Wound management is responsible for approximately 4% of the annual UK health-care budget (Posnett and Franks, 2007). There are no exact figures relating to how much of the Irish health-care budget is spent on wound care of all aetiologies; however, the cost of the management of chronic wounds to the Irish health service Executive (HSE) is estimated at €285.5 million per year (McDermott-Scales et al, 2009). In today’s fiscally challenging climate it is imperative that service managers and planners adopt clinical interventions that are effective, efficient and acceptable to both patients and staff (Gethin et al, 2005; Vowden and Vowden, 2008). At this point, there is a dearth of information regarding this clinical burden related to chronic wounds within the Irish health-care setting (Balanda et al, 2005; Clarke-Maloney et al, 2006; Laurant et al, 2006). Thus, as there is little evidence to determine the prevalence and aetiology of wounds in a community area, including the resources allocated to the provision of wound care, it is pertinent to conduct a study to enhance the understanding of this clinical problem (McDermott-Scales et al, 2009).

Wound management

In general, wound management is costly and challenging with respect to current health services scarce resources (HSE, 2009; Vowden and Vowden, 2008; Vowden et al, 2009; Cooper et al, 2010; Moore and Cowman, 2005). Although wound care has been brought to the forefront in terms of education and research, neither the incidence nor prevalence of wounds is reducing (Moore and Cowman, 2005; Dini et al, 2006; European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP), 2009). Wound management involves more than just selecting the right dressing—all factors that affect healing rates must be considered when treating chronic wounds (Moore and Cowman, 2005; Chandan et al, 2009).

Approaches to health care have changed over the last decade,
with a greater emphasis being placed on primary care, resulting in new challenges in the management of wounds within community nursing services (Laurant et al, 2006; HSE, 2009; McDermott-Scales et al, 2009). To provide cost-effective, quality wound care, it is important to have an understanding of the extent of the burden wound management places on community services (Posnett and Franks, 2007; Vowden and Vowden, 2008; Vowden et al, 2009). Indeed, having information regarding the number of wounds in a community care setting and their associated aetiology will provide nurses and nursing managers with an insight into the specific needs of these clients and may also highlight areas where care or services can be improved or further developed (Vowden et al, 2009). Changing population demographics and the predicted rise in the number of older people in the future suggests that there will be a corresponding increase in the number of people with wounds, highlighting the importance of implementing effective management strategies (HSE, 2009; Vowden and Vowden, 2008; Vowden et al, 2009; Moore and Cowman, 2005; Chandan et al, 2009).

**Method**

This was a single-site cross-sectional descriptive survey, employing a purposive sampling strategy. This research was carried out in a large community care area in Ireland that has a defined population of 118,379 (Central Statistics Office, 2011). This community area incorporates 16 health centres, 8 of which are in built-up urban areas and 8 of which are in large rural geographical areas. There were 14 community registered general nurses (CRGNs) with varying contractual working hours (equating to 8 full-time CRGNs) plus the equivalent of 17 area public health nurses (PHNs) (see Box 1) working in this community setting during the week of the study. During the week of the survey, the active caseload was 3596, all of whom were over 18 years of age. Data were collected pertaining to each client with a wound, over a 1-week period by CRGNs or PHNs as requiring wound management (point prevalence 0.1%).

During the specified week of the wound study, a total of 188 clients with 297 wounds were identified by CRGNs and PHNs as requiring wound management (point prevalence 0.1%). Furthermore, 58% (n=110) of clients presented with one wound, and the remaining 42% (n=78) had between 2 and 5 wounds. Data were collected pertaining to each client with a wound, over a 1-week period by CRGNs or PHNs as requiring wound management (point prevalence 0.1%).

**Inclusion and exclusion criteria**

The clients were given information sheets pertaining to the study, and written consent was obtained from each client participating in the study. Therefore, the exclusion criterion was expanded to include those with psychological disorders, dementia and clients for whom English was not their first language.

**Ethical approval**

To allow the commencement of this study, ethical approval was sought from the research ethics committee. Local approval from the site of the research was also granted.

