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LINKING PRESSURE ULCERS AND DIARRHOEA: RETROSPECTIVE REVIEW OF CLOSTRIDIUM DIFFICILE AND NOROVIRUS INFECTION OUTBREAK LISTS AND PRESSURE ULCER INCIDENCE INFORMATION

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Aim: A sudden rise above background levels of hospital acquired pressure ulcers (PU) was noted in the first quarter of 2006 which was concurrent with a number of ward based outbreaks of diarrhoeal infection (*Clostridium difficile and Norovirus*). The aim of the resulting investigation was to determine if there was any evidence of a potential link between diarrhoea and PU.

Methods: Scrutinise names on lists of diarrhoeal outbreaks and PU incidence in the period January – March 2006. Identify those patients who experienced both diarrhoea and PU. Compare the dates of the diarrhoea symptoms and the development of PU. Present any evidence of links and costs to Director of Nursing and discuss actions to be taken.

Results: An increase of pressure ulcer incidence from 1.8% in October – December 2005 to 2.4% in January – March 2006 represented an additional 23 patients acquiring skin damage. 23 patients with PU on the buttocks or sacrum also appeared on the diarrhoeal disease outbreak lists. Case note review showed faecal attack was probably contributory in 8 and possibly in 6 of these cases. One case had a grade 4 which cost over £3000 in dressings and topical negative pressure (TNP) therapy. Bed days associated with use of TNP alone were 39, costing in excess of £9,000.

Discussion: Sufficient circumstantial evidence was generated to gain agreement to institute use of a preventative skin care product on all patients with incontinence. Agreement was also gained to use a faecal management system. in patients with persistent liquid stool.

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MANAGEMENT OF AN ACUTE COLONISED FASCIOTOMY WOUND WITH AN ANTI-MICROBIAL ALGINATE GEL*

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Aim: To facilitate healing of an acute colonised fasciotomy wound in an elderly patient with an anti-microbial alginate gel*.

Methods: A 76 year old male patient was admitted to hospital with a *Clostridium difficile* infection, diarrhoea, vomiting and lethargy. He was very dehydrated and presented with a cold left leg: he had a weak femoral pulse, no distal pulses and poor capillary refill. Two days later he was reviewed by the Vascular Consultant Surgeon, who found he had a very tender calf, muscle weakness and loss of sensation in the foot. He was prepared for theatre immediately where he had a left femoral embolectomy, thrombolysis, completion angiogram and left anterior and lateral fasciotomy. The groin wound was closed with subcutaneous sutures. The fasciotomy wound was dressed with a paraffin gauze dressing**.

Results: The groin wound healed well, however the fasciotomy wound became sloughy. Intrasite™ Conformable or Gel was applied to the wound. Four weeks post-op haemolytic *Streptococci* was isolated from the fasciotomy wound and an anti-microbial alginate gel* was applied to the wound and changed on alternate days. After 10 days, haemolytic *Streptococci* had cleared, although *Staphylococcus aureus* was isolated, however this was not clinically significant. The wound is improving; slough has decreased, granulation tissue is visible and the wound looks red and healthy.

Discussion: The anti-microbial alginate gel* contains an antimicrobial enzyme system designed to promote wound healing whilst restoring bacterial balance. In this patient, the gel* was active against haemolytic *Streptococci* and facilitated healing in the fasciotomy wound.

*Flaminal® **Jelonet™