**Let’s Discuss Pressure Injuries**

**Accessible Transcript**

**Visual**

**A white screen bordered with blue and green lines. Blue and green text reading ‘Health Quality & Safety Commission New Zealand. Kupu Taurangi Hauora o Aotearoa.’ The blue and green company logo comprises of three thin square blocks with white circles of differing sizes within them. A heading reads ‘Let’s discuss pressure injuries. Welcome!’ The table of contents of the webinar reads ‘Checklist: Please mute your microphone; audio check – can you hear birds singing? (sound effect); Please open your chat screen to send and view questions/comments; for technical issues, text Jane: 021 151 4981.’ The agenda reads ‘3.45-4pm: Welcome screen; 4-4.05pm: Karakia Timatanga – Jane Lester. Welcome – Dr Leona Dann; 4.05-4.25pm: Presentation – Anj Dickson. 4.25-4.45pm: Q&A; 4.45-4.50pm: Closing – Dr Leona Dann. Karakia Whakamutunga – Anj Dickson.’ The table of contents fades. A woman, Jane Lester, sits in a living room, facing her computer screen. Behind her is a wooden dining table. She has straight blonde hair and wears glasses and a brown jumper.**

**Audio**

(Jane): OK. Tēnā koutou katoa. I hope everybody can hear me, and I hope everyone's been able to relax to the sound of birdsong thus far. We appreciate you making the time to join us today. Given the evolving Covid situation, we understand, obviously, that priorities and pressures can change promptly. I will begin today with a karakia.

Kia tau nga manaakitanga a te mea ngaro  
Ki runga ki tena, ki tēnā ō tātou  
Kia mahea te hua makihikihi  
Kia toi te kupu, toi te mana, toi te aroha, toi te reo Māori  
Kia tuturu, ka whakamaua kia tina! Tina!  
Hui e, Taiki e!

So, just a few very quick notes from me as we start the session. Just a reminder that the session is being recorded. And as noted in the invitation, acceptance and attendance is deemed as permission to use any part of the recording and publish online for the Commission. That includes any of the comments made in the chat thread today.

We did initially expect we would open the floor for discussion, but given the large number of people attending, we’ll rely on the Q&A via the chat function, and an open discussion won't necessarily be possible. I can't see everybody on the screen, so I won't know if you're trying to get my attention. And I'm aware that some of you may not have that function available if you're joining from a meeting room. So if you have questions that aren't covered, please feel free to email them to me afterwards.

When you are sending questions, obviously, we've left the chat function open so everyone can message everybody else. If you're able to put a ‘Q’ or question in front of your comment, that would be really useful so I can see them clearly and differentiate them from the other comments in the thread, and then I can collate those, and I'll present those to Anj after she's finished her presentation. If you're responding to other people as well, you can use the @mention function to respond specifically or message them privately as well.

So, I’ll collate those questions during the presentation, present them on your behalf. If you want to put your name against them, that would be great. If you have any questions, I will change my name tag. I've got my mobile number on there for tech issues if you need them, if you need it. And I will do my best to get through those questions. Anything we don't get to today, we will collate and we will write up a question and answer sheet, and we will circulate that as well after the session.

We'll also share our contact details and Anj’s slides, and the link to the recording will come out once it's ready. So now I will hand you over to Leona, Dr Leona Dann, for introductions.

**Visual**

**A woman, Dr Leona Dann, sits in a room facing her computer screen. Behind her are framed artworks on the wall. Leona has short brown hair and wears glasses, a neck scarf and a blue cardigan.**

**Audio**

(Leona): Kia ora, Jane.

E ngā mana, e ngā reo, e ngā hau e wha, tēnā koutou katoa.  
Ko Ruahine ngā pae maunga

Ko Manawatū te awa

Ko Manawatū te papa kainga

He wahine whakawhānau ahau

Ko Leona Dann tōku ingoa

Tēnā koutou katoa.

So, greetings, everyone. Thank you. My name is Leona Dann, and I'm a nurse and a midwife, and I work at the Commission as a specialist for patient safety. That means I get to work across lots of various programmes and projects, including areas of high harm, such as pressure injuries and falls. And I really want to just carry on from Jane and acknowledge and thank you for joining us today.

This is our inaugural Let's Discuss session, so we will do some more of these in the future. They are hopefully informal enough for you to be able to ask us questions through the chat function. And I also want to recognise that for many of you, starting your day today was quite different to how you went home last night thinking your day today would be. So, I acknowledge for many of you that is different, and also for those that wanted to attend today but, because of the pandemic following on our heels, they are unable to attend because of other commitments and just reiterate the use of the video in the future to share.

Well, I had the pleasure of meeting Anj Dickson last year, and I've been able to keep in touch with Anj over time and hear about some of the work that she leads at Counties Manukau. It's been really helpful for me as I've moved predominately from a midwifery career through to understanding some of the high harm and understanding about pressure injuries, and Anj has been really helpful in teaching me lots over that time. And there were many case studies that she shared with me and that we could have picked today.

