Facebook *live*

19:30 Wednesday 13th July

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Part 1 - Leg Ulcers:

Immediate care to prevention of recurrence

Journal of General Practice Nursing
GPN

Sponsored by LR People.Health.Care.

LIVE Q&A

SEND IN YOUR QUESTIONS BY COMMENTING ON THE VIDEO

LEARNING OBJECTIVES

To understand the national agenda for changing the approach to lower limb management

To understand recommendations and best practice implementation for:

- Immediate and necessary care
- Diagnosis and treatment
- Ongoing maintenance and prevention.

THE BURDEN OF WOUNDS

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- Guest et al (2020) published a cohort study evaluating the burden of wounds in 2017/18
- This was an update from 2012/13 data (Guest et al, 2015)
- Aim of new study was to assess the extent of change in the burden of wounds over five years in terms of:
  - Annual prevalence
  - Health outcomes
  - Healthcare resource use
  - NHS cost
- Leg ulcers continue to be the most prevalent wound type in the UK.

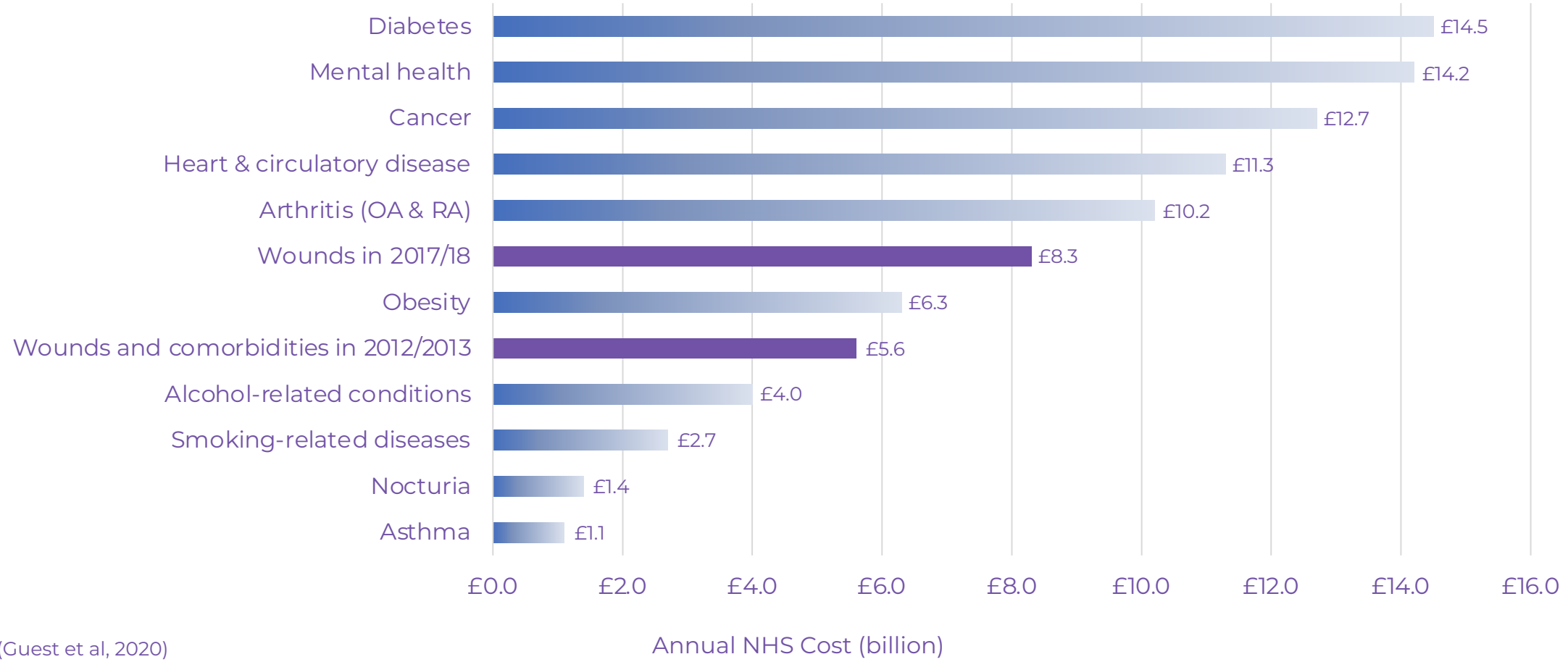
THE NATIONAL PICTURE

£3.1 billion is the annual estimated healthcare cost associated with leg ulcers (Guest et al, 2020).

Over 1 million patients, which equates to 2% of the UK adult population affected with a leg ulcer (Guest et al, 2020).

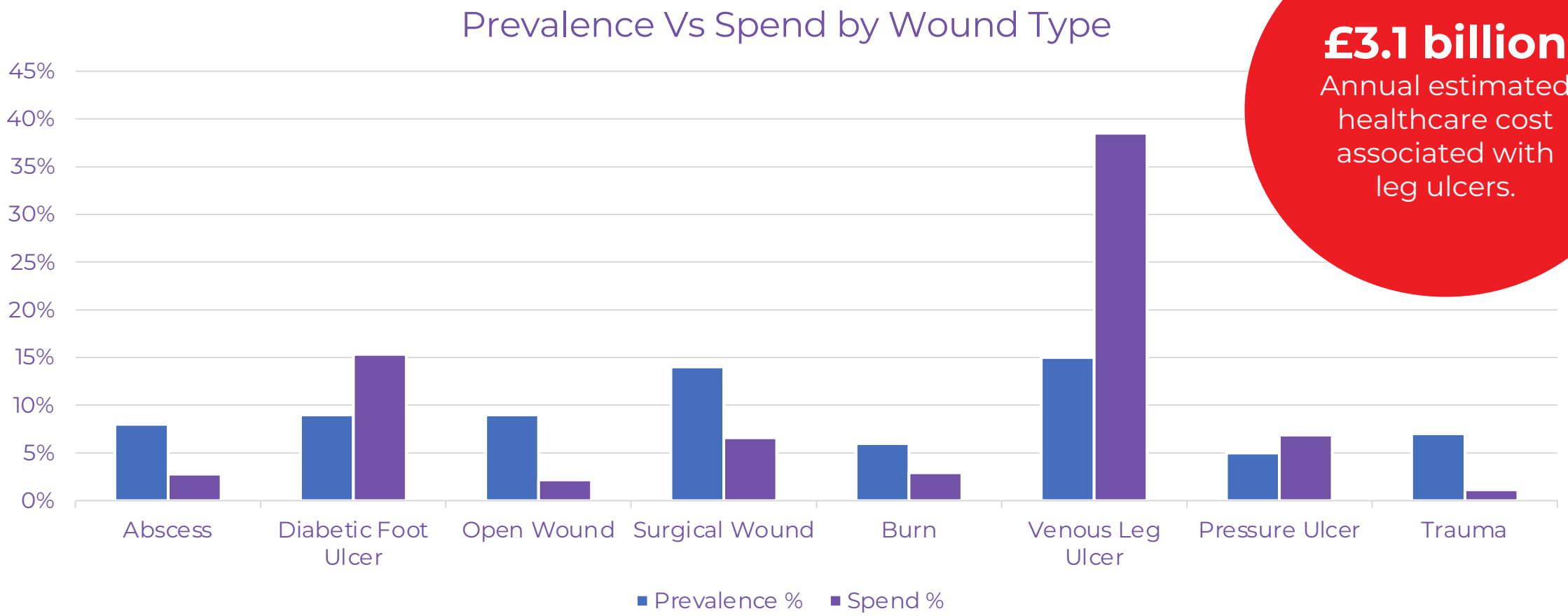
Up to 69% of leg ulcers reoccur once healed annually (Harding et al, 2015).

