

# “A Beacon for NHS Services” Wound Care: Issues of Everyday Practice

Review of the 11th annual Leg Club® conference,  
Worcester, 28th and 29th September 2011

The Leg Club® model was conceived as a unique partnership between the district nursing team and the local community, in which patients are empowered, through a sense of ownership, to become stakeholders in their own treatment. Leg Clubs aim to provide leg ulcer management in a social environment, where patients (members) are treated collectively and the emphasis is on social interaction, participation, empathy and peer support where positive health beliefs are promoted. The model impacts positively on healing and recurrence rates and helps isolated older people reintegrate into their communities. The annual Lindsay Leg Club conference is a unique opportunity for Leg Club volunteers and healthcare professionals to come together to share the latest clinical insights and practical issues in wound management.



This year, several international speakers presented to delegates on a wide variety of topics ranging from the clinical signs of vasculitis and skin cancer, through to the changes in the NHS and how these will affect the way patient care is delivered in the future.

Professor Michael Clark, Chief Executive of the Lindsay Leg Club Foundation and Chairman for the day, opened the sessions. Mike highlighted the recent patient satisfaction survey undertaken by the Leg Club. The results of the survey were highly promising:

## **Members commented that:**

‘Leg Clubs provide a nice environment in which to socialize with others’

‘Leg Clubs are a beacon for NHS services’

‘Leg Clubs provide treatment not available in the local surgery’

‘How do others cope without Leg Clubs?’

Such feedback shows how valuable the Leg Clubs are to their members, and what a great job the clinicians providing the care are doing.

We all know the difficulties encountered when managing patients with leg ulcers. In his welcome address, Dr Tim Cutler, patron of the Lindsay Leg Club Foundation, reminded us that often the underlying pathophysiology can make leg ulceration complex to manage, and clinicians should remember to look at the patient as a whole, not just the wound. There are many clues to the cause of ulceration, as well as clues to underlying pathology or comorbidities that can be picked up by examining the whole patient. An array of speakers throughout the day provided considerable guidance on these issues.

*References for these talks are available upon request*

Read on:

## I. CUTANEOUS VASCULITIS: A REAL CHALLENGE IN WOUND HEALING

Marco Romanelli, Professor, Department of Dermatology, University of Pisa

Cutaneous vasculitis refers to a group of disorders characterized by inflammation of the blood vessels. Its aetiology is unknown but certain types of malignancies are known to result in the disorder, including Hodgkin's and non-Hodgkin's lymphoma and carcinoma.

The most common types of vasculitis are:

- Leucocytoclastic vasculitis — caused by numerous factors including idiopathic disease; infection, e.g. HIV, Streptococcus, hepatitis; drugs such as non-steroidal anti-inflammatory drugs and over the counter products and malignancy.
- Henoch-Schönlein purpura — occurs most commonly on the lower limbs of children, following upper respiratory tract infection.
- Urticarial vasculitis — distinguished from urticaria by plaques on the trunk and proximal extremities that persist for over 24 hours. The lesions result in a burning sensation and are not pruritic in nature. Autoimmune diseases such as systemic lupus erythematosus and systemic sclerosis should be considered as an underlying cause of lesions in this patient group.
- Polyarteritis nodosa — a necrotic vasculitis that affects medium-sized vessels. The lesions are painful and deteriorate into ulcers with a distinctive 'punched-out' appearance. The development of lesions is accompanied by severe symptoms of fever, weight loss, and muscle and joint pain.

The different criteria used to classify vasculitis:

Vessel size (most commonly used)

Disease severity (systemic versus cutaneous)

Immunopathological cell involvement

Clinical classification of dermatological lesions

Primary (idiopathic disease) versus secondary disease

### Diagnosis and management

The key to the successful management of vasculitis is to get the diagnosis correct by carrying out a thorough assessment of the patient and wound and by ordering further investigations as appropriate, or referring to a dermatologist or rheumatologist, so that underlying illness can be identified and treated.

