Professional Record Standards Body

Better records for better care

Wound Care Consultation Survey Report

Apr-23

Document Management

Revision History

Version	Date	Summary of Changes
0.1	1/3/2023	Initial Version
0.2	20/3/23	Updates after internal review
1.0	14/3/23	V1 after Project Board and Assurance Committee approval

Reviewers

Reviewer name	Title / Responsibility	Date	Version
Martin Orton	Programme Manager	17/3/23	0.1

Approved by

Name	Title	Date	Version
Project Board		28/3/23	0.2
Assurance Committee		31/3/23	0.2

Glossary of Terms

Term / Abbreviation	What it stands for
Person	A person in receipt of wound care
Care Professional	A health or social care professional who is delivering wound care
Carer	An individual who provides care to a person in receipt of wound care
EPR	Electronic patient records
NHS	National Health Service
NHS E	NHS England
NWCSP	National Wound Care Strategy Programme
PCSP	Personalised Care and Support Plan
SNOMED CT	Systematized Nomenclature of Medicine -- Clinical Terms, a structured clinical vocabulary for use in an electronic health record.

Contents

1 Introduction

1.1 Background and Context

The National Wound Care Strategy Programme (NWCSP) has developed from several previous initiatives which addressed the issue of sub-optimal wound care. Evidence points to marked unwarranted variation in UK wound care services, underuse of evidence-based practices and overuse of ineffective practices[1].

This offers major opportunities to improve the quality of chronic wound care through innovative solutions that will improve wound healing, prevent harm, increase productivity of staff, and produce financial savings in line with the requirements of the recent NHS Long Term Plan[2].

In September 2018, the NWCSP was launched to address this situation. The vision is to develop recommendations which support excellence in preventing, assessing, and treating people with wounds to optimise healing and minimise the burden of wounds for patients, carers and health and care providers. The NWCSP was noted in the NHS Long Term Plan and in the National Patient Safety Strategy[3].

There is currently no recognised standard for a generic information record that can support the delivery of wound care (including assessment, management, or prevention) across a care pathway.

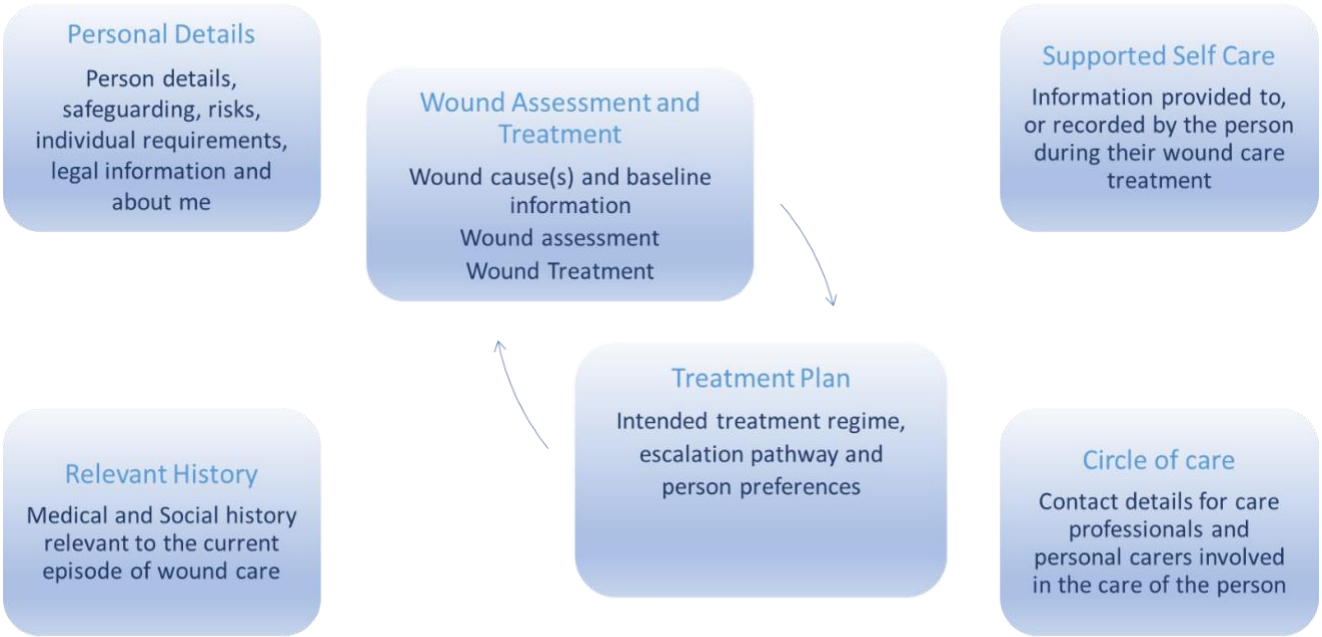
This has been identified as a key priority and area requiring standardisation. The premise is that a generic information standard could be used to support the delivery of wound care processes across different decision-making scenarios and use cases.

PRSB have been commissioned by the NWCSP to develop a wound care information standard which will enable health systems and economies to accelerate the adoption of best practice wound care in their priority pathways/services which in turn can help them meet their Long-Term Plan and Elective Recover commitments; effectively increasing the quantity, quality, and impact of these approaches for their populations.

A draft information standard was developed (after multiple webinars and focus groups), and a survey was launched in November 2022 to validate the draft standard.

1.2 Information Standard Structure

The standard has 6 domains as shown in the diagram below



Personal details, relevant history, and circle of care all use components from existing PRSB standards and are information which the health care professional providing wound care for the person should have access to from their electronic record. The other three domains constitute the main parts of the wound care standard and are the subject of this consultation.

The three main domains are built from existing PRSB components used in other standards wherever possible. In some cases, for example "Cause of wound" uses the existing "Problem" component, and the various assessments use the existing "Structured assessment" component. There are a few new components too for wound care specific items such as "Wound margin and edge description" and "Wound bed tissue type".

The treatment uses the existing Personalised care and support plan (PCSP) standard. This is person centred plan, developed with the person to address their overall needs and goals. The PCSP includes sections for Care and support plan, Additional supporting plans, and Contingency plans. The treatment plan will feed into the person's care and support plan and where appropriate can use an additional supporting plan for treatment details which don't fit into the person orientated needs/goals/actions, and a contingency plan for when things don't go as expected.

It is recognised that for surgical wounds the treatment plan will be developed pre surgery, but for other wounds the treatment plan will come from the initial (baseline) assessment.

The information model includes conformance (Mandatory, Required & Optional) and cardinality for each data item, these were at an early stage of development at the time that the consultation survey was issue, but respondents were asked for comments. Conformance and cardinality are defined from the perspective of the person completing the record. System suppliers would be expected to implement all items in the standard, although a minimum viable product will be defined when the standard is published for initial implementation.

Work to assign appropriate terminology, SNOMED CT, is underway in parallel and details will be added to the implementation guidance where elements have a coded item with the value sets showing SNOMED.

2 Methodology and Respondents

To send an online survey to stakeholders from across wound care to understand

- Whether any items of information were not needed
- Are there any concerns about any elements of the information standard?
- Is there any critical information that is missing from the current standard?

The survey was shared with:

- Care Professionals across health and social care
- People with wounds (and their carers)
- Suppliers of Wound Care management systems
- Suppliers of general electronic record systems
- Informaticians

In order to demonstrated that the survey had elicited responses from the full range of individuals involved in wound care, respondents were asked to self-identify their role, the breakdown of this are shown in the responses to the initial questions in the survey (questions 1, 2 and 3)

3 Question Analysis

Each question is shown in the following section together with quantitative statistics and key themes that emerged from qualitative analysis of the comments (where provided) and (where appropriate) where / how the comment was addressed in the Standard, Implementation Guidance, or Clinical Safety Case.
There was a total of 596 respondents to the survey, respondents were able to skip individual questions that were not relevant to them. Respondents were also invited to provide free text comments on several the

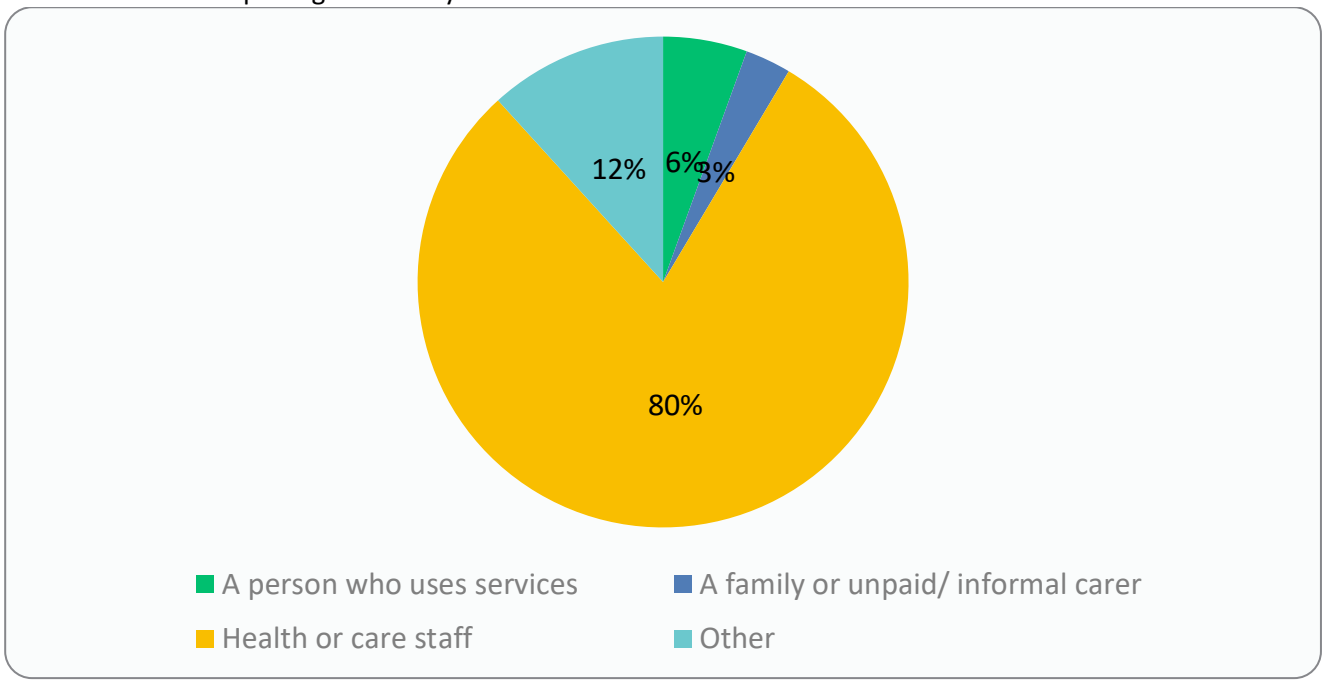
questions and the analysis of these comments is included in commentary below. There was a 71% completion for the survey and the estimated completion time was 8 minutes.

