

Raising gambling awareness

In This Together: a new website for your patients

New film celebrates international nurses in England

New free digital wellbeing resource for nurses

Open conversations and racism: finding a way forward

Pressure ulcer risk assessment tools — test your clinical skills

Optimising patient involvement in chronic wound care

Hidradenitis suppurativa: diagnosis and treatment

Wound preparation and the role of mechanical debridement

Challenges in skin tone assessment in moisture-associated skin damage

Cervical cancer: risk factors, screening and treatment

Life stories in dementia care: ensuring person-centred care

Keeping the person at the centre of digital communication in health care

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Contents

| | |
|---|----|
| Gambling: a hidden addiction Annette Bades | 4 |
| Raising gambling awareness Charles and Liz Ritchie | 8 |
| In This Together: a new website for your patients Nicola Rusling | 11 |
| New film celebrates international nurses in England Matthew Bradby | 12 |
| New free digital wellbeing resource for nurses Rebecca Howard | 14 |
| Open conversations and racism: finding a way forward Megan Rowlands, Satbir Saggu, John Walsh | 18 |
| Clinical skills: Pressure ulcer risk assessment tools — test your clinical skills | 20 |
| Optimising patient involvement in chronic wound care Luxmi Dhoonmoon | 24 |
| Hidradenitis suppurativa: diagnosis and treatment Cheryl Handley | 30 |
| Wound preparation and the role of mechanical debridement Jen Letchford | 38 |
| Challenges in skin tone assessment in moisture-associated skin damage Nyssa Cole, Sarah Waller | 45 |
| Cervical cancer: risk factors, screening and treatment Margaret Perry | 50 |
| Life stories in dementia care: ensuring person-centred care Karen Harrison Dening | 56 |
| Keeping the person at the centre of digital communication in health care Ellie Lindsay OBE | 64 |
| My community Liz Atkins | 66 |

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own for an article, please contact:
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Gambling: a hidden addiction



Taking a holistic approach and actively listening to patients is crucial in all patient encounters. It can allow you to understand patients' concerns, values and the impact that certain behaviours or conditions might be having on their lives. Gambling disorder, often referred to as a 'hidden addiction' is, as Charles and Liz Ritchie point out (pp. 8–10), an extremely serious issue which can have devastating consequences for individuals and their families. As community nurses visiting patients

in their own homes, we have a unique opportunity to identify signs of gambling harm and offer support. Clearly, it's a topic that needs to be approached sensitively and without judgement, but recognising gambling disorder as a public health concern and addressing it within the context of a patient's overall wellbeing can make a significant difference to their lives and the lives of those around them.

Person-centred care is a term we constantly hear, emphasising the importance of keeping the patient at the heart of their own care journey. However, with increasing demands on healthcare professionals and the integration of technology into various aspects of work, it can sometimes be challenging to maintain a truly patient-centred approach. Ellie Lindsay OBE, through her personal insight (pp. 64–65), highlights the significance of preserving the nurturing aspect of care even in the face of increasing digital communication in health care. While there's no doubt technology can improve communication and efficiency in some areas, it should not overshadow the need for empathy and individual attention that patients require.

The articles on wound care featured in this issue shed light on the diverse range of care that community nurses provide. For instance, diagnosing and treating hidradenitis suppurativa, a chronic skin condition, requires understanding of the condition itself, as well as the patient's unique circumstances and the importance of tailoring treatment plans to individual needs and preferences (pp. 30–37). Additionally, the article on challenges related to skin tone assessment in moisture-associated skin damage (MASD) discusses how skin tone variations can affect assessment of MASD, underscoring the need for healthcare professionals to be aware of and address potential biases (pp. 45–49). We are also reminded of the important role of mechanical debridement in wound management and promoting healing (pp. 38–44).

As always, I hope you enjoy reading the articles in this issue.

Annette Bades, editor-in-chief, JCN

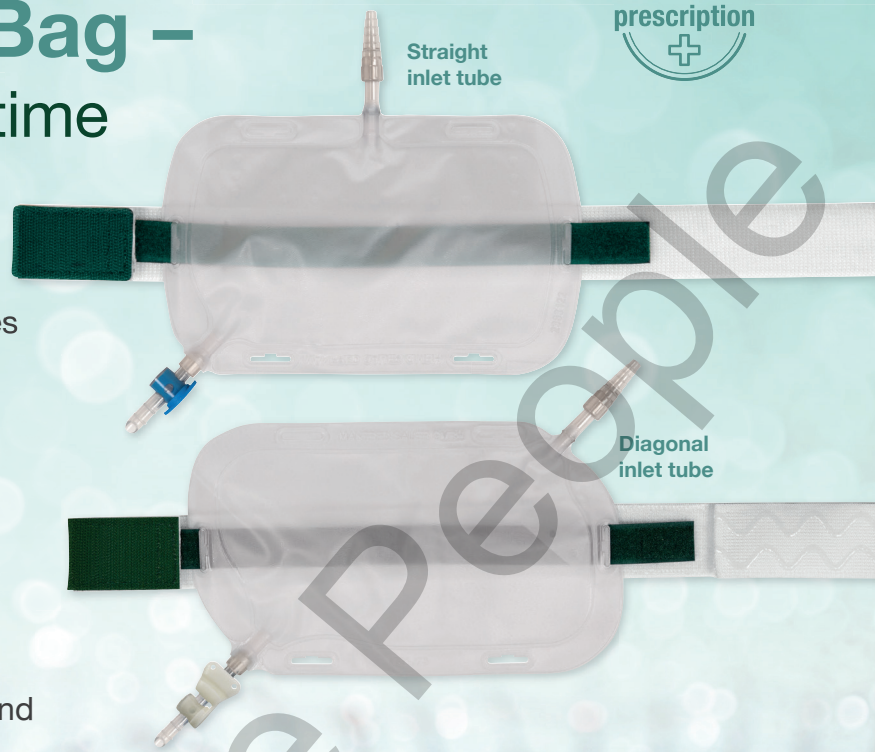


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Amanda Young, *director of nursing programmes (innovation and policy), Queen's Nursing Institute (QNI)*



I am a district nurse, nurse teacher in practice, associate lecturer and Queen's Nurse who believes that excellent community nursing is vital and that community nurses should be more visible. Care should be available to everyone who wishes to remain at home. I have an interest in dementia, end-of-life care and teaching in practice to support newly qualified nurses. I am very pleased to be a part of the JCN editorial board, an accessible journal for all community nurses to inform their practice and strive for excellent care.
Gail Goddard

I am a district nurse and an academic with a passion for end-of-life care, older people and nurse education. I believe that care at home gives people the best opportunity to remain in control of their own health and wellbeing. It is a privilege to be a guest in a person's house and to help them achieve their goals. It is also a privilege to train nurses of the future to adopt this personalised care approach to really make a difference. I am excited to join the editorial board of the JCN where I can see the hard work that community nurses undertake.
Amanda Young



I am a freelance tissue viability nurse (TVN) and health visitor. My true passions are in pressure area care and moisture-associated skin damage. I sit as a registrant panel member on the NMC Fitness to Practice Hearings, and work with the Institute of Health Visiting (IHV), where I have recently supported the development of a training package on domestic violence and abuse (DVA). I am delighted to be part of the JCN editorial board, where current best practice can be discussed.
Melanie Lumbers

I've been working in district and community nursing for 20 years. My particular passion is for continuity of care in community nursing, which encourages healthy behaviour, builds trusting relationships, can reduce healing times, and makes people feel more positive about their healthcare experience. We have a responsibility to prepare for the future by continuing to develop leadership and clinical skills. The JCN is a great resource for support, education and to share best practice.
Hattie Taylor

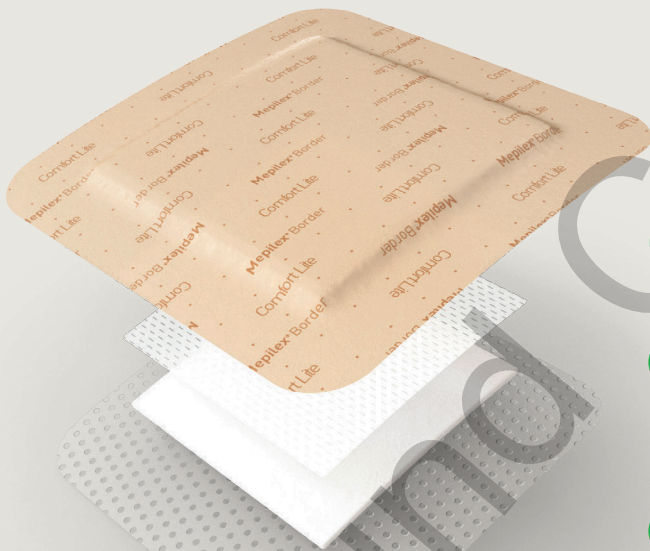
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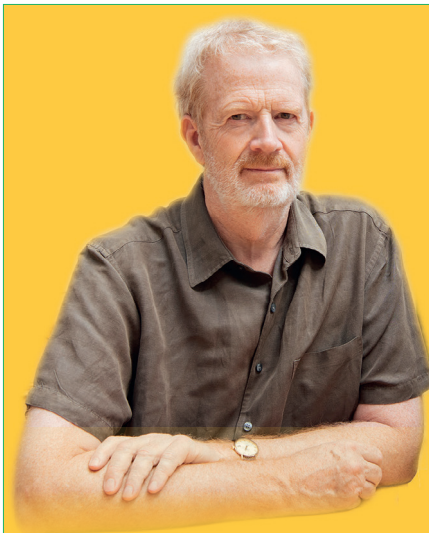
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Charles and Liz Ritchie, founders of Gambling with Lives

Raising gambling awareness

**GAMBLING
WITH
LIVES**

but rather the catastrophic effect that high-speed, industrialised forms of electronic gambling had on his mental health. The note said that he thought that he would never be free.

Since gambling was deregulated in 2005 it has been normalised, just as smoking once was. £1.5 billion is spent each year on advertising and marketing (Parliamentary business, 2020). People are offered inducements such as so-called 'free bets' and 'free spins', designed to keep people gambling as long as possible and to encourage the development of addiction. These predatory practices have been highlighted by recent multimillion-pound fines levied on gambling operators for breaching their licensing rules (Gambling Commission, 2023).

This is an industry which makes over £14 billion gross profit a year in the UK (Statista, 2023) and where 86% of gross online betting profits come from just 5% of customers (NatCen Social Research, 2021), likely those who are addicted or at risk of addiction. This has created a public health crisis in the UK, with up to 1.4 million people (Gunstone et al, 2021) — including 55,000 children (Parliamentary business, 2020) — addicted to gambling, and many more millions harmed.

Like most industries who have harmful products to sell, the gambling companies try to obscure the link between the products and the harm to health. The best way to do this is to label people who have become addicted to toxic products

through predatory practices, as weak, flawed, or vulnerable. This creates a narrative that minimises the risk to the wider public and disguises the reality that it is the products that create this addiction.

High-speed electronic gambling products are designed to target the brain's reward system and the speed and excitement of the game increases the risk of addiction. Previously thought to be a compulsion disorder, gambling addiction is now identified as a behavioural addiction and a serious diagnosable mental health condition (DSM-5). A gambling addiction can have catastrophic effects on a person's mental and physical health, their relationships, career and overall self-esteem and self-worth for years. The tool used to assess severity of gambling harm is the Problem Gambling Severity Index (PGSI), but unlike the AUDIT scale for alcohol harms, the PGSI is not well known or used in primary care.

Gambling disorder is highly correlated with suicide. A study from Sweden found that those addicted to gambling were 15 times more likely to end their lives than those not addicted (Karlsson and Hakansson, 2018). In 2021, a landmark Public Health England (PHE) study estimated that there are more than 400 suicides a year linked to gambling in England alone — more than one every day (PHE, 2021). Bereaved families believe that the normalisation of gambling and the narrative that it is all the individual's fault contributes to suicides. We know it does — we have read the suicide notes.

When our son Jack told my husband and I that he was gambling, we had no idea his life was at risk. As parents, we thought we knew all the dangers to warn our children about — drinking, drugs, smoking, road safety, sexual predators.

But there was one predator that no one warned us of, one with bright, flashing lights, a sickening simulation of friendship, pushing products with higher addiction and at-risk rates than that of heroin, marketed as an innocent leisure activity. Jack and his friends were gambling in their dinner hour with their school dinner money. They were told it was just a bit of fun.

Jack was 24 when he took his life because of gambling. He left a suicide note that made it clear it was not because of lost money, debt, or pre-existing mental health problems,

When Jack began gambling as a schoolboy on fixed-odds betting terminals (FOBTs) during his lunch hour, we had no idea about any of this, and nor did he. Jack had an early 'big win' — a common precursor to addiction — but he never lost huge, life-changing sums of money. He frequently abstained from gambling for long periods of time. He was the definition of what the gambling industry would call a 'responsible gambler'. He eventually began gambling online, where the most dangerous gambling products are available 24/7 in a completely unsupervised environment.

He actively sought help to stop gambling: he came to us, went to see his GP, and self-referred to psychological services, but no one had the information that could help him. If Jack had said he was taking heroin, we would have known the risks. We would have known how to help him, services would have known how to help him, but this was not the case with gambling.

Jack was ultimately misdiagnosed with an anxiety disorder, when really the symptoms he was presenting with — insomnia, anxiety, depression — were caused by an untreated gambling disorder. His GP did not know the severity and risks of gambling addiction and the impact it has on a person's health and wellbeing. Instead, Jack was seen as using gambling to cope with these symptoms. Consequently, the



Jack Ritchie.



Gambling with Lives at the Labour Party conference.

Screening in primary care, clear referral pathways, training about products, and how to talk to those at risk, and widespread knowledge about the link between gambling harms and the increased risk of suicide must become common practice.

right treatment was not provided, and the risk of suicide not seen.

To be clear, we do not blame the healthcare professionals for misdiagnosing Jack — they had also been kept in the dark and did not have the necessary information or training to help patients like Jack.

Last year at the inquest into Jack's death, the coroner confirmed what we already knew when he ruled that the 'warnings, information and treatment available to Jack were woefully inadequate' and ultimately contributed to his death.

During the inquest, the coroner heard how it was well known across government departments and the Gambling Commission (the body responsible for regulating the industry) that gambling carries a high suicide risk, but that not enough was done to warn the public.

The coroner issued a prevention of future deaths report (Courts and Tribunals Judiciary, 2022) to government departments and highlighted the urgent need for more training for GPs, nurses, and all healthcare professionals about how to diagnose and treat gambling disorder.

Things have improved since Jack died. There are now a growing number of specialist NHS gambling clinics that offer patients evidence-based treatments like cognitive behavioural therapy (CBT), but in the words of the coroner at Jack's inquest, 'significantly more' needs to be done.

Screening in primary care, clear referral pathways, training about products, and how to talk to those at risk, and widespread knowledge about the link between gambling harms and the increased risk of suicide must become common practice.

Identifying, supporting, and signposting someone to engage with specialist NHS treatment organisations and industry-free support services (see *Treatment and support box*) could change someone's life, and the people close to them.

After Jack died, my husband Charles and I started Gambling with Lives, a charity that supports

those who have lost loved ones to gambling-related suicide. We offer emotional support, peer support, arrangement of memorial events, help with legal proceedings, debt and probate, and the opportunity to campaign for changes that will save others lives.

Gambling with Lives is one of many organisations campaigning for life-saving amendments to the 2005 Gambling Act. A recently released white paper agreed to introduce a statutory levy on the gambling industry's profits to pay for treatment, education, and research. The levy's design and scope are being consulted on but, if implemented correctly, it could end the industry-funded commercial disruption of health care that stops treatment from being impartial and effective.

GPs, nurses, and mental health professionals need to know gambling disorder is a serious addiction that kills. Those on the frontline of care should understand that some products are far more dangerous than others, and that the shame, stigma, and misinformation that surrounds gambling will prevent patients seeking support.

Effective evidence-based treatment options and established pathways within the NHS are needed, as well as proper public health messaging, information, and education. Gambling disorder should be placed in the same territory as other addictions and primary care has a key role to play in the identification, assessment, and support of these harmed and maligned individuals. **JCN**

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Treatment and support

For gamblers

Blocking tools — treatment for gambling disorder is essential, but the first step to stopping gambling often involves using blocking tools, such as Gamban and GAMSTOP. Once set up and registered, these tools will automatically self-exclude you from all UK-licensed online bookmakers.

- ▶ Gamban: www.gamban.com
- ▶ GAMSTOP: www.gamstop.co.uk

Many banks also give you the option to block all gambling transactions, including Lloyds, Halifax, HSBC, Starling and Monzo.

Self-excluding from land-based venues:

- ▶ MOSES (multi-operator self-exclusion scheme)
- ▶ www.self-exclusion.co.uk

Treatment providers

- ▶ NHS Northern Gambling Service — NHS clinic offering specialist addiction therapy, covering the whole of the north of England; Tel: 0300 300 1490; Email: referral.ngs@nhs.net
- ▶ NHS National Problem Gambling Clinic — NHS clinic offering specialist addiction therapy based in London; Tel: 020 7381 7722; Email: gambling.cnwl@nhs.net
- ▶ The Southern Gambling Service — www.southernhealth.nhs.uk/our-services/a-z-list-of-services/gambling-service Tel: 02382310786
- ▶ The West Midlands Gambling Harms Clinic — www.inclusion.org/our-services/addiction-services/west-midlands-gambling-harms-clinic/

Peer support

- ▶ Gamblers Anonymous — organising meetings of people struggling with gambling addiction across the country: www.gamblersanonymous.org.uk
- ▶ GamLearn — support for people harmed by gambling by aiding their professional development: www.gamlearn.org.uk

For family and friends

- ▶ GamFam — help for families to recognise and deal with gambling addiction: www.gamfam.org.uk
- ▶ GamAnon — local meetings for families of gamblers: www.gamanon.org.uk
- ▶ Support for those affected by gambling-related suicide: www.gamblingwithlives.org

Information and resources for those suffering harm, affected others and professionals

- ▶ Chapter One — www.chapter-one.org/

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Nicola Rusling, editor, *In This Together* and director, *Wound Care People*

In *This Together* (ITT) is an informative magazine, now in its sixth year, for people with conditions that require long-term management with compression therapy. We are excited to also launch the *In This Together* website so that we can offer more frequent education, resources and updates in between issues of the magazine.

IN THIS TOGETHER

In This Together as a brand has always been dedicated to enabling people with conditions such as venous leg ulcers and lymphoedema to understand more about their condition, the products available to them — including prescription delivery services — and to access communities that can provide ongoing support. Healthy lifestyle advice that encompasses the psychosocial impact of living with a long-term condition is also featured to help people who wear compression to live life to the fullest.

DIFFICULTIES WITH COMPRESSION THERAPY

Compression therapy is well established as the gold standard therapy for the treatment of venous and lymphatic conditions (Wounds UK, 2016; Wound Care People, 2019). It is also known, however, that there are numerous reasons why people fail to wear their compression garments long term (Moffatt et al, 2007; Wounds

In This Together: a new website for your patients

UK, 2016; Wound Care People, 2019). Although this is a complex area with no 'one size fits all' explanation, key factors include pain and a lack of understanding of the role that compression plays in improving the underlying lymphovenous disease that results in signs and symptoms, such as swelling and ulceration (Moffatt et al, 2007; Wounds UK, 2016; Wound Care People, 2019).

From a psychosocial perspective, people with lymphovenous disease use different coping strategies influenced by their personality, degree of illness and support system, to live with their situation (Moffatt et al, 2007). Social isolation and no or little support is known to contribute to delayed healing (Moffatt et al, 2007).

Empowering patients with appropriate understanding of their condition and support can help them to live more successfully with their long-term condition, including the adoption of self-care strategies (Wounds UK, 2016; Wound Care People, 2019).

PATIENT EDUCATION AND SUPPORT

Both the ITT magazine and website are produced by the experienced team behind the JCN and GPN to provide patient information in an accessible way, while making sure it is line with current national guidelines. To do this, we engage with practicing clinicians to ensure our content is accurate, and with patients to make sure our content is pitched at a level that is easy to understand and contains information of value.

We produce the magazine in association with Daylong Direct, who distribute it to all their customers.

Both the magazine and website are free to access, which would not be possible without support from our industry partners JOBST and L&R Medical UK, who are both committed to providing products and resources for people living with lymphovenous disease to improve their lives. JOBST provide LymphConnect, a free online resource for people with lymphoedema and lipoedema. L&R Medical UK have Club Squeeze In for people with lower-limb conditions, such as venous leg ulcers.

Through ITT magazine, we also engage with national charities, providing regular updates, and also have articles, including patient experience stories. We aim to further promote these valuable communities through the website, so people with lower limb conditions know where to access support and share experiences.

Finally, we hope as clinicians you will find the ITT website of value, enabling you to direct your patients to a wealth of information, all in one place.

www.inthis-together.com launches in June 2023. **JCN**

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Matthew Bradby, head of communications, Queen's Nursing Institute (QNI)

New film celebrates international nurses in England

'The film explores a number of significant themes for nurses who are working in a new country, including driving, housing, education, professional and personal support.'

these positive and uplifting stories will give a new and richer understanding of the international nursing experience to a wider audience. The QNI would like to thank all the nurse stars who appeared in the film, the people they care for, their families and colleagues, and the healthcare trusts who supported them. The response we have received to the film so far has been overwhelming and I hope it will encourage others to consider a career in the community.

The Queen's Nursing Institute has been working for the past two years on a project to encourage more internationally educated nurses to look at community nursing roles in England. The project is supported by NHS England, hence the geographical focus on that country.

Over the past six months, we have been working on a short film about the lives of four international nurses who have taken up community nursing roles recently. The launch of the film, on International Nurses Day, celebrates the contribution of international nurses to community nursing services in England. Filming took place in March and April in four locations — Herefordshire, Sussex, Hertfordshire, and London.

The film features four nurses — Ananthu Ashok from India, Katrina Capito from the Philippines, Gustav Grib from South Africa and Merin Jolly from India. They all trained in their home countries and their professional and personal journeys have now brought them to new roles in England. In finding nurses to feature in the film, we tried to find nurses from different countries, and who were working in different parts of the country. We also wanted to show urban and rural settings.

Historically, most nurses coming to this country have worked in hospitals as a first destination, but this film shows the range of

opportunities that exist in the community, and the strong support structures that are available for nurses making this transition.

The film is the first of its kind to show the real experience of internationally educated nurses working in the community. It shows the four nurses delivering care in people's homes, in educational and clinical settings, and with friends and family in their local communities. It explores a number of significant themes for nurses who are working in a new country, including driving, housing, education, professional and personal support. It also explores the importance of autonomy in practice and delivering personalised care in the community.

Driving is one of the most common issues cited by nurses and employers for those moving to the UK — the adaptation to new highway regulations, taking a new test for a new licence, and getting access to a car to visit patients at home. Two of the nurses in the film were already driving and enjoying the mobility and independence this gave them.

Dr Crystal Oldman CBE, the QNI's chief executive said:

The film gives a privileged insight into their different life journeys and their aspirations for career and family. We hope

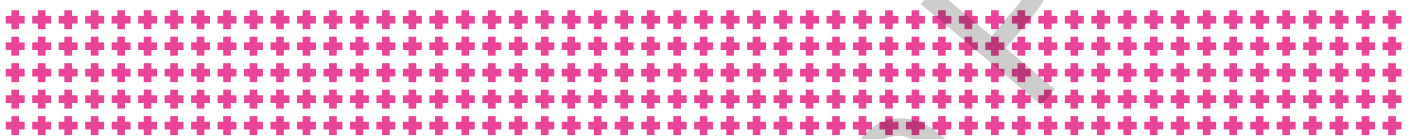
The film can be viewed on the QNI Vimeo channel: <https://vimeo.com/825763074> and can be embedded on third party websites with an attribution to the QNI. The film will be shared on social media platforms and can be used by healthcare organisations to help showcase the opportunities that exist for registered nurses in community settings in their region. The QNI has produced a number of short edits on specific themes that can be used for social media platforms.

The QNI would like to thank Central London Community Healthcare NHS Trust, Sussex Community NHS Foundation Trust, and Wye Valley NHS Trust for their support during the making of the films.

Ananthu Ashok from Sussex won the QNI's award for International Community Nurse of the Year in 2022. The QNI encourages all community healthcare providers to nominate eligible nurses for the award in 2023. Nominations will open during the summer of 2023 and full information is on the QNI website: <https://qni.org.uk/nursing-in-the-community/international-recruitment-to-the-community/international-community-nurse-award/> **JCN**

Community Nurses Touching People's Lives across the Lifespan

Registered Nurses in the community today have many different job titles, reflecting the wealth of opportunities and career pathways available. Community Staff Nurses form part of every team and can choose to specialise in many fields of practice.