BURDEN OF ILLNESS LEAGUE TABLE



(Guest et al, 2020)

BURDEN OF ILLNESS LEAGUE TABLE

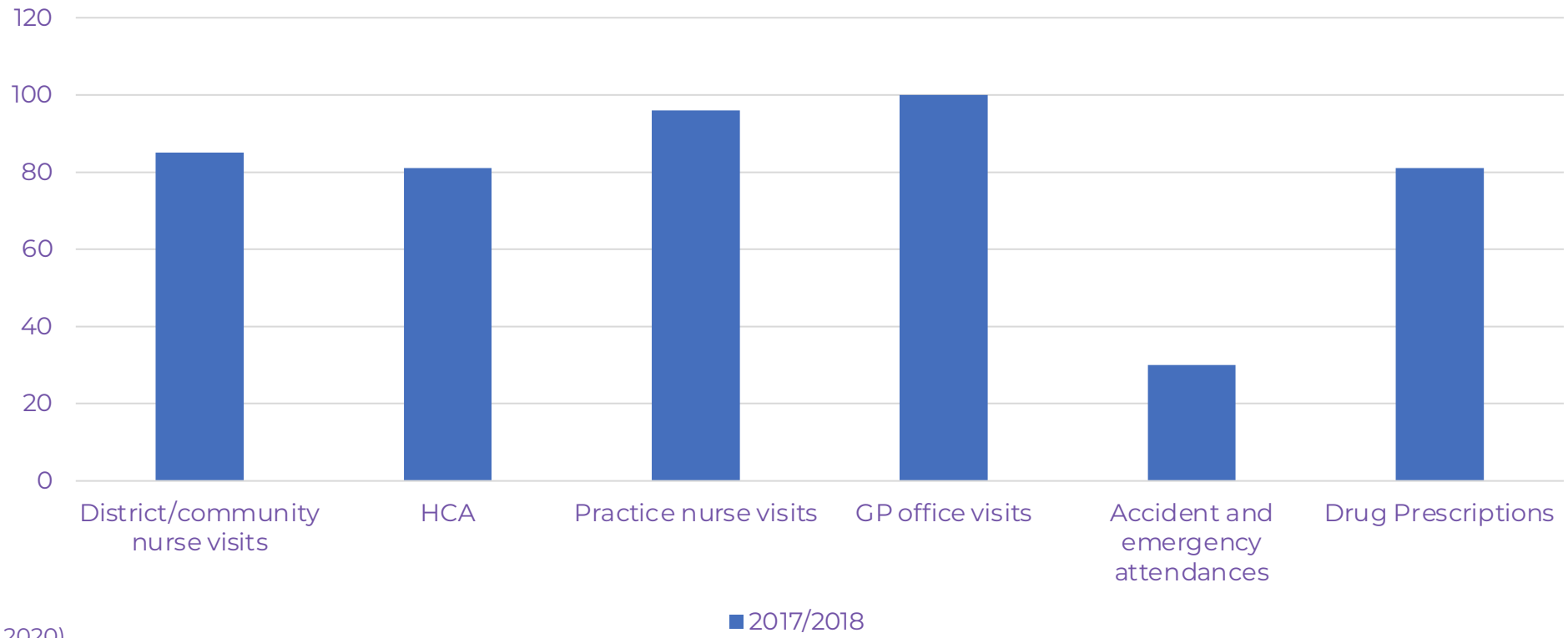


£3.1 billion
Annual estimated healthcare cost associated with leg ulcers.

(Guest et al, 2020)

BURDEN OF WOUND CARE IS ESCALATING

Percentage of venous leg ulcer patients using a resource 2017/2018



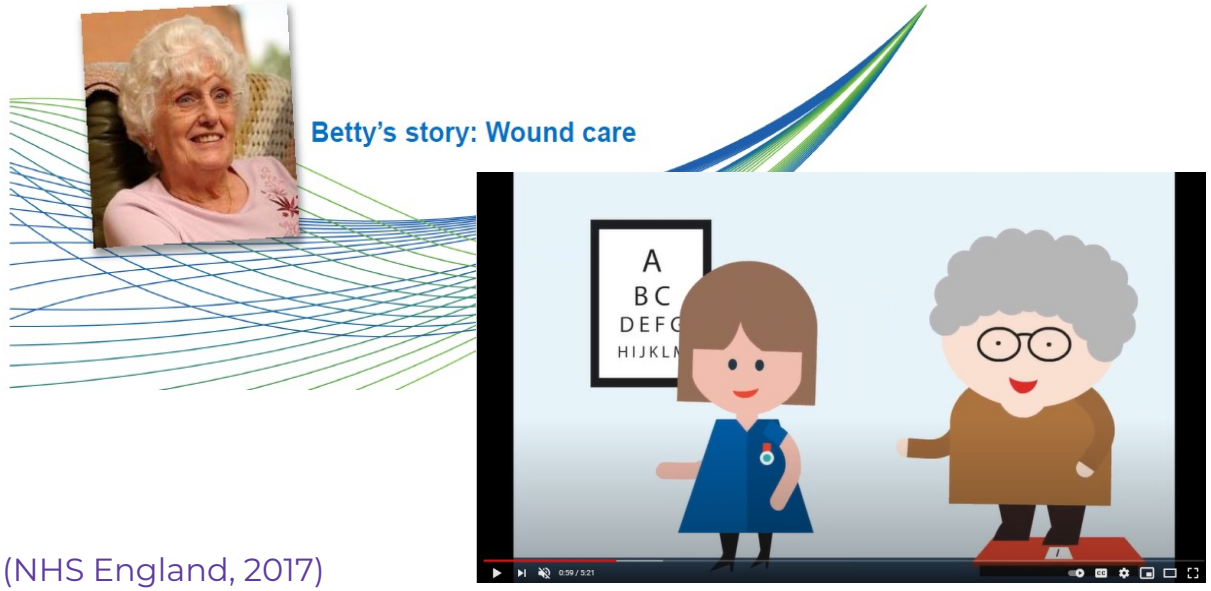
(Guest et al, 2020)

BETTY'S STORY

January 2017

NHS RightCare

NHS RightCare scenario:
The variation between standard and optimal pathways



(NHS England, 2017)

NHS RightCare

Financial information

Analysis by provider	Sub-optimal	Optimal
Acute	£1,703	£0
Ambulance service	£466	£0
Community teams	£2,167	£12
Primary care	£1,334	£346
Pharmacist	£3	£3
Leg ulcer pathway	£0	£144
Grand total	**£5,673**	**£505**

In the suboptimal scenario:
- Dressings represent £1,353 (24%) of the total costs versus £88 in the optimal pathway.
- Clinical time represents £2,139 (38%) of the total costs versus £195 in the optimal pathway.

Different thinking is needed in order to improve healing rates and reduce the burden to the NHS and sufferers.

