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# WEST AUSTRALIAN WOUND CARE ASSOCIATION *Newsletter*

**Edition No. 61**

**October 2006**

## COMING EVENTS

### **Wound Care for Rural Health Professionals 2006**

Proudly sponsored by Coloplast, ConvaTec, Hartmann,  
Molnlycke, Smith and Nephew, Tyco Healthcare

24 November – Bunbury

Speakers: Donna Angel CNC, Vascular and Wound Care RPH

Beth Sperring

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### **Burn Management Programme 2006**

Proudly sponsored by Smith and Nephew

1 December – Kondinin

For further details please contact:

Beth Sperring

### **AWMA conference in 2008**

The Northern Territory is hosting the next conference  
7-10 May, Darwin, NT

Evolving landscapes; dreams, diversity and disasters

*More details to follow in forthcoming newsletters.*

### **Clinical update and Annual General Meeting (AGM)**

Wednesday 22 November 2006

1700: AGM

1800: Supper

1830-2000: **Investigating iodines**, panel  
discussion, CNCs from medical and surgical  
background, pharmacist, lawyer, podiatrist and  
an endocrinologist

St John of God Hospital Subiaco, Subiaco Clinic  
Conference Centre Level 3, main entry off  
McCourt Street

*Disclaimer:- The opinions expressed by authors are their own and not necessarily those of the Editorial Board. The Board therefore accepts no responsibility for the accuracy of statements appearing herein.*

## Message from the President

### Clinical Update

The final Clinical Update for the year ends on an exciting note.

There is often controversy on the use of iodine in wound healing and this update promises to be an exciting one.

The topic **Investigating Iodines** will be a very informative panel discussion with a diverse group of experts from various medical fields.

There is some confusion as to the toxicity of povidone iodine. In vivo tests show that wound healing cells such as fibroblasts and keratinocytes are damaged, but at what concentrations and what is the safe level necessary to achieve an antiseptic effect without cytotoxicity.

This interesting panel of experts will ensure a stimulating discussion.

**Please note the change of venue for this Clinical Update**  
**Lecture Theatre St John of God Hospital Subiaco.**

### AGM

The Annual General Meeting will be held before the Update, please come along and support the Association.

Members are encouraged to nominate for positions on the committee. Meetings are held on the first Wednesday of every month at SCGH at 5pm usually for about 2 hours (max). The committee welcomes members to join us and have an input in the development of the association and become involved in the advancement of wound management through best practice guidelines and education.

We invite all members to consider joining the committee and develop your skills in wound management; please do not feel that you have to have a vast knowledge in this field as many of our former members have increased their knowledge during their time on the committee.

The association welcomes members' feedback, especially about continuous educational needs of its members.

Remember we need your input to enable us to meet your needs.

**Sue Hoskin**

**President WAWCA**

### Committee Members

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## WCET Conference report Hong Kong 2-6 July 2006

Jennifer Byrnes • Wound CNC / Stomal Therapist, Royal Darwin Hospital, NT



The World Council of Enterostomal Therapists (WCET) Conference was held in Hong Kong in July 2006. The conference covered specific topic presentations relating to the field of stomal therapy. The format of the meeting had a day dedicated to each specific field as the key focus, with the first day being stomal therapy, the second day being wound management and the final day covering continence management. The remaining days held 'meet and greets' plus keynote speakers from a multitude of international backgrounds.

There was a large Australian contingent at the conference, with 36 Australians in total attending including delegates and company representatives. A requirement of this type of international conference is to wear traditional dress and perform a traditional dance from your country of origin; in true Australian style the Aussies wore green and gold and sang *I still call Australia home* with a few cleverly changed words, composed by the QLD and SA girls, to incorporate the theme of the conference. As you can see from the photograph, it was truly an Australian experience!

One of the main impacting factors from this conference was the realisation that there are many countries that are still developing; their wound techniques and outcomes were reflected by the presentations, both orally and in poster format, at the conference. Techniques that we consider old and no longer best practice such as eusol and saline packs are still used in some of these countries as that is all that is available or that they can

afford. Some of these countries don't have the luxury of funding, Medicare and government support in their health regions.

However, with persistence and support from colleagues from other nations, these developing countries are making an impact, affecting change and moving forward in stomal therapy, continence and wound management. It was a timely reminder that in Australia we are lucky to have access to so many products and a supportive health system; even if we see it is struggling, it is considerably more advanced compared to these developing countries.