Laboratory investigations are crucial to support diagnosis when vasculitis is suspected. They usually focus upon identifying the presence of inflammatory mediators in the blood.

### Treatment

Treatment may include systemic treatment with anti-inflammatories, anti-platelets, systemic corticosteroids and/or immunosuppressants. Bed rest and bandaging should also be used locally to heal purpura effectively.

For most of us it is not necessary to know the intricacies of vasculitis, but an awareness of cutaneous presentation and the need for prompt referral if vasculitis is suspected, is essential.

## 2. WHAT IS A SIMPLE WOUND?

Andrew May, Consultant Vascular Surgeon and Past Chairman of the Circulation Foundation, Colchester General Hospital

So, why do some wounds heal simply while others do not? Here are some factors that influence healing outcome:

- Patient history
- Wound type
- Wound site and depth
- The presence of devitalized tissue
- The condition of the wound base

Intrinsic factors such as age and comorbidity, for example circulatory disease, rheumatoid arthritis, liver disease and neuropathy can all adversely affect wound healing. Extrinsic factors such as medication and smoking may also contribute to delayed closure.

Wound type and general health of the host are important predictors of wound healing, with wound closure technique also influencing outcome. **Remember that good wound bed preparation using debridement and wound cleansing can be more important than dressing choice.**

### Good wound care in India

The Christian Medical College Hospital (CMCH) in Vellore, South India, is a good example. It has been associated with Colchester General Hospital since 1989, when its first trainees were sent over to work. Since then, nine have been to the UK. CMCH hospital is large, with approximately 5,000 outpatients per day and at any time approximately 30,000 people on the hospital campus, which is in the centre of Vellore. The hospital has 1,800 nurses, 800 doctors and nine administrators, and so could teach the NHS a thing or two! It also always comes within the top 10 of any leagues of Indian hospitals. The hospital is not free; **everyone is billed according to their income, so the rich subsidize the poor.**

The hospital is a mix of third- and first-world facilities; it has cutting edge technology for neurosurgery and cardiac surgery, is renowned for transplantation throughout India, and also has one of the best stem-cell research centres in Asia. Yet on the wards, there are drum sterilisers, reusable needles, glass syringes and old metal beds.

The hospital has two types of dressing: 'lots of money dressings' as available in the UK, e.g. hydrogels, hydrocolloids, or 'little money' dressings such as gauze and saline. The hospital in Vellore uses very simple dressing packs for poor patients, but these still achieve good outcomes when used in combination with good medical and nursing care.

## 3. SKIN CANCERS: RISK FACTORS AND DIAGNOSIS

*Tim Cutler, Senior Consultant Dermatologist, The Nuffield Hospital, Ipswich*

Non-melanoma skin cancer (NMSC) is primarily caused by exposure to UV radiation and other environmental factors such as chemicals and X-rays. Other factors such as scarring can lead to NMSC, as can inherited genodermatoses including Gorlin syndrome and Xeroderma Pigmentosa. Long-term immunosuppressant therapy is also linked to NMSC development.

The main risk factor for development of malignant melanoma (MM) is also ultraviolet light, with genetics such as fair skin, freckles and multiple moles also increasing risk.

### Precursors

There are usually warning signs that cancer is a step away. Precursors of NMSC include arsenical keratosis, which can be identified by the presence of lesions in places where they don't usually appear; e.g. on the palms of the hands, and Bowen's disease which commonly presents as crusty plaques on the lower legs especially in females.

The precursors for MM include lentigo maligna, dysplastic naevus and congenital naevus. Lentigo maligna presents as irregular freckles that are macular; flat lesions with irregular/speckled pigmentation. Atypical naevus are irregular-shaped moles consisting of different colours. They do not necessarily become cancerous, but may be a marker of increased risk. Congenital naevus also has a small increased risk of malignancy.

