# Best Practice Statement

## Optimising wound care

This document was supported by the financial assistance of ConvaTec. The views expressed in this publication are those of the authors and do not necessarily reflect those of Wounds UK and ConvaTec.

To reference this document cite the following:
*Best Practice Statement: Optimising wound care.* Wounds UK, Aberdeen, 2008

# CONTENTS

# Foreword

Clinicians who care for patients with wounds in the UK and Ireland are faced with the challenge of ensuring that their practice is of the highest standard, however, in order to do this they require the support of their organisations. Unfortunately, many healthcare providers have not committed to clear protocols that guide practitioners in the management of wounds and, as a result, many patients are managed without clear treatment goals or obvious pathways of care.

When a patient with a wound is managed inappropriately, they can suffer from failure to heal which results in the wound being present longer than is necessary and an increased risk of complications. Posnett and Franks (2008) stated that a high proportion of chronic wounds remain unhealed for long periods and for almost certainly longer than necessary. Such ineffective management can result not only in prolonged patient suffering, but also increased cost to healthcare organisations.

In order to set minimum standards and outline guiding principles with the intention of optimising wound care delivery, this *Best Practice Statement* has been developed by an expert panel (see opposite) chaired by Professor Keith Harding, following the key principles of best practice:

- Best Practice Statements (BPSs) are intended to guide practice and promote a consistent and cohesive approach to care.
- BPSs are primarily intended for use by registered nurses, and the staff who support them, but they may also contribute to multidisciplinary working and be of guidance to other members of the healthcare team.
- Statements are derived from the best available evidence, including expert opinion at the time they are produced, recognising that levels and types of evidence vary.
- Information is gathered from a broad range of sources to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature, and establish consensus.
- Statements are targeted at practitioners, using language that is both accessible and meaningful.

This best practice document is intended for use by all those involved in the care of patients with wounds, at both a clinical and managerial level, to aid in the delivery of a consistent, high standard of wound care across all care settings in the UK and Ireland.

## Expert panel

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# Introduction

Any patient with a wound has a right to expect a good minimum standard of care regardless of the aetiology of their wound, where the care is delivered or by whom. In many cases this occurs routinely. There are frequently excellent clinicians in place delivering high quality, cost-effective care (Fletcher, 2006).

Unfortunately such provision is not consistent as wound management in the United Kingdom and Ireland is generally not organised or delivered in a uniform fashion against measurable standards of care and with clear referral pathways (Moore and Cowan, 2005).

Despite the existence of national guidelines and frameworks produced by the Department of Health (National Service Frameworks [NSFs]), National Institute of Health and Clinical Excellence (NICE), Clinical Resource Efficiency Support Team (CREST) and the Scottish Intercollegiate Guidelines Network (SIGN) for some wound types, these do not always give practitioners a clear expectation for their standard of knowledge, assessment capabilities, and treatment delivery.

Education provision for clinicians can also be haphazard with little if any information on wound care delivered in pre-qualification programmes, and access to post-qualification programmes being restricted by availability and funding (Fletcher, 2007).

Currently access to some therapies is restricted depending on where the patient lives or where and by whom they are cared for. This may be related to the complexity and cost of products or equipment but may also be related to local protocol and service provision. Unfortunately, the importance of wound healing is not always understood by the decision makers (Gray, 2005). This is recognised by Baroness Bottomley (2007) who challenges NHS managers to ensure that they purchase or provide wound care services that are based on evidence and responsive to future developments, rather than relying on what has happened previously.

Posnett and Franks (2007) suggested that the current cost to the NHS of caring for patients with chronic wounds is in the range of £2.3–3.1bn (at 2005/6 prices), and that this will increase over the next 20 years because of the ageing UK population. It is crucial, therefore, that services provided are both clinically efficacious and cost-effective. Posnett and Franks (2008) suggested that with proper diagnosis and treatment much of this burden should be avoidable, and the delivery of optimal wound care achieved.

## Defining optimal wound care

Optimal wound care is care that addresses every need of the patient in order to maximise their quality of life while they have a wound. This involves addressing concurrent issues that may impact on their health, such as under-nutrition, illness and infection, the environment in which the care is carried out and the expertise available to provide the care. Moffatt and Vowden (2008) suggested that this involves a complex interplay with the patient, their wound, the knowledge and skills of the healthcare professional and availability of resources all being important in planning and progression.

Understanding the patient's beliefs and values in relation to their health should be an integral part of this process, as listening to and engaging patients in a collaborative plan of care encourages patient participation and, therefore, the setting of more appropriate goals, resulting in their timely achievement (Dowsett, 2008).

## What are the barriers to optimal wound care delivery?

Although the provision of wound care should be relatively straightforward it is often not so. Over the last 30 or 40 years wound care has changed dramatically with significant

developments in scientific research and clinical knowledge (Queen et al, 2004). This has led to an explosion of dressing materials and therapies and the development of tissue viability as a new speciality. Although tissue viability nurses have been in existence since the mid-1980s (and nurse consultants since 2000), there are still areas where no specialist has been appointed and many healthcare provider organisations have not committed to clear protocols that guide practitioners in the management of wounds.

The result of this is that many wounds are managed without clear care/treatment goals or referral pathways; dressings and therapies are used without considered supporting rationale, and care continues without appropriate evaluation and review.

