New specialised wound care unit is proving a successful, cost-effective innovation

Mike Salter

The 'Wound Management Team' (WMT) at Southend Hospital NHS Trust was formed after a complex wound problem became further complicated by a delay in surgery. The resulting clinical governance issue led to a review of wound management at the trust. The team was formed by combining two specialist nurse teams — vascular and tissue viability — supported by a vascular surgical consultant (myself) as clinical lead.

The WMT service covers the entire trust and takes direct referrals from all specialties. The significant difference between this and the previous tissue viability service is that the presence of the consultant clinical lead allows for a fast track to theatre when needed, and other procedures and investigations as necessary. Consultant-to-consultant referral is no longer required as the team can be accessed by any healthcare worker who is worried about a patient's wound.

Two issues rapidly emerged after this was implemented:

- Ward rounds soon became inefficient due to the number of wards that needed to be visited, sometimes twice a day — once to review the patient and then to initiate the treatment
- It became obvious that there was a huge variation in standards of wound care, and perhaps, more worrying, the low priority given to it. For example, patients would quite often be treated for sepsis or uncontrolled diabetes while the infected foot was not considered to be the causative factor or the urgency for surgical debridement was not appreciated.

As a team we felt that the way to improve this service was to put these patients into one area or ward, the single criteria for admission being that the wound and its management was the sole reason for being in hospital. Thus, the concept of a Wound Management Unit (WMU) was born. By bringing all the patients together it would allow the team to concentrate the medical and nursing expertise required to facilitate treatment such as surgical debridement under local anaesthesia, topical negative pressure therapy and intermittent pneumatic compression.

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The WMU also allows for more consistent wound management, standardisation of dressings and treatment plans. It was envisaged that part of the unit could be run as an outpatient facility, which would allow early discharge but also close monitoring of patients with complex wound therapies such as topical negative pressure (TNP). Traditionally, these patients and others would have had to stay in a hospital bed as this treatment is not readily available in the community.

The perceived benefit of this unit was to improve healing rates, reduce limb loss, and reduce length of stay.

The main problems in achieving these aims came with the identification and protection of beds for this purpose. This was overcome by persuasive argument and the submission of a business case to the strategic development board. The concept was easily sold and, indeed, felt to be 'a no-brainer' (as described by a trust accountant). The strengths were that the patients were already in a hospital bed, so concentration of expertise, improved clinical outcomes, the reduction in length of stay would all combine to reduce overall costs. With the full support of the executive board, 14 beds have been identified on a medical ward and ringfenced. The site coordinators are kept informed of any patients with wound problems that would benefit from treatment on the ward and are then transferred to the unit once a bed is free. The WMU was opened in April 2009 and is a predominantly nurse-led service with regular consultant input. The unit is self-managing, responsible for its own budget and equipment and liaises with local providers.

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the past, a pre-tibial laceration would be referred to the orthopaedic department, an initial debridement carried out and then a referral would be made to the plastic surgeons (off site) for skin grafting. This would often mean a delay in treatment while referrals were being made and the patient waited for a bed. During this time infection may become a problem and the prospect of transfer to specialist plastic surgery units placed an unacceptable burden on the patients who were often elderly. Now these patients are referred directly to the WMT, surgical debridement is undertaken promptly, the patient undergoes vascular assessment and, if suitable, compression bandage therapy is commenced. Early discharge is possible and progression is monitored in outpatient departments at a separate clinic run by the specialist nurses of the WMT. Good healing rates have been achieved and major plastic surgery avoided. Similarly, the infected diabetic foot and associated sepsis are recognised and dealt with as an emergency, and associated peripheral vascular disease is corrected if possible by angioplasty or reconstructive surgery.

The WMU allows for education and training of the ward staff and has provided a focus that has greatly improved ward morale. A secondment of one of the ward sisters for two days a week has greatly improved the service. This unit is a prime example of advanced nursing practice. In common with all new services, demand rises rapidly and with this the problem of meeting needs becomes evident, particularly the need for more theatre time and the increasing workload for nursing and medical staff.

Costs incurred include the refurbishment of office space to relocate the WMT, the provision of trolleys stocked with relevant dressings that can be moved from bed to bed and the procurement of extra staff and equipment. One particular problem that is now apparent is the unsuitability of sharing the unit with a busy medical ward, as this dilutes nursing experience and distracts from wound care. After much negotiation it is anticipated that this facility will be moved to its own dedicated ward.

The challenge now is to prove the effectiveness of this unit to the management. This will involve audit of activity and patient outcomes, as well as length of stay and patient satisfaction surveys. It is hoped in the future that research will become an integral part of the unit's activity.

This innovation has been recognised both locally and nationally. It has received a trust staff achievement award for best practice and has been recognised in the *Health Service Journal* for innovation in improving the patient experience. It was presented at the Society of Vascular Nurses at the International Vascular Surgical Society Meeting in Bournemouth 2008 and won the James Purdie Prize presentation. More recently it has been awarded the Mölnlycke Team Scholarship Award, which we regard as a great honour.

It is our aim to establish a multidisciplinary unit involving specialist input from all disciplines involved in wound care, following the model presented by Finn Gottrup (2004).

With foresight, vision and continued support, it is hoped that this is just the beginning of an exciting innovation. **WUK**

Reference

Gottrup F (2004) A specialised wound healing center concept. *Am Med J* **187**: 38S–43S