JOURNAL OF COMMUNITY NURSING
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Overcoming compression bandaging challenges with Portrait of a Patient™

Paediatric continence: education to support today's children

Why we need to talk about dementia

Dermatology and skin care resources and support

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Frailty and the ageing skin: understanding skin tears

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Advanced practice district nursing in remote and rural areas

Understanding the psychological education needs of lymphoedema healthcare professionals

Basic guide to understanding compression therapy

A simple solution to falls prevention: could decaf be the answer?

Suicide: a personal tragedy and global health challenge

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The power of patient stories

Caring for patients with wounds is part and parcel of daily community caseloads. With an ageing population and more complex community cases, frailty is inevitably becoming more of an issue. This should never be considered in isolation, but rather as part of a wider picture interrelating with other age-related factors, such as ageing skin, increased susceptibility to skin tears, and other underlying health conditions that may complicate wound healing. Heidi Sandoz's article (*pp. 20–26*) on frailty emphasises the importance of recognising and assessing it, as frail individuals may often have compromised skin integrity making them more vulnerable to skin damage.

We also know that more patients are presenting with venous leg ulcers, owing to the same demographics outlined above, and the management of people with these chronic wounds incurs a significant cost to health services, the bulk of which is made up on community nursing time. Yet, a great deal of this time could be saved through the delivery of evidence-based care. Compression therapy has long been the gold standard for the prevention and healing of venous leg ulcers, yet evidence shows it is applied inconsistently in the community. So, in this issue there is a practical guide to compression therapy highlighting its importance in cases of venous leg ulcers and oedema (*pp. 48–55*). When it comes to using compression bandaging, there are challenges for clinicians and patients alike. Clinicians may not have the skills or confidence to apply bandaging, while patients may stop wearing it, with common issues relating to discomfort, pain, and restricted mobility. This is more likely to happen when the patient does not understand the role of compression in treating the underlying condition. Portrait of a Patient™ was launched with this in mind, and uses an animated platform to help clinicians have compression conversations with patients to help resolve their concerns through explaining how compression works (*p. 8*). Application is demonstrated in the module, which is quick and simple to do. I urge you to read these articles and visit Portrait of a Patient, as having competence, confidence and a good understanding of how and when to apply compression can transform your practice. Listening to our patients and truly hearing what they have to say is at the heart of patient-centred care, and we can empower them to maintain their treatment in the long term, reducing symptoms and promoting healing by working together.

Remember, this is your journal, so if there are any areas you would like to see covered, please just get in touch. We would love to hear from you.

Annette Bades, editor-in-chief, *JCN*

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1. Agren M (1990) Studies on Zinc in Wound Healing. Linkoping University Medical Dissertations No. 320. Department of Pathology II, Faculty of Health Science. Linkoping, Sweden.

ZIPZOC (zinc impregnated medicated stocking) **Abbreviated prescribing information**. Refer to summary of product characteristics before prescribing. **Composition**: A sterile rayon stocking impregnated with an ointment containing 20% Zinc Oxide. Each stocking (80cm x 7cm) contains about 41.5g of ointment. **Therapeutic indications:** Aid to the treatment of chronic leg ulcers and other associated skin conditions. Where chronic venous insufficiency exists, the medicated stocking can be used as a primary contact layer under compression bandaging or hosiery. **Method of Administration:** Because ZIPZOC is preservative free, it must be changed no less frequently than weekly. For topical application, ZIPZOC should be applied to cover the lower leg from the base of the toes to below the knee. All folds should be smoothed out. To protect clothing, a suitable outer bandage should be worn. If chronic venous insufficiency exists, ZIPZOC may be used as a primary contact layer under compression therapy and may be left in situ for one week, before re-application. **Contra-indications:** Arterial leg ulcers. Known hypersensitivity to zinc oxide or the excipients in the ointment. **Special Warnings and Special Precautions:** None known. **Interactions:** None known. **Pregnancy and Lactation:** There is no evidence to suggest ZIPZOC should not be used during pregnancy. **Undesirable Effects:** The skin of leg ulcer patients is easily sensitised to some topical medications. ZIPZOC contains no preservatives thereby reducing the risk of skin reactions. Reported reactions include, rash, erythema, itching and maceration of the wound edge. If the outer bandage is inappropriate or the medicated stocking is not changed with sufficient frequency it can cause the stocking to dry out. **Excipients:** Liquid Paraffin Ph. Eur. White Soft Paraffin BP. **Incompatibilities:** None reported. **Shelf Life:** 3 years. **Storage:** At or below 30°C. Keep all medicines out of the reach of children. **Packaging:** Polyethylene aluminium foil laminated pouches, each pouch containing a single medicated stocking. The outer carton will contain either 4 or 10 pouches. **Legal Category:** P **Market authorization number:** PL44616/0002 **Date of first authorisation/renewal of the authorisation:** 01 October 2006 **Date of revision of text:** 26 October 2018 Trade Mark of Evolan Pharma AB **Date of preparation:** October 2018

Editorial board

JOURNAL OF COMMUNITY NURSING
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I am a clinical research advisor, district nurse and Queen's Nurse. I am passionate about community care and developing evidence-based care to provide better outcomes for patients and amplifying the patient voice via qualitative research. I am pleased to be part of the JCN editorial board as the journal provides an accessible platform for community nurses to learn, discuss and share clinical practice.

Hannah Brady Sawant

I am a senior lecturer with a background in district nursing, continuing healthcare (CHC) funding, palliative care and diabetes.

I feel privileged to be able to influence the future district nursing workforce and love my job! I am passionate about innovation and encouraging district nurse students to reach their full potential. The JCN has been an integral part of my nursing career, with attendance at many JCN events and study days and the contemporary learning gained from reading each issue. The JCN published my first article and gave me the confidence to write more. A thirst for knowledge is fundamental in primary care, and this excellent free resource cannot be overstated. I am honoured to be part of the JCN editorial board.

Teresa Davies

I am a community nurse with a background in urgent community response. I am currently working as a senior lecturer and am passionate about raising the profile of community nursing (in all its forms) within pre-registration healthcare education. I am proud to be a Queen's Nurse and a non-medical prescriber and have a special interest in prevention of hospital admission, advanced physical assessment and multidisciplinary working. I am delighted to be joining the JCN editorial board and relish the opportunity to be a part of the ongoing conversation on developments in community nursing.

Abigail Brooks

As an advanced nurse practitioner focusing on chronic disease in Bristol, I am delighted to join the JCN editorial board. Sharing experience and knowledge within the community has become an important process with developments coming in nationally and internationally, and I am keen to be part of making the process easier and more accessible for clinical staff. I hope that my experience of community and primary care, which includes working for a festival charity providing medical cover in a field, a very different setting to that of a clinic, and as an expert witness for civil litigation, can contribute to JCN.

Wendy Smith

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Maria Hughes, nurse consultant, tissue viability, Countess of Chester Hospital NHS Foundation Trust, Chester; Queen's Nurse

Overcoming compression bandaging challenges with Portrait of a Patient™

Compression bandaging can present a challenge to healthcare professionals. Some clinicians may not have the necessary skills and training to safely and competently apply it, while others may be using it but not in accordance with the evidence base. As clinicians, it is our responsibility to make sure that our knowledge and skills are up to date so that we can deliver evidence-based care to patients and do no harm (Abu-Baker et al, 2021). The *NHS Long Term Plan* emphasised the importance of placing the patient at the heart of their care with their experiences, needs and preferences considered when developing a care plan with them (NHS England, 2019).

Evidence shows that for people with venous leg ulceration, a negative experience of care can have a detrimental impact on their treatment journey and ultimately, overall health and wellbeing (Phillips et al, 2018). This also applies to the use of compression therapy — the gold standard for long-term prevention and treatment of venous leg ulcers (Perry et al, 2023).

Unfortunately, evidence has shown that it is not being used consistently by clinicians in the community setting. Indeed, many components of evidence-based practice for the treatment of people with a venous leg ulcer, including a confirmed diagnosis documented in the notes and an ankle brachial pressure index (ABPI) measurement not being carried out or recorded (Guest et al, 2020).

PATIENT CHALLENGES

For patients placed into compression bandaging, usually traditional four-layer bandaging, common issues of pain, discomfort, and reduced mobility are often reported (Phillips et al, 2018). Patients may cope with this by removing their compression, and may then be labelled as non-compliant as a result. This time out of compression will lead to increasing severity of the underlying venous disease, and worsening of symptoms. The patient either may not recognise the link in the removal of compression and deterioration, or sometimes, if they do, would rather that than the restrictions that bandaging can place on their life (Phillips et al, 2018). It is important for clinicians to be aware of this and to work with each patient to find a compression solution.

With these factors in mind, Portrait of a Patient™ has been developed. This new learning platform uses animation to present a patient, Cynthia, in a clinical scenario where she presents with a venous leg ulcer. She has had the wound for a while, but her symptoms are becoming unbearable and impacting on all aspects of her life.

The platform guides the user through a series of prompts to ask Cynthia about her experience and challenges in relation to compression therapy. She is questioned about her understanding of how compression works, and presented with a short cartoon to aid her knowledge. Finally, 3M™ Coban™ 2 Layer Compression System is introduced as an evidence-based solution to overcome Cynthia's previous concerns about bandaging. A video demonstrates the benefits and ease of use of the Coban 2 Compression System, overcoming issues with skills and training.

While recognising that compression therapy and patient adherence is a complex topic (Phillips et al, 2018), Portrait of a Patient does challenge us as clinicians to reflect upon how we approach conversations with our patients around compression therapy. It also reminds us of our duty to keep up to date with practice, including knowledge of the products available that can help simplify care delivery (Abu-Baker et al, 2021). Visit Portrait of a Patient today — www.portraitofapatient.com — to see how it can help you to improve your clinical skills to enhance both your patient interactions and their outcomes. **JCN**

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Paediatric continence: education to support today's children

Debbie Gordon, head of commercial services and education, ERIC, The Children's Bowel and Bladder Charity

> **'Healthcare services across the country are struggling to meet the increased demand of families seeking support with bladder and bowel conditions.'**

Continence problems in children are more common than many people know — indeed, 1.5 million children in the UK are affected by bladder and bowel issues (Paediatric Continence Forum [PCF], 2024).

These conditions are life-changing for families, with children experiencing pain and discomfort, and wellbeing effects like missing out on schooling and socialising.

The average age of potty training has increased in recent years too, with one report saying that one in four children in England and Wales are now starting school not toilet trained (Kindred Squared, 2024). Later toilet training can cause many problems, even leading to long-term bowel and bladder conditions and a potential impact on bowel and bladder health (Li et al, 2020).

As a result, parents and carers need more help than ever to manage their children's toileting. At ERIC, The Children's Bowel and Bladder Charity, we have seen an increase in families reaching out for support.

Healthcare services across the country are struggling to meet the increased demand of families seeking support with bladder and bowel conditions. Many staff supporting these services may not have had training on the management of bladder and bowel conditions. Furthermore, it is not just that children's bowel and bladder services are struggling to cope with demand, in some areas services do not exist.

That's where ERIC can help.

PROVIDING EDUCATION

One of ERIC's missions is to deliver the best education and learning for healthcare, social care, early years and education professionals across the children's workforce.

ERIC has been providing expert training for over 20 years on a range of childhood bowel and bladder issues. Our aim is to ensure that anyone supporting children with continence problems receives high quality training so that these conditions can be identified, treated and managed as early as possible.

We provide education that supports anybody working with children and young people, whether in a nursery, day care, school or within a clinical environment. The development and delivery of ERIC's education is done in partnership with nationally recognised clinicians with specialist knowledge in bladder and bowel health.

ERIC recognises that bladder and bowel health is fundamental to physical growth and the development of self-esteem. Thus, everyone involved in the child's development should have an understanding of their individual toileting needs, ensuring that each child is given the best chance of becoming independent with managing their bladder and bowel.

This may be as simple as becoming toilet trained, or it could be around more complex needs like a child building confidence to manage their own intermittent catheter. We provide advice for all children, including those facing more complex challenges. Recognising the importance of avoiding mixed messages, ERIC's education helps to ensure that everyone gives the same evidence-based advice and guidance when supporting a child and their family/care providers.

TRAINING OPPORTUNITIES

ERIC offers four standard courses and can also tailor courses to meet the needs of teams working across health and social care.

Healthy bladders and bowels

This course covers how the bladder and bowel should work and what to do when things go wrong, including management of constipation, daytime wetting and general continence promotion.

This is ERIC's fundamental course — a great introduction for healthcare professionals new to the speciality or those requiring a full update.

> *This has given me valuable learning for helping with enuresis and encopresis clinics.*
> (Paediatric staff nurse)

Complex bladders and bowels

This interactive training day includes an introduction to clean intermittent catheterisation and management of indwelling catheters. It also looks at Mitrofanoff care and bowel washouts via antegrade colonic enema (ACE) and rectally. Case studies are presented and there is an opportunity to view a range of equipment.

Toilet training, including children with additional needs

This course looks at how to attain bowel and bladder control with particular attention given to children with additional needs. Guidelines on introducing care pathways and individual toilet training programmes are provided, including strategies for tackling challenging cases.

> *A personable and inspiring trainer — humorous and knowledgeable — this has been a most enjoyable training session!*
> (Assistant practitioner, school nurse continence team)

Nocturnal enuresis

This course introduces the ‘Three Systems’ as a means of understanding bedwetting, with a focus on a child-orientated, evidence-based approach to treatment. Recommendations from the National Institute for Health and Care Excellence (NICE, 2010) are included, exploring ways of applying this model to clinical practice and troubleshooting potential issues that might raise.

More information

Keep an eye on our website’s training for health professionals page: https://eric.org.uk/professionals/health-professionals-training/

Read more at: www.eric.org.uk

> *This is one of the best courses I have been on. I learnt so much in one day. The trainer delivered the course in a fantastic way. I came away that day feeling I gained so much more knowledge and confidence to be able to offer help, guidance and support to the families and children I see.*
> (Nursery nurse)

> *The trainer was fantastic. He was so passionate and knowledgeable. He was a pleasure to listen to and learn from. His bubbly personality also meant the day was informal and everyone felt comfortable to ask questions. I am very grateful he took the time to provide this training to us.*
> (Paediatric nurse)

ERIC also provides informative webinars for families to support everyone with the same messages.

MORE TO COME!

We continue to look for ways to develop evidence-based bowel and bladder education. During a three-year pilot project in Bristol, more than 1,000 health and early years professionals were trained. Of those trained:

- 98% said that they knew more about how to recognise a bowel or bladder problem
- 90% said they knew what to advise in terms of scheduling a toileting programme
- 100% said that they felt more confident to support parents or children around continence.

This has enabled ERIC to develop an affordable eLearning resource to support potty training and school readiness, which will be launched at our Conference in October, with more details to follow (https://eric.org.uk/professionals/paediatric-continence-care-conference/). **JCN**

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Why we need to talk about dementia

Dr Rosemary Leonard, practising NHS GP, South London

As a GP, I see a lot of people with dementia and their carers, and I also see those who are concerned that they may have dementia. These numbers have increased significantly since Covid, as people avoided seeing their GP and did not come forward if they had concerns.

Dementia is a growing problem in society. There are currently more than 944,000 people in the UK who have dementia and one in 11 people over the age of 65 have the condition (NHS, 2024a). It is estimated that up to 1.7 million people could be living with dementia in England and Wales by 2040 (Chen et al, 2023).

We need to start talking about dementia more and try and remove the taboos. People hear the word 'dementia' and automatically fear the worse — if ever there was a health condition that needs improved awareness and understanding, it is dementia.

That is why I am pleased to be working with Luye Pharma Ltd on its 'Let's talk Dementia' campaign, which aims to raise awareness of dementia and offer help and support for those whose lives have been affected by the condition. As part of the campaign, Luye Pharma carried out a survey with 1,000 people to find out more about their understanding of dementia, with insightful results.

Although 43% of those questioned said they knew someone with dementia, 50% were unaware that it can be treated. While there is no cure for dementia, it is important that people realise that it can be managed and treated and one of the most important things is to come forward early — the sooner treatment starts, the better the outcome can be.

When talking about treatment this does not just mean medical interventions — there are many lifestyle initiatives that can help. Staying active, eating a healthy diet, seeing friends, having a social life and doing things that make your brain work are all important for brain health.

Although the majority of the people in the survey were familiar with common early signs of dementia, such as memory problems (78%) and struggling with decision-making (69%), having memory problems does not necessarily mean that you have dementia. There are other conditions that can cause memory difficulties, such as urine infections or thyroid disorders. This is why it is important to come forward early so that what is causing the problem can be established.

As a society, we need to get to grips with the huge burden of care that dementia causes. In the survey, 87% of those questioned did not know that one in three people in the UK will care for someone with dementia at some point in their life (NHS England, 2024). Six out of 10 incorrectly thought that dementia care (such as care homes) is paid for by the NHS or a charity (NHS, 2024b), and 92% did not know that dementia costs the UK £42 billion annually (Alzheimer's Society, 2024).

Caring for someone with dementia can take a huge toll on the person doing the caring and it is important to try and find help and support. Organisations like the carer's charity 'Tide' (Together in Dementia Everyday: www.tide.uk.net/) do a great job offering support and advice for those navigating dementia care.

About 'Let's Talk Dementia'

This campaign, funded and initiated by Luye Pharma Ltd, encourages people to talk about dementia. Its website (see below) offers advice on how to stay active and healthy. Working with the campaign are partners and support groups with expertise in the dementia field, as well as the carers support group Tide.

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More information

To find out more about dementia and access resources, go to: www.letstalkdementia.co.uk

To watch Dr Rosemary's video: https://vimeo.com/960989121/a2140b4d2a?share=copy


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Dermatology and skin care resources and support

Jodie Newman, dermatology specialist nurse/education nurse, British Dermatological Nursing Group

'The BDNG website also has a dedicated primary care subgroup section which provides a range of resources that primary/community healthcare professionals can access to support their work/learning.'

The British Dermatological Nursing Group (BDNG) is a unique membership organisation, focused primarily, on offering accessible educational content for those working with skin. The organisation has roughly 4000 members comprising a range of health disciplines and offers a variety of educational resources supporting those working in clinical practice for a small fee of £20 annually.

Within the BDNG, there is an educational team, Jodie Newman (author of this piece), Teena Mackenzie (education lead), Molly Connolly (education nurse) and Emma Button (in person events lead), all of whom share the same passion — namely, education and dermatology.

The author works clinically as a dermatology clinical nurse specialist and part time as an education nurse for BDNG. Like most working within the specialty, she did not start her nursing career with a view to becoming a dermatology clinical nurse specialist. However, with nearly 10 years' experience working in this field she has found her niche.

In September 2024, the BDNG hosted its 33rd annual conference. The event was spread over three days and allowed delegates to grow, learn and connect with like-minded professionals. This year's event was inclusive of medical dermatology, skin cancer and paediatrics and offered those new to working in dermatology access to 'Derm School'. The conference offered access to fantastic speakers, new initiatives and hot topics.

October 2024 will showcase one of the group's autumn meetings in London, where delegates will have the opportunity to attend days related to dermatology practice, including primary care, menopause, patch testing and research meetings.

With the opportunity to join a specific subgroup of interest within the BDNG, members often find this a supportive platform and opportunity to share knowledge, and stay up to date with current issues and changes in practice. At present, the subgroups include the primary care subgroup, non-medical prescribing, aesthetics, research and dermoscopy.

The BDNG publishes a quarterly journal and has recorded podcasts, which are easy to access online and are hosted by education nurses with a diverse range of topics.

Members can apply for awards, including attending the Ego Australian Travel Award, practice development scholarship, and conference scholarships. The 'World' Dermatology Conference happens every four years, with the last event taking place in Singapore in 2023. The BDNG took several members who had been recognised as 'rising stars' in dermatology. This was a great success with an opportunity to build international relations. The next world event will be taking place in Mexico in 2027.

The BDNG also offers members exclusive access to supportive e-learning modules developed by those working within the specialty.

Furthermore, the BDNG website has a dedicated primary care subgroup section which provides a range of resources that primary/community healthcare professionals can access to support their work/learning. These include website links to resources to support management of patients with eczema, psoriasis, acne and rosacea, to name but a few.

The website has links to key guidelines used to support good dermatology nursing practice, as well as patient support groups, treatment demonstration videos and top tips for carrying out a good skin assessment/consultation. There are also links to key groups, such as the Primary Care Dermatology Society and the British Association of Dermatologists, who provide patient information leaflets as well as diagnostic pathways to support step-by-step management of common conditions. **JCN**

More information

To access these resources you need to be a member of the BDNG, so please visit: https://bdng.org.uk/bdng-membership/

Enhancing wound care: strategies for better outcomes

Ali Hedley, clinical engagement manager UK, Mölnlycke Health Care

Over 3.8 million people in the UK are living with chronic wounds — and how they are managed can shape a person's quality of life, for better or worse (Mölnlycke Health Care, 2022). However, their management often falls low on the priority list, and the system pressures facing the NHS since the Covid-19 pandemic have exacerbated the problem. This means that patients are facing worsening outcomes through inadequate services — and are paying the price with their physical and mental health.

HOW HAS THE PANDEMIC CHANGED WOUND CARE?

In 2022, Mölnlycke Health Care worked with the Patients Association to produce the *Making Wound Care Work* report exploring the effects that the pandemic had on patients and services. One major change was the shift to supported self-care, and while many patients welcomed it, a sizeable number felt that they lacked adequate guidance on self-management (Mölnlycke Health Care, 2022). And, while generally supportive, individual nurses have spoken of seeing an increase in patients presenting with wounds that have deteriorated due to inadequate remote management. Such anecdotal evidence is useful, but it serves to highlight that we still do not fully know the impact on patient care because there is not a consistent set of measurements for assessing wound care nationally, nor is there a centralised database or registry.

