The Leg Ulcer Forum Journal

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THE leg ulcer FORUM

President: Prof.C.Moffatt

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We are also grateful to the following companies for their kind sponsorship towards the leg ulcer forum:

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Editorial

Welcome to the 14th edition of the Leg Ulcer Forum Journal.

As we come to the close of our Indian summer and yet another year, I would like to bring your attention to some of the activities the leg ulcer forum executive have undertaken on your behalf. Firstly the executive committee has been busy organising this year's leg ulcer forum conferences – we are holding the same conference at two venues (London and Sheffield), details of which can be found on page 17. I'm sure many of you will have booked your seat but if you haven't already done so I suggest you book your place soon, as places are being taken up fast. In response to your request from the previous conference evaluations, we have included a slot for free papers and are delighted to inform you that we have had a good response. We now have an official web site, and e-mail address, details of which can be seen on the back page of this journal. Through the web site you should be able to download previous editions of the leg ulcer forum journals; watch this space for further developments.

I hope you enjoy the content of this journal, which includes a contribution from the Irish Branch – on page 10 you will find details of the Irish conference held in October. I have invited our sponsors to write about the development of their companies, and as will be seen they each have a unique history. Professor Peter Franks has kindly given us an update on research presented at the World Phlebology Congress, and finally we have contributions from our own leg ulcer forum poet Dawn French.

I would like to remind you to complete and return the renewal of membership form found on page 19; failure to do this will forfeit your membership to the leg ulcer forum. Within this edition of the journal we have enclosed the EWMA journal and a supplement on compression bandaging – we hope you enjoy the read and share them with your colleagues. Finally, a warm welcome to our two new co-opted members of the executive committee, Judy Harker and Irene Anderson.

On behalf of the executive may I wish you all a Merry Christmas and prosperous New Year and would like to bring your attention to our Christmas poem below.

Best Wishes

Lynfa M Edwards

Lynfa M Edwards, Editor

Memories of Childhood Christmas

Snowflakes falling softly down
Has father Christmas been to town?
I left a mince pie for him last night and
A carrot for Rudolph to take a bite.

Slowly down the stairs to see
Has he left any presents for me?
Mum and Dad follow behind
Bleary eyed and very kind.

Soon a roaring fire is lit
Am I excited? Just a bit!
Stocking bulging to the brim
Fruit and nuts galore within.

And what's that over by the chair?
A dolly with real rooted hair,
Chatty Cathy is her name,
It's mid sixties and she's shot to fame.

What a wonderful Christmas Day,
So perfect in every way.
When I grow up I hope Christmas will be,
As special to my children as it is to me!

Dawn French
District Nurse
Walsall Community Health Trust

Nurse *Prescribing*

Merry Collinson BSc(Hons) SRN, DN, Cert Ed,
Tissue Viability Nurse
Rotherham Priority Health Trust, South Yorkshire.

Historical perspective

Nurse Prescribing was initially proposed in the Review of Community Nursing chaired by Baroness Cumberlege (1986). The report team identified that "despite the highly skilled and caring work done by community nurses, there is substantial room for improvement if services are to be more sensitive and responsive to the needs of the consumer than they are now".

The report recommended that "The DHSS should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme". These recommendations were subsequently reviewed by the Department of Health Advisory group chaired by Dr June Crown (1989). Nurse Prescribing received Royal Assent in March 1992 (ENB,1998). This in turn led to the creation of the Nurse Prescribers Formulary (NPF) and the development of procedures through the Prescription Pricing Authority. Eight pilot sites were set up in 1994 within GP fundholding practices with the culmination of the Nurse Prescribing programme being rolled out nationally in May 1998.

Who can prescribe?

At the present time prescribing is limited to nurses who have first level registration with a District Nursing or Health Visiting qualification working within a primary health care setting. These nurses should have successfully completed the Nurse Prescribing programme and been identified by the UKCC as a Nurse Prescriber. With employers authorisation they are then permitted to prescribe from the NPF. The NPF provides a list of items from which the Nurse Prescriber can prescribe, however the products available are commonly used items mostly available as over the counter substances (McCartney *et al*, 1999).

The Implications of Nurse Prescribing on Wound Care (Luker *et al*, 1998) explored nurse-patient relationships, and found that patients were confident in their nurse's ability to prescribe. The patients expressed the view that nurses were in a better position than GPs to prescribe items such as wound care products, as nurses had expertise in this field. By enabling the District Nurse to prescribe wound care products, the District Nurse can assess the wound, write the prescription during that initial visit and instigate an appropriate treatment within 24 hours, if not sooner. Previously the District Nurse would have advised the GP what to prescribe and had to wait for the GP to countersign the prescription. If this occurred out of normal working hours the wait for a prescription would have been extended. Working in my previous role as a District Nurse I found that by being able to prescribe, my patients did not have the hassle of having to visit the GPs surgery to collect a prescription. I could prescribe smaller amounts of wound dressing products and as I was evaluating the wound on a regular basis I could change the treatment according to the condition of the wound. Sadly as a Tissue Viability Nurse I am not permitted to prescribe at present.

Prescribing for leg ulcer management

Nurse Prescribers need to be fully aware of the multi layer compression bandage systems available for leg ulcer management and consider the research available prior to making the decision to prescribe bandages. The most important issue within leg ulcer management is the holistic assessment of the patient to determine the aetiology of the leg ulcer. If the Nurse Prescriber has the responsibility for instigating compression bandaging accurate diagnosis is essential. A further issue relates to accountability, as the nurse prescribing the treatment you are responsible by law for the safe administration of that treatment (ENB, 1998). Restrictions may occur upon the bandage systems available due to the limitations of local formularies in line with Primary Care Group recommendations. Gooch (2000) highlights the issue of local formularies and suggests that these are not legally binding, nurses can still prescribe any item from the NPF, although PCG's may not be willing to fund the prescription. A further contentious issue is the cost to the patient of compression bandaging if the patient has to pay prescription charges.

Conclusion

The reality in practice is that the Nurse Prescribing initiative has the potential to improve services to the consumer envisaged by Cumberlege and be more responsive and sensitive to the individual needs of that client. A recent document issued by the Department of Health (2001) identifies the Governments intention to extend independent nurse prescribing, enabling nurses to prescribe a wider range of items. This would however entail further training for existing Nurse Prescribers. Primary Care Trusts and Primary Care Groups need to be responsive to the needs of the consumer and refrain from restricting local formularies. District Nurses have expertise in wound care and leg ulcer management and should be involved in recommending the most effective treatments without restriction on the type of compression bandaging they can prescribe.

