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Contents

Made Easy: Shared Wound Care Discussion Guide

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).

Shared Wound Care Discussion Guide made easy

Wounds International

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

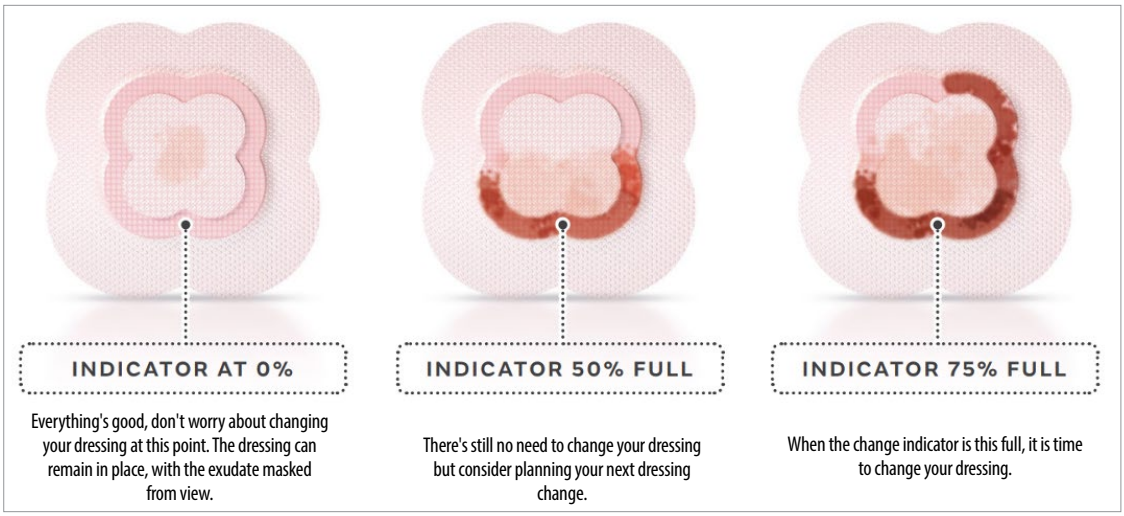

Figure 2: The ALLEVYN™ LIFE Dressing change indicator

Alla fine di uesto articolo potrai trovare la guida tradotta in italiano

Smith+Nephew

Shared wound care discussion guide[1]

Use this tool in conjunction with the ABCDE approach from the T.I.M.E. clinical decision support tool[2,3] and follow the steps below with the patient and/or carer (also known as informal carer or caregiver)

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

Yes

Talk with the patient/carer to establish:
- Wound knowledge, the impact of not treating the wound and the individual's wound care needs
- Fears and concerns regarding shared wound care
- Motivation for shared wound care
- Willingness to participate in shared wound care

No

Talk with the patient/carer to clarify the meaning of shared care:
- Shared care encompasses approaches and interventions that enable patients to participate in care planning over time, rather than just being a passive recipient of the services provided

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

Self-sufficient
- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care

Reassurance seeker
- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care

Unaware
- Not very involved in wound care
- Unaware that it is possible to engage more in their care
- Physically and mentally capable but unwilling to participate in shared care

Reliant
- HCPs lead in all aspects of wound care and other general health care needs
- Does not have the physical and mental ability or capacity to be involved in shared care

Approaches and interventions

Have regular discussion with the patient/carer regarding shared wound care, including motivational interviewing and attainable goal-setting, focusing on:

Knowledge | **Fears and concerns** | **Awareness**

Shared wound care may not be a suitable option at this time

Provide appropriate support and revisit potential for more involvement

3 Identify what the patient/carer can do as part of shared wound care

Wound care

Does the patient/carer have the potential to perform wound care, including dressing changes?

Yes

Considerations
- Demonstrate and educate on how to perform treatment requirements
- Identify needs and provide patient/carer with educational resources (e.g. online, electronic, written)
- A diary for goal setting and to record dressing changes
- Provide patient/carer with tools: dressing change indicator; signs of infection

No

Considerations
- HCP to conduct wound assessment and dressing change according to local protocol
- Periodically revisit the potential for involvement in dressing changes (e.g. if patient/carer circumstances change)

Lifestyle change

Does the patient/carer have the potential to make lifestyle changes to improve wound healing and address the underlying causes of the wound (e.g. appropriate nutrition, exercise as indicated, using compression, offloading)?

Yes

Considerations
- Coach patient/carer about appropriate lifestyle changes
- Assess results and make changes as needed
- A lifestyle diary to record/track lifestyle changes

No

Considerations
- Investigate and address reason (physical or cognitive impairment, fear, anxiety, resources)
- Assess whether patient/carer willingness and ability may be improved
- Refer to allied health professionals for review and support (e.g. dietitian or podiatrist)
- Periodically revisit the potential for lifestyle change (e.g. if patient/carer circumstances change)

Patient-practitioner relationship

Does the patient/carer have the potential to share information about wound progress and inform HCPs about wound deterioration?

Yes

Considerations
- Develop an open and honest patient–practitioner partnership
- Educate the patient/carer about how to recognise wound deterioration
- Educate the patient/carer to contact the HCP without delay if the wound deteriorates
- Provide HCP contact information according to local protocol

No

Considerations
- Periodically revisit the potential for greater partnership (e.g. if patient/carer circumstances change)

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Figure 1: Shared wound care discussion guide

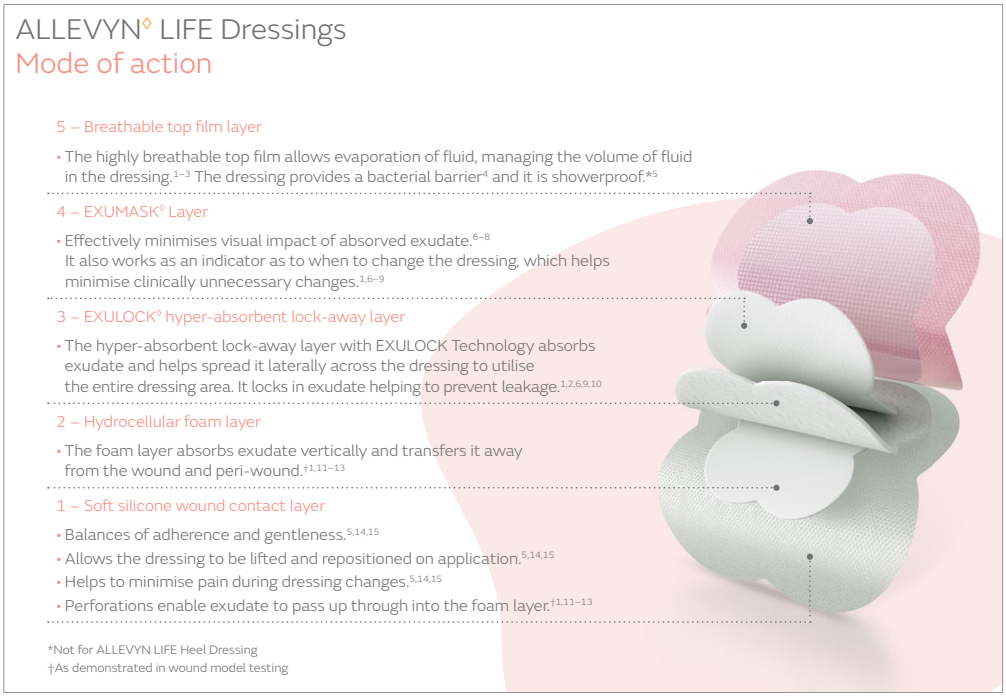

Figure 3: The ALLEVYN™ LIFE mode of action

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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(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

Shared Wound Care Discussion Guide made easy

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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Smith+Nephew

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.

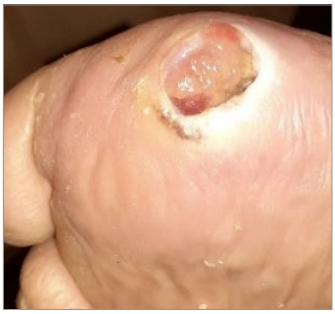
The shared wound care plan included:

- 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)

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Guida alla discussione sulle cure condivise delle ferite[1]

Usare questa guida, insieme all'approccio A,B,C,D,E dello strumento di supporto clinico decisionale T.I.M.E. 2.0[2,3] e seguire i seguenti passi con il paziente e/o il caregiver.

1 Consapevolezza: Il paziente/caregiver è consapevole che potrebbe essere coinvolto nella cura delle ferite?

Sì

Parlare con il paziente/caregiver per comprendere:

- Cosa sa della propria ferita, delle conseguenze delle mancate cure e di quali trattamenti necessiti la sua lesione
- Paure e preoccupazioni riguardo le cure condivise
- Perchè attivare l'assistenza condivisa nella cura delle ferite
- Disponibilità a partecipare alle cure condivise delle ferite.

No

Parlare con il paziente/caregiver per chiarire il significato delle cure condivise:

- Le cure condivise comprendono approcci e interventi che permettono al paziente di partecipare alla pianificazione delle cure nel tempo, piuttosto che essere solo un destinatario passivo dei servizi forniti.

2 Quale dei seguenti scenari descrive meglio il paziente/caregiver per quanto riguarda le cure condivise?

Autosufficiente

- Conosce relativamente bene la sua ferita
- Disponibilie e motivato a ottimizzare il proprio stile di vita per migliorare la guarigione delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Cerca l'approvazione

- Ha possibilità di migliorare la conoscenza e la fiducia
- Relativamente dipendente dagli operatori sanitari
- Cauto nella cura delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Inconsapevole

- Poco coinvolto nella cura delle ferite
- Non sa che può essere maggiormente coinvolto nella cura delle sue ferite
- Fisicamente e mentalmente in grado, ma non disposto a partecipare alle cure condivise.

Dipendente

- Gli operatori sanitari guidano tutti gli aspetti del trattamento delle ferite e le altre necessità di salute
- Non ha la capacità fisica e mentale di impegnarsi nelle cure condivise.

Approcci e interventi

Discutere regolarmente con il paziente/caregiver sulle cure condivise delle ferite, compreso il colloquio motivazionale e la definizione di obiettivi raggiungibili, concentrandosi su:

Conoscenza | **Paure e preoccupazioni** | **Consapevolezza**

Le cure condivise delle ferite potrebbero non essere un'opzione appropriata in questo momento.

Fornire un sostegno adeguato e rivedere il potenziale per un ulteriore coinvolgimento.

3 Identificare ciò che il paziente/caregiver può fare come parte delle cure condivise delle ferite

Cura della ferite

Il paziente/caregiver è in grado di effettuare le necessarie cure della ferita, compresi i cambi di medicazione?

Si

Considerazioni

- Dimostrare e insegnare come eseguire i trattamenti
- Identificare i bisogni e fornire al paziente/caregiver risorse educative (ad esempio, online, elettroniche, scritte)
- Usare un diario per fissare obiettivi e registrare i cambi di medicazione
- Fornire al paziente/caregiver i seguenti strumenti: indicatore di cambio della medicazione; identificazione dei segni di infezione.

No

Considerazioni

- Gli operatori sanitari dovrebbero eseguire la valutazione della ferita e il cambio della medicazione secondo il protocollo locale
- Rivalutare periodicamente se il paziente/caregiver può essere coinvolto nei cambi di medicazione (ad esempio, se le circostanze del paziente/caregiver cambiano).

Cambiamento dello stile di vita

Il paziente/caregiver è in grado di modificare lo stile di vita per migliorare la guarigione della lesione e gestire i fattori causali (ad esempio, alimentazione appropriata, livello di esercizio fisico adeguato, uso della terapia compressiva, scarico)?

Si

Considerazioni

- Insegnare al paziente/caregiver i cambiamenti appropriati dello stile di vita
- Valutare i risultati e apportare modifiche se necessario
- Usare un diario per registrare i cambiamenti dello stile di vita.

No

Considerazioni

- Indagare e affrontare la motivazione (menomazione fisica o cognitiva, paura, ansia, risorse)
- Accertare se la volontà e la capacità del paziente/caregiver possono essere migliorate
- Consultare altri operatori sanitari per avere un supporto e una rivalutazione da parte loro (ad esempio il dietista o il podologo)
- Rivalutare periodicamente il potenziale di cambiamento dello stile di vita (ad esempio, se le circostanze del paziente/caregiver cambiano).

Rapporto paziente-clinico

Il paziente/caregiver è in grado di condividere informazioni sui progressi della ferita e di informare gli operatori sanitari del suo peggioramento?

Si

Considerazioni

- Sviluppare una relazione aperta e trasparente tra paziente e operatore sanitario
- Educare il paziente/caregiver su come riconoscere il peggioramento della ferita
- Educare il paziente/caregiver a contattare immediatamente l'operatore sanitario se la ferita peggiora
- Fornire i contatti dell'operatore sanitario secondo il protocollo locale.

No

Considerazioni

- Rivalutare periodicamente la possibilità di avere una maggiore collaborazione (ad esempio se le circostanze del paziente/caregiver cambiano).

Referenze: 1. Moore Z, Kapp S, Loney A, *et al.* A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 2021;12(3):1-7. **2.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care.* 2019;28(3):154–161. **3.** World Union of Wound Healing Societies (WUWHS) (2020) Strategies to reduce practice variation in wound assessment and management: The TIME Clinical Decision Support Tool. London: *Wounds International.*

3.5 billion hours nurse time release model

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3.5 billion hours of nurse time released by 2030: Potential efficiency gains from shared care and long-wear advanced foam dressings

The prevalence of chronic wounds is increasing, adding to the burden on the already overstretched nursing population. There is a clear need for new ways of working to mitigate the issues faced by nurses. The benefits of shared care and greater patient involvement are well documented and can be applied to chronic wound care for clinically appropriate patients. Long-wear advanced foam dressings can support a shared-care approach by allowing nurses and patients to practice undisturbed healing. This article introduces a mathematical model that proposes by using long-wear advanced foam dressings within a shared-care approach some 3.5 billion nursing hours globally could be saved by 2030. 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 outcomes.

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3.5 billion hours of nurse time released by 2030: Potential efficiency gains from shared care and long-wear advanced foam dressings

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Zena Moore, Amanda Loney, Sebastian Probst, Hayley Ryan, Catherine Milne and Sylvie Meaume

The prevalence of chronic wounds is increasing, adding to the burden on the already overstretched nursing population. There is a clear need for new ways of working to mitigate the issues faced by nurses. The benefits of shared care and greater patient involvement are well documented and can be applied to chronic wound care for clinically appropriate patients. Long-wear advanced foam dressings can support a shared-care approach by allowing nurses and patients to practice undisturbed healing. This article introduces a mathematical model that proposes by using long-wear advanced foam dressings within a shared-care approach some 3.5 billion nursing hours globally could be saved by 2030. 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 outcomes.

Worldwide, healthcare professionals (HCPs) have identified their own time constraints as a significant barrier to providing optimal care to patients with chronic wounds (Moore and Coggins, 2021). Prior to the COVID-19 pandemic, there was a global shortage of almost 6 million nurses — as a result of the pandemic and taking into account that some nurses are set to retire — the nursing shortage could be as high as 10.6 million by 2030 (Buchan et al, 2020).

Furthermore, the prevalence of chronic wounds is also increasing, leading to escalating annual costs associated with treatment and management (Milne et al, 2020). The impact is also felt by patients with chronic wounds, who often undergo disruptive treatment regimens, which can impact on their quality of life and their ability to conduct their activities of daily living (Alam et al, 2018).

As a result, many nurses who treat patients with chronic wounds are adapting their practice to enhance patient experience and optimise the use of their time by encouraging greater patient involvement (Kapp and Santamaria, 2017). This approach is known as shared wound care, whereby patients are supported by clinicians to become more directly involved in managing their own wounds.

The benefits of improved patient involvement are well-documented, with shared care practices being successfully adopted among a variety of patient groups, for example, 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.

Shared wound care

It is estimated that 60% of patients with chronic wounds have some degree of involvement in their own wound care (Moore and Coggins, 2021). Results from two international surveys were published in 2021: one surveyed 511 HCPs who treat chronic wounds in a community setting (Moore and Coggins, 2021) and a second surveyed 715 patients (Moore et al, 2021). Key findings from the survey included:

- Two-thirds of patients with chronic wounds who have their dressings changed at home by a clinician require at least twice-weekly

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Box 1. Features of ALLEVYN◊ LIFE as long-wear advanced foam dressings.

- Wear time of 5 to 7 days (Simon and Bielby, 2014; Joy et al, 2015; Smith+Nephew, 2016b; 2016a)
- Change indicator to minimise the visual impact of exudate and shows 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, 2016d; 2016c)
- 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).

dressing changes, while 33% require dressing changes 4 to 7 times per week (Moore and Coggins, 2021). However, evidence suggests that up to half of such dressing changes may be clinically unnecessary (Joy et al, 2015).

- 44% of HCPs reported that some patients could benefit from the use of dressings with longer wear times (Moore and Coggins, 2021).
- 77% of HCPs reported that higher levels of patient involvement could improve patient quality of life (Moore and Coggins, 2021).
- *Table 1* summarises the reported benefits of shared wound care for patients and practitioners (Moore and Coggins, 2021).
- If suitable patients were able to be more involved in their own wound care, 74% of clinicians reported that it would enable them to spend more time with patients who require more specialist support (Moore and Coggins, 2021).
- Nearly half (49%) of patients would prefer a dressing that could be worn for 5 to 7 days (Moore et al, 2021).

Offering patients, for whom it is clinically appropriate, the choice of a long-wear advanced foam dressing may support the implementation of a systematic shared wound care programme. Such dressings that have an evidenced wear time of up to 7 days (e.g. ALLEVYN◊ LIFE Advanced Foam Dressings, Smith+Nephew, *[Box 1]*) and promote undisturbed wound healing, can help reduce wastage of time and resources associated with chronic wound care (Stephen-Haynes et al, 2013; Joy et al, 2015).

3.5 Billion Hours Model

This article aims to show that, when appropriate, the selection of long-wear advanced foam wound dressings by enhancing patient involvement in their care can have a demonstrable and quantifiable benefit on nursing time. To achieve this, a conservatively calculated model was devised to estimate how many working hours could be potentially liberated by nurses using long-wear advanced foam dressings on chronic wounds in the community.

The 3.5 Billion Hours Model estimates that up to 3.5 billion hours could be released by 2030 through the introduction of long-wear advanced foam dressings within a systematic shared care approach.

The 3.5 Billion Hours Model: how was it estimated?

The 3.5 Billion Hours Model was estimated by statisticians and created from published figures on the global nursing workforce and chronic wound burden. This was combined with reported clinical efficiencies that could be delivered by using long-wear advanced foam dressings. The lowest reported clinical efficiencies were used to maintain a conservative estimate of how many hours can be liberated *[Figure 1]*.

Number of nurses worldwide

The first step was to calculate the number of nurses by population density worldwide using World Health Organization (WHO) data, unless specific data were available to indicate a lower number (WHO, 2020; Europa.eu, 2021).

Regions were removed from the model if their healthcare infrastructure did not align with

Table 1. Reported benefits of shared wound care for patients and practitioners (Moore and Coggins, 2021).

Benefit to the patient	Benefit to the practitioner
Independence — Patients are more in control of their own time as they do not need to wait for a nurse to visit and they can go about their activities of daily living (i.e. not needing to take time off work for appointments). **Privacy** — There is no need for a new or different nurse to enter their home and examine them at each appointment. **Increased compliance** — Patients are more likely to comply (in wound treatment and other lifestyle advice) if they feel part of decision making process compared to a passive participant in their care. **Attitude** — Overall, patients may feel more positive, empowered and enthusiastic if they are fully engaged in their care.	**Timing** — The clinician can spend more time with patients with complex needs and wounds, who are unable to self-care. **Cost** — The cost for the care provider is reduced if there are fewer or shorter visits. There may also be fewer dressing changes as there is currently an attitude among clinicians of 'I might as well change the dressing now I am here'. **Relationship** — If the patient is engaged, the clinician and patient have a shared goal which can make the practitioner–patient relationship stronger. **Better reporting** — A patient who understands the wound can give accurate updates to the practitioner, as well as notifying the clinician if the wound deteriorates and needs specialist care.

Figure 1. The 3.5 Billion Hours Model — 3.5 billion nursing hours released by 2030.

published clinical evidence that supports patient involvement and shared care practices. Regions that were removed included Africa, the Middle East (except Israel), and some Central and South America countries.

Speciality relevance

To obtain an estimate of the total number of registered, professional community nurses globally, nurses in training and those with nursing assistant roles were removed from the model (Davies, 2020). While there is evidence that 25% of care home residents have some kind of wound (Kingsley et al, 2010) and that care home nurses are involved in wound care management, for the purposes of this model, nurses who work in care home were removed.

The data modellers also extracted those in specialist roles, such as midwives (WHO, 2022), theatre nurses (AACNNursing.org, 2019; Zippia, 2021) and mental health nurses (Samele et al, 2013; WHO, 2014, 2019; Itzhaki et al, 2018; Regis College Online, 2018).

The removal of non-comparable regions and associated nurse professionals yields a conservative estimate of 17.7 million registered community nurses who work with patients with chronic wounds.

Nurse's total working time — hours spent on changing wound dressings

Total nurses' working time was adjusted to account for nurses who are in full and part time employment (Trinkoff et al, 2006; China Labour Bulletin, 2018; Oecd-iLibrary.org., 2021; Sky News, 2021; Erieri.com, 2022). The model also takes into account that approximately 50% of community nursing time involves wound management and dressing changes (Lindholm and Searle, 2016).

Time on dressing change

Globally, it is estimated that community nurses administer 70% of wound care (Lindholm and Searle, 2016). The main calculations in this model were made on the basis of community wound care management, then scaled up to embrace the remaining 30% of wound care managed in the hospital setting. The result then equates to total wound care time.

The model applies to chronic wounds only

Acute wounds were removed from the model to reflect that community nurses typically manage chronic wounds (Nissanholtz-Gannot et al, 2017; Davies, 2020; Schnur, 2020), which comprise 48% of the total wound burden (Guest et al, 2017).

Apply clinical efficiencies — nurse time optimisation

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.

Allowing for further considerations

To further ensure this model remains a highly conservative estimate, a final reduction was applied to the potential nursing hours liberated by the implementation of dressing changes as part of a shared care approach to chronic wound care. The number of hours was reduced by 25% to allow for any remaining skewing factors that may affect the implementation of shared care approaches with long-wear advanced foam dressings. This includes current adoption rates of long-wear dressings as one such example, estimated to be at 20.5% worldwide (SmartTRAK, 2021).[1]

Results — how many hours can be liberated globally?

