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EMPIRICAL STUDY

Feeling confident in burdensome yet enriching care: Community nurses describe the care of patients with hard-to-heal wounds

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Abstract

Treating patients with hard-to-heal wounds is a complex task that requires a holistic view. Therefore this study focuses on the nurse's perspective with the aim on describing how community nurses experience the phenomenon *the care of patients with hard-to-heal wounds*. The method used was a reflective lifeworld approach. Seven qualitative interviews with community nurses were conducted. The findings show a tension between enriching and burdensome care. In this tension, the nurses try to find energy to reach harmony in their work through reflection, acceptance, and distance. This is further described by the constituents: "taking responsibility," "showing respect for the whole person," "being confident in order to offer confidence," "seeing time and place as important." The discussion highlights the importance for a nurse to find how to give ideal care in one's duty but not beyond it. As a consequence the concept "compliance" needs to be challenged in order to promote confidence and mutual trust between nurses and patients. Confidence can be seen as a key, both for nurses and patients, and is dependent on good inter-professional cooperation, competence, and closure.

Key words: *Hard-to-heal wounds, nurse, home care, reflective lifeworld research, confidence*

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Introduction

In Sweden, about 50,000 (0.6%) persons suffer from leg ulcers (Lindholm, 2003). Probably, there are an estimated number of unknown cases since several persons treat their leg ulcers themselves instead of involving the health care services. According to Hjerppe (2006), patients with chronic leg ulcers become older and the number of leg ulcers has increased from 1984 to 2005. Chronic leg ulcers are more complicated, last longer, and wound treatment is more time-consuming (Hjerppe, 2006). A long-healing wound or a hard-to-heal wound is per definition (McMullen, 2004) a wound that has not healed in 6 weeks. The most common in this group are leg ulcers, diabetic foot ulcers, and pressure ulcers.

There are several studies of wound assessment and treatment such as compression therapy (Escaleira, Cardoso, Rego, Macedo, & Midoes, 2010), how to treat infected wounds (O'Meara, Al-Kurdi, Ologun, & Ovington, 2010), different dressings and wound healing (Lazareth et al., 2007), and the relation between pain and wound healing (Woo & Sibbald, 2009). The complexity of the wound treatment is noticed and so is the importance of a prophylactic consent. Nurses need to be aware of this complexity and have appropriate knowledge in order to identify risk patients (Vowden, Apelqvist, & Moffatt, 2008). The patients' life quality decreases due to the consequences of having leg ulcers or pressure ulcers (Gorecki et al., 2009; Lindholm, 1993).

The patients' suffering (Briggs & Flemming, 2007; Ebbeskog & Ekman, 2001; Haram & Nåden, 2003) concerns all physical, mental, and social aspects. However, the caregiver perspective, such as wound treatment and what it is like to care for a patient with wounds, is more limitedly described. Lindahl, Norberg, and Söderberg (2008) show how nurses are affected both from staying physically close to patients with malodorous exuding ulcers and from seeing their bodily suffering. Kohr (2006) and Kohr and Gibson (2008) give insights to how nurses experience changing dressings in acute, long-term, or community care in Canada. Still, there is a lack of

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studies on the nurse's perspective, especially from a Swedish context. Therefore, the aim of our study is to describe how community nurses experience the care of patients with hard-to-heal wounds.

Approach and method

In order to gain knowledge about how community nurses experience the care of patients with hard-to-heal wounds, it is necessary to practice an approach and method that treats complex and ambiguous phenomena. We found that the reflective lifeworld research (Dahlberg, Dahlberg, & Nyström, 2008) meets these requirements, so by using it we come as close as possible to the essential meaning and its variations so that we can further develop the understanding of the phenomenon. A reflective lifeworld research approach demands a phenomenological attitude, as the leading methodological principles are characterised by openness for the phenomenon, bridling one's understanding, and having ongoing critical reflection of its meanings (Dahlberg & Dahlberg, 2003; Dahlberg et al., 2008).

