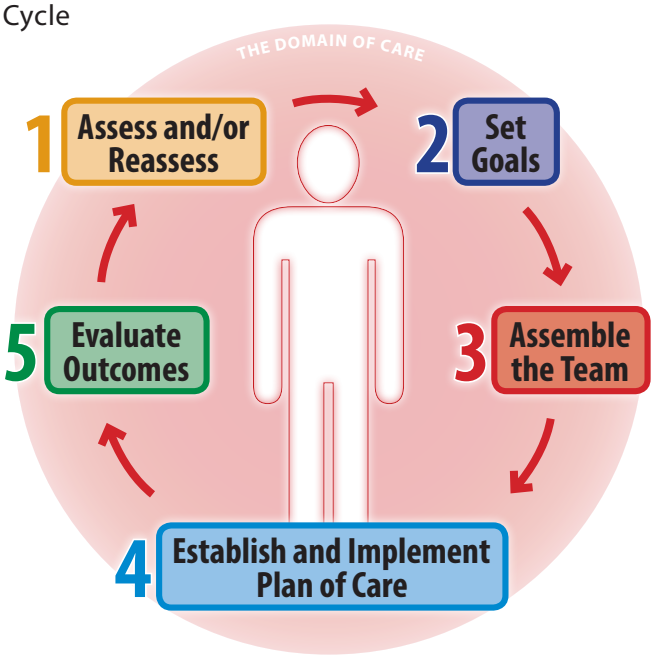
Using the Wound Prevention and Management Cycle to Create a Professional Development Process

By Heather L. Orsted, RN, BN, ET, MSc

"A leader is one that knows the way, shows the way and goes the way."
— John C. Maxwell, author on leadership

The Wounds Canada Wound Prevention and Management Cycle (WPMC)[1] (Figure 1), like other process tools, has multiple uses. In this article, the tool is used to assist readers who want to become effective wound care leaders, individuals who have the knowledge, skills and attitude to develop expertise in others and ensure the implementation of best practice in their health-care settings.

Figure 1. Wound Prevention and Management Cycle



Step 1:
Assess and/or reassess your current skills as a wound leader.

Wound leaders require more than a weekend wound care course—though that's a good place to start, as it lets you know if this is or could be your passion. But to be a wound leader, you need advanced training, usually a graduate program. Do you know where you stand? Do you have the advanced skills you will need to develop others?

"Leadership and learning are indispensible to each other."
— John F. Kennedy, former U.S. president

"There are no mistakes in life, just lessons."
— Robin Sharma, writer and leadership speaker

Do you have the in-depth knowledge required to overcome the barriers to best practice that you and the rest of your team will face?

Effective wound leaders need training and skills to be able to delegate, support change, empower and build consensus, support policy, deliver education, develop programs and communicate effectively both in person and through publications.

Step 2:

Set goals to plan for your future and keep ahead of the curve.

How do you want to grow over the next five years? Ten years? Do you have strategic goals and objectives? Have you set both short-term and long-term goals? Have you articulated them to others?

Professional development goals, like all goals, need to meet the SMART criteria (**S**pecific, **M**easureable, **A**chievable, **R**ealistic, **T**ime-based) to be effective. They may involve taking courses, developing mentoring relationships, working in multiple care settings or initiating change in your current setting.

Step 3:

Assemble a team to support and sustain best practice in a clinical setting.

I once said, "The blood on the wall is mine," when, as a newly minted wound leader, I lamented banging my head against the wall over the futility of practice change. Then I discovered Kitson.

Kitson et al.[2] described three factors that influence the uptake of evidence into practice:

- The evidence is scientifically robust (research, clinical experience, client preferences).
- The context is receptive to change (person, environment or clinical setting).
- The change process is appropriately facilitated (characteristics, role and style of facilitator).

In other words, if you want to implement change successfully, you must do the following:

1. Ensure the need for your proposed policy or procedure is backed by the evidence. Be prepared to explain your evidence-supported rationale for making a change.

"Alone we can do so little,
together we can do so much."
— Helen Keller, author, activist, lecturer

2. Get the support you will need to implement and then sustain the change you are trying to make. This support will need to come in two forms: a management team to support the leader in practice, policy and program development, and a clinical team to deliver best practice to the population. Both are equally important.

3. Identify and use the most effective members of your team to facilitate the implementation of the change. Ensure that the team is integrated, meaning it is multidisciplinary on the professional side and includes the patient, family and other supporters on the non-professional side.

In other words, don't try to do it without support!

Step 4:

Establish and implement coaching and mentoring strategies to develop your team.

Coaching and mentoring are two approaches wound leaders can use to develop individuals and teams. When creating a plan, effective leaders often use a mix of these two, depending on the needs of the learner and the availability of more experienced individuals who can serve as mentors and coaches. The leader does not necessarily have to fulfill either role.

What's the difference between the two approaches? Coaching is usually more short-term than mentoring, and has a more task-oriented, immediate focus. Coaching is useful for skills development and specific improvements. Mentoring generally takes place over a longer period of time, sometimes even over an entire career, and is centred more on long-term, career-type goals (see the case study on this page for specific examples of each).

"Coaching is the universal language of change and learning."
— Cable News Network (CNN)

"The delicate balance of mentoring someone is not creating them in your own image, but giving them the opportunity to create themselves."
— Steven Spielberg, film director, producer, screenwriter

Case Study:

Development of a SWAT (Skin and Wound Assessment and Treatment) Team in Calgary

The development of a SWAT team in Calgary illustrates the change process using the implementation of a system-wide plan that incorporated team-based care, ongoing professional development and policy change.