The methodology to develop the model was derived from a highly conservative estimation of the number of nursing hours that could be liberated using long-wear advanced foam dressings where clinically appropriate. The final time release for nurses globally was calculated at just over 433 million hours per annum. Over the next 8 years to 2030, it is estimated that almost 3.5 billion nursing hours could potentially be released if long-wear advanced foam dressings are adopted as part of an integrated shared care approach *[Table 2]*.

Discussion and recommendations

The 3.5 Billion Hours Model shows how the implementation of long-wear advanced foam dressings has the potential to liberate a proportion of nursing time currently devoted to potentially clinically unnecessary dressing changes (Joy et al, 2015). It is important to be cognizant that incorporating long-wear

[1]Based on SmartTRAK data, this article acknowledges that not all wound dressings can be substituted with foam dressings.

Table 2. 3.5 billion hours released by 2030 — regional breakdown.		
Region	**Wound care practitioner (e.g. nursing) hours liberated per annum**	**Hours released by 2030**
Europe (inc. Russia, Turkey)	136,090,072	1,088,720,576
China and Japan	114,776,619	918,212,952
North America	89,822,187	718,577,494
India	59,089,926	472,719,408
Central and South America	23,391,664	187,133,316
Australia and New Zealand	8,835,505	70,684,043
Israel	1,202,431	9,619,445
Total	**433,208,404**	**3,465,667,234**

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advanced foam dressings into existing practice in isolation would not be sufficient to release 3.5 billion hours of nursing time. It is only when strategies, such as shared wound care, are adopted alongside the use of long-wear advanced foam dressings that healthcare economies can realise the full clinical and economic benefits. In order for this practice shift to be implemented optimally, and embraced by healthcare systems, practitioners and patients, certain factors need to be considered:

- Access to long-wear advanced foam dressings
- Patient selection for shared wound care
- Nurse-led patient education and resources.

Access to long-wear advanced foam dressings

Dressings that have an extended wear time of up to 7 days may improve patient quality of life (e.g. washing, odour control); reduce unnecessary dressing changes allowing for undisturbed healing and minimising the risk of wound infection; manage exudate; and indicate when dressing change is required can yield optimum benefits within a shared care context (Moore and Coggins, 2021).

Long-wear advanced wound dressings have a comparatively higher price versus standard wound dressings. However, the use of long-wear advanced foam dressings can reduce time spent on dressing changes by at least 29% and are generally associated with better clinical outcomes (Stephen-Haynes, et al, 2013; Simon and Bielby, 2014; Joy et al, 2015; Krönert et al, 2016; Tiscar-González et al, 2021). Therefore, a cost-benefit case can be made through collaboration between those who manage organisational budgets and those who prescribe.

Patient selection for shared wound care

All patients and/or their carers have unique needs in relation to shared wound care, and not all may be suitable to be involved in shared wound care practices. Where a person sits on the 'shared care continuum' is dependent on their ability, confidence and willingness to be involved in their own wound care, alongside the particular wound needs and their support system away from the clinic (Moore et al, 2021). Additionally, the degree a patient/carer can be involved can change over time so the patient and/or informal carer requires ongoing assessment throughout treatment.

Assessment of the patient and/or carer's suitability for shared wound care should include the following: the patient's overall health status (including dexterity and mobility); their understanding of their condition and treatment; the extent to which they want to participate in their care; motivation to adhere to treatment and undertake lifestyle changes; their mental and physical capability; previous experience of treatments; and availability of family and carers to support shared care (Wounds International, 2016; Moore and Coggins, 2021).

Clinicians are already adopting shared care practices within wound care with some patients taking responsibility over their own dressing changes following clinician-led training and assessment. Furthermore, shared care practices have somewhat been accelerated by the COVID-19 pandemic and will likely continue to build momentum in the years to come. In order to support clinicians with patient selection and education, resources such as the Shared Wound Care Discussion Guide have been developed for HCPs to identify where patients sit on the shared wound care continuum and to understand how best to facilitate and support patients/carer who choose to be more involved in wound care (Moore et al, 2021). There is ongoing international evaluation of the Shared Wound Care Discussion Guide to identify its place in practice (Moore et al, 2021).

Nurse-led patient education and resources

Nurse-led patient education is the basis of effective shared wound management. 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 progression of the wound
- 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).

Next steps

Against the backdrop of increasing nursing shortages (Buchan et al, 2020) and an increasing chronic wound care burden (Sen, 2021), it is important that potential solutions are sought — of which shared care and long-wear advanced foam dressings may play an important role.

The 3.5 Billion Hours Model estimates that 3.5 billion hours of nursing time can be liberated by 2030. To achieve this, access to long-wear advanced foam dressings, systems to identify patient suitability for shared wound care and nurse-led education and resources will need to be in place.

One barrier to accessing long-wear advanced foam dressings use is perceived cost: often is it the per dressing cost rather than the total cost of care that is a marker of cost effectiveness. Additionally, the concept of shared wound care is often perceived to not be cost beneficial to the nurse if they are paid per visit (Moore and Coggins, 2021). Overcoming this perceived barrier will involve educating clinical staff and payers on the shared wound care model at the same time.

The 3.5 Billion Hours Model is one component of myriad considerations associated with the shared care concept. Evaluating it alongside the Shared Wound Care Discussion Guide to assess a patient's suitability for shared care and then use the appropriate product and evaluate the outcomes to get the approach right and from there could spread it more widely across their patient population. Focusing on the community setting will identify the potential of the 3.5 Billion Hours Model.

Conclusion

The model presented estimates that 3.5 billion nursing hours could be liberated by 2030 if long-wear advanced wound dressings are adopted within a shared wound care approach. Shared wound care, does not mean that patients are receiving less care, but a different approach to their wound care that has been shown to benefit both patients and practitioners.

While implementing shared care approaches requires time investment from the outset, a case can be made for the potential long-term benefits. Rigorous and internationally recognised materials may be required for widespread education, implementation and measurement of progress of integrating the 3.5 Billion Hours Model through shared wound care practices.

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3,5 miliardi di ore di assistenza infermieristica liberate entro il 2030: potenziali miglioramenti dell'efficienza grazie alla cura condivisa e alle medicazioni avanzate in schiuma a lunga permanenza

La prevalenza delle lesioni croniche è in aumento, con un conseguente aggravio del carico di lavoro per classe infermieristica, già messa a dura prova. Esiste un'evidente necessità di nuove modalità di lavoro per mitigare i problemi che gli infermieri devono affrontare. I vantaggi di una cura condivisa e di un maggiore coinvolgimento del paziente sono ben documentati e possono essere applicati alla cura delle lesioni croniche per i pazienti clinicamente idonei. Le medicazioni avanzate in schiuma a lunga permanenza possono favorire un approccio di cura condivisa, consentendo al personale infermieristico e ai pazienti di perseguire una guarigione indisturbata. Questo articolo presenta un modello matematico che propone di risparmiare circa 3,5 miliardi di ore di assistenza infermieristica a livello mondiale entro il 2030 grazie all'impiego di medicazioni avanzate in schiuma a lunga permanenza in un contesto di cura condivisa. Avere più tempo a disposizione può migliorare la qualità della vita dei pazienti e consente al personale infermieristico di concentrarsi laddove è più necessario, migliorando la qualità dell'assistenza e i risultati.

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3,5 miliardi di ore di assistenza infermieristica liberate entro il 2030: potenziali miglioramenti dell'efficienza grazie alla cura condivisa e alle medicazioni avanzate in schiuma a lunga permanenza

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La prevalenza delle lesioni croniche è in aumento, con un conseguente aggravio del carico di lavoro per classe infermieristica, già messa a dura prova. Esiste un'evidente necessità di nuove modalità di lavoro per mitigare i problemi che gli infermieri devono affrontare. I vantaggi di una cura condivisa e di un maggiore coinvolgimento del paziente sono ben documentati e possono essere applicati alla cura delle lesioni croniche per i pazienti clinicamente idonei. Le medicazioni avanzate in schiuma a lunga permanenza possono favorire un approccio di cura condivisa, consentendo al personale infermieristico e ai pazienti di perseguire una guarigione indisturbata. Questo articolo presenta un modello matematico che propone di risparmiare circa 3,5 miliardi di ore di assistenza infermieristica a livello mondiale entro il 2030 grazie all'impiego di medicazioni avanzate in schiuma a lunga permanenza in un contesto di cura condivisa. Avere più tempo a disposizione può migliorare la qualità della vita dei pazienti e consente al personale infermieristico di concentrarsi laddove è più necessario, migliorando la qualità dell'assistenza e i risultati.

In tutto il mondo, gli operatori sanitari (HCP) hanno individuato nella mancanza di tempo una barriera significativa per fornire un'assistenza ottimale ai pazienti con lesioni croniche (Moore e Coggins, 2021). Prima della pandemia di COVID-19, esisteva una carenza globale di quasi 6 milioni di unità di personale infermieristico; a seguito della pandemia e in considerazione del fatto che alcuni infermieri si stanno avvicinando alla pensione, questa carenza potrebbe raggiungere i 10,6 milioni entro il 2030 (Buchan et al, 2020).

Inoltre, la prevalenza delle lesioni croniche è in aumento, con conseguente incremento dei costi annuali associati al trattamento e alla gestione (Milne et al, 2020). L'impatto è percepito anche dai pazienti con lesioni croniche, spesso sottoposti a regimi non ottimali, con possibili conseguenze sulla loro qualità di vita e sulla capacità di svolgere le attività della vita quotidiana (Alam et al, 2018).

Pertanto, molti infermieri che trattano lesioni croniche stanno adattando l'assistenza per migliorare il vissuto del paziente e ottimizzare l'utilizzo del tempo incoraggiando un maggiore coinvolgimento del paziente (Kapp e Santamaria, 2017). Questo approccio è noto come "shared wound care" (ovvero cura condivisa delle lesioni) e prevede che i pazienti vengano aiutati dal personale sanitario o in alternativa infermieri e medici a partecipare più attivamente alla gestione delle loro lesioni.

I vantaggi di un maggiore coinvolgimento dei pazienti sono ben documentati e le pratiche di cura condivisa sono state adottate con successo da diversi gruppi di pazienti, ad esempio dagli stomizzati (Ketterer et al, 2021), incontinenza urinaria (Pizzol et al, 2021) e diabete (University of Southern California, 2021). Nella maggior parte dei casi, la cura condivisa richiede un approccio multiforme agli interventi (National Institute for Health and Care Excellence, 2021), che deve includere la considerazione di cambiamenti nello stile di vita, l'educazione del paziente e di chi lo assiste, la modifica dei processi decisionali e dei percorsi clinici, la telemedicina o la possibilità di variare i trattamenti, che si tratti della scelta delle medicazioni, di terapie farmacologiche o di soluzioni chirurgiche.

Cura condivisa delle lesioni

Secondo le stime, il 60% dei pazienti con lesioni croniche partecipa in certa misura alla cura delle proprie lesioni (Moore e Coggins, 2021). Nel 2021 sono stati pubblicati i risultati di due indagini internazionali: una ha incluso 511 operatori sanitari addetti alla cura delle lesioni croniche in un contesto di comunità (Moore e Coggins, 2021) e una seconda su 715 pazienti (Moore et al, 2021). I risultati principali dell'indagine sono stati i seguenti:

- Due terzi dei pazienti con lesioni croniche trattati a domicilio necessitano di cambio delle

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Riquadro 1. Caratteristiche di ALLEVYN◊ LIFE quale medicazione avanzata in schiuma a lunga permanenza.

- Tempo di permanenza da 5 a 7 giorni (Simon e Bielby, 2014; Joy et al, 2015; Smith+Nephew, 2016b; 2016a)
- Indicatore di cambio per la riduzione dell'impatto visivo dell'essudato e la segnalazione ai pazienti e operatori sanitari della necessità di sostituire la medicazione; contribuisce a ridurre al minimo i cambi di medicazione clinicamente non necessari (Rossington et al, 2013; Stephen-Haynes et al, 2013; Simon e Bielby, 2014; Smith+Nephew, 2016d; 2016c)
- Eccellente gestione dell'essudato per la prevenzione delle perdite (Smith+Nephew, 2012b; Rossington et al, 2013; Stephen-Haynes et al, 2013; Simon e Bielby, 2014)
- Comfort ottimale per il paziente (Rossington et al, 2013; Simon e Bielby, 2014)
- Controllo degli odori e prevenzione delle perdite per un prolungamento dei tempi di utilizzo e della tolleranza del paziente (Smith+Nephew, 2012a; 2016a; Rossington et al., 2013).
- A prova di doccia (Smith+Nephew, 2016b).

medicazioni almeno due volte alla settimana, mentre il 33% richiede cambi di medicazione da 4 a 7 volte a settimana (Moore e Coggins, 2021). Tuttavia, l'evidenza indica che una percentuale che arriva fino al 50% dei cambi di medicazione potrebbe essere clinicamente non necessaria (Joy et al, 2015).

- Il 44% degli operatori sanitari ha riferito che alcuni pazienti potrebbero trarre beneficio dall'utilizzo di medicazioni con un tempo di permanenza superiore (Moore e Coggins, 2021).
- Il 77% degli operatori sanitari ha riferito che livelli più elevati di coinvolgimento dei pazienti potrebbero determinare un miglioramento della loro qualità di vita (Moore e Coggins, 2021).
- La *Tabella 1* riassume i vantaggi riferiti per i pazienti e gli operatori derivanti dalla cura condivisa delle lesioni (Moore e Coggins, 2021).
- Se i pazienti idonei potessero essere maggiormente coinvolti nella cura delle proprie lesioni, il 74% degli operatori sanitari ha riferito che questo consentirebbe loro di dedicare più tempo ai pazienti che necessitano di un'assistenza più specialistica (Moore e Coggins, 2021).
- Circa metà (49%) dei pazienti preferirebbe una medicazione utilizzabile per 5-7 giorni (Moore et al, 2021).

Offrire ai pazienti, per i quali sia clinicamente appropriato, la scelta di una medicazione avanzata in schiuma a lunga permanenza può favorire l'adozione di un programma sistematico di cura condivisa delle lesioni. Queste medicazioni, che hanno un tempo di permanenza dimostrato fino a 7 giorni e promuovono la guarigione indisturbata delle lesioni, possono contribuire a ridurre gli sprechi di tempo e di risorse associati alla cura delle lesioni croniche (Stephen-Haynes et al, 2013; Joy et al, 2015).

Il modello di 3,5 miliardi di ore

Questo articolo vuole dimostrare che, quando appropriata, la scelta di medicazioni avanzate in schiuma a lunga permanenza con un maggiore coinvolgimento del paziente nella cura delle lesioni può avere un beneficio dimostrabile e quantificabile sul tempo di assistenza infermieristica. A tal fine, è stato elaborato un modello calcolato su base conservativa per stimare quante ore di lavoro potrebbero essere potenzialmente liberate dagli infermieri adottando medicazioni avanzate in schiuma a lunga permanenza per le lesioni croniche nella comunità.

Il modello di 3,5 miliardi di ore stima che entro il 2030 si potrebbero liberare fino a 3,5 miliardi di ore grazie all'introduzione di medicazioni avanzate in schiuma a lunga permanenza nell'ambito di un approccio sistematico di cura condivisa.

Il modello di 3,5 miliardi di ore: come è stato elaborato?

Il modello di 3,5 miliardi di ore è stato elaborato da statistici e sviluppato sulla base di dati pubblicati sulla forza lavoro infermieristica mondiale e sul carico imposto dalle lesioni croniche. Questo dato è stato combinato con i vantaggi clinici che potrebbero derivare dall'utilizzo di medicazioni avanzate in schiuma a lunga permanenza. Le minori efficienze cliniche riportate sono state utilizzate per conservare una stima conservativa del numero di ore liberabili *[Figura 1]*.

Numero di infermieri in tutto il mondo

Il primo passo è stato quello di calcolare il numero di infermieri per densità di popolazione a livello mondiale utilizzando i dati forniti dall'Organizzazione Mondiale della Sanità (OMS), a meno che non fossero disponibili dati specifici indicanti un numero inferiore (OMS, 2020; Europa.eu, 2021).

Tabella 1. Vantaggi riferiti per i pazienti e gli operatori derivanti dalla cura condivisa delle lesioni (Moore and Coggins, 2021).

Vantaggi per il paziente	Vantaggi per l'operatore sanitario
Indipendenza — I pazienti hanno un maggiore controllo del proprio tempo, in quanto non devono aspettare la visita di un infermiere e possono dedicarsi alle loro attività quotidiane (ad esempio, non devono assentarsi dal lavoro per gli appuntamenti). **Privacy** — Non è necessario che un infermiere nuovo o diverso entri in casa e conduca una visita a ogni appuntamento. **Maggiore compliance** — È più probabile che i pazienti si adattino (al trattamento delle lesioni e ad altri consigli sullo stile di vita) se si sentono parte del processo decisionale rispetto a chi partecipa passivamente alle loro cure. **Atteggiamento** — Nel complesso, i pazienti possono sentirsi più positivi, responsabilizzati ed entusiasti se sono pienamente coinvolti nelle loro cure.	**Tempo** — L'operatore sanitario può dedicare più tempo ai pazienti con esigenze e lesioni complesse, che non sono idonee alla cura indipendente. **Costo** — Il costo per il fornitore di assistenza si riduce se le visite sono meno numerose o più brevi. Potrebbero ridursi anche i cambi di medicazione, poiché attualmente tra i operatori sanitari si è affermata la consuetudine che li porta a dire "tanto vale cambiare la medicazione ora che sono qui". **Relazione** — Se il paziente partecipa, operatore e paziente condividono un obiettivo e questo può rafforzare il loro rapporto. **Comunicazione più efficace** — Un paziente che comprende la lesione può fornire aggiornamenti accurati all'operatore, oltre ad avvisarlo se la lesione peggiora e necessita di cure specialistiche.

Figura 1. Il modello di 3,5 miliardi di ore – 3,5 miliardi di ore di assistenza liberate entro il 2030.

Le regioni sono state rimosse dal modello se le loro infrastrutture sanitarie non erano in linea con l'evidenza clinica pubblicata che supporta il coinvolgimento dei pazienti e le pratiche di cura condivisa. Tra le regioni eliminate figurano l'Africa, il Medio Oriente (tranne Israele) e alcuni Paesi dell'America centrale e meridionale.

Rilevanza della specialità
Per ottenere una stima del numero totale di infermieri professionali di comunità registrati a livello globale, sono stati eliminati dal modello gli infermieri in formazione e quelli che ricoprivano ruoli di assistente infermieristico (Davies, 2020). Sebbene sia dimostrato che il 25% dei residenti nelle case di cura presenti qualche tipo di lesione (Kingsley et al, 2010) e che gli infermieri delle RSA partecipino alla gestione delle lesioni, ai fini di questo modello gli infermieri attivi nelle RSA sono stati esclusi.
I modellatori di dati hanno estratto anche il personale con ruoli specialistici, come le ostetriche (OMS, 2022), gli infermieri di sala operatoria (AACNNursing.org, 2019; Zippia, 2021) e gli infermieri attivi nel campo della salute mentale (Samele et al, 2013; OMS, 2014, 2019; Itzhaki et al, 2018; Regis College Online, 2018).
Eliminando le regioni non comparabili e il personale infermieristico con grado di associato, si ottiene una stima conservativa di 17,7 milioni di infermieri di comunità registrati che lavorano con pazienti che presentano lesioni croniche.

Tempo di lavoro totale dell'infermiere – ore dedicate al cambio delle medicazioni
Il tempo di lavoro totale degli infermieri è stato adeguato in modo da tenere conto degli infermieri attivi a tempo pieno e parziale (Trinkoff et al, 2006; China Labour Bulletin, 2018; Oecd-iLibrary.org., 2021; Sky News, 2021; Erieri.com, 2022). Il modello tiene anche conto del fatto che circa il 50% del tempo dedicato all'assistenza infermieristica di comunità riguarda la gestione delle lesioni e il cambio delle medicazioni (Lindholm e Searle, 2016).

Tempo per il cambio della medicazione
A livello globale, si stima che gli infermieri di comunità gestiscano il 70% della cura delle lesioni (Lindholm e Searle, 2016). I calcoli principali di questo modello sono stati effettuati sulla base della gestione della cura delle lesioni in comunità, poi ampliati per includere il restante 30% dell'assistenza delle lesioni gestite in ambito ospedaliero. Il risultato equivale al tempo totale di cura delle lesioni.

Il modello si applica solo alle lesioni croniche
Le lesioni acute sono state eliminate dal modello per riflettere il fatto che gli infermieri di comunità tipicamente gestiscono le lesioni croniche (Nissanholtz-Gannot et al, 2017; Davies, 2020; Schnur, 2020), che comprendono il 48% del carico totale relativo alle lesioni (Guest et al, 2017).

Applicazione delle efficienze cliniche – ottimizzazione del tempo del personale infermieristico
È dimostrato che l'utilizzo di medicazioni avanzate in schiuma a lunga permanenza riduce il tempo dedicato al cambio delle medicazioni in media del 47%, con valori superiori e inferiori rispettivamente del 64% e del 29% (Stephen-Haynes, et al, 2013; Simon e Bielby, 2014; Joy et al, 2015; Krönert et al, 2016; Tiscar-González et al, 2021). Includendo nel modello la valutazione di efficienza più prudenziale, il calcolo stima che l'utilizzo di queste medicazioni potrebbe ridurre l'onere temporale dei cambi di medicazione di almeno il 29%. Questo risparmio di tempo è stato utilizzato nel calcolo finale dei potenziali risparmi di tempo per il personale infermieristico.

Apertura a ulteriori considerazioni
Per garantire ulteriormente che questo modello rimanga una stima altamente conservativa è stata applicata una riduzione finale alle ore di assistenza infermieristica potenzialmente liberate dall'adozione dei cambi di medicazione nell'ambito dell'approccio condiviso alla cura delle lesioni croniche. Il numero di ore è stato ridotto del 25% per tenere conto di eventuali fattori di distorsione che possono influenzare l'adozione di approcci di cura condivisa con medicazioni avanzate in schiuma a lunga permanenza. Tra questi, per esempio, l'attuale tasso di adozione delle medicazioni a lunga permanenza, stimato al 20,5% in tutto il mondo (SmartTRAK, 2021).[1]

Risultati: quante ore possono essere liberate a livello globale?

