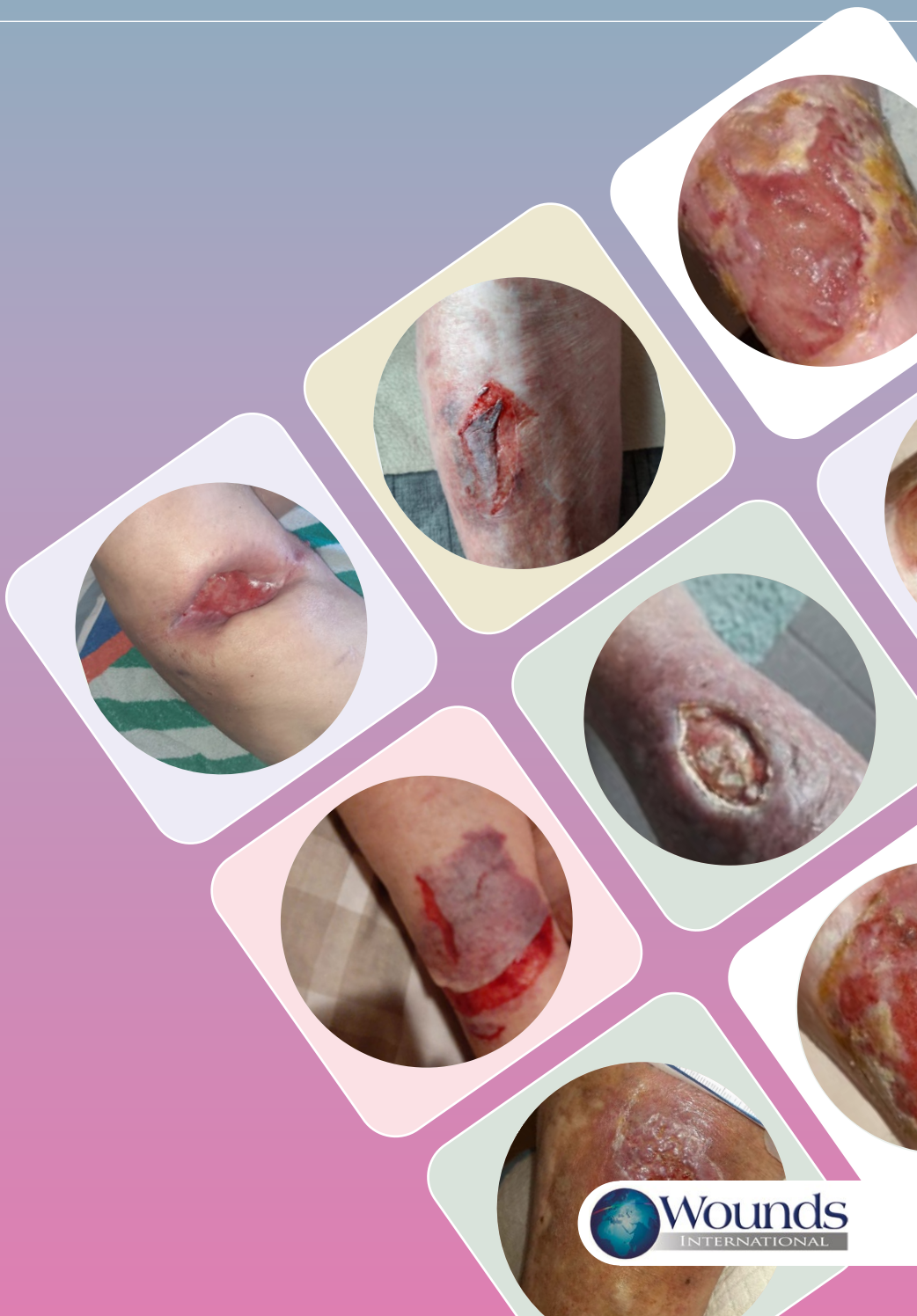
INTERNATIONAL
CASE REPORTS

Case series:
Shared wound care discussion guide

CASE REPORTS SERIES 2022



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Foreword

Shared care encompasses approaches and interventions that may enable patients to participate in care planning, decision making and care delivery. This approach values the patient as an active participant rather than a passive recipient of care, and is a key part of management for a range of other conditions (Wounds International, 2016). Patient involvement can not only improve wound care outcomes, but also reduce the economic burden and improve quality of life (Hibbard and Gilburt, 2014).

Shared wound care extends beyond the patient to engage with the patients' informal carer(s) (member[s] of a person's social network, e.g. family, friend or guardian) who helps the individual with activities of daily living, and may assist with the patient's wound-related care.

The shared wound care discussion guide (SWCDG) was developed as an aid for clinicians to use with the patient and informal carer(s) to discuss their awareness, willingness and ability to be involved in shared wound care (Moore et al, 2021). The SWCDG builds on international research and guidelines (e.g. Wounds International, 2016) plus survey results from clinicians (Moore and Coggins, 2021) and patients (Moore et al, 2021) that identified educational support is needed for clinicians to help patients and informal carers participate in shared wound care (Miller and Kapp, 2015; Kapp and Santamaria, 2017).

This case series describes how the SWCDG was evaluated in clinical practice by five wound care specialists in Australia, Canada, The Netherlands and the United Kingdom. The SWCDG was used during the initial patient and wound assessment to prompt conversation about shared wound care. The individual wound care dressing regimens were devised in collaboration between the clinician and the patient. The participants fears, concerns and thoughts on shared wound care were recorded. Each patient was monitored and reviewed for approximately 4 weeks or longer. Parameters of wound healing were recorded, such as wound size, wound bed condition and wound progression.

Overall, clinicians reported that using the SWCDG helped to facilitate shared wound care. The patients and their carers (if applicable) reported feeling more independent and empowered to be involved in their own care. There were decreased clinic visits and regular communication between the patient and clinician. If the patient was in a residential or nursing home, an additional benefit was that the nursing staff were upskilled in their wound care knowledge and felt confident that the patients could take an active role in their own wound care.

Shared wound care discussion guide

The shared wound care discussion guide (SWCDG; **Figure 1**) is an aid for clinicians that prompts discussion with the patient regarding their awareness and willingness to be involved in shared wound care. Use of the SWCDG should be considered at the start of the shared care journey with the patient. A patient's involvement in shared wound care is not static, so their ability and/or willingness to participate in care can change over time. Therefore, it is important to revisit the guide periodically to gauge success and satisfaction among all stakeholders of shared care.

The SWCDG is a tool that builds on international guidelines (Wounds International, 2016), data from a clinician survey (Moore and Coggins, 2021) and data from a patient survey (Moore et al, 2021) that identified an opportunity to provide educational support for clinicians in facilitating patients to participate in shared wound care. Patients who are involved in shared wound care would also benefit from standardised education (Moore et al, 2021). However, close professional supervision is required to optimise shared care practices and to optimise clinical outcomes (Kapp and Santamaria, 2017).

The guide is also based on the premise that informal carers are an integral and valuable part of the engagement process, and interventions and support for informal carers would also enhance wound healing (Miller and Kapp, 2015).

The SWCDG was developed by Moore et al (2021) with the following aims:

- To identify patient and informal carers who may benefit from being involved in shared wound care
- To improve clinical and service delivery outcomes by increasing education among patients and informal carers and encouraging more continuous, consistent and collaborative care
- To direct the clinician to implement the approaches and interventions that may be most suited to the patient's needs (e.g. wound-related care, lifestyle changes and/or supporting the patient–practitioner relationship).

DRESSING CONSIDERATIONS FOR PATIENTS AND CARERS INVOLVED IN SHARED WOUND CARE

The treatment and dressing selection for the patient should be based on effective holistic patient and wound assessment using a validated tool, such as the T.I.M.E. clinical decision support tool (Moore et al, 2019). For shared wound care, it was anticipated that using a dressing with a longer wear time of 5-7 days, where appropriate, could potentially be beneficial for patients (Moore and Coggins, 2021; Moore et al, 2021).

Patients and clinicians have also reported that they require dressings that control odour, are showerproof to allow bathing and are adherent to allow individuals to conduct their activities of daily living without the risk of the dressing falling off. If a dressing is to be used by patients and/or carers, it should be easy-to-use and take out of the packaging especially for people with low manual dexterity, with clear instructions on which side of the dressing goes next to the wound and how to use the dressing in general (Moore and Coggins, 2021; Moore et al, 2021).

Additional dressing attributes that may help patients to manage their own wounds include dressings that indicate when there is infection or when it is saturated and needs changing. For example, ALLEVYN® LIFE Foam Dressing (Smith+Nephew) incorporates a design feature that indicates when a dressing change is needed due to high exudate levels. This may reduce the amount of unnecessary tampering with dressings and wounds and, therefore, reduce the risk of infection. The dressing has also been shown to be of benefit to both patients and clinicians in promoting wound closure and improved patient wellbeing (Rossington et al, 2013; Tiscar-Gonzalez et al, 2021).

Shared wound care discussion guide[1]

Use this tool in conjunction with the ABCDE approach from the T.I.M.E. clinical decision support tool[2,3] and follow the steps below with the patient and/or carer (also known as informal carer or caregiver)

1 Awareness: Is the patient/carer aware they can be involved in wound care?

Yes

Talk with the patient/carer to establish:
- Wound knowledge, the impact of not treating the wound and the individual's wound care needs
- Fears and concerns regarding shared wound care
- Motivation for shared wound care
- Willingness to participate in shared wound care

No

Talk with the patient/carer to clarify the meaning of shared care:
- Shared care encompasses approaches and interventions that enable patients to participate in care planning over time, rather than just being a passive recipient of the services provided

2 Which of the following best describes the patient/carer in regard to shared wound care?

Self-sufficient
- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care

Reassurance seeker
- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care

Unaware
- Not very involved in wound care
- Unaware that it is possible to engage more in their care
- Physically and mentally capable but unwilling to participate in shared care

Reliant
- HCPs lead in all aspects of wound care and other general health care needs
- Does not have the physical and mental ability or capacity to be involved in shared care

Approaches and interventions

Have regular discussion with the patient/carer regarding shared wound care, including motivational interviewing and attainable goal-setting, focusing on:

Knowledge | **Fears and concerns** | **Awareness**

Shared wound care may not be a suitable option at this time

Provide appropriate support and revisit potential for more involvement

3 Identify what the patient/carer can do as part of shared wound care

Wound care

Does the patient/carer have the potential to perform wound care, including dressing changes?

Yes

Considerations
- Demonstrate and educate on how to perform treatment requirements
- Identify needs and provide patient/carer with educational resources (e.g. online, electronic, written)
- A diary for goal setting and to record dressing changes
- Provide patient/carer with tools: dressing change indicator; signs of infection

No

Considerations
- HCP to conduct wound assessment and dressing change according to local protocol
- Periodically revisit the potential for involvement in dressing changes (e.g. if patient/carer circumstances change)

Lifestyle change

Does the patient/carer have the potential to make lifestyle changes to improve wound healing and address the underlying causes of the wound (e.g. appropriate nutrition, exercise as indicated, using compression, offloading)?

Yes

Considerations
- Coach patient/carer about appropriate lifestyle changes
- Assess results and make changes as needed
- A lifestyle diary to record/track lifestyle changes

No

Considerations
- Investigate and address reason (physical or cognitive impairment, fear, anxiety, resources)
- Assess whether patient/carer willingness and ability may be improved
- Refer to allied health professionals for review and support (e.g. dietitian or podiatrist)
- Periodically revisit the potential for lifestyle change (e.g. if patient/carer circumstances change)

Patient-practitioner relationship

Does the patient/carer have the potential to share information about wound progress and inform HCPs about wound deterioration?

