

The shared wound care continuum: Factors that influence a patient's preference and suitability for shared wound care

Authors:

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Shared wound care encompasses practice interventions that facilitate interested and capable patients to take a more active role in care planning and delivery, such as the monitoring and changing of dressings. Clinicians report that up to 45% of patients may be suitable for shared wound care approaches, and up to 51% may be willing. This article examines factors that may influence patient preference for shared wound care and establishes a shared care continuum for suitability. This article demonstrates how shared wound care can benefit all patients' experiences regardless of where they sit on the shared care continuum, and how practitioners can facilitate shared wound care approaches.

There has been a consistent shift towards patient-centric care (Seppänen, 2019); involving a holistic view of healthcare, the collaboration between practitioner and patient, and flexibility of care aligned with patient preference (Lindsay et al, 2017).

Patient preference in wound care is clear. Patients want wound care that provides a quicker, less painful healing trajectory with minimal hospital time, and wound dressings that are tailored to the patient's individual needs, such as good exudate management and odour control (Corbett and Ennis, 2014; Eriksson et al, 2022). While the underlying cause of a wound must first be addressed, many of these requirements can be met through long-wear advanced foam dressings such as ALLEVYN™ LIFE Foam Dressings (Smith+Nephew). These offer fast healing times (Rossington et al, 2013; Smith+Nephew 2016a, 2018), minimised pain during dressing changes (Vowden et al, 2011; Rossington et al, 2013), and good exudate, leakage and malodour control through its hyper-absorbent lock away core and masking layer (Rossington et al, 2013; Simon and Biellby, 2014; Smith+Nephew, 2012, 2020).

Patient preference around delivery of care is more complex. There are some patients

who will always choose or require to be a passive recipient of care, with their healthcare professional directing and performing all wound care duties (Corbett and Ennis, 2014). These patients who are likely to remain reliant, are typically physically and/or mentally unable to participate, and have high levels of trust and dependency on their clinicians (Moore et al, 2021b).

Over the past three decades, however, there has been an increase in the proportion of patients who prefer active participation in their wound care decision-making (Chewning et al, 2012; Corbett and Ennis, 2014). And in some cases, where patient preference for shared decision-making or care has been overlooked, practitioners have reported a decrease in patient adherence, increased mental and physical burden on caregivers, and a lower quality of life (Squitieri et al, 2020).

Shared wound care builds on shared decision-making to involve the patient in practical tasks such as the monitoring, reporting, and changing of wound dressings. Clinicians estimate that up to 45% of patients with chronic wounds may be suitable for shared wound care, in which they are included in both decision-making and day-to-day wound management (Moore et al, 2021a). Beyond the suitability of patients,

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clinicians also report that up to 51% of patients may already be demonstrating a high level of 'willingness' to participate more actively in their wound care (Moore et al, 2021b).

This model of care, whereby patients are involved in changing and monitoring their own dressings, could release an estimated 3.5 billion nursing hours globally by 2030, when adopted alongside long-wear advanced foam dressings, equating to 3 hours per week per nurse (Moore et al, 2022). This time could also be used to benefit patients not suitable for shared care approaches. By allowing practitioners to maximise their patient-centric care by practising shared care with those who prefer it, it simultaneously offers more time with those patients with more complex needs or more reliant relationship preferences (Moore et al, 2021a).

Like patients, practitioner preference will affect implementation of shared care, and the use of released time will vary. Nurses face significant pressure, resource constraints, and a limited time for professional development (International Council of Nurses, 2021). There is an increasing requirement for non-wound specialist nurses to manage patients with chronic wounds, often without the appropriate level of training and support (Blackburn et al, 2019). The aim of this article is to demonstrate how shared wound care can benefit all patients' experience wherever they may sit on the shared care continuum. This continuum refers to patients with differing levels of suitability and willingness to participate in shared care practices, from patients who are completely reliant on their practitioner for their wound management, to self-sufficient patients, who with training and guidance are able and interested in managing

their own wound on a daily basis.

Challenges facing patients living with chronic wound care

Chronic wounds currently place a significant burden on healthcare care systems and this will only be exacerbated by the ageing population and increasing number of comorbidities (Lindsay et al, 2017; Olsson et al, 2019; Guest, 2021).