The papers presented encompassed many interesting topics and, for my own field of interest, there was a great paper presented on Fournier's gangrene in Hong Kong. This paper complemented the paper I presented the next day on necrotising fasciitis. A multitude of presentations and posters described interesting and various ways to manage complex wounds, continence and stomas problems in countries from all over the world, including Iran, Korea, China, Japan, Singapore, Ireland, Denmark, Switzerland, Romania, Spain, Slovenia, Italy, Netherlands, Belgium, Indonesia, Taiwan, Brazil, Lebanon, Turkey, France, England and the USA.

The downside to the oral presentations was the criteria for presentation. The presenters were required to present in English, even though there were translation headsets available. So, some presenters had amazing information to give from their presentation; however, having English as their second or third language and presenting in English did not do justice to the information provided. In saying so, I believe it was an amazingly 'gutsy' effort for those people to get up and present in a language they are not overly confident in; I know it is terrifying enough to present in my native language!

The upside to the conference was that it allowed for networking at an international level, plus the opportunity to view wound products that may be launched in Australia in the near future (such as Acticoat Moisture control™ and new paediatric stoma appliances from Coloplast) and also to see some devices and products that we could only wish would be launched in Australia. Company reps explained to us, when we enquired if these products would ever be launched in Australia, that we



are such a small market compared to Europe and the USA, that some companies don't see Australia as a financially viable area to support the use of their products. Disappointing but at the same time understandable; however, I don't believe we are too disadvantaged in the products we have available in Australia.

The keynote speaker, Dr Keryln Carville, spoke about the search for the holy grail in wound management; it was a presentation that made us all contemplate what is the holy grail of wound care and how can we achieve it. It appears the holy grail is evidence-based best practice; even so, it still seems elusive to us as we all try to reach ever higher standards in our practice as stomal therapists or wound care practitioners.

The newly elected President of the WCET is now Elizabeth English, an Australian from South Australia. Liz also presented an inspiring paper on empowerment of the future, which made us all contemplate where we are today in our practice, where we've come from, where we want to be in the future and how we can empower ourselves to achieve our future goals.

Other dynamic international keynote speakers included Dr Elizabeth Ayello (USA) and Dorothy Doughty (USA) who presented interesting case studies highlighting strategies in the management of complex stomas, pressure ulcers and continence management.

Overall, it was a worthwhile experience and I would like to say thank you to the WAWCA for the Winnie Fell sponsorship that enabled me to attend this inspiring and very informative international stomal therapy conference.

## Write on!

Help keep the WAWCA newsletter full of varied and interesting ideas, articles, research, projects, information, questions, literature reviews and what's going on around Western Australia. Please submit to:

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# Reflections 2006: Smith & Nephew silver forum

**Pam Morey • Clinical Nurse Consultant, Sir Charles Gairdner Hospital, Perth, WA and additional comments as noted**

In the middle of August, a number of health practitioners engaged in wound care were invited by Smith & Nephew to attend a one and a half day forum on silver. The event was held in Werribee, Victoria at a venue called the Mansion, located adjacent to the Werribee Zoo and the State Rose Gardens.

## Presentations

### The influence of bacteria on wound healing – Professor M Stacey

Approximately 50 clinicians from around Australia attended the event, which commenced after a light lunch. Professor Michael Stacey opened proceedings, outlining the *The influence of bacteria in the wound healing process*. Participants were reminded of the principles of wound bed preparation, and the influence of bacteria in leg ulcer wound healing, with particular reference to studies conducted at the leg ulcer clinic at Fremantle Hospital (University Department of Surgery).

*The number of proteins in wounds are reduced by debridement. Bacteria in chronic wounds contaminate, colonise and increase infection. One study found a reduction in cellulitis and wound bioburden with compression therapy on venous leg ulcers. Another study found that chronic wounds had a suppressed macrophagic activity. Another study investigated TNF-alpha in wound fluid environment, indicated it affects macrophagic activity and that some cytokines and endotoxins affect TNF-alpha production.*

Joy Fong – CNC Burns Unit RPH

### Taking the 'I' in TIME forward: update from the Wound Infection Institute – Terry Swanson

Terry Swanson, a nurse practitioner from Warnambool, Victoria, then relayed her experience as a one of five Australians who met with 130 international wound management colleagues from 23 countries at an inaugural meeting in Budapest in June 2006, to discuss wound infection.

