A wounds wish list for 2017

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Some of us have had a long career in wound care, while some of you are new to the field. But whether we can have a long look back or a short one, we all have our individual hopes that specific areas in the world of wound care that we love improve over the course of the year. Here is my wish list ...

Improvement in training in wound care

Wound care is complex, especially in terms of diagnosing the cause of the wound. General doctors learn how to diagnose them, mostly by their appearance. I have seen wounds on the buttocks classified as pressure ulcers because the wound was on the buttocks. Likewise, I have seen wounds of the foot and heel classified as diabetic foot wounds because the patient was diabetic. Every wound care provider needs to obtain a clear history of the wound — only then can an appropriate treatment plan be developed. Dr. Keith Harding has said that until we have 'woundologists' to practice along with other medical specialities, wound care will struggle, with everyone meaning well when trying to do something for the patient, but few educated in the actual science.

I do believe that wound care is a team-based effort. Nutritionists appreciate the need for more protein and calories to get wounds to heal, but can be slow to liberalise a diet in older people. Nurses do well with dressing changes, but do not always recognise when the wound could use a different approach. Few professionals are aware of the whole picture. I like to use the analogy of a 3-legged stool when teaching wound care. The three legs are to (1) remove the cause; (2) improve the intake of protein and calories; and (3) apply topical products to prevent infection and promote cellular migration. And just like the stool, when one leg is missing, the stool tips over. So it is with wound care; when one of the three components is missing, the wound fails to heal. Looking just at pressure injury ... the cause is pressure and shear, so those forces need to be minimised by reducing the intensity of pressure or limiting the duration of pressure. Seems easy enough, so why do we have to write orders such as "do not position the patient on the pressure injury" or "turn side to side only" or "limit time sitting in a chair"? Understanding nutrition is very important, but not often fully provided — why can't the orders for tube feeding be given over 24 hours, such as "provide 1,800ml of feeding every 24 hrs", rather than "provide 75/ml per hour". Then if the feeding needs to be turned off or stopped for meds or transport, the dose can be made up later in the day. And in the topical wound care realm, how can an order for "wet to dry dressings until healed" or "collagenase daily until healed" be an acceptable order? How can daily debridement lead to healing?

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Implementing the new pressure injury terminology

I would like to see the world in harmony over the terminology of pressure injuries. There are still people who call the wound a "decubitus ulcer", a term that was supposedly dropped in the 1980s in Europe and the US. I have heard the concern about getting sued more easily over the term "injury", however, the reason any provider is sued is that the patient or family feels that the care was negligent and the pressure injury was avoidable. It is not merely the word "injury" that will bring the patient or his/her parent or carer to court.

Payment models

We need to create a better model for determining who no longer benefits from aggressive wound care and who should be a palliative patient instead. With many payment models focused on outcomes, I am a bit concerned when the goals for patients with chronic wounds is to heal or close the wound. I'm not certain that is possible in all cases. We have many patients come to the outpatient wound centre and when asked what their goals of care are, they state: "I want you to fix my leg". Of course, the cynic in me wants to say "Give me a minute to go get my magic

wand!" The conversation then begins about the duration of the wound, the need for adherence to wearing shoes or compression stockings and the need for the control of other health problems. So, when in today's treatment paradigm does the conversation change to "the wound has not made any progress, should we look at just trying to control the odour, the drainage, etc?" Often, that conversation is never had, because we, as wound healers, don't like that conversation.

Somehow, we have failed when we talk about palliation. Perhaps, the outcome measurement will force our hand and we will have to identify the non-healers sooner. We will probably need a bit of help to overcome the anxiety of talking to the family about the change from cure to care.

Perhaps soon, wound care centres can account for the bulk of the work of wound care without having to fudge on the procedures done. This problem is complex — there are limited resources for health care and chronic conditions are the most expensive. I am fearful though that providers who claim to have performed full-thickness debridement weekly for weeks and weeks on end, with no improvement in the wound bed due to the underlying health problems, could cause payers (federal government, state government and insurance companies) to limit the number of débridements in the future.

Improving communication across settings

All too often, the patient arrives from another setting and the admitting staff have no idea that the patient has a wound, how severe it is and are not prepared for its care by having necessary equipment. In the US, hospitals are not paid for the treatment of a pressure injury that occurred during a hospital stay. This rule does not allow a hospital to claim the pressure injury was "unavoidable", regardless of the condition of the patient. The payment model in the US enables hospitals to be paid for pressure injury that is present on admission, but if an ulcer occurred during hospitalisation, whether or not it was unavoidable, the hospital gets no money for its care. Therefore, the admission assessment has become a crucial aspect of the admission process. The same approach should be used at the time of dismissal, in order to avoid gaps in care.

The amount of research done and being done on chronic wounds is beyond its infancy and I don't see a long gap in time from bench to bedside. The wound care manufactures are keenly aware of advances and capitalise on them to improve outcomes. The limitations in wound healing seem to be on our side with limitations in education, payment models and documentation systems to defer the provision of the care. I can tackle a few of these items, what can you do? WINT