REFERENCES

DHSS (1986)
Neighbourhood Nursing – a Focus for Care (Cumberlege Report)
HMSO, London

DOH (2001)
Extension of Independent Nurse Prescribing
Department of Health, London

DOH (1989)
Report of the Advisory Group on Nurse Prescribing (Crown Report)
Department of Health, London

ENB (1998)

Nurse Prescribing Open Learning Pack
Learning Materials Design: Milton Keynes

Gooch S (2000)
Expert Comment re Nurse Prescribing and Clinical Nurse Specialists
Nursing Times Plus 96,36,20.

Luker KA, Austin L, Hogg C, Ferguson B and Smith K(1998)
Nurse-patient relationships: the context of nurse prescribing
Journal of Advanced Nursing: 28 235-242

McCartney W, Tyrer S, Brazier M, and Prayle D (1999)
Nurse prescribing: radicalism or tokenism?
Journal of Advanced Nursing:29 348-354

'The Rep'

The rep is here again today,
Receptionists don't know what to say.
Just a minute of your time,
I won't go on it will be just fine.

A teddy bear, a mug for you,
A conference place, a key ring too.
Many offers just for your attention,
In the hope of intervention.

Change your treatment, this one's best,
I'll give you samples put it to the test.
The District Nurse just wants to say,
"please come back another day"
But being polite and professional she says,
"As Nurses we have different ways".

Make an appointment for lunchtime do,
Bring sandwiches, cakes and evidence too!
Then we can collaborate as a team,
By the time we have finished you'll want to scream.

For it's randomised controlled trials we want to see,
So you'd better know your stuff or else you will be,
Out of that door, samples too,
For research-based care is what we do!

Dawn French
District Nurse
Walsall Community Health Trust

New members of the *LUF Executive*

Irene Anderson

BSc(Hons), DPSN, RGN

Lecturer

I am a lecturer in tissue viability at the University of Hertfordshire and involved with students studying diploma, degree and masters level tissue viability courses. I was a nurse in the acute sector for many years and it was on a move to primary care in 1992 that I discovered the challenge of managing leg ulcers which has been a particular interest ever since. I have also worked in the healthcare industry in a training and education role prior to joining the University of Hertfordshire in 2000.

I have a first class honours degree in tissue viability and have also completed the N18 Advances in Leg Ulcer Management course. I am currently a co-opted member of the leg Ulcer Forum, actively involved in the writing of educational leaflets.

Judy Harker

RGN, DN Cert, BN(Hons) PGdip Wound Healing and Tissue Repair

Tissue Viability Nurse Consultant at Oldham NHS Trust

Her main responsibilitites include leading the tissue viability nursing team and further development of wound care services throughout Oldham. This involves a multi-disciplinary approach in driving services forward.

As nurse consultant Judy aims to raise the profile of the tissue viability speciality in order to influence decision making at a strategic level and gain equity and further credibility for this professional area.

Special interests within wound management include treatment of leg ulcers, colonised and infected wounds and the patients perspective.

Meet *the Sponsors*

The leg ulcer forum is very grateful for the continuing support given by sponsors. It should be acknowledged that without their support the forum would not exist in its present form. In order to gain an insight into the companies development we have asked each sponsor to enlighten you through a company profile.

Activa

Activa was formed in 1998 when a rare opportunity arose to bring together a number of experienced personnel. Although Activa was a new company, it held amongst its employees over 120 years of experience within the compression therapy market.

One of Activa's aims is to be viewed by its customers as the most respected supplier of compression therapy products in the UK. Following a period of product development and wearer trials, Activa launched a range of "new generation" medical hosiery with FP10 status, early in 1999. Up until this date, the market had seen little or no product innovation since the drug tariff specification last changed in 1987. By working closely with key nurse leaders across the UK, Activa developed the first range of medical hosiery containing Lycra Soft and Tactel Nylon by Du Pont. Both yarns had never been used in medical hosiery in the UK, and when combined with some innovative knitting techniques, they made the Activa product easier to apply and generally more attractive to wear. Activa now has the fastest growing medical hosiery range in the UK.

In June 2000, and in the spirit of innovation and change, Activa once again challenged tradition by launching a ground breaking cohesive short stretch bandage on drug tariff. In January 2001, Activa launched a completely new made to measure service. A new circular knit stocking in both class II and class III backed up by a state of the art computerised system, which has reduced the lead times on made to measure to around three weeks. March 2001 saw the launch of a class 1 below knee open toe and an air sock to help prevent deep vein thrombosis when flying.

Our national training team currently trains at many levels, including the National Pharmacy Associations pre and post-graduate courses, English National Board leg ulcer courses. Additionally the Activa team provides training and support at clinic level, which includes training on measuring and fitting hosiery, applying short stretch bandages and education materials. Perhaps an interesting way for you to learn more about Activa and its products, is to visit our web site www.activahealthcare.com. Alternatively, please ring our Customer Care Line on 01283 540957.

Coloplast

It was a Danish nurse who wrote the first chapter of Coloplasts history more than 40 years ago. Elise Sorensen conceived the idea of an adhesive bag after her sister had undergone bowel surgery. She went to the manufacturer Aage Louis-Hansen, who at that time had a plastics factory. Thanks to the understanding of Aage Louis-Hansen's wife, Johanne (who used to work as a nurse) and Louis' technical skills, the first ostomy appliance was put into production in 1955.

The first bag was a simple pvc bag with an adhesive plate welded to it. It was revolutionary and was the forerunner of the sophisticated products available today

In 1978 the Continence Care division was established and over the years Coloplast has used its experience within the ostomy field to develop a full range of collecting solutions for both males and females with urine or faecal incontinence or urine retention problems Coloplasts wound care division was established as a new area in 1982. Again Coloplast utilised its technology knowledge developed from both Continence and Ostomy divisions and applied it within the wound care arena. Since then, the principal of moist wound healing has met increasing acceptance within the medical and nursing field to ensure optimal healing environment.

Coloplast is a major player in wound care, providing better outcomes for patients with chronic wounds. The Coloplast Research Centre has close cooperation with leading universities, nurses and not least caregivers and users of our products, throughout the world, which fosters constant improvement and innovation. This results in quality solutions for difficult-to-heal wounds. This fruitful collaboration has enabled us to offer a full range of moist wound healing dressings. Coloplast has manufacturing sites in many different parts of the world from USA to Costa Rica and China and Germany. It also has sales subsidiaries and offices in 26 countries ensuring they meet the needs of each of their local populations.

Johnson & Johnson
ADVANCED WOUND CARE
a division of ETHICON

Johnson & Johnson

Johnson & Johnson are the World's most comprehensive manufacturer of health care products serving the consumer, professional, pharmaceutical and diagnostic markets.

The company was founded in the mid 1880s, with the development of the first ready-made, ready to use surgical dressing by Robert Wood Johnson and his two brothers.

Production and operations officially began in New Brunswick in 1886, with 14 employees on the fourth floor of a wallpaper factory. The company quickly expanded, producing new dressings and positioning them in the market place and it soon became established as a leader in the health care field.

