Chronic wounds: treating the cause rather than simply covering it with a dressing

A nurse-led national wound care strategy aims to banish assumptions about ‘chronic’ wounds

By Jennifer Trueland

Una Adderley was one week into her first community nursing post when she met the patient who would shape her career. The woman had leg ulcers, and it was the horror of what the young nurse saw – and the helplessness she felt – that ignited her passion for wound care.

‘I had never seen legs like it,’ she recalls. ‘They were terrible – there were open sores from the knees down, they were weeping, and they were infected. The patient was ill and living in deprived circumstances. And what shocked me was that it wasn’t clear what we could do. She actually died from leg ulcers...’
If you don’t know what’s causing the wound, develop skills in wound care that are appropriate to the area you work. Skin is the largest organ in the body and all clinicians should know the basics of how to look after it, how to clean wounds and how the body heals. Make sense of the research evidence. Don’t assume everything you are told is right – develop a healthy scepticism and don’t take everything at face value. Unbiased reports in plain English (such as plain language summaries of Cochrane reviews) are useful.

- Prioritise treatments for which there is strong evidence of benefit, such as compression therapy for venous leg ulcers, rather than reaching for treatments for which there is little evidence, such as antimicrobial dressings.
- Develop good relationships in your local health and care system and have a shared understanding of the local wound care pathways and protocols. This may prevent people ‘falling through the gaps’ and chair of Legs Matter, part of the problem lies with the terminology. ‘When people view a wound as chronic, what does the “chronic” mean? It means long-term, non-healing. But many of these wounds, particularly on the lower legs, do not have to be chronic,’ she says. ‘They can be wounds that heal within a normal healing trajectory, if the underlying pathophysiology is addressed.’ She gives the example of a patient who has a supposedly chronic wound that could be caused by a variety of conditions. ‘If you have underlying venous disease and then you have venous ablation and compression therapy in place, those wounds are going to heal,’ she says.

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Lesley Carter, nurse and Age UK clinical lead professionals and practice...
done anything special. It’s because I have appropriately assessed them, diagnosed their underlying pathophysiology and treated it. So that’s what’s caused the wound in the first place, whereas many clinicians simply focus on how to manage that wound. ‘That’s the wrong way round.’

Dr Atkin says that even clinicians often believe that chronic wounds will not heal. ‘We need a whole-system change, to look at these wounds with fresh eyes and review their healing potential from day one – rather than allowing them, even expecting them, not to heal.’

Transforming outcomes
She is optimistic that the wound care strategy – she is leading on the lower limb workstream of the programme – will help make this transformation happen. ‘We talk about the National Health Service but in wound care there’s no “national” standardisation of the wound care process,’ she says. ‘It can be provided by multiple specialties, for example in nursing or podiatry. It can be in multiple locations such as walk-in centres, community nursing centres, specialised leg ulcer services and so on. And each of those individuals will be looking at different pathways of care.’

The new strategy intends to provide clear clinical navigation tools to show exactly what should happen to the patient at each stage, and who should be assisting them. ‘We’ll never be able to standardise [completely] because of commissioning arrangements, but the individual assessing the patient should have a minimum set of core capabilities.’

The psychological impact of wounds should not be underestimated, says Jacky Edwards, who chairs the surgical wound stream of the programme and is a consultant nurse in burns at Manchester University NHS Foundation Trust. Her service is unusual in that it has a set pathway, which is followed consistently for all patients, and because psychologists are an important part of the multidisciplinary team. Patients are referred for the level of psychological support they require – some will be struggling to come to terms with scars, while others may be experiencing post-traumatic stress disorder as a result of burns.

She believes the absence of a national pathway – and the lack of shared understanding about wounds and their impact – has contributed to inconsistencies in treatment. ‘Even locally, we try to send patients out on the treatment pathway and the district nurses ignore it, so much so that we have to stop the pathway completely or manage the patient ourselves.’

Urgent issue for at-risk groups
People with diabetes are among the biggest group affected by wounds that do not heal and are 20 times more likely to have to undergo amputations.

Diabetic nurse specialist Dan Howarth, head of care at Diabetes UK, says: ‘Most foot ulcers can be treated successfully but many aren’t treated at all. Around the UK, there aren’t the foot protection services there should be.’

Age UK’s clinical lead professionals and practice, Lesley Howarth, wants to raise awareness of the issue, which disproportionately affects frail and older people.

‘People think wounds are inevitable in older people. Older people and their relatives don’t know how important it is to keep an eye on those little nips and cuts and strange coloured spots – particularly with diabetes,’ says Ms Carter, a nurse.

‘People are also reluctant to go to the GP, but then if they do get a diagnosis there can be a problem because there’s a whole lack of standardised treatment.’ This has a profound effect on the lives of older people, she adds. ‘These wounds are smelly, they’re painful, and they leak; people can’t walk, they can’t sleep, and they get depressed.

‘We need standardised treatment. We can’t have older people not going places, not doing things, because they have a wound that smells.’

Jennifer Trueland is a health journalist

The Legs Matter coalition is working to increase awareness and action on lower leg and foot conditions

‘It’s not reinventing the wheel’
Emma Williamson, practice nurse manager at Angel Hill Surgery in Bury St Edmunds, Suffolk, is proof that nurse leadership can transform wound care in general practice.

The winner of the wound prevention and treatment category of the RCNi Nurse Awards 2019, she set up a comprehensive wound service for people with leg ulcers, leading to hugely improved treatment times and outcomes. Most patients’ below-the-knee wounds heal within six weeks.

When Ms Williamson came to set up the practice’s leg ulcer service, she looked at best practice guidance (including from NICE and the RCN) and found that while her nurses were following most of it, there were inconsistencies. ‘What we do now is see patients as if they are new – and make sure we have ticked every box, every time,’ she says. ‘I’ve not reinvented the wheel, but it just works.’

Having previously worked in the community, Ms Williamson was aware that wound care wasn’t always what it should be. ‘There was nothing formalised about how we heal these people or prevent them from getting an ulcer in the first place,’ she says. ‘The best bit is nipping problems in the bud.’