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The contents of articles in this journal are the opinions of the authors, and do not necessarily reflect the opinions of the editors or the Leg Ulcer Forum

This journal is kindly sponsored by smith & nephew
Welcome to Issue 21 of the Leg Ulcer Forum Journal. Health professionals are continually being creative in attempts to improve the patient experience and increase healing rates; therefore this 21st issue of the Journal is focusing on differing aspects of living with and managing leg ulceration. We have contributions from two patients who express their views of leg ulceration, and Katie Fox describes a patient support group for those with or at risk of developing venous leg ulceration.

I am pleased to present to you an article from Tim Devey; some of you may have heard his presentation at our conferences in Scotland and England. Tim works with a group of patients that have drug misuse problems and many have leg ulceration. His article is packed full of information about drugs currently being used by some members of Sheffield’s homeless community. I am sure that many of you will find this article of interest and useful if you are involved in service provision for this client group.

There are times when patients being cared for in the community will need admission into the acute sector. Two articles discuss maintaining leg ulcer care and the provision of bandages appropriate to leg ulcer management in this sector of the NHS. Irene Anderson explores the well known terms compliance and concordance from the clinical practice perspective. For those of you that are considering further education Janice Bianchi’s article on the provision of education in leg ulcer management will be of interest.

The Executive Committee have been very busy over the last year and I am pleased to be able to include some photographs showing several members receiving awards in recognition of their contribution to practice. Unfortunately I do not have a photograph (as yet) of executive committee member June Jones – however I am sure that I am joined by the rest of the Committee in congratulating her on her PhD; she will receive the award in December. The subject of the thesis was the prevalence and experience of emotional distress in patients suffering with chronic venous leg ulceration. June has promised an article relating to her research topic for the next journal and I am really looking forward to reading it when it arrives!

In this issue are LUF conference reports and contributions from the Cochrane Wounds Group and VenUS III trial. New to the journal is a Question and Answer section with questions sent in by forum members; and for those of you who enjoy a challenge there is a clinically-based word quiz with a prize to be won for one lucky person. Please remember this is your journal and I would encourage you to become involved; please send in your questions, jokes, stories or even word quizzes. Any budding authors are welcome to submit work: check the inside back cover for guidelines.

Finally I would like to thank the authors for all their hard work and the Executive Committee members for their support in my first (hopefully not my last) year as journal editor. The Executive would like to join me in thanking our sponsors for their continuing generosity and support.

Best wishes

Susan Knight
Editor
On the 12th July 2007 over a hundred delegates were joined by the Leg Ulcer Forum Executive and the LUF sponsors for a day dedicated to issues in the assessment, management and support of people with leg ulcers and related conditions.

The success of last September’s conference in Bradford (www.cedarcourthotels.co.uk) and feedback from delegates that the topics deserved a wider audience, prompted us to run a similar programme again. The DeVeRe Harben House Hotel in Buckinghamshire is a purpose built conference venue very close to the M1 (www.devere.co.uk). The day began with all the delegates coming together to listen to Tim Devey describe his outreach service to homeless people in Sheffield. Tim took us on a guided tour of ‘street’ drugs: the ways in which they are used, their names, and the effect they have both physiologically and on behaviours. The methods of delivery of these drugs have enormous implications for the vascular system and tissues of the legs and Tim illustrated very clearly what damage can be done and types of wounds people present with. What really struck home with many delegates was the necessity to understand the lifestyle of this client group and the challenges of delivering effective services, ie not expecting rigid adherence to an appointment system that is completely at odds with chaotic lifestyles.

Professor Peter Vowden took us through the assessment and management of deep vein thrombosis; defining the disease, managing risk, and highlighting that the annual incidence of venous thromboembolism is estimated to be 1 in 2000 people. Jill Firth then dispelled a few myths about the ‘rheumatoid ulcer’ as a diagnosis and explained the pathophysiology of rheumatoid arthritis and its implications for the lower limb. Irene Anderson then highlighted issues and challenges around the management of mixed aetiology ulcers and the variety of practice in compression therapy. This presentation builds on work she is doing with Brenda King from the LUF Education group. Plans are underway to investigate this area in more detail and the delegates were enthusiastic about this initiative – we will need your help! The presentations from the plenary sessions are available on the LUF website in the Education section (www.legulcerforum.org).

We planned a longer than normal lunch to give delegates enough time to visit the exhibition and ask lots of questions. Our sponsors are very important to us and having such a focused audience means that healthcare professionals can really explain the issues in managing people with leg ulcers and related conditions. In this way manufacturers are more able to respond to the needs of our patients.

At both conferences we tried something different at lunchtime: a skills forum. ‘Stations’ were set up that could be visited at any time over lunch. This was well evaluated but not used as much as we anticipated – perhaps you will tell us whether it is worth continuing this idea? Topics included pulse oximetry, multilayer and short stretch bandaging, Doppler assessment and toe bandaging.

In the afternoon there were two out of three workshops to choose from. Brenda King and Judy Harker presented some case studies which highlighted the challenge of inflammatory complications of leg ulceration. Janice Bianchi took us through dermatological conditions related to leg ulcer and related conditions and gave practical guidance on management. Kath Vowden’s workshop focused on tools for predicting healing in leg ulceration which help to ensure that management is more timely and resources are used as effectively as possible.

The conferences in Bradford and in Buckinghamshire were a great success and the evaluation forms and feedback we received from delegates and sponsors made all the hard work worthwhile. We have taken note of your comments and suggestions for future sessions so
that we remain responsive to your needs. We are always happy to discuss ideas for topics, venues and offers of support.

On behalf of the Executive including the affiliation Executives in Scotland and Ireland, thank you for supporting our education events. Please don’t forget this is your Leg Ulcer Forum – let us know what you think and how we can support you.

Our sponsors are very important to us and having such a focused audience means that healthcare professionals can really explain the issues in managing people with leg ulcers and related conditions.

Please make a note in your diaries of our forthcoming events

The AGM and conference is to be held in the South of England on the 5th March 2008 and a conference in the North of England on the 9th July 2008.

The next conference in Scotland is to be held either in Stirling or Glasgow on or around the 13th March 2008.

Ireland’s next conference will be in Athlone on the 24th April 2008.

The venues and conference details will be announced when available.
‘BEYOND VENOUS’

This year’s Scottish conference on September 20th was well attended, with more than 85 delegates attending.

Edinburgh’s Dynamic Earth provided an excellent venue with views of Arthur’s Seat on a lovely sunny September day.

The conference speakers provided a varied programme which held everyone’s attention.

Both morning and afternoon sessions kicked off with patient experiences. Our first patient Sue Barrett is a nurse who gave an interesting insight into how the system can be slow to move in recognising patients with leg ulcers, and how being a nurse can actually hinder the process; as it was assumed she had an inner knowledge of leg ulceration when in fact her own speciality was orthopaedics. Our second patient was LUF’s own patient representative Ken MacDonald who gave a light hearted view of his ‘Ubiquitous Ulcers’ and also what he does as LUF’s patient representative. Although light-hearted no one could have failed to miss the effect leg ulcers have had on altering Ken’s life from a young age. He now hopes to give back as a thank you for the care he received by taking views of leg ulcer patients to larger groups to lobby for change, in the hope of promoting change, good practice and thereby improving overall outcomes for patients.

We had an amusing and entertaining talk on dermatological conditions which can affect the lower leg by Dr David Tillman, consultant dermatologist. Tim Devey delivered an interesting talk on drug use in Sheffield and the clients he deals with who have developed leg ulcers. He discussed the type of drugs found on the streets and how users are changing the way they use these drugs which can only lead to further problems in the future for this unfortunate group.

Diabetic foot disease was discussed by Sheila Mackie, District Nurse from Edinburgh, looking at the changes seen in the foot and what assessment is necessary. Margaret Armitage gave an edifying talk on the changes that have taken place in Glasgow from when the leg ulcer service was initially set up, how changes in the redesign of our health services have led to a change in leg ulcer service provision, and how we keep up to date and provide care for the future.

Professor Jill Belch, Department of Vascular Medicine, from Dundee gave a highly interesting talk on the implications of a reduced ABPI and cardiac risk factors. Looking at recent research and discussing the Sign Guideline 89 on peripheral arterial disease a reduced ABPI of 0.9 can be a predictor for future cardiac events; surely work which is going to affect our practice as nurses.

Our final speaker Janice Bianchi rounded off the afternoon looking at the evidence pyramid and how it can be applied to leg ulcers. She clarified the research process for many of us.

Dynamic Earth was a great venue and the feedback from delegates was very positive; certainly as a committee we were pleased that so many nurses were able to attend and we look forward to our next conference early in 2008.
November 2007 is the first anniversary of the death of Lilian Bradley, who was a key figure in the development of leg ulcer services and tissue viability education in Northern Ireland.

Lilian was a skilled and devoted nurse who developed expertise in tissue viability and a particular passion for leg ulcer services. Lilian was a key figure in tissue viability, both in Northern Ireland and abroad. She was instrumental, with a group of other nurses in Northern Ireland in getting the Tissue Viability Specialist post recognised within the region. Since then the Leg Ulcer Forum benefited from Lilian’s passion and drive to improve leg ulcer services, locally, nationally and internationally over many years. She has had a significant impact on the lives of people, patients and colleagues, throughout her professional life.

There was a formal ball on the 17th November in Belfast to celebrate 10 years of nurse-led leg ulcer clinics in Northern Ireland and also to raise funds for the orphanage in Uganda which was very close to the Bradley family’s heart. There is much to celebrate in Northern Ireland. The nurse-led clinics which Lilian set up are still going at full capacity with 6 weekly clinics in the community, plus a multidisciplinary clinic including input from Podiatry, Dietician and TVN. A Tissue Viability Nurse leads the clinics with District nurses rotating in on a 6 weekly basis in order to up-date their knowledge and skills. In addition to leg ulcer services Lilian was also instrumental in setting up general wound care services and education.

Lilian chaired a guideline development subgroup, from which the CREST Guidelines were published in 1998 in Northern Ireland. With the Ireland group she was in the final stages of developing competencies for leg ulcer services, and enlivened many a Leg Ulcer Forum national meeting with debate and discussion of detail. Her commitment to improving services was always at the forefront of her work. Lilian could see the changes occurring in practice as financial constraints tightened and the skill mix was subtly changing, she became more determined to ensure that competencies were used to benefit patients and make the best use of resources. She deplored the move towards using untrained staff where there was no training and competence frameworks underpinning leg ulcer practice.

As well as personal accolades Lilian was recognised at home and abroad as an excellent speaker, a clinical expert and researcher as well as a skilled and passionate teacher and mentor. Although the Leg Ulcer Forum benefited from her work in leg ulcer services, Lilian was also a clinical expert in other aspects of tissue viability and notably focused her Master’s dissertation on the management of pilonidal sinus disease. Some of the people attending her memorial service may have been bemused, but probably not surprised, to hear leg ulcers and wounds being talked about throughout the service as an integral part of her life. Anyone left in any doubt about wound care were directed to ask any one of the many tissue viability specialists, nurses, doctors and patients attending the service.

Lilian’s work in nursing was recognised by the RCN, when in 2002 she was joint winner of the Nurse of the Year award. Lilian has many publications to her name. For many years she was a teacher at Queens University in Belfast and developed leg ulcer education in Northern Ireland.

