WOUND CARE TODAY

IN PARTNERSHIP WITH

All Wales Tissue Viability Nurse Forum
Fforwm Nyrsys Hyfywedd Meinwe Cymru Gyfan

30 NOVEMBER 2023 7.30

SETTING STANDARDS FOR LEG ULCER CARE:

A WELSH PERSPECTIVE

KIRSTY MAHONEY

SENIOR TISSUE VIABILITY NURSE SPECIALIST AND OPERATIONAL PROGRAMME IMPROVEMENT LEAD, WELSH WOUND INNOVATION CENTRE (WWIC), ON BEHALF OF THE AWTVNF

WOUND CARE TODAY

LIVE Q&A

SEND IN YOUR QUESTIONS BY COMMENTING ON THE VIDEO

All Wales Tissue Viability Nurse Forum
Fforwm Nyrsys Hyfywedd Meinwe Cymru Gyfan

THANK YOU

Thanks to industry partners for supporting the production of this document.

www.essity.com

www. lohmann-rauscher.co.uk

www.sigvaris.com

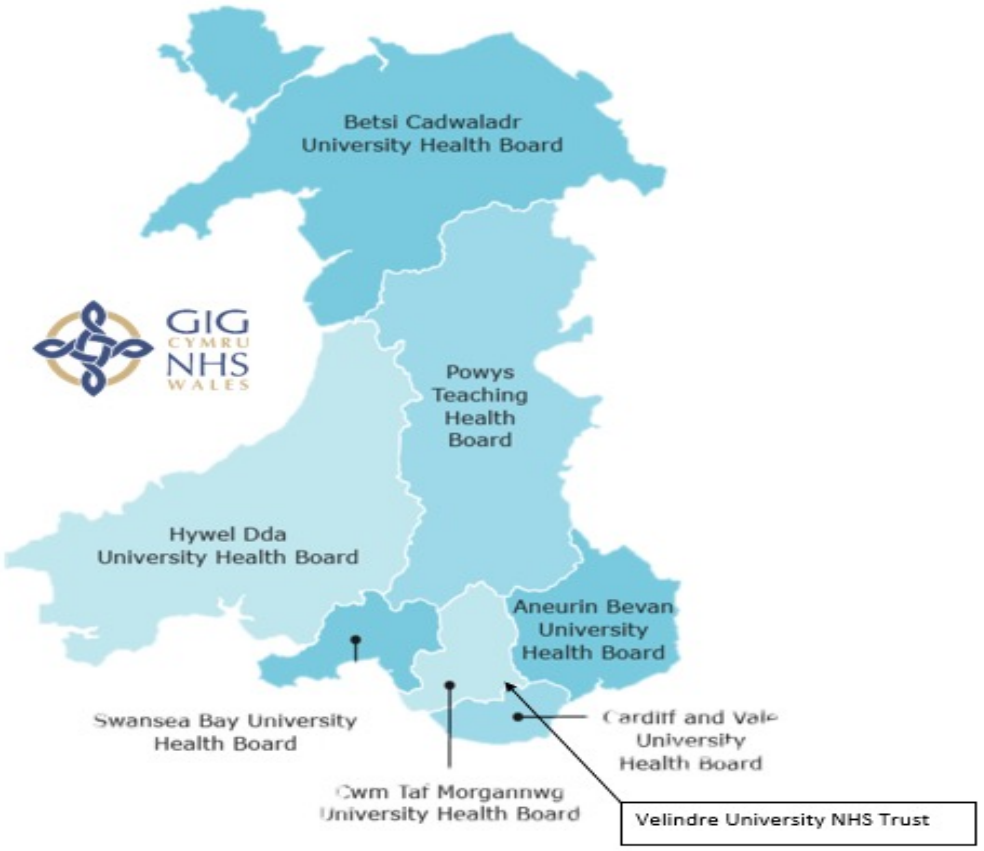
www.hadhealth.com

www.mediuk.co.uk

ALL WALES TISSUE VIABILITY NURSE FORUM
FFORWM NYRSYS HYFYWEDD MEINWE CYMRU GYFAN

Currently 51 members

- Swansea Bay UHB
- Aneurin Bevan UHB
- Betsi Cadwaladr UHB
- Cardiff & Vale UHB
- Cwm Taf Morgannwg UHB
- Hywel Dda UHB
- Powys THB
- Velindre Cancer Centre NHS Trust.