Yes

Considerations
- Develop an open and honest patient–practitioner partnership
- Educate the patient/carer about how to recognise wound deterioration
- Educate the patient/carer to contact the HCP without delay if the wound deteriorates
- Provide HCP contact information according to local protocol

No

Considerations
- Periodically revisit the potential for greater partnership (e.g. if patient/carer circumstances change)

References: 1. Moore Z, Kapp S, Loney A, *et al.* A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 2021;12(3):1-7. **2.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care.* 2019;28(3):154–161. **3.** World Union of Wound Healing Societies (WUWHS) (2020) Strategies to reduce practice variation in wound assessment and management: The TIME Clinical Decision Support Tool. London: *Wounds International.*

Advanced Wound Management, Smith & Nephew Medical Ltd, 101 Hessle Road, Hull, HU3 2BN, UK.
AWM-AWC-32124. Published September 2021.

Figure 1. Shared wound care discussion guide

EVALUATION OF THE SWCDG

Following a full wound and patient assessment by a wound care specialist, the SWCDG was used as a prompt to identify the patient and/or carer's suitability and willingness to be involved in shared wound care. The ability and willingness of a patient and/or carer to be involved in shared wound care is a continuum based on changing knowledge, understanding and ability, and willingness to engage in care (Moore and Coggins, 2021). The patient and/or carer were described in regard to their potential to be involved in shared wound care as either self-sufficient, a reassurance seeker, unaware or reliant. According to the chosen descriptor, the clinician was able to provide effective approaches and interventions and support the patient/carer on wound care, lifestyle changes and/or patient–practitioner relationship.

The wound care plan was agreed by the clinician and the patient/carer, and ALLEVYN LIFE Dressing was used if it was appropriate to the patient's needs. Each patient was monitored and reviewed for approximately 4 weeks or longer. Parameters of wound healing were recorded, such as wound size, condition of the wound bed, how the wound was progressing. Patient/carer wellbeing and their thoughts on shared wound care were also recorded.

Table 1 summarises the 10 case reports included in this evaluation. Figure 2 illustrates where the patients (and their carers if applicable) in the case series are positioned on the shared wound care continuum.

Table 1. Summary of case reports

Report	Clinician	Country	Wound type	Patient/carer description	Page
1	Amanda Loney	Canada	Venous leg ulcer	Reassurance seeker	8
2	Amanda Loney	Canada	Mixed aetiology ulcer	Self-sufficient	12
3	Henri Post	The Netherlands	Skin tear	Reassurance seeker	16
4	Henri Post	The Netherlands	Skin tear	Reassurance seeker	18
5	Ben Elsinga	The Netherlands	Clagett cavity	Reassurance seeker	20
6	Ben Elsinga	The Netherlands	Post-operative wound	Self-sufficient	22
7	Hayley Ryan	Australia	Diabetic foot ulcer	Reassurance seeker	24
8	Hayley Ryan	Australia	Skin tear	Unaware	26
9	Hayley Ryan	Australia	Skin tear	Reassurance seeker	28
10	Jan Ryzy	United Kingdom	Pilonidal sinus wound	Reassurance seeker	30

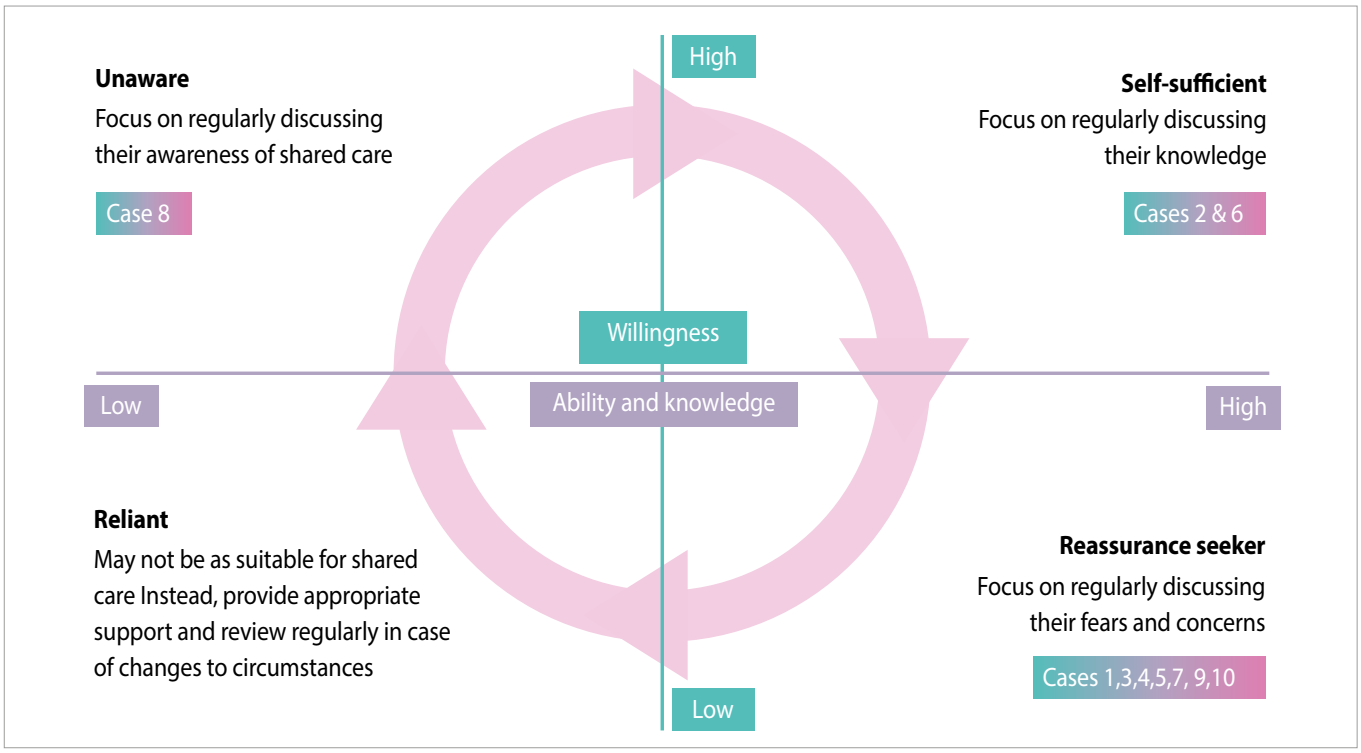

Figure 2. Positioning of case reports 1-10 on the shared wound care continuum (Moore and Coggins, 2021)

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Hibbard J, Gilburt H (2014) *Supporting people to manage their health. An introduction to patient activation.* The Kings Fund, May 2014

Kapp S, Santamaria N (2017) How and why patients self-treat chronic wounds. *Int Wound J* 14(6): 1269-75

Miller C, Kapp S (2015) Informal carers and wound management: an integrative literature review. *J Wound Care* 24(11): 489-90, 492, 494-7

Moore Z, Dowsett C, Smith G et al (2019) TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care* 28(3): 154-61

Moore Z, Coggins T (2021) Clinician attitudes to shared care and perceptions on the current extent of patient engagement in wound care: Results of a clinician survey. *Wounds International* 12(1): 48–53

Moore Z, Kapp S, Loney A et al (2021) A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 12(3): 86-92

Rossington A, Drysdale K, Winter R (2013) Clinical performance and positive impact on patient wellbeing of ALLEVYN™ Life. *Wounds UK* 9(4): 91-5

Tiscar-Gonzalez V, Menor-Rodriguez MJ, Rabadan-Sainz C et al (2021) Clinical and Economic Impact of Wound Care Using a Polyurethane Foam Multilayer Dressing. *Adv Skin Wound Care* 34(1): 23–30

Wounds International (2016) *International Best Practice Statement: Optimising patient involvement in wound management*. Wounds International, London. Available at: www.woundsinternational.com

CASE 1: Venous leg ulcer

Amanda Loney, Certified Nurse Specialized in Wound, Ostomy and Continence, Mississauga, Ontario, Canada

Wound and patient history

A 61-year-old man had a venous leg ulcer (VLU) on the medial side of his left ankle for 1–2 months. The patient had history of blood clots. The VLU measured 4 cm (length) x 2.8 cm (width) x 0.3 cm (depth). The wound bed comprised 90% granulation tissue and 10% slough, and the wound edges were described as non-advancing. The periwound skin was slightly inflamed extending out from the wound edges by 5-6 cm. Local infection was suspected due to an increase in wound size and purulent exudate.

There was a slight rash on the lower leg, which the patient felt was caused by wearing the two-layer compression bandaging system. His leg was hot and itchy, but the wound was not painful. Wound pain was rated as 2 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain).

The patient was receiving care at home and had been prescribed antibiotics for cellulitis prior to the evaluation period; this had improved the inflammation and reduced the amount of wound drainage.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The patient had no previous experience with shared wound care and did not have anyone to assist him with the practicalities of wound care. However, he was willing to learn and participate. The patient understood the cause of the wound, the impact of not treating the wound (e.g. the wound will be slow to heal or not heal at all, and potentially increase in size) and the importance of wearing compression therapy. The clinician felt that the patient would have the ability to be more involved in shared wound care if education was provided on signs and symptoms of wound infection, goals of the dressing product used (i.e. to provide a moist wound healing environment), autolytic debridement and treating the wound topically for infection.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as a 'reassurance seeker' (**Box 1**). He had been heavily reliant on clinic nurses for wound care, but he had a good understanding of treatment and wanted to proceed on his own between clinic visits. He hoped that clinic visits would reduce and that he would be able to remove and apply his compression bandaging to allow him to shower and be able to change the dressing when necessary. Regular discussion with the patient would focus on improving his knowledge, addressing his fears and concerns, and improving his awareness. For example, he is most worried about performing wound care incorrectly and of not recognising when the wound is progressing in the right direction.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient would be able to perform wound care after learning how to remove and apply the dressing and compression bandaging system.

Lifestyle change: The patient had the potential to make lifestyle changes to improve wound healing. Coaching included the role of compression therapy and how to use and wear it most efficiently.

Patient-practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and empowered to contact the clinician without delay if the wound deteriorated.

With the patient, the wound care specialist developed the shared wound care plan to include:

- Cleansing the wound with saline and application of DURAFIBER® Absorbent Gelling Silver Fibrous Dressing (Smith+Nephew) and ALLEVYN® LIFE Foam Dressing (Smith+Nephew) on the wound, with instructions to change both dressings every 3–4 days unless the dressing indicator of ALLEVYN LIFE Dressing alerted him to change the dressing earlier. Information was provided on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Application of a steroid cream to the rash on his lower leg
- Padding of the leg, from the toes to three fingers below the bend in the back of the knee (50% overlap)
- Application of two-layer compression bandaging system compression bandages, with video instructions on how to apply and to remove daily so he could shower and check the dressings. The patient would send a photo after he had finished applying the compression bandaging. The compression system was introduced on a trial basis as the patient experienced an allergic reaction to the previously used system, so he was cautious about using compression therapy again
- Details on when and how to contact the wound care specialist were supplied. The patient was instructed to send photos or text if he had any concerns about his wound or needed reassurance. He was also provided with a handout on the signs and symptoms

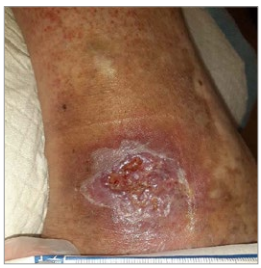
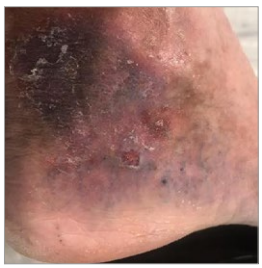
that would require him to contact the doctor for antibiotics.