Lilian’s memorial service was an uplifting and heart breaking experience. Her husband spoke movingly of Lilian’s life and their time together. Her two sons demonstrated their love of their mother in word and song. The hymns, songs and readings were largely chosen by Lilian and each one of us felt she had something special to say us individually. In death as in life Lilian is an inspiration, a driver and a role model. The Leg Ulcer Forum is proud and privileged to have had Lilian as one of ours, she flew over to the mainland for as many meetings as she could and never failed to make her mark with her wit, wisdom and passion. We still miss her but she has enriched our work in the Leg Ulcer Forum and remains a guiding light on the mainland and in the Ireland affiliation.
Smile please!
LUF achievements over the last year

Several members of the executive committee have been in the spotlight this year, receiving well-deserved awards.

Brenda King, Julie Stevens and Simon Barrett at the Houses of Parliament for the Journal of Wound Care awards

Brenda King, winner of the Lymphoedema and Chronic Oedema Award at the Wounds UK 2007 Awards Ceremony

Julie Stevens, winner of the Experienced Practitioner Scholarship from the Journal of Wound Care

Kath Vowden collecting the Award on behalf of Peter Vowden and Marco Romanelli for Innovations in New Technology at the Wounds UK 2007 Award Ceremony.
Recently a young nurse asked me how long I had had the ulcer. I got a very old-fashioned look when I said about 50 years. Then I went on hurriedly “But it is only three weeks this time!”

This set me thinking of the tyranny inflicted by my ankle. Without meaning to be a moaner or be what is a good scots phrase a ‘girn’, I thought that an insider’s look at the problem might be of interest.

I have had ulcers on both the inner and the outer sides of my ankle. Fortunately rarely at the same time but healed or not they have dominated my thinking and my way of life in a number of different ways. Some ways subtle, some ways not so subtle, and some downright ********!

At the moment, because it has broken down, it is being treated with a four layer compression bandage. This brings with it all sorts of problems. Any movement seems to cause the bandage to slip down and become uncomfortable (and I suspect less effective). It means also that shoes and trousers have to be carefully selected so that they can slide easily over the bandages.

These restrictions may seem trivial but because the healing is so slow, and the time incarcerated in the swaddling clothes is so long, they loom large in everyday living which must go on.

Until recently, showering or having a bath was a nightmare. The development of the aqua shield is a great advance. Prior to that it was a black rubbish bag with sticky tape covering the holes. Inevitably one of the holes was missed and the tape leaked. Have you ever tried to take a bath with one leg dangling over the side? It is a sure way to drown.

Over the 50 years there have been all sorts of different things tried:

- Gentian Violet
- Smelly stuff
- Ultra violet Radiation
- Eusol
- Infra red (for a change)
- Maggots
- White of egg
- Petroleum Gel Netting
- Penicillin
- Granuflex
- Sea weed
- Viscopaste
- Alginure?
- Blue line bandages
- Skin Lattice Graft
- Honey

All sorts of compression bandages have been tried

- Elastoplast
- Blue Line Bandages (great weals)
- Sorbo-rubber (raised huge blisters on my leg)
- Bandage (crept down)
- Green Line Bandages
- Viscous-paste
- Ordinary Plaster
- Stretch Bandage
- Three Layer Bandage
- Four Layer
- Five Layer (Nurse lost count?)

What is it like to have an ulcer?

Firstly what about pain and discomfort? When it is first broken it can be painful and first thing in the morning it is really quite annoying! Much of the time there is little pain all the time, but it can feel raw and chaffed. However sometimes it can be really quite painful, particularly if there is a slight infection.

It is worth noting the following:

- There are times when one suddenly realises that there is no pain
- The inside of the ankle is less painful than the outside
• The minor problems of managing living – washing, smell, etc, all become very important but to a non-sufferer appear trivial
• At times one might think it might be better to have the ankle amputated and be done with it, but such moments are rare.

After a period the ulcer heals. Then a different regime takes over – another tyranny takes the place of the 4/3/2 layer bandage – the ELASTIC STOCKING or the support stocking. These instruments of torture come in different shapes, sizes and colours. There are thigh length, knee length, two way – three way stretch, a whole miscellany of shapes and sizes.

Obviously these support stockings are the best method of prevention and protection, but they bring their own problems. The feeling of an elastic stocking slithering down a leg is a feeling to be experienced. A picture of a cross between a snake sliding down and a pair of underpants with broken elastic best describes the feeling. It is worse with thigh length ones. Little do doctors think when they blithely suggest “full length ones would be best – they are much better nowadays”. That should start the alarm bells ringing. “A suspender belt to keep them up” is suggested or “They fasten on to your belt loops”. Be warned, each and every one of these suggestions brings with it a problem. This means that trousers are dragged down as the elastic stocking tries to go back into the shape it was. It is just as well that the elastic stockings are a kind of ecru colour and not black, or pink with white tops... the picture of a porn queen comes to mind.

Even knee length stockings bring their own problems. They are extremely hot to wear in summer time particularly abroad on holiday. When every body else are wearing shorts the choice is either long trousers or top hose and hide the support stocking. Scots have a unique problem with a kilt! The one benefit comes with sandals. Even wearing the dread stockings toes can peek and no socks are necessary.

However, I know that it is for my own good (how I remember that phrase from my childhood) and so I will continue to wear my stockings from first thing in the morning to last thing at night. And oh the bliss when I take them off before bed!

Prevention

This continues with instructions such as “no standing for long periods” and “do not sit with crossed legs”. No instruction tells one that supermarkets can be a death trap with trolleys, especially ones wielded by either children or elderly ladies with their eyes hunting for a product. Perhaps the worst of all is a vacuum cleaner-wielding wife!

This then is the story of my ubiquitous ulcers. It may not have added much to the annals of Medical science but it has been a long partnership – my ankle and me.

To get it really healed I may need a spell or a miracle. Are there any offers? Until there are I will stay an Honorary Member of Ubiquitous Ulcers Anonymous.

KM
I am approaching my sixty-ninth birthday. I had previously thought that the early period of my retirement would be remarkably enjoyable, with plenty of golf and pleasure trips both in the UK and abroad. However, this has not proved to be the case.

In August 2003 I was admitted to the local general hospital for a hip replacement operation. (The left hip, which had been my constant companion up to this point, had become damaged after many years of club cricket and fast-medium bowling). This was only the second occasion on which I had spent a night in a hospital bed; the first instance was in 1983 when I overnighted at the local private hospital whilst having pieces of torn cartilage removed from my knee – again, the result of over-enthusiasm at cricket.

Subsequent to my discharge from the general hospital, silk stockings and all, I noted the appearance of an ulcer in the area of my left shin. This spread not only over my lower left leg, but also to my right leg. At this time the dressings on my legs were being changed every two or three days, sometimes by me; there was leakage and (unpleasant) odour. In 2004 I spent a further eight weeks in the general hospital, regarding myself almost as part of the fixtures and fittings. During this period I was under the supervision of the cardio-vascular surgeon, who is a charming fellow, but after this lengthy period in Ward 1A, I came home feeling worse than when I went in. I have mentally decided that I shall need to be at death’s door before I endure another spell, however short in the general hospital.

During the past three years several types of dressing have been used on my legs, generally applied by a district nurse or the surgery’s practice nurse, or the tissue viability nurse at the community hospital. It is she who advises which dressings to try and how to administer the bandaging; I have faith that she will, eventually, bring about the cure and subsequent banishment of these hated leg ulcers. The present status is that the remaining ulcer on my right leg is diminishing in size, whilst the more complex of them on my left leg are showing pleasing signs of granulation. Hope springs eternal!

My profession before I retired was that of an accountant. I was in fact, a senior internal auditor with a large international group of companies, and I spent much of my working life in a sedentary fashion, i.e. travelling to assignments by car in this country and by aeroplane and car when abroad. My physical exercise was therefore limited to a weekly round of golf or game of cricket, to which I always looked forward. In the year following my retirement from cricket I was diagnosed as diabetic (type II) and at the time I thought it the end of the world. To my knowledge there is no family history of diabetes, although my brother and two of my sisters appear to be fellow sufferers. My mother, God rest her, had serious problems with varicose veins.

When I consider the present state of my legs I become very depressed and think of what I have done in the past, but am unlikely to do again, like running, cycling, playing golf, hockey, cricket, squash and badminton. I go to a weekly session at a local gymnasium, where I do a minimum of half a mile on the treadmill and other exercises, mostly related to the maintenance of upper body strength.

My hope is that I shall eventually return to a life as it was pre-leg ulcers, that being the subject of angioplasties, colonoscopies, sigmoidoscopies (investigations carried out following routine assessment and the identification of chronic anaemia of unknown cause) and eighteen tablets each day will most definitely be a thing of the past.
It has been suggested that about 2% of the United Kingdom adult population is affected by venous leg ulceration (Husband 2001) and this figure is set to rise as the number of elderly people in the population continues to rise (Department of Health 2001).

The cost of treating chronic venous ulceration was estimated at between £230 million and £400 million per annum (Bosanquet et al 1993, Laing, 1992) and accounts for a large proportion of community nursing time (Royal College of Nursing 1998, Dale 1984).

There has been extensive research on the management of venous leg ulceration and it is now acknowledged that sustained high compression therapy is the cornerstone of effective management (Moffatt and Franks 1995). Excellent healing rates can now be achieved with the use of compression; however, the problem of recurrence and how to prevent it remains.

Vowden and Vowden (2006) have suggested that up to 50% of open ulcers are recurrent. They also suggest that the provision of compression hosiery alone is insufficient to reduce the incidence of recurrence and review of the literature on recurrence, indicating depressingly high rates, supports this view. Several studies have indicated that reduction in ulcer recurrence is far greater when patient education and contact with health professionals is maintained (Fassiadis et al 2002, Ruane-Morris et al 1995).

With this in mind, Leg Watchers was set up in 2006. It aimed to be a monthly support group for patients with open or healed ulceration or those at risk of developing leg ulceration. Set up to act as a resource and point of contact for patients who had concerns about their legs, it does not offer ‘active treatment’ but provides information on self-management and prevention strategies.

Leg Watchers is advertised around the local community in areas such as GP surgeries, pharmacies, libraries, supermarkets and church halls. The Leg Watchers flyer encourages people to attend if they have varicose veins, leg ulcers, varicose eczema, oedema, lymphoedema, history of deep vein thrombosis, or any other skin changes to their legs causing concern.

The group runs monthly for two hours and aims to offer advice, support and referral on, if necessary and, on average, 12 people attend each month. The first hour of the session delivers information on self-management and prevention strategies, delivered in a variety of ways:

- Video presentations/films
- Table top presentations
- Power point presentations
- Practical demonstrations
- Poster displays
- Group workshops

Health promotion talks so far have included:

- Skin care/application of emollient demonstrations
- Hosiery application/aids
- Exercises to encourage venous return
- Smoking cessation
- Healthy eating
- Diabetes management
- Aetiology of leg ulceration
- Prevention/management strategies of leg ulceration.

The second part of the session provides attendees with a ‘one-to-one’ consultation with the specialist nurses. This is where a provisional diagnosis is made and an action plan drawn up for either active or preventative management. This may include referring the person onto a Well Leg clinic or leg ulcer clinic for a more detailed assessment. Referrals may also be made to dermatology, podiatry, the vascular team, physiotherapy or other members of the multi-disciplinary team, if applicable. This has
been achieved by forging a well-established relationship with all the members of the multi-disciplinary team and results in a fast, seamless referral on, if necessary.