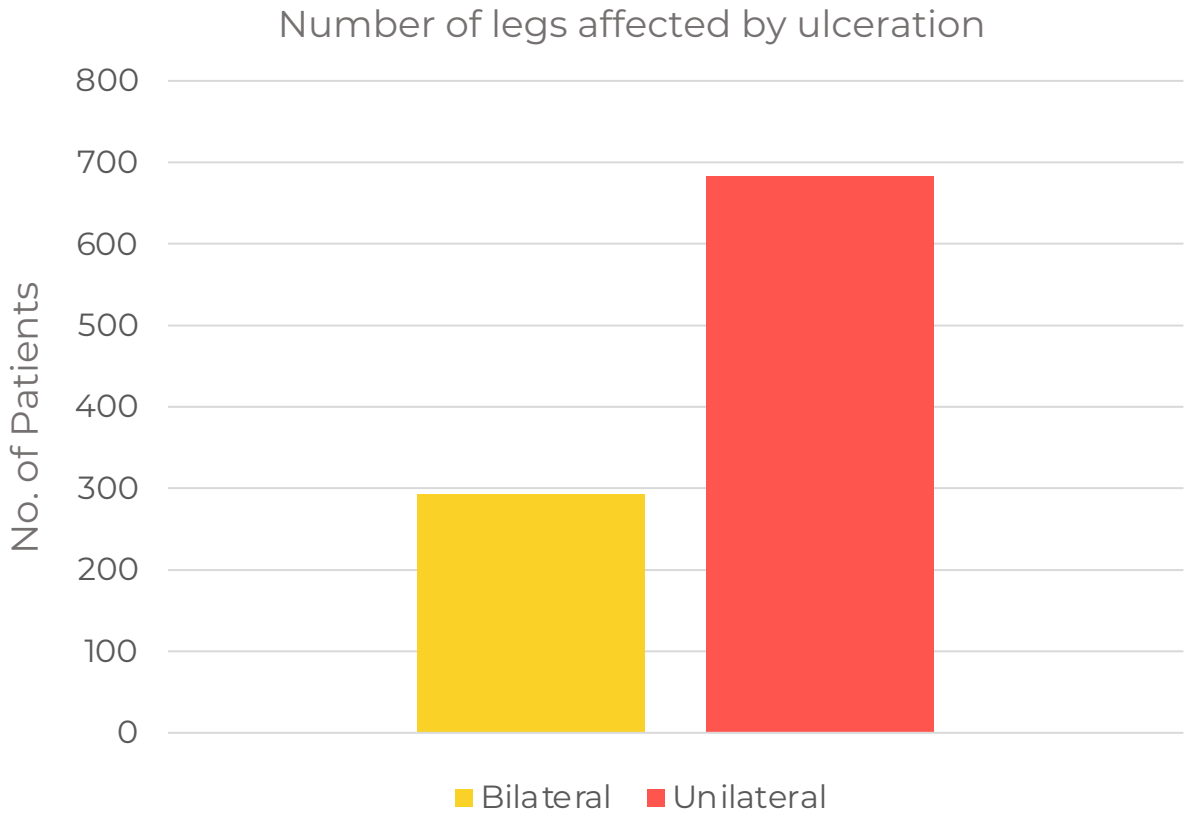
LEG ULCER CARE IN WALES

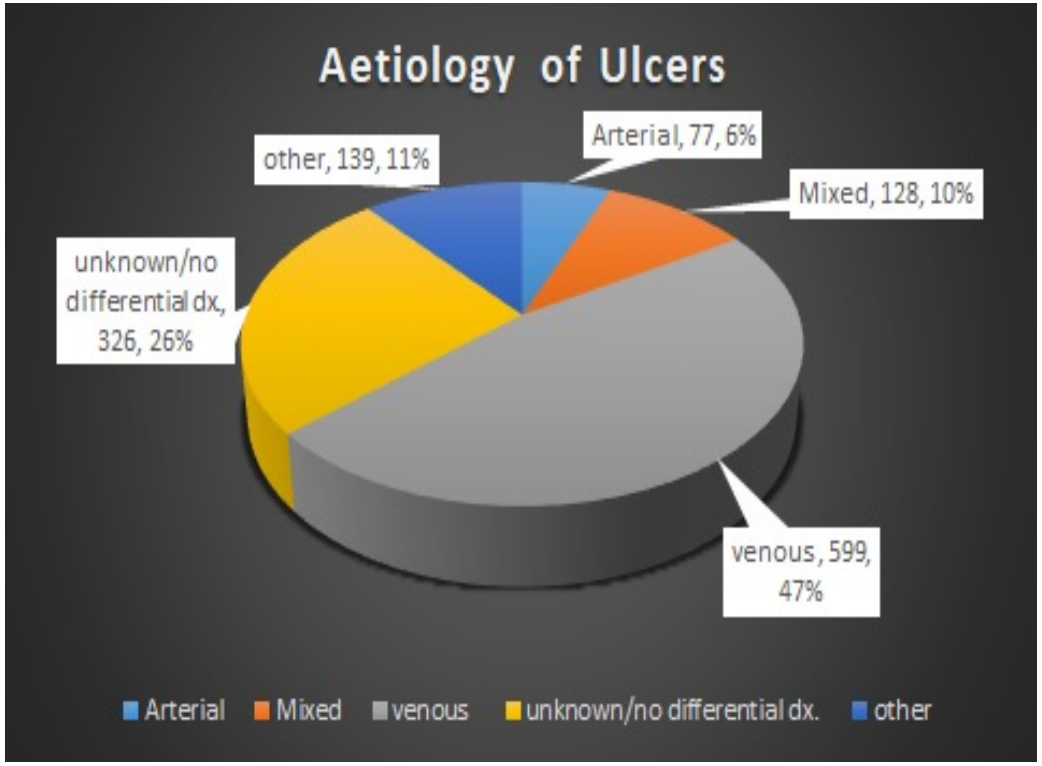
Venous leg ulcers are the most common chronic wound:

- Costly to the health service
- Costly to the individual with a negative effect on many aspects of mental and physical wellbeing
- Can take months or years to heal
- It is estimated that only 42% of venous leg ulcers (VLUs) heal by 12 months.

(Guest et al, 2017, 2018; Gray et al, 2018; Phillips et al, 2020)

SNAPSHOT OF LEG ULCERS ACROSS WALES





Total number of patients: 1269

WOUND CARE TODAY

All Wales Tissue Viability Nurse Forum
Fforwm Nyrsys Hylywedd Meinwe Cymru Gyfan

LEG ULCER CARE IN WALES

- Delayed healing is often a result of **sub-optimal care**
- Best practice guidelines exist but are **not followed** in some cases
- This leads to **avoidable morbidity** and **reduced quality of life**
- **Consistent evidence-based care** can reverse this.

