Using the Best Practice Statement 'Improving holistic assessment of chronic wounds' in practice

KEY WORDS
- Patient engagement
- Patient expectations
- Patient involvement
- Wound assessment

The Best Practice Statement 'Improving holistic assessment of chronic wounds' (Wounds UK, 2018a), supported by an unrestricted educational grant by Essity, was developed to support practitioners improve the assessment of patients with chronic wounds. Each Best Practice Statement has a unique 'Patient Expectation', which explains what patients can expect at each stage of assessment. The Patient Expectations reinforce the holistic approach to wound assessment and are a reminder to clinicians to consider the patient perspective. This article presents a case report where the Best Practice Statement and CASE (cause, assess, select, evaluate) assessment tool (Scott-Thomas et al, 2017) were used to complete an holistic assessment and reassessment.

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The 'Burden of Wounds' study highlighted inconsistencies in wound care practice, particularly in assessment (Guest et al, 2015). Rates of holistic assessment varied, and assessment itself was often sub-optimal; for example, approximately 30% of wounds in the study period were found to have no differential diagnosis.

As such, NHS England has identified wound assessment as a key focus for practice, and the Commission for Quality and Innovation (CQUIN) has introduced an indicator based on assessment to improve care (NHS England, 2016).

In 2018, an Expert Panel Group convened to discuss holistic wound assessment and develop a Best Practice Statement document to describe the key principles underlying holistic wound assessment (Wounds UK, 2018a).

Alongside each of the nine Best Practice Statements (BPSs), the Expert Panel Group developed an accompanying 'Patient Expectation' (*Figure 1*). Patient involvement plays a key role in optimising treatment. Engaging patients with their wound assessment and ongoing care is becoming an ever-growing part of the treatment paradigm and has been shown to improve outcomes (Moore et al, 2016). Clear communication, establishing family support and harnessing technology are some ways to foster patient involvement.

A recently published article by Fletcher and Barrett (2018) illustrates how clinicians can adopt and integrate the Patient Expectations into practice, by using them as a prompt for effective communication with patients, to engage them in the management of their own care.

CASE REPORT

The case report presented provides a detailed example of how the Best Practice Statement 'Improving holistic assessment of chronic wounds' (Wounds UK, 2018a) can be used in practice to guide holistic assessment and reassessment. The nine BPSs are ***summarised in italics***. The BPSs were used alongside the CASE assessment tool (*Figure 2*; Scott-Thomas et al, 2017), which is a framework that includes all the elements of the Generic Wound Assessment MDS (Coleman et al, 2017). The CASE tool was developed by Essity to support healthcare professionals when undertaking holistic wound assessment.

BACKGROUND

A woman in her 70s sustained a trauma to her lower limb, which later developed into a wound. On discharge as an inpatient, an holistic wound assessment was conducted by the community

The nine BPSs were derived from a one-day meeting of the Expert Working Group that convened to discuss holistic wound assessment. The BPSs were further developed during an extensive review process by the Expert Working Group and Review Panel.

Best Practice Statements

Each BPS is accompanied by a related statement that explains to patients with a chronic wound what they should expect from high-quality wound assessment.

Patient Expectation

Figure 1. Best Practice Statement and Patient Expectation defined

nurses. Community nurses visited twice weekly for 5 weeks. The patient was referred to the Wound Care Service (WCS) *to advise and assess* as the wound had deteriorated (BPS 1; Wounds UK, 2018a). The WCS responded within 2 days.

REFERRAL TO THE WCS

Communicating to empower and engage

Practitioners are encouraged to communicate with the patient in an appropriate style and use language that empowers and engages patient participation in the planning, delivery and evaluation of care (BPS 3; Wounds UK, 2018a). With this in mind, at the initial assessment by the WCS, the management options available and the patient's expectations of treatment were discussed to develop a clinician–patient relationship conducive to shared decision making (*Table 1*). *Telecommunication technology was considered to assist with wound monitoring and referral* (BPS 9; Wounds UK, 2018a), but it was felt that support could be effectively provided by telephone if required. The patient was given the clinician's contact details.