Pre-Conception

- General Practice Nurse
- Sexual Health Nurse
- Homeless and Inclusion Health Nurse
- Community Clinical Nurse Specialist
- Nurse Educators / Researchers
- Immigration and Refugee Nurses



Pregnancy

- Midwife
- Health Visitor
- General Practice Nurse
- Community Children's Nurse
- Homeless and Inclusion Health Nurse
- Family Nurse Partnership Nurse
- Community Clinical Nurse Specialist
- Immigration and Refugee Nurses
- Nurse Educators / Researchers



Baby

- Health Visitor
- Midwife
- General Practice Nurse
- Community Children's Nurse
- Homeless and Inclusion Health Nurse
- Community Learning Disability Nurse
- Family Nurse Partnership Nurse
- Community Clinical Nurse Specialist
- Immigration and Refugee Nurses
- Nurse Educators / Researchers



Toddler

- Health Visitor
- General Practice Nurse
- Community Children's Nurse
- Homeless and Inclusion Health Nurse
- Community Learning Disability Nurse
- Family Nurse Partnership Nurse
- Community Clinical Nurse Specialist
- Immigration and Refugee Nurses
- Nurse Educators / Researchers



School-Age Child

- School Nurse
- General Practice Nurse
- Community Children's Nurse
- Health Visitor
- Community Learning Disability Nurse
- Homeless and Inclusion Health Nurse
- Child and Adolescent Mental Health Nurse
- Community Clinical Nurse Specialist
- Nurse Educators / Researchers
- Immigration and Refugee Nurses



Teenager

- General Practice Nurse
- School Nurse
- Sexual Health Nurse
- Community Children's Nurse
- Child and Adolescent Mental Health Nurse
- Transition Nurse (Child to Adult Services in the Community)
- Homeless and Inclusion Health Nurse
- Community Clinical Nurse Specialist
- Community Learning Disability Nurse
- Paediatric Liaison Health Visitor
- Community Mental Health Nurse
- Nurse Educators / Researchers
- Immigration and Refugee Nurses



Adult

- General Practice Nurse
- District Nurse
- Occupational Health Nurse
- Sexual Health Nurse
- Community Learning Disability Nurse
- Community Mental Health Nurse
- Public Health Nurse
- Homeless and Inclusion Health Nurse
- Community Clinical Nurse Specialist
- Transition Nurse (Child to Adult Services in the Community)
- Adult Social Care/Care Home Nurse
- Prison Nurse
- Custody Nurse
- Nurse Educators / Researchers
- Immigration and Refugee Nurses



Older Person

- District Nurse
- General Practice Nurse
- Community Mental Health Nurse
- Homeless and Inclusion Health Nurse
- Adult Social Care/Care Home Nurse
- Community Clinical Nurse Specialist
- Community Learning Disability Nurse
- Immigration and Refugee Nurses
- Nurse Educators / Researchers
- End Of Life/Palliative Care Nurse
- Hospice Nurse



Find out more:
www.qni.org.uk



Rebecca Howard, CEO and founder of ShinyMind and a psychotherapist

Last November I was proud and privileged to be joined by over a thousand nurses, speakers and leaders across the country for the live launch of the new nursing version of our ShinyMind mental health and wellbeing app — available now, free of charge to all NHS nurses, midwives, nursing associates, and healthcare support workers in England.

ShinyMind is the only app co-created, developed and tested in partnership with NHS employees across all levels, and the new nursing version provides over 150 resources, tools and exercises to help support nurses' wellbeing, created in collaboration with nurses and nursing organisations from across the country, including the Florence Nightingale Foundation, Foundation of Nursing Studies, The Cavell Trust and NHS England and Improvement.

The ShinyMind nursing app includes tailored resources, co-designed with nurses, such as reflective supervision exercises, regular 'ShinyMind Live!' webinars and 'LifePacks', such as self-care, mental wellness and coping with anxiety, providing both daily support and help with professional needs such as continuing professional development (CPD). The ShinyMind app is evidence-based and also

New free digital wellbeing resource for nurses

provides other personalised psychotherapeutic masterclasses (including stress, sleep, self-compassion and resilience and 12 more, with others planned), responsive daily mental health support and health nudges.

Additional resources will continue to be added and co-designed with the nursing community, led by Karen Storey, NHS England and Improvement nursing retention and liaison lead, who is in her second year seconded into ShinyMind to support the ongoing development of the app for nurses, and to help engage nurses in co-designing all resources.

For almost 20 years, the majority of our work has involved supporting the NHS and its people. It is currently more important than ever that support is available, as the stark reality is that huge pressures exist in the system, built up over many years even before the additional hammer blow of Covid. We all repeatedly hear of burnout, of truly committed and talented people leaving due to stress and anxiety and, in coaching nurses across the country, I have heard first-hand sad and harrowing stories of anxiety, struggle and helplessness.

But, I also hear many more stories of strength, courage, positivity and passion for their profession from nurses. We never know when loved ones will need their support, but we trust that they will be there in our time of need, always doing their best for us.

At ShinyMind we felt that it was important to give nurses support in return. We want to instil confidence that they can trust in a resource to support them at their time of need, to enhance their wellbeing and

mental health, enabling them to have a positive mindset to continue in the job they love, and on which we all depend.

And because it's important, we wanted to make sure the app worked. Over five years of evidence gathering, live sessions with over 3,000 NHS employees, independent research and testing, and vital collaboration with the nursing professions it's created for, ShinyMind can and does help. Our latest research shows that 94% of a nursing group felt better after using it, 77% felt better at managing their own mental health, and 100% would recommend it to other nurses.

We are privileged to be supported by a nursing advisory board of senior leaders, including Professor Steve Hams MBE, chief nursing officer at North Bristol NHS Trust, who has been helped personally by ShinyMind and spoke at the nursing version launch:

I've been fairly open about my mental health. I've had two experiences of poor mental health and more recently anxiety and depression coming out of the pandemic. I genuinely believe that ShinyMind has helped my recovery this time round and I think that it's truly special, as things like the 'Inspire Me' messages I get at the most impromptu times during the day are really comforting and make me smile. The 'Daily Shine' helps me reflect on what's gone well, and what could've been better, and the Masterclasses really set this app way above the others — sleep, self-compassion and coping with anxiety are those I've used most frequently.

ShinyMind is in my kitbag now. My mental health is my superpower and defines me, and ShinyMind is a fab app!

Professor Gemma Stacey, deputy chief executive officer and director of policy unit at the Florence Nightingale Foundation, believes it is vital that nurses look after their own emotional needs so that they can best support the needs of their patients. Professor Stacey has more than 20 years' experience as a mental health nurse and helped to develop the restorative clinical supervision aspect of ShinyMind:

ShinyMind has so many different kinds of resources within it. It's like an education tool as well as something that you can use practically on a day-to-day basis and to support wellbeing.

Marsha Jones, deputy chief nurse at Epsom and St Helier University Hospitals NHS Trust, is also an advocate for Black, Asian and Minority Ethnic (BAME) employee wellbeing, and believes ShinyMind could help to reduce stigma surrounding mental health within minority ethnic communities. She said:

They're exhausted, they get some of the most awful shifts to work or some have the hardest tasks to complete. Sometimes people don't get a break. They're juggling family life, they're depleted, and that is often sometimes not comparable with the experiences of their white counterparts. So, that's why it is vitally important that we manage the stigma within mental health, especially for cohorts or communities who don't normally feel comfortable to talk about these things.

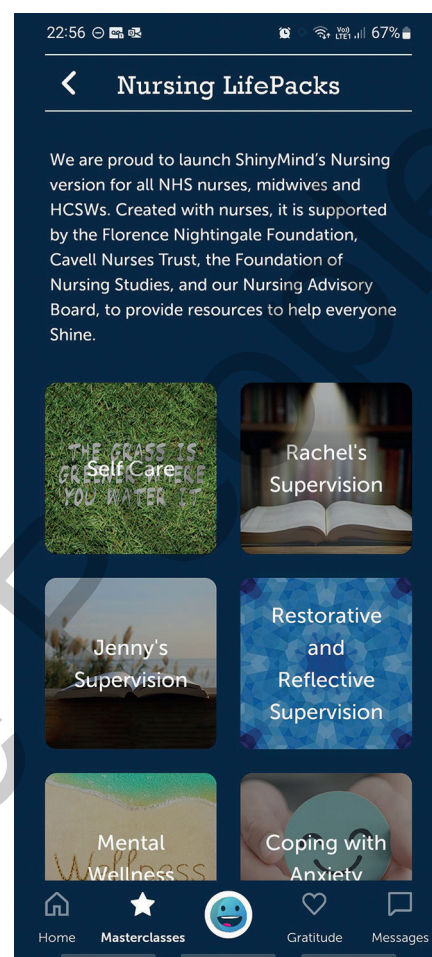
In addition, ShinyMind and primary care staff have co-designed a prescribing portal and NHS systems are now prescribing ShinyMind as a 'wellbeing prescription' for patients with stress and anxiety or suffering from long-term conditions. Initial feedback has

been positive, with 83% of patients stating that they would recommend it to others, 60% said that they were feeling better, and 28% reported an improvement in life satisfaction and a 17% improvement in GAD scores within six weeks.

While it is early days, we are also encouraged by 12-month longitudinal research which is showing that the same patients have 3.5 less GP contacts per year, so reducing pressure on services and staff. This has the potential to create a 'virtuous circle' with our Shine Programme already providing training to GP practice employees, including their own ShinyMind community to support their mental wellness. There are also many other settings where ShinyMind can help, such as in the heart of communities, and we are in discussions with nurse leaders about its potential in community nursing.

The NHS Fuller Stocktake report commissioned by NHS England in May 2022 recognises that 'there are real signs of genuine and growing discontent with primary care — both from the public who use it and the professionals who work within it.' It notes an ever-increasing pressure on primary care services, with teams stretched beyond capacity and staff morale at a record low — the same factors prevalent across the nursing community.

The launch is called 'You can't pour from an empty cup' and that's the reality. We all have different levels at different times, but Steve Hams is by no means alone in terming the situation around nursing burnout as 'endemic', and many of those working within the professional nursing community may have cups about to run dry, if they have not already. The nursing version of ShinyMind aims to help nurses to re-fill their cups, increase understanding of self, be kinder to themselves and help build a positive growth mindset. It also provides resources for professional practical needs such as CPD and reflective supervision.



At the live launch of the nursing version, Janet Thornley, strategic primary care nurse lead at Bedford, Luton and Milton Keynes Integrated Care System likened sharing the app with colleagues and patients to giving a gift you know the recipient is going to like, and 'a job well done.' ShinyMind is free and we believe it can help, so my hope is that as many of the nursing community as possible give it a try.

Given the wonderful support received from the nursing profession, the launch aims to be just the beginning of a journey with every member of the wider nursing community, to collaborate in creating exciting new resources to help and support nurses' mental health and wellbeing in the most trusted, highly regarded profession. **JCN**

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<https://qrco.de/bdRLdL>

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Open conversations and racism: finding a way forward

There is a wealth of evidence to demonstrate that racial inequalities persist in the UK in health, housing, employment, and the justice system. Some of this evidence is presented on the government's 'Ethnicity facts and figures' website, which provides experience and outcome data for people from a variety of backgrounds (www.ethnicity-facts-figures.service.gov.uk/).

A clear picture is emerging from NHS data that demonstrate these racial inequalities (GOV.UK, 2023). In health, Covid-19 has accelerated shedding light on some of these disparities. For example:

- ▶ 21% of NHS staff are from ethnic minority communities — 63% of healthcare workers who died were from Black, Asian and ethnic communities
- ▶ 20% of nursing staff are from Black, Asian and other minority communities and 64% of nurses who died were from these same communities
- ▶ 44% of medical staff and 95% of doctors who died were from these communities.

(British Medical Association [BMA], 2021)

'The beauty of anti-racism is that you don't have to pretend to be free of racism to be anti-racist. Anti-racism is the commitment to fight racism wherever you find it, including in yourself. And it's the only way forward.'

Ljoema Oluo

The Workforce Race Equality Standards (WRES), which provides comparative data on nine indicators, also illustrates some gaps between colleagues from Black, Asian and ethnic communities in the NHS, such as:

Colleagues from Black, Asian and ethnic communities in the NHS are 3.73 times more likely to enter formal disciplinary process.

(NHS England, 2021)

Leeds Community Healthcare (LCH) NHS Trust — a community provider based in Leeds covering Yorkshire and the Humber offering generalist and specialist services for adults, children and families — has

been seeking ways to understand, challenge and change.

The trust has sought to adopt an approach of taking action in our 'own sphere of influence'. This recognises that we may not be able to influence wider societal racial disparities, but have control over our own immediate environments in LCH.

This approach was put into action when a healthcare assistant in one team spoke up about racial abuse when visiting a patient at their home in 2020.

As part of the response to this incident, a series of open conversations were established to address racist behaviour experienced by colleagues who are Black, Asian and from different ethnic communities in the business unit, which is part of the trust. The purpose of the open conversations was two-fold:

- ▶ To hear the experience of colleagues and identify and act on what can be done individually
- ▶ As a service, to make things different for the better.



From left to right: Megan Rowlands, programme director; Satbir Saggi, head of service operational — Community Neurological Rehabilitation Service (CNRS) and Speech and Language Therapy (SLT), and co-vice chair, Race Equality Network; John Walsh, Freedom to Speak Up Guardian and organisational development and improvement team (ODI) lead, all at Leeds Community Healthcare NHS Trust

The open conversations involve staff and managers from across the service and enable other colleagues to share their experiences. We asked: What can we do to make things different? And, as a result, concrete actions have progressed over the last year, including:

- ▶ Working in partnership with the Leeds Community Healthcare Race Equality Network to develop and launch a poster describing what people can expect if they speak up with support from the chief executive and chair of the Race Equality Network
- ▶ Looking at systems so that they can work positively in terms of prevention
- ▶ Creating spaces within teams where staff from Black, Asian and minority ethnic backgrounds can talk about their experience at work openly and share concerns or issues
- ▶ Taking a more active approach to supporting Muslim colleagues who are fasting during Ramadan and initiating a conversation across the organisation about how we support each other with practical steps to make 'zero tolerance' to racist abuse a reality
- ▶ The whole trust has made the decision to formally name itself an anti-racist organisation, with a programme of anti-racist actions to embed this as organisational reality. This will appear in the workforce strategy and means that LCH should be a safe and supportive place for all people. It means working with all staff to ensure that language, behaviours and work are inclusive and welcome diversity. This self definition also means challenging offensive and racist attitudes and behaviours
- ▶ Starting a conversation about White privilege and what this means. This work is supported by reverse mentoring (i.e. when a more junior employee mentors someone more senior than them), allyship (i.e. listening to others and taking action to support colleagues) and a strong race equality network.



'... working with all staff to ensure that language, behaviours and work are inclusive and welcome diversity. This self definition also means challenging offensive and racist attitudes and behaviours.'

The work points to some essential principles for anti-racist practice and building a strong culture that opposes discrimination.

The first is the importance of good speaking up mechanisms in an organisation. At LCH we have a Freedom To Speak Up Guardian and 10 Speaking Up Champions from the Race Equality Network. There are also managers, directors, human resources (HR) and staffside/trade unions, which act as conduits for staff voices to be heard and understood.

The second principle is the practice of open conversations bringing people together to listen and learn. These conversations create a safe space for honest sharing and listening. They seek both to understand and co-create ways forward together. What we hear may challenge us, but it is from these open exchanges that people can learn and grow.

The third principle is the importance of actions to create change. True listening should galvanise individuals to seek and make change. Joanna Macey, a scholar of Buddhism, systems thinking and deep ecology (www.joannamacy.net/main), speaks of 'active hope' — hope that dares to dream, but also take steps to make things happen. In the authors' opinion, seeking concrete and immediate action is essential to this work at LCH.

This work is about having safe speaking up, finding allies and creating open conversations which can become vehicles of positive change. In this way, organisations can start to change to be more human, more just, and more caring places.

This is the start of an important journey, coming together not only to ensure that no staff member faces any form of discrimination, but also to create cultures which are the antithesis of racism — cultures which are welcoming, kind and embrace and learn from difference. Indeed, community services and community nursing have a huge part in ensuring that services are inclusive and that organisations represent communities. **JCN**

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This JCN clinical skills series provides a guide to the causes, assessment, categorisation and prevention and management of pressure ulcers.

Part 2: Pressure ulcer risk assessment tools — test your clinical skills

The second part in our series on pressure ulcer prevention and management looks at risk assessment tools or scales which can be used across all clinical settings in primary and secondary care. It presents the case of Mrs Smith and how the different tools can assess her risk of pressure ulcer development. The scores and risk levels vary according to the scale used so an explanation of how her risk level was assessed is given.

CASE STUDY: MRS SMITH

Mrs Smith is an 84-year-old lady who has been admitted to hospital with acute confusion. She is normally fairly mobile but suffers with osteoarthritis in her knees and hips, which limits her mobility. Since her admission, her increasing level of confusion has led to her becoming more and more chairbound. Urinalysis has indicated that she may have a urine infection, and as a result, she has had several episodes of urinary incontinence. She has a raised temperature and her skin alternates between being clammy at times and dry due to dehydration. On admission, her clothes looked too big for her, and she said she had not been eating very well but did not know if she had lost weight. She is quite pale and doctors are undertaking blood tests to

Annemarie Brown, Lecturer, BSc Adult Nursing, School of Health and Human Sciences, University of Essex

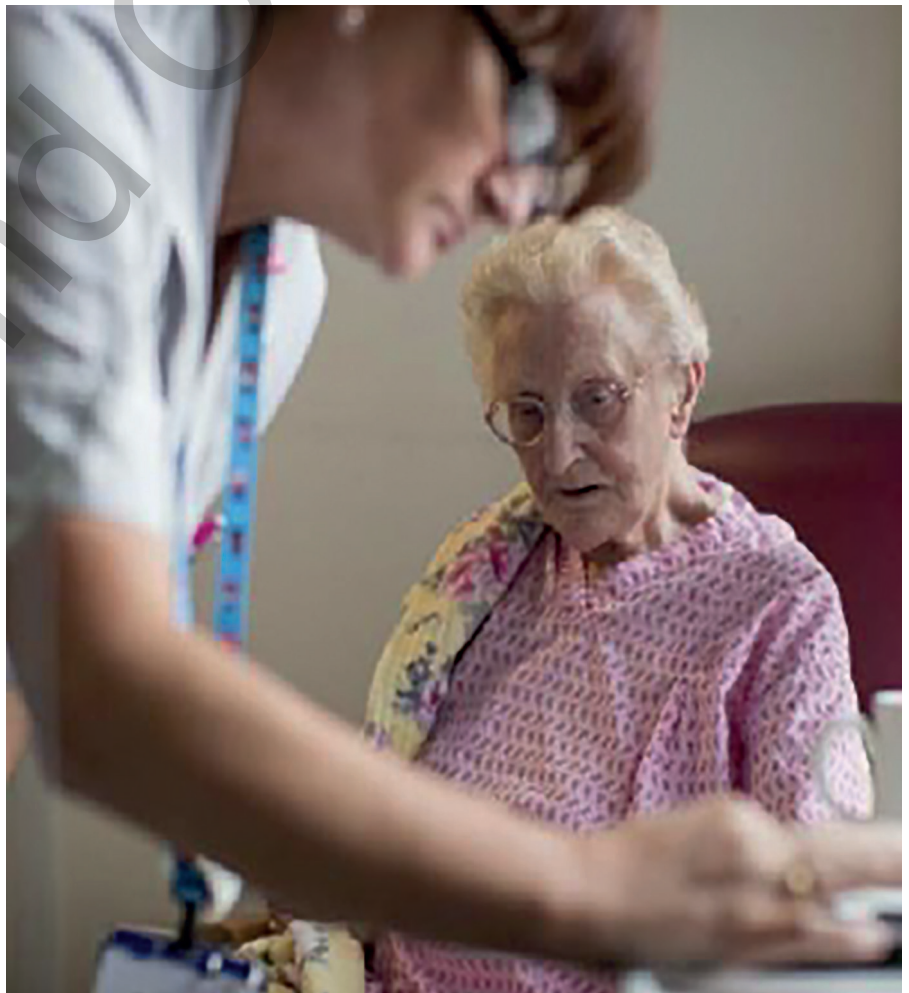


Table 1: Brief overview of Braden scale (Braden and Bergstrom, 1987)

| | | | | |
|--|------------------------|------------------------|------------------------|---------------------|
| Sensory perception Ability to respond meaningfully to pressure-related discomfort | 1. Completely limited | 2. Very limited | 3. Slightly limited | 4. No impairment |
| Moisture Degree to which skin is exposed to moisture | 1. Constantly moist | 2. Very moist | 3. Occasionally moist | 4. Rarely moist |
| Activity Degree of physical activity | 1. Bedfast | 2. Chairfast | 3. Walks occasionally | 4. Walks frequently |
| Mobility Ability to change and control body position | 1. Completely immobile | 2. Very limited | 3. Slightly limited | 4. No limitations |
| Nutrition Usual food intake pattern | 1. Very poor | 2. Probably inadequate | 3. Adequate | 4. Excellent |
| Friction and shear | 1. Problem | 2. Potential problem | 3. No apparent problem | |

rule out anaemia. She has had type 2 diabetes for several years; however, her blood sugar levels are well-controlled and within acceptable limits.

Her medications include non-steroidal anti-inflammatory drugs (NSAIDs) for her osteoarthritis, glibenclamide for her type 2 diabetes and enalapril for hypertension. While undertaking a comfort round, a blanching redness is noted to her sacrum. The ward nurses have been asked to undertake a pressure ulcer risk assessment.

Using the above scenario, this article will now explore a pressure ulcer risk assessment with the three most frequently used tools — Waterlow (Waterlow, 1985), Norton (Norton et al, 1962) and the Braden scale (Braden and Bergstrom, 1987). A recently developed pressure ulcer risk assessment tool, PURPOSE-T, is also discussed.

BRADEN SCALE (BRADEN AND BERGSTROM, 1987)

Developed more than 20 years ago for patients in acute and long-term care settings, the Braden scale evaluates the risk of skin breakdown in six domains: sensory perception, moisture, activity, mobility, nutrition, and friction and shear (He et al, 2012; Table 1). Each domain has four detailed descriptions (rated from one to four) for the healthcare

Table 2: Norton scale (Norton et al, 1962)

| | | |
|--------------------|----------------------|---|
| Physical condition | ▶ Good | 4 |
| | ▶ Fair | 3 |
| | ▶ Poor | 2 |
| | ▶ Very bad | 1 |
| Mental condition | ▶ Alert | 4 |
| | ▶ Apathetic | 3 |
| | ▶ Confused | 2 |
| | ▶ Stuporous | 1 |
| Activity | ▶ Ambulant | 4 |
| | ▶ Walks with help | 3 |
| | ▶ Chairbound | 2 |
| | ▶ Bedfast | 1 |
| Mobility | ▶ Full | 4 |
| | ▶ Slightly impaired | 3 |
| | ▶ Very limited | 2 |
| | ▶ Immobile | 1 |
| Incontinence | ▶ None | 4 |
| | ▶ Occasional | 3 |
| | ▶ Usually urinary | 2 |
| | ▶ Urinary and faecal | 1 |
| Greater than 18 | Low risk | |
| Between 18 and 14 | Medium risk | |
| Between 14 and 10 | High risk | |
| Lesser than 10 | Very high risk | |

professional to consider, choosing the one that best describes the patient's current status. A low total score indicates a high risk of developing pressure ulcers; a high total score indicates a low risk of developing pressure ulcers, namely:

- ▶ At risk = 15
- ▶ Moderate risk = 13–14
- ▶ High risk = 10–12
- ▶ Very high risk = 9 or below.

Mrs Smith's Braden score could be rated as:

| | |
|--------------------|-----------|
| Sensory perception | 0 |
| Moisture | 3 |
| Activity | 3 |
| Mobility | 3 |
| Nutrition | 2 |
| Friction and shear | 2 |
| Total score | 13 |

(moderate risk).

NORTON SCALE (NORTON ET AL, 1962)

The Norton scale was created in 1962, and looks at five parameters (Table 2). The scores for each parameter are added together with a lower Norton score indicating a higher risk of pressure ulcer development.

Mrs Smith's Norton score could be rated as:

| | |
|--------------------|----------------------------------|
| Physical condition | 2 |
| Mental condition | 3 |
| Activity | 2 |
| Mobility | 3 |
| Incontinence | 3 |
| Total score | 13 (high-very high risk). |

WATERLOW (WATERLOW 1985)

The Waterlow scale was developed in 1985 by Judy Waterlow, a clinical nurse teacher, and is commonly used today. It covers seven known risk factors for the development of pressure ulceration, namely:

- ▶ Build/weight for height
- ▶ Continence
- ▶ Skin type/visual risk areas
- ▶ Mobility
- ▶ Sex/age
- ▶ Malnutrition
- ▶ Special risks.