NATIONAL WOUND CARE STRATEGY PROGRAMME

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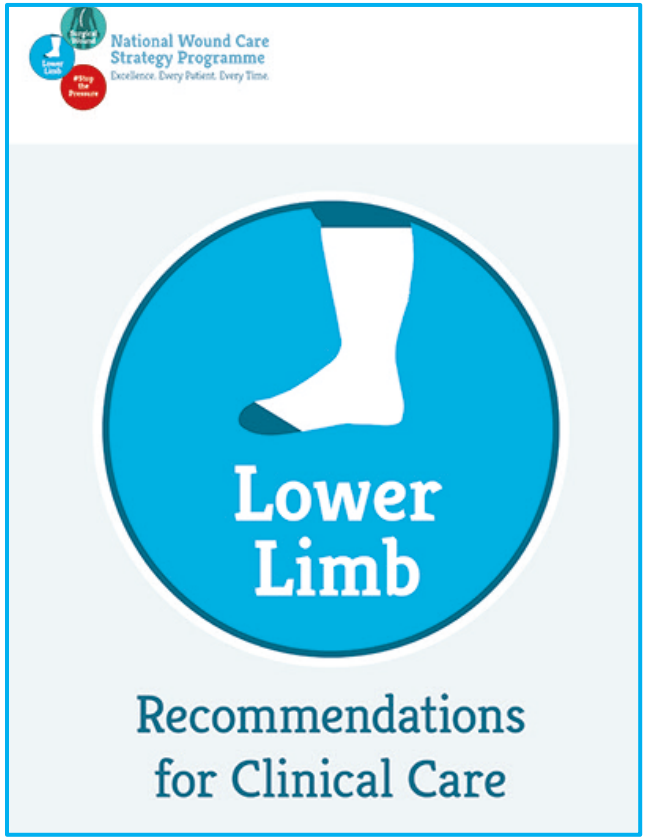


The unwanted variation in UK wound care services offers opportunities to improve healing rates and thus reduce:

- Patient suffering
- Spend on inappropriate and ineffective treatments
- Amount of clinical time spent on wound care (NWCSP, 2020).

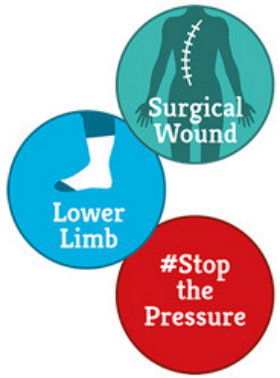
The guidance applies to people who have one or more wounds below the knee (NWCSP, 2020).

NATIONAL WOUND CARE STRATEGY PROGRAMME

Lower Limb Ulcers

The National Wound Care Strategy Programme (NWCSP) provides clear recommendations to support best practice implementation and can be seen as three areas on one treatment pathway:

- Immediate and necessary care
- Diagnosis and treatment
- Ongoing maintenance.



National Wound Care Strategy Programme

Excellence. Every Patient. Every Time.

IMMEDIATE AND NECESSARY CARE

IMMEDIATE AND NECESSARY CARE

Immediate and Necessary Care

For people with one or more wounds below the knee.

Leg wound- originating on or above the malleolus (ankle bone) but below the knee.

Foot wound - originating below the malleolus.

RED FLAGS

- Acute infection of leg or foot (e.g. increasing unilateral redness, swelling, pain, pus, heat).
- Symptoms of sepsis.
- Acute or chronic limb threatening ischaemia.
- Suspected deep vein thrombosis (DVT).
- Suspected skin cancer.

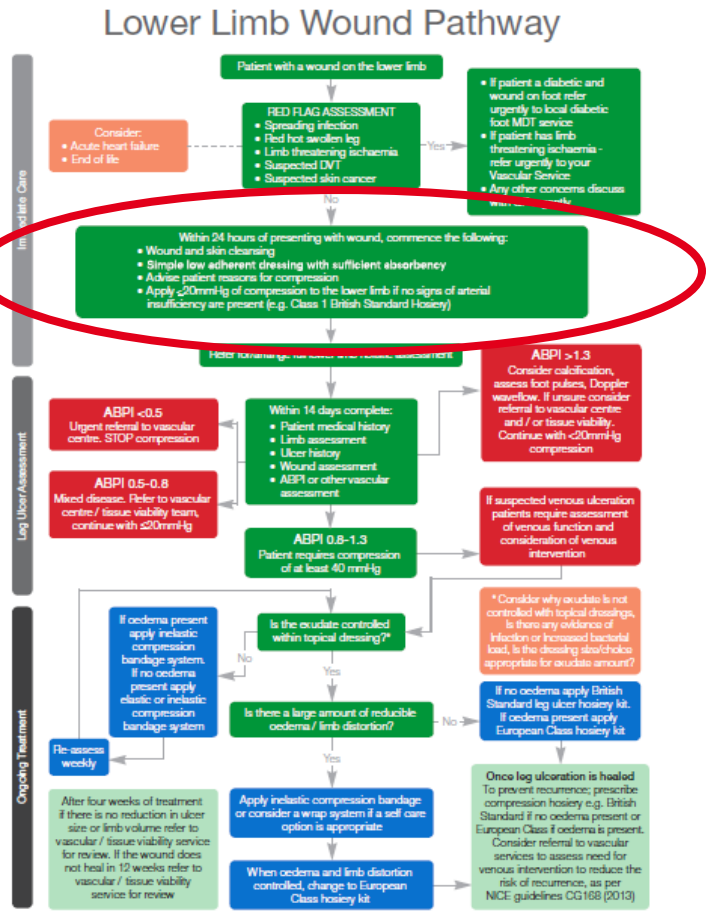
- Treat infection.
- Immediately escalate.
- For people in the last few weeks of life, seek input from their other clinicians.

Immediate care

- Cleaning and emollient.
- Simple low-adherent dressing.
- Leg wounds, first line mild graduated compression.
- Supported self-care (when appropriate).

Assessment times for diagnosis and treatment

- In hospital with diabetic foot wound - refer to MDT **within 24 hours.**
- Any other type of foot wound - refer to MDT **within 1 working day.**
- Leg wounds - **assess within 14 days.**



(Atkin and Tickle, 2016)

IMMEDIATE AND NECESSARY CARE

Immediate and necessary care can commence if red flags are excluded.

Red Flags

Immediately escalate to a relevant clinical specialist if any of the following are present or suspected (NWCSP, 2020):

- Acute infection (e.g. increasing redness, swelling, pain, pus, heat)
- Acute or chronic limb threatening ischaemia
- Suspected deep vein thrombosis (DVT)
- Suspected skin cancer.

ACUTE INFECTION OF LEG OR FOOT

Systemic features:

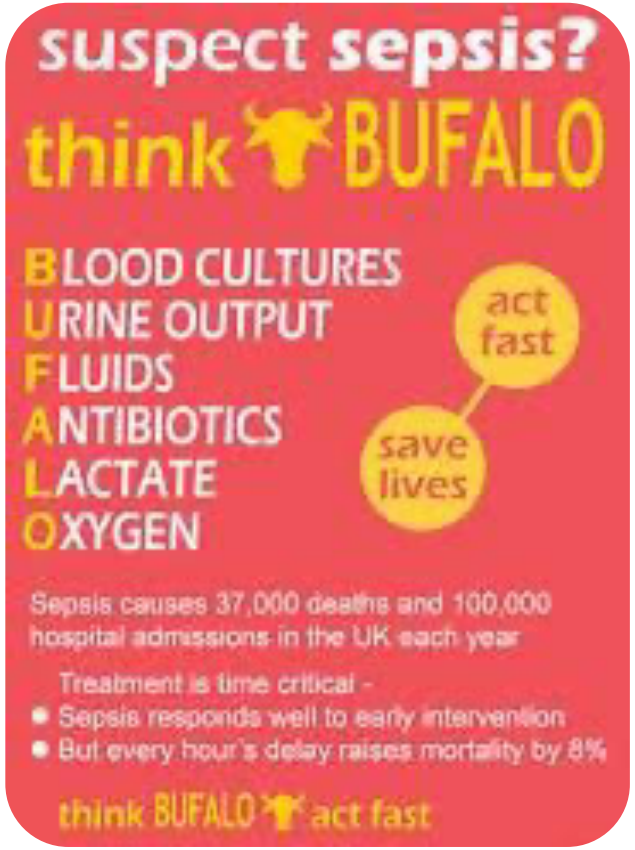
- Fever (30-80% may be afebrile)
- Tachycardia
- General malaise – flu-like symptoms.