La metodologia per lo sviluppo del modello è stata ricavata da una stima altamente conservativa del numero di ore di assistenza infermieristica che potrebbero essere liberate utilizzando medicazioni avanzate in schiuma a lunga permanenza, laddove clinicamente appropriato. Secondo i calcoli si otterrebbe una liberazione finale di tempo per gli infermieri a livello mondiale di poco più di 433 milioni di ore all'anno. Nei prossimi 8 anni fino al 2030, si stima che potrebbero essere potenzialmente liberate quasi 3,5 miliardi di ore di assistenza infermieristica se nell'ambito di un approccio integrato di cura condivisa venissero adottate medicazioni avanzate in schiuma a lunga permanenza *[Tabella 2]*.

Discussione e raccomandazioni

Il modello di 3,5 miliardi di ore mostra come l'adozione di medicazioni avanzate in schiuma

[1]Sulla base dei dati SmartTRAK, questo articolo riconosce che non tutte le medicazioni per le lesioni possono essere sostituite con medicazioni in schiuma.

Tabella 2. 3,5 miliardi di ore liberate entro il 2030 – ripartizione regionale.

Regione	Ore di vulnologia (es. personale infermieristico) liberate all'anno	Ore liberate entro il 2030
Europa (incl. Russia, Turchia)	136.090.072	1.088.720.576
Cina e Giappone	114.776.619	918.212.952
America settentrionale	89.822.187	718.577.494
India	59.089.926	472.719.408
America centrale e meridionale	23.391.664	187.133.316
Australia e Nuova Zelanda	8.835.505	70.684.043
Israele	1.202.431	9.619.445
Totale	**433.208.404**	**3.465.667.234**

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a lunga permanenza possa liberare una parte del tempo infermieristico attualmente dedicato ai cambi delle medicazioni potenzialmente non necessari dal punto di vista clinico (Joy et al, 2015). È importante essere consapevoli che la sola inclusione di medicazioni avanzate in schiuma a lunga permanenza nella pratica esistente non sarebbe sufficiente a liberare 3,5 miliardi di ore di tempo del personale infermieristico. Solo l'adozione congiunta di strategie come la cura condivisa delle lesioni e l'utilizzo di medicazioni avanzate in schiuma a lunga permanenza può consentire alle economie sanitarie di realizzare tutti i vantaggi clinici ed economici. Affinché questo cambiamento di prassi possa essere realizzato in modo ottimale e accettato dai sistemi sanitari, dagli operatori e dai pazienti, è necessario considerare alcuni fattori:

- Accesso alle medicazioni avanzate in schiuma a lunga permanenza
- Selezione dei pazienti idonei alla cura condivisa delle lesioni
- Risorse e formazione dei pazienti da parte del personale infermieristico.

Accesso alle medicazioni avanzate in schiuma a lunga permanenza

Le medicazioni con un tempo di permanenza prolungato, fino a 7 giorni, possono migliorare la qualità della vita del paziente (ad es. lavaggio, controllo degli odori), ridurre i cambi di medicazione non necessari con una conseguente guarigione indisturbata e una riduzione al minimo del rischio di infezione delle lesioni, gestire l'essudato e indicare quando è necessario cambiare la medicazione con benefici ottimali in un contesto di cura condivisa (Moore e Coggins, 2021).
Le medicazioni avanzate a lunga permanenza hanno un prezzo relativamente più elevato rispetto alle medicazioni standard. Tuttavia, l'utilizzo di medicazioni avanzate in schiuma a lunga permanenza può ridurre il tempo impiegato per il cambio della medicazione di almeno il 29% ed è generalmente associato a risultati clinici migliori (Stephen-Haynes, et al, 2013; Simon e Bielby, 2014; Joy et al, 2015; Krönert et al, 2016; Tiscar-González et al, 2021). Pertanto, con la collaborazione di coloro che gestiscono i budget delle organizzazioni e dei prescrittori è possibile stilare un'analisi costi-benefici convincente.

Selezione dei pazienti idonei alla cura condivisa delle lesioni

Tutti i pazienti e/o le persone che li assistono hanno esigenze specifiche in relazione alla cura condivisa delle lesioni e non tutti possono essere idonei a questo approccio. La posizione di una persona nel continuum della cura condivisa dipende dalla sua capacità, fiducia e volontà di partecipare alla cura delle proprie lesioni, oltre che dalle sue particolari esigenze e dal suo sistema di supporto al di fuori del contesto ospedaliero (Moore et al, 2021). Inoltre, il grado di coinvolgimento del paziente/caregiver può cambiare nel tempo, per cui il paziente e/o chi li assiste necessitano di una valutazione continua durante il trattamento.
La valutazione dell'idoneità del paziente e/o chi li assiste ai fini della cura condivisa delle lesioni dovrebbe includere i seguenti elementi: lo stato di salute generale del paziente (comprese la manualità e la mobilità), il grado di comprensione della sua condizione e del trattamento, la misura in cui desidera partecipare alla loro cura, la motivazione ad aderire al trattamento e ad intraprendere cambiamenti nello stile di vita, la capacità mentale e fisica, l'esperienza di trattamenti precedenti, la disponibilità di familiari e caregiver a partecipare alla cura condivisa (Wounds International, 2016; Moore e Coggins, 2021).
Gli infermieri stanno già adottando pratiche di cura condivisa delle lesioni con alcuni pazienti che si assumono la responsabilità di cambiare le proprie medicazioni dopo aver seguito una formazione. Inoltre, le pratiche di cura condivisa sono state in qualche modo accelerate dalla pandemia di COVID-19 e probabilmente continueranno a prendere piede negli anni a venire. Per aiutare i gli infermieri nella selezione e nella formazione dei pazienti, sono state sviluppate risorse come la Shared Wound Care Discussion Guide (Guida alla discussione sulla cura condivisa delle lesioni) che si prefigge di aiutare gli operatori sanitari a collocare i pazienti nel continuum della cura condivisa delle lesioni e a capire come favorire e sostenere al meglio i pazienti/caregiver che scelgono di essere maggiormente coinvolti nella cura delle lesioni (Moore et al, 2021). È in corso una valutazione internazionale della Shared Wound Care Discussion Guide per identificarne il ruolo nella pratica (Moore et al, 2021).

Risorse e formazione dei pazienti da parte del personale infermieristico.

La formazione dei pazienti da parte del personale infermieristico è la base di un'efficace gestione condivisa delle lesioni. A seconda di

ciò che il paziente e/o chi lo assiste è in grado e disposto a fare, gli elementi chiave della formazione e dell'affiancamento possono includere:

- come identificare i probabili rischi di complicanze, quali per esempio i segni e i sintomi di infezione
- come segnalare la progressione della lesione
- chi contattare in caso di dubbio o se la ferita mostra segni di deterioramento
- i passaggi necessari per cambiare la medicazione di una lesione
- la formazione dedicata alle medicazioni (Wounds International, 2016; World Union of Wound Healing Societies, 2020).

I passi successivi

In un contesto di crescente carenza di personale infermieristico (Buchan et al., 2020) e di aumento del carico assistenziale imposto dalle lesioni croniche (Sen, 2021), è importante cercare potenziali soluzioni, dove la cura condivisa e le medicazioni avanzate in schiuma a lunga permanenza possono svolgere un ruolo importante.

Il modello di 3,5 miliardi di ore stima che entro il 2030 si potrebbero liberare 3,5 miliardi di ore di tempo di assistenza infermieristica. Per raggiungere questo obiettivo, sarà necessario disporre dell'accesso alle medicazioni avanzate in schiuma a lunga permanenza, di sistemi atti a identificare l'idoneità dei pazienti alla cura condivisa delle lesioni e di risorse e formazione da parte del personale infermieristico.

Una barriera all'utilizzo delle medicazioni avanzate in schiuma a lunga permanenza è il costo percepito: spesso è il costo per medicazione anziché il costo totale dell'assistenza a costituire un indicatore di efficienza economica. Inoltre, il concetto di cura condivisa delle lesioni è spesso percepito come non vantaggioso se l'infermiere viene retribuito in base al numero di visite (Moore e Coggins, 2021). Per superare questa barriera percepita è necessaria un'opera di educazione al modello di cura condivisa contemporaneamente rivolta sia al personale clinico sia a chi sostiene il carico economico.

Il modello di 3,5 miliardi di ore è una componente della miriade di considerazioni associate al concetto di cura condivisa. La sua valutazione insieme alla Shared Wound Care Discussion Guide per determinare l'idoneità di un paziente alla cura condivisa e quindi selezionare il prodotto appropriato e valutare i risultati per individuare l'approccio giusto potrebbe favorirne la diffusione nella popolazione dei pazienti. La concentrazione dell'attenzione sul contesto di comunità consentirà di identificare il potenziale del modello di 3,5 miliardi di ore.

Conclusioni

Il modello presentato stima che entro il 2030 si potrebbero liberare 3,5 miliardi di ore di assistenza infermieristica se si adottassero medicazioni avanzate a lunga permanenza nell'ambito di un approccio di cura condivisa delle lesioni. La cura condivisa delle lesioni non significa che i pazienti riceveranno meno cure, bensì un approccio diverso alla cura delle lesioni che ha dimostrato di portare vantaggi sia ai pazienti sia agli operatori sanitari. Sebbene l'adozione di approcci di cura condivisa richieda fin dall'inizio un investimento di tempo, è ragionevolmente possibile sostenerne i potenziali benefici nel lungo periodo. Per una formazione diffusa, l'adozione e la misurazione della progressiva integrazione del modello di 3,5 miliardi di ore tramite pratiche di cura condivisa delle lesioni, potrebbero essere necessari materiali rigorosi e riconosciuti a livello internazionale.

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Patient perspective

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

Authors:
Hayley Ryan and Henri Post

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.

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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 Bielby, 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,

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

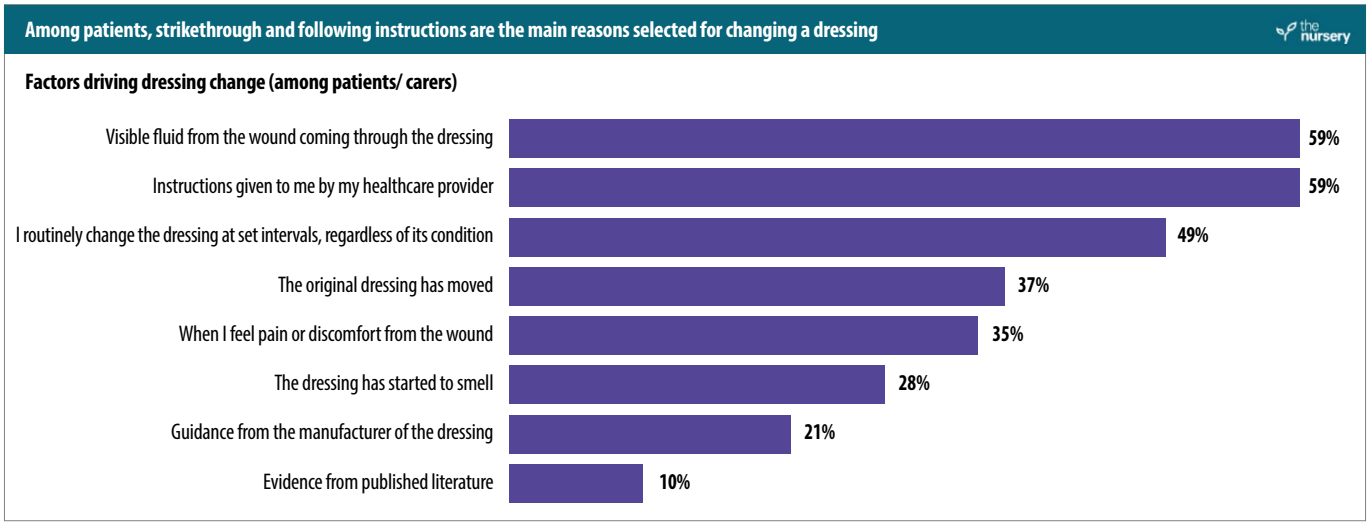


Figure 1. Factors influencing dressing change among patients and/or carers (The Nursery, 2022)

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

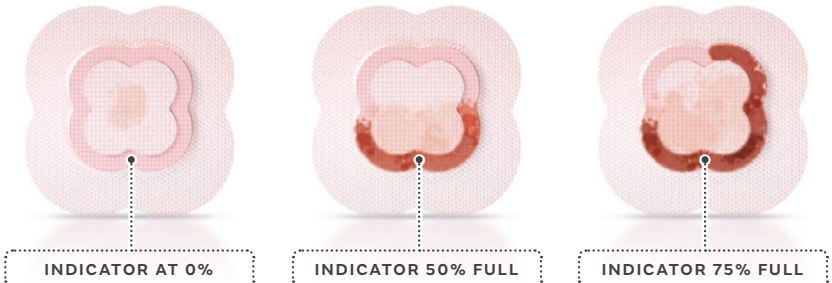
In addition to anxiety and depression, social isolation and shame are reported by patients living with a chronic wound (Lindsay et al, 2017; Platsidaki et al, 2017; Renner and Erfurt-Berge, 2017; Kapp et al, 2018; Tiscar-González et al, 2021). Scheduling at-home visits can be disruptive, and practitioners 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:



Everything's good, don't worry about changing your dressing at this point. The dressing can remain in place, with the exudate masked from view.

There's still no need to change your dressing but consider arranging an appointment with your medical professional, as appointment times and availability may vary.

When the change indicator is this full, it is time to change your dressing. Contact your medical professional to arrange a dressing change.

(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. WINT

Declaration

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Practitioner perspective

Shared wound care and the implementation tipping point: patient engagement to standardise practice

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Practitioners have advocated for new ways of working, such as shared wound care, to address the challenges in chronic wound management. Shared wound care practiced alongside the use of long-wear advanced foam dressings has the potential to optimise community wound care*; releasing time for nurses and healthcare systems, and empowering patients. Many practitioners already use elements of shared wound care with patients but require support to implement the approaches more formally and reduce practice variation. This article will discuss shared wound care from an individual practitioner's perspective, addressing how shared wound care is beneficial, accessible, clinically effective, scalable, and implementable, and facilitate discussions about standardising implementation within their health system.

Nurses globally are facing pressures that severely impact their ability to carry out their vital role (Barrett and Heale, 2021; Castro-Ayala et al, 2022; World Health Organization [WHO], 2022). With the prevalence of chronic wounds rising by 71% since 2012, we are currently facing a crisis and new ways of working are required to meet the challenge of chronic wound management for both patients and individual practitioners (Sen, 2019).

Innovation accelerated during the pandemic in an effort to make healthcare services more resilient, effective and efficient. However, greater focus is now needed to ensure these new pathways, technologies and protocols continue to be implemented to maximum effect, especially when we consider the prediction by WHO that by 2030, the nursing shortage globally could be as high as 5.9 million (WHO, 2020; Queen and Harding, 2021).

A recent review identified three main areas of stress that nursing staff experience (Broetje et al, 2020):

- **Work overload:** time constraints, staffing issues and high workloads
- **Lack of formal reward:** pay, growth and development opportunities and effort-reward imbalance
- **Work-life interference:** unsocial hours and stressful or traumatic work environments.

As well as factors that put pressure on all nursing staff, there are compounding factors for specialist wound care nurses. Pressures include increasing costs of management, an ageing population, increased prevalence of co-morbidities and growing antimicrobial resistance (Sen, 2019; Guest, 2021).

There has also been a marked shift towards community nursing; in some markets, there has been a 399% increase in community nurse visits between 2012 and 2018, while specialist nurse visits decreased over the same period (Guest et al, 2020). As non-specialist community nurses now take a more active role in wound care, managing practice variation will become increasingly important (Guest, 2021).

Studies (Moore et al, 2021; Tayyib and Ramaiah, 2021; Blackburn and Ousey, 2022) have identified areas where nurses feel there is room to improve the management of wounds, including:

- Higher patient involvement in wound

**Wear time of up to 5 to 7 days (Simon and Bielby, 2014; Joy et al, 2015; Smith+Nephew, 2016b; 2016a)*

management
- Staff education
- Dressing selections and dressing change frequency
- Multidisciplinary coordination
- Holistic approach to care, which encompasses wider aspects of the patient's health, not just their wound.

These areas for improvement can be addressed through the implementation of shared care practices. Shared wound care encompasses practice interventions that facilitate interested and capable patients taking a more active role in care planning and delivery.

Shared care practices are not a new concept and are already implemented to great effect in diabetes, incontinence and stoma management (Ketterer et al, 2021; Pizzol et al, 2021; University of Southern California, 2021). In wound care, shared care has been found to improve patient engagement, personalise dressing change schedules and support a holistic view to patient care (Wounds International, 2022).

Furthermore, the shared wound care approach combined with the use of long-wear advanced foam dressings has been estimated to release up to 3.5 billion nursing hours globally by 2030, achieved primarily through reductions in unnecessary dressing changes and a reduction in patient visits (Moore et al, 2021; Moore et al, 2022).

Despite the many benefits of shared wound care, there are a multitude of challenges facing those wishing to implement new protocols (Grothier, 2018).

This article aims to support clinicians to begin conversations about the implementation of shared wound care and overcoming common challenges or barriers (Moore et al, 2021).

Shared wound care: in practice

Implementing new ways of working can be done informally at first, often through conversations with patients during typical care activities to educate or engage. To standardise, however, more formal protocols are needed with the support of the healthcare system and change of practice champions to drive change and record outcomes.

With protocol or behaviour change programmes, common challenges centre around the following (Grothier, 2018):

- **Lack of cost benefits:** additional expenses and resources caused by new ways of working and the individual nurse's capacity
- **Accessibility:** inability to attend training and educational initiatives due to time pressure and staffing issue
- **Clinical effectiveness:** patient suitability, informal support from family members and research access may be limited
- **Scalability:** the available resources for implementation and the sharing of best practice
- **Ease of implementation:** need for stakeholder engagement and poor communication which can lead to reduced confidence in practice.

Shared wound care can be implemented with minimal practice disruption and reassurance provided around each of these cited challenges or barriers. Using long-wear advanced foam dressings can aid nurses and patients practicing shared wound care. But, it should be noted that long-wear advanced foam dressings are not vital for the practice, and shared wound care can be implemented using other dressing types.

Cost and resource benefits

The benefits of shared wound care are multi-faceted. Patient empowerment benefits can be seen across physical, mental and financial health. The 3.5-billion-hour time release model demonstrates the cost benefit to the global nursing profession (Moore et al, 2022). On the other hand, for individual practitioners, shared wound care has the potential to benefit daily working practice.

Community nurses have identified several benefits that shared wound care could bring to their working lives (Moore and Coggins, 2021):

- **Timing:** clinicians can spend more time with patients that have more complex needs
- **Cost:** fewer visits and fewer dressing changes result in reduced costs for care providers
- **Relationship:** patients that engage with their wound management have a better relationship with their clinician
- **Reporting:** patients that have a good understanding of their wounds provide better reporting information, which supports clinical decision making.

Time has been identified as one of the biggest constraints on clinicians, and one of the primary benefits of shared wound care is time release (Moore et al, 2021; Moore et al, 2022)*. Shared wound care when implemented alongside long-wear foam dressings, has the potential to save up to 3.5 billion hours globally by 2030 (Moore et al, 2022). What does this mean, however, to an individual starting a conversation with stakeholders about implementing shared care at a practice level? It means a potential 10% reduction in community nursing time spent

**The data set used to create the 3.5 billion hour model, revealed that globally, 4,011,188,929 hours is spent on dressing changes in the community per year, ALLEVYN LIFE as part of a shared wound care approach has the potential to release 10.8% (433,208,404) of these hours.*

Nursing hours released per year (total) = 433,208,404

Nursing hours spent on dressing changes in the community per year (total) = 4,011,188,929

Hours released as a percentage of total nursing hours spent on dressing changes in the community = 433,208,404 / 4,011,188,929 = 10.8%

changing dressings (Moore et al, 2022).

This time, currently dedicated to potentially unnecessary dressing changes or home visits, will allow nurses to optimise the time they have with patients with chronic wounds, wherever they sit on the shared care continuum.

For patients ready to embrace shared wound care, this approach allows their nurse to prioritise higher value tasks than dressing changes and provide more holistic care, for example spending more time treating co-morbidities or managing other issues related to chronic wounds that affect a patient's quality of life. If appropriate, it could also reduce the number or duration of visits, to allow the nurse to spend more time with patients that are not able or willing to participate in shared wound care, have more complex care needs and require a more hands-on approach (Smith+Nephew, 2016c; Moore et al, 2021).

While the implementation of shared wound care does not reduce a nurse's workload, improve remuneration, or improve work-life balance, it does allow a nurse to personalise wound care based on patient needs, which means an optimised use of finite nursing time (Moore et al, 2021).

Accessibility

Incremental efficiencies can be achieved by community and wound specialist nurses but implementing this can seem a daunting task when considering all aspects of shared wound care. This practice change, however, is more accessible than it may seem at first glance. Sixty percent of patients with chronic wounds already have some active role within their care, meaning that a proportion of patients will already be aware of some shared care practices as part of their standard care program (Moore et al, 2021).

Shared care is a continuum, meaning patients can become more or less involved in their care over time as their circumstances change. This means clinicians do not need to spend unnecessary time trying to fully involve a patient if they do not meet the criteria and regardless of a patient's capability they can fit somewhere on the shared care continuum (Moore et al, 2021; Wounds International, 2022).

A change in practice would not require additional qualifications, significant training or resources as it is nurse-led and much of the infrastructure, such as access to telehealth and reporting methods, are already in place as part of standard practices (Koonin et al, 2020; Mahoney, 2020; Moore and Coggins, 2021).

There are many tools available to aid clinicians in both the implementation and ongoing management of shared wound care:

- The T.I.M.E clinical decision support tool (CDST) *[Figure 1]* is a tool which aids clinicians to assess, treat and manage chronic wounds (Moore et al, 2019)
- The Shared Wound Care Discussion Guide (SWCDG) *[Figure 2]* is a tool used to discuss aspects of shared wound care with patients and informal carers, giving practitioners a better understanding of patient suitability (Moore et al, 2021)
- A Case Series illustrates types of cases that are applicable to shared wound care and where those cases sit on the care continuum (Wounds International, 2022).