International growth followed shortly with the establishment of an affiliate in Canada in 1919, and following a round the world trip by the brothers in 1923 Johnson & Johnson created its first overseas affiliate with Johnson & Johnson Ltd in Great Britain.

The 1920s saw rapid product expansion for Johnson & Johnson with the introduction of two of the most widely used products, Brand Adhesive Bandages and Baby Cream. The son of Robert Wood Johnson took control of the company in 1932 and brought with him a new philosophy to the company. He initiated a policy of decentralisation to the increasing number of affiliates and divisions in the company, shaping Johnson & Johnson into its present day structure.

Another significant feature of this time was the introduction of the Credo, which codifies the company's socially responsible approach to conducting business. It still acts as a focus for all the divisions and subsidiaries of Johnson & Johnson today.

Nowadays Johnson & Johnson have approximately 91,500 employees and over 170 operating companies in 50 countries around the world. Johnson & Johnson Advanced Wound Care has had continuing success over recent years. The business comprises a rapidly expanding business base. The consistent development of new products is vitally important to the business,

Johnson & Johnson strive to improve the effectiveness and suitability of their products to practitioner needs. Johnson & Johnson also endeavour to provide a range of added value services to their customers. These range from offering educational services to the customers to the development of the Institute of Wound Management for Tissue Viability Nurses.

For further information on our Advanced Wound Care business please contact us at;

Johnson & Johnson Ltd

Coronation Road, Ascot, Berks SL5 9EY

Tel: 01344 871000 (Switchboard), 01344 871078 (Julie Morgan) or contact your local representative.

medi UK

Manufacturing high quality medical compression hosiery is a highly technical and specialist occupation, focused in a small number of special areas in Northern Europe and North America where knitting skills have literally been passed on from generation to generation. Bayreuth, Bavaria, in Southern Germany is one such centre of excellence where the original Weihermuller and Voightman family, the founders of "WeCo", started the company that has become "medi". Still family owned medi is able to concentrate on knitting skills and quality and not allaying the financial concerns of city investors!

Today the original manually operated knitting machines have been largely, though not completely replaced by computer controlled fully automated round and flat knit machines which are individually set up in the medi factory to produce garments that we have grown used to and which your patients rely on. The number of employees has grown too with around 700 people being directly based in the factory and head offices, which were purpose built in the last ten years.

Medi has also grown from being a leading German hosiery manufacturer to now a world class international company who specialise in hosiery but who have other business interests in orthopaedic and prosthetic products. With medi's own Distributor companies in Britain, USA, France, Belgium, Holland, Italy, Spain and Portugal to name a few, medi is able to provide technical support and products first hand from personnel trained and directly employed by medi.

When you deal with medi you can expect a level of product support and competency that many other more diverse healthcare companies would struggle to match. That's the benefit to you and your patients of medi's focus on what we do best – design and manufacture high quality medical compression hosiery.

Whether your patient's medical compression needs are to control lymphoedema, venous disease or to prevent deep vein thrombosis, medi is there with hosiery that meets the compressive requirements as well as the comfort and styling that today's patients demand.

In vascular disease UK hosiery on FP10 is limited in its compression values offered by the British Standard and the Drug Tariff requirements. In Europe the higher values of medi compression garments, which are made to comply with the tough RAL European Standard, have been well known and widely accepted. These benefits have long been known of and understood by Vascular and Leg Ulcer Specialists in the UK. This reputation has led medi to become the market leader not just in Europe but also here in the UK

If you are interested in further information please contact:

medi UK Ltd, Fields Yard, Plough Lane, Hereford HR4 0EL, (T) 01432 351682, (F) 01432 342383, enquiries@mediuk.co.uk or visit our web site www.mediuk.co.uk

Mölnlycke Health Care Ltd

Mölnlycke Health Care was established as an independent company in late 1997 through an acquisition and merger of the clinical divisions of the SCA / Mölnlycke Group in Sweden and Tamro Oy in Finland.

The business was organised in 2 divisions, Wound Management Products with the brand name Tendra® and Surgical Products with the brand name Klinidrape®.

The 'new' Mölnlycke Health Care is now one of the world's leading manufacturers and suppliers of single-use surgical products such as drapes, sets, gowns and other apparel, with a strong global presence in wound care.

The Wound Care Business Area provides the acute care and primary care sectors with a complete wound management system under the brand name Tendra.

Tendra is the brand name for all Mölnlycke Health Care wound care products and these can be divided into two large groups – traditional and advanced. In the latter area, Mölnlycke Health Care have developed a patented technology – Safetac – based on soft silicone.

Parema

Parema Limited is a private company that was established in Leicestershire in 1928. Since that time it has specialised in elasticated fabrics for technical applications.

The Medical Division was formed in 1980, following the development of a range of innovative bandages. Since then it has used its expertise in emerging fibre and machine technology to develop new products. Today, Parema offers a wide range of dressings and compression hosiery to the UK and overseas markets. The company is now a major supplier to the NHS, both in hospitals and the community.

Parema's goal is to provide product innovation and excellence at competitive prices. This includes an "evidence based" approach to the development of its healthcare treatments that are fully supported, with published clinical trials conducted by opinion leaders. Awareness of how the treatments work is central to the service offered by Parema. To that end the company offers a range of training and development programmes from product information sessions through to self assessment of bandage techniques using pressure monitors. Parema has developed a range of products, which may be used for leg ulcer treatment and is involved in the development of this range and new products to ensure patients with lower limb vascular problems can be treated consummately and cost effectively.

Smith+Nephew

First Choice in Wound Management

Smith & Nephew

History

Smith & Nephew have a long established and distinguished history. In 1856, Thomas James Smith opened his first pharmaceutical chemist shop in Hull, England. The company became Smith & Nephew when Horatio Nelson Smith, the founder's nephew, entered into a partnership with his uncle in 1896 and began to develop medical dressings. To the present day, the company has continued to expand not only in the UK but globally to become a true world leader in the manufacture and marketing of sophisticated medical devices. With strong representation in many countries throughout the world including the USA, much of mainland Europe, South Africa and Australia, the company is the largest of its kind with a turnover of 1.134 billion in 2000.

A recent period of restructuring has strengthened the company's position. In 1998, Smith & Nephew announced strategic changes involving a major reshaping of the group with a focus on three key businesses – Orthopaedics, Endoscopy and Wound Management. In 2000, a further period of restructuring saw Smith & Nephew focus solely on becoming the leading advanced medical devices group. This year, the company has entered the BSN joint medical venture with Beiersdorf, along with the purchase of the Biesdorf advanced wound care business, which added critical mass to the Smith & Nephew portfolio.