*The Wound Infection Institute (WII) is an interest group of clinicians, scientists and other professionals working in wound management dedicated to furthering the advancement of infection control through best practice, education, training and research. With Professor Keith Harding as their chairman, the 130 members discussed the following principle objectives:*

- For members to work together as an institute to improve knowledge and understanding in infection control.
- To create clarity and a consensus of approach within the multidisciplinary field of wound infection control.

*Although the focus is on chronic wounds, all wound infection is considered. The WII does not intend to reinvent the wheel but asks permission to use relevant information from other societies. Ms Swanson spoke about host support, medical asepsis – in particular hand hygiene and the essential high priority that it*

*should receive from all health care practitioners – disposal of soiled dressings, wound cleansing and wound debridement.*

*The topics for the six working groups were: Research, Evidence, Diagnostics, Education, Systemic Antimicrobials and Topical Antimicrobials. Keryln Carville (WA) chaired the group, discussing Evidence with the following outcomes:*

*The WII will:*

- Partner with EUAP and NPUAP for peer review of the literature
- Develop an evidence repository of key articles and reviews
- Develop a tool to ascertain clinicians rationale for using topical antimicrobials

Jan Wright – CNC Wound Management RPH

### Wound microbiology – Dr Annabelle Duncan

Wound microbiology was the next item for discussion by Dr Annabelle Duncan, Deputy Director and Chief Operating Officer, Bio21 Molecular Science and Biotechnology Institute at the University of Melbourne. Annabelle revisited concepts of wound infection and the role of silver. Implications for the clinical setting were highlighted in relation to reports of silver resistance since 1966 and the dosage of silver for bacteriostasis or bacteriocidal activity. Once again, clinicians were reminded of the relevance of evidence and whether it reflected data from the laboratory (in vitro) or clinical (in vivo) setting.

*Wounds are contaminated by microorganisms from skin and environment. Wound infection is when the microbes cause host reaction. Toxins and enzymes produced by microbes damage tissue. Prolonged inflammation response damages tissue. In inflammatory response, neutrophil level are elevated which decreases chemotaxis and infiltration of cells for repair. There is also elevated MMP level which mediate tissue destruction and necrosis. The role of silver in wound healing is to act as a broad biocidal to control infection. Nanocrystalline silver has pro-healing effects. Care is needed to ensure silver resistance does not develop. An appropriate silver release of at least 50 parts per million in water is necessary for bacteriocidal effect*

Joy Fong – CNC Burns Unit RPH

### Evidence relating to silver in wound care – Associate Professor Keryln Carville

The evidence relating to silver in wound care was comprehensively reviewed by Associate Professor Keryln Carville, who is well known in Western Australia. Keryln reiterated issues of bacterial resistance to antibiotics and the emerging interest in topical antimicrobials, particularly silver, in wound care. Whilst silver has substantial historical roots and is known to be bacteriocidal, fungicidal and virucidal, the evidence for use of silver is still unclear in relation to the different modes of delivery, varying

concentrations and different tests used to demonstrate efficacy. Delegates were urged to consider safe and effective use of silver in case bacterial resistance to modern silver impregnated dressings emerges.

### The use of silver in the paediatric burns population – Associate Professor Roy Kimble

Associate Professor Roy Kimble, Clinical Director, Stuart Pegg Paediatric Burns Centre and Head, Royal Children's Hospital Burns Research Group, Brisbane, Queensland, relayed some of the latest findings with the use of silver in the paediatric burns population. In particular, the use Acticoat demonstrated faster re-epithelialisation, reduced grafting requirements, and a reduction in the number of children with burn injury requiring long-term scar management.

Delegates were amazed also at the types of skin injuries and wound infections that neonates as young as 24 weeks' gestation sometimes sustained, and the challenges of care. The long-term effects of silver in this very young population is being monitored and, whilst serum silver levels certainly rise with silver dressing use, there has not been any evidence of silver toxicity to date in this young and vulnerable group.

### Microbiological effectiveness of silver containing dressings – Dr Chris Roberts

The closing session for Day 1 and the opening session for Day 2 were both presented by Dr Chris Roberts who is the Director of Clinical Research for the wound management division of Smith & Nephew. Chris supported the use of consistent measures to determine the microbiological effectiveness of silver containing dressings. Other aspects of silver delivery included its release and replenishment in the wound environment and the speed of kill.