So, today I think you'll really enjoy the one that she's going to share. So, without any more, I would just like to welcome Anj Dickson. She’s here, as you can see. She is our wound care clinical nurse specialist for pressure injury prevention at Counties Manukau Health. Kia ora, Anj.

**Visual**

**A woman, Anj Dickson, sits in a room facing her computer screen. Behind her is a drawing of a yellow kowhai tree and a year calendar planner. Anj has her brunette hair tied up and wears a royal blue top.**

**Audio**

(Anj): Kia ora, everyone. I’ll just share the screen. Bear with me.

**VISUAL**

**Anj opens a PowerPoint presentation. The first slide is a white background with the Counties Manukau Health logo which is a blue woven pattern in the shape of a semicircle. A white heading on a blue strip reads ‘The whole of the patient…’ A subheading in black text reads ‘Understanding the importance of the patient in the healing of chronic pressure injuries.’ A small box showing Anj facing her computer screen remains in the top-right corner.**

**AUDIO**

(Anj): So, I wanted to talk to you about a case study of a patient that I have worked with quite closely over the last six months, and I’ve entitled it ‘the whole of the patient’. So,

talking about the importance of the patient in the healing of chronic pressure injuries.

**VISUAL**

**The next slide is a collage of photos titled ‘Pepeha’. The collage is made up of images, including Anj with a man and a woman, an aerial view of green land nestled amongst a harbour, a photo of a wharenui, a black and white photo of a long waka and green koru patterns beneath the text ‘Ngai Tahu’.**

**AUDIO**

(Anj): I'm just learning te reo at the moment, so I thought it would be a good opportunity to practice my pepeha. So, bear with me, everybody.

Tēnā koutou katoa.

Ko Takitimu te waka

Ko Motupohue te maunga

Ko Te Ara a Kewa o moana

Te Rau Aroha te marae

Ko Kai Tahu te hapu

Ko Pam Taylor tōku whaea

Ko John Taylor tōku matua

E noho ana ahau kei Tamaki Makaurau

Ko Anj Dickson taku ingoa

No reira, tēnā koutou, tēnā koutou, tēnā koutou katoa.

So, I basically just said that I originate from Bluff in the South Island, and I live in New Zealand. My mountain that I identify with is not so much of a mountain; it’s a hill – Bluff Hill. And the beautiful Te Rau Aroha marae down in Bluff is where I identify as my marae. So, let's talk about the patient.

**VISUAL**

**The next slide is an image of an old-fashioned brown hard-cover book with ornate golden text reading ‘Once Upon A Time’.**

**AUDIO**

(Anj): So I, wanted to kind of talk to you all about, you know, this little adventure that we call life, and I wanted to just talk about the fact that you go through life and you expect to have a happy ending for everything that you do. And I just wanted to kind of bring back and get you guys to just think a little bit about imagine having a pressure injury, for not one but two years, and how would that make you feel? They're incredibly painful. You know, they can be smelly. They can be highly exuding, quite embarrassing. So, it's really kind of about, what would your life be like if you had to make every single decision that you did and determine what your events of every day would be based on a wound? It’s something that starts to govern your life and kind of takes over your life, and that becomes what it's like. So, today I'm going to share with you a patient's story. He's had his pressure injury for over two years. And spoiler alert – it’s a happy ending. So it’s a good one.

**VISUAL**

**The next slide is a quote in a brown square. It reads “When you’re meeting someone for the first time, that’s not the whole book. That’s just the first page.” Brody Armstrong.**

**AUDIO**

(Anj): So, I wanted to just say that meeting patients is one of the most favourite parts of my job – hearing their stories, finding about how they came to be at Counties and how they… You know, just meeting people is a privilege. And I am a wound care nurse specialist, so obviously a lot of the times that I meet patients, they’re in a lot of pain, and so it's not always a pleasant experience for them. And I found that that connectedness and that talking and asking them questions can really break down some of those barriers, and sometimes it's an excellent distraction technique for when they are in really large amounts of pain. So that's something that I like to put into my everyday practice. Now, I first got involved with Mr A when one of the district nurses contacted me about him. She was a little bit concerned by his wound, and his name definitely sounded familiar to me, but I didn't really remember him. And as soon as I saw him in clinic, I saw his huge smile and I remembered his story, and it all kind of came flooding back. And I think that that definitely was a fantastic opportunity for

both of us because it made things a little bit easier for him because we'd already met. We'd already learnt that kind of… learnt about one another, and it meant that he kind of felt like there was somebody on his side, and so I think that that really contributed to the success of this interaction.

