

## Looking back at 10 years of wound care in the UK



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Welcome to the first issue of *Wounds UK* for 2014! Jacqui and I both hope you all had an enjoyable and restful Christmas and New Year and are ready to the challenges and opportunities that a new year brings.

This issue marks the 10<sup>th</sup> anniversary of Wounds UK. We remember the past decade in wound care in three special reports in this issue: Samantha Holloway looks at how wound care has grown as a specialism through higher education programmes; Caroline Dowsett examines the changing face of the NHS over the past decade; and Ellie Lindsay describes the revolution in patient engagement in care.

We are sure that everyone is exploring new ideas and innovations as to how we manage and improve quality of life for individuals who have a wound, as well as their families/carers. There is a wealth of research and evidence that focus on quality of life and promote wellbeing for those people who have a chronic wound (i.e. leg ulcer, pressure ulcer, infected wound etc) yet, surprisingly, there is very little investigation into how a non-infected wound can impact upon quality of life and wellbeing.

As clinical practitioners, academics, and researchers in tissue viability and wound care, we know that a large proportion of hospital beds, both private and NHS, are occupied by a person who has a wound. Many of these wounds will require little intervention from a healthcare practitioner or specialist as they heal with no problems. On discharge to the community, there is little follow-up service afforded to this group of people, providing there are no underlying medical conditions requiring medical/nursing interventions.

However, we believe these people require some type of wound care support on discharge to the community. Their “physical” wound may follow the normal, uncomplicated healing trajectory, but are we certain the wound itself is not causing other issues? For example, lower-limb surgery may cause the patient to struggle with bending down or getting dressed, while hand surgery may prevent

the fastening of zippers, tying shoelaces, cooking, cleaning etc.

In addition, what if the dressing is unexpectedly removed following a shower or bath – does the patient and their family/carer want to examine this wound? Are they able to recognise any early signs of inflammation or infection? These subtle changes to a person’s ability to maintain their normal activities of daily living can lead to physical problems, social concerns, emotional stress, and functional complications that can also lead to families/carers changing their own routines to meet the needs of the person with a wound.

Quality of life can be measured using a variety of tools (i.e. the Cardiff Wound Impact Schedule, SF12, and SF 36, to name a few), yet no one tool explores the physical, emotional, and functional complications for those with a non-infected wound.

As you all read this, I (Karen) will have been to Australia to explore and understand how we can improve quality of life and wellbeing for people living with a wound with academic and clinical colleagues, patients and carers in Western Australia, Alice Springs, Melbourne, and Brisbane.

This exciting adventure has been made possible through a Travel Scholarship with the Florence Nightingale and James Tudor Foundation. I urge you to access their website to see the great work they undertake and support. If you have an idea to improve patient care then you may want to consider applying for funding. The work you wish to explore does not have to be international. Their website is: [www.florence-nightingale-foundation.org.uk](http://www.florence-nightingale-foundation.org.uk).

It seems that travel is on the agenda. I’m (Jacqui) off to Baltimore at the end of the month to participate in the National Pressure Ulcer Advisory Panel (NPUAP) consensus meeting, the purpose of which is to:

- ▶ Define physical and pathophysiological variables likely contributing to the development of unavoidable pressure ulcers.
- ▶ Describe patient characteristics who develop unavoidable pressure ulcers.

► Propose criteria to substantiate the claim that the ulcer was unavoidable.

Despite the huge amounts of work focussed on reducing the number of pressure ulcers it seems that clinicians are still challenged, but sadly it seems more by the bureaucracy than by the patients. Many organisations have implemented robust ways of identifying at risk patients and mechanisms to reduce that risk, however, reporting systems remain complex and time consuming and the lack of agreed definitions mean that data are still not comparable.

This meeting in the USA is welcome as it provides an open forum at which the complexity of deciding avoidability can be discussed. It would be remiss of me not to suggest that a similar event is much needed in the UK and perhaps it could be broader than avoidability and look at what we do and don't count. The exclusion of device-related pressure ulcers from the NICE guidance has been a real blow for many clinicians who have worked hard to ensure that every single pressure ulcer is reported – yet it seems NICE is dismissing these as of lesser importance. We also need to return to the thorny issue of “do we even bother with giving a numerical category to the damage” as, increasingly, it seems there is such a lack of consistency in what is reported. Perhaps we need to go back to basics and think clearly about what we are counting and, much more importantly, WHY?

It is almost a year since the Berwick Report and I clearly remember being delighted with his statement that we should use quantitative targets with caution: “Goals in the form of such targets can have an important role en route to progress but should

never displace the primary goal of better care. When the pursuit of targets and prudence ... becomes the overriding priority the people may focus too narrowly. Financial goals require special caution; they reflect proper stewardship but are only a means to support the mission of the NHS: healing.” It also states: “Whilst ‘zero harm’ is a bold and worthy aspiration, the scientifically correct goal is ‘continual reduction’” (National Advisory Group of Patient Safety in England, 2013).

Yet it seems we are still counting pressure ulcers without any clear understanding of how – or indeed if – it will make any difference to the care patients receive.

We are told repeatedly that we need to change the culture of the NHS (Department of Health, 2014), but perhaps what we need to do is start with a clean slate, instead of looking at what we can count and how we would do it, start with what we want to know and why? What will we do with that information once we have it and how will it impact on care and outcomes for our patients? Radical perhaps, but as staffing shortages seem to be grabbing the political headlines (BBC, 2014) we need to ensure that we make the best of our most precious resource – our staff and their time. 

#### REFERENCES

- BBC (2014) *Lib Dems Plan Nurse Numbers Law for Welsh Hospitals*. Available at: <http://bbc.in/1nGYuv> (accessed 17.02.2014)
- Department of Health (2014) *Jeremy Hunt: Message to NHS Staff One Year on from Francis Report*. Available at: <http://bit.ly/1aNTZ1R> (accessed 17.02.2014)
- National Advisory Group of Patient Safety in England (2013) *A Promise to Learn – A Commitment to Act. Improving the Safety of Patients in England*. Williams Lea, London

### Writing for Wounds UK

Wounds UK welcomes a range of articles relating to the clinical, professional, and educational aspects of wound care. If you have written an article for publication it can be submitted online at <http://www.epress.ac.uk/wuk/webforms/author.php>

If you are interested in writing for us and would like to discuss an idea for an article, please contact the Managing Editor, Edda Hendry on 0207 960 9612 or email [edda.hendry@woundsgroup.com](mailto:edda.hendry@woundsgroup.com)