### Barriers to the use of silver products – Melissa O'Brien

The use of silver dressing products has brought about certain issues in the tertiary hospital setting. Melissa O'Brien, the Wound Care Program Manager at Royal North Shore Hospital and surrounding area health, discussed some of the barriers to the use of silver products experienced at that health facility. Concerns were raised in relation to staff turnover and maintenance of staff knowledge of silver product use, lack of availability and continuity of dressings on patient discharge, and issues with cost without consideration of outcomes.

Within Melissa's health facility, a protocol for the use of silver dressing products has been implemented and their use requires a prescription and supply through pharmacy. The 'prescription' can be made by a number of clinicians involved in wound care, including plastic surgeons, dermatologists, vascular surgeons, clinical nurse consultants in wound care, burns and stomal therapy and members of their Wound Care Committee. The protocol was devised to monitor the use and cost of these products, as well as patient outcomes.

### A general practice perspective of silver use – Dr Stephen Yelland

A general practice perspective of silver use was relayed by Dr Stephen Yelland, a GP from the Gold Coast, Queensland, and

Clinical Associate Professor in the Faculty of Health Sciences and Medicine at Bond University. Stephen outlined some of the Medicare items related to wound care, the chronicity of wound care in his practice setting which has a significantly aged population, and the use of antibiotics commonly used for wound infections.

Historically, silver products have been used for some time in this setting; however, Stephen stressed the need for remembering the basics of wound care. His practice relies on a team approach, and he included the importance practice nurses in the delivery of wound care, and referral to appropriate specialists including a clinical nurse consultant (CNC) in wound care and vascular surgeons. Other facets included broader support mechanisms such as information technology, education and human resource support from the GP Division to GPs.

### Guidelines in the use of silver products – Sue Templeton

After much discussion about silver in various settings, Sue Templeton, CNC Advanced Wound Specialist for the Royal District Nursing Service in South Australia, outlined the need for guidelines in the use of silver products. Sue's presentation reiterated key points outlined in her article in *Primary Intention, Management of chronic wounds: the role of silver-containing dressings*. Guidelines within this community/out patient setting included a commonsense approach with comprehensive patient and wound assessment, timeframes for silver use (relative to wound progress), and its judicious use to "...ensure silver dressings remain efficacious and financially sustainable for the health system".

### Silver workshops

This ended the formal presentations. The silver workshops topics which followed included:

- Addressing misconceptions about silver: what does the science say?
- How can we help other clinicians use silver properly?
- Understanding bacterial resistance: what are the implications for wound management?

The forum concluded with a summary of workshop discussions. As with other forums relating to the use of silver products in wound care, many more questions remain unanswered. Practical issues versus clinical science remain a conflict in some instances. Key questions clinicians may ask include:

- Which silver product should I choose?
- Are all silver products equally effective?
- How long should silver products be used for?
- Who should decide when to use silver?

At the end of the forum, I was challenged to think of silver dressing use in my own health setting and consider issues of potential silver resistance and the need for education and the development of clinical guidelines for silver product use.

# Collaboration and communication: team work in managing a chronic wound in burn scar tissue

**Sharon Rowe • Clinical Nurse, Telstra Burn Reconstruction and Rehabilitation Unit  
Royal Perth Hospital (RPH), Perth, WA**

## Introduction

The management of chronic wounds is often frustrating for both patient and practitioner. There is some literature to support the recommendation that chronic wounds need to be converted to acute wounds in order to heal<sup>1,2</sup>. Cells in chronic wounds do not respond to the normal cascade of events that occur in acute wound healing. They are 'stuck' in the inflammatory phase of wound healing. This is exacerbated by chronic wound fluid which is high in pro-inflammatory cytokines that further slows down cell proliferation.

Preparing the wound bed for healing requires removing eschar, slough, non-viable tissue and managing excess exudate often associated with chronic wounds. It is important to identify possible causes of the continuing breakdown and address patient centred issues.

## Case history

A 78 year old man suffered burns to both legs in 1966, resulting in extensive scarring. The dorsum of both feet periodically broke down and were difficult to heal. The patient was a non-smoker but enjoyed his 'home brew'. He wore custom made boots to accommodate the deformities resulting from the original burn. It was purported that these may have been contributing to the continued breakdowns. The patient was in the process of having new boots made.

