Shared Wound Care Discussion Guide made easy

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Introduction

'Shared wound care' encompasses approaches and interventions that enable patients to participate in care planning and delivery. These shared care practices, including the monitoring and changing of dressings, can transform a patient's role from that of a passive recipient of care to an active participant (Wounds International, 2016). Many nurses who treat patients with chronic wounds are adapting their practice, to enhance patient experience and optimise nursing time, by encouraging greater patient involvement (Kapp and Santamaria, 2017). This Made Easy document discusses what shared wound care means, and how clinicians can be supported to help empower patients and/or their informal carers to become more active in the wound care as appropriate.

What is shared wound care and how does it differ from self-care?

Shared wound care is an approach which encourages patients and/or their informal carers to take an active role in the day-to-day management of their wounds. Following patient assessment, shared wound care is often conducted remotely with the support of a clinician. The benefits of improved patient involvement are well-documented, with shared care practices being successfully adopted among a variety of patient groups, including those with stomas (Ketterer et al, 2021), urinary incontinence (Pizzol et al, 2021) and diabetes (University of Southern California, 2021). In most cases, shared care requires a multifaceted approach to interventions (National Institute for Health and Care Excellence, 2021), including consideration of lifestyle changes, patient and carer education, changes to clinical decision-making and pathways, telemedicine, or potential for varying treatments, whether it be dressing selection, drug therapies or surgical solutions.

It is estimated that 60% of patients with chronic wounds have some degree of involvement in their own wound care (Moore and Coggins, 2021). However, the COVID-19 pandemic has accelerated the burden of chronic wounds and highlighted the need to encourage adoption of a wound-related shared care approach (Moore et al, 2021).

What are the benefits of shared wound care for the patient?

The benefits of participating in shared wound care for the patient include the following (Moore and Coggins, 2021):

- Independence and greater control of their own time and activities of daily living
- Privacy and consistency of care, with less likelihood of meeting different nurses who they are unfamiliar with
- Increased tolerance and acceptance of treatment
- Positive attitude and greater engagement and enthusiasm in their self-care.

What are the benefits of shared wound care for the healthcare professional?

The benefits of implementing shared wound care for the healthcare professional include the following:

- More time available to be spent with patients with extensive wound care needs, and those who are unable to be involved in shared wound care
- Reduced cost for care providers, with fewer and/or shorter homecare visits
- Development of a stronger practitioner–patient relationship, due to shared wound care goals and greater trust in the patient and/or informal carer
- Improved reporting of wound progression and deterioration linked to knowledgeable and engaged patients capable of notifying their clinicians of wound-related changes.

What are the benefits of shared wound care for healthcare organisations/payors?

By integrating shared wound care into a multifaceted approach, there is the potential to release 3.5 billion hours of nursing time globally by 2030 (Moore et al, 2022). This would allow nurses to provide care for more patients with wounds.

Is the shared wound care concept clinically established and/or accepted across the globe?

A survey of over 500 clinicians from Australia, China, France, Germany, Spain, the UK, and the USA identified that 45% of their patients with chronic wounds could benefit from greater involvement in shared wound care (Moore and Coggins, 2021).

There is an opportunity for a standardised approach to promote shared wound care, particularly with respect to identifying individuals capable of participating in shared wound care (Moore and Coggins, 2021).

How can nurses implement shared care practices and what tools and resources are available to them?

The shared wound care discussion guide (SWCDG; **Figure 1**) is a tool for clinicians to use with their patients and/or informal carers to discuss their awareness, willingness, and ability to be involved in shared wound care (Moore et al, 2021). The SWCDG was developed by an international panel of clinical experts and was built on research and guidelines (e.g. Wounds International, 2016; Moore and Coggins, 2021).

Depending on what the patient and/or carer is able and willing to do, key elements of education and coaching can include:

- How to identify likely risks of complication, such as the signs and symptoms of infection
- How to report wound progression
- Who to contact if they have concerns, or the wound shows signs of deterioration
- The steps involved in changing a wound dressing
- Education on the dressings themselves (Wounds International, 2016; World Union of Wound Healing Societies, 2020).