People living with a wound often see three or more different healthcare professionals, highlighting the challenges in maintaining continuity of care, and a lack of a coherent patient pathway. This is further exacerbated by the lack of unified patient records (data on file, unpublished). Second, they reported on the wider impact on their lives, including experiences of discomfort, pain, loss of mobility, as well as depression and anxiety. This all serves to highlight the wider individual, social and NHS system costs associated with managing unhealed wounds, and the comorbidities that the wound is a result of, such as infections, gangrene, or sepsis. For example, across Europe, it is estimated that between 2 and 4% of total healthcare expenditure is for wound care (Posnett et al, 2009; Guest et al, 2021), and in England, the number of wounds is greater than the NHS' workforce trained to treat them, with the costs of wound care rising more quickly than any other increases in NHS budgets (Milne et al, 2020; Guest et al, 2021).

In 2023, Mölnlycke Health Care delved deeper into this by launching a survey in collaboration with Wound Care People. The 'In This Together' survey asked 52 patients to explain how they feel about current wound care services. The findings, despite the relatively small number of participants, were endorsed by speakers on the 'Together Making Wound Care Work' webinar earlier this year, including Rachel Power of the Patients Association, as consistent with their own anecdotal findings (www.youtube.com/watch?v=5Ijui9Lfe2E). The results show that the impact of hard-to-heal wounds on individual quality of life cannot be overstated:

- 60% stated experiencing pain
- 87% endure discomfort on a daily basis
- 40% reported a loss of mobility
- 33% face depression
- 43% struggle with anxiety as a result of their condition
- 10% of those living with a wound lose their ability to work.

In the pursuit of relief and healing, patients voiced their priorities, with 57% ranking healing as their top priority, followed by 38% prioritising the stopping of wound leakage, and 28% seeking pain relief. Interestingly, 60% expressed a desire to eliminate smelly symptoms, highlighting the significant impact on their self-esteem and social interactions. An even more human aspect can be seen by looking at the answers to the question, 'what would be the first thing you would do once your wound has healed?' Answers ranged from everyday tasks such as having a shower without also having to wear a plastic bag, being able to wear shorts on holiday, to having a day with no pain (data on file, unpublished). The 10% of those living with a wound losing their ability to work also demystifies the myth that wounds are an elderly demographic problem, as significant numbers of the working population are impacted by their wound, which clearly illustrates the wider socio-economic impact of chronic wounds.

In early 2024, in the webinar 'Together Making Wound Care Work', this conversation was taken further by bringing together the patient and clinical community, represented by the Patients Association and the NHS respectively, to discuss the survey's findings — the first time the results were discussed in an open forum.

WHAT IS THE SOLUTION?

One of the primary obstacles hindering progress in wound care lies in the absence of effective metrics integrated into the wound treatment pathway. At present, too many patients are seeing healthcare professionals about their wound for six months or more. If we were better at measuring healing milestones (or lack thereof), would we be able to better understand where further interventions would bring most value, to patients and the NHS? An approach of standardising wound care would be helpful here. In the author's opinion, not only would this create the potential to raise the bar across the country as to what treatments patients should expect, but also moving to a more standardised approach would make measurement easier. And, with improved measurement, a much better understanding of the efficacy of different treatments with different cohorts of patients could quickly be gained. As the recent webinar heard, lack of standardisation is a problem recognised by nurses, with one speaker pointing to standardised care contributing to an 86% healing rate at 24 weeks for venous leg ulcers, versus a non-standardised rate of just 37% in 12 months.

A reason for this could be that patient-centric measurements such as patient-reported outcome measures (PROMs) are not currently used in the pathway. Furthermore, Rachel Power pointed out the value of applying principles of patient partnership, and how these lead to better outcomes for patients, healthcare professionals and the NHS overall. Such measures combine both objective data and subjective patient experiences, offering valuable insights into patients' pain, suffering and anxiety. However, this lack of standardised measurement, along with the lack of centralised data, makes it difficult to understand the true impact of chronic wounds and evaluate the efficacy of treatments and services. Standardised care and giving everyone a role in measuring the outcomes of wounds (including upskilling GPs and even patients) is essential. After all, how do we know what is working best, and with which sorts of patients, if we do not collect and analyse that data?

> **'... despite the ever-increasing burden of wound care to patients, the NHS and wider society, it receives little attention compared to other illness areas... .'**

It is known that chronic wounds can have a major impact on a person's life, and can lead to pain, discomfort, and loss of mobility, which in turn can affect their quality of life and, in severe cases, be debilitating. Unhealed wounds can also have a notable effect on a person's mental health, with patients experiencing issues such as depression and anxiety (Fearns et al, 2017). And, while viewing the impact of wound care on the NHS through the lens of spiralling costs is vital, it is more important to remember that each statistic or cost is a person living with a wound.

Another way to look at this is through a patient safety lens. The 2019 NHS Patient Safety Strategy highlighted the need to develop an approach to data that prevents and manages wounds more effectively (NHS, 2019). However, in the author's opinion, since publication, no progress has been seen, despite the profound impact of data collection on improving outcomes in patient safety issues. For example, the NHS mandates the reporting of specific healthcare-associated infections (HCAIs) through a data surveillance system (UK Health Security Agency, 2022). This has positively impacted infection rates, with some HCAIs decreasing by almost two-thirds (Gerver et al, 2015). Could such an approach be applied to slow-healing wounds, or hospital/care home acquired pressure ulcers, for example, or be defined as patients coming into harm?

A CONVERSATION TO HEAL OUR WOUND CARE SYSTEM

Wound care is still profoundly impacting patients and the NHS. Yet, as described, despite the ever-increasing burden of wound care to patients, the NHS and wider society, it receives little attention compared to other illness areas — something that should be addressed. For it to receive the proper attention that it requires, wound care needs to be given the consideration it deserves. The two above suggestions are just potential approaches. It is hoped that the discussion points raised in this article will help generate further discussion to free the patient, clinician and carer from the burden of wounds. **JCN**

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Frailty and the ageing skin: understanding skin tears

Heidi Sandoz

The impact of ageing on the body and its association with skin harm and frailty in relation to multimorbidity, comorbidity and polypharmacy is clearly described in the literature. The ageing population globally brings with it the challenge for healthcare professionals of managing individuals with increasingly complex and inter-related needs. This article considers ageing skin and skin tears within the context of frailty as a syndrome. It discusses what frailty is understood to be, how to recognise and assess for it, and how to consider risk and prevention of harm to the skin of the ageing person with frailty.

KEYWORDS:
■ Ageing ■ Frailty ■ Skin tears ■ Assessment
■ Prevention and treatment

WHAT IS FRAILTY?

There is no universally agreed definition of frailty (Hall et al, 2024), which is probably due to the complexity and multiplicity of issues linked to it. In 2014, Ipsos Mori for Age UK defined frailty as affecting 'people over 65, and probably much older than this, who struggle to do everyday tasks themselves and are becoming increasingly vulnerable to setbacks and difficulties'. While this simple definition does associate frailty with age, other more medicalised definitions refer to it as a state when returning to the usual baseline following a stressor event becomes more difficult (Hall et al, 2024). This is due to the cumulative decline in physiological systems over a lifetime (Clegg et al, 2013) and can mean that even the slightest of stressors leads to disproportionate changes in the health of an individual (Clegg et al, 2013; Hall et al, 2024). As such, Clegg et al (2013) define frailty as 'a state of increased vulnerability to poor resolution of homoeostasis after a stressor event, which increases the risk of adverse outcomes, including falls, delirium, and disability'.

Frailty has been found to be associated with ageing (Casabona et al, 2024), polypharmacy (Casabona et al, 2024), multimorbidity (Vetrano, 2019), and even the gut microbiome (Bo et al, 2024).

While frailty is a recognised medical syndrome with assessment scores to determine levels of severity, the use of the word frailty does not sit well with older people and is seen more as a concept to be avoided (Ipsos Mori for Age UK, 2014; Hall et al, 2024).

AGEING AND THE IMPACT ON SKIN

Ageing has a degenerative impact on the body and multiple functions and systems within, including the skin itself. Some of these changes can also have a direct or indirect impact on the skin.

Mobility changes

Sarcopenia, a decline in muscle mass, occurs with ageing, resulting in reduced strength and function (British Geriatrics Society, 2014; Drew et al, 2017). In combination with cartilage and arthritic changes, joint stiffness and muscle weakness can decrease walking and movement speed. Changes to bone density and, in post-menopausal women in particular, the advent of osteoporosis, can increase the risk of fractures, particularly neck of femur (World Health Organization [WHO], 2015). These can all impact on a person's risk of lower limb skin changes, pressure ulcer damage and falls, which may lead to wounds caused by trauma.

Immune system changes

Immunosenescence, a fall in capacity to respond to infections and vaccinations, is a trend seen in the ageing population (WHO, 2015). Dysregulation of the immune system and an increase in systemic inflammation are also linked to frailty (Drew et al, 2017). A decline in T-cell activity and increase in inflammatory cytokines (linked to chronic stress) leads to a decline in immune function (WHO, 2015; Drew, 2017). In frailty, an increase in monocytes and neutrophils is seen with the latter having reduced phagocytotic function. While both these white cells are important in the process of tissue repair, neutrophils can also cause tissue damage in increased numbers resulting in further inflammation (Drew et al, 2017). It is clear to see how ageing and frailty can then impact the skin and its ability to heal when injured.

Sensory changes

Functional changes in both the ears and eyes can lead people to lose sight and hearing to varying

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degrees. If not managed with the use of interventions, this can affect their wellbeing and ability to socialise and function in society (WHO, 2015). Such changes can also increase the risk of falls and knocks.

Skin changes

Over time, as we age, the skin will suffer decreases in function. Changes in the skin due to ageing can be as a result of (WHO, 2015):

- Genetic predisposition
- External environmental insults, such as the sun or chemicals
- Physiological mechanisms.

The dermal-epidermal junction, where the dermis and epidermis lay next to each other, has an undulating structure formed by epidermal rete ridges, where the epidermis grows down within the papillary layer of the dermis (Roig-Rosello and Rousselle, 2020). These indentations substantially increase the surface area of the dermal-epidermal junction, strengthening the bond between the two layers, keeping them well connected. This improves the strength of the interface and of the mechanical properties of skin.

With age, the rete ridges flatten and lose their depth (*Figure 1*; Roig-Rosello and Rousselle, 2020) reducing the strength of the dermal-epidermal junction and making it easier for the two layers to separate from one another and less resilient to knocks and trauma (LeBlanc et al, 2018).

Cellular and vascular changes and the loss of collagen (Gohil et al, 2022) and elastin fibres reduce the skin's ability to act as a barrier, maintain tensile strength and skin health, increasing the likelihood of dermatitis, dry skin, skin tears and pressure ulcers.

Incontinence

The prevalence of urinary incontinence increases with age and is more common in women than men (WHO, 2015). It can add an additional insult to the skin (Beeckman et al, 2015) and is associated with a need for care support (WHO, 2015).

Table 1: Definitions of commonly used terms

Term	Definition
Morbidity	The state of being symptomatic or unhealthy due to a disease or condition
Comorbidity	Combined effects of additional conditions in reference to the index chronic condition such as diabetes mellitus, stroke, depression and asthma (Tugwell and Knottnerus, 2019)
Multimorbidity	No single condition holds priority over any of the co-occurring conditions from the perspective of the patient and the health care professional (Tugwell and Knottnerus, 2019)
Long-term condition	A condition that generally lasts a year or longer and impacts on a person's life (NICE, 2015a)
Mortality	Referring to death

Multimorbidity

Multimorbidity and comorbidity are often used interchangeably to describe people with more than one condition or disease (Harrison et al, 2021) and yet, by definition, they are distinctly different (*Table 1*). Diseases and/or conditions can co-occur completely independently of each other (one is not associated with the other), or they can be associative (where the risk factors for one such as diabetes mellitus are associated with the risk factors for another, such as vascular disease) (Marengoni et al, 2011).

For some people, the development of conditions affecting multiple systems — for example, vascular, respiratory, neurological, musculoskeletal, immune, endocrine and gastrointestinal systems — and how they interact with each other can impact negatively on life, mortality, frailty and skin health (Marengoni et al, 2011). Medications to manage these conditions can also add another layer of complexity, with side-effects and drug interactions between each other and with other conditions affecting quality of life. Multiple appointments for differing specialities, polypharmacy, alongside the health burden of any condition can lead to difficulties in self-managing life and conditions. The National Institute for Health and Care Excellence (NICE, 2016a) recommends considering an approach to care that takes account of multimorbidity, involves personalised assessment and the development of an individualised management plan, and aims to improve coordination of care across services, particularly if this has become fragmented.

Vetrano et al, (2019) found that most people with frailty were multimorbid, but those with multimorbidity were not necessarily frail.

Falls

Changes to the musculoskeletal system, eyesight and cognitive function can all increase the likelihood of falls. Increased frailty (Hollinghurst et al, 2022), polypharmacy and older age are among the risk factors for falls (Casabona et al, 2024). Hollinghurst

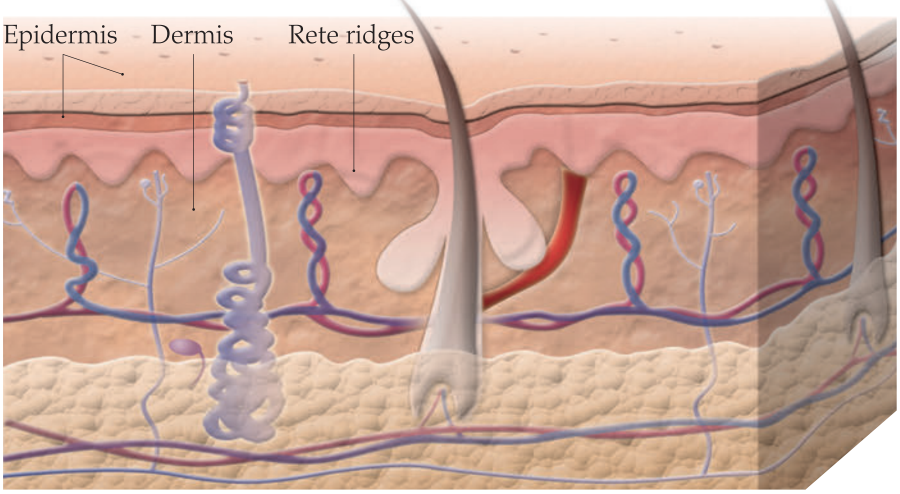

Figure 1.
Epidermal-dermal junction and rete ridges.

et al (2022) found that those with frailty had a greater risk of falling than with those without, and that this risk increased with the level of frailty. Morin et al (2019) found that there was a 2% increase in falls sustaining injuries with every additional medication taken. This study included both fracture and wounding injuries, with 15% of injuries being on the elbow and forearm, the commonest site for skin tears (LeBlanc et al, 2018).

ASSESSMENT OF FRAILTY

Understanding a person's level of frailty can trigger interventions that can help to reduce their risk of rapid deterioration in function (British Geriatrics Society, 2014).

NICE (2016b) recommends that older people with complex needs have a comprehensive geriatric assessment started on admission to hospital. This is an interdisciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old (NICE, 2015b).

In primary care in England, it is recommended to carry out a frailty assessment for anyone over the age of 65 and there are several tools that can be used for this (NHS England, undated a).

Practice points

Key interventions when considering prevention of skin tears are:

- Falls risk assessment and prevention
- Frailty and/or comprehensive geriatric assessment
- Management of dry skin with the use of emollients and maintaining good oral hydration
- Protection of vulnerable body areas (arms and lower legs) with clothing or protective pads/bandages
- Assessment of the immediate environment — consider knock, trip and fall hazards, such as loose rugs, sharp furniture edges and positioning of furniture

NICE (2016b) recommends that assessment of frailty is considered where multimorbidity exists. In England, all general practitioners have access to the electronic frailty index (NHS England, undated b), which electronic patient record systems can automatically calculate using the coded clinical information and diagnoses within the clinical records. This does come with the disadvantage that good clinical recording linked to codes is required. With this in mind, some providers may have chosen to use the Clinical Frailty Scale (CFS) (Rockwood and Theou, 2020) or another assessment of frailty risk/level, such as those recommended by NICE (2016a).

While tools such as the CFS use a graded scale from 1 to 9, with 9 being the severest level of frailty, frailty levels are often referred to as fit or living with mild, moderate or severe frailty.

RELATIONSHIP BETWEEN FRAILTY AND SKIN TEARS/OTHER WOUNDS

While Guest et al (2017) do not consider levels of frailty in a retrospective analysis of the records of 2000 patients aged over 18 years in The Health Improvement Network (THIN) database, they do demonstrate a correlation between older age and more comorbidities with having a wound. For example, 82% of people with a wound aged over 75 years had more than three comorbidities compared to 54% who did not have a wound. The mean age of someone with a leg ulcer of any aetiology was 77 years, a pressure ulcer 78 years, and a traumatic wound (which might be how skin tears are coded in clinical records) 68 years.

In a public health needs assessment in one health area in England (Sandoz and Walton, 2021), it was found that a higher percentage of people admitted to hospital with leg ulceration, lymphoedema, cellulitis, pretibial haematomas and skin tears had moderate and severe levels of frailty than the national average at the time (Walton, 2019). This demonstrates a strong correlation with frailty and skin frailty.

Pretibial lacerations and haematomas are a more severe form of skin tear usually occurring as a result of trauma of some kind, such as knocking legs or falling. In a small study looking at people admitted to hospital with pretibial injuries, Paavana et al (2023) found frail, elderly women with medical comorbidities were more likely to be affected (79.7%). 75.4% of admissions were taking some form of anticoagulant/antiplatelet therapy, and at 32% had a higher one-year mortality rate than hip fractures.

Given that the severity of frailty seems likely to increase with higher numbers of comorbidities, polypharmacy and immobility, in the author's clinical opinion, a higher level of frailty could be used as an alert for potential skin changes and harm. Undertaking skin-associated risk assessments, such as PURPOSE-T (pressure ulcer risk primary or secondary evaluation tool) for pressure ulcer risk assessment (National Wound Care Strategy Programme [NWCSP], 2024a) and a skin tear risk assessment (LeBlanc et al, 2018) can be helpful to identify individuals who may be more likely to develop pressure ulcers or skin tears.

It seems that where people have multiple comorbidities, higher levels of frailty and poor mobility (which can increase risk of falls), there is a likelihood that skin trauma may occur (Gohil et al, 2022).

SKIN TEARS, ASSESSMENT, PREVENTION AND TREATMENT

The International Skin Tear Advisory Panel (ISTAP) has produced best practice statements (LeBlanc et al, 2018) that include how to consider risk, prevention and treatment of skin tears.

It defines skin tears as wounds initially of an acute nature caused by mechanical forces such as shear, friction or trauma, resulting in separation of the skin layers. They can be full-thickness (through the subcutaneous tissue to the fascia) or partial-thickness (through the epidermis or dermis). While they can

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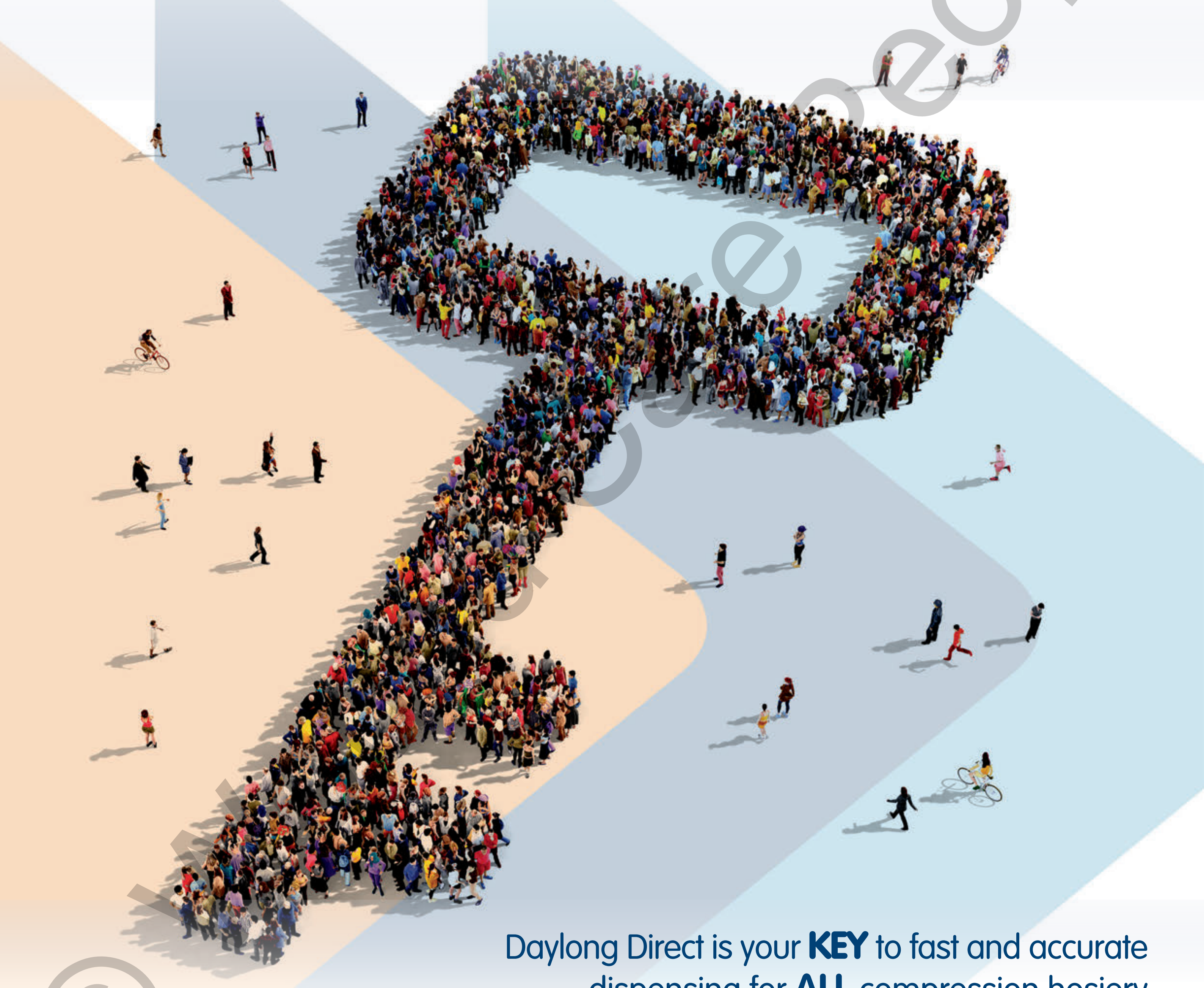

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occur anywhere on the body, up to 70–80% of skin tears occur on the hands and arms (LeBlanc et al, 2018).