Whilst still in its infancy, the aim is to further develop Leg Watchers into a six-week rolling self-management programme, focusing on the prevention of recurrence and empowering patients to undertake self-care activities. This is in line with the Expert Patient programme (DoH 2002), which was designed to enable patients with long-term conditions to self-manage their condition.

It is hoped that through regular audit, Leg Watchers will be able to demonstrate the impact that preventative measures have for patients, in terms of reduction in recurrence rates, patient concordance, quality of life issues and cost effectiveness in clinical practice, a recent patient satisfaction survey revealed that Leg Watchers was perceived by the attendees as:

“I was very impressed by the quality of the information given to my by the nurses”

“Thank you for all the information you provide month after month”

“I feel this group has been a great help to me, and also to my sister and a friend I introduced. I have great confidence in this group”

“This group has given me confidence and definitely helped to improve the quality of my life”

“Everything was done to put me at ease, even right down to the tea and biscuits which is a lovely gesture”

Further groups are looking to be set up in the local area, ideally incorporating out of hours, drop in sessions for patients who have concerns regarding their legs, but cannot access their GP or practice nurse in office hours.

Conclusion

Leg Watchers is a proactive approach to the prevention and management of venous leg ulceration in the local community and is only made possible with the kind support of volunteers who assist in the running of the group, providing administrative support and refreshments for the group attendees. The concept of Leg Watchers is dependent upon a close working relationship with local leg ulcer clinics and members of the MDT who support this innovative, proactive initiative, designed to reduce the recurrence rate of this distressing, costly long term condition.

KF

For further information on Leg Watchers, please email: Katie.fox@see-pct.nhs.uk

References


Recommendations for continuity of leg ulcer care in acute trusts

Lucy Aldeen

This article describes a new set of guidelines that aim to assist tissue viability nurses and managers working in acute trusts to implement national and local guidelines on the management of leg ulcers. The ultimate goal of the guidelines is to improve and sustain standards of care for inpatients when they are admitted into hospital with leg ulcers.

A group of tissue viability nurses working in acute trusts who attend the Tissue Viability Nurses Forum (South) (TVNFS) which is affiliated to the Tissue Viability Nurses Association (TVNA) had experienced problems trying to manage this group of patients due to the volume who require assessment and the time and resource issues involved in training staff properly. Even when staff nurses are trained, they are not always in the position to maintain their skills.

For example, when a patient requires compression therapy, ward staff are often not competent to carry out this care.

In some acute trusts compression therapy is discontinued until the patient is discharged. Reasons for this include the risks associated with pressure ulcers developing and not being identified under compression bandages and the added risk of damage if bandages are applied using a poor technique.

Some experts believe that the ulcers do not deteriorate when the patient is on bed rest as venous return is aided without the need for compression. However this can become an issue when the patient becomes mobile or is sitting in the chair and venous stasis reoccurs. Patients may also become anxious if their compression therapy is not maintained.

National guidelines for the management of patients with venous leg ulcers (RCN 2006, CREST 1998, SIGN 1998) advocate that only properly trained staff should assess patients with leg ulcers and apply compression bandages.

In view of this, a survey was sent nationally from the TVNFS through the TVNA via email asking for response from tissue viability nurses who work in acute trusts or forwarded to the person(s) working in the trust who manages leg ulcers (Aldeen 2005) with 33 responses. The aim of the survey was to determine the level of leg ulcer provision for inpatients and the objective of the survey was to try and identify areas where appropriate inpatient care was working in order to share effective and innovative practice. The survey report highlighted that acute trusts have many different strategies for training and educating staff about assessment of ulcers including use of the Doppler and bandaging but problems still occur with assessing and maintaining staff competence.

A subsequent unpublished survey of the initial respondents was undertaken to identify the percentage of patients seen with leg ulcers in acute trusts over a 3 month period. 11 responded, who were all tissue viability nurses. Their Trust sizes ranged from 450–1100 beds. It indicated that in these trusts on average one third of referrals to the tissue viability service were leg ulcer related with an average of 46% of these patients requiring continuation of care from the community.

Recommendations and guideline development

The group decided to produce recommendations, to inform local trust policies or complement existing ones, and to ensure that only competent practitioners manage the care of patients with leg ulcers.

The recommendations divide into 3 sections (Box 1) covering:

1. Implementing guidelines
2. Management
3. Education
Included within the recommendations is a template pathway (box 2). It can be adapted for use in clinical areas for multidisciplinary staff when a patient is admitted with bandages to their lower legs and directs the user towards correct referral pathways.

These recommendations have been reviewed by the Leg Ulcer Forum (LUF) who have agreed to make them available on their web site (www.legulcerforum.org) and can be downloaded in the form of a PDF file.

On this site there will also be the opportunity for readers to comment on the recommendations. These comments will then be used to aid review and update of the recommendations through the LUF and TVNFS.

**Acknowledgements**

Thanks to the Leg Ulcer Forum and particularly Irene Anderson, Senior Lecturer, Tissue Viability, University of Hertfordshire for support in developing the survey and data analysis.

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**Box 1: Recommendations for Tissue Viability Nurses**

**1 Implementing guidelines**


Ensure guidelines are available in hard copy or on the intranet.

 Patients should continue effective compression therapy unless otherwise indicated, for example, presence of cellulitis, DVT, pain, infection or arterial disease. (Some patients with DVT are put into hosiery following appropriate treatment, please refer to local policy documents)

If there is a delay in information being obtained from the community the dressing or bandages should still be removed as part of the patient admission assessment to view the condition of the patient’s legs for wound assessment and condition of surrounding skin.

Before reapplying compression bandages, consider if it is essential during this stage of the patients illness. For example, the patient is confined to bed, is acutely unwell or is terminally ill.

If a recent Doppler reading has been recorded in the last 3 months use clinical judgement before applying compression bandages.

If a camera is available pictures can aid assessment particularly when describing the appearance of leg ulcers. Ensure consent is obtained from the patient. If photographs are kept in medical records then other teams can refer to these rather than removing bandages unnecessarily.
2 Management
If only a few staff are competent in leg ulcer management provide a pathway for staff to follow in your absence (see box 2).
If there are a high number of patients admitted with leg ulcers, collect data and evaluate the workload to identify if there is a need for an additional specialist.
Investigate setting up a leg ulcer clinic for inpatients.
Consider referral to vascular ultrasound department if no competent practitioner is able to perform a Doppler.
If therapy cannot be continued due to a lack of competent staff available in the trust, this should be documented and raised as an issue either through managers or as a clinical incident.
Consider the physical and emotional impact on the patient if compression is not continued.
Liaise with preadmission clinics to identify if patients with compression bandaging require them to be changed and encourage them to bring in community care plan and current dressings into hospital.
Encourage wards to order simple supplies as stock for example, low adherent dressing, stockinette, wool and type 2 support bandages.
Consider having an emergency supply of dressings and bandages that are used in the community to give to wards when a carer cannot bring in supplies as the order may take several days.
If patient is due for discharge ensure ward staff inform district nurses of any changes including rationale that have been made whilst the patient has been in hospital.

3 Education
Ensure basic leg ulcer care is incorporated into wound care training.
Identify clinical areas that regularly see patients with leg ulcers to focus training. Don’t expect to train other nurses. Patients can be admitted into a variety of wards where it is not possible for staff to learn and maintain skills.
Doppler assessments or compression bandaging should only be performed by members of staff if they have been assessed as competent (RCN guidelines, 2006).
Nurses should have access to formal training and ideally use a competency framework to aid the assessment process in accordance with Trust policy.
Regular workshops will help maintain competence.
Leg ulcer management care plans should be agreed with the tissue viability nurse if ward staff have not undertaken training.
If your Trust works closely with a PCT, consider joint training for leg ulcer management and to improve working liaisons. For example, it is useful to have direct phone numbers for named district nurses.
Recommendations for continuity of leg ulcer care in acute trusts (continued)

Box 2: Continuity of leg ulcer care

Patient admitted to hospital with bandages to lower limbs

Ward staff to obtain diagnosis, full history and care plan from the:
- District Nurse
- Patient
- Carer
- Leg ulcer clinic
- Health care record

N.B. Some patients may only have bandages to manage oedema or skin conditions and do not have leg ulcers.

If ulcers are arterial, follow Trust guidelines for arterial ulcers

If patient presents with:
- Pain in leg
- Pyrexia
- Malodour
- Exudate strikethrough on outer bandages
- Bandages have become dislodged
- Bandages too tight
- Cyanosed Toes

If more than 24 hour delay in receiving information or information not up to date

If patient having compression bandages, ask carer to bring in from home or order from stores and arrange to change as per care plan.

An ABPI must be recorded. It should have been performed in last 3 months but could have changed. Patient must be redopplered by competent staff.

Compression bandages should only be renewed by staff nurses who have been deemed competent to perform this skill.

Remove bandages to assess wound and skin using Trust guidelines and documentation

Remember to note the type of bandages, number of layers and primary dressing in use on removal

If legs have deteriorated refer to medical team and to the Tissue Viability service for full assessment and advice.

Apply a simple non-adherent dressing supported with toe to knee bandaging i.e. wool and type 2 bandage must be provided.

Encourage leg elevation for patients on bed whilst compression has been removed and explain reasons why to patient to alleviate anxiety

If bandages do not yet require changing according to community care plan

Leave bandages intact.

Observe patient for signs of problems e.g. pain, dislodged bandages, strikethrough of exudate

Plan dressing change with Tissue Viability Nurse depending on patient’s length of stay

Ensure community nurses are informed of discharge.

If there are no available competent trained staff in leg ulcer management:

Contact Tissue Viability Service to arrange for assistance if no staff able to apply compression
Drug misuse and leg ulceration

Tim Devey

My role for the last two years has been to support the healthcare needs of Sheffield’s homeless community. The service was set up by a colleague and myself, as part of Sheffield Primary Care Trust’s vulnerable peoples team. Many homeless clients have a history of substance misuse, indeed many clients homelessness can directly be attributed to their substance misuse issues.

We initially expected most of our work to be treating minor illness, however it soon became apparent that wound care, and in particular leg ulcer care, is a huge and perhaps hidden issue for this client group. We are currently treating 22 venous leg ulcers regularly with many more clients attending sporadically. The age range of the clients we are currently treating is between 23 and 47 with the majority being in their early thirties. As a nurse working regularly with clients with substance misuse issues it is apparent that there are many misconceptions and myths around this group. Within this article I want to concentrate on the drugs that my clients are using, the means they use to deliver them and the lifestyle that then goes along with this. Most of the information contained in this article comes directly from clients. Quality research in the area of IV drug use and leg ulcers seems to be particularly thin on the ground, so I apologise in advance for the lack of reference material.

Heroin

The first drug I will focus on is heroin. Heroin is by far the most common illegally intravenously injected drug in the UK. There are around 40,000 registered addicts (BBC 2002) but many claim the actual number of addicts to be as high as 270,000 (Lowe 2002).

Heroin has many nicknames, in different parts of the country it may be known as Brown, Skag, Gear or Smack – essentially it is all the same thing. Street Heroin. When purchased, heroin comes in the form of a brown powder. This powder is not water soluble so cannot simply be mixed with water and injected, as would be the case with dia-morphine. Street Heroin has to be mixed with an acid and then heated in order to form an injectable solution. Acids that are commonly mixed with heroin include Vitamin C and Citric acid, which are given out in needle exchanges or found in home brew kits. If clients have not attended a needle exchange they may be forced to use vinegar or lemon juice in order to dissolve the heroin. Once mixed, the heroin is heated or ‘cooked’. It is then drawn up into a syringe usually through a cigarette filter in order to remove any debris that may be present. It is thought that the average bag of street heroin bought in the UK is 35% pure (Howarth 1998), which means it is 65% filler material. Fillers commonly used include powdered milk, starch, sugars, sand and even brick dust.

