than attend with expertise to the NURSING and BASIC emotional and physical needs of our patients is one that often enters the medical specialties. We, the stoma therapists, are exposed to this risk, which although stimulating and necessary, still take SECOND STATUS when it comes to priorities.

On return home, I have made it a rule to avoid being drawn into anything other than getting to know my new patients and seeing to their needs for the first week, following up the outpatients and getting returned into what my real role entails. The moment “office work” and other interesting side lines come into the picture, the involvement with the patient is bound to suffer. It is difficult once you are in demand, but perhaps you forget that the very reason for the advent of stoma care was because nobody had TIME, INTEREST or EXPERTISE to give to the ostomates.

Let’s not turn the clock back by losing this chance we have to provide this service. I will end by wishing all of you special fortune in carrying out your job. Hope for good facilities and appreciation and cooperation from your colleagues—and most of all, patients who feel confident and safe because YOU are there to look after them.

Priscilla J. de’E. Stevens
President WCET

MEMBERSHIP

(i) CHANGE OF FISCAL DATE
The fiscal date has been changed to 31 January.

(ii) INCREASE IN DUES
Dues have been increased to £10.00 (ten pounds) or US $20.00 (twenty US dollars).

(iii) Lapsed membership
Membership will lapse if dues are not paid to the Treasurer by 30 April. Reinstatement fee—£20.00 or $40.00.

(iv) “FREE” MEMBERSHIP FOR PAID-UP MEMBERS: AUGUST 1982—JANUARY 1983
Because of the change of the fiscal date, the WCET Executive takes pleasure in according six months’ “free” membership to fully paid-up WCET members.

Note: Members who have paid £5.00 or $10.00 in ADVANCE, have been credited with the amount and are expected to pay the balance owing for 1983, i.e., another £5.00 (if paid in sterling) or US $7.00 (if paid in dollars).

At the Congress in Munich, it was decided that the International Delegates would be responsible for collecting dues within their countries and forwarding the total amount to the Treasurer. Please advise CHANGES OF ADDRESS as soon as possible.

(v) MEMBERSHIP APPLICATION AND RENEWAL FORMS
Please amend the attached forms as indicated.

MARYLIN McMANUS
TREASURER: WCET
Development, validation and implementation of a pressure ulcer wound documentation form at Queen Mary Hospital, Hong Kong

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INTRODUCTION
“Pressure ulcers are areas of localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction”. It is a serious problem and is known to be common in hospitals and nursing homes. For many years, it has been suggested that the development of pressure ulcers is a key indicator of the quality of care that patients received. It is well known that the development of a pressure ulcer is a source of pain and discomfort to the individual and it also affects the individual’s ability to function, reduces mobility, nutritional intake, and negatively impacts on the patient’s psychological well-being.

In Queen Mary Hospital of Hong Kong, a Pressure Sore Risk Assessment and Nursing Intervention Record had already been developed in 2000 as a standard procedure for assessment and for keeping patient care record (last revised 18 May 2010). Departments may have different pressure ulcer wound documentation forms, such as intensive care and orthopaedic units. As the contents of the forms are different, there is no consensus between departments. Once the patient was transferred from one department to another department, the original wound documentation form was not used. As a result, there was no continuous communication of the wound condition between nurses and health care professionals and this consequently impacts the continuity of wound treatment/management. Therefore, the development of a pressure ulcer wound documentation form for use by all departments at Queen Mary Hospital was essential in order to facilitate communication and standardise documentation.

Since wound documentation forms are invaluable for proper, consistent and accurate clinical documentation, the proposition by Brown that the design of the form must be logical, structured, and at the same time provide guidance to the nurses in assessment and minimises the entry of wrong information was taken into account when designing the new form. In addition, the newly developed form needed to undergo two aspects of validity: face validity and content validity. Furthermore, training for the frontline nursing staff to ensure correct documentation and successful implementation of the newly developed form was also conducted.

LITERATURE REVIEW
Legal of medical record
In the health care system today, it is understood that medical records serve as the instrument to assist the health care professionals’ ability to plan, coordinate and evaluate patient care. Besides, it is also a legal document for issues involving alleged medical errors, physical damages or other issues. Therefore, effective and efficient nursing documentation can enable a clear and consistent way of nursing care planning, facilitate communication and evaluation. In addition, it is also the foundation for professional practice. Accurate documentation can protect the nurses who are delivering safe, effective, quality care to the patients. It can also provide
information about whether the nurses are delivering evidence-based and consistent care\(^6\). Additionally, there are increasing demands for gathering data from the medical records to serve other purposes, such as allocation of resources, assessment of the quality of care, and to guide future plan and health policy decisions\(^6\). “Anything that is not documented is not done”\(^8\). As a result, medical records serve as a document for evaluating whether the facility or staff are meeting an acceptable standard of care\(^4\).

Problems in pressure ulcer documentation

Accurate wound documentation can provide guidance for developing appropriate treatment plans and ensures quality and continuity of care, as well as evaluating the wound healing progress\(^5,10\). Recording a patient’s wound healing progress is also an important part of nursing accountability\(^11,12\). In contrast, inconsistent documentation can affect the proper management of a wound\(^4\). A cross-sectional survey, which was conducted by Gunningberg and Ehrenberg\(^6\), reflected that the quality of pressure ulcer documentation was insufficient and did not provide valid and reliable data on pressure ulcers. They found the overall prevalence of pressure ulcer obtained by patient record was 14.3% compared to 33.3% when patients’ skin was inspected. In that case, the deterioration of pressure ulcers could not be recognised promptly.

Detailed pressure ulcer documentation can improve the overall nursing care, reduce the incidence of pressure ulcers and lower the health care costs\(^8\). However, accurate transmission of information depends on objective signs or symptoms\(^13\). There are many issues that affect the proper wound documentation. Firstly, wound assessment and documentation is very subjective and requires broad knowledge to perform it accurately. Secondly, different levels of knowledge among caregivers may result in inaccurate documentation, which may result in inappropriate care\(^4\). Besides, the wound condition may be documented in different areas throughout the charts, narrative notes, forms and many other areas in the medical record without clear and specific organisation. The lack of organisational flow will increase the complexities in accessing the information by the health care team members\(^5\).

Separate studies also showed that without the framework of a wound assessment form, nurses did not record some potentially clinically significant features\(^11,14,15\). Therefore, the development of wound documentation charts or records is essential to evaluate the clinical efficiency and cost-effectiveness of treatment\(^2\). Different practitioners may also document differently. Therefore, creating a standard structure of wound documentation, using the same terms and diagrams is crucial to facilitate consistent documentation\(^1\). A standard documentation form can help ease the burden of pressure ulcer documentation. It also ensures consistency and improves communication with the clinical team\(^6\).

PREPARATION

A working group was set up with supervisors from various wards and departments of Queen Mary Hospital, including medical, surgical, orthopaedic, obstetrics and gynaecology, cardiac-thoracic surgery, ICU and community nursing service. The participants were senior nursing staff including ward managers and advanced practice nurses. Consensus was that the working group should work on this new pressure ulcer wound documentation form and serve as the resource people for communication within departments.

Face validity and content validity

Based on the different pressure ulcer wound documentation forms available in the hospital, a new form was drafted. The amended pressure ulcer wound documentation form was sent out to all working group members via email for further comment. Three meetings were held on face and content validity of this new form and amendments were made accordingly (Appendix 1).

Open forum

An open forum was organised for all the nursing staff of Queen Mary Hospital. The aim of this forum was to officially introduce the new documentation form.

Pressure ulcer training sessions

Three sessions of pressure ulcer training were organised for nurses for various departments to update them on the pressure ulcer staging system and use of the new wound documentation form. A total of 71 nursing staff from various departments participated in this program. These nurses were responsible for teaching their nursing staff how to use this new form. They were also asked to pilot this project.

DISTRIBUTION OF THE SURVEYS

Pre-implementation survey

Four weeks after the training session, a pre-implementation survey (Appendix 2) was sent out to the 71 nurses who had participated in the training sessions. The questionnaire was divided into three parts. The first part consisted of three questions concerning the documentation in the nurses’ clinical setting. The second part contained three questions related to nursing practice. There were four questions in the third part, which focused on aspects of communication. The participants were expected to complete and return the survey to Central Nursing Department within one week after distribution. Afterwards, the new form was formally implemented in Queen Mary Hospital.

Post-implementation survey

Three months after the implementation of the new form, all the participants were requested to again fill out the same questionnaire as in the pre-implementation stage (Appendix 3). In addition, they were requested to fill the “Level of complexity of wound assessment form” giving comments
and suggestions on complicity of filling in the new form. Suggestions for improvement were also provided. The survey was sent to the participants through the hospital internal mail and return envelope to Central Nursing Department was attached. As before, the participants are expected to complete and send back the survey within one week of distribution.

RESULTS AND DISCUSSION

In the pre-implementation survey, a total of 32 questionnaires were returned with a response rate of 45%. In the post-implementation survey, 30 questionnaires were returned with a response rate of 42%. However, only 28 participants completed the “Level of complexity of wound assessment form”, hence the response rate was 39%. Since most of the participants did not fill in their specialty and post in the survey form, detailed analysis of their working specialty and seniority could not be measured.

Documentation in your clinical setting

It was surprising to find that two nurses still indicated that pressure ulcer wound documentation forms were only available sometimes, despite the promotion of this wound documentation form for more than three months. It was clear that in order to ensure that all nurses utilise this form in the future, further promotion of this form may be necessary to achieve better compliance.

On the other hand, it was encouraging that there was an increase in the percentage of nurses who regularly used the form (80%). However, this should be at 100%. Therefore, further nursing education is necessary to ensure that all nurses use the same form for documentation. The same is applicable to the recognition of the guidelines on how often wound assessment should be performed and documented, considering that only 80% of nurses indicated their awareness of these guidelines. It is expected that 100% of nurses should know and understand how to use the guideline and hence further promotion and education in relation to this issue is also necessary.

Practice

In the nursing practice, there was an increase in the percentage of nurses who were familiar with the pressure ulcer staging system (from 81.25% to 86.7%). Nevertheless, all nurses should know and understand the staging system.

### Table 1: Comparison of the pre- and post-implementation surveys on documentation in your clinical setting (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pressure ulcer wound documentation forms are available.</td>
<td>100%</td>
<td>93.3%</td>
</tr>
<tr>
<td>2. Pressure ulcer wound documentation forms are regularly used and provide a clear picture of monitoring the progress of pressure ulcer.</td>
<td>62.5%</td>
<td>80%</td>
</tr>
<tr>
<td>3. There are guidelines on how often wound assessment should be performed and documented.</td>
<td>71.9%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Table 2: Comparison of the pre- and post-implementation surveys on practice (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am familiar with the Pressure Ulcer Staging System in Pressure Ulcer Assessment Form of Queen Mary Hospital.</td>
<td>81.25%</td>
<td>86.7%</td>
</tr>
<tr>
<td>2. I feel comfortable making a comprehensive pressure ulcer wound measurement and assessment for the patients.</td>
<td>71.87%</td>
<td>80%</td>
</tr>
<tr>
<td>3. I feel comfortable in using different kinds of advanced wound care product for different stages of pressure ulcers.</td>
<td>46.87%</td>
<td>40%</td>
</tr>
</tbody>
</table>
Therefore, it would be also recommended that further nursing education should be planned to ensure that all nurses should become familiar with this staging system. This is a similar outcome to making a comprehensive pressure ulcer wound measurement and assessment. Although the percentage of familiarity/understanding increased, it was hoped that 100% of nurses would have become familiar with the guidelines. It is also disappointing that there was a decrease in the percentage of nurses who were feeling comfortable in using different kinds of advanced wound care product for different stages of pressure ulcers. However, due to the anonymity of the questionnaires, the nurses who filled in the post-survey questionnaire might not be the same as those who filled in the pre-survey questionnaires. Although this issue could represent a weakness in the design of the study, maintaining anonymity was a priority.

Aspects of communication
There are four questions in this aspect. The questions include: current level of communications between nurses in regard to pressure ulcer; current level of communications between nurses and health care professionals in regard to pressure ulcer; I feel comfortable communicating with nurses in other wards concerning the progress of pressure ulcer during the transfer of patients; and I feel comfortable consulting other nurse specialist for advice on pressure ulcer wound management.

It is noted that the majority of participants express medium and high level of communication within these four questions. However, only 76.6 % participants state the communication between nurses and health care professionals is in the medium and high level. This may require further investigation in the future.