**VISUAL**

**The next slide is made up of five images on a white background. The first is the gender symbol for male – a circle with an arrow pointing northeast. The second is the Samoan flag. The third is a speed limit symbol reading 50. The digits are within a red circle. The fourth is a diagram of a spinal cord injury, with an image of the thoracic section of the spine with an arrow leading to an image of a figure labelled T6 injury. The figure is coloured blue from the chest downwards. The fourth image is the text ‘ASIA Impairment Scale. A = complete’ in a grey box.**

**AUDIO**

(Anj): So, he was a 50-year-old male from Samoa. He's a T6 spinal cord injury. He fell from a tree when he was in Samoa when he was 19 year’s old. He's an ASIA A, complete spinal, so he has bowel and bladder spasticity. He’s a really friendly and very outgoing person. Like, he's very ‘the glass is half full’ kind of guy. Very, very social. He lives in a Housing New Zealand home that he's lived in for 17 years. He's very independent. The house is completely outfitted for him, and he's very independent. He's got a wonderful, supportive family. He's always out and about. He's just a really social character. Really, really nice guy. He was visited by the district nurses, like, every… I guess every second day for his pressure injury, and he would do self-cares in between. He also… They would also routinely change his suprapubic catheter. So, he was… He had a lot of support and that type of thing, but he would often self-care for his own dressings because he is a social kind of guy. He wanted to go out and about and do things in his day, and he didn't really want to have to wait around all day for the district nurses to come. So, one of his key things was he just was super happy to help out. And if he could do self-care for his dressings, then he was more than happy to do that. So, yeah, he just liked to be out and about. That's really important about him – that he was really, really social.

**VISUAL**

**The next slide is a quote on a light brown background. It reads “Insanity is doing the same thing over and over again but expecting different results.” Albert Einstein.**

**AUDIO**

(Anj): I remember one of the really kind of key things is that he talked to me about how incredibly frustrated he was by his journey, about how he’d had this wound for over two years, and it started to kind of define him and he was unable to kind of do the things that he wanted to do. He started withdrawing a little bit more. So, someone who went from being really social, outgoing, out and about, was always, like, going somewhere or doing something now started to modify that behavior because he was… he just… his wound was so unpredictable. He didn't know what was going to happen from moment to moment. Was it going to leak? Was someone going to smell a wound odour? Really it was one of those things where his wound, after two years, had kind of almost broken his spirit, and he was getting very despondent. And he just felt very helpless and hopeless, and he didn't know what to do. The district nurses had tried everything – every plethora of dressing product you could imagine. They’d had VAC dressings on him, they’d tried antimicrobials, they’d tried moisture management. Everything had been done, but, unfortunately, they weren't able to heal this pressure injury.

Now, during this time, he was up in his chair. He was still doing his every day-to-day activities, but he did modify some of that behaviour and did try and stay on his bed in effort. But I always like the Albert Einstein saying that's there. So, “insanity is doing the same thing over and over again but expecting different results.” So, you know, keep applying the VAC, keep doing all those things, but if you don't modify some of the behaviours or change in some ways, then you can’t actually achieve the goal. And, obviously, the goal for him was healing, getting his life back and getting back on track. So, I mean, he was seen by pretty much every service imaginable. He’d been seen by the acute spinal rehab unit. He'd been seen by general surgeons. And he basically just was feeling really helpless and hopeless, and he needed some sort of modification to figure out what it was to finally get it on the road to recovery. So, what was it that changed this time for him?

**VISUAL**

**The next slide is a series of four red boxes of text in a flow chart joined by arrows. The first box reads ‘Email from district nurse voicing concerns regarding wound deterioration.’ The second box reads ‘Forced booked into complex wound care clinic for urgent review.’ The third box reads ‘Review in complex wound care clinic.’ The fourth and final box reads ‘Planned admission from complex wound care into surgical ward.’**

**AUDIO**

(Anj): Well, I got the initial email from the district nurses. They were quite concerned about his wound because the wound entrance had collapsed, and, as a result, they had to stop VAC therapy, and since stopping VAC therapy, they'd noticed that there had been, like, larger deterioration and that his cavity was getting bigger and bigger. As a result, we’re very lucky at Counties – we have a complex wound care clinic that runs on a Monday and a Thursday, and so I was able to force book him into urgent review to that. So, he waited two days and he was able to be reviewed in our Complex Wound Care Clinic. And then I… We’re also very lucky at Counties because we have really a lot of great consultants that are very approachable, and that makes it very easy. So, I was able to identify who his previous surgeon was, and I was able to just let them know of my concerns. So, when I reviewed him in clinic, his wound was about 3cm wide by 2cm wide. It's an ischial stage 4 pressure injury. When I probed it, it was 7cm deep and I could feel his bone. So obviously my first instinct was I was concerned that he had osteomyelitis, and I wanted him to be reviewed. So, when I contacted the consultant, she was more than happy for him to come in as a planned admission. And so within four hours of him coming to the clinic, he was actually waiting at a ward to be admitted into the ward for review.