These tools address several of the barriers to implementing evidence-based practice as identified by nurses, allow for personalisation of best practice to align with local requirements, and enhances patient, practitioner and healthcare provider discussions (Moore et al, 2019; Moore et al, 2021).

Clinically effective

As a new way of working, there are some limits to the evidence for shared wound care in clinical practice, especially around healing parameters such as wound size, wound bed condition and wound progression. However, qualitative data collected from patients and practitioners over a 4-week period and across five countries, suggests shared wound care enhanced the experience of wound healing (Wounds International, 2022).

This recent case series illustrates how practitioners and patients of varying capacity all benefited from a shared wound care approach. Patients and practitioners reported that they experienced: a decrease in patient visits, regular communication between patient and clinician, increased patient confidence and independence (Wounds International, 2022).

The more quickly and effectively a wound heals, the less chance there is of further complications such as infection occurring during the healing process. This poses issues with chronic non-healing wounds as they are inherently slow to heal (Guo and DiPietro, 2010). Shared wound care practices when used in conjunction with ALLEVYN LIFE foam dressings can help undisturbed healing and efficiency (Chewning et al, 2012; Smith+Nephew, 2012, 2016a, 2016d, 2018b; Moore et al, 2021; Wounds International, 2022).

Patient selection and effective communication between the clinician and patient are important for clinically effective wound management. The tools discussed above ensure that effective communication and patient selection can be

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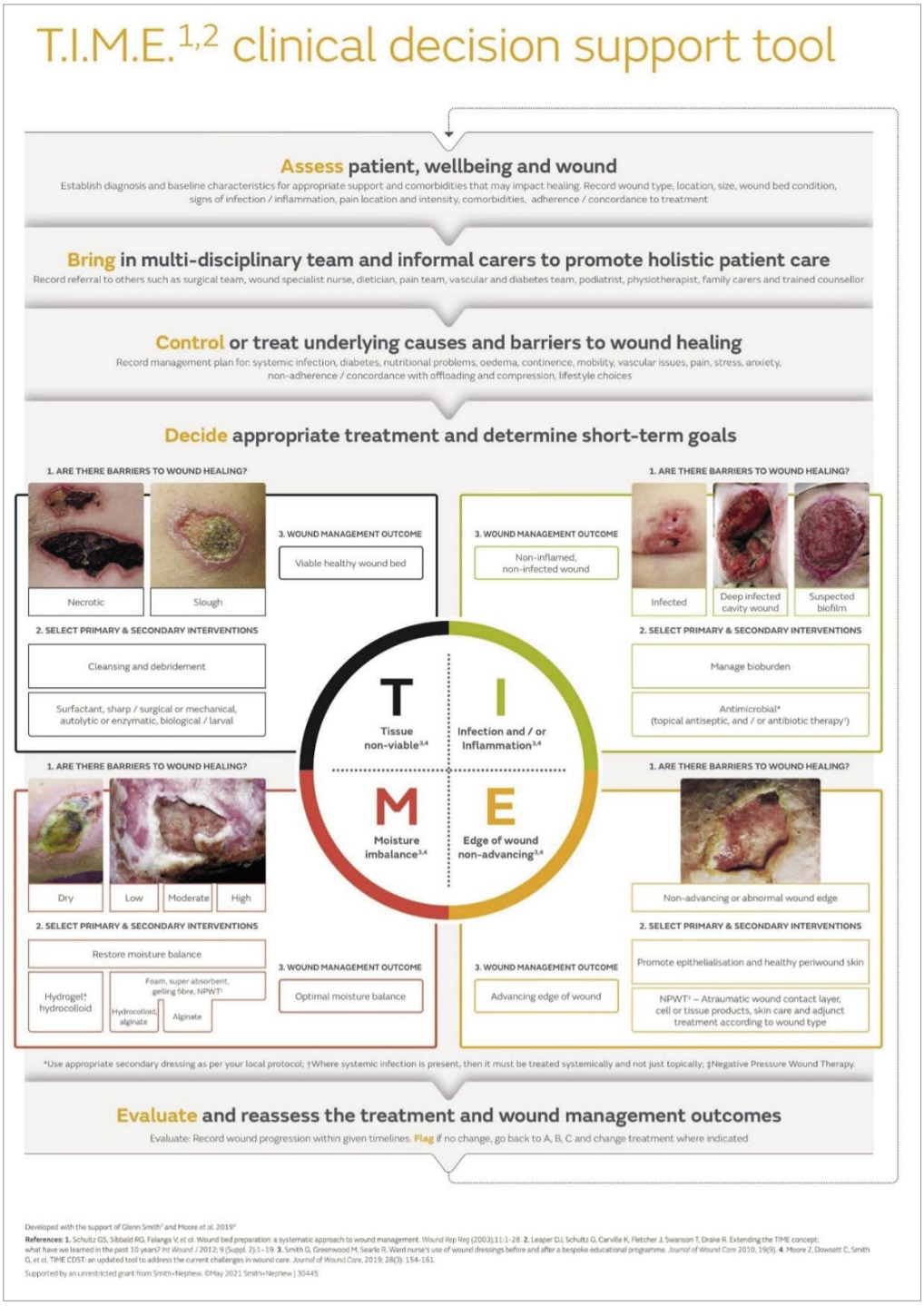

Figure 1. T.I.M.E clinical decision support tool (CDST) for wound management (Moore et al, 2019).

achieved within a shared wound care practice (Moore et al, 2019; Wounds International, 2022). The tools allow for clinicians to select the suitable patients with the suitable wounds for full involvement in shared wound care, as well as identifying patients that can't or don't want to be involved in shared wound care.

Longer wear approaches require clinicians and clinically appropriate patients to leave their dressings on for longer to facilitate undisturbed healing, which is a key aspect of why shared wound care is an effective practice**. Undisturbed healing has been shown to be a beneficial practice in the treatment of acute wounds and non-healing wounds when practiced with long-wear advanced foam dressings, such as ALLEVYN LIFE (Stephen-Haynes, 2015).

Some of the major reasons for premature dressing changes are due to the dressing itself (i.e. dressing has moved, dressing smells, guidance from dressing manufacturer *[Figure 3]*. This can lead to

***Manufacturer's IFU should always be consulted.*

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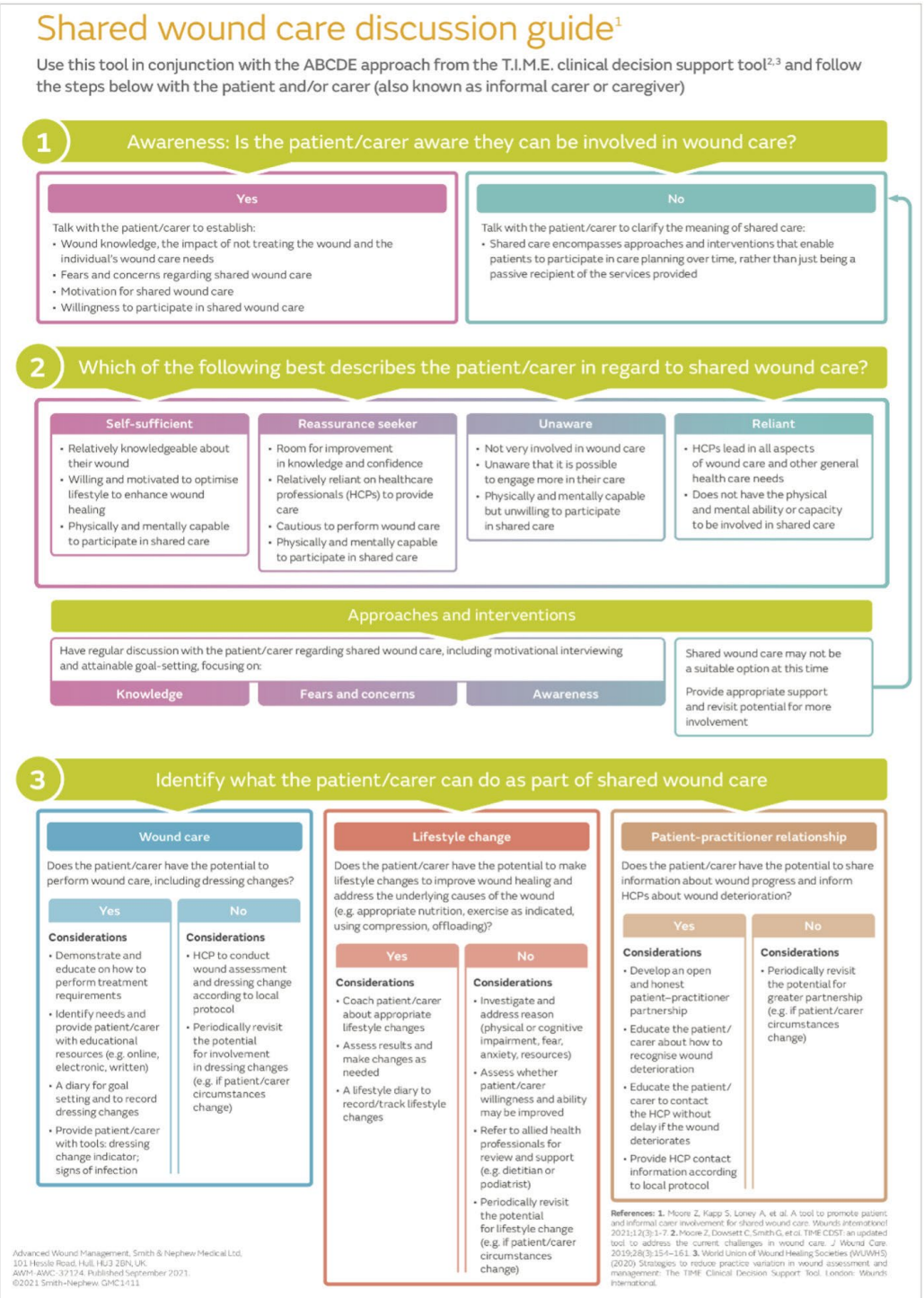


Figure 2. Shared wound care discussion guide (SWCDG) (Wounds International, 2022)..

reduced trust in dressings and more frequent dressing changes.

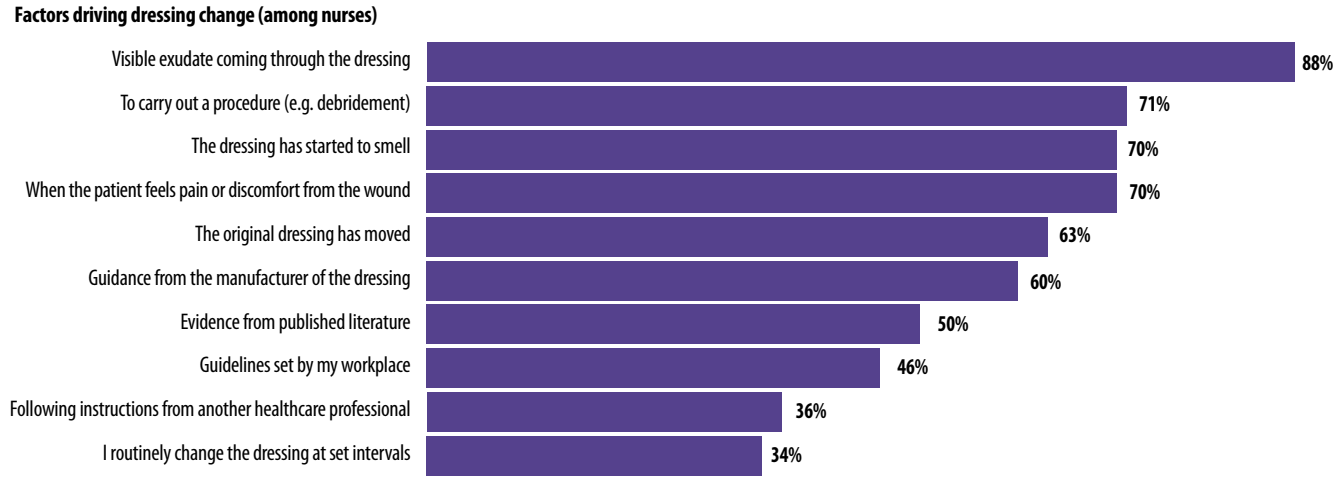
Shared wound care, when used alongside appropriate advanced foam dressings, can be an effective practice that offers clinical confidence to patients, practitioners and healthcare systems (Grothier, 2018).

Scalability

Shared wound care is a scalable strategy that can be tailored to the specific healthcare system in which it is implemented. Clinicians are already practicing shared wound care as 60% of patients already take an active role in their treatment. Specific steps can be taken to scale shared care approaches with more patients, more formally and with less practice variation (Moore et al, 2021).

The nature of shared wound care makes it suited to a phased rollout, with initial

Figure 3 – Common factors that drive dressing changes by nurses* (Smith+Nephew, 2022).



* In response to the following question: 'Here are some factors that people use to assess the condition of wound dressings and decide when to change the dressing. Based on your experience of managing chronic wounds, which of these factors most apply to you?' Base: All nurses (230). Manufacturer's IFU should always be consulted.

implementation carried out using a small cohort of patients that are most suitable for shared wound care (Moore et al, 2021). Not all patients need to be engaged in shared wound care right away, only the most clinically appropriate. This gives clinicians the ability to implement the practice at a pace that suits them and the demands of their practice.

As implementation progresses, practitioners will have more time to invest in scaling up shared care practices, and identifying, training and engaging new patients. A phased approach will have a cumulative effect on the time released, as more patients are enrolled onto a shared wound care pathway, more time will be released to nurses to enrol more patients. Alternatively, clinicians can dedicate more time to patients who are not able or don't want to be involved in shared wound care and require more hands-on care (Moore et al, 2021).

Other care areas such as diabetes management have utilised a shared care approach to improve quality of life for patients. Reports by stakeholder groups have highlighted areas that should be of focus when implementing shared care programs, areas such as care planning, clinical engagement and leadership, and clinical governance (Diabetes UK, 2014). By learning from experiences in other therapy areas, wound care specialists can streamline their implementation efforts, increasing scalability and the speed of uptake.

Implementation

Shared wound care is welcomed by many patients and practitioners and is a proven way to streamline wound management and improve clinical outcomes. However, there are still barriers to implementation which need to be addressed. While discussions about becoming involved in shared care can take place between practitioners and patients without involvement from all relevant stakeholders, implementing a formalised change of practice can be difficult.

This has been shown in the implementation of local diabetes shared care programs where involvement from senior hospital managers (e.g. chief executive officers), specialist clinical leads, community nurses, care commissioners, patient groups and disease specific charities were required to set up effective shared care pathways (Diabetes UK, 2014). This is a broad stakeholder group so effective engagement with all parties is required for effective implementation of shared wound care. *Box 1* shows the steps that should be taken when implementing a change of practice within a healthcare system and can be used to aid implementation of shared wound care within a healthcare organisation.

Experiences from stoma management can teach us a lot about how training, resourcing and product availability can be barriers to shared care. In the UK, Rotherham Clinical Commissioning Group found that patients were housebound due to poor continence equipment, patients had to modify their equipment and patients received equipment they did not need (Di Gesaro, 2012; NHS, 2021). This highlights the need for training, adequate resourcing, access to correct equipment and a robust and comprehensive business case to successfully implement shared wound care.

Conclusion

Shared care is a natural progression in chronic wound management, it is well evidenced in practice in the management of other chronic conditions and evidence in wound care is

Box 1: Implementation of shared wound care using long-wear advanced foam dressing, such as ALLEVYN LIFE Advanced Foam Dressings — Clinical pathway considerations (see Appendix 1 for full list of implementation steps).

- **Assess:**
  - Patient identification using the SWCDG and assess the wound using the T.I.M.E CDST
- **Dress:**
  - Choose a dressing that can best help the facilitation of shared wound care practices
- **Educate:**
  - Use standardised training modules to educate patients on shared wound care and ensure to check for comprehension by patient
- **Define:**
  - Care strategy – Define a care and follow-up strategy that is aligned to the patient's quality of life
  - Escalation – Define a clear escalation pathway with the patient and all responsible clinicians
- **Reassess:**
  - Periodically reassess the patient and adapt care and follow-up strategy.

growing rapidly (Diabetes UK, 2014; Ketterer et al, 2021; NHS, 2021; Pizzol et al, 2021; Wounds International, 2022). Implementation of this practice can release a significant amount of time for every nurse that treats chronic wounds as well as improving outcomes by engaging patients in their own care and focusing more time on patients that can't. The time released can be optimised by each nurse depending on the demands and priorities of their role.

Practitioners can take steps now to begin implementing shared wound care and tools are available to assist pilot programs. Practitioners can start assessing where patients may sit on the shared care continuum using tools such as the T.I.M.E CDST *[Figure 1]*, SWCDG *[Figure 2]*, shared care case series and the international best practice guidelines (Moore et al, 2016, 2019, 2021; Wounds International, 2022). Starting with discussions with management, whether that is clinical leads or executive level management, is another way practitioners can begin the process. The last step practitioners can take is identifying a change of practice champion that can help drive change within their healthcare organisation.

The next article in the series will focus on implementing change of practice at an organisational level, aiming to aid practitioners to engage payors and higher-level management to implement shared wound care practices. Implementing shared wound care will be an incremental process but investment of the required time and resources promises to yield real improvements for practitioners, patients and healthcare providers in the management of chronic wounds. WINT

Declaration

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Appendix 1: Implementation of shared wound care using long-wear advanced foam dressing such as ALLEVYN LIFE Advanced Foam Dressings - Clinical pathway considerations.

Assess:

- Ability and capacity, self-confidence and motivation, carer status and wound type are all aspects that should be considered when assessing patients and their wounds
- Keep in mind that every patient and every wound is different and that patients can become more or less able to participate in their own care at any point
- Let the patient define what success is e.g. less smell or pain, greater independence or greater quality of life
- Utilise the SWCDG and the T.I.M.E CDST

Dress:

- Wear time of up to 5-7 days*
- Change indicator to minimise the visual impact of exudate and to show patients and clinicians when to change the dressing, helping to minimise clinically unnecessary dressing changes
- Excellent exudate management to prevent leakages
- Optimal patient comfort
- Odour control to extend wear times and patient tolerance
- Showerproof

Educate:

- Create a standardised patient training programme with tools to aid the patient training process
- Tailor your training programme to the care setting in which shared care is being practiced
- Make the training process incremental to allow for differing patient abilities

Define:

- Care strategy
  - Follow-up schedules need to be tailored to patients – some may need an in-person appointment twice a week while others only need a phone appointment each week.
  - Offer a range of ways for patients to make contact e.g. In-person, clinic, phone, text
  - Standardised documentation will help keep accurate records and improve care- especially when multiple nurses are seeing one patient
  - Include patient reassessment to ensure that patients are receiving the appropriate level of care
- Escalation
- Standardised training for nurses, carers and patients on when escalation is required
- Clearly define who to contact in the event of an escalation as well as how to contact them

Reassess:

- Periodically reassess the patient and adapt care and follow-up strategy accordingly.

**5 days for sacral*

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T.I.M.E.2.0 a supporto delle tue scelte cliniche

A: Valuta il paziente, lo stato di salute e la ferita

Stabilisci la diagnosi e le condizioni generali di partenza incluse le comorbidità che possono influenzare la guarigione. Annota il tipo di lesione, posizione e dimensione, le condizioni del letto di ferita e della cute perilesionale, segni di infezione, dolore, problemi sistemici rilevanti, anamnesi clinica, collaboratività del paziente.

B: Coinvolgi un team multidisciplinare per promuovere un approccio olistico

Consulta altri professionisti come ad esempio: l'equipe chirurgica, l'infermiere specializzato in wound care, il nutrizionista, lo specialista del dottore, il vascolare, il diabetologo, il podologo etc.

C: Controlla o tratta le cause e le barriere alla guarigione

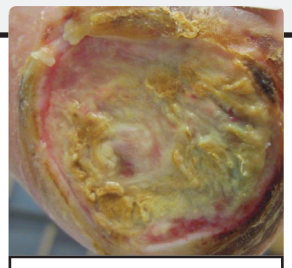
Prevedi un piano di gestione di: infezione sistemica, diabete, problemi nutrizionali, edema, incontinenza, mobilità, problemi vascolari, dolore, stress, ansia etc.

D: Decidi il trattamento appropriato

T – Tessuto non vitale[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Tessuto necrotico



Slough

3. OBIETTIVO CLINICO PER LA FERITA

Fondo di ferita vitale

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Debridement

Collagenasi o Idrogel*

Cadexomero iodico*

Collagenasi INTRASITE◊ GEL o **INTRASITE CONFORMABLE**

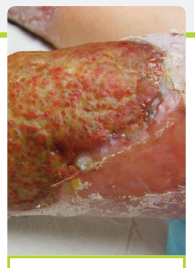
Gamma IODOSORB◊

I – Infezione e/o infiammazione[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Carica batterica elevata/Infezione

Lesione cavitaria profonda infetta



Sospetto di biofilm

3. OBIETTIVO CLINICO PER LA FERITA

Ferita non infiammata e non infetta

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Gestione della carica batterica

Medicazione antimicrobica*

Gamma ACTICOAT◊

DURAFIBER◊ Ag o **ACTICOAT Flex**

Gamma IODOSORB

M – Medicazione o secchezza[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Secchezza

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Ripristina l'ambiente umido ottimale

Idrogel*

Schiuma, fibra gelificante, NPWT†

INTRASITE GEL o **INTRASITE CONFORMABLE**

ALLEVYN◊ GENTLE BORDER, ALLEVYN GENTLE, DURAFIBER o **PICO◊‡**

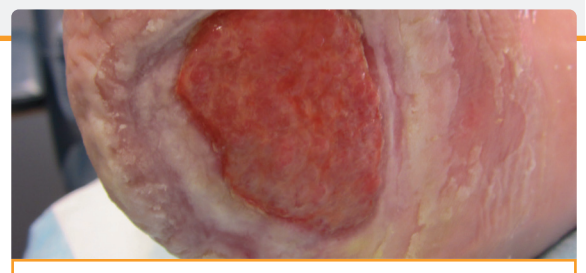
ALLEVYN LIFE, ALLEVYN LIFE Non-Bordered, DURAFIBER o **RENASYS◊**

3. OBIETTIVO CLINICO PER LA FERITA

Ambiente umido ottimale

E – Epitelizzazione/ Margine non proliferante[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE



Margine epiteliale non proliferante

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Progressione del margine e cura della cute perilesionale

NPWT monouso e/o collagene, protettivo cutaneo

PICO e/o **CONDRESS®**
SECURA◊ NO STING BARRIER FILM

3. OBIETTIVO CLINICO PER LA FERITA

Progressione del margine epiteliale

*Utilizza una medicazione secondaria appropriata come da protocollo clinico locale. Per esempio una medicazione della gamma ALLEVYN o OPSITE◊

E: Rivaluta il trattamento e i risultati raggiunti nel tempo

Registra i progressi rispetto ai tempi previsti. Se la ferita non migliora ritorna ad **A, B, C, D,** e cambia il trattamento dove appropriato.