Does leaving a dressing on longer (>2-3 days) lead to better or worse clinical outcomes?

A dressing wear time of 5-7 days is indicated as potentially beneficial for patients by clinicians (Moore and Coggins, 2021) and by patients (Moore et al, 2021). A long-wear advanced foam dressing has been shown to promote wound closure and help lead to improved patient wellbeing (Rossington et al, 2013; Tiscar-González et al, 2021).

Reduced dressing change frequency, and avoiding unnecessary dressing changes, allows for undisturbed healing. Undisturbed healing has been shown to minimise the risk of wound infection and delayed cellular activity that slows wound progress (McGuiness et al, 2004). Additionally, a dressing which can manage exudate and indicate when dressing change is required can yield optimum benefits within a shared care context (Moore and Coggins, 2021).

When considering patient and/or carer responsibilities to monitor and change dressings, what is the recommended approach to training and dressing selection?

Patients have identified that educational support is needed for clinicians to help them and/or their informal carers to participate in shared wound care (Kapp and Santamaria, 2017). Before shared wound care is initiated, clinicians should talk to the patient about their knowledge of their wound, their understanding of shared wound care, and their willingness to be involved – a tool like the SWCDG can help to guide conversation (Moore et a, 2021; Wounds International, 2022).

If the dressing is to be used by patients, it should be easy to take out of the packaging, and easy to apply and remove, especially for people with low manual dexterity. Further, there should be clear instructions for the patient on how to use the dressing including which side of the dressing is applied to the wound bed.

Advanced wound dressings which clearly indicate to patients and informal carers when infection or high levels of exudate are present would be beneficial. This may reduce unnecessary tampering with dressings and wounds, and therefore reduce the risk of infection. The ALLEVYN™ LIFE Foam Dressing (Smith + Nephew) is an example of an advanced wound dressing which incorporates a design feature indicating when a dressing change is needed due to exudate levels (**Figure 2**). The dressing has been shown to be beneficial to both patients and clinicians in promoting wound closure and improving patient wellbeing