Table 3: Mrs Smith's Waterlow score

| Domain | Score | Assessment findings |
|-----------------------------|-------|---|
| Build/weight for height | 3 | BMI <20 |
| Continence | 1 | Currently has urinary incontinence due to urinary tract infection, however this may resolve once treatment is initiated |
| Skin type/visual risk areas | 3 | Dry due to dehydration; clammy due to pyrexia and tissue paper due to age/medication. This may change once treatment is initiated |
| Mobility | 2 | Apathetic currently but may resolve once treatment is initiated |
| Sex/age | 7 | Female; 84 years |
| Malnutrition | 2 | Unsure of weight loss |
| Special risks | 6 | Anaemia; anti-inflammatory medication |
| Mrs Smith's current score | 24 | Very high risk |

The total scores achieved within each factor are summed to derive the Waterlow score, with higher scores believed to mark greater vulnerability (Waterlow, 1985). A score of more than 10 is classified as at risk, between 15 to 20 as high risk, and more than 20 as very high risk.

Table 3 summarises the findings of Mrs Smith's assessment using the Waterlow scale.

Practice point

Please note that the 'Diabetes' score under 'Neurological deficit' in the Waterlow tool is not applicable here, as she has well-controlled diabetes and no known neurological deficits as a result. If she had confirmed neuropathy in her feet, for example, 4–6 points would be added. This is a very common error, leading to over-estimated risk scores.

PURPOSE-T PRESSURE ULCER RISK ASSESSMENT (NIXON ET AL 2015)

This recently developed pressure ulcer risk assessment tool consists of three steps:

1. Screening
2. Full assessment
3. Assessment decision.

Colour coding is integrated throughout PURPOSE-T:

- ▶ **Blue** indicates 'no problem'

- ▶ **Yellow** indicates a 'potential impact on pressure ulcer risk'
 - ▶ **Orange** indicates 'risk'
 - ▶ **Pink** indicates that the 'patient already has a pressure ulcer or ulcer scar'
- (Coleman et al, 2018).

Decision boxes are provided to guide healthcare professionals as to whether a full assessment is required.

Step 1: initial screening to be completed for all patients

This is required for all patients and assesses mobility status. The options are:

- ▶ 'Walks independently with or without walking aids'
- ▶ 'Needs the help of another person to walk'
- ▶ 'Spends all or the majority of time in bed or chair'
- ▶ 'Remains in the same position for long periods'.

Healthcare professionals tick all that are applicable, and the decision boxes of the tool help them to decide whether to go on to step 2 of the assessment process. If only option 1 is ticked (blue) on the initial screening, the skin status section should be completed.

Clinical judgement

In addition, there is also a 'Clinical judgement' section which allows healthcare professionals to consider other potential risk factors that may impact on the patient's pressure ulcer risk, such as:

- ▶ Poor perfusion
- ▶ Epidurals
- ▶ Oedema
- ▶ Steroids.

If any of these are ticked, the score is 'yellow', and the healthcare professional should progress onto the full assessment stage. If none are present, the colour is 'blue', and the clinician should just complete the skin status section.

In Mrs Smith's case, 'Needs the help of another person to walk'; 'Remains in the same position for long periods' and 'Spends all or the majority of time in bed/chair' would be applicable (yellow). This requires progressing to step 2 full assessment.

Step 2: full assessment

This section comprises eight sections covering:

- ▶ Analysis of independent movement
- ▶ Previous pressure ulcer history
- ▶ Current detailed skin assessment
- ▶ Perfusion
- ▶ Nutrition
- ▶ Medical devices
- ▶ Moisture due to perspiration, urine, faeces or exudate
- ▶ Diabetes.

Each decision box gives potential responses which are colour coded, and healthcare professionals can select multiple options.

Table 4 outlines Mrs Smith's scores according to PURPOSE-T.

Step 3: assessment decision

The final step requires healthcare professionals to assess the patient's pressure ulcer risk according to the prevailing colour. Any 'pink' scores require a secondary prevention and treatment pathway; any 'orange' scores require a primary prevention pathway, and if only 'yellow' or 'blue' boxes are ticked, the patient does not need the implementation of a prevention pathway. According to PURPOSE-T, Mrs Smith is at risk of developing pressure injuries and a primary prevention pathway should be put in place. An example

Table 4: Mrs Smith's scores according to PURPOSE-T

| Stage 1 | | |
|--|--|--------|
| Mobility status | <ul style="list-style-type: none"> ▶ Needs the help of another person to walk ▶ Spends all or the majority of the time in bed or chair ▶ Remains in the same position for long period | Yellow |
| Stage 2: full assessment | | |
| Analysis of independent movement | ▶ Moves occasionally | Orange |
| Sensory perception and response | ▶ No problem | Blue |
| Current detailed skin assessment and pain assessment | <ul style="list-style-type: none"> ▶ Sacrum (vulnerable skin) ▶ Right buttock ▶ Left buttock | Orange |
| Previous pressure ulcer history | ▶ No known history | Blue |
| Perfusion | ▶ No problem | Blue |
| Nutrition | <ul style="list-style-type: none"> ▶ Unplanned weight loss ▶ Poor nutritional intake | Yellow |
| Medical devices | ▶ This would include items such as nasogastric tube or oxygen tubing. No problem in Mrs Smith's case | Blue |
| Moisture | ▶ Frequent | Yellow |
| Diabetes | ▶ Diabetic | Yellow |

includes the SSKING framework (NHS Improvement, 2018):

- S Skin assessment and skin care
- S Surface provided — pressure-relieving equipment
- K Keep moving — repositioning; frequency; manual handling aids
- I Incontinence and how this is managed
- N Nutrition
- G Giving information — to both patient and relatives.

CONCLUSION

Mrs Smith's risk score will change as her condition improves and therefore should be reassessed at regular intervals (National Institute for Health and Care Excellence

Practice point

No pressure ulcer risk tool has perfect predictability and should always be used in combination with clinical judgement (NICE, 2014). Healthcare professionals should consider that even patients who have low scores on the risk assessment tool may still require some interventions, particularly if their clinical condition changes.

[NICE], 2014). Her risk of developing pressure injuries ranges from 'at risk' to 'moderate, high to very high', depending on which tool is used. As a result, a pressure ulcer prevention plan must be formulated and documented, for example the SSKING framework (NHS Improvement, 2018).

Undertaking pressure ulcer risk assessment is often seen as an initial 'tick box' exercise. However, if no further actions are implemented as a result of the score and a pressure injury develops, this would be seen as a breach of nursing duty. PURPOSE-T enables healthcare professionals to document their assessment, clinical judgement and decision-making when undertaking pressure ulcer risk assessment. **JCN**

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Revalidation Alert

Having read this article, reflect on:

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Optimising patient involvement in chronic wound care

Luxmi Dhoonmoon

Delivery of health care is undergoing unprecedented changes. There are increasing requirements for care which are not matched by a comparable increase in resources. Services are frequently under pressure and at times overwhelmed; wound care is no exception. The Covid-19 pandemic led to a significant decrease in community nursing visits, limited outpatient appointments, and fewer face-to-face appointments (Blackburn et al, 2021). Yet, a growing number of people are living with chronic wounds, due in part to an aging population, compounded by a rising prevalence of obesity, diabetes and other long-term conditions (Moore et al, 2016). One strategy to help ease pressure on wound care services is to 'encourage supported self-care, where possible', as recommended by the National Wound Care Strategy Programme (NWCSP, 2020). This approach is being actively adopted by the Complex Wounds Clinic (Central and North West London NHS Foundation Trust), as part of its quality improvement (QI) practice. This article discusses how the clinic is supporting shared self-care, parameters for assessing patient suitability, and how a simple questionnaire is helping to improve wound management.

KEYWORDS:

■ Chronic wounds ■ Supported self-care ■ Quality improvement

Chronic wounds are a major health burden and have a severe impact on wellbeing. They affect an estimated 2.21 per 1000 population, are a significant source of morbidity, and have a physical, psychological, social and financial impact (Gethin et al, 2020).

The latest available data on the number of people with a wound managed by the NHS is 3.8 million patients. This represents a 71% increase between 2012/13 and 2017/18 (Guest et al, 2020). Almost 60% of chronic wounds heal if there is no evidence of infection, compared with 45% if there is a definite or

suspected infection. In the five years between 2013 and 2017, there was a substantial increase in resources used and patient management costs increased by 48% in real terms. It is worth noting that the percentage increased cost of resources falls far behind the increased annual prevalence of wounds (Guest et al, 2020).

Management of chronic wounds uses significantly more resources than acute wounds, ranging from 162% more community nurse visits, to 47% more GP visits, 100% more drug prescriptions, and 178% more wound care products per patient (Guest et al, 2017). This underlines the need for new models of wound care, where limited resources are effectively employed for optimal patient care.

The annual NHS cost of wound

management in 2017/18 was £8.3 billion, of which £2.7 billion and £5.6 billion were associated with managing healed and unhealed wounds, respectively. Eighty-one percent of the total annual NHS cost was incurred in the community (Guest et al, 2020).

Patients with chronic wounds have significant more comorbidities than those with acute wounds (Guest et al, 2017). Comorbidities include the prior presence of cardiovascular disease, dermatological symptoms, nutritional deficiency and respiratory disease. These are all considered to increase the relative risk of developing a chronic wound (Guest et al, 2017).

Assessment, diagnosis and management of chronic wounds is a nurse-led discipline, with most wound care management being delivered in the community. This might be in specialist clinics or undertaken by community and district nurses. Increasingly, general practice nurses are playing a role in chronic wound care (Guest et al, 2020). Given that most chronic wound management is already undertaken in a community setting, facilitating supported wound self-care at home is a logical corollary.

SUPPORTED SELF-CARE

Actively involving patients in their own care is not a new concept and has been the stated aim of healthcare provision for many years (Coulter, 2008). Supported self-care is the model for most chronic long-term conditions, such as diabetes, arthritis, asthma and chronic obstructive pulmonary disease (COPD). The benefits include enhanced patient

motivation and knowledge about their own condition, resulting in patients having increased capacity to monitor and look after themselves (Coulter et al, 2008). Supported self-care often leads to a positive effect on health outcomes and satisfaction with care (Bastiaens et al, 2007).

Supported self-management also has potential economic benefits and may help relieve some pressure on healthcare services (De Silva, 2011). Given the current workforce shortages in the NHS, rising demand for services, population increases and budgetary constraints, it is not surprising that this approach is increasingly becoming the focus of healthcare strategies, particularly in the community.

PATIENT INVOLVEMENT IN WOUND CARE

From a wound care perspective, patient involvement in their own management has tended to be limited and wound care has sometimes been viewed as the sole remit of healthcare professionals. However, the National Wound Care Strategy Programme (NWCSP) identified a need for greater patient involvement, describing it as an 'opportunity for quality improvement to deliver better patient outcomes,' and recommends 'encouraging supported self-care, where possible' (NWCSP, 2020). In many ways, it is surprising that this approach has only recently been advocated for chronic wound management.

The coronavirus pandemic acted as a catalyst for thinking more innovatively about how chronic wound care is delivered. A survey by the Patient's Association found that 42% of wound care patients reported that the place where they usually received care changed during the pandemic (Patients Association, 2022). Lockdowns and stringent infection control measures led to more supported self-care, with patients taking responsibility for monitoring their wound and changing dressings, supported by healthcare professionals, often remotely. The positive aspects of managed self-care can now be built

on in the post-pandemic era, where the patient is valued as an active participant in their own care.

Research by Kapp and Santamaria (2020) found that wound self-treatment improves physical and emotional wellbeing as well as wound healing. However, it is not suitable for all patients and may be physically challenging for some (Kapp and Santamaria, 2020). In the author's clinical experience, optimising patient selection and providing the necessary support are key drivers for successful self-care.

THE COMPLEX WOUND CLINIC

The Complex Wound Clinic (CWC) at Central and North West London (CNWL) NHS Foundation Trust was set up in 2009. The primary objective was to provide enhanced wound assessment and management, thereby improving healing rates, while simultaneously providing this complex care closer to patients' homes and avoiding sometimes lengthy journeys to a hospital clinic.

The specialist team of 10 staff provide a varying mix of skills, ranging from bands 7 to 4. The nurse-led team assists other healthcare professionals, such as nursing home staff, community and general practice nurses, in the care of patients with complex wounds, offering the expert support required to deliver the most appropriate management. The service is provided in the community, in patients' homes (including nursing homes) and in clinics.

The majority of patients seen by the service have chronic, challenging leg and pressure ulcers. The number of patients seen has increased year on year. 4390 patients were seen by the CWC team between February 2019 and February 2020. This represented an increase of 500 patients compared to 2018/19.

INVOLVING PATIENTS IN SUPPORTED WOUND SELF-CARE

As part of the clinic's commitment to continually improve patient care, the clinic team are proactively involving appropriate outpatients in their own

wound care management. This is always in agreement with the patient and their carer(s). It is a partnership with patients to understand their needs and share decision-making to achieve the best possible wound care outcomes.

Shared wound care management enables patients to actively participate in their care, rather than being a passive recipient. It is essential to identify suitable patients who may or may not have support from a family member or close friend. There are different levels of patient engagement, which range from a patient who is able to monitor and manage a wound on a daily basis, with healthcare professional support where needed, to patients who need more support and those who are unable to take any responsibility for their wound care, but may have some assistance from a friend or relative.

Involvement may change over the care trajectory and will be influenced by the patient's age, health, comorbidities, support network and complexity of wound care required. Therefore, shared wound care should be revisited with the patient at regular review appointments as circumstances may change.

To provide optimal patient care, a detailed holistic assessment of the wound(s) and the patient needs to be undertaken at the outset. While total wound healing is not always achievable, it is usually a primary goal of wound management.

At the outset, it is essential to develop an understanding of how involved a patient (and their carer or partner) wishes to be. They need to feel confident about managing the wound and be able to monitor any signs of deterioration in the wound bed and surrounding area. It should be the right patient with access to the right support services at the right time.

In the author's clinical experience, a supportive carer/partner is beneficial when involving patients in self-management. A study found that more than half of participants had another person to assist them

with their chronic wound self-treatment. The domestic partner was the person who most commonly assisted (51%), followed by relatives (24%) and friends or neighbours (10%) (Kapp and Santamaria, 2017). This is why the CWC involves not only the patient, but also appropriate members of their support network.

There is evidence that patients with chronic wounds value a strong therapeutic and personal relationship with healthcare professionals, in which the patient feels they have some control over treatment and a feeling of increased independence, while knowing that they have support when needed. This patient-centred approach is central to the clinic's ethos. Good communication and trust between staff and patients are vital.

Involving patients more actively in their wound care management may help reduce healthcare costs, but should not be the key driver for change. The primary aim should always be to get the treatment right first time for the patient, as this will support improved outcomes and potentially lead to more efficient use of resources in the future.

QUALITY IMPROVEMENT (QI)

The CNWL NHS Trust is committed to quality improvement (QI), which includes the 'use of tools and techniques to continuously improve the quality of care and outcomes for our patients' (www.cnwl.nhs.uk/ia/what-is-qi). As part of QI, the CWC adopted a tick box questionnaire, which was used at a patient's initial assessment, at their four-week follow-up and at completion of treatment. However, there were considerable anomalies in the experiences reported by patients using the questionnaires, which led the team to reconsider the validity of the data being collected and the impact this was having on patient care.

It was agreed by the clinic team to simplify the approach and ask patients a single question at their first assessment: 'What is the one thing you want to achieve or be able to do again

but have not been able to do because of your wound?'

The same question incorporating 'Has treatment made a difference?' is asked again at week four of the assessment and at completion of treatment. The aim is to ascertain whether or not the patient's personal goals have been met and the subsequent impact on their quality of life. While a tissue viability nurse may see total wound healing as the ultimate aim of treatment, a patient may care more about being able to resume a hobby or activity. Understanding what really matters to a patient means that tailored care can be given. It also gives patients a sense of empowerment about their own care, which often leads to more active involvement in the daily care of their wound.

Data obtained from the question can easily be entered onto a spreadsheet and is simple to analyse. The question is now embedded in standard practice at the clinic and has been printed onto wall posters to ensure consistency of approach. Over the following six months, the data collected so far will be analysed to assess if further improvements can be made.

WASH MITTS FOR PERIWOUND CLEANSING

One of the key areas where patients and carers can be supported to participate in shared management is in wound-related care, where they are taught how to remove a dressing, clean the wound and periwound areas, then apply a clean dressing.

Wound care products need to be simple to use with good skin compatibility. At the CWC, antimicrobial wash mitts are regularly used for periwound cleaning both in the clinic and in the community. The octenidine-impregnated cloth wipes are used to decontaminate the skin around the wound before the application of a new dressing. The disposable mitts are used to decontaminate an area at least as large as the dressing. Dressings can be securely applied once the area is dry.

Practice point

The CWC prefers to use products which have proven efficacy. Octenidine dihydrochloride is an antimicrobial with broad-spectrum efficacy (including multi-resistant strains) and no known microbial resistance, whereas resistance to chlorhexidine is 5–10% (Spencer et al, 2013). It is also known to have good tissue compatibility (Vanscheidt et al, 2012), prevents bacterial growth (Cutting and Westgate, 2012) and is well tolerated. Octenidine also has deodorising properties, is active in as little as 60 seconds, and its biocidal activity lasts at least 48 hours (Sharpe et al, 2018).

These properties make the octenidine-impregnated wash mitts ideal for periwound care. Octenidine containing irrigation solution can be used for wound bed cleansing, in conjunction with the mitts. In the author's clinical experience, this regimen is easy for patients and their relatives to understand and carry out in a non-clinical setting.

A 12-month evaluation of the cleansing mitts by the CWC found a real reduction in the prescription of antibiotics for wound infections compared to the previous year. There were no reported cases of *Pseudomonas* in wound assessments during the evaluation period. In the author's clinical experience, such infection around the toes is usually common in patients with chronic leg ulcers (Dhoonmoon and Dyer, 2020). Qualitative data showed patient satisfaction with the mitts with comments including, 'my skin felt much cleaner' and 'the mitts were better at removing dead and dried skin' (Dhoonmoon and Dyer, 2020).

As part of their self-care regimen, most of the patients at the author's clinic are offered a prescription for octenidine-containing wash mitts for periwound cleaning between clinic visits, and also for maintenance after a wound has healed. Maintaining periwound skin integrity is vital to wound healing, as skin damage

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around the wound can lead to increased wound size, delayed healing and increased levels of pain (Bianchi, 2012).

CONCLUSIONS

Patients have a right to be at the centre of their own healthcare management, as this improves their experience and satisfaction with care, as well as offering clinical and economic benefits. Given the rising prevalence of chronic wounds, it is essential that patients feel empowered to manage appropriate aspects of their care. Providing easy to use, effective wound management products, such as wash mitts which have undergone evaluation, appears to aid compliance with treatment regimens, as evidenced by patient feedback at the author's clinic, which has been highly positive.

Data is being collated to validate the reported benefits, as well as identify any obstacles to success. Analysis of the QI question responses will form part of this evaluation, which will also examine the effectiveness of self-care on wound healing and patient wellbeing. The longer-term strategy at the author's clinic is to embed self-management into routine wound care and promote a shared care model for all suitable patients. **JCN**

Case report one

A 93-year-old female patient was referred to the clinic during the SARS-CoV-2 pandemic. She had been diagnosed with atrial fibrillation, hypothyroidism, hypertension and squamous cell carcinoma (SCC), and had refused palliative care. She had a facial fungating wound spreading to the left side of her face. The crusts were so severe she was unable to open her eyes. There was a high volume of thick, malodorous exudate from the wound. This affected the surrounding skin, which was friable and bled on contact.

The aims of treatment were to improve her quality of life, reduce the exudate volume and malodour and manage the friable areas more effectively. The patient's key

concern was not being able to open her eyes. This was having a significantly negative impact on her quality of life. Her answer to the key QI question 'What is it that you used to enjoy doing, that you can't do now because of your wound?' was 'watching television'.

An initial factor was the patient's unwillingness for nursing staff to visit her at home, due to her fears of contracting Covid. Fortunately, her grandson was living with her and was her primary carer. The team at the CWC taught him to undertake simple wound care, which included gentle cleaning of the periwound area with the wash mitt for five minutes daily. He also applied an antimicrobial gel to the affected areas.

After two weeks, the scabs started to lift and were gently coming off. Malodour was reduced and there was minimal exudate leaking onto her face. She was able to start eating again. After four weeks the eye had cleared and was slightly opened, and there was no exudate.

The crusts have now been completely removed and she can open her eyes. When asked at follow up, 'Has our treatment made a difference?' her response was to describe her care as 'life-changing'.

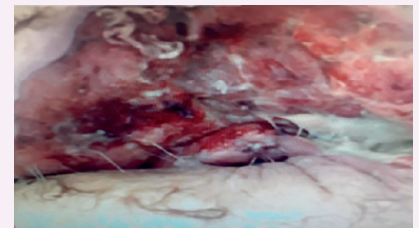


Case report one: before treatment.

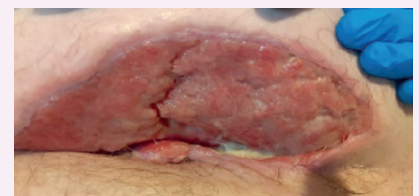
Case report two

A 53-year-old male presented to his GP with an anal boil. Apart from a body mass index (BMI) of 28+, the patient had no previous

medical history and was not taking any medications. He became very unwell, had breathing difficulties and the wound area expanded rapidly to affect both buttocks, which became black. He was admitted to hospital where anal necrotising fasciitis was diagnosed. Surgical debridement of the area was undertaken three days later. Following surgery, he spent time in intensive care. The wound bed was treated daily using kerlix gauze soaked in octenilin solution. This was held in place using an incontinence pad. On discharge, the patient's partner was taught how to cleanse the periwound area using wash mitts in between clinic visits. The wound is now completely healed, but the wash mitts continue to be used for maintenance.



Case report two: on admission.



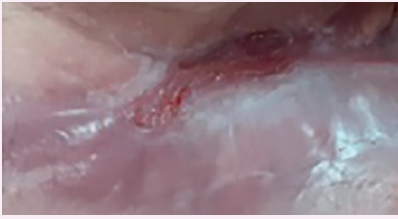
Case report two: two weeks after starting daily skin care with octenisan wash mitt.



Case report two: six weeks after starting daily care with wash mitts.



Case report two: nine weeks after starting wash mitt — reduced to alternate days.



Case report two: wound completely healed.

Case study three

A doubly incontinent 79-year-old patient was referred to the clinic with moisture-associated skin damage (MASD), caused by urine and stools coming into contact with the skin. The affected area presented with erythema and maceration, together with skin breakdown. The patient had refused care except from her daughter, who had been using baby wipes to clean the area after a bowel movement. Her medical history included type 2 diabetes mellitus, ischaemic heart disease, hypertension and elevated cholesterol levels. Following a recent fall, her mobility was impaired and she was only able to walk for a short distance around the house with assistance. All these comorbidities have contributed to her skin integrity being vulnerable to damage, meaning that her skin deteriorated rapidly in the presence of faecal and urinary incontinence.

The patient's key concern was pain when sitting down, which was having a negative impact on her quality of life, together with itching and irritation around the perianal area.

Her daughter was advised to discontinue the scented baby wipes to minimise skin irritation. Octenidine containing wash mitts were prescribed in conjunction with a barrier cream. She was shown how to carry out the treatment.

At the four-week review the patient reported that 'it was not painful to sit down' and her skin no longer felt irritated. Also, there

was no odour present and the skin felt softer.



Case report three: initial assessment.



Case report three: week four follow-up.

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Hidradenitis suppurativa: diagnosis and treatment

Cheryl Handley

Hidradenitis suppurativa (HS) is a painful and distressing skin disease of the hair follicle affecting nearly as many people as psoriasis. Despite this, not many healthcare professionals know much about it, or can recognise it. This is probably the reason why there is such a considerable delay in people receiving a diagnosis and treatment. In recent years, there has been a significant effort to raise awareness of HS among both healthcare professionals and the general public so that timely access to treatment and support is provided, preventing progression of the disease, permanent damage, physical side-effects and a negative impact on patient wellbeing. This article gives an overview of HS and examines a wound dressing system developed and tested by people with the condition. Two case studies demonstrate potential benefits the system can offer to patients, clinicians and healthcare organisations.

KEYWORDS:

- Hidradenitis suppurativa ■ Diagnosis ■ Treatment
- Wound dressing system

Hidradenitis suppurativa (HS) is a devastating, progressive disease of the skin which is poorly understood and often misdiagnosed (British Dermatological Nursing Group [BDNG], 2022; Moloney et al, 2022). It affects the hair follicles and is characterised by recurring inflammatory nodules, abscesses, draining lesions and tunnels (World Union of Wound Healing Societies [WUWHS], 2016; Moloney et al, 2022).

The condition is sometimes referred to as apocrinitis, *acne inversa* and *pyoderma fistulans significa* (WUWHS, 2016). In recent years, various treatment guidelines have been developed (Moloney et al, 2022), but a delay in diagnosis and lack of effective wound management has led to enormous patient distress (Hendricks et al, 2021).

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'... a delay in diagnosis and lack of effective wound management has led to enormous patient distress.'

The reported prevalence of HS varies across geographical areas (Table 1) due to misclassification and selection bias (Young, 2018), however, it is thought to be around 1% in Europe (WUWHS, 2016).

Ingram et al (2018) state that many studies have not quantified undiagnosed cases and in an analysis of 4.3 million research-standard records, a HS prevalence of 0.77% is demonstrated.