The prevalence of skin tears is not understood with estimates across different care settings ranging from 2.23% to 92% (LeBlanc et al, 2018). Reports of numbers presenting to the emergency department with pretibial lacerations range from 0.4–5.2 out of every 1000 emergency department attendances in the UK (Ousey et al, 2010; Gohil et al, 2022; Paavana et al, 2023).

Skin tear risk assessment

Understanding who might be at risk of a skin tear can help guide preventative strategies.

A skin tear risk assessment involves consideration of the person at risk, the environment they are within and their skin (*Figure 2*; LeBlanc et al, 2018).

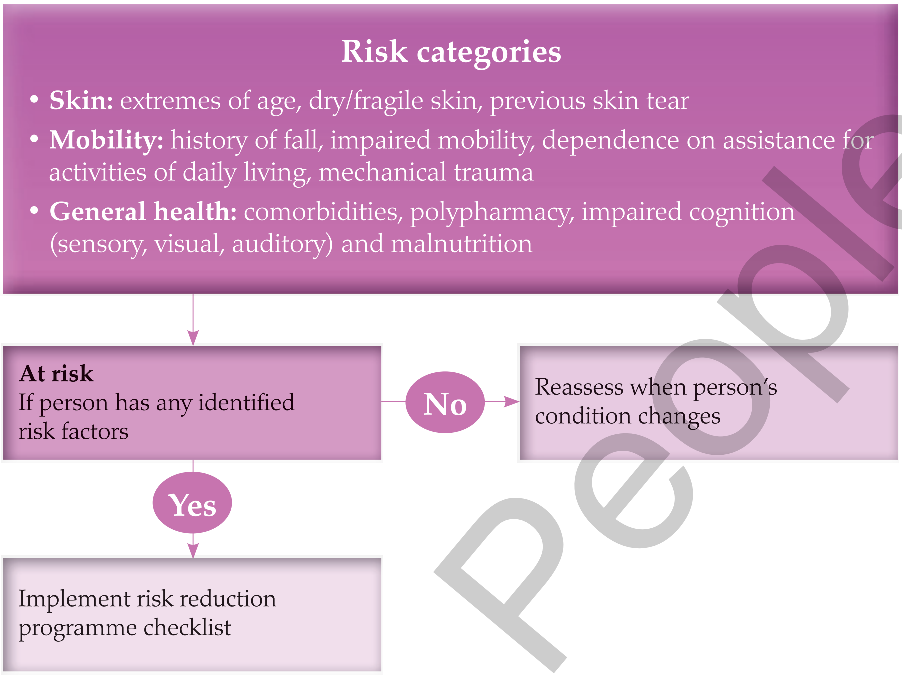
Prevention of skin tears

Prevention of skin tears is about a full holistic assessment, recognising the multiple risk factors that might be involved, and taking steps to reduce these where able (LeBlanc et al, 2018).

ISTAP (LeBlanc et al, 2018) has produced a helpful checklist that can guide a risk reduction programme for individuals deemed to be at risk (*Table 2*).

Treatment of skin tears (LeBlanc et al, 2018)

First steps to treatment might take place in the immediate moments after the trauma has been sustained. Initial first-aid care may need to consider other potential injuries, such as head or fracture where a fall has taken place. Depending upon the setting where the injury has occurred and its severity, emergency help may need to be called for. Once the person is stabilised, and as quickly as possible after this, the bleeding from the skin injury needs to be controlled. Bleeding can be controlled by applying pressure and elevating the limb if appropriate/possible. If available, dressings that support haemostasis might also be useful temporarily. It may be that a non-clinical person, such as a carer or family member, has managed the bleeding skin tear initially and used any material to hand to cover the damage, such as kitchen towel or tissue paper.



Risk categories

- **Skin:** extremes of age, dry/fragile skin, previous skin tear
- **Mobility:** history of fall, impaired mobility, dependence on assistance for activities of daily living, mechanical trauma
- **General health:** comorbidities, polypharmacy, impaired cognition (sensory, visual, auditory) and malnutrition

At risk
If person has any identified risk factors

No

Reassess when person’s condition changes

Yes

Implement risk reduction programme checklist

Figure 2.
Skin tear risk assessment tool (adapted from Le Blanc et al, 2018).

Once bleeding is controlled and a clinician is present, any materials used to control bleeding can be carefully removed, the wound can be cleansed as per local guidelines,

Table 2: Risk factor checklist (LeBlanc et al, 2018)

Risk factor	Action
Skin	▸ Inspect skin and investigate previous history of skin tears ▸ If person has dry, fragile, vulnerable skin, assess risk of accidental trauma ▸ Manage dry skin and use emollients to rehydrate limbs as required ▸ Implement an individualised skin care plan using a skin-friendly cleanser (not traditional soap) and warm (not hot) water ▸ Prevent skin trauma from adhesives, dressings and tapes (use silicone tape and cohesive retention bandages) ▸ Consider medications that may directly affect skin (e.g. topical and systemic steroids) ▸ Be aware of increased risk due to extremes of age ▸ Discuss use of protective clothing (e.g. shin guards, long sleeves or retention bandages) ▸ Avoid sharp fingernails or jewellery when carrying out direct care
Mobility	▸ Encourage active involvement/exercises if physical function is impaired ▸ Avoid friction and shearing (e.g. use glide sheets, hoists), using good manual handling techniques as per local guidelines ▸ Conduct falls risk assessment ▸ Ensure that sensible/comfortable shoes are worn ▸ Apply clothing and compression garments carefully ▸ Ensure a safe environment — adequate lighting, removing obstacles ▸ Use padding for equipment (as per local policy) and furniture ▸ Assess potential skin damage from pets
General health	▸ Educate the person and carers on skin tear risk and prevention ▸ Actively involve the person/carer in care decisions where appropriate ▸ Optimise nutrition and hydration, referring to dietician if necessary ▸ Refer to appropriate specialist if impaired sensory perception is problematic (e.g. diabetes) ▸ Consider possible effects of medications and polypharmacy on the person’s skin

any residual debris can be removed if present, and the edges of the skin flap can be re-approximated if viable. This can be done using gloved wet fingers or a moistened cotton tip. Tweezers/forceps might be helpful but should be used with care as they might tear the skin flap.

When able, a full holistic assessment should be undertaken, considering full medical history, medications, history of previous skin tears or other skin conditions, level of frailty, nutritional status, psychosocial and lifestyle factors, history of the mechanism of injury, factors that might delay healing and comorbidities.

Assess and classify the skin tear at the earliest opportunity (*Box 1*). Thorough wound assessment should be performed (Coleman et al, 2017), including photos and classification of the injury (LeBlanc et al, 2018). Several classification tools have been devised over the years. The ISTAP system (*Box 1*) simplifies categorising and has been validated (LeBlanc et al, 2018). Consider local referral pathways into hospital for surgical management, especially for type 3 skin tears, pretibial lacerations and presence of haematoma. Given the high mortality rate, early medical and surgical management where required, are essential (Gohil et al, 2022; Paavana et al, 2023).

A suitable dressing can then be applied (*Box 2*). When applying dressings, removal should be taken into account. Mark the dressing with a date for removal and an arrow to indicate the correct direction (i.e. following the direction of the skin flap not against it so it cannot be peeled back off the exposed area) (LeBlanc et al, 2018; Hickey and Ayres, 2021) and document clearly in any clinical records. The use of adhesive skin strips is no longer recommended for the management of skin tears in fragile skin (LeBlanc et al, 2018).

Box 1 ISTAP Skin Tear Classification System (LeBlanc et al, 2018)

Type 1 skin tear — no skin loss: linear or flap tear where the skin flap can be repositioned to cover the wound bed.

Type 2 skin tear — partial flap loss: the skin flap cannot be repositioned to cover the whole of the wound bed.

Type 3 skin tear — total flap loss: total skin flap loss that exposes the entire wound bed.

Box 2 Suitable dressing considerations (LeBlanc et al, 2018)

- Be easy to apply and remove
- Not cause trauma on removal
- Provide a protective anti-shear barrier
- Optimise healing
- Be flexible and mould to contours
- Provide secure, but not aggressive, retention
- Have an extended wear time.

If the injury has occurred on the lower limb, immediate and necessary care should be carried out and compression therapy considered, as well as comprehensive lower limb assessment, including vascular assessment within two weeks of injury (NWCSP, 2024b).

Most skin tears should heal within two to four weeks with good management. Where healing is delayed, repeated full holistic wound assessment should be undertaken, considering factors that might be delaying healing, e.g. underlying health conditions such as diabetes mellitus, poor nutrition, or the wound is on the lower limb and leg ulcer recommendations have not been followed (NWCSP, 2024b). Referral to tissue viability nursing should also be considered at this point.

Other considerations

Once the skin tear has been suitably stabilised and managed, full assessment of the person affected is advised (BGS, 2014; NICE, 2013; 2015a). In the acute setting, this would be a comprehensive geriatric assessment. In the community or care home setting, further assessments might be necessary, such as:

- Frailty assessment (BGS, 2014)
- Falls risk assessment (NICE, 2013)
- GP review — holistic medical review (BGS, 2014)
- Pharmacology review (BGS, 2014
- Environment assessment (NICE, 2013).

SUMMARY

There is a clear correlation between frailty, falls, multi- and comorbidity and polypharmacy. The risk factors for skin tears and pretibial lacerations are closely related to those for these situations/syndromes.

There are clear and easily accessible international recommendations for the prevention and management of skin tears (LeBlanc et al, 2018), which offer a useful resource to all those caring for people with frailty who might be at risk of skin harm. However, assessment and consideration of skin harm risk should not be undertaken in isolation of frailty assessment. **JCN**

Red Flags **Dressings**

- Adhesive skin strips are no longer recommended to approximate the edges of skin tears in those with fragile skin
- Very adhesive dressings and tapes that may lead to further harm and skin stripping on removal should be avoided.

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Leg ulcers, debridement and pain management

Jane Hampson

Lower limb ulcers are one of the most common chronic wounds in the UK and have a negative impact on health-related quality of life (Phillips et al, 2020). Venous leg ulcers (VLUs) often present with excessive exudate, which may damage the wound bed and periwound skin; and therefore act as a barrier to wound healing. Cleaning and debridement are key to the management of devitalised tissue and exudate. Although debridement helps promote the healing of both arterial and venous leg ulcers, its use may be restricted by pain levels associated with the procedure (Claeys et al, 2011). Because pain can be a barrier to patients tolerating debridement, this may compromise the healing process (Roberts et al, 2019). A small-scale evaluation was recently completed to investigate the efficacy of wound debridement pads, together with patient perceptions of the treatment. The impact on pain and tolerance of pain during the use of pads was explored. Spending time explaining the potential benefits of debridement on wound healing and listening to patient concerns appeared to have a positive impact on acceptance of treatment.

KEYWORDS:
■ Leg ulcers ■ Debridement ■ Debridement pads ■ Pain

It is estimated that at least 1% of people experience a chronic wound at some point during their life (Thomas et al, 2021), but this figure could be an underestimate as the annual prevalence of wounds managed by the NHS increased by 71% between 2012/2013 and 2017/2018 (Guest et al, 2020); with an estimated 3.8 million patients treated in 2017/18 (Guest et al, 2020).

> **'In the community, chronic venous insufficiency, which results in increased venous pressure, is the most common cause of leg ulceration.'**

Leg ulcers are the most common type of chronic wound in the UK, with a 2020 study reporting that 28% of wounds are leg ulcers, most of which are venous leg ulcers (VLU), (Guest et al, 2020). Between 70–80% of lower limb ulcers have a venous origin, around 10% are arterial and 10–20% are of mixed venous/arterial aetiology (Primary Care Dermatology Society [PCDS], 2023).

A VLU is defined as a break in the skin below the knee, which has not healed within two weeks (National Institute for Health and Care Excellence [NICE], 2021). People with VLUs can present with repeated cycles of ulceration, healing, and recurrence (NICE, 2021).

Several factors may predispose a person to VLUs, including family history, obesity, deep vein thrombosis (DVT), and increasing age (NICE, 2024). It is estimated that over 500,000 people live with a form of venous ulceration in the UK (PCDS, 2023); this figure has doubled in the last 10 years (PCDS, 2024).

VLUs are a major cause of morbidity and lead to decreased health-related quality of life (Phillips et al, 2020). They have significant emotional and psychological consequences for patients, including shame, embarrassment, social isolation, depression and anxiety (Hughes and Balducyk, 2022).

The direct cost of managing a patient with a VLU is estimated to be £7,706 per patient per year, rising to £13,500 for an unhealed VLU (Guest et al, 2018). They frequently recur, with 12-month recurrence rates ranging from 26% to 69%. Many patients develop at least three or more VLUs during their lifetime (Nelson and Bell-Syer, 2014; Harding et al, 2015). Fifty-five percent of healed VLUs recur within the first 12 months of closure, and 28% of patients experience more than 10 episodes of venous leg ulceration in their lifetimes (Finlayson et al, 2018).

In the community, chronic venous insufficiency, which results in increased venous pressure, is the most common cause of leg ulceration. This leads to a chronic inflammatory response and local thrombosis (atrophie blanche), which can result in skin breakdown and ulceration, (Chapman 2017; Wounds UK, 2019).

Jane Hampson, advanced lower limb nurse specialist, Accelerate CIC

INITIAL MANAGEMENT OF VLUs

All patients with a VLU should have a wound assessment, which includes a review of the limb and the vascular system as well as a general consideration of patient-related factors, including lifestyle, quality of life, overall health, medical history and medication (Wounds UK, 2019).

Compression therapy is usually initiated following diagnosis of a VLU, as compression improves the healing of venous ulcers, reduces venous hypertension (Tkaczyk et al, 2021), and may improve patient quality of life (Shi et al, 2021). Compression also helps aid debridement of devitalised tissue and control wound exudate (Wounds UK, 2022), so that long-term use of superabsorbent dressings can be reduced.

WOUND EXUDATE

One of the challenges when managing patients with a VLU is wound exudate. Although exudate contains electrolytes, nutrients, proteins and inflammatory mediators, which are essential for healing, excess exudate increases the risk of wound infection and maceration (Sharp, 2013). This may lead to deterioration of the wound edges, increased odour, and discomfort for the patient (Wounds UK, 2022).

Management of excess exudate involves cleansing and debriding the wound of devitalised tissue, and applying a dressing to help absorb the exudate (Wounds UK, 2022). As said, compression also helps manage and control the volume of exudate.

DEBRIDEMENT

Debridement is a key intervention in promoting the production of healthy granulation tissue. It helps support the wound healing process by reducing the bacterial burden and biofilm, while minimising the risk of infection (Thomas et al, 2021).

In acute wounds, autolytic debridement occurs naturally. During the inflammatory stage, neutrophils and macrophages digest and remove devitalised tissue, cell debris and contaminants, clearing the wound of many cellular barriers to healing, (Atkin, 2014). In chronic wounds, the autolytic process becomes overwhelmed by high levels of endotoxins released from damaged tissue (Atkin, 2014). Chronic wounds may require repeated debridement as devitalised tissue tends to resurface, (Thomas et al, 2021).

Types of wound debridement

There are various types of debridement, including:

- Autolytic
- Biological
- Enzymatic
- Sharp and surgical
- Mechanical.

> **‘Debridement is a key intervention in promoting the production of healthy granulation tissue. It helps support the wound healing process by reducing the bacterial burden and biofilm.’**

Autolytic debridement is the most conservative method and is a natural process by which endogenous phagocytic cells and proteolytic enzymes break down necrotic tissue (Manna et al, 2023).

Biological debridement involves the use of larval therapy; while enzymatic debridement uses enzymes to break down tissue.

Sharp instrument debridement involves removing devitalised tissue (slough, necrotic, or eschar) with a scalpel or curette. Healthcare professionals require specialist training and certification in this technique. If deep debridement is required, it may be carried out surgically under anaesthetic.

Mechanical debridement uses a physical action to remove necrotic tissue, but is non-selective meaning that both viable and non-viable tissue may be removed (Manna et al, 2023). An alternative form of physical debridement is with single-use pads, specifically designed for effective wound cleaning. Slough, exudate and debris are actively loosened from the wound by the fibrous material of the pad. This method of debridement appears to be less painful than sharp debridement, so is likely to be better tolerated by patients (Nowak et al, 2022).

IMPACT OF PAIN ON WOUND CARE

There is evidence that pain or the fear of pain during non-surgical wound care procedures, including dressing changes and wound cleansing, is an issue of concern for many patients and healthcare professionals (Matsuzaki and Upton, 2013; Gardner et al, 2017).

A 2017 study found that dressing changes cause moderate-to-severe pain in 74% of patients. Thirty-six percent of patients reported severe pain (rated as 8 to 10 on a 10-point numeric rating scale, where 10 is the most painful) (Gardner et al, 2017). Debridement is associated with pain and a number of factors have been identified as influencing a patient’s experience of pain, including their mood, anxiety levels and anticipation of pain (World Union of Wound Healing Societies [WUWHS], 2008). Indeed, a single episode of pain can affect nociceptive pain pathways and elevate the anticipation of pain in future procedures (Gardner et al, 2017).

Conducting procedures that cause pain leads to stress both for the patient and healthcare professional. This may result in potentially painful procedures being hurried, and cleansing may be incomplete with an increased risk of infection and delayed healing (Gardner et al, 2017). This highlights why pain management should form part of the overall woundcare treatment plan.

PATIENT INVOLVEMENT

While wound debridement is usually undertaken by a healthcare professional, this should not negate the need for patients to feel engaged in their own care. Setting agreed treatment goals and creating a management plan empowers patients, who are subsequently more likely to positively engage with treatment. Explaining the debridement process and the potential healing benefits; then listening and responding to patient concerns is an excellent starting point and helps improve concordance with treatment (Harding et al, 2015). This was observed in the author's debridement pad evaluation.

ACCELERATE CENTRE OF EXCELLENCE AND INNOVATION

The Accelerate Centre of Excellence and Innovation (CEI) is a London-based clinic dedicated to the treatment and management of complex non-healing wounds and lymphoedema, where experimental new treatments for challenging and complex chronic wounds are pioneered. The clinic has a multidisciplinary approach to patient care, which is underpinned by a commitment to patient engagement with their own treatment. Referrals are made from a wide range of healthcare professionals, including GPs, consultants and specialist nurses.

DEBRIDEMENT PAD EVALUATION

In November 2023, a small-scale evaluation of 10 patients over a one-month period was undertaken at the CEI. The aim was to assess the efficacy and acceptability (particularly in terms of treatment pain) of single-use debridement pads, which are designed to remove slough, biofilm and non-viable tissue from wounds. They are easy for healthcare professionals to use, and often require minimal training. The level of pressure applied to the pad can be adapted according to pain levels and to suit the patient's tolerance of the procedure.

Understanding the patient experience of debridement, including their perceptions of pain, knowledge of the process and willingness to continue debridement treatment were key parameters to be explored.

Digital photography was used to capture wound imagery and support data collection by the Accelerate team. Patients were assessed at day one, when the first debridement was carried out, further debridement and wound cleansing took place at days seven, 14 and 28.

10 patients with chronic lower limb wounds who required regular

CASE EVALUATION ONE

Patient A is a 72-year-old male who presented to the clinic with recurrent lower leg ulceration. New ulceration had been present for approximately four months. The patient was on holiday when his wound broke down. He managed the wound with dressings from a previous episode of ulceration. Compression hosiery was also applied. When he first attended the clinic, the wound showed signs of odour and infection.

His past medical history included:

- Venous disease
- Venous calcification
- Antiphospholipid syndrome (an autoimmune disorder that causes abnormal blood clots to form).

He had been on amitriptyline in the past for pain relief. His current care plan involved:

- Alginate dressings as wound was thick and sloughy, with odour present
- Two-layer compression bandage system
- Regular debridement using two methods, sharp and mechanical.

Previous treatments included:

- Two-layer compression bandage system
- Compression hosiery when healed with liner
- Wound debridement.

The plan of care decided upon was vascular referral for a more intensive examination of the calcification noted in the wound. Wound debridement was to be continued to remove the occasional piece of calcification.

His limb was measured and made-to-measure flat-knit compression hosiery requested.

Summary

Healing of the ulceration progressed when patient A was able to tolerate at least two minutes of mechanical debridement with a pad. Initially, he was reluctant to have debridement to the ulceration due to high pain levels. His GP was contacted and appropriate analgesia was prescribed. Patient A had taken amitriptyline in the past, but had stopped. This was recommenced along with other prescribed analgesia. When his pain was under control, patient A was able to tolerate debridement for longer periods using a debridement pad, and was happy for this to be used at his next visit. Patient A noticed a positive difference in wound healing and changed his perception of debridement, realising that it was effective and, although sometimes painful, had a positive impact on wound healing.