**Data collection**

The researcher was granted permission to use a specific wound prevalence and aetiology questionnaire (Vowden et al, 2009). The questionnaire was modified to include the travel time, location of wound management and whether the nurse was working in a rural or urban area. The main aim of this questionnaire was to determine the prevalence and aetiology of wounds; however, data retrieved has also provided further information regarding wound management. This is due to the inclusion of questions that retrieved the following information:

- The length of time required to travel to the client
- The nursing time for the provision of wound care
- The number of clients receiving full vascular assessments
- The frequency of dressing changes

**Pilot study**

A pilot study was carried out to test the proposed method of data collection (Anderson et al, 2013). The reliability and validity of the data submitted was dependent on the nurses completing the questionnaire. Therefore, education sessions were organised for the participating nurses prior to the study. These efforts increased the consistency of data collection.

**Data analysis**

Data were analysed using SPSS 20. In the main, simple descriptive analysis was conducted with the results expressed as percentages, including analysis of the dispersion of data. Point prevalence was calculated as a percentage by comparing the number of people with a wound with the total number of persons in the population at the specific point in time.

**Results**

All of the CRGNs and PHNs in the community care area participated in the study and returned 188 completed questionnaires, yielding a response rate of 98.9% (two clients were excluded due to dementia).

**Total number of wounds**

During the specified week of the wound study, a total of 188 clients with 297 wounds were identified by CRGNs and PHNs as requiring wound management (point prevalence 0.1%). Furthermore, 58% (n=110) of clients presented with one wound, and the remaining 42% (n=78) had between 2 and 5 wounds.
Wound care providers

The CRGNs provided 70% (n=132) of the wound care and the remaining 30% (n=56) was provided by PHNs. Urban areas had a slightly higher clinical caseload, treating 62% (n=117) of the wounds, compared to 38% (n=71) of the wounds being treated in the rural setting. However, only 22% (n=42) of these wounds were treated in a wound clinic. Thus, 78% (n=146) of clients had their wounds managed in their home.

Demographics

The age of the clients varied from 28 to 98 years old, with a mean age of 72.5 years. There were more women (71% (n=133)) receiving wound management. The presence of contributing medical problems was also recorded, and 85% (n=159) of the clients had an underlying medical condition. Unsurprisingly, the majority of clients (55%, n=63) with any form of leg ulcer presented with vascular disease. Diabetes was also noted to be predominant among clients with leg ulcers, mainly these clients presenting with venous ulcers (46%, n=16) and 37% (n=13) of clients with unclassified leg ulcers.

Wound aetiology

Table 1 provides an outline of the wound aetiology by client. The most common wound reported was leg ulceration, which accounted for 60% (n=112) of all clients. Among these clients, venous leg ulcers presented the most often, accounting for 55% (n=61) of wounds, whereas 3% (n=4) were classified as arterial, 8% (n=9) were classified as mixed (arterial/venous ulcer), 2% (n=2) presented with neuro-ischaemia and 32% (n=36) were unclassified. A total of 22% percent of clients (n=42) had a pressure ulcer (point prevalence 0.04%). Of these wounds, 50% (n=21) were grade 2, whereas 17% (n=7) were grade 1, with 26% (n=11) and 7% (n=3) grade 3 or grade 4 respectively (see Table 1). Of the 42 pressure ulcers reported, 74% (n=31) occurred in women and 26% (n=11) in males. Of the remaining clients, 16% (n=30) had an acute wound either due to surgery or trauma, whereas 1% (n=2) had either a fungating breast wound or a radiation burn. Only 1% of clients (n=2) had a diabetic foot wound.

Wound duration and size

The mean duration of the wound being present was 5.41 months, ranging from less than 1 week to 20 years. Around a third of wounds (36%, n=67) were recurrent, while the remainder (64%, n=117) were diagnosed as primary wounds. Interestingly, 52% (n=59) of leg ulcers were noted as being recurrent wounds, compared to 33% (n=14) of pressure ulcers. The mean size of wounds was established to be 2.34cm², ranging from <2cm² to <25cm². For 36% (n=68) of clients, their wound surface area measured <2cm², whereas a further 35% (n=66) of clients presented with a wound size of 2–5cm² (see Table 2).

Diagnosis of wounds

In this section of the questionnaire, respondents were requested to tick as many answers as were relevant; thus, it was possible that nurses could report more than one method to diagnose the wound aetiology. The most frequently reported methods were medical history, nursing history, physical examination and visual examination (62.8%, n=118; 56.9%, n=107; 70.2%, n=132; 69.1, n=130) respectively. Of clients with leg ulcers, only 43% (n=50) were assessed using Doppler studies.