Informants and data collection

The inclusion criteria were nurses who worked in home care (i.e., in the patients' homes), that they had experience treating patients with hard-to-heal wounds, and that they were willing to share their stories with us. In reflective lifeworld research, variation should be considered when choosing informants. The heads of two home care districts gave their permission for the study and asked nurses with accordance to age, gender, years of working as a registered nurse, and years as a nurse in home care. The nurses received verbal and written information about the study from the first author. Seven nurses participated in the study. They were 35–62 years of age, of which five women and two men, all registered nurses with 3–32 years of professional experience who had worked in home care for 3–8 years.

In order to carry out reflective lifeworld research, we chose qualitative interviews in the form of open dialogues (Dahlberg et al., 2008). By gaining access to the community nurses' lived experiences, the meaning of the studied phenomenon could be illuminated. The interviews were conducted by the first author, were tape-recorded, and lasted 30–60 min. The initial question was, "Would you like to tell me about how you experience caring for a patient with hard-to-heal wounds?" Also, follow-up questions were asked such as, "What do you mean?" "Can you tell me more about this?" and "Could you please give me an example of that?" The informants chose the setting. All seven interviews took place in separate rooms at their workplace.

Data analysis

The interviews were transcribed verbatim and the text was analysed for meaning. The analysis followed the structure described by Dahlberg et al. (2008). The goal of the analysis was to describe the essential meaning of the phenomenon and its constituents. The analysis can be described as a movement between whole–parts–new whole. First, the interviews were read several times in order to get a sense of the whole. With this in mind, we moved to the next step (i.e., the phenomenological parts). Then, the character of the reading changed and we focused on the meaning of the parts. Meaning units were marked and described. The analysis was characterised by an awareness not to impose meaning from the outside but patiently wait until the phenomenon presented itself and its meanings. The meanings were then clustered through a dynamic process; a movement between the concrete and the abstract, and by relating the similarities and differences of meaning to each other. When analysing a text for meaning, it is necessary to understand each part in terms of the whole, but also the whole must be understood in its parts. A new whole; that is, the essential meaning of the phenomenon *the care of patients with hard-to-heal wounds* was reached by synthesising the transformed and clustered meaning units so that the inner structure of the phenomenon was illuminated. Finally, a structure of the essential meaning of the phenomenon was formulated and further described by its constituents.

Ethical considerations

The study was approved by the heads of two home care districts in western Sweden. The informants received information verbally as well as in written form. The informants are not previously known to either of the two authors and therefore not in position of dependence. According to Swedish law (Vetenskapsrådet, 2010), an ethical review was not necessary for this study but the demand for information, consent, confidentiality, and usage was nevertheless taken into consideration (World Medical Association of Helsinki, 2008). A phenomenological research emphasis on openness and entails an ethical approach in terms of dignity and respect for the informants (Dahlberg et al., 2008). This approach permeates the entire conduction of the study.

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Findings

The essential meaning of the phenomenon *the care of patients with hard-to-heal wounds* is presented below. The constituents are elucidated by excerpts from the interviews. Interview questions within a quotation are put in parentheses ( ). Short breaks in the interview are marked by dots (. . .) If the interview excerpt is too long to be quoted in full, two forward slashes (//) are used to indicate that a paragraph is excluded.

According to our findings, the phenomenon as it is experienced by community nurses is characterised by a tension between perceiving the care as enriching yet burdensome. Nurses experience commitment alongside hopelessness. In this tension, they try to find energy to reach harmony in their work through reflection, acceptance, and distance. Sometimes they find strategies and tools to cope with the burdensome but nevertheless feelings of frustration and hopelessness persist. Consistently, several aspects of care show that it is challenging, engaging, and thereby enriching.

The following constituents further illuminate the meaning of the phenomenon and the tension between enriching and burdensome care. These are as follows: "Taking responsibility," "Showing respect for the whole person," "Being confident in order to offer confidence," and "Seeing time and place as important."