Final comments

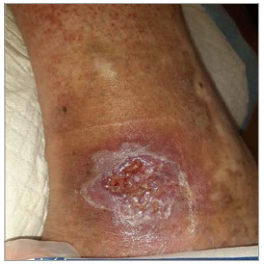
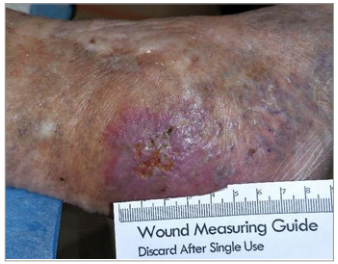
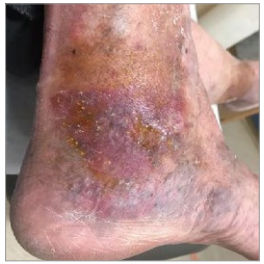
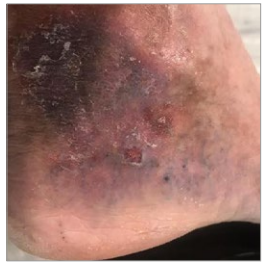
The patient was very happy with the ongoing support he received over the evaluation period. The clinician also felt reassured when the patient contacted them with questions and sent images of the wound, which confirmed that the patient was still engaged in being involved in shared care. He did not deviate from the treatment plan and the wound did not deteriorate as he knew the signs of infection and when to alert a clinician. The patient was pleased that he had become more knowledgeable around wound care and wound progression.

The patient felt well supported and was able to carry out the care plan beyond the evaluation period. Several positive outcomes were noted by the patient and clinician as a result of using the shared wound care discussion guide, such as:

- Decreased clinic visits
- Regular communication between the patient and clinician
- Increased patient confidence in wound management
- Increased independence, such as reduced reliance on the nurses and more autonomy in taking steps to support healing, such as wearing compression therapy.

Wound progression in brief		
Initial presentation	**Week 9**	**Wound condition**
		The wound had fully healed, but, according to the patient, the area had begun to deteriorate.

Wound progression in detail

Initial presentation	Week 1	Week 3	Week 6	Week 7	Week 9
	No image available			No image available	
Wound condition: 90% granulation tissue and 10% slough; edges non-advancing, low levels of purulent exudate, local infection was suspected due to an increase in wound size, inflammation (greater than 3 cm), pain and purulent exudate. Wound size: 4 cm (length) x 2.8 cm (width) x 0.3 cm (depth)	**Wound condition:** 60% granulation tissue and 40% slough, inflammation to the periwound area has cleared, low purulent exudate, rash to lower leg is improving. Wound size: 1.3 cm (length) x 1.2 cm (width) x 0.2 cm (depth)	**Wound condition:** 60% slough, 20% red granulation tissue and 20% scabby tissue, slight increase in pain and itch. Wound size: 2 cm (length) x 1.5 cm (width) x 0.2 cm (depth)	**Wound condition:** The wound has decreased in size, and there is reduced drainage and pain. Wound size: 1 cm (length) x 1 cm (width) x 0.2 cm (depth)	**Wound condition**: 100% granulation tissue with new epithelial tissue, which is a significant improvement since last week. There is slight inflammation to the periwound skin and drainage is low. Wound size: 0.2 cm (length) x 0.2 cm (width) x 0.1 cm (depth)	**Wound condition**: The wound has fully healed, but according to the patient, the area had begun to deteriorate.
	Patient feedback: The patient is proud that he has learnt how to apply the compression bandages. He can see that the wound is improving and feels supported that should he have any questions or concerns he can contact the clinician.	**Patient feedback:** The patient is concerned that the wound is looking 'meaner' (i.e. more inflamed, more painful) and that wound progression has slowed.	**Patient feedback:** The patient is very pleased with the progress of the wound.	**Patient feedback:** The patient remains satisfied with wound progression and is very pleased with the support he receives from the clinician.	**Patient feedback:** The change indicator dressing has been useful as the patient could see a change was indicated when the dressing was 50–75% saturated. The patient wore compression daily and is very happy with the ongoing patient–practitioner relationship.

	Clinician feedback: The patient is happy to be involved in shared wound care.	**Clinician feedback:** Close monitoring, support and education around treatment choices are needed as the wound is displaying signs of local infection. The patient is supported to continue with shared care. Treatment plan is changed to the following: • Cleanse with saline and soak with an antiseptic wound solution • Apply IODOSORB◊ 0.9% Cadexomer Iodine Ointment (Smith+Nephew) and ALLEVYN LIFE Dressing or ALLEVYN◊ GENTLE BORDER LITE Foam Dressing (Smith+Nephew) to the wound, hydrocortisone cream to the surrounding rash and a moisturising cream with urea and alpha hydroxy acid (AHA) to the rest of the leg • Apply a two-layer compression bandage system (compression socks to be used but if unavailable a high compression bandage; change twice a week).	**Clinician feedback:** Very pleased – the patient is independent with care and contacts the clinician for support and encouragement.	**Clinician feedback:** As the wound improves, the treatment plan is changed to the following: • Cleanse with normal saline and soak with a wound solution • Application of an antimicrobial dressing, hydrocortisone cream to the rash and a moisturising cream with urea and alphahydroxy acid to the rest of the leg • Apply ALLEVYN GENTLE BORDER LITE Foam Dressing and a two-layer compression bandage system (change twice a week).	**Clinician feedback:** The patient has become more knowledgeable about wound care and feels confident to continue to participate in shared care until the wound has healed.

CASE 2: Mixed aetiology ulcer

Amanda Loney, Certified Nurse Specialized in Wound, Ostomy and Continence, Mississauga, Ontario, Canada

Wound and patient history

This case describes a 49-year-old woman who had a mixed aetiology ulcer on her right shin. She had anti-neutrophilic cytoplasmic autoantibodies (ANCA) vasculitis with pyoderma gangrenosum. ANCA vasculitis is an autoimmune disease affecting small blood vessels in the body; it is caused when ANCAs target and attack neutrophils. As a result, she was under the care of a rheumatologist and a dermatologist specialising in wound care and received anti-rheumatic and immunosuppressant therapy.

The wound bed of the ulcer consisted mainly of granulation tissue with a few islands of new epithelialised tissue. The wound edges were advancing, but the periwound skin was very macerated. On occasion, the macerated tissue would lift off to reveal new epithelial tissue or it would sluff off to expose open ulceration.

There were moderate to high levels of serous exudate depending on the patient's level of activity. There were no signs of local infection, but biofilm was suspected due to the very slow progress of wound healing. Wound pain level was low (1-2 out of 10 on the Numeric Rating Scale; 0=no pain; 10=worst pain), but it wound increase during cleansing, sharp debridement and dressing change.

The patient had experience of being involved in wound care as the wound had been present for over 10 years. In the past, she had changed the dressing before a clinic appointment if odour or wound pain were intolerable or there was exudate leakage. She recently had to stop working due to the pain and high exudate levels, and required daily clinic visits to change the dressing.

For this individual, the main treatment goals included frequent ongoing debridement and moist wound management; infection control, risk management and treatment and oedema management

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The patient was aware that she could be more involved in her wound care. She understood that the cause of the wound was complex: mixed disease aetiology complicated by vasculitis, pyoderma gangrenosum and venous disease. Although the complexity of the wound presented challenges, the clinician hoped that the wound would decrease in size and the patient would be able to lead a more 'normal' life by being more involved in the day-to-day management of the wound and that this would decrease the number of clinic visits required.

The patient was motivated and eager to participate in shared wound care and felt able to change the dressing herself when it was causing her discomfort. She was also pleased that she would be able to change the dressing when it was convenient for her.

Box 1. Description of a 'self-sufficient' individual

- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as 'self-sufficient' (**Box 1**), as she was knowledgeable and willing to perform wound care and to optimise her lifestyle to enhance healing; for example, although not ideal, she stopped working to decrease her stress level and pain, and to elevate her leg when required during the day.

The patient was concerned about not recognising infection soon enough to prevent deterioration, which would impede wound healing. The main approaches to support shared care for this individual were to improve knowledge around compression therapy application and to address her fears and concerns.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient would be able to perform wound care after learning how to apply and remove the dressing and compression bandaging system.

Lifestyle change: The patient had the potential to make lifestyle changes to manage the underlying causes of her wound by using compression therapy.

Patient-practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and was empowered to contact the clinician without delay if the wound deteriorated. The wound care specialist's contact details (email and phone) were given to the patient. There was an open-door policy to encourage the patient to contact the clinician any time she had questions or concerns or to come to the clinic if ever in doubt of her wound status. She was also encouraged to send photos and to get in touch regularly, even if she just required reassurance.

With the patient, the wound care specialist developed a shared wound care plan. Due to high odour, dressing change should occur every 2 days:

- Wound and limb should be soaked for 10 minutes in a cleansing solution containing 0.033% hypochlorous acid
- Application of a cream containing tacrolimus (a topical macrolide immunosuppressant) around the edge of the wound
- Application of a moisturising cream containing urea and alpha hydroxy

acid (AHA) to the intact skin with an option to use a steroid cream if the skin becomes itchy
- Cover with a collagen and oxidised regenerated cellulose silver wound contact layer
- Cover with ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needed to be changed more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Application of two-layer compression bandaging system
- Weekly clinic appointments for sharp debridement, wound assessment and patient support, and then to decrease to every 2 to 3 weeks as patient becomes more independent.

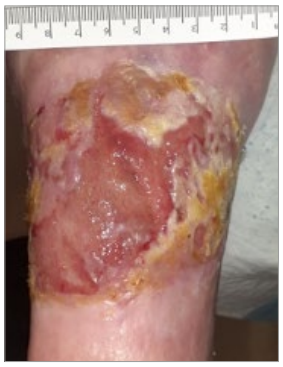
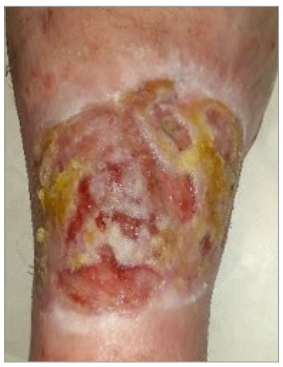
Final comments

It is important for patients with wounds to be able to return to independence as soon as possible, and shared wound care is an opportunity to facilitate this, even if there are minor setbacks in wound healing. Shared care allows the patient more time to live their life and less time focused on the wound. For this chronic, complex wound, the patient understood that the wound status would fluctuate overtime, and as long as the symptoms are managed and controlled (i.e. drainage, odour, pain), wound healing would progress.

