



National Wound Care Strategy Programme

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Wound Care Digital Case Study: Molly's Story

This is the story of Molly and how digital technology improved her care for her leg ulcer.

Molly is 68 years old and has a leg ulcer. She also has other long-term chronic conditions, including chronic obstructive pulmonary disease, longstanding lymphoedema, asthma, chronic heart failure, Type 2 diabetes mellitus and depression.

Molly takes a combination of medication to control her long-term conditions and has been seen daily by the community nurses for 6 years for leg ulcer dressings due to the volume of wound exudate.

Different clinicians would visit Molly at home and there was confusion about her care as other specialists did not have access to the patient record and over time, the visiting community nurse assumed complete responsibility. Some of the written clinical documentation was incomplete or illegible so it was difficult to ensure continuity, adhere to an agreed treatment plan or evaluate progress. There were few wound measurements, even fewer wound photographs and no information about referrals to tissue viability or other specialist services.

Molly's wound care record was made up from a mixture of paper forms, spreadsheets, scans, reports and images, not presented in a single file. This made it difficult to track any progress or produce historical reports without intense manual work.

Using a Mobile Wound Management Digital System

The community nurses were issued with an app on a tablet device and given training on how to use the Wound Management Digital System (WMDS) to record their wound assessments. The WMDS allows consent to capture images for use within the patient record to be logged. It also enables wound photography and wound measurement (using a semi-automated wound measuring tool) and for each tissue type. The WMDS can also record information relevant to wound care such as co-morbidities and medication.

Every clinician who visits Molly can access all previous wound assessments and treatment plans and see graphical representation of Molly's wound healing.



Although the WMDS record depends on how well the clinician enters data, the WMDS identifies who has entered data so any problems can be easily identified and addressed through support and education. Any subsequent changes made to the record are captured and available through an audit trail.

The first visit is undertaken by both the community nurse and the lymphoedema specialist nurse. The assessment (including an ankle/brachial pressure index recording 'Doppler') and treatment plan (visits three times a week, antibacterial topical treatment and compression therapy) is recorded on the WMDS along with the treatment aims (such as wound healing and improved patient satisfaction and quality of life).

At each subsequent visit, the clinician records treatment and progress, including regular wound photography and weekly wound measurement using the integrated measuring tool. Other items recorded include dressing change frequency and pain levels.

All clinicians involved in Molly's care can access the WMDS data. When a visiting clinician has questions or concerns, while at Molly's home, they can photograph the wound and share the image with colleagues for advice. The healing progress graph gives useful visual information and encouragement to both Molly and her clinicians.

Molly had received care for her leg ulcer for 6 years but following introduction of the WMDS, she heals within 6 weeks. This success is attributed to the WMDS supporting a consistent approach to care and better communication between the different clinical teams involved in Molly's care. The WMDS also enables quicker clinical assessment and recording and less time spent searching for information.

Recording clinical data at the point of care improves care and reduces bureaucratic overheads.

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