Will providing ‘care closer to home’ result in more complex wound care?

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Depending on the patient’s presenting factors, managing complex or ‘hard-to-heal’ wounds can be a significant challenge for the community nurse. Increased longevity, while a positive also means that people are surviving medical and surgical procedures which were life-threatening in the past, with a 20% reduction in avoidable deaths. The delivery of complex community wound care is not a new concept, however, it is dependent on a number of factors such as the expectations of commissioners, providers, and health and social care policymakers, as well as the patient and the skill of the clinicians performing the care. Financial cutbacks in the NHS have also had a negative impact on the delivery of some community healthcare services. This article investigates whether all of these factors have impacted on the amount of complex wounds now being managed in the community setting.

KEYWORDS:
- Wound Care
- Complex wounds
- Skill-mix
- Longevity

In modern times medicine has been successful at keeping people alive for longer, achieving a significant reduction in avoidable deaths (NHS England, 2014). However, increased longevity means that elderly patients can present with a significant number of comorbidities and are often taking multiple medications, both of which can have a serious effect on the wound-healing process (Ferreira et al, 2006; Vowden, 2011). For example, steroids used in the treatment of chronic obstructive pulmonary disease (COPD) or rheumatoid arthritis can inhibit inflammation, which is an essential element in the initial phase of wound healing.

In addition to the individual patient’s circumstances, recent government directives such as ‘care closer to home’ (Department of Health [DH], 2009) have promoted the early discharge of patients, the theory being that they can receive the appropriate care at home rather than spending extended periods in hospital (The Health Foundation, 2011; Royal College of Nursing [RCN], 2014). All this is exacerbated by the various cost-cutting initiatives that form part of the NHS-wide cost improvement programme.

As a result of all these factors, the outcomes of patients with complex wounds vary across the country depending on the level of support community nurses receive from their local acute trust and wider multidisciplinary team, as well as their own skills in dealing with more difficult wound care challenges (Timmons, 2006; Shepherd, 2012; Eskes et al, 2013). This variation in patient outcomes across the country is also influenced by the lack of wound care on the core curricula of university nursing programmes.

COMPLEX WOUNDS

In most situations, wounds heal without any complications as the wound margins are brought together and secured (primary intention). A number of acute surgical wounds will dehisce (where the edges come apart) due to infections or other complications — as a result these wounds tend to heal from the ‘bottom up’ (secondary intention) and are usually termed chronic or complex wounds (Hall et al, 2014).

There are many definitions of complex wounds in the literature. For example, Butcher (1999) defined a complex wound as ‘one which either does not heal as expected, cannot be easily managed with the available resources or extends beyond nurses’ experience or knowledge base’.

Although these wounds are all healing through secondary intention, they can be superficial, partial-thickness or full-thickness and can include leg ulcers, pressure ulcers, foot ulcers, fungating lesions and dehisced surgical lesions (Ferreira et al, 2006; Hall et al, 2014).

Patients who have complex wounds will experience a number of symptoms including prolonged healing, persistent pain, excessive exudate, malodour, distress and a negative impact on quality of life (Vowden, 2011). A position document from the European Wound Management Association [EWMA] (2008) highlighted a number of factors known to precipitate wound complexity or delaying healing (Table 1).

COMMUNITY EXPERIENCE OF WOUND CARE

Treatment for patients with complex wounds in the community is mainly delivered by nurses, with district nurses doing the bulk of the care. In turn, nurses are supported by the multidisciplinary team including tissue viability nurses, dermatologists, vascular teams, podiatrists,
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physiotherapists, occupational therapists (Ferreira et al, 2006; Hall et al, 2014), and at times psychologists.