Chronic wounds often severely impact patients' quality of life (Olsson et al, 2019), physical and mental health, work, and relationships. Informal carers can also be significantly affected by the burden of chronic wounds (Miller and Kapp, 2015).

Shared wound care may offer solutions to some of the patient's most critical challenges through ongoing engagement, education, and empowerment (Moore et al, 2021b).

Physical health

Pain and reduced mobility are the most frequently reported problems for patients living with chronic wounds (Kapp et al, 2018; Olsson et al, 2019; Tiscar-González et al, 2021). This pain often relates to exudate management and dressing changes (Atkin et al, 2018), so a shared care approach that reduces dressing change frequency through exudate control is likely to reduce patient pain.

Strikethrough and physical discomfort can contribute to clinically premature dressing changes within a shared wound care approach. Patients report that visible exudate on the wound dressing is the most influential factor for their decision to change their own dressing, as shown in Figure 1. More than half of patients also say that they feel discomfort (52%) or

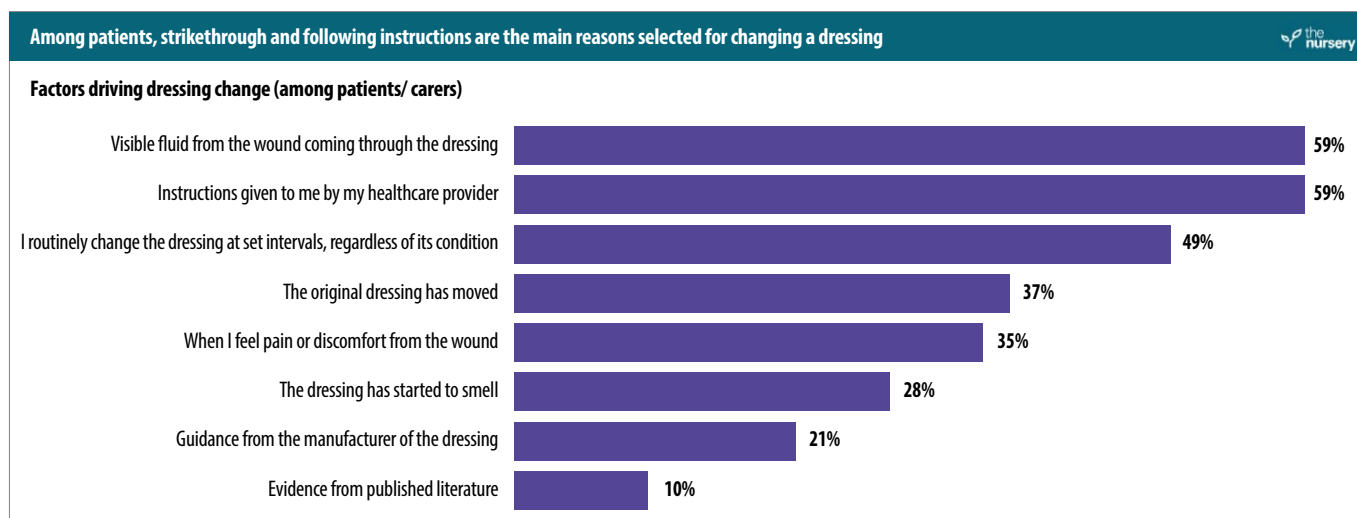


Figure 1. Factors influencing dressing change among patients and/or carers (The Nursery, 2022)

anxiety (55%) if their dressing becomes too saturated with exudate (The Nursery, 2020). Strikethrough, while visually unpleasant, does not always indicate a dressing requires immediate changing and advanced wound care features such as the EXUMASK™ Change Indicator have been shown to reduce these potentially unnecessary dressing changes.

Carrying out instructions set by the healthcare provider is the second-most influential factor for patients, suggesting that a change of approach within the practitioner-patient partnership can help reduce unnecessary dressing changes. Approximately half of patients with chronic wounds (49%) also report preferring a dressing that can be left in situ for 5 to 7 days (The Nursery, 2021). When shared care is established using ALLEVYN LIFE long-wear advanced foam dressings to reduce the number of dressing changes, the patient will typically be involved in other aspects of their wound care, as described in Box 1. If pain or any potential complications are of concern to the patient, they are encouraged to contact their wound care specialist.