Documentation of assessment findings allows continued care planning and clear lines of communication within and between allied healthcare professionals responsible for care (Lagerin et al, 2017). *All holistic wound assessments and reassessments were documented* (BPS 2; Wounds UK, 2018a), and it was discussed with the patient how and why their notes were stored.

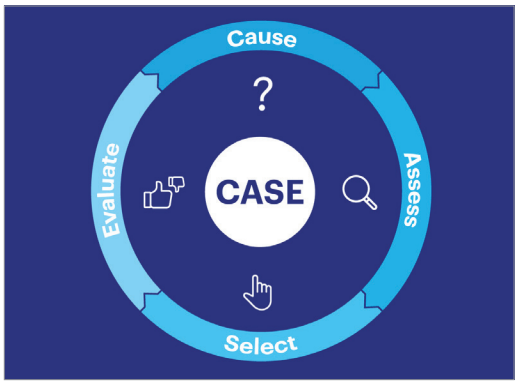


Figure 2. The CASE wound assessment framework takes a holistic approach for better wound healing outcomes

HOLISTIC WOUND ASSESSMENT

Establishing wound cause and type is fundamental to objective setting, care planning and management (BPS 5; Wounds UK, 2018a). The CASE (cause, assess, select, evaluate) wound assessment framework (Scott-Thomas et al, 2017) was used to assess the wound.

Cause of the wound

The patient walked past a building site and was knocked to the ground by a falling metal frame. She sustained large extensive bruising and closed haematomas to her left hip and her lateral gaiter area of the right leg (where the frame impacted). The haematoma to her lower limb later developed into a wound after hospital discharge.

Some of the clinical signs suggestive of venous disease to the lower limbs (i.e. presence of varicose veins and ankle flare) were observed so an ABPI assessment was included as part of the treatment plan.

Table 1. Open-ended questions asked during wound assessment (adapted from Moore et al, 2016; Wounds UK, 2018a)

Questions	Patient responses
What worries you most about your wound?	*"The wound is very painful, and I'm worried what [the nurses] will do and if it will hurt more. I have also been feeling anxious about the accident. It's been a while since I was discharged from hospital [5 weeks], and I am unable to leave the house. In the past, I would have been able to attend the GP nurse, for appointments. I can't now."*
How does your wound affect your ability to get on with every day activities?	*"I need someone to accompany me when going out. I've only been out once since coming home from hospital, and that was to go to the dentist for toothache. It's been painful to eat."*
How do you feel about doing some of the care for your wound yourself?	*"I don't feel comfortable changing wound dressings, but after seeing how the compression wrap works, I would be keen to participate in removal."*
Who else can be involved to help you manage caring for your wound?	*"My daughter, she lives locally."*

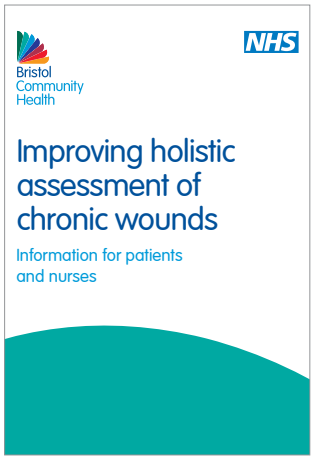


Figure 3. Patient information leaflet on 'Improving holistic assessment of chronic wounds: information for patients and nurses'

Assess the wound

Patient factors

A review of the patient's medical history and comorbidities should identify the factors that could hinder wound healing (BPS 4; Wounds UK, 2018a). The patient had been previously mobile, but was no longer able to leave the house because of wound-related pain and anxiety. She had also recently lost weight and had not been eating as well as before, potentially due to some toothache. She also felt very tired even though she was sleeping well. The patient was borderline hypothyroid and was monitored with blood tests every 3 months. A full blood count and thyroid function test (TFT) were ordered to discount recent changes.

The patient is widowed and has one daughter. Her son-in-law had recently begun chemotherapy, which was adding to the patient's distress and anxiety.

Table 2. Wound factors at initial assessment.