Sviluppato con il supporto di Gl enn Smith[3] e Moore *et. al* 2019[4]

†NPWT: Terapia a pressione negativa. ‡Livello di essudato delle lesioni idoneo per NPWT.

Riferimenti bibliografi ci: 1. Schultz GS, Sibbald RG, Falanga V, *et al*. Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19. **3.** Smith G, Greenwood M, Searle R. Ward nurse's use of wound dressings before and aft er a bespoke educational programme. Journal of Wound Care 2010, vol 19, no.9. **4.** Moore Z, Dowsett C, Smith G, *et al*. TIME CDST: an updated tool to address the current challenges in wound care. *Journal of Wound Care*, vol 28, no 3, March 2019: 154-161.

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Guida alla discussione sulle cure condivise delle ferite[1]

Usare questa guida, insieme all'approccio A,B,C,D,E dello strumento di supporto clinico decisionale T.I.M.E. 2.0[2,3] e seguire i seguenti passi con il paziente e/o il caregiver.

1 Consapevolezza: Il paziente/caregiver è consapevole che potrebbe essere coinvolto nella cura delle ferite?

Sì

Parlare con il paziente/caregiver per comprendere:

- Cosa sa della propria ferita, delle conseguenze delle mancate cure e di quali trattamenti necessiti la sua lesione
- Paure e preoccupazioni riguardo le cure condivise
- Perchè attivare l'assistenza condivisa nella cura delle ferite
- Disponibilità a partecipare alle cure condivise delle ferite.

No

Parlare con il paziente/caregiver per chiarire il significato delle cure condivise:

- Le cure condivise comprendono approcci e interventi che permettono al paziente di partecipare alla pianificazione delle cure nel tempo, piuttosto che essere solo un destinatario passivo dei servizi forniti.

2 Quale dei seguenti scenari descrive meglio il paziente/caregiver per quanto riguarda le cure condivise?

Autosufficiente

- Conosce relativamente bene la sua ferita
- Disponibilie e motivato a ottimizzare il proprio stile di vita per migliorare la guarigione delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Cerca l'approvazione

- Ha possibilità di migliorare la conoscenza e la fiducia
- Relativamente dipendente dagli operatori sanitari
- Cauto nella cura delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Inconsapevole

- Poco coinvolto nella cura delle ferite
- Non sa che può essere maggiormente coinvolto nella cura delle sue ferite
- Fisicamente e mentalmente in grado, ma non disposto a partecipare alle cure condivise.

Dipendente

- Gli operatori sanitari guidano tutti gli aspetti del trattamento delle ferite e le altre necessità di salute
- Non ha la capacità fisica e mentale di impegnarsi nelle cure condivise.

Approcci e interventi

Discutere regolarmente con il paziente/caregiver sulle cure condivise delle ferite, compreso il colloquio motivazionale e la definizione di obiettivi raggiungibili, concentrandosi su:

Conoscenza | **Paure e preoccupazioni** | **Consapevolezza**

Le cure condivise delle ferite potrebbero non essere un'opzione appropriata in questo momento.

Fornire un sostegno adeguato e rivedere il potenziale per un ulteriore coinvolgimento.

3 Identificare ciò che il paziente/caregiver può fare come parte delle cure condivise delle ferite

Cura della ferite

Il paziente/caregiver è in grado di effettuare le necessarie cure della ferita, compresi i cambi di medicazione?

Si

Considerazioni

- Dimostrare e insegnare come eseguire i trattamenti
- Identificare i bisogni e fornire al paziente/caregiver risorse educative (ad esempio, online, elettroniche, scritte)
- Usare un diario per fissare obiettivi e registrare i cambi di medicazione
- Fornire al paziente/caregiver i seguenti strumenti: indicatore di cambio della medicazione; identificazione dei segni di infezione.

No

Considerazioni

- Gli operatori sanitari dovrebbero eseguire la valutazione della ferita e il cambio della medicazione secondo il protocollo locale
- Rivalutare periodicamente se il paziente/caregiver può essere coinvolto nei cambi di medicazione (ad esempio, se le circostanze del paziente/caregiver cambiano).

Cambiamento dello stile di vita

Il paziente/caregiver è in grado di modificare lo stile di vita per migliorare la guarigione della lesione e gestire i fattori causali (ad esempio, alimentazione appropriata, livello di esercizio fisico adeguato, uso della terapia compressiva, scarico)?

Si

Considerazioni

- Insegnare al paziente/caregiver i cambiamenti appropriati dello stile di vita
- Valutare i risultati e apportare modifiche se necessario
- Usare un diario per registrare i cambiamenti dello stile di vita.

No

Considerazioni

- Indagare e affrontare la motivazione (menomazione fisica o cognitiva, paura, ansia, risorse)
- Accertare se la volontà e la capacità del paziente/caregiver possono essere migliorate
- Consultare altri operatori sanitari per avere un supporto e una rivalutazione da parte loro (ad esempio il dietista o il podologo)
- Rivalutare periodicamente il potenziale di cambiamento dello stile di vita (ad esempio, se le circostanze del paziente/caregiver cambiano).

Rapporto paziente-clinico

Il paziente/caregiver è in grado di condividere informazioni sui progressi della ferita e di informare gli operatori sanitari del suo peggioramento?

Si

Considerazioni

- Sviluppare una relazione aperta e trasparente tra paziente e operatore sanitario
- Educare il paziente/caregiver su come riconoscere il peggioramento della ferita
- Educare il paziente/caregiver a contattare immediatamente l'operatore sanitario se la ferita peggiora
- Fornire i contatti dell'operatore sanitario secondo il protocollo locale.

No

Considerazioni

- Rivalutare periodicamente la possibilità di avere una maggiore collaborazione (ad esempio se le circostanze del paziente/caregiver cambiano).

Referenze: 1. Moore Z, Kapp S, Loney A, *et al.* A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 2021;12(3):1-7. **2.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care.* 2019;28(3):154–161. **3.** World Union of Wound Healing Societies (WUWHS) (2020) Strategies to reduce practice variation in wound assessment and management: The TIME Clinical Decision Support Tool. London: *Wounds International.*

Shared wound care case series

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INTERNATIONAL
CASE REPORTS

Case series: Shared wound care discussion guide

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Foreword

Shared care encompasses approaches and interventions that may enable patients to participate in care planning, decision making and care delivery. This approach values the patient as an active participant rather than a passive recipient of care, and is a key part of management for a range of other conditions (Wounds International, 2016). Patient involvement can not only improve wound care outcomes, but also reduce the economic burden and improve quality of life (Hibbard and Gilburt, 2014).

Shared wound care extends beyond the patient to engage with the patients' informal carer(s) (member[s] of a person's social network, e.g. family, friend or guardian) who helps the individual with activities of daily living, and may assist with the patient's wound-related care.

The shared wound care discussion guide (SWCDG) was developed as an aid for clinicians to use with the patient and informal carer(s) to discuss their awareness, willingness and ability to be involved in shared wound care (Moore et al, 2021). The SWCDG builds on international research and guidelines (e.g. Wounds International, 2016) plus survey results from clinicians (Moore and Coggins, 2021) and patients (Moore et al, 2021) that identified educational support is needed for clinicians to help patients and informal carers participate in shared wound care (Miller and Kapp, 2015; Kapp and Santamaria, 2017).

This case series describes how the SWCDG was evaluated in clinical practice by five wound care specialists in Australia, Canada, The Netherlands and the United Kingdom. The SWCDG was used during the initial patient and wound assessment to prompt conversation about shared wound care. The individual wound care dressing regimens were devised in collaboration between the clinician and the patient. The participants fears, concerns and thoughts on shared wound care were recorded. Each patient was monitored and reviewed for approximately 4 weeks or longer. Parameters of wound healing were recorded, such as wound size, wound bed condition and wound progression.

Overall, clinicians reported that using the SWCDG helped to facilitate shared wound care. The patients and their carers (if applicable) reported feeling more independent and empowered to be involved in their own care. There were decreased clinic visits and regular communication between the patient and clinician. If the patient was in a residential or nursing home, an additional benefit was that the nursing staff were upskilled in their wound care knowledge and felt confident that the patients could take an active role in their own wound care.

Shared wound care discussion guide

The shared wound care discussion guide (SWCDG; **Figure 1**) is an aid for clinicians that prompts discussion with the patient regarding their awareness and willingness to be involved in shared wound care. Use of the SWCDG should be considered at the start of the shared care journey with the patient. A patient's involvement in shared wound care is not static, so their ability and/or willingness to participate in care can change over time. Therefore, it is important to revisit the guide periodically to gauge success and satisfaction among all stakeholders of shared care.

The SWCDG is a tool that builds on international guidelines (Wounds International, 2016), data from a clinician survey (Moore and Coggins, 2021) and data from a patient survey (Moore et al, 2021) that identified an opportunity to provide educational support for clinicians in facilitating patients to participate in shared wound care. Patients who are involved in shared wound care would also benefit from standardised education (Moore et al, 2021). However, close professional supervision is required to optimise shared care practices and to optimise clinical outcomes (Kapp and Santamaria, 2017).

The guide is also based on the premise that informal carers are an integral and valuable part of the engagement process, and interventions and support for informal carers would also enhance wound healing (Miller and Kapp, 2015).

The SWCDG was developed by Moore et al (2021) with the following aims:

- To identify patient and informal carers who may benefit from being involved in shared wound care
- To improve clinical and service delivery outcomes by increasing education among patients and informal carers and encouraging more continuous, consistent and collaborative care
- To direct the clinician to implement the approaches and interventions that may be most suited to the patient's needs (e.g. wound-related care, lifestyle changes and/or supporting the patient–practitioner relationship).

DRESSING CONSIDERATIONS FOR PATIENTS AND CARERS INVOLVED IN SHARED WOUND CARE

The treatment and dressing selection for the patient should be based on effective holistic patient and wound assessment using a validated tool, such as the T.I.M.E. clinical decision support tool (Moore et al, 2019). For shared wound care, it was anticipated that using a dressing with a longer wear time of 5-7 days, where appropriate, could potentially be beneficial for patients (Moore and Coggins, 2021; Moore et al, 2021).

Patients and clinicians have also reported that they require dressings that control odour, are showerproof to allow bathing and are adherent to allow individuals to conduct their activities of daily living without the risk of the dressing falling off. If a dressing is to be used by patients and/or carers, it should be easy-to-use and take out of the packaging especially for people with low manual dexterity, with clear instructions on which side of the dressing goes next to the wound and how to use the dressing in general (Moore and Coggins, 2021; Moore et al, 2021).

Additional dressing attributes that may help patients to manage their own wounds include dressings that indicate when there is infection or when it is saturated and needs changing. For example, ALLEVYN® LIFE Foam Dressing (Smith+Nephew) incorporates a design feature that indicates when a dressing change is needed due to high exudate levels. This may reduce the amount of unnecessary tampering with dressings and wounds and, therefore, reduce the risk of infection. The dressing has also been shown to be of benefit to both patients and clinicians in promoting wound closure and improved patient wellbeing (Rossington et al, 2013; Tiscar-Gonzalez et al, 2021).

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Shared wound care discussion guide[1]

Use this tool in conjunction with the ABCDE approach from the T.I.M.E. clinical decision support tool[2,3] and follow the steps below with the patient and/or carer (also known as informal carer or caregiver)

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

Yes

Talk with the patient/carer to establish:
- Wound knowledge, the impact of not treating the wound and the individual's wound care needs
- Fears and concerns regarding shared wound care
- Motivation for shared wound care
- Willingness to participate in shared wound care

No

Talk with the patient/carer to clarify the meaning of shared care:
- Shared care encompasses approaches and interventions that enable patients to participate in care planning over time, rather than just being a passive recipient of the services provided

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

Self-sufficient
- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care

Reassurance seeker
- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care

Unaware
- Not very involved in wound care
- Unaware that it is possible to engage more in their care
- Physically and mentally capable but unwilling to participate in shared care

Reliant
- HCPs lead in all aspects of wound care and other general health care needs
- Does not have the physical and mental ability or capacity to be involved in shared care

Approaches and interventions

Have regular discussion with the patient/carer regarding shared wound care, including motivational interviewing and attainable goal-setting, focusing on:

Knowledge | **Fears and concerns** | **Awareness**

Shared wound care may not be a suitable option at this time

Provide appropriate support and revisit potential for more involvement

3 Identify what the patient/carer can do as part of shared wound care

Wound care

Does the patient/carer have the potential to perform wound care, including dressing changes?

Yes

Considerations
- Demonstrate and educate on how to perform treatment requirements
- Identify needs and provide patient/carer with educational resources (e.g. online, electronic, written)
- A diary for goal setting and to record dressing changes
- Provide patient/carer with tools: dressing change indicator; signs of infection

No

Considerations
- HCP to conduct wound assessment and dressing change according to local protocol
- Periodically revisit the potential for involvement in dressing changes (e.g. if patient/carer circumstances change)

Lifestyle change

Does the patient/carer have the potential to make lifestyle changes to improve wound healing and address the underlying causes of the wound (e.g. appropriate nutrition, exercise as indicated, using compression, offloading)?

Yes

Considerations
- Coach patient/carer about appropriate lifestyle changes
- Assess results and make changes as needed
- A lifestyle diary to record/track lifestyle changes

No

Considerations
- Investigate and address reason (physical or cognitive impairment, fear, anxiety, resources)
- Assess whether patient/carer willingness and ability may be improved
- Refer to allied health professionals for review and support (e.g. dietitian or podiatrist)
- Periodically revisit the potential for lifestyle change (e.g. if patient/carer circumstances change)

Patient-practitioner relationship

Does the patient/carer have the potential to share information about wound progress and inform HCPs about wound deterioration?

Yes

Considerations
- Develop an open and honest patient–practitioner partnership
- Educate the patient/carer about how to recognise wound deterioration
- Educate the patient/carer to contact the HCP without delay if the wound deteriorates
- Provide HCP contact information according to local protocol

No

Considerations
- Periodically revisit the potential for greater partnership (e.g. if patient/carer circumstances change)

References: 1. Moore Z, Kapp S, Loney A, *et al.* A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 2021;12(3):1–7. **2.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care.* 2019;28(3):154–161. **3.** World Union of Wound Healing Societies (WUWHS) (2020) Strategies to reduce practice variation in wound assessment and management: The TIME Clinical Decision Support Tool. London: *Wounds International.*

Figure 1. Shared wound care discussion guide

EVALUATION OF THE SWCDG

Following a full wound and patient assessment by a wound care specialist, the SWCDG was used as a prompt to identify the patient and/or carer's suitability and willingness to be involved in shared wound care. The ability and willingness of a patient and/or carer to be involved in shared wound care is a continuum based on changing knowledge, understanding and ability, and willingness to engage in care (Moore and Coggins, 2021). The patient and/or carer were described in regard to their potential to be involved in shared wound care as either self-sufficient, a reassurance seeker, unaware or reliant. According to the chosen descriptor, the clinician was able to provide effective approaches and interventions and support the patient/carer on wound care, lifestyle changes and/or patient–practitioner relationship.

The wound care plan was agreed by the clinician and the patient/carer, and ALLEVYN LIFE Dressing was used if it was appropriate to the patient's needs. Each patient was monitored and reviewed for approximately 4 weeks or longer. Parameters of wound healing were recorded, such as wound size, condition of the wound bed, how the wound was progressing. Patient/carer wellbeing and their thoughts on shared wound care were also recorded.

Table 1 summarises the 10 case reports included in this evaluation. Figure 2 illustrates where the patients (and their carers if applicable) in the case series are positioned on the shared wound care continuum.

Table 1. Summary of case reports

Report	Clinician	Country	Wound type	Patient/carer description	Page
1	Amanda Loney	Canada	Venous leg ulcer	Reassurance seeker	8
2	Amanda Loney	Canada	Mixed aetiology ulcer	Self-sufficient	12
3	Henri Post	The Netherlands	Skin tear	Reassurance seeker	16
4	Henri Post	The Netherlands	Skin tear	Reassurance seeker	18
5	Ben Elsinga	The Netherlands	Clagett cavity	Reassurance seeker	20
6	Ben Elsinga	The Netherlands	Post-operative wound	Self-sufficient	22
7	Hayley Ryan	Australia	Diabetic foot ulcer	Reassurance seeker	24
8	Hayley Ryan	Australia	Skin tear	Unaware	26
9	Hayley Ryan	Australia	Skin tear	Reassurance seeker	28
10	Jan Ryzy	United Kingdom	Pilonidal sinus wound	Reassurance seeker	30

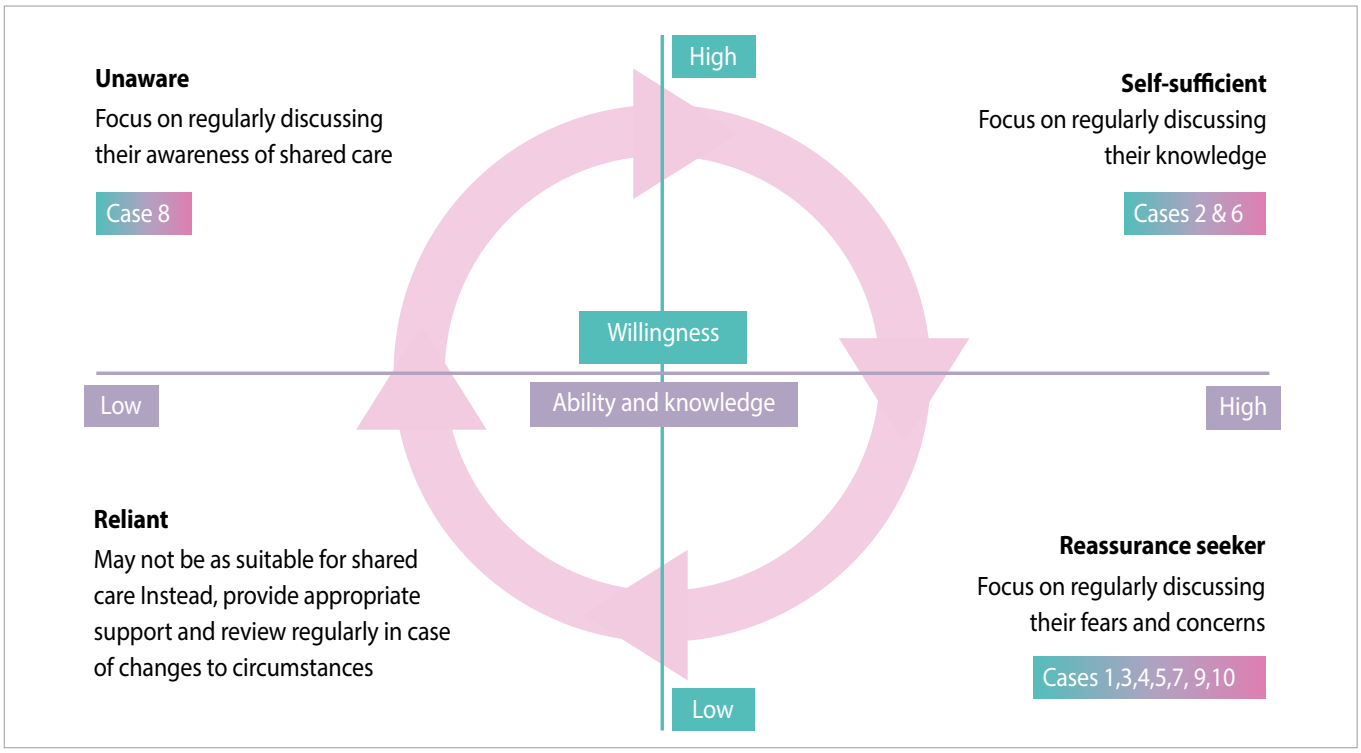

Figure 2. Positioning of case reports 1-10 on the shared wound care continuum (Moore and Coggins, 2021)

REFERENCES

Hibbard J, Gilburt H (2014) *Supporting people to manage their health. An introduction to patient activation.* The Kings Fund, May 2014

Kapp S, Santamaria N (2017) How and why patients self-treat chronic wounds. *Int Wound J* 14(6): 1269-75

Miller C, Kapp S (2015) Informal carers and wound management: an integrative literature review. *J Wound Care* 24(11): 489-90, 492, 494-7

Moore Z, Dowsett C, Smith G et al (2019) TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care* 28(3): 154-61

Moore Z, Coggins T (2021) Clinician attitudes to shared care and perceptions on the current extent of patient engagement in wound care: Results of a clinician survey. *Wounds International* 12(1): 48–53

Moore Z, Kapp S, Loney A et al (2021) A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 12(3): 86-92

Rossington A, Drysdale K, Winter R (2013) Clinical performance and positive impact on patient wellbeing of ALLEVYN™ Life. *Wounds UK* 9(4): 91-5

Tiscar-Gonzalez V, Menor-Rodriguez MJ, Rabadan-Sainz C et al (2021) Clinical and Economic Impact of Wound Care Using a Polyurethane Foam Multilayer Dressing. *Adv Skin Wound Care* 34(1): 23–30

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CASE 1: Venous leg ulcer

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Wound and patient history

A 61-year-old man had a venous leg ulcer (VLU) on the medial side of his left ankle for 1–2 months. The patient had history of blood clots. The VLU measured 4 cm (length) x 2.8 cm (width) x 0.3 cm (depth). The wound bed comprised 90% granulation tissue and 10% slough, and the wound edges were described as non-advancing. The periwound skin was slightly inflamed extending out from the wound edges by 5-6 cm. Local infection was suspected due to an increase in wound size and purulent exudate.

There was a slight rash on the lower leg, which the patient felt was caused by wearing the two-layer compression bandaging system. His leg was hot and itchy, but the wound was not painful. Wound pain was rated as 2 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain).

The patient was receiving care at home and had been prescribed antibiotics for cellulitis prior to the evaluation period; this had improved the inflammation and reduced the amount of wound drainage.