Level of complexity of wound assessment form
In the new pressure ulcer wound assessment form, there is a total of 25 items for the participants to evaluate the complexity of filling the form. There are four rating scales, which vary from 1=easy to fill to 4=very complicated. Overall, 92.9 % nurses rated 1 to 2, which indicated the items were easy to fill in. Of the nurses, 6.8 % rated these items were complicated and 0.3% indicated two items were very complicated to fill in. It was noted that there are some items where over 10% of nurses were found to have difficulties filling in details. These are: staging system, tunnelling/undermining, amount of exudate, surrounding skin maceration and assessment of pain level. For that reason, plans for future nursing education should consider those areas as essential components of the education program.

CONCLUSION
The aim of this project is to develop a pressure ulcer wound documentation form for use by all departments at Queen Mary Hospital through face and content validity. In addition, it included provision of training for the frontline nursing staff to ensure correct documentation and successful implementation of the newly developed form.

In reference to part A of the questionnaire, “Documentation in your clinical settings”, it was expected that all nurses should have the form available in their wards and are regularly using it for patients with pressure ulcer and are also aware of the guidelines on how often wound assessment should be performed and documented. However, a percentage ranging from 80 to 93.3% was only achieved in relation to the above aspects. In reference to part B of the questionnaire, “Practice”, there was a percentage ranging from 80 to 86.7% of the nurses who are familiar with pressure ulcer staging system and make comprehensive wound measurement and assessment.

It should be noted here that to ensure correct documentation, a percentage of 100% response needs to be achieved. In view of the above results, further promotion and education for the nursing staff should be reinforced in the future.
Table 4: Level of complexity of wound assessment form (%)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location (site no.)</strong></td>
<td>Refer to diagram at back</td>
<td>71.42%</td>
<td>25%</td>
<td>3.57%</td>
</tr>
<tr>
<td><strong>Staging system</strong></td>
<td>SDTI, I, II, III, IV, Unstageable (NA for healing ulcer)</td>
<td>54%</td>
<td>28.5%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>(L) x (W) x (D) cm</td>
<td>60.7%</td>
<td>32.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Tunnelling/undermining</strong>*</td>
<td>_____cm</td>
<td>50%</td>
<td>32.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Colour</strong> (25%, 50%, 75%, 100%)</td>
<td>Pink</td>
<td>46.4%</td>
<td>50%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>Red</td>
<td>46.4%</td>
<td>50%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>Yellow</td>
<td>50%</td>
<td>42.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Black/Brown</td>
<td>50%</td>
<td>42.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Exudate</strong></td>
<td>Type: Serous / S / B / P</td>
<td>60.7%</td>
<td>32.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Amount: L / M / S / No</td>
<td>53.6%</td>
<td>35.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td><strong>Odour</strong></td>
<td>Offensive / Some / None</td>
<td>78.6%</td>
<td>17.9%</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>Surrounding skin</strong></td>
<td>Normal</td>
<td>71.4%</td>
<td>28.6%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Erythema</td>
<td>64.3%</td>
<td>32.1%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>Induration</td>
<td>50%</td>
<td>42.9%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Oedema</td>
<td>53.6%</td>
<td>39.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Maceration</td>
<td>53.6%</td>
<td>28.6%</td>
<td>17.8%</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td>Present / Suspect / No</td>
<td>46.4%</td>
<td>53.6%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Swab obtained: Yes / No</td>
<td>67.9%</td>
<td>32.1%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>0–10</td>
<td>50%</td>
<td>32.1%</td>
<td>17.8%</td>
</tr>
<tr>
<td>*<em>Dressing protocol/<em>Topical negative pressure therapy @____mmHg</em></em></td>
<td>Cleansing lotion</td>
<td>78.6%</td>
<td>17.9%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>Primary dressing</td>
<td>71.4%</td>
<td>21.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Secondary dressing</td>
<td>60.7%</td>
<td>32.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Outer dressing / Fixation</td>
<td>64.2%</td>
<td>32.1%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td>67.9%</td>
<td>32.1%</td>
<td>0</td>
</tr>
</tbody>
</table>

Rating scale: 1= easy to fill and 4=very complicated
# Appendix I

**Hospital Authority**

**Hong Kong West Cluster**

**Wound Assessment Form** *(Pressure Ulcer)*

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Location (Site no.)</td>
<td>Refer to diagram at back</td>
</tr>
<tr>
<td>Staging System</td>
<td>SDTI, I, II, III, IV, Unstageable (NA for healing ulcer)</td>
</tr>
<tr>
<td>Size</td>
<td>(L) x (W) x (D) cm</td>
</tr>
<tr>
<td>Tunneling / Undermining*</td>
<td>___ cm</td>
</tr>
<tr>
<td>(NA for Nil)</td>
<td>@ _______ o’clock</td>
</tr>
<tr>
<td>Colour</td>
<td>Pink, Red, Yellow, Black / Brown</td>
</tr>
<tr>
<td>Exudate</td>
<td>Type: Serous / S / B / P</td>
</tr>
<tr>
<td></td>
<td>Amount: L / M / S / No</td>
</tr>
<tr>
<td>Odour</td>
<td>Offensive / None</td>
</tr>
<tr>
<td>Surrounding Skin</td>
<td>Normal, Erythema, Induration, Oedema, Maceration</td>
</tr>
<tr>
<td>Infection</td>
<td>Present / Suspect / No</td>
</tr>
<tr>
<td>Pain</td>
<td>0-10</td>
</tr>
<tr>
<td>Dressing Protocol / *</td>
<td>Cleansing lotion</td>
</tr>
<tr>
<td>Topical negative pressure therapy @____ mmHg</td>
<td>Primary dressing, Secondary dressing, Outer dressing / Fixation</td>
</tr>
<tr>
<td>Remarks:</td>
<td></td>
</tr>
<tr>
<td>Nurse’s Name</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td></td>
</tr>
</tbody>
</table>

*Delete as appropriate*
### Instruction for Wound Assessment Chart for Pressure Ulcer

<table>
<thead>
<tr>
<th>Location</th>
<th>Refer to diagram below</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staging System</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Stage</strong></td>
<td><strong>National Pressure Ulcer Advisory Panel (NPUAP), 2007</strong></td>
</tr>
<tr>
<td>Suspected Deep Tissue Injury (SDTI)</td>
<td>Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.</td>
</tr>
<tr>
<td>Stage I</td>
<td>Intact skin with non-blanchable redness of a localized area usually over a bony prominence.</td>
</tr>
<tr>
<td>Stage II</td>
<td>Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured serum filled blister.</td>
</tr>
<tr>
<td>Stage III</td>
<td>Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.</td>
</tr>
<tr>
<td>Unstageable</td>
<td>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) is the wound bed.</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA Healing ulcer. Staging System is irreversible</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>L = Length; W = Width; D = Depth</td>
</tr>
<tr>
<td><strong>Tunneling</strong></td>
<td>Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; result in dead space with potential for abscess formation (WOCN, 2010). Example for description: 3cm @ 10 o’clock (Clockwise).</td>
</tr>
<tr>
<td><strong>Undermining</strong></td>
<td>Area of tissue destruction extending under intact skin along the periphery of a wound (WOCN, 2010). Example for description: 1-2cm from 1-5 o’clock (Clockwise).</td>
</tr>
<tr>
<td><strong>Colour</strong></td>
<td>Pink = Epithelialization; Red = Granulation; Yellow = Slough; Black/Brown = Necrosis, presence of eschar</td>
</tr>
<tr>
<td><strong>Exudate</strong></td>
<td>Type (colour and consistency) Serous = Clear fluid, light yellow colour S = Serosanguineous, pale red to pink colour B = Bloody, red colour P = Purulent, opaque tan to yellow colour, pus made up of inflammatory cells and tissue debris</td>
</tr>
<tr>
<td><strong>Amount</strong></td>
<td>Large = wound tissue bathed in fluid, dressings are saturated and exudate is leaking out. Moderate = wound tissue saturated, the primary dressing is wet and strike-through, the outer dressing are extensively marked. Small = wound tissue moist or wet, the primary dressing is lightly marked. No = wound bed had no visible moisture, the primary dressing is dry.</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>Refer to Pain Score below</td>
</tr>
</tbody>
</table>

(Please indicate the location of pressure ulcer on the body diagram)

### Pain Score

<table>
<thead>
<tr>
<th>Pain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Hurts little bit</td>
</tr>
<tr>
<td>Hurts little more</td>
</tr>
<tr>
<td>Hurts even more</td>
</tr>
<tr>
<td>Hurts whole lot</td>
</tr>
<tr>
<td>Hurts worst</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location / Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Back of head</td>
</tr>
<tr>
<td>2. Right ear</td>
</tr>
<tr>
<td>3. Left ear</td>
</tr>
<tr>
<td>4. Right shoulder</td>
</tr>
<tr>
<td>5. Left shoulder</td>
</tr>
<tr>
<td>7. Right scapula</td>
</tr>
<tr>
<td>8. Left scapula</td>
</tr>
<tr>
<td>9. Right elbow</td>
</tr>
<tr>
<td>10. Left elbow</td>
</tr>
<tr>
<td>11. Right wrist</td>
</tr>
<tr>
<td>12. Left wrist</td>
</tr>
<tr>
<td>13. Right hand</td>
</tr>
<tr>
<td>14. Left hand</td>
</tr>
<tr>
<td>15. Vertebrae (Upper-mid)</td>
</tr>
<tr>
<td>16. Sacrum</td>
</tr>
<tr>
<td>17. Coccyx</td>
</tr>
<tr>
<td>18. Right iliac crest</td>
</tr>
</tbody>
</table>

www.wcetn.org
Pre-implementation Survey

Survey Questionnaire

Wound Care Practices in Queen Mary Hospital

- Please be informed that all information in this survey form is confidential and is only for the purpose of evaluating the outcomes of the study to be undertaken by the researcher.
- Please note that you will be requested to fill in the same form 3 months later.

Specialty ___________________________ Rank ___________________________

Read the following statements and circle your response to each

A. Documentation in your clinical setting:

1. Pressure ulcer wound documentation forms are available.
2. Pressure ulcer wound documentation forms are regularly used and provide a clear picture of monitoring the progress of pressure ulcer.
3. There are guidelines on how often wound assessment should be performed and documented.

B. Practice

1. I am familiar with Pressure Ulcer Staging System in Pressure Ulcer Assessment Form of Queen Mary Hospital.
2. I feel comfortable making a comprehensive pressure ulcer wound measurement and assessment for the patients.
3. I feel comfortable in using different kinds of advanced wound care product for different stages of pressure ulcers.

C. Please rate the followings aspects of communications on a (0) to (3) scale; Where;

0 = no communication, 1 = low level, 2 = medium level, 3 = high level of communication

Not applicable (N/A): choose N/A if the aspect of communication is not applicable to you.

<table>
<thead>
<tr>
<th>Aspects of communication:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Current level of communications between nurses in regards to pressure ulcer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Current level of communications between nurses and healthcare professionals in regards to pressure ulcer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel comfortable communicating with nurses in other wards concerning the progress of pressure ulcer during the transfer of patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel comfortable consulting other nurse specialist for advice on pressure ulcer wound management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Post-implementation Survey

Survey Questionnaire

Wound Care Practices in Queen Mary Hospital

- Please be informed that all information in this survey form is confidential and is only for the purpose of evaluating the outcomes of the study that was undertaken by the researcher.

Specialty ___________________________ Rank ___________________________

Read the following statements and circle your response to each

A. Documentation in your clinical setting:
1. Pressure ulcer wound documentation forms are available.
2. Pressure ulcer wound documentation forms are regularly used and provide a clear picture of monitoring the progress of pressure ulcer.
3. There are guidelines on how often wound assessment should be performed and documented.

B. Practice
1. I am familiar with Pressure Ulcer Staging System in Pressure Ulcer Assessment Form of Queen Mary Hospital.
2. I feel comfortable making a comprehensive pressure ulcer wound measurement and assessment for the patients.
3. I feel comfortable using different kinds of advanced wound care product for different stages of pressure ulcers.

C. Please rate the following aspects of communications on a (0) to (3) scale; Where;
0 = no communication, 1 = low level, 2 = medium level, 3 = high level of communication
Not applicable (N/A): choose N/A if the aspect of communication is not applicable to you.

