

# Wound care and pressure ulceration in midwifery: a neglected area?

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Wound care and pressure ulceration in midwifery are important and neglected areas within the profession where much work needs to be done, both clinically and educationally. Indeed, the National Patient Safety Agency (NPSA) has announced plans to work with the NHS to reduce levels of harm in ten high risk areas and one of these is 'reducing avoidable harm in childbirth' (NPSA, 2010). Although I am now an academic midwife, I still practise as a bank midwife in local NHS birth centres and community midwifery and have a long career history in the NHS. During my career I have seen advice and treatments for wound care in our profession change regularly, and often according to the preferences of the obstetrician and midwife. Pressure ulceration is not a new phenomenon in midwifery, but the need to avoid unnecessary harm to women in childbirth is becoming increasingly important because of advances in pain management and choices now available for women.

Advances in pain management mean that many women making informed decisions when completing their birth plans choose epidural

anaesthesia as a form of pain relief. Women may also choose, or be advised, to use this option when they are in labour. Indeed, some women are transferred from birth centres to hospital settings because they have chosen to have an epidural sited. Epidurals come with disadvantages;

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women are not able to fully mobilise, are usually cannulated (often with an intravenous [IV] infusion), and are also attached to a cardiotocograph to monitor fetal wellbeing for some, or all, of their labour (Hughes, 2001).

In my clinical experience, most anaesthetists are able to site epidurals so that women have some leg mobility, but they are often sitting in the same position for the majority of their labour. Women whose labours are prolonged, or end in caesarean sections, are at increased risk of developing pressure ulcers because of their reduced mobility. It is imperative therefore, that midwives become familiar with recent trends in prevention and management of pressure ulceration and the required risk assessment.

Supporting women to breastfeed is a crucial part of the midwife's

role, and both professional and peer support have been identified as key components to successful breastfeeding (Schmeid et al, 2010). Correct positioning of the baby at the breast is vital, and, as midwives, we work hard with women to optimise this aspect of their breastfeeding experience. However, cracked (broken skin) nipples do sometimes occur despite best efforts from women and midwives. Women often ask what they can apply to cracked nipples to expedite the healing process. In the past exposing the nipples to air has been advised (which we now know is ineffective), but expressed breast milk is still recommended to aid healing as the epidermal growth factor in breast milk could have potential benefits in promoting the growth and repair of skin cells (Renfrew et al, 2000).

Mixed conclusions are presented in the evidence regarding the effectiveness of topical treatments such as ointments or lanolin creams (Morland-Schultz and Hill, 2005), although such treatments are popular with women and midwives. Cracked and sore nipples should be able to heal without ointments or lanolin creams providing advice about positioning the baby at the breast is given (Renfrew et al, 2000).

What we have not been good at in midwifery is prioritising wound care and treatment; this has almost become 'unimportant' in a culture where midwives are swamped by immediate process driven demands, such as paperwork and meeting targets, that currently seem to control the organisation of midwifery work (Bryson and Deery, 2009).

The same situation applies to wound care for labial and perineal tears and episiotomies. When I began my midwifery career, midwives examined a woman's perineum on a daily basis as part of the care plan. Now, and for reasons alluded to above, we tend to rely more heavily on a woman's account of how her 'wound' feels, rather than closer visual examination. This, coupled with whether a perineal or labial tear has been sutured, adds to the wound care debate. Ousey and White (2010) remind health practitioners of the importance of understanding the quality agenda (e.g. risk assessment, education and accurate documentation). This is crucial when the vision for the NHS is to go from 'good to great', while focusing on improving quality and productivity.

Caesarean section rates have increased dramatically over recent years, partly as a result of increasing interventions in midwifery and obstetrics (Johanson et al, 2002), and also because some women exercise their right to choose a caesarean birth. Gone are the days of staying in hospital for seven days following a caesarean section; women are now transferred home two or three days postoperatively leaving all wound care to the community midwife. Furthermore, dressings have usually been removed leaving the wound exposed, although this would be in accordance with trust policy and guidance. Infected wounds and areas on the incision line that do not heal can occur and usually require referral to the GP. Such wound care and infections can be costly in relation to wound dressings and the 'time' of the midwife. Women also have

to experience further discomfort and pain. In my clinical experience, midwives do not see wound care as a matter of concern, and education in this area is limited with priority being given to mandatory training within

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each trust's policy. When wound care has to be referred to GPs, childbirth can be experienced negatively by some women because of a lack of continuity or an unexpected increase in pain.

The incidence of pressure ulceration is increasing in midwifery (Newton and Butcher, 2000), and wound care can receive inadequate attention. It is the responsibility of individual midwives to ensure that their knowledge base is up to date and in accordance with the clinical governance agenda in their own NHS trust. The Department of Health (DH) is seeking a culture where high quality standards are achieved, and managing risk is a fundamental part of clinical practice. It is essential that midwives take a full risk assessment of women's needs and how current tools and advice can be used in practice. I

would welcome the opportunity to work with experienced clinicians in this field and to undertake research to support pressure ulceration and wound care in midwifery. **WUK**

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