**VISUAL**

**The next slide is an X-ray of the pelvis area labelled with an R and with an arrow pointing to a portion of bone at the site of the pressure wound.**

**AUDIO**

(Anj): The following day, he was taken to theatre. They were able to do a debridement on him and they took some bone biopsies and they determined, in fact, he did have osteomyelitis in his ischial and in his pubic ram. So, it was on his right side where the pressure injury was. So, we were able to get him some antibiotics. He had six weeks of antibiotic therapy, just orals. And, I guess, this is very much where kind of the hard part of the journey began for us because we had to try and convince an outgoing, social 50-year-old that he might need to be confined to a bed for a period of strict bed rest because offloading pressure is one of the clinically best gold-standard things to do for these chronic pressure injuries. So, this had actually been discussed with him before by the acute spinal rehab consultant, and it was something that he kind of said, no, he wasn't ready to do, that was something he wasn't willing to consider because he just… it just seems quite extreme, and he felt like there was just better ways of dealing with it.

**VISUAL**

**The next slide is a black silhouetted male figure using a wheelchair.**

**AUDIO**

(Anj): So, during his hospital admission, I visited him quite a lot of times, and very early on in the piece, we started talking about what the spinal consultant had recommended  
and that actually best practice would be for him to have strict bed rest. And he kind of opened up a little bit to talk about why he was hesitant about having bed rest. He talked about the fact that he has had his own house with Housing New Zealand for 17 years, and when they said that you have to go to a rest home, he kind of thought that that would mean that that was it for him, that he was going to be… he would lose his house and then he wouldn't have a home any more. And, so, like, when they were recommending that, it was a really scary thing for him. So I think that, you know… that it's a very realistic concern when you've been in your own home for 17 years and you're used to your own environment, it must be incredibly scary to be told that you need to leave that safe place and go and spend some time in a place that you're not familiar with and you have no idea how they do things, and you're going to depend heavily on them.

So, we talked to the social worker, and the social worker was able to come in and kind of ease his mind on several of these—of this concern, particularly, and kind of ease his mind so that he understood that that wasn't actually going to be the reality – that he wasn't going to lose his home and that it was a period of rehab rather than him kind of giving up his 17-year-old house and then going in there and then having to find something else afterwards. So, I think that was quite helpful to him.

Kind of another thing that I found along the way is that when he talked to me about the self-caring that he did, I was asking him to explain how he would do it. And I was like, ‘Can you actually see your wound or have you got any idea what it looks like or what to do?’ And he's like, ‘I take photos of it.’ But I’m, like, ‘Can you see it?’ Because I'm an able-bodied person. I do not think that I could change a dressing on an ischial pressure injury. It's in a very difficult kind of place. And he said that he uses his phone a lot to find the placement of the pressure injury, and he also feels for it. And then that's how he covers it up and does the dressing. So, things were kind of starting to make a little bit of sense for me. So, we talked a little bit more.

**VISUAL**

**The next slide is a cartoon caricature image of a person with their limbs tied in knots, with their eyes bulging.**

**AUDIO**

(Anj): So, I kind of liken him to having to be a bit of a contortionist to, like, contort his body around to try and put a dressing on and to get a good seal. Obviously, they   
weren't expecting him to do VAC dressings, but even putting something simple like an AQUACEL Foam adhesive on and getting a really good seal without being able to see that area is a complete challenge in itself, if you ask me.

**VISUAL**

**The next slide is a cartoon image of a pinky-orange stomach and intestine which have little smiling faces and limbs and are holding hands.**

**AUDIO**

(Anj): So, I also started talking to him about his bowel and his bladder habits, and he talked to me about the fact that he initially had a lot of trouble with an indwelling catheter, and then they'd given him his SPC and things had been a lot better for him. He still sometimes got a little bit of penile leakage of urine, but otherwise he felt like the SPC was a really good thing for him, and it got routinely changed. And when we started talking about his bowels… So, remember he's an ASIA A, so he needs assistance with both. And we started talking about his bowels, and he said that even though he doesn't have sensation, so he doesn't have feeling in his bowel, he has a sensation. So, he definitely knows when his bowels need to open, and so he does manual evacuations over a toilet using a commode, and he just gets a sensation that his rectum is full and that he needs to go to the toilet. So he will take himself to the toilet and manually evacuate. He started telling me that sometimes that was, like, two or three times a day he would get that sensation, and he would empty himself out and that would be fine.

So, I guess this confused me a little bit because every spinal patient that I know has quite a robust bowel regime, and I was kind of concerned that there might be an element of cross-contamination because of the location of the ischium to his rectum. I thought that there could be some sort of cross-contamination, so I contacted one of the senior nurses at the acute spinal rehab unit, and she said that some spinal patients do have bowel regimes that are, like, once or twice a day, but they tend to settle on, like, once a day, and they’re usually quite predictable. So that was kind of another thing that I thought was something that could be worked on, if we could find a different setting for him.