<table>
<thead>
<tr>
<th>Aspects of communication:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Current level of communications between nurses in regards to pressure ulcer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Current level of communications between nurses and healthcare professionals in regards to pressure ulcer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel comfortable communicating with nurses in other wards concerning the progress of pressure ulcer during the transfer of patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel comfortable consulting other nurse specialist for advice on pressure ulcer wound management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Evaluation of Wound Assessment Form

**Please tick as appropriate**

<table>
<thead>
<tr>
<th></th>
<th>Easy to fill</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Very complicated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location (Site no.)</strong></td>
<td>Refer to diagram at back</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staging System</strong></td>
<td>SDTI, I, II, III, IV, Unstagable (NA for healing ulcer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>(L) x (W) x (D) cm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tunneling / Undermining</strong></td>
<td>_____ cm (NA for Nil) @ ________ o’clock</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colour</strong></td>
<td>Pink</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(25%, 50%, 75%, 100%)</strong></td>
<td>Red</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yellow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black / Brown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exudate</strong></td>
<td>Type: Serous / S / B / P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amount: L / M / S / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Odour</strong></td>
<td>Offensive / Some / None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surrounding Skin</strong></td>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(Please “√” if appropriate)</strong></td>
<td>Erythema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Induration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oedema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maceration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td>Present / Suspect / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swab obtained: Yes / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>0-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dressing Protocol / * Topical negative pressure therapy</strong></td>
<td>Cleansing lotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@____ mmHg</td>
<td>Primary dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secondary dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outer dressing / Fixation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rating scale: 1 = easy to fill and 4 = very complicated

**Comment**

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
The aim of the Norma N Gill Foundation is to facilitate education in enterostomal therapy (ET) nursing worldwide. We would not be able to carry out this task without the support of our members and sponsorship from our colleagues in industry.

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- Saraswati Bhandari — Nepal

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- Stella Rithara — Kenya
- Grace Wanyoike — Kenya
- Josephine Gachango — Kenya

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- Patrick Kiambi
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**REFERENCES**

簡介
“壓瘡是局部皮膚和/或下層組織的損傷，通常位於骨性隆起的區域，為壓力，或壓力與剪切力和/或摩擦的組合的結果” (NPUAP, 2007)。是一個嚴重的問題，並常見於醫院和護老院。多年來，壓瘡的形成是護理質量的一個關鍵指標 (Wicks, 2007)。眾所周知壓瘡是疼痛和不適的來源，它影響個人功能，減少活動性，營養攝取和對病人的心理有負面的影響 (Beldon, 2006)。

在香港瑪麗醫院，壓瘡風險評估及護理干預記錄已於2000年制定，成為病人評估及護理記錄的標準程序 (2010年5月18日最新修訂板)。可是各部門仍有不同的壓瘡傷口記錄表格，如重症監護和骨科部門。由於記錄表格的內容不同，各部門之間沒有達成共識。一旦患者從一個部門轉移到另一部門，原來的壓瘡傷口記錄表格便不再使用。結果護士和醫療專業人士對傷口狀況沒有持續的溝通，進而影響到傷口處理/管理的連續性。因此，為了方便溝通及統一標準記錄，發展一份壓瘡傷口記錄表在醫院各部門使用是必需的。

文獻綜述
病歷的法律效力
在當今的醫療系統，眾所周知，病歷是作為協助醫護人員規劃，協調和評估病人護理的工具 (Hess, 2005)。此外，病歷也是涉及醫療錯誤，身體損傷或其他問題的法律文件 (Brown, 2006)。因此，有效和高效的護理記錄可以提供一份明確和一致的護理計劃，方便溝通和評估。此外，它也是專業實踐的基礎 (Gunningberg & Ehrenberg, 2004; Maylor, 2003)。準確的記錄，可以確保護士是提供安全，有效，優質的護理。而準確的記錄，可以確保護士是提供安全，有效，優質的護理 (Hon & Jones, 1996; Foster & Moore, 1999)。

壓瘡記錄的問題
準確的傷口記錄可以制定相應的治療方案，以保證質量和服務的連貫性，及給與傷口癒合進展提供指導 (Gunningberg & Ehrenberg, 2004; Maylor, 2003)。記錄患者的傷口癒合進展也是護理間的關鍵部分 (Hon & Jones, 1996; Foster & Moore, 1999)

表1: 實施前和後“臨床的文檔記錄”的比較 (%)

<table>
<thead>
<tr>
<th></th>
<th>前</th>
<th>後</th>
</tr>
</thead>
<tbody>
<tr>
<td>壓瘡傷口記錄文件可供使用</td>
<td>100%</td>
<td>93.3%</td>
</tr>
<tr>
<td>壓瘡傷口記錄文件有定期使用，並在監控壓瘡的進展下提供一清晰畫面</td>
<td>62.5%</td>
<td>80%</td>
</tr>
<tr>
<td>現存有指引關於傷口評估及記號的頻密程度</td>
<td>71.9%</td>
<td>80%</td>
</tr>
</tbody>
</table>
訓的護士。調查問卷分為三部分。第一部分的3條問題關於護士在臨床的文檔記錄。第二部分的3條問題是關於護理實踐。第三部分的4條問題著重於溝通方面。參與者預計在1週內,將完成的問卷發回中央護理部。此後,新的壓瘡傷口記錄文件正式在瑪麗醫院實施。

實施後的調查

實施三個月後,所有的參與者被要求再次填寫相同的問卷(附件3)。此外,他們還被要求填寫“傷口評估表的複雜程度”及提供改善建議。這項調查是通過醫院內部郵件發送給參與者,並附帶回郵信封送至中央護理部。如之前,參與者預計在1週內完成問卷,並發回給中央護理部。

結果和討論

在實施前的調查中,共有32份問卷返回,回應率是45%。在實施後的調查,有30份問卷返回,回應率是42%。然而,對於“傷口評估表的複雜程度”,只有28人填寫,故這部份的回應率為39%。由於大部份參與者沒有填寫自己的所屬專科和職位,故無法分析他們的專科工作和資歷。

臨床的文檔記錄

令人驚訝地發現,儘管壓瘡傷口記錄文件推廣達3個月以上,仍有2名護士表示此記錄文件只是有時使用。很明顯,為了確保所有的護士使用這記錄文件及達到更佳的依從性,在未來,進一步推廣是必需的。另一方面,令人鼓舞的是,護士經常使用的百分比增加(80%)。不過,我們的目的是100%。因此,進一步的護理教育是必要的,以確保所有的護士使用相同的文檔。而在“現存有指引關於傷口的評估和記錄的頻密程度”,只有28人填寫,故這部份的回應率為39%。由於大部份參與者沒有填寫自己的所屬專科和職位,故無法分析他們的專科工作和資歷。在護士和醫療人員之間的溝通,只有76.6%的受訪者認為溝通是在中高水平。這方面可能需要作進一步的調查。

壓瘡傷口評估表的複雜程度

在此新壓瘡傷口評估表,總共有25項給參與者評估此表格的複雜性。它有4個等級量表,從1 =容易填寫到4 =非常複雜。總體而言,92.9%的護士評為1-2等級,這表明該項目是容易填寫。6.8%的護士評定此等項目是複雜的,0.3%的人表示有2項是非常複雜。其中有超過10%的護士發現填寫時有困難。它們是分期系統,隧道/潛行,滲液份量,周圍皮膚浸漬和疼痛程度的評估。基於這個原因,這些部份是在計劃未來護理教育的重點。

結論

此項目的目的是通過表面效度和內容效度,開發一個可給與瑪麗醫院各部門使用的壓瘡傷口評估表。另外,提供了一線護理人員的培訓,以確保正確的填寫文檔和成功實施。關於問卷A部分的“臨床記錄”,預計所有的護士都應該知道和理解此分期系統。因此,建議計劃再作進一步的護理教育,以確保所有的護士熟悉這分期系統。這也適用於壓瘡傷口的測量和評估這方面。雖然熟悉或理解的百分比有增加,但同樣也希望100%護士能熟悉這指引。至於護士對使用不同種類的傷口敷料於不同階段的壓瘡的信心信心百分比降低,這是令人失望的。然而,由於問卷的匿名性,調查前及後可能不是相同的護士。這問題顯示此研究設計的弱點,但保持匿名是優先事項。

信息傳達方面

在這方面有4條問題,這些問題包括現時護士之間關於壓瘡的溝通,現時護士和醫療人員之間關於壓瘡的溝通,在病人的轉移過程中,與其他病房護士溝通壓瘡的進展及在諮詢專科護士關於壓瘡管理的意見的感覺。在這4條問題中,大部份參與者表示處於中等和高水平的溝通。然而,在護士和醫療人員之間的溝通,只有76.6%的受訪者認為溝通是在中高水平。這方面可能需要作進一步的調查。

表3: 信息傳達方面的前和後比較 (%)

<table>
<thead>
<tr>
<th></th>
<th>前</th>
<th>後</th>
<th>前</th>
<th>後</th>
<th>前</th>
<th>後</th>
<th>前</th>
<th>後</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0</td>
<td>0</td>
<td>9.37%</td>
<td>0</td>
<td>53.13%</td>
<td>66.7%</td>
<td>37.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>b</td>
<td>0</td>
<td>0</td>
<td>28.13%</td>
<td>0</td>
<td>43.75%</td>
<td>53.3%</td>
<td>28.13%</td>
<td>23.3%</td>
</tr>
<tr>
<td>c</td>
<td>0</td>
<td>0</td>
<td>12.5%</td>
<td>0</td>
<td>50%</td>
<td>53.3%</td>
<td>31.25%</td>
<td>30%</td>
</tr>
<tr>
<td>d</td>
<td>0</td>
<td>0</td>
<td>15.63%</td>
<td>0</td>
<td>28.13%</td>
<td>50%</td>
<td>56.25%</td>
<td>50%</td>
</tr>
</tbody>
</table>

a. 現時護士之間關於壓瘡的溝通。
b. 現時護士和醫療人員之間關於壓瘡的溝通。
c. 我在病人的轉移過程中,與其他病房的護士溝通壓瘡的進展,感覺良好。
d. 我在諮詢專科護士關於壓瘡管理的意見,感覺良好。

0 = 無溝通, 1 = 低水平, 2 = 中等水平, 3 = 高水平的溝通, NA = 不適用

www.wcetn.org
### 表4: 傷口評估表的複雜程度 (%)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>位置 (站點編號)</strong></td>
<td>參照頁後的圖像</td>
<td>71.42%</td>
<td>25%</td>
<td>3.57%</td>
</tr>
<tr>
<td><strong>分期系統</strong></td>
<td>S D T I, I, II, III, IV, Unstageable (NA=癒合中的潰瘍)</td>
<td>54%</td>
<td>28.5%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>尺寸</strong></td>
<td>(長) x (寬) x (深) 厘米</td>
<td>60.7%</td>
<td>32.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>隧道/潛行</strong></td>
<td>________厘米</td>
<td>50%</td>
<td>32.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td>@ ________ 時鐘</td>
<td>50%</td>
<td>35.7%</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>顏色</strong></td>
<td>粉紅</td>
<td>46.4%</td>
<td>50%</td>
<td>3.5%</td>
</tr>
<tr>
<td>(25%，50%，75%，100%)</td>
<td>紅色</td>
<td>46.4%</td>
<td>50%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>黃色</td>
<td>50%</td>
<td>42.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>黑色/棕色</td>
<td>50%</td>
<td>42.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>滲液</strong></td>
<td>種類:漿液性/ S / B / P</td>
<td>60.7%</td>
<td>32.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>份量: L / M / S /沒有</td>
<td>53.6%</td>
<td>35.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td><strong>氣味</strong></td>
<td>強烈 / 有 / 沒有</td>
<td>78.6%</td>
<td>17.9%</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>周圍皮膚</strong></td>
<td>正常</td>
<td>71.4%</td>
<td>28.6%</td>
<td>0</td>
</tr>
<tr>
<td>(如合適請“√”))</td>
<td>紅斑</td>
<td>64.3%</td>
<td>32.1%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>硬結</td>
<td>50%</td>
<td>42.9%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>水腫</td>
<td>53.6%</td>
<td>39.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>浸漬</td>
<td>53.6%</td>
<td>28.6%</td>
<td>17.8%</td>
</tr>
<tr>
<td><strong>感染</strong></td>
<td>有 / 懷疑 / 沒有</td>
<td>46.4%</td>
<td>53.6%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>拭子採集: 有 / 沒有</td>
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<td><strong>疼痛</strong></td>
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<td><strong>換症指示/局部負壓治療</strong></td>
<td>清洗溶液</td>
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<td>@____mmHg</td>
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<td>第二層敷料</td>
<td>60.7%</td>
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<td>64.2%</td>
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等級：1 = 容易填寫和4 = 非常複雜
Case study — unusual wound: rheumatoid arthritis, lupus anti-coagulant regional anaesthesia

**ABSTRACT**

Our interdisciplinary team reports a case of a woman with multiple medical issues including rheumatoid arthritis (RA) and lupus anticoagulant who developed a wound on her left lower extremity after suffering a fall.