Shared wound care discussion guide

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

The patient had no previous experience with shared wound care and did not have anyone to assist him with the practicalities of wound care. However, he was willing to learn and participate. The patient understood the cause of the wound, the impact of not treating the wound (e.g. the wound will be slow to heal or not heal at all, and potentially increase in size) and the importance of wearing compression therapy. The clinician felt that the patient would have the ability to be more involved in shared wound care if education was provided on signs and symptoms of wound infection, goals of the dressing product used (i.e. to provide a moist wound healing environment), autolytic debridement and treating the wound topically for infection.

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

The clinician described the patient as a 'reassurance seeker' (**Box 1**). He had been heavily reliant on clinic nurses for wound care, but he had a good understanding of treatment and wanted to proceed on his own between clinic visits. He hoped that clinic visits would reduce and that he would be able to remove and apply his compression bandaging to allow him to shower and be able to change the dressing when necessary. Regular discussion with the patient would focus on improving his knowledge, addressing his fears and concerns, and improving his awareness. For example, he is most worried about performing wound care incorrectly and of not recognising when the wound is progressing in the right direction.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

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 learning how to remove and apply the dressing and compression bandaging system.

Lifestyle change: The patient had the potential to make lifestyle changes to improve wound healing. Coaching included the role of compression therapy and how to use and wear it most efficiently.

Patient-practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and empowered to contact the clinician without delay if the wound deteriorated.

With the patient, the wound care specialist developed the shared wound care plan to include:

- Cleansing the wound with saline and application of DURAFIBER® Absorbent Gelling Silver Fibrous Dressing (Smith+Nephew) and ALLEVYN® LIFE Foam Dressing (Smith+Nephew) on the wound, with instructions to change both dressings every 3–4 days unless the dressing indicator of ALLEVYN LIFE Dressing alerted him to change the dressing earlier. Information was provided on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Application of a steroid cream to the rash on his lower leg
- Padding of the leg, from the toes to three fingers below the bend in the back of the knee (50% overlap)
- Application of two-layer compression bandaging system compression bandages, with video instructions on how to apply and to remove daily so he could shower and check the dressings. The patient would send a photo after he had finished applying the compression bandaging. The compression system was introduced on a trial basis as the patient experienced an allergic reaction to the previously used system, so he was cautious about using compression therapy again
- Details on when and how to contact the wound care specialist were supplied. The patient was instructed to send photos or text if he had any concerns about his wound or needed reassurance. He was also provided with a handout on the signs and symptoms

that would require him to contact the doctor for antibiotics.

Final comments

The patient was very happy with the ongoing support he received over the evaluation period. The clinician also felt reassured when the patient contacted them with questions and sent images of the wound, which confirmed that the patient was still engaged in being involved in shared care. He did not deviate from the treatment plan and the wound did not deteriorate as he knew the signs of infection and when to alert a clinician. The patient was pleased that he had become more knowledgeable around wound care and wound progression.

The patient felt well supported and was able to carry out the care plan beyond the evaluation period. Several positive outcomes were noted by the patient and clinician as a result of using the shared wound care discussion guide, such as:

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

Wound progression in brief		
Initial presentation	**Week 9**	**Wound condition**
		The wound had fully healed, but, according to the patient, the area had begun to deteriorate.

Wound progression in detail

Initial presentation	Week 1	Week 3	Week 6	Week 7	Week 9
	No image available			No image available	
Wound condition: 90% granulation tissue and 10% slough; edges non-advancing, low levels of purulent exudate, local infection was suspected due to an increase in wound size, inflammation (greater than 3 cm), pain and purulent exudate. Wound size: 4 cm (length) x 2.8 cm (width) x 0.3 cm (depth)	**Wound condition:** 60% granulation tissue and 40% slough, inflammation to the periwound area has cleared, low purulent exudate, rash to lower leg is improving. Wound size: 1.3 cm (length) x 1.2 cm (width) x 0.2 cm (depth)	**Wound condition:** 60% slough, 20% red granulation tissue and 20% scabby tissue, slight increase in pain and itch. Wound size: 2 cm (length) x 1.5 cm (width) x 0.2 cm (depth)	**Wound condition:** The wound has decreased in size, and there is reduced drainage and pain. Wound size: 1 cm (length) x 1 cm (width) x 0.2 cm (depth)	**Wound condition**: 100% granulation tissue with new epithelial tissue, which is a significant improvement since last week. There is slight inflammation to the periwound skin and drainage is low. Wound size: 0.2 cm (length) x 0.2 cm (width) x 0.1 cm (depth)	**Wound condition**: The wound has fully healed, but according to the patient, the area had begun to deteriorate.
	Patient feedback: The patient is proud that he has learnt how to apply the compression bandages. He can see that the wound is improving and feels supported that should he have any questions or concerns he can contact the clinician.	**Patient feedback:** The patient is concerned that the wound is looking 'meaner' (i.e. more inflamed, more painful) and that wound progression has slowed.	**Patient feedback:** The patient is very pleased with the progress of the wound.	**Patient feedback:** The patient remains satisfied with wound progression and is very pleased with the support he receives from the clinician.	**Patient feedback:** The change indicator dressing has been useful as the patient could see a change was indicated when the dressing was 50–75% saturated. The patient wore compression daily and is very happy with the ongoing patient–practitioner relationship.

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	Clinician feedback: The patient is happy to be involved in shared wound care.	**Clinician feedback:** Close monitoring, support and education around treatment choices are needed as the wound is displaying signs of local infection. The patient is supported to continue with shared care. Treatment plan is changed to the following: • Cleanse with saline and soak with an antiseptic wound solution • Apply IODOSORB◊ 0.9% Cadexomer Iodine Ointment (Smith+Nephew) and ALLEVYN LIFE Dressing or ALLEVYN◊ GENTLE BORDER LITE Foam Dressing (Smith+Nephew) to the wound, hydrocortisone cream to the surrounding rash and a moisturising cream with urea and alpha hydroxy acid (AHA) to the rest of the leg • Apply a two-layer compression bandage system (compression socks to be used but if unavailable a high compression bandage; change twice a week).	**Clinician feedback:** Very pleased – the patient is independent with care and contacts the clinician for support and encouragement.	**Clinician feedback:** As the wound improves, the treatment plan is changed to the following: • Cleanse with normal saline and soak with a wound solution • Application of an antimicrobial dressing, hydrocortisone cream to the rash and a moisturising cream with urea and alphahydroxy acid to the rest of the leg • Apply ALLEVYN GENTLE BORDER LITE Foam Dressing and a two-layer compression bandage system (change twice a week).	**Clinician feedback:** The patient has become more knowledgeable about wound care and feels confident to continue to participate in shared care until the wound has healed.

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CASE 2: Mixed aetiology ulcer

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Wound and patient history

This case describes a 49-year-old woman who had a mixed aetiology ulcer on her right shin. She had anti-neutrophilic cytoplasmic autoantibodies (ANCA) vasculitis with pyoderma gangrenosum. ANCA vasculitis is an autoimmune disease affecting small blood vessels in the body; it is caused when ANCAs target and attack neutrophils. As a result, she was under the care of a rheumatologist and a dermatologist specialising in wound care and received anti-rheumatic and immunosuppressant therapy.

The wound bed of the ulcer consisted mainly of granulation tissue with a few islands of new epithelialised tissue. The wound edges were advancing, but the periwound skin was very macerated. On occasion, the macerated tissue would lift off to reveal new epithelial tissue or it would sluff off to expose open ulceration.

There were moderate to high levels of serous exudate depending on the patient's level of activity. There were no signs of local infection, but biofilm was suspected due to the very slow progress of wound healing. Wound pain level was low (1-2 out of 10 on the Numeric Rating Scale; 0=no pain; 10=worst pain), but it wound increase during cleansing, sharp debridement and dressing change.

The patient had experience of being involved in wound care as the wound had been present for over 10 years. In the past, she had changed the dressing before a clinic appointment if odour or would pain were intolerable or there was exudate leakage. She recently had to stop working due to the pain and high exudate levels, and required daily clinic visits to change the dressing.

For this individual, the main treatment goals included frequent ongoing debridement and moist wound management; infection control, risk management and treatment and oedema management

Shared wound care discussion guide

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

The patient was aware that she could be more involved in her wound care. She understood that the cause of the wound was complex: mixed disease aetiology complicated by vasculitis, pyoderma gangrenosum and venous disease. Although the complexity of the wound presented challenges, the clinician hoped that the wound would decrease in size and the patient would be able to lead a more 'normal' life by being more involved in the day-to-day management of the wound and that this would decrease the number of clinic visits required.

The patient was motivated and eager to participate in shared wound care and felt able to change the dressing herself when it was causing her discomfort. She was also pleased that she would be able to change the dressing when it was convenient for her.

Box 1. Description of a 'self-sufficient' individual

- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care.

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

The clinician described the patient as 'self-sufficient' (**Box 1**), as she was knowledgeable and willing to perform wound care and to optimise her lifestyle to enhance healing; for example, although not ideal, she stopped working to decrease her stress level and pain, and to elevate her leg when required during the day.

The patient was concerned about not recognising infection soon enough to prevent deterioration, which would impede wound healing. The main approaches to support shared care for this individual were to improve knowledge around compression therapy application and to address her fears and concerns.

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 learning how to apply and remove the dressing and compression bandaging system.

Lifestyle change: The patient had the potential to make lifestyle changes to manage the underlying causes of her wound by using compression therapy.

Patient-practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and was empowered to contact the clinician without delay if the wound deteriorated. The wound care specialist's contact details (email and phone) were given to the patient. There was an open-door policy to encourage the patient to contact the clinician any time she had questions or concerns or to come to the clinic if ever in doubt of her wound status. She was also encouraged to send photos and to get in touch regularly, even if she just required reassurance.

With the patient, the wound care specialist developed a shared wound care plan. Due to high odour, dressing change should occur every 2 days:

- Wound and limb should be soaked for 10 minutes in a cleansing solution containing 0.033% hypochlorous acid
- Application of a cream containing tacrolimus (a topical macrolide immunosuppressant) around the edge of the wound
- Application of a moisturising cream containing urea and alpha hydroxy

acid (AHA) to the intact skin with an option to use a steroid cream if the skin becomes itchy
- Cover with a collagen and oxidised regenerated cellulose silver wound contact layer
- Cover with ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needed to be changed more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Application of two-layer compression bandaging system
- Weekly clinic appointments for sharp debridement, wound assessment and patient support, and then to decrease to every 2 to 3 weeks as patient becomes more independent.

Final comments

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, even if there are minor setbacks in wound healing. Shared care allows the patient more time to live their life and less time focused on the wound. For this chronic, complex wound, the patient understood that the wound status would fluctuate overtime, and as long as the symptoms are managed and controlled (i.e. drainage, odour, pain), wound healing would progress.

The patient received information about dressings, compression therapy and lifestyle that supported wound healing in a way that fitted in with her daily activities. Reviewing with the patient what to look out for regarding the signs and symptoms of infection provided her with the confidence to listen to her body and trust her instinct. The patient was able to acknowledge the cause when the wound deteriorated at week 4 and to reach out for assistance when it was urgently needed. Working together to change the treatment plan helped to ensure the patient felt involved in care.

Using ALLEVYN LIFE Dressing with the change indicator provided guidance for the patient and the confidence and reassurance that she was changing the dressing appropriately. It also was a trigger to change to a less absorbent secondary dressing when it was required.

The shared wound care discussion guide gave the clinician prompts to consider when embarking on shared care. For this patient, using the guide gave the patient a sense of control when agreeing on the terms and extent of shared care. This discussion guide could be very beneficial for newly qualified clinicians. If nurses were able to review the discussion guide with their patients more routinely, they would realise that there is an opportunity for many more patients to participate in their own care, and similarly more patients themselves would realise that they can safely be involved in their care with positive outcomes for all concerned.

Wound progression in brief

Initial presentation	Week 11	Wound condition
		Significant improvement in the wound: new areas of epithelialised tissue, decrease in exudate and odour. Gone from one large area to smaller wound areas.

Wound progression in detail

Initial presentation	Week 1	Week 3	Week 7	Week 11
				
Wound condition: The wound bed consists mainly of granulation tissue and there are a few islands of new epithelialised tissue. The wound edges are advancing, but the periwound skin is very macerated. There is a moderate to high level of serous exudate. There are no signs of local infection, but biofilm is suspected due to the very slow progress. Wound pain levels are low, but this can increase during cleansing and dressing change.	**Wound condition:** New epithelial tissue developing from the edges is very slow. There is no odour, but there is a moderate level of seropurulent exudate. Debridement is required as the tissue is macerated and non-viable.	**Wound condition:** Some previously closed areas have reopened; however, the depth of the wound has decreased and new epithelial tissue is advancing from the edges. No inflammation to the periwound area. No increase in pain, odour or drainage.	**Wound condition:** The lower aspect has deteriorated following an injury. The patient reports a very slight increase in odour, seropurulent drainage and pain to the site of injury. The signs suggestive of biofilm are present.	**Wound condition:** There has been significant improvement in the wound: new areas of epithelialised tissue, decrease in exudate and odour. The lower aspect of the wound bed where the injury occurred has become more granulated. There are some areas of slough and increasing epithelial tissue.
	Patient feedback: Going very well and she is happy that she can change the dressing at a time that is convenient to her. She is thinking of returning to work part time.	**Patient feedback:** The patient thinks she and the clinician are working well together. She has returned to work part time and is very excited about this. She feels better emotionally; the wound is no longer the focus of her entire day.	**Patient feedback:** The patient is very upset following the injury and subsequent wound deterioration. However, she understands that the injury and deterioriation was not her fault. She is happy to be able to balance both the wound and her life rather than her wound being her life.	**Patient feedback:** The patient is pleased with the improvement over the past few weeks and pleased that the changes to the treatment plan at the last review led to some healing progression.

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	Clinician feedback: The patient is starting to feel more 'normal' and reaches out when she has concerns. The clinician feels confident that shared care is going well and that together 'we will not miss something that would cause a setback in healing'.	**Clinician feedback:** The patient has a good grasp of wound care and is excelling at being a part of shared care.	**Clinician feedback:** The patient was able to reach out for assistance after the injury. Together, the clinician and patient changed the treatment plan. The dressing regimen was changed to IODOSORB◊ 0.9% Cadexomer Iodine Powder (Smith+Nephew) to manage the suspected biofilm and ALLEVYN◊ GENTLE BORDER LITE Foam Dressing (Smith+Nephew) was used as a secondary dressing. The patient agreed to elevate her leg more when at home.	**Clinician feedback:** Shared wound care has given the patient a sense of control, enabling them to balance living life with their health issues. For this patient, her wound had been dominating her entire life for years.

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CASE 3: Skin tear

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Wound and patient history

This case describes a 73-year-old woman who had a skin tear on her right leg for 4 days, which occurred when she removed her therapeutic stockings. The patient had chronic obstructive pulmonary disease, hypertension, chronic venous insufficiency (CVI) and a history of skin tears. The wound measured 6 cm (length) x 3 cm (width) x 0.2 cm (depth) and there was partial tissue loss. The wound bed consisted of 100% granulation tissue and wound edges were open and advancing.

The surrounding skin was fragile and there were moderate levels of serous exudate. The patient rated wound pain at 4 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain) during dressing changes. She was referred to a wound care specialist and was receiving care at home. Her daughter was very supportive and helped her to apply and remove her stockings. When she'd had skin tears previously, she was visited by a nurse once a week.

Shared wound care discussion guide

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

Using the shared wound care discussion guide, the clinician was able to explain how the patient could be more involved in their wound care. The patient and her daughter both understood the cause of the wound and the need to wear compression stockings; but they were not aware that CVI was the underlying problem. The patient was excited, but slightly nervous, to be involved in wound care; she was pleased that her daughter would be able to help. The patient was most concerned about knowing the signs of infection, when to alert the wound care specialist, when to change the dressing, and how to use the compression stockings. They hoped that, by being more involved in care, they could prevent future skin tears.

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

The clinician felt that they would have the ability to be more involved in shared wound care with the appropriate education and support, and described the patient and her daughter as 'reassurance seekers' (**Box 1**). Both were motivated to share the wound care and to become more independent and less reliant on clinical assistance. Regular discussion with the patient and her daughter regarding shared care would focus on improving their wound care knowledge.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient could perform the wound care with the help of her daughter, but would require more information on when and how to change the dressings and about the underlying cause of delayed wound healing (i.e. CVI).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

Lifestyle change: It would be helpful to coach the patient on how to safely remove their therapeutic stockings to avoid damaging the skin.

Patient-practitioner relationship: The signs and symptoms of wound infection that should alert the patient and her daughter to contact the wound specialist without delay were discussed.

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

- Cleansing the wound with gauze wetted with tap water
- Using ALLEVYN® LIFE Foam Dressing (Smith+Nephew) 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. if exudate covers more than 50% of the change indicator, the exudate had 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 daughter
- Details on when and how to contact the wound care specialist if the wound deteriorated (i.e. if the signs and symptoms of acute wound infection develop, such as swelling, redness of the surrounding skin, increasing temperature of the skin or increasing pain).

Final comments

Throughout the evaluation period, the patient and her daughter felt more confident and increasingly independent to care for the skin tear. They were also pleased to avoid the disruption of travel for clinic visits and felt well supported with the weekly calls and sharing of wound images.

The clinician felt that the wound progression was as expected and communication between the patient and her daughter allowed the observation that hypergranulation had become a problem at week 4, which prompted the need for a face-to-face consultation. When using shared wound care, a balance is needed so as not to overload the patient with information and instructions; the discussion guide is a useful tool that provides prompts to help guide what information is required.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
		Image not available		
Wound condition: 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate serous exudate, advancing wound edges.	**Wound condition:** Wound healing has progressed; hyper-granulation tissue is present, no signs of infection, moderate serous exudate, edges are intact. The wound is no longer painful.
Patient/carer feedback: The patient and her daughter were optimistic about the shared wound care initiatives and were interested to see if this approach would improve their independence.	**Patient feedback:** The patient confirms they are happy with treatment and has no questions.	**Patient feedback:** The patient dials in to every appointment on time and is pleased with the progress of her wound.	**Patient feedback:** The patient remains satisfied with wound progression. Stocking changes with her daughter are going well.	
Clinician feedback: The patient and her daughter are physically and mentally capable to participate in shared care.	**Clinician feedback:** Wound healing is progressing, and no treatment changes are necessary. The patient finds using ALLEVYN LIFE Dressing easy as the change indicator provides an objective way to identify excessive exudate.	**Clinician feedback:** No need to intervene as there are no reports of exudate spreading to the dressing's edges or leaking.	**Clinician feedback:** Wound healing is progressing, and no treatment changes are necessary.	**Clinician feedback:** Hyper-granulation tissue could be due to bacterial imbalance. The patient was asked to attend a face-to-face appointment at the clinic where treatment was commenced with a silver nitrate dressing.

CASE 4: Skin tear

Henri Post, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

This case describes a 68-year-old woman with type 2 diabetes, Crohn's disease and arthrosis who presented with a skin tear on her right upper arm. The wound had been caused by the patient moving her sweater sleeve up and down her arm repeatedly. The wound measured 10 cm (length) x 3 cm (width) x 0.2 cm (depth), and the wound bed was 100% granulation tissue.

The skin flap appeared viable and was immediately replaced. The edge of the wound was advancing and intact, and the condition of the surrounding skin was described as fragile. Moderate levels of serous exudate were present. There were no signs of infection, but the patient rated pain at 6 out of 10 on the Numeric Rating Scale (NRS; 0=no pain; 10=worst pain). Pain medication included paracetamol 1000 mg four times daily and ibuprofen 400 mg twice daily.

The patient was newly registered at the wound care centre and had no history of wounds. She was an excellent individual to discuss shared care with as she had no prior experience or expectations of wound care. She attended the appointment with her granddaughter who lived close by and was 'not afraid' to be involved in her grandmother's care.

Shared wound care discussion guide

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

Using the shared wound care discussion guide, the clinician established that the patient and her granddaughter were aware that they could be involved in wound care. At first, the patient was unsure about being more involved in her care as '*it's the wound care specialist who knows what's best for [me]*'. But after the potential benefits of shared wound care were discussed, she seemed happier that she would not be dependent on a homecare nurse to change the dressing.

The patient understood the cause of her skin tear and was concerned about the wound becoming infected. The clinician felt that, with her granddaughter's support, the patient could be more involved in shared care.

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

The clinician described the patient and her granddaughter as 'reassurance seekers' in relation to shared wound care (**Box 1**). Both were willing and motivated to participate in shared wound care as they did not want to be completely reliant on healthcare professionals. Changing the dressing themselves would be more convenient for them so they could continue their usual daily activities. Regular discussion with the patient and her granddaughter regarding shared care would focus on improving knowledge and addressing fears and concerns – mainly about the risks of wound infection (e.g. what the symptoms are and when to alert the wound care specialist).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient, with the help of her granddaughter, would require coaching on how to perform wound care (i.e. dressing changes).

Lifestyle change: The patient was aware that, because she had diabetes, she needed to take extra care of her skin, feet and legs and that she may be at increased risk of wound infection. Discussion on how to protect the skin integrity and reduce the risk of skin damage would be beneficial.

Patient-practitioner relationship: The signs and symptoms of infection needed to be discussed (e.g. swelling, redness of the surrounding skin, increasing skin temperature, increasing pain) and the importance of contacting the wound specialist if the wound deteriorates.

The wound care specialist developed the shared wound care plan with the patient/carer to include:

- Gentle cleansing of the wound with tap water and gauze soaked onto the wound
- Weekly dressing changes of ALLEVYN® LIFE Foam Dressing (Smith+Nephew) and information on how to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Weekly telephone contact between the patient and clinician, and the granddaughter would email a photo of the wound
- Pain medication with instructions to stop after 3 days and only restart if the pain returns
- Details on how to recognise wound deterioration and when to contact the wound care specialist — swelling, redness of the surrounding skin, increased temperature of the skin, increased pain.

Final comments

At the beginning, the patient was slightly hesitant to be involved in shared care. But with the support of her granddaughter, an understanding of the signs and symptoms of wound infection, and knowing that healthcare professionals were available close by if needed, her confidence grew.

The patient stated she felt empowered and proud to be sharing the wound care with her granddaughter and was pleased she did not need to rely on the clinician. The progress in wound healing gave both confidence and evidence that they were successful in performing wound care and it was agreed that shared wound care would continue going forward until the wound fully healed.