Taking responsibility

Nurses feel responsible for their patients and they want their patients' wounds to heal, to relieve their pain, and instil hope in them. They speak in the patients' behalf when the patient needs help. In that way, nurses regard their role important and they point out that their contact with the physicians is dependent on mutual trust.

Unfortunately, nurses have experienced indifferent physicians when it comes to patients with hard-to-heal wounds and their care. This disinterest results because they feel that their responsibility increases, as they lack support from the physicians. One aggravating factor is substitute physicians with temporary work at the medical centre, as they lack knowledge about a patient's medical history and might not be there on the follow-ups. This breaks off the continuity and makes the nurses' assessment even more important. Unfortunately, the physicians often had a disinterested attitude. "The doctors' attitude is often quite tiresome, I think it doesn't seem as if they think it is fun; often they hand over a great deal of responsibility to the nurses."

Nurses experience that their patients have trust in them, confide in them, and expect their wounds to heal. So if the wounds do not heal, nurses feel unsuccessful and a failure in their caring action. They truly wish that the patients' wounds would heal and when this does not happen, feelings of guilt emerge and their responsibility becomes even more burdensome.

> It's like a failure, sort of // I mean, they're helped and their wounds were supposed to heal // but I couldn't save this one, really, and it feels like when you were little and you wanted to be a superhero and fix it, you want it to end well, but that's not always the case . . . yeah, it's like a failure, sort of.

If a hard-to-heal wound lacks the prerequisites to heal and the patient risks amputation, a mourning process takes place in the patient's home. Nurses are deeply affected by this grief and it is hard to look beyond that which is burdensome in such a situation. They are taken by the difficult situation of their patient. In order to cope with this, nurses find support by sharing their thoughts with their colleagues by working together or through reflection. "No, it's hard, you know, the whole situation is so hard, it's mourning in the patient's home."

When a patient is in pain, nurses try the best they can to relieve it. When pain eases off, this is a consolation also for the nurse. Nurses describe when a patient is satisfied and experiences well-being, this affects their wound healing process. For nurses, it is important that their patient is in as little pain as possible. By listening to patients and being sensitive to their needs, nurses try to sense if they are in pain. During the whole wound care process, nurses are acutely aware of the fact that they should not cause their patients unnecessary pain.

> Yeah, it's important that she's in as little pain as possible, I think. Part for my own good, to know she's not in pain; part for her own sake. And I know the wound doesn't get better if she's in pain. So when I care for it, I try to do it in such a way that I cause her as little pain as possible. You have to be light-handed.

The nurses' patience are tested and they express both hopelessness and despair if they have completed all caring actions at hand but the wound still does not heal. They feel frustrated if the patients are not responsive to the recommended care and treatment. The responsibility that the nurses feel also comes to include alternative solutions. They realise

that they are not more than human beings and cannot force the patients against their will.

> You'd think that it wasn't clean and you'd never make it heal and that the home wasn't the cleanest on earth. First a cat and then there were three or four kittens . . . and when you got there, there could be a compression bandage or an ointment stocking lying around somewhere in a corner . . . so you had to do your best, then, really.

Patients' need of care and the nurses' experiences of responsibility are not always congruent. The responsibility that nurses feel has a backside in the pressure and expectation they feel from their patients. The patients' great trust in their nurse and their expectations carry forth a wish of all to be well. Nurses experience that the patients want a nurse of their own who would replace many roles—from carer to relative. Nurses feel dissatisfied when they can only carry out isolated measures, which results in a feeling of not being enough. They become forced to distance themselves from their patients and stay away in order to cope with the pressure that they feel.

> (Int: Do you see a risk that this might be too much?) Yeah, you get a lot of responsibility and trust // you almost feel a sort of pressure to do a lot so that all gets really well and yeah, sure you want to but that's not the way it works, unfortunately, so indirectly you get a bad conscience // you can't take it . . . they rely on you so much when you get there and then, it's like they want an own nurse who's everything to them.