HOW DOES HS DEVELOP?

The pathophysiology of HS is not completely understood (Ingram, 2016). It is a skin disease of the hair follicles, specifically the hair shaft, the hair follicle, the sebaceous gland, and the erector pili muscle (also known as the follicular pilosebaceous unit)

(Zouboulis et al, 2015b; Young, 2018; Ferris and Harding, 2019).

The upper part of the hair follicle is occluded by a keratin plug which prevents drainage of the gland. This causes inflammation, dilation and rupture of the follicle with contents deposited into the surrounding dermal tissue. It can also cause subsequent sinus tract or abscess formation and destruction of the pilosebaceous unit (Zouboulis et al, 2015b; Ingram, 2020).

Typical HS lesions are mainly (Zouboulis et al, 2015a):

- ▶ Deep-seated, inflamed or non-inflamed nodules (Figure 1)
- ▶ Chronic painful abscesses
- ▶ Fistulas
- ▶ Cysts
- ▶ Draining sinus tracts
- ▶ Open tombstone comedones
- ▶ Scars (Figure 2).

WHAT ARE THE RISK FACTORS?

While the exact cause for the condition is not known, numerous studies have discussed how the disease may be triggered by genetic and environmental factors. Many risk factors have been identified and researched over recent years. Risk factors and associated comorbidities for HS include:

- ▶ Family history of HS
- ▶ Obesity
- ▶ Smoking
- ▶ Female
- ▶ Type 2 diabetes
- ▶ Crohn's disease
- ▶ Hyperlipidaemia
- ▶ Down's syndrome
- ▶ Acne
- ▶ Depression
- ▶ Presence of other inflammatory conditions and syndromes, e.g. acne, arthritis, *pyoderma gangrenosum* — PASH (PG, acne and suppurative hidradenitis) PA-

Box 1 Myth and fact

Myth

- ▶ *HS is a result of poor hygiene and/or is contagious.*

Fact

- ▶ *It is important to reassure patients that HS is not linked to poor hygiene and is not contagious.*

PASH (pyogenic arthritis, acne, PG and suppurative hidradenitis) (adapted from WUWHS, 2016; Ingram et al, 2018; Isoherranen et al, 2019; BDNG, 2022; Mahoney, 2023).

There are several myths surrounding HS which cause great distress to patients (Young, 2018; Smith and Lindsay, 2019). As a result, patients often experience high levels of shame (Keary et al, 2020).

WHERE DOES HS OCCUR?

HS most commonly involves axillary, inguinal, genitofemoral, gluteal, perineal and inflammatory areas.

Other less common anatomical sites include peristomal areas, areola of the breast, submammary fold, periumbilical skin, scalp, zygomatic and malar areas of the face, buttocks, thighs and popliteal fossa (Zouboulis et al, 2015a).

WHAT DO I NEED TO LOOK OUT FOR?

HS is a condition often overlooked, despite it affecting nearly as many people as psoriasis (BDNG, 2022). While there is no cure for HS, it is important that healthcare professionals are aware of the disease, so that they can provide timely access to treatment and support, and prevent permanent physical side-effects, as well as the negative impact on emotional and mental health which it can have (BDNG, 2022).

Therefore, the most important thing is recognising HS by being aware of the clinical presentation. There are two questions that can lead to an accurate and timely diagnosis:

- ▶ Have you had outbreaks of boils during the last six months?
- ▶ If yes, how many and which locations? (Vinding et al, 2014).

Two boils in one of the following five locations, axilla, groin, genitals, under the breasts or other less common locations (e.g. perianal, neck and abdomen), can be diagnosed as HS (Zouboulis et al, 2015a).

DIAGNOSIS

Diagnosis of HS is primarily clinical as there are no tests currently available (WUWHS, 2016). HS can be confused with other skin diseases, e.g. acne. As a result, diagnosis is often late (Anduquia-Garay et al, 2021).

Patients with HS need to be diagnosed as early as possible to control the disease and reduce the risk of the condition worsening, the skin architecture being damaged beyond repair and HS becoming established (Wolk et al, 2020; BDNG, 2022).

Consensus diagnostic criteria currently state that individuals must have typical lesions at typical sites and that the disease is chronic and recurrent, with at least two episodes in six months (Zouboulis et al, 2015a; Anduquia-Garay et al, 2021).

A positive family history of HS and the presence of normal skin microbiota (microorganisms seen in a particular site) can be considered positive support for diagnosis (Zouboulis et al, 2015a; WUWHS, 2016).

A recent consensus document (BDNG, 2022) has suggested key recommendations to improve diagnostic rates, including:

- ▶ The development of a diagnostic framework
- ▶ A poster or infographic that shows diagnostic signs which could be placed in GP surgeries,

- pharmacies and accident and emergency departments
- ▶ Education for all healthcare professionals, but particularly GPs, pharmacists and accident and emergency department staff
- ▶ Self-assessment tool for patients and information added to NHS Choice’s ‘Boils’ and ‘Abscesses’ pages to ensure HS symptoms are not treated in isolation
- ▶ Improving public awareness, e.g. awareness campaign designed for schools and universities as the condition often starts in puberty.

HS ASSESSMENT

HS assessment should include severity of the disease, its impact on quality of life and wound assessment.

Severity of the disease

There are a number of assessment or staging tools available, but the most widely used is Hurley’s staging system, which has been used clinically since 1989 (Young, 2018). It is based on presentation of the lesions and the extent of the scarring (Cassarino, 2022).

The Hurley staging system comprises three stages (Figure 3):

- ▶ Stage 1 (mild): single isolated lesions, no sinus tracts/scars
- ▶ Stage 2 (moderate): single/multiple lesions with sinus tracts
- ▶ Stage 3 (severe): widespread diffuse areas with sinus tracts (WUWHS, 2016; Cassarino, 2022).

Most patients have stage 1 disease, stage 2 affects about one-third of patients, with about 4% of patients categorised as stage 3 (Vanlaerhoven et al, 2018).

Impact on quality of life

HS can have a profound physical and psychological impact on an individual. It is vital that the condition is seen as a debilitating

Table 1: Reported prevalence of HS across geographical areas

| Prevalence | Geographical area |
|------------|---|
| 0.05% | USA from an analysis of patient insurance claims (Cosmatos et al, 2013) |
| 0.67% | Australia (Calao et al, 2018) |
| 1% | Europe (Zouboulis et al, 2015b) |
| 4% | Denmark when young adult women were examined in person (Jemec, 1988) |

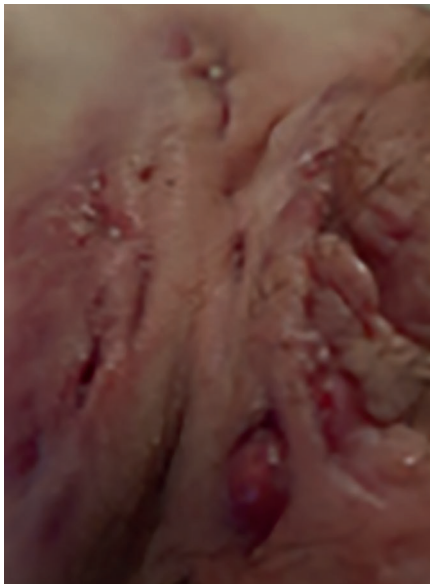


Figure 1.
Distorted skin. Reproduced courtesy of Suzanne Moloney.



Figure 2.
Scars. Reproduced courtesy of Suzanne Moloney.

disease and its impact on daily life, self-esteem and social interaction should not be underestimated (WUWHS, 2016). Indeed, the impact of HS on patients is reported to be worse than that from other serious skin diseases, such as psoriasis (Storer et al, 2018).

A fundamental part of HS assessment is the impact the disease has on quality of life. The Dermatology Life Quality Index (DLQI) has been used in many studies to assess the burden of HS (WUWHS, 2016) and is recommended for use (Chernyshov et al, 2019. See *Practice point* box).

The impact of HS on quality of life can be described in five groups (WUWHS, 2016):

- ▶ Psychological factors can have a profoundly negative influence

on patients, family members and carers (Matusiak, 2020; Narla et al, 2020). Many psychological issues relate to the physical symptoms (e.g. pain, exudate leakage and itching) (WUWHS, 2016; Smith and Lindsay, 2019)

- ▶ Economic impact: this is related to being disabled or unable to work, reduced ability to work or perform responsibilities, unable to find work and frequent absences from work due to hospitalisation and mental health issues, sometimes resulting in unemployment (Garg et al, 2020; Matusiak, 2020)
- ▶ Pain: this is one of the most significant problems in patients with HS. In one study, pain was estimated to affect up to 97% (Krajewski et al, 2021)
- ▶ Living in dressings and bandages: wounds are often located in awkward areas to apply dressings such as the groin and axilla (Moloney et al, 2021)
- ▶ Social impact: HS can cause stigmatisation, social rejection and social isolation. HS most commonly affects young people during puberty exacerbating difficulties this group may already be having related to personal relationships, socialisation and their social networks (WUWHS, 2016).

In a recently published pilot study, Moloney et al (2022) examined the impact of an HS specific wound dressing system (HidraWear) on patient quality of life and dressing-related pain. The authors conducted a 21-day, single-arm, unblinded pilot trial to assess ease of use and the impact of the trial dressing system (primary objective) compared with the patient's previous product use. The secondary objectives were to evaluate if the trial dressing system was comfortable, improved quality of life, was faster to use than current product, reduced

dressing-related pain and provided secure dressing retention. A seven-item questionnaire and DLQI questionnaire were completed on days 0, 7, 14 and 21.

All 15 participants were female, aged 18 or older, and had a diagnosis of HS. In 100% of patients, the mean DLQI score was reduced significantly following use of the trial dressing system. Dressing-related pain was also significantly reduced. Patients reported improvements in terms of comfort, body confidence and the dressing's ability to retain exudate. The authors concluded that improvements can be made to patients' day-to-day activities and quality of life when HS-specific wound care products are provided (Moloney et al, 2022).

WOUND ASSESSMENT

Once HS severity has been identified, wound assessment should include assessment of:

- ▶ Pain — using for example visual analogue scale (VAS), an 11-point scale (0–10) for self-report of pain, the most commonly used unidimensional pain scale (Faculty of Pain Medicine and British Pain Society, 2019)
- ▶ Wound bed and edge, exudate, odour and periwound skin — using for example the principles of TIMES (tissue, infection/inflammation, moisture balance, edge, surrounding skin) (Ferris and Harding, 2019; Krajewski et al, 2021; Mahoney, 2023).

TREATMENT OPTIONS

As with any long-term condition, treatment options should always have the patient at the centre of decision-making, ensuring that they are well informed about their condition and understand the treatment options available (Mahoney, 2023).

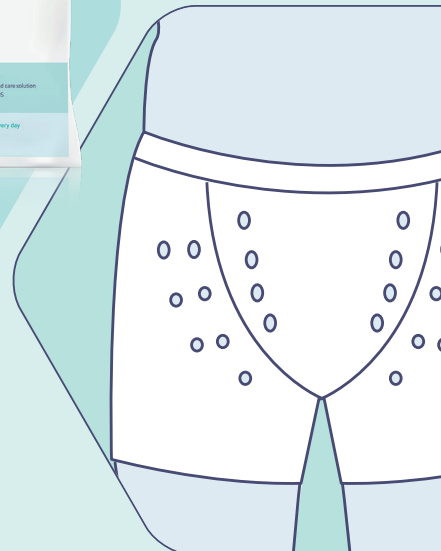


Figure 3.
Hurley stage 1 (left), stage 2 (middle) and stage 3 (right).



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Practice point

What is the Dermatology Life Quality Index?

The Dermatology Life Quality Index, or DLQI, is a simple, self-administered and validated questionnaire to assess patient's quality of life in adults suffering from a skin disease.

First published in 1994, the DLQI consists of ten questions concerning patients' perception of the impact of skin diseases on different aspects of their health-related quality of life over the last week (Finlay and Khan, 1994). A minimum score is 0 and maximum score is 30. A score higher than 10 indicates the patient's life is being severely affected by their skin condition.

It has been used in many different skin conditions in over 80 countries and is available in over 110 translations. The DLQI is the most frequently used patient reported outcome measure in randomised controlled trials in dermatology.

Medical

A number of medical therapies have either been suggested or are considered first line (Ingram et al, 2019), but they are supported by few randomised controlled trials (WUWHS, 2016).

British Association of Dermatologists (BAD) guidelines for the management of HS (Ingram et al, 2019) recommend two main medical therapies for use in patient management pathways — clindamycin 1% solution twice daily for affected skin regions and oral tetracycline for 12 weeks. In Hurley stage 3 disease, BAD recommends immediate clindamycin and rifampicin therapy (Ingram et al, 2019).

BAD (Ingram et al, 2019) and National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2016) recommend adalimumab (an antibody that inhibits tumour necrosis factor [TNF]) as an option for treating active

moderate-to-severe HS in adults whose disease has not responded to conventional systemic therapy.

Surgical

Surgical interventions are relatively underrepresented in management pathways because high quality evidence is sparse (Gulliver et al, 2016; Ingram et al, 2019). As a result, optimal surgical treatment in HS is controversial (Scuderi et al, 2017).

Surgical treatments are based on severity of the disease and the anatomical site involved (WUWHS, 2016), and include incision and drainage, skin grafts and flaps, and lesion roof removal followed by wound healing by secondary intention (WUWHS, 2016; Ingram et al, 2019; Sabat et al, 2020).

Laser

Carbon dioxide laser excision has been reported to have a significant impact on quality of life (Saunte and Lapins, 2016). It is suitable for patients with mild-to-severe disease and can be performed under local or general anaesthetic (WUWHS, 2016).

Another method is long-pulsed Nd:YAG (neodymium-doped yttrium aluminium garnet) laser excision, in which the follicular pilosebaceous unit cells are destroyed (used to target hair follicles for permanent hair removal) (Ingram et al, 2016; Anduquia-Garay et al, 2021).

Photodynamic therapy

Photodynamic therapy (PDT) utilises a molecular energy exchange between visible light and photosensitive drugs resulting in the production of reactive oxygen species (ROS). It causes selective cell necrosis, breaks up biofilm and can modulate inflammation (WUWHS, 2016).

PRODUCT FOCUS

HidraWear is a novel wound dressing system intended for home use by people with HS who require routine wound management (Moloney et al, 2022; Figure 4). HidraWear was developed and tested by people with HS. The dressings, with a backing which has a customised loop coating that allows the fastener to adhere through the perforations, are placed over the wound area and secured in place with external fastening tabs (hook and loop mechanism).

HidraWear retention garments are available in a women's base layer, female and male briefs and unisex T-shirt.

CASE STUDY: PATIENT ONE

Primary care centre, Birmingham

Mr X is a 60-year-old male patient who attended a primary care centre for two non-healing wounds in the axilla and groin. The patient had been under the care of the nursing team for two years and the wounds were



Women's Crop Top



Men's Boxer Briefs



Unisex T-shirt



Women's Briefs

Figure 4.

HidraWear, wearable wound care systems developed specifically for use with HS patients.

Practice point

HS immediate care/first aid

- ▶ Alarm bells should start to ring if you are seeing someone with repeated boils and abscesses, particularly if they affect the axillae or the groin area (Penzer-Hick, 2022). Ask the two key questions that can lead to an accurate and timely diagnosis:
 - Have you had outbreaks of boils during the last six months?
 - If yes, how many and in which locations?
- ▶ If HS is suspected, refer to a GP or onwards to a dermatologist as soon as possible
- ▶ Manage pain using a pain ladder to guide choice (NICE, 2021)
- ▶ When choosing a wound dressing, preferably choose a dressing or system specifically designed for HS wounds, or a wound dressing/tape that has a gentle medical adhesive. Strong medical adhesives and makeshift dressings can cause extreme pain and adhesive sensitivity.

described as deteriorating, painful, highly exuding and malodorous. The surrounding skin was macerated, excoriated and bleeding.

Treatment comprised a silver Hydrofiber® primary dressing with a silicone adhesive bordered foam secondary dressing, which needed to be changed every day, taking nurses over 45 minutes. However, this daily dressing regimen failed to contain the exudate, resulting in leakage and the patient becoming housebound. His quality of life score using DLQI showed a score of 17.

Daily traditional wound dressing usage included:

- ▶ Two silicone adhesive bordered foam retention dressings and two silver Hydrofiber primary dressings
- ▶ Weekly cost of supplies: £118.16
- ▶ Weekly cost of nurse time at £75/unit: £375
- ▶ Total monthly cost at four weeks: £1,972.64.

Following assessment and wound management discussion with the patient, it was decided to change the treatment regimen. After showing the patient how to self-care using HydraWear, nursing time reduced to one visit per week for two weeks to check on the performance of the product. Subsequent visits were reduced to once every two weeks to check on wounds and to supply dressings to patient. Pain, exudate volume and malodour reduced while the surrounding skin condition improved (Figure 5). The patient's quality of life score using DLQI showed a clinically meaningful improvement, reducing from 17 to 0.

Daily HydraWear usage:

- ▶ Three HydraWear dressings, two HydraWear boxer briefs and two HydraWear T-shirts
- ▶ Weekly cost of supplies: £63.16
- ▶ Weekly cost of nurse time at £75/unit: £37.50
- ▶ Total monthly cost at four weeks: £397.

This case report demonstrates the benefits of HydraWear in community and primary care, both to patients and clinicians. The patient's quality of life improved and he now leads a normal life. Clinician time was reduced with a monthly saving of £1,575 to the NHS.

CASE STUDY: PATIENT TWO

Dermatology department, Dudley

Mr Y is a male patient, who was

attending a dermatology clinic for two non-healing HS wounds in the axilla and groin. His treatment duration was described as 'constant', and he was receiving adjunct treatment for the condition of the wounds. The wounds were described as deteriorating, extremely painful, highly exuding and malodorous. The surrounding skin was inflamed and excoriated while he was being treated with traditional dressings. Mr Y self-manages his wound care.

Treatment composed of a film plus pad and silicone adhesive bordered foam primary dressing which needed to be changed every day, taking the patient 20 minutes.

Daily traditional wound dressing usage included:

- ▶ Two silicone adhesive bordered foam and two film plus pad primary dressings plus film tape and traditional adhesive tape
- ▶ Weekly cost of supplies: £71.40
- ▶ Monthly cost of supplies: £285.60.

Following assessment and wound management discussion in which the patient was involved, the treatment regimen changed to HydraWear. Subsequent dressing changes took 4–10 minutes for the patient. Pain, exudate volume and malodour reduced, while the condition of the surrounding skin improved (Figure 6). The patient stated that the garments provided were excellent — soft and comfortable to wear. The dressings were easier to apply and lasted longer

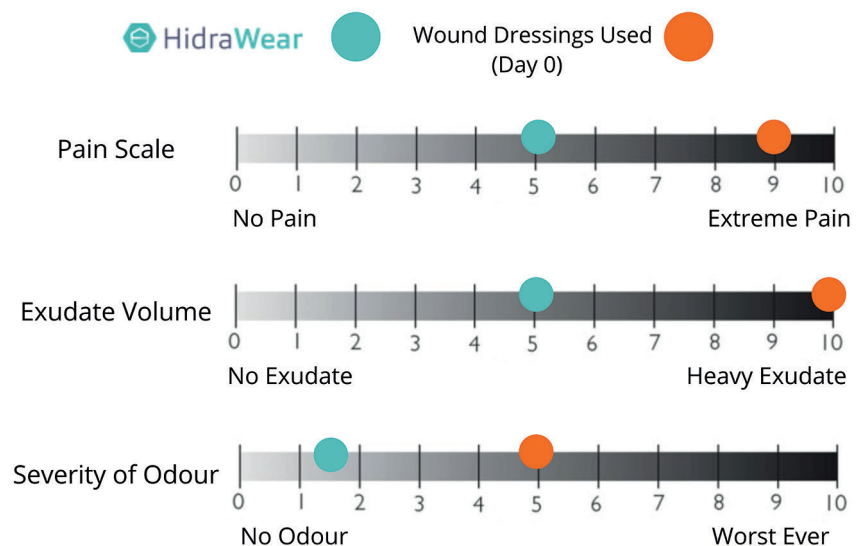


Figure 5. Patient one — wound characteristics assessment.

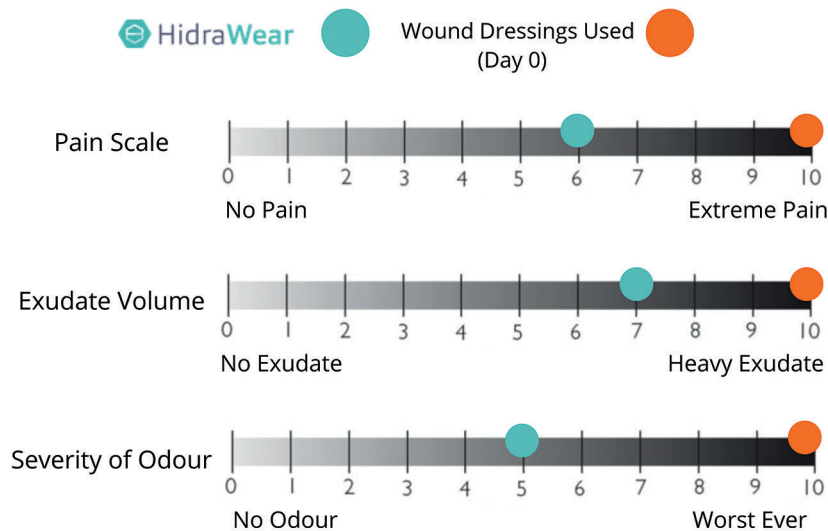


Figure 6. Patient two — wound characteristics assessment.

between dressing changes. Mr Y was happy to wash the garments and said he would recommend the treatment regimen to other patients with HS.

Daily HidraWear usage:

- ▶ Two HidraWear dressings, two HidraWear boxer briefs and two HidraWear T-shirts
- ▶ Weekly cost of supplies: £46.86
- ▶ Monthly cost of supplies: £187.40.

This case demonstrates the benefits of HidraWear in dermatology practice, both to the patient and the clinician. A monthly saving of £98.20 on the cost of supplies to the NHS was seen, as the HidraWear dressings lasted longer than previous products.

CONCLUSION

HS is a chronic inflammatory skin disease with a profound physical and psychological impact on quality of life for individuals. The pathophysiology of HS is not completely understood, but it is primarily a skin disease of the hair follicles. The primary diagnostic criteria of HS is that individuals have typical lesions at typical sites and that the disease is chronic and recurrent.

There are many problems associated with traditional wound dressings for this patient cohort, but wearable wound care systems have been developed specifically for use for HS patients.

As more healthcare professionals and the general public become aware

of this devastating disease, speed of diagnosis, referral and treatment will hopefully dramatically improve. JCN

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KEY POINTS

- Hidradenitis suppurativa (HS) is a painful and distressing skin disease of the hair follicle affecting nearly as many people as psoriasis.
- While there is no cure for HS, it is important that healthcare professionals are aware of the disease, so that they can provide timely access to treatment and support.
- HS assessment should include severity of the disease, its impact on quality of life and wound assessment.
- It is vital that the condition is seen as a debilitating disease and its impact on daily life, self-esteem and social interaction should not be underestimated.
- HidraWear is a novel wound dressing system intended for home use by people with HS who require routine wound management.

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Resources

HS support groups (Malcolm et al, 2015):

- ▶ British Skin Foundation <https://www.britishskinfoundation.org.uk/>
- ▶ European Hidradenitis Suppurativa Foundation <https://ehsf.eu/>
- ▶ Hidradenitis Suppurativa online https://www.hsonline.ae/en_ae/home.html
- ▶ Patient UK <https://www.patient.co.uk>
- ▶ British Association of Dermatologists <http://www.bad.org.uk>
- ▶ NHS Choices <https://www.nhs.uk/conditions/hidradenitis-suppurativa/>

JCN eLearning module: www.jcn.co.uk/course/understanding-hidradenitis-suppurativa/details

Facebook Live, 17th May: www.woundcare-today.com/facebook-live/facebook-live-treating-wounds-in-challenging-areas-hidradenitis-suppurativa

HS Awareness week: the first full week of June every year — raising awareness of HS and highlighting the challenges that people living with HS face

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Wound preparation and the role of mechanical debridement

Jen Letchford

Chronic wounds are complex by nature and require thorough assessment and carefully planned management. Part of that management often includes preparing the wound and periwound skin for healing, for which debridement is frequently required. While there are several methods of debridement available, often requiring specialist referral, there are some that can be used by generalist nurses and patients and carers themselves. This article describes one of those methods, mechanical debridement, examining the benefits of use and where it would not be appropriate. It concludes by focusing on a new debridement tool designed in collaboration with healthcare professionals and looks at four patient case studies where it was used in clinical practice.

KEYWORDS:

- Chronic wounds ■ Wound preparation ■ Debridement
- Wound cleansing and debridement pads

Chronic wounds affect patient quality of life and are a burden on the healthcare system (Atkin et al, 2019; Guest et al, 2020). Therefore, anything that can be done to move a chronic wound towards a healing state will benefit everyone (Atkin et al, 2019).

