

Effective wound management and wellbeing: guidance for clinicians, organisations and industry

In February 2011, a multidisciplinary group of clinicians and researchers met at the Wounds International conference in Cape Town, South Africa, ahead of a consensus meeting in Brussels in May 2011. The aim of the meeting was to explore patient wellbeing in relation to wound management. Several themes were discussed and are presented in this article. The key points raised will form the starting point of the consensus meeting which will aim to provide three key stake holders — clinicians, healthcare organisations and industry — with a framework to ensure that patient wellbeing is optimised when delivering effective wound management.

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KEY WORDS

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Quality of life
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Industry

A meeting was held at the Wounds International Conference in Cape Town on 1 February 2011 with the goal of gathering information on how patient wellbeing could be optimised by clinicians, healthcare organisations and industry while providing wound management. The meeting was attended by healthcare professionals from USA, Europe and Australia. It was identified that patient wellbeing and the impact of a wound concerned far wider issues than just pain, the main focus of much of the literature on patient quality of life (QoL). Achieving optimal wellbeing in patients with wounds requires a coordinated approach with a significant responsibility resting with the clinician (*Figure 1*). The resultant consensus document aims to provide guidance to clinicians, organisations and industry on how to

provide wound care that optimises patient wellbeing.

What is patient wellbeing?

'Wellbeing is a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community' (Government Office for Science, 2008: 10).

In the meeting it was discussed that quality of life (QoL) was a component of wellbeing. The World Health Organization (WHO), as far back as 1948, identified that a patient who is technically 'cured' may not necessarily be well and went on to demonstrate three aspects of wellbeing:

- ▶▶ **Physical wellbeing:** the ability to function normally in activities such as bathing, dressing, eating, and moving around
- ▶▶ **Mental wellbeing:** this implies that cognitive faculties are intact and that the patient is free from fear, anxiety, stress, depression, or other negative emotions
- ▶▶ **Social wellbeing:** the ability to participate in and engage with family, society, friends, and workers.

Thus, wellbeing goes further than measuring QoL and more

incisive indicators are needed for its assessment.

Issues in wound care affecting QoL and wellbeing

Living with a wound can negatively impact upon a patient's quality of life (QoL) (Lindholm et al, 1993; Phillips et al, 1994; Charles, 1995; Chase et al, 1997; Franks et al, 1999; Franks and Moffatt, 2001; Franks and Moffatt, 2003; Price and Harding, 2004; Goodridge et al, 2005; Grocott et al, 2005; Franks and Moffatt, 2006; Palfreyman, 2008).

Pain has a significant impact on QoL, emotional state and a patient's sense of wellbeing (Charles, 2002; Hopkins et al, 2006; Ribu et al, 2006). A Cochrane review of patients with venous leg ulcers found that as many as 80% of patients reported acute or chronic wound pain, with half of them rating pain as moderate to the worst possible (Briggs and Nelson, 2010). Patients with venous leg ulceration cite pain as being of overwhelming concern (Chase et al, 1997; Douglas, 2001; Price et al, 2008), and the physiological stress it causes can have an adverse effect on healing (Kiecolt-Glaser et al, 1995; Ebrecht et al, 2004; McGuire et al, 2006; Soon and Acton, 2006; Walburn et al, 2009).

Hofman and Lindholm (1997)

All authors were members of the consensus meeting panel;
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investigated 140 patients at two centres (Oxford and Uppsala, Sweden) and found that 64% of patients with venous leg ulcers reported severe pain and for 38% the pain was continuous. Living with pain on a day-to-day basis disrupts daily activities, such as walking, standing, climbing stairs, etc — all of which may trigger pain, affecting personal, social and family life, as well as work (Price et al, 2008; Woo et al, 2008).

Immobility can lead to social isolation which can prompt depression. It has been seen that talking with other patients with wounds, for example at Leg Clubs, can help patients not to feel so alone with their condition (Stephen-Haynes, 2010).

