



➤ An Insight into the Smith & Nephew Education Resource The Clinical Specialist Team

Page 3

➤ Letter requesting assistance

Page 6

—Editorial—

The complexity of the patient groups which we treat now and in the future is set to increase significantly over the coming years. Such changes in the patient population will provide us with new challenges and ask questions of current practice. Whilst it can be argued that wound care has progressed over the past 2 decades, it is also apparent that many of our patients are presenting with far more complex clinical pictures. This has a huge effect on our ability to heal wounds and may indeed change the way we treat wounds, with the emphasis being on symptom control and wound management strategies which are an integral part of the overall patient care.

In returning to see clinical cases after two years in education, I have found that there is an increase in the number of cases which will not reach the endpoint which we would have hoped for, but instead we are dealing with a group of patients who have multiple pathologies and for whom wound healing is not their main concern. It has now been recognised that for this patient group we are addressing a palliative care need which supports the control of symptoms such as pain, malodour and exudate. It is important to add that we must not ignore 'state of the art treatments' for this patient group. Too often we assume that

➤ Latest references

Page 7

palliative management is associated with the end of life and treatment has to be the simplest of product choices, for example in many cases, if tolerated the use of careful debridement may provide a reduction in odour from the wound and allow conventional treatments to be applied. It may also be the case that patients with prolonged disease may require Topical Negative Pressure therapy in order to assist in the speedy closure of a wound that is large and heavily exuding. The use of this technology could be employed for a short period of time to promote faster healing and reduce the systemic burden of the wound. The same ethos could be applied to the nutritional status of the patient, where short term tube feeding be used to assist the healing process. This would allow the patient a better quality of life through management of the wound and maximise healing in a short period of time, allowing more quality time with the patients family.

Recently I have witnessed a number of patients who have leg ulcers which have developed in patients with advanced cardiac failure and resultant lower limb oedema. For these patients the key aims of treatment are to reduce limb swelling and to reduce the size of the ulcer over time. The number of patients with these problems appears to be increasing and in many there is the chance that there could be other confounding factors such as vasculitis. Regardless of the cause, these patients are immensely debilitated by the presence of the ulceration and efforts to heal them are not always successful.

It would also appear that in many cases, the quality of the new tissue which develops is very

fragile and breaks down easily.

It is very common to find patients who have difficulties in healing due to the multiple pathologies with which they present. In order to deal with these patient groups more effectively we may have to adjust our approach and consider what would best meet the needs of the patient as well as the wound. In addition, we may need to consider the complete impact of chronic illness on the healing ability of patients with wounds, both in terms of the clinical presentation and on a cellular level.

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Editor

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➤ **An Insight into the Smith & Nephew Education Resource The Clinical Specialist Team**

The Smith & Nephew Clinical Specialist team provides a hugely respected education resource to many healthcare practitioners and organisations throughout the country. They have extensive clinical experience from their diverse backgrounds, enabling them to relate to, not only the service that they provide, but also to the people they are helping, supporting and working with. "NHS trusts are constantly challenged to achieve a balance between their resources and meeting the needs of the society they serve"(1). A way this may be achieved is through working in partnership with a commercial company. "... joint working projects must promote and enhance equitable access to evidence-based health care"(2). With this in mind the team strives to ensure that the best interests and needs of all those working in the partnership are fulfilled. This ensures that cost-effective wound management is achieved to benefit the patient and improve their overall healthcare experience. Inappropriate wound care can

result in delayed healing, loss of confidence by the patient in the clinician or inappropriate and poor use of resources. Flanagan argues that, with regard to tissue viability, "...the close relationship between product manufacturers and clinicians has been used to everyone's advantage to develop a wide range of high-quality educational resources"(3). The clinical specialist team seek to both emulate and develop this mutually beneficial relationship.

The clinical experience of the 6-strong team equates to over 40 years practical clinical experience and includes both ex-Clinical Nurse Specialists (Tissue Viability) and Podiatrists. Their expertise varies and covers all aspects of tissue viability, including Research and Clinical Practice, Nurse Prescribing, Leg Ulcer Management, Diabetic Foot Ulcer Management, Policy Development and Implementation, and the Development of Tissue Viability Services and Publications.

The Smith & Nephew Clinical Specialists are a unique and integral part of the Care Partners package that incorporates a wealth of value-added services, which are offered as ongoing support for Smith & Nephew customers.

The team's day-to-day activities include provision of Clinical Specialist Training and Educational Days. In partnership with the clinicians/customers, educational needs are addressed and incorporated into the agenda. The Clinical Specialists have familiarized themselves with local policies and protocols, and the recognized learning outcomes of the areas in which they are active. Additionally, the team are also involved with university lecturing, for both pre-registration student nurses and post-graduate students studying towards further tissue viability-related qualifications. Further to these, the team supports clinicians/customers with Clinical Studies, Evaluations, Audit, Access to Research & Development teams, and helps with publication of papers and posters. The team also supports formulary development, implementation and monitoring.

It is a recognised fact that education is an integral part of the clinical governance agenda, which includes "...education, clinical audit, clinical

effectiveness, risk management, research and development and openness" (4).

The introduction of a formalised educational programme provides the clinician with evidence-based rationales from which they can challenge their practice and build on their knowledge and skills in wound management. With this in mind, the Smith & Nephew Clinical Specialist team role should be viewed as an ongoing value-added service, used to assist you, the clinician, in achieving better patient outcomes.

Through the utilisation of a structured approach to education, and dovetailing it with current in-house initiatives, this will assist you to meet and improve the core Care Standards set out by your Trust, and those found within the Standards for Better Health document (5). This will ensure that such initiatives are not only implemented but are specific, measurable and achievable.

For any additional information please contact Smith & Nephew on 01482 222 200.

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▼ **Letter requesting assistance**

The following letter was sent to Wounds UK requesting assistance from practitioners who have used ultrasound in wound treatments in the past. Please respond to the address given if you can be of help.

Dear Editor,

We are carrying out research related to the treatment of wounds using therapeutic ultrasound. This form of treatment has been quite widely used in the UK in the past, but apparently is not used much at present, despite research evidence in its favour for particular types of wound. In many of the studies, ultrasound has been applied to the periphery of the wound. Few have looked at treatment of the wound area itself, partly because of concerns about disturbance of the wound by the movement of the ultrasound head, and because of worries about infection. Our area of interest is in the ability of wound dressings to transmit ultrasound, so that treatment can be carried out with the dressing in place. With insonation of the wound bed itself rather than the periphery, the treatment might be more efficacious.

We would be keen to hear from anyone who has used or is using therapeutic ultrasound in the management of any type of wound - venous or pressure, diabetic or traumatic, surgical or burns - in order to gauge current use and views of this treatment approach.

Leon Poltawski
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