Letters

Response to comment on 'Nurses' practice in preventing postoperative wound infections: an observational study' *JWC* January 2017; 26: 1.

We thank the reader for their thoughtful comments in relation to our study[1] and in sharing their experiences in clinical practice. Our study findings have demonstrated the disparity that currently exists between clinical practice and the use of evidence-based clinical practice guidelines (CPGS) in preventing surgical site infections (SSI). Currently, the Australian Wound Management Association's (recently renamed Wounds Australia) wound care standards reflect the evidence based CPGs as published by the NICE,[2] CDC[3] and Anderson et al.[4]

The reader has rightly pointed out the inconsistencies in clinical practice when it comes to providing wound care for postoperative patients. Her reflections on her experiences with wound care audits conducted by the UK Nursing and Midwifery Council (NMC) suggest that there are necessarily situations where adherence is challenging because of a constantly changing practice landscape, and, more quietly, because of the inconsistencies in wound care information that nurses use to base their practice. However, to promote greater practice adherence with the guidelines, evidence-based CPGs need to be implemented in response to contextual barriers and facilitators.

We have subsequently undertaken a three-phased implementation study, informed by the findings we have reported in this paper. This implementation study was designed to enable greater adherence to recommended CPGs in preventing SSIs (unpublished data). In this subsequent study, we firstly identified barriers and facilitators to adhering to evidence based CPGs on SSI prevention (phase 1). In consultation with clinicians, implementation strategies were developed to address the barriers, assisted by the facilitators (phase 2). Finally, we evaluated whether these strategies worked effectively to improve adherence to evidence-based CPGs, and under what circumstances this occurred.

Clearly there is a lengthy lag period between when research evidence is reported and when it is used in clinical practice. In a paper published in 17-year gap from doing the research, through to publication and implementation in clinical practice was reported.[5] These recognised lags in implementation of research into clinical practice has resulted in the translation of research evidence into clinical practice being high on the agenda of governments and organisations worldwide. Consistency in implementation remains an ongoing challenge for clinicians, researchers and policy makers.

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Comment on Guest et al. 'The health economic burden that acute and chronic wounds impose on an average clinical commissioning group/health board in the UK' *JWC* June 2017; 26: 6.

The apparent lack of accurate data on leg ulcer costs and clinical outcomes has long been a topic of controversy in the UK and elsewhere. Without such data, the appropriate allocation of resources for assessment, management, and supply of materials cannot be made. In recent years a number of articles by Guest et al. and others[1–5] have addressed these issues. In the 2012 article we learned that healing

rates achieved for venous leg ulcers in primary care were woefully low. This led to comparisons with rates achieved in community specialist wound clinics.[6] One might have anticipated that such discrepancies would elicit appropriate responses for health-care providers and budget holders, however, no such responses are yet evident. With the advent of clinical commissioning groups (CCGs) in the UK, an opportunity exists for community wound care, in all aspects, to warrant specific attention. The need for accurate assessment of patients, preparation of appropriate care plans, and implementation of 'best practice' is unquestioned. However, once again the opportunities have been missed. Instead we are subject to a futile exercise in dressings assessments with a view to cut costs, without any baseline of standards of care whereby clinical outcomes might be measured.[7–9] Now much better data exists upon which financial efficiencies may be made without impact on clinical outcomes.

The inconsistency in wound care provision highlighted by Guest et al.[3] (see page 292) and many others must be addressed in the immediate future as it will undoubtedly help to reduce the burden wounds have on society and the National Health Service (NHS). We need a method of data collection that is specific to wounds and gives us a more accurate idea not only of the scale of the problem but of the level of growth. Areas where the Lindsay Leg Clubs, leg ulcer clinics, diabetic foot clinics and other such initiatives exist must have their clinical outcomes compared with those without these services to see just what impact they have on the prevalence and healing of these wounds. Successful models can then be extrapolated to other regions. 'Betty's Story',[10] a paradigm of poor care compared with best practice, has been written with the purpose of highlighting these issues. It is an overt and accurate portrayal of the NHS RightCare scenario i.e. the variation between sub-optimal and optimal pathways. From this document the following questions arise for commissioners, general practioners (GPs), providers and nurses to consider:

- Do you know how many venous leg ulcers there are in your population?
- What are the healing rates for venous leg ulcers in your locality?
- Do you know how many of these have had an ankle-brachial pressure index (ABPI) measurement to support diagnosis and treatment?
- Who delivers care to people with leg ulcers?
- What is the cost of managing leg ulcers in your locality?
- Is there unwarranted variation in treatment and outcomes? How do you know?
- What are the barriers to seamless care for people with leg ulceration?
- Is investment needed or reorganisation of care needed?
- Has any engagement activity taken place with patients with regards to wound care?
- Do you already have valuable local data around patient experience and outcomes for wound care in your area?
- How could this local data be used to identify and drive improvements?