Pre-debridement.

Post-debridement.

CASE EVALUATION TWO

Patient B is a 66-year-old female with a long history of recurrent atrophy blanche with ulceration to the medial malleolus. This was affecting her daily life and mobility. Her current wound had been present for one year and she was manged under shared care with the local leg ulcer service. She had also previously self-managed with compression bandages.

Her past medical history included:

- Colitis, had surgery 30 years ago
- Recurrent cellulitis
- Chronic venous insufficiency.

She was on:

- Fentanyl patch 72 hours
- Ibuprofen
- Paracetamol.

Patient B's current care plan involved:

- Various alginate dressings to remove sloughy area
- Weekly debridement if tolerated
- Two-layer compression bandage system
- Control of pain, even though analgesia prescribed
- Waiting for vascular surgery.

Previous treatments included:

- Compression bandaging when wound was present, including four-layer compression bandage system
- Compression hosiery when wound healed — made-to-measure flat-knit garment
- Regular debridement, but patient reluctant due to pain
- Participation in various randomised controlled trials and evaluations.

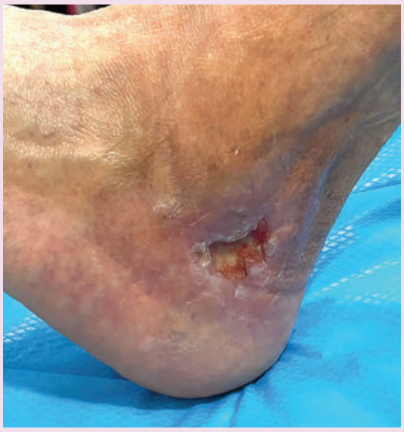
The new treatment plan was to refer to the vascular team to carry out surgery, continue with debridement using a debridement pad, if tolerated due to pain, and the application of compression bandaging.

Summary

Pain was the most significant issue for patient B. Although she was on prescribed analgesia, this was not relieving the pain, meaning that the correct therapeutic level of compression treatment was not applied to facilitate wound healing. The local leg ulcer service was unable to carry out sharp debridement but were using debridement pads, with EMLA cream applied before debridement. However, patient B did not feel this made a difference to the pain.

She participated in the author's evaluation and found she was able to tolerate at least four minutes of debridement with a pad. She commented that she was pleased the pad was used as she could see the benefit it was making in terms of wound healing, with minimal discomfort, and that this was required to kickstart the healing process.

Pre-debridement.



Post-debridement.

CASE EVALUATION THREE

Patient C is a 72-year-old male with recurrent pustular dermatitis to the anterior of his leg for approximately four years. He was originally referred to the clinic due to ulceration to the malleolus, which had now healed. He has mixed aetiology ulceration and is under shared care with the general practice nurse who applies compression bandages.

Previous medical history included:

- Renal impairment
- Non-diabetic hyperglycaemia
- Suspected lung cancer
- Disorder of the adrenal gland
- Psoriasis
- Chronic kidney disease
- Venous leg ulceration of mixed aetiology
- Low mood.

His medications included:

- Betamethasone
- Omeprazole
- Tacrolimus 0.1% ointment
- Amitriptyline
- Gabapentin.

Patient C's current care plan comprised:

- Application of compression bandage: one layer due to mixed aetiology
- Simple dressing to pustular erosions
- Application of steroid ointment
- Debridement using a debridement pad
- Ankle exercises.

Past treatments involved:

- Compression bandaging
- Compression hosiery
- Vascular referrals
- Debridement.

The plan decided upon was to continue with shared care and compression bandaging. Also, to apply compression hosiery so that he could self-care and carry out daily skin care and debridement once a week.

Summary

Patient C had been very anxious about the healing of his malleolus ulceration and the dermatitis. Pain had also been a problem. He had some issues with the application of high compression therapy, as a result of previously being advised at a vascular appointment to use low compression due to an occlusion.

The wound has now healed, but the dermatitis remains. The patient is now self-managing with compression hosiery and a debridement tool. This means that he can debride the area of dermatitis and apply emollients and steroid ointment when required.

Visit 1 — pre-debridement.

Visit 1 — post-debridement.

Visit 2 — pre-debridement.

Visit 2 — post-debridement.

debridement as part of their management plan were randomly recruited to the study, with an age range from 53 to 87 years. Seven patients had a venous leg ulcer, two had mixed aetiology leg ulcers, and one had a dermatological leg condition. All treatment was carried out on an out-patient basis at the clinic.

Based on the team's experience, two to four minutes' debridement is the most effective length of time to remove devitalised tissue with debridement pads. This was explained to each patient and helped alleviate fears about how long the process would take. At each debridement session, a patient is shown a four-minute countdown on a phone or clock, so that they feel more in control of the procedure, rather than a passive recipient. There is no pressure to tolerate the full four minutes and it is explained that even 20 seconds will help the healing process.

Negative language is avoided during debridement; words like 'hurt' and 'pain' are replaced by positive reinforcement of the benefits. Saying 'I hope this isn't hurting too much', is replaced by 'the pad is working well, and your wound looks cleaner already'. Just talking to the patient acts as a distraction from the process and appears to enhance tolerance levels.

A visual analogue scale (VAS) was used to record pain scores, with zero indicating no pain and 10 describing 'the worst possible pain' (Heller, 2016). The team found that thorough pain assessment (which may identify the need for analgesia before debridement), discussing concerns with patients and introducing them to the debridement process and pad, significantly helped alleviate concerns. The pain level experienced by each patient was monitored and recorded at every dressing change.

Two patients recorded zero pain during all four treatments and assessments. With a single exception, the remaining eight patients scored between one to five during the evaluation. Six patients tolerated debridement for four minutes, one patient for three minutes, and the remaining three patients for two minutes. All ten patients wanted to continue with their debridement treatment, despite expressing previous concerns about pain.

CONCLUSION

This small evaluation gave an insight into patient perceptions and acceptability of debridement and the impact this had on concordance with treatment. The evaluation was limited in that it only involved 10 patients over a 28-day period; and chronic leg ulcers typically require significantly longer for full healing to take place. However, all patients tolerated debridement with the pad for two to four minutes as part of their management and all wounds showed signs of improvement by the end of the evaluation period.

While wound debridement may cause pain to some extent, there are steps which can be taken to help control the impact this has on patients. Their ability to cope is strengthened by good preparation, analgesia (if required) and, most importantly, spending time to ensure that they fully understand and are engaged with the procedure.

The CEI will continue to use a variety of debridement modalities for wound bed preparation where indicated, with sharp and mechanical being the choice of the clinical team. A future evaluation to examine patient communications, pain tolerance and woundcare outcomes in more depth would be a useful next step. **JCN**

KEY POINTS

- Lower limb ulcers are one of the most common chronic wounds in the UK and have a negative impact on health-related quality of life.
- Cleaning and debridement are key to the management of devitalised tissue and exudate.
- Although debridement helps promote the healing of both arterial and venous leg ulcers, its use may be restricted by pain levels associated with the procedure.
- Spending time explaining the potential benefits of debridement on wound healing and listening to patient concerns appeared to have a positive impact on acceptance of treatment.

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Advanced practice district nursing in remote and rural areas

Jenna Gettings

The aim of this article is to identify challenges for advanced practitioners within the district nursing services in remote and rural areas and the impact of the new Scottish GP contract. Advanced nurse practitioners (ANPs) working within the community providing care in patients' homes have a wide skill base to draw upon. However, community care is often not reviewed or studied to identify the impact it makes to patients and the wider community. This article looks at a review of the qualitative research provided by a search on CINAHL, Medline, PsychINFO and Google scholar between 2019 to 2023. Studies needed to be about advanced practice in remote and rural areas with a focus on district or community nursing. A separate search was conducted for reviews on the new Scottish GP contract and the impact on services this has had, using the same search engines and between the same dates. Articles that were based on ANPs working in GP practices were excluded.

KEYWORDS:
■ Advanced practice ■ Community nurse ■ District nurse
■ Remote/rural nursing ■ Scottish GP contract

Healthcare systems across the world are faced with how to provide healthcare for an ageing population. In 2030, one in six people will be over the age of 60 (World Health Organization [WHO], 2022). The longer people live, the greater proportion of the population will have one or multiple long-term conditions. Their needs are complex and require different services, such as social care to support living in their own homes (Health Foundation, 2021).

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'Reform of primary care services and efforts to reduce costs of inpatient admission are drivers behind the shift to treat patients with complex needs in the community.'

Inevitably, as people live longer with more complex comorbidities, demand increases for hospital beds, leading to accelerating costs. This has pushed healthcare providers to change where healthcare can be provided (Gillham et al, 2021).

Reform of primary care services and efforts to reduce costs of inpatient admission are drivers behind the shift to treat patients with complex needs in the community. New services, such as hospital-at-home and online telehealth consultations, are leading to direct referrals to community teams, thus reducing hospital visits (Gillham et al, 2021).

In 1999, Scotland's health policy was devolved to the Scottish parliament, including organisational and financial control (Shuttleworth and Nicholson, 2020). Devolved healthcare in the UK is funded from the UK central government using the Barnett formula — this is for all of the devolved governments spending with the devolved countries deciding how to spend it (Shuttleworth and Nicholson, 2020).

In Scotland, the health system was reconfigured by the Public Bodies (Joint Working) (Scotland) Act 2014 (Scottish Government, 2014). This resulted in integrated health and social care services and the formation of health and social care partnerships (HSCPs) (Donaghy et al, 2023). GPs in Scotland also formalised a new contract in 2018. The idea behind this was to provide more local services to reduce their workload and enable them to develop roles as expert generalists (Donaghy et al, 2023). The new services were to include staff with advanced practice, such as advanced paramedics, advanced nurse practitioners (ANPs), advanced physiotherapists and mental health nurses (Strachan et al, 2022; Donaghy et al, 2023).

WHAT IS AN ADVANCED NURSE PRACTITIONER (ANP)?

Lamb et al (2018) stated that advanced practice roles vary by title and description. These can

Reflective point

Will district nurses be identified as advanced practitioner specialists within their field of practice? If so, will they still need the district nursing specialist qualification or a specialist advanced practitioner qualification?

also differ between employers, not just countries, because of variations in role development. There is no protection or registerable qualifications for ANPs under the Nursing and Midwifery Council (NMC), unlike the district nursing title (specialist community public health nurse [SCPHN] or specialist practitioner qualification [SPQ]). The NMC (2022) protects nursing titles in order that the public are not put at risk and the reputation of the profession is not undermined.

Scotland introduced advanced clinical skills into district nursing training and offered this at master's level in 2013 (Bain and Moggach, 2019). District nurses are lone workers. As a result, student district nurses in advanced practice find it difficult to be assessed and consolidate their skills (Bain and Moggach, 2019), which can be further compounded in remote and rural areas as there are less opportunities for career development (Rose et al, 2023). Providing district nurses with advanced practice skills will help to meet the Health and Care (Staffing) (Scotland) Act 2019, coming into force in 2024, the *NHS Long Term Plan* (NHS England, 2019), and the Scottish GP contract (Scottish Government, 2018). These plans hope to increase the responsiveness of community services to reduce hospital admissions and support people with long-term conditions in the community (Hill, 2020).

DISCUSSION

In 2008, the NMC decided that the minimum qualification for the nursing profession should be a bachelor's degree (NMC, 2010). This has increased the pressure for district nursing courses to be postgraduate (Jarnulf et al, 2019). As postgraduate courses became available in 2013 in Scotland, the majority of newly qualified district nurses have a postgraduate diploma or masters in advanced district nursing. In these courses, students undertake clinical examination, history-taking, differential diagnosis and develop treatment plans and become independent prescribers (Bain and Moggach, 2019).


Photograph: David Hughes/Shutterstock

The International Council of Nurses (ICN) describes ANPs as generalist or specialist nurses who have gained postgraduate qualifications at master's level, with an expert knowledge base to provide excellent clinical and complex decision-making skills (ICN, 2020). The Scottish Government's definition of ANPs is equivalent to the ICN (Strachan et al, 2022). However, many qualified district nurses are constrained by their job description, which was developed before the introduction of ANP roles (Queen's Nursing Institute [QNI], 2019). The Scottish Government (2023) is currently looking to review the roles of nurses and job descriptions which are under the Agenda for Change in recognition of skills and experience.

The ANP role is not yet recordable with the NMC, however district nursing is recordable on a nurse's PIN number. This can cause high attrition rates as GPs offer better paid positions to staff to work in ANP roles, as they have transferable skill sets, thus depleting one primary care team for another (Strachan et al, 2022). In their review of the literature, Cooper et al (2019) identified some differences between ANPs and clinical nurse specialists (CNS); all ANPs were paid at band 7, but CNS were wider ranging, 50% were band 7, 42% were band 6, and the remaining were paid other grades up to 8C.

It is also difficult for nurses to understand the advanced practitioner role when it is not recognised by the governing board (Anderson et al, 2020). In Ireland, the title of ANP is protected and is only used by nurses practising at an advanced level. This is regulated by the Nursing and Midwifery Board of Ireland (NMBI) (Thompson and McNamara, 2022). Anderson et al (2020) also stated that nurses could be dismissive towards ANPs. The weak professional identity of experienced ANPs has also exacerbated a lack of acceptability and understanding, which could lead to underutilisation and retention of staff (Anderson et al, 2020).

Thompson and McNamara (2022: 835) agreed that there is great confusion around the ANP role, even though it has become more widespread in the health service. They also suggest that without clarity of the role, the full potential of ANPs may not be realised, resulting in the underutilisation that Anderson et al (2020) expressed. Thompson and McNamara (2022) argued that ANPs found that their role was aligned with that of a traditional nurse, but also used as a bridge between medical and nursing domains. This is what constrained their practice, unless it received strong managerial support from implementation.

REMOTE AND RURAL NURSING

Nursing in remote and rural areas requires different knowledge and skills from other settings (McCullough et al, 2022). In Australia, nurses working in rural areas are called remote area nurses (RANs) and are identified as a specialist within this area of practice, providing a wide range of clinical skills and healthcare knowledge in professional and geographical isolation (McCullough et al, 2022). In Scotland, this same practice falls to the district and community nurses. McCullough et al (2022) identified that nursing practice in remote and rural practice has a component of GP substitution, utilising skills beyond the expected scope of nursing practice. This is also seen in the remote islands off Scotland where nurses are the only medical personnel on the island and regularly deal with general practice nursing and district nursing roles, as well as out of hours and urgent care (Strachan et al, 2022).

McCullough et al (2022) explain that RANs in Australia are working at the level of a nurse practitioner with associated qualifications, but this role is not clearly stated as an ANP due to lack of research in remote and rural nursing, and so they continue to practice as a RAN. The same could be said for district nurses working in remote and rural areas of the UK. The complexities of patients living in these areas are exacerbated by underfunded/under-resourced primary care systems, the spread of infrastructure geographically, and extended services provided by healthcare centres large distances away from patients' homes (Penz et al, 2019; Gillham et al, 2022).

Due to the unique knowledge base and skills practised by remote and rural nurses, this specialist role should be supported by specific training. This could be crucial for the determinates of health and health outcomes of rural populations and reduce the feeling of professional and geographical isolation (Penz et al, 2019).

Furthermore, living and working in remote and rural areas means that personal and professional boundaries are often blurred, which can lead to unrealistic expectations from communities. Gillham et al (2022) explained that most practitioners lived within the communities they worked. This allowed them to draw upon local knowledge and relationships to overcome some of the challenges in remote and rural practices. Whiteing et al (2021) stated that most nurses felt that they should meet the community's needs. However, Turner (2019) argued that when practising in isolation healthcare professionals needed to be more self-reliant, as meeting individual care needs had a direct impact on how stressful their practice was. Stanley and Stanley (2019) explained that working in remote and rural areas was less anonymous for practitioners because of the community links, such as friends and relatives. These reasons result in practitioners working beyond their scope of practice (McCullough et al 2022).

Due to providing care in remote areas, where healthcare resources are limited, practitioners may have to make difficult decisions outside of their scope of training to ensure timely and effective treatment — referred to as 'clinical courage' (Konkin et al, 2020; Brooks et al, 2023). This can cause stress or vicarious trauma to staff as the NMC (2015) 'Code of conduct' clearly says: 'recognise and work within the limits of your competence'. However, it also states: 'make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay' (NMC, 2015).

McKinless (2020) highlighted the risk of compassion fatigue and burnout in nurses who worked in the community due to the psychological demands of patient care over self-care. Adia (2023) reviewed community nurses who directly cared for patients with long-term progressive illnesses or palliative and end-of-life patients and found that they were more likely to suffer from compassion fatigue and burnout. Unfortunately, this is a large part of community nurses' workload. Furthermore, reduced job satisfaction is a direct result of stress, which, in turn, leads to retention issues (McKinless, 2020).

The change in the Scottish GP contract could have been a positive experience for all primary care services. The policy recognises the need to transform primary healthcare and not to shift workload from one speciality to another (Strachan et al, 2022). However, this has not been the case. Stewart et al (2022) explained that significant investment is needed to reduce GP workload. The plan, in theory, was to have multidisciplinary teams which included ANPs, allied health professionals (AHPs), link workers and mental health professionals who would be employed by the health board rather than individual practices (Stewart et al, 2022). The memorandum of understanding in 2021 acknowledged that shifting vaccinations from GPs to health boards failed, as vaccination teams were not in place by April 2021 as expected (Stewart et al, 2022). In the author's local area, vaccination pressures have been moved over to community nurses and the Scottish ambulance service to support one or two vaccination team nurses in a remote and rural area the size of Belgium. This has a direct impact on services ANPs can provide to patients if they are incorrectly utilised to replace a gap in service (Whiteing et al, 2021).

Reflective point

How can primary care services be shaped to be fit for purpose in remote and rural areas with the increasing demands of an ageing population?

Donaghy et al (20232) reviewed responses from stakeholder and quality leads regarding the progress of the new Scottish GP contact. Their findings were that the contract had been slow in implementation, leading to little or no reduction in GP workload and no improvement in patient care. Barriers to implementation have been identified as:
- Time scale
- Inadequate support from local boards
- The need for better workforce planning to enable the new Scottish GP contract to succeed

(Donaghy et al, 2023: 232).

McSwiggan et al (2023) also identified that when transforming primary care, projects improved with greater empowerment and engagement with local communities.

Adequate infrastructure, appropriate skills within the local area need to be developed and continually reviewed in order that transformation projects can be effective (McSwiggan et al, 2023). The Scottish Government and the British Medical Association (BMA) wrote a joint letter in 2020 highlighting that in remote and rural areas there had been no satisfactory options identified to move the services away from GPs and that separate arrangements and funding would need to continue (Scottish Government and BMA, 2020). From a three-year qualitative study, Munoz and Bradley (2021) found that community engagement in service changes can be difficult in rural communities, as patients or the local community can view change as the removal of valued services which support the identity of their community.

The role of ANPs based within the community is still developing, but while the new Scottish GP contract has changed pressures to reduce GP workload it has increased that of ANPs within the multidisciplinary team (MDT) (Strachan et al, 2022; De Leede-Brunsveld et al, 2023). The role is not clearly defined as there are numerous titles given, e.g. advanced district nurse practitioner or community matron. They are autonomous healthcare professionals who combine nursing care with advanced practice, which is delivered holistically to identify both patients' emotional and practical and medical needs (Gillham et al, 2021; Strachan et al, 2022; De Leede-Brunsveld et al, 2023). They often coordinate social networks within communities to support patient outcomes and improve community resilience (Gillham et al, 2021; Ready Scotland, 2024).

Indeed, McCullough et al (2022) and Rose et al (2023) identified that nurses working in remote and rural areas, especially those in advanced practice, should be considered, similar to GPs, as specialists/generalists. If this is so, should their roles also be protected or will the new GP contract lead to extra pressure on the current services, due to the slow implementation of the new MDT services by the health boards? (Donaghy et al, 2023).

Health boards have not currently managed to build and deliver MDTs to enhance and support general practice, as envisaged by the Scottish Government and the BMA (2020). There is no current research on the impact of the new Scottish GP contract on other primary care services, so no further deductions can be drawn until the change has been completed.

> **'... McCullough et al (2022) and Rose et al (2023) identified that nurses working in remote and rural areas, especially those in advanced practice, should be considered, similar to GPs, as specialists/generalists.'**

LIMITATIONS

The lack of research in remote and rural primary care, especially involving ANPs, makes it difficult to define the scope of practice and understand their impact on the rural communities they serve (McCullough et al, 2022). Furthermore, advanced practice and the new Scottish GP contract are still being implemented (Strachan et al, 2022).

CONCLUSIONS/ RECOMMENDATIONS

Remote and rural nursing should be seen as an advanced specialty. Research has shown that these nurses have a unique set of skills and qualifications to provide effective care in challenging environments, but their role is not acknowledged (McCullough et al, 2022).

The QNI (2015) wrote a report stating that the district nursing specialist qualification is critical to the role. The report aimed to demonstrate the value of the qualification and the author feels that the same needs to be done with the advanced practice qualification.