The dressing change indicator of ALLEVYN LIFE Dressing was a useful tool when deciding if there was excessive exudate or if the dressing needed to be changed earlier than expected. In this case, the granddaughter felt the indicator was an easy parameter to determine if a dressing change was needed.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** The wound has progressed and confidence of both the patient and granddaughter has improved. The patient has no wound pain.
Patient/carer feedback: The patient and granddaughter are eager to perform the wound care.	**Patient/carer feedback:** The patient confirms that she is optimistic about the progress of her wound. The skin tear is almost healed and the patient only experiences pain during wound cleansing.	**Patient/carer feedback:** The patient and granddaughter are committed to the treatment plan. The dressing stayed in place for 1 week despite a slight increase in moisture. There was no odour.	**Patient/carer feedback:** The wound has reduced in size and the tear has healed. The cooperation between patient and granddaughter is going well.	
Clinician feedback: The patient and her granddaughter are physically and mentally capable to participate in shared care.	**Clinician feedback:** Wound healing is progressing, and the condition of the surrounding skin is healthy. No treatment changes are needed.	**Clinician feedback:** The cooperation between wound care specialist, patient and granddaughter is consistent. There is no need to intervene as exudate has not spread to the dressing's edges and there is no leakage.	**Clinician feedback:** Wound healing is progressing normally, and granulation tissue is visible.	**Clinician feedback:** Pale granulation tissue is observed after 4 weeks of treatment. It is suggested that the next review will be a face-to-face appointment with the wound care specialist nurse.

CASE 5: Clagett cavity

Ben Elsinga, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

A 77-year-old man had a clagett cavity on the right side of his chest of 10 months' duration that was created following a thoracotomy. He had an extensive medical history including psoriasis, skin cancer and lung empyema. The patient had been referred to the wound care team by the rehabilitation centre when he was transferred home. He had no known history of chronic wounds.

A claggett is an open window in the lateral aspect of the chest to allow continuous drainage and irrigation of the cavity with antibiotic solution. At first, the clagett cavity wound required twice-daily dressing changes, but, as the wound improved, dressing changes were reduced to twice a week.

The wound measured 11 cm (length) x 8 cm (width) and the wound bed comprised 100% granulation tissue. New epithelial tissue was covering the wound bed, and the wound edges were described as advancing. The surrounding skin was mostly healthy with a small amount of dry skin. There were moderate levels of serous exudate and there were no signs of infection. The patient had no wound pain.

Shared wound care discussion guide

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

Using the shared wound care discussion guide, the clinician felt the patient and his wife were capable to be involved in shared wound care with further coaching. The patient had a good support system, and he had experience changing the dressings as his wife had previously shared the wound care with the district nurses. The patient and his wife understood the cause of the wound, but they felt they had limited knowledge of how the wound should progress.

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

The clinician described the patient and his wife as 'reassurance seekers' (**Box 1**). They were reassured that shared wound care did not mean they were alone in performing wound care, and that there was a 'safety net' of district nurses nearby to help when necessary.

Regular discussion with the patient and his wife would focus on addressing their fears and concerns surrounding shared wound care, for example, he was worried about being alone if there was a complication, excessive moisture or he became ill again.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient could carry out dressing changes with the help of his wife, but they needed more information on what to do if there were signs of infection or his psoriasis escalated.

Lifestyle change: It was not applicable for the patient to make lifestyle changes at this time.

Patient-practitioner relationship: The district nurse and wound care specialist contact information was provided in the event of an emergency.

The wound care specialist developed the shared wound care plan with the patient and his wife to include:

- Cleansing the wound with gauze and tap water, applying CUTICERIN◊ Low Adherent Surgical Dressing (Smith+Nephew), covering with an absorbent dressing and applying OPSITE◊ FLEXFIX Transparent Film Roll (Smith+Nephew) as per local protocol.
- Instructions on how to change the dressing if there is an increase of exudate
- If psoriasis returned, treat it as before with a steriod cream or neutral cream
- Weekly telephone contact with the patient and the wife would send a photo of the wound
- Details on how and when to contact the district nurse/wound care specialist (i.e. if the signs and symptoms of acute wound infection develop, such as swelling, redness of the surrounding skin, raised temperature of the skin, increasing pain).

Final comments

The patient and his wife felt well supported by the team to participate in shared wound care and did not feel the need to contact the district nurse during the evaluation period — although it was reassuring for them that they would be able to if the need arose. Both were pleased with the patient-practitioner relationship that developed, and their growth in self-confidence and improvements in wound progression.

The shared wound care discussion guide facilitated the patient and his wife to become more independent in their care. For them, knowing that help and clinical support was easy to access at any time contributed to their willingness to participate. The patient and his wife were happy to continue to participate in shared wound care.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
				
Wound condition: 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges. The wound measures 11 cm (length) x 8 cm (width).	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition:** 100% granulation tissue, no infection, moderate levels of exudate, advancing wound edges.	**Wound condition**: The wound has improved significantly and has reduced in size to 4 cm (length) x 3 cm (width).
Patient/carer feedback: The patient and his wife have agreed to participate in shared wound care, particularly for the day-to-day wound care.	**Patient feedback:** Shared wound care is going well. The patient's wife is feeling confident and has observed wound progression. There was an increase in exudate levels; therefore, an extra dressing change was necessary.	**Patient feedback:** The patient is thankful for his wife's involvement, and both have more self-confidence with the shared wound care than at initial presentation.	**Patient feedback:** The wound is reducing in size. The patient was able to go out on a family trip for the first time in months.	
Clinician feedback: Both the patient and his wife appear capable of carrying out the shared care wound measures introduced.	**Clinician feedback:** Wound healing is progressing. The patient and wife sound apprehensive about carrying out wound care themselves but are committed to the shared wound care plan.	**Clinician feedback:** Both patient and his wife sound enthusiastic and the shared wound care continues as before.	**Clinician feedback:** The shared wound care plan is going better than expected. It is great to hear that the family are more committed with their involvement.	**Clinician feedback:** The patient and his wife are more self-reliant; there are no reports of pain, and the patient is more confident to leave the house.

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CASE 6: Post-operative wound

Ben Elsinga, Nurse Practitioner Wound Management, Evean Koog aan de Zaan, The Netherlands

Wound and patient history

An 86-year-old woman had a wound over her right anterior lower leg following the removal of a squamous cell carcinoma. The operation was successful, and all the wound surfaces were clean of malignant cells. For the first fewweeks following surgery, the patient was under strict supervision from the dermatologist. During this time, the dermatologist's advice was to treat the wound with INTRASITE◊ Gel Hydrogel Wound Dressing (Smith+Nephew) and wear compression stockings. Compression stockings were prescribed as the patient had been diagnosed with chronic venous insufficiency before the operation.

The patient requested specialised home wound care for assistance with the dressing changes as she did not feel confident or comfortable with the wound care plan advised by the dermatologist. She indicated that she would prefer a 'simpler' dressing plan that would require less frequent changes and products that were easier to use, so that she and her husband could manage the wound themselves. The patient had no previous experience of shared wound care as this was their first wound. The patient was confident and self-reliant to apply and remove their compression stockings.

The wound had been present for 6 weeks and measured 7 cm (length) x 4 cm (width) x 0.5 cm (depth) and the wound bed comprised 30% granulation tissue and 70% slough. The wound edges were advancing and the periwound skin was described as slightly swollen. The surrounding skin was very dry. There were no signs of wound infection or wound pain, and there was a moderate level of serous exudate. The clinician expected the wound to be healed within 2 months as there were no barriers to healing, except for some minor oedema.

Shared wound care discussion guide

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

The fact that the patient called in the home care team to ask for a simpler dressing plan shows that the patient and her husband were aware that they could be involved in shared wound care. The patient wanted the minimum amount of involvement with professional health carers and a simple wound care plan. The clinician agreed that a simpler wound care plan is possible, and with a few instructions, the patient and her husband could do the wound care by themselves. The patient had sufficient understanding of the cause of the wound, and understood the symptoms of infection and importance of reducing the risk of wound infection. The patient had a 'good support system'; her husband would be involved and accompany her for hospital appointments.

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

The clinician described the patient and her husband as 'self-sufficient', see **Box 1**. The patient and her husband were both physically and mentally capable to carry out the wound care.

Box 1. Description of 'self-sufficient'

- Relatively knowledgeable about their wound
- Willing and motivated to optimise lifestyle to enhance wound healing
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient and carer were capable and willing to perform the wound care.

Lifestyle change: It was not necessary for the patient to make lifestyle changes at this time.

Patient-practitioner relationship: The patient was given guidelines on when to contact the wound care specialist and how to reach the district nurse.

The wound care specialist developed a wound care plan with the patient and her husband to include:

- Twice weekly gentle cleansing of the wound with gauze wetted with tap water
- Application of ALLEVYN◊ LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Wearing of compression stockings
- Weekly telephone contact with the wound care specialist, and the patient's husband will send a photo by e-mail every week. If the patient and her husband had questions, they were to contact the district nurse in the first instance. If signs and symptoms of infection appeared, they were to contact the wound care centre (e.g. swelling, redness of the surrounding skin, raised temperature of the skin, increasing pain).

Final comments

The patient wanted clinical support and to be involved in shared wound care with minor telephone supervision. She was pleased that she did not have to wait for the district nurse to dress her wounds. The family stated they received good support and felt that the patient's requests were taken seriously.

The patient was happy that the wound had progressed and was nearly healed over the 4-week evaluation period. The patient, husband and wound care specialist plan to continue with shared wound care. By using the shared wound care discussion guide, it was possible to provide a more personalised care plan tailored to this patient's individual needs.

Wound progression				
Initial presentation	**Week 1**	**Week 2**	**Week 3**	**Week 4**
				
Wound condition: 30% granulation tissue, 70% slough; no infection; moderate levels of exudate; advancing wound edges. The wound measured 7 cm (length) x 4 cm (width) x 0.5 cm (depth).	**Wound condition:** 60% granulation tissue, 40% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition:** 70% granulation tissue, 30% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition:** 60% granulation tissue, 40% slough; no infection; moderate levels of exudate; advancing wound edges.	**Wound condition**: 70% granulation tissue, 30% slough; low level of exudate; advancing wound edges. The wound has improved significantly and has reduced in size to 2 cm (length) x 1.5 cm (width) x 0.5 cm (depth).
Patient/carer feedback: The patient and husband have agreed to perform wound care themselves.	**Patient/carer feedback:** Patient and her husband are happy to do the wound care themselves.	**Patient/carer feedback:** Patient and her husband are happy to do the wound care themselves.	**Patient/carer feedback:** The patient is positive about the healing process. She has had no concerns conducting wound care.	**Patient feedback:** There was a growth in self-confidence and the patient felt that she has been taken seriously by the wound care specialist.
Clinician feedback: Both the patient and her husband appear capable of carrying out the wound care measures introduced.	**Clinician feedback:** Both seem capable and confident to carry out wound care.	**Clinician feedback:** Wound care and progress is going to plan. No further actions needed. The wound bed is reducing in size.	**Clinician feedback:** The wound care is going to plan. No further actions needed. The wound bed is reducing in size.	**Clinician feedback:** The patient and her husband are fully able to continue to be involved in shared wound care.

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CASE 7: Diabetic foot ulcer

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

This case describes a 92-year-old man with type 2 diabetes, heart failure, hypertension and atrial fibrillation. He had a history of diabetic foot ulceration and currently had a diabetic foot ulcer on his left medial malleolus for 6 weeks. The patient lived in an aged care residential home and used a bed cradle at night and an alternating mattress to offload pressure.

The ulcer measured 10 cm (length) x 14 cm (width), the wound bed was sloughy and the wound edges were macerated. The periwound skin was inflamed and very painful (8 out of 10 on the Numeric Rating Scale; 0=no pain; 10=worst pain). The wound was highly exuding and soaked through the dressings.

In the past, the patient would remove his wound dressings and cover the wound with tissues. Several different nurses at the care home had been involved in his care and the patient felt frustrated because each clinician would use a different dressing type. He wanted to attend the specialist wound care clinic for a consistent care plan.

Shared wound care discussion guide

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

The patient was aware of the concept of shared wound care but was initially reluctant to be involved due to previous poor experiences of wound care. After talking and listening to his concerns, the patient decided he was willing to 'give it a go'. The clinician felt that by being an active participant, the patient would be less likely to remove his dressings and the wound pain could be managed more effectively.

The patient did not want to actively change his dressing, but he could support wound healing by being involved in his diabetes management through diet and monitoring his blood glucose levels. He understood what could happen if diabetes management and good foot care were not carried out (e.g. amputation), and that the wound required frequent attention.

The patient did not have family, friends or informal carers, but the residential care nurses were involved and accompanied him to the wound care clinic once a week. The aged care nurses were comfortable being involved in wound care and were keen to learn the treatment protocol.

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

The clinician described the patient as a 'reassurance seeker' (**Box 1**) as he had a long history of ulceration that made him feel uneasy about receiving care. The patient's fear and mistrust of care were the main driver for not being engaging and following the clinician's advice. The main approaches for this individual were to improve knowledge and to address his fears and concerns.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: The patient was reluctant to physically participate in his wound care, but he agreed to leave the dressings in place for a longer duration. The risks of removing the dressing too early were also discussed (i.e. risk of infection and subsequent amputation). ALLEVYN® LIFE Foam Dressing (Smith+Nephew) is designed to remain *in situ* for 5-7 days; however, as the patient was known to remove dressings, twice weekly dressing changes were planned in order to meet his needs. To increase his involvement, the wound care specialist gave clear guidance directly to the patient on how to apply and monitor the dressing so he could check that the correct steps were followed by the aged care nurses. The aged care nurses were also trained to ensure a more consistent care provision.

Lifestyle change: The patient was given a diary to record his diet and he was coached on how to make appropriate lifestyle changes. His footwear was reviewed and changed to a show that was easier to put on and remove.

Patient-practitioner relationship: The patient expressed a lot of fear and limited trust in clinicians to manage the wound. So it was vital to develop an open and honest patient–practitioner partnership. He was educated on the importance of ongoing treatment, prevention of wounds and when to escalate to a specialist according to local protocol. The patient was advised to contact the wound care clinic for any concerns — odour, pain, dressing leaking, not feeling well — and he was reassured that if this situation occurred, he would be prioritised to the wound care specialist.

In discussion with the patient, the wound care specialist developed a shared wound care plan that the aged care nurses could undertake:

- Cleanse the wound with an antimicrobial wound solution and mechanically debride the wound with gauze twice a week
- Cover the wound with ALLEVYN LIFE Dressing. Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)

- The patient would attend the wound care clinic once a week and the aged care nurses would do a dressing change on the second day post clinic visit
- Offload pressure with shoes, and use of a bed cradle and alternating mattress at night.

Final comments

Introducing shared care with the shared wound care discussion guide was a great experience for the patient and the aged care nurses. The wound care specialist saw a shift in knowledge of both the staff and patient who both felt they could manage the wound better.

The patient's relationship with staff also became more trusting. The clinician felt this shift in perspective and acceptance was the main reason why the wound healed so quickly.

Throughout the 4-week period, the aged care nurses felt more confident conducting wound care and the patient was empowered to assist at many dressing changes. The patient felt at ease with his wound care because he felt in control of his own body; as a result, his diet improved and his activity levels increased. He especially enjoyed being able to attend to his own dressing change needs and felt supported if he needed assistance.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: The wound bed comprises 5% granulation tissue and 95% slough. The wound edges are non-advancing and macerated. There is a moderate level of purulent exudate that leaks from dressing. Erythema is spreading 3 cm from wound edges, oedema present, dry limbs. Wound pain is rated as high.	**Wound condition:** Erythema and odour remain but have decreased; exudate remains moderate and purulent.	**Wound condition:** Erythema and odour have resolved. Exudate remains moderate of serous consistency. Wounds size has decreased.	**Wound condition:** Exudate has resolved; eschar formation noted. No signs of infection. Dressing changes reduced to once a week.	**Wound condition:** Wound healed and no wound pain. Scar tissue (remodelling phase) remains.
	Patient feedback: Patient noted he was still a little uncertain about the idea of shared wound care, but he liked the diaries, brochures and meetings and felt in control of his care.	**Patient feedback:** Patient noted he was becoming comfortable with the share care approach.	**Patient feedback:** Patient noted he is very happy with shared care and now understands its importance.	**Patient feedback:** The patient was surprised the wound had healed so well given his history of ulceration. Patient noted he has regained his trust in the clinicians to manage his wound care.
	Clinician feedback: It is working well.	**Clinician feedback:** Working exceptionally well, there is a noticeable change in the patient's mindset.	**Clinician feedback:** Great outcome and the patient has shown a real change of care.	**Clinician feedback:** This was an excellent outcome and mindset change not only for the patient but also for the home care nurses who now ensure shared care is used for all suitable patients.

CASE 8: Skin tear

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

An 86-year-old woman sustained a skin tear on her left anterior lower leg when using her electric wheelchair. It had been present for 8 weeks and measured 5 cm (length) x 7 cm (width). The surrounding skin was fragile with dry skin, and an emollient cream was applied to protect the skin.

She had experienced significant falls resulting in fractures and joint replacement surgeries. She lived in a residential aged care home and used a bed cradle at night, limb protectors to reduce the risk of injury, and an alternating mattress to offload pressure.

The registered nurses noted that the patient had no experience with shared wound care and the patient had not been involved in the treatment plan. The wound care specialist was concerned that the current dressing used at the aged care home was causing some trauma to the fragile surrounding skin.

Shared wound care discussion guide

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

The patient was unaware of the concept of shared wound care. She was aware that her skin was 'paper thin' and dry, which would increase the risk of skin damage. The patient was unaware that the wound could develop into a chronic ulcer if it not managed efficiently from the start.

Initially, she did not want to be involved in day-to-day wound care. The clinician felt the patient had the ability to be more involved in helping to maintain skin integrity and reducing the risk of trauma.

The patient felt comfortable with the staff changing her dressing, but she had some concerns because previously there was a lack of consistency in the dressing regimen, and the registered nurses would change the dressing regimen regularly. The patient wanted all the staff to follow the treatment plan devised by the wound care specialist.

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

The clinician described the patient as 'unaware' (**Box 1**), as she was unaware that she could participate in reducing her risk of injury. She had experienced many haematomas and skin tears previously, but the clinician felt she was capable of helping to reduce the risk of skin damage.

3. Identify what the patient can do as part of shared wound care

For this individual, educating the registered nurses at the aged care facility presented an excellent opportunity to deliver more consistent care. Access to an online webinar was provided to staff, which the patient also chose to attend.

Box 1. Description of an 'unaware' individual

- Not very involved in wound care
- Unaware that it is possible to engage more in their care
- Physically and mentally capable but unwilling to participate in shared care.

Wound care: The patient and staff were given an infographic to help them to identify wound deterioration and the signs of wound infection, and they were shown how to perform dressing changes.

Lifestyle change: The patient was given a diary to record and track lifestyle changes. The patient expressed that she was fearful to leave her room due to previous falls and skin tears, so a mobility plan was devised with the physiotherapist to increase her confidence and activity level.

Patient-practitioner relationship: The goal was to develop an open and honest patient–practitioner partnership between the patient, aged care staff and the wound care team. The nursing staff were provided with the contact details of the clinic if the wound deteriorated or there was a change in the patient's condition.

Through discussion with the patient, the wound care specialist developed the following shared wound care plan:

- Ongoing education on skin tear prevention
- Maintaining skin integrity using emollient cream twice a day
- Cleansing the wound with an antimicrobial spray
- Application of a barrier cream to the surrounding skin
- Weekly dressing changes using ALLEVYN LIFE◊ Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- Wearing limb protectors to help minimise risk of developing skin tears and haematomas
- Encourage leg elevation
- Provide bed cradle to offload when in bed.

Final comments

The aged care nurses felt that using shared care discussion guide had given them new knowledge that they would use in the future for other patients with wounds.

Initially, the patient did not wish to be involved in her own care, but

during the process, the patient became more engaged in wound care and was asking more questions and receptive to what she could do to support healing and avoid skin damage.

The patient's involvement helped to improve not only the wound outcome, but also her mindset and quality of life. She became more active and no longer stayed in her room. Her pain had reduced so much so that her pain relief was decreased. Going forward, the patient felt empowered to care for her own wound and to voice her concerns to nurses if they arose.

Wound progression

Initial presentation	Week 1	Week 2	Week 3	Week 4
				
Wound condition: The wound bed consists of 100% granulation tissue; the wound edges are advancing. There is a moderate level of haemoserous exudate. There is a haematoma, and the surrounding skin is fragile and dry. Wound pain is rated as 9 out of 10.	**Wound condition:** Wound healing well as the skin flap has adhered to the wound bed. There are no signs of infection and pain has decreased from previous dressing change.	**Wound condition:** Wound is improving and the haematoma has resolved. There is minimal pain during dressing change.	**Wound condition:** Exudate has resolved, eschar formation noted. Dressing changes reduced to once a week.	**Wound condition:** Wound has healed.
	Patient feedback: Patient is happy with the healing of the wound.	**Patient feedback:** Patient is very happy with the wound healing.	**Patient feedback:** Patient is happy with how the wound is progressing.	**Patient feedback:** The patient enjoyed working with everyone on a common goal.
	Clinician feedback: The care plan is working well and the wound is improving.	**Clinician feedback:** Shared wound care with the home care staff is showing very good wound healing results and the treatment plan is remaining consistent. Reassurance has been provided to the patient who is responding well to ongoing updates.	**Clinician feedback:** The care plan is working well.	**Clinician feedback:** It was great to work with the home care staff and patient, providing ongoing support and education.

CASE 9: Skin tear

Hayley Ryan, Director WoundRescue, and Wounds Australia Board Director Chair, Wound Clinical Nurse Consultant, Australia and New Zealand

Wound and patient history

A 77-year-old man sustained a traumatic wound after a fall on his left lateral hand. The skin tear measured 4 cm (length) x 3 cm (width), the wound bed consisted of 100% granulation tissue and there were no signs and symptoms of infection. The nurses at the residential home where he lived performed his wound dressings. Adherent dressings have been used, but there was concern that the adhesive was damaging the surrounding skin on removal. The patient had a history of not following wound care plans.

He has a complex medical history that included dementia, non-insulin-dependent type 2 diabetes, pancreatitis and a cerebral vascular accident in 2018. He was prescribed a high-protein diet and over 10 different medicines, including anticoagulant therapy.

