

Reflections from down under: understanding quality of life



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In this editorial, I want to share my experiences of a travel scholarship undertaken in February 2014. I was awarded a Florence Nightingale Foundation Travel Scholarship last year that enabled me to visit Australia to investigate and develop my understanding of quality of life and wellbeing for people living with a wound. I would like to thank the Florence Nightingale and James Tudor Foundation, without whom I would not have been able to undertake this fascinating journey.

The study tour included visiting the Royal Perth and Fremantle hospitals; Silver Chain Healthcare and Curtin University; Alice Springs, Northern Territories; the Australian Catholic University, St. Vincent's Private and Public Hospital, Melbourne; and Queensland University of Technology, Brisbane.

I left the cold and wet UK at the end of January 2014 to arrive in a sunny Western Australia. It was very odd to see the sunshine in February and as a typical Brit overseas, I commented on the weather. However, this comment in itself provided an insight into the differences between countries when managing quality of life for patients with wounds; for instance, many people are discharged home to housing that has no air conditioning.

If the treatment of a wound involves bulky dressings and bandages, the heat can prove a barrier to concordance, with patients wanting to remove the dressings to allow the affected area to cool down; something we probably never have to worry about! There was also a clear difference between the role of the Tissue Viability Nurse (TVN) in the UK than in Australia. In Australia, the TVN role is the wound, ostomy and continence nurse, and is responsible for all three areas.

The distances patients had to travel to access specialist care in Australia was breathtaking. In the UK, we see a couple of hundred miles as being a long distance, yet in Australia, this is seen as being 'just around the corner'. Patients accessing specialist services would use air travel as the preferred means of travel and were accepting of the need to board a plane for an outpatient appointment. However, this

is obviously costly both in financial and social terms and, as such, telehealth is used as much as possible. I was lucky enough to observe a telehealth clinic and believe that here in the UK we should be exploring the use of this in more depth. Even though we do not expect patients to travel thousands of miles, there are still rural areas, for example, in the north of Scotland, where patients find it difficult to easily access services.

I was shocked at the extent of burns seen in Western Australia caused by fire and the debilitating effect they have on both the patient and their families' lives. The Burns Unit worked in an interdisciplinary fashion and it was clear that all members of staff, regardless of professional group, were respected for their ideas and views. The patients and families were kept at the centre of all care interventions and were instrumental in all care planning activities.

The concept of quality of life and wellbeing was an integral aspect of all care administered, with research being undertaken to ensure that quality of life was maintained. Interestingly, burns were perceived to be an acute wound with chronic side effects, for example, changes to family and personal relationships and altered body image, with referral to psychology being an integral aspect of the care package.

The importance of working as an interdisciplinary team was prevalent throughout my visit across Australia. At the Fremantle Hospital, Perth, a team comprising vascular surgeons, endocrinologists, podiatrists, nurses, dieticians, occupational therapists and physiotherapists, worked together in a wound care clinic. This team ensured that each patient was only required to attend for one appointment and would be seen by all members of the team. This guaranteed that the patient did not have to attend multiple clinic appointments and maintained quality of life for the patient and their family.

While in Alice Springs, I learnt that renal disease was ten times more common among

indigenous people than among non-indigenous people; diabetes was more than three times more common among Indigenous people than among other Australians. The care interventions in this area of Australia recognised this and services were in place that allowed ease of access to renal dialysis and specialist practitioners in the field of diabetes. More importantly, healthcare staff were aware of the various cultural and spirituality needs of the indigenous population and ensured these needs were met to maintain quality of life for patients, who were often 1,000s of miles away from their home community.

During the tour, I held many discussions with healthcare practitioners from a range of professional groups, academics, researchers and patients, exploring how to manage and appreciate quality of life and wellbeing. We all agreed that the management of quality of life outcomes for a patient

with a chronic wound is well established, researched and implemented, however, for those patients who have an acute or a non-infected wound, there is less research available. This may be due to the wound having no physical complications, yet the wound can still affect daily living — the individual may need to make changes to social activities, their mental health may be affected, there may be a reduction in mobility and depression may develop. This is an area that requires further research and investigation on a global level. As does the importance of meeting the needs of various cultural groups and understanding their spirituality needs.

I would like to thank all of the staff and patients who allowed me to observe them during my trip and would encourage anyone who wants to develop patient care to apply to the Florence Nightingale Foundation travel scholarships to make their ideas a reality.



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