First appointment with the WCS, prior to conservative sharp debridement	
Wound location	Lateral gaiter area of right leg
Wound size	▸▸ 14cm (length) x 4cm (width) ▸▸ Measured with paper measuring tool
Wound depth	▸▸ 1.5–2cm ▸▸ Measured with measuring probe
Wound bed composition	100% necrosis/dry eschar
Wound edge condition	Non-advancing
Periwound skin condition	Healthy
Exudate level and description	Exudate level: Very low Exudate consistency: Thick Exudate colour: Red Exudate description: Haemoserous
Signs of local infection	No, however pain present
Wound pain (visual analogue scale; 0=no pain, 10=unbearable pain)	▸▸ 4 out of 10: especially at the bottom of the wound around the ankle area ▸▸ The GP prescribed codeine phosphate (30–60mg 4 times/day), as only discharged on paracetamol (1g 4 times/day)
Other underlying conditions that may cause or contribute to wound pain	▸▸ Tight eschar across the gaiter area ▸▸ Anxiety

Wound factors

A summary of the wound characteristics after initial assessment are in *Table 2*. The patient did not want to see photographs of her wound, so the wound dimensions was regularly mapped to show changes in wound size.

Select objectives and care planning

Based on the findings of the holistic wound assessment and discussion with the patient, a care plan should be devised to prioritise achievable objectives (BPS 6: Wounds UK, 2018). *Table 3* includes an overview of the treatment objectives. The aims were for some improvement or progress of each objective to be visible at each review, and for complete wound healing to occur within 12–18 weeks.

A patient information leaflet ('Improving holistic assessment of chronic wounds: information for patients and nurses' [*Figure 3*]) on what to expect in the next few weeks was given to the patient.

Evaluate treatment plan

Intermediate reviews

Intermediate reviews (shorter and less formal assessments) were conducted at each dressing change to monitor the patient and wound for improvement or deterioration that would require a change in management plan (BPS 7; Wounds UK, 2018). The objectives were evaluated at weekly intermediate reviews (*Table 3*).

HOLISTIC WOUND REASSESSMENT

A full holistic wound reassessment is required after 4 weeks of the initial assessment (BPS 8; Wounds UK, 2018). The patient factors that may hinder healing had not changed since the first assessment, but the patient's appetite had improved and she was generally feeling better.

A clean wound bed had now been achieved; the wound had advancing edges and had reduced in size by 33% (now measuring 11cm [length] x 4cm [width]). There had also been a reduction in wound pain, which made the patient feel less anxious and more confident in participating in self-care (i.e. removing and applying compression wrap).

Healing was on a positive trajectory and all involved were pleased to continue the same treatment plan.

Table 3. Treatment objectives and actions at initial assessment and intermediate reviews.

Treatment objectives	Initial assessment Baseline	Intermediate review 1 +9 days	Intermediate review 2 +16 days	Intermediate review 3 +23 days
				
▸▸ To monitor the patient and wound condition to detect improvement or deterioration		Improved	Improved	Improved
▸▸ To debride the wound bed of necrotic tissue and encourage granulation within 2 weeks ▸▸ To protect periwound skin ▸▸ To promote wound closure and re-epithelialisation	CSD at initial assessment. The patient was reassured throughout and the majority of non-viable tissue was debrided. At each subsequent dressing change, perform mechanical debridement until the wound bed is clean. Dress the wound bed with hydrogel sheets for autolytic debridement. Clean surrounding wound edges, and protect periwound area with skin protector spray.	15% granulation, a thin layer of slough over the wound. Continue with hydrogel sheet for 1 week.	100% granulation Debridement no longer required. Single-use NPWT vacuum dressing applied to accelerate wound closure for up to 4 weeks. Community nurses to review in 4 days with support and supervision from WCS.	100% granulation, no depth. Single-use NPWT vacuum renewed. The dressing will be changed in 1 week's time but may need re-dressing by the community nurse in 4 days' time depending on exudate level.
▸▸ To avoid pain	Check pain level and that analgesia has been given before dressing change. Ensure that patient is reordering analgesia from GP.	Pain much improved.	No pain.	No pain.
▸▸ To address tiredness (despite sleeping well)	To rule out anaemic issues, regular TFT brought forward, and undertake full blood count. Follow up results within 5–7 days. Communicate results to patient and action any requirements.	TFT: borderline abnormal. FBC: normal. Recommence regular TFT re-test in 6 weeks.	Taking thyroxine and eating better. Patient feeling "*much brighter*" in herself and not so tired.	
▸▸ To apply compression safely to both legs as signs of venous disease are present	ABPI delayed until next review as CSD has been quite traumatic. As per local protocol, 2-layer supportive bandages will be applied twice weekly until the ABPI assessment can be performed.	ABPI result: 1.2. Measure for JOBST® FarrowWrap. Begin high compression therapy using 2-layer bandaging system of inelastic and elastic components until wrap is available.	JOBST® FarrowWrap applied with sock over single-use NPWT dressing.	Patient demonstrated application, and is confident they can remove the JOBST® FarrowWrap at night and change the sock in between dressing changes.
Patient comments		Very happy with progress, and keen to participate in self-care with compression wrap.	Very pleased with progress and that her daughter can see the improvement. Patient found compression system comfortable.	Likes to see mapping of wound shape to show measurement.