3.1 Who are the respondents

The first 3 questions focussed on the role / involvement of the respondent. These showed that the 596 respondents included, care professionals, carers and people receiving wound care and that the care professionals were covered a wide range of disciplines.

3.1.1 Q1- Are you answering as

Question 1 identified the number of care professionals, person receiving wound care and family members / informal carers completing the survey



ANSWER CHOICES	RESPONSES	
A person who uses services	5.54%	33
A family or unpaid/ informal carer	3.02%	18
Health or care staff	79.70%	475
Other	11.74%	70
TOTAL		596

3.1.2 What is your role?

We then asked the care professionals to pick the most appropriate role from a provided list. 70 respondents skipped this question and the breakdown of the 526 responses was a follows.

ANSWER CHOICES	RESPONSES	
Nurse	53.04%	279
Podiatrist	13.50%	71
Other (please specify)	13.50%	71
Administration/ Management	3.42%	18

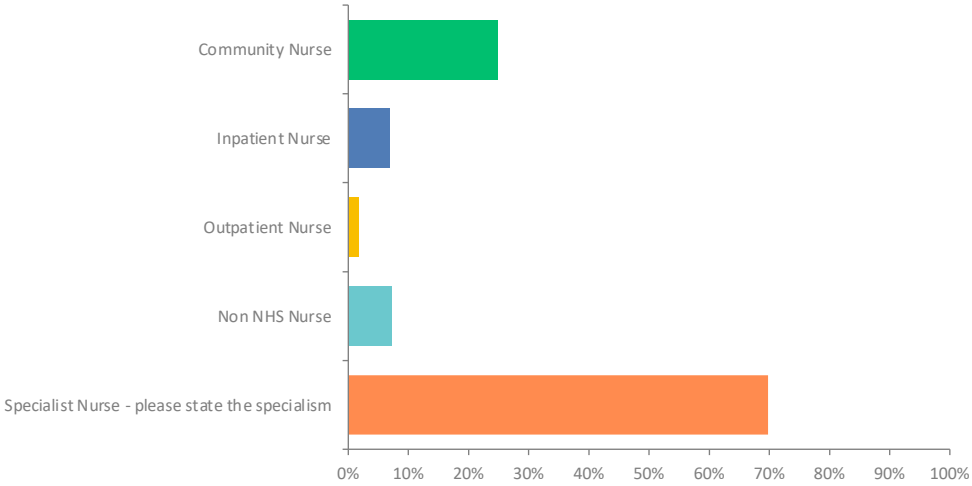
Other Allied Health Professional	3.04%	16
Care Home Management	1.90%	10
IT professional	1.90%	10
Surgeon	1.71%	9
Informatician	1.33%	7
Medic	1.33%	7
System supplier staff	1.33%	7
Healthcare Assistant	0.76%	4
Director of Social Care	0.57%	3
General Practitioner	0.57%	3
Nurse Associate	0.57%	3
Paramedic	0.57%	3
Midwife	0.38%	2
Volunteer	0.38%	2
Paid Carer	0.19%	1
Occupational Therapist	0%	0
Orthotist	0%	0
Pharmacist	0%	0
Physiotherapist	0%	0
Prosthetist	0%	0
Social Worker	0%	0
Support worker	0%	0
TOTAL		526

3.1.3 What type of Nurse are you?

We then asked the nurses to identify where they practiced, respondents could tick multiple boxes and we asked specialist nurses to state their specialism. 278 respondents answered this question and there where 307 “ticks”.

Q3: What type of Nurse are you? Please tick all that apply

Answered: 278 Skipped: 318



Powered by SurveyMonkey

ANSWER CHOICES	RESPONSES	
Community Nurse	24.82%	69
Inpatient Nurse	6.83%	19
Outpatient Nurse	1.80%	5
Non-NHS Nurse	7.19%	20
Specialist Nurse - please state the specialism	69.78%	194
TOTAL		307

Analysis of the 194 specialist nurses showed the following breakdown

Tissue Viability Nurse	126
Vascular	15
GP Practice Nurse	11
Wound care	10
Lower limb / leg ulcer	4
Surgical	4
Burns	3
Informatics / CNIO	3

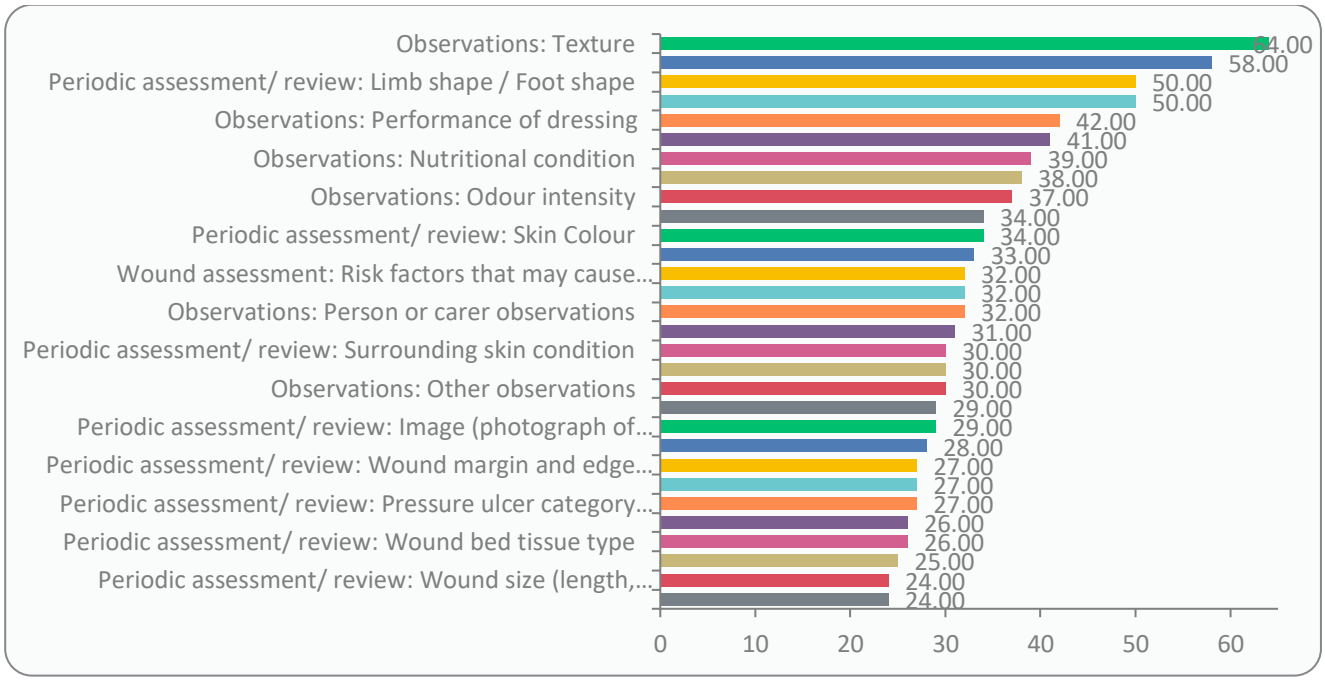
Palliative Care	3
District Nurse	2
Nurse Practitioner	2
Paramedic	2
School Nurse	2
Senior nurse	2
Care homes	1
Health Visitor	1
Infection prevention	1
Lymphoedema	1
Paediatric	1

3.2 Information standard domains

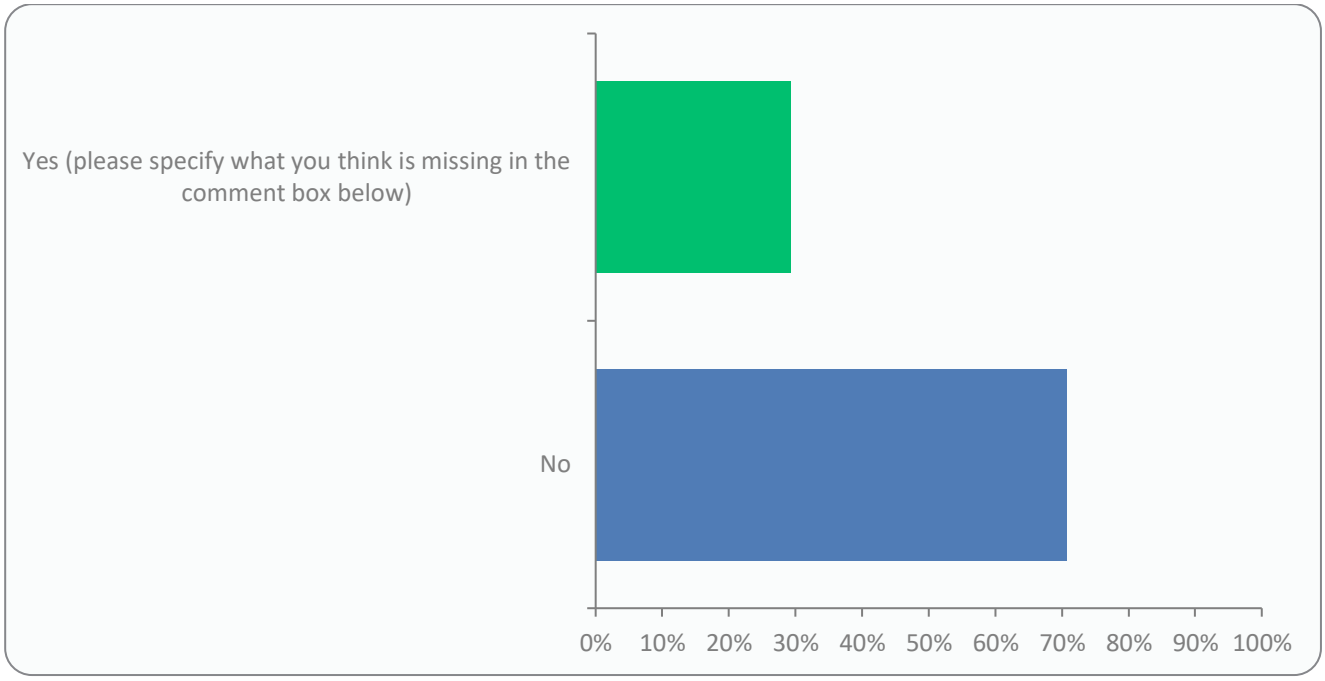
The next group of questions focused on the information standard domains and asked respondents to identify any elements that were NOT needed in the standard. Secondly respondents were asked whether any information was missing, and, if so what. The missing items that respondents identified was a free text response and therefore there was variation in terminology and language. These questions also showed that respondents didn't necessarily understand the structure of the standard, with elements being cited as missing, being present in another part of the standard.