An independent review into the new Scottish GP contract would help to understand what needs to be addressed to improve the reorganisation of services, so that they can better serve their communities (McSwiggan, 2023). **JCN**

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Understanding the psychological education needs of lymphoedema healthcare professionals

Jayne Williams, Melanie Thomas, Ioan Humphreys

Lymphoedema is a progressive long-term condition that detrimentally affects many aspects of quality of life — physical, emotional, and social. The introduction of lymphoedema patient-reported outcome measures (PROMs) has supported patients to communicate the psychological impact, raising concerns such as anxiety, fear, low mood, and poor body image. However, some healthcare professionals report feeling ill-equipped to respond effectively to these needs. This study explored lymphoedema healthcare professionals (LHCP) psychological and emotional education needs. A Google Forms survey was developed based on literature and expert opinion and disseminated via email to all staff (120) within Lymphoedema Wales Clinical Network (LWCN). Data demonstrated statistically significant correlations between levels of perceived confidence, perceived skills to discuss psychological issues, and level of psychological training received ($p < 0.001$). However, nearly three-quarters of participants reported never receiving psychological training. This study represents the first step in understanding psychological education needs of LHCP and indicates future opportunities to potentially improve clinical practice in this area.

KEYWORDS:
■ Lymphoedema ■ Psychological need ■ Emotional need
■ Education ■ Training

Lymphoedema is a chronic condition affecting children, young people, and adults, through damage or failure of the lymphatic system, causing an excess gathering of lymph fluid within the tissues in the affected area (Mortimer, 2018). The prevalence of lymphoedema is reported to be four people in every 1,000 (Moffatt et al, 2017). Physically, lymphoedema presents as an area of swelling, and increases the risk of skin complications and wounds, mobility issues, falls, and cellulitis (Thomas et al, 2024). Furthermore, lymphoedema detrimentally affects wellbeing and quality of life (QoL) across all parts of daily living, including relationships, clothes and/or shoe shopping, hobbies and the ability to work (Bowman et al, 2020; Thomas et al, 2020; Gabe-Walters and Thomas, 2021).

Within the literature, reports of psychological distress, stigma, rejection, anxiety and depression have been associated with cancer-related lymphoedema (Fu and Kang, 2013; Taghian et al, 2014). Fear of disease progression or recurrence in the future has been discussed as well as social event avoidance, low self-esteem and issues with intimacy and desirability (Thomas et al, 2020). Interestingly, cancer-related lymphoedema distress appears to be more impactful than primary lymphoedema (Río-González et al, 2021); although the majority of research is factored around cancer-related lymphoedema impact, leading to gaps in the literature with regard to primary lymphoedema.

Established in 2011, Lymphoedema Wales Clinical Network (LWCN) provides a value-based service to those living with lymphoedema across Wales (Thomas and Morgan, 2017). Patient reported information has been gathered to understand the impact of living with lymphoedema and, since 2020, has been more formally collected using the lymphoedema patient-reported outcome measure (LYMPROM©) (Gabe-Walters and Thomas, 2021). LYMPROM has supported patients to communicate the impact of their condition to lymphoedema healthcare professionals (LHCP) to inform their care priorities and establish the true holistic severity of the effect on their lives.

> **‘LYMPROM has supported patients to communicate the impact of their condition to lymphoedema healthcare professionals (LHCP) to inform their care priorities and establish the true holistic severity of the effect on their lives.’**

Jayne Williams, national lymphoedema consultant psychologist; Melanie Thomas, clinical director, both at Lymphoedema Wales Clinical Network; Ioan Humphreys, senior researcher, Health and Wellbeing Academy, School of Health and Social Care, Faculty of Medicine, Health and Life Sciences, Swansea University

This information has led to an understanding that caring for patients with a diagnosis of lymphoedema involves more than just treating the physical components of the condition. However, HCP in similar situations often report feeling ill-equipped with the appropriate counselling skills required to effectively respond to patients' psychosocial needs (Reiss and Sandborn, 2015). Attempts to support staff navigating compassionate conversations for those patients scoring a high emotional impact on the LYMPROM have been *ad hoc* and not executed in a structured and reproducible manner.

From further evaluation of LYMPROM data by the authors, it was clear that the psychosocial impact of lymphoedema was largely neglected in the LWCN. This led to the LWCN applying for additional funding to employ two national lymphoedema psychologists and develop a dedicated psychological service for lymphoedema patients. However, there remains no published guidelines for incorporating psychosocial care into routine clinical practice in lymphoedema, and there are no studies directly exploring LHCP's psychological and emotional education needs in this area.

Therefore, the authors undertook a survey to identify the self-reported educational needs of LHCP in relation to addressing emotional and psychological aspects of lymphoedema care with patients to inform the psychological service development.

The survey included three fundamental questions:

1. What psychological and emotional issues do people with lymphoedema currently report or present to LHCP?
2. How confident and skilled do LHCP feel in discussing, exploring and supporting these psychological and emotional issues?
3. What, if any, are LHCP's education needs to support people with lymphoedema emotionally and psychologically?

METHOD

The survey was designed based on the current literature, LYMPROM analysis, discussions with lymphoedema experts within the national team, and the first author's own psychological expertise. A survey was chosen as the best method for dissemination, recognising time restraints, as it was efficient and effective in engagement and accessibility to inform promptly the early development plans of the new lymphoedema psychology service.

Survey content

The survey had 16 questions covering demographics, perceived current skills, confidence and competence, the level of psychological and emotional issues observed in practice, and the education requirements considered beneficial for service delivery. The survey contained closed and open style questions and utilised Likert scales.

Survey dissemination

The survey was created in Google Forms and was disseminated from May 2023 and kept open for 15 weeks. The link for the survey was shared via email to 120 colleagues employed by LWCN in NHS Wales, regardless of role. The email link included detail on how the data was going to be used, explained it was entirely voluntary to participate, and that all data was analysed anonymously. A reminder email was sent monthly after the initial contact. All data collection was completed by the first author.

Inclusion and exclusion criteria

Inclusion criteria included healthcare professionals working in LWCN. Exclusion criteria were colleagues who did not have direct clinical contact with people with lymphoedema, e.g. administrative colleagues.

Ethical approval

The study was reviewed using the Health Research Authority (HRA) decision tool and did not require NHS Research Ethics Committees (REC) review. Nonetheless, this service evaluation ensured appropriate ethical treatment of all participants and is published as part of an overarching approved policy on 'Evaluations of Value-Based Healthcare in Lymphoedema Wales Clinical Network' from the local research and development department of Swansea Bay University Health Board.

Data analysis

Pearson correlations and means were calculated using IBM SPSS Statistics for Windows (version 26) and a p-value <0.05 was considered statistically significant. Open text data were analysed using a thematic framework approach by the authors.

RESULTS

The survey had 85 responses, providing a 71% response rate.

Table 1: Mean frequency scores of psychological and emotional issues encountered by LHCP

Presentation	N	Mean frequency (max=5)
Trouble with clothing	74	4.34
Pain and discomfort	74	4.07
Difficulty sticking to their plan of care	74	3.89
Low mood	74	3.31
Identity/body image concerns	74	3.72
Frustration	74	3.70
Eating issues (too much or too little)	74	3.64
High anxiety/panic	74	3.51
Loss of meaningful activity, e.g. job/hobbies	74	3.51
Fear (of progression of condition or return of physical issues, e.g. cancer)	74	3.38
Sleeping issues	74	3.22
Withdrawal/isolation due to condition	74	3.19
Healthcare professionals needing to support family members with their concerns about the client	74	2.99
Grief/loss (for person or life they had)	74	2.88
Body dysmorphia (where perception of their body differs significantly from objective)	74	2.82
Intimacy/relationship concerns	74	2.39
Previous or current life trauma, e.g. abuse	74	2.15
Stigma/bullying	74	2.12
Obsessions and compulsions, e.g. checking over and over	74	1.97

Table 2: Level of psychological training received previously

Level of psychological training	N	%
I have never received any psychology related training	53	72%
I have been trained in a few psychological techniques	13	17%
I have been trained in a specific therapy (e.g. cognitive behavioural therapy [CBT])	3	4%
I have completed lots of therapy training	2	3%
I have a qualification in counselling, therapy, or psychology	3	4%

Of the 85 responses, 87% (74) were clinical posts and 13% (11) were excluded, as they were administrators or project staff without direct clinical contact. Of the 74 clinical posts, 53% (39) were registered nurses, 26% (19) were healthcare assistants, 15% (11) were physiotherapists, and 7% (7) were other clinical professions or not stated. All health boards in Wales were represented in the responses.

Types of psychological or emotional issues identified

All 74 clinical LHCP were asked to identify how frequently patients presented with certain psychological concerns in their everyday clinical practice. For each psychological concern, they were asked to rate the frequency they saw its presentation, from one to five, with one being never, and five being all the time.

As can be seen in *Table 1*, the five most frequent concerns LHCP reported patients presenting with are:

- Trouble finding clothes and shoes
- Pain and discomfort
- Difficulty in sticking to a plan of care
- Low mood
- Identity and body image concerns.

None of the psychological concerns were rated as unseen. All but four of the categories had a mean reported frequency above the mid-point of 2.5, suggesting that the psychological impact of lymphoedema is wide-ranging and frequent overall.

The least frequently presented issues with a mean under 2.5 were intimacy and relationship concerns, previous or current life trauma, stigma or bullying and obsessions and compulsions.

LHCP perceived psychological knowledge and experience

Over 70% of respondents had never worked alongside a psychologist before. Twenty-eight percent (21) of the LHCP had worked with a psychologist previously during their career, although half of these only briefly. The same 28% (21) had received some training around using psychological techniques in their work, with the majority of these having been trained in only a few brief techniques (18%, n=13). Only eight participants (11%) had received more substantial training in this area (see *Table 2*).

LHCP perceived levels of confidence and skill in discussing psychological and emotional issues with patients

LHCP were asked to rate their confidence in discussing psychological and emotional issues with their lymphoedema patients on a scale of one to five, with one being not at all confident, and five being extremely confident. The majority rated themselves as scale three — neutral (37%, n=27), with 39% (n=29) rating themselves one and two, i.e. feeling lower in confidence.

Overall, LHCP rating of their perceived skills in discussing psychological issues raised by the LYMPROM was slightly lower, with 47% (n=35) scoring either one or two out of five (*Figure 1*). Scores were rated on a 5-point Likert scale, with one being not at all skilled and five being extremely skilled.

Relationships between previous level of training and perceived skills and confidence

A Pearson correlation coefficient (r) was performed to evaluate the relationships between perceived confidence in discussing emotional issues and perceived skills when discussing emotional issues on the LYMPROM. There was a significant high positive correlation between

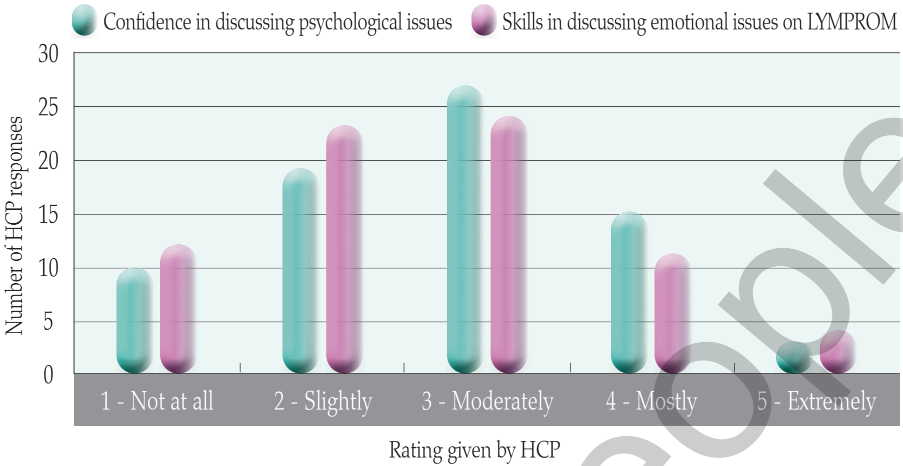

Figure 1.
Perceived confidence and skills of LHCP in discussing psychological and emotional issues.

participants perceived confidence and perceived skills (r [72]=.748; p=<.001).

When looking at the relationship between perceived skills and confidence in these areas and the level of psychological training previously received, further significant positive correlations were noted, showing more confidence and skills with more training received (*Table 3*).

LHCP were also asked how they currently manage discussions related to the emotional and psychological impact of lymphoedema. Three percent stated that they avoid it and never ask; 24% reported that they feel okay if the person brings it up and it is not that serious; 37% stated that they would ask and then discuss if it was not that serious; and finally, 37% reported that they are happy to ask and discuss a range of severity issues.

LHCP psychological and emotional education needs

All LHCP reported psychological and support education needs. *Table 4* highlights the mean value of benefits reported on a Likert scale from one to five. The majority (93%) wanted consultations with psychology and a suite of colleague training on psychological techniques they could use in their work. Ninety-two percent wanted resource development, including leaflets and videos which they could share, and felt that patients would also benefit from individual consultations with a psychologist. The lowest scoring element was reflective practice with colleagues (72%).

On a free text question, LHCP stated which specific education topics they felt would support their management with lymphoedema patients (*Table 5*). Key areas identified were:

- Weight management
- Motivational interviewing
- Supporting people to engage more with self-management/compliance with treatment planning.

> **'With busy clinics and patients not always seeing the same LHCP, it seems likely that some psychological issues may not be discussed or recognised.'**

The lowest scoring topics, at one each, included domestic abuse support, loneliness, and mindfulness.

DISCUSSION

This is the first evaluation examining the psychological and emotional needs of LHCP identifying how they can be best supported and trained to address the clear emotional and psychological impact of living with lymphoedema.

Considering the three initial questions, the responses suggest that a wide range of emotional and psychological issues are frequently encountered within lymphoedema services by LHCP. Interestingly, the most common psychological and emotional concerns reported are those that appear in the LYMPROM tool, such as shopping for clothes and shoes, low mood, and pain/discomfort (Gabe-Walters and Thomas, 2021). These items are also more likely to be commonly encountered in a more physical health focused consultation. The least encountered psychological issues may well be present, but may not be identified by LHCP, or may not be raised by patients. For example, previous trauma or current relationship issues would require a trusting relationship to disclose, and psychological skills to identify a presentation as such. With busy clinics and patients not always seeing the same LHCP, it seems likely that some psychological issues may not be discussed or recognised. Potentially, this could have a negative impact on the quality of support and care received by the patient.

There is a wide variation in the levels of perceived skills and knowledge, and levels of experience and training in psychological areas of care. Clearly, there is a strong need for a more comprehensive education and support pathway for LHCP if they are expected to adopt a more holistic approach to lymphoedema care and to encourage self-management. Even those who

Table 3: Relationships between levels of perceived confidence, perceived skill and level of psychological training received

	N	Mean frequency
How confident do you feel currently discussing psychological and emotional issues with patients?	Pearson correlation	0.513
	Sig(2-tailed)	<0.001
	N	74
How skilled do you feel in discussing high emotional scores on the LYMPROM with patients, e.g. anxiety, intimacy issues?	Pearson correlation	0.467
	Sig(2-tailed)	<0.001
	N	74

Table 4: Education and support needs seen of benefit by LHCP

Education or support required	N	Mean value of benefit (rated 1–5)	% of responses rated 4 or 5
Colleague training — a suite of training for colleagues covering psychological techniques to use in everyday work, e.g. active listening, motivational interviewing skills	74	4.66	93%
Individual therapy	74	4.66	92%
Consultations	74	4.65	93%
Resource development — where leaflets and videos are produced to share with patients around a range of psychological needs	74	4.64	92%
Psychoeducational groups — where group programmes are developed for clients around specific topics including psychological elements, e.g. weight management	74	4.42	87%
Group therapy	74	4.22	77%
Reflective practice — where a local team of colleagues has a set time to meet as a group and reflect on their work, its impact and learn together	74	4.01	72%

had some previous knowledge or higher level of skill and confidence had significant educational needs in supporting patients.

The clear correlation between training, skills and confidence suggests that a package of training and support will increase perceived skills and confidence in both asking and then feeling able to address conversations about the psychological impact of lymphoedema. It is essential, however, that if LHCP are to widen their remit to emotional issues alongside physical ones, that they have the time and psychological support to do this safely. Vitally, they need to know where to signpost and seek additional advice for more complex identified needs.

Reflective points

- How many people do you see in your work who have lymphoedema?
- Do you consider the emotional and psychological needs of people with lymphoedema?
- Do you feel that you have the necessary skills to provide emotional and psychological support to people with lymphoedema?
- What resources and/or training could you seek to improve your practice?
- How can you signpost the emotional needs of people with lymphoedema?

Being more supported and skilled to address these needs may reduce LHCP feelings of frustration when patients are unable to adhere to treatment plans, or helplessness when they are not able to support this aspect of care. This common occurrence may suggest that LHCP are more vulnerable to experiencing burn out, emotional fatigue, and frustrations at their inability to support patients with their greatest needs (McGrath et al, 2024).

Respondents reported that they felt the psychological interventions listed in *Table 4* would be highly beneficial, suggesting a clear wish for more expertise. It is crucial therefore to provide some form of educational support to:

- Maintain wellbeing of LHCP
- Improve patient care and experience
- Support the sustainability of lymphoedema services.

If skills in helping people increase motivation for self-care are shared among LHCP, this may also have a significant positive impact on clinical physical outcomes for patients, such as limb volume and pain.

Highest scoring educational topics identified for training were again related to barriers to the physical care being provided, e.g. support with motivation, weight and not adhering to planned treatments. Again, this could be an indication of lack of knowledge about what may be helpful given lack of access to psychological knowledge and expertise.

Interestingly, reflective practice, where teams have protected confidential time to support one another, was the lowest scoring need at 72%. However, given the low numbers of people who had experienced psychological work previously, this may be attributable to other reasons, such as lack of understanding or anxiety about what reflective practice entails, a lack of clarity about how it would benefit, or a feeling that LHCP do not have the time capacity for this.

Although the authors focused on the responses of clinical LHCP in this study, 11 administrators also responded and they too stated that they encountered psychological issues with patients, especially if they were dealing with people on the telephone as they are the first line of contact. Thus, they may also need specific training to support signposting and alleviate patient distress, their own wellbeing and avoidable complaints.

Table 5: Specific psychological and motivational education needs requested

Topic	N
Supporting weight management	16
Motivational interviewing	15
Everything	13
Unsure	12
Non-compliance support	12
Dealing with PROMs	9
Body image	8
CBT	6
Supporting staff	6
Reflection sessions for local teams	6
Language used in conversations	5
Coping strategies	4
Active listening	3
Signposting	2
Domestic abuse support	1
Mindfulness	1
Tackling loneliness	1

Clearly, a training package for LHCP is not only indicated for high scoring topics, but also less physically linked areas so that identification of more 'hidden' concerns, such as relationship issues, are more easily recognised. In the authors' clinical opinion, increased training should raise skills and confidence and, more importantly, lead to a more holistic care experience for patients.

LIMITATIONS

Any survey to a specific nation is limited in its ability to make generalisations due to the differences in service delivery. However, 74 LHCP of differing disciplines is a good start in this investigation. Additionally, as this was an initial scoping intended to inform service development, there are likely to be areas of the questionnaire that could have been expanded. For example, age, sex, or numbers of years practicing as a LHCP were not captured, which might have provided improved demographical information, i.e. do more experienced practitioners feel more confident in this area, are younger people more comfortable with emotional conversations?

Future work could distribute the survey across the United Kingdom to make more generalisable interpretations. Although the authors completed a general literature search focused on LHCP educational needs, a forward citation which may have yielded further papers was not completed.

CONCLUSION

This study is the first of its kind and represents an initial step in understanding the psychological education needs of LHCP. It indicates future opportunities for potentially improving clinical practice through psychological training and support, to promote holistic care for people living with this chronic condition. Improving education may therefore foster a shift in focus, by enabling LHCP to spend more time with patients discussing and addressing psychological issues to improve holistic patient care and experience.

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Conflict of interest

The authors declare no conflict of interest and no funding was received for this study.

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KEY POINTS

- Lymphoedema is a progressive long-term condition that detrimentally affects many aspects of quality of life — physical, emotional, and social.
- In this evaluation, lymphoedema healthcare professionals (LHCP) commonly report seeing lymphoedema patients suffering impact with purchasing shoes and clothes, low mood, pain and discomfort, eating issues, frustration, difficulty in following self-management, and identity/body image issues.
- Nearly three-quarters of LHCP reported that they had not received any psychological training in their career.
- Just over a third of LHCP were happy to ask and discuss a range of psychological and emotional issues with their lymphoedema patients.
- Increased levels of psychological training correlate with increased confidence and perceived skills in discussing the emotional impact with people with lymphoedema.

Basic guide to understanding compression therapy

Julie Stanton, Aaron Knowles

Suboptimal management of leg ulcers is a growing burden on NHS nursing and financial resources (Guest et al, 2015; 2017; 2020). Compression therapy plays a crucial role in leg ulcer management by improving outcomes and reducing the burden of disease, however it is not routinely applied in practice and knowledge and confidence between bandage types and application styles often varies greatly (Guest et al, 2017; Hopkins, 2023). This article focuses on the importance of compression therapy in the management of leg ulceration and how to select the appropriate compression therapy based on the patient's presenting symptoms. It identifies possible barriers to application and offers potential strategies and suggestions to support the use of compression options in the community.

KEYWORDS:
■ Compression therapy ■ Leg ulceration ■ Barriers to application
■ How to select compression therapy

The growing incidence and cost of chronic wound management to the National Health Service (NHS) is widely acknowledged in the literature (Guest et al, 2017). Gray (2013) reported an annual prevalence of 100,000 new wounds within the United Kingdom (UK); and it has been estimated that incidence will reach 148,000 by 2025, with venous leg ulcers (VLU) alone annually costing the NHS £2 billion (Phillips et al, 2020). Guest et al (2020) approximated that new wound incidence already exceeded 174,500 by 2018, suggesting that demands on NHS wound care services were accelerating.

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The costs of treating unhealed ulcers are 4.5 times higher than those which are healed. The estimated annual cost of an unhealed venous leg ulcer is £5673 (NHS England, 2017). The 'Making Legs Matter' campaign stated that 'vast amounts of money is spent trying to tackle the problem of leg ulceration, but it is clear that NHS financial resources are not being spent efficiently, for maximum gain, in this specific area' (Atkin et al, 2021).