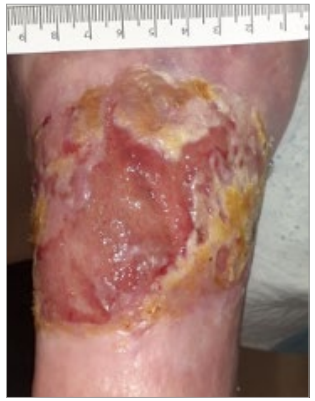
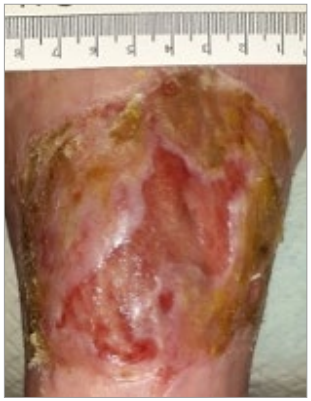
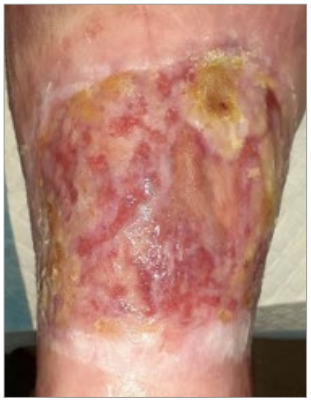
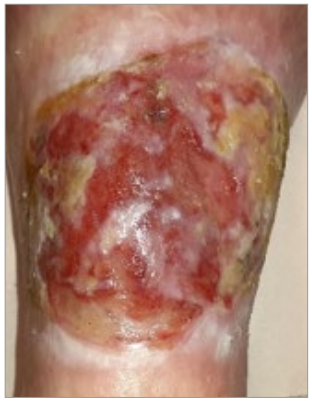
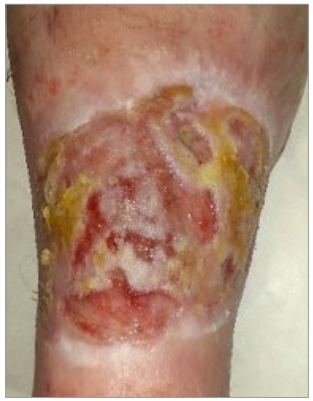
The patient received information about dressings, compression therapy and lifestyle that supported wound healing in a way that fitted in with her daily activities. Reviewing with the patient what to look out for regarding the signs and symptoms of infection provided her with the confidence to listen to her body and trust her instinct. The patient was able to acknowledge the cause when the wound deteriorated at week 4 and to reach out for assistance when it was urgently needed. Working together to change the treatment plan helped to ensure the patient felt involved in care.

Using ALLEVYN LIFE Dressing with the change indicator provided guidance for the patient and the confidence and reassurance that she was changing the dressing appropriately. It also was a trigger to change to a less absorbent secondary dressing when it was required.

The shared wound care discussion guide gave the clinician prompts to consider when embarking on shared care. For this patient, using the guide gave the patient a sense of control when agreeing on the terms and extent of shared care. This discussion guide could be very beneficial for newly qualified clinicians. If nurses were able to review the discussion guide with their patients more routinely, they would realise that there is an opportunity for many more patients to participate in their own care, and similarly more patients themselves would realise that they can safely be involved in their care with positive outcomes for all concerned.

Wound progression in brief		
Initial presentation	**Week 11**	**Wound condition**
		Significant improvement in the wound: new areas of epithelialised tissue, decrease in exudate and odour. Gone from one large area to smaller wound areas.

Wound progression in detail

Initial presentation	Week 1	Week 3	Week 7	Week 11
				
Wound condition: The wound bed consists mainly of granulation tissue and there are a few islands of new epithelialised tissue. The wound edges are advancing, but the periwound skin is very macerated. There is a moderate to high level of serous exudate. There are no signs of local infection, but biofilm is suspected due to the very slow progress. Wound pain levels are low, but this can increase during cleansing and dressing change.	**Wound condition:** New epithelial tissue developing from the edges is very slow. There is no odour, but there is a moderate level of seropurulent exudate. Debridement is required as the tissue is macerated and non-viable.	**Wound condition:** Some previously closed areas have reopened; however, the depth of the wound has decreased and new epithelial tissue is advancing from the edges. No inflammation to the periwound area. No increase in pain, odour or drainage.	**Wound condition:** The lower aspect has deteriorated following an injury. The patient reports a very slight increase in odour, seropurulent drainage and pain to the site of injury. The signs suggestive of biofilm are present.	**Wound condition:** There has been significant improvement in the wound: new areas of epithelialised tissue, decrease in exudate and odour. The lower aspect of the wound bed where the injury occurred has become more granulated. There are some areas of slough and increasing epithelial tissue.
	Patient feedback: Going very well and she is happy that she can change the dressing at a time that is convenient to her. She is thinking of returning to work part time.	**Patient feedback:** The patient thinks she and the clinician are working well together. She has returned to work part time and is very excited about this. She feels better emotionally; the wound is no longer the focus of her entire day.	**Patient feedback:** The patient is very upset following the injury and subsequent wound deterioration. However, she understands that the injury and deterioriation was not her fault. She is happy to be able to balance both the wound and her life rather than her wound being her life.	**Patient feedback:** The patient is pleased with the improvement over the past few weeks and pleased that the changes to the treatment plan at the last review led to some healing progression.

	Clinician feedback: The patient is starting to feel more 'normal' and reaches out when she has concerns. The clinician feels confident that shared care is going well and that together 'we will not miss something that would cause a setback in healing'.	**Clinician feedback:** The patient has a good grasp of wound care and is excelling at being a part of shared care.	**Clinician feedback:** The patient was able to reach out for assistance after the injury. Together, the clinician and patient changed the treatment plan. The dressing regimen was changed to IODOSORB◊ 0.9% Cadexomer Iodine Powder (Smith+Nephew) to manage the suspected biofilm and ALLEVYN◊ GENTLE BORDER LITE Foam Dressing (Smith+Nephew) was used as a secondary dressing. The patient agreed to elevate her leg more when at home.	**Clinician feedback:** Shared wound care has given the patient a sense of control, enabling them to balance living life with their health issues. For this patient, her wound had been dominating her entire life for years.

CASE 3: Skin tear

Henri Post, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

This case describes a 73-year-old woman who had a skin tear on her right leg for 4 days, which occurred when she removed her therapeutic stockings. The patient had chronic obstructive pulmonary disease, hypertension, chronic venous insufficiency (CVI) and a history of skin tears. The wound measured 6 cm (length) x 3 cm (width) x 0.2 cm (depth) and there was partial tissue loss. The wound bed consisted of 100% granulation tissue and wound edges were open and advancing.

The surrounding skin was fragile and there were moderate levels of serous exudate. The patient rated wound pain at 4 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain) during dressing changes. She was referred to a wound care specialist and was receiving care at home. Her daughter was very supportive and helped her to apply and remove her stockings. When she'd had skin tears previously, she was visited by a nurse once a week.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

Using the shared wound care discussion guide, the clinician was able to explain how the patient could be more involved in their wound care. The patient and her daughter both understood the cause of the wound and the need to wear compression stockings; but they were not aware that CVI was the underlying problem. The patient was excited, but slightly nervous, to be involved in wound care; she was pleased that her daughter would be able to help. The patient was most concerned about knowing the signs of infection, when to alert the wound care specialist, when to change the dressing, and how to use the compression stockings. They hoped that, by being more involved in care, they could prevent future skin tears.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician felt that they would have the ability to be more involved in shared wound care with the appropriate education and support, and described the patient and her daughter as 'reassurance seekers' (**Box 1**). Both were motivated to share the wound care and to become more independent and less reliant on clinical assistance. Regular discussion with the patient and her daughter regarding shared care would focus on improving their wound care knowledge.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient could perform the wound care with the help of her daughter, but would require more information on when and how to change the dressings and about the underlying cause of delayed wound healing (i.e. CVI).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

Lifestyle change: It would be helpful to coach the patient on how to safely remove their therapeutic stockings to avoid damaging the skin.

Patient-practitioner relationship: The signs and symptoms of wound infection that should alert the patient and her daughter to contact the wound specialist without delay were discussed.

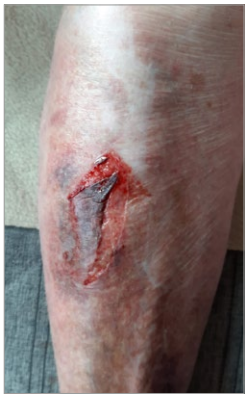
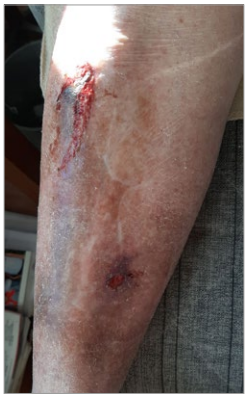
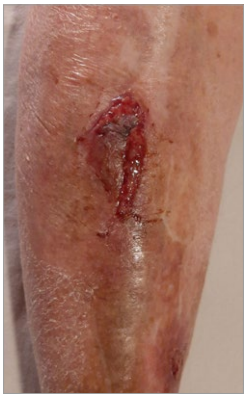
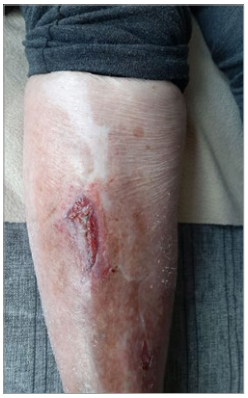
The wound care specialist developed the shared wound care plan with the patient/carer that included:

- Cleansing the wound with gauze wetted with tap water
- Using ALLEVYN® LIFE Foam Dressing (Smith+Nephew) to cover the wound for 7 days
- Information on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Daily use of compression stockings, with instructions on how to apply and remove
- Weekly telephone contact with the patient and weekly photographs of the wound sent by the daughter
- Details on when and how to contact the wound care specialist if the wound deteriorated (i.e. if the signs and symptoms of acute wound infection develop, such as swelling, redness of the surrounding skin, increasing temperature of the skin or increasing pain).

Final comments

Throughout the evaluation period, the patient and her daughter felt more confident and increasingly independent to care for the skin tear. They were also pleased to avoid the disruption of travel for clinic visits and felt well supported with the weekly calls and sharing of wound images.

The clinician felt that the wound progression was as expected and communication between the patient and her daughter allowed the observation that hypergranulation had become a problem at week 4, which prompted the need for a face-to-face consultation. When using shared wound care, a balance is needed so as not to overload the patient with information and instructions; the discussion guide is a useful tool that provides prompts to help guide what information is required.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
		Image not available		
Wound condition: 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** Wound healing has progressed; hyper-granulation tissue is present, no signs of infection, moderate serous exudate, edges are intact. The wound is no longer painful.
Patient/carer feedback: The patient and her daughter were optimistic about the shared wound care initiatives and were interested to see if this approach would improve their independence.	**Patient feedback:** The patient confirms they are happy with treatment and has no questions.	**Patient feedback:** The patient dials in to every appointment on time and is pleased with the progress of her wound.	**Patient feedback:** The patient remains satisfied with wound progression. Stocking changes with her daughter are going well.	
Clinician feedback: The patient and her daughter are physically and mentally capable to participate in shared care.	**Clinician feedback:** Wound healing is progressing, and no treatment changes are necessary. The patient finds using ALLEVYN LIFE Dressing easy as the change indicator provides an objective way to identify excessive exudate.	**Clinician feedback:** No need to intervene as there are no reports of exudate spreading to the dressing's edges or leaking.	**Clinician feedback:** Wound healing is progressing, and no treatment changes are necessary.	**Clinician feedback:** Hyper-granulation tissue could be due to bacterial imbalance. The patient was asked to attend a face-to-face appointment at the clinic where treatment was commenced with a silver nitrate dressing.