3.2.1 Wound Assessment and Observations domain

143 respondents (out of 596) thought that some data elements from the wound assessment and observations domain were not required. Of the items that were identified as not being required the observed "Texture" was the highest at 64, the full list is given below. These items were reviewed by the project's clinical leads and given the response received indicated that the majority of respondents did not consider that these were superfluous it is not proposed to remove any items from the draft model.



383 respondents answered the question about whether any information was missing from the wound assessment section with the vast majority (70%) saying no



The respondents who considered that there were gaps were given the opportunity to provide more detail and 131 comments were recorded, of these

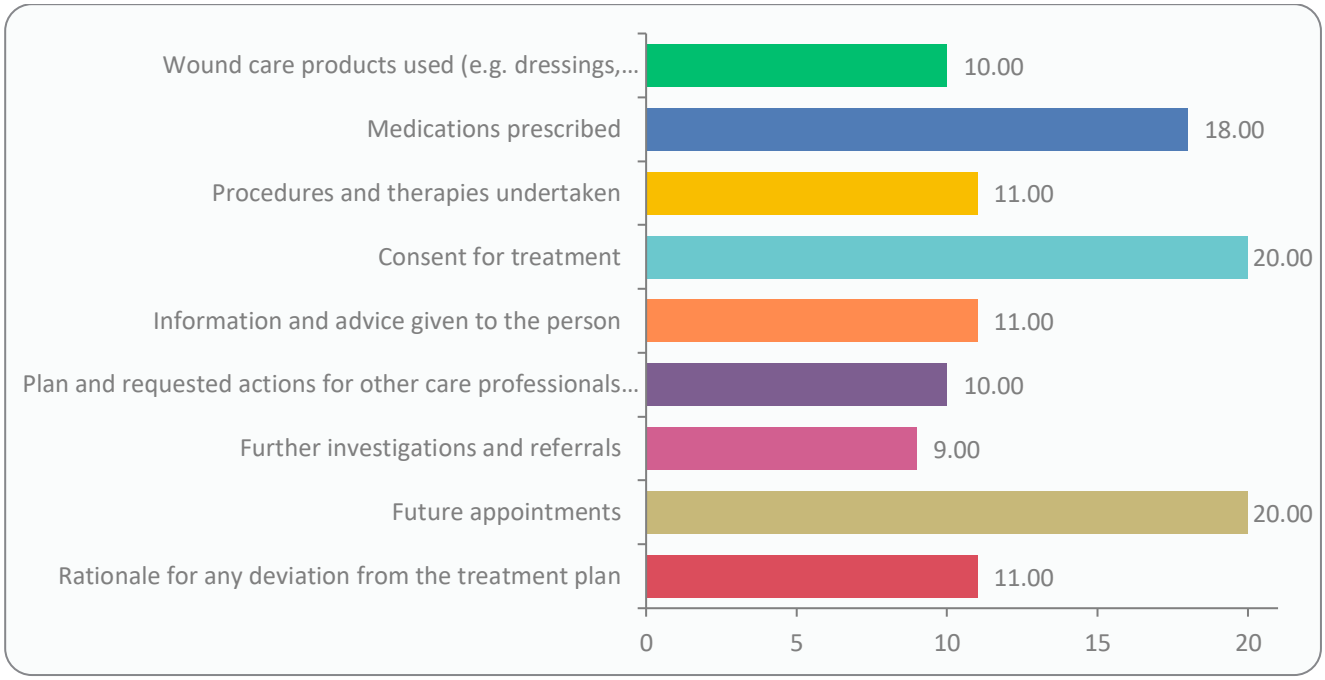
- 95 were already included in the standard
- 22 related to possible new requirements or updates to the implementation guidance
- 14 were comments rather than information requirements

The 22 potential requirements were reviewed by clinical leads and the following changes were made to the model, there was some repetition within the comments.

Addition to the model	**Update to implementation guidance**	**Out of scope / not supported by project team**
Wound swab taking	Pulse palpation	Palliative care phase of illness
Oedema codelist	Foot / limb shape to include ankle and calf circumference	Competence of staff / issues of unpaid carers looking after the wound
Hydration	Sepsis / infection – link to IWII recommendations	Bowel movements / continence (could be part of general history)
		Diabetes
		Exposed bone
		Stemmers / lymphedema

3.2.2 Wound and skin care treatment domain

45 respondents identified data elements from the wound and skin care treatment domain were not required. Of the items that were identified as not being required Consent and Future Appointments were the highest at 20 each, the full list is given below. These items were reviewed by the project's clinical leads and given the response received indicated that the majority of respondents did not consider that these were superfluous it is not proposed to remove any items from the draft model.



383 respondents answered the question, is anything missing from the treatment domain and of these, over 80% said no. The 69 respondents who thought that there were elements missing provided 75 comments, the vast majority of these (61) related to elements that were already in the standard, 10 were comments and 4 related to potential new requirements

- Swab taking (covered above)
- Alternative appointment arrangements - out of scope for wound care standard
- Recalls for healed ulcers – out of scope for wound care standard
- Chaperone present – out of scope for wound care, but would be part of the circle of care

3.2.3 Supported self-management domain

24 respondents identified data elements from the supported self-management domain were not required, of these 11 respondents considered that wound care information was not needed and 21 respondents that documents and images provided by patient were not needed. 45 respondents identified data elements from the wound and skin care treatment domain were not required. The project team reviewed this data but given that most respondents did not identify data elements that needed to be removed no updates to the model should be made.

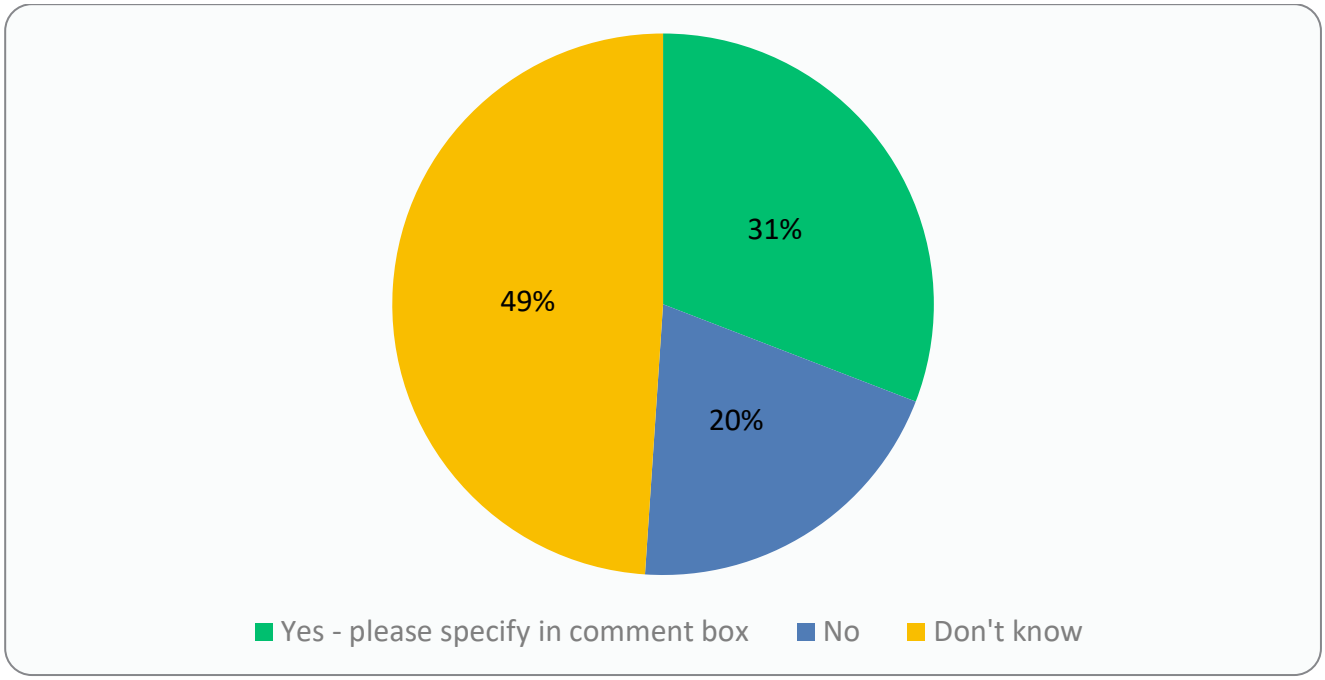
There were 111 comments on missing items and of these the vast majority of these (86) related to elements that were already in the standard, 24 were comments (of which 7 related to education / training) and 1 related to clinical guidance with respect to infection control.
Therefore, it is not proposed to make any changes to the self-management domain of the model.

3.3 Other aspects of the standard

The next set of questions related to wider, context aspects of the standard and how it should be implemented

3.3.1 Differences for children

Respondents were asked Are there any differences which need to be made or considered for the standard for use with children? 376 respondents answer this question however just under half said that they didn't know; a further 20% said no and 31% yes