WHY IS COMPRESSION IMPORTANT

Compression therapy is the most important part of leg ulcer management, as it provides valuable support in the treatment of vascular and inflammatory lower leg skin disorders (Romanelli et al, 2023), which promotes healing (Barnes, 2023). Venous and/or lymphatic insufficiency, or otherwise identified chronic oedema, can be effectively treated with compression therapy. Franks et al (2016) state that:

> *Compression therapy is based on the simple concept of applying an external pressure to the limb, which is able to improve venous haemodynamics, control oedema, reduce inflammatory mediators, improve microcirculation, improve arterial inflow, and improve the lymphatic drainage.*

This is achieved by the components of the compression therapy system forming a semi-rigid sleeve around the lower leg (Harding et al, 2015).

BARRIERS TO APPLICATION

Barriers can relate to patient, clinician and organisational factors. Patient concordance with compression therapy can be affected by education, pain/discomfort, physical limitations, and psychosocial issues (Hopkins and Worboys, 2005; Moffatt et al, 2009; Barnes, 2023) (*Table 1*).

A commonly held perception is that compression therapy is always uncomfortable or painful, which can discourage clinicians from attempting it, or subconsciously setting an expectation for patients that it will be intolerable, especially for those with painful ulceration (Patton et al, 2024). This fear of causing injury to the patient is often misplaced, stemming from a lack of understanding as to how compression therapy interacts with underlying tissues. Indeed, if applied correctly, compression often relieves pain associated with venous or lymphatic disease, as the excess fluid which causes stress and overstretching of tissues is dispersed (Patton et al, 2024). Likewise, patients often report reduced numbness and improved range of motion once their limb is decongested (Bishop and White, 2017).

There are also common organisational and financial restrictions, such as limited compression formulary options, and lack of organised support to deliver effective care and/or education on new compression garment styles (Annells et al, 2008; Chamanga, 2014; Bishop and White, 2017). Clinicians may not have had the opportunity to reach the level of professional competency needed to correctly apply compression bandaging, particularly where resources for training are limited (Bishop and White, 2017). *Table 2* outlines some further barriers to effective care.

Hopkins et al (2018) state that:

> *Fear of blame attached to causing unintentional harm may mean that nurses do not always have the courage to compress. Paradoxically, failing to apply optimum levels of compression for that individual does, in itself, cause harm.*

Therefore, healthcare professionals should ensure that they are competent and confident to apply compression therapy for venous/lymphatic leg ulceration. In the authors' clinical experience, a key example of this is taking a patient that is being treated and is tolerating the compression therapy out of compression garments/bandaging when it is noticed that their last ankle brachial pressure index (ABPI) measurement has just exceeded one year and needs updating. While the patient should certainly have an ABPI measurement taken, if there is no pain, discomfort or signs of injury, their maintenance compression preventing chronic oedema should not be stopped as this might otherwise cause rebound oedema with potential ulceration and/or cellulitis (Moffatt et al, 2012).

Table 1: Patient barriers to compression therapy

Physical/psychosocial factors	Potential solutions
Limited strength or dexterity	Alternative options such as compression wrap systems Social care provision (carers/attendance allowance) and education of caregivers Consider the provision of the materials and textiles in line with their strength and dexterity Provision of aids to assist hosiery application, such as parachute material to aid pulling garments over the heel to more robust frame aids, which stretch the garments open and have long handles to help patients manoeuvre the sock into place without needing to reach their feet
Issues with mobility	Selection should be based on clinical need based on mobility issues — take into account dependency issues, the degree of movement and any restrictions to movement Consider physiotherapy, gait analysis and individualised tailored exercise programmes (Legs Matters, 2024) Similarly, some patients may find it easier to put their garment on depending where they seat themselves, be it on the bed with the leg extended, on a reclining chair with the leg partially raised, or on a normal chair at a height that is best for them, particularly if they are otherwise relatively short or tall
Pain	Liaise with GP to provide appropriate analgesia Provide education and ensure selection of the most comfortable type of compression therapy for the patient's presenting symptoms Consider walking and resting pressures (inelastic compression)
Anxiety/depression/ social isolation/ non-concordance	Recognising and addressing the issues and developing strategies with the provision of education, advice and social support Empower the patient with motivational interviewing skills (Morris and White, 2007) Provide continuity of care and education and support (Stanton et al, 2016) Give patients options between garment styles, fabrics and types where possible — involving them in their management choice may improve concordance

Table 2: Clinician barriers to compression therapy

Organisational barriers	Potential solutions
Lack of education and training	Accessing online training courses Accessing industry partners' training courses and advice and support Where available, arranging shadowing opportunities with local specialist services
Formulary limitations/ lack of range of products	Check your local compression hosiery formulary, there should be a range of products available which include non-elastic and elastic compression, or 'stiff' and 'stretchy' compression options in both bandages, wraps systems, and both flat- and circular-knit hosiery
Fear of harm	Competency assessment by competent mentors Development of relevant guidelines, protocols and simple pathways Development of ankle brachial pressure index (ABPI) measurement and assessment clinics Reviewing understanding of compression therapy aims and underlying pathologies
Lack of understanding of compression therapy and selection	Development of patient-centred compression therapy pathways and patient education leaflets and supported self-care initiatives
Organisational/financial barriers	Develop time-saving pathways and encourage the selection of easy to use wrap systems, optimising the selection of the compression therapy Business cases to prove efficiency savings (Dowsett and Taylor, 2018; Atkin et al, 2021)

While ABPI measurement remains the gold standard tool for assessing if there is sufficient vascular flow for compression to the legs, its completion is often delayed due to available competent nurses, lack of equipment, or poorly recorded or absent notes in patient records. There is growing discussion about the overreliance on the final figure and that the absolute systolic pressure should also be considered when deciding on compression level (Vowden et al, 2020). This is particularly important in patients with hyper- or hypotension, where abnormal brachial pressure might lead to inaccurate ABPI results. In these cases, a more holistic approach, including using audible Doppler sounds, assessing waveforms, evaluating toe reperfusion and temperature, and considering the patient's medical history and pain

Table 3: Strengths of compression therapy (Wounds UK, 2019)

Strength	Pressure
Mild	<20 mmHg
Moderate	20–40 mmHg
Strong	40–60 mmHg
Very strong	>60 mmHg

reports should be taken to make informed decisions about the required compression level.

Ultimately, ABPI should form just part of vascular assessment of the patient's limb that needs compression, particularly when 46% of clinical specialists managing chronic oedema consider accuracy of ABPI in the presence of oedema to be altered (British Lymphology Society [BLS], 2018). In 2018, the BLS released a simple checklist to support clinical decision-making when assessing if a patient's limb is suitable for compression for cases where undertaking ABPI measurement is not possible or is suspected to be inaccurate. It supports consideration of likely perfusion status through clinical signs, such as colour, temperature, palpable pulses and capillary refill, alongside common arterial-related reported signs from the patient, such as night or rest pain. If still unsure but the patient needs compression, or is likely to deteriorate, the Welsh chronic oedema wet leg pathway goes into more detail compiling expert consensus statements to support use of up to moderate compression, and provides a guide of padding and bandaging materials to achieve this in community settings with basic dressings (Thomas et al, 2022).

UNDERSTANDING DIFFERENT TYPES OF COMPRESSION THERAPY

Compression therapy is delivered at different levels of strength, also referred to as dosage (*Table 3*).

In practice, the leg is a dynamic system, and the actual strength of compression at a given time, known as the 'interface pressure', varies depending on the patient's activity and position (lying or standing). The pressure will change whenever the shape of the leg changes with contractions of the muscle when exercising or walking (working pressure) (Partsch and Mortimer, 2015).

A compression system's ability to resist calf muscle expansion is known as its dynamic stiffness index (DSI). The resistance to stretch is known as the working pressure; this pressure dynamic produces the 'micro massage' effect to stimulate a positive impact on lymphatic, venous and arterial circulation (Partsch and Mortimer, 2015; Bjork and Hettrick, 2019; Wounds UK, 2019). The interface pressure can also be affected by a variety of clinician and patient variables, which is why accurate assessment is essential (*Table 4*).

There are a several different compression systems available, and choice should be matched to the following individual patient factors:

- Activity levels and mobility
- Ankle circumference
- Dexterity
- Disease pathology (presence of arterial disease)
- Lifestyle
- Skin texture (hard or soft)
- Wound size, duration and complexity

(Fletcher et al, 2013; Bjork and Hettrick, 2019; Vowden et al, 2020).

Compression systems need to achieve several goals (Harding et al, 2015; Vowden et al, 2020), as shown in *Table 5*.

In general, strong compression (>40mmHg) is recommended for the treatment of leg ulcers (O'Meara et al, 2012; Vowden et al, 2020). Stiffer systems with higher working pressures are better at promoting healing in wounds with lymphatic disease present — a predominant presentation with patients with chronic venous insufficiency (CVI) (McGuire et al, 2022).

Working pressures are important when selecting compression type, which is calculated as a static stiffness index (SSI). An elastic system will be yielding and give way when standing or walking, with a narrow dynamic profile and relatively modest difference between resting and working pressures. Likewise, these systems stretch and contract with limb changes, but always try to return to their unstretched state, increasing resting pressure while reducing working pressure. These dynamics make elastic systems particularly suitable for immobile patients with elevated limbs that need some supportive bandaging, but less effective for patients with limbs dependent for long periods or those who are very active (Harding et al, 2015).

Conversely, a stiff system will have a broad dynamic profile, with a relatively high difference between resting and working pressures as the fabric resists further stretching. Likewise, when at rest, the fabric does not continue to retract which reduces resting pressure and may improve comfort at rest as a result. These properties make stiff systems particularly beneficial for highly active patients who get more of a massaging effect than less active people, or those with predominantly dependent limbs as the fabric resists

Table 4: Clinician and patient variables affecting interface pressure (Mortimer and Browse, 2003; Schuren et al, 2011; Mauck et al, 2014; Wounds UK, 2019)

Clinician variables	Patient variables
Poor bandaging techniques (incorrect padding, inconsistent tension and/or overlap, too light tension when using short-stretch materials)	Limb circumference and shape distortion
Inappropriate knowledge (compression classes, application and types)	Soft tissue covering of the leg or vulnerable areas (bony prominences)
Lack of training and education	Type and texture of oedema
Fear of causing harm	Underlying pathology
Lack of assessment of patient abilities, such as movement and exercise	Activity level of the patient

Table 5: Ideal compression system (Vowden et al, 2020)

- Adapts to cope with limb distortion
- Allows patient to wear appropriate clothing and footwear
- Avoids causing allergic reactions (non-sensitising)
- Delivers sufficient active pressure for standing and walking
- Delivers tolerably low resting pressure
- Encourages safe, accurate and consistent application
- Enhances calf muscle function
- Lasts for up to seven days
- Stays in place until next application
- Permits patient to mobilise

additional swelling. Stiff systems are not indicated for very sedentary patients with elevated limbs, as they have little resting pressure to provide therapeutic benefit (Vowden et al, 2020; *Figure 1*).

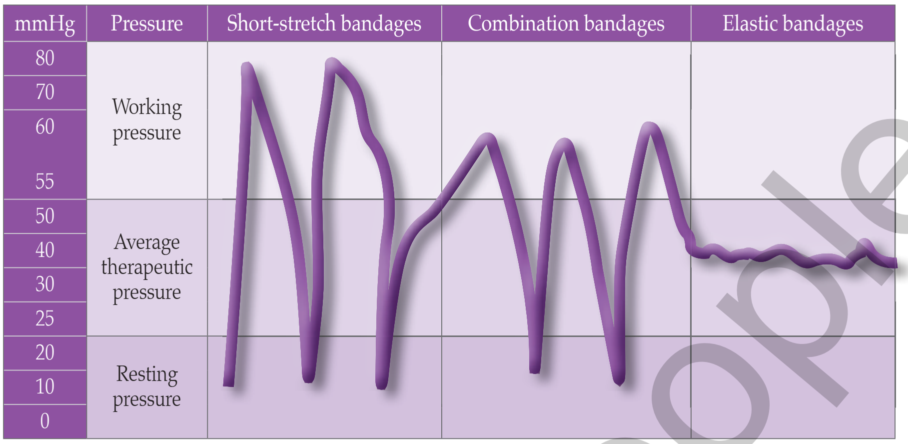

Figure 1.
Therapeutic pressures of compression bandages (adapted from Vowden et al, 2020).

Compression therapy can be applied with a variety of systems, including both dynamic pneumatic pumps and static systems, such as bandages, hosiery and adjustable wraps, all of which have different advantages, disadvantages and dynamic profiles (*Table 6*).

The chosen system should provide the ideal interface pressure on the affected leg, as well as comfort and tolerability for continued adherence. Its ability to achieve these goals will be determined by the features in *Table 7*.

SELF-CARE INITIATIVES

Many self-care initiatives were set up during the Covid-19 pandemic

Table 6: Advantages and disadvantages of dynamic profiles (Vowden et al, 2020)

Type	Advantages	Disadvantages	Dynamic profile
Short-stretch bandages	High working pressure Low resting pressure Create a semi-rigid compression system providing resistance to tissue movement, enabling pressure variations within the tissues, thereby promoting lymphatic and venous function (Mosti et al, 2015) Does not dig into any skin folds or creases as relatively inelastic A single short stretch at 100% stretch with sufficient padding provides very light compression, less than a 20mmHg kit, but is often seen as moderate or strong compression	Low resting pressure (higher pressure requires movement) Loss of pressure over time Often applied too loose, reducing efficacy	Stiff — better at containing oedema/resisting dependency oedema
Multilayer bandage kits	Consistent working pressure Suitable for less mobile or immobile patients Greater combined stiffness provided by use of elastic bandages in 2–4 layers rather than individually	Loss of pressure over time Inability to reach higher peak pressure Potential discomfort due to consistent pressure Over-reliance of kit systems may deskill or reduce understanding of compression dynamics	Individually elastic; stiff in multiple layers
Combination elastic/ inelastic bandages	High working pressure Suitable for less mobile patients	Lower working pressure than full inelastic short-stretch bandages	Stiff
Two-layer hosiery kits	Ability to reapply to achieve consistent pressure Suitable for self-management Reduction in nursing time	Removability Loss of pressure with improper application Loss of compression dosage due to fabric fatigue	Relatively elastic
Adjustable wraps	Suitable for self-management Reduction in nursing time Reduced competency required, often these systems are short stretch and will 'lock out' preventing excess compression Ability to reapply to achieve consistent pressure — create a semi-rigid compression system providing resistance to tissue movement, promoting lymphatic and venous function (Mosti et al, 2015)	Removability Loss of compression dosage due to fabric fatigue Prone to wear, reduced adhesion of Velcro if poorly cared for	Stiff

Table 7: Features of compression therapy

Feature	Considerations
Compression strength	The strongest therapy tolerated needs to be implemented wherever possible. In some cases, start at a low strength to gain confidence and trust, but quickly build up to full strength (Hopkins, 2023). Consider the patient — it is best to start directly with level of compression required so as to reduce moving therapeutic goalposts with them. Confidence and explaining your chosen system with the patient often goes a long way to improve their confidence and compliance
Consistency of pressure over time	How often can you see the patients or can they be seen? Determine the type of oedema, is it soft or hard? Softer oedema will need compression reapplied more frequently. Consider self-care initiatives or the use of wrap systems if the patient can reapply (Wounds UK, 2023). If a limb is needing active reduction, they will require twice weekly appointments as a minimum, as any effective bandaging will cause slippage as the limb reduces if it is too long between visits
Durability	Consider how long the patient will require compression therapy. This will depend on the size of the wound and any comorbidities (if the therapy is considered longer term, use of wrap systems may be more cost-effective, especially if self-caring) (Lee and Lawrence, 2017; Williams, 2017; Ehmann and Bock, 2018) If there is oedema present post healing, flat-knit hosiery lasts longer than circular-knit and is more effective at containment (Bjork and Hettrick, 2019)
Dynamic profile (stiffness or elasticity or stiffness)	Stiffness is valuable when standing or walking, as the higher working pressure can compensate for increased pressure on the vessels known as the hydrostatic load. It is also valuable during rest, especially bed rest, as a lower resting pressure is more comfortable and thus better tolerated (Bjork and Hettrick, 2019; Partsch and Mortimer, 2015; Vowden et al, 2020). It is also better suited for containment, as the fabric resists being stretched, preventing oedema from coming back into the limb (Bjork and Hettrick, 2019; Partsch and Mortimer, 2015) Elastic bandage systems provide higher working pressures. Therefore, they are better suited to patients with reduced or no mobility, although they are not appropriate for patients with excessive time spent with limbs dependent/down on the floor, as will stretch with the gravity-related oedema
Ease of application	Can the patients apply themselves? Consider dexterity, comprehension and understanding. Choose the textile to match patient ability
Slippage	Compression systems, including bandages, can lose their pressure over 24 hours following application (Green, 2007). Therefore, reapplication needs to be considered when producing treatment plans and choosing compression. Combination short-stretch and comfort layer bandage kits or wrap systems can be useful to stop slippage
System type	Is the patient suited to the systems recommended, can they be given a choice? For example, short-stretch bandages, elastic bandages, two-layer hosiery kits, or wrap systems. Flat- or circular-knit hosiery for prevention

which encourage patients to manage aspects of their condition independently where appropriate (Legs Matter, 2020). A study showed that 50% of all new patients assessed in a community with wounds were eligible for a self-care pathway, which ultimately released nursing time (Kapp and Santa Maria, 2020). Self-care has the potential to release nursing time, reduce costs and contributes to sustainability of healthcare systems.

However, self-care needs to maintain pressure and comfort, and so it relies on clinicians delivering effective patient education on how to apply compression correctly and when to seek professional assistance (Stanton et al, 2016; McDonald et al, 2020; Dowsett, 2021). Therefore, it is important to assess whether your patient is suitable for self-care — there are useful resources available to assist clinicians (Wounds UK, 2023).

COMPRESSION BASED ON OEDEMA PRESENTATION

Those treating patients with leg ulcers need to consider not only the strength level, but also the stiffness or elasticity of a system's dynamic profile and how this affects the venous and lymphatic systems. This understanding can be used to select the most appropriate compression system for patient needs.

In Western countries, lymphovenous disease is the most commonly diagnosed form of lymphoedema — a secondary lymphoedema that develops in patients with CVI, as a symptom of both lymphatic and venous insufficiency (Farrow, 2010; Ellis, 2015). Moffatt et al (2019) identified the misdiagnosis of chronic oedema as a global crisis, given its contribution to impaired wound healing, and demonstrated how simple tools such as the Stemmer's sign or pinch test can be used to identify its presence and encourage appropriate compression interventions. The pinch test simply requires clinicians to try and gather the skin at the base of the toes up into a narrow pinch. When the lymphatics are functioning normally this is easy to do. However, when they are damaged and there is excess fluid and protein in the skin tissues or fibrotic changes in the skin, this becomes impossible and is known as a positive Stemmer's or pinch test outcome indicating chronic oedema (Bjork and Hettrick, 2019).

To improve outcomes for patients with leg ulcers, it is important to recognise the interconnected nature of both venous and lymphatic systems (Wennen et al, 2019; Gasparis et al, 2020). Patients with lymphatic disease usually require a compression system to be stiffer. Application techniques in relation to short-stretch bandages may also need to be changed to make them stiffer, i.e. changing from a spiral to a figure-of-eight application and another layer can be applied dependent on ankle circumference (always starting at the base of the toes in patients with lymphovenous disease).

When multi-component bandages are used, the addition of each bandage layer will increase the stiffness of the final bandage because of the increase of friction between the layers (Partsch et al, 2019). These techniques can be taught by industry clinical nurse specialists and lymphoedema services.