Mental health

The pain associated with chronic wounds can contribute to further physical problems, such as increased sleep disturbances, and be correlated with poor mental health (Renner and Erfurt-Berge, 2017). An estimated 30% of patients with chronic wounds suffer from anxiety and/or depression, and the risk of depression increases with the duration of the wound (Renner and Erfurt-Berge, 2017). Patients engaged in shared care have experienced noticeable changes in attitude, feeling more empowered, positive, and enthusiastic about their treatment (Moore et al, 2021a).

Work, relationships, and overall quality of life

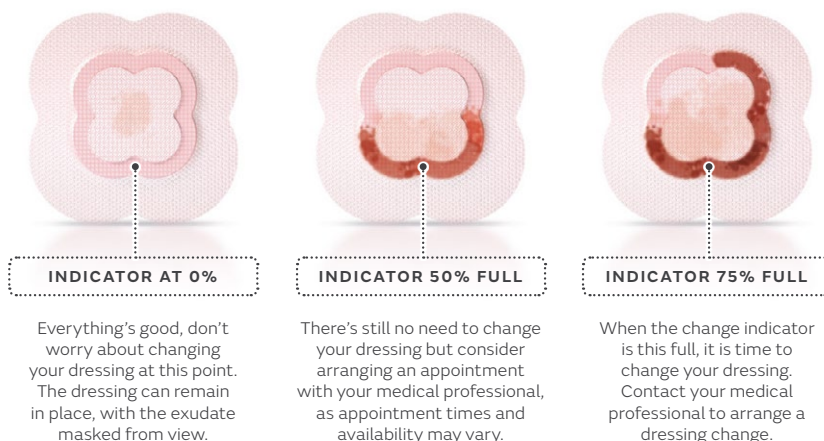
In addition to anxiety and depression, social isolation and shame are reported by patients living with a chronic wound (Lindsay et al, 2017; Platsidaki et al, 2017; Renner and Erfurt-Berge, 2017; Kapp et al, 2018; Tiscar-González et al, 2021). Scheduling at-home visits can be disruptive, and practitioners recognise the need to minimise the impact on a patient's daily life

Box 1. An example of a shared wound care plan using ALLEVYN LIFE Foam Dressings for up to 7 days (Wounds International, 2022)

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

- Cleansing the wound
- Using ALLEVYN LIFE Foam Dressings 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. dressings should be changed depending on the condition of the wound and surrounding skin, or when exudate covers 75% of the EXUMASK Change Indicator. Consider changing if: the exudate covers more than 50% of the change indicator, the exudate has 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 patient's daughter
- Details on when and how to contact the wound care specialist if the wound deteriorated (i.e. if any signs and symptoms of acute wound infection develop, such as swelling, redness of the surrounding skin, increasing temperature of the skin or increasing pain)

Here's a helpful diagram to show you when to get your dressing changed:



(Kapp et al, 2018; Seppänen, 2019).

Over a quarter of wound patients see friends and family less, and a third can't work full-time (Wounds UK, 2018). Studies have also found that the indirect costs or productivity losses due to a chronic wound can be substantial and often related to sick leave or early retirement (Kapp et al, 2018; Olsson et al, 2019). As a third of patients with chronic wounds are now aged 65 or younger (Guest, 2021), this financial impact of chronic wounds is only set to increase.

Shared care, however, does not necessarily mean fewer interactions between practitioner and patient, but that a practitioner assesses and trains a patient on shared wound care techniques, and then continues to support the patient remotely, often through telehealth services (Sen, 2021).

Alternatively, the patient may receive the same frequency of in-person visits, but they may be shorter in duration or provide the practitioner with greater time to dedicate to other factors, such as holistic care or managing comorbidities rather than routine dressing changes (Moore et al, 2021a).