Chronic wounds are characterised by (Atkin et al, 2019; Smith and Sharp, 2019):

- ▶ Prolonged or excessive inflammatory stage
- ▶ High levels of proteases (enzymes contained in wound exudate that maintain the balance between tissue synthesis and degradation) and cytokines (small proteins that include growth factors)
- ▶ Cellular senescence (where the cells are not actively dividing, but are alive and metabolically active)
- ▶ Persistent infection

‘Wound preparation is exactly what it says, preparing the wound for healing. Debridement is a critical step in this process...’

- ▶ Often associated with an underlying pathophysiology that compromises healing, such as vascular insufficiency.

Due to the range of pre-existing conditions and patient-related factors (e.g. age, nutritional status), managing chronic wounds is complex (Smith and Sharp, 2019).

WOUND ASSESSMENT

To promote optimum wound healing, healthcare professionals should first thoroughly assess the wound bed, wound edge and periwound skin in the context of holistic patient care (World Union of Wound Healing Societies [WUWHS], 2016). Including the skin beyond the edge of the wound (periwound skin), develops the concept of wound preparation

(also known as TIME, which stands for tissue, infection/inflammation, moisture imbalance, wound edge), and facilitates early identification of at-risk patients (e.g. those with a high volume of exudate at risk of maceration), so that appropriate prevention and treatment strategies can be implemented to improve patient outcomes (WUWHS, 2016). Other structured holistic tools that have been developed to extend the principles of TIME to assess and manage wounds include, for example, the Triangle of Wound Assessment (Dowsett et al, 2019), or following a three-step approach of assess, prepare, and treat (Barrett et al, 2022).

During this assessment, healthcare professionals may encounter chronic wounds that contain devitalised tissue within the wound bed (dead or damaged tissue, debris, biofilm or bacteria), also known as necrotic tissue, eschar or slough (Kalan et al, 2023). Devitalised tissue can vary in appearance — black/brown, hard necrotic tissue, yellow/green/grey/black leathery eschar, or yellow/green/black soft and slimy slough (Wounds UK, 2013). In the case of a haematoma, the tissue will have a purple or dark red, coagulated blood appearance (Gray et al, 2011).

WOUND PREPARATION AND DEBRIDEMENT

Wound preparation is exactly what it says, preparing the wound bed for healing. Debridement is a critical step in this process, which aims to promote the production of healthy granulation tissue and speed the wound healing process, while also helping to reduce bacterial burden and biofilm, minimising the risk of infection (Thomas et al, 2021; International Wound Infection Institute [IWII], 2022).

There are different methods of debridement, each taking varying lengths of time to achieve full removal of devitalised tissue (Vowden and Vowden, 2011; Strohal et al, 2013; Wounds UK, 2013; Thomas et al, 2021), namely:

- ▶ Autolytic debridement: enhancing the body's own enzymes (autolysis) to rehydrate and soften devitalised tissue using wound dressings
- ▶ Enzymatic debridement: some enzymatic agents are considered outdated and can cause pain, wound and skin complications
- ▶ Sharp debridement: conventional 'bedside' debridement using a scalpel blade, curette or scissors to remove necrotic tissue
- ▶ Surgical debridement: conducted in a sterile environment, such as an operating theatre, and usually involving a wider excision and removal of tissue
- ▶ Biological debridement: usually known as maggot therapy using sterile larvae of the green bottle fly (*Lucilia sericata*) which produces an antibacterial and chemical secretion that can break down dead tissue
- ▶ Mechanical debridement: using debridement pads and cloths.

The decision to debride and debridement method selected should be based on the amount and type of devitalised tissue (e.g. hard, necrotic tissue will need rehydrating in the first instance), anatomical location of the wound (e.g. debridement method may be different in heel areas of mobile patients or the sacral area in seated patients), and on the holistic wound assessment undertaken and management plan (e.g. the assessment and risks identified may require a management plan for immediate debridement) (Vowden and Vowden, 2011; Gray et al, 2011). Other considerations are the patient's choice and pain assessment (Strohal et al, 2013).

Debridement should not be confused with wound cleansing, which is actively removing surface contaminants, loose debris, non-attached non-viable tissue, microorganisms or remnants of

previous dressings from the wound surface and its surrounding skin (Haesler et al, 2022).

In summary, wound debridement is important because it:

- ▶ Reduces the number of bacteria and biofilm present in the wound bed, reducing the risk of wound infection (IWII, 2022)
- ▶ Encourages progress of the epithelial edge, removing barriers to healing and promoting formation of new epithelial cells (Atkin et al, 2019)
- ▶ Reduces wound malodour and exudate, improving quality of life for the patient (Strohal et al, 2013)

'Mechanical debridement is reportedly the least time consuming method of debridement, requiring no special expertise or training and causing little or no pain or damage to health tissue.'

- ▶ Prevents a prolonged inflammatory phase of wound healing and therefore wound chronicity (Haesler et al, 2022)
- ▶ Enables better visibility of the wound bed (Gray et al, 2011).

Wound debridement is an ongoing process and should be performed frequently, at each dressing change (Vowden and Vowden, 2011; Wilcox et al, 2013). Evidence from a retrospective cohort study (follows research participants over a period of time) of 312,744 wounds has shown that the more frequent the debridement, the better the healing outcomes with shorter healing rates (Wilcox et al, 2013).

However, it should be noted that there are some situations where wound debridement requires caution (e.g. wound pain), specialist referral (e.g. high-risk areas such as face, hands, feet, genitalia or exposed blood vessels, bone or tendon), or is unsafe (e.g. spreading infection, ischaemic limbs, feet or toes) (Vowden and Vowden, 2011; Barrett et al, 2022).

Practice point

It is important to choose a method of wound debridement that is in the best interest of the patient and not necessarily the ritualistic use of one method of debridement which the healthcare professional is able to perform (Price and Young, 2013).

Healthcare professionals need to recognise the importance of debridement, be able to perform it safely within their scope of practice, and be aware of where to refer the patient for specialist advice when required (Laryea, 2020).

This article will now focus on mechanical debridement, a method of debridement which is readily available to the majority of generalist nurses.

MECHANICAL DEBRIDEMENT

Mechanical debridement is a non-selective debridement, with examples including (Kalan et al, 2023):

- ▶ Therapeutic irrigation — 4 to 15 psi (pound per square inch, a measure of pressure)
- ▶ Debridement pads and cloths
- ▶ Low-frequency ultrasound
- ▶ Hydrosurgery.

Mechanical debridement can be used in a variety of acute and chronic wounds and, in the form of debridement pads and cloths, can be ideal for self-care, as products can be easily used by patients and/or their carer. Mechanical debridement can be less effective when there is a thick layer of devitalised tissue and it is not appropriate if the tissue is hard and necrotic (Strohal et al, 2013; Kalan et al, 2023), or in patients who express high levels of wound pain or those with acute wounds, such as burns (Barrett et al, 2022).

An early method of mechanical debridement involved using dry or wet-to-dry gauze or impregnated gauze being ripped off devitalised tissue. However, due to severe pain, new advanced mechanical debridement methods have emerged

Red Flag

Dry gauze, wet-to-dry gauze dressings, impregnated gauze/tulle dressings are associated with many disadvantages, such as:

- ▶ Significant pain and tissue injury, e.g. damage to new, granulating tissue
- ▶ Frequent dressing changes/ time consuming, therefore costly despite low cost of gauze
- ▶ Increased risk of infection.

Due to such disadvantages, it is therefore recommended that their use in clinical practice should be precluded (Strohal et al, 2013).

(Strohal et al, 2013; Thomas et al, 2021 [see *Red flag box*]).

Mechanical debridement is reportedly the least time consuming method of debridement, requiring no special expertise or training and causing little or no pain or damage to healthy tissue (Strohal et al, 2013).

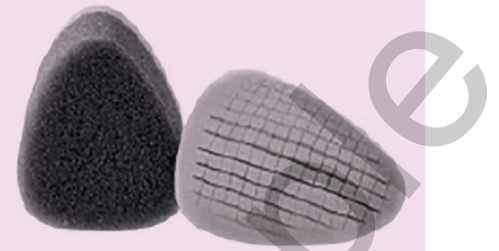
Antimicrobial stewardship

Wound management has historically involved the use of antimicrobial treatments, but antimicrobial resistance has now become a global crisis (Cooper and Kirketerp-Møller, 2018). The use of non-antibiotic or antimicrobial interventions, such as debridement and negative pressure wound therapy (NPWT), has the potential to play a role in antimicrobial stewardship (AMS) by removing devitalised tissue and therefore microbes from the wound bed, reducing the risk of infection and/or biofilm and potentially the need for antibiotics or antimicrobial agents (Cooper and Kirketerp-Møller, 2018). A recent best practice document (Wounds UK, 2020), advised healthcare professionals managing wounds to play their part in AMS by implementing wound preparation to:

- ▶ Reduce wound or skin microbial load
- ▶ Debride the wound of necrotic tissue, debris, foreign bodies, wound dressing remnants and slough
- ▶ Cleanse the wound at each dressing change.

PRODUCT FOCUS: ALPREP® PAD

Alprep® Pad (Coloplast Limited) is a 2-in-1 cleansing and debridement tool designed to prepare the wound bed, wound edge and periwound skin to optimise healing. It physically disrupts bioburden and removes non-viable tissue through the mechanism of mechanical debridement (Jones and Barnett, 2022). The pad can also be used to cleanse the surrounding skin. The tool is designed for improved absorption of devitalised tissue and can help to simplify cleansing and debridement to support optimal wound preparation (Barrett et al, 2022).



The dark grey foam is for loosening debris and devitalised tissue. If the wound has a lot of slough, the dark grey side can be used first to loosen the slough from the wound bed. The light grey softer foam is for absorbing and capturing debris and devitalised tissue. If there is a large volume of exudate present, the light grey side can be used first to absorb the exudate. The 'slits' in the light grey foam increase the surface area of the pad for absorption and removal of non-viable tissue from the wound bed, wound edge and periwound skin and hyperkeratotic skin scales (Barrett et al, 2022). It also removes biofilm and microorganisms from the wound surface. The pad is designed to be moistened before use and either side of the pad can be used first depending on the wound presentation. The triangular-shaped pad is ergonomically designed for ease of use and comfortable handling.

Alprep Pad has been designed to be used as part of holistic assessment, and fits into the 'Assess, Prepare, Treat' paradigm:

- ▶ Step 1: assess wound and patient to identify management goals and understand patient expectations and concerns
- ▶ Step 2: prepare wound for healing using Alprep Pad (or follow local protocol)
- ▶ Step 3: treat wound in accordance with underlying aetiology and specific wound treatment objective (Barrett et al, 2022).

A five-patient case series was undertaken to evaluate the cleansing and debriding performance of Alprep Pad in loosening, absorbing and removing non-viable tissue, bioburden, skin scales including hyperkeratosis, slough and exudate from the wound bed, wound edge and periwound skin (Jones and Barnett, 2022). Over a four-week evaluation period, patients with diabetic foot ulcers with a recurrent history of infection showed reduction in wound surface area and in one patient, complete healing. None of the patients required treatment with an antimicrobial dressing or antibiotic therapy over the four-week evaluation period. The authors suggest that Alprep Pad was effective in physically disrupting bioburden and removing non-viable tissue from the wound bed (Jones and Barnett, 2022).

In another recent product evaluation, the clinical use of Alprep Pad for cleansing and debriding wounds was evaluated to determine effectiveness and ease of use for healthcare professionals. A total of 46 patients with 53 different wounds were evaluated in up to three debridement sessions per wound. All patients, except five, completed three debridement sessions; a total of 153 debridement sessions were performed (Moore and Baxter, 2021). Results showed a reduction in pain before and during each debridement session, and effective removal and absorption of debris/necrosis/slough. It was perceived to be gentle and left newly formed granulation tissue either completely, or to some extent, undamaged (Moore and Baxter, 2021).



*The product presentation shown is for illustrative purposes only and should not replace clinical judgement by a qualified healthcare professional.

Wound management can be complicated, choosing the right solution doesn't have to be.

When you visit a patient, you bring the solution that can help create optimal wound healing conditions. Prepare your patient's wound with the Alprep Pad and then choose a wound bed conforming dressing, such as Biatain Silicone or Biatain Silicone Ag, based on your treatment objectives.

Visit www.coloplast.com/wound-care to request your free samples.



Alprep® Pad
Biatain® Silicone
Biatain® Silicone Ag

CASE STUDIES

Case one

(Penny Rubio, clinical lead tissue viability, Oxford Health)

Mr A was 70 years old with a history of multiple deep vein thrombosis (DVT) and obesity, limited mobility, with hard-to-heal and recurrent bilateral venous leg ulcers which were:

- ▶ Painful to debride
- ▶ Highly exuding
- ▶ Suspected of containing biofilm.

The patient had previously been seen in a dermatology leg ulcer clinic. Following this appointment, he was self-caring with basic dressings and compression hosiery but having limited success. The patient had also had a previous hospital admission with infected leg ulcers. Mr A had extensive bilateral leg ulcers which were over granulating in areas with evidence of bleeding on dressing removal.

Following a referral from the district nurse team to tissue viability, compression therapy was started. However, his wounds failed to progress.

The ulcer was treated with a two-sided cleansing and debridement pad following unsuccessful treatment with previous techniques. Patient assessment (using TIME) and history-taking indicated bacteria/biofilm and slough in the wound bed:

- T Over granulating, dark red in colour, occasional bleeding present when debrided: around 70% slough present, 30% thick slough
- I Local wound bed infection present
- M Highly exuding, thick purulent and malodorous
- E Vulnerable periwound skin with some maceration present.

Treatment objectives were to:

- ▶ Loosen and remove non-viable tissue
- ▶ Disrupt biofilm with the two-sided cleansing and debridement pad and an antimicrobial cleansing solution, followed by application of an antimicrobial dressing and modified compression.

Results

Two wounds on the right calf and left inner malleolus were debrided with Alprep® Pad. The left wound was painful to debride and Mr A was only able to tolerate 30 seconds of cleansing with the pad. However, this removed 80% of the slough. On the right calf wound debridement was successful, removing 100% of the slough, but causing a little bleeding. This is not uncommon in friable wounds.

Alprep Pad was quick to debride, easy to use and accessible to the wound care team.



Case study one: pre and post debridement of both wounds.

Case two

(Kate O'Brien, general practice nurse, Morden Hall Medical Centre)

Mr B was 60 years old presenting with a one-month old superficial ulcer and excoriated skin extending over the left calf and shin. A venous leg ulcer was diagnosed following assessment and ankle brachial pressure index (ABPI) measurement. Local infection was suspected, and

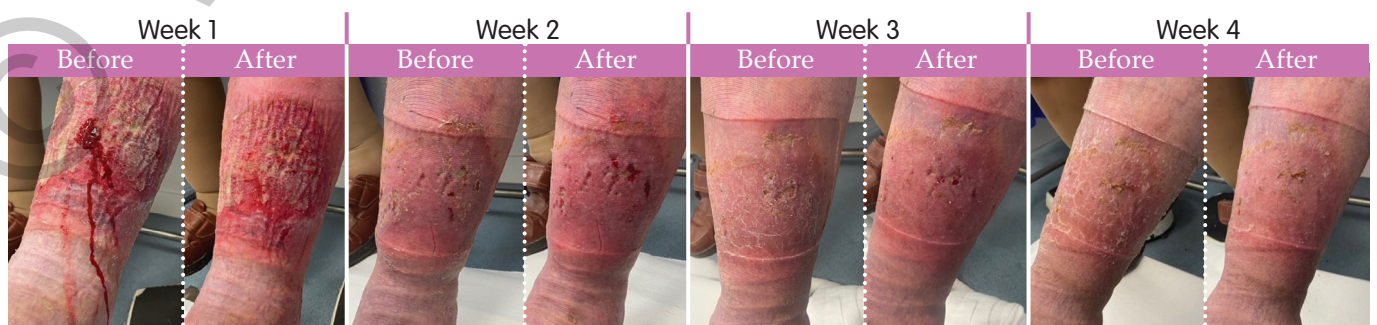
the patient was initially prescribed a course of oral flucloxacillin, with no effect, followed by a course of doxycycline.

Following publication of best practice recommendations (Barrett et al, 2022), a two-sided cleansing and debridement pad was used in conjunction with a non-adhesive antimicrobial foam with 3DFit

Technology™ and two-layer compression bandages.

Results

This treatment plan proved to be effective, as indicated by the pictorial timeline below, resulting in complete wound healing within four weeks. The two-sided cleansing and debridement pad was used for four minutes at each dressing change.



Case three

(Jane Hampson, lower limb specialist, Accelerate CIC)

Mrs C had a history of bilateral venous leg and foot ulceration of eight years' duration with persistent/difficult-to-remove slough, high volume of exudate and recurrent infection with a recent flare up. She has sickle cell anaemia and a history of cervical spine fracture, total hip replacement, DVT and splenic abscess. Previous dressings and weekly debridement techniques (sharp and mechanical) had been unsuccessful, with high levels of pain reported requiring pre-dressing and debridement analgesia.

Four debridement sessions

with a two-sided cleansing and debridement pad were conducted between December 2021 and January 2022. Wound dimensions and tissue type was recorded as well as wound photography, fluorescent imagery and an overall healthcare professional evaluation of the debridement session completed.

Results

One debridement pad was used at each session. The two-sided cleansing and debridement pad was used for two to three minutes in session one removing <20% of the slough/necrosis and debris. The time to cleanse and debride was increased to three to four minutes in the two subsequent sessions,

removing 20–50% of slough/necrosis and debris. The time spent in the final session was five minutes and removed 20–50% of slough/necrosis and debris.

In all four sessions, the healthcare professional reported a visible effect of cleansing and debridement with three to five minutes being the optimal time. The wound team found that the new cleansing and debridement pad was a time-efficient solution and that mechanical debridement with the two-sided cleansing and debridement pad was as efficient as sharp debridement and commented on the improvement the debridement pad had made to the wound.



Case four

(Gabriela Korn, wound care specialist nurse, Accelerate CIC)

Mrs D was a 63-year-old patient with complex comorbidities. Her wound had been present for three to four years, and diagnosed as *pyoderma gangrenosum* by a dermatology consultant, complicated by lower limb lymphovenous disease.

Four debridement sessions with a two-sided cleansing and debridement pad were conducted between December

2021 and January 2022. At each of the four sessions, pre- and post-debridement photos (using eKare — InSight® [eKare inc] and MolecuLight [wound imaging device to visualise bacterial]) and wound measurements were taken, and the wound bed tissue type assessed.

Results

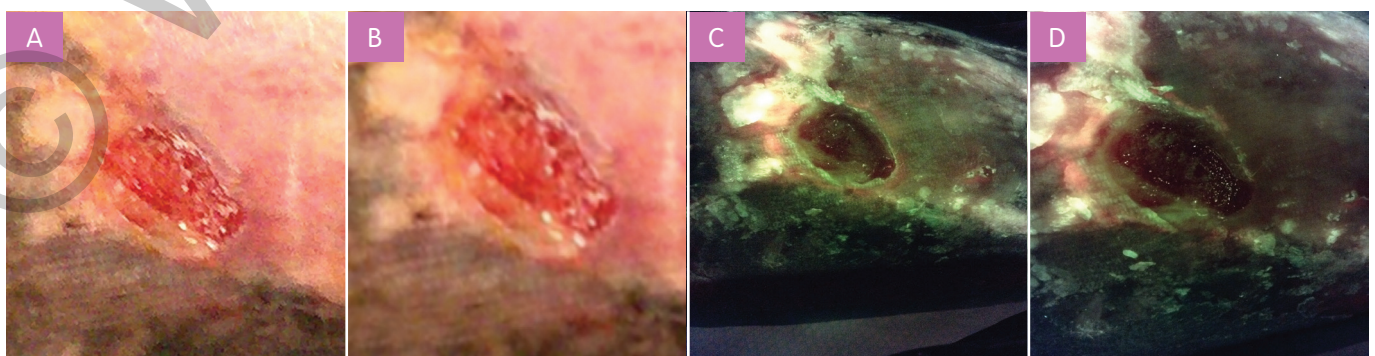
Wound dimensions were as follows:

- ▶ Session one (length) 20mm x (width) 21mm x (depth) 2mm
- ▶ Session four (length) 17mm x (width) 20mm x (depth) 1mm

- ▶ This represented a 60% reduction in wound size.

Granulating tissue increased from 81% (*image A*) to 100% (*image B*), with slough decreasing from 19% to zero after one minute of wound preparation.

The pink/red colour from the fluorescent scan in *images C* and *D* indicates the presence of bacteria at the wound surface. The lighter pink blush colour in *image C* around the wound edge shows a level of sub-surface bacterial fluorescence.



The maroon black florescent image (*image D*) shows successful wound preparation resulting in a well vascularised wound bed following one minute of cleansing and debridement.

The new debridement tool demonstrated a reduction in non-viable tissue and biofilm in this case.

CONCLUSION

Thorough assessment of the patient as a whole, including the wound bed, wound edge and periwound skin is a vital first step to enable optimum wound healing management. This assessment should help to identify management goals and understand patient expectations and concerns. The next step is to prepare the wound for healing by implementing wound preparation and treating the wound in accordance with underlying aetiology and specific wound treatment objectives.

Mechanical debridement in the form of debridement pads and cloths, can be ideal for self-care, as products can be easily used by patients and/or their carer. Alprep Pad is a two-sided cleansing and debridement tool designed to prepare the wound bed, wound edge and periwound skin to optimise healing. It has been shown to be not only quick and easy to use, but also effective at removing devitalised tissue, bacteria and biofilm (using fluorescence imaging in one case) in the case studies presented. **JCN**

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KEY POINTS

- Chronic wounds are complex by nature and require thorough assessment and carefully planned management.
- To promote optimum wound healing, healthcare professionals should first thoroughly assess the wound bed, wound edge and periwound skin in the context of holistic patient care.
- Wound preparation is exactly what it says, preparing the wound bed for healing.
- Debridement is a critical step in this process which aims to promote the production of healthy granulation tissue and speed the wound healing process, while also helping to reduce bacterial burden and biofilm.
- Mechanical debridement in the form of debridement pads and cloths, can be ideal for self-care, as products can be easily used by patients and/or their carer.
- Alprep® Pad (Coloplast Limited) is a 2-in-1 cleansing and debridement tool designed to prepare the wound bed, wound edge and periwound skin to optimise healing.

Challenges in skin tone assessment in moisture-associated skin damage

Nyssa Cole, Sarah Waller

Moisture-associated skin damage (MASD) is a term used to describe skin damage that is caused by prolonged exposure to moisture, such as incontinence-associated dermatitis (IAD), intertriginous dermatitis, periwound moisture-associated dermatitis and peristomal moisture-associated dermatitis. MASD is a hugely prevalent issue in hospitals and long-term care facilities (Voegeli, 2019). Studies have shown that skin tone bias exists in the diagnosis and treatment of MASD, the impact of which this paper discusses as well as how to prevent such bias while assessing and diagnosing MASD.

KEYWORDS:

■ Skin tone bias ■ Dark skin tones ■ Assessment ■ Management

Inequalities in healthcare have always been a problem. A study on undergraduate nurse education at five higher education institutions in the UK confirmed that learning was predominantly framed through a white lens, with white normativity being strongly reinforced through teaching and learning activities (Oozageer Gunowa et al, 2022). These findings highlighted that teaching skin tone diversity is needed to ensure meaningful teaching and learning experiences, with educators having a duty of care to inform and highlight health inequities in nursing to enhance equity in care.

In wound care, optimising treatment and outcomes for individual patients depends on accurate assessment and diagnosis, for which knowledge of signs and symptoms across skin tones is essential (Mukwende, 2020). In the

authors' clinical opinion, there is generally a lack of evidence around skin tones in wound care. Indeed, healthcare professionals diagnose moisture-associated skin damage (MASD) more frequently in patients with light skin tones and it has been found that patients with dark skin tones are more likely to be diagnosed with higher stage pressure ulcers (PUs), due to a lack of accurate assessment and early identification (Oozageer Gunowa et al, 2017). This can result in:

- ▶ Delayed healing
 - ▶ Prolonged hospitalisation
 - ▶ Increased risk of infection
- (Oozageer Gunowa et al, 2017).

In the authors' opinion, by applying colour awareness to holistic wound assessment, healthcare professionals can more appropriately manage skin conditions among patients of all skin colours and help reduce disparities in healthcare delivery.