On first review at RPH, the patient's wounds were inflamed and non-progressive. The edges were callused and vertical and the wound bed senescent, with moderate to large amounts of exudate. The wound was not clinically infected, although at times the peri wound tissue was inflamed, flakey and dry. The patient stated he couldn't remember when it was last healed but he thought it was 18 months. The Vascular Wound Care CNC was consulted with the regard to perfusion problems associated with scar tissue.

After reviewing his medical history and lifestyle issues, a wound management plan was devised with priority given to manage exudate and prevent further breakdown, whilst preparing the wound bed to promote healing.

- Photography and VISITRAK\* was utilised to monitor wound progress.
- IODOSORB\* was used to assist exudate management, reduce bacterial burden and help remove the slough.

- Mepilex® was used as the secondary dressing to further control exudate and provide protection against footwear.
- The patient was asked to sit with feet elevated and to rest periodically throughout the day.
- The fitting of new boots was delayed.
- Consistency of care was achieved between clinic visits by regular communication with Silver Chain.

## Wound progress

From 18 April (Figure 1) until 31 May 2006, IODOSORB was a daily treatment changed by Silver Chain. Within this time granulation tissue became evident, slough decreased and VISITRAK tracings showed a 49.4% area reduction. The edges became flat and there was no further slough. The patient had been booked for debridement and split skin graft of left and right foot wounds.

Continued use of IODOSORB showed a further reduction in area of 40.7% with VISITRAK (Graph 1) from the previous visits by the end of June (Figure 2). The wound was hypergranulating and there was a small amount of slough at the lateral wound edge, but mostly a vascular wound bed. Exudate was small to nil. In consultation with vascular wound care CNC, treatment was changed to Inadine® with Mepilex® as the secondary dressing. It is significant to note that, on this day, surgery was cancelled due to the extent of healing of the wounds of both feet. A few weeks later, VISITRAK showed a 94.5% reduction in area from previous appointment (Graph 1). The wound had reduced in size to 0.1cm<sup>2</sup> and continued with the same dressing regime.

By 8 August (Figure 3), the dorsum of the right foot had completely epithelialised. Skin integrity was maintained with a moisturising lotion to the dry and flaky areas. A foam dressing will continue to be used over the area for up to 12 months to prevent further skin breakdown. At a 4 week review, the wound remained healed. New boots were being made.

## Discussion

Cadexomer iodine is a controlled slow release iodine preparation reducing the likelihood of toxicity and making it particularly effective in chronic wounds<sup>2,3</sup>. Mepilex™ uses Safetac technology allowing atraumatic removal, protecting surrounding skin leaving no residue, and providing a moist wound healing environment whilst minimising maceration. In combination, these two products addressed the main issues identified.

A percentage area reduction within the first 4 weeks is documented as a good prognostic indicator of healing progress or deterioration in wound status<sup>4,5</sup>. This is important as the nurse can change treatment if there is no improvement. Use of VISITRAK enhanced wound assessment and helped to monitor progress as the shape of the wound changed, as some changes may not be visible to the naked eye. This technique also reduces inconsistencies in measuring only width and breadth and allows for more than one person to do the tracing accurately<sup>4,5</sup>.

**Conclusion**

Chronic wounds require a team approach identifying patient centred problems as well as environmental issues that delay healing. This is vital when ongoing care is required outside the metropolitan area. Normal wound healing timeframes do not apply in chronic wounds and this must be taken into account when devising the plan of action.

**Acknowledgements**

Many thanks and appreciation go to Julie Armstrong and Pat Coppins of Silver Chain, Lancelin, who continued to dress the patient’s wound accepting my input and offering their suggestions and feedback on progress. Thanks also to Donna Angel, CNC Vascular Wound Management, for her advice and Rhonda Harris, my colleague.

Thanks to Smith & Nephew for assistance with this article.