This flexibility with scheduling offers both patients and practitioners increased independence and convenience (Kapp and Santamaria, 2017). Of those patients currently involved in their wound management, 43% say they adopted a more active role in their care to reduce the number of visits to a healthcare setting (The Nursery, 2021).

Nearly half of patients (46%) say they chose shared wound care in order to lead a more 'normal' life, with 46% also reporting it would make them less of a burden to healthcare systems (The Nursery, 2020).

These benefits can be seen across chronic wound types, with shared wound care having a positive impact on wound healing and recurrence, mood, sleep, quality of life, and pain when treating wounds such as leg ulcers (Abu Ghazaleh et al, 2019), diabetic ulcers (Aghakhani et al, 2020), and pressure injuries (García-Sánchez et al, 2019).

Patient selection and suitability

A patient's suitability for shared wound care must be assessed from two perspectives. Firstly, whether the patient has the appropriate willingness, knowledge, relationship with their practitioner, and informal support system to benefit from a shared care pathway (Moore et al, 2021b). Secondly, whether the patient's wound is suitable for a more 'hands-off' clinical approach, with consistent reports of a healthy wound bed,

being infection-free, moisture-balanced, and free from maceration (Blackburn et al, 2019).

As shared wound care extends beyond shared decision-making to include shared caregiving, the right combination of decision-making skills and wound assessment is crucial. Clinician wound assessments can directly impact patient outcomes and healing trajectory, at its best creating a positive patient experience, and at its worst contributing to infections or delayed healing (Blackburn et al, 2019).

Tools have been created to assist clinicians in both assessing a wound: The T.I.M.E Clinical Decision Support Tool (CDST); and assessing a patient's behavioural suitability for shared care: the shared wound care discussion guide (SWCDG) (Moore et al, 2021b).

The T.I.M.E CDST has been shown to increase non-specialist wound practitioners' confidence and ability to manage chronic wounds, creating consistent care and identifying potential risk factors or complications more quickly (Blackburn et al, 2019). The tool allows clinicians to assess patients' needs holistically, bring in appropriate multi-disciplinary teams, control or treat underlying barriers to wound healing, and decide treatment priorities (World Union of Wound Healing Societies, 2020). This cyclical process enables practitioners to manage factors that may negatively impact a patient's quality of life, such as malodour, by providing guidance on treating underlying infections. This can support wound healing to the point where shared wound care and long-wear advanced foam dressings may be appropriate.

The SWCDG determined four behavioural factors to consider when deciding if a patient is suitable for shared care, based on an international survey of global perceptions around involvement in wound care of patients and informal carers:

- Patient support system - can the patient care for themselves? If not, is there a carer capable or willing to take part in shared wound care? (Kapp and Miller, 2015; Moore et al, 2021b)
- Knowledge and understanding - does the patient or caregiver have the appropriate knowledge and skills to participate? If they don't, can they be trained? (Wounds International, 2016; Moore et al, 2021b)
- Willingness to engage - a patient can refuse to participate or opt out at any point (Moore et al, 2021b)
- Patient-practitioner relationship - shared wound care relies on good communication between patient, carer, and practitioner (Wounds International, 2016; Moore et al, 2021b).

These markers were used by clinicians to estimate the proportion of patients at different stages of suitability along the shared care continuum and assign classifications. Moore et al (2021b) defines and quantifies these patient types as the following;

- Self-sufficient (40% of phase 2 survey cohort): patients who are knowledgeable and able, likely to have an established support group and should discuss their knowledge with their practitioner
- Reassurance-seekers (11% of phase 2 survey cohort): patients with low self-perceived knowledge, confidence, or ability, where practitioners should focus attention on discussing their concerns
- Unaware (42% of phase 2 survey cohort): patients who may lack understanding and willingness to the required level, who require practitioners to regularly discuss awareness of shared care
- Reliant (7% of phase 2 survey cohort): patients who are unsuitable for shared care, who may benefit from more support with their daily wound management.

Combining both cohorts that show willingness for shared care, self-sufficient and unaware, it is estimated that 51% of patients with chronic wounds are willing to take a more active role in their daily care (Moore et al, 2021b).