Local features:

- Redness – clear edge, increasing
- Skin can resemble orange peel
- Pain – worse on touch
- Heat – warm on touch
- Oedema – resulting in elimination of fine wrinkles
- Presence of pus.

SIGNS OF SEPSIS

- Shivering, fever or very cold
- Confusion, slurred speech or not making sense
- Sleepy, difficult to rouse
- Blue, pale or blotchy skin, lips or tongue
- Rash that does not fade when you roll a glass over it
- Difficulty breathing
- Increased breathlessness
- Elevated temperature, pulse and respirations (TPR).

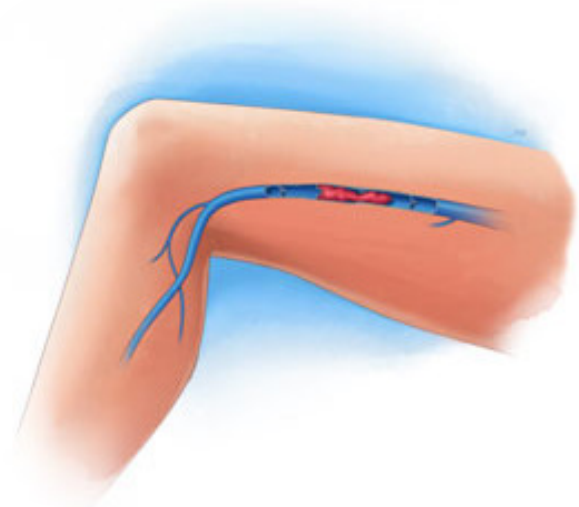


ACUTE OR CHRONIC LIMB THREATENING ISCHAEMIA

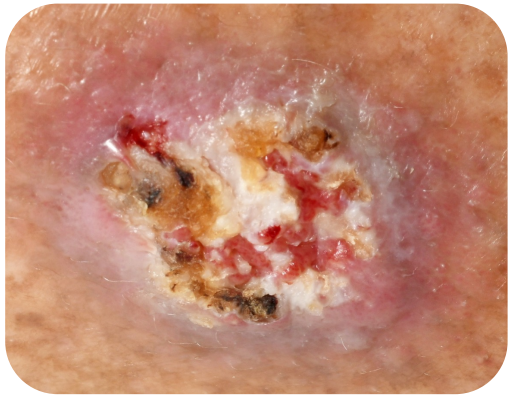
- Dependent rubor
- Red sunset foot
- Induration reduces on elevation
- Associated with severe pain (unless diabetic)
- If revascularisation not timely, tissue loss will follow
- Often on background of claudication
- No need for urgent admission
- Requires urgent referral to vascular team
- Capillary refill time and Buerger's test can be useful indicators of disease (Wright and Rajachandran, 2017).

SUSPECTED DVT

- Limb congestion
- Sudden onset oedema over 12 hours
- Pain on flexing of ankle
- Red/purple discolouration
- Warm to touch
- Often preceding event:
  - Surgery
  - Flight
  - Period of immobility (NICE, 2022).



SUSPECTED SKIN CANCER



- Lump, blemish or mark which changes
- Crust, oozing or bleeding
- Itchy, tender or painful
- Lower tolerance for biopsy
- Clinical pathways with red flag time points (NICE, 2020).

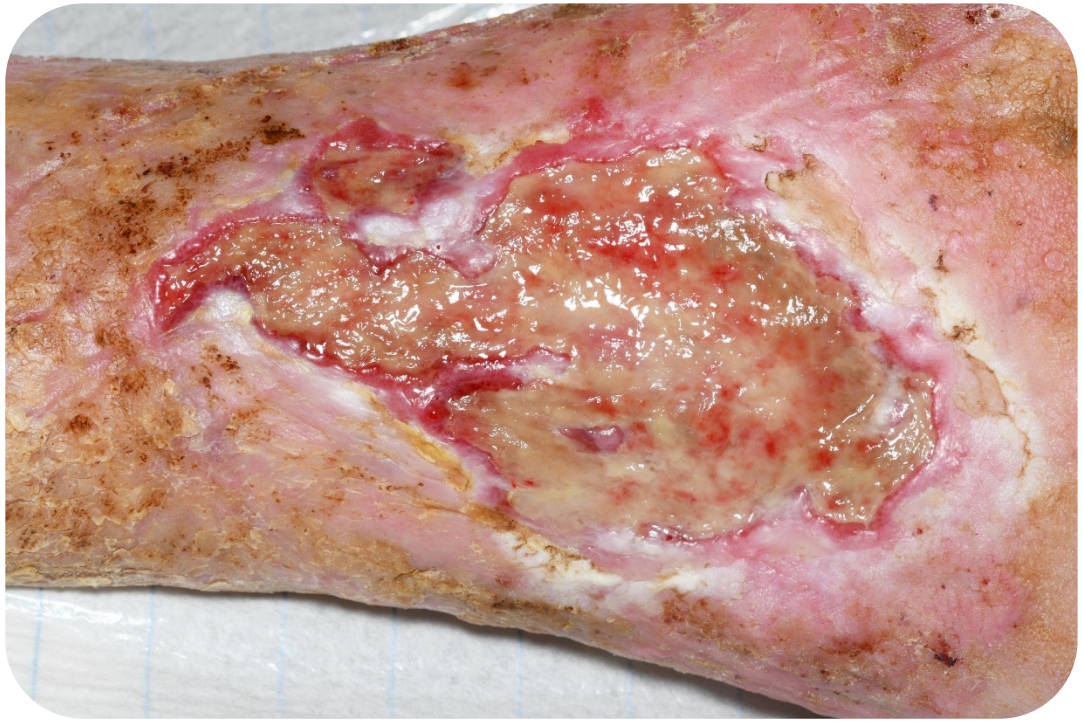
IMMEDIATE AND NECESSARY CARE

Immediate care should include:

- Cleaning and emollient
- Simple low-adherent dressing
- Leg wounds, first-line mild graduated compression <20mmHg
- Supported self-care (when appropriate).

The NWCSP (2020) recommends the use of **mild compression** as a component of immediate care for wounds on the leg, providing ‘red flag symptoms’ are excluded.

WOUND AND SKIN CLEANSING



SIMPLE LOW-ADHERENT DRESSING WITH SUFFICIENT ABSORBENCY

FIRST-LINE MILD GRADUATED COMPRESSION

- For wounds on leg, first-line mild graduated compression (<20 mmHg)
- Without any formal vascular assessment
- Simple assessment of red flags.

We are causing harm if we delay compression.