**Keywords:** Rheumatoid arthritis, lupus, haematoma, anaesthesia, surgical debridement.

**INTRODUCTION**

For most people, a fall does not result in serious injury or numerous subsequent hospital visits. But when the integrity of the vasculature is compromised, a usually innocuous fall can cause a haematoma, necessitating medical intervention. The composition of the haematoma is an ideal medium for bacterial growth, and is therefore sometimes surgically evacuated. Large haematomas can cause venous compression, impaired tissue perfusion, and potentially tissue necrosis.

**PATIENT HISTORY**

A 60-year-old female suffered a fall and developed a subsequent haematoma and non-healing wound on the anterior left lower extremity. The patient has a past medical history of rheumatoid arthritis (RA), lupus anticoagulant, gastro-oesophageal reflux disease (GORD), and mitral valve prolapse. She takes numerous medications, including celecoxib, prednisone, sulfasalazine, metoprolol, warfarin, hydroxyzine and lansoprazole. Surgical history was extensive, including bilateral hip and knee replacements with numerous subsequent revisions. RA is a chronic inflammation of joint synovial tissue. It affects about 1% of adults, with a prevalence two to three times higher in women than in men.

**CLINICAL DATA**

Clinical data for this patient is summarised in Table 1. During the first procedure, a skin substitute was inserted into the wound in an attempt to expedite healing. In the last procedure, the tibia was still visible and a multilayered closure for a total of 4 cm was performed. The multi-layer surgical closure begins with the deep layers of fascia with interrupted sutures followed by more superficial sutures with either interrupted or continuous sutures (Figure 1).

![Figure 1: Wound on anterior lower left leg, two months post-fall](https://example.com/wound1.jpg)

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LUPUS ANTICOAGULANT

Lupus anticoagulant is an antiphospholipid antibody which causes a hypercoagulable state. While it prolongs clotting time in vitro, it actually facilitates clot formation in vivo by interacting with the phospholipids on platelet membranes and increasing platelet adhesion and aggregation. Antiphospholipid syndromes are one type of systemic disease that can cause cutaneous leg ulcers.

VENOUS ULCERS

Chronic wounds are usually one of three types: diabetic ulcers, pressure ulcers, and venous ulcers. These three types of ulcers may be similar in appearance though they each call for different treatment strategies.

Venous ulcers are the most common ulcer type on the legs and are estimated to account for 70–90% of cases. Their aetiology is thought to include incompetent valves in the venous system, causing venous hypertension and oedema. In this case, the pertinent positives of a prior fall and a remarkable medical history were elicited, allowing for the correct diagnosis of venous ulcer to be made and appropriate plan of care including compression to be selected.

THE TREATMENT PLAN: ANAESTHESIA CONSIDERATIONS IN PATIENTS WITH RA

There are numerous systemic manifestations of both the RA and its treatment (Table 2) which should be taken into account when planning the surgical and anaesthetic care of a patient with RA. The local infiltration of a sodium channel blocker such as lidocaine decreases the need for intravenous and inhalational anaesthetic agents to provide comfort during the time of surgical stimulus (anti-nociception). Therefore, the airway management strategy to maintain airway patency, oxygenation, and ventilation usually requires less invasive methods than endotracheal intubation to compensate for possible central and obstructive apnoeas secondary to general anaesthesia. The minimally invasive anaesthetic strategy can be desirable for “small cases”, especially in large-volume outpatient surgery settings. However, the mechanical considerations and challenges related to passage of an endotracheal tube given her limited mouth opening, neck extension, and the narrow glottic opening, were avoided since this patient only required a simple oxygen mask for spontaneous ventilation. Of note, this patient was taking celecoxib and prednisone daily, which could potentially increase the risk of gastritis, renal insufficiency, and hyperglycaemia.

Like many chronic wound patients, this woman required multiple debridements in the operating room (Table 1). Due to her co-morbidities, the wound healed seven and a half months after her fall (Figure 2).

CONCLUSIONS

Patients with wounds can have several co-morbidities and therefore may have complex needs that should be considered when developing a plan of care. Collecting a complete Post-fall month 4 5 6

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<tr>
<th>Procedure</th>
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<td>Debridement and living skin substitute</td>
<td>Local and sedation</td>
<td>Oxygen mask</td>
<td>Midazolam</td>
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Figure 2: Healed wound on anterior lower left leg, 7.5 months post-fall © 2012 O’Neill
medical history as part of the pre-anaesthesia evaluation is important in order to evaluate wound care and anaesthesia options. If surgical intervention is necessary, a discussion of regional and/or general anaesthesia would be required to develop a customised anaesthetic plan for the individual patient’s needs. This plan was successful and resulted in a positive outcome of healing of her leg wound after seven and a half months. Attention to her medical conditions, coordination of care among the multidisciplinary team, along with patient education regarding fall prevention facilitated a successful outcome in this case.

CONFLICT OF INTEREST DISCLOSURE
The authors declare that there are no conflicts of interest.

REFERENCES
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- Convexity - addressing the controversies surrounding the use of convex stoma appliances.

**Wound:** Gary Sibbald & Hiske Smart
- Infrared thermometry. A cost effective tool for every wound care practitioner & their patients.

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With love from Africa
Monica Franck
WCET2016 Congress Convener

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We will see you soon in Cape Town!

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Monica Franck
WCET2016 Congress Convenor

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**Gumboot dancers.**

The gumboot dance is an African dance performed by dancers wearing wellington boots or gumboots as it is called. Gumboot dancing started in South African mines.

![Gumboot dancers](image1)

Photo: © South African Tourism

The Pan African Market in Long Street in Cape Town is one of the many popular African markets that you have to visit when you get to Cape Town.

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Quantitative study of visual nursing competence in Chile to identified and classified incontinence-associated dermatitis, pressure ulcers and mixed lesions

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ABSTRACT

Objective: Ascertain the competence of registered nurses in the visual identification and classification of dermal lesions associated with incontinence, pressure ulcers and mixed lesions.

Population and sample: The participants in the study consisted of 46 nursing professionals in the public health services in Chile. All the participants had qualifying clinical hours in the undergraduate program in the assessment of these wounds.

Methodology: Quantitative study, exploratory, not experimental. The subjects were presented with 14 pictures of skin lesions chosen according to the criteria of the National Pressure Ulcer Advisory Panel, based on the criteria of Mikel Gray and colleagues. This included five lesions associated with incontinence dermatitis, four pressure ulcer lesions and five mixed lesions. These were to be independently identified and classified utilising a written questionnaire. The answers were coded and processed with the statistical program SPSS 15.0. Statistical descriptions were calculated and the results were presented in tables and bar graphs.

Results: The nursing professionals correctly identified an average of 8±2 correct answers from 14 pictures. The lesions that were identified readily were the pressure ulcers with 82% validity, followed by the dermatitis lesions associated solely with incontinence with 57.28%, and the mixed lesions with 30.4%. The subjects also correctly identified the classifications for the pressure ulcers with 45.6%, 23.9% for incontinence-associated dermatitis, and 2.6% for mixed lesions.

Conclusion: There is a lack of competence in the classification and identification of pressure ulcers and incontinence-associated dermatitis. The picture that was best identified was the type III pressure ulcer with 95.7% (picture 9). The worst identification was the dermatitis associated solely with incontinence with a 10.9% (picture 2). These findings have a significance impact on the quality of nursing care for the patients with these conditions; they also have a direct repercussion on the appropriate treatment strategies, and may slow skin/wound healing, add days to hospitalisation, and even aggravate the pre-existing pathology.

Keywords: Pressure ulcers, nursing, incontinence-associated dermatitis.

INTRODUCTION

Skin lesions caused by prolonged bed rest and/or humidity are problematic in the nursing field, since the destruction of the skin’s integrity is considered an indicator of the quality of nursing care and patient safety. In clinical practice, it is fundamental for clinicians to have the ability to correctly identify and classify skin erosion that is caused by humidity and urinary incontinence and/or faecal incontinence-associated dermatitis (IAD), pressure ulcers (PUs), and mixed lesions. Good identification will guide the clinician’s specific care for the skin, whether it is IAD or a PU.

IAD is a reactive response of the skin to the chronic exposure to urine, faecal material, or both. It is manifested as inflammation, oedema and erythema with or without erosion, accompanied by blisters, with serous exudates, erosion, or secondary cutaneous infection. The exposure of the skin to humidity and to irritating substances (urine, dregs and soaps) weakens the skin and diminishes its tolerance to pressure and shear stress. Gray and colleagues reveal that IAD is a frequent problem, affecting almost half of the people with urinary or faecal incontinence that have been treated with absorbing materials such as diapers. The prevalence of these lesions in those hospitalised fluctuates between 5.6% and 50% and the impact varies 3.4-25%.
Pressure ulcers are defined as a lesion localised on the skin and/or underlying tissue, generally over a prominent bone as a result of the pressure, or the pressure in combination with the friction and/or forces of shear stress. The prevalence of stage II pressure ulcers oscillates between 8.7% and 14.1% in the intensive care unit, while the frequency varies between 5% and 9%7. The realisation of this differentiation allows one to orient and plan clinical strategies on skin care through prevention and treatment. The presence of PUs is considered by many an indicator of poor quality of health care7.

The National Pressure Ulcer Advisory Panel (NPUAP) and the European Pressure Ulcer Advisory Panel (EPUAP) express that the term IAD is a condition that should be differentiated from PUs or skin lacerations since they are commonly confused8,10,11-13,15,17. Gray and colleagues affirm that IAD lesions are frequently classified erroneously as PUs, despite the fact that IAD lesions are not caused by ischaemia. Doughty and colleagues emphasise the need to establish a good diagnostic difference between IAD and other lesions of the skin caused by humidity versus a stage I or II PU13. The realisation of this differentiation allows one to orient and plan clinical strategies on skin care through prevention and treatment. On the other hand, the NPUAP considers that a stage II ulcer should not be used to describe skin lesions caused by tears or provoked by surgical tapes, or IAD, maceration, or excoriation13.

With the end goal to differentiate between IAD and PUs, the EPUAP established criteria to facilitate their visual evaluation. The characteristics to consider for visual inspection are: cause of original injury; colour of the lesion; localisation of the wound; depth of the lesion (edges, form and distribution of the lesions); presence of necrotic tissue; exudate; significant associated factors and symptoms, such as pain, odour, and pruritus8,13,14,16,17. In practice, the differential diagnostics of these lesions are identified by clinical nurses, on the basis of a visual assessment, which requires one to have competency, knowledge and nursing assessment skills that permits the identification of these lesions1,2,6. Beeckman and colleagues11 evaluated the capacity of nurses (212) and nursing students (214) in their final year of studies, in the differentiation of IAD lesions with erosion caused by humidity associated with PU-associated incontinence in stage II or mixed lesions caused by humidity and pressure. The results showed that nurses and students alike presented difficulty in the differentiation of IAD lesions and stage II PUs.

Defloor and Schoonhoven, 2004, calculated the reliability or capacity to correctly identify the lesions utilising Cohen’s Kappa, by nurses who were experts on pressure ulcers, and the result was 0.8. By applying Cohen’s Kappa, nurses without experience with PUs, the value found was much less that 0.37-0.52, respectively. These authors indicate that the erythema that does not pale was confused with the erythema that does pale in incontinence-associated lesions. On the other hand, they indicated that incontinence-associated lesions were not well classified17. They concluded in their study that the differentiation between PUs and IAD is difficult and that, despite the assessment of the tissue affected in depth, they should take into account the clinical presentations of these lesions15,16.

Other studies done by Defloor and colleagues in 2006 and 2007 show that nurses with different levels of specialisation and from different countries saw Cohen’s Kappa as inter-observers (degree of concordance in the evaluation of two or more independent observers) and low intra-observers (grade of the evaluation’s reliability of only one observer at a time)15. The reliability of the system is low and there is frequent confusion between lesions caused by humidity, blanchable erythema, and grade I PUs15.

It was noted that regular inspection of the skin, the assessment of risk to present a PU, and the clinical history of a patient (background of urinary and/or faecal incontinence or other forms that cause humidity like the excess perspiration or a wound with high deposits of exudate), do not permit a clear differentiation between a lesion by humidity and one by pressure.