### Types of non-melanoma skin cancer

There are several different types of NMSC including basal cell carcinoma (rodent ulcer), squamous cell carcinoma (SCC), keratoacanthoma and verrucous carcinoma. Basal cell carcinoma has lots of different stages and presentations; it can be nodular, ulcerative, invasive, superficial or morpheic. Common basal cell carcinomas generally present as pearly-rimmed lumps containing tiny thread veins or telangiectasia. They often appear on the legs as ulcers that will not heal. A delay in making a prompt referral may result in the cancer spreading, so NMSC should be considered as a differential diagnosis in patients with leg ulceration. Keratoacanthoma presents as a volcano-like growth with a central core. It is quick growing but is not as aggressive as SCC, so does not require the same aggressive treatment. Verrucous carcinoma can be mistaken for corns; it is a relatively uncommon, but aggressive cancer.

### Malignant melanoma

The ABCDE tool can be used to help identify malignant melanoma.

The ABCDE tool.

- A: A symmetry (the lesion should be uniform)
- B: Order, irregularity (the lesion should have smooth rounded edges)
- C: Colour, irregularity (no more than two shades)
- D: Diameter over 1cm (take note)
- E: Evolution (melanoma is moving, changing, growing).

There are different types of malignant melanoma but type does not influence treatment.

To summarize, malignancy must be kept in mind when seeing ulcers that will not respond to care or that are behaving unusually.

## 4. THERAPEUTIC CHALLENGES OF THE DIABETIC FOOT WOUND

*Alastair McInnes, Senior Lecturer in Podiatry, University of Brighton*

**Diabetes is a world-wide pandemic:**

- There are an estimated 285 million adults in the world with diabetes. This figure is expected to increase to 439 million in 2030.
- Currently, 100 people every week lose a toe, foot or lower limb as a result of the condition. In this group, more than one in 10 foot ulcers result in amputation of a foot or a leg.

**Prevention and early intervention is essential:**

- Good glucose control is crucial since if it is well maintained, it may help to prevent the occurrence of many of the complications that arise from uncontrolled levels.
- An aggressive cardiovascular risk policy in patients with diabetic foot ulcers using statins, anti-platelet drugs, and (angiotensin-converting enzyme (ACE)) ACE inhibitors has led to a reduction over a three-year period of the five-year mortality rate from 58% to 36% in neuroischaemic patients, and 36% to 19% in neuropathic patients.

Diabetic foot ulcers are a source of major morbidity and mortality. Only 50% of ulcers are healed by six months, and of these, 40% recur in 12 months. 11% of patients have amputations (50% major) and 16.7% patients die within 12 months.

**The diabetic foot wound is much more likely to become a chronic wound than any other wound type due to the altered wound biology that occurs.**

There is no robust evidence to justify the choice of any specific dressing for the diabetic foot, but that lack of evidence does not necessarily mean that there is no difference between products. We need to reflect long and hard on the rationale for using more expensive dressings in the absence of any evidence to support their use.

The use of negative pressure wound therapy (NPWT) is not recommended for routine use in patients with diabetic foot ulcers, by the NICE (National Institute for Health and Clinical Excellence) guidelines, but is advocated as a rescue therapy when the only other option is amputation. Many clinicians have found this recommendation disappointing, as it conflicts with anecdotal evidence of the effectiveness of NPWT in clinical practice.

As a rule of thumb, if a patient with a diabetic foot ulcer presents with poor glycaemic control and cellulitis of greater than 2cm<sup>2</sup>, then hospitalization should be considered, or at the very least, systemic antibiotics initiated if circumstances prevent admission. Each hospital should have antibiotic guidelines for the management of diabetic foot infections.