MILD GRADUATED COMPRESSION

Ways of applying ≤20 mmHg of graduated compression:

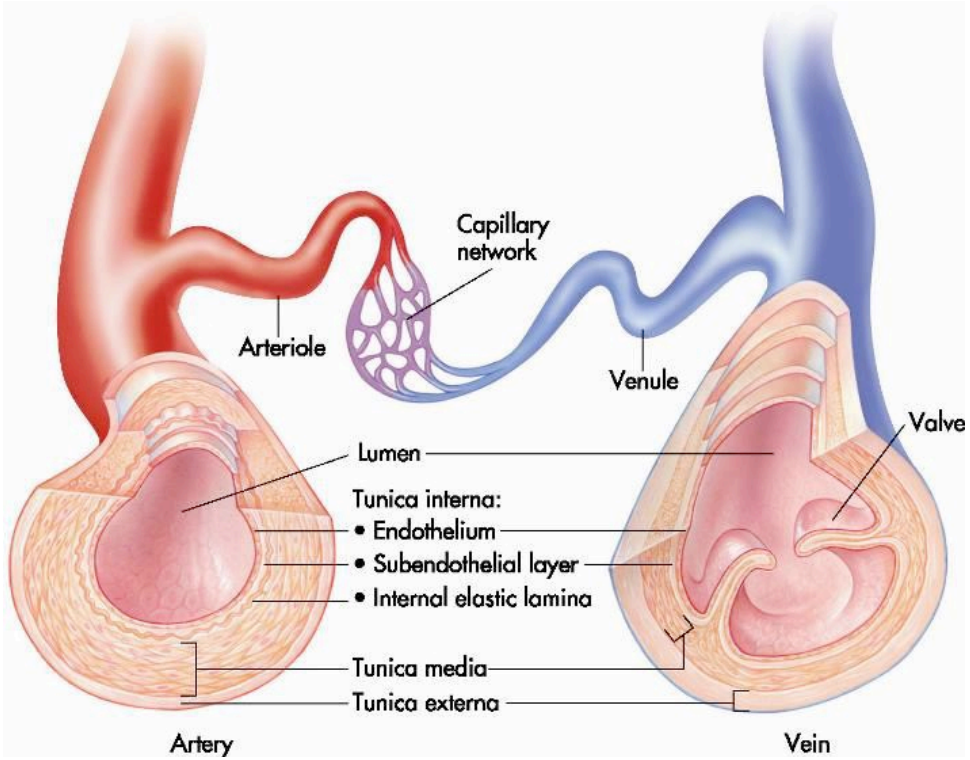
- Mild compression is classified as ≤20mmHg, e.g. Activa® British Standard Class 1 Hosiery or layering of two liners
- Reduced/light compression bandages
- Compression wrap systems (with adjustable pressure measurements)
- Tubular elasticated bandages (e.g. Tubigrip®) but cylindrical compression.

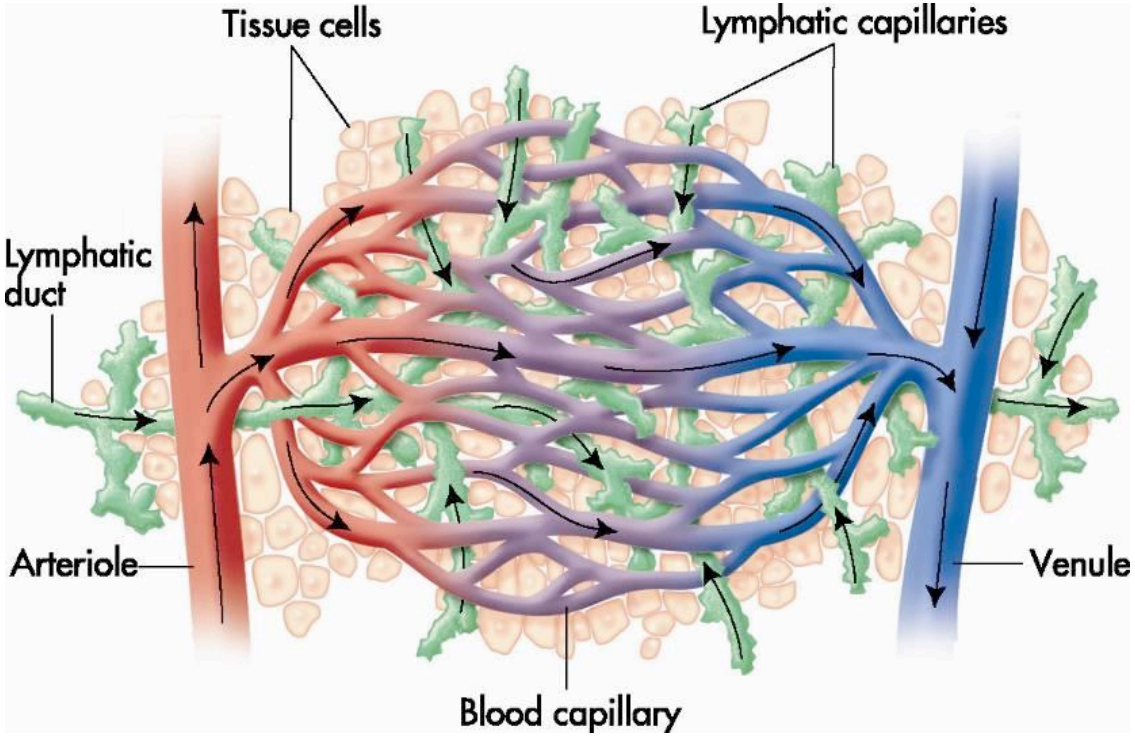
BENEFITS OF COMPRESSION

- Venous incompetence and oedema will reduce arterial flow
- Venous hypertension reduces the intravascular pressure gradient – reducing perfusion pressure
- Oedema pushes blood capillaries apart – increasing distance between blood capillary and cells – impeding nutrient transportation
- Compression helps all the above
- Compression of 40 mmHg proven to be safe in mixed disease ulceration – Ankle Brachial Pressure Index (ABPI) 0.5 – 0.8
- Compression therapy is a potent anti-inflammatory.