Gray, Beeckman and colleagues affirm that there is a significant improvement noted in the ability to realise differential diagnostics between IAD and PUs once there has been an implementation of a learning program such as Pressure Ulcer Classification (PUCLAS) via e-learning or a traditional class utilising photographs8,14,15.

In Chile, in the case of PUs, the rating scales of risk utilised in the health services are those of Braden and Norton9. In addition to these instruments, there are prevention and treatment protocols that include measures such as: decreasing pressure with elements that redistribute the pressures areas; changes of positions; humidity control; and skin protection. The treatment goal is oriented to restore the skin with advanced healing, nutritional support, and relief of pressure. In IAD lesions the key is prevention; it is recommended to engage in a cleansing routine, protection, and hydration of the skin, plus eliminating the factors caused by humidity1-4.9. For the treatment of IAD, expert recommendations are as follows: removal of irritating substances on the skin; protection and avoiding exposure to urine and stool; treatment of associated infections; and the taking of measures oriented to contain and alleviate incontinence14.

The clinical importance of knowledge to correctly differentiate the diverse lesions can be found in the impact it has on prevention and opportune treatment, whenever PUs corresponded to lesion caused by ischaemia, tissue hypoxia, and necrosis. In contrast, IAD lesions are inflammatory responses to a prolonged exposure of urine and/or stool to the skin14,17. The physiopathology of both lesions is very different, thus the management of the prevention and treatment differ enormously.

In our country, there are no existing investigations that demonstrate the development of competence through
images and e-learning programs to identify lesions caused by humidity and lesions caused by pressure. Considering the importance of the strategies to prevent and treat these lesions, it is fundamental to know how to identify and classify them correctly, inasmuch as the consequences of a wrong recognition can aggravate the patient’s condition. An exploratory study was conducted to evaluate the competence of clinical professionals in identifying and classifying IAD lesions, PUs, and mixed lesions.

**METHODOLOGY**

An exploratory, quantitative study was conducted, implementing a non-experimental design in two public health centres located in the communities of Viña del Mar and Copiapo, Chile. The subjects in this study consisted of 46 nursing professionals (26 registered nurses and 20 nursing students from the last period); all of them completed their nursing studies in accredited programs.

To establish the competence in the identification and classification of dermal lesions, a visual assessment technique utilised by Grey and colleagues\(^1\) was applied, and the EPUAP\(^1\). A presentation was performed utilising PowerPoint, in which they were shown 14 images of colour photos: five lesions corresponding to pure IAD lesions, four lesions of pure pressure ulcers and five photos where skin lesions occurred from mixed causes (PUs and IAD). The validation of the photographs utilised was accomplished by a system of judges: Doctor Dorothy Doughty confirmed that each of the photographs effectively correspond to the types of selected lesions.

The subjects were gathered in a hall with an explanation of the objective of the study, the procedures, and were invited to participate. They all verbally agreed to confidentiality and anonymity of the patient information they would receive. The sequence of photographs with lesions were presented and they were given two minutes to identify and classify each, plus record in a designed questionnaire their finding. The results in the questionnaire were encoded and processed in a statistical program SPSS 15.0. Descriptive statistics were calculated (distribution of frequency, averages, median, mode, and standard deviations), for both the number of identified cases and those that were classified correctly. The results were presented in tables and bar graphs.

**ETHICAL CONSIDERATIONS**

The pictures taken for the visual assessment only showed the affected area. Protection of the rights of the people who participated in the study was assured (subjects photographed, professionals, and students). In the case of the patients, they and their families were directly asked for permission to take these photographs. They were informed of the implications of the study and assured about the safeguarding of the confidentiality of the information collected. The pictures were anonymous.

**RESULTS**

In Figure 1, it was found that participants correctly identified 8 lesions ±2 lesions on average, with a minimum of 4 and a maximum of 12.
In Figure 2, the frequency of correct identification of the 14 displayed lesions was shown in photographs to nurses and students.

In analysing Figure 2, it was noted that type III PUs are the best identified lesions, at 95.7%. It was also noted that the photos of lesions number 1, 3, 4, 6, 7 and 9 were correctly identified by over 80% of the participants of the study, assessing these IAD lesions and PUs in pure form, which explains the adequate identification on the part of the group in study.

Meanwhile, lesions 2 and 5 (both pure IAD lesions) were not identified by the majority of the studied group. These lesions correspond to IAD with erosion in the sacral region, which explains the confusion with PUs.

Finally, lesions 10 and 14 were only identified by around 40% of the professionals, which is due to the mixed nature of these lesions, making it difficult to correctly identify them, bringing confusion and the wrong classification to PUs.

In reference to the pure IAD lesions, the frequency of their correct classification was analysed in Figure 3. It is observed that only 19 of 46 nursing professionals could correctly classify pure IAD lesions 3 and 4 shown in photographs and only 1 nurse could classify lesion 5 (Figure 3).

In relation to pure PUs, it is observed that 27 participants correctly classified lesion 9, which corresponds to a stage III pure PU; 25 participants could correctly classify lesion 6, which corresponds to a pure PU with deep tissue damage. Only 10 participants could classify lesion 8, which corresponds to a stage II pure PU.

In relation to mixed lesions, it is observed that very few nursing professionals can correctly classify them. Only 4 participants correctly classified lesion 10 that corresponds to a PU with IAD, while not one of the participants could classify lesions 11 and 13, both corresponding to mixed lesions (PUs and IAD).

Figure 6 compares, in terms of frequency, the identification and correct classification of lesions. In general, the visual identification is an ability or competence that is better achieved than classification for all participants. This is evident in that 6 of the 14 lesions (1, 3, 4, 6, 7, and 9) are identified by more than 80% of participants (Figure 2), though the percentage of correct classification is considerably low.

The lesions that reach the greatest percentage of classification are lesions 6, 7, and 9. It is notable that these lesions correspond to PUs in pure states, reaffirming observations in Figure 4, which shows a greater ability to identify and classify these types of lesions than IAD. Observing Figure 6, it is evident that nursing professionals in this study lack the competency and knowledge to correctly identify and classify lesions numbered 10 to 14; those in mixed state.

**DISCUSSION**

The principal finding of this study is the demonstration of the lack of competency in nursing professionals (registered
nurses and nursing students) in the identification and classification of skin wounds from visual images. There were no significant differences in the ability to identify or classify injuries among both groups of IAD and PUs and especially those in their mixed states. The difficulty of classification was notable, when the wound is located in the sacral area. In our study, the greatest difficulty in correct identification corresponded to lesions 2 and 5, both pure IAD lesions.

Skin care administered by nurses to bedridden and incontinent patients is changing, and the state of health of the bedridden is more critical and with an increased level of complexity. These skin lesions are notably more common in hospitals with the increased admissions of elderly patients, with chronic and traumatic illnesses. This creates an environment that requires health professionals and especially nurses to be knowledgeable and prepared to offer opportunite, specialised and quality care to this population; especially implementing evidence-based practice. Nurses should be required to have the necessary competencies, especially in the identification and classification of lesions and the assessment of people at risk for skin injury.

In our investigation, the participants only correctly identified around 8±2 lesions of the 14 shown. That indicates a general lack of understanding of the visual characteristics of each lesion. The photo best identified was the type III PU with 95.7% (picture 9). The photo that caused the biggest problem was photo 2, which was a pure IAD, which was identified by only 10.9% of the participants. Another finding in our investigation was the lack of competency in identifying mixed lesions from 10–14; only 40% of professionals could identify them.

This is comparable with the studies of Gray and colleagues, Beeckman and colleagues11-13,17, which showed the difficulties of students and professionals in identifying lesions in pure and mixed forms.

As with other investigations, we observed in our study that the medical history of patients and skin observation do not permit, by themselves, clear differentiation between an IAD or a PU. Since both types of lesions are presented in areas of skin where PUs can occur, the presence of urinary and/or faecal incontinence is a predicting factor of IAD4.

Judging from our results and the importance of the problem in literature, it is evident that there is a necessity to improve the competence of nursing professionals to correctly identify and visual classify IAD lesions, PUs, and mixed lesions. This can be accomplished through the implementation of educational/training programs. This will create a positive environment, allowing the choice of correct treatment(s), with reduced complications; it may decrease days in the hospital, and prevent aggravation of pre-existing pathologies and infections associated with hospitalisation.

The aforementioned notion directly impacts the quality of attention and the efficient management of resources. This is related to indications by Gray and colleagues8,15,17, who insist on the necessity to train health professionals accordingly.

One of the shortcomings of this study is that it was conducted in a small group of nursing professionals (26 registered nurses and 20 nursing student from the last period) and another aspect is that there was a difference in years of experience between the participants that may influence the ability to correctly identify the pictures.

CONCLUSIONS
A lack of competency was seen in 46 nursing professionals in the visual identification and classification of dermal lesions associated with incontinence; lesions caused by pressure, and mixed lesions. There were no significant differences in the ability to identify or classify skin injuries among both groups.
PUs were easier to identify by the group in study; however, when a PU appears together with lesions caused by humidity, the ability of nursing professionals to correctly classify the lesion decreased. Identification is not always easy and many times they are confused with lesions caused by pressure, that leads to incorrect nursing care This frequently aggravates patients’ health condition, increasing the risk of infections, increasing the days of hospitalisation and adding to the health costs.

With respect to the competency of identification of IAD lesions, PUs, and mixed lesions, only 57.28% correctly identified IAD lesions, 82% correctly identified the PUs, and only 30.44% of the mixed lesions were identified. We found that great difficulty was encountered in identifying lesions when more than one was found on the same patient.

The identification of IAD presents great difficulty when they are severe with extreme loss of an area(s) of skin and located in the sacral zone and physical areas that favour the confusion between stages I and II PUs. This is explained, in part, because protocols and assessment instruments exist for determination of PUs, but that is not the case with IAD. This leads to the difficulty of identification and classification on the part of the nurses.

In classifying these lesions, the participants were able to classify PU lesions at 45.6%; but greater difficulty was observed in classifying mixed lesions; only 2.6% of these were accomplished correctly. This can be explained since Chilean health services offer protocols and instruments to assess and classify PUs, but none exist in the case of IAD.

Just as PUCLAS has allowed health professionals to expand their visual capacities in the European community,7,8,14-16, we propose the utilisation of the instrument created in this study once it has been approved. With it, we know how to increase the visual competencies that allow the differentiation between an IAD lesion, a PU, and a mixed lesion.

The incorrect identification and classification of lesions generates erroneous notifications and statistics, which is harmful to the treatment of the patient in particular and for the health system’s efficiency.

As a solution to this problem, this study supports the need to perform continuous education and evaluation of competency in nursing professions to correctly identify and classify a PU from an IAD lesion or from a mixed lesion with the purpose of focusing our care towards prevention and proper treatment.

Finally, this study can be extended to a greater number of professionals who work in the public and private spheres, and can consider variables of health professionals not covered in this research such as years of practice, age, place of performance (nursing home, clinic, emergency service and so on), and previous training injuries. This would allow us to identify how other variables affect the competence of care.

CONFLICT OF INTEREST DISCLOSURE

There are no conflicts of interest, nor financial support.

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Mucus and urinary diversions

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ABSTRACT

When a segment of the gastrointestinal tract is used to form a urinary diversion, whether internal or external, it continues to produce mucus, which does not decrease in volume with time. Mucus is not usually a problem for people who have an ileal conduit (external urinary diversion) as it takes a lot of mucus to block the conduit. It can happen on rare occasions though, and mucus can block the outlet tap or the overnight drainage system. Mucus is also not usually a problem for people with a neobladder (internal urinary diversion). Most people with a neobladder can usually empty their bladder by ‘bearing down’ with their abdominal muscles, but some may need to use catheters, as mucus can block the catheters.

Mucus can be a problem for people who have to catheterise continent urinary diversions (CUDs), for example, Indiana Pouches, which are internal urinary pouches accessed by a catheterisable stoma located on the lower abdomen or hidden in the umbilicus. Mucus retention can lead to incomplete emptying, infection and stone formation. Thus, some clinicians and patients see mucus as the cause of all problems with urinary pouches.

All patients who had their CUDs formed at one Sydney public teaching hospital were taught to routinely practise clean, intermittent self-catheterisation (CISC) and irrigation of the CUD using normal saline. Patients who had neobladders and used catheters were also taught CISC and irrigation with saline.

A survey of Australian patients with a urinary diversion indicated that this patient education practice was also carried out at other public and private hospitals. Survey findings provided some indications of a relationship between receipt of education and overall satisfaction with mucus management.