Pressure ulcer prevention practices

Just 69% (n=29) of those with pressure ulcers had a risk assessment carried out, and only 40% (n=17) had the result recorded in the clinical notes. Interestingly, some patients with existing pressure ulcers (19%, n=8) were determined not to require risk assessment. Where pressure ulcers were evident, 54% (n=23) were reported to have developed in the patient’s home. However, only 4% (n=2) had a pressure ulcer incident reporting form completed. Pressure relieving equipment was made available to 22% (n=9) of clients with pressure ulcers and 7% (n=13) had a planned schedule for repositioning. Interestingly, two of the three (66%) clients with grade 4 pressure ulcers did not have a planned schedule for repositioning.

Dressing use

A wide variety of dressings were in use, although not always appropriately. For example, for wounds that were necrotic (7%, n=13), 2% of these wounds (n=5) had a non-adherent
(impregnated with soft paraffin) dressing applied. Furthermore, 17% \( (n=32) \) of wounds were noted to have a problem with exudate management, and of these highly exuding wounds, 31% \( (n=10) \) were dressed with a low-adherent dressing. The majority of wounds \( (79%, n=148) \) were found not to have a problem with exudate. However, of these low exuding wounds, 31% \( (n=46) \) were dressed with an absorptive dressing (data are missing for 3% \( (n=7) \) wounds). In addition, in 76% \( (n=144) \) of clients, no infection was suspected in their wounds. However, of these non-infected wounds, an antimicrobial dressing was used as the primary wound dressing in 42% \( (n=61) \) of cases. It is important not to use antimicrobial dressings when infection is not present, or when there is no significant risk of infection as some of these dressings can result in damage to healthy tissue (Vowden et al, 2011; Schultz and Dowsett, 2012; Weir, 2012).

**Compression therapy**

Compression therapy was utilised in 53% \( (n=32) \) of clients with venous leg ulcers. Of these, three-layer compression therapy was the most common \( (9%, n=16) \), followed by four-layer compression \( (6%, n=12) \), the remaining 3% \( (n=6) \) used short-stretch bandaging, compression stockings or the Unna boot.

**Travel time**

The time taken to travel to patients located in the community and the time required to treat all wounds was reported for all 188 wounds. Only a small number \( (22%, n=42) \) of clients did not require the nurse to travel to them as they attended a wound dressing clinic. The mean travel time was 14.53 minutes, varying from 5 minutes to 40 minutes.

**Frequency of dressing change**

The frequency of dressing changes varied from daily to once weekly. The 5% \( (n=9) \) of wounds that were dressed daily took 2 hours and 18 minutes of travel time per week. A total of 20% \( (n=38) \) of wounds were dressed three times a week, equating to 28 hours of travel time. Twice weekly was the most common frequency of dressing change \( (58%, n=110) \), equating to 53 hours and 27 minutes in travel time. The remaining wounds \( (16%, n=31) \) were dressed once a week equating to 7 hours and 50 minutes of travel time. The total time that community nurses spent travelling minus the 22% \( (n=42) \) that were treated in a wound care clinic was calculated at 81 hours and 18 minutes.

**Time spent on wound management**

The mean time taken to treat a wound was 20.10 minutes, varying from 5 to 60 minutes. The total number of clients identified was 188 and, as already outlined, some of these clients had more than one wound. The mean number of wounds per client was 1.56, equating to 293 wounds. The mean frequency of dressing changes was three per week, equating to a total of 879 dressing changes. The number of dressings \( (879) \) was multiplied by the mean time calculated to perform dressing changes \( (20 \text{ minutes}) \). The total time for the provision of wound management in this Irish community setting was therefore calculated at 293 hours a week.

**Discussion**

The most common wound reported was leg ulceration, which accounted for 61% of all wounds. However, this figure may be underestimated by the fact that 31% of these patients’ ulcer aetiologies were undiagnosed or unknown. A previous Irish study also recorded a substantially high percentage \( (42\%) \) of undiagnosed leg ulcers ( McDermott-Scales, 2009). These figures were similar in the UK, where 26% of wounds classified as leg or foot ulcers had no definite diagnosis (Drew et al, 2007).