Once mixed and heated, the heroin is injected directly into a vein, usually using an insulin syringe. Any and all veins will be used for this purpose. The average addict will have to intravenously inject 3 times daily, every day, which means the search for a vein becomes increasingly desperate for long term users. Once surface veins become varicosed and no longer usable, deeper veins are looked for, such as the femoral vein or even the jugular vein. Once clients ‘find their fem’ they will often use this vein repeatedly sometimes for years on end. This repeated injury to the femoral vein causes the formation of scar tissue in the lumen, thus obstructing venous outflow. This in turn creates higher pressures in the superficial veins resulting in venous hypertension. I have clients as young as 23 who already show signs of hypertrophic skin changes.

Heroin is a depressant drug and it does not produce a ‘high’, it produces oblivion. Clients who have taken heroin appear sleepy and are often difficult to rouse, sometimes appearing to
slip in and out of consciousness. This is a state users call ‘gouching’. Clients describe a feeling of being wrapped in cotton wool. Heroin is often described as an escape route from real life. Many of my clients have had very troubled pasts or upbringings. Some have suffered various types of abuse or neglect; others describe traumatic events, or simply a feeling of inadequacy. I have two clients who were formerly soldiers and just could not adapt to civilian life and another who was a former fireman and could not come to terms with the loss of colleagues in a fire. What most homeless drug users do share is a desire to escape from their own reality for a brief period each day.

Heroin is extremely addictive and clients will quickly build up a tolerance to its effects. More heroin will then be needed to produce the same effect. If this increasing amount of heroin is not obtained clients will begin to withdraw or ‘rattle’. Symptoms of withdrawal include vomiting, sweating, shaking and hallucinations. Most clients have a justifiable fear of withdrawal, which they know is only ever a few hours away.

Crack cocaine

The second most commonly injected drug among my client group is Crack Cocaine. As with heroin, crack can be smoked but many long-term users prefer to inject, as less drug is required to produce the same effect, making injecting a cheaper option.

Crack is a stimulant drug, which gives people a genuine high. People describe experiencing a feeling of euphoria and well-being. Unfortunately this is quite a short-lived feeling with the average crack hit only lasting around 15 minutes. As the effects of the drug wear off, people often become tense and paranoid. This leads to them using again to try and re-capture that initial feeling of euphoria and well-being. Such behaviour can result in a crack binge where a person may use twenty or thirty times consecutively. Sometimes this will mean twenty or thirty injections into the femoral vein in a single day.

Recently it has become common to mix and inject crack and heroin together. This is a practice known as ‘speed balling’. This gives the intense high from the crack but without the accompanying paranoia from the come down, as the heroin sedates this away. Almost all my clients now inject this crack/heroin mix, which leaves them with a dual addiction. Since most addicts will need in excess of £50 a day to support their habit, existence becomes very much hand to mouth. Women often turn to prostitution and men to petty crime. Every day becomes a battle to obtain enough money to support their habit. Healthcare and wound care will always come second to raising enough money to support a habit.

Many clients never receive proper treatment for their leg ulcers. Clients may not be registered with a GP, or if they are, they will often miss appointments with Practice Nurses or will not be at home when District Nurses call. Clients’ ulcers then deteriorate and often become infected which leads to hospital admission. Clients then spend a period in hospital where their ulcers begin to improve. They are then discharged and again don’t attend appointments, and the cycle repeats itself. This is good for neither the client nor the NHS, as repeated hospital admission costs soon escalate.

In reality a centralised clinic or hospital service is probably not the most effective way of treating this client group. Clients may attend initially, but getting them back often enough to receive clinically effective care is another matter. Taking the service to the clients has proved a successful way of ensuring clients receive regular dressing changes. This has been achieved by setting up clinics in already well-established projects for homeless people and IV drug users. We now do Fig 1: patient aged 23 years with a venous leg ulcer of 2 years that had not received treatment
regular clinics at a breakfast project run by the Sheffield Cathedral, at Turning Point (Sheffield’s main needle exchange), and at the two largest homeless hostels in the city. We also travel on the mobile needle exchange vans and attend an evening ‘soup kitchen’ run by a local church. This way, we usually run into clients somewhere and can do effective and timely dressing changes.

Most clients I have treated with compression bandaging have responded very well. Most find it comfortable and are very relieved when the smell from infected ulcers begins to subside. Some clients have had ulcers for years and healing these can have a remarkably positive effect on their life. One client, who had a circumferential ulcer, was homeless and a heavy user of heroin. His ulcer had been present for 3 years and was heavily exudating and infected with pseudomonas. Everywhere this client went people told him how bad he smelled. The client had had numerous hospital admissions but had never been treated consistently with compression bandaging. The level of social exclusion this client suffered was enormous. After a long struggle and a few ups and downs his ulcer healed. As his ulcer began to heal he began to re-engage with services and gradually sort his life out. This client now has his own flat, a girlfriend, a part time job and has been clean for 6 months. Healing this client’s ulcers allowed him to re-enter society. So whilst beginning a therapeutic relationship with clients from this group may be initially difficult and time consuming, the end results can be incredibly rewarding.

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This article is a short report presenting one of six themes that emerged from a qualitative study exploring the experiences and views of seven non-specialist nurses involved in the management of people with leg ulcers. The theme is the nurses’ understanding of the terms *compliance* and *concordance*. The terms appear commonly in leg ulcer-related literature; often used interchangeably without operational definitions. Therefore this study sought to explore these terms from the perspective of the participants’ clinical practice experience.

**Introduction**

There are an increasing number of qualitative studies, which explore the lived experience of leg ulceration from the patient’s perspective, but the impact on nurses of caring for this patient group is poorly understood. Following ethical approval and informed consent, seven non-specialist community nurses were asked about their experience of caring for patients with leg ulcers. Six key themes emerged from the narratives and it is evident that building relationships with patients is very important in leg ulcer management and that pragmatism, empathy and persistence is an essential quality for nurses. The focus of this article is on one of the themes which emerged; perceptions of *compliance* and *concordance*.

**Rationale for this study**

This study was prompted by the knowledge that patients often have difficulty engaging in some aspects of their care and that nurses can sometimes find this challenging and frustrating. An assertion made by Edwards (2003) in a patient study was that nurses had not taken time to listen to the patients, which nurses may perceive as unfair. In addition the nurses appear to be criticised because the patients generally had little recall about the aetiology of their ulcer. Studies have shown that even after structured educational programmes patients often cannot articulate their underlying disease process (Flanagan et al 2001). Cline et al (1999), reported from a study of older people (post retirement age) with heart failure that only one in four people could remember any of the verbal and written information they had been given about medication. Although some of the experiences recounted by patients in the Edwards study are in accordance with other studies (Charles, 1995; Douglas, 2001; Krasner, 1998; Walsh, 1995, Rich and McLachlan, 2003) it is apparent that there is very little data about how nurses experience caring for people with leg ulcers. To understand both patient and nurses’ perspectives may facilitate strategies to harmonise the patient/professional relationship in leg ulcer treatment regimens. Relationships with patients are complex and it is clear that good interpersonal skills are key to developing partnership and therapeutic relationships with patients.

Rich and McLachlan (2003) carried out a phenomenological study of eight participants with a mean age of 77, all of whom had an ulcer duration of more than five months. The participants illustrated the impact of interpersonal issues with the nurses in the clinic, for example, inconsistent approaches among nurses; and a perception that not all nurses appeared knowledgeable and capable. Ebbeskog and Emami (2005) conducted a phenomenological study with 15 older people in Sweden who had had their ulcer for more than 12 months. Patients reported that the relationship with the nurses was very important and that gentle handling and a friendly demeanour was valuable in making them feel secure and cared for. One participant said that “not all the nurses are able to imagine what it feels like to have your leg wrapped up for a whole week” and said that his nurse kept him informed of how his wound was healing and ‘scolded’ him if he did not follow her advice. When there was
no such interaction with other nurses in the clinic he felt ‘neglected’ (page 1226).

Moffatt (2004a) speculates that non-healing causes feelings of anxiety and a sense of ‘failure’ by nurses (pg 247). There are many tissue viability nurses and leg ulcer specialists who have developed innovative and effective services (Moffatt and Oldroyd, 1994, Scanlon and McGinnis, 1998, Bourne, 1999), and many nurses and other health care practitioners who become involved in organisations dedicated to service improvement (eg Leg Ulcer Forum, www.legulcerforum.org). However the reality is that while most community nurses look after people with leg ulcers there is little understanding of how they perceive the leg ulcer patients in their care.

Hallett et al (2000) interviewed 62 nurses (including 9 health care assistants) about perceptions of their work. When discussing wound care many of the participants referred to ‘non-compliance’. The frequency with which this issue appeared in the transcripts led the researchers to analyse this as a discrete elements of ‘non compliant behaviour’ and ‘reasons for seeking compliance’ (page118 & 120). Under the former heading, themes emerged such as:

- Flogging a dead horse
- Her own doing
- Doesn't help himself
- Didn't believe me

And the latter heading included:

- They just won't do as they are told
- If we can educate them
- We can try different things
- We have to respect the patient's request

(Hallett et al, 2000)

Hallett et al discussed that the participants wished patients would leave the care to the experts (the nurses). There was also a sense of frustration among the nurses that when patients were not complying, other health disciplines withdrew from care and the district nurses were left to carry on. Although the research team highlighted in their conclusion that the nurses displayed patience and perseverance there is nevertheless a demonstration of the frustrations and perceived lack of progress experienced when caring for some patients.

Defining Compliance

‘The extent to which the patient’s behaviour (in terms of taking medications, following diets, or executing other lifestyle changes) coincides with medical advice’ (Sackett and Haynes, 1976). This definition has been criticised as being authoritarian; for example, McGann (1999) is concerned that it assumes the health care provider to be the expert and does not take into account how treatment impacts on patients’ lifestyle. Murphy and Canales (2001) reviewed sixty papers related to compliance and found that thirty did not define the term at all. Compliance “requires a dependent layperson and a dominant professional” (Trostle 1988 p.1301).

There is clear evidence from patients that healthcare professionals do not always demonstrate understanding or empathy regarding what it is like to live with a leg ulcer, to live with pain and discomfort, and to wear compression bandages constantly (Krasner,1998; Charles, 1995). Patients are often labelled as non-compliant when they do not tolerate compression therapy. Clinical experience, anecdotal reports and myriad literature suggest that this is a source of frustration for health care professionals and the focus of blame is on the patient (Brown 2005b). Indeed Bellamy (2004) asserts that health professionals find it hard to believe that patients do not follow advice and that compliance is seen as the responsibility of the patient.

Defining Concordance

‘A negotiation between equals and the aim is therefore a therapeutic alliance between them. This alliance may, in the end, include an agreement to differ. Its strength lies in a new assumption of respect for the patient’s agenda and the creation of openness in the relationship, so that both doctor and patient together can proceed on the basis of reality and not of misunderstanding, distrust and concealment.’ (Royal Pharmaceutical Society, 1997).