Mukwende et al (2020) published a book, *Mind the Gap*, to educate students on the importance of recognising that certain clinical signs do not present the same on dark skin. Indeed, many of the signs

and symptoms that clinicians have been educated to look for when assessing patients' skin may present differently, depending on their skin tone. For example:

- ▶ Nurses are usually trained to assess skin breakdown by testing the skin's blanch response to light finger pressure. When evaluating for a stage I pressure ulcer, light pressure is applied to the skin; this temporarily squeezes blood out of the underlying area, reducing local blood volume and causing an area of blanching, or whitening. If the skin appears red, blue, or purplish and does not blanch, you might classify the area as a stage I pressure ulcer. But, in patients with dark skin, the blanching test has limited value, as the greater amount of melanin in dark skin may mask the blanch response, making the colour change invisible despite the local change in blood volume. It has been found that dark skin rarely shows the blanching response that clinicians are trained to look out for (Grimes, 2009)
- ▶ It is important to remember that skin irritation in patients with dark skin tones may cause hyperpigmentation (increased pigmentation) or hypopigmentation (reduced pigmentation), with no redness visible (Nijhawan and Alexis, 2011)
- ▶ Some of the issues with skin bias were highlighted during the Covid-19 pandemic when family members were being asked if potential Covid patients looked 'pale' or if their lips had 'turned blue' — not useful descriptors for patients with black skin, therefore compromising care (Mukwende et al, 2020).

Skin colour can reflect a patient's overall health and is an important

part of assessing skin breakdown and wound healing. For instance:

- ▶ Pallor may indicate anaemia
- ▶ Cyanosis may signal hypoxemia
- ▶ The degree and extent of skin redness is important in burn care
- ▶ Understanding skin colour changes is crucial for detecting and staging pressure ulcers (Everett et al, 2012).

The exact nature of colour changes such as pallor, cyanosis, and redness varies with the patient's natural skin colour — and this can be challenging in providing clinically competent and culturally sensitive care. Long a source of discrimination, skin colour is a socially sensitive issue. Identifying and evaluating skin colour raises questions about stereotyping. It is clear that a systemic change is needed to eradicate the significant health inequities due to skin tone across care settings (Oozageer Gunowa et al, 2017; Mukwende, 2020).

WHAT CAUSES DIFFERENT SKIN TONES?

Simply said, skin tone is the result of melanin, a brown pigment in the skin. Melanin is produced in the epidermal layer of the skin and its purpose is to protect the skin by absorbing harmful ultraviolet (UV) radiation from the sun (Spierings, 2022). When the skin meets UV rays, cells called melanocytes produce additional melanin, which gives the appearance of darker skin. There is no difference in the number of melanocytes between skin types. The palest and darkest person will, on average, have the same number of these cells, i.e. melanocytes in their skin. However, the production and concentration of melanin in the epidermis is greater in dark skin (Spierings, 2022).

Skin tone can be constitutive or facultative. Constitutive skin tone refers to the genetically determined levels, types, and distribution of epidermal melanin, which is not influenced by intrinsic or extrinsic factors. Facultative skin tone refers to an increased epidermal melanin content as a result of intrinsic factors (e.g. hormones) or extrinsic factors

(e.g. environmental factors such as sunlight) (Everett et al, 2012). This means that skin colour can be changeable across all skin tones.

CHALLENGES IN DIAGNOSIS AND TREATMENT

There are several challenges in diagnosing and treating MASD in patients with dark skin tones. One is the visual appearance of MASD. MASD often presents as erythema or redness, which can be difficult to see in patients with dark skin tones. Additionally, healthcare providers may be less familiar with the visual appearance of MASD in patients with dark skin tones, leading to underdiagnosis and undertreatment.

MASD represents another area of skin damage where identifying 'redness' is often referred to, and consideration needs to be made of how this may present in a range of skin tones. Classification of IAD — for example, the Ghent Global IAD Categorisation Tool (GLOBIAD) — relies on 'redness' as a key indication of damage, while noting that, in patients with dark skin tones, this may present as skin that is paler or darker or more purple than red (Beeckman et al, 2018). It is important that healthcare professionals are aware of this distinct difference.

Erythema

Erythema (from the Greek, *erythros*, meaning red) means a change in colour of an area of skin, caused by increased blood flow (British Association of Dermatologists [BAD], 2021). It has traditionally been used to detect skin areas that may be infected or have other abnormalities. It is a symptom common to many diseases, such as infections and inflammatory skin diseases like eczema or psoriasis (Dhoonmoon et al, 2023). While redness can be an obvious symptom in people with less deeply pigmented skin, where it contrasts clearly against light skin tones, this is not necessarily the case in people with dark skin tones, for example, black, brown and olive skin tones (Dhoonmoon et al, 2021). Changes in colour can run the spectrum of pink, red and purple — in some

Practice point

In wound care, it is important to remember that skin tone is separate from race, e.g. not all people classified as Black have dark skin tones. Terms like 'brown' or 'black' should be used, i.e. those that do not centre around lighter skin tones or use light skin as the 'norm' or baseline, as this raises the question 'darker than what?' For example, this would mean saying 'dark skin tones' rather than 'darker' or 'non-white'.

cases, it may be limited to a subtle darkening of the existing skin tone (Dhoonmoon et al, 2023).

An example of this is sunburn. Indeed, it is a common misconception that people with dark skin tones do not burn in the sun. It can and does happen, but may not be easily visible. If it does occur, it may not appear as 'redness' that people generally associate with sunburn. In the authors' clinical opinion, while signs of erythema in dark skin can be easy to miss, there are ways of spotting it. For example, it can be easier to spot when affected areas are compared with unaffected skin.

In the authors' clinical opinion, there is no straightforward way to predict exactly what colour erythema will look like in an individual's skin. It is dictated by a person's skin tone, of which there are many more variations than most people realise, and the nature of the disease in question. In addition to this, if inflammation is not easy to spot on a patient's skin, it is sensible to consider other potential symptoms of their condition, such as pain, warmth, swelling, signs of feeling unwell or illness (Dhoonmoon et al, 2023).

Another challenge, as discussed earlier, seen across the world is the lack of diversity in medical education and training (Dhoonmoon et al, 2021). Medical education and training often does not include sufficient instruction on the diagnosis and treatment of skin conditions in patients with dark skin tones.

Does skin tone bias exist in the diagnosis and treatment of MASD?


The answer is YES





Symptoms that clinicians have been educated to look for when assessing patients' skin, may present differently, depending on their skin tone*

Studies show that...

ASSESSMENT IS KEY!




Patient Mr. X following an episode of chest infections and sepsis, had urinary incontinence, used incontinence pads & was nursed in bed**

| | |
|---|--|
|  | Severe IAD to natal cleft, skin was broken & weeping; skin is hyperpigmented and darkened |
|  | MEDI DERMA-PRO Ointment & Cleanser helped heal and protect the skin from further breakdown. Treatment was stepped down to MEDI DERMA-S Barrier Film for protection |


TREATMENT STRATEGY

Initial Treatment
MEDI DERMA-PRO Helped heal the skin, reduced severity of moisture damage, less exudate, less broken skin



OINTMENT FOR **SEVERE** SKIN DAMAGE

Step Down
MEDI DERMA-S After 7 days, skin management stepped down for protection



FILM FOR **MODERATE** SKIN DAMAGE

SKIN DAMAGE METER

MEDI DERMA-PRO Skin Protectant Ointment and Foam & Spray Incontinence Cleanser

MEDI DERMA-S Total Barrier Film



Medicareplus
INTERNATIONAL



SCAN HERE to request a free
MEDI DERMA-S film sample

*References available on request
**Cole & Waller, JCN 2023

In wound care, a lack of education around skin tone awareness may mean that clinicians are not trained to spot signs and symptoms in all skin tones. The challenge then being that if skin changes are not seen, they will not be treated. Healthcare professionals may miss these even when inspecting the skin, leading to late identification and diagnosis of skin damage, and potentially patient harm (Oozageer Gunowa et al, 2022).

SKIN TONE CHANGES IN MOISTURE-ASSOCIATED SKIN DAMAGE (MASD)

Risk assessment and prevention strategies are of key importance in MASD (Fletcher et al, 2020a). Clinicians must be vigilant, both in maintaining optimal skin conditions and in diagnosing and treating early stages of MASD, to prevent progression and skin breakdown (Beeckman et al, 2020). More specifically in dark skin tones:

- ▶ Limited research suggests that the hydrophilic/lipophilic balance of the skin differs across skin tones, which may affect how the skin holds moisture (Fotoh et al, 2008)
- ▶ Anecdotal evidence also suggests that dark skin tones may have increased need for moisturising treatments, but further research is required in this area.

When assessing MASD:

- ▶ A baseline should be established against which to assess/track healing or deterioration. The standard for documentation of skin assessment is within 24 hours of admission to inpatient care
- ▶ Skin tone changes must be noted. Skin may present as redness, darkening, lightening or purple tones. Damage may be difficult to spot if clinicians are just looking for signs of redness
 - ▶ Inspect the skin thoroughly and regularly. Skin assessment should be ongoing in inpatient and long-term care
 - ▶ Ensure protective measures, such as barrier products, are used when patients are at significant

risk of MASD, before the damage occurs

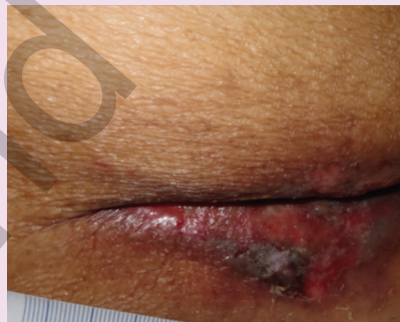
- ▶ It is important to be aware of changes when MASD is classed as severe, i.e. the epidermis has been eroded away due to prolonged exposure to moisture. Melanin is in this epidermal layer and so when the lower layers, i.e. the dermal layers of skin, are exposed, MASD will present as pink or red in all skin tones (Fletcher et al, 2020b).

Good skin assessment is fundamental and should include:

- ▶ Touching the skin, feeling for heat, moisture, texture of the skin
- ▶ Listening to the patient's perspective to aid accurate assessment and understanding their personal choices and preferences
- ▶ Looking and comparing similar anatomical locations
- ▶ Photographing and documenting wound and skin changes.

The cases below illustrate how MASD will appear in dark skin tones.

Case study one



This patient was admitted to hospital from a care home following an episode of recurrent chest infections and sepsis. The patient had urinary incontinence and used incontinence pads and was nursed in bed. The patient was prescribed several medications but was not using any prescribed skin care, such as emollients or barrier products. The patient was extremely dehydrated and had severe incontinence-associated dermatitis (IAD) to the natal cleft and the skin was broken and weeping.

The image shows that the skin has become hyperpigmented and darkened. This would have been the first sign of moisture damage and changes to the skin due to prolonged exposure to moisture. Post inflammatory hyperpigmentation (PIH) is when the skin in an area of injury becomes darker due to increased pigment (melanin) left from the healing process. Dark skinned individuals are more prone to have PIH and it can appear as dark brown or a reddish brown in colour (Grimes, 2009). Because the patient's skin was not protected and had been exposed to continuous moisture from urinary incontinence, the IAD progressed to severe. This is when the skin has broken, and the area has become pink and red where the dermal layers are now exposed.

Medi Derma-PRO Skin Protectant Ointment and Medi Derma-PRO Foam & Spray Incontinence Cleanser were used to help heal and protect the skin from further breakdown. After four days of use with the ointment, the moisture damage was less severe. The skin had started to heal, with less exudate and fewer broken areas. The patient appeared more comfortable. After seven days of treatment the patient's skin management was able to be stepped down to a film product for protection.

Case study two



This patient was admitted for acute confusion and a urinary tract infection (UTI). The patient was incontinent of urine and had previously had episodes of IAD and been prescribed a barrier cream. As seen in the image

above, there is extensive scarring to the natal cleft from previous episodes of IAD.

In the authors' opinion, dark skin does tend to be more prone to scarring, which can be a barrier to diagnose IAD, as the skin is already very discoloured. In this case, the wound was bleeding from the creases in the natal cleft, which suggests that this area is damaged from moisture and is open. It is important for the skin to be clean and thoroughly dry in the skin folds, to prevent further damage (Fletcher et al, 2020b). A barrier film product, Medi Derma-S Total Barrier Film, which can be applied to wet skin that is open was prescribed to give longer lasting protection against the moisture damage.

Using a film allowed the skin to be protected from further moisture damage in the skin fold by diverting the moisture and reducing friction. After using Medi Derma-S Total Barrier Film for three days, the patient's skin improved — it was no longer open or bleeding. Moving forward, it was advised that the patient continued to use this barrier film, as it is a more suitable product to use in skin folds that are regularly exposed to moisture.

DISCUSSION

Considering the clinical cases shared here, it is important to understand that lack of awareness, education, and training in correctly assessing/diagnosing different skin tones may have easily led to misdiagnosis or an incorrect diagnosis, and possibly delayed treatment for certain patients with MASD. Collaborative efforts across different sectors of influence (such as universities, hospitals, primary care, industry partners and care sectors) and training are required — first, by incorporating education to increase awareness of different skin tones; second, avoiding skin tone bias to facilitate and ensure equality in treatment across patients.

CONCLUSION

Regardless of patient demographics, clinicians should have the knowledge and awareness to provide optimal care for all. Healthcare providers need to understand that different skin tones require varying approaches to wound care, and patients from diverse backgrounds may have different needs to skin and wound care. When assessing and diagnosing MASD, a clear distinction across different skin tones from white to olive, to brown and black, and different types of dark skin tones, is essential.

An overarching goal should be to drive awareness, enhance education, provide exposure to different skin tones and provision of ongoing training for all healthcare professionals. In all wound types, it is important to be aware of how signs and symptoms may present in a range of skin tones. Wound care education must be ongoing and constantly evolving to keep pace with changes in healthcare practice and technology. By staying up to date with best practice, healthcare providers can ensure that they are providing the best possible care to all patients, regardless of their skin colour. **JCN**

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Cervical cancer: risk factors, screening and treatment

Margaret Perry

Cervical cancer can affect women around the world and despite screening and prevention in the form of vaccination, deaths continue to occur. Nurses are at the forefront of promoting the currently available services with the aim of increasing uptake and reducing mortality rates in the future. This article gives community nurses more information on this disease, including risk factors, detection, treatment, and management and hopes to increase confidence in advising and educating any patient at risk of this disease.

KEYWORDS:

■ Cervical cancer ■ Women ■ Diagnosis ■ Treatment

Despite advances in knowledge, understanding, risk factors and treatment, cervical cancer continues to be a cause of death in women around the world. The disease is the fourth most frequent cancer type in women, with an estimated 342,000 deaths in 2020, with the majority of these (approximately 90%) occurring in low and middle-income countries (World Health Organization [WHO], 2022). In more affluent countries, advances in medicine have led to implementation of screening programmes, and nurses working in primary care in the UK are actively involved in encouraging uptake for this service. This article gives nurses and non-medical prescribers more information relating to risk factors, as well as treatment and management options with the aim of improving knowledge and understanding of this potentially devastating disease.

STATISTICS

Estimates suggest that there were approximately 850 deaths per year in the UK between 2017 and 2019, which equates to two per day, and the disease is the 14th commonest cancer death in women in the UK, with females living in deprived areas being the most affected (Cancer Research UK, 2022a). Indeed, in England, incidence rates are around 65% higher in deprived areas compared to more affluent regions. Between 2013 and 2017, incidence rates were much lower among women of black or Asian ethnicity than among white females, and most cases developed in women aged between 25 and 45 (Cancer Research UK, 2022a). The disease is rare below the age of 25, although some cases develop in older or younger women (Harding 2018; Cancer Research UK, 2022a).

PATHOPHYSIOLOGY

The majority of cervical cancers (more than 95%) are due to the human papillomavirus (HPV) (WHO, 2022). However, of all the women who have the virus, very few will progress to cancer, which has led to the suspicion that other factors may play a role (Table 1).

High-risk types include HPV-16 and HPV-18, which contribute to over 70% of cervical cancer, while types 31, 33, 35, 45, 52 and 58, account for an additional 20% of cervical cancers (McGrath, 2022). HPV infection occurs in a high percentage of sexually active women, however, approximately 90% of HPV infections clear on their own within months to a few years and with no further problems (Boardman, 2022). In some women, HPV infection can lead to the development of cervical intraepithelial neoplasia (CIN), which is the presence of abnormal changes to the cells that line the cervix (Macmillan Cancer Support, 2022). Approximately 80% of cervical cancers are squamous cell carcinomas (SCC) of the epithelial lining of the ectocervix, a further 20% are adenocarcinomas of the glands within the lining of the cervix (Cancer Research UK, 2020a).

Cervical intraepithelial neoplasia is graded as (Ramirez and Salvo, 2022):

- ▶ Mild cervical dysplasia
- ▶ Moderate dysplasia
- ▶ Severe dysplasia and carcinoma *in situ*.

Red Flags

- Estimated to account for 342,000 deaths worldwide, approximately 90% occurring in low and middle-income countries
- Disease is the 14th commonest cancer death in women in the UK
- Most frequently seen in women aged 25–45, but occasionally affects older or younger women
- More common in white Caucasian females and in deprived areas.

Severe dysplasia and carcinoma *in situ* are very unlikely to regress and if untreated, over time, progression to invasive carcinoma may take place as penetration of the basement membrane occurs, although this may take anything from months to years (Ramirez and Salvo, 2022).

RISK FACTORS

In addition to HPV virus, several other factors have been identified as possible causative elements (American Cancer Society, 2022). These are:

- ▶ Sexual history: this includes early age at first occurrence of sexual activity, multiple partners, or high-risk partner, i.e. partner who has HPV infection or who has themselves had many sexual partners

- ▶ Low immunity: human immunodeficiency virus (HIV) weakens the immune system and increases the risk of HPV infections. In these women, cervical pre-cancer may progress more rapidly than it normally would. In addition, those with an autoimmune disease, taking medication to suppress the immune system, or women who have had an organ transplant may be at higher risk. Additional risk factors are shown in *Table 1*.

SIGNS AND SYMPTOMS

In the early stages, there may be no symptoms and the diagnosis is made during routine screening or following cervical cytology results (Macmillan Cancer Support, 2022). However, the diagnosis should be considered in any woman who presents with (McGrath, 2022):

Red Flags

- Cervical screening aims to detect early cell changes, facilitate early treatment, and reduce mortality rates
- Offered to women aged 24.5 to 65
- Screening is undertaken three yearly until the age of 50, then five yearly
- Testing for HPV is the primary method in England, Scotland and Wales, Northern Ireland screens for abnormal cell changes.

- ▶ Abnormal vaginal bleeding (after intercourse), intermenstrual or postmenopausal bleeding
- ▶ Women experiencing pelvic pain and/or dyspareunia (painful intercourse)
- ▶ Abnormal vaginal discharge (purulent, blood stained or mucoid).

Table 1: Factors associated with increased risk of developing cervical cancer (American Cancer Society, 2022)

| Risk factor | Additional information |
|------------------------|---|
| Smoking | Women who smoke are approximately twice as likely as non-smokers to develop cervical cancer. Tobacco by-products have been found in the cervical mucus of women who smoke. It is thought that these substances damage the DNA of cells of the cervix contributing to the development of cervical cancer. Smoking also makes the immune system less effective in fighting HPV infections |
| Weakened immune system | Women being treated for autoimmune diseases and taking drugs to suppress their immune response are at greater risk. In women with HIV, a cervical pre cancer may develop into invasive cancer at a faster rate than would normally be expected |
| Pregnancy | Women who are below the age of 20 when they have their first full-term pregnancy are more likely to develop cervical cancer than those who are older. Multiple pregnancies (three or more) may be linked to greater exposure to HPV because of increased sexual activity. Also, hormonal changes in pregnancy may make women more susceptible to HPV or cancer growth |
| Oral contraceptive use | Long-term use of oral contraceptives is associated with increased risk, however this declines when the pill is stopped and returns to the same rate as for other women many years after stopping |

Table 2: Changes to NHS cervical screening programme (NHSCSP) (PHE, 2020)

| Year | Change to the programme |
|------|---|
| 1988 | The NHSCSP was set up with the introduction of computerised call and recall systems |
| 2004 | Introduction of liquid-based cytology (LBC), which has significantly reduced the number of inadequate results |
| 2008 | Introduction of the national HPV vaccination programme 12 to 13 (girls aged 12–13 years in schools, along with a catch-up programme for girls aged from 13 to under 18 years) |
| 2012 | Introduction of HPV triage and test of cure protocol |
| 2019 | Introduction of primary HPV testing in England to replace cytology as the primary screening test |
| 2019 | HPV vaccine is now routinely offered to boys aged 12 to 13 years with a second dose offered six to 24 months after the first |

SCREENING

The NHS cervical screening programme started in the 1960s and since then has seen many changes (*Table 2*). The programme aims to detect and facilitate early treatment, reducing the number of people who develop invasive cervical cancer (incidence) and the number of people who die from it (mortality) (Public Health England [PHE], 2020). Screening is currently offered to women with a cervix every three years for those aged 24.5 to 50, and five yearly from the age of 50 to 64. Testing for HPV is the primary screening method used in England, Scotland, and Wales (Cancer Research UK, 2022b). Northern Ireland is hoping to use this in the future, but currently screens for abnormal cell changes (nidirect, 2022). See *Table 3* for more information.

RESULTS AND DIAGNOSIS

Once the smear sample has been analysed, women receive a letter to advise them of the findings. This may take anything between two and six weeks and will inform the woman of (Cancer Research UK, 2022b):

Table 3: Current cervical screening results in Northern Ireland (Cancer Research UK, 2022b)

| Result | Additional information |
|-------------------------|---|
| Normal | No abnormal cells detected in the sample |
| Abnormal | Abnormal cell changes detected. These will be classified as borderline (low grade), moderate or severe (high grade) |
| Low grade changes | Sample analysed for HPV. If negative, patient will be advised no further action and will be invited for screening in three or five years depending on their age. If positive, referral for colposcopy |
| High grade cell changes | Referral to colposcopy with or without presence of HPV |

Table 4: Advice for women before attending for colposcopy (NHS, 2022)

| |
|--|
| ▶ If a woman commences her period and will be bleeding at the time of her appointment, she should advise the clinic as appointment may need to be rescheduled (excess blood will obscure the cervix making it difficult to view) |
| ▶ Vaginal intercourse should be avoided for at least 24 hours |
| ▶ Advise women they may find the procedure causes discomfort, so they may wish to take paracetamol an hour before |
| ▶ Wearing a loose skirt will negate the need to remove all the lower clothing |
| ▶ Some women may have minor bleeding so should be advised to bring a sanitary pad with them just in case |
| ▶ It is advisable to bring someone to the appointment in case treatment is done during the first appointment |

- ▶ No evidence of HPV: routine screening in three or five years, depending on the woman's age
- ▶ HPV found with no cell changes: HPV present but has not affected the cervical cells. Cervical screening will be offered after 12 months to assess whether HPV infection has cleared
- ▶ HPV found with abnormal cell changes: patient will be referred for colposcopy and further tests if needed.

REFERRAL FOR COLPOSCOPY

For those women whose results indicate the need for referral to colposcopy, this can be very frightening. They should therefore be sent information with the appointment explaining the procedure and what to expect, giving them the chance to speak to

either their GP or the clinic if there is anything they do not understand. General guidelines prior to attending for colposcopy are shown in *Table 4*.

At the appointment itself, the colposcopist can take biopsies of abnormal areas and some women will be offered treatment there and then or will be invited back once biopsy results are available.

Biopsy results

Biopsy results are graded as follows (Jo's Cervical Cancer Trust, 2022):

- ▶ CIN 1 (low grade): this means that cell changes are approximately one-third deep into the outer layer of the cervix. This grade is monitored rather than treated, as in most cases regression to normal will occur
- ▶ CIN2 (high grade): cell changes have reached two-thirds of the depth of the outer layer of the cervix, which may or may not be treated. The colposcopist will discuss options with the patient to decide on monitoring or treatment
- ▶ CIN3: this type reflects cell changes affecting the full depth of the outer surface of the cervix and is usually treated
- ▶ Cervical glandular intraepithelial neoplasia (CGIN): named because of the areas of the cervix affected, which are the glandular cells inside the cervix. Treatment is usually offered because monitoring of this area is more difficult
- ▶ Stratified mucin-producing intraepithelial lesion (SMILE): treated in the same way as CGIN but this type is much rarer.

It is important that women are reassured that none of the above changes are cervical cancer.

TREATMENT

There are several treatment options available, namely (Cancer Research UK, 2020b):

- ▶ Large loop excision of the transformation zone (LLETZ): this is the most common treatment and removes a small area of the cervix at the site of cell changes and is done with local anaesthetic. Women should be advised to expect some pain or vaginal bleeding and changes to their normal vaginal discharge. An estimated 85% experience bleeding and a further 67% have pain post procedure. Additional risks include late miscarriage and premature birth
- ▶ Needle excision of the transformation zone (NETZ): similar to LLETZ, but the thin wire used to cut away the area is straight rather than a loop.
- ▶ Cone biopsy: this is done under general anaesthetic and involves excision of a cone-shaped area of tissue.

Following treatment, risk of progression is related to the grade of the abnormal cells. Statistics relating to progression are shown in *Table 5*.

CERVICAL CANCER DETECTED WITH BIOPSY

If a diagnosis of cervical cancer is confirmed, further investigations will be needed to assess whether spread has occurred and to evaluate the extent of the disease, with multidisciplinary team involvement.