Patient classification can change over time as the patient becomes more or less able to participate. For example, a patient may be a 'reassurance seeker' but, through improving the relationship with their clinician, they may be able to move into the 'self-sufficient' category and become more independent. Inversely, a patient considered 'self-sufficient' may lose confidence in their ability to care for themselves due to comorbidities and move towards 'reassurance-seeking' (Wounds International, 2016, 2022; Moore et al, 2021b).

Supporting patient involvement in shared wound care

Monitoring ongoing patient engagement and attitude towards shared care is important, for even the most self-sufficient of patients. Successful patient empowerment is dependent on three factors: patient autonomy, patient rights, and patient literacy (Beger, 2006). Patient empowerment can increase a patient's capacity for critical and informed decision-making, as seen in diabetes care (Corbett and Ennis, 2014).

Patient autonomy refers to the ability to act intentionally with understanding (Beger, 2006).

Patients with chronic wounds may experience reduced autonomy, anxiety, or depression which may inhibit compliance or decision-making; and physical mobility may prevent adequate delivery of self-care. To enable a patient to remain autonomous, communication between practitioner and patient is key. Removing communication barriers, regularly revisiting assessment tools such as the T.I.M.E CDST and the SWCDG, and ensuring remote telehealth technology will enable practitioners to support patient autonomy and monitor their position on the shared care continuum [Box 2].

Patient rights, in relation to patient empowerment, encompasses acknowledgement of a patient's preference and the right to preventative and beneficial medical treatment (Beger, 2006). The shared care continuum allows practitioners to centre care around patient preference, tailoring involvement to the individual's ability, willingness, and interest and offer the clinical benefits of undisturbed healing where appropriate.

Patient literacy refers to the patient's understanding and knowledge of their condition and the treatment required (Beger, 2006). Patients who are well informed about their condition and the treatment often go on to take a more active role in the shared care process (Stacey et al, 2017). Patient training can be done in person and online using decision aids such as videos, audiobooks, or online interactive activities (Wounds International, 2016; Stacey et al, 2017).

These patient factors that can contribute to the success of shared care implementation can also be supported by products and dressings that facilitate a shared care regime. Selecting the most appropriate products to facilitate a shared care approach is essential. For example, ALLEVYN LIFE Advanced Foam Dressings:

- Feature the unique EXUMASK visual change indicator to assist with patient monitoring and changing of their dressing
- Use EXULOCK™ technology to absorb exudate, prevent leakage, and control malodour
- Minimise premature removal, can be left in place for 5-7 days to further reduce dressing changes, and offer 'very good' or 'excellent' exudate management (Lisco, 2013; Stephen-Haynes et al, 2013; Simon and Bielby, 2014; Smith+Nephew, 2016b, 2016c).

There are barriers to the implementation of shared wound care, such as wounds that are too complex for self-care (Simon and Bielby, 2014;

Box 2. List of factors to consider for patient involvement in shared wound care (Wounds International, 2016; Moore et al, 2021a)

- Patient's overall health status
- Understanding of their condition and treatment
- Motivation to participate in treatment
- Motivation to adhere to treatment and undertake lifestyle changes
- Mental/physical capability
- Previous experience of treatment
- Availability of family or non-professional carers to support shared care
- Patient-carer-clinician relationship

Moore et al, 2021b), a lack of informal carers or support networks (Wounds International, 2022), and lack of patient willingness or ability (Moore, 2016). Good communication is often key to overcoming these barriers, but clinicians may lack time to personalise patient training and education (Wounds International, 2016). By using tools such as the SWCDG and the T.I.M.E CDST, clinicians and patients can discuss the appropriate level of patient involvement, and careful monitoring and communication can optimise clinical outcomes and shared care partnerships (Kapp and Santamaria, 2017; Wounds International, 2022).

Conclusion

Ultimately, every patient is different, so how best to support a patient's involvement in their own wound care will change on an individual basis. Some patients will always prefer fully managed wound care from their wound specialist nurse, and shared care is able to give those patients more clinician time, while giving more independence and control to patients who are willing.

For practitioners, shared wound care offers greater choice, more opportunity to innovate, and more standardised best practice that has the potential to release up to 3.5 billion hours of nursing time globally, by 2030.

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Declaration

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