The population of the United Kingdom is increasing in size and age. During the period 1985–2010, the number of people aged ≥65 years increased by 20% to 10.3 million; in 2010, 17% of the population were aged ≥65 years, with people aged ≥85 years more than doubling to 1.4 million. The percentage aged <16 years fell from 21% to 19% (Office for National Statistics [ONS], 2011). The ageing population is forecast to continue to grow over the next few decades, with projections suggesting that the number of people aged >85 years by the year 2035 will be 2.5 times larger than in 2010, accounting for 5% of the population, and that those aged 16–64 years will decrease from 65% to 59% by 2035 (ONS, 2011). This is important, because if the younger population is decreasing we can assume that there may be a lack of healthcare personnel in the future to care for the increasing older population. Added to this is the ageing workforce of the health and social care sector, where a high proportion of employees are aged >45 years. In England in 2011, 583,285 nurses were registered with the Nursing and Midwifery Council (NMC, 2011; The Centre for Workforce Intelligence, 2013) Around 80,000 nurses on the NMC register are aged 50–55 years, and 100,000 are aged ≥55 years (Higher Education Policy Institute, 2005). The expectation is that approximately 25,000 nurses will retire by 2015 (Buchan, 2005). The Centre for Workforce Intelligence (2013) projects an overall decline in the number of nurses between 2011 and 2016 because of reduced education commissions, attrition, rising retirements, net emigration of UK-trained nurses and other trends. We can assume that as the ageing population increases, there will be an increase in the need to prevent and treat challenges associated with skin integrity. However, as a large proportion of the experienced workforce in the health and social care sector is due to retire by 2015, there is a need for tissue viability practitioners to understand the current prevalence and categories of wounds, treatments and the grade of staff managing wounds, and cascade this knowledge to new practitioners, ensuring the understanding of the importance of accurate assessment and timely interventions. Everyone who undertakes wound assessment and management should be able to access appropriate education and skills to ensure competency and confidence. Cook (2011) presented results of a survey of registered and unregistered staff members’ perceived competency of wound bed assessment. The author concluded that most respondents believed they were competent or average, but 16% highlighted that they were unsure at times, and 9% stated they would benefit from further training. Importantly

This survey aimed to identify and quantify the demographic characteristics, treatment objectives, and wound characteristics of patients from five English NHS Trusts receiving wound treatment. Data from 4772 patients (59.8% female; 79.7% aged ≥65 years) were received. Approximately half were leg wounds. Most patients had one or more comorbidity, most commonly vascular and cardiovascular. The majority of wounds were <3 months’ duration and had no associated infection indicators (a small minority had ≥3 infection indicators). Swabbing was considerably more common in wounds showing no primary infection indicators than in infected wounds. Nurses were most commonly involved with dressing changes. Protecting granulation was the most common treatment objective and dressings were changed most commonly twice-weekly as a scheduled care change. No significant differences in wound or patient characteristics were observed between Trusts.

KEY WORDS
- Ageing
- Infection
- Survey
- Wound
- Wound dressing

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RESEARCH AND AUDIT

Wound care in five English NHS Trusts: Results of a survey
all registered staff have a professional obligation to maintain their knowledge, as defined by the NMC in *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* who are clear that nurses should recognize the limits of their competence, and be accountable for keeping their knowledge and skills up-to-date (NMC, 2008).

This article presents the results of a wound care survey from five English Trusts, which aimed to identify and quantify the age and gender of patients receiving wound treatment, treatment objectives, and the type, duration and characteristics of wounds. The total population for the five Trusts was 2090000 people (exact figures for each Trust are not given to maintain anonymity). When interpreting the data, it was not always possible to distinguish between missing/invalid data, and questions that were correctly left blank. For example, respondents were not obliged to tick any boxes for the question relating to comorbidities, so it was not possible to distinguish between those who missed out the question and those who (correctly) left it blank because there were no comorbidities. Hence the calculated proportion refers to the proportion of the total sample who recorded one or more comorbidities. In such cases, proportions of missing data have not been calculated.