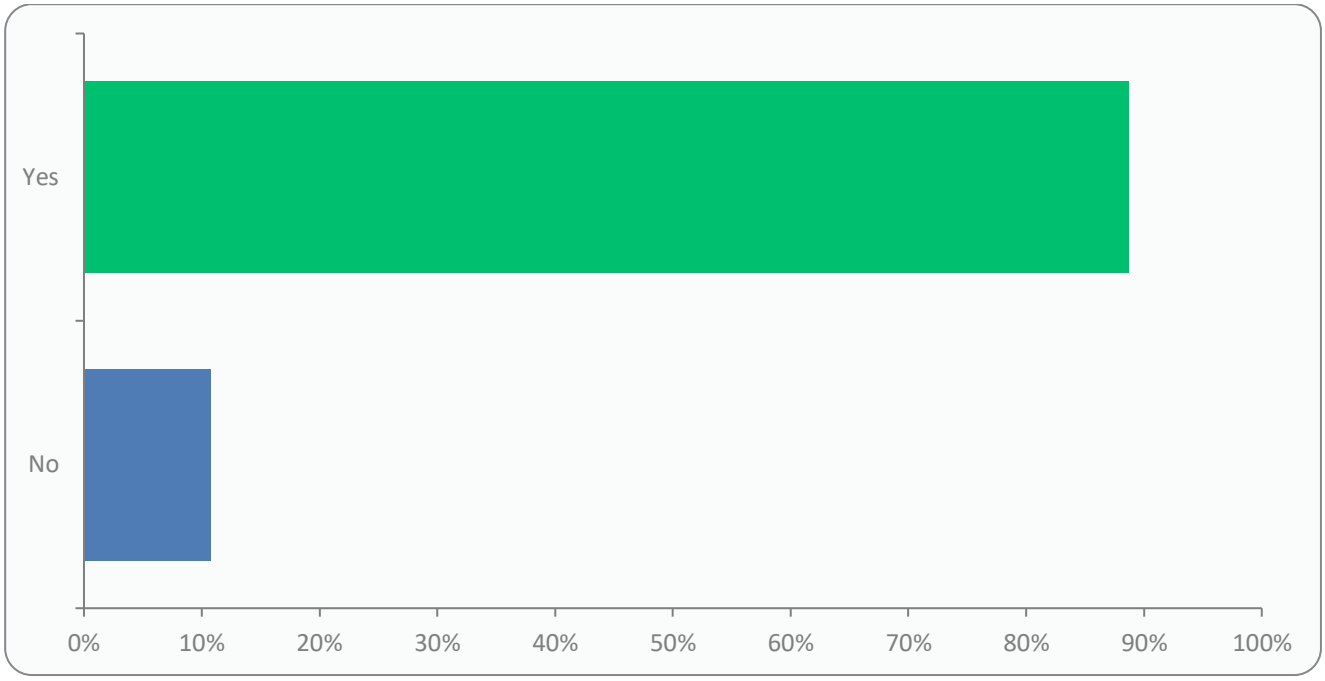
There were 137 free text comments on this question, with 74 of these not being a new requirement or not relevant. A further 23 related to safeguarding or consent issues, and 32 related to the language being used to enable children to understand the wound care treatment. One respondent raised the issue of whether congenital issues would affect wound healing and the project team agreed that this would, if relevant, form part of general care record.

3.3.2 Person preferences

The treatment plan includes gathering and using patient preferences, as shown below, to use with the wound assessment when creating and updating the person's treatment plan. If a patient has an About me profile (information a person wants to share with health and care professionals) this should also be available in their record. The treatment plan will use the existing personalised care and support plan standard for managing the needs, goals, actions and their outcomes for the person. An additional support plan can also be used to detail wound care specific items such as the wound care products, wound-bed preparation, dressing changes, turning frequency, other equipment and other items as required.

Respondents were asked whether they consider that this section would capture the person's wishes and needs?

358 respondents answered this question and 90% of those agreed that it did, there were 93 comments on this question, these comments focused on ensuring that the person preference addressed specific patient requirements, such as chronic wounds or where medical improvements in the wound were not possible, comments also identified the overlap with data held elsewhere in, for example, EPRs. Several comments also identified barriers to treatment and patient concordance to treatment, patient capacity and consent (and ability to consent).



3.3.3 Patient access to records

Respondents were asked whether patient access to the wound care information, described above in their record, help them with supported self-management (this is self-care supported by healthcare professionals). This applies to people who agree to self-management. 362 respondents answered this question, and the breakdown was as follows

	NO DIFFERENCE	NOT SURE	YES, A LITTLE	YES, A LOT	TOTAL
	4.42% 16	11.60% 42	31.49% 114	52.49% 190	362

This suggests that patient access to records would make supported self-managed care more effective, 93 comments on this question were received, they focussed on making sure that information was appropriate and in easy-to-read language. There was also reference to the escalation plan, specifically what to do if the wound deteriorates. Several respondents stressed the value of multimedia and pictorial guidance and a focus on education and training for the person. There was a suggestion that access to FAQ would be beneficial.

3.3.4 Appropriate care

Respondents were asked will the information we have set out to manage wound care, help a person or their carer trust that appropriate care is being provided? 362 people responded to this question.

	NO DIFFERENCE	NOT SURE	YES, A LITTLE	YES, A LOT	TOTAL
	2.49% 9	8.56% 31	27.62% 100	61.33% 222	362

This shows a good level of confidence that the information standard will help people, or their carers trust that appropriate care was being provided. There were 49 comments to this question, these were quite wide ranging, but included points about accessibility of the information provided, the need for the person to have access to care professionals and the reference to evidence based best clinical practice

3.4 General questions

3.4.1 Update on the projects

197 respondents indicated that they wished to be updated on this project or other PRSB work. They provided their contact details.

3.4.2 PRSB monthly newsletter

150 respondents (50% of those who answered this question) asked to be subscribed to the monthly PRSB newsletter.

4 Appendix – Free text comments

The appendix contains all free text comments that were received against each question, these comments are included exactly as they were entered into survey monkey, there has been updating to spelling or formatting

4.1 Wound Assessment and Observation

What is missing? Any other comments?

Wound assessment and observations comments

Quality of life assessment Previous wound care experience Allergies/ sensitivities General skin condition (Not just surrounding skin) Patients understanding of their condition/ wound

Specialist bandaging techniques for venous/ mixed aetiology leg ulcers

Clinician's aim of treatment. Patient's aim of treatment - may not be the same as that of the clinician, may not even be focused on wound healing ie: the improvement of a specific symptom, quality of life.

Observation: current offloading

is the person nutritionally compromised or isn't able to hydrate effectively and how much fluid is being consumed

Pulse palpation and then change "pulse sounds" to Doppler signals

Contextual clinical information is also important. Eg: Past medical history, surgical history, socio-economic factors, family history. For limb and wound shape, image is preferred (if available).

Provenance needs to include automatic data collection from wearable devices and remote monitoring

previous dressing applied Initial stage of wound Wound aetiology , example ; pressure ulcer, leg ulcer, surgical, traumatic , other.. Wound Location sign of bleeding or exudate strike through swab sent for children pain management area- play specialist required or not analgesia given prior to dressing change, specific medication pain score prior to dressing change, during dressing change and after dressing change.

List of all HCP roles/teams involved in provision of the wound care

maybe get one template national instead of all these questions and different templates that are used. it is confusing

Wound assessment and observations comments

But need to consider the competence of the nurse completing the assessment, some of the above are specialist roles

Consent for examination. Shared decision making discussion regarding treatment options.

past medical history, including medications (for example, previous or long term use of steroids) dexterity of the patient, to enable self care avialbility.

Patients wishes/ goals for wound

Time of dressing change and when dressing change is next needed

There is no reference to 'wound swab taking', there MUST be a mention of using the 'Levine technique'. Standardizing of this technique across the country will aid microbiology with interpretation of results and in return more efficient antibiotic stewardship.

Any issues or difficuties experienced by unpaid carer in looking after the wound.

Patient mobility. Ability of patient to manage wound. Actions taken by patient / carer to manage wound. Whether pressure is the cause of the wound or an exacerbating factor. Hygiene assessment - is incontinence an exacerbating factor

In palliative care Phase of Illness AKPS

Department afterwards as only interested in putting patients into A&E to get off spreadsheets

Diabetes or no diabetes Wound tissue sample for microbial culture

I wonder should we have a prompt for stage/ grade of pressure ulcer in here.

food diary - nutritional intake weight BMI, blood tests

Observations: Emotional/Social/Mental condition

Depending on where the wound is - bowel movements

maybe specify neuropathy in the risk factors that may delay healing

Deconditioning/ self neglect / safeguarding status of patient

Bloods , medications

associated eczema, dressing clean and intact, dressing impaired

Yes and No. This is not good. There is far too much routine recording. The process will take over and less will be achieved. It will drive away non experts and then there will be too many patients for the specialist staff. This list is comprehensive but it cannot all be collected routinely. There is a point to all of them at times the problem is that this list will turn it into a tick box exercise. Choices need to be made. As a GP (and therefore not dressing the wound) this is far too much to assess a wound. Missing is prevention. What could be done before there is a wound.

Patients mental status

Wound assessment and observations comments

sounds comprehensive, lots that we don't currently include

impact esp on mobility

Medications Past medical history Social issues (live alone/where they sleep etc)

Changes in patient mobility Changes in mental health status - depression, anxiety, etc. Changes in frailty score

Need to add technology-based assessments - body mapping, thermography, sub-epidermal moisture scanning for example

positive stemmers sign , fibrosis of the wound bed and the oedema , oedema to the foot and toes and above the knee

Observations: condition of bone if exposed (specifically for significant pressure ulcers)

I can see only a partial relevance to Emergency Department management - it is unlikely that we will be dealing with the longer-term care of significant trauma wounds/ surgical wounds. However, the acute elements of this assessment are important and relevant. The initial documentation re wound care will of course become a part of the ongoing care record. Coherency and consistency are the key to ensuring effective communication and continuity of care.

Duration of wound

Changes in cognition - ie new confusion/ worsening confusion if known to have cognitive impairment.

How the patient views their wounds and how it impacts them

Diagnosis of the wound - eg Venous Leg ulcer, malignancy, dehisced surgical wound
Cognitive abilities of the individual - has capacity, Best Interest decisions, POA, IMCA etc
Safeguarding concerns - eg self harm, self-neglect, Pressure Ulcer Safeguarding tool

How the wound/ dressing affects the individuals' quality of life (may be in a subsequent question)

Impact to my quality of life - my wounds affect my day to day life, prevent me from working sometimes, socialising and having sex sometimes. They ruin my self esteem.

It may already be included in the section 'Wound baseline information comprising initial assessment (first periodic assessment), site, body map and description', but if not then the age of the wound, as there's a high proportion of non-healing wounds that are just being managed not actively treated.

Impact of quality of life

Does the patient go to bed at night. Is pain an issue more at night ? does the pt need to hang the limb out of the bed to reduce pain?

Wound assessment and observations comments

A re-assessment date box for when the dressing type or treatment option should be re-evaluated and changed if no improvement. Additionally should have tick section to be able to close old episodes of wounds without full assessment for times in which wounds have not been registered as healed properly.

Footwear information

Limits to social care - so can the patient dress themselves, can they ask friends or relatives for help, do they have clean environment and enough to eat and drink.

How long has the wound been present

Honestly, I found the above too hard to follow and read alongside the information above it. As a layperson who has a far more than average medical knowledge, I wonder if that will be a barrier to your responses from non-medical respondents as I'm surprised that I can't engage with it.