(Guest et al, 2017, 2018; Gray et al, 2018; Phillips et al, 2020)

STANDARDS FOR LEG ULCER CARE

All Wales Tissue Viability Nurse Forum (AWTVNF) have produced the new *Standards for Leg Ulcer Care in Wales* to set the minimum standards for care delivery in order to optimise clinical outcomes and healing rates in this patient group.

STANDARDS FOR LEG ULCER CARE

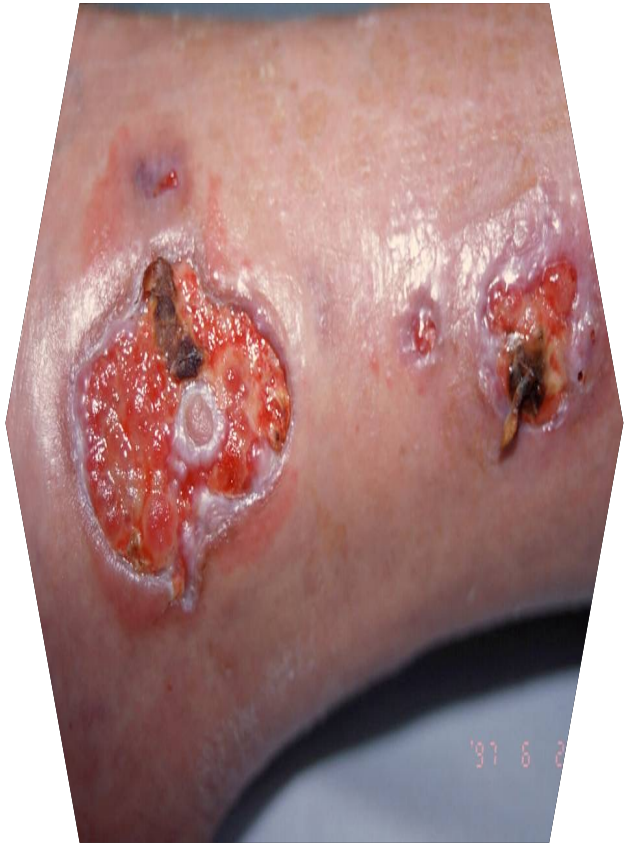
The document:

- Is based on **best available evidence** and **expert opinion** of the AWTVNF
- The standards apply to **all individuals with active leg ulcers** or patients who **present with lower limb wounds**
- Intended for use by **all healthcare professionals** involved in the delivery of care to patients with leg wounds and ulcers.

STANDARDS FOR LEG ULCER CARE: CONTENTS

- Introduction
- Initial contact
- Two, four, eight-week review
- Compression therapy selection guide
- Glossary of terms.

LEG ULCERS



- A leg ulcer is defined as '*a break in the skin below the knee which has* ***not healed within 2 weeks***'
- **Over 60%** are due to venous insufficiency and are classified as VLUs
- VLUs are the **most common chronic wound** in the lower leg, affecting 0.1–0.3% of the adult population, increasing to 3% in those aged over eighty years
- VLUs often occur **following minor trauma** to the leg that fails to heal normally as the patient has **risk factors** for their development.

(NICE, 2023)

RISK FACTORS: VENOUS

- Increasing age
- Obesity or being overweight
- Issues with mobility and/or walking
- Limited range of ankle function
- Previous ulcer
- Personal/family history of varicose veins or VLU
- History of deep vein thrombosis
- Female sex
- Multiple pregnancies
- Arteriovenous fistula
- History of leg fracture/trauma or surgery to leg
- History of intravenous drug use
- Chronic oedema
- Sedentary lifestyle
- Prolonged standing.

(NICE, 2023)

RISK FACTORS/RED FLAGS: ARTERIAL

- Myocardial infarction
- Transient ischaemic attack (TIA)
- Diabetes
- Renal disease
- Rheumatoid arthritis (RA)
- Lupus
- Arterial surgery (leg/heart)
- Smoking
- Pain on leg elevation
- Intermittent claudication
- Pale, cool hairless leg
- Capillary refill time (CRT) >3 seconds.

RED FLAGS

Does the patient have any arterial risk factors or **RED FLAGS** (tick all that apply)	
Ischaemic heart disease/MI	☐
CVA/TIA	☐
Diabetes	☐
Renal disease	☐
Previous arterial surgery	☐
Smoker/ex-smoker	☐
Rheumatoid arthritis or Lupus	☐
• Intermittent claudication (cramping in calf when walking or leg pain on elevation that's relieved by lowering leg)	☐
• Cool leg with pallor on elevation (Use Buerger's test See appendix K)	☐
• Capillary refill time →3 secs (test great toe with room at ambient temp.)	☐
• Absence of palpable or audible foot pulses	☐

YES

- Avoid compression
- Complete wound assessment
- Complete **Formal Leg Assessment** form ASAP or within 2 weeks
- Follow **Topical Management Guidance**
- Consider referral
- NB: If only risk factor and no red flags please discuss with specialist

NO

- Proceed to reduced compression using either class 1 hosiery (14–20mmHg) or reduce compression/light support bandaging as per All Wales Leg Ulcer Standards Quick Guide (see reverse of this form)
- Complete wound assessment
- Follow Topical Management Guidance
- Complete Formal Leg Assessment form within 2 weeks or refer immediately to appropriate HCP/service to complete further assessment.