From a clinical point of view, complex wound care in the community is known to increase nurses’ workload as well as pushing up the cost of treatment (Vowden, 2011; Chamanga, 2014). A report from the Queen’s Nursing Institute (QNI) (2014) showed that many of the community nurses surveyed were experiencing low morale, with 70% grading this as ‘quite poor’ or ‘extremely poor’. The factors listed as having a particular impact on morale included:

- High workloads
- Working unpaid hours
- Fear of letting patients down
- Poor management
- Too much paperwork
- Cuts to the service

Obviously, any community nurses dealing with the challenges outlined above will find that managing complex wounds becomes increasingly difficult, potentially supporting the argument of Persoon et al (2004) and Parkinson, (2006) that in some cases nurses may come to regard wound care as a burden. Not only does this deviate from the principles of patient-centred care, which focuses on the individual’s perception of his or her healthcare needs (Manley et al, 2011); there is also the risk that once nurses start to feel that they are letting patients down due to consistently high workloads, they may become task- rather than patient-oriented.

### EFFECTS OF POLICY ON WOUND CARE SERVICES

Over the past few years government directives have focused on providing health care closer to patients’ homes, encouraging early hospital discharges or avoiding admission in the first place (DH, 2006, 2009). These directives aim to see more care provided by community staff and/or in primary care settings instead of hospitals. Similarly, the Health Select Committee (2014) strongly advises that health and social care services should be integrated, again with the focus on treating the person not the condition.

In places where integrated services have been successful, there is evidence to show that close collaboration between local commissioners, service providers and frontline staff have been instrumental in that success (RCN, 2014). Contrary to this, poor implementation has also been reported in some places (All Party Parliamentary Group [APPG], 2014), with the following consequences for wound care:

- Feelings of frustration, distress and anxiety for patients and families
- Unnecessary trips to hospital
- Higher rates of wound infection
- Poorly managed exudate leading to wound deterioration (Shepherd, 2013).

According to NESTA (2013), an independent charity that promotes innovative research, a significant number of the NHS leaders accept that over the next 15 years the organisation will have to improve health outcomes without a concomitant rise in resources. This brings into question expectations around the level and quality of services for patients with multiple comorbidities who are more likely to be at risk of complex wounds. Similarly, it is a model that is only viable if more patients are empowered to manage their own conditions (NESTA, 2013; APPG, 2014).

However, there are further variables that need to be taken into account, such as changes in population demographics — with people now living longer — and the impact of other diseases that are either on the increase or about which more is now known, such as dementia. These groups of patients can also have a serious impact on wound care provision as a result of poor concordance. NHS England (2014) has also noted that not all patients wish to be more informed and involved with their own disease management, making it difficult to implement preventative strategies and support self-care.

NESTA (2013) argues that for any savings to be achieved, commissioners must be prepared to invest in support clinicians as care moves from the hospital to the community. Both commissioners and providers need to have the same ultimate aim of improving patient outcomes, even if their care business and perspectives may be different (Figure 1). However, seeing as both commissioners and providers are targeting hospital avoidance, it may be difficult to guarantee the quality of complex wound care being provided in the community across the whole service.

Furthermore, the increased focus on community care is underpinned by the need to make £20 billion in NHS efficiency savings by 2014/15, which is likely to widen to £30 billion by 2020/21 (Health Select Committee, 2014). It is difficult to see how either commissioners or providers can guarantee improved health outcomes for patients while simultaneously seeking to lower costs.

### SKILL-MIX

Moving more hospital-based health care into the community has been on the government’s agenda for the past decade (DH, 2006; RCN, 2014). However, there has been little extra investment set aside to facilitate the shift from secondary to primary care (RCN, 2014), with community nurses in particular reporting a lack of training opportunities (Stephenson, 2014), which in turn impacts on the quality of wound care services they are able to provide (Chamanga, 2014).

On the other hand, one community nursing team from Merseyside reported a 21% reduction in bed days for patients with complex wound care needs (Nursing Times, 2009). This was achieved by...
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introducing advanced therapies (such as negative pressure wound therapy [NPWT]) into the community, which sped-up the wound-healing process. The success was also attributed to patients being discharged from hospital with clear care pathways and making sure that the community nursing team received specific training in complex wound management.

