A patient-centred wound management clinic: theory put into practice

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Abstract

In 1996, lack of wound management services within the north and western suburbs of Melbourne was highlighted by the number of bed days devoted in one hospital to a single diagnostic related group (DRG); the then North West Hospital, a rehabilitation and aged care facility, funded 7,050 bed days to the treatment of leg ulcers alone. The mean average length of stay was 51 days. This observation formed the catalyst for the successful submission by the campus to develop and implement an age-specific wound management clinic at the North West Hospital – now known as Melbourne Extended Care and Rehabilitation Service – Parkville Campus. This paper will discuss the aims and objectives of the clinic, analysis of clients referred to the service and examples of how theory has been linked to the practical application of this clinic.

Primary Intention 2001; 9(2) 68-72.

Introduction

One of the main barriers to optimal wound management occurs when the chronological age of a client rather than their functional assessment takes priority with respect to management strategies and outcomes. This ageism by health professionals and patients themselves can be viewed as a contributing factor for older people in relation to optimal wound healing management and services. Such stereotypes are based primarily on prejudices and myths [1]. Ageism devalues older people; reduced equity and access to health care in comparison to services offered to younger population is often the outcome [2].

Multidisciplinary practice in wound care is generally implemented in hospital settings but, according to Franks [3], is under represented in the community due to reduced access and resources. Australia has seen the establishment of services which focus on those in the community with wounds [4], for example, high risk foot clinics for people with diabetes.

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One such example is the Melbourne Extended Care and Rehabilitation Service (MECRS) wound management clinic.

MECRS clinic aims and objectives

In May 1998, the MECRS wound management clinic was commissioned. Access to the clinic include MECRS inpatients and older community dwellers via medical referral. The primary aims of the clinic are:

- to provide an inter-disciplinary tertiary referral service providing wound management services to inpatients and community dwelling elderly people;
- to optimise the management of wounds and so minimise the number of inpatient bed days utilised.

Secondary aims and objectives are:

- to improve the capacity of services to the largest hospital network in Melbourne;
- to provide a venue for the education of health care professionals;
- to provide a vehicle for education and support to referring general practitioners;
- to provide an opportunity for clinical research;
- to document the financial and improved quality of life (QOL) benefits for clients and their families.

The clinic's multi-disciplinary team includes:

- two medical consultants (rehabilitation and geriatrician);

- one registrar (rehabilitation, when available);
- two clinical nurse consultants;
- one clinical nurse specialist;
- two pharmacists;
- one podiatrist;
- one dietitian;
- three researchers.

Whilst team members practise within their specific discipline, overlap with respect to knowledge, skills and expertise occurs and is encouraged via a 'level playing field' approach. Each team member is valued. Wound management decisions occur in atmosphere of consultation, comprising of team members, clients and significant others. Gray[5] highlights that an underlying philosophy which respects the value, talent and creativity of individual members of a team is central to the clinical development model. This model was initially developed by nurses to provide processes which could improve the multidisciplinary approach to patient care and was initially implemented in the practice of pressure ulcer management.

Referral process

All patients attending the MECRS wound management clinic require a medical referral. As part of this process, the clinic referral form must be completed by the referring medical officer or general practitioner prior to the clinic appointment. The clinic has placed considerable emphasis on this process.

In addition to the universal information pertaining to relevant medical and social history of each client, the form also requests the collection of other clinical parameters, including:

- Full blood examination (FBE);
- Random glucose;
- HbA1c (glycosulated haemoglobin indicating glycaemic control for diabetes over the past 3 months);
- Biochemistry, including albumin levels;
- Histopathology and bacteriology (where appropriate);
- Imaging results (when appropriate).

Clients attend the MECRS clinic often at high costs (for example, taxi fares) and at high effort. Therefore, what appears to be a basic process of collecting useful clinical data and indicators has proven beneficial with respect towards ensuring that each appointment is productive for all stakeholders. The clinic team also views the referral form as a useful teaching tool for other health professionals, in particular, general practitioners.