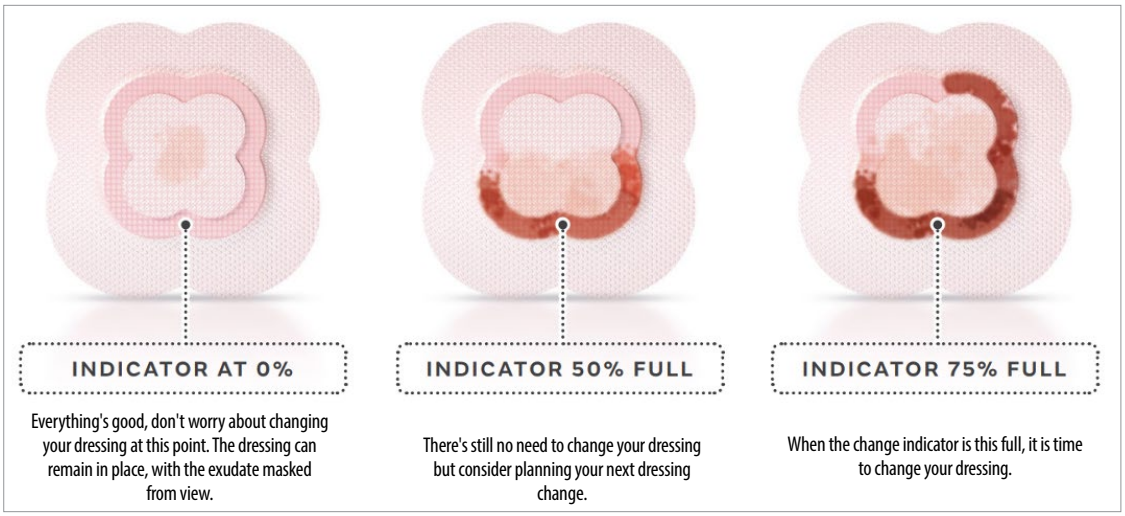

Figure 2: The ALLEVYN™ LIFE Dressing change indicator

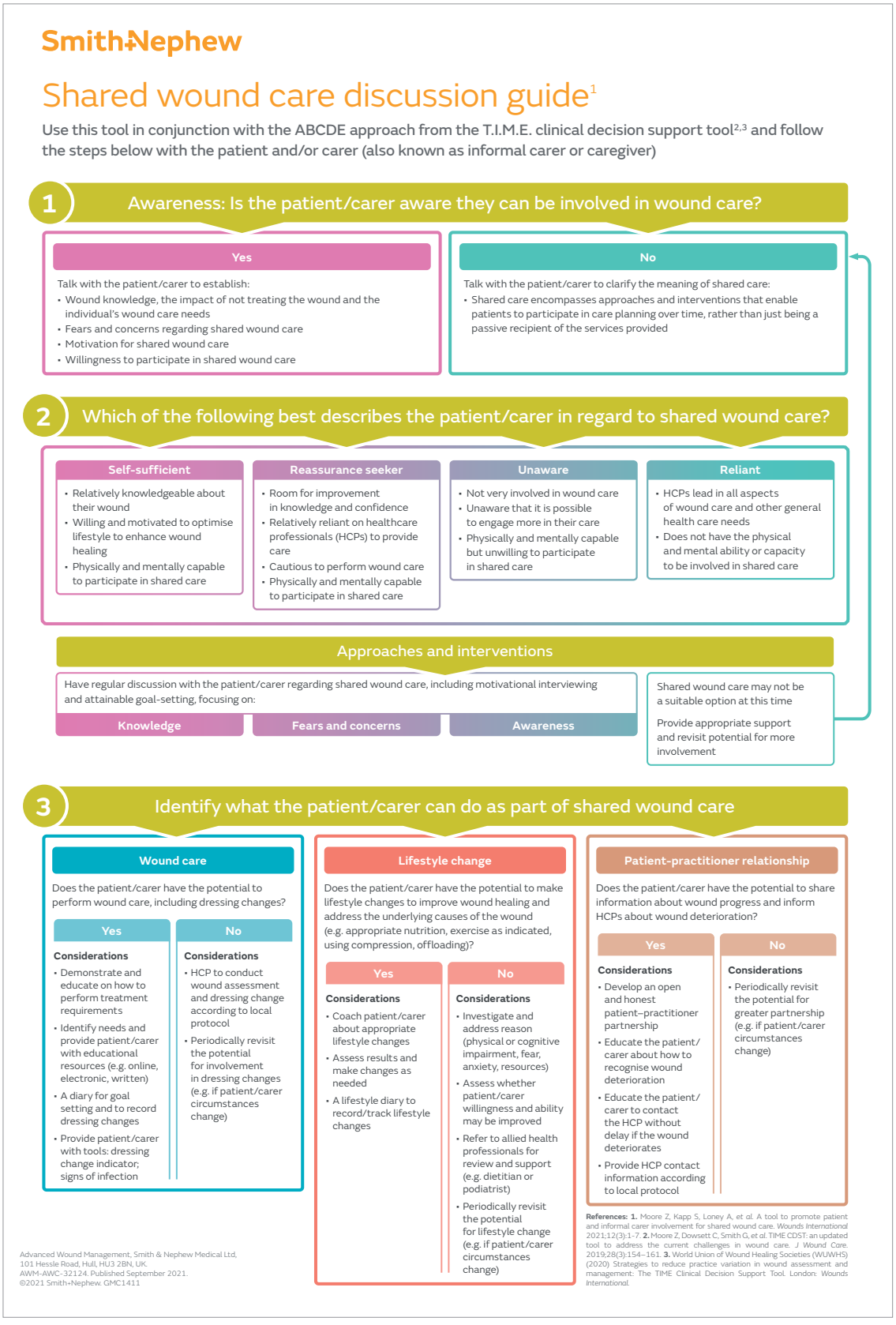

Figure 1: Shared wound care discussion guide

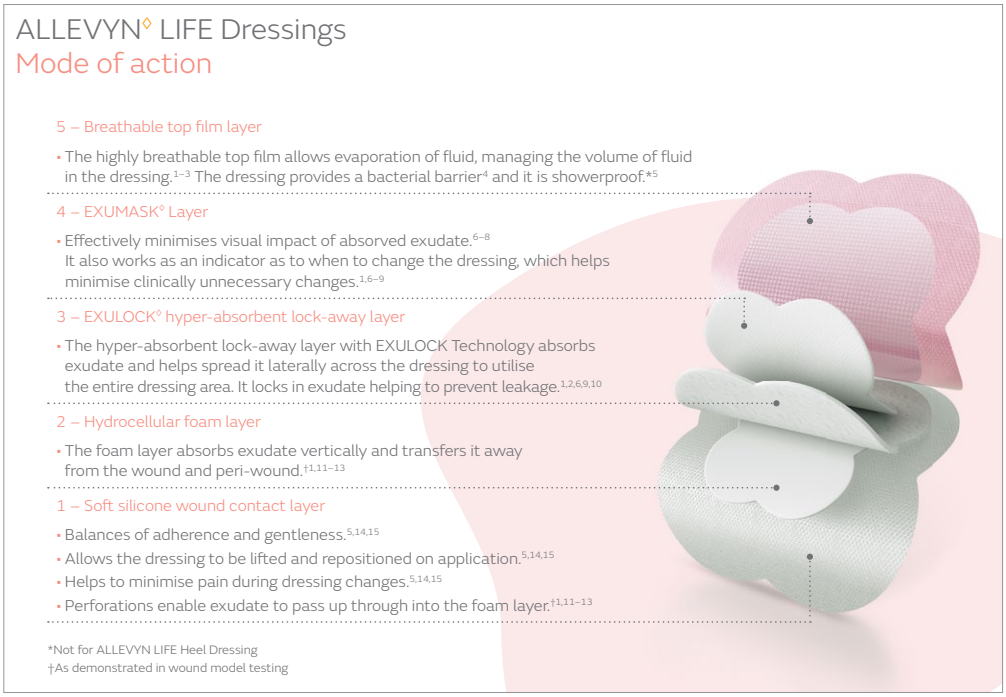

Figure 3: The ALLEVYN™ LIFE mode of action

1. S+N Data on File (2016) Wound Model Testing of New ALLEVYN LIFE Gen2 wcl Dressing using Horse Serum at a Flow Rate Modelling that of a Moderately Exuding Wound. DS/14/303/R
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11. S+N Data on File (2016) Wound Model Testing of New ALLEVYN LIFE Gen2 wcl on a Flat Model with a Moderate Flow Rate of 0.4g/g Foetal Calf Serum. DS/16/144/R
12. S+N Data on File (2019) ALLEVYN LIFE - Wound model testing using horse serum at a flow rate modelling that of moderately exuding wound for 3 days. Internal Report. DS/19/281/R v1
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(Rossington et al, 2013; Tiscar-González et al, 2021). **Figure 3** and **Box 1** show the mode of action and additional features of the dressing.

How do we change practice and promote shared wound care when nurses have been incentivised to change dressings frequently?

Using the ALLEVYN™ LIFE Dressing (Smith+Nephew) as part of a shared wound care approach has the potential to achieve beneficial clinical (Tiscar-González et al, 2021) and economic outcomes (Moore et al 2022). A mathematical model proposes that using long-wear advanced foam dressings within a shared care approach will release 3.5 billion nursing hours globally by 2030 (Moore et al, 2022). Releasing this time has the potential to improve patient quality of life and allow nurses to spend more time where it is most needed, improving quality of care and patient outcomes.

Evidence shows that using long-wear advanced foam dressings reduces time spent on wound dressing changes by an average of 47%, with upper and lower values of 64% and 29% (Stephen-Haynes et al, 2013; Simon and Bielby, 2014; Joy et al, 2015; Krönert et al, 2016; Tiscar-González et al, 2021). Incorporating the most conservative efficiency rating into the model, the calculation estimates that applying such dressings can reduce the time burden of dressing changes by at least 29%. This time saving was factored into the final calculation for potential nurse time savings. See Box 2 for tips on incorporating change into practice.