## 5. IT'S ALL IN THE MIX: BRINGING THE RIGHT INGREDIENTS TOGETHER

*Peter Vowden, Professor and Consultant Vascular Surgeon, Bradford Teaching Hospitals NHS Foundation Trust*

Hard-to-heal ulcers are essentially wounds that do not respond to treatment in a timely manner. Recurring ulceration has a huge implication on patients' lives. Chronic illness, pain, sleep deprivation, reduced quality of life, depression and wound odour are all issues with which patients with chronic wounds have to deal. This will be further disrupted by the need to meet clinic appointments.

For the healthcare provider, the longer the ulcer is present, the more resources are needed in terms of nursing time and dressing usage. Costs increase dramatically if delayed healing is not addressed.

**Clinicians working in wound care are provided with an array of guidelines on how they should practice, which provides a real challenge in terms of coordinating all the knowledge to benefit the patient. Here are some thoughts on how to bring it all together:**

- Multidisciplinary working is crucial; no individual can manage the patient individually, nor can wounds be treated in isolation; a link needs to be made between the wound and the background aetiology and both factors need management.
- Patients should be carefully examined to see which elements of the service should be utilized to make sure their treatment is successful. This may mean disrupting the cycle of care to enable the patient to undergo referral to the most appropriate member of the multidisciplinary team.

## Competency

- We all know how things can go wrong. Referrals can be made after two years of failed treatment, instead of six weeks as recommended in the NICE guidelines. **Delaying referral can make it difficult to reverse any damage done and can also result in the patient losing faith in the clinician.**

This is why staff competency is so important. If healthcare assistants are to treat wounds they need to be competent and aware of signs and symptoms of improvement and/or deterioration.

Treatments need to be available at times to suit the patient, to enable them to fit it in around their career and family life. It is important for clinicians to reflect upon for whom their service is organized. As far as possible it should be for the patient, not the clinician.

## 6. LEG CLUBS THE AUSTRALIAN WAY

**Debbie Blanchfield**, *Clinical Nurse Consultant Wound Care, Illawarra Health Service, New South Wales, Australia*

As a Clinical Nurse Consultant Debbie consults with patients with wound problems, and spends time speaking on the telephone, communicating via email or visiting patients. She covers nine hospitals and three community health sectors.

Debbie first met Ellie Lindsay, **Founder of the Lindsay Leg Club Foundation**, in 2004 and was inspired by the Leg Club model and the effect that providing care in a social setting had on the patient. She was particularly impressed with how it provides members with an opportunity to share their lived experience of having a leg ulcer.

- In Australia, approximately 70% of all ulcers were venous in origin and cost 400–500 million Australian dollars per year to treat.
- In Debbie's region, community health nurses were seeing approximately 200 clients with leg ulcers per month at a huge cost resource-wise in terms of home visits, product use and nursing time. Despite this evidence, management still refused to allow a Leg Club to be formed!

### The strategic importance of the Leg Club

- Leg Clubs provide early intervention strategies and address chronic care needs
- Leg Clubs focus upon client/carer education, self-care and prevention of future skin breakdowns and ulcers
- Leg Clubs prevent complications and reduce hospitalization
- Leg Clubs provide a valuable teaching resource for nurses and students

A great deal of work was then done to change forms and documentation in order to meet required standards. Health and safety was the next issue; patients had to be treated in a chair that could be easily accessed by elderly frail patients, and that could raise the leg to a work level so that the nurse did not need to bend over, kneel down, or squat while working.

**This final hurdle was overcome by a patient who carried out a fund-raising event in order to obtain a pneumatic chair.**

The Leg Club was finally launched in 2007, as a weekly club providing drop-in, collective leg ulcer care in a non-medical setting. One registered nurse and one clinical nurse consultant were allocated to treat the patients. The Leg Club now has 10–12 members, with an average of one new client per week.

With each new government and management change, the worth of the Leg Club needs to be demonstrated — a situation with which many of us are surely familiar!

