

Optimising Wound Care in the UK and Ireland: a best practice statement

In the UK and Ireland, many patients with wounds are managed without clear treatment goals or obvious pathways of care, since many healthcare providers have not committed to clear protocols that provide wound management guidance. In order to set minimum standards and outline guiding principles with the intention of optimising wound care delivery, the Best Practice Statement *Optimising Wound Care* was developed for use by both healthcare professionals and service providers. By using the document, ritualistic care can be avoided and optimal care delivered that is tailored to the individual and their wound.

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KEY WORDS

Optimising wound care
Best practice statement
Care pathway
Wound care service provision

In the UK the actual number of patients with chronic wounds and the cost of managing them is largely unknown. However, it is well accepted that as the population continues to age and as patients live longer with chronic long-term conditions (the most common complication of which is often a chronic wound) (Harrison, 2006), the number of patients with wounds, and therefore associated costs, will increase.

There have been many studies which demonstrate the impact of having a chronic wound on the quality of life of both the patient and those caring for them (Wilkes et al, 2003; Spilsbury et al, 2007; Gilpin and Langan, 2008; Philcox et al, 2008). Pain, reduction in independence, poor sleep, worry about odour or leakage and loss of earnings

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are frequently identified as factors which negatively impact upon the lives of patients with chronic wounds. It seems appropriate therefore to suggest that wounds should be cared for in a standardised way where possible, with clear objectives for care, management strategies based on the best available evidence, regular review and onward referral to specialist services when they are not progressing as they should.

Wound management in the UK is generally not organised or delivered in a uniform fashion against measurable standards of care and with clear referral pathways, therefore there is little evidence of standardised practice.

Following these simple steps should optimise the chance of the patient having a straightforward, uncomplicated and timely healing process.

It is widely believed that optimal care can be most successfully achieved by a multidisciplinary team, however, in reality the majority of day to day wound care is provided by nurses. Bianchi (2007) suggests that the

ultimate goal of nursing is to be clinically effective by delivering the best possible care to patients. Despite the existence of national guidelines and frameworks in the UK (and elsewhere, e.g. Robson and Barbul, 2006) 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. Furthermore, wound management in the UK 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), therefore there is little evidence of standardised practice.

The care an individual receives depends very much on by whom and where they are cared for. In many care settings (both primary and acute) specialist clinicians (Tissue Viability Nurses [TVNs]) are employed to drive forward good practice in wound care. As Timmons (2007) states, the existence of these specialists means that patients are much less likely to

experience poor quality wound care. However, these specialist clinicians are not in place in all areas and where they are they will only ever see a small number of patients with complex wounds relying on general nurses to deliver care to the majority of patients based on protocols devised by the TVN. While this should not be a problem it can lead to great diversity in practice. The amount of theoretical knowledge and clinical practice nurses have in wound care is very variable (Fletcher, 2007). Many pre-registration nursing courses contain very little wound care information apart from the basics of the aseptic technique (Ashton and Price, 2006), indeed Jones (2007) suggests that basic wound care is becoming non-existent in wards with an increasing reliance on TVNs. Access to post-qualification courses depends on interest and the availability of funding and support (Ashton and Price, 2006; Fletcher, 2007; Jones, 2007).

A survey of community nurses by Ovens et al (2007) identified that a lack of training in wound care was a particular problem resulting in a lack of confidence when faced with a patient with a wound. Mudge et al (2008) demonstrated clearly how this can affect practice both in the UK and elsewhere. They surveyed 2018 patients and found that 3361 dressings were being used with some patients having up to 7 products in use at any one time; clearly this is not reasonable and demonstrates flawed assessment and decision making. This lack of knowledge and confidence does not only apply to nurses. McIntosh and Ousey (2008) surveyed 102 clinicians (primarily nurses $n=47$ and podiatrists $n=47$) attending a wound care conference and found that there were huge inconsistencies in the respondents' level of knowledge and perceived skill which they suggest could result in patients receiving suboptimal care. This variation was similar in both professions. The authors also identified that a lack of multi-professional working was a major barrier to gold standard 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 are at an increased risk of complications. Posnett and Franks (2008) state that a high proportion of chronic wounds remain unhealed for long periods and almost certainly longer than necessary. Such ineffective management can result not only in prolonged patient suffering but also increased cost to healthcare organisations.