Red Flags

- Once cancer has been confirmed, grading and staging is done to guide treatment choice
- Grading shows how abnormal the cells are compared to healthy cells, and gives an indication as to how quickly abnormal cells may grow and spread
- Staging gives information relating to the size of the cancer and whether spread has occurred.

Table 5: Risk of progression of abnormal cell changes to cervical cancer
(Jo's Cervical Cancer Trust, 2022)

| Type and grade of cell change | Regress | No change | Progress |
|-------------------------------|---------|-------------------|------------------------------|
| CIN1 | 60% | 30% | 10% progress to CIN2 or CIN3 |
| CIN2 | 50–60% | 32% | 18% will progress to CIN3 |
| CIN3 | 32–47% | No data available | 32% will progress |

Investigations will include (McGrath, 2022):

- ▶ Full blood count (FBC): to assess for anaemia caused by bleeding and check white cell count (raised in infection)
- ▶ C-reactive protein (CRP) test: raised in infections
- ▶ Urea and electrolytes (U&E): to assess for renal dysfunction in metastatic disease.
- ▶ Liver function test (LFT): may be abnormal in metastatic disease and may indicate bone or liver involvement.

Further investigations, such as computer tomography (CT) scan, magnetic resonance imaging (MRI) and chest X-ray will help the oncology team determine whether spread has occurred to lymph nodes and/or local organs, such as the abdomen, pelvis, bowel or bladder, and whether metastatic spread to distant organs (e.g. the lungs) has occurred (Harding, 2018; McGrath 2022).

Once results are available, the relevant information will be used to determine the grade and stage of the cancer (see below) which will help to plan best treatment options.

The grade (Table 6) shows the degree of abnormality and how the cancer cells differ from healthy cells, and is useful to give an indication of how quickly abnormal cells might grow and spread. The stage (Table 7) shows the size of the cancer and whether it has spread.

TREATMENT AND FOLLOW-UP

If cervical cancer is confirmed, further management will depend on the stage of the cancer, the woman's personal choices and whether she wishes to retain her fertility for the future, and will involve the

multidisciplinary team who will decide the best course of action.

Management options may be as follows (GOV.UK 2023).

Stage 1A1

The woman may be offered hysterectomy if she does not wish to preserve fertility. Alternatively, she may be offered loop electrosurgical excision and conisation.

Stages 1A2–1B2 (early-stage disease)

Women will be offered radical hysterectomy, which will involve resection of the cervix, uterus and the fibrous, fatty tissue surrounding the uterus (parametria), plus the upper portion of the vagina. Bilateral salpingectomy, and/or bilateral oophorectomy with removal of pelvic lymph nodes.

Tumours small in size may be suitable for removal, as well as lymph nodes as an alternative to radical hysterectomy. Chemotherapy and/or radiotherapy may be considered for women thought to

be at risk of recurrence, but this will depend on other factors such as lymph node involvement and size of the tumour.

Stage 1B3–1VA (locally advanced disease)

This is usually treated with a combination of chemotherapy and external beam radiation (aims x-rays at the cancer from a machine outside the body) and radiation placed into the uterus and vagina (intracavity brachytherapy). Surgery or a combination of surgery and chemotherapy/radiotherapy are usually not considered, as these options carry a high risk of adverse effects and morbidity

Stage 1VB (spread to other parts of the body)

Chemotherapy is usually first-line treatment.

Recurrent or metastatic disease

Multiple factors need to be taken into account, such as the woman's overall health, comorbidities, previous treatments, symptoms and, of course, their wishes.

Salvage surgery may be an option, which can include removal of all the reproductive organs, the lower urinary tract and, in some cases, excision of a portion of the rectosigmoid bowel (if relapse is confined to the central pelvis and other treatments have failed).

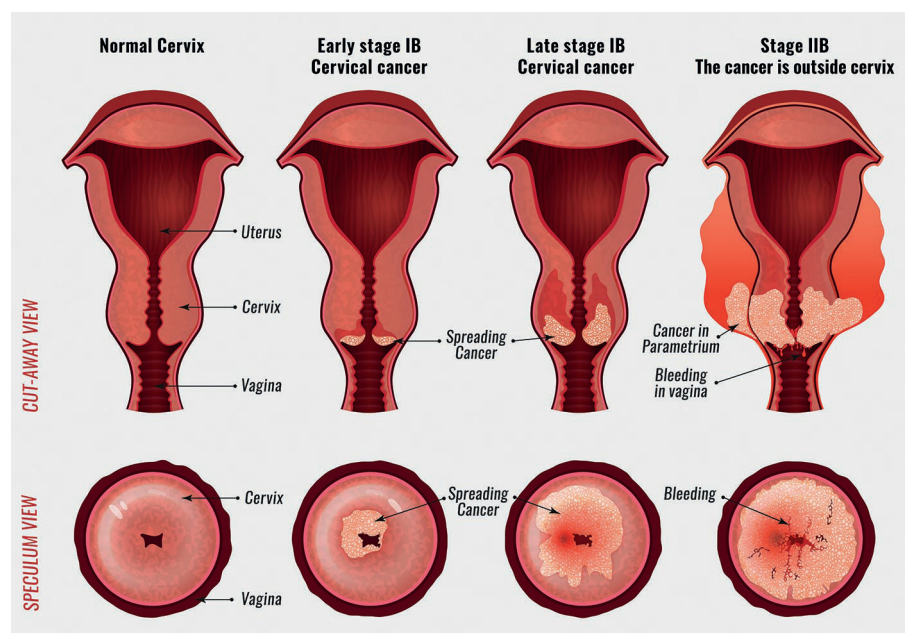


Table 6: Grading of cervical cancer (Jo's Cervical Cancer Trust, 2022)

| Grading | Additional information |
|---------|--|
| Grade 1 | Similar in appearance to healthy cells and will grow at a slower rate than higher grades |
| Grade 2 | These cells still appear similar to healthy cells, but will grow at a higher rate |
| Grade 3 | These cells look different to healthy cells and are likely to grow more quickly and may spread. They may need more intensive treatment than cell in lower grades |

Table 7: Staging of cervical cancer (Jo's Cervical Cancer Trust, 2022)

| Staging | Additional information |
|-----------|---|
| Stage 1A | Cancer is small and can only be seen with a microscope |
| Stage 1A1 | These cells still appear similar to healthy cells, but will grow at a higher rate |
| Stage 1A2 | The cancer is between 3–5mm deep into the cervix |
| Stage 1B | The cancer is slightly larger and may be visible without a microscope |
| Stage 1B1 | Cancer is more than 5mm deep into the cervix and less than 2mm wide |
| Stage 1B2 | The cancer is 2cm or more deep into the cervix but less than 4cm wide |
| Stage 1B3 | The cancer is 4cm or more wide |
| Stage 2 | The cancer has spread outside of the cervix |
| Stage 2A1 | The cancer is less than 4cm wide but has spread into the top of the vagina |
| Stage 2A2 | The cancer is more than 4cm wide and has spread into the top of the vagina |
| Stage 3 | Spread may include the lower part of the vagina, the pelvic floor, or the lymph nodes. May also cause hydronephrosis (swelling of one or both kidneys due to a build-up of urine) and affect renal function |
| Stage 3A | Spread has occurred to the lower part of the vagina but not the pelvic wall |
| Stage 3B | The cancer has spread to the pelvic wall and may affect kidney function |
| Stage 3C | Cancer has spread to the lymph nodes |
| Stage 3C1 | Cancer has only spread to the pelvic lymph nodes |
| Stage 3C2 | The cancer has spread to the para-aortic lymph nodes. Lymph nodes above the pelvic area |
| Stage 4 | The cancer has spread to the rectum, bladder or to more distant sites |
| Stage 4A | Spread has occurred to sites in close proximity to the cervix, such as the rectum or bladder |
| Stage 4B | The cancer has spread to distant sites, such as the liver, bones or lungs |

PREVENTION

Cervical screening is one of the best ways for any woman to protect herself from developing cervical cancer (NHS, 2020). Estimates have indicated that in England alone, cervical screening currently prevents 70% of cervical cancer deaths, and if all eligible women attend screening regularly, 83% could be prevented (Public Health England, 2017). In addition, the HPV vaccination was started 10 years ago as part of the routine vaccination programme, and statistics suggest that approximately 80% of women aged 15–24 have received the vaccine (Saliba, 2018). Changes to the programme now include both boys and girls aged 12–13 who are offered the first vaccine when they are in school year 8, the second dose six to 24 months later

‘A global strategy has been developed to accelerate the elimination of cervical cancer as a public health problem.’

(NHS, 2019). Since the introduction of HPV vaccination, infections of HPV types 16/18 in 16–21-year-old women have reduced by 86% in England alone. Considering around 80% of all cervical cancers are caused by these types, it is anticipated that there will be even greater reductions in cervical cancer in years to come (Saliba, 2018).

A global strategy has been developed to accelerate the elimination of cervical cancer as a public health problem. Elimination has been defined as a country

reaching the threshold of less than four cases of cervical cancer per 100,000 women per year (WHO, 2022). For this to be achieved and maintained, WHO (2022) has set up the following targets to be reached and subsequently maintained by 2030:

- ▶ 90% of girls to be fully vaccinated with HPV vaccine by age 15
- ▶ 70% of women screened with a high-performance test by age 35, and again by 45 years of age
- ▶ 90% of women identified with cervical disease to receive treatment: 90% of women with pre-cancer treated; 90% of women with invasive cancer managed.

PROGNOSIS

It would seem logical that the stage of the disease at diagnosis will impact on prognosis, and statistics from Cancer Research UK (2022b) suggest that:

- ▶ 96% of women will survive for one year or more if diagnosed at stage 1
- ▶ 50% of women will survive for one year or more if diagnosed at stage 1V.

Age also impacts on survival rates, with 90% of women diagnosed between the ages of 15 and 39 living for five years or more, while those aged 85 or older have only a 25% chance of survival beyond five years (Cancer Research, 2022a).

CONCLUSION

Cervical cancer continues to be a cause of death in women around the world despite advances in screening, which aims to detect cell changes early, and the introduction of vaccination aimed at preventing HPV infections, a major cause of cervical cancer. Nurses in primary care have a vital role to play in advising and promoting uptake of these services. Statistics have shown that death rates have fallen. However, there is still work to do and it is hoped that with the suggested global strategies in place, deaths from this devastating disease can be reduced to a minimum and ideally eliminated. **JCN**

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KEY POINTS

- Cervical cancer can affect women around the world and despite screening and prevention in the form of vaccination, deaths continue to occur.
- A large majority of cervical cancer (more than 95%) is due to the human papillomavirus (HPV).
- In the early stages, there may be no symptoms and the diagnosis is made during routine screening or following cervical cytology results.
- If cervical cancer is confirmed, further management will depend on the stage of the cancer, the woman's personal choices and whether she wishes to retain her fertility for the future.
- A global strategy has been developed to accelerate the elimination of cervical cancer as a public health problem.
- Nurses are at the forefront of promoting the currently available screening services with the aim of increasing uptake and reducing mortality rates in the future.

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Revalidation Alert

Having read this article, reflect on:

- Risk factors for developing cervical cancer
- The importance of screening and your role in advising and promoting these services
- Advice you would offer women before attending for a colposcopy
- Your knowledge of grading and staging cervical cancer.



Then, upload the article to the free JCN revalidation e-portfolio as evidence of your continued learning: www.jcn.co.uk/revalidation

Life stories in dementia care: ensuring person-centred care

Karen Harrison Dening

Telling stories and story-making is integral to our consciousness and lived experience and is part of what it is to be human. Stories can be told about many different topics and shared in many different ways — whether spoken, written down, or told through film or photography. Life story work (LSW) has been used therapeutically over several decades, initially with children in the adoption process and more recently in dementia care. It involves the intentional or planned efforts to encourage people to think about, remember, share and record information about themselves. Life story work, its purpose, development and use are considered a cornerstone to providing person-centred care for people with dementia. This article discusses the origins of life stories in dementia and goes on to consider their different formats and how to initiate LSW in people with dementia.

KEYWORDS:

■ Dementia ■ Life story work ■ Person-centred care

Storytelling is the act of telling or writing stories, or narratives. Typically, stories are told for entertainment, for informational or educational purposes. Telling stories and story-making is integral to our human consciousness and lived experience. Indeed, telling stories, in whatever format we are most familiar with, is part of what it is to be human and to identify with a shared cultural and linguistic heritage (National Geographic, 2022).

Stories can be told about many different topics and shared in many different ways; for example, they

'Stories, and life stories in particular, are individual, relational, (auto) biographical, meaningful and universal and are hugely significant in providing person-centred care for people with dementia.'

can be spoken and shared orally between individuals and groups, written down, drawn, animated, performed, painted, represented via visual media, such as through film or photography, and communicated in non-verbal languages, such as through sign language. Nowadays, stories can also be told through digital and online platforms with social media 'Apps' — such as 'Twitter' — transforming the way in which our personal narratives and stories are instantly shared with others and, should we wish, with the world.

Story telling also has a place in health and social care and the support of patients, especially those with a diagnosis of dementia as an approach to telling the patient story (Park et al, 2021).

Stories are told by everyone every day, either as a conscious act or often unconsciously. Some stories shared might have great personal significance, such as recounting a wedding ceremony of a family member, while others may be much more ordinary in their content, such as sharing stories about the weather over the last week while on holiday, or recipes, perhaps a story about a recipe that has been passed down by a grandparent. Stories also perform a valuable social role and function as they connect us through time to our past, our present and also extending to our future. Stories, and life stories in particular, are individual, relational, (auto) biographical, meaningful and universal and are hugely significant in providing person-centred care for people with dementia (Gridley et al, 2016; 2020).

LIFE STORY WORK IN DEMENTIA

Life story work (LSW) involves the intentional or planned efforts to encourage people with or without dementia to think about, remember, share and record information about themselves. As stories define who we are and how others understand and see us, it is perhaps of no surprise that in dementia care, LSW has long held an important place and positioning. A main reason for this is that the autobiographical memory of people with dementia will become significantly compromised as the condition

progresses and the person finds it more and more difficult to remember and share stories about their own life in a chronological order and in a way that is always understandable to others (Sweeney et al, 2021). Listening to people with dementia and understanding that they have rich and varied histories is essential to good care (Kitwood, 1997a).

Recall and memory become more difficult for a person as their dementia progresses, although visual recognition is often a more enduring feature of memory and may enable a person with dementia to recall past events when visually represented (Ismail et al, 2018). However, stories and experiences from the past of a person with dementia can become entangled with experiences and life in the present. Furthermore, without a grasp of who you are, and an ability to clearly articulate this to others, an individual's personhood can become diminished or devalued and their actions misunderstood and stigmatised (Kitwood, 1997b), as the dementia diagnosis can often overshadow meaning behind some expressed behaviours (Pape et al, 2021).

Listening to people with dementia and understanding that they have rich and varied histories is essential to good person-centred care (Kitwood, 1997a; 1997b). National UK policy recommends the importance of understanding people with dementia via their life stories and biographies (National Institute for Health and Care Excellence [NICE], 2018), as embracing such person-centred knowledge leads to an enhancement of care processes and so improves health and care outcomes for people with dementia (NICE, 2019).

Life story work is a therapeutic intervention, which is being increasingly used to understand the person with dementia, their individual story, beliefs, values, wishes and preferences. It involves gathering information and artefacts about the person, their history and interests, and producing an articulation of this in whatever format is desired (Sweeney et

al, 2021). LSW has been used in health and social care settings for over three decades, with children (Ryan and Walker, 1985), people with learning disabilities (Hewitt, 2000), and older people (Clarke et al, 2003). Since the 1990s, there has been growing interest in its potential to deliver person-centred care for people with dementia (Kitwood and Bredin, 1992; Murphy, 1994; Kindell et al, 2014).

As we go through life we build up a personal history with a unique mixture of joys and pleasures, sadness and pain. Our sense of who we are is linked to that history and if we lose that history, we lose something of ourselves. For a person with dementia who is losing their memory and trying most of the time to make sense of who they are, a life story book can be an atlas, the compass, the guide to finding their self.

(Kitwood and Bredin, 1992)

The approach of LSW is distinct from pure reminiscence and biographical work in dementia care, because it emphasises using the life story of a person with dementia in their day-to-day care to improve communication, relationships and understanding of the individual's past life, and in its orientation to the future (Kindell et al, 2014).

MODELS OF LIFE STORY WORK

How LSW is done and the outcomes vary, although there are two recognised models or approaches (Gridley et al, 2016). The first model of LSW is led by the person with dementia, usually at a relatively early stage of their disease, and serves to reinforce a sense of identity and support pride in the life led to date (Subramaniam and Woods, 2012). This sort of LSW may be carried out over a long period and generate detailed and substantial life story products and is often narrative or autobiographical, as told (at least initially) in the first person.

The second model, found more often in institutional care settings and perhaps initiated later in the

course of the condition, may be less likely to involve the person with dementia and be led by family carers and/or care staff (Gridley et al, 2016). However, in the author's clinical opinion, there is no reason why LSW should not involve the person with dementia at all stages of their condition. Although this second model is also about telling the story of a person's life, it is more often directed to aspects of and contents about a person's life that might aid communication with and increase staff understanding about the person to support personalised care (McKinney, 2017). A person's life story may also be used to calm or soothe them at times of distress. This type of LSW tends to be almost entirely care-focused, although there is no reason why the first model of a life story should not inform the second, with perhaps one naturally progressing into the other (Gridley et al, 2016).

One of the inherent risks for people with dementia is that without a life story that can be remembered and told solely by the person, is that their sense of self and personal identity can be significantly compromised (Kitwood, 1997a; 1997b). Kitwood wrote of the importance of biographical knowledge about a person with dementia and how this becomes increasingly essential if their identity is still to be held in place as the condition progresses (Kitwood, 1997b: 56), and also that, in order to maintain the identity of a person with dementia, LSW was foundational to delivering person-centred care.

SUPPORTING THE DEVELOPMENT OF LIFE STORIES IN DEMENTIA CARE

For health and social care practitioners, developing and compiling a life story helps to both uphold and give detail to the personhood and identity of people with dementia. The mechanics of undertaking LSW can be facilitated by any health or social care professionals and in any care setting, whether that is in a person's own home or in supported living

environments, such as a care home. In addition, there is no time limit on how long such a life story should take to develop. Importantly, there is no one correct way to develop a life story and it is often a highly individualised activity which can take many forms (Gridley et al, 2020). For example, some families, people with dementia and care practitioners may work together to develop a chronological life story that starts with the person’s childhood and moves forward in recounting and recording aspects of their lives, embracing major life milestones and events, such as siblings, schooling, teenage years, marriage, favourite holidays and so forth, and on to the present day (Box 1).

Sometimes, such a life story progresses naturally to consider their future. As a clinician, the author often starts with LSW when supporting a person with dementia to make an advance care plan (ACP) for future care, as their wishes and preferences for the future are often based upon those held in the past (Harrison Denning et al, 2013). These life story books can be



Photograph: Gtground Picture/Shutterstock

‘... a life story is not a static object but a living record (and/or document) and a sensory connection to the outside world.’

supplemented by photographs or other personal mementos from the person’s life, for example, education certificates, tickets for a memorable sports occasion, to help give additional insight and awareness in the storytelling.

In contrast, some families and people with dementia (and/or care practitioners) may take a more structured approach and follow a specific life story template, which can be downloaded for free from the internet, such as the life story book template suggested by Dementia UK (2022). However it is tackled, the compilation and use of a life story enables the person with dementia to remain at the forefront of their care through evidence of their lived experiences, and previous/current wishes, preferences, beliefs and values. Furthermore, in the author’s clinical experience, a well-developed life story can help to initiate and sustain interaction for and by the person with dementia by giving others, such as younger family members or care staff now and in the future, key insights from which to develop meaningful

communication approaches.

This could involve the life story being an impetus for personalised reminiscence work, creative art practices or engaging in meaningful and person-centred conversations.

As seen from documented case studies about LSW in the literature (Age UK, 2022; Oliver, 2022; Banger, 2023), a life story is not a static object but a living record (and/or document) and a sensory connection to the outside world. Bangar (2023) in describing the support she gave to her mother in recording her life story, talks about moving beyond the collation of chronological facts of her mother’s life and into the generation of life story as a product that could stand as a testimony to her mother’s life, memories and standing in the family.

LIFE STORY AND MEANING FOR ALL

As Bangar (2023) shared her writing about supporting her mother to develop her life story, the breadth, depth and connectivity of her mother’s presented life story started to evolve and grow when other family members also started to participate in its construction. The benefits of LSW often go beyond the immediate benefits for the person with dementia, but embrace others within its circle of creation. The process of undertaking LSW in addition to the outcomes when developed can be meaningful for

Box 1 Possible contents of a life story

- ▶ Personal details such as name, age, address etc
- ▶ Significant relationships with family and friends
- ▶ Childhood history
- ▶ Education
- ▶ Work history
- ▶ Significant places and life events
- ▶ Preferences with their appearance
- ▶ Food/drink likes and dislikes
- ▶ Routines
- ▶ Preferred books
- ▶ Preferred music, films, plays and TV programmes, or even ones they do not like!
- ▶ Activities they do (and do not) enjoy
- ▶ General likes and dislikes

Box 2 Tips for creating a life story

- ▶ Involve the person with dementia as fully as possible to ensure that the life story reflects their personality, wishes and preferences
- ▶ Offer help where needed, and write/type/record the information with the person so they can see their story forming
- ▶ Go with the flow and let the person talk freely about their life — it is not necessary to start from the beginning
- ▶ Try taking one topic at a time so that the person does not get overwhelmed
- ▶ Take breaks and complete the story at their pace — it might take days, weeks or months. More can always be added later
- ▶ Try prompting the person with photos of familiar people and places
- ▶ Be sensitive, think carefully about what information the person would want to be shared, and be prepared for them to find the process emotional
- ▶ If the person with dementia finds it difficult to communicate, family members and friends may be able to provide key information

many of its stakeholders. Such benefits can include (see also Box 3):

- ▶ Enhancing a sense of identity for the person with dementia. This is especially useful when they are having difficulty in sharing this information themselves
- ▶ Encouraging better communication and an understanding of the person's needs and wishes across wider family groups and health and social care networks by informing their care and ensuring that it is provided in a positive and person-centred way
- ▶ Supporting the person with dementia to develop and maintain closer relationships with family carers and health and social care staff through sharing stories
- ▶ Helping family members develop

a closer bond with the person with dementia by sharing personal stories and improving communication

- ▶ Giving professional carers an appreciation of the person's life and background to enable good communication and inform a better understanding of the person's needs.

'When creating a life story, the ideal is to start as soon as possible after a diagnosis of dementia to ensure full participation of the person with dementia...'

Thus, LSW is not simply a 'task' to collate and produce a person with dementia's history, important though that is, but is something to be actively used and applied for the wellbeing of that person. In their evaluation of LSW, Gridley et al (2020: 191) suggested that good LSW practice should:

- ▶ Be tailored to the individual needs and preferences of the person living with dementia
- ▶ Recognise that not everyone will want to take part in LSW with some people finding it distressing
- ▶ Ideally be led and paced by the person with dementia themselves
- ▶ Recognise the need for training and support for staff, carers and volunteers
- ▶ Include the potential for LSW to celebrate the person's life today and look to the future.

In the case of Bangar (2023), supporting the 'telling' of her mother's life story was not undertaken as a task to be performed to enable person-centred care to take place, but rather an expression of family love and gratitude and a way of keeping their mother's identity alive and ever-present.

SUPPORTING THE DEVELOPMENT OF A LIFE STORY

When creating a life story, the ideal is to start as soon as possible after

a diagnosis of dementia to ensure full participation of the person with dementia (as we have seen in model 1 of LSW); it makes it a more positive and meaningful activity for them — after all, it is their life story. With the person with dementia as the starting point and impetus, the life story is more likely to reflect what is important to them, their wishes and preferences, encouraging a sense of ownership, not just participation.

WHERE TO START

The content of life stories is about an individual and such individuality may also be reflected in the choice of format that is used to tell their story (Box 2). They can be a written document, perhaps containing images, photographs, drawings, or they can be voice or visually recorded using audio recording devices or film cameras (Table 1). There is no right or wrong way and families may often 'experiment' with different formats before they find one that suits their purpose. Indeed, a life story can be a combination of ways — whichever is chosen, the results can be powerful on all involved.

BENEFITS AND USES OF A 'LIFE STORY'

Life stories can be brought into use on many different occasions.

Box 3 Why LSW is important

- ▶ It draws on residual long-term memory
- ▶ It provides a medium for communication that promotes self-esteem and well-being
- ▶ It safeguards personal identity
- ▶ It maintains links with familiar people and lessens social isolation
- ▶ It increases a carer's understanding of the basis for some confused or agitated behaviours
- ▶ It assists in care planning, person- and relationship-centred care

For example, when a person with dementia is feeling anxious or low about their dementia, a life story may enable them to focus on positive aspects of their life rather than dwell on negative feelings. Similarly, life stories, as tangible products, can ‘travel’ with the person with dementia to smooth the transition to other settings, for example, into acute medical care or from home to long-term care. However, life stories are distinct from biographical ‘work’ in care settings (Kellet et al, 2010), or the simple recording of personal likes and dislikes and/or life history details in a person’s health or social care records. A much abbreviated and simplified form is seen in the ‘This is me’ document, which is widely used when a person with dementia is admitted into an acute hospital (Alzheimer’s Society, 2022).