Healthcare professionals are now encouraged to embrace partnership and negotiation with patients who have long-term conditions; to embrace concordance (Jones 2004 and Carpenter 2005). The concepts of concordance and patient partnerships are championed in all aspects of health care (Cahill, 1998) including leg ulcer management (Harker, 2000, Moffatt, 2004a).
The Royal Pharmaceutical Society (RPS, 1997) advocates a shift from compliance to concordance in an attempt to promote openness and empathy in patient–professional relationships.

**Results of this study: Compliance and Concordance.**

All but one of the participants mentioned compliance and/or concordance unprompted in the course of the interview. When pressed on a definition, no one was able to articulate clearly what they understood by the terms. No one was able to explain the origins of the term or the philosophy behind them although two participants mentioned that they appeared to have a basis in medication.

“Compliance to me would just mean that they do as you tell them I suppose... I suppose I’m the one with the knowledge more than them generally speaking. I can’t say that about everybody and as long as I’ve discussed with it them and they agree that the regime is correct then compliance would be doing as we’ve discussed basically... Concordance I suppose is more of a partnership perhaps... I’ve not actually looked the word up, but I’m guessing it means more of a partnership thing and both working towards the same goal ...perhaps with more input from the person... Compliance I think is more being told what to do, where concordance is kind of doing more what you’ve agreed to, together” (2)

“I just think compliance means they’re a bit more sort of passive, with concordance they get more involved” (3)

“To me it means you offering the patient a form of treatment and they go along with it. I prefer to think of it as concordance where you reach an agreement with the patient that they are having what they want, that the emphasis is on the patient choice” (6)

“...compliance is more about medication than treatment really. Some patients are not taking their medication... they have decided not to take their medication. I don’t know where I have got that from...” (7).

Participants were asked what approach they tended to use.

Participant 3 explained that with one patient the nursing team had spent many weeks trying to persuade a patient to rest and elevate her legs. The oedema was building to the extent that fluid was leaking and the ulcers were rapidly deteriorating and medical opinion indicated that amputation was likely. The patient’s husband was upset adding to the concern and distress of the nursing team.

“...and we said to her... [name] if you don’t keep your feet up your gonna lose your leg and scared her basically... I am not sure if it is compliance or bullying. It was done with the best of intentions to save her leg. Umm... Its kind of a fine line compliance and concordance because well, she did agree to it... I don’t know, compliance, concordance or bullying – I don’t know?” (3).

Following this encounter the patient began to engage with the treatment and the condition of her leg improved. The patient appeared motivated to engage in care (and stated to the nurse) “I’ve got my leg up, they’ve been up for a couple of hours every day” – “ and that’s really nice actually, she listened to me (laughs). And what we said worked!” (3). This links to the Ebbeskog and Emami (2005) study which indicates that some patients may benefit from this kind of approach and that therapeutic relationships have to evolve and be sensitive to the patient and their carers.

One participant had heard the term concordance but had not thought about the definition.

“...well it’s (pause)... patients complying with and agreeing to treatment that they’re offered, in negotiation with the nurse, in theory.” [Interviewer: “in theory?”]. “I don’t think that’s the official definition. I think from a nurse’s point of view it’s the patient’s accepting and keeping their bandages on.... putting their legs up if they’ve been advised to, eating a good diet, all the things that we encourage them to do... [on concordance]... some of the patients have dementia and you can’t have a meaningful negotiation with patients who aren’t on the same wave length, and other patients don’t necessarily want to know” (5).

One participant made the point that concordance may have to be a state that evolves in the course of care rather than something that can be achieved immediately.

“...so I think inevitably at when you very first go and see somebody and you order up something that you know has got a good record in healing, I think it’s difficult to actually bring concordance

Nurse understanding of the terms Compliance and Concordance (continued)
“...it appeared that perhaps they were unclear of the definition, or that they could explain the term but were uncertain how their practice fitted into the definition into that, I think that perhaps comes along later when you’ve tried something and then you can compare with what they’ve tried” (5).

It was pointed out by participants that it is important to understand the patient and to know when treatment plans are not being followed. “If they’re not going to agree to the treatment then it’s like anything, like giving them tablets or something, they say ‘yes nurse’, and then throw them in the bin. You’d rather know they are doing that... It would be nice if patients were just compliant but it doesn’t work out... (laughs)” (3).

There were some contradictory views on compliance and concordance from most of the participants and it appeared that perhaps they were unclear of the definition or that they could explain the term but were uncertain how their practice fitted into the definition.

“...[if I say to them] ...you are suitable for full compression and you can either have long stretch or short stretch or hosiery. They make the choice... Actually they are choosing between the types of compression and they haven’t noticed that they are going into compression” (6).

One participant expressed concern about concordance and felt that the elements of choice were perhaps too much for patients and there had to be a mixture of compliance and concordance to facilitate optimum care.

“My first line of approach is in conjunction with what we’re supposed to be doing. Gaining concordance by usually asking the patient to work in conjunction with me, etc, etc, but often that doesn’t work because the patient’s given too much leeway I feel, to get out of this whenever they want and something needs to be reinforced by the professional ‘I’m trying to help you, listen to my expertise, this is what should be done’ ” (1).

As well as a definition of concordance the participants were asked when and how they had heard the term. Most could not recall, but it was interesting to hear the experiences of those who could remember it emerging in practice.

“I didn’t realise until the word concordance was broadly used” (2).

“I am not really aware of it but somewhere we dropped compliance and we started reaching concordance, it was sometime in the last 6 years. It was while I was community nursing. We had to stop writing compliance and start writing concordance. [Interviewer: ‘Who told you?’]. I suppose it was the line manager. ‘Compliance is out, reach concordance’. I remember people going round in circles saying ‘what’s concordance?’ (laughs)...” (6).

Discussion
None of the participants were able to give the source of concordance in recent literature (RPS, 1997) and it was interesting that participant 6 stated it was a management directive and that no-one in the nursing team seemed to know what was expected of them or their patients. It was recognised by two participants that its focus was on medication. The participants felt that they worked towards concordance to some extent and they almost invariably felt it was a desirable thing, but there were reservations particularly when the nurses felt the patient might come to some harm if they did not follow advice.

Participants were unsure about what their own approach was and as well as compliance and concordance they reflected on coercive aspects of nurse-patient interactions. The literature suggests that many patients prefer relaxed approaches with humour and a cajoling bantering relationship...
(Ebbeskog and Emami, 2005) but if taken out of context may appear as the bullying that so concerned participant 3.

Conclusion

Moffatt (2004) reflected on the definition of concordance and compliance expressing concern that patients who do not do exactly as they are told are seen as difficult and run the risk of being distanced from health services. It is clear that the relationship between the patient and the health care professional is key to partnerships in care (Chase et al, 1997; Ebbeskog and Emami, 2005).

The extent to which patients engage in their care is variable. Nurses are encouraged to form partnerships with their patients but it is unclear how, or indeed if, this happens. The literature focuses on compliance and non compliance, and advocates concordance without any explanation of what these terms mean to individuals.

Henderson (2003) states that nurses have to be more proactive in empowering patients to engage more fully in their care and to create a climate where questioning is actively encouraged, so that in time it becomes the norm. Patient choice is a laudable and achievable aim but healthcare staff need to be sufficiently skilled to facilitate this and there needs to be a greater understanding of their perspectives, concerns and resources in achieving concordance.

Thank you to the participants of this study who gave their time willingly and were invariably impressive in their empathy for people receiving leg ulcer treatment, and in their determination to improve care.

References

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The development of a bandage formulary for wound management within an acute NHS trust

Judy Harker and Debbie Ruff

The Tissue Viability and Vascular Nursing Services decided to develop a bandage formulary to standardise clinical practice, following the merger of a large acute NHS Trust.

A multitude of bandages were used by clinicians and the standard of bandage application varied significantly. A number of bandage-related critical incidents were highlighted to the authors, these involved poorly applied bandages resulting in tissue damage (Figure 1). Such incidents clearly fell within the remit of Clinical Governance, requiring the reduction in clinical risk, thus maximising patient safety. A Clinical Governance framework can be defined as one in which ‘NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (Scally and Donaldson, 1998).

Aims

The aims of this project included:

• The development of a trust-wide bandage formulary
• The standardisation of bandages across hospital sites
• A reduction in the number of critical incidents associated with poor application of bandages
• The enhancement of knowledge and skills of staff in bandage selection and application
• Adopting a common language across all clinical areas to improve the quality and exchange of information between healthcare professionals
• Demonstrating value for money
• Collaborative working between different healthcare settings promoting continuity of patient care from acute to primary care settings

Figure 1: Examples of poor bandage techniques and bandage-induced tissue damage to the lower limb
Methods

A group of key stakeholders comprising: Nurse Consultant Tissue Viability, Tissue Viability Nurses (Acute and Primary Care Trust), Vascular Nurse, Leg Ulcer Specialist Nurse (Primary Care Trust) and a Senior Category Manager from the North West Collaborative Procurement Hub, met over a period of two months to undertake the bandage evaluation and achieve consensus agreement.

The purpose of the meetings was:

• To gain understanding of the current use of bandages in the Trust
• To agree a defined list of generic bandages to be included in the evaluation process
• To review and evaluate the range of bandages used in wound management available via NHS Logistics
• To work in partnership with local Primary Care Trusts and the North West Collaborative Procurement Hub

In the first instance a list of bandages, available through NHS Logistics, and their associated suppliers was drawn up (see Box 1).

<table>
<thead>
<tr>
<th>Bandage</th>
<th>Supplier</th>
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<tbody>
<tr>
<td>Hospicrepe 233, 239</td>
<td>Paul Hartmann Ltd</td>
</tr>
<tr>
<td>Cellona</td>
<td>Vernon-Carus Ltd</td>
</tr>
<tr>
<td>Surepress</td>
<td>ConvaTec Ltd</td>
</tr>
<tr>
<td>Profore 2, Profore 3, Profore 4, Profore +, Proguide layer 1.</td>
<td>Smith and Nephew Ltd</td>
</tr>
<tr>
<td>Flexiban</td>
<td>Activa Health Care</td>
</tr>
<tr>
<td>K Soft, K Lite, K Plus, Koflex</td>
<td>Urgo Ltd</td>
</tr>
<tr>
<td>Velband, Soffban Plus Synthetic / Natural, Soffcrepe, Elvic (Vic), Litepress, Co Plus, Tensopress</td>
<td>BSN Medical Ltd</td>
</tr>
<tr>
<td>Multicrepe</td>
<td>Frontier Multigate</td>
</tr>
<tr>
<td>Coban</td>
<td>3M Health Care Ltd</td>
</tr>
<tr>
<td>Setocrepe, Setopress, Elset</td>
<td>Molnlycke Healthcare Ltd</td>
</tr>
<tr>
<td>Ultra Soft, Ultra Lite, Ultra Fast, Ultra Plus, Ultra 4 kit</td>
<td>Robinson Healthcare Ltd</td>
</tr>
</tbody>
</table>
Specific attention was given to orthopaedic wool, type 2 support, type 3a, 3b and 3c compression and multi-layer compression kits. Each group member was assigned the responsibility for contacting an agreed number of bandage suppliers to obtain samples (in a range of sizes) and supporting literature. Following this, members were required to present their products to the group.

A ‘table top’ evaluation methodology was deemed most appropriate for this project due to the wide ranging experience of the group members and their knowledge of the products concerned. The evaluation review criteria included packaging/presentation, instructions for use, ease of use, range of sizes available, conformability, unique product features, quality of training and education provided by the supplier, drug tariff availability, clinical evidence and cost. Products were evaluated against these criteria and a scoring system developed ranging from very good to poor. A rationale for scores was provided by members of the group wherever possible.