**VISUAL**

**The next slide is an image of a glowing yellow cartoon light bulb with the word ‘AHA!’ beneath it.**

**AUDIO**

(Anj): And it was definitely my ‘aha’ moment because I felt like it definitely was something that was contributing to the chronicity of his wound, and I felt very confident that if we could modify these two areas that we could have success with healing his wound. Now, it's one of those things – you know, like, if you're an independent person, then taking something away that you have full autonomy of is quite difficult as well. And so I was very mindful that I needed to be very cautious about the way that I approached him because I didn't want to disable him. I didn't want him to not feel like he was independent. And I just wanted him to give an opportunity to trial this and see if someone else doing a manual evacuation or something for him could eliminate that potential of cross-contamination.

**VISUAL**

**The next slide is a cartoon image of a red and white circular badge which has ‘hard sell’ emblazoned on it.**

**AUDIO**

(Anj): So I kind of thought it was going to be a super hard sell. I thought I was really, really going to have to work on him quite consistently. But I think because he'd already been in hospital for five days, he'd been on bed rest, like, we had been reviewing the wounds and talking quite positively about the way that they were looking, he’d just been told that he had osteomyelitis, so he knew that it was a bit more serious than perhaps he thought in the long run. And he also had his daughters had come over. One lives in Australia and had come over from Australia to be with him on his journey, and his sister was there as well. So he was really wrapped in support from his the family, and I think that they did a lot of talking when we weren’t in the room and kind of, like, really kind of coaching him on and giving him lots of support and saying that, you know, like, ‘Whatever you have to do, you should do, because, you know, this is really impacting on your life negatively and you want to get on with your life.’

So, I think that when I finally just said out loud that I think that the most positive way to address his pressure injury and to get it to heal would be strict bed rest for a period of at least six weeks in a private hospital that had capacity to do VAC dressings on him and also were able to manage his manual evacuation. So I kind of lay it all out for him, let him mull it over, talk to his family, kind of talk everything about it, and, I mean, he'd called me back within an hour and said, ‘OK, how do we do this?’ So, he had jumped on board really quickly. And I think that I had a lot to do with the fact that we had been really talking it through over the way and talking really positively about that and a lot of positive visualisation as well. I’m, like, ‘Where do you want to be at?’ Like, ‘What is it that you want for yourself?’ And he’s, like, ‘I just want my life back. I just want to get back in my chair and be able to go and do the things that I want to do without worrying about my wound.’ So, it was a really easy sell in the end.

**VISUAL**

**The next slide is a template of a document titled ‘Comprehensive nursing + wound assessment for the virtual complex wound clinic’, and is an assessment form for a patient which can be completed by a medical professional.**

**AUDIO**

(Anj): So, we have a virtual wound care clinic here at Counties. It's been going for three years. The clinic itself, it gets referred from district nurses, the ARC facilities within our area. We have GPs that contact us. We have, like, a lot of ways of people feeding in, but essentially there's a virtual clinic form that they fill in, and that is how we find the patients for the clinic. And then they give us comprehensive photos, we provide assessments of that and then provide recommendations for treatment plans for them. It's been working very, very successfully, and definitely in the last year it's increasing capacity, but it's also a really fantastic way of supporting ARC facilities.

So, we also have a discharge policy which was created by my colleague Penny McAuley. So it's, like, discharge with VAC to private hospitals. So, it's a pathway where we tap into some funding from POAC, and we're able to provide consumables, as well as funding for patients to be in VAC therapy. So, it makes it a bit more favourable for the ARC facilities because it means that they are given funding and it's not something that they have to self-fund. And particularly with Mr A, because it was a temporary thing – it was always going to be for a period of rehab, initially six weeks. So, we had kind of spoken to him about it. He was on board, so then we just had to find a private hospital that had availability and that could cope with his needs.

**VISUAL**

**The next slide is a cartoon image of the grounds in front of a multi-storey nursing home building. Cartoon figures in the grounds include a member of staff pushing a person in a wheelchair, a woman using a cane and a doctor standing with a member of staff.**

**AUDIO**

(Anj): We were really lucky because we have the virtual clinic. We have good relationships with the ARC facilities, and so we were really, really lucky. The social worker found us one of the private hospitals that had availability for him, and we were able to… basically within maybe four days, we got all the paperwork sorted out and he was able to… the manager from the facility came in and he met with Mr A, and he talked about, kind of, the environment that he would be in.

And he was… the patient was still really kind of concerned because although he has beautiful English, he's quite a shy speaker of English, and so he was really worried about going into an environment where he didn't have people that spoke Samoan and he didn't have people that he could kind of interact with. So, he felt that it was going to be really boring for him, that he was going to be very much alone and that it was it was going to be quite a hard call for him. So, the clinical manager of the rest home was able to reassure him that they did have some Samoan speakers, that they were more than happy for his family to come in and see him and spend time with him. And they kind of just talked about the process, and I think that kind of meet-and-greet really made it a lot easier, because then he knew someone when he left to go to the private hospital. And he also just kind of had a  
pre-understanding of what would happen and that his family were allowed to come and see him. And I think that that really works really well. So within, kind of, four days, he was being transferred to his new bed rest private hospital for a period of six weeks. So, that was going really, really well, and then lovely Covid hit. (CHUCKLES)