CASE 4: Skin tear

Henri Post, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

This case describes a 68-year-old woman with type 2 diabetes, Crohn's disease and arthrosis who presented with a skin tear on her right upper arm. The wound had been caused by the patient moving her sweater sleeve up and down her arm repeatedly. The wound measured 10 cm (length) x 3 cm (width) x 0.2 cm (depth), and the wound bed was 100% granulation tissue.

The skin flap appeared viable and was immediately replaced. The edge of the wound was advancing and intact, and the condition of the surrounding skin was described as fragile. Moderate levels of serous exudate were present. There were no signs of infection, but the patient rated pain at 6 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain). Pain medication included paracetamol 1000 mg four times daily and ibuprofen 400 mg twice daily.

The patient was newly registered at the wound care centre and had no history of wounds. She was an excellent individual to discuss shared care with as she had no prior experience or expectations of wound care. She attended the appointment with her granddaughter who lived close by and was 'not afraid' to be involved in her grandmother's care.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

Using the shared wound care discussion guide, the clinician established that the patient and her granddaughter were aware that they could be involved in wound care. At first, the patient was unsure about being more involved in her care as '*it's the wound care specialist who knows what's best for [me]*'. But after the potential benefits of shared wound care were discussed, she seemed happier that she would not be dependent on a homecare nurse to change the dressing.

The patient understood the cause of her skin tear and was concerned about the wound becoming infected. The clinician felt that, with her granddaughter's support, the patient could be more involved in shared care.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient and her granddaughter as 'reassurance seekers' in relation to shared wound care (**Box 1**). Both were willing and motivated to participate in shared wound care as they did not want to be completely reliant on healthcare professionals. Changing the dressing themselves would be more convenient for them so they could continue their usual daily activities. Regular discussion with the patient and her granddaughter regarding shared care would focus on improving knowledge and addressing fears and concerns – mainly about the risks of wound infection (e.g. what the symptoms are and when to alert the wound care specialist).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient, with the help of her granddaughter, would require coaching on how to perform wound care (i.e. dressing changes).

Lifestyle change: The patient was aware that, because she had diabetes, she needed to take extra care of her skin, feet and legs and that she may be at increased risk of wound infection. Discussion on how to protect the skin integrity and reduce the risk of skin damage would be beneficial.

Patient-practitioner relationship: The signs and symptoms of infection needed to be discussed (e.g. swelling, redness of the surrounding skin, increasing skin temperature, increasing pain) and the importance of contacting the wound specialist if the wound deteriorates.

The wound care specialist developed the shared wound care plan with the patient/carer to include:

- Gentle cleansing of the wound with tap water and gauze soaked onto the wound
- Weekly dressing changes of ALLEVYN® LIFE Foam Dressing (Smith+Nephew) and information on how to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Weekly telephone contact between the patient and clinician, and the granddaughter would email a photo of the wound
- Pain medication with instructions to stop after 3 days and only restart if the pain returns
- Details on how to recognise wound deterioration and when to contact the wound care specialist — swelling, redness of the surrounding skin, increased temperature of the skin, increased pain.

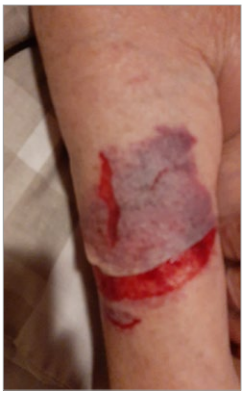
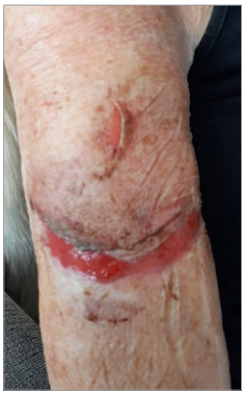
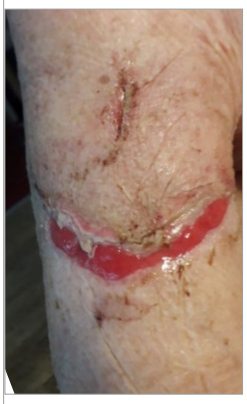
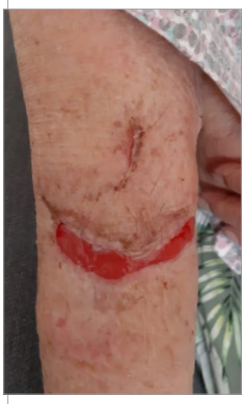
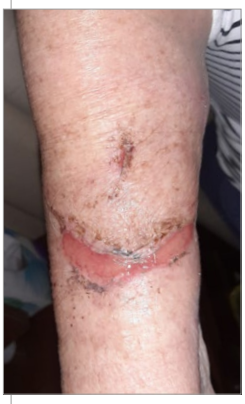
Final comments

At the beginning, the patient was slightly hesitant to be involved in shared care. But with the support of her granddaughter, an understanding of the signs and symptoms of wound infection, and knowing that healthcare professionals were available close by if needed, her confidence grew.

The patient stated she felt empowered and proud to be sharing the wound care with her granddaughter and was pleased she did not need to rely on the clinician. The progress in wound healing gave both confidence and evidence that they were successful in performing wound care and it was agreed that shared wound care would continue going forward until the wound fully healed.

The dressing change indicator of ALLEVYN LIFE Dressing was a useful tool when deciding if there was excessive exudate or if the dressing needed to be changed earlier than expected. In this case, the granddaughter felt the indicator was an easy parameter to determine if a dressing change was needed.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** The wound has progressed and confidence of both the patient and granddaughter has improved. The patient has no wound pain.
Patient/carer feedback: The patient and granddaughter are eager to perform the wound care.	**Patient/carer feedback:** The patient confirms that she is optimistic about the progress of her wound. The skin tear is almost healed and the patient only experiences pain during wound cleansing.	**Patient/carer feedback:** The patient and granddaughter are committed to the treatment plan. The dressing stayed in place for 1 week despite a slight increase in moisture. There was no odour.	**Patient/carer feedback:** The wound has reduced in size and the tear has healed. The cooperation between patient and granddaughter is going well.	
Clinician feedback: The patient and her granddaughter are physically and mentally capable to participate in shared care.	**Clinician feedback:** Wound healing is progressing, and the condition of the surrounding skin is healthy. No treatment changes are needed.	**Clinician feedback:** The cooperation between wound care specialist, patient and granddaughter is consistent. There is no need to intervene as exudate has not spread to the dressing's edges and there is no leakage.	**Clinician feedback:** Wound healing is progressing normally, and granulation tissue is visible.	**Clinician feedback:** Pale granulation tissue is observed after 4 weeks of treatment. It is suggested that the next review will be a face-to-face appointment with the wound care specialist nurse.

CASE 5: Clagett cavity

Ben Elsinga, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

A 77-year-old man had a clagett cavity on the right side of his chest of 10 months' duration that was created following a thoracotomy. He had an extensive medical history including psoriasis, skin cancer and lung empyema. The patient had been referred to the wound care team by the rehabilitation centre when he was transferred home. He had no known history of chronic wounds.

A claggett is an open window in the lateral aspect of the chest to allow continuous drainage and irrigation of the cavity with antibiotic solution. At first, the clagett cavity wound required twice-daily dressing changes, but, as the wound improved, dressing changes were reduced to twice a week.

The wound measured 11 cm (length) x 8 cm (width) and the wound bed comprised 100% granulation tissue. New epithelial tissue was covering the wound bed, and the wound edges were described as advancing. The surrounding skin was mostly healthy with a small amount of dry skin. There were moderate levels of serous exudate and there were no signs of infection. The patient had no wound pain.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

Using the shared wound care discussion guide, the clinician felt the patient and his wife were capable to be involved in shared wound care with further coaching. The patient had a good support system, and he had experience changing the dressings as his wife had previously shared the wound care with the district nurses. The patient and his wife understood the cause of the wound, but they felt they had limited knowledge of how the wound should progress.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient and his wife as 'reassurance seekers' (**Box 1**). They were reassured that shared wound care did not mean they were alone in performing wound care, and that there was a 'safety net' of district nurses nearby to help when necessary.

Regular discussion with the patient and his wife would focus on addressing their fears and concerns surrounding shared wound care, for example, he was worried about being alone if there was a complication, excessive moisture or he became ill again.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient could carry out dressing changes with the help of his wife, but they needed more information on what to do if there were signs of infection or his psoriasis escalated.

Lifestyle change: It was not applicable for the patient to make lifestyle changes at this time.

Patient-practitioner relationship: The district nurse and wound care specialist contact information was provided in the event of an emergency.

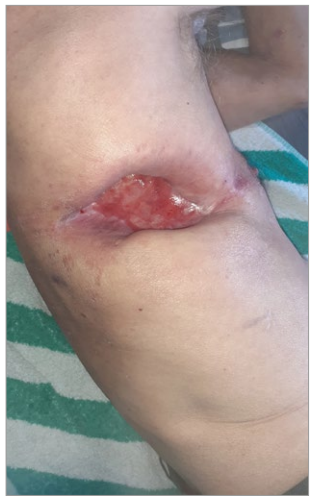
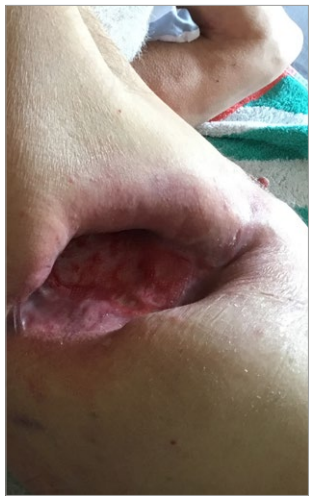
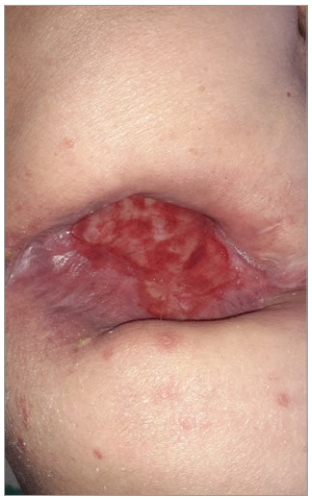
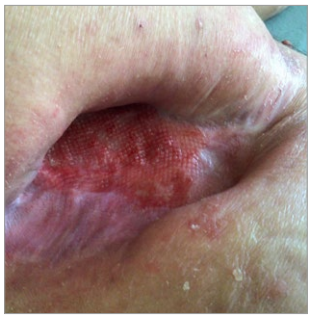
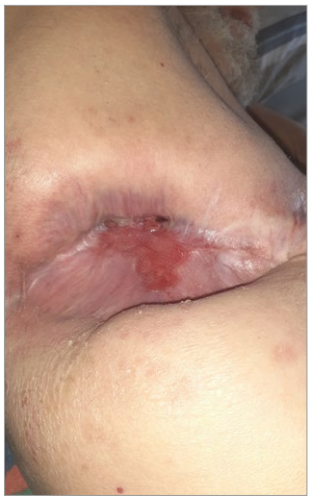
The wound care specialist developed the shared wound care plan with the patient and his wife to include:

- Cleansing the wound with gauze and tap water, applying CUTICERIN◊ Low Adherent Surgical Dressing (Smith+Nephew), covering with an absorbent dressing and applying OPSITE◊ FLEXFIX Transparent Film Roll (Smith+Nephew) as per local protocol.
- Instructions on how to change the dressing if there is an increase of exudate
- If psoriasis returned, treat it as before with a steriod cream or neutral cream
- Weekly telephone contact with the patient and the wife would send a photo of the wound
- Details on how and when to contact the district nurse/wound care specialist (i.e. if the signs and symptoms of acute wound infection develop, such as swelling, redness of the surrounding skin, raised temperature of the skin, increasing pain).