The North West Collaborative Procurement Hub provided valuable usage data so that key wards/departments could be targeted to gain user feedback on products. An example of this information is provided in Chart 1.

### Results

The evaluation process yielded a range of valuable data, which was used to inform the decision making process regarding the content of the Trust’s formulary. The findings are detailed opposite:

![Figure 2: Examples of different packaging for orthopaedic wool](image)

![Figure 3: Examples of different type 3a compression bandages](image)
Reasons for including specific bandages within the formulary

**Orthopaedic wool**  
Ability to tear easily, ease of application, sealed packaging reducing risk of product contamination (Figure 2)

**Type 2 support bandage**  
Conformability, smooth texture of bandage

**Type 3a bandage**  
Clear identification on packaging and product indicating that bandage has compression properties

Other general findings included education and training support from the supplier, clinical evidence, cost and availability of the full range of products from one supplier.

Reasons for excluding bandages from the formulary

**Orthopaedic Wool**  
Drug Tariff availability, poor conformability, poor unsealed packaging (risk of product contamination)

**Type 2 Support Bandage**  
Lack of availability of different widths, cost (eg range from £0.43 to £0.71), abrasive texture of some bandages (considered to pose a risk to vulnerable skin on the adjacent limb)

**Type 3a compression**  
Bandage overlap indicators causing confusion in application. Difficulty in identifying product as a compression bandage due to poor packaging information and faintness of stripe (see Figure 3). Danger of staff confusing bandage with type 2 support bandage.

**Type 3b**  
Poor information on packaging. Short length of bandage

Other general findings included lack of education and training support from the supplier, lack of clinical evidence, cost and lack of availability of full range of products from one supplier.
Bandage kits were excluded from the Formulary for the following reasons:

- Cost
- Potential for wastage as experience had shown that staff remove individual items from kits
- Inadequate storage space at ward/department level to accommodate bulky packaging
- Kits are specific to limb size and are therefore not universally applicable to all patients, unlike bandages which can be ordered separately

The Trust has agreed a product range with a sole supplier and a new formulary has been launched. This has enabled the group to mask non-formulary bandages via the Supplies Department, thus maximising compliance with the agreed product range. The supplier and the Trust are now working in partnership to develop training materials to enhance knowledge and skills in bandage usage (see Figure 4).

In order to empower Tissue Viability Link Nurses, a simple, easy to use, training package is being devised to cascade information amongst staff. Bandage formulary education will link into existing local wound management and leg ulcer guidelines. The results of this project have been shared with the procurement Hub, other acute trusts in the UK and presented at a European Wound Management Conference. A North West contract with the supplier has been secured for 12 months resulting in potential cost savings.

**Conclusion**

This collaborative project has resulted in the development of a bandage formulary for wound management. This has been achieved by pooling the experience and expertise of key stakeholders whilst demonstrating not only value for money, but importantly ensuring quality remained a central theme. Awareness will be raised amongst staff regarding the potential hazards and clinical risks related to the inappropriate use of bandages.

A future audit aims to determine improvement in the knowledge and skills of clinicians in bandage selection and application. A comparison of critical incidents will also be made to identify trends in clinical risk.

**Acknowledgement**

Thanks go the following individuals who contributed to this project:

- Tissue Viability and Leg Ulcer Specialist Nurses
- North West Collaborative Procurement Hub
- Tissue Viability Link Nurses
- Members of the Trust’s Supplies department

**References**

Background
Healing of venous leg ulcers is improved by the use of compression bandaging but some venous ulcers remain unhealed, and some people are unsuitable for compression therapy. Pentoxifylline, a drug which helps blood flow, has been used to treat venous leg ulcers. An earlier version of this review included nine randomised controlled trials, but more research has been since been conducted and an updated review is required.

Objectives
To assess the effects of pentoxifylline (oxpentifylline or Trental 400) for treating venous leg ulcers, compared with placebo, or other therapies, in the presence or absence of compression therapy.

Search strategy
For this second update we searched the Cochrane Wounds Group Specialised Register, CENTRAL, MEDLINE, EMBASE and Cinahl (date of last search was February 2007), and reference lists of relevant articles.

Selection criteria
Randomised trials comparing pentoxifylline with placebo or other therapy in the presence or absence of compression, in people with venous leg ulcers.

Data collection and analysis
Details from eligible trials were extracted and summarised by one author using a coding sheet. Data extraction was independently verified by one other author.

Main results
Twelve trials involving 864 participants were included. The quality of trials was variable. Eleven trials compared pentoxifylline with placebo or no treatment; in seven of these trials patients received compression therapy. In one trial pentoxifylline was compared with defibrotide in patients who also received compression.

Combining 11 trials that compared pentoxifylline with placebo or no treatment (with or without compression) demonstrated that pentoxifylline is more effective than placebo in terms of complete ulcer healing or significant improvement (RR 1.70, 95% CI 1.30 to 2.24). Significant heterogeneity was associated with differences in sample populations (hard-to-heal samples compared with “normal” healing samples). Pentoxifylline plus compression is more effective than placebo plus compression (RR 1.56, 95% CI 1.14 to 2.13). Pentoxifylline in the absence of compression appears to be more effective than placebo or no treatment (RR 2.25, 95% CI 1.49 to 3.39). A comparison between pentoxifylline and defibrotide found no statistically significant difference in healing rates.
More adverse effects were reported in people receiving pentoxifylline (RR 1.56, 95% CI 1.10 to 2.22). Nearly three-quarters (72%) of the reported adverse effects were gastrointestinal.

**Authors’ conclusions**

Pentoxifylline is an effective adjunct to compression bandaging for treating venous ulcers and may be effective in the absence of compression. The majority of adverse effects were gastrointestinal disturbances.

**Plain language summary**

Pentoxifylline increases the healing of venous leg ulcers.

Venous leg ulcers are a common, recurring disabling condition. The mainstay of treatment is the use of firm compression bandages or stockings to support the veins of the leg. Some leg ulcers take many months or years to heal and treatment is aimed at preventing infection and speeding up healing. Pentoxifylline is a tablet taken to improve blood circulation. The review of trials suggests that pentoxifylline, 400 mg tablet taken three times a day, increases the chance of healing.

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**Further information**

For further information on conducting a systematic review, contact:

**Sally Bell-Syer**, Wounds Group Coordinator. Email: sembs1@york.ac.uk
A nurse-led study is preparing to compare the clinical effectiveness of weekly ultrasound with standard care in the treatment of ‘hard to heal’ venous leg ulcers.

Background
A number of studies have investigated the impact of ultrasound on skin cells (in vitro) and chronic wounds (in vivo). In general there have been few good quality studies demonstrating that any of the ‘in-vitro’ effects have any clinical importance. Given that a systematic review of ultrasound for venous ulcers identified seven trials of ultrasound, and despite weakness in the studies (for example, small sample sizes, inconsistent reporting of outcomes, different types of ultrasound therapy used) found that the trials all reported a tendency for ultrasound to be better than placebo (sham ultrasound) or standard care (Flemming and Cullum, 2000).

This prompted the commissioning of a large randomised controlled trial by the NHS Health Technology Assessment Programme, to evaluate the clinical and cost-effectiveness of ultrasound (VenUS III).

We have established 12 sites for the VenUS III trial across the UK and Ireland:

i) Western Health & Social Care Trust (Northern Ireland)
ii) Bolton
iii) Bradford
iv) Cumbria
v) Dunfermline
vi) Hull – Dermatology Dept at Princess Royal Hospital and Institute of Wound Care at Hull Royal Infirmary
vii) South Essex
viii) Leeds Community
ix) Scarborough
x) Nottingham
xi) Birmingham
xii) Dublin

Nurses in each of these sites have been trained in recruiting people into the trial, applying ultrasound and recording trial outcomes. We have supplied ultrasound machines so that clinical teams can deliver ultrasound during bandage renewal, and digital cameras to record ulcer healing.

Progress
We have more than 200 people recruited to the trial so far (203 as of the 19th October 2007) so there is still some way to go until we hit our target of 336. The VenUS III trial is already the largest trial ever conducted on ultrasound therapy (the next largest had 108 participants) and has the longest duration of follow-up at 12 months. Importantly, it incorporates patients’ perspectives and cost-effectiveness to evaluate whether any clinical benefit for ultrasound therapy is worth it! Depending on news from the funding body, the Health Technology Assessment Programme, we may extend both the number of clinical sites, and the time for recruitment into 2008.

If you are interested in finding out more about this and want to get involved, contact the trial manager, Dr Judith Watson at jmw19@york.ac.uk.

VenUS III is registered so that people consulting different publications arising from the trial can readily identify that they all arise from the one study. The trial has International Standardised Randomised Controlled Trial Number: 21175670 and EudraCT Number 2004-004911-51.

References
All you have to do to uncover the word list for this quiz is to answer the clues below. As you can see we have given you the initial letter of each answer and one has been filled in to help you start. When you have filled in the list you can then try to fill in the tiles.

For a chance to win a £10 M&S voucher send your completed puzzle to the Leg Ulcer Forum (see back cover) before 20 April 2008. Correct entries will be entered into the prize draw. The completed puzzle and the name of the winner will be posted on the web site after 1 May 2008.

**Clues**

4 letters
Calculation of arterial efficiency
A _ _ _

6 letters
Continuous dull pain
A _ _ _ _ _

7 letters
Patients often complain of itching over these
V _ _ _ _ _

8 letters
Pulse found near the lateral malleolus
P _ _ _ _ _ _
Name of the pulse in the arm
B _ _ _ _ _ _

9 letters
Pulse found below and behind the medial malleolus
P _ _ _ _ _ _ _ _ _

Patients may complain of this symptom when they have oedema
H _ _ _ _ _ _ _ _

10 letters
Dilation of superficial blood vessels found in the medial aspect of the foot (2 words)
A _ _ _ _ F _ _ _

12 letters
Staining of the skin
P _ _ _ _ _ _ _ _ _
Irritating skin changes associated with venous disease (term used by dermatology) (2 words)
S _ _ _ _ E _ _ _

13 letters
Pulse found at the Pedal Arch (2 words)
D _ _ _ _ _ _ _ _ P _ _ _
Your Forum (3 words)
L _ _ U _ _ _ F _ _ _

14 letters
Pulse found in front of the tibia (2 words)
A _ _ _ _ _ _ _ _ T _ _ _
Areas of scarring often associated with previous leg ulceration (2 words)
A _ _ _ _ _ _ _ B _ _ _

16 letters
Things looked for during assessment
S _ _ _ A _ S _ _ _ _ _ _

20 letters
Fibrosis of the dermis and superficial adipose tissue
L _ _ _ _ _ _ _ _ _ _ _ _ _

The LUF word quiz
A review of the provision of education in leg ulcer management in four UK universities
Janice Bianchi

With a point prevalence of between 1.1 and 3.0 per thousand (Cornwall et al, 1986; Baker et al, 1991; Callam et al, 1985) and an increase in prevalence with age (Lees et al, 1992), leg ulcers are a major health problem in the UK. Predicted demographic changes suggest prevalence is likely to increase.

Most patients with leg ulcers are treated in the community setting where nurses will carry out a detailed assessment including examining the patient’s vascular status. They will also diagnose, prescribe and initiate treatment or where appropriate, refer to specialist services.

The majority of leg ulcers are venous in origin (Scottish Intercollegiate Guidelines Network (SIGN), 1998). Compression systems improve the healing of venous leg ulcers and are routinely used in uncomplicated venous ulcers (Fletcher et al, 1997; Cullum et al, 2002). Compression of the leg, can however be hazardous in limbs with occult arterial disease (Callam et al, 1987).