INITIAL CONTACT ASSESSMENT: UNTREATED LEG WOUND/ULCER

Timeline	Assessment	Management
INITIAL CONTACT **Patient with an untreated leg wound: initial contact with a healthcare professional** *This guidance is to be followed for all adults who present with a wound or skin breakdown that originates on or above the malleolus but is below the knee (NWCSP, 2021).* Arterial risk factors/red flags Myocardial infarction; transient ischaemic attack (TIA); diabetes; renal disease; rheumatoid arthritis (RA); Lupus; arterial surgery (leg/heart); smoking; pain on leg elevation; intermittent claudication; pale, cool hairless leg, capillary refill time (CRT) >3 secs **Contraindications (without further assessment or treatment):** groin-injecting drug users, suspected or untreated deep vein thrombosis (DVT)	**At first presentation:** - Complete **initial contact assessment for untreated leg wound/ulcer and *All Wales Leg Ulcer Standards Quick Guide (Appendix a)*** - Complete local wound assessment form - Take relevant past medical history and ulcer history - Determine patient goals, quality of life/pain management issues, educational needs and self-management capabilities (Harding et al, 2015) - If patient is self-caring complete **Supported Self-Care document** and provide copy to patient (*Appendix d*) - Identify any arterial disease risk factors, red flags or contraindications for compression therapy (*Box 1*) - Complete core care plan (*Appendix c*)	**At each visit follow:** *Topical Management Guidance* **If no arterial risk factors/red flags present (*Box 1*)** Up to 20mmHg compression can be applied without Doppler ABPI with product selection dependent on clinical presentation and/or patient preference **If normal leg shape/exudate is contained easily within dressings:** • Apply Class 1 hosiery/garment (14–20mmHg) *OR* **If leg shape is unsuitable for hosiery/exudate and is not contained easily within dressing:** • Apply reduced multi-layer compression kit with equivalent 20mmHg compression (consider ankle circumference in selection) *OR* **If excessive exudate/wetness or oedema is present:** • Apply a super absorbent dressing • One layer of blue/yellow line tubular stockinet • Three rolls of wool padding • Apply 10cm width short-stretch (inelastic) bandage in a spiral application from the base of the toes with a 50% overlap up to the knee as per level 2 recommendation from *Chronic Oedema Wet Leg Pathway V8.0* (Lymphoedema Wales Clinical Network (LWCN), 2022) **If arterial risk factors/red flags/contraindications present (*Box 1*):** • Follow *Topical Management Guidance* and refer **If arterial risk factors and excessive exudate/wetness is present:** **Do not apply compression therapy (follow level 1 *Chronic Oedema Wet Leg Pathway*)** • Apply a super absorbent dressing • One layer of blue/yellow line tubular stockinet • One or more roll/s of wool • One layer of blue/yellow line tubular stockinet toe to knee (LWCN, 2022) **Patients with pain** Refer to pain management guidance (*Appendix d*) **Patient information and education: Provide leg ulcer leaflet, compression leaflet and leg exercise leaflet** (*Appendices e & f*)

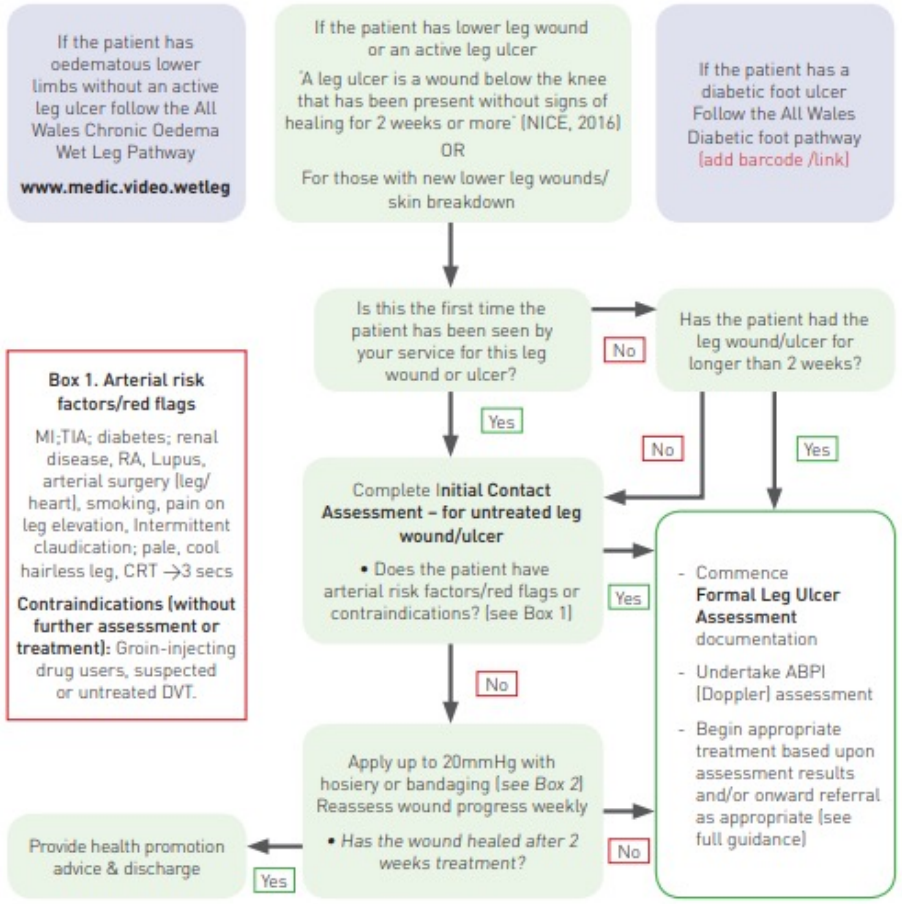
Referral: • Immediate referral to appropriate healthcare professional/service for a full leg ulcer assessment, diagnosis and management plan. • If arterial risk factors, red flags or contraindications for compression are present refer to tissue viability nurse, leg ulcer nurse specialist, vascular services or drug dependency services as appropriate • If oedema present refer to lymphoedema services

INITIAL CONTACT

- Initial contact with a healthcare professional
- Initial contact assessment
- Red flags
- Supported self-care
- Complete core care plan
- If no arterial risk factors/red flags – up to 20mmHg compression without Doppler ankle brachial pressure index
- Topical management.