**METHODS**

**Ethical issues**

Local research governance was received from each participating Trust’s research and development office. All data were anonymised and no identifying place, staff or patient names were used. Completed surveys were stored in a locked cupboard in a locked office and all electronic data stored on encrypted computers. Completed data sets have been stored on a secure server at the University of Huddersfield.

**Sampling Overview**

A total of 4772 usable responses were received. The contribution from each Trust was as follows:
- Trust 1: 823 (17.2% of the total sample).
- Trust 2: 1114 (23.3% of the total sample).
- Trust 3: 914 (19.2% of the total sample).
- Trust 4: 691 (14.5% of the total sample).
- Trust 5: 1230 (25.8% of the total sample).

Data were recorded on paper and transferred to SPSS statistical software (version 20.0) for subsequent analyses.

Proportions quoted are based on valid responses to the relevant questions in the survey (*Appendix I*). All percentages and proportions quoted in this study refer to valid responses.

**RESULTS**

**Patient demographics**

The gender balance was similar across all Trusts, with female patients outnumbering male patients in every Trust. Overall, 2154 (59.8%) of all patients were female, and 1449 (40.2%) were male. Patient ages ranged from <14 to ≥81 years. Ages were grouped; the exact ages of patients was not recorded. While the majority of patients from all Trusts fell into the older age groups, there were some differences in the age distribution between different Trusts; fewer elderly patients were represented in Trust 2 (about 31.4% aged ≥81 years) than in other Trusts, with the greatest proportion of patients in the oldest age group being found in Trust 4 (58.7%). Just under half (1964; 47.9%) of patients were aged ≥81 (*Table 1*).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Valid n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>3603</td>
</tr>
<tr>
<td>Male</td>
<td>1449 (40.2)</td>
</tr>
<tr>
<td>Female</td>
<td>2154 (59.8)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td>4102</td>
</tr>
<tr>
<td>&lt;14</td>
<td>7 (0.2)</td>
</tr>
<tr>
<td>14–49</td>
<td>336 (8.2)</td>
</tr>
<tr>
<td>50–64</td>
<td>489 (11.9)</td>
</tr>
<tr>
<td>65–74</td>
<td>648 (15.8)</td>
</tr>
<tr>
<td>75–80</td>
<td>658 (16.0)</td>
</tr>
<tr>
<td>≥81</td>
<td>1964 (47.9)</td>
</tr>
</tbody>
</table>
| Comorbidities<br>1. More than one comorbidity could be stated per patient. Percentages refer to full sample. A total of 3296 patients (69.1%) recorded one or more comorbidities. | 5299
| General infection                           | 355 (7.4)   |
| Immunosupression                            | 187 (3.9)   |
| Dermatological conditions                   | 370 (7.8)   |
| Vascular disease                            | 835 (17.5)  |
| Cardiovascular conditions                   | 882 (18.5)  |
| Anaemia                                     | 204 (4.3)   |
| Malnutrition                                | 146 (3.1)   |
| Obesity                                     | 470 (9.8)   |
| Diabetes                                    | 738 (15.5)  |
| Palliative                                  | 220 (4.6)   |
| Other                                       | 892 (18.7)  |

1. Table 1. Demographic characteristics of patients (n=4772).
The majority of patients from all Trusts had at least one contributing/underlying disease factor. The proportion of such patients ranged from 61.1% in Trust 1 to 74.3% in Trust 5. Approximately a quarter of all patients were reported to have two or more contributing/underlying disease factors, with small numbers with three or more factors. In most Trusts, cardiovascular conditions were the most frequently reported conditions (amounting to 882 patients over all Trusts; 18.5% of all patients). However, in Trust 2, obesity was the most frequently reported condition, although over all Trusts, total numbers with this condition were lower (470 patients; 9.8% of all patients). Other commonly reported conditions included vascular conditions (835 patients; 17.5%), diabetes (738 patients; 15.5%) and dermatological conditions (370 patients; 7.8%) which were recorded in significant numbers in all Trusts (Table 1).