There are many reasons why this is so, including:

- Lack of education provision at both pre- and post-qualification level across all disciplines
- Lack of commitment to tissue viability by the organisation resulting in no appointed lead or inadequate service provision
- Conflicting information (including evidence of efficacy and effectiveness of treatments)
- The low priority of wound care on both the local and national agenda
- Inter- and intra-professional politics
- Absence of a multidisciplinary approach
- A focus on short-term cost savings in an increasingly cost conscious health care environment.

Large scale audits carried out within the last 10 years suggest that these factors are leading to a high incidence of non-healing wounds (O'Brien et al, 2002; Moore and Cowan, 2005; Drew et al, 2007); in one study of patients with chronic wounds 28% remained unhealed for a year or more (Drew et al, 2007), and in an Irish study, 27% of patients were reported to have continuous ulceration for more than two years (O'Brien et al, 2002). This places an incredible burden on NHS resources and can have a significant and detrimental effect on the patient's life (Briggs and Flemming, 2007). In younger patients with chronic wounds there is also an impact on working capacity and job security, this may include formal employment or informal roles such as child care and, in some instances, leads to enforced retirement or a decision to stop working (Herber et al, 2007). Non-healing chronic wounds affect patients' lives emotionally, mentally, physically, and socially; they can be pivotal in preventing full recovery, increasing hospital stays and increasing the need for ongoing treatments (Spilsbury et al, 2007).

Although many healthcare providers do employ specialist nurses to drive their tissue viability services, the majority of patients are cared for by non-specialist general clinicians. Austin et al (2006) describe the challenges associated with the deskilling of general practitioners where strong expertise exists yet this is not the aim of either those employing or undertaking the specialist post. However, it is easy for busy general clinicians to abdicate responsibility for even the most basic wound care when they have multiple demands on their time, they have had little preparation in either their pre- or post-qualification training and there are no agreed national standards for what they are being asked to do. Furthermore, there is huge variability in the knowledge and skills of these clinicians with some care, particularly fundamental aspects such as skin assessment and care, being delivered by unqualified practitioners.

## How to deliver optimal wound care

In acknowledgement of the large number of practitioners involved in wound care, this document aims to provide a baseline or benchmark against which practitioners and organisations can measure their current service provision. It focuses upon the management of wounds by the non-specialist practitioner and has avoided defining who this practitioner might be. This document has been produced with the hope that its use will

ensure that all patients with a wound receive regular assessment and review with clear objectives defined for their care, reflecting both their wound care and more holistic general needs.

## Best Practice Statement: Optimising wound care

This document will present a care pathway for the patient with a wound. The pathway ensures that the patient is central to the care process, so that throughout the patient and what is best for them is considered and addressed. The pathway is cyclical, conveying the need for the patient to be continually reassessed and their treatment amended according to findings, until the desired outcome is achieved and they leave the pathway.

Each key stage of the care pathway is then elaborated upon in the best practice statement section of the document, with two sets of statements presented for the healthcare professional and the manager/service provider. The statements lead the clinician in a logical way through assessment and diagnosis to the setting of objectives and provision of care, or, where appropriate, to onward referral to specialist services. Definition of these steps, as well as providing guidance for the clinicians delivering care, also allows the organisation to plan and allocate resources in a logical and structured way. The focus on regular review encourages rapid detection and possibly prevention of complications, thus maximising the use of resources and optimising the patient's journey.

This document if applied correctly can aid the practitioner in ensuring that every patient with a wound is on a pathway leading to effective management whether that be healing, symptom management or an alternative goal. The document focuses the care clearly on the achievement of appropriate objectives with a regular review of progress and thus avoidance of routine or ritualistic care, where treatments can be continued for months and sometimes years with little or no improvement. It should also alert the clinician in a timely way to the presence of any complications which may delay progress, or of the need to make referrals to specialist services. Achievement of care objectives is not only beneficial to the patient but also a source of immense satisfaction for most clinicians, and appropriately planned and delivered care although occasionally 'expensive' in the short term is usually considerably more cost-effective in the long term.

For managers the provision of defined standards allows them to proactively plan and deliver services but also measure the outcomes achieved. It will allow hard-pressed clinical staff to treat more patients to a higher standard of care facilitating huge health economic benefits (Smith and Nephew Foundation, 2007). Failure to address these issues will result in escalating costs, failure to meet government targets and increasingly demoralised staff.