INITIAL CONTACT ASSESSMENT: PATHWAY

INITIAL CONTACT ASSESSMENT – UNTREATED LEG WOUND/ULCER



Box 2. Selection criteria for reduced compression up to 20mmHg

- **Normal leg shape/ exudate contained easily within dressings:** Apply class 1 hosiery/garment 14–20mmHg
- **Leg shape unsuitable for hosiery/exudate not contained within dressings:** Apply K2 REDUCED at 20mmHg as per ankle circumference measurement
- **Excess exudate/wetness or oedema:** • Three rolls of wool padding e.g. k-soft • Apply one 10cm width inelastic bandage (e.g. Actico) in spiral application from base of toes in a 50% overlap & 50% stretch up to the knee

NB: All wounds should have a wound assessment & dressings selected as per the **Health Board Wounds & Dressing Formulary**

FORMAL LEG ULCER ASSESSMENT: TWO WEEKS

Timeline	Assessment	Management
2 WEEKS **Formal leg ulcer assessment by appropriately trained professional within 2 weeks of initial contact** *This guidance is to be followed for people who present with a leg wound/s where there are no signs of healing within two weeks or more after occurring (NICE, 2016).* A person presenting with a leg wound should be assessed (including vascular assessment of arterial supply) within 14 days of original presentation (NWCSP, 2021).	Complete ***Formal Leg Ulcer Assessment*** documentation (see appendix g) and include: - Local wound assessment - Ulcer measurement length/width/depth in cm or area measurement in cm^2 - Vascular assessment to include ABPI/TBPI NB: TBPI recommended for patients with diabetes or grossly oedematous limb (IWDGF, 2021) - Test for neuropathy – ***Ipswich touch technique/'Touch the Toes Test'*** (Diabetes UK, 2012) (***Appendix h***) - Review pain assessment - Review core care plan - Review patient self-management as required **Determine probable diagnosis based on the clinical presentation and vascular assessment:**	**At each visit follow: *Topical Management Guidance*** **VENOUS ULCER** Healing Target =12 weeks ABPI =0.8 –1.3; Select compression from guidance to provide 40mmHg at the ankle If ABPI range not within normal range (0.8–1.3) seek specialist advice about compression. **MIXED AETIOLOGY ULCER** ABPI=0.51–1.3; ABPI →1.3 or TBPI= 0.65–0.69 Select dressing based on assessment of the wound; follow loca formulary/protocol to meet wound bed needs Discuss compression/management with TVN, leg ulcer specialist or vascular services **SEVERE ARTERIAL DISEASE WITH ULCER** Follow topical management guidance **SEVERE ARTERIAL DISEASE AND EXCESSIVE EXUDATE/WETNESS** **Do not apply compression therapy (follow Level 1 Chronic Oedema Wet Leg Pathway)** • Apply a super absorbent dressing • One layer of blue/yellow line tubular stockinet •One or more roll/s of wool • One layer o blue/yellow line tubular stockinet toe to knee (LWCN, 2022) Aim to keep limb as warm and well perfused as possible.

FORMAL LEG ULCER ASSESSMENT: TWO WEEKS

Date referral received _____ Date/Time assessment _____

Referred by _____

FORMAL LEG ASSESSMENT – LEG ULCER/NON-HEALED LEG WOUND AFTER 2 WEEKS

NB: Use this document in conjunction with the All Wales Leg Ulcer Standards Pathway & local HB wound assessment form

Name: _____ Site of wound/s or ulcers: _____

Address: _____

Duration of current wound/s or ulcers: _____ Cause: ☐ Trauma ☐ Blister ☐ Spontaneous breakdown

☐ Other (specify) _____ DOB: _____ ID Number: _____ Previous history of leg ulceration? ☐ Yes ☐ No

ALLERGIES: _____ SENSITIVITIES: _____

Wound/ulcer impact on patient & patient goals: _____

_____ Can patient be involved in self-management? ☐ Yes ☐ No Advice leaflets given? ☐ Yes ☐ No

Possible Arterial Indicators (Tick all that apply)	
Predisposing/contributory factors:	
Ischaemic heart disease/MI	☐
CVA/TIA	☐
Diabetes	☐
Renal disease	☐
Previous arterial surgery	☐
Smoker/ex-smoker	☐
Rheumatoid arthritis or Lupus	☐

Possible Venous Indicators (Tick all that apply)		
Predisposing/contributory factors:		
Reduced mobility/sedentary lifestyle	☐	
Obesity/raised BMI	☐	
Sleeping in chair/lack of leg elevation	☐	
Trauma/ surgery/fracture to limb	R☐	L☐
Venous thrombosis/ DVT/ phlebitis	R☐	L☐
History of cellulitis (✔which leg & no. of episodes for each leg)	R☐ ___	L☐ ___

FORMAL LEG ASSESSMENT – LEG ULCER/NON-HEALED LEG WOUND AFTER 2 WEEKS

Possible Arterial Indicators (Tick all that apply)		
Clinical Signs & Symptoms on leg	Right	Left
• Positive Buerger's sign - Pallor on elevation and duskiness on dependency (see guidance)	☐	☐
• Capillary refill time →3 secs (test great toe with room at ambient temp.)	☐	☐
• Absence of palpable or audible foot pulses	☐	☐
• Intermittent claudication (cramping in calf when walking or leg pain on elevation that's relieved lowering leg)	☐	☐