Treatment personnel and location
In all Trusts, nurses made decisions about treatment plans in a majority of cases. In most Trusts, nurses were involved in 75% or more of treatment plan decisions (Table 2). However, in Trust 2 the proportion was lower at around 58% (a significant proportion of responses from this Trust were reported as “Other” (i.e. not a nurse, medic/GP or case manager). In the majority of cases, the occupation of these individuals was not recorded: a range of occupations, including “podiatrist”, “consultant”, “dermatologist” and “surgeon” were recorded in low frequencies. In all Trusts, the majority (77% or more) of personnel involved with the changing of dressing were nurses or district nurses.

The overall distribution of treatment locations was similar across all Trusts, with the majority of wounds treated in community clinics or in the patient’s home. A minority of wounds were treated at a hospital clinic. The Trusts in which the largest proportion of patients were treated in their own homes were Trusts 4 and 5, with over 80% of wounds treated in this way in these Trusts (Table 2).

Wound categories
A proportion of patients were reported as having multiple wounds and these were recorded by staff on separate forms during the audit, with each wound being counted and analysed separately. The most common wounds in all Trusts except Trust 4 were venous leg ulcers, with 849 venous leg ulcers being recorded in total (20.0% of all wounds). In Trust 4, the most common wounds were traumatic wounds, which were recorded in slightly higher numbers ($n=93$) than venous leg ulcers ($n=91$) in that Trust. However it is worth noting that the majority (80.1%) of these traumatic wounds were located on the lower limb and as such may have in fact been leg ulcers if the duration had been in excess of 6 weeks. After venous leg ulcers, traumatic wounds (591; 13.9%) and surgical wounds (535; 12.6%) represented the next most common types of wounds recorded over all Trusts. No other wound type accounted for more than 8.4% of the total number of recorded wounds; however, all types of pressure ulcer considered together amounted to 767 (18.1%) of all wounds (Table 3). The European Pressure Ulcer Advisory Panel classification (2010) was used by all respondents when identifying a pressure ulcer.

Substantive associations recorded between common wound types and comorbidities at Trust level were also found to exist on the combined data set. Venous leg ulcers were most strongly associated with vascular and cardiovascular conditions, with 215 patients with a venous leg ulcer (39.7%) having vascular conditions, and 117 patients with a venous leg ulcer (21.6%) having cardiovascular conditions. Mixed leg ulcers were also strongly associated with vascular conditions, with 93 mixed leg ulcer patients (46.0%) having this condition. Main reported comorbidities are summarised in Figure 1.

Table 2. Personnel involved and location of treatment plan and dressing change.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment plan decision personnel</td>
<td></td>
</tr>
<tr>
<td>Nurse/district nurse</td>
<td>3223 (79.6)</td>
</tr>
<tr>
<td>Medic/GP</td>
<td>142 (3.5)</td>
</tr>
<tr>
<td>Other</td>
<td>686 (16.9)</td>
</tr>
<tr>
<td>Personnel changing dressing</td>
<td></td>
</tr>
<tr>
<td>Nurse/district nurse</td>
<td>3304 (83.6)</td>
</tr>
<tr>
<td>Support worker</td>
<td>144 (3.6)</td>
</tr>
<tr>
<td>Other</td>
<td>506 (12.8)</td>
</tr>
<tr>
<td>Treatment location</td>
<td></td>
</tr>
<tr>
<td>Patient’s home / community</td>
<td>2987 (76.8)</td>
</tr>
<tr>
<td>Community clinic</td>
<td>526 (13.5)</td>
</tr>
<tr>
<td>Nursing home</td>
<td>284 (7.3)</td>
</tr>
<tr>
<td>Other</td>
<td>90 (2.3)</td>
</tr>
</tbody>
</table>
Few obvious associations between gender and wound type were recorded in any of the individual Trusts or in the total sample; however, despite females outnumbering males by 3:2 in the whole sample, the majority of surgical wound patients (237; 53.3%) and diabetic foot ulcer patients (84; 55.6%) were male. Females outnumbered males in all other wound categories.

