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Ousey, Karen

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Do we understand health-related-quality-of-life outcomes?



KAREN OUSEY
Clinical Editor, *Wounds UK*,
Reader in Advancing Clinical
Practice, School of Human and
Health Sciences, University
of Huddersfield, Clinical As-
sociate Professor, Australian
Catholic University

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Last year I was afforded the opportunity of investigating Health Related Quality of Life (HRQoL) outcomes for patients with wounds, through a Florence Nightingale Travel Scholarship. Since my return from Australia, I have been thinking about how we identify and enhance HRQoL outcomes for the range of wound conditions that we see and treat in clinical practice. When I speak to practitioners, they all assure me that understanding and maintaining quality of life for their patients is a priority. However, how do we know we have enhanced quality of life for patients? How do we measure it and, importantly, how do we record the effect our interventions have had upon HRQoL outcomes?

Can we all define HRQoL? Do we use these definitions when planning and evaluating care? Do we fully understand the concept? The concept of HRQoL and its determinants has been discussed and researched since the 1980s, encompassing both physical and mental health domains and how these affect an individual's quality of life (Centers for Disease Control and Prevention, 2000; Selim et al, 2009). Quality of life (QoL) was defined by the World Health Organization (1949) as a state of complete physical, mental, and social wellbeing and not merely an absence of disease and infirmity. We can therefore assume that HRQoL focusses specifically on the impact that treatment may have on QoL. With this in mind, how do wound care treatments affect HRQoL? We use a range of pressure-redistributing devices to prevent skin damage, numerous wound care products to enhance wound healing, compression bandaging and hosiery to manage leg ulceration; we advise patients to rest at regular intervals, not to sit out of bed for lengthy periods of time, or indeed instruct them to wait in the home for a visit from the district nurse. We do this because we want to encourage wound healing and prevent deterioration; however, what impact do our interventions have on HRQoL outcomes? Do we assess the impact this may have and record the outcomes?

Asking a patient to wait at home for the district nurse, for example, may be negatively affecting the social domain of care through missing social appointments. Application of wound dressings that may be bulky due to bandaging may affect mobility of a limb and have adverse consequences for normal activities of daily living; for example, a bandage to the upper limb can restrict getting dressed and cooking. These are areas we must consider and, while I believe the majority of practitioners do consider these, documentation of the impact they have on both QoL and HRQoL can be minimal. Recognition of improving and maintaining QoL has developed since April 2010 (DH, 2012), when Trusts have been required to produce an annual Quality Account incorporating three principles of safety, effectiveness and patient experience. Much of this data has been retrieved from information analysed through Patient Reported Outcome Measures and Patient Reported Experience Measures. So my questions are: how do you measure QoL and HRQoL, which tools do you use for measurement, and do you know where to access data relating to your own service? If you do not, then this is the time to locate that data and share with your colleagues. Importantly, the only way to improve HRQoL and enhance the patient experience is to understand what QoL means to your patient groups. How do we do this? We need to sit with patients and communicate with them, listening to what they say and listening to the carers and families of these patients. What help and advice do they need to assist them in caring for their family's needs? With time as an in-patient shortening, families and carers are taking on a more demanding role in caring in the community. It is here that we need to focus our attention, to enhance and improve the patients' experience of living with a wound. **WUK**

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