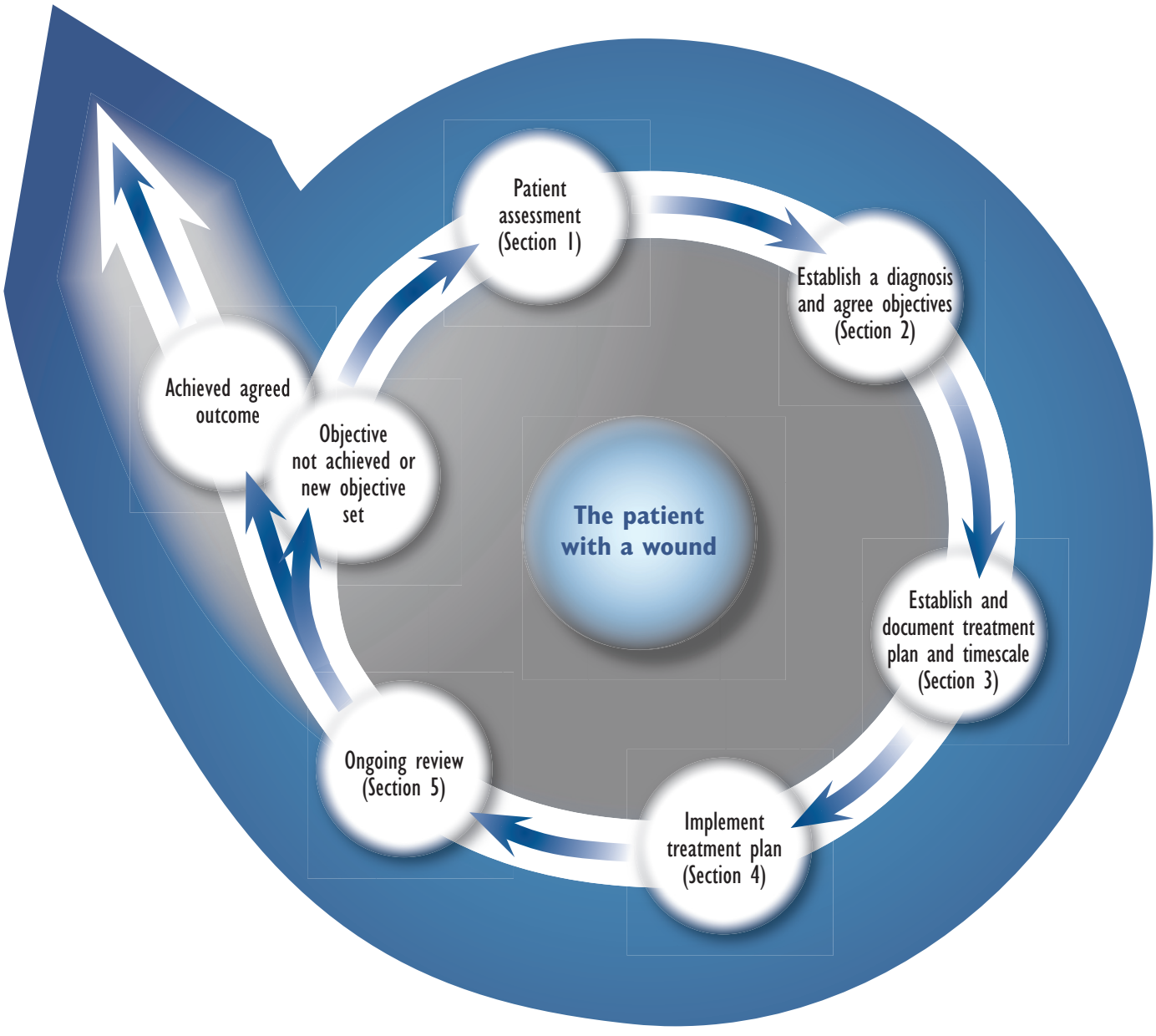
Every patient has the right to high quality care and the setting of best practice standards as laid down in this document is the first step towards achieving this goal.

## The pathway of care for a patient with a wound

It is helpful to have a structured approach to the assessment, diagnosis and management of any type of wound. This pathway presents the key stages of assessing and managing the patient with a wound, placing the patient and their needs at the centre of all decisions. The circular nature of the diagram shows that the patient must remain on the pathway, undergoing continual review of their treatment and wound progress. On review, treatment objectives may change according to the findings and, if so, the patient will require reassessment and the setting of new objectives, etc., continuing around the pathway until the desired outcomes are achieved. The patient may leave and re-enter the pathway at any point, for example, the patient may need specialist referral and leave once a diagnosis has been established, re-entering the pathway at the implementation of treatment.

Managers and service providers can also use the pathway, enabling their organisation to plan care and allocate resources in a logical and structured way.

By using this pathway and the accompanying best practice recommendations that make up the remainder of this document, the delivery of routine or ritualistic wound care can be avoided and optimal wound care that is tailored to the individual and their wound delivered.