**VISUAL**

**The next slide is an image of a yellow, white and orange official Unite Against Covid-19 poster titled ‘Level 4 – Eliminate. Likely that the disease is not contained.’ It outlines the risk assessment and the range of measures applicable for alert Level 4.**

**AUDIO**

(Anj): So, he'd been there for one week, and I had promised him that he was going to have his family visiting him all the time, it was going to be a social hub for him, and it was going to be great. And then no one could have predicted what happened with Covid and going into level 4. And then last night we went into level 3, so you just never know when these kind of things are going to hit. And he was very understanding about it. I think that it made it a lot more difficult for him because, obviously, he didn't have that daily contact. Thank goodness we live in a modern world. He has a modern phone, and he was able to Zoom or FaceTime his family, so he still had that contact with them. But it definitely made the next few weeks really, really difficult for him.

**VISUAL**

**The next slide is comprised of a photo of an old-fashioned black rotary dial telephone and a cartoon image of a yacht at sea with the words ‘Stay the course’.**

**AUDIO**

(Anj): And then I received a phone call that I kind of thought was coming but I didn't want to have, and that was a phone call from his sister. So, basically, he was four weeks in. He was bored beyond belief. He was absolutely sick of being on his side, from side to side. He just said that it was so hard and he didn't want to do it. He’d asked his sister to call me because obviously he's not confident with his English, and he really just wanted her to convince me that it was time for him to come home.

So, I kind of explained to his sister that the process of the virtual clinics means that every week they send me an updated photo with wound dimensions, and I can really kind of keep an eye on it. So, I could confidently tell him that his 7cm cavity had decreased to 4.5cm at that time. So, I said that he just needs to stay the course. Like, he was doing so well. He was doing all the right things. And a result of that was that the depth of that wound… Now, you think of that. It’s four weeks for a depth of 3.5cm. That's phenomenal wound healing. So, my theory of the fact that he was contaminating his wound seemed like it was right, because when we removed those kind of modifiable risk factors away from him, we saw positive results. And because he wasn't sitting on his wound and causing additional pressure, then it definitely progressed quite quickly. And so, his sister basically said to me… She's, like, ‘Well, if you think that it's working for him, he will stay.’ And that was kind of the end of it. He never said another word about it, and he stayed for that six weeks.

**VISUAL**

**The next slide is a large black and white arrow sign with the word ‘Funding’.**

**AUDIO**

(Anj): And then at the six weeks, his wound still wasn't healed, and so we had to have another difficult conversation with him to say that basically it's progressing very positively, we're really happy with the way that it's going, but we need to extend the period of POAC to see if we could get results. So, he was pretty open to that. I thought that it was going to be another tough sell because two weeks earlier, he had definitely told me that, through his sister, that he didn't want to be there anymore. And so adding another… like, doubling the time just seemed like a really mean thing to do, but with the positive results that he had seen and the way that his wound was progressing, then I was convinced that it was the right thing to do. And I think that he also knew in his heart of hearts that it was getting better because the pain was reducing and there was no more odour. So he was really kind of, ‘OK, I can do that’ because, you know, always looking to the future, always looking to the goal that, in fact, he wants to be back up in his chair, he wants his life back, and if it means that he takes another six weeks out of his life to get that, he was willing to have that.

**VISUAL**

**The next slides are two photos showing the progression of healing of the pressure wound. The first photo shows the red, tender-looking deep wound to be approximately 3cm wide. A red arrow points to the next photo, which is of the wound in a far more healed state. The skin has healed over the previously open wound and is now simply white scar tissue in the shape of a divot.**

**AUDIO**

(Anj): So, I’ve put up some gory slides. I probably should have done a preface of it. But you kind of look at his wound. It’s 3cm by 2cm. It’s a difficult wound because it's a posterior cavity. So, this is… What the first picture is is what his wound was like when I

first met him, and that was obviously 7cm deep, going on to bone. And after his six weeks in POAC, on week seven, his wound entry collapsed, and obviously I was fearful that he had had another collapse at the front and that there was a cavity in behind it. And we had recommended that the GP do an ultrasound because we were quite cautious. And I'm very happy to report that it just was time for him to heal. And so, two weeks later, he was fully healed. He had a little bit of dry debris on the wound, and so we were able to talk to the spinal unit. The plan for him, because he's a spinal patient, a T6, was always that he would need a period of rehab at the acute spinal rehab unit where they could do wound… they could do pressure mapping and really make sure that they put the most appropriate pressure-relieving surfaces on for him and that they were able to give him tools and resources so that he understood what he needed to look for. He understood, kind of, the safe amount of time that he could be in his chair for before he needed to spend time on the bed and how many hours that would be.

So, he's actually left the spinal unit now. He spent three weeks there. So, all up, it was a 12-week journey for him, but it was nine weeks from a 7cm cavity to a healed cavity. So that's really exciting because he definitely stayed the course.