Wound Management

In the UK, Smith & Nephew Wound Management provides an advanced range of products for difficult to heal wounds. The strategic aim is to provide products that are truly beneficial and superior for the NHS, nurse, specialist, pharmacist and most importantly, the patient. Between May 2000 and May 2001, Smith & Nephew accounted 38m sales in the 97.2 UK wound care market with many brands in a market-leading position within their respective areas. Smith & Nephew has the most extensive range of solutions to support protocols for many conditions:

- **Pressure Ulcers**
- **Leg Ulcers**
- **Burns**
- **Scars**
- **Surgical wounds and IV fixation**

Within these broad therapy areas, a common theme prevails: The issue of wound bed preparation encompasses the importance of removing the barriers to healing. Removal of necrotic tissue, slough and debris can reduce the bacterial burden within the wound and create a biochemical balance in order to stimulate healing.

Leg Ulcer Forum (Ireland Branch)

Conference report

Athlone in the Midlands of Ireland was the venue for the Irish Branch's 4th Annual Leg Ulcer Forum Conference, held on the 12th October 2001. Over 130 delegates attended with many having to make the journey the previous day, which was a good excuse to enjoy some Irish hospitality on the eve of the conference!

The content of the conference, ably chaired by Ms Mary Courtney, Director of Nursing and Midwifery for the Western Health Board, was both affirming and challenging as speakers shared their considerable expertise of, and insight into, the many issues surrounding prevention and management of lower limb ulceration.

Georgina Gethin, Wound Care Specialist in Sligo General Hospital gave a comprehensive overview of the causes of ulceration and the challenge presented to practitioners and patients in preventing recurrence. She introduced us to the LURRAS scoring system which aims to predict degrees of risk

Georgina Gethin and Paul Blair, speakers at the conference

Two vascular surgeons explored advances in vascular investigations and surgical interventions with Mr Paul Blair, Royal Hospitals Trust, Belfast, endearing himself to nurses by confirming what we already knew, that nurses keep 95% of patients with leg ulceration out of hospital! He also admitted what we often suspect, that in the past some venous surgery was carried out without proper investigations to establish the seat of incompetence, hence the chronicity of ulceration seen today in patients who have previously undergone stripping of the superficial veins. Regarding arterial surgery in the arterially compromised limb, Mr Blair emphasised that the aim of treatment was to improve the patient's quality of life by keeping them ambulant for as long as possible, reserving amputation for life-threatening situations. There was a strong recommendation that all patients with diabetic foot lesions should have an angiogram prior to the decision to amputate a limb as many benefit from distal by-pass surgery.

If surgical interventions are to be successful, vascular investigations are essential to determine the type of surgery required. Our after dinner speaker, Mr Martin Feeley, Vascular Consultant at Tallaght Hospital Dublin, emphasised the need for good history taking and clinical examination and suggested that this skill can be lost in the quest for advances in technology.

Dr Gerald Glynn gave a clear and logical presentation on the microbiology of leg ulceration differentiating between contamination, colonisation and infection and classing bacteria and their potential to cause infection in legal terms as, those commensals not proven, the endotoxin producing bacteria as guilty of manslaughter and the exotoxin producing bacteria as being guilty of murder. Further legal jargon is seen in table 1.

Bystanders
Skin flora, Coagulase negative staphylococci, Diphteroids

Passengers (colonisers)
E.coli, Proteus, Klebsiella, Enterobacter, Pseudomonas, Enterococci, Bacteroides

Passengers with criminal records (potential pathogens):
Staphylococcus aureus, MRSA, Clostridia, Haemophilus Influenzae, Streptococcus Pneumoniae

Habitual offenders (obligate pathogens):
Beta Haemolytic Streptococci, A, C, G, B, Toxin-producing Staphylococcus aureus, Clostridium Tetani, Clostridium Botulinum

Critical incidents shared by Lilian Bradley and Frances Curry highlighted the need for a comprehensive multidisciplinary approach and the usefulness of old therapies and new technology such as larvae and VAC in the management of difficult cases.

Helen Broderick presented the results of an audit in the Carlow/Kilkenny area, examining the cost-effectiveness of past and current treatment, healing rates and quality of life issues. Quality of life as measured through pain assessment demonstrated a decrease in pain in 172 patients from 41% experiencing no pain at the start of the project to 73% after nine months. There was a 56% healing rate over 9 months compared to 22% pre-project and the cost of treatment had dropped considerably from 171,000 to 17,000. Much of the cost was due to nurse travel and time in this very rural area of Ireland.

Pat O'Driscoll, senior head of information technology in Kerry enthusiastically shared how a pilot study to improve communication in wound management is proving successful through the development of a data base held at Tralee hospital of patient assessment and treatments which can be accessed by Public Health Nurses from their lap-top computers and computer cell phones. Again, in rural Ireland this saves time, travel, duplication of work and improves continuity of care.

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Leg Ulcer Forum (Ireland Branch)

Patient Assessment and Issues Relating to Leg Ulceration

Georgina Gethin RGN HE Dip. Wound Care
Tissue Viability Nurse
Sligo General Hospital, Sligo, Ireland

Leg ulceration affects 1-2% of the population (Callam et al 1985, Cornwall et al 1986). With reported open ulcers spanning 60 years (Moffatt and Dorman, 1995, Lindholm et al 1993) and 35% of people reporting four or more episodes of ulceration (Callam et al 1985) it is a huge problem for both the adult population and the health service. Proper assessment and appropriate treatment enhances quality of life for patients, improves service and saves time, money and resources for both the patient and health service. This article outlines some of the clinical features of leg ulceration that are assessed. Wound assessment will not be covered in this article.

Assessment

The purpose of assessment is not only to find factors that may impede healing (Moffatt and Franks 1994), but also to gain clues as to the aetiology and factors which may promote healing (Colgan et al 1998). Moffatt and Franks (1994) give a comprehensive definition: 'holistic assessment of the patient which allows any physical, social or psychological factors that may impede progress to be identified, while assessment using doppler ultrasound ensures patients with arterial disease are identified'. This is the responsibility of accountable practitioners and helps to give objective records of progress or otherwise of wound healing (Flanagan 1997). All documentation must be precise, accurate and legible with no false, misleading or unsubstantiated statements. This is a legal document and under the Freedom of Information Act 1997 (Department of Health 1997) the patient is entitled to see it.

Clinical History

Holistic assessment involves taking a full clinical history from the patient. This includes other diseases and conditions, injuries and surgeries, medication record and allergies, along with observation of gait, footwear and level of mobility. Take particular note of history of D.V.T. (deep vein thrombosis). Approximately 40% of patients with a venous ulcer will have had a D.V.T. prior to ulceration (Vowden and Vowden 1998). It has been identified as a major risk factor associated with recurrence (Franks et al 1993). Lack of physical activity has been associated with venous disease (Moffatt and Franks 1994). Limited ankle movement leads to poor use of the calf muscle pump, which is important for improving venous return (Williams 1996). Limited mobility in 50% of patients with leg ulcers may be due to other causes, such as osteoarthritis, but secondary immobility can occur as a consequence of leg ulceration (Vowden and Vowden 1998). As well as a risk factor it is also a quality of life issue for many people as over 30% rate restricted mobility as the worst thing about their leg ulcer (Hamer et al 1994).