Across all Trusts, older patients had generally higher frequencies of wounds than younger patients.

Table 3. Wound type.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound type</td>
<td>4247</td>
</tr>
<tr>
<td>Pressure ulcer category 1</td>
<td>121 (2.8)</td>
</tr>
<tr>
<td>Pressure ulcer category 2</td>
<td>355 (8.4)</td>
</tr>
<tr>
<td>Pressure ulcer category 3</td>
<td>203 (4.8)</td>
</tr>
<tr>
<td>Pressure ulcer category 4</td>
<td>88 (2.1)</td>
</tr>
<tr>
<td>Venous leg ulcer</td>
<td>849 (20.0)</td>
</tr>
<tr>
<td>Mixed leg ulcer</td>
<td>275 (6.5)</td>
</tr>
<tr>
<td>Diabetic foot ulcer</td>
<td>200 (4.7)</td>
</tr>
<tr>
<td>Total leg/foot ulcers</td>
<td>1324 (31.2)</td>
</tr>
<tr>
<td>Traumatic wound</td>
<td>591 (13.9)</td>
</tr>
<tr>
<td>Arterial leg ulcer</td>
<td>151 (3.6)</td>
</tr>
<tr>
<td>Fungating lesion</td>
<td>60 (1.4)</td>
</tr>
<tr>
<td>Surgical wound</td>
<td>535 (12.6)</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>104 (2.4)</td>
</tr>
<tr>
<td>Skin tear</td>
<td>243 (5.7)</td>
</tr>
<tr>
<td>Burn</td>
<td>31 (0.7)</td>
</tr>
<tr>
<td>Moisture lesion</td>
<td>95 (2.2)</td>
</tr>
<tr>
<td>Haematoma</td>
<td>27 (0.6)</td>
</tr>
<tr>
<td>Other</td>
<td>319 (7.5)</td>
</tr>
</tbody>
</table>

Wound characteristics

Across all Trusts, the proportion of wounds located on the leg was consistently found to be about half the total number of wounds recorded. Overall, leg wounds amounted to 2350 (50.3%) of all wounds. Interestingly, some practitioners differentiated between leg, thigh, and foot/toe, and as such, there were an additional 286 (6.1%) wounds recorded as being located on the thigh, and a further 705 (15.1%) wounds recorded as being located on the foot/toe.

Of all wounds 434 (9.3%) were recorded on the buttck. No other location amounted to >5.0% of reported wounds. There were no obvious differences in the proportions of wounds in various locations between Trusts (Table 4).

In all Trusts, most recorded wounds were short in duration. The proportion of wounds of <6 weeks’ duration was lower in Trust 5 (49.7%) than in other Trusts. In all other Trusts, this category represented over half of all recorded wounds. In the entire sample, 2493 (53.5%) of all wounds were of <3 months’ duration, with the median wound duration between 6 weeks and 3 months (Table 5).

In most Trusts, the majority of observed wounds were judged to be improving on observation, although in Trust 5 this proportion was slightly lower (49.5%). Overall the total number of wounds judged to be healing was 2563 (55.4%). However, there were no obvious differences in the improvement rates shown over the five Trusts. The proportion of wounds judged to be deteriorating was very consistent at between 8.9% and 9.7% (Table 6).

In all Trusts, a very wide variety of wound lengths and widths was recorded, with most Trusts recording wounds up to about 50–60cm in length (no wounds >28cm in length were recorded in Trust 2). Mean wound lengths and widths were very consistent, ranging from 3.14 cm (length) and 2.23 cm (width) in Trust 1 to 3.84 cm (length) and 2.65 cm (width) in Trust 4. Over the whole data set, mean wound length
was 3.46 cm (standard deviation [SD], 4.24 cm) and mean wound width was 2.42 cm (SD, 2.95 cm). Depth assessments were also very consistent with between 77% and 82.3% being classified as superficial in each Trust (79.6% overall, Table 6).