McCaffery (2001) stated that pain is whatever the patient says it is and so management of pain not only requires pharmacological agents, but also listening to the patient and their experience. Stress and anxiety can also lower the pain threshold, leading to a vicious cycle of pain, anxiety and heightened awareness of pain. By removing or reducing stress or pain, quality of life can be improved which will have a positive influence on a patient's wellbeing.

It is crucial that healthcare professionals acknowledge that anxiety can occur both in anticipation of and at dressing-related procedures and adopt strategies to help allay this stress (Woo et al, 2008), and develop a therapeutic relationship which can improve treatment outcomes and patient concordance (Morgan et al, 2004).

In addition to pain, anxiety may be caused by delayed wound healing, fear of amputation, body disfigurement, odour, exudate leakage and social isolation.

Jones et al (2006) studied the prevalence of anxiety and depression in 190 patients with chronic venous leg ulcers across nine trusts in the northwest of England using the Hospital Anxiety and Depression Scale (HADS, Zigmond and Snaith, 1983). Fifty-two patients (27%) scored above the cut-off for being categorised as depressed, and 50 patients (26%) scored above the anxiety cut-off. Cole-King and Harding

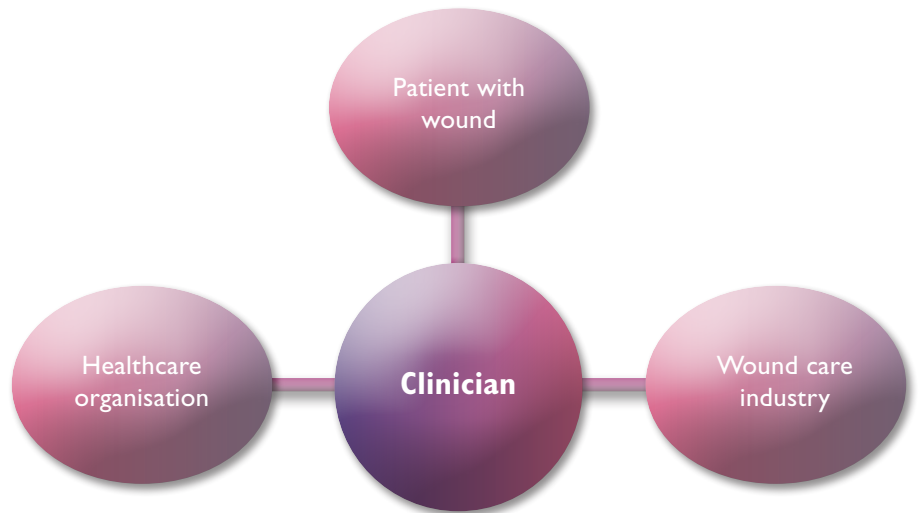


Figure 1. Model of care placing the clinician, rather than the patient, at the centre.

(2001) also explored the link between chronic wound healing and anxiety and depression, using a 5-point Likert scale to rate wound healing and the HADS to measure anxiety and depression. They found that delayed wound healing was associated with a higher mean HADS score, thus demonstrating the association between depression and anxiety and chronic wound healing. The two symptoms most associated with anxiety and depression were pain and

odour: Phillips et al, (1994) also found that patients who were psychologically distressed and suffering from depression, anxiety or social isolation may have difficulties in tolerating compression therapy. Thus, psychological factors should be considered when managing patients with wounds.

Franks et al (1999) observed changes in 200 patients' perceived health in both an outpatient setting and in patients'

BOX 1

Members of the multidisciplinary group

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homes. Phillips et al (2004) assessed the financial, social, and psychologic implications of leg ulcers on 73 patients with chronic leg ulcers. Data were collected by personal interviews covering several domains that were selected to determine the impact of a leg ulcer on overall QoL. A significant number of patients had moderate to severe symptoms, principally pain, related to the leg ulcer. Eighty-one percent believed that their mobility was adversely affected by the ulcer; the dominant predictor of impaired mobility was swelling of the leg ($p < 0.001$). For younger, working patients, leg ulceration was correlated with time lost from work ($p < 0.001$), job loss ($p < 0.01$), and adverse effects on finances ($p < 0.02$). Fifty-eight percent of patients found caring for the ulcer burdensome. There was a strong correlation between time spent on ulcer care and feelings of anger and resentment. Sixty-eight percent of patients reported that the ulcer had a negative emotional impact on their lives, including feelings of fear, social isolation, anger, depression, and negative self-image.

