Sharing the care at home with your patients

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This article is based on a Made Easy workshop held online at the Wounds UK Annual Conference on 9th November 2020, sponsored by HARTMANN. The aim of the workshop was to discuss shared care and the benefits for both patient and clinician, and to explore the right tools, information and support available to optimise a wounds ability to heal at home.

The workshop consisted of presentations by two speakers: Dawn Stevens, who explained the potential opportunity that a shared care approach can achieve and introduced 'HOME', a shared care initiative; and Debbie Simon, who showcased the success of working in partnership with her patients to develop a shared care approach.

WHAT WOULD YOU DO WITH MORE TIME?

To kick-off the workshop, Dawn posed the following question: What would you do with more time? An opportunity for the audience to reflect on the prospect of having more time for their patients, but also for themselves as a clinician. In particular, during the COVID-19 pandemic, clinicians are having to spend more time working to manage the increased and changing demand on healthcare services. Additionally, there is a need to avoid face-to-face visits and to protect patients who are shielding and at high risk of increased mortality. This in part has triggered renewed energy and an interest in shared care.

Empowering patients to have more ownership and take an active role in their health and wellbeing should be championed now, more than ever. This can help patients to:

- Understand their condition better
- Feel more in control of their care
- Retain more of their independence
- Optimise their ability to heal
- Feel a part of the decision-making process.

A case study example was put forward involving a young male patient with a Sarcoma, who required three appointments per week at an outpatient clinic to help manage his highly exuding wound. The average cost of each visit was £105. Over five months (22 weeks), with three visits per week, this totalled to 66 appointments at a cost of £6930. After this time, it became apparent that this patient was in a position to develop a shared care approach. As a result, only one clinical visit was required per week. The average cost remained at £105. Over five months (22 weeks), with one visit per week, this totalled to 22 appointments at a cost of £2310. This released 44 appointment slots and led to a saving of £4620 in resource costs. This case study highlights the importance of encouraging patients to actively participate in their care. For patients, this can lead to improved self-esteem and quality of life and promote wound healing much more effectively due to patient engagement and concordance. For clinicians, it is an opportunity to move patients through the service in a timely manner and reduce caseload numbers, leading to increased job satisfaction and staff morale.

NEW WAYS OF WORKING

As a tissue viability nurse specialist working in the community, Debbie Simon began by discussing the challenges facing the healthcare workforce. Since 2009, the number of nurses in community services have fallen by around 14%, and the number of district nurses by 45% (Dayan and Palmer, 2018). Alongside this, community funding has decreased by 4%. Guest et al (2017) estimates that the cost of wound management will increase by 11% annually; however, additional funding will be required to support this demand. Wound complexity and frailty are increasing in the community, and the extra pressures faced during COVID-19 indicate that alternative ways of delivering care need to be identified.

As clinicians, it has become more important than ever to encourage patients/carers to adopt a shared care approach, whenever possible. For this to be successful patients/carers need to feel supported, this includes providing a review date and time and to have someone to contact should there be any issues. The case study described by Debbie Simon below illustrates how a shared care approach can be used in practice.

CASE STUDY

A 54-year-old male named Tony was diagnosed with carcinoma of the prostate, which very quickly progressed and bony metastases were identified. He had spinal cord compression and paralysis from the middle of his spine downwards and was discharged home for end-of-life care. He had developed a Category 3 pressure ulcer to the perianal area. The wound was producing copious amounts of exudate, requiring twice daily dressing changes, at a minimum. Dressing changes were challenging as there were two areas of moisture damage, which meant keeping the dressing in place was very difficult. Tony was low in mood and was supported by his wife and family at his preferred place of care, which was in his own home.

WHAT DOES EXUDATE DO?

Exudate is important as it supports healing by providing a moist environment. It helps:

- Healing, such as growth factors diffuse across a wound
- Promote cell growth
- Supply nutrients for cell metabolism
- Aid autolysis of necrotic or damaged tissue (Cutting, 2003; WUWHS, 2007; WUWHS, 2019).

It is well recognised that wounds with a moist environment heal quicker than those that dry out (Winter, 1962) and that, in fact, moist wounds heal 2–3 times faster than dry wounds (Swezey, 2014). A delicate balance is therefore needed to prevent a wound from becoming too moist or too dry. Often, clinicians are faced with exudate-related complications, these include:

- **Infection** — wounds are more prone to bacteria and infection, particularly with the addition of necrotic tissue and slough
- **Odour** — distressing for the patient and as smell accounts for 85–90% of taste and flavour, malodour can impact upon the patient's nutritional intake (Van Toller, 1994)
- **Protein loss** — exudate is rich in protein and may cause a protein deficiency if lost in excess amounts
- **Increased pain** — presence on the surrounding skin may cause an increase in pain, wound size and periwound skin damage (from too frequent dressing changes), such as maceration/skin erosions/skin stripping (WUWHS, 2019).

For most clinicians, the impact on patients' quality of life is most concerning. Footwear can become an issue, and clothes and wet shoes that no longer fit may cause them to avoid going out. They may reach out to a family member to get them a bigger size of shoes, but this can then create a fall hazard. Patients may no longer go to bed as changing bedding can become difficult and active, outgoing individuals may become anxious and housebound, as they are worried others will smell the wound.