Nurses express that they are not satisfied with the care they give. They do not perform the caring action as they would wish. One reason for this is that they are responsible for too many patients and that each patient needs much more than they can give. Therefore, the practical solution is to perform isolated measures only. Through experience, nurses become better at constructively handling feelings of insufficiency. For example, they could mark this by telling the patient that time is somewhat restricted. Nurses feel a responsibility to always be at hand for the patient, but they could solve this by giving the patient the possibility to reach the nurse via telephone. Or they could make a promise that they can continue talking next time they meet. Nurses' basic assessment in terms of care and approach toward the patient are not changed, but through experience they learn to prioritise care needs and seek help from their colleagues. One nurse describes it this way:

> (Int: Would you do this differently now?) Actually, I think I'd do it just the same, I mean, you have your basic values // You have to stay off when it's needed and you have to be there when it's needed, but I can't say you should keep a distance to all your patients, but once again you have to get a feel for who needs help and who doesn't, and when it becomes too much or too hard you have to ask your colleagues for help.

Showing respect for the whole person

For the nurses, it is important to show respect for the patient as a whole person. Nurses try to identify boundaries, both for the patients' practical needs and for that which is existentially allowed:

> I think it's quite natural . . . if you get signals // you have to be sensitive, you have to feel like this is almost some kind of role play, working with human beings, you have to have a feel for where the boundaries are // you have to feel, like, where's her integrity, how deep does she want this conversation to be . . . how close a relationship does she want to have with me.

During wound dressing, nurses are sensitive to the patients' state of mind, body language, and how they are feeling. If the wound looks bad, smells, or is on a patient's private parts, nurses are anxious of showing respect for the patient. They assure the patient that they have seen such things before, perhaps even worse ones, and are keen on not putting the patient in an awkward position. The wound, which might be on a leg, is only the part of a whole. So the nurses emphasise the importance of respecting the whole person so that the patients are not to feel repulsive because of their wounds. One informant describes a patient's guilt over the smell of her wound as follows:

> She was a bit ashamed of it and didn't want to be a burden, so then I felt that it was even more important to show her that this is nothing to be ashamed of; we respect your leg as well as the rest of you, you're like a whole, and I tried to explain to her that this is not your fault. So OK, here's a leg that's more or less rotten, but it's on her, it's her leg, and then she needs to feel that we respect the whole of her and she's not to feel like we think this is gross // that, I think, is respect . . . I want her to feel that we do the best we can and that we respect her as a whole person—that, I think is really important.

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One nurse describes how focus is transferred from the wound to the whole person. This holistic view is strengthened by meeting the patients in their homes and through increased experiences of care. The important thing is instilling hope spreading a positive spirit and supporting the patients' positive attitudes, which is important for obtaining well-being and promoting the wound healing process. It is not merely good wound care, good nutrition, or compliance to the treatment that promotes the healing process. Nurses describe that a greater complexity and a whole is what works the best for the patient:

> You don't always know which dressing is the best for that particular wound, and at the same time it's the body and soul that heal the wound, not the dressing.

In the caring relationship, the nurses try to find their own limitations in relation to the patient, which means having a balance between closeness and distance. One nurse describes it as an invisible boundary. Some see it as unproblematic, since experience has made them better at being personal without being private. Others describe difficulties when the relationship becomes too close and that they get drained on energy.

Being confident in order to offer confidence

Confidence is experienced as ambiguous. In order to provide confidence to the patients, nurses need to feel confident themselves. For nurses, this confidence is strengthened through increased knowledge, competence, and experience. They describe that they feel better at their profession and more devoted when they have had the opportunity to participate in wound education. Another contributing factor that nurses feel confident about is the opportunity to cooperate with doctors and receive their support and advice. When nurses have experiences of wound care, doctors meet them with trust and their assessments are taken seriously. Also, the nurses describe disinterest from the physicians, which is both irritating and frustrating. On the other hand, this strengthens their profession as they realise their own competence in comparison to the doctors.