\*Trademark of Smith & Nephew

**References**

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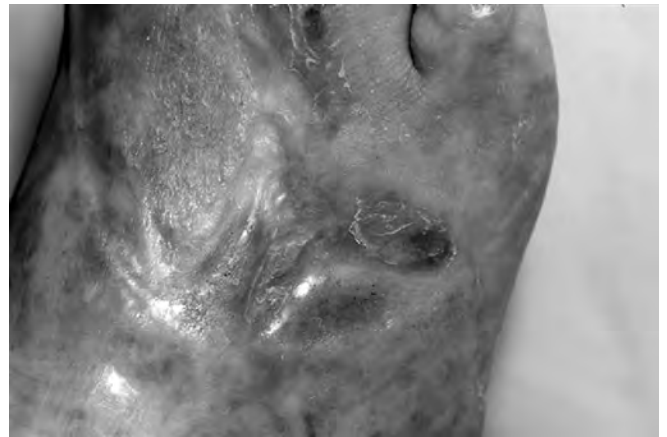
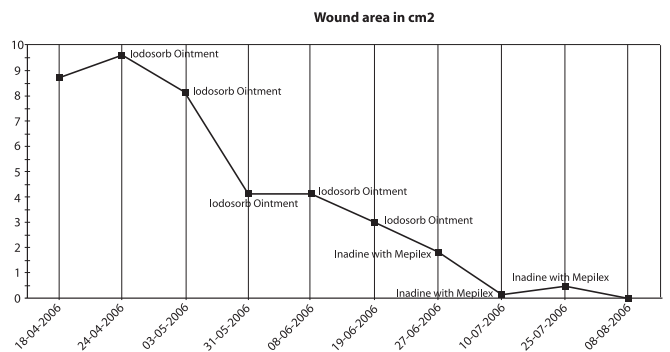


Figure 3. 8 August 2006.



Graph 1. The VISITRAK Data Capture graph shows the trend to healing.



Figure 1. 18 April 2006.



Figure 2. End of June.

**Expression of interest in provision of services to lecture**

WAWCA receives frequent requests to provide speakers for metropolitan and country study days. If members are interested in providing their services for education, please forward your details to the Secretary of the WAWCA committee. A pool of speakers interested in providing ongoing educational support will be developed.

Remuneration is the individuals responsibility.

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## WAWCA Inc. Annual General Meeting 9 September 2005, Parmelia Hilton, Perth WA Minutes

50 members present

1. OPEN: at 1305 hours by Pam Morey (Vice President/ chairperson)
2. APOLOGIES: S Hoskin, M Phillipson, L Barnden, F Wood, R James, G Lum, G Sadler.

### 3. CONFIRMATION OF PREVIOUS MINUTES

3.1 Minutes of the AGM held November 2004 were distributed, read and accepted as a true and correct record of that meeting.

Moved: L Foley Seconded: D Angel CARRIED

### 4. BUSINESS ARISING FROM THE MINUTES

4.1 Constitutional Changes as passed at the 2004 AGM:

Due to delays in submitting the changes to the Department of Consumer and Employment Protection, the changes need to be resubmitted at this meeting.

Constitutional Changes:

PROPOSED CHANGES TO: 12, 13. ii, 13.1.i, 13.1.ii of the Constitution

The existing statement reads as follows:

12. Amendments

Amendments to the constitution shall be referred to the Committee. The amendments shall then be submitted in writing to the committee secretary at least forty nine (49) days prior to the Annual General Meeting or Special General Meeting for this purpose. The amendments shall be debated and put to vote and must be approved by two-thirds (2/3) of the membership voting.

MOTION: put and carried at the 2004 AGM:

“that in section 12 of the Constitution, Amendments, the words forty nine (49) be replaced with twenty one (21).”

Moved: L Foley Seconded: G Brunt CARRIED

12. Amendments now reads:

Amendments to the constitution shall be referred to the Committee. The amendments shall then be submitted in writing to the committee secretary at least twenty one (21) days prior to the Annual General Meeting or Special General Meeting for this purpose. The amendments shall be debated and put to vote and must be approved by two-thirds (2/3) of the membership voting.

The existing statement reads as follows:

13. ii Participation in advanced wound management education programs other than for undergraduate and post-graduate courses at tertiary institutions.

MOTION: as put and carried at the 2004 AGM

‘that 13. ii reads ‘ Participation in recognised courses related to wound management.’”

Moved: L Foley Seconded: G Brunt CARRIED

The existing section 13.1 Eligibility:

In order to be a recipient of a WFE&RF grant applicants must:

- i. Have been a member of the Association for longer than twelve (12) months;
- ii. Have not received a grant in the previous twelve (12) months;
- iii. Have completed the application form and provided additional information as requested on the application form;
- iv. Meet all other application criteria required by the Association;
- v. Monies allocated will be determined by a majority decision of the Executive Committee.