TONY'S EXUDATE MANAGEMENT

Managing the copious amounts of exudate from Tony's wound was essential. There was nothing more the hospital could offer, and further radiotherapy did not help to reduce exudate levels. The plan of care was discussed with Tony and his wife — they wanted life to be as normal as possible and to have flexibility with the dressing regimen, allowing Tony to retain some independence. A shared care model was discussed. Staff demonstrated how to manage the wound and change dressings and then Tony's wife repeated the process. This included:

- Handwashing
- How to clean the wound
- When to be concerned e.g. signs of infection
- How to open and apply the dressing.

Nursing staff applied an antimicrobial to the cavity, and covered the cavity and open wounds surrounding this area with a Zetuvit® Plus Silicone Border, ensuring the dressing had intimate contact with the wound surface. To help Tony's wife gain confidence in managing the wound, guidance was given on wear time of the dressings, according to the instructions and product information supplied in each box. In addition, Tony's wife was advised to change the dressing when exudate could be seen approx. 1cm from the adhesive border.

POSITIONING OF DRESSINGS

The positioning of a dressing is extremely important, and every assessment should be used as an opportunity to look at where the patient spends the majority of their time and for the dressing to be applied accordingly. Considering the effect of gravity and understanding that exudate will drain downwards as a direct result can help to prevent the wound from becoming saturated, more fragile and easily damaged. A dressing may not need to be central over the wound — if the patient lies down, it

Figure 1. Poorly applied dressing — notice the excoriation around the surrounding skin

Figure 2. Correctly applied dressing — surrounding skin intact

may be appropriate for the majority of the dressing to sit underneath that area, and if standing up the majority of the dressing may need to go downwards towards the leg.

Intimate dressing contact with the wound should be encouraged by gently pressing the entire dressing surface and not just the edges. *Figure 1* shows where the dressing had been poorly applied, a wound on the natal cleft that was constantly leaking past the adhesive because the entire surface was not in contact with the periwound area. *Figure 2* shows where the dressing had been correctly applied, as the dressing had been in intimate contact — the periwound area and wound has notably improved.

TONY'S PLAN FOR SHARED CARE

The dressing plan for shared care initially involved twice daily dressing changes until exudate was better controlled. It was important for Tony and his wife to feel confident in changing the dressing in between nurse visits. As it was a complex, deep cavity wound with undermining *(Figure 3)*, it was agreed that for the first week district nurses would carry out the morning dressing change, including packing a dressing into the cavity, and for the secondary dressing to be changed in the evening by Tony's wife.

During this time, Tony used a low air loss pressure mattress with assisted turn and a support cushion when spending short periods out of bed. A nutritional supplement in the form of a high protein drink was also recommended, as one of

Figure 3. A complex, deep cavity wound with undermining

the problems associated with excessive exudate production is protein loss and fluid/electrolyte imbalance (WUWHS, 2019).

OPTIMISING AN ABSORBENT DRESSING

When selecting an absorbent dressing, it needs to:

- Absorb and lock the fluid in
- Minimise the need for an increase in nursing visits
- Prevent strikethrough
- Protect the surrounding skin.

It should also be easy to apply and remove and available in a good range of dressing sizes that have the ability to stay in place. A dressing with a silicone layer that can protect the wound bed and vulnerable periwound skin by reducing the risk of skin damage during dressing changes is recommended (Wounds International, 2019).

WHY IS IT IMPORTANT TO MANAGE EXUDATE?

By effectively managing the exudate, this will help to:

- Reduce the time for a wound to heal
- Prevent exudate-related problems, such as maceration and infection
- Improve patient quality of life
- Ensure effective and cost-effective care (Wounds UK, 2013).

It is vital to remember that insufficient exudate production (as well as too much) can be detrimental to healing and wound contraction and may increase pain (Benbow and Stevens, 2010; WUWHS, 2019). By using a step-up and step-down approach, this will help to manage exudate levels appropriately.

TONY'S WOUND CARE JOURNEY

After two weeks, daily/twice daily dressing changes were reviewed, and the periwound area was much improved. There was also a reduction in odour. District nurse visits were reduced to three times a week, and Tony's wife renewed the secondary dressing — a Zetuvit® Plus Silicone Border, depending on the levels of exudate. Both Tony and his wife were happy with this regimen, they were confident in carrying out dressing changes but also knew that if needed, they could reach out to a nurse for help. Due to reduced odour, Tony felt comfortable for his family to visit.

After six weeks, the periwound skin was fully healed *(Figure 4)* and odour had gone. Tony was feeling well, and his wife found the dressings easy to apply and remove. Tony began to spend longer periods out of bed and had the confidence to go out for an evening and spend time with his friends. Treatment with topical negative pressure commenced.