BACKGROUND

Since the 1950s, ileal conduit (Figure 1) has been the permanent urinary diversion of choice for adults needing bladder removal or urinary stream diversion. This external urinary diversion is easy for people to learn to manage and their outcomes are generally good. It is still the most popular urinary diversion operation performed worldwide, but it does mean that people have to live with a stoma and use an external urine collection bag which adheres to their abdomen.

Neobladder and continent urinary diversion surgery

For the past 30 years, some urologists in specialised centres have been offering patients alternative options to ileal conduits. The principal alternative options are the neobladder and the continent urinary diversion (CUD). A neobladder (Figure 2) is formed when the main part of the bladder is removed, leaving only the base of the bladder and the urethra. Small and large bowel is used to augment this in order to make a pouch that can store urine. A CUD (Figure 3) is formed when the bladder and urethra are removed and a pouch is made from large and small bowel which is accessed by a catheterisable stoma hidden in the umbilicus or placed on the right side of the lower abdomen. Sometimes a CUD is referred to as an Indiana Pouch or other type of pouch, for example, Florida Pouch, depending on the method of construction. Bowel tissue is used to make the Indiana Pouch and gastric tissue is used to make the Florida Pouch.

Mucus production

When a person has their bladder substituted with small and large bowel, mucus continues to be produced by the transplanted portion of bowel and this does not decrease with time. People with neobladders can usually empty them by ‘bearing down’ with their abdominal muscles, but some may...
need to also catheterise to totally empty their neobladder. People with CUDs have to catheterise at regular intervals.

Mucus is not usually a problem for people unless they have to catheterise to empty their internal urinary pouches, and then mucus can block catheters, because catheters are designed to drain clear urine. Also, mucus may block the small holes through which urine enters catheters. Some people produce more mucus than others and this is unable to be determined preoperatively.

**How to care for neobladders and CUDs**

If a person can empty their neobladder by ‘bearing down’ with their abdominal muscles and have no residual or small residues of urine, there is no need to learn clean, intermittent self-catheterisation (CISC) and irrigation. If a person is unable to completely empty their neobladder and all persons who have a CUD need to learn CISC and irrigation with normal saline.

Following neobladder and CUD surgery there are several catheters and external stents that drain the urine until healing takes place. A cystogram is carried out between days 8 and 10 postoperatively, in order to demonstrate that the CUD/neobladder has healed. Once this is demonstrated, the two stents, the catheter into the stoma with CUDs and the catheter in the urethra with neobladders, can be removed and the person can be taught CISC and irrigation.

Patients are taught to use a clean technique when catheterising and irrigating. My usual practice is to start early in the morning and clamp the remaining catheter for two hours to allow the CUD/neobladder to fill with urine prior to catheterisation. The time between catheterisations is increased until the person is catheterising every four hours. This usually takes about two to three days, and the remaining catheter goes on to free drainage at night so that the person does not have to catheterise day and night.

Initially the CUD and neobladders are like small, collapsed balloons, and they need to expand slowly so as to be able to hold a reasonable volume of urine. The aim is approximately 500 ml.

Once a person is catheterising every four hours they can be discharged from hospital. They are encouraged to expand the size of the neobladder/CUD by extending the time between catheterisations to about six to seven hours, especially at night. During the training period, people are taught to catheterise immediately if there is any leakage.

Normal saline irrigation is also taught at the same time as CISC and initially people need to irrigate at each catheterisation because of blood and debris from the operation, as well as mucus in the neobladder/CUD. This frequency of irrigation reduces and the majority of people irrigate daily when they are discharged from hospital. People need to use enough normal saline to ensure a clear return by the end of the irrigation. People can often do a good irrigation with about 500 ml of saline weekly, once they are established. People need to also make sure that they get back the amount of saline used plus the estimated amount of urine in the CUD/neobladder.

People with CUDs and neobladders need to be warned that if they get any illness that irritates mucosa such as a respiratory infection, mucus production increases.

**What is mucus?**

Mucus is a viscid, slippery gel covering the epithelial surface of the gastrointestinal tract where it serves as a barrier against noxious substances. More mucus is required and produced in response to noxious chemical agents, for example, some medications, and when the mucosa becomes inflamed. Mucus is a mixture of mucin (glycoprotein), water, electrolytes, serum macromolecules (lipids, proteins) microorganisms and sloughed cells. Mucin is produced by goblet cells in the gastrointestinal tract. The layer of cells that line the intestine are called enterocytes. Mucus gel covers the enterocytes and is replaced constantly as it is used in digestion.
Why is mucus important?

Mucus is a barrier and in order for it to be effective, it needs to be able to flow and maintain this barrier function whilst the mucosal surface beneath it moves during peristalsis. Production of mucus is increased in response to noxious chemical agents, inflammatory medications and bacterial toxins. For example, mucus stops *Escherichia coli* adhering to enterocytes. This is mediated by pili (hair-like appendages made from protein) on the bacterial surface, which adhere to mucus, thus preventing bacteria from adhering to the enterocytes.

Mucus in the urinary pouch increases when any mucus membrane is irritated, for example, when a person has a common cold, other respiratory infections or diarrhoea. Other unique properties of mucus include it being able to reform if “fractured” and being able to “flow” and also to have “rigidity.” When it aggregates and forms into plugs (Figure 4), mucus can block catheters and if not cleared this can lead to overfilling and pouch perforation in people with internal urinary pouches when catheters are used for emptying, for example, neobladders and CUDs.

Mucus and infection

There are various reasons why infection is not uncommon in urinary pouches. Firstly, the mucosal surface (which has been transplanted from the gastrointestinal tract) has a higher pH or is more alkaline than that seen with bladder mucosa, and so is a better medium and more likely to have bacterial growth. Secondly, catheterisation and high residual urine may also lead to an increase in bacterial growth. Furthermore, an increase in stone formation in urinary pouches due to mucus production and higher residual urine may lead to infection.

During urinary diversion surgery a piece of the gastrointestinal tract (which usually tolerates a range of bacteria and contains mucus-secreting goblet cells) is interposed into the urinary tract, which is normally sterile and normally does not contain mucus-secreting goblet cells. Histological studies of ileal and caecal pouches indicate that 12 months after transposition, the goblet cells are still present in normal amounts and keep secreting mucus. This is probably due to the urine in the man-made reservoir being a chronic threat to the transplanted enterocytes. The mucus in the urinary diversion may be heavily colonised, but bacteria are unable to adhere to the enterocytes due to the mucus barrier, thus mucus may function as an important host defence.

Because of the above-mentioned processes, patients and doctors often blame mucus for a range of pouch-related problems. Whether or not this is true, it is worth studying and discussing the nature of mucus and its role in management of urinary diversions.

Evidence from a randomised, double-blind, crossover study conducted by N’Dow et al., which included a questionnaire administered by an independent third party, confirmed that for the majority of patients with CUDs (67%), mucus had not decreased with time and incidents of catheter blockage was high, with one-third of respondents reporting daily blockages.

Catheterisation can introduce bacteria, especially if a person’s technique is poor and if they have to catheterise multiple times due to mucus and mucus plugs. It is, therefore, very important that a person’s technique is checked if they get infections, as poor catheterisation technique can contribute to urinary infections. Neobladder emptying can result in small pockets of urine being left in the intestinal folds. It has been established that the mucosa has some anti-bacterial properties (production of antibacterial peptides or defensins), as long as the residuals are less than about 20 ml.

The mucosal surface of a pouch absorbs some substances from urine, making its pH higher or more alkaline than in a native bladder; thus a CUD/neobladder is more prone to bacterial growth than a native bladder, especially as components of mucus, for example, serum protein and carbohydrates also provide nutrients for bacteria.

N’Dow et al. investigated several mucolytic agents to see if they were effective against mucus. These included N-acetyls cystine (Mucomyst), Aspirin and Ranitidine in various combinations and found no benefit with regard to the amount of mucus produced, incidence of catheter blockage or incidence of infection.

Mucus and stones

There are some characteristics of CUDs/neobladders that affect stone formation (Figure 5), including: stagnant residual urine, foreign bodies, for example, staples and mucus, using...
Figure 6: Survey about mucus and your urinary diversion pouch

Q1. What type of urinary diversion operation did you have?
☐ Indiana Pouch ☐ Continent Urinary Diversion ☐ Neobladder ☐ Augmentation Cystoplasty
Other (please name) .................................................. ☐ Unsure

Q2. In what year did you have the operation? ……… Q3 In which hospital was the operation done? …………………

Q4 Do you ever have any mucus in your urine?
☐ Yes ☐ No ☐ Not sure

If you answered yes to Q4, please continue to Qs 5, 6 and 7. If you answered no to Q4, please Skip Qs 5, 6 and 7 and go straight to Q8

Q5 How often do you have mucus in your urine?
☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Q6 What is the usual amount of mucus you notice when it is there?
☐ A trace ☐ Small amount ☐ Moderate amount ☐ Large amount

Q7 Do you irrigate (wash out) with a syringe to clear the mucus:
☐ Yes ☐ No

If yes, how often do you irrigate?
☐ Every day ☐ Sometimes ☐ Rarely ☐ Only if the catheter is blocked

Q8 Do you take any medications to reduce mucus? ☐ Yes ☐ No

If yes, please indicate which medications you use to reduce mucus and whether you think they help:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often do you take it?</th>
<th>Do you think it helps with mucus?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucomyst</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranberry Juice</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranberry Tablets</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandostatin</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zantac</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please name)</td>
<td>☐ Yes, definitely; ☐ Yes, sometimes; ☐ Not really; ☐ Definitely not</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q9 Overall, are you satisfied with your management of mucus?
Very satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐ Dissatisfied ☐ Very dissatisfied ☐

Q10 Have you ever received education regarding the management of mucus? ☐ Yes ☐ No

If yes, please provide details: ………………………………………………………………………………………………………………………………………………..

Q11 Any further comments about mucus and your urinary diversion? ………………………………………………………………………………………考察

Q12 What is your age range?
☐ <21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 81-90 ☐ >90

Q13 What is your gender?
☐ Male ☐ Female
an intestinal segment, for example, ileum or colon, and self-catheterisation. It is interesting that stones are not formed in CUDs/neobladders made of stomach. This is because gastric tissue does not produce mucus. Woodhouse and Robertson state that when stones are removed they leave mucus and a chalk-like material, which can result in crystallisation and so washouts are recommended to prevent stone formation, that is, clean the sand out before stones are formed.

Urolithiasis or stone formation is a multifactorial problem influenced by metabolism and lifestyle, among other things, which explains why some people get stones and others don’t. The most important symptoms of stone formation in CUDs/neobladders is recurrent infection. Routine x-rays often diagnose stones.

Cranberry

Cranberry may have a role in preventing urinary tract infections as it prevents the adhesion of E. coli to the bladder wall by binding with A-type proanthocyanidins and thus the blocked bacteria are flushed from the urinary tract. Cranberry has also been found to be useful in that it helps to decrease the viscosity of mucus so that it can pass down catheters more easily and thus catheters do not block when catheterising the CUDs/neobladders. Cranberry is the only anti-mucolytic agent that has been proven to be useful with regards to infection and mucus.

THE NEW SOUTH WALES MUCUS SURVEY

In 2014 a survey (Figure 6) was sent to all people in New South Wales (NSW), Australia, who were identified as having a urinary diversion and obtaining catheters via Australia’s federally funded Stoma Appliance Scheme. This represented a patient group who had had a neobladder or CUD formed between 1986 and 2013. Because catheters are provided at no charge under this scheme, it is probable that the target sample reflected a significant proportion of all NSW people living with a urinary diversion, who catheterise.

The survey canvassed urinary diversion patients’ experiences of mucus. Sixty-seven (n=67) patients were identified as having urinary diversions and receiving CUD-related products, and subsequently mailed surveys. Replies were received from n=38 participants. This represents a survey response rate of 57%. The survey was approved by the South-eastern Sydney Human Research Ethics Committee (Eastern Section).

RESULTS

Sample characteristics

Fifty-eight per cent (58%) of respondents (n=22) were female and two-thirds of respondents (n=25) were aged greater than 60 years. Surgery dates ranged from 1986 to 2013 and 55% of respondents (n=21) had their surgery at one of two major Sydney hospitals (one public and one private). Most respondents (n=24; 63%) reported having an Indiana Pouch.