Final comments

The patient and his wife felt well supported by the team to participate in shared wound care and did not feel the need to contact the district nurse during the evaluation period — although it was reassuring for them that they would be able to if the need arose. Both were pleased with the patient-practitioner relationship that developed, and their growth in self-confidence and improvements in wound progression.

The shared wound care discussion guide facilitated the patient and his wife to become more independent in their care. For them, knowing that help and clinical support was easy to access at any time contributed to their willingness to participate. The patient and his wife were happy to continue to participate in shared wound care.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
				
Wound condition: 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges. The wound measures 11 cm (length) x 8 cm (width).	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition**: The wound has improved significantly and has reduced in size to 4 cm (length) x 3 cm (width).
Patient/carer feedback: The patient and his wife have agreed to participate in shared wound care, particularly for the day-to-day wound care.	**Patient feedback:** Shared wound care is going well. The patient's wife is feeling confident and has observed wound progression. There was an increase in exudate levels; therefore, an extra dressing change was necessary.	**Patient feedback:** The patient is thankful for his wife's involvement, and both have more self-confidence with the shared wound care than at initial presentation.	**Patient feedback:** The wound is reducing in size. The patient was able to go out on a family trip for the first time in months.	
Clinician feedback: Both the patient and his wife appear capable of carrying out the shared care wound measures introduced.	**Clinician feedback:** Wound healing is progressing. The patient and wife sound apprehensive about carrying out wound care themselves but are committed to the shared wound care plan.	**Clinician feedback:** Both patient and his wife sound enthusiastic and the shared wound care continues as before.	**Clinician feedback:** The shared wound care plan is going better than expected. It is great to hear that the family are more committed with their involvement.	**Clinician feedback:** The patient and his wife are more self-reliant; there are no reports of pain, and the patient is more confident to leave the house.

CASE 6: Post-operative wound

Ben Elsinga, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

An 86-year-old woman had a wound over her right anterior lower leg following the removal of a squamous cell carcinoma. The operation was successful, and all the wound surfaces were clean of malignant cells. For the first fewweeks following surgery, the patient was under strict supervision from the dermatologist. During this time, the dermatologist's advice was to treat the wound with INTRASITE◊ Gel Hydrogel Wound Dressing (Smith+Nephew) and wear compression stockings. Compression stockings were prescribed as the patient had been diagnosed with chronic venous insufficiency before the operation.

The patient requested specialised home wound care for assistance with the dressing changes as she did not feel confident or comfortable with the wound care plan advised by the dermatologist. She indicated that she would prefer a 'simpler' dressing plan that would require less frequent changes and products that were easier to use, so that she and her husband could manage the wound themselves. The patient had no previous experience of shared wound care as this was their first wound. The patient was confident and self-reliant to apply and remove their compression stockings.

The wound had been present for 6 weeks and measured 7 cm (length) x 4 cm (width) x 0.5 cm (depth) and the wound bed comprised 30% granulation tissue and 70% slough. The wound edges were advancing and the periwound skin was described as slightly swollen. The surrounding skin was very dry. There were no signs of wound infection or wound pain, and there was a moderate level of serous exudate. The clinician expected the wound to be healed within 2 months as there were no barriers to healing, except for some minor oedema.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The fact that the patient called in the home care team to ask for a simpler dressing plan shows that the patient and her husband were aware that they could be involved in shared wound care. The patient wanted the minimum amount of involvement with professional health carers and a simple wound care plan. The clinician agreed that a simpler wound care plan is possible, and with a few instructions, the patient and her husband could do the wound care by themselves. The patient had sufficient understanding of the cause of the wound, and understood the symptoms of infection and importance of reducing the risk of wound infection. The patient had a 'good support system'; her husband would be involved and accompany her for hospital appointments.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient and her husband as 'self-sufficient', see **Box 1**. The patient and her husband were both physically and mentally capable to carry out the wound care.

Box 1. Description of 'self-sufficient'

- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient and carer were capable and willing to perform the wound care.

Lifestyle change: It was not necessary for the patient to make lifestyle changes at this time.

Patient-practitioner relationship: The patient was given guidelines on when to contact the wound care specialist and how to reach the district nurse.

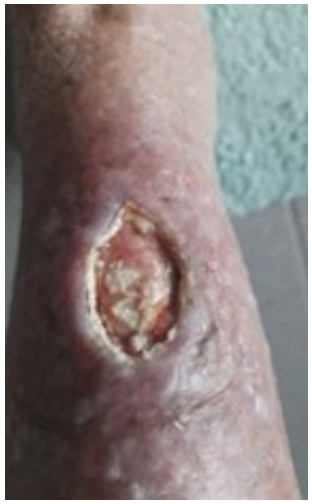
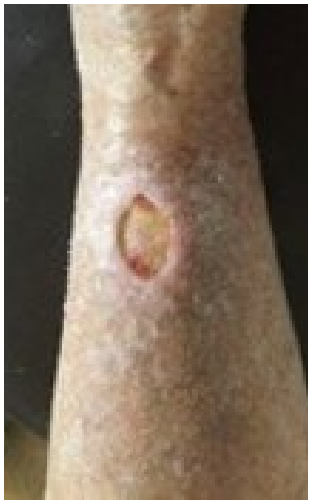
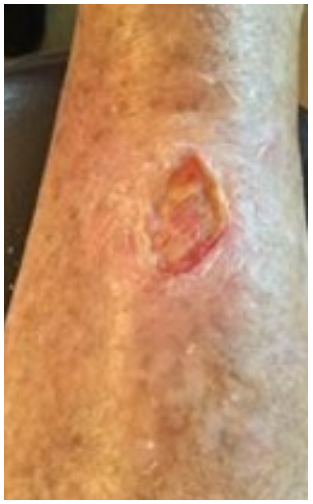
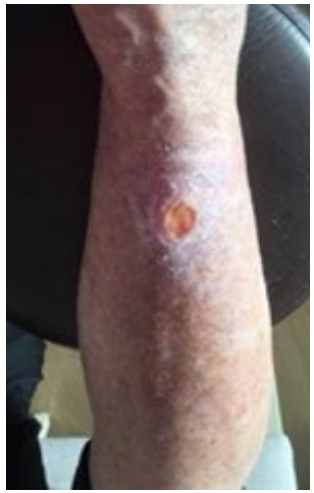
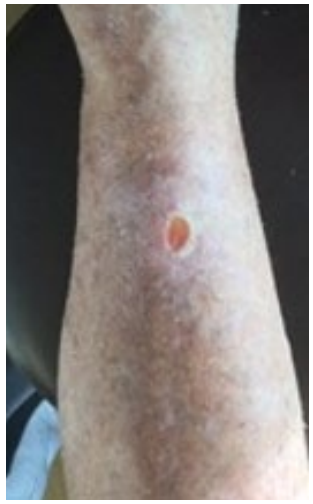
The wound care specialist developed a wound care plan with the patient and her husband to include:

- Twice weekly gentle cleansing of the wound with gauze wetted with tap water
- Application of ALLEVYN◊ LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Wearing of compression stockings
- Weekly telephone contact with the wound care specialist, and the patient's husband will send a photo by e-mail every week. If the patient and her husband had questions, they were to contact the district nurse in the first instance. If signs and symptoms of infection appeared, they were to contact the wound care centre (e.g. swelling, redness of the surrounding skin, raised temperature of the skin, increasing pain).

Final comments

The patient wanted clinical support and to be involved in shared wound care with minor telephone supervision. She was pleased that she did not have to wait for the district nurse to dress her wounds. The family stated they received good support and felt that the patient's requests were taken seriously.

The patient was happy that the wound had progressed and was nearly healed over the 4-week evaluation period. The patient, husband and wound care specialist plan to continue with shared wound care. By using the shared wound care discussion guide, it was possible to provide a more personalised care plan tailored to this patient's individual needs.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
				
Wound condition: 30% granulation tissue, 70% slough; no infection; moderate levels of exudate; advancing wound edges. The wound measured 7 cm (length) x 4 cm (width) x 0.5 cm (depth).	**Wound condition:** 60% granulation tissue, 40% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition:** 70% granulation tissue, 30% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition:** 60% granulation tissue, 40% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition**: 70% granulation tissue, 30% slough; low level of exudate; advancing wound edges. The wound has improved significantly and has reduced in size to 2 cm (length) x 1.5 cm (width) x 0.5 cm (depth).
Patient/carer feedback: The patient and husband have agreed to perform wound care themselves.	**Patient/carer feedback:** Patient and her husband are happy to do the wound care themselves.	**Patient/carer feedback:** Patient and her husband are happy to do the wound care themselves.	**Patient/carer feedback:** The patient is positive about the healing process. She has had no concerns conducting wound care.	**Patient feedback:** There was a growth in self-confidence and the patient felt that she has been taken seriously by the wound care specialist.
Clinician feedback: Both the patient and her husband appear capable of carrying out the wound care measures introduced.	**Clinician feedback:** Both seem capable and confident to carry out wound care.	**Clinician feedback:** Wound care and progress is going to plan. No further actions needed. The wound bed is reducing in size.	**Clinician feedback:** The wound care is going to plan. No further actions needed. The wound bed is reducing in size.	**Clinician feedback:** The patient and her husband are fully able to continue to be involved in shared wound care.

CASE 7: Diabetic foot ulcer

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

This case describes a 92-year-old man with type 2 diabetes, heart failure, hypertension and atrial fibrillation. He had a history of diabetic foot ulceration and currently had a diabetic foot ulcer on his left medial malleolus for 6 weeks. The patient lived in an aged care residential home and used a bed cradle at night and an alternating mattress to offload pressure.

The ulcer measured 10 cm (length) x 14 cm (width), the wound bed was sloughy and the wound edges were macerated. The periwound skin was inflamed and very painful (8 out of 10 on the Numeric Rating Scale; 0=no pain; 10=worst pain). The wound was highly exuding and soaked through the dressings.

In the past, the patient would remove his wound dressings and cover the wound with tissues. Several different nurses at the care home had been involved in his care and the patient felt frustrated because each clinician would use a different dressing type. He wanted to attend the specialist wound care clinic for a consistent care plan.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The patient was aware of the concept of shared wound care but was initially reluctant to be involved due to previous poor experiences of wound care. After talking and listening to his concerns, the patient decided he was willing to 'give it a go'. The clinician felt that by being an active participant, the patient would be less likely to remove his dressings and the wound pain could be managed more effectively.

The patient did not want to actively change his dressing, but he could support wound healing by being involved in his diabetes management through diet and monitoring his blood glucose levels. He understood what could happen if diabetes management and good foot care were not carried out (e.g. amputation), and that the wound required frequent attention.

The patient did not have family, friends or informal carers, but the residential care nurses were involved and accompanied him to the wound care clinic once a week. The aged care nurses were comfortable being involved in wound care and were keen to learn the treatment protocol.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as a 'reassurance seeker' (**Box 1**) as he had a long history of ulceration that made him feel uneasy about receiving care. The patient's fear and mistrust of care were the main driver for not being engaging and following the clinician's advice. The main approaches for this individual were to improve knowledge and to address his fears and concerns.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient was reluctant to physically participate in his wound care, but he agreed to leave the dressings in place for a longer duration. The risks of removing the dressing too early were also discussed (i.e. risk of infection and subsequent amputation). ALLEVYN® LIFE Foam Dressing (Smith+Nephew) is designed to remain *in situ* for 5-7 days; however, as the patient was known to remove dressings, twice weekly dressing changes were planned in order to meet his needs. To increase his involvement, the wound care specialist gave clear guidance directly to the patient on how to apply and monitor the dressing so he could check that the correct steps were followed by the aged care nurses. The aged care nurses were also trained to ensure a more consistent care provision.