Some differences across Trusts were noted in the proportion of wounds observed to be granulating; varying from 54.0% in Trust 2 to 38.5% in Trust 5 (45.7% overall). Most wounds across all Trusts were categorised as moist. Surrounding skin was categorised as dry or healthy/normal in a majority of cases in all Trusts, with no significant differences across Trusts in the proportions of wounds classified in this way.

Practitioners across all Trusts assessed all wounds for signs of infection using appropriate indicators of wound infection. While a majority of wounds in all Trusts were classified as free from infection, the proportions varied slightly from 58.3% in Trust 1 to 68.2% in Trust 2 (overall 64.3%). The most common infection indicator was delayed healing (639; 13.4%), significantly greater in frequency than the indicators increased pain and increased exudate (Table 6). A total of 310 patients (6.5%) had three or more infection indicators. Amongst these patients, a different pattern was apparent. The most common infection indicator was increased exudate (194; 17.9%); followed by delayed healing and increased pain (Table 6).

Antimicrobials were used in 151 patients with 3 or more infection indicators (48.7%). The incidence of wound swabbing varied widely between Trusts, from 2.4% in Trust 3 to 12.1% in Trust 2 (8.4% across the whole sample). Hence rates varied by a factor of 5 across Trusts, although the baseline proportion was low. Likewise, use of antibiotics varied widely. Again rates were lowest in Trust 3 (9.0%) and highest in Trust 2 (17.0%) – greater by a factor of 2. The rate for the whole sample was 12.6%. In all Trusts, swabbing was considerably more common in wounds showing no primary infection indicator (Table 7).

In all Trusts, the most commonly quoted treatment objective was protecting granulation, stated as a treatment objective in a majority of cases (ranging from 55.9% in Trust 5 to 66.1% in Trust 1). Quoted objectives were consistent across Trusts. In addition to protecting granulation, all five Trusts quoted protection of surrounding skin and managing exudate as key treatment objectives (Table 7).
The incidence of the Doppler/ankle–brachial pressure index (ABPI) procedure also varied widely (by a factor of 3) between Trusts – from 48.4% in Trust 3 to 16.0% in Trust 5 (32.3% overall). The incidence of compression therapy varied by a factor of 2 between Trusts – from 31.2% in Trust 3 to 16.1% in Trust 4 (26.6% overall). In all Trusts, the majority of patients who received either the Doppler/ABPI procedure or compression therapy also received the second procedure (728 out of 1292 patients; 56.3%).

While in all Trusts the majority of dressings were changed weekly or twice-weekly, the proportions of dressings changed at this rate varied from 75.6% (Trust 5) to 62.5% (Trust 4), with an overall proportion of 70.2%. Remaining dressings were changed three or more times per week. For over half of all patients (2420; 55.0%), the primary reason for the dressing change was a routine care change, with individual proportions varying from 51.3% (Trust 5) to 60.9% (Trust 4).

Dressings changed because of expected wear time being reached (1331 patients; 27.9%) and because the dressing was saturated (720 patients; 15.1%) also amounted to a significant proportion of the reported reasons in both the individual Trusts and in the whole sample. No other reason for a dressing change was quoted in more than 10% of cases (Table 8).

Across all Trusts, practitioners formulated treatment plans that encompassed clear treatment objectives. These are presented in Figure 2.

**SUMMARY**

This survey was performed across five English Trusts consisting of 4772 responses from practitioners involved in wound care activities. It was interesting to note that practitioners reported that those patients who were diagnosed as having venous leg ulcers also presented with vascular and cardiovascular conditions. This requires further investigation, as there may have been some level of misdiagnosis with ulcers being of mixed aetiology. If this is the case, there is an educational need to ensure that all practitioners are able to accurately assess and diagnose ulcer aetiologies and understand the importance of seeking guidance if there are any uncertainties regarding diagnosis.