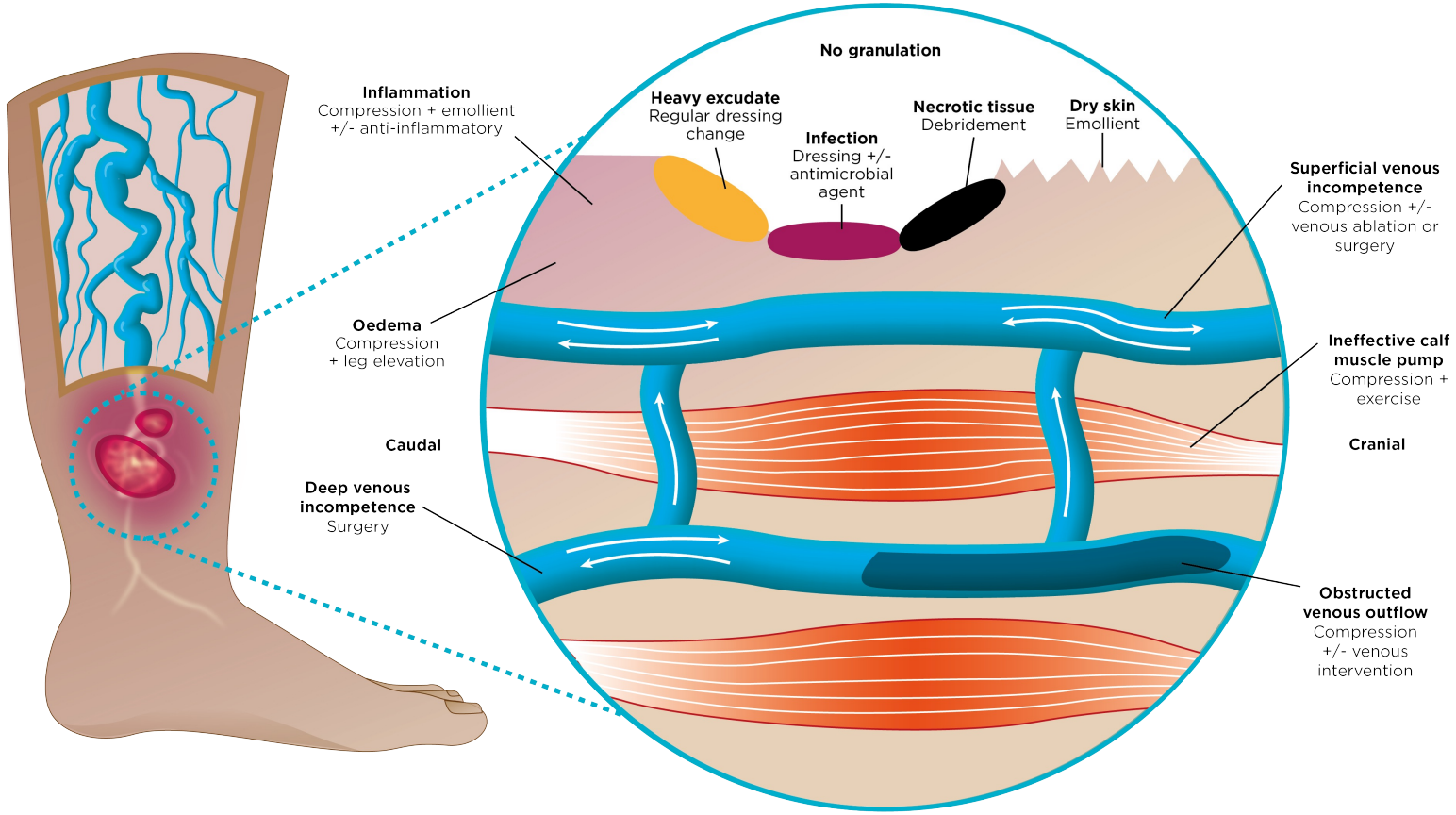
(Meissner et al, 2007; Mosti et al, 2012)

VEINS AND LYMPHATICS

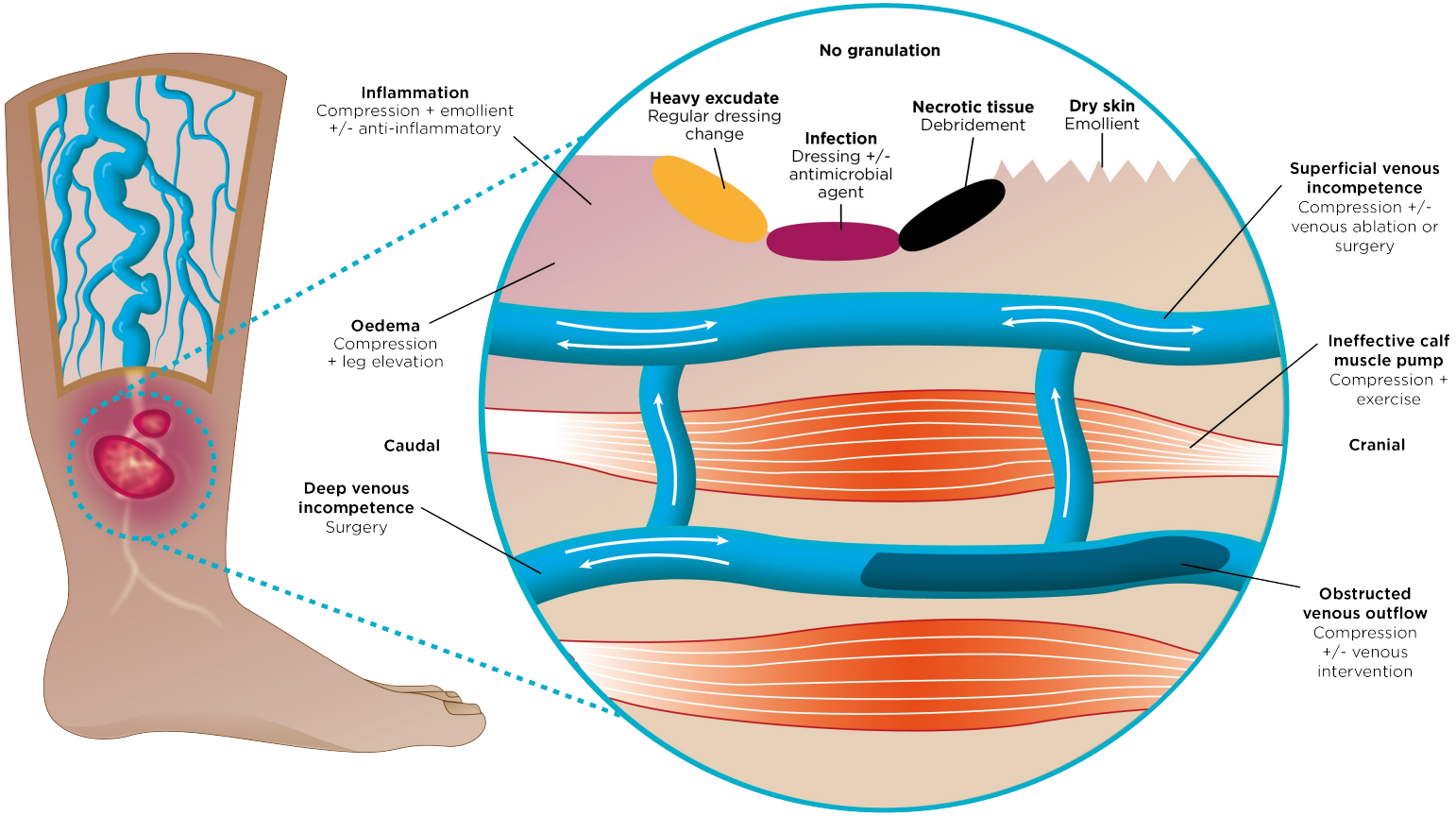


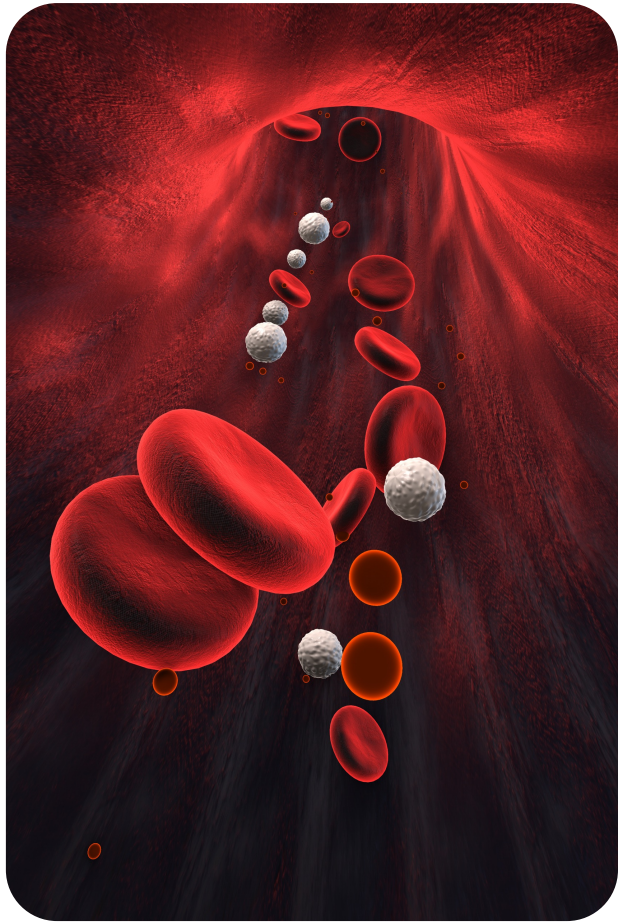


LEG ULCER – ‘A WEED’