Pain

Pain for patients with leg ulceration needs serious attention and understanding. Patients with what appears to be minor altered pathology are often considered to have pain of a psychological origin (Moffatt and Harper 1997). Simply asking the patient whether there is pain or not results in insufficient and inefficient assessment. Assessment should differentiate the type of pain experienced in arterial and venous disease.

continued on next page >

Anne Rooney, Jean Noonan and Liz Long

Anne Rooney, Jean Noonan and Liz Long from Monaghan and Dundalk General Hospitals told how an innovative telemedicine link improved service delivery, increased nurses' knowledge and broke down geographical and political boundaries between north and south. This project has recently won the Nursing Standard Wound Care Award for the team. Project initiator, Jeanette Collins, Dermatology Ward Manager at Craigavon Area Hospitals Trust, goes forward to the Nurse of the Year Awards later this month.

This conference affirmed the level of expertise in Ireland relating to the prevention and management of lower limb ulceration, and revealed the innovativeness of practitioners in improving care delivery and overcoming barriers to implementation of evidence-based practice.

Next year the conference will be hosted in the North of Ireland with plans already under way for another opportunity to communicate best practice.

Pain associated with venous disease is often described as dull, heavy or bursting and for some patients there is increased pain on putting their feet to the ground, which may be due to sudden venous filling (Moffatt 1998). For those with arterial disease complaints are of severe, unremitting pain which is exacerbated on elevation and relieved by hanging the limb out of the bed (Moffatt 1998). Ask the patient about night cramps or pain on walking. Be sure the patient understands the questions as to ask if there is pain on walking may not necessarily be indicative of intermittent claudication but pain in the ulcerated area. Underestimation of wound pain can lead to muscle tension, fatigue and anxiety, which if inadequately managed can delay healing by depressing the action of the immune system (Flanagan 1997). Pain can further negatively effect the quality of life of a patient by affecting their well being, loss of confidence and depression. In one study by Hamer et al (1994) 37% of patients stated that pain was the worst thing about their ulcer. The use of a simple pain assessment tool helps both the practitioner and the patient. Asking the patient to score their pain on a scale of 0 – 5 is simple and repeatable. Further questions should include;

1 **Severity of pain**
2 **Time when pain is most severe.**
3 **Current analgesia regime.**
4 **Presence of night cramps or symptoms of intermittent claudication.**
5 **Type and duration of pain.**

Constant recording of pain is important. A sudden increase in the severity of pain may indicate the bandages are to tight or an underlying infection or change in patients' arterial status (Moffatt and Harper 1997).

Oedema

This is the accumulation of excess fluid in body tissues causing swelling. It has the effect of inhibiting the microcirculation thus preventing adequate perfusion and nutritional exchange (Cherry et al 1991). This in turn will delay healing and put other areas at increased risk for tissue breakdown. Its cause may be varied. Note should be taken of the type of oedema, whether it is unilateral or bilateral, present all the time or since the ulceration. This has implications as patients with heart failure may have oedema in other parts of the body and compression should only be used under medical supervision. Elevation of the limb will help to reduce it.

Skin Changes

The skin changes seen in the presence of lower limb ulceration may be characteristic of venous or arterial disease but again should not be viewed in isolation but as part of the overall assessment. In venous disease the skin looks discoloured, dry and scaly. The brown discoloration is from the leakage of red blood cells, which deposit their haem. content. The dry scaly skin is the result of varicose eczema.

Varicose eczema

Eczema affects the epidermis in the early stages, progressing to the dermis with vascular dilation and collection of inflammatory cells giving the erythema. The dry flaky appearance seen in varicose eczema is due to the accumulation of the outer epidermal layer which is forming rapidly (Moffatt and Harper 1997).

Dermatitis

This is a non-infective inflammatory disorder of the skin triggered by internal or external factors and at times both. Contact dermatitis develops in response to topical agents (Hunter *et al* 1995).

Atrophe blanche

This is seen as areas of scar tissue within, which are prominent, dilated capillaries. Scattered pink dots are seen on a white background. Such areas are very prone to ulcerate and the ulcers are usually extremely painful (Graham-Browne and Burns 1996). Back flow of blood leads to venous hypertension which leads to oedema of the lower leg and pigmentation of the 'gaiter' area. This pigmentation is the result of haemoglobin being released from red blood cells which have leaked out of the distended blood capillaries. A fibrin cuff forms around these capillaries and has the effect of interfering with oxygen diffusion into the tissues (Bale and Jones 1997). The overlying skin can become hypoxic. Prolonged ulceration with liposclerosis gives the leg the look of an inverted champagne bottle (Hunter et al 1995).

Ankle Flare

A distinctive vein pattern noted on the medial aspect of the ankle as a result of distension of the veins in that region (Collier 1999).

In arterial disease the leg is red, shiny and hairless. The blood vessels are maximally dilated to compensate for ischaemia giving the red colour (Moffatt and Harper 1997). The leg is shiny due to oedema. The nails are often thickened and brittle. On touching the leg it is usually cold. The dryness is due to the lack of sweat glands. To observe how slowly the tissues perfuse apply the thumb to the nail bed and count the number of seconds until the colour returns. In a patient with arterial disease this takes longer than 3 seconds (Moffatt and Harper 1997). Palpating the pedal pulses can be difficult due to oedema but absence of them is not a diagnosis of arterial disease as the pedal pulse is congenitally absent in 12% of people (Barnhorst and Barner 1968) .

Doppler Ultrasound

It is important that accurate diagnosis of the underlying pathology is established as this has significant influence on the treatment and subsequent prophylaxis (Whiston et al 1992). It is no longer acceptable or sufficient to palpate foot pulses as an indicator of arterial status (Morrison and Moffatt 1994). Although general physical examination can indicate ulcer aetiology, many studies have highlighted the inaccuracy of such methods. Whiston et al (1992) cites many reports, which show that in some cases only 39% of clinical examinations agreed with duplex ultrasound and recommended the use of Doppler. Taken in isolation Doppler readings are meaningless and offer only a snap shot of current arterial blood supply. Its role therefore is valuable in confirming the holistic assessment diagnosis and for the screening against the inappropriate use of compression (Hislop 1997). Be cautious of false high readings particularly in patients with diabetes mellitus. Use the results in conjunction with the clinical examination and history. While the role of the nurse is primarily not of diagnosis, this procedure has led to appropriate treatment being given to patients who may otherwise have missed out on treatment or received inappropriate care (Moffatt and O'Hare 1995). Results mean quicker transfer of patients for vascular assessment with base line tests already completed and a better use of resources (Colgan et al 1998). Follow up measurement should be made every 3 months, as arterial disease can often become apparent during treatment (Simon et al 1994).