CHOOSING SHARED CARE

Debbie Simon asserted that self-care should not be used in isolation and a shared care approach must be taken; however, it is crucial to remember that this may not be appropriate for every patient, family member or carer. It may depend on the wound complexity, access to the wound or the patient/carer feeling comfortable to take on the task set. It is important to take the opportunity to work with industry to identify the shared care model that works best for both a clinician and their team, but, nevertheless, all approaches to care must be supported by a clear plan and robust documentation.

Figure 4. Moisture damage to the surrounding skin had healed

CHOOSING A PRODUCT TO SUPPORT SHARED CARE

Selecting an appropriate dressing based on the current exudate levels is vital to assist healing and prevent complications (Gardner, 2012), and to support shared care. A retrospective audit of the treatment of wounds with moderate to high exudate levels was carried out by Stephen-Haynes et al (2018), which found that almost 2 out of 3 patients were treated with inappropriate dressings to manage exudate levels.

Zetuvit® Plus Silicone Border is a superabsorbent polymer (SAP) dressing with a silicone interface and border, suitable for treatment of injured skin in acute and chronic wounds with moderate to high levels of exudate, providing optimal moisture management (Wounds UK, 2020). The dressing is ideal to use when exudate levels exceed the absorbency capacity of a foam dressing but switching to a superabsorbent dressing with secondary fixation is not yet appropriate. Zetuvit® Plus Silicone Border absorbs wound exudate from the wound bed and the SAP within the dressing retains exudate away from the wound bed, which in chronic wounds often contains damaging components (e.g. excess MMPs). The silicone wound contact layer of the dressing allows dressing changes to be carried out atraumatically and helps to protect the surrounding skin, and the wound bed itself. It is recommended as a primary and secondary dressing (Wounds International, 2019; WUWHS, 2019), and it is available in a range of sizes.

For use in shared care, the dressing has further characteristics to help aid the patient, including:

- Ease of use, being able to be self-applied and removed; pain-free during both activities (Barrett et al, 2020)
- Indicate when the dressing needs to be changed

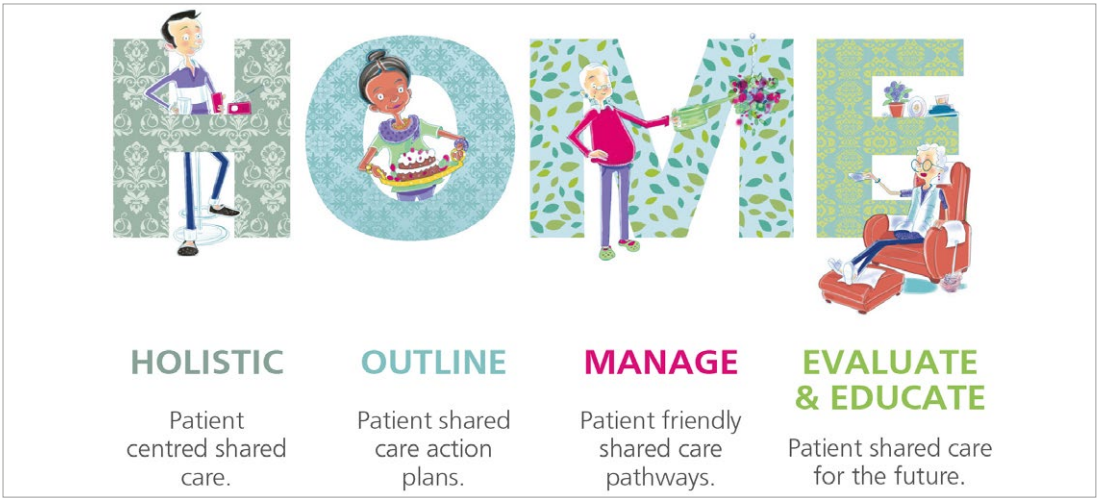

Figure 5. HOME, a shared care initiative

(exudate should be apparent within the dressing; Wounds UK, 2020).

SHARE THE CARE AT HOME WITH HARTMANN

HOME has been devised by HARTMANN to help support clinicians starting a shared patient journey. The HOME acronym stands for: Holistic — patient centred shared care, Outline — patient share action plans, Manage — patient friendly shared care pathways and Evaluate & Educate — patient shared care for the future *(Figure 5)*.

Using the HOME approach will help to identify which patients can safely take part in their care, making the shared management of their wounds part of everyday life. Tools are available for holistic assessment/planning and implementation during the shared care journey, in order to manage the process and evaluate the success of each individual plan. Patient postcards, friendly care plans, pathways and a wound journal are available from HARTMANN, more information can be found at www.sharedcareathome.com.

To offer further support, clinicians also have the opportunity to enrol on HARTMANN's 'Shared care at Home Education Programme' *(Figure 6)* — a structured educational package aimed at providing clinicians with all the necessary support and tools to actively identify, support and implement a shared care approach with patients.

CONCLUSION

Ultimately, a shared care approach should be considered by clinicians whenever possible — placing patients at the centre of decisions about their care and treatment and allowing them to take a more active role in their health and wellbeing. It is important to remember to continually assess if a patient is able to participate in a shared care approach, as the situation may change throughout their wound healing journey. WUK

Figure 6. HARTMANN's 'Shared care at Home Education Programme'

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