Lifestyle change: The patient was given a diary to record his diet and he was coached on how to make appropriate lifestyle changes. His footwear was reviewed and changed to a show that was easier to put on and remove.

Patient-practitioner relationship: The patient expressed a lot of fear and limited trust in clinicians to manage the wound. So it was vital to develop an open and honest patient–practitioner partnership. He was educated on the importance of ongoing treatment, prevention of wounds and when to escalate to a specialist according to local protocol. The patient was advised to contact the wound care clinic for any concerns — odour, pain, dressing leaking, not feeling well — and he was reassured that if this situation occurred, he would be prioritised to the wound care specialist.

In discussion with the patient, the wound care specialist developed a shared wound care plan that the aged care nurses could undertake:

- Cleanse the wound with an antimicrobial wound solution and mechanically debride the wound with gauze twice a week
- Cover the wound with ALLEVYN LIFE Dressing. Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)

- The patient would attend the wound care clinic once a week and the aged care nurses would do a dressing change on the second day post clinic visit
- Offload pressure with shoes, and use of a bed cradle and alternating mattress at night.

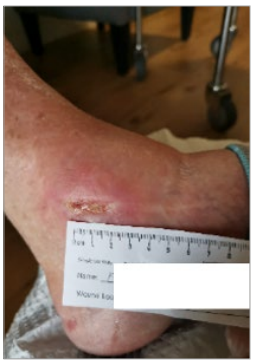
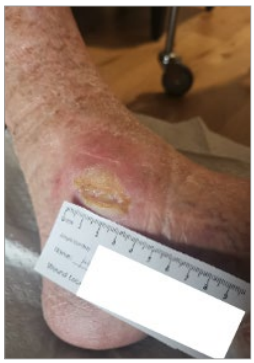
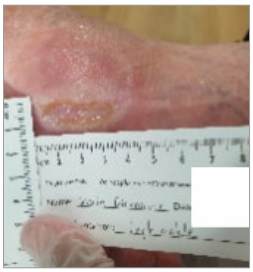
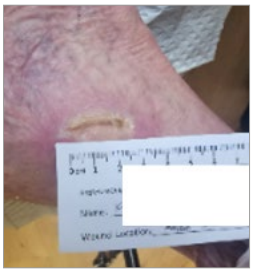
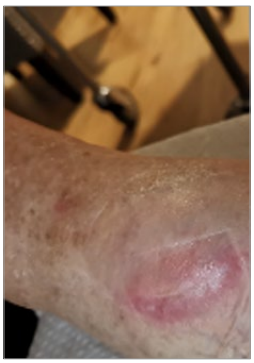
Final comments

Introducing shared care with the shared wound care discussion guide was a great experience for the patient and the aged care nurses. The wound care specialist saw a shift in knowledge of both the staff and patient who both felt they could manage the wound better.

The patient's relationship with staff also became more trusting. The clinician felt this shift in perspective and acceptance was the main reason why the wound healed so quickly.

Throughout the 4-week period, the aged care nurses felt more confident conducting wound care and the patient was empowered to assist at many dressing changes. The patient felt at ease with his wound care because he felt in control of his own body; as a result, his diet improved and his activity levels increased. He especially enjoyed being able to attend to his own dressing change needs and felt supported if he needed assistance.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: The wound bed comprises 5% granulation tissue and 95% slough. The wound edges are non-advancing and macerated. There is a moderate level of purulent exudate that leaks from dressing. Erythema is spreading 3 cm from wound edges, oedema present, dry limbs. Wound pain is rated as high.	**Wound condition:** Erythema and odour remain but have decreased; exudate remains moderate and purulent.	**Wound condition:** Erythema and odour have resolved. Exudate remains moderate of serous consistency. Wounds size has decreased.	**Wound condition:** Exudate has resolved; eschar formation noted. No signs of infection. Dressing changes reduced to once a week.	**Wound condition:** Wound healed and no wound pain. Scar tissue (remodelling phase) remains.
	Patient feedback: Patient noted he was still a little uncertain about the idea of shared wound care, but he liked the diaries, brochures and meetings and felt in control of his care.	**Patient feedback:** Patient noted he was becoming comfortable with the share care approach.	**Patient feedback:** Patient noted he is very happy with shared care and now understands its importance.	**Patient feedback:** The patient was surprised the wound had healed so well given his history of ulceration. Patient noted he has regained his trust in the clinicians to manage his wound care.
	Clinician feedback: It is working well.	**Clinician feedback:** Working exceptionally well, there is a noticeable change in the patient's mindset.	**Clinician feedback:** Great outcome and the patient has shown a real change of care.	**Clinician feedback:** This was an excellent outcome and mindset change not only for the patient but also for the home care nurses who now ensure shared care is used for all suitable patients.

CASE 8: Skin tear

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

An 86-year-old woman sustained a skin tear on her left anterior lower leg when using her electric wheelchair. It had been present for 8 weeks and measured 5 cm (length) x 7 cm (width). The surrounding skin was fragile with dry skin, and an emollient cream was applied to protect the skin.

She had experienced significant falls resulting in fractures and joint replacement surgeries. She lived in a residential aged care home and used a bed cradle at night, limb protectors to reduce the risk of injury, and an alternating mattress to offload pressure.

The registered nurses noted that the patient had no experience with shared wound care and the patient had not been involved in the treatment plan. The wound care specialist was concerned that the current dressing used at the aged care home was causing some trauma to the fragile surrounding skin.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The patient was unaware of the concept of shared wound care. She was aware that her skin was 'paper thin' and dry, which would increase the risk of skin damage. The patient was unaware that the wound could develop into a chronic ulcer if it not managed efficiently from the start.

Initially, she did not want to be involved in day-to-day wound care. The clinician felt the patient had the ability to be more involved in helping to maintain skin integrity and reducing the risk of trauma.

The patient felt comfortable with the staff changing her dressing, but she had some concerns because previously there was a lack of consistency in the dressing regimen, and the registered nurses would change the dressing regimen regularly. The patient wanted all the staff to follow the treatment plan devised by the wound care specialist.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as 'unaware' (**Box 1**), as she was unaware that she could participate in reducing her risk of injury. She had experienced many haematomas and skin tears previously, but the clinician felt she was capable of helping to reduce the risk of skin damage.

3. Identify what the patient can do as part of shared wound care

For this individual, educating the registered nurses at the aged care facility presented an excellent opportunity to deliver more consistent care. Access to an online webinar was provided to staff, which the patient also chose to attend.

Box 1. Description of an 'unaware' individual

- Not very involved in wound care
- Unaware that it is possible to engage more in their care
- Physically and mentally capable but unwilling to participate in shared care.

Wound care: The patient and staff were given an infographic to help them to identify wound deterioration and the signs of wound infection, and they were shown how to perform dressing changes.

Lifestyle change: The patient was given a diary to record and track lifestyle changes. The patient expressed that she was fearful to leave her room due to previous falls and skin tears, so a mobility plan was devised with the physiotherapist to increase her confidence and activity level.

Patient-practitioner relationship: The goal was to develop an open and honest patient–practitioner partnership between the patient, aged care staff and the wound care team. The nursing staff were provided with the contact details of the clinic if the wound deteriorated or there was a change in the patient's condition.

Through discussion with the patient, the wound care specialist developed the following shared wound care plan:

- Ongoing education on skin tear prevention
- Maintaining skin integrity using emollient cream twice a day
- Cleansing the wound with an antimicrobial spray
- Application of a barrier cream to the surrounding skin
- Weekly dressing changes using ALLEVYN LIFE◊ Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Wearing limb protectors to help minimise risk of developing skin tears and haematomas
- Encourage leg elevation
- Provide bed cradle to offload when in bed.

Final comments

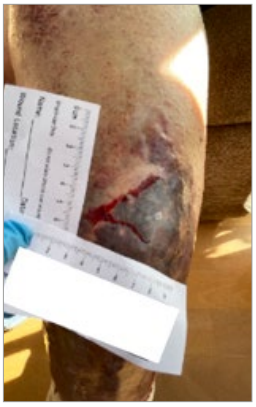
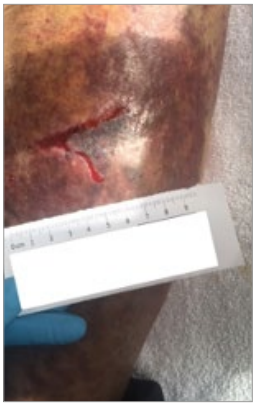
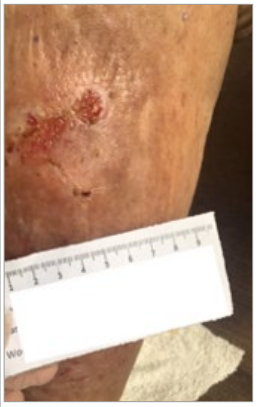
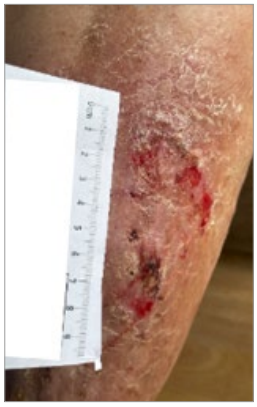
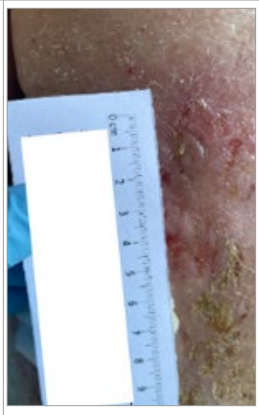
The aged care nurses felt that using shared care discussion guide had given them new knowledge that they would use in the future for other patients with wounds.

Initially, the patient did not wish to be involved in her own care, but

during the process, the patient became more engaged in wound care and was asking more questions and receptive to what she could do to support healing and avoid skin damage.

The patient's involvement helped to improve not only the wound outcome, but also her mindset and quality of life. She became more active and no longer stayed in her room. Her pain had reduced so much so that her pain relief was decreased. Going forward, the patient felt empowered to care for her own wound and to voice her concerns to nurses if they arose.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: The wound bed consists of 100% granulation tissue; the wound edges are advancing. There is a moderate level of haemoserous exudate. There is a haematoma, and the surrounding skin is fragile and dry. Wound pain is rated as 9 out of 10.	**Wound condition:** Wound healing well as the skin flap has adhered to the wound bed. There are no signs of infection and pain has decreased from previous dressing change.	**Wound condition:** Wound is improving and the haematoma has resolved. There is minimal pain during dressing change.	**Wound condition:** Exudate has resolved, eschar formation noted. Dressing changes reduced to once a week.	**Wound condition:** Wound has healed.
	Patient feedback: Patient is happy with the healing of the wound.	**Patient feedback:** Patient is very happy with the wound healing.	**Patient feedback:** Patient is happy with how the wound is progressing.	**Patient feedback:** The patient enjoyed working with everyone on a common goal.
	Clinician feedback: The care plan is working well and the wound is improving.	**Clinician feedback:** Shared wound care with the home care staff is showing very good wound healing results and the treatment plan is remaining consistent. Reassurance has been provided to the patient who is responding well to ongoing updates.	**Clinician feedback:** The care plan is working well.	**Clinician feedback:** It was great to work with the home care staff and patient, providing ongoing support and education.