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 also the expertise available to provide the care.

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 also the expertise available to provide the care.

Moffatt and Vowden (2008) suggest 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. 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 because of 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 recognized by Baroness Bottomley (2007) who challenged NHS managers to ensure that they purchase or provide wound care services that are based on evidence and are responsive to future developments rather than relying on what has happened previously.

Understanding the patient's beliefs and values in relation to their health should also be an integral part of wound care delivery, 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 timely achievement of these (Dowsett, 2008).

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

The current 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 a dramatic increase in the availability of dressing materials and therapies and to 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) with 28% remaining unhealed for a year or more (Drew et al) and in an Irish study 27% of patients having continuous ulceration for more than 2 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

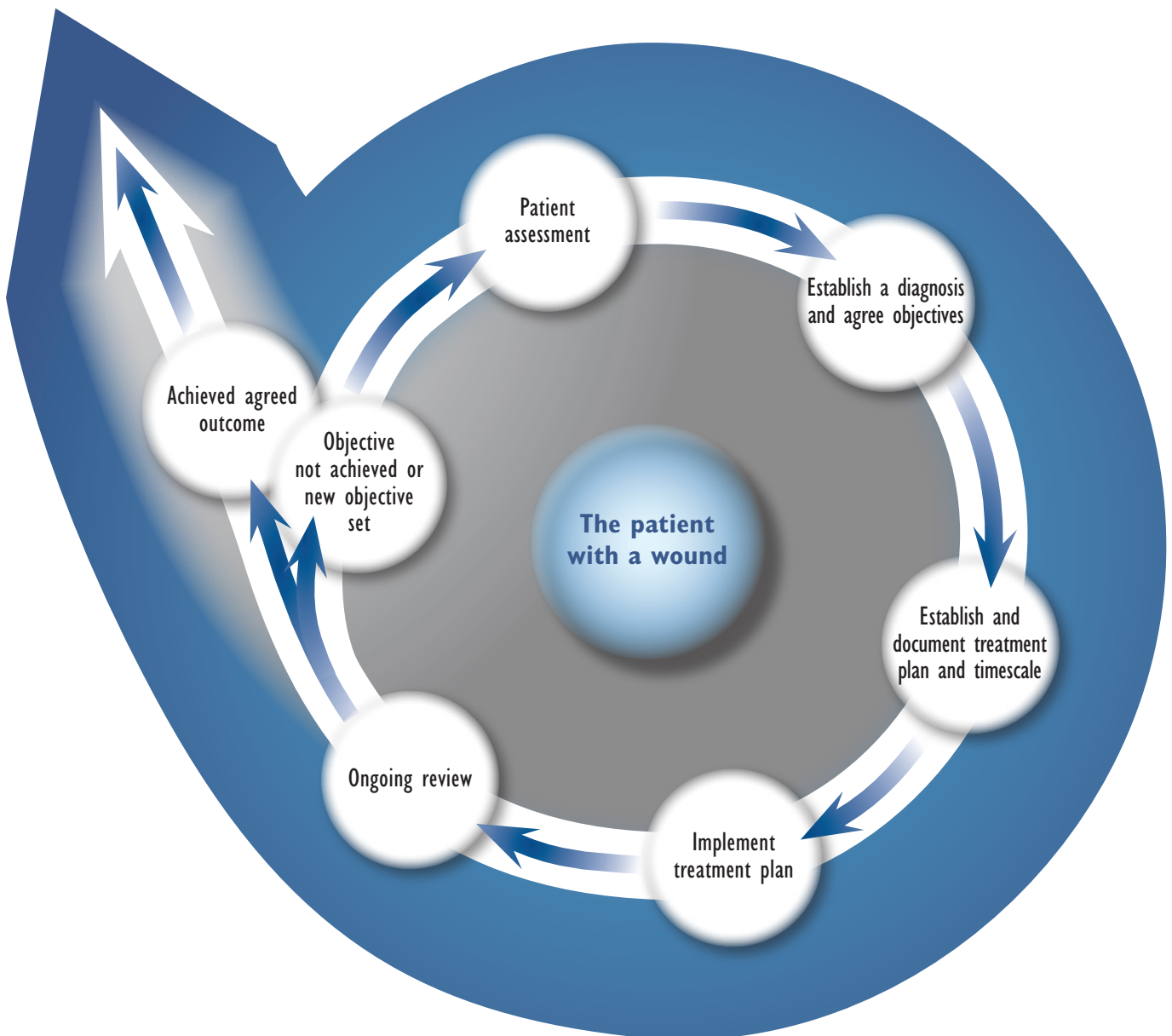


Figure 1. The *Optimising Wound Care* best practice statement care pathway. The circular nature of the diagram shows that the patient must remain on the pathway, undergoing continual review of their treatment and wound progress.

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 on going 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, a best practice statement *Optimising Wound Care* has been developed by a panel of experts in conjunction with Wounds UK and ConvaTec to provide a baseline or benchmark against which practitioners and organisations can measure their current service provision. The document focuses upon the management of wounds by the non-specialist practitioner without defining who this practitioner might be as this may vary depending upon the setting within which the care is delivered. In this way it is hoped that all patients with a wound will receive regular assessment and review with clear objectives defined for their care, reflecting both their wound care and more holistic general needs.

The best practice statement presents a care pathway (Figure 1) for the patient with a wound. The pathway places the patient at the centre of the care process, ensuring that throughout the patient and what is best for them is considered and addressed. The pathway is cyclical, conveying the need for all patients to be continually reassessed and their treatment amended according to findings, until the desired outcome is achieved and they leave the pathway.