ABPI=Ankle Brachial Pressure Index; CSD=conservative sharp debridement; FBC=full blood count; NPWT=negative pressure wound therapy; TFT=thyroid function test; WCS=Wound Care Service.

Select objectives and care planning

After reassessment, the objectives were to maintain and optimise the moist wound environment and to continue to promote independence and self-care (*Table 4*). The patient became more confident to participate in self-care and less anxious about issues relating to the wound. She was able to look at the photographs of the wound for the first time.

Evaluate treatment plan

The wound continued to reduce in size and was now on a healing trajectory. The clinician was confident that complete healing would occur within the 12–18 week estimation. Pain had reduced and analgesia was no longer necessary. The patient became less anxious and more confident participating in self-care. Over the treatment period of 8 weeks, the patient became aware of the implications of venous disease and the need to prevent recurrence and the importance of compression therapy, which should reduce the likelihood of complications following future trauma.

Throughout care, the patient's expectations were discussed and she felt well-informed and included in the treatment decision-making process. The patient was very grateful for the care she received and wrote a thank you card to the WCS: "*Thank you for your outstanding care and knowledge which helped contribute to my recovery*".

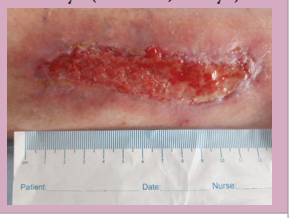
The patient was later discharged from the community nurses when she was no longer housebound.

FINAL COMMENTS

The case report presented here is a useful example of how the Best Practice Statement 'Improving holistic assessment of chronic wounds' can be used with the CASE tool to complete holistic assessment. Using the CASE assessment tool to complete the wound assessment with the Best Practice Statement for this patient had positive outcomes: the wound was reduced in size and depth, and was less painful to the patient. The patient became more confident to manage their own care, in part, due to the focus on their expectations throughout treatment.

The patient expectations are designed to encourage patient ownership of their health

Table 4. Treatment objectives and actions at holistic reassessment and intermediate reviews.

Objectives	Holistic reassessment +33 days	Intermediate review 1 +44 days	Intermediate review 2 +52 days	Intermediate review 3 +58 days (8 weeks, 2 days)
				
▸▸ To maintain and optimise moist wound environment to continue wound progression, and patient comfort and confidence ▸▸ To promote quick return to life without a wound	Clean wound bed with debridement cloth to debride 5% slough (95% granulation tissue). Protect periwound area with skin protector spray. Use single-use NPWT vacuum dressing. Compression wrap to be worn during the day. Patient will wash the liner when required and reapply a clean liner.	Decrease in wound size: 10.5cm x 3cm. Clean surrounding wound edges, and protect periwound area with skin protector spray. Single-use NPWT vacuum dressing applied for 1 more week.	Decrease in wound size: 10cm x 2.5cm. NPWT discontinued and foam dressing applied. Leg washed and creamed and compression wrap reapplied.	Decrease in wound size: 9cm x 2–2.5cm. Foam dressing reapplied, after leg washed and cream applied. Use of compression wrap continued.
▸▸ To inform and empower the patient to self-care, particularly to manage wound dressing changes, and to be able to manage compression wrap independently	Encourage and empower patient to change own wound dressings safely and confidently.	Patient can apply liner and wrap independently. Patient is keen to self-manage dressing changes.	Patient shown how to change dressing, wash and apply cream to the leg, in readiness for self-care.	Patient reshown how to remove and reapply wound dressing. Patient is confident using compression wrap.