Length of time wound present (initial assessment)

the level of information on the form is accpetable for a stand alone form, but there may be duplication across other forms in use for the patient, depending on the environment of care (e.g. home, hospital)

Person expectations of outcome

Patient capacity Alongside nutrition I think hydration needs to be included. Skin tone assessment Psychosocial assessment

What is "pulse sounds" Do you mean Doppler assessment? Note ABPIs are really not a very good way of excluding arterial disease. Surely Nutritional condition is an assessment not an observation

Ankle and calf circumference

Frequency of wound dressing replacement. Dry or moist wound healing dressings? Infection control dressings or standard? Type of pain relief, ie addictive? Frequency and dosing? (High risk in trauma wounds of addiction)

quality of life impact

All applicable depending on the wound aetiology being assessed, but not all are applicable to each aetiology e.g. pulse sounds are not applicable to pressure ulcers but they are for the lower limb. Is a core group applicable for all e.g. nutrition, pain score, signs and symptoms of infection etc. Question would be better split into wound type i.e. surgical wounds, pressure ulcers, lower limb. Co-morbidity assessment/management is a significant omission from this list. Add hydration to the list. Psychosocial assessment to be included. Performance of dressing needs clarification. Skin tone assessment to be included. Patient capacity, concordance and compliance. All vital signs need to be measured i.e. blood pressure. More factors need to be included for surgical wounds e.g. wound dehiscence. See comment 6 and include additional elements from question 5. Useful resources - Wounds UK (2018) Best practice statement: Improving holistic assessment of chronic wounds. Available to download from www.wounds-uk.com. Plus Implementing TIMERS: the race against hard to heal wounds

Wound assessment and observations comments

Exposed bone or probe to bone trst

Equipment check Enviroment assessment

Wound dressing allergy if any?

Initial or recurring wound/ulcer Allergies/sensitivities patient cognitive ability

would skin colour and skin condition be described in same sentence?

Information for patient/relative/carer and include patient wishes

Frailty status

1)capturing of advice given- whether written or verbal or both 2)consent 3) sensitivities and allergies

Pressure relief type and is it being used

Is the care shared?

how long has the wound been present Skin colour should be skin tone

Current Treatment, medical history and medication

What is patient social status (able to look after themself, has care agency involved, has district nurse involved , independent and other).

Dates of assessment and recommended date of next assessment

continence

Date wound first noticed, is the patient house bound/able to attend Clinic for treatment.

Patient information

which pain tool is being used as part of the pain assessment

All of the above are relevant, but not to all wound aetiologies and some observations only periodically.

previous/current dressing plan +/- effect

In observations pulse sounds should be reworked to hand held Doppler signals.

How frequent dressings are being changed

Symptoms of ischaemia ie claudication or rest pain History of previous vascular intervention

Very detailed

Wound assessment and observations comments

I can't really know the answer to this unless I know how the data will be used. For example, if collecting data on skin colour and images of wounds will this drive improvements in healthcare inequalities? From a patient perspective, anything that helps monitor, assess and treat works for me.

Patient willingness/ability to self care

What is the aim e.g healing, debridement, reduce bioburden

Prevention of wounds. We have a product which has been shown at 2 NHS hospitals to reduce Heel Pressure ulcers

Previous non-healing wounds/previous pressure uclers

Quality of life for the patient - how the wound is affecting the persona ability to live their life

In with pain score, is important to know type of pain which may help to prompt GP with correct analgesia for example neuropathic

Footwear

Psychological effect on patient and family ie how it restricts their life and the lives of others

Offloading in place - type , periodic review . evidenced Wound classification system (Texas) , consent . Underlying neurovascular assessment if foot wound . Consent for photographs . Modifiable risks eg smoking , weight . Diabetes / known to vascular

Previous vascular interventions Previous foot infection and site e.g osteomyelitis

Past Medical History Equipment available to patient Compliance/Ability for self-management

HbA1c and who seeing if not within normal range

Exudate

Palpation of femoral, popliteal pulses as well as foot pulses as part of vascular assessment.

Need to make sure data is quick to collect so does not take extra time

I think the infection part should be seperated into covert and overt to match the IWII recommendations

Length of time, previous wounds, therapy already tried eg larval, VAC, anti microbial, compression

as well as odour intensity, length of time would be relevant too ie is odour prolonged

What matters to the patient, expectations and previous experiences

Mental Health/Depression/Anxiety Home situation- loneliness/ social isolation/ carers Medication- including over the counter and recreational

Dressing appearance prior to removal

Wound assessment and observations comments

Sepsis symptoms?

consent to assessment allergies

Off loading for pressure ulcers & support surface

Allergies to dressings etc..

In terms of monitoring wound healing rates, there are validated measures which combine many of the elements above (the PUSH score is probably the best known). This would seem to be a good approach because the tools are validated and comparable across all functions, yet they seem relatively unknown and unused. I note wound cause or diagnosis is first on the list. I don't see how you can ascertain a cause or diagnosis at the beginning of the assessment.

signs of infection

Patient attitude towards the problem

Duration patient has had wound. Factors that may complicate healing

Specifically - drug therapy that may delay healing?

i am a health care assistant that is doing everything a nurse is supposed to be doing nurses I worked with say they don't do this or that so i will jump and do with a lot of training. online meetings I am doing compression dressings, basic wound check, basic burns and more

Requiring a photograph negates the need for visual descriptions. Pain should be separate records but can be correlated if needed.

How wound was caused and if an object caused the wound, describe object. If person is at home, is there anything in their environment that could obstruct proper healing of the wound in question.

patient wishes or feelings

Social situation Blood picture Cultural barriers, such as using dressings that contain animal derivatives Patient, family and carers understanding of wound healing. Concordance

off-loading

any known Dermatoses

psychological effect on patients life style

Impact of wound on Quality of life Capacity to consent to treatment/ understanding of risk

patients level of understanding concordance

Positive stemmers sign and fibrosed oedema

Wound history- what has worked previously/ site of previous wounds. eg- If DFU then risk of further ulceration increases dramatically Current or recent antibiotics/ swab results of the wound in question.

Wound assessment and observations comments

Capacity assessment/review

4.2 Wound and skin care treatment

What is missing? Any other comments?

Wound and skin care treatment comments

Issues with concordance and what has been done to address this. Timeline for review and expectations. Contacts of other teams involved in the patient's care.

Clients need to be made fully aware of who has overall responsibility for managing the wounds. If a client is in a residential bed, they need to be made aware that DN services or TVN's will oversee their care plans. If in a nursing bed, clients need to be informed the nursing staff with the added support of other wound specialists will have overall responsibility for managing wound care.

Overall plan of care/treatment goals. Eg, if someone is not expected to heal and goal is maintenance and infection prevention, that should be clearly visible (not hidden in flowsheet) for any other clinicians to know up front.

Information and advice given to informal carers

Dressing undertaken using- standard ANTT or Clean Procedure skin /wound cleanser primary dressing & secondary dressing also Rationale for primary and secondary dressing , example debridement, Re- hydration, Absorption, manage infection, protection, N/A and others. proposed frequency of dressing change date of next review

i think how the patient is feeling example how are they feeling about the wound today ? how they are coping with this wound and how we can help with the moving forward their wellbeing of wound care

This fits in with the overall patient record therefore some information not specifically needed here

Pain score.

Changes to wound observed and compared to previous 3-4 visits

Information and/or advice given to carer.

Ability of patient / carer to follow advice. Information / advice given to person should explicitly include advice relating to nutrition / hygiene / mobilisation / sleep habits (sleep - not unknown for people with restricted mobility or depression to sleep in a chair rather than a bed)

Some things would not be included for our patients but of course this is for all areas

Linkage between departments and senior clerical managers need to be more aware of failures SmARTER

Shared decision on the goal of wound and skin care treatment with the individual concerned, carer if involved.

Wound and skin care treatment comments

I think everything is covered here, FREQUENCY of dressing change will be covered in requested actions I suspect.

The person's ability to comply with treatment plan.

Sensitivity to products or topical applications

patient led application or carer/ HCP only application

Yes and No. Again too much process. Just recording this would take a lot of time. Some elements are recorded already and need brought in electronically. The focus is patients with a problem. The biggest savings would be in prevention. I haven't got to the end and dont know if you will ask that.

Intended / agreed duration of treatment.

Progress of the intervention

Details of any wound swab sent, specific section for NPWT, details of any nutritional plan and details about specific equipment in place for Pressure Ulcer prevention

Dressing /Ingredient allergies or intolerences

I have not ticked some of the boxes because an enterprise EHR should link to sections such as referrals, requests made, future appointments and it is time consuming and unnecessary to document these a second time. So while they are useful I am not sure they need to be in the standard

any allergies to any dressings or treatments used to ensure another HCP does not attempt to use the same dressings etc if using steriod creams what finger tip prescriptions are advised to avoid over used

Goals of the treatment plan - eg healing, palliation, reduction of exudate etc Cognition - who to involve

Referring me on or changing my treatment if something isn't healing properly - I don't like having wounds for months and months at a time.

Allergies and sensitivites

Allergies and sensitivities Other MDT professionals involved.

Alternative arrangements/appointments: eg I had to contract a private nurse to administer wound dressings on a Sunday when no service was available on the NHS. We need to signal the 24/7 for wound treatment.

we should be able to put on recalls for individuals of healed ulcers allowing us to follow up long term plan

Further investigations and treatment should have a section to note if referral has been completed and when patient has received appointment or acknowledgement from service.

Pressure relief information

Wound and skin care treatment comments

Name of person giving advice and name / position of other staff who the plan has been discussed with.

Perhaps it would be helpful to provide some visual aids to future questions as if you're non-medical it can be hard to conceptualise what you're actually asking. Again, I can't answer properly and suggest you keep everything.

Allergies/sensitivity to products

isn;t verbal consent sufficient? I would assmue that at this stage, the patient has given consnet just by being there .

Non compliance

Patient's ability to tolerate treatment plan and alterations made to best practice treatment plan to enable patient to tolerate treatment plan although this would almost fit in to rationale for deviation from treatment plan.

My only comment is that there is a fine line between a WMDS and a EHR, When it comes to general (Non woundcare related), perhaps this is something that is not captured, but VIEWABLE and EDITABLE within a WMDS that links back to an EHR. if clinicians are constantly required to add MORE data that is already in a system this does not make sense

Medication's Rx, class, dose and frequency

previous treatments tried and reasons for failure

compliance with treatment

We don't understand how this section differs to Question 4. Elements above should be included within an initial, holistic wound assessment. If the question is directed to skin care, then all patients should have a thorough, holistic skin assessment. Useful resource - Wounds UK (2018) Best Practice Statement Maintaining skin integrity. London: Wounds UK. See page 7 Available to download from: www.wounds-uk.com

Specific patient information leaflets issued

Topical steroid usage

no all are relevant

Allergies/sensitivities. A reminder of what not to use on wound eg. Certain adhesives

capturing of advice given- whether written or verbal or both and sensitivities and allergies

Treatment plan, proposed frequency of dressing changes. Check box to confirm patient or carer has been shown how to do dressing change competently if self caring.

Dressing used, why this dressing if the correct dressing for that wound.