MOTION: as put and carried at the 2004 AGM

‘that in 13.1.i the words “for longer than twelve (12) months;” be replaced with “of not less than two (2) years with an expectation of continued membership for a further two (2) years;”’

Moved: J Connolly Seconded: J Wright CARRIED

MOTION: as put and carried at the 2004 AGM

‘that in 13.1.ii the words WFE&RF be inserted to identify the specific source of the grant.

Moved: J Connolly Seconded: J Wright CARRIED

MOTION: ‘that the constitutional changes as presented and accepted at the 2004 Annual General Meeting be accepted without change.’

Moved: J Wright Seconded: L Foley CARRIED

### 5. CORRESPONDENCE: nil

### 6. BUSINESS ARISING FROM THE CORRESPONDENCE: nil

**7. TREASURER'S REPORT**

See Box

MOTION: 'that the Treasurer's Report be accepted.'

Moved: L Foley    Seconded : B Pedersen    CARRIED

## INCOME AND EXPENDITURE - WAWCA 2004 -2005

*S6 ACCOUNT: WINIFRED FELLE EDUCATION & RESEARCH FUND*

Balance @ 30/6/04	\$11,846.24	Balance @ 1/7/03	\$11,709.50
Interest accrued	\$181.70	Interest accrued	\$200.39
		Less late chq	\$63.35, govt charge 0.30
	\$12,027.94	\$11,846.24	

*TERM DEPOSIT (POLICE NURSES CREDIT UNION)*

Balance @ 1/7/04	\$67,335.51	Balance @ 1/7/03	\$64,190.19
Interest accrued	\$3,646.08	Interest accrued	\$3,145.32
	\$70,981.59	Balance @ 30/6/04	\$67,335.51

*PREMIUM BUSINESS ACCOUNT COMMONWEALTH BANK*

Balance @ 1/7/05	\$12,487.46
Inward	\$28,360.82
Outward	\$26,289.82
Balance @ 30/6/05	\$14,561.46

*ACCOUNT TOTALS @ 30/6/05*

S6 (WFERF)	\$12,027.94
Investment account	\$70,981.59
Commonwealth Bank account	\$14,561.46
Total	\$97,570.99

**INCOME**

Membership fees	\$20,570.00
Non-Members donations/ Sale of publications	\$1,958.74
Fees collected from Trade	\$1,750.00
Return OF WFERF funds	\$1,500.00
Conference fee (50% of Parmelia fee ICAWA/WAWCA)	\$2,500.00
	\$7,708.74
+ \$82.08 int	\$28,360.82 = Bank Statement

## Interest:

S6 (WFERF)	\$181.70	
Term Deposit	\$3,646.08	
Premium Chq	\$82.08	
Sub Total	\$3,909.86	\$3,909.86
Total		\$32,270.64

**EXPENDITURE**

	<b>2004-05</b>	<b>2003-04</b>
Catering (Clinical Updates)	\$3,146.00	\$897.60
Printing	\$649.00	\$198.00
Winne Felle Grants	0 *	\$14,951.00
AWMA - Airfare reimbursements	\$1,066.98	\$ 1,304.12
- Capitation fees	\$4,590.00	\$ 3,848.00

Bank charges-	\$ 300.34	\$ 476.21
Merchant Fees	\$ 73.55	
Membership Secretary fees	\$ 4,688.03	\$ 2,152.85
Gifts /Refunds to members	\$ 847.27	\$ 684.30
Other	\$10,874.29	
(Accountant fees \$1126		
Deposit Parmelia \$5000		
ICAWA/WAWCA seed funding) \$3000		
Refund ICAWA,overpayment \$853)		
Late presented chq 34		
Refund to member	\$ 51.36	
Total	\$ 26,286.82 = Bank Statement	\$26,290.28
<b>CASH BOOK</b>		<b>BANK STATEMENT</b>
Income	\$28,360.82	Statement 30/6/05
Expenditure	\$26,286.82	\$14,561.46
Statement 30/6/04		
CR Balance	\$2,074.00	
Plus Credit Balance B/F		
From 30/6/04	\$12,487.46	
Credit Balance 30/6/05	\$14,561.46	Credit Balance 30/6/05
		\$14,561.46

**8. BUSINESS ARISING FROM THE TREASURER’S REPORT**

8.1 Election of Auditors – L Foley explained that the Auditor had been changed as a result of the difficulty experienced over the last few years and that he had been working successfully with the firm FA Jones and Associates since the beginning of 2005.