'Why are so many wounds not being healed in a reasonable amount of time?' The answer to this question encompasses three essential components: workforce, budgets and training. In the current NHS climate GP surgeries are overrun (GP Online link).[11] Most surgeries struggle to keep continuity of care between clinicians (doctors/nurses) and patients. District nurses in the community are also woefully underfunded, understaffed and continuity is difficult for these reasons.[12] Individuals with chronic wounds suffer as a result of this. Attempting to monitor progression or regression of wound healing is reliant on continuity, as comparison is key. If comparison cannot be done clearly then weeks may go past with no idea of what therapy is effective, prolonging treatment. The Guest paper[3] demonstrates that economically this approach cannot continue. It does not comment on the fact that we are also facing a workforce crisis within the community. Both GPs and nursing posts lie empty with no applicants as applicants do not exist or no-one is willing to work in the high-pressure roles on offer.

Budgets have been divided out so far that people are responsible for what are, in the scheme of things, relatively small budgets covering small areas of care. In some cases these people are under immense pressure to stay within budget or, even better, lower their spend. So in the case of wounds the tissue viabilty nurses (TVNs) may be responsible for the cost of dressings but not in the cost of personnel doing the dressings. Therefore it is in the TVN's interest to use the cheapest dressings available in order to keep her spend down but in turn, and in general, the less technical the dressing the more dressing changes are required. This increases the spend not only on physical resources (such as gloves, gowns, dressing packs, cleansing and irrigation fluids, and bandages) which will be used more frequently, but also, and more importantly and expensively, the increased number of 'appointments' required by the nursing staff to perform these dressing changes.

Training is an issue. Nurse training itself has changed insofar that there is less clinical time, and whether or not a student nurse gets a good grounding in wound care is dependent on their placements. The advent of the specialist nurse has resulted in a large number of front line nurses (in all areas) not having to think for themselves, and instead waiting for TVN assessment. This would work if there were enough appropriately qualified and

experienced specialist nurses available to do this, but in most trusts/CCGs there are generally only one or two such nurses. This leaves nurses inexperienced in wound care having to use dressings on a limited formulary which may not have the most appropriate dressing available, and indeed the nurses themselves may lack the knowledge as to which dressings heal in which way. There are those clinicians who will treat by applying compression without understanding, essential assessment, and without training: these will be causing more harm than good! Most worryingly are the health-care assistants, who within their capabilities are invaluable, but are requested to do things for which they are not trained because of time pressures, cost pressures and staffing levels.

These issues are all interlinked: better training, better selection and use of products and shorter times waiting for assessment will all result in improved wound healing and longer remission—therefore reducing overall costs without compromising clinical outcomes. Clear treatment pathways are required so that intervention can be given to wounds which are not progressing as they should, with an assessment by a specialist, for example, tissue viability, diabetic specialist podiatrist or vascular nurse before patients are passed back to their practice or community nurse with a clear plan of care and specified time period for review if healing is not progressing (like the 'escalation of care ladder' in this current paper). Although pathways are already in existence in most areas for some wound types, they are not routinely followed. Community nurses (and most GPs) lack the necessary education and confidence regarding when to refer to specialist help, and how the process works. In some areas care is being provided by health-care assistants who probably do not have sufficient training. This being the case, we should not be surprised when clinical outcomes are poor.

The NHS and UK Department of Health must realise that poor clinical outcomes equate with increased costs. An unhealed wound is more expensive to manage in purely financial terms. It is essential for our social health-care system that health economics be accepted as meaningful, and that resource planning take account of this reality. The short-term approach to managing health care and obsessive focus on 'bottom line' finances is ultimately counter-productive.

Thanks to this article,[3] we now know how inefficient and costly the current system is in primary care.

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