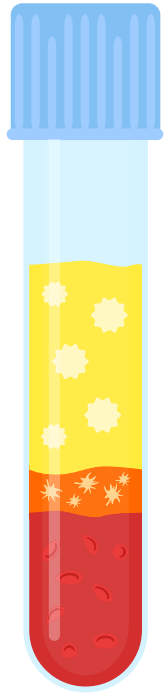


COMPONENTS OF BLOOD





BLOOD PRODUCTS IN SKIN



WHITE BLOOD CELLS

PLATELET-RICH PLASMA

RED BLOOD CELLS

- Plasma/platelets = Oedema
- Red blood cells = Haemosiderin staining
- White blood cells = Chronic inflammation.

TIME FOR ACTION

IMPORTANCE OF PREVENTION

As clinicians in primary care and community setting, **you are ideally placed** to have an impact on preventing venous disease progression to reduce prevalence of leg ulcers.

- Who is at risk of developing a wound on the leg?
- What prevention methods can be put in place?

FOCUS NEEDS TO BE ON PREVENTION!




Increasing negative impact on the patient and increasing resources used via the NHS.

LEGS MATTER

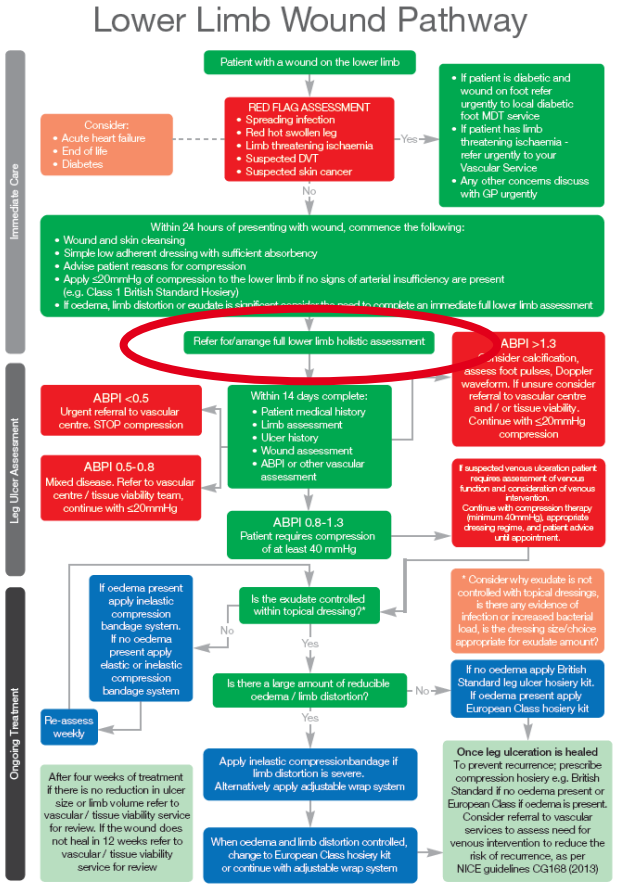
Leg and foot problems are one of the biggest health challenges of our time.

Legs Matter: https://societyoftissueviability.org/community/legs-matter-campaign/

BUT WHAT IF A LEG ULCER IS PRESENT?

ASSESSMENT AND REFERRAL

If the wound fails to heal within a two-week period, a full lower limb assessment, incorporating an ABPI should be carried out, with a view to diagnosing and treating the wound as a venous leg ulcer if appropriate (NWCSP, 2020).



(Atkin and Tickle, 2016)

TREATMENT OF A VENOUS LEG ULCER

NWCSP (2020) recommendations for managing wounds on the leg:

Diagnosis and treatment

1 Assess and identify contributing causes for non-healing

2. Diagnose cause of non-healing and formulate treatment plan

Leg wounds with an adequate arterial supply and no aetiology other than venous insufficiency

- Refer for venous surgical/endovenous interventions.
- Strong compression therapy.

Leg wounds with signs of arterial disease

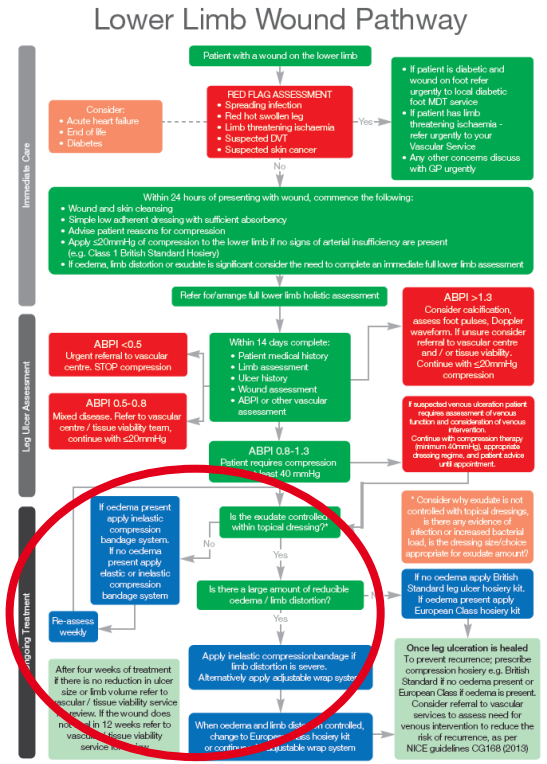
- Refer for vascular surgical/endovenous interventions and advice on compression.
- Pending vascular opinion, if no symptoms of arterial insufficiency, continue with mild graduated compression.

Leg wounds of other or uncertain aetiology

- Refer for dermatology opinion (or other specialist depending on symptoms and service arrangements).
  - Pending specialist opinion if no symptoms of arterial insufficiency, continue with mild graduated compression.

Lymphoedema

- Refer for expert diagnosis and advice about lymphoedema.



(Atkin and Tickle, 2016)

Watch out for
The Leg Ulcer Series: Part 2

A Facebook Live event which will look in depth at the treatment of a venous leg ulcer.

RECURRENCE OF A VENOUS LEG ULCER

Up to 69% of leg ulcers reoccur once healed annually (Harding et al, 2015)

Recurrence rates of VLU are reported at

26-69%

(Nelson and Bell-Syer 2014)

Impact of recurrence

- **Patient quality of life:** associated pain and distress of experiencing recurrent ulceration
- **Finances:** impact of increased costs of healing an ulcer versus maintenance of a healed ulcer (£7886 versus £119)
- **Workforce:** impact on service resources for managing an active venous leg ulcer versus maintenance (active = 85% community nursing, 81% healthcare assistant (HCA), 96% practice nurse (PN), 100% general practitioner (GP)
- **Morale:** impact on clinician motivation and morale when managing re-ulceration.