## 7. PATIENTS DO DRESS THEMSELVES

**Jacqui Fletcher**, *Senior Professional Tutor, Department of Wound Healing, Cardiff University School of Medicine*

Patients increasingly want to manage their own dressings, and for a variety of reasons.

The current government agenda is actively encouraging patients to participate in their care choices ('no decision about me, without me'.) They are also becoming increasingly aware of the inadequacies of NHS care as a result of negative press coverage.

Recent interviews conducted with patients attending the complex wound clinic in Cardiff have shown that the majority of patients desire to perform their own dressing changes. At Cardiff, approximately one-third currently do just that. The reasons for this are varied but include convenience ('why wait around for appointments?'), and consistency ('to ensure it is done properly') or care ('I take more care than the clinician' and 'at least I wash my hands'). All of these are a real indictment of service provision in a variety of locations and care settings and a real cause for concern.

**When asked how best to inform the patient on how best to prepare them to carry out their own dressing changes, patients said they wanted to know:**

- How to apply and remove the dressings
- When to replace them
- What to expect when the dressing is in place, for example, will they experience pain or a drawing sensation?
- How to identify if there is a problem, for example, infection
- How to contact a healthcare professional if needed, for example, if a different product is required.

This led the complex wound clinic at Cardiff to consider obtaining a supply of non-sterile dressings for patients to handle and play with, and for the healthcare professional to demonstrate different aspects of the products. The clinic is also considering the use of wound models so the patients can be shown how to pack wounds, protect the surrounding skin, and apply and remove the dressing, etc.

Patients also requested paper-based materials that were easy to read and understand, with photographs of wounds similar to theirs that were free of jargon. They felt that many existing patient information leaflets were generic and did not apply to them, their wounds or their dressings.

In summary, **patients want specifics on their wound and dressing, some generic information and contact with other patients going through a similar experience.** Patients do dress themselves.

## 8. LEG ULCER CARE: ISSUES IN EVERYDAY PRACTICE

**Professor Jackie Stephen-Haynes**, *Consultant Nurse and Senior Lecturer, Worcester PCT and University of Worcester*

Patients have identified several issues relating to lower leg health which will influence how their care is delivered in the future in the UK. **It is important not to think of leg problems just as ulceration when considering lower leg health, but the whole range of lower limb conditions** including venous hypertension, oedema, lymphovenous disease and lymphoedema.

There are many studies that have been published which demonstrate the impact of living with a lower leg wound. Leg ulcers have a significant impact on individual lives, but the degree to which this occurs varies from patient to patient. Most studies highlight pain as the most significant experience, along with limited mobility, reduced activity and poor body image. Frustration at the situation, disruption to work and the need to make life changes all impact negatively upon the patient. A sense of powerlessness was associated with slow healing and high recurrence rates of venous leg ulceration. Pain has also been reported as a major factor influencing compliance with compression therapy.

The significance of the patient-professional relationship was also highlighted by Douglas (2001) as a factor that influences the wellbeing of patients with leg ulcers. He interviewed eight patients with venous leg ulceration about their experiences. It emerged that a positive relationship with the healthcare professional has a positive impact on the patient.

All of this evidence presents a challenge for clinicians when thinking about healthcare delivery for patients with leg ulcers.

**Economic evaluations have demonstrated that the Leg Club model is a cost-effective model for health service providers that**

**makes a difference to patients and outcomes.** The social and caring elements of the Leg Club model make people feel better and their health improves as a result.

Therefore, clinicians should continually evaluate their service provision. Where is the venue for care delivery? Is it appropriate? What are the knowledge and skills of the patient and the professional delivering care? Where is the evidence that influences what we do and how quickly do we react to it?

A multiprofessional team approach is needed in the care of people with lower limb problems, with skilled and competent practitioners setting clear objectives and outcomes for treatment that the patient has agreed to and is happy to work towards.

In patients who are non-concordant, we may need to seek alternative solutions, or just ensure that compression therapy is applied correctly following assessment and that the patient is educated about the aetiology of their ulcer and how compression helps to treat it.

