

Target areas in wound care

Jeanette Milne, Clinical Lead, Tissue Viability, Northumbria Healthcare NHS Foundation Trust, and Treasurer, Wound Care Alliance

Tissue viability has been in the spotlight in recent times with a focus on reducing pressure ulcers (NHS Improvement, 2018), improving wound assessment and reducing unwarranted variations in leg ulcer care (NHS England, 2017). In my trust we have flatlined in the process of reducing the number of healthcare-acquired pressure ulcers in both acute and community care. To that end we have recently invested in an SEM Scanner (subepidermal moisture scanner) to see if scanning skin provides an early warning of impending harm. It is hoped that we can intervene at an earlier stage with bespoke programmes of care.

Teams have made great progress with the Commissioning for Quality and Innovation (CQUIN) target for wound assessment (NHS England, 2018). In my trust we have moved from 25% of patients with a complete wound assessment in quarter 1 (Q1) to just under 60% in Q4 (March 2018), thanks to the commitment of my team and the district nursing teams. We still have a way to go to ensure that all patients receive a full assessment and to ensure that reassessment informs rational treatment choices and onward referrals. It is hoped that technology can assist with this.

This year sees the introduction of the high impact intervention (HII) for chronic wound infection in line with the antibiotic stewardship programmes (Infection Prevention Society, 2017). Community care must embrace this. Perhaps the challenge here is not collecting endless data but acting on themes that emerge from pilot results. This will include engaging with GP colleagues to address their response to a positive swab result and ensuring they ask if the patient is systemically unwell before prescribing systemic antibiotics. In addition, we must encourage clinicians to act on signs and symptoms of covert infection, such as failure to progress, by reducing wound bioburden before it leads to systemic signs. We must encourage them to substitute non-antimicrobial dressings for antimicrobial ones and get them to adopt successful strategies to minimise the impact of high levels of microbial flora. Using regular debridement and choosing substances that have sustained release and replenishment profiles, and knowing when to change them, is a key objective in order to realise this plan. As a long-time supporter of the 2-week antimicrobial challenge, I now wonder whether that is the correct timeframe. Emerging data suggests that biofilms are non-confluent entities that exist and thrive in different parts of the wound biome (Phillips et al, 2010) so can we expect their reduction in a 2-week window? Surely, given the right circumstances, they reoccur? As such, should we use cyclical application with different antimicrobials because the cost of an antimicrobial dressing is a fraction of the cost of the care for a non-healing wound? And, if you see progress do you withdraw the antimicrobial or continue to healing?

Perhaps we need to call on leaders in the field and industry to come together to give bedside clinicians consistent, clear messaging and evidence-based tools that enable them to make wise decisions, especially given the backdrop of falling numbers of nursing student applications and the introduction of new roles such as nursing associates.

The future focus must be to simplify and standardise guidance for grouped populations that centre on the key factors that have the most value i.e. seeking to identify and understand the key to the biggest gains that have an impact on patient outcomes. Is the holy grail of these healing? Or is this remission in the case of chronic wounds so that we can improve quality of life?

I urge readers to define the key deliverables—the ‘must do’ actions—for each factor that provides a challenge in the field of wound care. In addition, we must agree and share best practice both internally and across organisations. If we can do this we will achieve goals that we once thought impossible.

Infection Prevention Society. High impact interventions: care processes to prevent infection. 4th edn. 2017.

<https://tinyurl.com/y79jj9so> (accessed 13 June 2018)

NHS England. NHS RightCare scenario: the variation between sub-optimal and optimal pathways: Betty's story: leg ulcer wound care. 2017. <https://tinyurl.com/yajfwbwo> (accessed 13 June 2018)

NHS England. Commissioning for quality and innovation (CQUIN). Guidance for 2017-2019. 2018 (updated 2016 document).

<https://tinyurl.com/yadf2vdv> (accessed 13 June 2018)

NHS Improvement. Stop the pressure: helping to prevent pressure sores. 2018. <https://tinyurl.com/pgrdvqg> (accessed 13 June 2018)

Phillips PL, Wolcott RD, Fletcher J, Schultz GS. Biofilms made easy. *Wounds International*. 2010; 1(3):1-6.

<https://tinyurl.com/pjubwos> (accessed 13 June 2018)

Article published in British Journal of Nursing 2018, Vol 27 No 12, Tissue Viability Supplement