When using the best practice statement the clinician is led in a logical way through assessment of the patient and diagnosis to setting of objectives and provision of care, or where appropriate, to onward referral to specialist services...definition of these steps also allows the organisation to plan and allocate resources in a logical and structured way.

Every key stage of the care pathway is elaborated upon in the best practice statement section of the *Optimising Wound Care* document. Statements are presented for both the healthcare professional and the manager/service provider to ensure that there is appropriate recognition of what is required at both a clinical and more strategic level, providing not only guidance but also a benchmark against which to measure wound care provision.

When using the best practice statement the clinician is led in a logical way through assessment of the patient and diagnosis to 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.

Conclusions

It is essential that practitioners have a way of 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 care planned and delivered should focus 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. This should not be forgotten when caring for patients with chronic wounds as it is frequently described as a source of stress for clinicians as well as patients (Wilkes et al, 2003; Lazelle Ali, 2007).

For managers the provision of defined standards allows them to proactively plan and deliver services but also measure the outcomes achieved. The use of the best practice statement 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 demoralized staff. Posnett and Franks (2008) clearly state that costs can be reduced by appropriate and cost effective treatment choices. In addition they identify that the key to reducing costs is to prevent admission to the acute sector and/or delayed discharge due to wound-associated complications.

Harrison (2006) suggests that best practice statements from credible

Key Points

- ▶▶ Every patient with a wound has a right to expect a good minimum standard of care regardless of the cause of their wound, when the care is delivered or by whom.
- ▶▶ Although this occurs in the majority of situations such provision is not consistent in the UK and Ireland due to a lack of organisation and measurable standards of care.
- ▶▶ Optimising wound care is a document developed by an expert panel in conjunction with Wounds UK and ConvaTec that aims to provide a benchmark against which clinicians and organisations can measure their current service provision.
- ▶▶ It is hoped that the *Optimising Wound Care* document will ensure all patients with wounds receive regular assessment and review with clear objectives defined for their care.

groups may be one way of improving both knowledge and practice. Every patient has the right to high quality care and the recommendations set out in *Optimising Wound Care* may be the first step towards achieving this goal. **WUK**

This article was supported by financial assistance from ConvaTec Ltd. The Best Practice Statement Optimising Wound Care is available to download for free from www.wounds-uk.com

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