## 9. CHANGES TO THE NHS; CURRENT THINKING FOR COMMUNITY STAFF

**Richard Shorney**, *Trustee, Lindsay Leg Club Foundation, and Director, Real Healthcare Solutions*

Chronic wound care costs in the UK in 2005/6 totalled £2.3–3.1 billion, which equates to approximately 3% of total healthcare spending. Of these wounds, venous leg ulcers had an annual expenditure of 168–198 million, compared with foot ulcers (300 million) and pressure ulcers (1760–2640 million).

We need to address these issues in an evolving NHS landscape where the only constant is change. Although unsettling, change happens for a reason, and it is important that it is embraced rather than resisted. There are lots of elements to the change which need to be understood by clinicians working in wound care. The value of services must be demonstrated in this new environment, and clinicians need to adopt a business-like approach.

The key metrics of quality in the NHS are patient safety, patient experience and effectiveness of care. Most clinicians keep their patients safe and consider their patients' experience and the effectiveness of care as a routine part of practice, but changes mean that this now has to be demonstrable. If quality of service provision cannot be proven, there will be no stakeholder funding which in turn will lead to a loss of jobs. Conversely, if a good quality service can be demonstrated, funding may be increased and an improved service provided as a result.

A Leg Club member satisfaction questionnaire was distributed to the members of six leg clubs in Scotland, England and Wales to establish their opinions of the care provided. Preliminary results from 111 members were:

- 64.3% of members felt able to cope with life better or much better
- 71.9% felt better placed to understand their leg problem
- 75.9% felt better able to cope with their leg problem
- 66.3% of respondents felt better able to maintain their health.

Although these are preliminary results, they relate directly to the two NHS quality domains of patient experience and patient safety. In the fullness of time, the findings from the survey will be used to justify service provision.

Dowsett and Shorney recently demonstrated effectiveness in care provision by carrying out an evaluation of pressure ulcer care that demonstrated that for every £1 invested in pressure ulcer care, a return of £51.56 was received. This work and that of the Leg Club provide examples of how to demonstrate quality and worth of wound care service provision.

The Any Qualified Provider stance is taking the lowest common denominator and focusing upon it, which in the case of chronic wound care is venous leg ulceration and wound healing. Venous leg ulceration and wound healing is one of seven service areas of which three have to be implemented by April 2012. Different Public Health Trust commissioning clusters have been allocated to the different service areas, with venous leg ulceration and wound healing being managed on the South East Coast.

In order to be a qualified provider, providers must qualify and register to provide services via an assurance process that tests the provider's fitness to offer NHS-funded services. Commissioners will set local clinical pathways and referral protocols and thresholds that the provider must accept. Referring clinicians must offer patients a choice of qualified providers to choose from, with competition being based on quality, not price. How is quality proved? Patient experience, patient safety and effectiveness of care. A business-like approach to your service provision can help to prove your worth.

'Having had the opportunity to read these summaries, I am convinced that the Lindsay Leg Club conference is the UK's most prestigious annual wound care meeting. Once again we have had the privilege to work with internationally renowned speakers who have been most generous with their time and willing to fulfill unusual roles such as managing our workshops, as well as the superlative support of our Leg Club industry partners. Once again, we have come together in a real spirit of collaboration and sharing of knowledge in wound care. We very much look forward to seeing you in 2012.'

Professor Mike Clark, Chief Executive Officer of the Lindsay Leg Club Foundation

For more information about Lindsay Leg Clubs or the Lindsay Leg Club Foundation, log on to:  
[www.legclub.org](http://www.legclub.org)

## DON'T FORGET

TO PUT NEXT YEAR'S CONFERENCE, ON 'WOUND WISDOM',  
IN THE DIARY — 26TH AND 27TH SEPTEMBER 2012,  
WORCESTER RUGBY CLUB