Possible Venous Indicators (Tick all that apply)		
Clinical Signs & Symptoms on leg	Right	Left
Oedema/lymphoedema	☐	☐
Haemosiderin staining (brown staining/ pigmentation)	☐	☐
Atrophy Blanche (small white atrophy scars)	☐	☐
Varicose veins or ankle flare (Small prominent veins to ankle/foot)	☐	☐
Dry/wet eczema (Irritation of skin)	☐	☐

Does the patient have other health conditions that might be causing/contributing to leg ulceration?
(If you suspect any conditions below to be a direct cause of ulceration please refer to appropriate specialist)

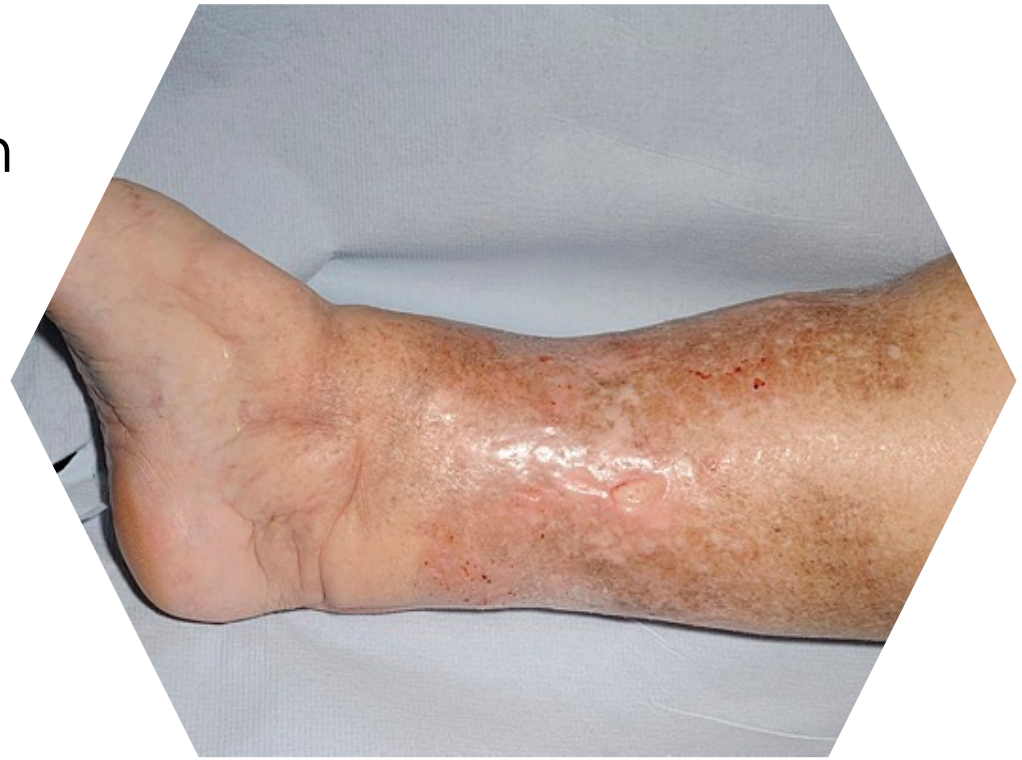
Any autoimmune disorder ,e.g. Ulcerative colitis, RA, Lupus, etc. ☐ Previous skin cancers or Bowen's disease

Pain Assessment NB: Tick all that apply for when pain is experienced & description of pain. Complete pain score on local HB wound assessment form & complete a pain care plan if required

☐ No pain	☐ During exercise	☐ Constant	☐ Intermittent	☐ Day	☐ Night	☐ Dressing change
☐ Throbbing Nociceptive	☐ Aching Nociceptive	☐ Heavy Nociceptive	☐ Burning Neuropathic	☐ Shooting Neuropathic	☐ Stabbing Neuropathic	☐ Tingling Neuropathic
Other pain description:			Action taken/comments (see guidance):			

FORMAL LEG ULCER ASSESSMENT: TWO WEEKS

- By appropriately trained professional
- Within 14 days of original presentation (NWCSP, 2023)
- Determine probable diagnosis based on clinical presentation and vascular assessment
- Simple/complex VLU
- Mixed/severe arterial/other aetiology.



REGULAR LEG ULCER ASSESSMENT: FOUR WEEKS AND EIGHT WEEKS

Timeline	Assessment	Management
4 WEEKS **Reassessment at 4 weeks following formal leg ulcer assessment and instigation of management**	- Record local wound and pain assessment - Ulcer measurement length/width/depth in cm or area measurement in cm^2 - Calculate % size reduction in ulcer area - Review core care plan	Continue current management Reassess in a further 4 weeks to determine % area reduction If healed: ensure appropriate compression therapy (at least 30mmHg) is continued for life. **Patient information and education** - When healed, provide *Caring for your legs once your leg ulcer has healed* leaflet (*Appendix i*)
Referral: • Refer to additional speciality/service if wound not reduced by 30% by week 4 (WUK, 2016). • Seek advice from specialist if patient unable to tolerate recommended treatment		

Timeline	Assessment
8 WEEKS **Reassessment at 8 weeks following formal leg ulcer assessment and instigation of management**	- Record local wound and pain assessment - Ulcer measurement length/width/depth in cm or area measurement in cm^2 - Calculate % size reduction in ulcer area - Review core care plan