MOTION: ‘that FA Jones and Associates of Fremantle be retained as auditors for the financial year 2005/2006.’

Moved: L Foley    Seconded: D DiSilva    CARRIED

**9. REPORTS**

9.1: President’s Report:    P Morey on behalf of S Hoskin

P Morey outlined the many activities undertaken by the WAWCA throughout the last year, thanking the Trades for their support and the committee for the work they had undertaken. She outlined the educational activities including the Clinical Updates and the two country education sessions held in association with the College of Nursing. She commented on the financial sponsorship of members in relation to registration for attendance at the Silver Symposium. Membership of the Association stands at 374. A copy of the report was tabled.

MOTION: ‘that the Report as presented, be accepted.’

Moved: B Pedersen    Seconded: J Wright    CARRIED

**10. ELECTION OF OFFICE BEARERS**

The following positions were declared vacant and the voting procedure was outlined according to the Constitution. As there were no positions with more than one nomination the following names were put to the vote:

Secretary: Beth Sperring

Education Officer: Donna Angel

Newsletter Editor: Tania Baker/Jan Wright

Medical Representative: Genevieve Sadler

Membership Secretary: Barb Pedersen

Allied Health Rep: no nomination received

Committee Members: Carmel Boylan, Nelly Newall, Jenny Faithfull, K Carville,

MOTION: ‘that all nominations be accepted.’

Moved: L Foley    Seconded: B Pedersen    CARRIED

Positions held for the second year

President: S Hoskin

Vice President: P Morey

Treasurer: L Foley

**11. NEW BUSINESS: nil**

**12. NEXT AGM: to be announced for 2006**

**13. CLOSE: Meeting closed at 1338hrs.**

## Useful websites for clinical research and evidence based practice

### Cochrane Library

NICS (National Institute for Clinical Studies) have renewed the national license for another 2 years. The library is an online database that synthesises scientific research drawn from around the world and is renowned as the best single source of evidence on the effects of health care.

[www.cochrane.org](http://www.cochrane.org)

NICS has produced a user guide, for help navigating the Cochrane library:

[www.nicsl.com.au](http://www.nicsl.com.au)

### NICS

National Institute of Clinical Studies (NICS) is Australia's national agency for helping close the gap between the best available evidence and current clinical practice in health care. It is good for practice guidelines.

The where's the evidence? website is an informative site that provides health professionals with a range of useful resources, dedicated to supporting clinicians finding evidence that is relevant and current.

[www.nicsl.com.au](http://www.nicsl.com.au)

### Medline/Pubmed

Part of the US National Library of medicine and useful for medically related literature searches but also has references to many articles relating to ageing issues. It includes links to full text articles and other related resources.

[www.ncbi.nlm.nih.gov/entrez/query.fcgi](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi)

### Medscape

Access to many online journals in 25+ specialties that are full text, search under subject heading; wound care is particularly good.

<http://www.medscape.com/home>

### Journal of Community Nursing

Relatively new online journal from the UK; all articles are full text and back issues can be accessed.

[www.jcn.co.uk](http://www.jcn.co.uk)

**Thank you to Nellie Newall who provided these websites. Please continue to forward your suggestions.**

**DO YOUR CLIENTS/  
RESIDENTS/PATIENTS HAVE  
SKIN TEARS?**

**DO YOU WANT TO BE  
PART OF AN EXCITING  
RESEARCH PROJECT?**

**DO YOU HAVE ACCESS TO  
A DIGITAL CAMERA?**

**★ SKIN TEAR AUDIT  
RESEARCH (STAR) PROJECT**

In order that people with skin tears can be provided with the best possible treatment for their wound it is necessary for all clinicians to be using the same way of describing tears.

However, there is currently no universally accepted definition and classification of skin tears. This research project aims to fill this gap.

For this project we need to collect a large number of photographs of skin tears and are therefore asking for your assistance in forwarding photographs of your clients'/residents' skin tear(s). We particularly want ones that are viable and approximated as well as those not approximated, but any photos would be great!

**If you can assist with forwarding photographs of skin tears or require further information about this project, please contact Nelly Newall, Clinical Research Coordinator at Silver Chain on 9201 6721.**

This newsletter is produced with the generous support of