Clinical statistics

By the end of August 2000, 79 patients had attended the clinic. The number of clinic contact visits made by clients range between 1 and 30 visits. The average age of clinic clients is 79.3 years. On face value, this half day, weekly clinic would appear to have an exceptionally low throughput of clients. However, such numbers actually reflect the complexity of patients referred. Length of consultations are also highly variable, lasting anywhere between 20 minutes to more than 2 hours in length. This indicates the flexibility of service delivery provided by the clinic. Generally, most new consultations require 60-90 minutes and review consultations average 40 minutes. The clinic therefore limits the number of client bookings in order to provide flexible review schedules.

Co-morbidities add complexity to wound management in older people. The common co-morbidities of clients presenting to the clinic (n=79) identified include:

- 29 per cent of clients have cognitive impairment;
- 30 per cent of clients have cardiac disease;
- 22 per cent of clients have hypertension;
- 28 per cent of clients are known to have diabetes;
- of those clients experiencing incontinence, more than half have double incontinence.

With respect to the diagnosis and location of wounds, half of the clinic's clients presented with a leg ulcer. However, of concern, was that 43 per cent presented with at least one pressure ulcer (often in addition to leg ulceration). Skin tears represented 11 per cent of wounds referred. Actual wound numbers have not been recorded as some clients have presented with wounds too numerous to accurately count (Figure 1).

Other issues

A variety of other issues have been identified by the clinic team as warranting attention. The notion of 'compliance' or the perception held by some health professionals of 'non-compliance' can occur in older clients primarily for three reasons:

- the monetary costs of wound products to a group of individuals where many live below the poverty line;
- cognitive impairment, i.e. dementia;
- conflicting management strategies, i.e. when health professionals external to the clinic and without

communication with clinic staff change the dressing regimen.

At all times, the team attempts to address these issues. With respect to the monetary costs of dressing products, strategies to reduce costs to a minimum are paramount. For example, the use of incontinence products as a secondary dressing has proved a useful and cost effective way to control exudate. Asking the fundamental question of whether or not a wound can be healed helps formulate realistic treatment goals. Therefore, the goal of wound management for some of our clients is not always wound healing, but rather wound maintenance and client comfort, particularly if a client is moving towards palliative care.

Choosing wound products that blend into skin colour or can be camouflaged is useful for the client who has a cognitive impairment especially if frequent dressing removals are performed by the client. Socks, trousers and bike pants under dresses and pantyhose can increase the difficulty for self-removal of dressing products.

When clients are first reviewed by the clinic, where and with whom clients reside with and what services they utilise is of interest to clinic staff. Of the 16 clients living at home alone, 15 require support services for their wound care. Yet nearly half of our clients who live with a spouse or other family member do not use external health visiting services (Figure 2). Staff at the clinic are concerned that approximately 40 per cent of hostel residents who attend the clinic are devoid of nursing services, relying on untrained and unregistered health care workers to perform dressing changes.

QOL is an issue attracting more attention by health professionals and researchers working in wound management. Intensive wound treatment strategies in older people may not necessarily improve QOL for the individual. Health is measured by older people in terms of their participation, their involvement and their enjoyment in society, rather than in the absence of disease [4].

Case studies

The following case studies may assist to illustrate the complex psycho-social issues dealt with by the clinic.