Psychosocial issues

There is much anecdotal evidence of ulceration being a problem of the elderly and the stereotypical image of one who is non-compliant, elderly, socially isolated and from the lower socio-economic group (Moffatt and Dorman 1995). Women outnumber men in a ratio 1: 2.8 (Callam et al 1985). Hamer et al (1994) found that almost 20% of patients could not remember or didn't know what caused their leg ulcer and 52% did not want any further information. This could possibly be telling us more about patient's perceptions of the health service than it is about the patients. Franks and Moffatt (1998) concluded that leg ulceration has a major impact on quality of life having the greatest impact on younger male patients. This is supported by Cullum et al (1993) that patients with leg ulceration had lower life satisfaction scores than those without leg ulcers. Studies on the impact on the quality of life for people with leg ulceration show consistently that it is affected in a negative way.

Conclusion

Assessment is multi factorial and should be carried out by trained personnel. It includes patient factors, wound factors and objective testing and forms the basis for future treatment. Inaccurate or incomplete assessment can adversely affect treatment and ultimately outcomes. Patients with leg ulceration must live with a visible problem 24 hours a day. Bandages and stockings may affect their style of footwear and clothing. Odour is often a problem leaving them self conscious and further isolated. Pain restricts mobility and social interaction, while clinic appointments or health visitor visits impinges on their freedom. As a result of accurate and complete assessment, reassessment allows for appropriate treatment plans to be implemented. The patient benefits from a good service and the professional benefits from being able to deliver good care.

References

Bale, S and Jones, V (1997)
Wound Care Nursing: A Patient Centred Approach
London, Balliere Tindall

Barnhorst, DA and Barner, HB (1968)
Prevalence of congenitally absent pedal pulses.
New England Journal of Medicine 278 pp264-265.

Callam, MJ, Ruckley, CV, Harper, DR and Dale, JJ (1985)
Chronic ulceration of the leg, extent of the problem and provision of care
British Medical Journal 20 pp1855-1856.

Cherry, G, Cameron, J and Ryan, T (1991)
Blueprint for the treatment of leg ulcers
Convatec, Uxbridge.

Colgan, MP, Moore, DJ and Shanik, GD (1998)
Management Practices at leg ulcer clinics: challenges in diagnosis
Journal of Wound Care 7(4) pp199-202.

Collier, M (1999)
Venous Leg Ulceration in Wound Management
Miller, M and Glover, D (eds) London, Nursing Times Books.

Cornwall, JV, Dore, CJ and Lewis, JD (1986)
Leg ulcers; epidemiology and aetiology
British Journal of Surgery 73 pp693-696

Cullum, N, Roe, B and Hamer, C (1993)
The effect of leg ulceration on quality of life in the elderly
Proceedings of 3rd European Conference on Advances in Wound Management EMAP Healthcare, London, p57

Department of Health and Children, Ireland (1997)
Freedom of Information Act
Government Stationary Office, Dublin

Flanagan, M (1997)
Access to Clinical Education Wound Management
London, Churchill Livingstone

Franks, PJ and Moffatt, CJ (1998)
Who suffers most from leg ulceration?
Journal of Wound Care pp383-385

Franks, PJ, Oldroyd, MI, Sharp, EJ, Greenhalgh, RM and Moffatt, CJ (1993)
Factors associated with leg ulcer recurrence
Proceedings on 3rd European Conference on Advances in Wound Management, London, EMAP Healthcare, p67

Graham-Browne, R and Burns, T (1996)
7th Edition Dermatology
London, Blackwell-Science

Hamer, C, Cullum, NA and Roe, BH (1994)
Patients perception of chronic leg ulcers
Journal of Wound Care 3(2) pp99-101

Hislop, C (1997)
Managing Wound Infection
Journal of Wound Care Resource File, EMAP Healthcare

Hunter, JAA, Savin, JA and Dahl, MV (1995)
Clinical Dermatology 2nd Edition
London, Blackwell Science

Lindholm, C, Bjellerup, M, Christensen, O and Zederfeldt, B (1993)
Quality of life in chronic leg ulcer patients. An assessment according to the Nottingham health profile
Proceedings of 3rd European Conference on Advances in Wound Management, London, EMAP Healthcare pp57-58

Moffatt, C (1998)
Issues in assessment of leg ulceration
Journal of Wound Care 7(9) pp469-473

Moffatt, CJ and Dorman, MC (1995)
Recurrence of leg ulcers within a community leg ulcer service
Journal of Wound Care 4(2) pp57-61

Moffatt, CJ and Franks, PJ (1994)
A prerequisite underlying the treatment programme. Risk factors associated with venous disease
Professional Nurse, June pp637-642

Moffatt, CJ and Harper, P (1997)
Access to Clinical Education; Leg Ulcers
London, Churchill

Moffatt, CJ and O'Hare, L (1995)
Graduated compression hosiery for venous ulceration
Journal of Wound Care 4(10) pp459-462

Morrison, M and Moffatt, CJ (1994)
A Colour Guide to the Nursing Management of Leg Ulcers 2nd Edition
Mosby, London

Simon, DA, Freak, L, Williams, IM, and McCollum, CN (1994)
Progression of Arterial Disease in patients with healed leg ulcers
Journal of Wound Care 3(4) pp179-180

Vowden, KR and Vowden, P (1998)
Venous leg ulcers Part 2; Assessment
Professional Nurse 13(9) pp633-638

Whiston, RJ, Berry, DP, Lane, IF and Harding, KG (1992)
Investigation of Lower Limb Ulceration Using doppler Ultrasound
Proceedings of 2nd European Conference on advances in Wound Management, EMAP Healthcare, London, pp176-178

Williams, C (1996)
Treatment of venous leg ulcers;1
British Journal of Nursing 5(4) pp208-215.

Research *Update*

Peter J Franks
Professor of Health Sciences
Wolfson Institute of Health Sciences, Ealing

World Congress of Phlebology
9-14th September 2001, Palazzo dei Congressi, Rome

The World Congress of Phlebology is a meeting of clinicians and scientists interested in understanding disorders of the venous system, which occurs every 3-4 years. The most recent meeting was held in Rome, where representatives of many countries attended. While the presentations focused on all aspects of the venous system, many presentations examined the issues surrounding leg ulceration, particularly its development and methods employed to treat them.

I have selected a number of presentations which I feel may be of interest to you which may have either a direct, or indirect influence on your practice or understanding of issues related to leg ulceration.