Management

Continue current management

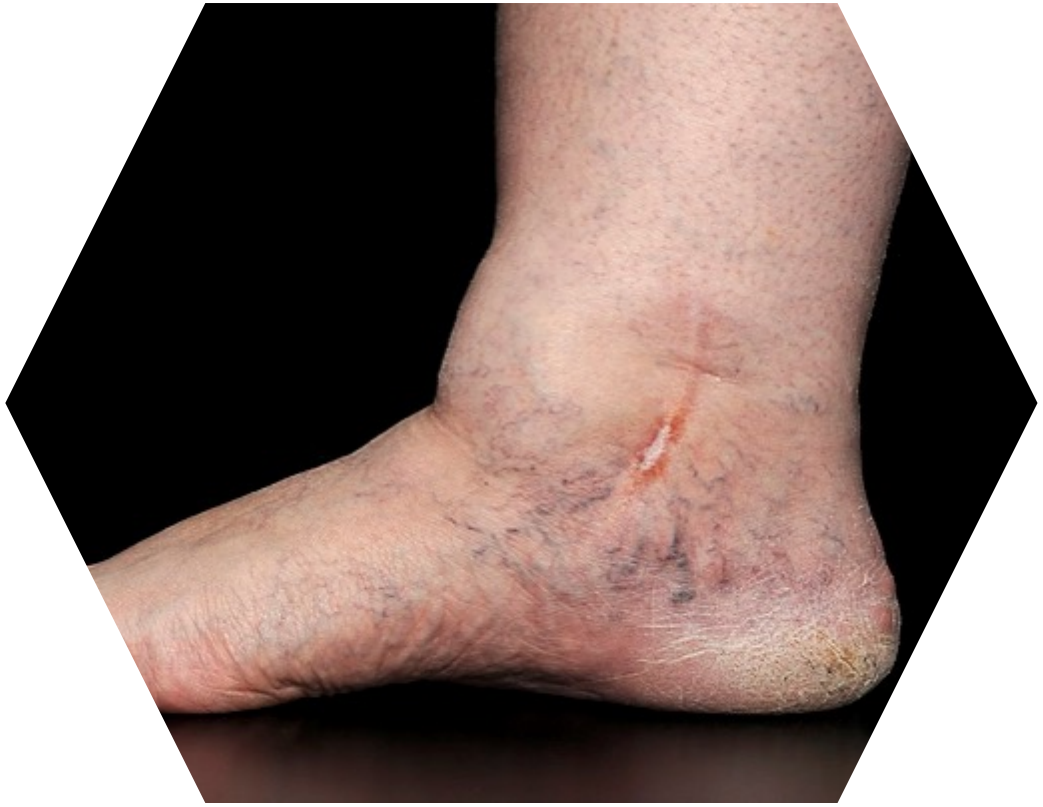
Reassess in a further 4 weeks to determine % area reduction

If healed: ensure appropriate compression therapy (at least 30mmHg) is continued for life.

Referral: • Refer to additional speciality/service as required. • All VLU's not healed within 12 weeks refer to Vascular services (NWCSP, 2021) • Seek advice from specialist if patient unable to tolerate recommended treatment

REASSESSMENT AT FOUR AND EIGHT WEEKS

- Simple VLU – reduced size by at least 30%
- How do we measure percentage healing?
- When should you refer to specialist service?
- When should you refer to vascular service?



FUNDAMENTALS OF LEG CARE

- **Promote co-production** with patient and identify shared goal(s)
- Provide **patient information** in an appropriate format
- Address **factors delaying healing** (if possible)
- Provide **health promotion advice**
- Optimise **pain management** and **nutrition**
- Promote **movement** and leg and foot exercises.

FUNDAMENTALS OF LEG CARE

- Encourage **leg elevation** when resting and avoidance of chair sleeping
- Provide **application aid** for hosiery kit if required
- Record local wound assessment **weekly**
- Ulcer/symptom deterioration requires **full re-assessment** to identify the reason for deterioration and appropriate management.

TOPICAL MANAGEMENT GUIDE

At each dressing change:

- Cleanse ulcer and wash skin
- Remove loose skin scales and dried exudate
- Moisturise skin after drying
- Treat venous eczema
- If black eschar is present in ischaemic/severe arterial ulcers, keep it dry
- Apply simple non-adherent dressing unless complex (i.e. if slough to wound bed more than 30%) or infected
- For complex/mixed ulcers, select dressing according to wound bed tissue type and aims of management.