Box 1. Features of the ALLEVYN™ LIFE Dressing

- Wear time of 5 to 7 days (Simon and Bielby, 2014; Joy et al, 2015; Smith+Nephew, 2016a; 2016b)
- Change indicator to minimise the visual impact of exudate and show patients and clinicians when to change the dressing, helping to minimise clinically unnecessary dressing changes (Rossington et al, 2013; Stephen-Haynes et al, 2013; Simon and Bielby, 2014; Smith+Nephew, 2016c; 2016d)
- Excellent exudate management to prevent leakage (Smith+Nephew, 2012b; Rossington et al, 2013; Stephen-Haynes et al, 2013; Simon and Bielby, 2014)
- Optimal patient comfort (Rossington et al, 2013; Simon and Bielby, 2014)
- Odour control and leak prevention to extend wear times and patient tolerance (Smith+Nephew, 2012a; 2016a; Rossington et al, 2013)
- Showerproof (Smith+Nephew, 2016b).

Is the concept of shared wound care proven to provide positive outcomes from a clinical and patient quality of life perspective?

An international case series was conducted in 2021 to evaluate the SWCDG in clinical practice by five wound care specialists in Australia, Canada, The Netherlands and the UK. The SWCDG

was used during the patient's initial assessment; the individual wound care dressing regimen was devised with the clinician and the patient (and informal carer if present). Where appropriate, the ALLEVYN™ LIFE Dressing (Smith+Nephew) was selected as a primary or secondary dressing.

Across the 10 cases, several positive outcomes were noted by the patient and clinician after using the SWCDG (Wounds International, 2022):

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

The following case study illustrates how the SWCDG can help guide discussions around shared wound care and how the use of long-wear advanced dressings can help support patients and healing.

Are there any risks associated with empowering patients to monitor and/or change their own dressings?

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. Healthcare professionals also have professional responsibilities to protect and safeguard the public and be accountable for safe, person-centred, and evidence-based practice that respects and maintains patient dignity (NMC, 2014). Shared care allows the patient more time to live their life and less time to be focused on the wound. However, this should only be done when it is clinically appropriate to do so following wound assessment and a patient discussion. The patient's capability to be involved in shared care should be regularly reviewed as it can change over time.

Ways to reduce the risk of possible complications include:

- Working together to develop and/or change the treatment plan to help ensure the patient understands the rationale and steps of wound care
- Providing the patient with red flags/causes for concern (e.g. signs of deterioration, wound infection, systemic infection)
- Providing the patient with details of who to contact if they do encounter changes in their wound
- Encouraging the patient to contact the clinician with any concerns or queries they may have
- Using dressings and technology that can alert patients when dressing changes are required.

Conclusion

The SWCDG is a powerful aid to prompt discussion between clinicians and patients regarding knowledge, awareness, and willingness to be involved in shared wound care. The benefits of shared wound care and patient involvement are well-documented with the potential to release 3.5 billion nursing hours globally by 2030, improving patient quality of life through holistic assessment, patient education, and supported self-care. Based on the premise that informal carers form an integral part of the patient engagement process, the SWCDG also extends beyond the patient and provides support for informal carers who may assist with the patient's wound-related care.

Shared care enhances communication between clinicians and patients and supports patients to make lifestyle changes to improve their wound healing, including dietary changes and increased physical activity. Moreover, the SWCDG supports information-sharing, including patient education on how to recognise the signs and symptoms of infection to prevent deterioration and when and how to change dressings. Tools and interventions to promote shared care empower patients to engage in self-care, optimising their quality of life and enhancing their wound healing.

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Case study: Patient with a diabetic foot ulcer (courtesy of Amanda Loney)

A 70-year-old woman presented with a diabetic foot ulcer (DFU) with underlying venous disease on the 1st metatarsal head of her right foot, which had been intermittently present for around 2 years. The patient had a history of diabetes, obesity, congestive heart failure, and kidney disease. The DFU measured 1.9cm (length) x 1.5cm (width) x 0.5cm (depth) and occurred due to shearing, pressure, and friction. The wound bed comprised of 90% granulating and 10% sloughy tissue, and the wound edges were described as non-advancing. The periwound skin was slightly inflamed, extending out from the wound edges by 2-3cm.