## Section 1A. Healthcare professionals: patient assessment

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The practitioner should have sufficient training, knowledge and expertise before undertaking the assessment of any wound | ❖ Wounds can be multi-factorial and complicated in aetiology and management | ❖ The practitioner should be able to demonstrate a level of expertise via formal education and measured competency |
| ❖ The practitioner should take a full social and medical history of the patient, including:<br>• Presenting complaint<br>• History of the complaint<br>• Medical background (surgery, previous wounds, etc)<br>• Drug history<br>• Social background<br>• Nutritional status<br>• Psychological status<br>• Patient's perspective | ❖ These factors can give clues to the cause of wounding and/or delayed healing, and can influence the choice of treatment given, helping to ensure that all the needs of the patient are met | ❖ Patient history and current status should be accurately documented in the patient's notes |
| ❖ The patient's pain intensity should be investigated using a simple pain scale such as a visual, numerical or verbal scale, or pain diary (WUWHS, 2004) | ❖ The routine systematic use of a pain scale provides a method of measuring the success of analgesic and wound care choices (WUWHS, 2004). In some wound types, such as leg ulcers, pain is recognised as a prime cause of patient's non-concordance with treatment (Moffatt, 2004). Changes in levels of pain experienced may be an indicator of infection or a marker of improvement or deterioration of the wound or patient's condition | ❖ The case records should contain documentation of pain assessment, a management plan and evaluation indicating successful management |
| ❖ The patient should undergo a basic skin assessment to determine the condition of the skin (dry, flaky, excoriated, discoloured, etc). Skin should be observed, where appropriate, for varicose veins, varicosities, acute or chronic oedema, skin conditions and skin staining. A more complex examination may be carried out depending on specialty of the practitioner | ❖ Skin assessment enables the correct and suitable preventative measures to be initiated and maintained. It also allows identification of any underlying disease processes that may be responsible for wound development/chronicity and which may influence wound healing | ❖ Evidence of a skin assessment should be documented in the patient's notes |
| ❖ A risk assessment appropriate to local policy should be carried out if the patient is thought to be at risk of pressure ulcer development | ❖ Risk assessment provides early identification of the individual's level of risk and enables the correct and suitable preventative measures to be initiated and maintained | ❖ Evidence of an appropriate risk assessment must be documented in the patient's notes |

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The practitioner will undertake or request general or wound appropriate clinical investigations: | | |
| • Vascular assessment, such as Doppler ultrasound, ankle brachial or toe/brachial pressure index (ABPI or TBPI) or pulse oximetry index | ❖ To check for the presence or absence of arterial disease which will influence treatment decisions regarding compression therapy and other wound management. Abnormal values may indicate the need for further referral or investigations | ❖ Documentation of initial readings and interpretation of the result should be present in the patient's notes and an appropriate plan of action and specialist referral initiated and documented if outside the normal range |
| • X-ray or other radiological imaging | ❖ To check for bone and soft tissue abnormalities, e.g. osteomyelitis and bursitis | ❖ Evidence that the appropriate imaging investigations have been carried out should be provided |
| • Blood pressure | ❖ To establish the absence of undiagnosed hypertension/ cardiovascular disease which can contribute to the development of ulcers or add to factors which may delay healing (RCN, 2006) | ❖ Documentation of a blood pressure within the normal range or evidence of specialist referral if outside of these limits should be present in the patient's notes |
| • Weight | ❖ Obesity exacerbates venous hypertension and will require intervention by practitioner and patient (RCN, 2006) | ❖ Documentation of patient's weight and appropriate plan if outside normal range should be present in the case notes |
| • Urinalysis and random blood sugar | ❖ To check for undiagnosed diabetes (RCN, 2006) which can result in ulceration/delayed wound healing | ❖ Documentation of normal range of blood sugar and an appropriate plan and medical referral if outside the normal range should be available |
| • Moving and handling considerations should be assessed and documented including the correct use of equipment | ❖ Moving and handling issues should be assessed in order to reduce risks to the patient | ❖ Local guidelines should be available to assist staff in obtaining appropriate equipment including bariatric products where necessary |
| ❖ Investigations should be carried out by the appropriate clinician, who is able to interpret the findings and utilise the information to enhance the care of the patient | ❖ To ensure that expertise in a given area is utilised to benefit the patient and relevant members of staff | ❖ The efficacy of such investigations and the actions based upon them should be demonstrable<br>❖ Evidence of clear referral pathways to appropriate clinicians should be available |

## SECTION 1A. HEALTHCARE PROFESSIONALS: PATIENT ASSESSMENT (CONT.)

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The effect of wounding on the patient's quality of life should be established by asking the patient to consider the impact of the wound on their quality of life over time: has it worsened, stayed the same or improved? | ❖ By asking this simple question, the practitioner establishes a baseline against which the success of future treatment can be monitored, and involves the patient in their treatment | ❖ Evidence of the patient's response is documented in the patient's notes |
| ❖ The practitioner is able to anatomically describe wound location, accurately measure the size of the wound using a reproducible system, describe wound bed appearance, exudate volume and colour, wound odour, pain and condition of surrounding skin | ❖ Accurate assessment of the wound provides a baseline against which to measure the progress/success of treatment | ❖ Documentation indicates evidence of thorough wound assessment, treatment plan and evaluation of the plan |
| ❖ If a pressure ulcer is present, the practitioner should be able to grade the damage preferably using the EPUAP system (EPUAP, 2001) though other scales may be mandated by local policy | ❖ The use of a recognised severity scale enables all members of the multidisciplinary team to be aware of the severity of the pressure damage | ❖ Documentation contains evidence of the pressure ulcer grading according to the EPUAP scale or other scale approved in organisational policy |
| ❖ If a diabetes-related foot ulcer is present, the practitioner should be able to classify the ulcer using the San Antonio Ulcer Classification System, a common model used in multidisciplinary foot clinics in the UK (Armstrong et al, 1998) or another system mandated by local policy | ❖ Classification enables all members of the multidisciplinary team to be aware of the severity of the ulceration | ❖ Documentation contains evidence of classifaction of the ulcer using the San Antonio Ulcer Classification System or other scale approved in organisational policy |
| ❖ The practitioner should be aware of the extrinsic factors which can prolong the time to healing for example, pressure, shear, or a lack of moving and handling policy | ❖ To ensure the practitioner is able to make a full assessment of the patient, their illness and their surroundings | ❖ Auditing of documentation including risk assessment, case notes and outcome measurement, can be performed |

