Woundology — still the missing piece of the jigsaw

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One of my favourite memories of Christmas was playing cards with my family. We always played '500' — not rummy and not bridge, but a combination of the two. The rules were unusual; with every new deal, there was a different trump suit and then the jacks of that colour got promoted to 'bowers'. The bower of the trump suit became the second highest card in the deck, just below the joker. I know, it sounds complicated, and it was, so it took a while to learn the rules of the game. I can't tell you anymore who won or lost all those years ago, but I vividly remember one thing. My mother, who had played the game longer than anyone else, would 'come unglued' if someone did not follow the rules. She accused them of playing with a different deck of cards!

Fast forward to the present day and I think there are a lot of wound care providers playing with a different deck of cards. The variance in wound care is stunning and certainly not helpful for the patient. Years ago, Keith Harding was giving a keynote address and commented that "until there is 'woundology', that is the formal science and training of wound providers like is done for other specialties, wound care will remain in its infancy". He was spot on then and is spot on now.

Just for examples of how wound care changes, years ago, ordering beta-blockers for a patient with heart disease would have been substandard; today, it is a measured and expected treatment. Similarly, getting a patient out of bed after orthopaedic surgery would have not been attempted for 5–7 days; today, patients are up and standing within hours. I'm sure you are wondering what I see that is so far behind the science of wound care. I put some of these 'treatments' in the Ten Top Tips article in this issue, but there are others. You could probably add to the list.

Perhaps the biggest issue I see in wound care is the lack of assessment of the patient as a whole and instead, the focus of the documentation is the measurements of the wound and the topical treatments provided.

The chronic wound remains unhealed because of an issue in the body. Wound care records often detail little about the patient's history, even those aspects of the medical history and medications that would negatively influence healing. There is little assessed or recorded on nutritional status. The ability of the patient to adhere to the planned for treatment, if it is discussed, is not recorded. Rather, the focus of the care and documentation is the size of the wound before and after debridement, and that process goes on week after week.

Case in point: a patient's wound was rapidly enlarging and becoming more necrotic each week. The weekly wound assessment reports detailed the deterioration very clearly. So what was missing? It was the fact that this bedbound patient had frequent diarrhea. All the changes in topical treatment and weekly debridements were not working, because nothing was being done about the diarrhea and the resultant malnutrition and dehydration.

How do we, as wound care providers, fix this? Perhaps the best new year's resolution you might make this year is to examine your wound care practices against the standards that do exist. There are evidence-based guidelines on the treatment of venous leg ulcers, diabetic foot ulcers and pressure injury. Review them and judge your own orders for wound care. Examine your records; did you consider the systemic issues? Medications? Nutrition? Adherence? Then pass on the information to others to provide better holistic care. Until woundology is applied, we must teach all providers the best practices. WINT

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