Odour can also force patients to stay at home for fear of embarrassment (Snyder, 2006; Fagervik-Morton and Price, 2009), again perpetuating social isolation.

Different coping strategies of patients with chronic and/or complex wounds have also been looked at by Vermeiden et al (2009) using the Utrecht Coping List (UCL). While the study was limited by the small sample size, they found that inadequate coping skills can increase stress which, in turn, affects the healing process and influences QoL (Vermeiden, 2011).

The findings in the literature are consistent that poor wound management and living with a wound impact on QoL and the patient's 'lived experience' (Charles, 2004; Edwards et al, 2002).

The group agreed that the evidence now needs to be translated into practice, with baseline principles being established against which service provision can be benchmarked to ensure that all stakeholders — clinicians, organisations and industry — are striving to promote patient wellbeing.

It is also vital to recognise that a wound affects many aspects of a patient's life. Pain may well be a concern, but the greatest impact could be felt in their social wellbeing. The group acknowledged that the current gateways to care are designed to meet the needs of the clinicians and the organisation, not the patient, and that the balance needs to be redressed to consider issues of importance to patient wellbeing.

Improving wellbeing and concordance Education

Patients do not always understand why their wound has developed, making it important to assess their knowledge of their condition and its treatment (Edwards et al, 2002). This is particularly so for patients with venous ulceration where the patient is responsible for exercising and complying with compression therapy. Involving the patient in their care plan can also lead to greater concordance. Improved patient education may influence clinical outcomes. For example, smokers heal slower when compared to non-smokers (Silverstein, 1992; Kean, 2010). Møller et al (2002) found that individuals who had taken part in smoking cessation programmes for 6–8 weeks before surgery had reduced wound-related and other post-surgical complications compared to those receiving standard care. Poor nutrition and heavy alcohol use are also associated with slower healing (Benveniste and Thut, 1981; Steptoe et al, 1996; Johnson, 2007; Stechmiller, 2010; Wild et al, 2010; Kavalukas and Barbul, 2011).

Improved communication could be achieved through a better therapeutic relationship provided in the patient clinician interaction, which could be supported by written information to remind patients of the clinic discussion (with the input from industry in making educational patient material accessible).

It should be remembered that verbal interaction is crucial in assessing the psychological status of the patient to gain an understanding of their particular behaviour; and providing a starting point to promote behavioural change.

Clinician knowledge and practice

The group felt that clinician variability also impacts upon patient wellbeing. For example, if the clinician is not up to date with atraumatic dressings or today's advanced wound care products, the patient may fear dressing changes because of the pain caused or be inappropriately treated. Moreover, if the patient does not feel he can discuss his treatment with the clinician, this may impact upon compliance with the patient avoiding treatment appointments thereby delaying the healing process.

The establishment of a therapeutic relationship between a nurse and patient is well-documented (Hawkins, 2003; Foster and Hawkins, 2005; Robinson et al, 2008). It is crucial that the patient feels that they can talk and be listened to. With current heavy caseloads, healthcare professionals may feel there is little time to listen to their patients' concern — what Hawkins referred to as a 'Task to Talking model' (Hawkins, 2003). Personal, empathetic, individualised care will lead to holistic rather than disease-centred care (Price, 2005).

The consensus group mentioned examples of patients being non-concordant with their care because the wound or management of the wound did not fit in with their lifestyle, and agreed that there is a need to create an environment where patients can verbalise how having a wound impacts on their wellbeing. Care is more likely to be effective if the clinician has listened to the patient and/or their carer; and chosen a treatment/product that fits in with their lifestyle and which they understand.