## Section 1B. Managers/service providers: patient assessment

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ A thorough patient assessment should be carried out by a skilled and competent practitioner adhering to local and national guidelines, when appropriate, at all levels in the service | ❖ The best possible evidence-based care should be readily available to all patients regardless of where their care is accessed. Providers should be able to support claims of providing best practice both for internal and external audit purposes | ❖ Regular audits of routine practice should benchmark services against best practice/guidelines. Patient complaint and satisfaction surveys should be carried out locally and regionally |
| ❖ Where relevant national guidelines exist, these should inform practice and should be supported by local health service guidance | ❖ Adherence to nationally accepted guidelines is an integral part of internal performance management metrics, while also contributing to national audit requirements (e.g. The Heathcare Commission). The health service is responsible for creating an environment which supports guideline implementation and compliance | ❖ Guideline audit data should be collected and measurement of guideline-related patient outcomes should be carried out. Staff should be surveyed to assess guideline-related knowledge and support. An audit trail should be in place to support compliance with guidelines/best practice principles |
| ❖ Health authorities should plan for the increase in patients with wounds and related problems due to demographic changes in the patient population | ❖ To ensure there are sufficient resources available to meet demand and to prevent acute shortages of capacity | ❖ Primary, secondary and tertiary care settings should demonstrate appropriate service development plans and associated wound care education for staff. All healthcare settings should ensure that the provision of tissue viability and other services such as podiatry match patient need |
| ❖ Regular audit of key outcomes should be carried out including wound infection, pressure ulcer prevalence and incidence | ❖ To encourage proactive management | ❖ Reporting of hospital infection figures, pressure ulcer prevalence and incidence will indicate monitoring/review of management strategies |
| ❖ Single patient assessment and multidisciplinary documentation should be available | ❖ To prevent duplication and to promote multidisciplinary care | ❖ The health service will provide evidence of multidisciplinary care records with single patient assessment |
| ❖ Procedures should be in place to ensure that funding follows the patient | ❖ Mechanisms should be in place to ensure that funding supports access to the best available care, regardless of setting | ❖ Funding should be arranged across the whole treatment pathway/local health economy, to avoid disruptions in treatment across secondary, primary and community care settings |

## SECTION 1B. MANAGERS/SERVICE PROVIDERS: PATIENT ASSESSMENT (CONT.)

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Care pathways should be developed that ensure the patient is seen by the most appropriate person | ❖ To avoid inappropriate specialist care and ensure the efficient use of healthcare resources | ❖ Documentary evidence should be provided which demonstrates that all disciplines have clear guidance as to when to refer patients to specialist services. Existing care pathways should be audited |
| ❖ Where possible, patients should remain in a primary care setting with easy access to specialist services when required | ❖ To ensure that scarce healthcare resources, particularly in secondary care, are used optimally | ❖ Evidence should be provided which demonstrates support for patients in community settings. Audit of patients admitted to secondary care with wound-related problems should be performed |
| ❖ Staff should be provided with the opportunity and support to update their knowledge of wound management in areas relevant to their usual clinical work | ❖ Each organisation has a responsibility to support staff in ensuring their knowledge levels match the requirements of their role | ❖ The organisation should keep a register of staff training in the area of wound management and this should be audited annually. Knowledge levels should be reviewed individually at the practitioner's personal development review |
| ❖ All patients regardless of their referral route or geographical location or care setting should be able to access a practitioner capable of conducting an accurate assessment of their wound | ❖ Equity of access/care is a key government aim. In some cases patients are unable to access accurate assessment because of local practices, e.g. access to tissue viability in secondary care but not primary care | ❖ Patients and staff should have access to clear, seamless referral routes |
| ❖ Staff required to deliver care/treatments should be competent before undertaking the care/treatment, and, if they are not, should have a clear reporting structure | ❖ If staff feel under pressure to deliver care/treatments they are not trained to deliver the patient can suffer; a reporting structure allows skill deficits to be identified | ❖ A clear reporting structure for staff who identify a deficit in their skills should exist within each organisation. This should be addressed at personal development review and a plan of action to support learning needs developed. A database of competency for advanced skills such as sharp debridement should be maintained |
| ❖ Professionalism and accountability should be nurtured within the care setting | ❖ To ensure staff are motivated and that patient care is of the highest standard. To encourage staff to develop and flourish within the scope of their roles | ❖ Staff and patient surveys should be carried out to ascertain the level of patient and staff satisfaction within the care setting |

## Section 1B. Managers/service providers: patient assessment (cont.)

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Both staff and patients should have access to care/ treatments/products which are both clinically and economically effective | ❖ Using care/treatments/products which are not economically and clinically effective can lead to sub-optimal care/treatment. Evidence-based national, regional or local wound care formularies should be developed, with inclusion being based on the value of the product rather than the price. Healthcare professionals should be integral to formulary decisions | ❖ Adherence to national or regional or local wound care formulary should be evidenced through an audit trail |
| ❖ Health authorities should encourage benchmarking care with centres of excellence | ❖ To measure practice against what is considered to be optimal care delivery | ❖ Regular audit of patient outcomes and patient satisfaction surveys should be carried out locally and regionally. Audit of documentation compared with recognised centres of excellence should be carried out |