Shared wound care discussion guide

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

The patient was unaware of the concept of shared wound care until the wound care specialist mentioned it during the consultation. The specialist and patient both expected the wound to heal. The specialist also hoped to engage the patient with wound care.

The patient wanted to be fully involved in all decisions regarding his care and considered the possibility of changing his own dressings. The clinician felt he was very capable to change his own dressings. In the past, he felt that the residential care nurses would "*just take over care*", and he wanted to show the nursing staff that he was capable.

He had limited knowledge regarding wound care and did not believe it would take as long as 4-6 weeks for the skin tear to heal. He was unaware of the factors that could delay wound healing, such as infection.

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

The clinician described the patient as a 'reassurance seeker' (**Box 1**), as he had good dexterity and a willingness to learn more about caring for his wound; he just needed more confidence.

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

The main approaches for this individual were to improve his wound knowledge and to address his fears and concerns. Besides the weekly dressing changes, the patient was provided with education about next steps of treatment to relay fears and wounds in the future. Details were also provided to the aged care home nurses.

Wound care: The clinician demonstrated to the patient how to perform the treatment requirements. For this individual, a guide of the signs of a infection and a deteriorating wound were also provided. The patient was coached on the importance of managing wounds early to avoid delays in healing.

Lifestyle change: The patient was coached on following his prescribed high-protein diet and medication.

Patient-practitioner relationship: The goal was to develop an open and honest patient–practitioner partnership with the wound care specialist and to strengthen the relationship between the individual and the aged care home nurses.

The wound care specialist and patient developed the following shared wound care plan:

- Cleanse the wound with an antimicrobial spray
- Weekly dressing changes using ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing).

Once he saw how simple it was to manage his wound, he was able to apply the dressings with some assistance before being able to independently attend to his wound. He was advised to contact the wound clinic administration team for any concerns, which would be prioritised to the wound care specialist (e.g. odour, pain, dressing leaking, not feeling well). He was able to contact the administration team via email, phone, text message or video calling.

Final comments

After the 4-week evaluation period, the patient was very happy that the wound had healed and he could return to his usual level of activity. He felt very confident that he could be involved in shared wound care in the future.

His relationship with the aged care nurses also improved as they developed a more trusting and collaborative relationship. Staff were initially nervous to allow him to manage his own wound in case something went wrong. After this experience, they felt more confident that it is possible for patients to be more involved in their own care. They also noted they felt empowered to continue this with other patients.

Wound progression			
Initial presentation	**Week 1**	**Week 2**	**Week 3**
			
Wound condition: The wound bed consists of 100% granulation tissue, and the wound edges are advancing. The surrounding skin is intact, with some bruising identified. There is a moderate level exudate. The wound is very painful to the touch.	**Wound condition:** The wound shows signs of healing.	**Wound condition:** The wound has almost completely healed.	**Wound condition:** The wound has healed. There is some bruising and scar tissue, which will take months to years to fully recover. An emollient cream will be applied to moisturise, as dry skin is more susceptible to injury. Patient noted that the wounded area remains slightly tender if the area is 'bumped'.
	Patient feedback: Patient is now comfortable to attend to his own dressings. Patient is happy with the progress of the wound.	**Patient feedback:** Patient is happy with the progress of the wound.	**Patient feedback:** Patient is happy with wound management and feels more knowledgeable and willing to attend to his own wounds into the future.
	Clinician feedback: The care plan is working and the wound is improving.	**Clinician feedback:** The wound is improving.	**Clinician feedback:** It has bee a good outcome to engage the patient in his own care. The process increased his wound care knowledge, particularly around prevention.

CASE 10: Pilonidal sinus wound

Jan Ryzy, Lead Practice Nurse, Caerphilly, Wales

Wound and patient history

A 29-year-old woman had a pilonidal sinus that was successfully removed 5 years ago. The wound initially healed, but had dehisced on several occasions. In these instances, she received home visits from the community nursing team. The wound had re-dehisced again 7 days ago, and she attended the primary care facility.

The wound measured 4 cm (length) x 1.5 cm (width). The wound bed comprised 50% granulation tissue and 50% red/pink tissue without granulation tissue; the wound edges were described as non-advancing and excoriated. The periwound skin was red and fragile. There was a moderate level of serous exudate. Local infection was suspected due to wound pain (4 out of 10 on the Numeric Rating Scale; NRS; 0=no pain; 10=worst pain), erythema and pus.

Shared wound care discussion guide

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

She had no previous experience with shared wound care as it had never been discussed. The patient expected that shared wound care would allow her to change the dressings herself so she would not have to take so much time off work. The patient had the support of her husband who was also willing to be involved in her care.

The clinician felt the patient had the ability to be involved in care. She had a good knowledge of wound care and was willing and motivated to make changes.

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

The clinician described the patient as a 'reassurance seeker' (**Box 1**). The patient was quite anxious that she would be alone, but the clinician reassured her that she would have regular support and contact from a clinician.

It was felt that regular discussion with the patient regarding shared care should focus on improving knowledge, addressing fears and concerns and improving awareness, including to contact the nurse by phone or e-consult at the first signs of wound deterioration or infection (e.g. pain, redness, exudate, fever).

Box 1. Description of a 'reassurance seeker'

- Room for improvement in knowledge and confidence
- Relatively reliant on healthcare professionals (HCPs) to provide care
- Cautious to perform wound care
- Physically and mentally capable to participate in shared care.

3. Identify what the patient can do as part of shared wound care

Wound care: Because of the wound location, the patient's husband was coach to cleanse the wound and apply and remove the dressing.

Lifestyle change: The patient had the potential to make lifestyle changes that would improve wound healing, such as nutrition and physical activity to support weight loss.

Patient–practitioner relationship: The patient was supported to confidently recognise the signs of wound deterioration and empowered to contact the clinician without delay if the wound deteriorated. Contact information was provided according to local protocol.

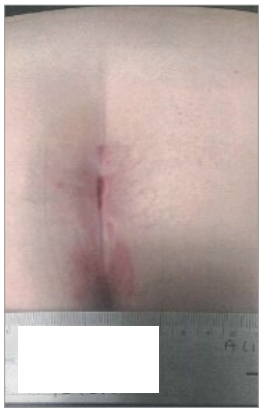
With the patient, the wound care specialist developed the shared wound care plan to include the following steps:

- Remove dressing, cleanse the wound in the shower and dry
- Take a photo of the wound if possible
- Apply ALLEVYN® LIFE Foam Dressing (Smith+Nephew). Information was provided to the patient on how to read the dressing change indicator and to recognise if the dressing needs changing more frequently (i.e. if exudate covers more than 50-75% of the change indicator, the exudate had reached the dressing's edges, or there is leakage of exudate from the dressing)
- The patient was advised to change the dressing twice a week or when indicated on the change indicator if sooner
- Two-weekly phone calls were scheduled with the clinician, but the patient was able to call more frequently if needed.

Final comments

The patient and her husband felt supported by the clinician via the phone or on e-consult. The patient had gained more knowledge about wounds and the healing process. The patient's husband was involved in shared wound care and monitored the level of exudate as per the ALLEVYN LIFE Dressing change indicator. Once the wound healed, the patient was able to return to her exercises. As a result of being more involved in care, the patient did not have to take time off work.

Shared wound care works very well for the willing patient. Person-centred care plans are essential for both the clinician and the patients — poor care leads to poor outcomes. Following this experience, the clinician would consider using the shared wound care discussion guide with other patients and hopes this will become an integrated part of future care.

Wound progression				
Initial presentation	**Week 1**	**Week3**	**Week 4**	**Week 5**
			no image available	
Wound condition: Moderate amounts of serous exudate; slightly raised wound edges; erythema; slight wound pain.	**Wound condition:** Moderate amounts of serous exudate; slightly raised wound edges; erythema; slight wound pain.	**Wound condition:** Improved wound condition and wound size; reduced exudate; slightly raised wound edges; no erythema or wound pain.	**Wound condition:** The wound bed is much improved; and there is a minimal amount of exudate; much less painful.	**Wound condition:** The wound has healed.
	Patient/carer feedback: The patient's husband is proud he has learnt how to apply the dressing appropriately. He can see that the wound is improving and feels supported that should he have any questions or concerns he can contact the clinician.	**Patient/carer feedback:** The patient is happy with how the wound is progressing.	**Patient/carer feedback:** The patient and her husband found shared care very helpful, enjoyed taking control of her care with support from the clinician. She did not need to miss as much work as last time the wound dehisced.	
	Clinician feedback: The patient and her husband are happy to be involved in shared wound care.	**Clinician feedback:** The wound care regimen is working very well for the patient and her husband.	**Clinician feedback:** The wound care plan continues to work well.	**Clinician feedback:** The wound care plan helped to heal the wound.

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Guida alla discussione sulle cure condivise delle ferite[1]

Usare questa guida, insieme all'approccio A,B,C,D,E dello strumento di supporto clinico decisionale T.I.M.E. 2.0[2,3] e seguire i seguenti passi con il paziente e/o il caregiver.

1 Consapevolezza: Il paziente/caregiver è consapevole che potrebbe essere coinvolto nella cura delle ferite?

Sì

Parlare con il paziente/caregiver per comprendere:

- Cosa sa della propria ferita, delle conseguenze delle mancate cure e di quali trattamenti necessiti la sua lesione
- Paure e preoccupazioni riguardo le cure condivise
- Perchè attivare l'assistenza condivisa nella cura delle ferite
- Disponibilità a partecipare alle cure condivise delle ferite.

No

Parlare con il paziente/caregiver per chiarire il significato delle cure condivise:

- Le cure condivise comprendono approcci e interventi che permettono al paziente di partecipare alla pianificazione delle cure nel tempo, piuttosto che essere solo un destinatario passivo dei servizi forniti.

2 Quale dei seguenti scenari descrive meglio il paziente/caregiver per quanto riguarda le cure condivise?

Autosufficiente

- Conosce relativamente bene la sua ferita
- Disponibilie e motivato a ottimizzare il proprio stile di vita per migliorare la guarigione delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Cerca l'approvazione

- Ha possibilità di migliorare la conoscenza e la fiducia
- Relativamente dipendente dagli operatori sanitari
- Cauto nella cura delle ferite
- Fisicamente e mentalmente in grado di partecipare alle cure condivise.

Inconsapevole

- Poco coinvolto nella cura delle ferite
- Non sa che può essere maggiormente coinvolto nella cura delle sue ferite
- Fisicamente e mentalmente in grado, ma non disposto a partecipare alle cure condivise.

Dipendente

- Gli operatori sanitari guidano tutti gli aspetti del trattamento delle ferite e le altre necessità di salute
- Non ha la capacità fisica e mentale di impegnarsi nelle cure condivise.

Approcci e interventi

Discutere regolarmente con il paziente/caregiver sulle cure condivise delle ferite, compreso il colloquio motivazionale e la definizione di obiettivi raggiungibili, concentrandosi su:

Conoscenza | **Paure e preoccupazioni** | **Consapevolezza**

Le cure condivise delle ferite potrebbero non essere un'opzione appropriata in questo momento.

Fornire un sostegno adeguato e rivedere il potenziale per un ulteriore coinvolgimento.

3 Identificare ciò che il paziente/caregiver può fare come parte delle cure condivise delle ferite

Cura della ferite

Il paziente/caregiver è in grado di effettuare le necessarie cure della ferita, compresi i cambi di medicazione?

Si

Considerazioni

- Dimostrare e insegnare come eseguire i trattamenti
- Identificare i bisogni e fornire al paziente/caregiver risorse educative (ad esempio, online, elettroniche, scritte)
- Usare un diario per fissare obiettivi e registrare i cambi di medicazione
- Fornire al paziente/caregiver i seguenti strumenti: indicatore di cambio della medicazione; identificazione dei segni di infezione.

No

Considerazioni

- Gli operatori sanitari dovrebbero eseguire la valutazione della ferita e il cambio della medicazione secondo il protocollo locale
- Rivalutare periodicamente se il paziente/caregiver può essere coinvolto nei cambi di medicazione (ad esempio, se le circostanze del paziente/caregiver cambiano).

Cambiamento dello stile di vita

Il paziente/caregiver è in grado di modificare lo stile di vita per migliorare la guarigione della lesione e gestire i fattori causali (ad esempio, alimentazione appropriata, livello di esercizio fisico adeguato, uso della terapia compressiva, scarico)?

Si

Considerazioni

- Insegnare al paziente/caregiver i cambiamenti appropriati dello stile di vita
- Valutare i risultati e apportare modifiche se necessario
- Usare un diario per registrare i cambiamenti dello stile di vita.

No

Considerazioni

- Indagare e affrontare la motivazione (menomazione fisica o cognitiva, paura, ansia, risorse)
- Accertare se la volontà e la capacità del paziente/caregiver possono essere migliorate
- Consultare altri operatori sanitari per avere un supporto e una rivalutazione da parte loro (ad esempio il dietista o il podologo)
- Rivalutare periodicamente il potenziale di cambiamento dello stile di vita (ad esempio, se le circostanze del paziente/caregiver cambiano).

Rapporto paziente-clinico

Il paziente/caregiver è in grado di condividere informazioni sui progressi della ferita e di informare gli operatori sanitari del suo peggioramento?

Si

Considerazioni

- Sviluppare una relazione aperta e trasparente tra paziente e operatore sanitario
- Educare il paziente/caregiver su come riconoscere il peggioramento della ferita
- Educare il paziente/caregiver a contattare immediatamente l'operatore sanitario se la ferita peggiora
- Fornire i contatti dell'operatore sanitario secondo il protocollo locale.

No

Considerazioni

- Rivalutare periodicamente la possibilità di avere una maggiore collaborazione (ad esempio se le circostanze del paziente/caregiver cambiano).

Referenze: 1. Moore Z, Kapp S, Loney A, *et al.* A tool to promote patient and informal carer involvement for shared wound care. *Wounds International* 2021;12(3):1-7. **2.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *J Wound Care.* 2019;28(3):154–161. **3.** World Union of Wound Healing Societies (WUWHS) (2020) Strategies to reduce practice variation in wound assessment and management: The TIME Clinical Decision Support Tool. London: *Wounds International.*

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T.I.M.E. Clinical decision support tool

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T.I.M.E. clinical decision support tool

Di seguito potrai trovare la guida tradotta in italiano

Assess patient, wellbeing and wound

Establish diagnosis and baseline characteristics for appropriate support and comorbidities that may impact healing. Record wound type, location, size, wound bed condition, signs of infection / inflammation, pain location and intensity, comorbidities, adherence / concordance to treatment

Bring in multi-disciplinary team and informal carers to promote holistic patient care

Record referral to others such as surgical team, wound specialist nurse, dietician, pain team, vascular and diabetes team, podiatrist, physiotherapist, family carers and trained counsellor

Control or treat underlying causes and barriers to wound healing

Record management plan for: systemic infection, diabetes, nutritional problems, oedema, continence, mobility, vascular issues, pain, stress, anxiety, non-adherence / concordance with offloading and compression, lifestyle choices

Decide appropriate treatment and determine short-term goals

T – Tissue non-viable[1-2]

1. ARE THERE BARRIERS TO WOUND HEALING?

Necrotic

Slough

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

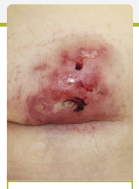
- Cleansing and debridement
- Surfactant, sharp / surgical or mechanical, autolytic or enzymatic, biological / larval

3. WOUND MANAGEMENT OUTCOME

- Viable healthy wound bed

I – Infection and / or Inflammation[1-2]

1. ARE THERE BARRIERS TO WOUND HEALING?



Infected

Deep infected cavity wound

Suspected biofilm

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

- Manage bioburden
- Antimicrobial* (topical antiseptic, and / or antibiotic therapy†)

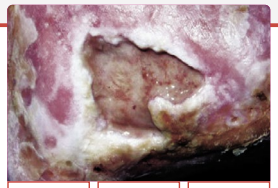
3. WOUND MANAGEMENT OUTCOME

- Non-inflamed, non-infected wound

M – Moisture imbalance[1-2]

1. ARE THERE BARRIERS TO WOUND HEALING?

Dry



Low | Moderate | High

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

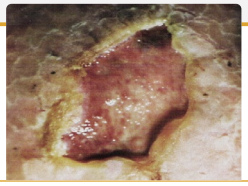
- Restore moisture balance
  - Hydrogel*, hydrocolloid
  - Foam, super absorbent, gelling fibre, NPWT‡
    - Hydrocolloid, alginate
    - Alginate

3. WOUND MANAGEMENT OUTCOME

- Optimal moisture balance

E – Edge of wound non-advancing[1-2]

1. ARE THERE BARRIERS TO WOUND HEALING?



Non-advancing or abnormal wound edge

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

- Promote epithelialisation and healthy periwound skin
- NPWT‡ – Atraumatic wound contact layer, cell or tissue products, skin care and adjunct treatment according to wound type

3. WOUND MANAGEMENT OUTCOME

- Advancing edge of wound

*Use appropriate secondary dressing as per your local protocol; †Where systemic infection is present, then it must be treated systemically and not just topically; ‡Negative Pressure Wound Therapy.

Evaluate and reassess the treatment and wound management outcomes

Evaluate: Record wound progression within given timelines. **Flag** if no change, go back to A, B, C and change treatment where indicated

Developed with the support of Glenn Smith[3] and Moore *et al.* 2019[4]

References: 1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19. **3.** Smith G, Greenwood M, Searle R. Ward nurse's use of wound dressings before and after a bespoke educational programme. *Journal of Wound Care* 2010, 19(9). **4.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *Journal of Wound Care*, 2019; 28(3): 154-161.

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T.I.M.E.2.0 a supporto delle tue scelte cliniche

A: Valuta il paziente, lo stato di salute e la ferita

Stabilisci la diagnosi e le condizioni generali di partenza incluse le comorbidità che possono influenzare la guarigione. Annota il tipo di lesione, posizione e dimensione, le condizioni del letto di ferita e della cute perilesionale, segni di infezione, dolore, problemi sistemici rilevanti, anamnesi clinica, collaboratività del paziente.

B: Coinvolgi un team multidisciplinare per promuovere un approccio olistico

Consulta altri professionisti come ad esempio: l'equipe chirurgica, l'infermiere specializzato in wound care, il nutrizionista, lo specialista del dottore, il vascolare, il diabetologo, il podologo etc.

C: Controlla o tratta le cause e le barriere alla guarigione

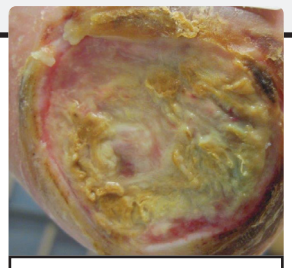
Prevedi un piano di gestione di: infezione sistemica, diabete, problemi nutrizionali, edema, incontinenza, mobilità, problemi vascolari, dolore, stress, ansia etc.

D: Decidi il trattamento appropriato

T – Tessuto non vitale[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Tessuto necrotico



Slough

3. OBIETTIVO CLINICO PER LA FERITA

Fondo di ferita vitale

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Debridement

Collagenasi o Idrogel*

Cadexomero iodico*

Collagenasi INTRASITE◊ GEL o **INTRASITE CONFORMABLE**

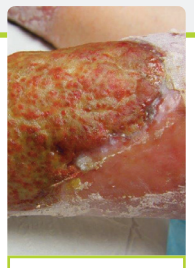
Gamma IODOSORB◊

I – Infezione e/o infiammazione[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Carica batterica elevata/Infezione

Lesione cavitaria profonda infetta



Sospetto di biofilm

3. OBIETTIVO CLINICO PER LA FERITA

Ferita non infiammata e non infetta

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Gestione della carica batterica

Medicazione antimicrobica*

Gamma ACTICOAT◊

DURAFIBER◊ Ag o **ACTICOAT Flex**

Gamma IODOSORB

M – Medicazione o secchezza[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE

Secchezza

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Ripristina l'ambiente umido ottimale

Idrogel*

Schiuma, fibra gelificante, NPWT†

INTRASITE GEL o **INTRASITE CONFORMABLE**

ALLEVYN◊ GENTLE BORDER, ALLEVYN GENTLE, DURAFIBER o **PICO◊‡**

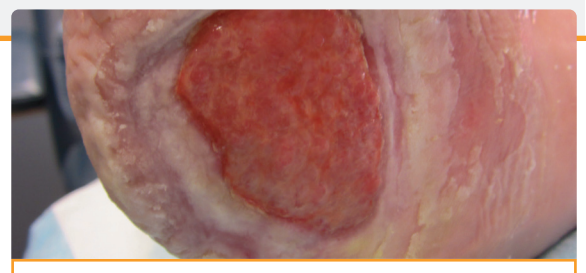
ALLEVYN LIFE, ALLEVYN LIFE Non-Bordered, DURAFIBER o **RENASYS◊**

3. OBIETTIVO CLINICO PER LA FERITA

Ambiente umido ottimale

E – Epitelizzazione/ Margine non proliferante[1-2]

1. IDENTIFICA LE BARRIERE ALLA GUARIGIONE



Margine epiteliale non proliferante

2. SELEZIONA L'INTERVALLO PRINCIPALE E IL SECONDARIO

Progressione del margine e cura della cute perilesionale

NPWT monouso e/o collagene, protettivo cutaneo

PICO e/o **CONDRESS®**
SECURA◊ NO STING BARRIER FILM

3. OBIETTIVO CLINICO PER LA FERITA

Progressione del margine epiteliale

*Utilizza una medicazione secondaria appropriata come da protocollo clinico locale. Per esempio una medicazione della gamma ALLEVYN o OPSITE◊

E: Rivaluta il trattamento e i risultati raggiunti nel tempo

Registra i progressi rispetto ai tempi previsti. Se la ferita non migliora ritorna ad **A, B, C, D,** e cambia il trattamento dove appropriato.

Sviluppato con il supporto di Gl enn Smith[3] e Moore *et. al* 2019[4]

†NPWT: Terapia a pressione negativa. ‡Livello di essudato delle lesioni idoneo per NPWT.

Riferimenti bibliografi ci: 1. Schultz GS, Sibbald RG, Falanga V, *et al*. Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19. **3.** Smith G, Greenwood M, Searle R. Ward nurse's use of wound dressings before and aft er a bespoke educational programme. Journal of Wound Care 2010, vol 19, no.9. **4.** Moore Z, Dowsett C, Smith G, *et al*. TIME CDST: an updated tool to address the current challenges in wound care. *Journal of Wound Care*, vol 28, no 3, March 2019: 154-161.