Identification and management of infected wounds was explored in the survey and highlighted that clinical decision making varied between the

---

**Table 7. Wound treatment factors.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid n (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound swabbing</td>
<td></td>
<td>4557</td>
</tr>
<tr>
<td>Yes</td>
<td>384 (8.4)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4173 (91.6)</td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
<td>4500</td>
</tr>
<tr>
<td>Yes</td>
<td>566 (12.6)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3934 (87.4)</td>
<td></td>
</tr>
<tr>
<td>Treatment objectives†</td>
<td></td>
<td>10355</td>
</tr>
<tr>
<td>Protecting granulation</td>
<td>2804 (58.8)</td>
<td></td>
</tr>
<tr>
<td>Debridement of necrosis</td>
<td>1024 (21.5)</td>
<td></td>
</tr>
<tr>
<td>Manage bacterial burden</td>
<td>778 (16.3)</td>
<td></td>
</tr>
<tr>
<td>Rehydration of wound bed</td>
<td>354 (7.4)</td>
<td></td>
</tr>
<tr>
<td>Palliative</td>
<td>162 (3.4)</td>
<td></td>
</tr>
<tr>
<td>Manage exudate</td>
<td>2052 (43.0)</td>
<td></td>
</tr>
<tr>
<td>Protection of surrounding skin</td>
<td>2003 (42.0)</td>
<td></td>
</tr>
<tr>
<td>Managing wound pain</td>
<td>790 (16.6)</td>
<td></td>
</tr>
<tr>
<td>Minimise odour</td>
<td>388 (8.1)</td>
<td></td>
</tr>
</tbody>
</table>

† More than one treatment objective could be selected per patient. Percentages refer to full sample. A valid response to this question was recorded in 94.9% of cases.

**Table 8. Dressing changes.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid n (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of dressing change</td>
<td></td>
<td>4610</td>
</tr>
<tr>
<td>More than daily</td>
<td>119 (2.6)</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>309 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Alternate days</td>
<td>358 (7.8)</td>
<td></td>
</tr>
<tr>
<td>3 times per week</td>
<td>587 (12.7)</td>
<td></td>
</tr>
<tr>
<td>Weekly</td>
<td>1079 (23.4)</td>
<td></td>
</tr>
<tr>
<td>Twice weekly</td>
<td>2158 (46.8)</td>
<td></td>
</tr>
<tr>
<td>Reason for dressing change</td>
<td>54071</td>
<td></td>
</tr>
<tr>
<td>Dressing coming off</td>
<td>356 (7.5)</td>
<td></td>
</tr>
<tr>
<td>Scheduled care change</td>
<td>2517 (52.7)</td>
<td></td>
</tr>
<tr>
<td>Reaction to dressing</td>
<td>21 (0.4)</td>
<td></td>
</tr>
<tr>
<td>Patient expectation</td>
<td>160 (3.4)</td>
<td></td>
</tr>
<tr>
<td>Dressing saturated</td>
<td>720 (15.1)</td>
<td></td>
</tr>
<tr>
<td>Patient removal</td>
<td>171 (3.6)</td>
<td></td>
</tr>
<tr>
<td>Expected wear time</td>
<td>1331 (27.9)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>131 (2.7)</td>
<td></td>
</tr>
</tbody>
</table>

Note: More than one reason could be selected per patient. Percentages refer to full sample. A valid response to this question was recorded in 92.2% of cases.

---

“In addition to protecting granulation, all five Trusts quoted protection of surrounding skin and managing exudate as key treatment objectives.”
expansion is required as to which indicators of infection lead a practitioner to swab a wound or prescribe an antimicrobial wound dressing. The importance of the ageing population was clearly identified in the workload of practitioners managing all wound types and the promotion of skin integrity. It was noted that over 50% of patients were over the age of 81 years. This relates to the figures produced by the Office of National Statistics (2011). Examination of the data has identified that there are a wide range of wound types that require assessment and treatment, with a percentage of these wound types being complex. If, as predicted, a large proportion of the health workforce retires by 2015, and managers and other unregistered staff. If workforce numbers do not increase, there will be a need to investigate and explore the feasibility of teaching patients and their families/carers to manage uncomplicated wounds when discharged to their home environment, thus ensuring that the wound is managed effectively and that patients, their families and carers understand how to promote skin integrity.