Leg ulceration is a considerable health problem in Ireland, having a debilitating effect on clients and a substantial effect on health-care budgets (HSE, 2009). Therefore, individuals need to be correctly and efficiently assessed to provide the most appropriate treatment, ensuring cost effective, evidence-based wound care (Clarke-Maloney et al, 2008; Coldridge-Smith, 2009).

The similarities between the current study and published literature (Clarke-Maloney et al, 2008; McDermott-Scales, 2009) raise concerns regarding the appropriate management of leg ulcers. These studies concurred that there is a problem regarding undiagnosed leg ulceration and a lack of full clinical and holistic assessment, which in turn pose a real problem for effective wound management. A lack of an accurate assessment and diagnosis impacts negatively on good clinical outcomes being achieved in individuals with leg ulceration. Furthermore, this will increase the financial cost of these problematic wounds to the health-care service, while also adding to the psychological, physical and social impact that these wounds place upon the individual (Drew et al, 2007; Clarke-Maloney et al, 2008; HSE, 2009; Chandan et al, 2009).

**Compression therapy**

The use of high compression bandages in the treatment of venous leg ulcers is uncontested, as the evidence has shown that compression therapy can enhance healing rates by up to 70% at 12 weeks (Gethin, 2008; Jorgensen, 2008; Moffatt et al, 2009). Furthermore, applying compression therapy in conjunction with a programme to prevent ulcer recurrence can improve patients’ quality of life and reduce the financial and resource burden of venous ulcer disease on health-care services (Grace, 2003; Gethin, 2009; Posnett et al, 2009). In this study, compression therapy was utilised in only 53% of clients with venous leg ulcers. The lack of use of compression in some cases may have been due to a lack of confidence regarding the underlying arterial status of the affected clients, as only 43% had been assessed using the hand-held Doppler. Nonetheless, what is apparent is that individuals with venous leg ulceration managed in this community setting are not always offered treatments in keeping with national and international best practice (Grace, 2003; Gethin, 2009; Posnett et al, 2009; Finlayson et al, 2010). As leg ulceration is frequently chronic and relapsing in nature, it is essential that patients have early access to diagnostic and vascular assessments so that the best possible outcomes are achieved and patient suffering is reduced (Drew et al, 2007; HSE, 2009; Moffatt et al, 2009). Inappropriate management compounds fiscal challenges and exacerbates the...
negative impact that the presence of these wounds has on client
and community nursing service resources (Clarke-Malone, 2006; 
Drew et al, 2007; Jorgensen, 2008; Vowden and Vowden, 2008; 
Gethin, 2009).

**Pressure ulcers: risk assessment**

Pressure ulcer prevention and management is of great importance
in today’s fiscally challenging health-care environment (EPUAP
and NPUAP, 2009; Moore and Cowman, 2011). Indeed, the
literature states that most pressure ulcers can be prevented with
little or no additional expense (Moore and Cowman, 2011; 
Suriadi et al, 2008). The completion of a risk assessment tool
is one of the first steps in the prevention of pressure ulcers 
(Jordan-O’Brien and Cowman, 2011) and, as such, 70% of the
respondents stated that a risk assessment had been completed 
for the client. However, only 40% of the questionnaires had the 
result of the risk assessment recorded. Surprisingly, some patients 
with existing grade 2 and grade 3 pressure ulcers (19%) were 
classified as not requiring risk assessment.

**Increased risk of pressure ulcers**

Community care providers are delivering services to an
increasingly ageing population, yet this vulnerable population 
is facing a growing prevalence of chronic disease and disability 
(Gethin et al, 2005; HSE, 2009; Moore and Cowman, 2011). There is 
a positive association between the development of pressure ulcers and age; thus, older individuals are at significantly 
increased risk of developing pressure ulcers (Moore and 
Cowman, 2001; HSE, 2009; EPUAP and NPUAP, 2009). Therefore, it is important that there is a consistent methodology 
for pressure ulcer prevention within the community care 
setting (McDermott-Scales et al, 2009; Chandan et al, 2009). However, the findings from this study note an unreliable 
approach and reflect what seems to be a level of confusion
around pressure ulcer management and prevention. From a 
patient safety perspective, this is not acceptable as it means that 
vulnerable individuals will be placed at increased risk (Gethin 