**VISUAL**

**The next slide is a photo of a number of hands coming together in a huddle, where people have put their palms one on top of another.**

**AUDIO**

(Anj): And I think that one of the things that's really important to recognise is that this wasn't able to happen without Mr A, the patient. First and foremost, it was patient-centered care all the way. Everyone was focussed on his recovery, and there were so many different disciplines that worked with him – from the surgeons to the nurse specialists to the private hospital who did phenomenal wound care. And they were so wonderful with their turns and keeping him on strict bed rest. He's a super nice guy. So, one week after he’d healed, he’d convinced them to let him up in his chair, but we quickly nipped that in the bud. (LAUGHS) We told him he had to get back in his bed until he went to the acute spinal rehab, which he was, like, ‘Oh, it was worth a try.’

So, yeah, the acute spinal rehab were fantastic with him as well because he was able to reintegrate, and he really understands and was given a lot of resources and told to kind of look… what to look for and how long it is to safely reintegrate him into his chair. They kind of realised that, in fact, he does need a little bit of extra support. So, he definitely… his wound is fragile because, obviously, it’s only in its first two months of healing. So, he does need to have extra support, so he now has caregivers that go in and assist him with showering and transferring so that he's not doing any sliding or shearing on his fragile wound.

**VISUAL**

**The next slide is a photo of a silhouetted figure using a wheelchair, positioned to look out to the glowing sun hanging low in the sky over the ocean. The sun’s rays illuminate the surrounding clouds.**

**AUDIO**

(Anj): But he is incredibly happy and he understands that, you know, like, a nine-week sacrifice – it turned out to be a 12-week sacrifice. But once he got to the spinal unit, he really felt like it was just all over for him. He was just, like, ‘I’m so close to home, I can  
practically see it, and I'm very excited.’ So ,it was very much about a combined effort. And I think it's one of the most important things to think about is that when you've got a chronic wound, is there something that people just are missing? The fact that he was doing self-care and the fact that he was doing manual evacuations in an area that's quite intimate and that there is potential for cross-contamination, you know, maybe that wasn't the best plan. And the fact that gold standard strict bed rest is… like, it's been proven to be the best way for these pressure injuries. So, it was very much a combined approach by lots of really passionate health professionals and a patient who just really, really wanted to get his life back. And so, it's really happy to think that 12 weeks down the track, he is able to spend three hours up in his chair two times a day.And he feels those are kind of his golden hours.

I gave him a call to talk to him about whether or not I could talk about him on the webinar, and he was so excited when I spoke to him. And I guess one of the really exciting things for him is normally I wouldn't be able to talk to him on the phone because he's not a confident English speaker, but because he was put into that private hospital environment, his English has come along, and he feels really confident. We were able to have a really good conversation on the telephone, and he was just so incredibly grateful for all the combined support that he had. And he very much gave me goosebumps when he said it's just so nice that he's finally got his life back and he's going to be so good and he's going to only sit up in his chair for as long as he's been determined to be safe.

And, yeah, it's kind of those feel-good stories that make it really real for you, and I think that that's why I wanted to share his story, because I think that there are a lot of other patients out there that have had these very difficult journeys, and it's really about putting your heads together with other health professionals and seeing is there something that you’re just missing that could be the difference between a wound healing and not healing? And I think that that was, in his case, it was done really well, and it was such a happy ending. And to be able to tell the surgeons and everyone that had been involved, everyone was really overwhelmed because he's just such a lovely guy, and everyone wanted him to have his happy ending, and he has it now and he's determined to stay healed. And, yeah, it's just really exciting to be part of that particular journey. So, thank you very much, everybody. I think I've talked under, which is, like, a miracle for me, because I'm a chatty Cathy.

**VISUAL**

**Anj ends her PowerPoint presentation and the screen goes black. The screen’s view switches to Leona facing her computer screen.**

**AUDIO**

(Leona): Kia ora, Anj. Thank you so much. What a fantastic story that you're able to share with us today. For me, it was really interesting to hear you talk about chronic pressure injuries and how they can actually redefine a person and the real importance of having that relationship that you build up with the patient so that then they can disclose things to you because you listen authentically to what they're describing. And then you can probe and unpack – no pun intended – unpack what's going on for him, which is exactly what happened in this case, and then you're able to put in all those wraparounds to support him. So fantastic. Thank you so much. And I think, by all accounts—I think Jane's got a few questions. We've got about seven minutes or so. So, I'll just hand over to Jane, and she'll ask some questions on behalf of the people on the screen. Thank you.

**VISUAL**

**The screen’s view switches to Jane facing her computer screen.**

**AUDIO**

(Jane): Kia ora, Leona and kia ora, Anj. I'll start with a couple of the comments that have just come through at the end. So, really impressive. Great work, great approach identifying goals and being able to reflect on those. And a couple of other people just saying thank you. And there is a question about asking if you can talk more about the POAC funding and whether this was arranged through planning and funding.