CEAP Classification

The CEAP classification system was the focus of a number of presentations. It is the first international attempt to categorise disorders of the venous system in a way that is repeatable and valid, and was devised by a meeting of experts in 1995, supported by the American Venous Forum. CEAP stands for Clinical, Etiologic, Anatomic and Patho-physiologic, and is a method of grading patients' disease according to these areas. Presentations described the associations between the CEAP classification and venous symptoms, and its relationship with objective measurements such as duplex scanning of the veins.

While it may not be essential for all clinicians to understand the detail of the methods that underpin the CEAP classification, this description of patients disease will become more prevalent in the literature, and as such it is important that clinicians have an understanding of what is being described.

Deep vein thrombosis and air travel

The so-called 'Economy class' syndrome has hit the headlines in the UK and across the world over the past couple of years. It is a mark of the interest in this problem that a complete session in the programme was allocated to this problem, with contributions from USA, UK, Germany, Australia and Italy. It is interesting to note that this symposium was sponsored by Alitalia, indicating of how seriously the airline industry is taking this issue.

Mr John Scurr presented a prospective study of 200 passengers aged over 50 years with no history of thrombo-embolic disease who were undertaking a flight of >8 hours. One half were given class I compression hosiery (18 mmHg), to wear during their flight and return flight, while the remainder were not. 12/100 without stockings showed 'evidence' of DVT, with four treated with heparin. Eight of the 12 had evidence of thrombosis in small calf veins, though none developed extensive DVT, or developed symptoms, or developed pulmonary embolism. None of the patients on stockings developed evidence of DVT, though 4 developed superficial thrombo-phlebitis behind the knee.

Dr Eklof presented the evidence from a consultation at the World Health Organisation on the risk of DVT during air travel. This conference concluded that there probably was an association with air travel, but this was also true of other forms of transport, and that the associated risk of DVT during air travel was small. However, it was agreed to establish further epidemiological studies using objective methods and to examine different interventions to reduce this risk.

Social Dimension in Leg Ulcer Management

Little attention has been paid to the social and demographic impact that leg ulceration has on people. Ellie Lindsay presented a poster on her work in developing leg clubs in community cottages in rural villages, where patients can attend for nursing care in a non- medical environment, while providing a social environment to build the patients' self esteem (www.legclub.org.uk). This delivery of care also allows for patients to become stakeholders in their care, an important topic in the current health climate. This work builds on one of our own presentations, which examined the role of social factors in the development of chronic leg ulceration. We have been able to show that social class, being single (never married), living in rented accommodation and having low perceived social support were all associated with the presence of leg ulceration. While nurses may understand the role of social factors in leg ulcer development and the success of care, this message needs to be disseminated to our medical and surgical colleagues.

Other Themes of the Congress

Clearly an audience composed principally of vascular surgeons and phlebologists will concentrate on their contribution to the patients' health. Other themes included new methods of assessing patients with venous disease, and understanding the patho-physiology of venous disease (and venous ulcer) development. There were a number of randomised trials of bandage systems in the treatment of venous ulcers, and double blind placebo controlled trials of pharmaceutical interventions. While some of these have shown evidence of benefit to patients with chronic venous disease, it remains to be seen whether these treatments will be universally adopted. This was a well attended conference, and an opportunity to catch up with new innovations in venous research. The next conference will be in Rio de Janeiro in 2005!

Guidelines for Submitting Articles for Publication in *the Leg Ulcer Forum Journal*

Once you have decided to write an article for the leg ulcer forum journal, make sure the content is appropriate for the readers. The following gives guidelines for authors.

Format

- Front page

  Title of article

  State author's name/s, qualifications, position, and place of work. Name, address and contact telephone number of the author responsible for correspondence.

- Introduction

  This should be approximately 30 words in length. It should introduce the reader to the areas covered in the article.

- Headings

  Headings are useful to break up the text; they also help to organize the main points of the article.

- Conclusion

  Should summarize the article, identify gaps in knowledge and suggest recommendations for future practice.

Please send a hard copy printed on one-side only on A4 paper, double-spaced with wide margins. Please type in upper and lower case – don't use 'all capitals' anywhere. Don't forget to keep a spare copy. Also, a copy of the article should be sent on a floppy disc, saved in 'Text Only' format. Clearly state on disc label: the file name and format saved.

The journal welcomes articles of interest. This could include a literature review, research project that you have been a part of, any innovations you feel would benefit our readers. Care studies are an invaluable source to practitioners, particularly when complex situations have successfully been addressed, colour photographs and tables can be included to complement the text (the client must give written permission before publication of photographs).

All manuscripts should be between 1,000 to 2,000 words. However if you wish to submit a short report then 500 words would be acceptable.

References

Please reference the manuscripts using the Harvard system. If you need further details of this, contact the editor.

Articles should be sent to the Editor:

Lynfa Edwards

Centre for Research and Implementation of Clinical Practice

Wolfson Institute of Health Sciences

Thames Valley University

32-38 Uxbridge Road

London W5 2BS

NOMINATIONS FOR THE LEG ULCER FORUM EXECUTIVE COMMITTEE

I ..... **wish to nominate** .....

of.....

(The above mentioned candidate has agreed to this nomination)

Please complete and return by 30 November, 2001 to:
Mark Collier, Chairman, The Leg Ulcer Forum, CRICP, Wolfson Institute of Health Science, Thames Valley University, 32-38 Uxbridge Road, London W5 2BS

The Cochrane *Wound Group*

What is the Cochrane Collaboration?

The Cochrane Collaboration was set up in 1993 and aims to help people make well-informed decisions about healthcare by preparing, maintaining and ensuring the accessibility of systematic reviews of the effects of healthcare interventions. These reviews are disseminated in the Cochrane Library which is published quarterly.

Who can do a review?

All the reviewers in the Cochrane Collaboration are volunteers. We do not commission reviews in particular topics as we appreciate that volunteers are more likely to be able to review a question to which they want the answer. In general, there are no restrictions on who can undertake a review. All that is required is access to a computer, time, enthusiasm and a sense of adventure!

We currently have approximately 50 active members of the review group, from five different countries. They include nurses, surgeons, public health specialists, statisticians, medical physicists, review specialists, physicians, and a health care consumer.

We welcome more reviewers and are particularly seeking more representation from surgeons, physicians, therapists, reviewers from developing countries, as well as people who have experienced wounds of any sort themselves.

How can I help?

Are you involved in making clinical decisions in wound care ? The Cochrane Wounds Group aims to produce high-quality systematic reviews of the effects of wound care interventions for those people, including users of health services, who are involved in making decisions about wound treatments. It is essential that these reviews are written in a way that is accessible and useful to the target audience, and therefore we always looking for people involved in the clinical practice of wound care who could read our reviews at the final draft stage and comment on their usefulness and readability. In return you would be acknowledged in the Cochrane Library, and be the first to see new reviews in wound care, in addition to contributing directly to evidence-based wound care.