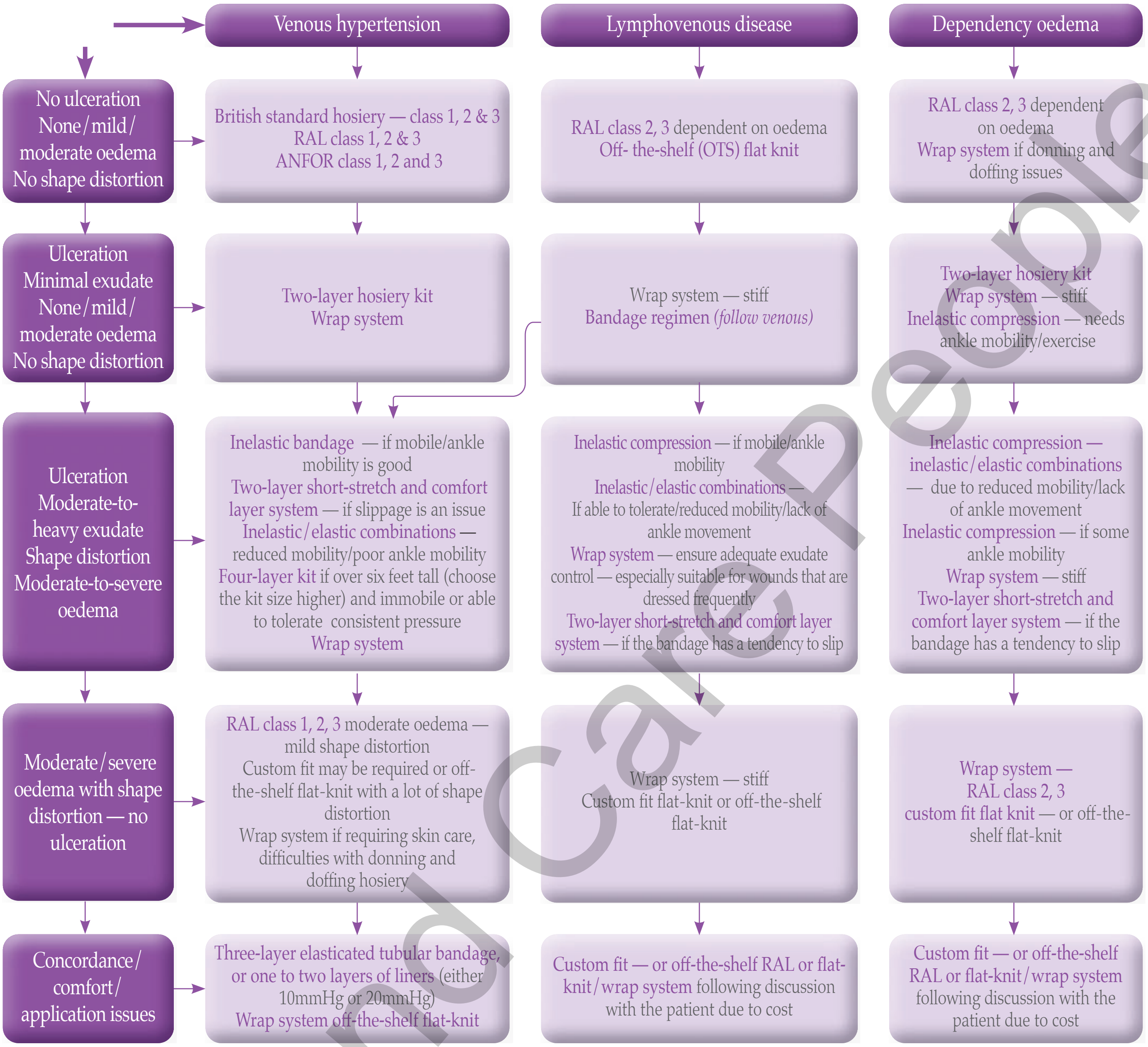

Figure 2.
Compression therapy selection pathway (authors' own work).

If patients have wrap systems, to maintain oedema reduction they need to be taught to tighten the straps every four to six hours throughout the day, especially in the first few weeks of oedema reduction (Bradley et al, 2017; Lee and Lawrence, 2017).

A guide to compression systems based on presenting ulceration, oedema and symptoms has been devised to assist in the development of pathways to help clinicians to choose appropriate compression systems (*Figure 2*). Discuss with industry providers the type of hosiery they supply and the differences in stiffness of their products (*Table 8*).

> **'Overcoming barriers related to compression therapy and increasing its usage can improve patient outcomes and quality of life.'**

HOW TO IMPROVE USE OF COMPRESSION THERAPY

Studies have shown that the use of high pressure compression treatment for life, exercise therapy, and health education to promote self-care are recommended strategies of leg ulcer prevention and recurrence (He et al, 2024).

Overcoming barriers related to compression therapy and increasing its usage can improve patient outcomes and quality of life (Annells et al, 2008). Adherence to treatment can be challenging, but modern technologies and specific materials have improved compliance (Barnes, 2024).

If healthcare professionals have a better understanding of the types of compression and how they work, and which patients they are best suited for, this can also assist in promoting the best possible care. This, in turn, can help to reduce the stress and potential anxiety felt by clinicians.

Table 8: Guide to compression classes (British National Formulary [BNF])

Class	Pressures	British	RAL	Indications
1	18–24mmHg	14–17mmHg	18–21mmHg	Minor varicose veins without oedema
2	25–32mmHg	18–24mmHg	23–32mmHg	Varicose veins, mild oedema, lymphoedema stage 0–1
3	36–46mmHg	25–35mmHg	34–46mmHg	CVI 2–3 (no ulcer), lymphoedema stage 2
4	50–70mmHg		35–70mmHg	Lymphoedema stage 3

Indeed, ensuring a more personalised approach using pathways and providing follow-up care not only improves concordance rates and reduces ulcer recurrence, but also meets individual needs and ultimately ensures maximum use of resources to deal with the predicted growing demand. **JCN**

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A simple solution to falls prevention: could decaf be the answer?

Ruth French

Falls in the elderly come at a high cost, both to the NHS and to the health and confidence of the person who has fallen. Hospital-based trials in 2021 started to explore potential links between caffeine and falls associated with going to the toilet, given caffeine's diuretic effect. In 2023, following positive trial outcomes, the project spread to social care, where a 35% reduction in falls associated with going to the toilet was seen when decaffeinated products were introduced as standard in eight care homes for the elderly. This article explores the Decaf Project and potential benefits of decaffeination in wider community settings, including for elderly people living in their own homes. It examines ways in which community nurses can support those in their care to understand potential benefits of decaffeination.

KEYWORDS:
■ Decaf ■ Caffeine ■ Falls prevention ■ Continence ■ Elderly

Caffeine can serve as a stimulant, an irritant, and a diuretic. It increases blood flow to the kidneys, increasing the amount of fluid and sodium filtered in the renal cortex and eventually increasing urine production (Coombes, 2024). The impact caffeine has on the body can raise the frequency and urgency with which individuals need to urinate or defecate (Jura et al, 2011).

In 2021, as a part of Continence Awareness Week, University Hospitals of Leicester NHS Trust (UHL) adult continence team launched the 'Taste the Difference Challenge' to trial decaffeinated products for patients. Having experienced an increase in inpatient falls relating to toileting, the trial drew on research suggesting a high correlation between falls and lower urinary tract symptoms in hospital (Roggeman et al, 2020). The initiative aimed to explore whether a reduction in caffeine would, by limiting its diuretic effect, reduce toileting-related falls as patients did not rush to the toilet as urgently.

'Falls are the most common cause of injury-related deaths in people over the age of 75 and contribute significantly to fragility fractures among older people (Age UK, 2019).'

Ruth French, director of Stow Healthcare, a family run group of award winning care homes in East Anglia. Ruth was awarded Care Leadership of the Year in the 2023 National Care Awards. Ruth specialises in change management and prior to her career in social care worked as a civil servant in Whitehall.

WHAT IS THE COST OF FALLS?

Falls are the most common cause of injury-related deaths in people over the age of 75 and contribute significantly to fragility fractures among older people (Age UK, 2019). People living in care homes are three times more likely to fall than those living at home; they are usually older, more frail and less mobile than people living in the community (National Institute for Health and Care Research, 2022).

The Office for Health Improvement and Disparities (OHID) highlights that:

> *Falls and fractures are a common and serious health issue faced by older people in England. People aged 65 and older have the highest risk of falling; around a third of people aged 65 and over, and around half of people aged 80 and over, fall at least once a year. Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality.*
>
> (OHID, 2022)

In terms of costs to the NHS, the figures are also stark: 'the total annual cost of fragility fractures to the UK has been estimated at £4.4 billion which includes £1.1 billion for social care; hip fractures account for around £2 billion of this sum' (OHID, 2022).

In the author's opinion, reduction of falls, based on the monetary and wellbeing costs set out above, should therefore be a high priority.

TASTE THE DIFFERENCE

In 2021, UHL, in a project led by continence specialist nurse, Sarah Coombes, implemented the 'Taste the Difference Challenge', an initiative whereby hospital patients were offered decaffeinated hot drinks as the default option in an attempt to reduce falls relating to toileting.

Patients and staff were invited to see whether they could 'taste the difference' between caffeinated and decaffeinated hot drinks and were informed about the benefits of switching to decaffeinated tea and coffee for a healthy bladder. Patients were invited to opt-in to the trial, meaning that they would be offered decaffeinated tea and coffee as the default option, with caffeinated drinks still available on request. Over 50% of patients said they could not 'taste the difference' and over 76% reported that they would switch to decaffeinated once they knew about the potential health benefits of doing so.

The result of the hospital-based 'Taste the Difference Challenge' was a 30% reduction in the number of falls occurring on the way to the toilet. Furthermore, 63% of patients attending UHL's outpatient continence clinic reported an improvement in overactive bladder symptoms after switching to decaffeinated drinks. Following a recommendation based on the trial results, UHL's leadership team decided to support the initiative and in February 2022 the switch to decaffeinated drinks was officially launched.

EXPANSION TO SOCIAL CARE

Having learned of the results of the 'Taste the Difference Challenge', care sector representative body, Care England, and Stow Healthcare, sought to expand the initiative to the adult social care sector. Considering the high level of falls in care homes, the general frailty of residents in these settings, and arguably greater levels of incontinence, it was hypothesised that the results of the 'Taste the Difference' challenge could translate to a care home setting. It was hoped that this could lead to considerable improvements in health outcomes for residents and a reduction in costs associated with falls.

Between June and November 2023, with the support of Care England, East Anglian-based Stow Healthcare implemented a decaffeination trial across eight of their residential care homes. The research focused on older people over the age of 65.

Many of the care home residents live with complex comorbidities, including dementia or Parkinson's disease. Most are very frail, and some are receiving end-of-life care. Care homes with fewer falls are often those looking after residents with higher nursing needs, often nursed in bed and not as mobile as other residents. Care homes supporting people living with dementia, who may still be very mobile, often experience notably more falls. It is worth noting that where residents' conditions mean that they are at a high risk of falls in any event, caffeine may not be a dominant factor in their falls risk.

Eighty-nine percent of Stow Healthcare's approximately 350 residents chose to be part of the trial from the outset in June 2023, drinking solely or predominantly decaffeinated drinks, rising to 92% by November 2023. Documented preferences were received for 63 residents who completed blind taste testing across four homes. From this, the following information was collated:

- Only 19% of residents in the blind trials were able to tell accurately whether a drink contained caffeine or not
- 22% of residents said that they would prefer to continue to drink caffeinated drinks
- 33% of residents said that they would prefer to drink decaffeinated products
- 46% of residents said that they had no preference
- 3% gave multiple answers (decaffeinated and no preference)
- 43% said that they would switch to decaffeinated products having been told of the potential benefits.

Promotional information such as posters, drinks coasters and easy read one-pagers were circulated to residents to support awareness and decision-making about participation. Overall, residents were positive about the changes; some commented that they 'always had decaf at home', while another said she would like to try it as it might help her continence.

RESULTS

Falls data were collated at the end of each complete month for the six-month duration of the project. Falls data were also retrospectively collated for the four previous months, as a comparator. Falls were always reviewed as a percentage of occupied beds in a home, as occupancy may vary month to month.

It is worth noting that there is a degree of interpretation involved in recording data relating to falls associated with toileting. Falls were documented as being associated with using the toilet if the falls report noted the resident said that they had

Table 1: Caffeine quantities (source: Gloucester Hospitals NHS Foundation Trust)

Caffeine source — coffee 200ml	Caffeine (mg)	Caffeine source — tea 200ml	Caffeine (mg)
Weak (instant)	45	Bags/leaves weak	20
Medium (instant)	60	Medium	40
Strong (instant)	90	Strong	70
Percolated	100	Herbal	0
Filter coffee	140	Green tea	59
Decaffeinated (instant)	2	Decaffeinated	1

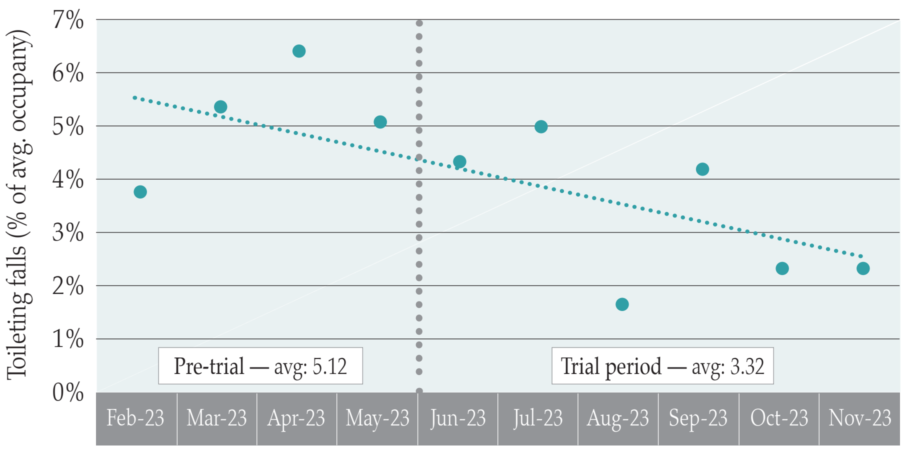

Figure 1.
Toileting-related falls as a proportion of occupancy (February to November, 2023).

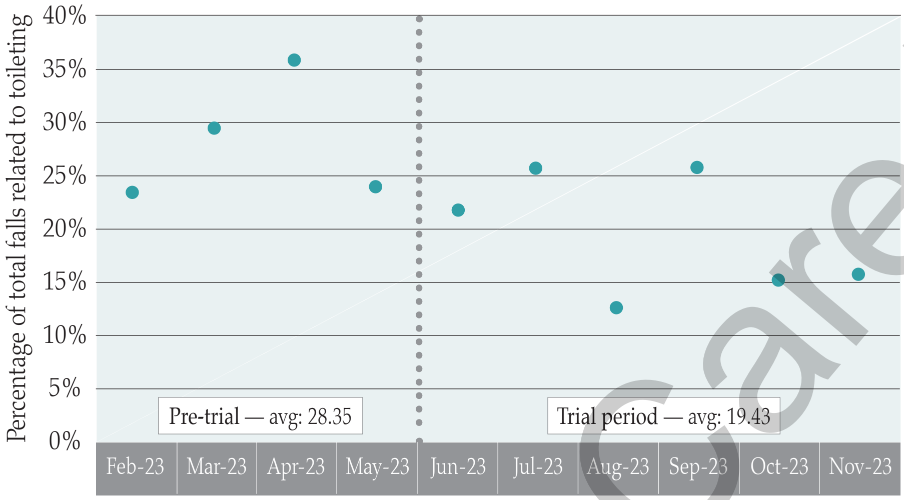

Figure 2.
Toileting-related falls as a proportion of total falls (February to November, 2023).

fallen while trying to use the toilet, or if they were found to have fallen in their bathroom, or while clearly being en route to the bathroom, as described by the location they were found in.

Before the rolling out of decaffeinated products as the default option, there were an average of 15.75 toileting-related falls per month across Stow Healthcare's eight homes, ranging from 12 to 19 across the four-month period. During the trial period, this fell to an average of 9.83 toileting-related falls per month, ranging from a high of 15 in July 2023 to a low of five in August 2023. This represents a 37.59% reduction in toileting-related falls following the implementation of decaffeinated drinks as the default option.

These figures, however, fail to account for changes in average occupancy levels, which ranged from an average of 286 to 321 residents between February and November 2023. *Figure 1* outlines toileting-related falls as a proportion of average occupancy over that period.

Pre-trial, toileting-related falls as a proportion of average occupancy was 5.12% — meaning that there was roughly one toileting-related fall for every 20 residents each month. This ranged from a low of 3.80% in February 2023 to a high of 6.37% in April 2023.

During the trial period, this fell to 3.32% — roughly one toileting-related fall for every 30 residents, each month. This ranged from a low of 1.72% in August 2023 to a high of 4.97 in July 2023.

The drop from an average of 5.12% pre-trial to 3.32% during the trial represents a 35.16% reduction in falls relating to toileting, as a proportion of occupancy.

Figure 2 outlines how toileting-related falls, as a proportion of total falls, changed over the course of 2023.

Before the decaffeination trial, an average of 28.35% of total falls related to toileting — i.e. just under three in 10 falls that took place were associated with a resident going to the toilet. This ranged from 23.53–35.85% between February and May 2023.

After the implementation of decaffeinated hot drinks, the proportion of total falls that related to toileting fell to 19.42% — i.e. just under two in 10 falls that took place were associated with a resident going to the toilet. This ranged from 12.82–25.53% between June and November 2023.

The drop from 28.35% to 19.42% represents a 31.46% reduction in the falls relating to toileting, as a proportion of total falls, following the implementation of decaffeinated hot drinks as the default option.

CONCLUSION

The results of this trial appear to corroborate the findings of the 'Taste the Difference Challenge' conducted by UHL in 2021. The reduction in falls observed across Stow Healthcare's homes (35.16%) is comparable to the reduction observed at UHL (30%). In the author's experience, this is despite factors which might have suggested otherwise, such as:

- Hospital patients might expect to see their overall health improve

Practice point

Benefits of switching to decaffeinated drinks include:

- Reduction in sleep disturbance and insomnia
- Reduction in tachycardia and palpitations
- Helps to prevent dehydration and headaches
- Reduces indigestion
- Lowers risk of osteoporosis (caffeine may prevent absorption of calcium) (NHS inform, 2021) (Coombes, 2024).

over time, while care home residents' wellbeing tends to deteriorate

- Care homes tend to have more ensuite facilities than hospitals, meaning a lesser distance is travelled by care home residents to reach the toilet
- Care home residents often have complex comorbidities which may mitigate the potential positive impact of decaffeination on falls related to toileting.

Stow Healthcare's sample size was relatively small, nevertheless the results of this trial were encouraging and deserving of further investigation.

If these findings are corroborated on a larger-scale, decaffeination has the potential to considerably improve health outcomes for those at higher risk of falls and deliver considerable savings to the NHS.

There are number of areas for further study that fell outside of the scope of this project, including:

- Improved sleep: reduced behaviours that may challenge in people living with dementia (de Pooter-Stijnman et al, 2018); reduced tachycardia and palpitations; dehydration and headaches; indigestion; lowered risk of osteoporosis due to the effect of caffeine on calcium absorption (NHS Inform, 2021)
- The impact of decaffeination on total falls: with appropriate controls in place, a study exploring the impact on total falls would help quantify the potential benefit of decaffeination to the NHS in terms of cost-savings
- Potential benefits of decaffeination to working-age adults with a learning disability and/or autism.

Robert's story (care home resident)

Since being on decaf, once I go to sleep, I sleep right through until about 5am. I used to wake frequently through the night to go to the loo. Having an undisturbed night has made a huge difference to me, as I am no longer so tired during the day.

Michelle's story (registered nurse)

It has been great to see the difference that decaf appears to have made to some of our residents. I know that some of them feel proud to be part of this project. I think decaf has helped people's urinary continence — one person just has a pad for reassurance now as they know they can get to the loo on time. I never drank coffee personally as it made me shake. However, I didn't realise how much caffeine tea has in it and since changing to decaf as part of this project, I have found that I sleep better, and my concentration levels seem improved as I do not have highs and lows following a caffeinated drink.

> **'Community nurses could have a role to play in sharing potential health benefits of decaffeination in the patient contact they have.'**

There has already been considerable interest in wider scale trials into decaffeination, both in social care and acute settings, with a number of projects being initiated. Community nurses could have a role to play in sharing potential health benefits of decaffeination in the patient contact they have, thereby supporting improved bladder and bowel health. Connected to this, there is also the opportunity to prevent falls that are connected with patients who may be placed at higher risk through attempting to mobilise quickly to the toilet. **JCN**

Resources

More information and free resources can be found at: https://stowhealthcare.co.uk/the-decaf-project/

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Suicide: a personal tragedy and global health challenge

Teresa Burdett

Suicide is a stark word that provokes a deluge of emotions in all of us, including community nurses and society at large, both on a personal/community and professional level. Suicide provokes a wide range of questions and has many ramifications that ripple outwards. It can cause consternation on the part of the community practitioner by questioning themselves and their actions and also on the part of the families and friends while coping with grief and all asking, among other things, should I have acted or spoken differently. Suicide and attempted suicide impacts all of us, our colleagues, our patients and ourselves.

KEYWORDS:
■ Suicide ■ Attempted suicide ■ Emotional response
■ Actions and strategies ■ Role of community nurses

Suicide is defined as 'death caused by self-directed injurious behaviour with intent to die as a result of the behaviour…' (National Institute of Mental Health, 2024). Suicide rates between the ages of 10 to 24 years have significantly increased by 22.7% between 2012 to 2016 and 2018 to 2022 (Office for Health Improvement and Disparities, 2024). Suicide rates are affected by factors such as age, gender and geographical region. For example 'all female age groups in the Yorkshire and the Humber region showed increasing rates — females aged 25 to 44 years showed a significant increase from 5.0 (4.3, 5.8) to 7.9 (7.0, 8.9) per 100,000 population, between 2012 to 2016 and 2018 to 2022', and male rates of suicide, apart from in the London region, also continue to increase (Office for Health Improvement and Disparities, 2024). Other factors also impact suicide rates, such as poverty and low socio-economic status (Naher et al, 2019; Stack, 2021).

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This public health concern is not just restricted to the United Kingdom. In 2021, suicide was the 11th leading cause of death overall in the United States, claiming the lives of over 48,100 people, with the suicide rate being four times higher among males than females (National Institute of Mental Health, 2024).

Attempted suicide on the other hand is seen as:

> *An umbrella term that covers a number of different behaviours. Common to these behaviours is that people inflict acute harm upon themselves, poison or injure themselves or try to do so, with non-fatal outcome. Also common to these behaviours is that they occur in conditions of emotional turmoil.*
>
> (Kerkhof, 2000: 50)

Attempted suicide and suicide have many causes, and the modes of actions and implementation may vary widely between individuals. However, in essence, there is a human being who is under extreme stress and is responding to emotional disorder.

POTENTIAL FACTORS

Factors that may support suicide and suicidal attempts include:

- Mental health conditions, including depression
- Limited support or access to support
- Stigma
- Serious or a life-limiting illness
- Chronic pain
- Social isolation, including being situated in a rural community
- Use of substances, including alcohol or drugs
- Traumatic experiences in childhood or adulthood, including abuse and sexual assault
- Financial issues
- Relationship issues
- Previous suicide attempts.

(Centers for Disease Control and Prevention [CDC], 2024).