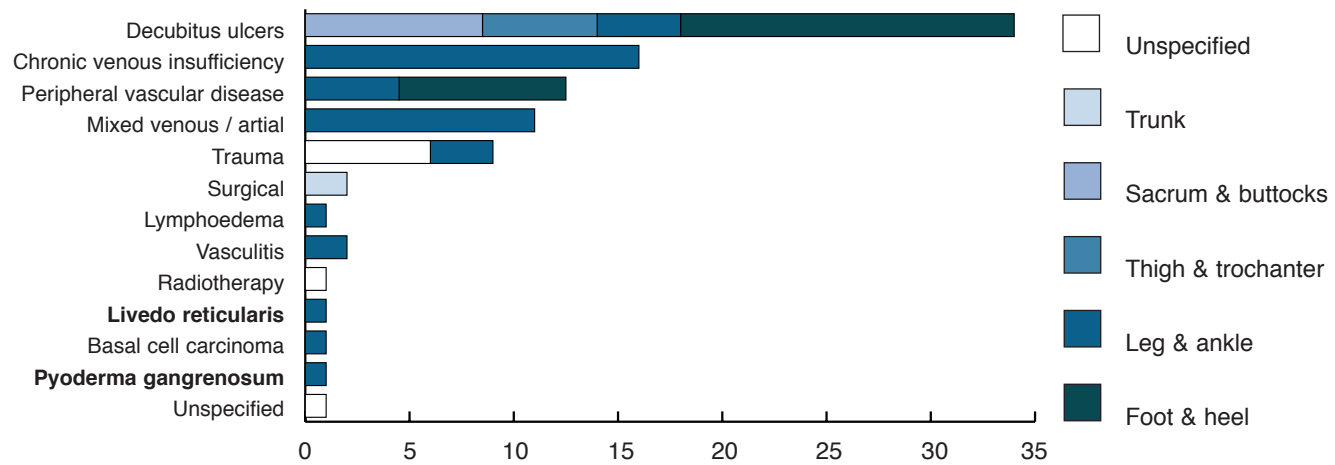
Case study 1

Ms M, a 90 year old unmarried lady was first referred to the clinic 2 years ago. The initial referral was instigated by staff from the nursing home in which Ms M's 108 year old mother resided. Staff at the nursing home were concerned with respect to Ms M's appearance, nutritional status and leg ulcers. The nursing home provided Ms M with lunch each day she visited her mother and, through a conscious process of rapport building, began to review her leg dressings. At this stage, Ms M's general practitioner continued to dress the ulcers daily with combine and 'blueys'. Ms M had not been registered for an aged pension, nor would she allow any health or government officials through her front door.

At Ms M's first clinic appointment, her large leg ulcers, which were completely covered with green slough and producing copious amounts of exudate, had been present for more than 10 years. Whilst Ms M had become climatised to their profound offensive odour, she had ceased taking any form of public transport following the humiliation of watching all passengers quickly disembark due to the ulcer odour.

Investigations included the taking of a detailed history, ankle brachial index (ABI), wound swabs, photography and

Figure 1. Diagnosis & location of wounds.



measurements. A diagnosis of venous leg ulcers and concurrent pseudomonas infection was made. Although Ms M's ABI was normal, high graduated compression therapy was not recommended due to the infection.

The primary factor to be addressed was the issue of how daily dressings could be achieved without visiting nursing services entering Ms M's house. Using a problem solving approach, members of the clinic team, in conjunction with Ms M, communicated and liaised with several stakeholders including the general practitioner, nursing home staff, Royal District Nursing Service and the community support services located at MECRS. The strategy chosen proved to be very successful. Each day during her lunchtime visits at her mother's nursing home, the district nurse would review and redress Ms M's ulcers.

Improvement was observed until Ms M fell over at home and developed trochanter pressure ulcers after spending more than a day on the floor. Months of hospitalisation resulted. During this time, Ms M's pressure ulcers healed, her nutritional status and cognition improved and hostel accommodation was found.

Ms M's leg ulcers were partially healed, initially using Aquacel™ and Profore™ and are one quarter their original size. Possibly they may never fully heal, however, they have a much reduced affect on her QOL. Ms M's bi-lateral venous leg ulcers are currently managed with Jobst ulcer care stockings™, with visiting nursing services redressing the ulcers three times a week using Exudry™.