NPWT=negative pressure wound therapy.

and empower self-care wherever possible. It is important to consider that patients' ability and willingness to engage will vary with levels of involvement tailored accordingly (Fletcher and Barrett, 2018). Patient's ability to self-care can also change throughout treatment, as it did for the patient featured in this case report.

The Best Practice Statement 'Improving holistic assessment of chronic wounds' emphasises the need for a wide-ranging holistic assessment that considers all aspects of the patient's health and wellbeing, resisting the temptation to make the wound the sole focus (Wounds UK, 2018a). It also provides tools and recommendations to complete holistic wound assessments, such as tips on how to communicate with the patient, emphasised by the unique patient expectations. WUK

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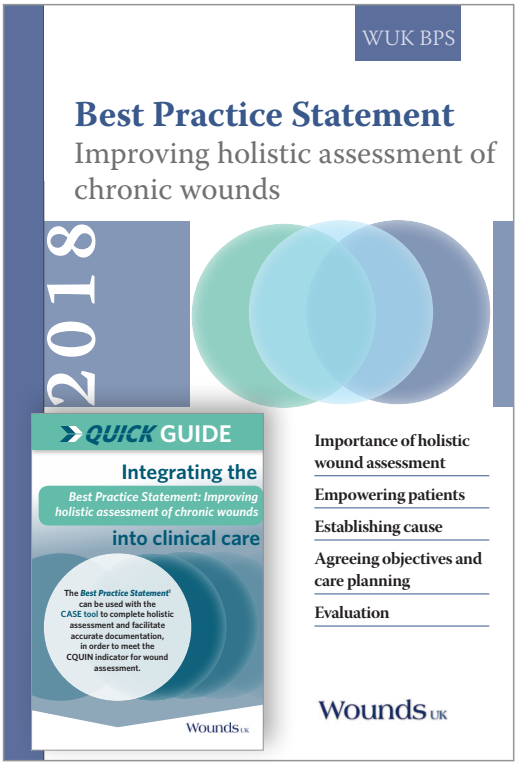

The Best Practice Statement: Improving holistic assessment of chronic wounds and associated Quick Guide are available free to download from Wounds UK at https://www.wounds-uk.com/resources/details/best-practice-statement-improving-holistic-assessment-chronic-wounds

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REFERENCES

Coleman S, Nelson EA, Vowden P et al (2017) Development of a generic wound care assessment minimum data set. *J Tiss Viabil* 26(4): 226–40

Guest J, Ayoub N, McIlwraith T et al (2015) Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 5(12):e009283

Fletcher J, Barrett S (2018) Improving holistic assessment of chronic wounds: how to meet patient expectation using the new Best Practice Statement. *Wounds UK* 14(5): 92–5

Lagerin A, Hylander I, Törnkvist L (2017) District nurses' experiences of caring for leg ulcers in accordance with clinical guidelines: a grounded theory study. *Int J Qual Studies Health Well-being* 12(1): 1355213

Moore Z, Bell T, Carville K et al (2016) *International Best Practice Statement: Optimising patient involvement in wound management*. London: Wounds International, 2016

NHS England (2016) *Commissioning for Quality and Innovation (CQUIN). Guidance for 2017–2019*. Publications gateway reference 06023. Available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Scott-Thomas J, Hayes C, Ling J et al (2017) A practice guide to systematic wound assessment to meet the 2017–19 CQUIN target. *J Community Nurs* 31(5) 30–4

Wounds UK (2018a) *Best Practice Statement: Improving holistic assessment of chronic wounds*. London: Wounds UK. Available to download from: www.wounds-uk.com

Wounds UK (2018b) *Quick Guide. Integrating the 'best practice statement: improving holistic assessment of chronic wounds' into clinical care*. London: Wounds UK. Available to download from: www.wounds-uk.com