# SECTION 2A. HEALTHCARE PROFESSIONALS: ESTABLISH A DIAGNOSIS AND AGREE OBJECTIVES

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The practitioner must recognise that the diagnosis is either absolute or provisional | ❖ To allow continuity of care within all care environments | ❖ Evidence should be provided which demonstrates a clear assessment methodology and the use of logical diagnostic tests |
| ❖ The practitioner must be aware of, and able to predict, any complications | ❖ To protect the patient and ensure that untoward events are dealt with and the patient is protected at all times | ❖ Documentation of untoward events or complications should provide evidence that appropriate care has been provided |
| ❖ The practitioner must be able to identify any factors that can influence outcome, such as:<br>• Unrelieved pressure<br>• Poorly fitting footwear<br>• Poor glycaemic control<br>• Malnourishment<br>• Smoking<br>• Excess alcohol intake.<br>The practitioner must be able to communicate the effects of the relevant factors on outcome to the patient | ❖ There are a number of factors which can impact on wound healing (and contribute to wound development) and which can be identified and addressed. Some aspects of treatment are partially dependent on the effectiveness of patient behaviour | ❖ Identified factors must be documented in the patient's notes along with evidence that appropriate action has been taken, such as the patient has been informed of the impact that their lifestyle choices can have on wound healing |
| ❖ The primary treatment goal of the patient should be established. Depending on wound type, there may be short and long-term treatment goals. All goals should be patient-centred and pragmatic, based on wound characteristics | ❖ Clinicians need to be aware of the objectives of treatment in order to plan and evaluate care. Achieving concordance with the management plan requires agreement between patient and clinician | ❖ There is documented evidence of the agreed goals of treatment in the patient's notes |
| ❖ The practitioner may need to negotiate treatment outcomes with the patient where necessary | ❖ To engage the patient and empower them in the care of their wound, and to get their agreement with treatment decisions and goals | ❖ Documentation should reflect patient involvement in decision-making and patient information should be available |
| ❖ The practitioner must ensure that the goals set are appropriate and achievable | ❖ Gold standard care should be readily available to the patient | ❖ Case notes should reflect optimal care has been provided |

## Section 2B. Managers/service providers: Establish a diagnosis and agree objectives

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Wound management should seek to improve wound status and minimise the impact of their wound on the patient's quality of life. Staff should work in partnership with patients, including them in care decisions | ❖ Patient quality of life should be a key concern when making care decisions. Patient concordance is key to the success of treatment | ❖ Evidence should be provided that the patient's quality of life has been considered in treatment decisions. Patient satisfaction surveys which include quality of life measures should be integrated into audits of practice. Consideration should be given to how best to capture patient quality of life or patient outcomes |
| ❖ The patients' privacy and dignity should be protected at all times | ❖ Patients have a right to privacy, dignity and confidentiality | ❖ Evidence should be available that case notes and images are not accessible by unauthorised persons. Documentation should be protected from the public and this should be evidenced. Images stored on computer systems should be encrypted. Consent forms should be in evidence before photos are taken and local policy adhered to when storing the images |
| ❖ Patients' cultural and ethnic background should be treated sensitively | ❖ This may impact on care decisions and practitioners should be aware of cultural needs of patients | ❖ Evidence should exist that there is inclusive policy in place to inform staff of the cultural needs of patients |
| ❖ Optimal patient function/independence should be encouraged by the institution and appropriate services should be made available | ❖ To allow the patient to make a full recovery beyond wound healing | ❖ The health authority should provide evidence that the patient pathway provides access to the appropriate services |
| ❖ Risk assessment should be carried out at all stages of the patient journey, e.g. infection control, moving and handling, pressure care and complications | ❖ To identify potential risk factors thus allowing preventative strategies to be employed | ❖ Documented evidence should be available that strategies are in place to minimise risks to patients and to prevent problems occurring |

## SECTION 2B. MANAGERS/SERVICE PROVIDERS: ESTABLISH A DIAGNOSIS AND AGREE OBJECTIVES (CONT.)

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Pressure-relieving equipment should be provided whenever necessary, that is appropriate for the assessed needs and acceptable to the patient | ❖ To minimise the risk of pressure ulcer development | ❖ Prevalence and incidence data should be reported to allow assessment of performance, taking into account the at-risk population |
| ❖ Services should be shaped around the appropriate national policy documents: *Standards for Better Health* (2006); *Designed for Life* (2006); *Better Health, Better Care* (2007); *Health Transformation Programme* (2007) | ❖ To ensure that services are shaped to fit with national guidelines and care priorities | ❖ Evidence of alignment of care strategies with national guidelines. Practice should be measured against the recommendations in the relevant policies |