CASE 9: Skin tear

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

A 77-year-old man sustained a traumatic wound after a fall on his left lateral hand. The skin tear measured 4 cm (length) x 3 cm (width), the wound bed consisted of 100% granulation tissue and there were no signs and symptoms of infection. The nurses at the residential home where he lived performed his wound dressings. Adherent dressings have been used, but there was concern that the adhesive was damaging the surrounding skin on removal. The patient had a history of not following wound care plans.

He has a complex medical history that included dementia, non-insulin-dependent type 2 diabetes, pancreatitis and a cerebral vascular accident in 2018. He was prescribed a high-protein diet and over 10 different medicines, including anticoagulant therapy.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

The patient was unaware of the concept of shared wound care until the wound care specialist mentioned it during the consultation. The specialist and patient both expected the wound to heal. The specialist also hoped to engage the patient with wound care.

The patient wanted to be fully involved in all decisions regarding his care and considered the possibility of changing his own dressings. The clinician felt he was very capable to change his own dressings. In the past, he felt that the residential care nurses would "*just take over care*", and he wanted to show the nursing staff that he was capable.

He had limited knowledge regarding wound care and did not believe it would take as long as 4-6 weeks for the skin tear to heal. He was unaware of the factors that could delay wound healing, such as infection.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as a 'reassurance seeker' (**Box 1**), as he had good dexterity and a willingness to learn more about caring for his wound; he just needed more confidence.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

The main approaches for this individual were to improve his wound knowledge and to address his fears and concerns. Besides the weekly dressing changes, the patient was provided with education about next steps of treatment to relay fears and wounds in the future. Details were also provided to the aged care home nurses.

Wound care: The clinician demonstrated to the patient how to perform the treatment requirements. For this individual, a guide of the signs of a infection and a deteriorating wound were also provided. The patient was coached on the importance of managing wounds early to avoid delays in healing.

Lifestyle change: The patient was coached on following his prescribed high-protein diet and medication.

Patient-practitioner relationship: The goal was to develop an open and honest patient–practitioner partnership with the wound care specialist and to strengthen the relationship between the individual and the aged care home nurses.

The wound care specialist and patient developed the following shared wound care plan:

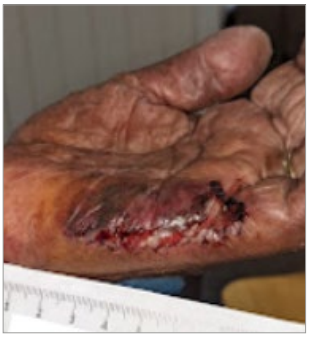
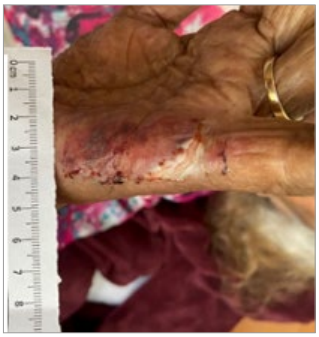
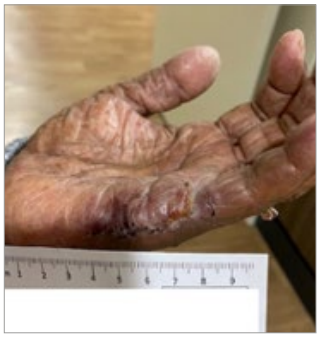
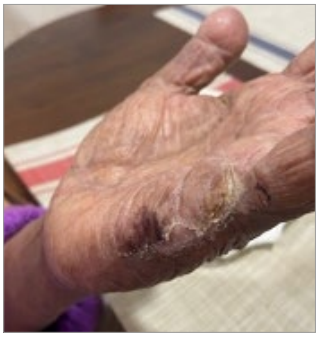
- Cleanse the wound with an antimicrobial spray
- Weekly dressing changes using ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing).

Once he saw how simple it was to manage his wound, he was able to apply the dressings with some assistance before being able to independently attend to his wound. He was advised to contact the wound clinic administration team for any concerns, which would be prioritised to the wound care specialist (e.g. odour, pain, dressing leaking, not feeling well). He was able to contact the administration team via email, phone, text message or video calling.

Final comments

After the 4-week evaluation period, the patient was very happy that the wound had healed and he could return to his usual level of activity. He felt very confident that he could be involved in shared wound care in the future.

His relationship with the aged care nurses also improved as they developed a more trusting and collaborative relationship. Staff were initially nervous to allow him to manage his own wound in case something went wrong. After this experience, they felt more confident that it is possible for patients to be more involved in their own care. They also noted they felt empowered to continue this with other patients.

Wound progression			
Initial presentation	**Week 1**	**Week 2**	**Week 3**
			
Wound condition: The wound bed consists of 100% granulation tissue, and the wound edges are advancing. The surrounding skin is intact, with some bruising identified. There is a moderate level exudate. The wound is very painful to the touch.	**Wound condition:** The wound shows signs of healing.	**Wound condition:** The wound has almost completely healed.	**Wound condition:** The wound has healed. There is some bruising and scar tissue, which will take months to years to fully recover. An emollient cream will be applied to moisturise, as dry skin is more susceptible to injury. Patient noted that the wounded area remains slightly tender if the area is 'bumped'.
	Patient feedback: Patient is now comfortable to attend to his own dressings. Patient is happy with the progress of the wound.	**Patient feedback:** Patient is happy with the progress of the wound.	**Patient feedback:** Patient is happy with wound management and feels more knowledgeable and willing to attend to his own wounds into the future.
	Clinician feedback: The care plan is working and the wound is improving.	**Clinician feedback:** The wound is improving.	**Clinician feedback:** It has bee a good outcome to engage the patient in his own care. The process increased his wound care knowledge, particularly around prevention.

CASE 10: Pilonidal sinus wound

Jan Ryzy, Lead Practice Nurse, Caerphilly, Wales

Wound and patient history

A 29-year-old woman had a pilonidal sinus that was successfully removed 5 years ago. The wound initially healed, but had dehisced on several occasions. In these instances, she received home visits from the community nursing team. The wound had re-dehisced again 7 days ago, and she attended the primary care facility.

The wound measured 4 cm (length) x 1.5 cm (width). The wound bed comprised 50% granulation tissue and 50% red/pink tissue without granulation tissue; the wound edges were described as non-advancing and excoriated. The periwound skin was red and fragile. There was a moderate level of serous exudate. Local infection was suspected due to wound pain (4 out of 10 on the Numeric Rating Scale; NRS; 0=no pain; 10=worst pain), erythema and pus.

Shared wound care discussion guide

1. Awareness: Is the patient aware they can be involved in wound care?

She had no previous experience with shared wound care as it had never been discussed. The patient expected that shared wound care would allow her to change the dressings herself so she would not have to take so much time off work. The patient had the support of her husband who was also willing to be involved in her care.

The clinician felt the patient had the ability to be involved in care. She had a good knowledge of wound care and was willing and motivated to make changes.

2. Which of the following best describes the patient in regard to shared wound care?

The clinician described the patient as a 'reassurance seeker' (**Box 1**). The patient was quite anxious that she would be alone, but the clinician reassured her that she would have regular support and contact from a clinician.

It was felt that regular discussion with the patient regarding shared care should focus on improving knowledge, addressing fears and concerns and improving awareness, including to contact the nurse by phone or e-consult at the first signs of wound deterioration or infection (e.g. pain, redness, exudate, fever).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: Because of the wound location, the patient's husband was coach to cleanse the wound and apply and remove the dressing.

Lifestyle change: The patient had the potential to make lifestyle changes that would improve wound healing, such as nutrition and physical activity to support weight loss.

Patient–practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and empowered to contact the clinician without delay if the wound deteriorated. Contact information was provided according to local protocol.

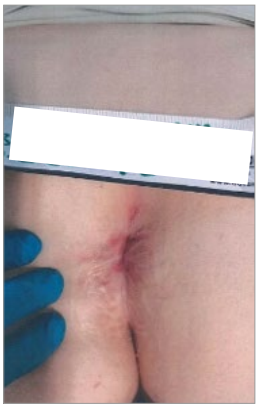
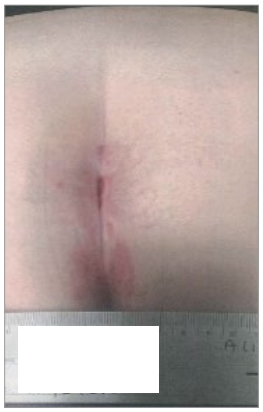
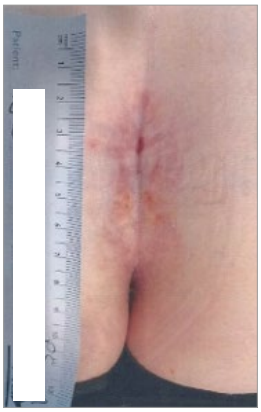
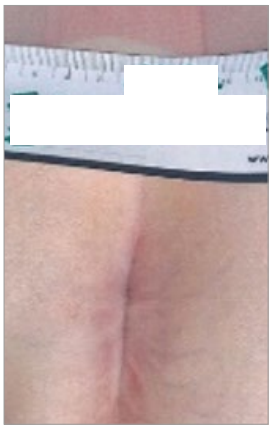
With the patient, the wound care specialist developed the shared wound care plan to include the following steps:

- Remove dressing, cleanse the wound in the shower and dry
- Take a photo of the wound if possible
- Apply ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- The patient was advised to change the dressing twice a week or when indicated on the change indicator if sooner
- Two-weekly phone calls were scheduled with the clinician, but the patient was able to call more frequently if needed.

Final comments

The patient and her husband felt supported by the clinician via the phone or on e-consult. The patient had gained more knowledge about wounds and the healing process. The patient's husband was involved in shared wound care and monitored the level of exudate as per the ALLEVYN LIFE Dressing change indicator. Once the wound healed, the patient was able to return to her exercises. As a result of being more involved in care, the patient did not have to take time off work.

Shared wound care works very well for the willing patient. Person-centred care plans are essential for both the clinician and the patients — poor care leads to poor outcomes. Following this experience, the clinician would consider using the shared wound care discussion guide with other patients and hopes this will become an integrated part of future care.

Wound progression				
Initial presentation	**Week 1**	**Week3**	**Week 4**	**Week 5**
			no image available	
Wound condition: Moderate amounts of serous exudate; slightly raised wound edges; erythema; slight wound pain.	**Wound condition:** Moderate amounts of serous exudate; slightly raised wound edges; erythema; slight wound pain.	**Wound condition:** Improved wound condition and wound size; reduced exudate; slightly raised wound edges; no erythema or wound pain.	**Wound condition:** The wound bed is much improved; and there is a minimal amount of exudate; much less painful.	**Wound condition:** The wound has healed.
	Patient/carer feedback: The patient's husband is proud he has learnt how to apply the dressing appropriately. He can see that the wound is improving and feels supported that should he have any questions or concerns he can contact the clinician.	**Patient/carer feedback:** The patient is happy with how the wound is progressing.	**Patient/carer feedback:** The patient and her husband found shared care very helpful, enjoyed taking control of her care with support from the clinician. She did not need to miss as much work as last time the wound dehisced.	
	Clinician feedback: The patient and her husband are happy to be involved in shared wound care.	**Clinician feedback:** The wound care regimen is working very well for the patient and her husband.	**Clinician feedback:** The wound care plan continues to work well.	**Clinician feedback:** The wound care plan helped to heal the wound.

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