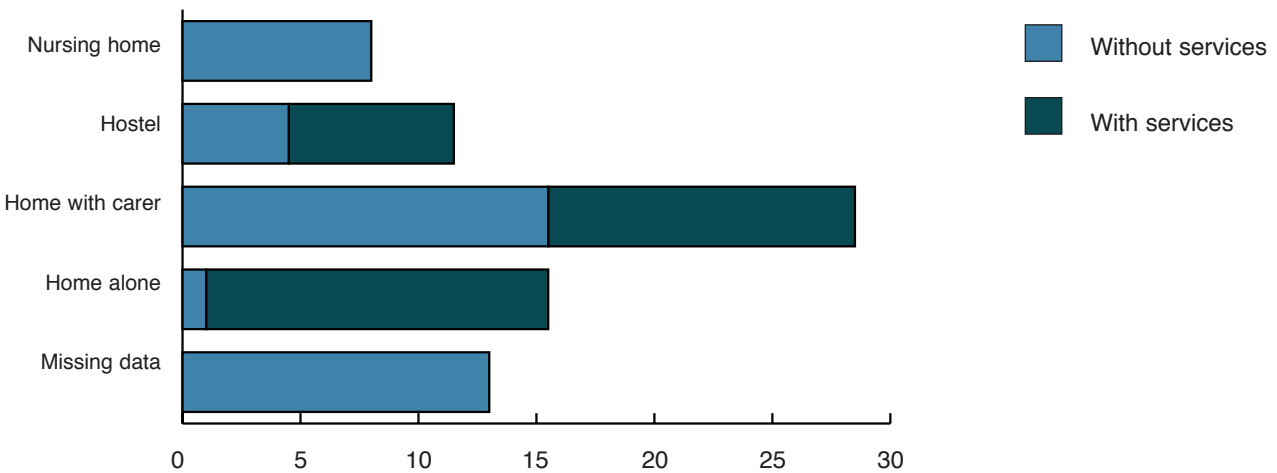
Case study 2

Mr G, an 85 year old gentleman, was first reviewed by the clinic in January 2000. He had experienced a series of strokes and this, combined with Parkinson's Disease, had severely diminished his mobility. After developing a heel pressure ulcer in his nursing home, Mr G's family refused a vascular surgeon's recommendation for amputation. Mr G's general practitioner referred him to the clinic.

Dressing (daily hydrogel and foam) and pressure relieving recommendations were made to nursing home staff with respect to the management of Mr G's heel ulcer. These recommendations were not implemented by the nursing home for reasons which remain unclear. Following review by the clinic of Mr G 2 weeks later, further deterioration was observed, including new ulceration to both hips and sacrum (later determined to be as a direct result of the administration of large doses of sedatives by nursing home staff resulting in complete immobility) and non-compliance to heel dressing regimen (combine). Mr G's new symptomatology indicated systemic infection was present. The clinic was able to facilitate inpatient admission into MECRS.

During the first month, it was thought that Mr G may not recover from his septic state. In addition, other issues apart from Mr G's direct wound management needed to be addressed by the clinic team during his hospitalisation. The clinic worked with the inpatient inter-disciplinary team providing support, expertise and continuity of care. Mrs G had found the entire process of Mr G's illness harrowing. Part of Mr G's healing progress included Mrs G's healing, that is, providing an avenue for her to work through feelings of guilt, anger and sheer helplessness. This role was shared between the clinic staff and hospital unit staff. The hospital unit social worker was able to assist Mrs G to find a new nursing home for her husband. His wound completely healed by August 2000 and, with regularly physiotherapy, he now walks up to 30 metres with a frame.

Figure 2. Place of residence.



Conclusion

Chronic wounds occur in older people for a variety of reasons and factors that affect healing are numerous. Identifying those factors and implementing strategies to overcome some of these barriers takes time and resources. Low volume wound management clinics may not be the 'bean counters' idea of a highly productive or successful service.

The two case studies presented are not designed to illustrate our 'worst' or most problematic clients. They are representative of the complex issues presented to a clinic of our nature. Wound management in older people is multi-faceted. A multidisciplinary approach that is client-focused promotes continuum of care.

This clinic may not be viewed as being 'successful' if success is measured only by the through-put of numbers, healing times or cost per episode of care. The clinic team would argue that the provision of quality care and service does not come cheaply, nor should older people with wounds be short-changed. However, deficient from the team are other allied health professionals including a social worker, physiotherapist and occupational therapist, due to insufficient funding.

Patient-centred care in a wound management clinic, where theory is applied into practice, is not just about wound outcomes. It is about life outcomes for one of our most vulnerable groups in society.

References

1. Stein Irene (ed). Aged Care: A Contemporary View. Royal College of Nursing, Canberra, 1999.
2. Nay R & Garratt S. Nursing Older People: Issues and Innovations. MacLennan and Petty Pty Limited, Sydney, 1999.
3. Franks Y. Healthy alliances in wound management. Journal of Wound Care 1999; **8**(1):13-17.
4. Fitzpatrick L, Edwards F & Tennant J. Establishing a high risk foot care clinic. Primary Intention 1997; **5**(2):12-17.
5. Gray B. Developing a model for clinical practice. Journal of Wound Care 1996; **5**(9):428-432.

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