Nurses need to feel that they are in control of the situation. This makes them feel confident. They have experiences of wounds that have rapidly become worse as a result of too many caregivers being involved in the wound care and not being competent enough. Even if nurses know that they are not irreplaceable, it feels difficult handing over control of the wound care to somebody else. The nurses fear that the wounds might get worse or new ones appear.

The relation between nurse and patient is personal and based on confidence. Nurses experience patients who might reschedule their wound care to get "their" nurse. Others may have difficulties letting go of a contact once the treatment is over. Nurses want to give answers, but sometimes the patient's wondering whether the wound is going to heal or not often is impossible to answer. Sometimes, healing seems a utopia. Nurses want to be honest and have a straightforward communication with the patient but not take away their hopes. One nurse describes how a relationship was affected at the time of an amputation. Before the amputation, she found it hard to know what the patient wanted to talk about and what she as a nurse could say or ask. The nurse was loyal to the patient and stayed by the patient's side and dared confront the mourning process. The nurse experienced that their relationship was strengthened. Their mutual trust remained, and confidence was strengthened as the nurse did not try to avoid the situation but stayed even though it was difficult.

> (Int: How did this affect your relationship?) I almost think it got stronger. Somewhere deep inside, I think that she felt that we were a few, not that many, though, but a few who didn't take off but were there for her even when things were at their worst.

For the confidence of their patients, the nurses are keen on showing them that they care for them. One nurse made a habit of making home visits more often than needed for the wound care. By more frequent visits, the nurse experience that the patients' feelings of being seen and validated were strengthened. At every visit, the nurse strived for being sensitive and responsive to how her patients were feeling. In that way, she would instil a sense of stability and trust in them.

Seeing time and place as important

Caring in a patient's home is described as burdensome as the nurses need to accept what they would normally feel are inappropriate in terms of hygiene, compliance to treatment, and ergonomic prerequisites for wound care. A home offers a caring environment that could be smoky, dirty, and ergonomically unpractical. Nurses experience that they feel unclean in a dirty environment. Wound care often takes a long time, and inappropriate working positions make it strenuous. This affects the whole meeting so that it feels troublesome going to the

patient and relieving when their work is done and they are free to leave.

> To some extent, working environment might play a role // you know that you're going to get incredibly tired in your back because you have to stand in such a way that you almost get . . . crazy, because it hurts so much and you get stiff // and you build this up before you even get there // and when you're done you can finally feel like . . . (Int: Relief when you're leaving?) Yeah, that's right, a relief.

Caring of patients with hard-to-heal wounds is time-consuming, which has an impact on the rest of the nurses' work. Nurses can feel injustice when they have to forsake, for example, meetings because they are responsible for a patient with hard-to-heal wounds. Time could feel limiting and they describe different ways of coping with the stress. Some nurses might be focused and present when meeting with the patient and not feel stressed until afterwards. Others have difficulties concentrating when meeting with the patient and feel as if they are already on their way to the next one.

Nurses emphasise the importance of time and place to experience the caring relationship as enriching. They see how home care makes it easier to see the patients in their context and everyday life. Their relationship is even further strengthened since wound care is often time-consuming. Therefore a personal caring relationship in a home environment is seen as a contributing factor to the nurses describing their work as enriching.