This model demonstrates that complex wound care management can be a success in the community, both complying with government directives on early discharge while also realising efficiency savings. However, other research showed that there are too few community nurses with the right skills and qualifications to deliver care for patients with complex needs (Chamanga, 2014; Stephenson, 2014).

If good wound care services are to be provided for patients with complex needs in the community, then training will have to be provided to improve the skills of community nursing staff.

**HOW CAN COMPLEX WOUNDS BE MANAGED IN THE COMMUNITY?**

Although it has been noted that some patients may be less than enthusiastic when it comes to getting involved with their own care (NHS England, 2014), according to the National Institute for Health and Care Excellence [NICE] (2012) many others do wish to participate.

This is demonstrated in the author's clinical practice where patients are happy to learn about advanced wound care therapies (such as learning how to change NPWT canisters) so that they can troubleshoot or advise community nurses on whether or not the therapy is working.

Similarly, in the case of chronic leg ulcers patients have become experts in managing their own wounds with the help of organisations such as the Lindsay Leg Club Foundation, an evidence-based initiative that provides community-based treatment, health promotion and ongoing care for people with leg-related problems (www.legclub.org).

NICE (2012) has also drafted guidance on patients' experiences of adult NHS services with the points listed in Table 2 aimed at enhancing the provision of care for patients with complex wounds in the community.

**CONCLUSION**

Evidence demonstrates that the provision of complex wound care in the community is as safe as hospital care. However, to effectively support wound care provision in the community, frontline nurses need to be properly resourced to be able to meet the needs of patients with complex comorbidities.

The government, commissioners, healthcare providers and policymakers need to be aware of complex wound care-related factors (such as healing rates and the impact of wounds on patients), clinical competencies and resource issues before making strategic decisions.

Reconfiguring the way complex wound care is provided has to take account of local clinical skill-mix and provide holistic patient assessments that factor in all of the patients’ comorbidities. It is also unlikely that all complex wound care patients will be simply discharged home and some may need relocation — in nursing homes for instance — when they leave hospital, therefore health and social care models need to be seamless.

Similarly, the provision of best practice community-based complex wound care requires patients who are nursed at home to be fully engaged in any decision-making about their care.
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Case study

This case study features a semi-complex community wound care case. Achieving the aim of allowing patients to remain in their own homes can be difficult, but it can become extremely problematic if those patients have other complex comorbidities, as illustrated here.

Background

Mr X was a 78-year-old man with a grade three lower thoracic pressure ulcer and a grade four sacral pressure ulcer. He had a history of dementia and confusion and was bed-bound, requiring regular repositioning from visiting care staff in an attempt to manage his pressure ulcers. He lived alone in a cold four-bedroom house with only an electric heater in the main room.

Challenges

Mr X’s carers were only contracted to visit four times a day. As a result of his confused state he found it difficult to remain in the correct position for any length of time, usually repositioning himself once the care staff had left. Mr X’s nutritional needs were often unmet with staff needing to spend a prolonged period of time encouraging him to eat his food.

Risks

The risk is that Mr X would deteriorate further until he ended up with multiple pressure ulcers. The worse-case scenario would have been hospital admission with sepsis from multiple pressure ulcers, which would have required safeguarding measures and multiagency investigations, not to mention the terrible price for Mr X himself in pain and suffering.

Ideal situation

Mr X required either an increased package of care that provided for both his social and wound care needs (in this case, hourly repositioning on a pressure-relieving mattress). If this could not be arranged, then Mr X should have been placed in a healthcare setting where staff and wound care specialists would be better able to care for him. For example, a nursing home would have been able to provide him with a two-hourly repositioning regimen and qualified nurses and carers would be at hand to support his needs around the clock.

REFERENCES


RCN (2014) Moving Care to the Community: an international perspective. RCN, London.