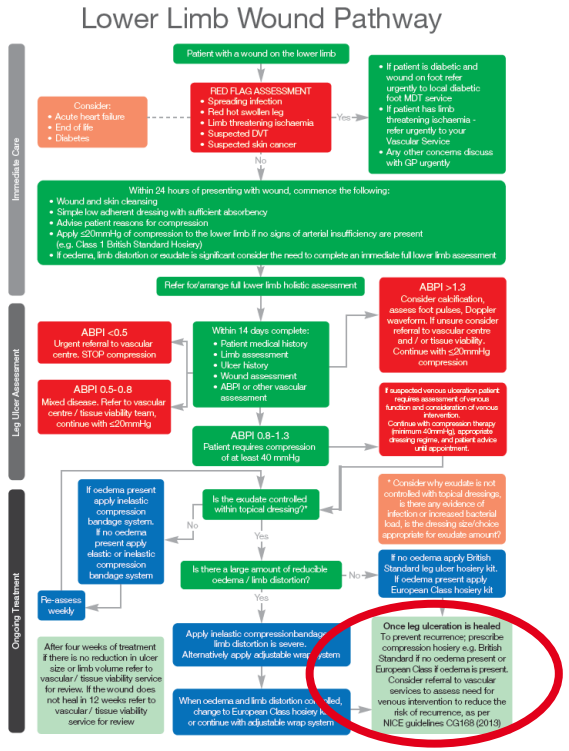
ONGOING MAINTENANCE

NWCSP (2020) recommendations for reducing recurrence rates:

Following healing

Venous Leg Ulceration

- Compression hosiery.
- 6-monthly review for replacement of compression garments and ongoing advice.
- If changes in lower limb symptoms or skin problems relating to hosiery, undertake comprehensive re-assessment.



(Atkin and Tickle, 2016)

PATIENT ENGAGEMENT

Prevention of recurrence for all types of leg ulcers (NWCSP, 2020):

- People with healed leg ulcers should be offered advice on skin care, footwear, exercise and mobility, rest and limb elevation, nutrition and self-care and on appropriate smoking cessation and weight loss
- People with healed leg ulcers should be provided with written information about their diagnosis and treatment plan and opportunities for supported self-care should be identified, discussed and incorporated into treatment plans as agreed with the individual.

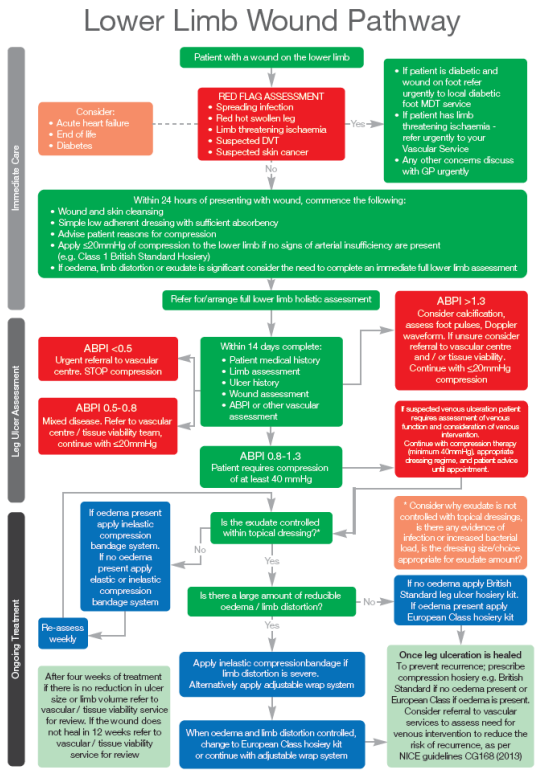
CLUB SQUEEZE IN

Club SQUEEZE IN

- ‘Squeeze In’ aims to empower people to manage their leg health to support improved outcomes and release nursing time back to care.
- To support your patients with leg ulcers from first aid to prevention of recurrence sign up to squeeze in today: **www.squeezein.life**

IN SUMMARY

- Prevention is key – take every opportunity
- End-to-end management:
  - Necessary and immediate care
  - Treatment of a venous leg ulcer
  - Recurrence and on-going maintenance
- Continuous support – care does not stop when the wound is healed.



(Atkin and Tickle, 2016)

A SOLUTION FOR THE WHOLE PATIENT JOURNEY

KEY TAKE AWAY QUESTIONS

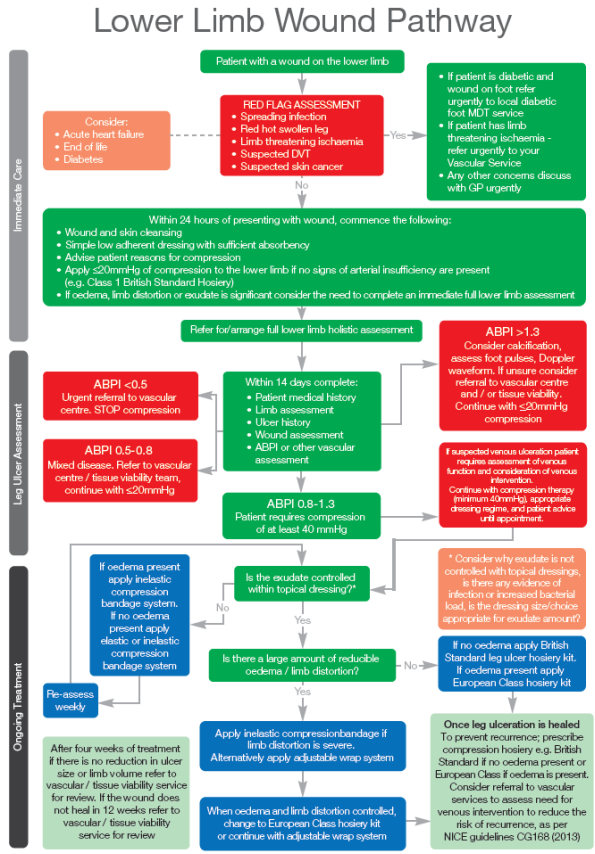
- Do you follow an evidenced based pathway to inform lower limb/leg ulcer care?
- Question your colleagues and system processes. What is the approach to lower limb management in your trust?
- Do you apply <20mmHg compression for all lower limbs while awaiting vascular assessment (subject to absence of red flags)?
- How do you ensure your patients know what they need to do to reduce the risk of recurrence?

CALL FOR ACTION

To get a copy of the pathway, please email:

CustomerServices@UK.LRMed.com

or call: 01283 576800



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FURTHER READING

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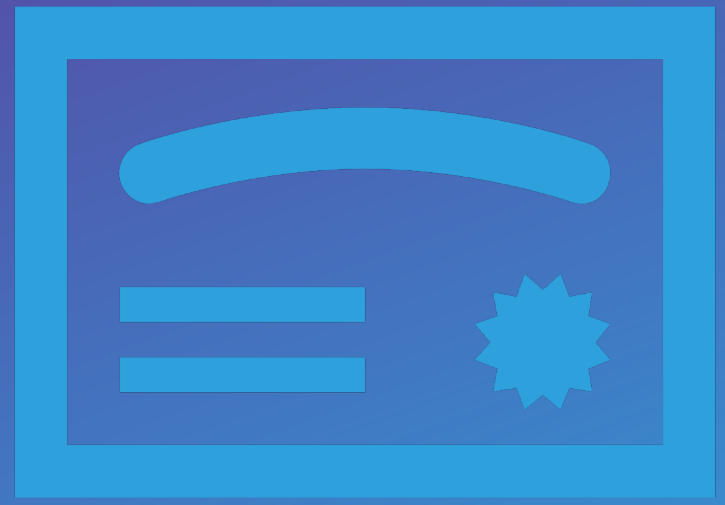
CERTIFICATE



www.gpn-live.co.uk/certificate