Her foot was very warm to the touch and there were moderate levels of serous exudate. Wound pain was rated as 2 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain).

The patient had prior experience of being involved in shared wound care. She would regularly change her own dressing and visited her clinic occasionally to receive dressing supplies. However, a lack of communication with nurses and physicians regarding her wound status between visits caused her DFU to deteriorate over time. Moreover, the patient rarely wore her offloading device unless she saw significant wound deterioration and was only occasionally wearing compression.

The patient's individual care needs were sharp debridement on a regular basis, treating local infection, ensuring a moist wound healing environment, and utilising offloading as much as possible. Wound closure was the main expectation of treatment for both the patient and clinician. A further treatment goal for the clinician was education in regard to reducing the risk of reoccurrence. The patient was very open to the idea of shared wound care and expressed a willingness to participate.

Shared wound care discussion guide

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

The patient was keen to be more involved in wound care; however, her husband/carer did not wish to be involved in dressing changes. The patient had very little understanding of dressings and their purpose. Regardless, the patient understood that without dressing, her wound would deteriorate and this would increase the likelihood of her foot becoming infected and eventually amputated. The clinician felt that the patient required more education on dressings, dressing change frequency, and the use of offloading devices and compression therapy.

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

The clinician described the patient as a 'reassurance seeker'. The patient had been heavily engaging with her own wound care previously; however, there was room for improvement concerning her knowledge of wound care, appropriate dressing selection, and when to communicate with healthcare professionals to avoid wound deterioration. Touching base with the patient once a week with photos would focus on improving her knowledge and awareness. Regular communication via text, email, and phone conversations was established. The patient also received a handout on the signs and symptoms of local and deep tissue infection, which would require antibiotics.

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 receiving guidance, being given educational resources, and being provided with a dressing change indicator and tools to increase her awareness on the signs and symptoms of infection.

Lifestyle change: The patient had the potential to make lifestyle changes to improve wound healing. Coaching involved informing the patient and her carer about appropriate lifestyle changes and assessing these results to make changes as needed.

Patient-practitioner partnership: An open and honest patient-practitioner partnership was developed. The patient was also supported to recognise the signs of wound deterioration and contact the clinician without delay if the wound deteriorated.

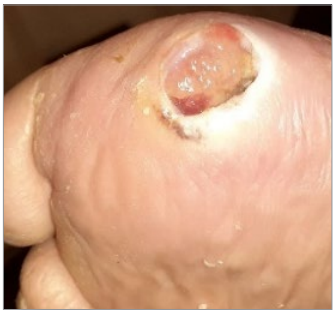
The shared wound care plan included:

- Cleansing the wound with normal saline and application of a soak with Vashe Wound Solution to the wound bed
- Rinsing with normal saline
- Application of ACTICOAT Flex with the ALLEVYN™ LIFE Foam Dressing (Smith+Nephew)
- Application of a two-layer TubiGrip bandaging system from the toes to the knee to reduce swelling and encourage the patient back into her own compression offloading shoe (to redistribute pressure across the foot) and her air cast walker
- Details on when and how to contact the clinician were supplied. The patient was instructed to reach out the clinician if she had any concerns about her wound and if it showed signs of deteriorating.

Final comments

The patient felt she had an improved awareness and knowledge of dressings, how to promote wound healing, and how to reduce the risk of wound deterioration. She was very appreciative of her clinician's quick responses to her concerns and of their patient-practitioner relationship, which had developed. The clinician also believed that the patient was sufficiently equipped with the knowledge, skill, and judgement to better attend to her wound care. Moreover, the ALLEVYN™ LIFE multi-layer dressing seemed to provide some off-loading and protection from pressure, shear and friction where other foam dressings had shown no improvement in the past. Maceration was down and wound healing had occurred.

Wound progression in brief

Initial presentation	Week 4	Wound condition
		The wound had closed, and a new thin layer of epithelial tissue was covering the entire wound bed. No drainage or signs and symptoms of infection. Wound size: 0.5cm (length) 0.4cm (width) 0.1cm (depth)