DECLARATION OF INTEREST
This article was sponsored by an unrestricted grant from Coloplast Ltd.

TABLE 1. Multicentre wound care survey form (based on Fletcher[2010]).

<table>
<thead>
<tr>
<th>A MULTICENTRE WOUND CARE SURVEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please only complete this form if the patient has a <strong>NEW</strong> healed wound</td>
</tr>
</tbody>
</table>

1. **Patient demographic – Please tick appropriate**
   - Age
     - Under 16
     - 16–30
     - 31–40
     - 41–50
     - 51–64
     - 65–74
     - 75–84
     - Over 85
   - **Occupation**

2. **Exclusion criteria**
   - a. **Past medical history**
     - Registered Nurse
     - Medical Doctor
     - Specialist Nurse
     - Other
   - b. **Past medical history**
     - Registered Nurse
     - Medical Doctor
     - Specialist Nurse
     - Support Worker
     - Other
   - c. **Past medical history**
     - Registered Nurse
     - Medical Doctor
     - Specialist Nurse
     - Support Worker
     - Other

3. **Other options**
   - Please tick an appropriate generalisation of infection
   - Immunocompromised
   - Immunodeficient
   - Immunological Condition
   - Traumatic injury
   - Surgical Incision
   - Other

4. **Other options**
   - Please select
   - A. Please select
     - Arthritis
     - Diabetes
     - Parkinson's
     - Other

5. **Other options**
   - Please select
     - A. Please select
       - Rheumatoid Arthritis
       - Osteoarthritis
       - Other

6. **Wound characteristics – Please tick appropriate**
   - **Wound size**
     - Please state the maximum length (___cm), maximum width (___cm) and depth
   - **Wound characteristics**
     - Full thickness skin loss
     - Partial thickness skin loss
     - Epithelialising (pink)
     - Granulating (red)
     - Mixed (leg ulcer)
     - Mixed (arm/hand ulcer)
     - Mixed (other)
   - **Wound characteristics**
     - Moisture
     - Dryness
     - Viscous surface layer
     - Thick crust
     - Odour
     - Malodour
     - Infection
     - **Wound characteristics**
       - Please state the infection – Please select
         - Generalised infection
         - Abscess
         - Cellulitis
         - Ischemia
         - Nocardia infection
         - Other
   - **Wound characteristics**
     - Wound pain
     - Please select
       - No
       - Yes
       - Pain at dressing
       - Other

7. **Wound pain**
   - Please select
     - Yes
     - No
     - Pain at dressing
     - Other

8. **Wound management**
   - Please select
     - Yes
     - No
     - Pain at dressing
     - Other

9. **Wound management**
   - Please select
     - Yes
     - No
     - Pain at dressing
     - Other

10. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

11. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

12. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

13. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

14. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

15. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

16. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

17. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

18. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

19. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

20. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

21. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

22. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

23. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

24. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

25. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

26. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

27. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

28. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

29. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

30. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

31. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

32. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

33. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

34. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

35. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

36. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

37. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

38. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

39. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

40. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

41. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

42. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

43. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

44. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

45. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

46. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

47. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

48. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

49. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

50. **Wound management**
    - Please select
      - Yes
      - No
      - Pain at dressing
      - Other

Thank you for your time.

REFERENCES
Labour Market in 2004/2005: Intelligence, London
Within the Nursing and Midwifery Education Institutions, The Education and Training of Medical Professionals 4(1):23–32
Dunkley L, Haider S (2011) Nursing and Midwifery Workforce Risks and Opportunities: A Report to Review the Key Workforce Risks and Opportunities Within the Nursing and Midwifery Workforce. Centre for Workforce Intelligence, London
Figures 2. Wound treatment objectives.