Editorial

# Wound management in residential care – we can do better

**Woodward M**

There were around 169,000 people living in residential aged care (RAC) in Australia at 30 June 2011, nearly all on a permanent basis. In New Zealand, almost one million bed-days monthly are occupied by people in residential care. In Australia, about three-quarters (77%) were aged 80 and over and 57% were aged 85 and over. Women tended to stay longer than men, at an average of 168.1 weeks compared with 109.5 weeks, and most residents left due to death (91%). The average completed length of stay for permanent residents in 2010–11 was 145.7 weeks. Fifty-two per cent of residents are reported to have been diagnosed with dementia, but it is likely that the true prevalence of dementia is closer to 85%. Maintaining good nutritional status and healthy skin can be challenging, and incontinence and immobility are common. Care is largely provided by health care professionals, supervised by nursing staff rather than directly by nursing staff. Access to timely medical care is not infrequently problematic, and resources to maintain health and treat conditions such as chronic wounds are often in limited supply.

Against this background, improving the prevention and management of wounds, and in particular pressure injuries is, arguably, even more difficult in residential care than in hospital and community settings. Mandy Pagan and her co-authors, in their work published in this issue of the journal, have reviewed wound management programs in residential care and distilled some very practical and useful wisdom. We don't just dump an off-the-shelf package of education and other resources and expect the problem to be fixed. Indeed, it may be that a significant proportion of staff have limited literacy in English and much of the training and follow-up will not be fully understood. To increase programme success, the authors have shown that it is important to pre-assess facilities to determine the readiness for change, the organisation's culture and potential programme barriers and facilitators. Evidence-based pressure injury programmes in RAC are recommended to increase staff knowledge and skill to improve resident care and reduce pressure injury rates. Continuous quality improvement methods provide an adjustable and effective process to plan, implement, evaluate and sustain programmes in RAC facilities. Audit and feedback is an essential element to motivate staff and monitor adherence. It is vital to allow a sufficient period of time for programmes to be implemented, measured and evaluated. No program will be successful if it does not engage, involve and update relevant key stakeholders, including administrators, managers, nurses, health care assistants, doctors, residents and family before, during and after implementing programmes. The use of multiple programme interventions is recommended to increase the success of implementation and outcomes. The use of staff incentives when developing, implementing and evaluating programmes will likely increase staff engagement. Flexible, realistic and achievable programmes that anticipate staff turnover, and resident and administrative work demands, are more likely to succeed. Project teams and/or champions are recommended to build staff confidence, skills and leadership, and facilitate self-sufficiency and programme ownership. Enrolled nurses and health care assistants should be considered in these roles to work alongside registered nurses. These roles need to be supported by managers and staff alike. The use of expert, external mentors that assist facilities and staff to identify practice issues, develop programmes, model and guide best practice should be considered. Finally, programmes should be implemented into compulsory staff training schedules and ensure evidence-based updates are routinely provided for current and new staff.

This sensible and research-based approach should improve wound management and, in particular, reduce the incidence and prevalence of pressure injuries, but is it enough? We also need to consider adequate resourcing, including funding for pressure-relieving surfaces and wound dressings, and funding specialists in wound care to attend and provide advice on particular residents. There should also be access to funding to allow staff to attend external educational seminars on wound management. Finally, a major incentive is tying external funding to the quality of care, based on indicators such as the incidence of pressure injuries and the duration of wounds, including venous leg ulcers and skin tears.

However we achieve it, we need to do even better for the large number of predominantly older people in Australia and New Zealand, and indeed the whole region, who are in residential care, usually in the last two to three years of their life. This is a time that carries numerous stresses and burdens — poorly managed and preventable wounds should not be a part of this final stage of life.

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