**Appropriate use of dressings**

The overarching goal from the perspective of dressing selection 
is to provide an environment at the wound dressing interface 
that is conducive to achieving healing (Harding, 2007; Moore 
and Cowman, 2011). Therefore, the selection of an appropriate 
dressing should be made bearing in mind the wound bed 
condition and the requirement to prevent the wound bed from 
drying out, or, conversely, to manage excess fluid that may 
cause maceration to the surrounding skin (Gray et al, 2005; Schultz 
and Dowsett, 2012). There are patient-related factors that should be 
considered as they can influence the management of care. These factors should also be acknowledged and addressed by the health-care 
provider to ensure that the selected dressing enhances the 
quality of patient care (Edwards, 2003; Finlayson et al, 2010). The 
findings of this study clearly demonstrate that dressing selection caused some confusion among CRGNs and PHNs regarding 
the most appropriate dressing to apply to infected wounds and 
exudating wounds.

**Wound exudate**

Wound exudate is produced in response to a complicated 
interaction between wound environment, wound healing and 
compounding pathological processes (Harding, 2007; Schultz 
and Dowsett, 2012). However, exudate may become a problem 
for the patient or caregiver when the quantity produced delays 
or prevents wound healing (White and Cutting, 2006; Stephen-
Haynes et al, 2011), causes physical and psychosocial morbidity and 
increases the demand on health-care resources (Spilsbury et 
al, 2007).

The majority of wounds (79%, n=148) were found not to 
have a problem with exudate. However, of these low-exuding 
wounds, 31% (n=46) were dressed with an absorptive dressing. 
Use of absorptive dressings when there is little exudate may result 
in these dressings adhering to the wound, causing damage to the 
wound bed and unnecessary pain to the client.

In contrast, 17% (n=32) of wounds were noted to have a 
problem with exudate management, and of these highly exuding 
wounds, 31% (n=10) were dressed with a low-adherent dressing. 
The inappropriate utilisation of dressings for exudating wounds 
can increase the risk of infection, delay healing and cause the skin 
around the wound to become macerated (Harding, 2007; 
White and Cutting, 2006; Stephen-Haynes, 2011). Unsuccessful 
management of wound exudate can also affect the physical, social 
and psychological aspects of a client’s life (Hopkins et al, 2006; 
Spilsbury et al, 2007).

**Wound infection**

In 76% (n=144) of clients, no infection was suspected in 
their wounds. However, of these non-infected wounds, an 
antimicrobial dressing was used as the primary wound dressing 
in 42% (n=61) of cases. Antimicrobial dressings should only be 
considered after thorough assessment and investigation, and they 
should not be applied when infection is not present, or when 
there is no significant risk of infection, as some of these dressings 
can result in damage to healthy tissue damage (Vowden et al, 
2011; Moore, 2013).

Dressings represent a small proportion of the total cost of 
wound care. However, if dressings are used inappropriately, this 
can place a disproportionate amount of influence on the other 
factors that will increase the wound care cost (Grace, 2003; 
Moore et al, 2011). Furthermore, deviations from appropriate 
dressing selection may lead to delay in healing, thereby increasing 
both human and economic cost (Chandan et al, 2009; Fife, 2010).

**Cost**

There has been an increasing awareness of costs related to 
wound care in recent years, but economic analyses are still 
largely lacking (Drew et al, 2007; Posnett and Franks, 2007). 
This survey found the average time required for both travel and 
wound management, and, when calculated with the frequency of 
dressing changes, the final figure for the time community nurses 
spend on wound care provision was calculated to be 374 hours.
Clinical focus:
Community wound study

S20

The time required for wound care was equivalent to 18.5 part-time CRGNs. Currently, in this community care area, there are the equivalent of 14 part-time CRGNs. Therefore, the level of wounds in this community care area is responsible for over 100% of the CRGN workload.

The PHN is the caseload manager for child health and the older person, and, unlike a decade ago, PHNs (alongside CRGNs) now provide wound care, end-of-life care, clinical assessments, incontinence assessments, hospital discharge visits, home help reviews and home care package applications and reviews. The clinical aspect of the PHN role has had to change because of the increasing clinical demands placed on CRGNs, and this was reflected in this study, showing that they provided 30% of the wound care. Nurse time is an important factor in the process of analysing cost for wound care; this information is currently not available for the Irish health service. However, in the UK, nurse time was estimated to account for 33–41% of the overall cost of wound care (Chandan et al, 2009). These data demonstrate that the impact of nursing time required for the provision of wound care is often an underestimated or hidden cost to health-care organisations. Having information such as the utilisation of nursing resources, which this study presented as 374 actual nursing hours, will enable the measurement of nursing time allocated to wound management. This will serve in turn to inform service managers and planners and, in doing so, assist with decision making when allocating budgets and resources.

