Deery, Ruth

Wound care and pressure ulceration in midwifery: a neglected area?

Original Citation


This version is available at http://eprints.hud.ac.uk/id/eprint/9642/

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: E.mailbox@hud.ac.uk.

http://eprints.hud.ac.uk/
Wound care and pressure ulceration in midwifery: a neglected area?

Wound care and pressure ulceration in midwifery are important and neglected areas within the profession where much work needs to be done, both clinically and educationally. Indeed, the National Patient Safety Agency (NPSA) has announced plans to work with the NHS to reduce levels of harm in ten high risk areas and one of these is ‘reducing avoidable harm in childbirth’ (NPSA, 2010). Although I am now an academic midwife, I still practise as a bank midwife in local NHS birth centres and community midwifery and have a long career history in the NHS. During my career I have seen advice and treatments for wound care in our profession change regularly, and often according to the preferences of the obstetrician and midwife. Pressure ulceration is not a new phenomenon in midwifery, but the need to avoid unnecessary harm to women in childbirth is becoming increasingly important because of advances in pain management and choices now available for women.

Advances in pain management mean that many women making informed decisions when completing their birth plans choose epidural anaesthesia as a form of pain relief. Women may also choose, or be advised, to use this option when they are in labour. Indeed, some women are transferred from birth centres to hospital settings because they have chosen to have an epidural sited. Epidurals come with disadvantages; women whose labours are prolonged, or end in caesarean sections, are at increased risk of developing pressure ulcers because of their reduced mobility.

Women whose labours are prolonged, or end in caesarean sections, are at increased risk of developing pressure ulcers because of their reduced mobility.

In my clinical experience, most anaesthetists are able to site epidurals so that women have some leg mobility, but they are often sitting in the same position for the majority of their labour. Women whose labours are prolonged, or end in caesarean sections, are at increased risk of developing pressure ulcers because of their reduced mobility. It is imperative therefore, that midwives become familiar with recent trends in prevention and management of pressure ulceration and the required risk assessment.

Supporting women to breastfeed is a crucial part of the midwife’s role, and both professional and peer support have been identified as key components to successful breastfeeding (Schmeid et al, 2010). Correct positioning of the baby at the breast is vital, and, as midwives, we work hard with women to optimise this aspect of their breastfeeding experience. However, cracked (broken skin) nipples do sometimes occur despite best efforts from women and midwives. Women often ask what they can apply to cracked nipples to expedite the healing process. In the past exposing the nipples to air has been advised (which we now know is ineffective), but expressed breast milk is still recommended to aid healing as the epidermal growth factor in breast milk could have potential benefits in promoting the growth and repair of skin cells (Renfrew et al, 2000).

Mixed conclusions are presented in the evidence regarding the effectiveness of topical treatments such as ointments or lanolin creams (Morland-Schultz and Hill, 2005), although such treatments are popular with women and midwives. Cracked and sore nipples should be able to heal without ointments or lanolin creams providing advice about positioning the baby at the breast is given (Renfrew et al, 2000).

What we have not been good at in midwifery is prioritising wound care and treatment; this has almost become ‘unimportant’ in a culture where midwives are swamped by immediate process driven demands, such as paperwork and meeting targets, that currently seem to control the organisation of midwifery work (Bryson and Deery, 2009).
Do you have a topic that you would like to raise and discuss in Wounds UK?
If so, please contact binkie.mais@wounds-uk.com

Wounds UK, 2011, Vol 7, No 1