We are also involved in hand searching journals and conference proceedings on subjects relevant to wound care and welcome anyone who would like to join our hand searching team - full training and support will be given but you must have access to the original journals or proceedings.

How do I contact you?

Address for correspondence:

Roz Thompson, The Cochrane Wounds Group
Department of Health Studies, University of York
Genesis 6, York Science Park, YORK YO19 5DQ
Email: mrt4@york.ac.uk

Please let us know how you would like to contribute to the Wounds Group.

Which topics are reviewed by the Wounds Group?

The Wounds Group collects report of trials and helps people undertake reviews of the effectiveness of interventions to prevent and treat wounds and their complications, The list below shows the reviews completed as of November 2000, and registered protocols, also known as reviews in progress.

Reviews

- Therapeutic ultrasound for venous leg ulcers NEW
- Compression to prevent venous ulcers NEW
- Compression bandages & stockings for venous leg ulcers - updated
- Oral zinc for chronic leg ulcers
- Laser therapy for venous leg ulcers
- Dressings and topical agents for painful venous leg ulcers
- Skin grafts for venous ulcers
- Oral pentoxifylline for venous leg ulcers
- Therapeutic ultrasound for pressure sores NEW
- Beds, mattresses and cushions for prevention and treatment of pressure sores
- Pressure relieving interventions for preventing and treating diabetic foot ulceration

Protocols

- Dressings and topical agents for venous leg ulcers
- Intermittent pneumatic compression for venous ulcers
- Intra-operative warming and post-operative complications
- Patient education in the prevention of diabetic foot ulceration
- Electricity for treating pressure sores
- Electricity for treating venous leg ulcers
- Community clinics vs. home management for venous leg ulcers
- Antimicrobial prophylaxis in colorectal surgery
- Oral antibiotics for treating venous leg ulcers
- Therapeutic touch for acute wound healing
- Dressings and topical agents for pressure sore treatment
- Antimicrobial prophylaxis for mammalian and human bites
- Dressings and topical agents to prevent pressure sores
- Antibiotics for hand surgery (2 protocols)
- Dressings and topical agents for burns
- Topical negative pressure for chronic wounds

How can I access the Cochrane Library?

Abstracts of reviews are free of charge. Brief abstracts of Cochrane Reviews can be accessed on the Internet at this web page: http://www.cochrane.org/cochrane/revabstr/abidx.htm

In order to access the full text of the reviews and the other databases, you need to consult the Cochrane Library on CD-ROM or via the Internet. It is available by subscription, and is updated 4 times a year. Many hospitals and university libraries subscribe to the Cochrane Library. For further information on subscribing, contact:

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Final Reminder

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Can I get some help Using Cochrane Reviews?

If you want help using the Cochrane Library - then the UK National Health Service Centre for Reviews and Dissemination (NHS CRD) provides:

1. Website with audio-visual materials for those of you delivering training in the use of the Cochrane Library – see http: //www.york.ac.uk/inst/crd/clibintro.htm

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Education Courses in Wound Care

The Centre for Research and Implementation of Clinical Practice (CRICP) of which Professor Christine Moffatt is Director, is experienced in running educational programmes designed for a range of health care professionals from different settings. Details of the courses currently offered by the Centre in partnership with the Wolfson Institute of Health Sciences, Thames Valley University, are as follows:

Leg Ulcer Management

ENB N18 – Professional Development in the Management of Leg Ulcers

Day release: 10 January – 14th March 2002
at Nurse Education Centre,
Royal Berkshire Hospital, Reading

Study block: 8 – 12 April; 13 – 17 May
17 – 21 June; 22 – 26 July 2002

Study block courses are held at Wolfson Institute of Health Sciences, Ealing, London.

Pressure Sores

ENB N36 – Professional Development in the Prevention and Management of Pressure Sores

Study block: 5 – 9 November; 10 – 14 December 2001
10 – 14 June; 8 – 12 July 2002
at Wolfson Institute of Health Sciences, Ealing

Tissue Viability and Wound Management

ENB N49 – Tissue Viability and Wound Management

Day release: 3 April – 19 June 2002
at Nurse Education Centre,
Royal Berkshire Hospital, Reading

Study block: 14 – 18 January; 18 – 22 February
24 – 28 June; 22 – 26 July 2002
at Wolfson Institute of Health Sciences, Ealing

Vascular Nursing

ENB A85 – Vascular Nursing

Day release course commencing September 2002

Further details of CRICP courses can be obtained from:

The Centre for Research and Implementation of Clinical Practice

Wolfson Institute of Health Sciences

32-38 Uxbridge Road

London W5 2BS

Tel: 020 8280 5020

Courses held at Kings College London

• Tissue Viability in Clinical Practice PIN222

15 Credits Level 2

Sept – Feb, alternate Tuesdays

Course leader: Louise Gibson

Tel: 0207 848 3596 email: louise.gibson@kcl.ac.uk

• Clinical issues in leg ulcer management PIA206

15 credits level 2 or 3

Sept – Feb, Feb – July, alternate Fridays all day

Course Leader: Jenny Bentley

Tel: 0207 848 3530 email: jenny.bentley@kcl.ac.uk

Further information on both course can be found on the Kings College website www.kcl.co.uk in the nursing department virtual campus.

Joining or renewing membership of *the Leg Ulcer Forum*

Membership of the Forum is free of charge to professionals involved in the prevention and treatment of leg ulceration. If you are interested in joining, please complete the following membership form and return it to:

The Leg Ulcer Forum

PO Box 337, Hartford

Huntingdon PE29 1FX

Membership includes

- Mailing of the Leg Ulcer Forum Journal (Spring and Winter editions)
- Educational leaflets*
- Annual Conferences* and other LUF Meetings (reduced rate)
- Annual Forum Update

** Denotes a small charge*

If you are *renewing* your membership, please return this form no later than January 31 2002. Failure to do so will mean removal of your name from the members list. If this is your *first application*, however, then you are under no time constraints.

Membership Form

President: Prof.C.Moffatt

☐ I wish to JOIN the leg ulcer forum

☐ I wish to REJOIN the leg ulcer forum

☐ I lead, or am regularly involved with, a specialist service

☐ I give consent for my name to be included on the leg ulcer forum database. Please send me the appropriate form

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THE leg ulcer FORUM

President: Prof.C.Moffatt

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Providing a forum for nurses working within the field of leg ulcer management and wound care

•

Facilitating discussion, debate and reflective practice in which all members are encouraged to participate

•

Disseminating new research and identifying and supporting areas of good practice

•

Providing support to specialist nurses involved in establishing leg ulcer services

•

Encouraging continuous professional development

THE LEG ULCER FORUM

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