Cranberry

Cranberry may have a role in preventing urinary tract infections as it prevents the adhesion of E. coli to the bladder wall by binding with A-type proanthocyanidins and thus the blocked bacteria are flushed from the urinary tract.
Mucus experience and related self-management practices

Figure 7 outlines the incidence, frequency and relative amount of mucus experienced by respondents. Most respondents (n=35; 92%) reported having mucus, with 60% of this group (n=21) reporting it "always or often". Thirteen respondents who reported mucus (37%), reported experiencing moderate amounts of it.

In response to questioning about irrigation practices, 50% of respondents (n=17) stated that they irrigated. About half of those who reported irrigating (n=8), indicated that this occurred sometimes. Smaller numbers reported frequent irrigation or only when the catheter blocks. Irrigation practice was cross-sectionally analysed against recency of surgery. Patients who had undergone surgery relatively recently (post-2000), were more likely to be irrigating than those who whose surgery occurred prior to 2000. Due to the relatively small sample size, this difference was not statistically significant, though of likely clinical importance.

In response to questioning regarding medication practices, 34% of respondents (n=12) reported taking cranberry tablets to help manage their mucus. Cranberry was the principal medication reported by respondents. Most (82%; n=10) who reported taking cranberry stated that it helped.

Sixty-eight per cent (68%) of respondents (n=26) stated that they received mucus management education from the stomal therapist or medical officer and 61% (n=23) expressed satisfaction with the education. Cross-sectional analysis of education experience against satisfaction with overall mucus management indicated that patients who reported receiving education regarding mucus management were more likely to be satisfied with their mucus management than those who reported not receiving education. This difference was not statistically significant, though of likely clinical importance. Receipt of education was cross-sectionally analysed against age and gender, with no differences noted.

DISCUSSION

The review of literature supports a view that mucus has protective properties. Mucus management has received little focus in the stomal therapy literature, and warrants further exploration.

The findings from this representatively sampled Australian survey indicate that mucus is a persistent and ongoing problem for a majority of CUD patients and neobladder patients who need to catheterise. The intensity of experience of mucus varied considerably among survey respondents, as did their irrigation practices. Recency of surgery emerged as a likely predictor of regularity of irrigation practice. Cranberry was reported as the principal ameliorative medication used by patients.

Encouragingly, a majority of respondents reported receiving mucus management education, and interestingly, there was some indication of a relationship between receipt of education and overall satisfaction with mucus management.

CONCLUSION

Mucus may be a problem for people with CUDs/neobladders when they have to catheterise. It does not decrease with time. It can block catheters, lead to perforation of the CUD/neobladder if not cleared, and may predispose to infection and stone formation. Patients with CUDs/neobladders need to be taught to irrigate with normal saline using a clean technique in order to clear the mucus if they catheterise. People may find taking cranberry tablets useful as they decrease the viscosity of the mucus so that it is able to pass more easily through the catheter and also help to prevent urinary tract infections.

ACKNOWLEDGEMENT

Dr Julia Thompson (retired), who prompted this focused inquiry regarding mucus and urinary diversions and also reviewed and commented on the manuscript.

REFERENCES

This is the fourth and final paper in a series of articles presenting a discussion of published clinical research. More specifically, this is a discussion of what the critical reviewer (the reader) of the research should know and understand in order to properly interpret the results of the published data, and make informed decisions as to the credibility of the research. As clinical evidence in the form of published research contributes to our knowledge base, and enhances clinical expertise and best practices, the ability to critically review it is vital to any clinician.

INTRODUCTION

In the previous three articles in this series the discussion first centred on the data attributes of reliability and validity, and three forms of evidence that from a position of scientific rigour are not considered to contain these: the anecdote, the expert opinion, and the case report (case series). This was followed by a discussion of published research in which the credibility of the research is premised on the number and selection of patients or study subjects. Specifically, the ability to generalise, that is, adequately describe patient/study subject characteristics, distinguish between treatment groups, and infer what is known of the sample to the population. The third article discussed p-values and confidence intervals in decision making in the context of the need to describe a practical situation followed by the need to prescribe a course of action.

We now turn our attention to two broad categories of non-experimental studies commonly reported in the literature: the cohort study and the case-control study. These studies are further classified as prospective (proceeding from cause to effect), and retrospective (proceeding from effect to cause). However, as pointed out by Rothman and Greenland, distinctions must be made when referring to studies as prospective and retrospective\(^1\). In the past, cohort studies were commonly referred to as prospective studies, and case-control studies, commonly referred to as retrospective studies. However, the more appropriate meaning of the terms should be in the “timing of disease occurrence with respect to exposure measurement”\(^2\). As an example, a case-control study can be retrospective or prospective depending on whether the exposure measurement is prior to the disease, or after. Cohort studies, usually characterised as prospective can be retrospective if historical. Note: the term cohort simply refers to a group of people sharing a common characteristic, such as exposure to chemical, or presence or absence of a disease.

Before we proceed, it should be mentioned that an analog to the prospective cohort study is the clinical trial. Clinical trials are prospective in that they move forward in time. They are cohort studies in that study participants share a common characteristic such as the presence of a disease. But they are unique in that they are experimental with a treatment or intervention controlled by the investigator, thus we speak of them as a trial, not as a prospective cohort study, which in the literature is a term usually reserved for its non-experimental observational analog.

A distinguishing feature in a clinical trial, for our purposes the randomised controlled trial, is the ability to demonstrate cause and effect: more specifically, the ability to credit observed differences to factors under control, or to random error (see article 3 in the series\(^3\)). It should be noted that while randomised controlled clinical trials are considered a top-tier source of evidence they are expensive to conduct, require a collaborative effort between many people with unique responsibilities (including patients), are subject to review and oversight by regulators and review boards, and are time-consuming, often requiring years to complete\(^4\). The constraints put on clinical trials are not always present in non-experimental observational studies.

COHORT STUDIES

Not all medical research is experimental; some is observational and focuses on identifying associations between disease and factors thought to contribute to disease. Consider a situation in which a researcher proposes to
study the association between cardiovascular disease and potential known or unknown risk factors. How would the researcher go about doing this? One way to do this would be to postulate hypotheses about potential risk factors, find a sample of people free of cardiovascular disease, and then follow them over time to determine if changes in health are associated with any predetermined risk factors, or the discovery of formerly unknown risk factors. This is actually a general description of the Framingham Heart Study, a prospective cohort study which began in 1948.

The Framingham study is non-experimental in nature and focuses on cardiovascular disease (CVD). The study is observational. The study is not interventional. It is premised on the belief that CVD does not have a single cause, but rather results from multiple causes. The original objective of the study was to identify common factors or characteristics that may contribute to CVD. It did this by following the development of CVD over an extended period of years in a large group of participants initially free of the disease. Hypotheses were then generated around factors which may have a relational basis for CVD. To begin the study a group of participants were randomly selected and enrolled from the town of Framingham, Massachusetts, in the US (hence the name). Extensive medical histories were compiled on each participant and physical examinations were given. Those participants, at time of enrolment, who were free of the disease (the cohort) continued in the study. Those enrolled would then be re-examined at intervals over a period of years. Once a “sizable” number of people had developed CVD, the data would be searched for factors influencing CVD. The study is now in its third generation. As the study is longitudinal, that is, moving forward in time, it is prospective. It is important to remember that this type of study cannot determine cause and effect, but rather it can identify relationships suggesting cause and effect. This is its strength.

I mentioned that cohort studies are prospective in that they look forward in time, and this is generally the case. The distinguishing factor is the time of occurrence in relation to the time in which the study is initiated. In the Framingham study, the outcomes occur after the study is initiated, but not all cohort studies are defined this way. There is such a thing as a retrospective cohort study (also called a historical cohort) in which outcomes occur prior to the start of the study. In this design, the researcher goes back in time to determine the cohort, for example, free of the disease or event of interest, then uses available records to determine exposure status and subsequent health outcomes over time (longitudinal). The distinguishing feature is that all outcomes have occurred prior to the beginning of the study. The retrospective cohort study, or historical cohort, is often found in the assessment of environmental or occupational hazards.

As an example, if a researcher wanted to investigate whether exposure to certain airborne particulates were associated with increased risk of death he or she could find an industry in which the airborne particulates were known to exist. The investigator would then define the cohort based on a time in which individuals would have been free of exposure, identify those in the cohort in which exposure increases versus those continuing with no exposure, and at some point in time look at death records. One could then report the relative risk of disease based on exposure. This is what Garshick et al. did in a retrospective cohort study of lung cancer and diesel exhaust exposure in railroad workers in which they reported the risk of lung cancer was 1.45 times greater in the exposed group than in the non-exposed group. In this study, the researchers looked back in time to a point in which the study subjects were free of the outcome of interest (lung cancer), they then defined the exposure and then moved to a point in time to analyse death records. The important thing to remember is that while the study moved forward in time from the point at which study subjects were free of the disease, the study began after the outcome of interest and looked back in time to determine the relationship: hence it is retrospective.

CASE-CONTROL STUDIES

In the studies described above, study subjects were selected because they were initially free of the outcome of interest and then followed over time to determine the rates of the outcomes of interest. This is in contrast to retrospective studies such as case-control studies in which study subjects are selected based on the presence or absence of a disease (or item of interest) and then traced backward in time to determine an association with a factor that may have a high incidence of occurring.

It should be noted that because the event of interest has already occurred, the data used in retrospective studies is often data that was collected for other reasons than research. The data is often patient chart information (medical records) and such studies are often referred to as chart reviews. For purposes of research medical records are commonly limited in the data they contain, and the selection of data may be prone to bias.

Although often limiting in usable data there are various reasons why a researcher would turn to a retrospective study. Measures of disease association can be obtained fairly quickly, that is, the effect of exposure on an outcome of interest can be quickly estimated. Studies of rare outcomes are often feasible from sample size, time, and cost perspective in a retrospective study. Equally important is the ability to identify relationships where it would be unethical, or morally irresponsible to implement a clinical trial to experimentally determine the existence of cause and effect.

An example of a retrospective study is the case-control study reported by Manouso et al. In this study, individuals with
the outcome of interest, that is histologically confirmed colorectal cancer, are the cases, and were compared with individuals without the outcome of interest (controls). The study is retrospective in that a matched sample of people characterised by ethnic homogeneity, but differing on health outcome, were asked to recall dietary habits and asked about prior exposure. The study consisted of 100 consecutive patients with a cancer outcome during a 16-month period and matched to orthopaedic patients by age and sex. Dietary histories of the consumption frequency of 80 food items were investigated. Colorectal patients reported significantly less consumption of vegetables and a greater frequency of consumption of lamb and beef. In this study, as in the Framingham study, it was not cause and effect, but rather relationships that were important. This difference being the Framingham study started with people initially free of the disease and then followed over time (prospective), whereas this study started out with people either with or without the disease and then looked back over time at eating habits (retrospective).

It is worth noting that not all case-control studies are retrospective. Prospective case-control studies are studies in which measurements of the risk factors are recorded prior to the classification of study subjects as cases or controls. The assignment of case or control is dependent on the measure of the risk factor. Consider the study published by Miller et al. in which the relationship of future coronary heart disease to HDL cholesterol concentrations were examined in a case-control follow-up study. The study was two years in duration. Risk factors were first identified, study subjects were assigned to case or control dependent on the risk factor measurement and then followed forward in time to assess if the risk factors were influential in the determination of outcomes.

Whether the study is a cohort study or a case-control study, each has advantages and disadvantages. Case-control studies are the choice for investigations into rare diseases. They are easy to conduct and fairly inexpensive, but the data not originally recorded to be part of a research investigation may be unreliable, or inconsistent with the investigator’s needs. Additionally, rates of disease cannot be determined. On the other hand, cohort studies allow the advantage of more complete and reliable information, allow for multiple factors to be assessed, and allow for the determination of rates of disease. However, cohort studies can be expensive, are generally of long duration, and require very large sample sizes for studies of rare diseases. Cohort studies can estimate exposure-specific incident rates, attributable risk, relative risk, and odds ratios, whereas case-control studies are typically limited to odds ratios. An odds ratio is odds of an outcome occurring given a particular exposure, compared to the odds of the outcome occurring, given the absence of exposure.

**CONCLUSIONS**

As clinical evidence contributes to our knowledge base and enhances clinical expertise and best practices, the ability to critically review it is vital to any clinician. In this paper, the clinical trial was briefly discussed as a formal method of prospectively assessing treatment or intervention. The clinical trial is a rigorous experiment allowing the assessment of cause and effect within its parameters. However, there are studies that do not assess cause and effect, but rather assess relationships. These can be both prospective and retrospective; each with their own advantages and disadvantages. It is important to the clinician, particularly in the inferential process that the strengths and limitations of study types, and what is presented within the published literature, be understood.