## Section 3A. Healthcare professionals: Establish and document treatment plan and timescale

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The treatment plan should be shared with the patient, even if in a simplified form, so they can monitor the progress of their treatment | ❖ Patient will know that they are making positive progress as treatment goals are met | ❖ Documentation exists that the patient has been involved in treatment decisions |
| ❖ When initiating wound care treatments the patient should have optimal care of concurrent illnesses by the multidisciplinary team | ❖ In order to maximise the patient's wellbeing and wound healing potential | ❖ Documented evidence of care given and charting of progress should be available |
| ❖ Details of any shared care should be included in the treatment plan | ❖ Management of the wound and any underlying conditions may demand the skills of several specialist practitioners | ❖ Documentation of the assessment and interventions of each specialist is made in the patient's records |
| ❖ The patient should be involved in treatment decisions and be made aware of possible outcomes relating to quality of life | ❖ Wound healing may not always be achievable, but symptom control such as reduction in pain or exudate can greatly improve quality of life | ❖ Evidence of patient satisfaction should be provided and their involvement in decision-making should be recorded in the patient's notes. Audit of documentation and patient survey may provide evidence of patient involvement |
| ❖ The treatment plan should be reflective of assessment findings | ❖ To provide continuity and rationale for care decisions | ❖ Regular audit of documentation at local and departmental level should be carried out. A patient satisfaction survey should be carried out at local level |
| ❖ A timescale for patient and wound review should be included | ❖ To allow appropriate evaluation of wound progress or deterioration | ❖ Evidence of regular audit of documentation on a local level should exist. Wound infection incidence data should be collected where appropriate |
| ❖ The practitioner will be aware of their responsibilities in the health education of the patient/carer and provide information in a form and at levels suited to the individual | ❖ Information both given and received engenders trust and respect and assists in achieving concordance with the treatment plan | ❖ When asked by the practitioner, the patient and/or carer is able to demonstrate their understanding of their disease, fully participate in the care and comply with treatment programme |
| ❖ The practitioner should have the knowledge to select the most appropriate wound management treatment for the patient, based on the assessment of the patient and the wound, e.g. analgesia, antibiotics, pharmacological therapy, wound dressing | ❖ Patients should receive the most appropriate treatment for them as an individual | ❖ Thorough assessment and documentation of a treatment plan with accompanying rationale which is consistent with local organisational policy and guidelines should be recorded in the patient's notes |
| ❖ Care should be documented in a single multidisciplinary document | ❖ To provide continuity of care among all staff | ❖ Documentary evidence that shared access is a reality |

## SECTION 3B. MANAGERS/SERVICE PROVIDERS: ESTABLISH AND DOCUMENT TREATMENT PLAN AND TIMESCALE

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ All patients should have a clear documented care pathway which reflects the initial assessment and is accessible to all healthcare professionals working with the patient | ❖ This is a legal and professional requirement that must be regularly updated. This ensures all staff understand the patient's care needs and prevents duplication of information | ❖ Documentation audit should be carried out to ensure that all patients have a treatment plan that is timely and relevant to their health needs |
| ❖ All staff involved in providing care should have the appropriate knowledge and skills to care for the patient | ❖ To protect the patient and ensure that care is of the highest quality | ❖ Staff should demonstrate the ability to work within their own scope of practice and knowledge and skills should be assessed at individual personal review. Clear referral pathways should exist which allow staff to transfer care to specialist services |
| ❖ Professionalism and accountability should be nurtured within the care setting | ❖ To ensure staff are motivated and that patient care is of the highest standard. To encourage staff to develop and flourish within the scope of their roles | ❖ Staff and patient surveys should be carried out to ascertain the level of patient and staff satisfaction within the care setting |
| ❖ Policy should reflect the need for multidisciplinary integrated care | ❖ Local policy should reflect the need for quality care provided by highly qualified staff working together | ❖ The care setting/institution should provide evidence that integrated care is promoted and encouraged within local guidelines |
| ❖ Health authorities should plan for the increase in patients with wounds and related problems due to demographic changes in the patient population | ❖ To ensure there is sufficient planning and prevent crisis and over stretching of future services | ❖ All healthcare settings should demonstrate investment in wound care education for staff. All healthcare settings should establish tissue viability and other services which match patient need |
| ❖ Staff should be aware of all options for treating wounds which will include knowledge of dressings, devices, drugs and surgery and other interventions which may be necessary | ❖ Patient and staff choice is vital to allow the patient to have optimal care. The choice of treatment should be evidence-based wherever possible | ❖ Evidence that staff receive appropriate education relating to all wound care treatments and diagnostics should be available. Patient outcomes should be measurable at all stages of the patient journey. Staff should provide evidence of their knowledge and ability to provide optimal treatment for patients |

## Section 3B. Managers/service providers: establish and document treatment plan and timescale (Cont.)

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Local and national guidelines should be adhered to where possible<br>❖ All treatment provided should be done so with adherence to local and national infection control guidelines | ❖ To ensure that care is provided with the best evidence available to support that care<br>❖ To reduce the risk of HAI. To improve the quality of patient care. To reduce the spread of infection within the care setting | ❖ Auditing or measuring of services according to the guidelines which have been published<br>❖ Regular audit of both HAI and other infections which may occur. Publishing of audit reports. Evidence of staff education programmes |

## Section 4A. Healthcare professionals: Implementation of treatment plan

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Before initiation of invasive treatment/photography the practitioner should obtain and document written informed patient consent | ❖ To provide legal support for interventions and inform the patient of the risks and benefits of the procedure | ❖ Audit of documentation and patient questionnaire |
| ❖ Treatment should be evidence-based or based upon best practice recommendations in accordance with local and/or national guidelines where appropriate | ❖ National and local guidelines can provide evidence to support practice decisions | ❖ Treatment recorded in the patient's notes is supported by national/international guidelines |