Patient preferences

Safety netting advice

Wound and skin care treatment comments

See my comments above - same applies here. It would be good to track service intervention. I really want someone who is able to broker my care, advocate and signpost.

Break the wound care product used down into categories. So ask what wound cleanser used What skin cleanser used What moisturiser used Ect

What if patient does not have capacity to consent. What if patients capacity or mental health restricts the choice of dressings.eg restricted use of bandages on a mental health ward.

Patient Activation - Importance and confidence scaling to self manage

Offloading used if needed Wound cleansing choice

Order Codes - access to equipment/dressing materials

Photos consent.

Data for next assessment. Assessment of it the current treatment plan working

Review of nutritional status - weight and varied diet also diabetes control for diabetic patients and last blood tests and results

Equipment provision

Stated documented and review of patient centric goals of care - in simple languague

Handover from previous clinician e.g midwife to health visitor

Within Podiatry off loading or specialist footwear would form part of the wound/pressure ulcer treatment plan and should be recorded, with rationale for its use and when to use it eg in bed.

method of wound cleansing (if required); aim of treatment eg. reduction in bacterial load, palliative, pain reduction etc.

Aim of treatment, Patient wishes and choice which may be different to clinicians'

Wound cleaning. Debridement, irrigation etc.

Contraindications Allergies Concordance

Patient's goals

Chaperone present?

Have a category for pressure ulcer prevention products such as boots, undergarments, gel pads, prophylactic dressings etc

Under medications it will be useful to differentiate between topical and systemic medications, especially antibiotics. Also make notes of what the patient might have been doing to the dressings etc since the last visit.

informed consent needs to be more than a tick box of informed consent- does this include sharp debridement- a discussion of risks and benefits- needs a box to comment

4.3 Wound care education and information available to the person to help support their care

What is missing? Any other comments?

Wound care education comments

Information needs to include point of contact for HCP/ open door agreement for follow up

Details of how to contact the relevant professional if the person has concerns about their wound or difficulty carrying out the personalised care procedure. Has the treatment plan been adhered to. If not why.

Safety netting and sign posting to ensure the patient has a contact should they have concerns.

Application of dressings and application of emollients

Overall discussion note: care of compression, care of cast, pressure relief information, handouts, etc. Disease/etiology related information beyond wound bandage instructions.

documents and images should have consent of parent/ person with parental responsibility or child/ young person if considered competent to give/ refuse consent

Access to Telehealth app to send wound images directly to their provider if they cannot make an office visit

Information and advice given to informal carers

Planned HCP review date

more appointments can be made for self care with the pt to see how they are caring for the wound and where we can help more . 15min slots do not cover everything that is needed

steps they are taking to help themselves, for example eating habits, pressure relief actions

Need to be wary of defensive medicine, the burden of documenting everything. This should be limited to what improves the outcome for the patient, rather than something needed for any legal claim down the line

reporting of changes to the wound noticed by the patient themselves eg increase in exudate, increase in pain

Documents and images relating to the wound provided by an NHS source.

Standards for involving informal carers at request of patient.

Wound care education and info available to the unpaid carer to help support their care. General support needed by carer.

Financial ability to source the recommended materials. Ability to obtain the materials - getting to the shops, getting someone else to do so, getting a delivery, ease of requesting

Wound care education comments

further materials (not having to spend hours on the phone to a surgery, alternatives to the use of internet access or phone apps)

What to do if it isn't healing. Who to contact: next steps

Has capacity for patient to undertake supported self-management been assessed?

No facility to share certain CD, scans between NHS GP and others fragmented

capacity and capability assessment

Education of carers

Outcome measurement. How are assessments, the wound and skin care treatments connected by shared goals and goal attainment?

I think we need to record patient concordance with treatment plan. this is very relevant to pressure ulcer management ie we need clear evidence that patients have made proper informed decisions about their care. This is very important when patient has declined their treatment plan (or part of) for example episodes of bedrest, types of equipment). We need clear evidence that patients have been provided with clear information about the consequences of declining care, ie pressure ulcer deteriorates, infection, sepsis, osteomyelitis etc.

The role of good nutrition and particularly protein intake required in wound healing

Evidence non biased nutritional information from BDA

follow up for person

Contact information if any concerns between appointments

Yes and No. This puts some patients (poor and less informed) at a disadvantage. I doubt this is your intention but we see in the move to on line and telephone consultations with photos that some miss out. If a photo is needed the staff member should be able to take and there should not be a time penalty on clinicians who see those who cannot cope with the technology.

A care plan over the next 12 weeks or so that the patient can follow (e.g. next appointments) when to change dressings or stop steroid cream's for example. Anything that makes the care plan specific to their care.

Agreed first point of contact for support or questions.

Home wound care template plans ie step 1 wash hands, step 2 open dressing pack etc

Signed consent

How to assess if someone is able to undertake self care Contract between patient and HCP should be considered

what to look out for such as deterioration / signs of infection and who to contact

Cognition/ Best interest/ POA/ IMCA

Wound care education comments

Confidence and competence to perform self care.

A help line / support line I can call if I am in doubt, save me going to A and E . SOmetimes I just need reassurance that the wound is ok and if I could talk to my nurse, or a nurse who knew what I was dealing with, it would be helpful so I could now it was ok and I'd be more confident managing it at home myself.

Capacity assessment Consent to self care Family/carer/social network support and education Think about types literature - youtube for exercises etc

Consent Capacity Family/carer involvement

A digital messaging function for self-caring patient to reach someone if an issue develops.

The cost of wound care supplies does the person buy their own dressings And want happenings when they can't afford to buy the supplies?

Notes made by patient at dressing changes and questions to ask healthcare professionals. Also, medications left in their stock versus what they need.

Information on signs that a wound is degrading, photos on this, information on who to contact in full (GP, District Nurses, TVNs), information about sepsis and wound infection.

Infection control - ANTT?

Self care and being able to do daily activities as close to normal are crucial for patient well being

Assessment of patient's motivation and commitment to complete self-care along with cognitive and physical ability to implement self-care.

Is there access to remote review such as video consultations?

Pain relief (esp trauma) ongoing focus on addictive pain relief

Ensure all contact details are available and clear for patients and carers.

support details and who to contact

Patients diary to record self care

Above statements very vague - would benefit from further detail. List is missing physical and mental capacity assessment to see if the patient can perform self-care. Assessment of patient motivation to implement this also required. Assess patient fears around successful self-management. Need to assess practicalities e.g. patient's ability to physically reach the wound. Has the patient easy access to relevant educational resources and information to help them self-care.

competency of the person to carry out the self management following education

Instruction for the patient how to contact a HCP Signs and symptoms of wound infection and what to do if suspected identifying the HCP has gone through how to apply and remove a dressing safely Handwashing technique observed

Wound care education comments

Information both digital and hard copies in different languages

Somewhere to document capacity of person

signposting to contact HCPs and comms re image or concerns

Shared care with patient

Contacts - should further advice / direction be required or escalation

Mental capacity assessment to confirm patient is able to understand information and instruction given

how has ability and understanding been evidenced?

who to contact in case of a problem

How the person can contact a healthcare professional for support - direct line to a duty community nurse - facetime/text service/calls.

? quantity of dressing ordered to monitor usage. ? documented review date by a professional

Supplies requests? Prescription details for wound care products for re ordering / liaising with pharmacy

Advice on assessing for complications e.g. infection and signposting as to where to go for review and when Product information/IFU

If they are able to self care, they may be able to complete a management plan with some/all of the variables in Q4.

information on were to get help if it needed before next visit what to look out for eg infection

Are there non formal carer which support eg family who redresses, carers who apply cream to legs.

If any training may be needed to manage /change a dressing, such as using the Pico vac therapy.

As part of the wound care education package, links should be included RE mental health support as there is a lot of evidence out there of the psychological impact of living with such wounds. I also think it would be helpful to include a description of each role and how they can support so that a patient is better able to self-refer (or educate their GP!)

Assessment to identify person is suitable for supportive self management

Education to detect possible signs of an ulcer and to help the patient intervene or contact a HCP

PAM Patient activation measures

A plan for the patient to follow with written and verbal instructions.

Wound care education comments

Patient Activation - Importance and confidence scaling to self manage

Contact numbers given if wound deteriorates

How to escalate concerns/emergency contact

The information needs to be share cared with acute if in community and vice versa. Care plan needs to be agreed with patient

Adherence to any self-care requirement/expectation

care plan - step by step how to redress wound signs of infection contact detail of DN/PN etc out of hours

Written consent

Emergency event/ deterioration advice re: who to contact.

How to recognise infection. When to contact hcp. How to contact hcp

Understanding of education provided

I think the preferred term is shared care.

Frequency of follow up by HCP as part of the self care programme

unsure if education covers reserach opportunities? There's a lot of research happening on wounds - I wouldn't want them to miss out

Formats for education- You Tube, paper, Links

Patient contracts - with agreed actions and measurement - roles and responsibilities

How to apply the dressing and when to change it, signs of infection to look out, who to call if and problems arise

A tool to assist the person

How do we assess if they are able ??

Patient's perception of wound treatment progress and patient-related outcomes, eg mobility, pain, ADL's.

Does wound care education include information on early identification of infection? Also would this include an agreed plan?

Compliance Cognition that will also affect compliance

Mental capacity assessment, how do we know they are able to support self -management?

Decision tree to support whether patient is suitable for self-management - patient may say they are willing to do this but need to ensure competent to change dressing and be aware when to notify nurses when there is a problem

Wound care education comments

Red flags

Shared care agreement

possibly a competency checklist to complete to say you have observed the correct technique by the carer/patient.

I feel this can fall outside the standard as is purely documenting that it is self managed and info provided.

Would the documents and photos provided by the patient help a professional assess the quality of self care?

Where to get help in emergency

signed consent

patient understanding /concordance

Escalation in of concerns in wound changes Red flags to look out for

confirm patient has capacity

Criteria for inclusion into the Self care supported management

document for pt to sign to say they will participate in treatment and if they do not they can be discharged

4.4 Differences for children

Are there any differences which need to be made or considered for the standard for use with children?

Differences for children comments

Does the child have a voice/ understands or is compliant with the treatment.

Safe guarding issues

Somewhere to document the most comfortable environment when undertaking wound care for the child - who they like to be present, do they prefer to remove the dressing themselves, do they have a favourite distraction aid/toy/item of comfort. Likes and dislikes pertaining to their wound care procedure.

Self care section needs rewording to parent / guardian

Developmental differences and if bandages are approved for use in children.

durability/ acceptability/ robustness of dressing any self care to be provided by parents/carers including competency to undertake dressing changes outside office working hours any specific pain relief/ play/ distraction techniques/ support from significant others to support child/ young person during dressing change time to undertake the procedure - can take up to 4 x longer in children/ vulnerable adults - allows for appropriate time management etc

Differences for children comments

I have mentioned on earlier about play specialist wound care education to parents if its pressure ulcer, pressure ulcer prevention management leaflet to be provided to prevent further pressure injury.