It is therefore essential that practitioners have a sound knowledge of the complex aetiology and epidemiology of leg ulceration and be highly skilled in leg ulcer assessment and management. As nursing practice evolves the Continuous Professional Development courses (CPD) delivered by Higher Education Institutions (HEI) also need to develop to meet the needs of the National Health Service (NHS) and the individual practitioner in preparing them for the workplace.

Eight HEI leg ulcer modules were identified throughout the UK. The aim of this article is to review in detail a sample these modules. Each of the HEI reviewed offers modules at different academic levels, for the purposes of this paper only level 3 modules were reviewed.

Glasgow Caledonian University (GCU), University of Hertfordshire (UH) Cardiff University (CU) and Queens University Belfast (QUB) were invited to participate. Main areas of interest are:

- mode of delivery
- module content and alignment of this to national leg ulcer guidelines (SIGN 1998; Royal College of Nursing (RCN) 1998; Clinical Resource Efficiency Support Team (CREST) 1998)
- theoretical and practical aspects to the module
- alignment to the National Health Service Knowledge and Skills Framework (NHS KSF), (Department of Health 2003a)

Mode of delivery

The modules reviewed here are delivered either face-to-face or web-based (table 1).

Traditionally university courses were taught face-to-face. Recent developments have seen new methods of teaching being introduced such as blended learning which is the bringing together of traditional physical classes with elements of virtual learning, print-based study or web-based modules. Students perceptions of the different modes of delivery vary. Hagle and Shaw (2006) surveyed a group of undergraduate nursing students on their perception of the benefits of face-to-face classes, web-based study and print-based study. Two benefit types were identified through factor analysis which were engagement and functionality. The respondents rated face-to-face classes highest on engagement and print-based highest on functionality. There was no clear distinction between engagement and functionality between web-based and print-based study.

Mentzer and Cryan (2007) compared student learning outcomes and perceptions of satisfaction in two sections of the same class. Students were randomly assigned to either web-based or face-to-face learning. Identical end-of-semester evaluations were completed by each group. Findings suggested that students’ performance on test was equivalent. However students’ final
grades were lower in the web-based course due to incomplete assignments. In both sections, students’ perception of the course and instructor were generally above average but the face-to-face group rated both variables statistically significantly higher. Finally, Ryan et al (1999) compared traditional teaching methods and web-based modules in 96 graduate nurses and found conventional methods were rated significantly higher in terms of content, interaction, participation and faculty preparation. Technical skills were higher for web materials. Web modules also resulted in higher levels of critical thinking and analysis.

From the studies reviewed here there appear to be advantages and disadvantages with both traditional and web-based learning. Traditional face-to-face teaching was favoured in terms of engagement, interaction and participation. Web-based or print-based study rated higher on technical skills and functionality. Offering students choices in modes of delivery may be of value as some students will prefer the traditional classroom environment, while work commitment, geographical challenges or a preference for distance learning may make web-based or print-based study more attractive to others.

Module Content and alignment to national evidence based guidelines
The ultimate goal of nursing is to deliver to patients the best possible care; in other words be clinically effective. Quinn (2000 p565) suggests evidence-based practice/nursing and clinical effectiveness, although often discussed as separate entities, are effectively the same. Applying Evidence-Based Nursing (EBN) to practice can be a huge challenge to the clinical nurse. Flemming (2007) argues the expectation of reading the vast amount of publications produced and maintaining continuing education requirements alongside ever increasing workloads and diminishing study time makes keeping practice up to date difficult. Evidence-based guidelines can help to make this task less onerous. In the UK, there are three published national evidence-based guidelines on the care of patients with leg ulceration (RCN, 1998, SIGN, 1998, CREST, 1998). The authors of these documents have extensively reviewed the research evidence and the recommendations of the guidelines are graded from what is considered

the most robust form of evidence to the weakest eg systematic review or meta-analysis of randomised controlled trials to evidence obtained from expert committee reports. Part of the role of academic institutions is to ensure nurses have the skills to practice EBN. Logically relevant evidence-based guidelines should be a central part of the programme produced by a HEI. The academic content of all four modules reviewed here is closely aligned to national guidelines on the care of patients with leg ulcers.

Table 1: Alignment to the NHS KSF

<table>
<thead>
<tr>
<th>University</th>
<th>Mode of delivery</th>
<th>Aligned to KSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCU</td>
<td>Face to face</td>
<td>Mapping process underway</td>
</tr>
<tr>
<td>UH</td>
<td>Face to face</td>
<td>Mapping process complete</td>
</tr>
<tr>
<td>CU</td>
<td>Distance learning</td>
<td>No</td>
</tr>
<tr>
<td>QUB</td>
<td>Face to face</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Theoretical and practical aspects
The theoretical components common to the four modules and additional components for each course are listed in Table 2. All courses are broadly similar in course content.

In integrating theory to practice, different methods were utilised. All provided classroom-based workshops in vascular assessment and the application of compression bandaging. However, differences were observed between the HEI’s in how these skills were developed (Table 3). GCU and UH used a mentorship and clinical competency framework, QUB utilised mentorship and Objective Structured Clinical Examination (OSCE), where Doppler and bandaging skills were assessed. CU did not assess skills.

Bridging the practice-theory gap is frequently identified as a problem in nurse education. Strategies have been developed to reduce the theory to practice divide to consolidate the
student learning experience. Students can be supported in their clinical area so that the theory they learn in the classroom is reinforced through direct application to practice. Mentorship is one such strategy. Quinn (2000 p 427) describes the mentor as

“a qualified and experienced member of the practice placement staff who enters into a formal arrangement to provide educational and personal support to a student…the support may involve teaching, supervising, guidance, counselling, assessment and evaluation.”

The OSCE was originally developed in Dundee in the mid seventies in an effort to make exams more valid, reliable and practical (Harden & Gleeson 1979). The researchers created this test to assess clinical competencies of trainee doctors. The trainee rotated through a number of ‘stations’ where they were assessed individually using precise sets of criteria in the form of a checklist. OSCE has been widely used in medical education since it was developed. Research has shown it to be an effective evaluation tool to assess practical skills for medical practitioners (Sloan et al, 1995). The assessment method is less widely used in nurse education. Khattab & Rawlings (2001) used this technique both formatively and summatively to assess clinical competence of nurse practitioners. The researchers identified some drawbacks such as the cost of running and OSCE being higher than administering a traditional examination but argued that the costs are outweighed by the clinical benefit. OSCE may well be a useful method of evaluating nurses skills in vascular assessment and bandage application.

Clinical competencies frameworks are frequently used as a means of assessing the development of skills, attitudes and knowledge (Swider et al, 2006). Over recent years, several definitions of competencies have been described. Molloy (2006) suggests confusion in the variety of definitions have contributed to the current difficulties in defining competency and indeed fitness for practice. Inevitably, the competencies developed by different HEI’s will vary in content. Standardisation may be enhanced by recent work carried out by Skills for Health. The Sector Skills Council for the health service (www.skillsforhealth.org.uk) is undertaking the development of National Workforce Competencies for use within the health sector across the UK. In developing their competencies they work with clinical experts and educationalists. Currently they have several competency frameworks developed and under development. To date, however, there is no competency framework for management of patients with leg ulceration. When this framework becomes available, adoption both within healthcare and education would ensure consistency in assessment and development of clinician’s skills, knowledge and attitude.

**Alignment to the NHS KSF**

The KSF was introduced as part of the Agenda for Change reforms to link pay and career progression to competencies (Gould et al, 2007). The KSF is an outcome-focused competency framework that has been has been developed to support the Agenda for Change (Department of Health, 2003b.) pay restructuring within the NHS. In all there are six core dimensions and a further 24 specific dimensions. Although adoption has been slow and problematic (Gould et al, 2007), the project is now well underway within the NHS.

HEIs who provide education for health care workers constantly strive to meet service needs. Alignment of HEI courses to the KSF may be beneficial to the employer in assisting their decision making in choosing relevant courses for their staff and for the individual practitioner who aims to progress their career.

The skills based approach to the KSF requires assessment other than those traditionally used on academic courses such as examination, essay, practice portfolio and reflective journals (Jasper,

<table>
<thead>
<tr>
<th>Theoretical elements common to all courses</th>
<th>Additional theoretical components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetiology</td>
<td>Diabetic foot (GCU) (UH)</td>
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<tr>
<td>Epidemiology</td>
<td>Psycosocial issues (CU)</td>
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<td>Physiology</td>
<td>Pain (GCU)</td>
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<td>Surgical aspects</td>
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<tr>
<td>Dermatological aspects</td>
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<tr>
<td>Evidence based practice</td>
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<tr>
<td>Vascular assessment</td>
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<tr>
<td>Wound assessment</td>
<td></td>
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<tr>
<td>Theory of vascular assessment</td>
<td></td>
</tr>
<tr>
<td>Theory of bandaging</td>
<td></td>
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</tbody>
</table>

*Table 2: Course components*
Methods such as OSCE and competency frameworks with effective assessment should show that the individual is able with practice to perform new skills (Gould et al, 2007). Of the courses reviewed here the assessment methods utilised by GCU, UH and QUB are most closely aligned to the KSF. A further process where the courses are mapped against KSF dimensions and levels to give more detailed information to prospective candidates and employers has been completed by UH and is underway at GCU (table 1).

### Conclusion

It is encouraging to note the modules reviewed here are comparable in many ways. The theoretical components vary only slightly. Mode of delivery differs, but this can be seen as beneficial as it offers students the opportunity to have face-to-face classroom teaching or if this is problematic or for those who prefer it, online education. Evidence-based practice/nursing plays a central role in the content of all courses. Bridging the theory to practice gap has been considered by the programme developers for each course. GCU, UH follow a mentorship and competency framework while QUB utilised mentorship and OSCE. All should help to develop new skills during the module. CU has less of a skill-based component and may be more suitable for students who do not care for leg ulcer patients in their general caseload but who wish to have an in-depth understanding of the theoretical aspects of leg ulceration, or alternatively for clinicians who care for leg ulcer patients and are already skilled in vascular assessment and application of compression systems. Collaboration between all HEIs delivering leg ulcer modules to develop standardise course materials and skills development in line with the national agenda may be of value to inform future curriculum development.

### Developing practical skills

<table>
<thead>
<tr>
<th>HEI</th>
<th>GCU, UH</th>
<th>GCU, UH, QUB</th>
<th>QUB</th>
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</thead>
<tbody>
<tr>
<td>Clinical competence framework</td>
<td>GCU, UH</td>
<td>GCU, UH, QUB</td>
<td>QUB</td>
</tr>
<tr>
<td>Mentorship</td>
<td>GCU, UH</td>
<td>GCU, UH, QUB</td>
<td>QUB</td>
</tr>
<tr>
<td>OSCE</td>
<td>GCU, UH</td>
<td>GCU, UH, QUB</td>
<td>QUB</td>
</tr>
</tbody>
</table>

**Table 3**


Hagel P Shaw RN (2006) Students’ perceptions of study modes. Distance Learning 27(3).283-302


Molloy (2006) www.rlhleagueofnurses.org.uk/Education/Progress_ Index/Progress_14/Definin. [accessed14.05.2007]


www.skillsforhealth.org.uk
Ask LUF

Q What stance does the Leg Ulcer Forum take on healthcare assistants applying compression bandages?