## Section 4B. Managers/service providers: Implementation of treatment plan

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Treatment should be evidence-based where such evidence exists | ❖ Quality of care should be the goal for all patients and evidence is one way to ensure this is the case. Evidence-based treatment ensures that the patient accesses the best proven treatment while ensuring that resources are allocated efficently | ❖ Care settings should be aware of and implement local/national guidelines that reflect best practice or evidence-based treatment for the specific client group. Evidence should be provided which demonstrates treatment is measured against the national standard |
| ❖ Patient choice should be included in all treatment decisions | ❖ To involve the patient in their care. To allow informed consent to treatment. To empower the patient | ❖ Documented evidence that patients are involved in their care decisions. Patient satisfaction surveys will provide relevant feedback |
| ❖ Staff required to deliver care/treatments should be competent before undertaking the care/treatment and if they are not should have a clear reporting structure | ❖ A clear reporting structure allows skill deficits to be identified | ❖ A clear reporting structure for staff who identify a deficit in their skills should exist within each organisation. Annual performance review should be used to develop an action plan to address any deficits |

## Section 5A. Healthcare professionals: Ongoing review

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ The practitioner should carry out regular reassessment of the wound,at each dressing change, or on a regular basis if changed by patient/carer, according to the patient's condition and/or if the individual's condition changes for the better or worse | ❖ To assess wound healing outcomes, to identify potential adverse incidents and take appropriate remedial action. To identify potential difficulties (with products) in product application. To ensure clinical and cost effectiveness which ensures appropriate use of healthcare resources | ❖ Patient assessment and response to treatment with measurable end points such as condition of the wound bed, pain reduction, wound tracings or measurements and clinical photographs should be recorded in the patient's notes |
| ❖ Patient review should be planned, timely and comprehensive, reflecting the original treatment objectives | ❖ To gain agreement from the patient. To maximise benefits of given therapy. To compare progress with set objectives | ❖ Local level audit of patient satisfaction by staff or ward manager. Evidence of appropriate use of products within documentation |
| ❖ The practitioner should determine the patient's satisfaction with treatment and if they are being concordant | ❖ To ensure that the patient is involved in their own care plan and to empower them | ❖ This should be assessed by the staff at ward level and documentary evidence should be provided. Patient questionnaires could be carried out to assess this |
| ❖ On assessment, the practitioner should identify if the treatment plan is successful and has met the agreed objectives, e.g. debridement, exudate management, reducing bioburden | ❖ To allow progress to be compared to agreed objectives | ❖ Audit of outcomes at stages along care pathway. Audit of therapies used and effectiveness |
| ❖ On assessment, if the outcomes are not being met, the practitioner must be able to determine why this is, e.g. does the plan need more time, is the treatment appropriate, are there resource issues (funding, products, staffing, skills)? The practitioner must adapt the treatment plan as necessary | ❖ To encourage regular re-evaluation and encourage adaptation of goals to enhance patient care | ❖ Evidence that objectives are re-evaluated when necessary. Evidence that the clinician can adapt care to make \| progress possible |
| ❖ If outcomes have been met the patient can be discharged from the care of practitioner into care of other agency/care area | ❖ To ensure that patient and staff objectives have been met. To provide continuity of care between other healthcare providers | ❖ Evidence should be provided which demonstrates that objectives have been achieved and that accurate information is safely and completely transferred to other providers |

## SECTION 5B. MANAGERS/SERVICE PROVIDERS: ONGOING REVIEW

| Statement | Reason for statement | How to demonstrate statement is being achieved |
|---|---|---|
| ❖ Guidance should be in place to promote regular and thorough patient reassessment with clear pathways for specialist referral available if required | ❖ To examine effectiveness of treatment. To monitor problems with treatment or the wound, such as infection. To ensure that patients are referred to the correct specialist according to need | ❖ Evidence of clinical guidance should be available. Staff should be able to demonstrate awareness of the care pathways involved and how to ensure appropriate specialist referrals are made |
| ❖ Both staff and patients should have access to care/ treatments/products which are both clinically and economically effective | ❖ Using care/treatments/products which are not economically and clinically effective can lead to sub-optimal care/ treatment | ❖ Each organisation should ensure its staff have access to a formulary which includes care/treatments/products which are clinically and economically effective |
| ❖ Where possible, care delivery should be closer to home, for example, one stop management | ❖ To improve patient access/satisfaction and to ensure that healthcare resources are used efficiently | ❖ Where possible, healthcare settings should be encouraged to provide multidisciplinary care in central locations that are easily accessed by patients. Local policy should reflect the need to move care towards the primary sector and if possible the patient's home |
| ❖ Quality of life should be seen as a primary outcome of care. Patients should be part of the decision-making process and included in care decisions where possible | ❖ Care should not be provided which negatively impacts on the patient's quality of life. Patient concordance is key to the success of treatment | ❖ Evidence should be provided that the patient is involved in treatment decisions. Patient satisfaction surveys should be carried out |
| ❖ Review procedures should be measured against best practice and/or national guidelines | ❖ To ensure that patient review is thorough, accurate and is used to determine future treatment provision | ❖ Regular audit and comparison with national guidance should be carried out |

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# Notes

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Date of preparation: July 2008