Perhaps make information more pictorial, depending on age of child

yes more assessing of how self care of wounds are done and teaching the pt parent ,friend, partner to make sure no infections can effect the wound care as well.

options for both child and parents to add information separately

Competency assessment for those over 12 to give consent

Usual daily care arrangements or schooling commitments.

Don't deal with children

this needs further investigation and evaluation.

emphasis in kindness and respect

age of child and relevant clinical observations relating to their age. Aetiology of wound and links to safeguarding. Preference of young person if not a 'child'

Unsure- I am not a children's nurse

Involvement of child's primary carers

Information provided in a way suitable to the child's age.

The principles are the same

To look at surrounding support and resources

Disjointed Processss for processes NoT patients

n/a for our setting

Detailed information to be given to the parent/guardian about the state of the wound and also the plan and decisions to be made.

certain dressings

I do not care for childres

I cant think of any differences in relation to children's assessment. do we need to mention any safeguarding concerns maybe?

Children are more likely to deviate from the treatment plan without parental/carer supervision.

Portion sizes in nutritional information

Differences for children comments

supporting information gained from parent/guardian information discussed with parent/ guardian children's wishes for wound management

Degree of agitation /fear is often greater in children and young children (or adults/children) with intellectual disabilities ...

Differences for consent purposes Specific education material aimed at children

These are rare or surgical. For complex wounds I feel a specialist service is required. I think that would harm adults because comorbidity would not receive care, so there is a difference.

Involvement of family/carers and what support they have been given to be able to provide this

Choices of dressing not all dressing has research evidence in children Pressure relieving euqipment

I am an adult nurse

Done deal with children

Perhaps a comment to identify the adult/carer that will be supporting the child's care.

Treatment plan must be agreed / understood by both children and parents - and confirmation in writing.

If the child has complex needs details of specific equipment used should be included

caregiver details

yes i dont think you need to consider arterial insufficiencies that occur with age or ABPI scores

Is the dressing appropriate for children

Depending on age they may need specific levels of consent

Safeguarding concerns - who to notify

Support for parents and carers, also are schools involved?

Communication-Think about types literature - youtube for exercises etc Different pain chart etc

Other means of communication to family and Child

Images need to age appropriate maybe more cartoon type images. Language used needs to age appropriate aswell

Who will manage care? as in child or parent due to competency.

sorry i do not work with children

Perhaps details of any hobbies/sporting activities they may partake in.

Differences for children comments

Pt allergies previous trauma associated with dressing change management of same.??

Maybe age specific guidance with reference to newborn skin, under 5, over 5

Safeguarding concerns

depending on the age of the child they should be involved as much as the parent/care giver, so age appropriate information needs to be provided

Any congenital issues that possibly affect wound healing. Documentation of discussion held with the other relevant specialties involved with the child and parents

They will be less likely to have self-supported care. Maybe you need a children's simplified guide with visual images to just say "if it hurts, tell a parent" so someone who is more able to then assess the wound, can. Maybe provide them an animated video.

I do not have experience in children's nursing however I think it's important to note if technologies are indicated and safe for use with children.

vascular assessment not relevant

child and parent views as they may differ

We do not see patients under 18.

MORE EXPLAINATIONS

support content needs to be child friendly but also parent/carer friendly

May need supportive information in the way of pictures, for parents to use for the supportive self care model.

HCP/carer must understand whether technologies are specifically indicated for use with children. Plus who has the parental right/accountability to make decisions for the child and support care implementation.

Who is cater Is carer compliant with directions given?

If reported history of wound (if by parent) is plausible. I.e. for safeguarding

Who information is given to. What the child's understanding is.

the parts ive said are not required are the not for children as i only work in paediatric settting

Parent / carer involvement

Details of whom accompanied the child to the appointment any safeguarding issues

Dont think so as the differences between adults and children such as skin integrity mobility pain assessment etc are points in the assessment and can be adapted for use in children utilising relevant tolls such as pain tools in your trust

Parental consent

Differences for children comments

Parent Carer information, Whether the patient understands the care plan and is competent to make own decisions

Possibly picture diagrams, information for Parents

any signs of unusual injury, bruises etc for safeguarding

Requirement for vascular assessment

all above to be available/ received from parent/ guardian

directed to parents

Consider any help needed to remove the dressing- we often use Appeel to help

Communication with Parent throughout

? signs of pain instead of pain score

the length information is kept Parental agreement for treatment and assessment Distraction methods

Distraction / Approach Plan - What works for this child, where should they be seen, is there a specific technique, do they need medical adhesive remover to remove dressings, how many people are required

parent/carer information and education for self care links to child friendly pain tools ensuring child/young person's views/voice are recorded as well as parent/carers

Consent to care from their legal guardian. Educational information written in a way that children and families will understand

the language used to children allowing them to participate, for the parents the reasons why we would not use the dressings we use with adults eg silver.

Ensure that the products used are suitable for use on a child.

You'd need to do some research here as I can't tell you this as a patient. Perhaps start with a desk-based assessment of the literature.

More details about the care provider and what there role is

Parental consent. Gillick competent child

Not all dressings are sanctioned for use with children. Not all dressings come in appropriate sizes for use on children

Escalation protocols for deterioration?

Activities ie. PE, sports, clubs etc

Wound healing trajectory in the young and dressing regimes

Identified (not implied) consent by parent/carer or legal other as applicable

Differences for children comments

I don't treat children with wounds but I would expect there would need to be differences with some advice & be geared towards care givers & pitched at level of child do they can understand.

Accompanying adult name or title

Education for parents and involvement with other services ie wheelchair services and children's nursing team

Parental guardian consent for assessment obtained

Pictures/Images/ graphics/pictorial

Participation by family members/carers

children may pull dressings off - dementia patients too. Can there be any advice on this

extra measures, considering child activity and potential noncompliance

evidence of understanding (age related) What is deemed normal for that child, eg moisture, equipment, age related pain score, age related information leaflet and carer guidance, age related equipment

What techniques, distractions or support is needed to support the patient emotionally and physically whilst wound assessment and care is completed. i.e. favourite toy to be held, music played or sitting on parents lap.

medication review Involvement of family, carers, school

support from parents / carers with agreed actions -roles and responsibilities

Child friendly health literate infographics

Consenting adult

certain products might not be able to used on children so should be somewhere? Parents consent

Parental involvment

Important that what is going to be done and is being is explained clearly and in words the the child will understand.

don't treat children

Where possible/feasible, a means of recording their consent to treatment in addition to any parental and responsible adult consent.

Would need to carefully consider supported self management eg. would this be via parents or guardians? Safeguarding considerations etc

parents' involvement

ability to override sections that are not pertinent

Differences for children comments

Body mapping sizes. Parents discussion

Neonates - if product used is licensed to be used

Parental consent

Important to determine underlying cause of wound, consideration of inflicted wounds/abuse if no rational underlying cause can be determined

Role/involvement of parent/guardian/carer identified. Ability of child to participate in care and decision-making process.

children may prefer more visual material especially for the pain score and viewing the progress of their wound. Some children with a disability like to feel the product you are using on them. For example what does wet Aqaucel feel like.

speak to the parent as well as the child - unless the child is non-verbal they should have things explained to them

Are they happy for parents to give their care How old are they? If teenagers may want to give their own care.

I don't do children unless a dr or nurse is on site

Children wouldn't be administering self care and overseeing of the parent or guardian providing care would have to be taken into account to maximise child safety

suitability of products, family involvement and fear

Consent Products

body akin surface area

I never work with children's wounds

age-appropriate information, age-appropriate support, how consent is obtained and different people involved in their care.

use of supporting materials e.g cartoon images/pictorial information

Chaperone? Involvement of other agencies including school?

Assuming children are age 0 - 18(?) the carers must talk to the children as well as parents. The childrens' Comments must be noted.

4.5 Person preferences.

The treatment plan includes gathering and using patient preferences, as shown below, to use with the wound assessment when creating and updating the person's treatment plan. Would you want to add anything else to this section?

Person preferences comments

No

Mostly yes. “What matters to me” is maybe the most important bit—specifically for patients with chronic wounds and helping them develop short term goals. Perhaps missing a goal section—are we aiming to manage the wound or heal the wound? Ie, setting expectations with the patient.

is this information not captured elsewhere in electronic care records - do not want to duplicate these if already done in previous healthcare interactions.

Clear guidance of abbreviated capture for those who wish to be private. Advice to respect and value the persons experience, and to avoid patronising

who will be able to support them - this could be friends/family or carers support they may need - for example help with shopping physically or financially to get the right foods in for them to eat

Separate section for patients preferences when there is no further medical improvements possible i.e. "would like to have a major amputation only to save life" OR "does not want admission to hospital even for life saving antibiotics" It would show that these important conversations have been had and that the patient understands the seriousness of their wound/ulcer etc. A lot of patients, carers, family, health professionals do not understand if they are not specialists in this field.

barriers to attending appointments

what if the patient wishes to decline ongoing treatment?

Again emphasise kindness, respect and dignity

Ensure patient view in involving family/ informal carers is recorded.

This would capture basic wishes and needs but what if the patient has dementia, mental health or other such needs? Extra care will be needed to elicit info from them.

Details of any power of attorney completed

Has the patient been advised to review their preferences in the light of current problems and given enough info to do it meaningfully

Make it first person. My preferences Who I want to look after my wound What’s important to me My previous wound treatment experience Equipment and treatment for my previous wound

To make sure this is whY paitents have said

Joined up departments and thinking instead of dividing and winning dept spreadsheets wars

Food allergies, intolerances, dietary restrictions

As stated for 9. what about outcome measurement?

Person preferences comments

I think I have covered this in previous question, What matters to me question will definitely capture patient preferences which is great, but I think we need to clearly capture that they have made an informed decision if they are not happy with the recommended treatment plan. We need to elaborate more on when patient declines care, why have you declined? can we change anything? and make sure they are aware of the risks.

The About Me standard aims to show what is 'really important information' as distinct from 'what is worth knowing', which can only enhance the way records are shared and ultimately improve a person's care.

Food and drink likes and dislikes

footwear advice

How good intentions will casue harm. I am very much in favour or personalised care but setting this up as described and if monitored will result in a tick list. What matters is listening to the patient. This cannot be quantified. It could all happen and the patient not be listened to. It will focus recording but not quality. Too many vague indicators.

Perhaps information pertaining to the patient's advocate or details of a best interest plan in the case of the patient presenting with dementia.