LSW can help encourage better communication, both between a family carer and/or care staff and a person with dementia. As said, it can be an effective way of connecting with the person with dementia, especially during times when they are feeling disorientated, distressed or anxious. It can also assist a family member to feel part of the world and reality of the person with dementia and meet them where they are, as opposed to trying to get them to fit into their reality. Furthermore, it can both help the person with dementia to develop closer relationships with family carers and staff through sharing stories, and support carers/healthcare professionals in developing and maintaining a closer bond with the person with dementia (Bangar, 2023).

Similarly, information from a life story can support health and care staff to enable the person with dementia to feel more at ease in a clinical or care setting, such as a hospital appointment, by engendering a sense of familiarity, trust and feelings of safety as the person with dementia sees that you know who they are (Dementia UK, 2022). Used in this way, can enhance their sense of identity. This is especially useful when a person

Table 1: Format for life stories (see resources for product examples)

| Format | Characteristics |
|-------------------------------------|--|
| Scrapbook | We have all probably had a scrapbook as a child, perhaps to give evidence of a story of a holiday or hobby. This is a simple and accessible format to document stories of life. The nature of a scrapbook is to paste in, for example, pictures, memorabilia, photos or recipes — anything that is meaningful to that person. There is the opportunity to scribble notes alongside these items, or to scribble, doodle and draw, adding to the personalisation of the scrapbook. The nature of a scrapbook is that it may look scruffy over time, but this can also become part of its ‘loved’ look |
| Photograph album | As for a scrapbook, a photo album is an instantly recognisable and traditional way to store memories. Most people will have photo albums in their house from which to extract those of significance to develop a life story. Adding extra details, such as the names of people in the photos, the year it was taken, the event (perhaps a christening or a memorable holiday) and even the relationship of people in the photo to the person with dementia to assist sense making as they continue to engage with its content. There are also talking photo albums where a voice recording can accompany each photograph. A voice can be pre-recorded to say what the occasion was and who else was there, a good way to engage several senses at the same time |
| Auditory life story | An auditory life story can be a collection of songs and music that has specific meaning to the person with dementia over time, such as their own ‘top 10’ songs they sang as a child or danced to as a teenager. Some people prefer listening rather than looking for the format of a life story. Listening to an auditory life story can be done while walking and can often be of value at times of distress or ill-being. An example of a more music-based life story could be captured as a playlist with different playlists for different times of the day |
| Collage | We all think, see and feel differently and so will also respond to life story formats differently. Some prefer a more visual or image-based way of understanding the world, while others prefer a more word-based approach, or narrative in our view of the world. It is important to consider this when supporting life story development with a person with dementia. A collage may be a good example of a format that is visually compelling and may be displayed on a wall, for example, next to the person’s bed or chair if they are less mobile. Collages can be a creative approach to life story and include photographs, theatre tickets or even swatches of fabric from a favourite piece of clothing, for example. This can also make this type of life story tactile, which can be particularly useful in people with dementia who have poor vision |
| Memory box/ rummage box | As for a tactile collage, a memory or rummage box can engage the sense of touch as well as sight, and perhaps even smell if, for example, a favourite perfume, flower or scent is included such as lavender. This form of life story can be a collection of significant or memorable items that the person can move and handle. They can be directly accessible to touch and ‘rummage through’ or sometimes used as a wall mounted box to aid orientation, such as outside their bedroom in a care home corridor |
| Life story book | Similar to a scrapbook, there are many templates or ‘off the shelf’ life story products. They are often presented in sections, such as biographical information (name, age, place of birth), and in a chronological format (early years, school years and education, etc). They also have sections that talk about wishes and preferences, likes and dislikes, favourite music, etc |
| Apps | There are a number of Apps that provide multi-media opportunities to help save and share photos and memories of special places; by marking them on a map, or playing video and audio or attaching narrative text. They are simple to use and can be used independently for people in earlier stages of dementia and then with assistance as dementia progresses |
| Portable personal profiles | Personal profile documents, one or two pages of key information, are short versions of a life story that are often used in situations where a person with dementia is admitted into an acute hospital, or transferred from one care setting to another. They enable care staff to know the person sufficiently to start to deliver personalised care through having a basic understanding of the person’s needs. These are useful but only help in exchange of key personal information in the first few days of a transition in care and the care team should always aim to build on their knowledge of the person |
| Illustrated lifespan or family tree | A family tree, or illustrated lifespan, is a chart representing family relationships in a conventional tree structure. More detailed family trees, used in medicine and social work, are known as genograms. These can be used to visually represent a person’s life events over its course and bring in other family connections to support and maintain relationships |

with dementia and/or their family carer are having difficulty in sharing this personal information and history themselves.

LSW can inform care planning and ensure care is provided in a positive and person-centred way, giving professional carers an understanding of the person's life, and a better understanding of the person's needs, allowing them to communicate with the person and care for them in the best way possible (Dementia UK, 2022).

FUTURE EVIDENCE BASE FOR LIFE STORY WORK

Despite LSW's use in dementia care settings in the NHS and elsewhere, its outcomes for people with dementia, their carers and staff, its costs and its impact on care quality remain unevaluated. With the current drive towards embedding LSW in dementia care, robust evaluation of the technique, its outcomes and costs, and how it can best be applied is still needed (Gridley, et al, 2016). Gridley et al (2016) identified the need for further research, such as:

- ▶ To understand how LSW might improve interactions and relationships between staff,

carers and people with dementia in a range of health and long-term care settings

- ▶ To see its effect on quality of life of people with dementia and carers and other individual outcomes
- ▶ To reduce the use of antipsychotic drugs for behavioural 'problems'
- ▶ To establish the likely costs and benefits of implementing LSW more widely in health and long-term care settings.

THINKING OF YOUR OWN LIFE STORY

Often we can frame our understanding of the concept of LSW in people with dementia by giving thought to our own stories and what is important for us from the past, now and in our own future (Barham, 2022).

Barham (2022) asks us to think about the following:

- ▶ Life experiences from birth onwards. How have these experiences affected you and made you into the person you are now?
- ▶ What kind of things you enjoy doing?
- ▶ What made you happy as a child, and what makes you happy now?
- ▶ How can revealing and sharing these things help family and carers understand what is important to you, so they can help you live well?

CONCLUSION

LSW has several benefits to all stakeholders, not least for the person with dementia in affirming a sense of identity and worth in the context of receiving a life changing diagnosis. For family carers, supporting the development of a person's life story can offer insights into the events and things that are valued by the person they care for, as well as affirming wishes and preferences for care now and in the future. Similarly, information from a life story can support health and care staff to deliver care that is both individual and person-centred to

Resources

The following items are examples only, there are many similar products available so it is important to explore the range of options available while also considering the most appropriate format for an individual.

- ▶ Age UK Life story template: www.ageuk.org.uk/bp-assets/globalassets/oldham/new-content/documents/life-story-form.pdf
- ▶ My Life Story (template): www.dementiauk.org/wp-content/uploads/2017/04/Dementia_UK_Life_Story_Template-April-2017.doc
- ▶ Music and life story; Playlists for life: www.playlistforlife.org.uk/
- ▶ Purple Angels MP3 Players: <https://purpleangelcornwall.weebly.com/mp3-players-and-music-fordementia.html>
- ▶ Talking photograph album: www.alzproducts.co.uk/talking-photo-album-for-dementia
- ▶ This is me: www.alzheimers.org.uk/sites/default/files/2020-03/this_is_me_1553.pdf

enable the person with dementia to feel more at ease in a clinical or care setting. There are many formats and approaches available to support people with dementia to develop their life story. Healthcare professionals can frame their understanding of the concept of LSW by considering their own life story and what is important to them that would inform others. **JCN**

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Revalidation Alert

Having read this article, reflect on:

- Why life story work can help and support people with dementia
- Different ways in which LSW can be done
- How you can incorporate LSW when caring for a person with dementia.

Then, upload the article to the free JCN revalidation e-portfolio as evidence of your continued learning: www.jcn.co.uk/revalidation

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KEY POINTS

- Telling stories and story-making is integral to our consciousness and lived experience and is part of what it is to be human.
- Life story work, its purpose, development and use are considered a cornerstone to providing person-centred care for people with dementia.
- LSW involves the intentional or planned efforts to encourage people with or without dementia to think about, remember, share and record information about themselves.
- Listening to people with dementia and understanding that they have rich and varied histories is essential to good person-centred care.
- The compilation and use of a life story enables the person with dementia to remain at the forefront of their care through evidence of their lived experiences, and previous/current wishes, preferences, beliefs and values.
- The benefits of LSW often go beyond the immediate benefits for the person with dementia, but embrace others within its circle of creation.
- However it is tackled, the compilation and use of a life story enables the person with dementia to remain at the forefront of their care through evidence of their lived experiences, and previous/current wishes, preferences, beliefs and values.
- LSW has several benefits to all stakeholders, not least for the person with dementia in affirming a sense of identity and worth in the context of receiving a life changing diagnosis.

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Let's Talk Veins: An Uphill Journey

Programme for Wednesday 27th September

08.00 – 09.00 Registration, coffee & exhibition

09.00 – 09.15 Welcome and introduction: Roland Renyi, LLCF Project Consultant

09.15 - 15.30 Workshops (40 minutes each)

- International guidelines: recommendations & comparison among different nations
- Innovative practice
- How assertive are we to truly advocate for those in lower limb management care?
- Prevention and management of skin tears in the lower limb
- The importance of exercise in the management of venous and lymphatic disease
- Current investigations in venous disease
- The role of aesthetics of the lower limb

13.10 - 14.10 Lunch & Exhibition

15.30 - 17.00 Leg Club & LCIP Forum



On Request – Concurrent workshop

Meet the experts on the Social Prescribing Leg Club model of lower limb care

- Why you need a Leg Club
- How to set-up a Leg Club

Thursday 28th September

08.00 – 09.00 Registration, coffee & exhibition

09.00– 09.15 **Welcome:** Roland Renyi, LLCF Project Consultant

Opening address: Professor Keith Harding CBE, **Morning Chairperson:** Trudie Young

09.15 – 09.50 **Dermatology problems related to venous disease**

Professor Marco Romanelli, Professor and Consultant Dermatologist at the Division of Dermatology, Department of Clinical and Experimental Medicine, University of Pisa

09.50 – 10.25 **Saving tomorrow's legs today**

Professor Mark Whiteley, Professor and Consultant Venous Surgeon and Consultant Phlebologist, The Whiteley Clinic, London

10.25 – 11.05 **Mid-morning coffee and exhibition**

11.05 – 11.35 **Embedded inequality in the treatment of lower limb ulcers**

Mr Adam Gwozdz, Clinical Lecturer / Vascular SpR Imperial College London

11.35 – 12.10 **My legs are killing me!**

Rebecca Elwell, Macmillan Lymphoedema Advanced Nurse Practitioner and Team Leader, NHS University Hospitals of North Midlands

12.10 – 12.45 **Complex Revascularisation for Chronic Limb-Threatening Ischemia: state of the art & cutting-edge technologies**

Mr Lukla Biasi, Consultant Vascular Surgeon Guy's and St Thomas' NHS Foundation Trust King's Health Partners and Tunbridge Wells Hospital

12.45 – 13.30 **Lunch & exhibition, Afternoon Chairperson:** Mike Hoskins

13.30 – 14.00 **The legs that did so much now need your help!**

Dr Melanie Thomas, National Clinical Lead for Lymphoedema in Wales, NHS Wales & Karen Morgan, National Lymphoedema Education and Research Lead

14.00 – 14.30 **Complexities in leg ulcer management: case study discussion**

Dr Jemell Geraghty: Nurse Consultant Tissue Viability & Lecturer in Adult Nursing King's College London

14.30 – 15.00 **Who's in charge of my wound?**

Trudie Young, Director of Education and Training for the Welsh Wound Innovation Centre and Tissue Viability Nurse, Velindre NHS Trust

15.00 – 15.45 **Looking through the key hole: the role of social models of care in addressing social isolation**

Dr Anna Galazka, Cardiff Business School

15.45

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Keeping the person at the centre of digital communication in health care

Here, Ellie Lindsay OBE explores why, with the increased use of virtual technology in health care, good communication skills are more vital than ever to ensure person-centred, holistic care.

The evolution of technology and electronic devices, such as smart phones, has greatly influenced the way we communicate today, improving the speed and ease of reaching out to others. But, the downside of the speed of, for example, a text messaging service, may be that individuals are no longer taking the time to converse in person and to be truly present — in mind and body.

In the field of health care, use of virtual care technologies is expanding. Automated text-messaging systems, in combination with widespread use of smart mobile devices, has the potential for wide-reaching use as an alternative to telephone calls, traditional mail, and emails. For example, text reminders are used to prompt patients ahead of their appointments. However, increasing reliance on evolving electronic devices and digital communication to cope with rising demands on the healthcare system may lead to inadvertent oversights, misunderstandings, and important messages being lost in translation, thereby posing a challenge to keeping the communication patient- or person-centred.

COMMUNICATING IN PERSON

Due to excessive weight loss and other health issues, a colleague of the author was informed by the

Ellie Lindsay OBE, honorary professor, College of Phlebology, London; independent specialist practitioner visiting fellow, Queensland University of Technology, Australia; visiting senior fellow, University of Suffolk; associate lecturer CRICP, Thames Valley University, London

'... increasing reliance on evolving electronic devices and digital communication to cope with rising demands on the healthcare system may lead to inadvertent oversights, misunderstandings, and important messages being lost in translation.'

general practitioner (GP) that a fast-track referral appointment to see a specialist had been arranged within two weeks. Understandably, the individual involved experienced an upsetting mixture of emotions, which can be isolating and daunting no matter how old, educated, or stoic one is. Over the coming weeks, the fast-track route involved numerous members of an extremely professional, multidisciplinary team (MDT) undertaking invasive procedures, including biopsies and computer tomography (CT) scans. Apart from the biopsies sent for histology, good information reviews were provided by the consultant at each consultation clinic/unit.

However, after a three-week wait for the CT results, the only communication received was a text message stating an appointment had been made by the MDT to attend another clinic for further investigations. No explanation was provided either by email or other means of communication. Naturally, to someone who had experienced multiple clinics within the healthcare system and was awaiting results, the need for good verbal communication skills was essential. Instead, there was stress and bewilderment at a

text message communication with no explanation or feedback on the CT results — just an appointment received in an electronic format, with an unknown consultant and further procedures.

It is widely accepted that communication technology and successful interaction are essential components in health care, especially when an individual needs a triangulation pathway within a hospital/clinic environment. However, effective face-to-face communication is still needed in practice, as it can help reduce misunderstandings when diagnostic procedures and treatments are increasingly prearranged on an outpatient basis. Indeed, effective verbal communication is a means to impart sensitive information.

In the author's opinion, having a good communication pathway between healthcare professionals and individuals requiring assessment and/or procedures and results improves the overall clinical experience. Involving those in our care in good, informative communication can ensure that their views and experiences are central to the MDT's decision-making regarding appropriate referral pathways, treatment and care. The key is to provide positive psychological factors — such as hope, optimism and resilience — to enable better overall psychological health, increased treatment adherence, and improved healing speed.

DO WE COUNT AND DO WE MATTER?

Every sensation experienced during a healthcare journey from the initial GP visit to a specialist referral pathway provides an emotional reaction and,

as practitioners, we should be able to recognise fear, embarrassment, confusion, vulnerability, and dread when someone is trying to make sense of what is happening to them. Communication can be extremely stressful, especially when lack of continuity means interactions with different clinical teams. Communication through verbal or written means is important throughout the navigation journey. Questions regarding treatment plans and making the best decision can be difficult for those without a medical background, illustrating why effective communication is important, as well as listening carefully to individuals regarding their understanding of the results of investigations.

The nursing role and computer informatics have broadened, with computers being used in the administrative areas of care delivery for fundamental tasks that were once done on paper. Today's person-centred care demands many disciplines and skills, and prime consideration should be given to address individual wants and feelings when planning care with MDTs.

Among the many skills required by every member of the MDT, one of the most frequently underestimated is the art of communication. In the author's opinion, communication requires skilled management, careful planning, good inter-personal skills, and realistic timescales and accountability. This means not only having to answer for an action when something goes wrong, but also a continuous process of monitoring how a MDT performs professionally. Responsibility will vary in different situations, but there is always a need to be aware that one is constantly responsible — and therefore constantly accountable — to ensure that effective communication between an individual requiring care and the healthcare professional is maintained.

The skill of giving appropriate information in a way that the individual can accept, understand, and remember cannot be minimised, and their adherence to information



is clearly linked to satisfaction with, and recall of, the practitioner–patient interaction.

ARE WE GETTING TOO BUSY TO CARE?

With nursing skills becoming more complex and technical, it is important that we do not lose the nurturing and caring aspect of the profession. Nursing should embrace a person-centred approach involving a three-way relationship between the individual, their carer, and the nurse, in which people are encouraged to be equal partners (Lindsay, 2019). The patient's voice needs to be heard at every level of their care — a major challenge is how to create meaningful pathways for people when experiencing care. As healthcare professionals, we should provide patients and their families with sufficient information to enable them to play an active part in their care, with transparency in information-sharing facilitating patient input.

CONCLUSION

If we fail to communicate, we fail to advocate (Lindsay et al, 2017). This requires paying increasing attention to the human dimension of illness, investigations, procedures, as well as good communication skills. The core concept is looking at the whole person, which is achieved by considering the needs of the individual using a MDT approach.

The value of person-centred care is the practice of caring for individuals (and their families) in ways that are meaningful and valuable.

A good relationship between the clinician, individual and family is at the heart of health care and is what those in our care value most. Part of this communication may be provided electronically — this might be what some patients prefer — but digital communication should have person-centred care and compassion at its core.

No single service should work in isolation within the healthcare system, specifically when individuals already feel helpless and powerless in the face of uncertainty and find experiencing and navigating clinic and hospital procedures complicated. It is also important to engage from the outset, addressing every stage of the therapeutic communication journey as opposed to becoming reliant on an automated message service. **JCN**

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My community



Liz Atkins has been a community diabetes specialist nurse at Warrington and Halton Teaching Hospitals NHS Foundation Trust for the last six years. Previously, she worked as a practice nurse in St Helens for 15 years. Liz was awarded a Cavell Star Award in 2022 for going above and beyond during the Covid-19 pandemic.

In December 2017, I started working at Warrington and Halton Teaching Hospitals as one of two new community diabetes specialist nurses (CDSN). It was a new role working within an already established diabetes specialist service implementing the Warrington diabetes model of seamless care. The role of the CDSN worked alongside primary care colleagues to review tier 2 and complex diabetes patients in GP surgeries at face-to-face appointments with the aim of reducing complications.

This involved providing direct teaching, support, and advice to improve the three treatment target areas of blood pressure (BP), haemoglobin A1c (HbA1c) and cholesterol. This role included upskilling primary care staff, preventing unnecessary referrals into secondary care, reducing inappropriate A&E attendances, and improving diabetes outcomes and enhancing professional relationships. The CDSN role included working with secondary and primary care colleagues — ‘the jam in the sandwich’, so to speak.

When the Covid-19 pandemic took hold in March 2020, half of the diabetes team at Warrington hospital were redeployed onto the wards. Most surgeries in Warrington reduced seeing patients face to face, therefore impacting diabetes reviews. I was asked to remain within the team and support diabetes patients in primary care. I provided an emergency line support to primary care via telephone virtual clinics and email support.

I also offered vital support to our inpatient diabetes team by following up on post discharge patients, including those newly diagnosed who had been discharged from hospital on higher doses or additional glucose-lowering therapies, including insulin, and required follow-up and adjustment. There were a cohort of patients who were in hospital with Covid-19 who required steroid therapy and subcutaneous insulin to manage their diabetes/steroid-induced diabetes, while recovering from the effects of Covid-19. Some patients required insulin therapy for longer compared to others in this cohort and needed virtual, or telephone follow-up and support on discharge from hospital.

A small number of GP surgeries during this time continued with their diabetes reviews and I was able to support them by using Microsoft Teams, titrating medication, and starting insulin therapy with the support of the general practice nurse — a new way of working and supporting GP practices.

This experience during the pandemic has made the diabetes team and myself more resilient in the way we work, as we have learnt to adapt and work in different ways. It has identified that the use of technology to support patients and practices is both beneficial to patients and primary care colleagues, and can improve outcomes to patient care, such as early intervention of treatment preventing a hospital admission.

During Covid-19, I worked more closely with my inpatient diabetes specialist nurse (DSN) colleagues to provide seamless transition from inpatient to primary care. This reduced readmission to hospital and demand on the inpatient DSN team to follow up post discharge, allowing them to focus on inpatient demands. It also enabled me to develop and improve my acute inpatient diabetes knowledge and skills, having only worked in the community before, which has helped me to support not only patients who have been in hospital, but also acute colleagues.

When primary care reopened its doors post pandemic, I continued to support primary care with face-to-face clinics, but also continuing with virtual and telephone clinics to support patients who are not able to attend surgeries. During the shutdown period of the pandemic, some patients in primary care may not have had their annual review and so I worked with the GP practices to identify these patients, bringing them into community diabetes nurse clinics if their diabetes control had deteriorated.

While the pandemic was challenging, it also encouraged us to review and improve the way we work together for the benefit of our patients. Post pandemic, areas have been identified for improvement. For example, a community rapid access clinic has been developed for GP practices to refer patients who require urgent face-to-face reviews. This is increasing accessibility and timely initiation of treatment, which, in turn, improves patient diabetes care outcomes and complications, reducing patient hospital admissions and demands on secondary care. **JCN**

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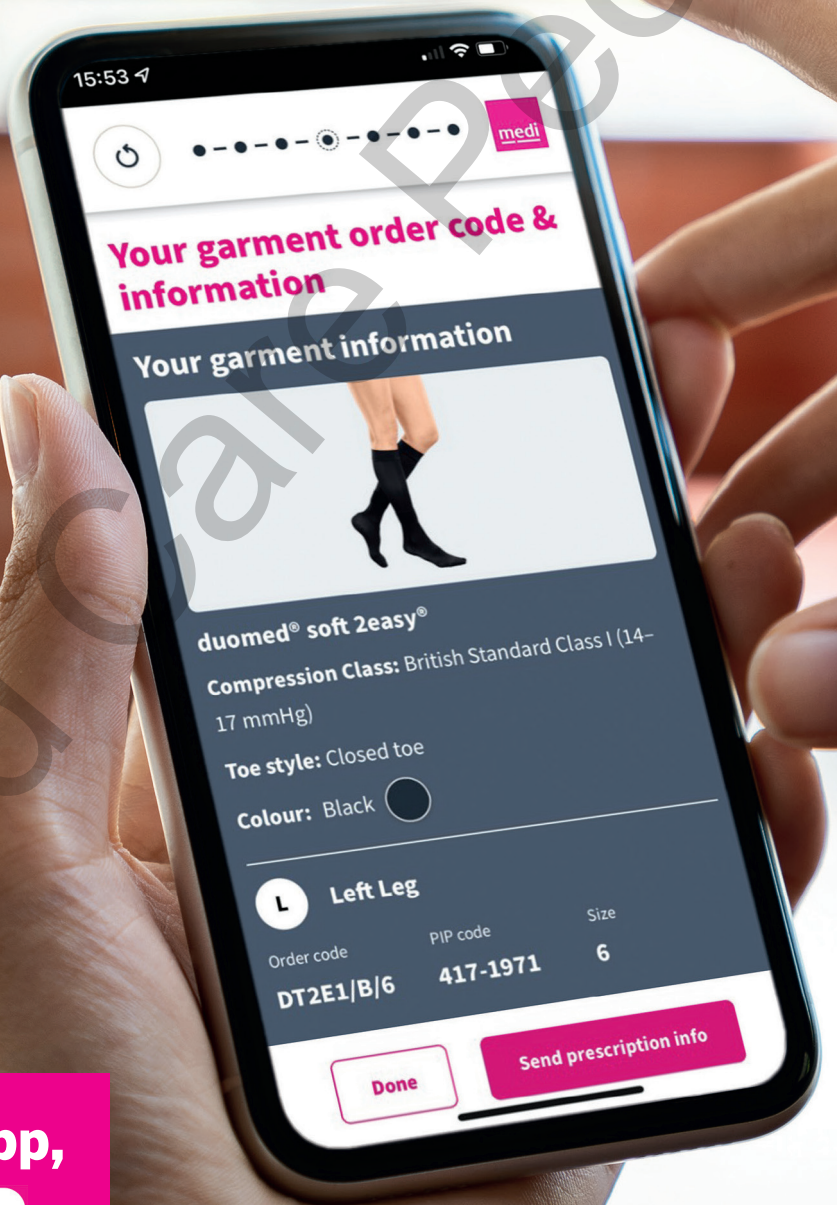
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