A The Leg Ulcer Forum consensus statement is ‘The Executive Committee agreed that Health Care Assistants do have a role in the care of patients with leg ulcers. However they would not support the assertion that Health Care Assistants have a role in the application of compression bandages.’ This statement has been made on the basis that a venous leg ulcer can be considered a complex wound (Leg Ulcer Forum Journal, 2004).

Q How frequently should registered staff have a leg ulcer update?

A There are no current national standards to answer this question definitively. The Nursing and Midwifery Council’s code of conduct states it is the responsibility of each registered nurse to maintain knowledge and competence in their area of practice. In some Trusts there is a rolling programme of updates but this is variable across the UK.

Q I have a patient who wishes to shave her legs. She has varicose eczema and wears hosiery. I have advised her not to use a razor as she has cut herself in the past. I am also reluctant to recommend depilatory creams or waxing in case this causes skin sensitivities or trauma. Do you have any advice?

A Your patient could try a depilatory cream for sensitive skin, but if the leg hair is dark this may not be effective. An alternative would be to use a electric shaver having washed the legs carefully with an antimicrobial shower or bath emollient to reduce the risk of infection from shaving.

Q Can we ask our healthcare assistants to do Doppler Assessments?

A Doppler assessment involving calculation of the ABPI is an important component of the assessment process and helps determine ulcer aetiology and clinical decision making. It is more than just recording the ABPI; it gives information on the presence or absence of pedal pulses and the nature of the pedal signals in terms of pattern and pitch. As the practitioner becomes more experienced with the procedure, it may then become possible to distinguish between the quality of the sounds as well as the waveforms. For example, the audible pitch or sound omitted from the Doppler can be indicative of the velocity of the blood flow within a vessel. Waveforms / signals can be interpreted both audibly and diagrammatically. The RCN (2006) guidelines also clearly state that assessment and ‘clinical investigations should be undertaken by a health care professional trained in leg ulcer management’.

Q Should practitioners have received training before undertaking leg ulcer management? If so does this have to be a university accredited course or can it be in-house?

A It is vital that practitioners who manage people with leg ulcers and related conditions are competent in assessment and clinical management. The RCN Guidelines (2006) stipulate training should be in place but there are no recommendations for the format of the training. As you can see in the article by Janice Bianchi (page 36) there are a variety of educational formats available. In short, the Leg Ulcer Forum recommends that education and training should encompass theoretical and practical skills and those delivering this education should be sufficiently educated and experienced, ideally holding an educational qualification themselves. There should be a competency assessment to ensure the practitioner has the necessary theoretical, practical and interpersonal skills to deliver safe and effective patient care, and the assessor be adequately prepared, qualified and supported to conduct that assessment.

Any questions submitted to the journal are answered by the members of the executive committee unless stated otherwise.
Courses
• CRICP at TVU
• Macmillan Lymphoedema Academy
• University of Hertfordshire

CRICP at TVU
The following courses are run by the Centre for Research and Implementation of Clinical Practice (CRICP) at Thames Valley University, at both Level 5 and Level 6.

CPPD in the Prevention and Management of Leg Ulceration
Dates: to be arranged

CPPD in the Prevention and Management of Pressure Ulceration:
Study Days: Feb 21, 28, Mar 6, 13, Apr 3, 10, 17, 2008 at Paragon House, Boston Manor Road, Brentford, Middx.

Distance Learning – at Level 6 all the above can be undertaken by distance learning as well as in the taught mode. They can also be undertaken as part of the degree pathway leading to a BSc(Hons) Professional Practice with Tissue Viability.

CPPD in the Management of Care of People with Lymphoedema
Dates: to be arranged

CPPD in Advances in Lymphoedema Management – Manual Lymphatic Drainage
Dates: to be arranged

BSc(Hons) Professional Practice – with Lymphoedema
For further information and an application form please telephone 020 8209 4020

Macmillan Lymphoedema Academy
Casley-Smith Specialist Education Programme 2008

Courses for practitioners wishing to train in the Casley-Smith method of Manual Lymphatic Drainage/Multi-layer Lymphoedema Bandaging. Fees vary. N.B. Lymphoedema Keyworker courses available at all venues.

<table>
<thead>
<tr>
<th>Start Dates</th>
<th>Venue</th>
<th>Course type</th>
<th>Facilitators</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 Feb 08</td>
<td>Glasgow</td>
<td>Accredited courses (10-days in 3 parts)</td>
<td>Margaret Sneddon</td>
<td><a href="mailto:K.Hegi@clinmed.gla.ac.uk">K.Hegi@clinmed.gla.ac.uk</a> 0141 330 2071</td>
</tr>
<tr>
<td>Apr 08</td>
<td>Sedgefield</td>
<td>Accredited courses (10-days in 3 parts)</td>
<td>Jeanne Everett</td>
<td><a href="mailto:jeanne.everett@btopenworld.com">jeanne.everett@btopenworld.com</a> 01740 626649</td>
</tr>
<tr>
<td>Jun 08</td>
<td>Swansea</td>
<td>Non -accredited</td>
<td>Mel Lewis / Cath Groom</td>
<td><a href="mailto:Beverley.morgan@swansea-tr.wales.nhs.uk">Beverley.morgan@swansea-tr.wales.nhs.uk</a> 01792 285252</td>
</tr>
</tbody>
</table>

For Casley-Smith Practitioners: 3-day course to develop your skills in difficult clinical cases)
Fee £275 (Possible discounts available locally/ Macmillan funding for postholders)

<table>
<thead>
<tr>
<th>Start Dates</th>
<th>Venue</th>
<th>Facilitators</th>
<th>Contact</th>
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<tr>
<td>6-8 Feb 08</td>
<td>Belfast</td>
<td>Lynne Whiteside</td>
<td><a href="mailto:Lynne.whiteside@uh.n-i.nhs.uk">Lynne.whiteside@uh.n-i.nhs.uk</a></td>
</tr>
<tr>
<td>Feb/Mar 08</td>
<td>Sedgefield</td>
<td>Jeanne Everett</td>
<td><a href="mailto:jeanne.everett@btopenworld.com">jeanne.everett@btopenworld.com</a> 01740 626649</td>
</tr>
<tr>
<td>5-7 Mar 08</td>
<td>Cirencester</td>
<td>Anita Hopkins / Sue Desborough</td>
<td><a href="mailto:anita.hopkins@glos.nhs.uk">anita.hopkins@glos.nhs.uk</a></td>
</tr>
<tr>
<td>29 Apr-1 May 08</td>
<td>Swansea</td>
<td>Cath Groom / Mel Lewis</td>
<td><a href="mailto:Beverley.morgan@swansea-tr.wales.nhs.uk">Beverley.morgan@swansea-tr.wales.nhs.uk</a> 01792 285252</td>
</tr>
<tr>
<td>3-5 Jun 08</td>
<td>Glasgow</td>
<td>Margaret Sneddon</td>
<td><a href="mailto:K.Hegi@clinmed.gla.ac.uk">K.Hegi@clinmed.gla.ac.uk</a> 0141 3302071</td>
</tr>
<tr>
<td>9-11 Jul 08</td>
<td>Cirencester</td>
<td>Anita Hopkins / Sue Desborough</td>
<td><a href="mailto:anita.hopkins@glos.nhs.uk">anita.hopkins@glos.nhs.uk</a></td>
</tr>
<tr>
<td>10-12 Oct 08</td>
<td>Leeds</td>
<td>J Todd / J Banks</td>
<td><a href="mailto:cottamj@leedsth.nhs.uk">cottamj@leedsth.nhs.uk</a> 0113 3921807</td>
</tr>
</tbody>
</table>
## University of Hertfordshire

**Faculty of Health and Human Sciences**  
**School of Nursing and Midwifery**

**BSc (Hons) Tissue Viability**  
Courses are delivered by tissue viability key opinion leaders, and offer opportunity for:

- Full or part time study and flexible modes of study in a modular format
- Stand alone courses for continuing professional development

The University of Hertfordshire is easily accessible by road, rail and airport. The campus is situated at Hatfield in Hertfordshire on the A1(M) and is in close proximity to the M1 and M25. For further information see Travel Information and Map sections at www.herts.ac.uk.

Students studying on these programmes can expect a high level of tutorial support and can take advantage of state-of-the-art study facilities with 24 hour and remote access. Students attend one day a week or in block depending on the module selected.

### Course Descriptions

<table>
<thead>
<tr>
<th>Course</th>
<th>Description</th>
<th>Level and Credits</th>
<th>Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexities in Leg Ulcer Management</td>
<td>For experienced leg ulcer practitioners: encompassing advanced assessment and strategic planning for leg ulcer service delivery.</td>
<td>L3 or M 30 credits</td>
<td>A (block format)</td>
</tr>
<tr>
<td>Leg Ulcer Theory and Practice</td>
<td>Aetiology, epidemiology, assessment and management of leg ulceration. Competency based training for Doppler and bandaging skills</td>
<td>L2/3 15 credits</td>
<td>A or B</td>
</tr>
<tr>
<td>Wound Assessment</td>
<td>Explores key concepts of wound assessment including tools, measurement, pressure ulcer risk assessment etc.</td>
<td>L2/3 15 credits</td>
<td>A or B (distance learning option in B)</td>
</tr>
<tr>
<td>Wound Management</td>
<td>Contemporary practice with exploration of; wound cleansing, debridement, skin care, dressing selection, infection, and pressure ulcer equipment selection, decision making .</td>
<td>L2/3 15 credits</td>
<td>A or B (distance learning option in B)</td>
</tr>
<tr>
<td>Problem Wound Management</td>
<td>Aetiology, assessment and management of non healing wounds. Factors that prolong healing</td>
<td>L2/3</td>
<td>A</td>
</tr>
<tr>
<td>Tissue Viability Modalities</td>
<td>Reviews advanced tissue viability treatment modalities and wound assessment techniques to raise the students’ awareness of contemporary developments in wound management and to explore how these may impact on tissue viability services in the future.</td>
<td>L3 30 credits</td>
<td>B (block format)</td>
</tr>
<tr>
<td>Psychological Impact of Wounds</td>
<td>To assist practitioners working in tissue viability to appreciate the psychosocial impact of wounding and to explore the concept of therapeutic relationships as a method of providing support.</td>
<td>L3/M 15 credits</td>
<td>B (block format)</td>
</tr>
</tbody>
</table>

### Applications

For an application pack please contact:

Carol Taylor, Admissions Officer, University of Hertfordshire, School of Nursing and Midwifery, College Lane, Hatfield, Hertfordshire AL10 9AB, 01707 284956  c.r.taylor@herts.ac.uk

### Further information

For further information please contact:

Irene Anderson  
01707 285233  i.l.anderson@herts.ac.uk

Jacqui Fletcher  
01707 285266  j.fletcher@herts.ac.uk

Julie Vuolo  
01707 284417  j.c.vuolo@herts.ac.uk

### Post Qualifying Courses

http://perseus.herts.ac.uk/courses/nursing-and-midwifery/bsc-&-bsc-hons-tissue-viability.cfm
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 or CD-Rom, saved in ‘Text Only’ format. Please send any charts, diagrams and photos as separate files. Clearly state on the 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 editors.

*Articles should be sent to:*

Susan Knight (Editor)
The Leg Ulcer Forum
PO Box 337
Huntingdon PE28 2WH

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*Care studies are an invaluable source to practitioners, particularly when complex situations have successfully been addressed*
Supporting the professionals

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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web: www.legulcerforum.org