ACTION PLAN

Considering that suicide and attempted suicide is an issue of significant concern, in the author's opinion, an effective inclusive, person-centred integrated action plan needs to be in place with a robust strategy for implementation. This could draw together strands of best practice and what has proven effective nationally and internationally, while still being flexible to local or specific needs.

LOCAL STRATEGIES

There are a number of local suicide prevention strategies in place. Being familiar with your own local strategy and who to contact is key for community nurses when caring for individuals experiencing distress and/or their families and friends.

One example of such a plan is in Dorset in the south coast of England, where they have formed a multi-agency group which consists of statutory organisations including National Health Services, police and fire services, and the local council.

Their aim is to oversee a joined-up suicide prevention programme with the laudable aim of preventing all deaths by suicide, if at all possible. The Dorset suicide prevention vision aims to achieve 'zero-suicides' (Dorset Integrated Care Board [ICB], 2024) with the belief that, 'no one of any age living in Dorset will reach the point where they feel or believe that they have no other choice but to attempt suicide or to end their life by suicide' (Our Dorset, 2024).

National legislation and policy drivers, such as the NHS *Five Year Forward Plan* (NHS England, 2014) and the *NHS Long Term Plan* (NHS England, 2019) have helped to form part of the Dorset structure and background thinking. However, the Dorset aim is for no suicide deaths, whereas the *NHS Long Term Plan* has reduction targets of 10% (NHS England, 2019). In Dorset, the aim for all-age suicide reduction includes the use of six workstreams, including the utilisation of real time surveillance of data in relation to suicide and attempted suicide to help shape planning and formation of response, supporting the development of a group of individuals who have lived experience of the implications of suicide and attempted suicide and who are able to advise and comment on the formation and development of the prevention strategy, and strengthening community development and voluntary partnership working. Local media campaigns are also being developed across the Dorset region, and ongoing suicide training and bereavement support is to be provided to those who have experienced loss through suicide.

Other areas in the UK also have plans and strategies in place to contextualise and accommodate specific regional and gender differences. For example, in the Essex region, there is a particular focus on prevention around younger people (https://bit.ly/47AMaeR). East Cheshire is also focusing on children and young people but also on men and individuals in the rural and farming communities (https://bit.ly/4dcuDuK).

NATIONAL STRATEGIES

National strategies have included the *NHS Long Term Plan* (NHS England, 2019) in relation to suicide, which has had different interpretations in various parts of the UK. For instance, Dorset has a zero policy on suicides (Dorset ICB, 2024), and Cheshire and Merseyside also aim for their region to be suicide free, where people in their region live in hope and suicide is not viewed as a solution (https://bit.ly/3XwnHTm). These are more elevated aims than the 10% reduction target that the *NHS Long Term Plan* has set out (NHS England, 2019). Many charities are regionally based, although some also cover all parts of the UK (see below). National strategies also help to promote this very difficult to discuss issue. This year, the London Marathon's chosen charity was the Samaritans, who are heavily involved in supporting individuals in distress, including experiencing suicidal ideation and the aftermath of suicide.

GLOBAL OUTLOOK

Internationally, it appears that many countries are experiencing issues with suicide and attempted suicide:

> *Every 40 seconds a person dies by suicide somewhere in the world. Over eight hundred thousand people die by suicide every year.*
>
> (World Health Organization [WHO, 2014)

However, action does appear to be beneficial and effective. For example, the all-encompassing national strategy to combat suicide in Finland has reduced the death rate of suicide by half (Prencipe et al, 2024). The main strategies include educating all health and care workers to collect data around each suicide, which has increased the pool of knowledge. Media involved have been educated to write in a more neutral way about suicides, reducing the use of romanticisation or glorification. National strategies to limit the use and access of firearms and poisons have also been implemented. In Norway, growth in technology with the increased use of mobile phones has helped to reduce social isolation, a known risk factor for suicide, as Norway is a sparsely populated country (Motillon-Toudic et al, 2022).

The International Association for Suicide Prevention (IASP; www.iasp.infowspd) supports the annual World Suicide Prevention Day. The theme this year was 'Change the Narrative', previous themes have included 'Creating Hope Through Action' (2023) and '40 Seconds of Action' (2022). WHO has been the co-sponsor for this day and this year it was held on 10 September, 2024. 'Change the Narrative' is a plea for intervention to 'Start the Conversation'. The theme aims to increase awareness about how important it is to change the narrative permeating suicide in order to better understand this multi-faceted and complex societal issue. In the author's clinical opinion, this is a challenge that community nurses may well be able to address and embrace by virtue of their training, skill, knowledge and their unique setting of being embedded within their community.

WHAT IS THE ROLE OF COMMUNITY PRACTITIONERS?

Community nurses are uniquely situated within the community arena to start having these conversations by asking how the individual is feeling. Changing the language and narrative is fundamental, including the importance of the words and tone of language that is used and how we engage in talking about suicide. This is a key message from the World Suicide Prevention Day.

Starting the conversation includes choosing an environment where the participant feels comfortable and safe and where there are minimal distractions. Use of open-ended questions can help to encourage discussion. Indeed, asking the individual directly about suicide enables them to be freer to discuss their feelings, without feeling judged or pressured (https://bit.ly/3XQbTN8).

If the discussion raises concerns, it is important not to be afraid to take action by referring to an appropriate organisation, following local policy guidelines and utilising the Nursing and Midwifery 'Code of Conduct' (NMC, 2018). In the author's opinion, being compassionate and using an integrated, person-centred approach will help to ensure that the individual feels supported and empowered to discuss how they feel, and the practitioner feels empowered to listen and act. Although this is not a step-by-step approach, one size fits all methodology, in the author's opinion, following robust principles, such as utilising suggested communication techniques and styles and being person-centred and adaptable in your actions can help community practitioners to provide useful and supportive dialogue in often tense and stressful situations.

SUPPORT AVAILABLE

There is accessible support available. Community practitioners should feel confident to recommend such services to others, or use them as needed. They should also have access to support through supervision, line management, as well as professional support. Support appears to fall into three categories:

- Support for individuals experiencing distress
- Support for carers
- Support for the bereaved following suicide.

Examples include the Samaritans and NHS 111. The Samaritans are accessible 24 hours a day, every day of the year: 116 123 (freephone), Freepost SAMARITANS LETTERS, or Samaritans.org. There are also branches for people to visit in person and a Welsh helpline open in the evenings from 7pm until 11pm: 0808 164 0123. In England, there is NHS 111 and the same number is also for Wales NHS 111. This service provides non-emergency advice for people with concerns about a number of issues, including mental health and suicidal thoughts.

For carers, there are also several services including:

- Stay Alive — this is an app service which has help and resources for individuals who feel suicidal or for those who are caring for these individuals
- Grassroots Suicide Prevention — a charity run by people who are passionate about preventing suicide, both clinicians and those who have lived experience, which has resources and campaigns both at local and national level: prevent-suicide.org.uk
- Carers UK — available on 0808 808 7777 and in Wales 029 2081 1370 advice@carersuk.org

Survivors' groups are for individuals who have been impacted by suicide. For example, Survivors of Bereavement by Suicide (uk-sobs.org.uk) provides support, including emotional and practical advice for individuals who are bereaved or affected by suicide.

Internationally, there is support, for example in Australia there is Lifeline (www.lifeline.org.au/), a national charity for those experiencing emotional distress which offers 24-hour crisis support and suicide prevention services: 13 11 14. Additional helplines for other international countries can be located at Befrienders Worldwide, global suicide prevention: befrienders.org.

CONCLUSION

Suicide is a very emotive topic, but by adding to the 'narrative' and discussing suicide in this article and how to support an individual experiencing these thoughts will help to allay some of the understandable fears of being involved. Importantly, it is hoped that raising this complex issue with suggested strategies of action and highlighting support available will not only help community nurses to feel more empowered and enabled to be involved, but also more comfortable with what can be an extremely difficult, highly charged and emotive situation. **JCN**

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Supporting people towards wellbeing: promoting self-care

Here, Professor Michelle Howarth, professor in health and social care, associate director CSR (Centre for Social Responsibility), Faculty of Health, Social Care and Medicine, Edge Hill University, Rhian Last, nurse educator, Self-Care Forum self-care champion and Libby Whittaker, Self-Care Forum manager, explore the findings of a project undertaken last year on self-care, highlighting ways that community nurses can support self-care both in their day-to-day role and more strategically across primary care populations.

WHAT IS SELF-CARE?

The Self-Care Forum defines self-care as 'the actions that individuals take for themselves, on behalf of or with others in order to develop, protect, maintain and improve their health, wellbeing or wellness' (Self-Care Forum, 2022). The World Health Organization (WHO) has a similar definition and reports that self-care is 'the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider' (WHO, 2020).

Research by the consumer health association, the Proprietary Association of Great Britain (PAGB), found that education is key to increasing self-care with four in five (83%) of those surveyed saying they need more education to encourage people to take a more proactive approach. The research also found that two in five adults (39%) requested a GP appointment for common health conditions, including colds, a blocked nose, insect bites and stings and headaches; with 8% of people visiting A&E for conditions such as dandruff, acne, head lice and other non-urgent and relatively minor health conditions (PAGB, 2023).

There is a need to support people through education to better take care of their own health. This piece describes an initiative undertaken by the Self-Care Forum to design and deliver education about self-care and prevention of illnesses to a range of people who attended GP services. Financial support for the project was provided as an independent medical education grant from Pfizer Limited.

OVERVIEW OF THE PROBLEM

Recently published research undertaken by the Self-Care Forum and Imperial's Self-Care Academic Research Unit (SCARU) suggests that there may be a discordance between professional and public attitudes to self-care (Smith et al, 2023). This may contribute to poorer take up of self-care behaviours both in the general public and professionals. The research demonstrated that, while professional views on self-care changed dramatically during the pandemic, there was a consistent view that the greatest barriers to self-care were public understanding of self-care and willingness to engage. Yet, as far back as the first full NHS baseline research into attitudes to self-care in 2005 (Department of Health [DH], 2005), the views of the general public suggested that they were already undertaking self-care and had not received encouragement to do so. Moreover, Google hits for 'self-care' have risen from 330 million in 2017 to over six billion (an 1800% increase) in 2023. During the pandemic there was a report that 'self-care' was the most searched for term on Google. Presumably, partly as a result of the significant hurdles of cost and effort required to publish peer-reviewed papers, self-reported changes in attitudes in the research suggest that the importance of self-care has taken on a greater significance since the onset of the pandemic. Findings also suggested that professionals themselves have not fully embraced self-care in their own lives.

In the last 10 to 15 years there has been a huge increase in the evidence base which supports the adoption of self-care practices (Hughes et al, 2020), such as good nutrition, movement, connection, meditation, green exercise, as well as preventative measures such as early diagnosis, vaccinations and screening. Moreover, findings from the Office for National Statistics (ONS) reported that in the UK, deaths from causes considered avoidable, treatable, or preventable given timely and effective healthcare or public health interventions in those aged under 75 years was 'statistically significantly higher in 2020 than all years since 2010'.

Professionals tasked with looking after the population are also struggling to stay well themselves. Sickness absence rates in NHS staff, according to the King's Fund, are higher in comparison to the rest of the economy (Copeland, 2019). Hadley and Kar in their blog for the BMJ, 'the cobbler's children have no shoes' use the familiar aviation analogy about putting on your own oxygen mask first to illustrate the problem, explaining that healthcare workers simply cannot help those around them if they do not look after themselves first (Hadley and Kar, 2022). While there is clear evidence on what we should be doing to better take care of our physical health and mental wellbeing, there is a lack of evidence on why individuals and health workers are not heeding the advice and putting the theory into practice.

EDUCATIONAL PROGRAMME

An education programme was thus designed by the Self-Care Forum to raise the understanding of health literacy and views of self-care in the public and professionals, make access to evidence-based resources more readily available, and to serve those most at risk and to inform policies and strategies on self-care.

Materials

Two new factsheets on common illnesses were developed and eight of the existing factsheets updated. These were used to form the basis of the education content. The two factsheets produced were entitled 'Winter Wellness' and 'Winter Illness', helping people prepare for winter and look after their overall health and supporting NHS providers to cope with winter pressures. The factsheets were peer-reviewed by the Self-Care Forum board and Self-Care champions for accuracy, readability and understandability and uploaded to the Self-Care Forum website and promoted through its networks.

To ensure that a diverse population were reached, the Self-Care Forum worked with Kingston Upon Thames' Local Authority Translation Services to translate the winter factsheets and eight further factsheets into Urdu. Once translated, they were uploaded on to the Self-Care Forum website. Since development, the factsheets have been shared widely, including on social media. NHS England's National Menopause Clinical Group, praised and welcomed the Urdu menopause fact sheet.

Format of the educational programme

Two webinars which lasted two hours each and attended by 66 people in total were delivered. They were presented by four self-care experts with clinical and behavioural science backgrounds and had the following learning outcomes:

- Understand what is meant by self-care
- Appreciate why self-care is important to the wider health and care system
- Identify symptoms of common ailments and how long they normally last
- Know when to seek professional health advice and where to go for that advice
- Consider what makes us adopt certain health behaviours.

The webinar focused on the Self-Care Forum's winter wellness and illness factsheet, and aimed to increase people's knowledge and understanding of key aspects of self-care.

Box 1.

Tips to help patients become self-care aware during consultations

- Ask open questions to explore what the person perceives as self-care and identify any myths, misconceptions, concerns and behaviours which may be impacting on this
- Facilitate self-care conversations that will enable people to feel confident to self-care and to know when to seek help
- Direct patients to good sources of self-care material
- Remember to summarise and check back at the end of your consultation. It is not just giving advice and information to people, it is also ensuring that they have understood what has been shared with them

(Elwyn et al, 2003).

Testing the educational programme

Pre- and post-test surveys were used to establish knowledge and understanding of self-care in relation to the education content. Such test questionnaires are commonly used to understand the impact of educational initiatives and identify any increase in level of knowledge on particular subject. Participants were invited to attend the webinars through the GP surgeries. A total of 63 people registered for the July webinar and 33 attended. A total of 79 people registered for the October webinar and 33 attended. The surveys had a good pre-event response rate — the July pre-event survey had a response rate of 56%, with October being slightly less at 48%. The follow-up survey was sent seven to 12 weeks after each webinar. The response rates were lower, with July at 15% and October 36%. Data from the surveys were inputted into an Excel spreadsheet. Pre- and post-test answers were analysed using descriptive statistics to understand how the webinars increased confidence and whether participants would attend a future webinar and/or recommend to a friend.

LEARNING AND DISCUSSION

Overall, the survey demonstrated an increase in confidence in sources of good self-care material — from 83% to 100% post webinar. Moreover, analysis indicates that 100% of responders said that they would recommend the Self-Care Forum webinar to friends, family, and colleagues, which suggests that they were valued by attendees. The findings from the survey highlighted that the webinars were effective in improving knowledge about self-care for common healthcare problems.

SUPPORTING PATIENT SELF-CARE

Self-care is not about leaving people to cope on their own. In keeping with all clinicians, general practice and community nurses have an essential role to play in empowering individuals to take control of their treatment and helping patients to nurture positive attitudes towards self-care (*Box 1*). It is acknowledged that anyone can self-care if they have been assessed as being both capable and willing to be involved. Clinicians and patients should be honest and open with each other about what level of engagement in self-care is appropriate, and be mindful that this can change over time.

Nurses are a trusted profession (Ipsos Mori, 2023). The contact and care delivery of general practice and community nurses is embedded

Practice point

Education is key to enabling the population to manage self-care and take proactive steps towards a healthier lifestyle.

within the self-care continuum (*Figure 1*). As such, they have a crucial role in facilitating people to feel confident to self-care and know when and where to seek help when needed.

Recommendations

Promoting self-care can be interwoven through all patient contacts. Some examples might be:

- The GP surgery website and the surgery waiting room, where self-care initiatives can be promoted (such as National Self-Care Week, see below) as well as good, reliable resources. The Self-Care Forum produce free to download evidence-based, peer-reviewed resources that are developed by experts in their field and updated regularly
- Promoting positive conversations supporting self-care during telephone contacts, face-to-face consultations and group consultations (sometimes called group clinics). These opportunities can be used to signpost people accordingly.

NATIONAL SELF-CARE WEEK 2024

This annual national awareness week, which has been organised by the Self-Care Forum since 2011, focuses on embedding support for self-care across communities, families and generations. This year it will run from 18–24 November, with the theme being 'Mind and Body'.

Resources

- www.selfcareforum.org
- www.selfcareforum.org/events/self-care-week/
- www.selfcareforum.org/events/self-care-week-resources/
- www.selfcareforum.org/2023/07/27/self-care-aware-webinar/
- www.selfcareforum.org/fact-sheets/
- https://wounds-uk.com/wp-content/uploads/sites/2/2023/09/LR23_BPS_self-careVLU_WUK-WEB.pdf

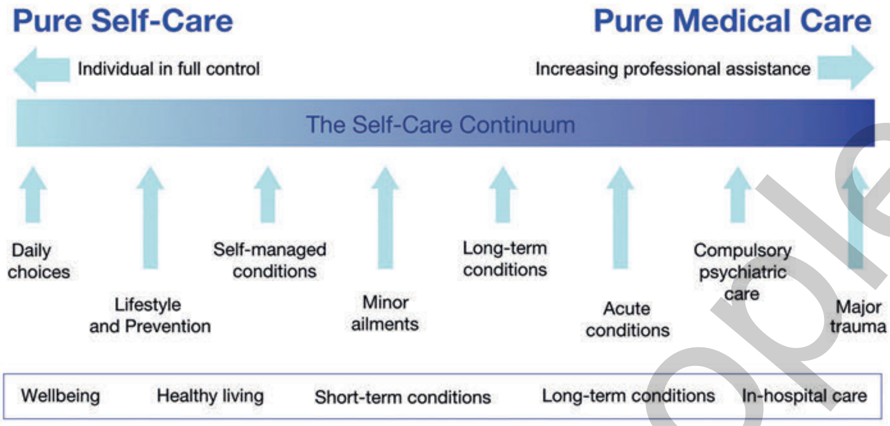

Figure 1.
Self-care continuum (Self-Care Forum).

A wealth of resources supporting Self-Care Week are available at: www.selfcareforum.org/events/self-care-week/

COLLABORATIVE WORKING

The Self-Care Forum is continually seeking funded opportunities for furthering research and is keen to collaborate with wider organisations to expedite this. If this is of interest to you, your GP surgery/PCN/GP Federation, please contact Libby Whittaker at: libby.whittaker@selfcareforum.org

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Practice point

Self-care involves clinicians relaxing control and trusting patients to complete tasks related to their health and wellbeing, while also being a vital contact for additional support.

My community

Sarah Jarvis, advanced clinical practitioner, Queen's Nurse, HMP Erlestoke

HOW DID YOU BECOME INVOLVED IN PRISON HEALTH?

My first experience of working in a prison was delivering rehabilitation programmes and I left this post to undertake my nurse training. After spending several years working in acute hospitals and community drug and alcohol services, a post for an advanced clinical practitioner came up in a prison. The job description really appealed to me with being able to work across the four pillars of advanced practice, and having worked in a prison environment previously, I thought it would be a good opportunity to expand and develop my skills further.

WHAT SKILL SETS ARE NEEDED TO MEET THE CHALLENGES OF WORKING IN A PRISON ENVIRONMENT?

Within a prison environment you could be dealing with a number of clinical situations such as medical emergencies, minor injuries or illness, mental health concerns, drug and alcohol dependencies, long-term health conditions, and even end-of-life care. I think being able to maintain boundaries and providing clear communication are important skills when working in this environment. These skills are important not only for managing the needs and expectations of patients, but also when liaising with prison colleagues. Balancing the needs of healthcare against the competing demands of the prison security and regime can be challenging at times and it is important to be able to advocate for patient needs while respecting working within the hosted environment of a prison.

WHAT DOES YOUR TYPICAL DAY LOOK LIKE?

No two days are ever the same, which is what I really enjoy about working in this environment. In my role as an advanced clinical practitioner, a typical day could include seeing patients in clinic, supporting staff with complex decision-making, supporting and delivering quality improvement projects, and developing polices and processes to ensure that we are adhering to best practice guidance. Most days will often involve being engaged in meetings with colleagues, both internally and externally, to help develop this work to improve the services we provide.

> **'Within a prison environment you could be dealing with a number of clinical situations such as medical emergencies, minor injuries or illness, mental health concerns, drug and alcohol dependencies, long-term health conditions, and even end-of-life care.'**

DO YOU HAVE ONE PRACTICE EXPERIENCE THAT HAS TAUGHT YOU SOMETHING VALUABLE ABOUT PRISON NURSING?

Situations where patients are deemed to be non-concordant with treatment and how this is viewed and managed by the wider team has been a valuable learning experience. I have noticed that if a patient declines something and is considered to have capacity, it is happily accepted that they are refusing treatment. While everyone has the right to make an unwise decision, I think it is important to explore the reasons behind this choice to establish if there is anything that can be done to support them to receive treatment. Sometimes patients are reluctant to open up and discuss this, which can lead to them being viewed as being difficult. Taking the time to explore why can often make a huge difference.

WHAT ONE THING WOULD MAKE THE MOST DIFFERENCE TO YOUR PRACTICE?

Better links between prison colleagues and healthcare so that we could have a more consistent, joined-up approach to meeting the needs of the population we serve and for the prisoners themselves to have representation within this.

WHAT ADVICE WOULD YOU OFFER ANYONE THINKING OF NURSING WITHIN A CORRECTIONAL FACILITY?

To remember that the services you provide to patients in prison should be equitable to what they would receive in the community. Being able to think creatively and look for ways to improve services to help achieve this is essential.

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