Discussion

Giving the "little extra" in one's duty but not beyond

Several times, the nurses expressed their good intentions to meet patients in an emphatic and warm manner. They find it enriching to meet the patients' needs. What is clear is that they find care burdensome when they find themselves insufficient, only have time for isolated measures, or when they cannot play all parts that the patients expect from them. Arman and Rehnsfeldt (2007) demonstrate in their study what nurses, students, and patients describe what ideal care could be. This is described as, "giving the 'little extra'," and "being a fellow human being." Giving the little extra would not be a heroic act for nurses but a rather natural way of acting. The patients can notice this little extra as something extraordinary in their care, which makes them feel as individuals seen by the caregiver. If a caregiver is to give this little extra and be a fellow human being, it is necessary for them to understand and interpret the ethical demands from the patient. According to Bengtsson (1990), this is central within phenomenological ethics. The ethical demand starts from the patient and is directed toward the caregiver. The demand is absolute in that aspect that the person towards which the demand is directed has an obligation to meet it. However, it can only be absolute for the person who is able to perceive it. By being competent in caring science, a caregiver can perceive the ethical demand and thereby act on it. Arman and Rehnsfeldt (2007) explain responses to the ethical demand such as, "charity, compassion, hope and open speech," whereas rejection is rather to be seen as "bound by rules, principles and routines than to the patient" (Arman & Rehnsfeldt, 2007, p. 373). When responding to the ethical demand, the caregiver gives this ideal care described as genuine commitment and interest that goes beyond their duty. Then, the ideal care in terms of the little extra and being a fellow human being can be problematized.

The nurses in our study described how pressed they are because of the obstacles to giving ideal care, no matter if they want to give it. In such frustration, it is important that nurses do not become overwhelmed by wishes they cannot fulfil. This would add to the burden and make them feel guilty and discouraged. So there is a risk in discussing this little extra as going beyond one's duty. Many nurses already feel that they go beyond their duty, and not even then are they able to perform more than isolated measures. Rather, caregivers ought to see the potential in giving this little extra within the frames of that which is possible for them but not more. Thus, caregivers need to be encouraged when striving for giving ideal care, but they must also realise that this little extra not necessarily is about time. On the contrary, it is a patient approach when caregivers act naturally as fellow human beings with a sense for the patient's ethical demands. This approach is emphatic and personal but requires enough distance not to become private. It needs to be applied on one's duty but not beyond.

Compliance and the need for a change of perspectives

Being frustrated over patients who do not "do what we tell them to do" is common and they are often labelled as noncompliant patients. The term "compliance" is problematised by Hansson Scherman and Friberg (2009) who discuss a change of perspectives as necessary. Today, the term compliance is used too one-sidedly and the patient is often regarded as someone to be compliant to the caregiver's recommendations. The new perspective is seeing the patient as a learner and a reflecting person, which

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results in the fact that every pedagogic situation turns into mutual learning for patients as well as caregivers. The caregiver gains knowledge about lived experiences that demonstrates the patient's learning needs. This forms the basis for which form of education suits the individual patient. Then, it becomes a movement that can be described as, "following and letting oneself be followed." If both parts can have their say in an open dialogue, they meet on the same terms (Hansson Scherman & Friberg, 2009). But there may be special circumstances, for example, if a patient has limited cognitive skills. Then it is especially important to see his/her resources and form a suitable pedagogy based on his/her ability. By viewing compliance this way, the nurse and the patient in cooperation can find greater safety, confidence, and mutual trust.

Confidence depends on good cooperation

The complexity to care for patients with wound calls for improved inter-professional cooperation (Lindahl et al., 2008). The nurses' disappointment with the cooperation of the physicians emerged as particularly important. Storch and Kenny (2007) point out the importance of sustaining professional strengths for nurses and physicians as well as working in close collaboration as a prerequisite for giving good care. Even if there are differences between the medical and the nursing perspective, moral work ought to bridge the gaps. In all care, the moral aim is to relieve suffering and restore well-being and health. In this struggle, both nurses and physicians need a professional work view. Thus, there is a need for joint education to clarify the moral goals and share the moral work (Storch & Kenny, 2007). If such cooperation rests on understanding and good communication between nurses and physicians, there are support and confidence for both parts that contributes to giving the patient good care.