**VISUAL**

**The screen’s view switches to Anj facing her computer screen.**

(Anj): So, it was. That was something that my colleague had previously done because we identified that there was a real deficit within the facilities. They were quite hesitant to take VAC dressings because they didn't have the patients that were—they didn't have the nurses that were familiar with it. And quite often there's only one nurse to one rest home and that can take up a lot of time. And so it was really about kind of empowering the rest home so that they know that we have worked with the intermed who supply our VACs that would go into the rest homes and support them to learn how to do the dressings. From a funding side of things, um, so, it was… POAC is [Primary] Options for Acute [Care]. So, it's basically the way that we… the way that we rolled it is basically we could have early supported discharge. So that is how we kind of got the sign off on it is actually these patients don't necessarily need an acute bed, that this could be managed in a hospital facility, and so that is how we kind of developed that pathway to get that funding, because, actually, it's a patient that could be managed in a private hospital or rest home if they were given the required support and if they had the funding to do it.

Because obviously everyone knows that funding is everything, and so when you don't have it, it's really, really difficult. So to be able to develop that pathway, I think, was really, really important, because it meant that everyone was able to just have a really smooth transition into that area, and it meant that we developed a pathway so that everyone was kind of on the same page and everyone knew the expectations. And not all rest homes or private hospitals are ready, like, to have them. And, that's okay as well, and so it's really about liaising with the rest homes and private hospitals to make sure that it's the right thing for them as well. So that's why it's really important that they come into the hospital and see the wound and see the dressing as well so they can understand if it's actually within the realms of possibility. And we have it that some of them can't. They look at the wounds and they go, ‘No, they're far too big. I don't think we can manage those.’ And that's absolutely fine, and we just look for an alternate placement for the patient. So, yeah, it's a well-utilised stream, and I think that it's something that could be easily implemented in other DHBs because I think it is really beneficial for the patient, because who really wants to be in the hospital when they don’t have to be, you know?

**VISUAL**

**The screen’s view switches to Jane facing her computer screen.**

**AUDIO**

(Jane): That kind of segues into my next question. So, you talk about pathways, and  
obviously part of that pathway is communication and multidisciplinary communication

across different areas of the sector. So, you said it was a group of passionate professionals involved in his care. Did you have, sort of, planned regular meetings, and were there any issues with communication? And in this case study in particular, how did that enable you to work with, like, district nursing colleagues to reduce any time for referrals in the future?

**VISUAL**

**The screen’s view switches to Anj facing her computer screen.**

**AUDIO**

(Anj): I guess one of the really good things is that I'm an ex-district nurse, and so to them I’ll always be a district nurse, so I'm very approachable because I've worked in that setting. And I think that in terms of district nursing, they do know that wound care are here, and we are constantly approached by the district nurses via emails and referrals. So, it's something that's done quite well at Counties. And we've actually—they’ve recently just restructured to actually have their own community wound care nurse, so that's going to be even better for district nursing. So, I think there were regular meetings. I did a lot of go-between. I did a lot of kind of liaising with the different areas just to make sure that everything was working kind of seamlessly. And I guess one of the most important things was that the whole time the patient was well informed, that he knew everything and he was involved in every single decision, and we know that his family was important to him. So, there was always someone there for him so that he felt that he was included in these decisions and we weren't making decisions for him.

**VISUAL**

**The screen’s view switches to Jane facing her computer screen.**

**AUDIO**

(Jane): Cool. Thank you. We do have another couple of questions, but I'm aware that there are people who need to head off, and so I will wrap that up there and any other  
questions, obviously, we'll send those out with answers afterwards as well. So, thank you again, Anj, and I'll pass to Leona. Any further comments from you?

**VISUAL**

**The screen’s view switches to Leona facing her computer screen.**

**AUDIO**

(Leona): Oh, thank you. So, at the very end Anj will close with a karakia, but before we head into that, I would just like to acknowledge her sharing and her willingness today to answer the questions and any other questions that come through. As Jane says, please remember to send your questions through in the next 24 hours so we can put them to Anj and then get them back out with the video. I'd also like to take a moment to remind you of the inaugural Wound Care Week that commences next week. So, some of you will know about it; some of you won't. But the Wound Care Society, I'm sure their website will help you find your way to that. So that's a big moment for them, so we'd like to acknowledge that.

Thank you to Jane Lester who coordinated the session today and all the intricacies that are involved in recording and making the session available in due course. There's lots of little things that have to be done that Jane’s much better at doing than me. So, thank you, Jane, for all of that work. And, finally, I'd like to wish you all the very best. Most of all, please stay safe, and thank you for joining. Kia kaha. Thank you, Anj.

**VISUAL**

**The screen’s view switches to Anj facing her computer screen.**

**AUDIO**

(Anj): Manawa mai te mauri nuku

Manawa mai te mauri rangi

Ko te mauri kai au,

He mauri tipua

Ka pakaru mai te pō

Tau mai te mauri

Haumi e, hui e, taiki e!

**VISUAL**

**The screen goes black.**

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