RESPECT form Allergies

Agreed first point of contact for queries. I'm not sure that I fully understand this section.

No

Whether the person has capacity

Need to establish previous clinical treatment experience in general, as well as wound care experience - I don't think the suggestions above make this explicit, and often wound care work can be 'task' orientated, the person's experience of wound care may be influence by previous experience elsewhere.

But as in another section this information should be held elsewhere (for example a patient facing application) that provides the information for the practitioner to use

dexterity issues can often complicate self management maybe an area on what they perceive the barriers to self management would be

Much relates to previous experiences and although person preferences are included on a general basis it would be good to specifically include future preferences and aims for their ongoing/future treatment

Quality of life - honestly being able to manage myself would make me feel more in control and improve my daily life.

Reminder to review to ensure preferences are continuously updated

Review date Short term goals Long term goals

Person preferences comments

The rationale for their preference and if that choice will impact on the ability to heal so if they are making bad choices. Also, 3rd party might have a different rationale for their preference which might be completely different from the patients

allergies and sensitivities to certain dressings or wound care products

What about those that do not have capacity or need help decision making

Capacity statement

With so many sections, this is going to be quite time consuming to complete and this needs serious consideration with the current staffing pressures in the NHS. All the points above are important, but anything published needs to be user friendly for both the professional completing it and the patient using it as a guide.

I think it may capture their wishes and desires but not their medical needs. The patient should be informed so they can have choice and influence but we still need medical professionals to support them and not provide worse care just because of the patient's wishes (unless they wish to waiver this e.g. I don't want to wear compression because I don't like it - and if the medical person allows that - is that negligence or following their needs?)

What actions have been taken - in particular if the `what matters to me` is outside of the scope of wound care

I am wondering if all of this infomrtion is required for all types of wounds and all patients?

Are we wanting to add this section into the WMDS ?

Treatment escalation plan details

This section needs to be underpinned by an in-depth mental capacity assessment. A patient may have preferences and a voice but the first step needs to be an assessment of mental capacity to see if they are fit to make those decisions. If the patient has the capacity regarding the care in hand and this has been appropriately documented, then the individual has the right to make an unwise, informed decision. E.g. re: frequency of re-positioning, does the patient understand the need for re-positioning; can they retain the information; can they evaluate its impact and feed it back to the HCP undertaking the assessment. The mental capacity act says a person is unable to make a decision if they cannot do this. Note, 3rd party preference can only be considered with the consent of the patient, if the patient has capacity. If the patient lacks capacity (best interests least restrictive), then 3rd party preferences need to be considered. Useful resource https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

Capacity & ability to consent. Does anyone hold power of attorney for health if capacity is an issue.

Are there any other documents / passports they would like to share . LD patients often have passports , getting to know you booklets

patient's reason for refusal to treatment: (this will be good to highlight when pt refused any care provided

The desired outcome/ goal in the patient's own words (may be different to ours)

Person preferences comments

may need to be adapted for children, as would be the parents preferences/ experiences in certain age groups

Social support available eg family

goals

What are my expectations of treatment

person centred goals- is it to heal or just be comfortable for example

Need to capture if preferences may not be in best interests

Consent wise - I was 'this' to happen, I don't want 'this' to happen.

additional information/education provided to the patient

any disability that will mean that a patient cannot mobilise/change position for a dressing change

but lots of family members feel they have the right to dictate there loved ones care

are there any barriers to optimum treatment?

The main thing is to ensure that it is read by the HCP. So often medical records aren't referred to and so there is some need for some education in this area.

Persons concerns

What outcome are they aiming for

Doesn't address phycological impact?

We would also need to record treatment in patients best interest.

Patient activation - importance and confidence scaling

Option for patient anxieties/worries and expectations could be useful

Outcome

Patients social/ emotional status along with family intervention

Do you need third party preference as this may completely differ to the patients, and it's the patient we are treating

Patient centred care plan which patient agrees to follow.

If the patient wants the wound to heal, is this the patients main aim? Or is it just to reduce pain or odour or for example in a patient who is drug dependent to ensure that they still are able to have recreational drugs.

QOL metrics

Person preferences comments

Consent for medical photography

some info re when preferences can't be accommodated?

religious or dietary needs for selection of topical dressings and treatments

What environment specifics are preferred by patient, where do they wish treatment care to be completed. Do they like to have bathed prior to treatment? Do they wish to be in a specific position in a warm or cool environment.

Could we include any products used to remove dressings at each dressing change

Should be an agreed goal of care not a treatment plan - treat as a person not a patient for better compliance and outcomes

Level of support provided (i.e. on a scale from minimal (self care) to maximal)

consistency between health care providers

Need to be careful the patient and third party's preferences don't disagree.

Previuos exeperince of dressings and any medical devices eg compression bandaging /hosiery

If completed correctly - The information is only as good as to the quality of the documentation.

mental capacity assessment and ability to make decisions assessment, level of education and understanding to be assessed

Patients aim for the wound - do they want it to heal?

What we have to remember is people don't just have a wound, they may have multiple problems, therefore this needs to fit with other assessments for the person. We don't want to increase the amount of documentation for health care professionals. Understanding the patient's goal is very important, there's can be so different to ours.

no

Lots of other information can contribute, such as mental capacity, communication needs, contact and medication allergies. Very easy to overkill the information provided however.

Patients understanding of what is happening to them Can they understand what is being said? Can they read & write? Can they see adequately? Any other disabilities Can they hear adequately?

Link to positive risk assessment

This is often missed- a patient will attend with a DFU which we want to treat however to them they need to work as priority number 1 and we fail to recognise the mental/financial implications.

4.6 Patient access to wound care information

Is there any other information that would help a person to self-manage and self-care

Patient access to information comments

Depends on how the information is delivered! Needs to be from confident and competent HCPs

An understanding that they can Fast track back into the service if and deterioration. Maybe weekly upload of images with a quslified remore review?

The information is very important to ensure there is open transparency that the professional is competent and the person is carrying out the care.

It would be nice also to have a standardized/evidence-based approach for patients for different etiologies that is a checkbox so they know they are receiving a standard of care, creates more of a safety net.

depends on age an understanding of child/young person

It is important to capture the ideal and intended frequency of treatment/ re dressing as in practice resource constraints often mean that a gold standard is not met. Longer periods between treatments often lead to worsening or to much longer recovery periods

section for relevant health professionals and their contact details

For some people it will not because that is the nature of human beings. However, patients attending my service, often report that we have explained things much better than anyone else and it helps patients come to terms with what is happening TO THEIR BODY AND WHAT THEY CAN DO TO HELP THEMSELVES.

Named clinician to ensure consistent approach and to build trust.

rationale for treatment plan would help

Right to regular overview of photographic evidence if patient cannot see wound.

Training support and feeling that help is at hand if needed is what patient and carer need. Not everyone wants to manage wound care themselves.

Confirmation that they will have continuity of access to the doctor of their choice, and a record of who they have actually seen

My responses are repetitive in terms of the importance of outcome measurement.

as above.

Its more what you say and do than what you record... especially if it takes longer to record than it does to do the F2F eye to eye contact..

You have to be able to read well and manipulate concepts to understand. Many are not healht literate enough to benefit.

Must include written confirmation of agreed plans.

No

Patient access to information comments

Providing access to best practice standards, i.e. the lower limb and demonstrating that this is being followed within the framework

I do think a helpline would be good though, in case the wound changes or something happens and I am unsure of what to do. I want to do more myself and manage myself, but am not so confident sometimes.

Yes a formal 'progress' review meeting to review progress of their wound, what the overall goal is with realistic timelines & with milestone's of progression.

I think it worth patient knowing if they are seeing a registered nurse or a health care assistant so they know if treatment plans can be changed or if needs should be escalated to a trained professional.

Interesting you don't allow a deficit answer.

From experience, it is wound healing that makes a person trust that care is appropriate.

In my opinion, none of this would help. You can make all the plans in the world but if the medical staff are unavailable to turn a patient who can't do so, or to advise on the right bandage for a wound that is degrading - then whilst it is nice to have patient wishes included, it's the icing on the cake. There needs to be a cake first and the system is not foundationally solid enough to support people from what I have witnessed. I feel we are looking at patients which may empower them, but largely because we know the system is exhausted and we can't do anything there. None of the above will help a patient with mobility issues/mental health issues/who isn't aware of what is going on and is reliant on medical professionals supporting them properly. Any guidance needs to ensure that these things are taken seriously as what I have witnessed in care settings is that these steps are often skipped and wounds are not considered important. I would trust that care is being given if the standard demands that actions taken are noted down - if patients need a wound cleaned, or to be turned, then I think it should be noted and a staff member should take responsibility just like with medical rounds. I do not think it's enough to say that the patient wishes are there, or the plan is in place - when there's no consequence when these things are consistently not done in practice.

Provided it is explained correctly to them. It’s very easy to end up confusing a patient through lack of information or trying to over complicate things

I feel being able to see rationale for care and that there is an effective plan in place can increase confidence in health care professionals and their knowledge and skills.

More focus on pain relief, esp. addictive meds. This is overlooked as risk factor for patients, esp trauma.

Ability to contact someone or helpline if concerns about products being used or develop problems

If you are referring to a patient having access to their wound assessment document, then we feel this would provide some reassurance about the management of their wound

Providing access to information for public issued by NICE and similar bodies to support the provision of evidence based practice

Patient access to information comments

leaflet setting out what to expect and simple advice to being healthy

remove the stigma its for trained staff only eg in care homes staff often say its not there job

This is hard to know and depends on the individual / context. For many (patient and carer) the system is broken and is hard to navigate / get the best care. Trust is so important, and I know I would benefit from being asked the question: Do you trust your current care provision? How could this trust be enhanced? Why is trust important to you? etc.

Being able to access face to face help when they need it at GPS and dressing hubs.

Need to work in collaboration with the patient to ensure that the patient is an equal partner in their care and that managing wound care is a shared responsibility with the patient

Makes things more Transparent I guess Or act as a reminder if they forget what the healthcare professionals have advised them on.

Maybe a named nurse who visits on a specific regularity eg fortnightly/monthly so they can have some consistency, i think a little more around QOL and Mental health may be needed.

can't think of any

Good communication, consistency within expectations.

for some- video link to discuss management

as above

trained, competent, and knowledge has been adopted into practice

That they have a named person to go to with any concerns / named person who reviews every other week for example to provide continuity. I have found this helps with patients attending appts and getting them involved in the care plan so they agree to some form of treatment

self help will make a big difference in the nhs and help reduce a and e aswell

Consider that there is a very thin line between the care provided by a carer/nurse/health care professional.

Evidence of outcomes if self care versus clinic care

Avoid giving false hopes