Strengths and limitations
The methodology used for this study was effective in gathering the information required; however, the reliability and validity of the data submitted was dependent on the professional completing the form, their level of experience and knowledge with regard to wound care. Despite all attempts made by the author, there is no guarantee that all clients receiving wound care from community nursing services were included.

Recommendations
To enhance treatment of wounds in this community care area an integrated approach to wound care is needed, with a clear strategy and policy supported by management. Wound care is an area where there is evidence of a wide variation in practice, some of which may not be effective, rendering it time consuming and costly to both clients and the health service. Internationally, the benefits of nurse-led specialist services in primary wound management, with direct access to multidisciplinary teams, has demonstrated faster healing times, reduced prevalence rates, reduced variation in wound care practice and improved quality of life for clients, while providing an evidence-based, cost-effective service that is both equitable and accessible (Clarke-Maloney et al, 2008; Vowden and Vowden, 2008; Vowden et al, 2009).

The introduction of a tissue viability service in this community care area would provide appropriate interventions for the diagnosis of wounds, thereby improving client outcomes and reducing demands on acute care services. The population of clients with leg ulcerations can be addressed through the provision of a community-based nurse-led leg ulcer clinic, providing timely, expert assessments and a broader range of diagnostic methods for clients with acute and chronic wounds within a collaborative multidisciplinary care framework. This service would prove to be cost effective, reducing resources by promoting best standards in tissue viability and wound management practices across a community-based nursing service. A tissue viability nurse would act as a resource of information for all members of the community-based interdisciplinary team and contribute to staff development through education leadership and collaboration (Vowden and Vowden, 2008; HSE, 2009; Clarke-Maloney et al, 2008; Moffatt et al, 2009). The ultimate goal of educating CRGNs and PHNs in wound care must be to improve patient outcomes.

A structured programme of training for practitioners involved in wound care, supported by best practice guidelines, has the potential to reduce the variation in clinical practice and improve patient outcomes (Drew et al, 2007; Clarke-Maloney et al, 2008; Colridge-Smith, 2009; Moffatt et al, 2009).

This study recorded the wounds treated by the community nursing service, not individuals who attended outpatient departments, GP services or who treated their own wounds. Therefore, it may not be a true measure of the prevalence of wounds in the community setting.

Conclusion

Wounds do not have a one-dimensional impact but rather can affect three domains; that is, the individual, the health service and society. There is a growing body of evidence that suggests that a structured, organised and planned approach to wound management—whether for specific wound aetiologies or for wounds in general—improves patient outcomes and is cost effective for the health service (Department of Health and Children, 2000; Balanda et al, 2005; Jorgensen, 2008; Chandan et al, 2009). However, without baseline information we cannot identify areas of strength or weakness (Cooper et al, 2010). It is therefore essential to have information about care provided with a view to ensuring that it is both clinically effective and cost effective (Posnett and Franks, 2007).

This study has highlighted the amount of time required by the community nurse for the provision of wound care. Furthermore, it highlights a major cost to the community health service incurred by wounds, during a time of intense pressure to deliver quality care within increasing financial constraints and reduced numbers of community nurses. Problems with chronic wounds and delayed healing will continue to increase if the current trend of managing leg ulceration (for example, for long durations without a holistic assessment) prevails. The data from this study emphasise that, irrespective of aetiology, problematic wounds are a common and very expensive health-care problem with community nurses being the main providers of care (Vowden and Vowden, 2008; HSE, 2009; Vowden et al, 2009; Anderson et al, 2013).

This, combined with changing approaches to health-care provision, with its emphasis on primary care, is resulting in new
challenges to the management and treatment of wounds in the community (Drew et al, 2007; Vowden and Vowden, 2008; HSE, 2009; Vowden et al, 2009; Posnett et al, 2009).

The findings of this survey are an indicator of the significant impact wound care has on health service resources. It also identifies areas for further research, highlighting fundamental data for the future planning of health-care resources, focusing on cost containment while providing quality patient outcomes.

References