In 1994 I began working in a home-care setting that was large in area and population. I was responsible at any given time for about 400 clients with wounds. As the one person with advanced wound care knowledge and skill, I did my best to keep up and put out fires, but I quickly assessed that one person could only do so much (Step 1). A team was what was needed, and I set this as a priority goal (Step 2) to move forward.

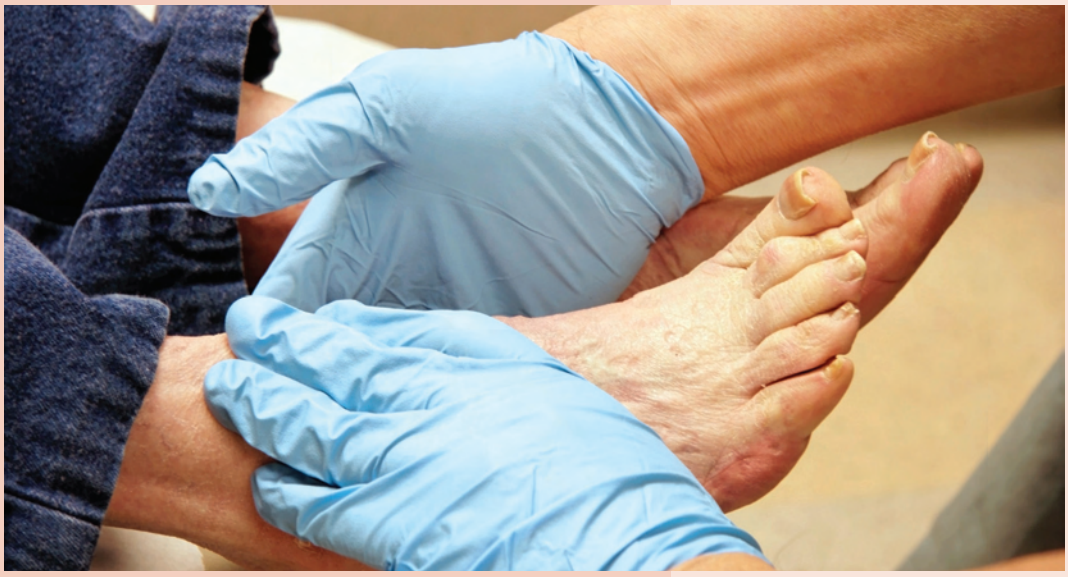
When I initially proposed the development of a wound care team, the concept was rejected. After a change in upper management, the proposal was resubmitted and this time it received strong agency support. The SWAT team was created.

In March 1996 the 25-member multidisciplinary SWAT team of registered nurses (RNs), physiotherapists (PTs) and occupational therapists (OTs) was formed (Step 3) and they began a self-paced journey through 10 structured, evidenced-based learning modules (Step 4) based on our mission, vision and values.

I built these modules on the evidence identified by the two newly released Agency for Health Care Policy and Research (AHCPR) clinical practice guidelines.[3,4] Referred to by our team as the "purple books," they were among the first of their kind, and, though they were based on the treatment of pressure wounds, the content and references related to wounds in general.[5] In time, the textbooks by Krasner et al.[6,7] became our major resource, and we accumulated an extensive reading library. The team also attended two to three hours of in-service training every month to discuss practice issues.

I had been using Benner as a model to develop my wound care novices, but within a couple of years, I realized I no longer had novice learners and needed to revisit my approach (Step 5) to allow them to advance their learning.[8] As they continued to develop professionally, many of them attended and presented at national and international conferences. Some became leaders in their own right, obtaining advanced education and moving into leadership roles themselves.

Additional team support was provided by the family physician and other medical staff involved in care, social workers, a dietitian, and, as required and by referral, other health-care professionals. This team also availed themselves of the great support from local vendors who provided garments, shoe fits and home-support services.



Interestingly, over time I rarely saw a client without members of the team in attendance. Often we had the client, caregiver, family, nurse, and members of the SWAT team in the home. My goal was to ensure everyone was learning and developing skills in a safe, patient-centred environment designed to meet the needs of our clients, and this was something I evaluated regularly, both formally and informally (ongoing Step 5).

Coaching and Mentoring

Staff development through coaching:
The SWAT team program had milestones that needed to be met, from knowledge and skill development to learning and change in practice. To reach the milestones, it was important that coaching be part of the professional development mix. To effectively coach in order to drive performance, we needed strong performance parameters that were supported by equally strong policies and procedures.

Staff development through mentoring:
Mentoring was quite different, in that some team members chose to move forward beyond what was expected of them within the parameters of their position. Looking for and encouraging that spark for learning is a big part of being a mentor. I came to see the team environment as an incubator, with many on the team developing leadership skills themselves as they moved from novice to expert over the years. Mentoring proved to be the strongest driver toward sustainability of the program, in that the mentored staff became leaders supporting the ongoing development of the SWAT team program.

The RNs were the only members to approve advanced dressings, OTs were the only members to do pressure mapping and the PTs addressed vascular flow through Doppler assessments. So to discourage isolated practices and encourage full team involvement and mutual coaching, teams were required to visit the clients together.

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Step 5:

Evaluate outcomes to determine if leadership has been effective in supporting learning.

After moving through the WPMC steps, evaluate your outcomes to determine if they have met the goals you set in Step 2. If not, go back and reassess, revisit your goals and revise the plan as necessary.

Becoming a wound leader can be both rewarding and frustrating, but it's something that is worth doing. And rest assured that having a process to help you through it will reduce the frustration and increase the rewards.

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