This again shows how the clinician should take an holistic approach and not just focus on the wound that needs medical treatment (Price, 2005). Such an approach will involve the multidisciplinary team, as while the wound care specialist can treat the wound, if the patient is having difficulties in mobilising it may be necessary to enlist the help of a physiotherapist, or if they are nutritionally compromised, the advice of a nutritionist can be sought to assess the patient and offer guidance.

The intervention of the psychologist might also be needed for psychological strategies to alleviate pain and anxiety.

Family and significant others

It was also felt that family and carers play a key role in a patient's journey that is often overlooked in developed countries. For example, in Africa or India they, or members of the community, are central (Ryan, 2010).

Reflective practice

The group agreed that the patient with wounds or skin issues should be viewed in the widest context across all care settings, and that some basic principles, such as ensuring the patient has the opportunity to provide feedback to clinicians, be that via Twitter for the middle-aged internet 'savvy', or via the local elders' network in remote African settings, should be established. Such basic principles will ask questions of service provided and promote reflection among clinicians on service delivery and future directions for practice.

Responsibilities of the clinician, organisation and industry

Clinician — engaging rather than persuading

Patients may be labelled as non-compliant or non-concordant. However, by looking further than just the wound, it may be found that the problems lie with the clinician's relationship with the patient, or the manner in which the organisation delivers care, e.g inflexible appointment times.

After discussion, the group agreed that the clinician is pivotal in promoting patient wellbeing, acting as the conduit between the organisation, patient and industry (Figure 1). Patients are often labelled as non-concordant, but how often are they given the chance to contribute to their care planning? How many clinicians take the time to provide a feedback mechanism on the provision of service for their colleagues/patients or organisation?

It was agreed that clinicians should be:

- ▶ Committed to interprofessional collaboration and seeking opinions from colleagues as required

- ▶ Clinically competent within their own scope of practice
- ▶ Committed to identifying and communicating shortcomings within their service, be they personal or organisational
- ▶ Committed to obtaining feedback and evaluating service provision to ensure a voice for the patients
- ▶ Committed to developing therapeutic relationships
- ▶ Committed to change.

Organisation — supportive not critical

The organisation also plays a part in patient wellbeing through:

- ▶ Provision of flexible services and accessible care, such as open clinic appointments or promotion of self-care
- ▶ Provision of adequate resources, both human and consumable, to ensure the delivery of effective wound management which supports patient wellbeing
- ▶ Commitment to knowledge-based, cost-effective care by their staff
- ▶ Commitment to research.

Patient — participative not reactive

From exploring the patient's role in their wound management, the key themes that emerged were:

- ▶ Having an opportunity to find their voice, with mechanisms in place for feedback
- ▶ Feeling comfortable to disclose their expectations/issues/concerns
- ▶ Willingness to participate
- ▶ Having the right to refuse/right to be guided
- ▶ Acceptance that the patient's journey is a dynamic one.

Industry — developing not counting

The third stakeholder, industry, likewise has a role to play in patient wellbeing, namely:

- ▶ Product development in line with patient lifestyle. By exploring practical and body image issues with patients, manufacturers can develop products that will improve concordance (Lund et al, 2010)
- ▶ Education founded on the five basic principles (learn by doing principle, learn when you are ready principle, learn what is relevant principle, learn by association principle, learn by

reinforcing principle), and product function

- ▶ An open-minded approach to professional and interpersonal relationships with practitioners, being prepared to listen to feedback
- ▶ An approach based on the best available knowledge and evidence
- ▶ Maintaining an ethical approach to product sales.

Conclusion

Having a wound is a life-changing event, reverberating into every aspect of a patient's life and wellbeing, be it family, social or work. There has been a great deal of literature to explore and measure the impact of wounds on QoL, much of which has focused on pain. By discussing and debating the role that the clinician, organisation and industry play in the management of wounds, it is hoped that a consensus document can be developed to highlight areas that need addressing in order that clinicians can provide optimal care, and achieve the best possible outcomes for their patients, while ensuring that patient wellbeing is valued and acknowledged at every stage of the journey. **WUK**

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