The focus of this article and the previous three has been on the understanding of published research from the perspective of the critical reviewer, that is, the ability to make informed decisions as to what the data is saying and assess the credibility of the research. Fundamental to all of this is the sample selection process that the data is derived from. Reasonable and accurate inference, that is, the process in which data is used to describe a situation is dependent on and limited by sample selection, and this has been an underlying theme in this series. We have discussed such issues as the expert opinion, the isolated case or series of cases, random and convenience samples, powered samples, quantitatively assessing the sample data, and retrospectively or prospectively gathering sample data. As previously mentioned and worth mentioning again; from the sample know the population!

**REFERENCES**

2. ibid, p. 74.
5. www.framinghamheartstudy.org/about-fhs/
WCET journal submissions

As the recognised global centre of Enterostomal Therapy Nursing (ET) information, WCET members are encouraged to contribute to the WCET Journal. Your articles are an important way for the WCET to accomplish its mission of the ongoing education of Enterostomal Therapy Nurses.

To submit an article for publication, please read and follow the following guidelines. Articles will only be accepted on the WCET manuscript management system at https://mc04.manuscriptcentral.com/wcet

To create an account when using the system for the first time, click on ‘Create Account’ in the top left hand side of the screen or on ‘Register here’ under ‘New User?’ in the middle right of the screen. Please enter as much information as possible when creating an account.

**GUIDELINES FOR AUTHORS**

The World Council of Enterostomal Therapists Journal welcomes your contributions that relate to the clinical, administrative, research and/or educative roles of the Enterostomal Therapy Nurse (ETN). These include scientific papers, case studies, reports, letters of comment and enquiry and informal papers that discuss items of interest. The WCET Journal is peer-reviewed and indexed in CINAHL.

The language of the journal is English, however translations into other languages are encouraged and both the English and translated versions will appear together. Please note that the WCET Journal does not accept responsibility for errors and omissions, which may occur when publishing non-English text.

Generally, manuscripts should be no longer that 3000 words and should be submitted as a Word document or raw text file. PDFs cannot be accepted. An abstract of your manuscript is required.

Once in the system, the steps to submit an article are:

Step 1 – Manuscript type, title and abstract.
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A separate title page must be submitted with the main document and include the following information:

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All tables, figures and photographs, as well as the main document and title page, are to be uploaded separately. Please ensure image files are uploaded as high-resolution jpegs and are a **MINIMUM of 300Kb, or 300 DPI, and no larger than 2Mb in size**. The manuscript may be accompanied by a Word document with tables, figures and photographs embedded so as to show the preferred positions of these. This separate file can be uploaded at Step 4 of the submission process as a cover letter.

Use numbers to cite references. They must be in numerical order in the text of your manuscript with a complete reference list provided at the end of your manuscript in the correct referencing format.

Where possible, use generic names for pharmaceuticals and products.

Contributions will be acknowledged when received by the editor.

Manuscripts are peer-reviewed and will be edited to WCET journal style. The editorial board review process takes time, so please understand that it may be several months before publication decisions are made. Please feel free to communicate with the editor during this waiting time. The editor will communicate with you via email the editorial decision regarding your manuscript.

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### Definitions for continence

Karen Zulkowski  
DNS, RN  
Associate Professor Montana State University, Bozeman MT, Executive Editor JWCET

Previous issues have defined terms for ostomy and wound. These definitions are for continence or incontinence-related problems.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Additional information including causes</th>
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<tr>
<td>Bowel (faecal) incontinence</td>
<td>1. Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum. 2. Complaint of involuntary loss of faeces. Could be solid, liquid, passive faecal incontinence: such as soiling without sensation or warning or difficulty wiping clean, or coital faecal incontinence: occurring with vaginal intercourse.</td>
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<tr>
<td>Continence</td>
<td>Control of the bladder and/or bowel</td>
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<td>Constipation</td>
<td>Bowel movements are infrequent and/or incomplete, stools are dry or hard and/or there is a need for frequent straining or manual assistance to defecate.</td>
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<td>Chronic retention of urine</td>
<td>Non-painful bladder where there is a high PVR.</td>
<td>PVR is post-voiding residual.</td>
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<td>Enuresis</td>
<td>Any involuntary loss of urine.</td>
<td>If it is used to denote incontinence during sleep, it should always be qualified with the adjective ‘nocturnal’.</td>
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<td>Neurogenic bladder</td>
<td>A person lacks bladder control due to a brain, spinal cord, or nerve condition.</td>
<td>Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury, tumour/lesion, or pelvic nerve damage from surgery or radiation therapy.</td>
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<td>Pelvic organ prolapse</td>
<td>This diagnosis by symptoms and clinical examination, assisted by any relevant imaging, involves the identification of descent of one or more of the anterior vaginal wall (central, paravaginal or combination cystocele), posterior vaginal wall (rectocele), the uterus (cervix) or the apex of the vagina (vaginal vault or cuff scar) after hysterectomy.</td>
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<td>Rectal prolapse</td>
<td>External protrusion of the rectum.</td>
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<tr>
<td>Condition</td>
<td>Description</td>
<td>May involve a number of transitory or chronic progressive factors that affect the bladder and/or the urethral sphincter.</td>
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<td>Urinary incontinence</td>
<td>Involuntary loss or leakage of urine. (There are several types of urinary incontinence, and an individual may experience more than one type at a time.)</td>
<td>Any condition, medication, or factor that affects lower urinary tract function, bladder capacity, urination, or the ability to toilet can predispose to urinary incontinence and may contribute to incomplete bladder emptying.</td>
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<td>Urinary retention</td>
<td>The inability to completely empty the urinary bladder by micturition.</td>
<td>Urine retention may result from outlet obstruction (for example, benign prostatic hypertrophy [BPH], prostate cancer, and urethral stricture), hypotonic bladder (detrusor under activity) or both. Hypotonic bladder may be caused by outlet obstruction, impaired or absent contractility of the bladder (neurogenic bladder) or other causes.</td>
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<td>Urinary tract infection (UTI)</td>
<td>A clinically detectable condition associated with invasion by disease causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (ureteritis), and/or kidney (pyelonephritis).</td>
<td>An infection of the urethra or bladder is classified as a lower tract UTI and infection involving the ureter or kidney is classified as an upper tract UTI.</td>
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<tr>
<td>Urosepsis</td>
<td>A systemic inflammatory response to infection (sepsis) that appears to originate from a urinary tract source. It may present with symptoms such as fever, hypotension, reduced urine output, or acute change in mental status.</td>
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<td>Voiding dysfunction</td>
<td>Abnormally slow and/or incomplete micturition which is diagnosed by symptoms and urodynamic investigations.</td>
<td>Abnormal slow urine flow rates and abnormally high post-void residuals (PVR)</td>
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<td>Transient urinary incontinence</td>
<td>Temporary episodes of urinary incontinence that are reversible once the cause(s) of the episode(s) is (are) identified and treated.</td>
<td>May be related to a variety of causes, for example: delirium, infection, atrophic urethritis or vaginitis, some pharmaceuticals (such as sedatives/hypnotics, diuretics, anticholinergic agents), increased urine production, restricted mobility or faecal impaction. The incontinence is transient because it is related to a potentially improvable or reversible cause.</td>
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<td>Urge incontinence (overactive bladder)</td>
<td>Associated with detrusor muscle overactivity (excessive contraction of the smooth muscle in the wall of the urinary bladder, resulting in a sudden, strong urge to expel moderate to large amounts of urine before the bladder is full).</td>
<td>Characterised by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). It may be age-related or have neurological causes (for example, stroke, diabetes mellitus, Parkinson’s disease, multiple sclerosis) or other causes such as bladder infection, urethral irritation, etc. The resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode.</td>
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<td>Mixed incontinence</td>
<td>Combination of stress incontinence and urge incontinence.</td>
<td>Many elderly persons (especially women) will experience symptoms of both urge and stress called mixed incontinence.</td>
</tr>
</tbody>
</table>

3. CMS. MDS 3.0 Manuel V01 07. 2011, HHS.
A warm and vibrant welcome awaits you at the forthcoming WCET 21st Biennial Congress to be held in Cape Town, South Africa from 13 to 16 March 2016.

Come and indulge in the spectacular scenery, cosmopolitan culture and warm and welcome ambience whilst sharing in the stimulating and scientific exchange of learning and educating.

Embrace the Circle of Life — a turning circle from the 5th WCET Biennial Congress held in the Transkei region of South Africa in 1984 and now, 32 years later, we welcome you again.

Many of we “Old Timers” recall the 1984 Congress with fondness and wonderful memories, a successful congress without the modern technology and electronic communication of today. The “African” flavour abundant in our evening entertainment, with drums beating and vibrant dancing to the rhythmic music to feed our souls — our days filled with education and learning, with a focus on the needs of our global patients and their physical and emotional care, all with the quest to enhance quality of life.

Historically, South Africa has been involved with the WCET from its inception.

In 1976, the pioneers led by our brave and inspirational founder Norma N Gill (with encouragement from her mentor Dr Rupert Turnbull Jnr), together with Prilli Stevens and others, held a meeting in London where Norma’s dream of a global service to ostomates was born.

In 1978, several South African delegates attended the 1st WCET Congress in Milan, Italy. The WCET logo was developed and approved and the WCET objectives got under way and canvassing was encouraged in earnest.

In 1979, the 2nd Congress was held in Düsseldorf, Germany, and the WHO gave WCET international recognition.

In 1980, the 3rd Congress was held in Cleveland, USA, and our South African colleague, Prilli Stevens, was proudly elected as the President of the WCET. Planning was facilitated by ER Squibb offering concepts from the manufacturers’ points of view regarding stomal and wound equipment. Following in Prilli’s footsteps, Marylyn McManus became the WCET Treasurer, and in later years, Norma Briggs the Constitution Chairperson, Judy Truscott (now Chamberlain) the Publications committee member then Publications Chairperson, and Dee Waugh the WCET Secretary and now the Congress and Meetings Organiser. We also have three Life Members — the current total being eight globally.

All 20 WCET Congresses to date have been well attended by South African delegates, speakers and committee members. Three members, the ID Judy Truscott (now Chamberlain), Prilli Stevens, and Marylyn McManus got through the very stressful and emotional experience of having South African ETs banned from the Scandinavian Congress in 1988 on political grounds, but then immediately reinstated at the general meeting, thanks to the loyalty and foresight of the attending delegates from around the world.

Originally stoma care was co-pioneered in Durban, South Africa, by Doris Williams and Judy Truscott (now Chamberlain) in 1971 under the auspices of the Natal Branch of the National Cancer Association. In no time, it grew from strength to strength and clinics were opened all over the country … With the arrival of Prilli Stevens in the Cape a few years later, stomal therapy was officially accepted and her stomal therapy course at Groote Schuur Hospital was completed by many nursing sisters who benefited greatly from expert education and experience. This expertise, together with that of the late Mara Ferreira at the Red Cross Children’s Hospital, together with their babies and toddlers, one could only be totally in awe of their dedication. South African and Zimbabwean ETs have presented papers at Congresses, workshops and provided material for relevant journals, plus other methods of learning skills.

Being a member of WCET is indeed a privilege, and the advantages are indescribable. One only has to check its credibility in the WCET Journal, the Bulletin and the website to appreciate what we have at hand. Thank you WCET! This forthcoming Congress needs your support and we wish Dee Waugh, Monica Franck and their committees a wonderful and inspiring Congress!

Kindest regards.

See you soon!
Product news

NEW AURUM® XTRA — THE FLUSHABLE POUCH
Combining two revolutionary innovations in one unique pouch

Welland Medical is pleased to announce the launch of Aurum Xtra, the NEW flushable colostomy pouch. Aurum Xtra includes our kindest flange yet, with medical grade Manuka Honey added to the Hyperflex® hydrocolloid.

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Convex without compromise
Convex appliances have traditionally had stiff baseplates that felt restrictive and uncomfortable when bending and stretching.

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• Possible alternative to a flat appliance
• Fits over dips, creases and folds

Stability for inward areas
SenSura® Mio Convex Light
• Moderate support
• For stomas level with the skin that need help to protrude
• Fits securely to shallow inward areas
• For moderate challenges in the peristomal area

SenSura® Mio Convex Deep
• Maximum support
• For stomas with an opening below skin level that need a lot of help to protrude
• Fits securely to deeper inwards areas
• For major challenges in the peristomal area

SenSura® Mio Convex is available in 1-piece, 2-piece Click and Flex systems.
### WCET International Delegates

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