Dahlberg and Segesten (2010) highlight the similarities between how caregivers act around a patient and how caring science can be used as a unifying approach. According to the lifeworld-theory, our lifeworld is where we experience everything—our health, well-being, and suffering. Then, care simply cannot be care unless you count on, understand, and meet the patient's lifeworld. Even if there are different professions and perspectives involved for providing optimal care, their aim ought to be the same. Thus, caregivers need to interlace their theoretical competence both in biomedicine and caring science and tailor it to suit all patients and their individual lifeworlds. This contributes to health and well-being, so as the patients' narratives guide the caregivers to meet them with respect and dignity in their individuality. With caring science and the patient's lifeworld as its basis, inter-professional collaboration can be improved by the use of a unifying value system.

Such cooperation is improved by good communication among caregivers; if not, forums should be created. A "wound healing network" for caregivers could be one forum for sharing experiences and receiving new information. Given that all professions involved are represented in the group, such a network would contribute to cooperation. However, it is not only important to discuss medical questions but also involve reflections about the essence of care with the lifeworld as its basis.

Confidence depends on good competence

Nurses need knowledge, competence, and experience in order to be confident in their profession and offer the patient confidence. Since wound assessment, treatment, and caring for patients are complex issues, nurses need to be continuously provided with new competence. This need for education has also been found in other studies (Lindahl et al., 2008). Education in wound care is under development in several parts of Europe but needs further elaboration. However, learning does not merely concern academic education but is a never-ending process, so as Ekebergh (2007) emphasises the lifeworld and reflection as a basis for learning in order to unite theory with best practice. In order to be aware of one's own lifeworld, which mostly consists of one's unreflected life, it is necessary to come to a halt by use of reflection. A reflecting attitude (Dahlberg et al., 2008) can problematize and verbalize lived but unreflected experiences in one's lifeworld. Ekebergh (2009) presents a didactic method used in nursing education where the basis for the learning process is to connect theoretical knowledge with best practice by use of a reflective lifeworld approach. Students as well as nurses may find this way of learning helpful. Through guidance, reflection, and learning, it can be achieved and lead to in-depth experience, increased knowledge, and professional development. Higher priority given to professional tutoring would be valuable for increasing well-being and confidence among caregivers.

Confidence contributes to a "good closure"

The nurses described the comfort in having control over wound care by being in charge of it. Frustrating issues were if wounds got worse when others were in charge and lack of continuity. At the same time, the nurses know that no one is irreplaceable and that care sometimes is delegated or finished if wounds

improve or heal. Still, they could find it frustrating to let go since wounds may get worse or come back. If both parts would be prepared for the fact that care sooner or later comes to an end, they would be more comfortable with letting go of each other. Dahlberg and Segesten (2010) demonstrate the importance of ending a caring relation in a planned way. This could be seen as a process where the final step is to conclude the commitment. The patient should not feel abandoned after having had such a long contact with caregivers but feel ready to take on greater responsibility for his/her own health. In this closure, relatives and new caregivers (if any) would be involved. This could be applied to the context of our study and give patients, relatives, and nurses greater confidence. It is easier for a nurse to leave a patient who is well prepared and feels confident than if the caring relation is ended without being planned and thought through.

Key words for care

In the heart of this burdensome yet enriching care, both nurses and patients need confidence. To remember and strengthen this confidence, there are certain key words that begin with the letter C:

- ***C**ooperation with **C**ommunication.* The caregivers around the patient need to act as a team. They must have the same objectives and be interested in what is best for the patient. It might be necessary to clarify the responsibility and role for each profession, perhaps by creating forum and routines in order to communicate and make care more constructive.
- ***C**ompetence* in wound care is essential. It strengthens the nurses' confidence and increases the status for wound care. There is a need for supervised reflection in order to support the learning.
- ***C**losure*. A planned and structured closure of the caring relationship makes the patients feel responsible for their own health as well as the nurse becomes more confident to end the care period.
- ***C** as in Seeing.* This study has a nurse perspective, but the patient should always be in focus. In every meeting and in every relation, nurses need to *see the patient*. By use of a lifeworld approach, nurses can meet patients openly, based on lived experiences and in that way improve the care for patients with hard-to-heal wounds.

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