SKIN AND WOUND CLEANSING FOR PATIENTS WITH CHRONIC LEG ULCERS

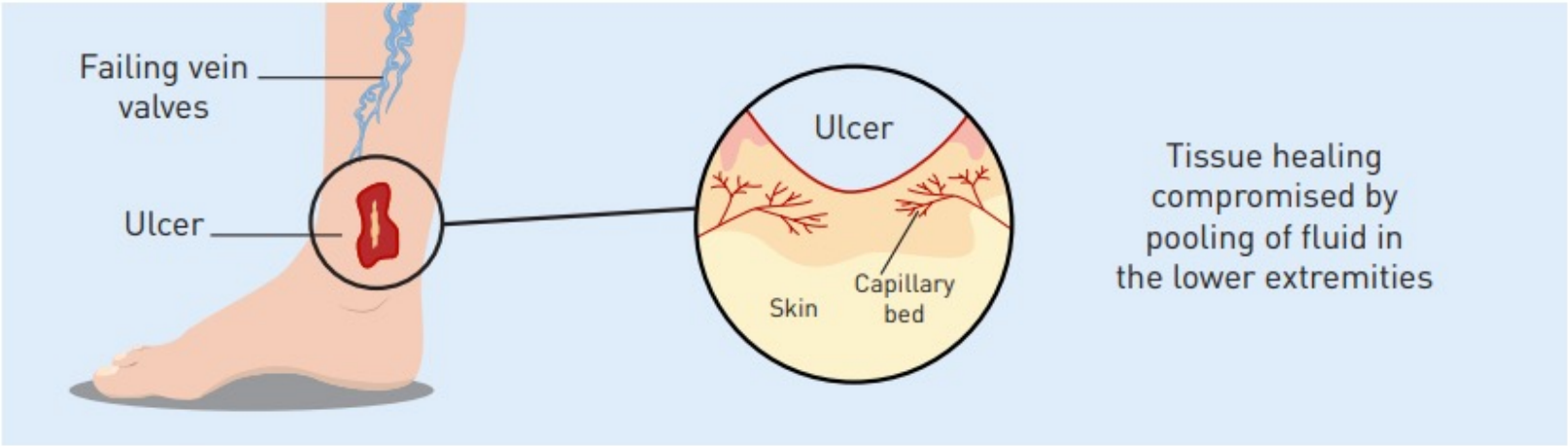
First-line cleansers for wound hygiene		Why use them?	How to use them	Comments
Non-Antimicrobial cleaning agents	Drinking quality tap water	Non-toxic to human cells Cost effective Can be used for chronic wound and skin cleansing Helps to remove dry skin used in combination with soap substitute	Can be delivered in a variety of ways e.g. patient showering or washing leg using a lined bowl or bucket Aim for water to be at body temperature Cleanse wound bed using drinking quality tap water and gauze swabs. Emollient soap substitute can be added - useful for removing dry skin scales and for rehydrating skin	Can be a moving and handling risk if using large volumes – requires risk assessment Do not use for wounds requiring sterile procedure Limited ability to reduce bacterial load Taps can become colonised transmitting infection if not flushed regularly Some emollients are flammable and should be used with caution
	Sterile normal saline	Should be used if drinking quality water is not available Low toxicity	Aim for saline to be at body temperature. Available in a sachet, spray can or ampule Cleanse wound bed using saline and gauze swabs Emollient soap substitute can be used if removing debris, dry skin scales and for rehydrating skin	Caution to protect surrounding environment if using a spray saline Limited ability to reduce bacterial load Must be used for wounds that require a sterile procedure

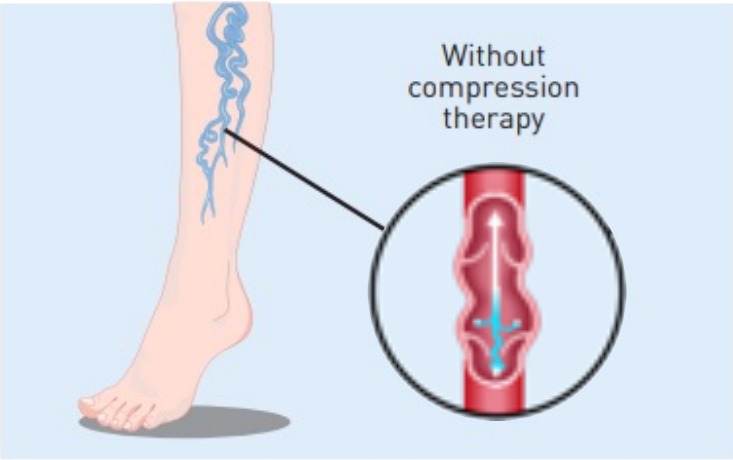
First line Cleansers for wound hygiene		Why use them?	How to use them	Comments
ANTISEPTIC ANTIMICROBIAL AND ASTRINGENT AGENTS The following solutions are not for routine use. They are used in specific circumstances and can may reduce potential for infection. They are prescribed individually for the patient and are for short-term use. Refer to Local Health Board/Trust specific guidance for use.	Potassium Permanganate 0.01% (1:10,000)	Wet and infected eczema Pseudomonas Aeruginosa infection	Dissolve 1x 400mg tablet in 4 litres of body temperature water Make sure tablet is fully dissolved before use Use solution immediately it is made up to prevent oxidisation Soak gauze swabs and apply to wound or soak leg in a plastic bag lined bucket for 15 minutes Review use following local guidance	Must not be taken orally Possible harm and death if ingested Staining of skin and clothes and ceramic basins Can be irritant Caution with raised potassium levels/renal failure Patient information leaflet to be given to explain storage and use
	Acetic Acid	Effective against Pseudomonas Aeruginosa infection Skin and soft tissue infection Low toxicity	Product made up ready for use by pharmacist Soak gauze swabs in solution and apply to affected area for 15 mins. Review use following local guidance	Can cause irritation
	Antimicrobial emollient eg. Oilatum® Plus, Dermol® 600 Bath Emulsiderm®	Eczematous or pruritic skin conditions At risk from infection (Oilatum Plus)	Some formations can be used direct to skin as soap substitute other will require dilution – follow manufacturer's instructions. Emollient in tubs should be removed using a clean spoon or spatula to reduce bacterial contamination	Care should be taken as these preparations will make skin and surfaces slippery
	Antimicrobial cleansers containing surfactants Polyhexanethylene biguanide (PHMB) eg Octenidine dihydrochrloride eg.	Cleansing and decontamination of infected wounds Loosens devitalised tissue Disrupts biofilm	Use at room temperature Apply gauze swabs soaked in the solution to the affected area for manufacturers recommended period of time Wipe wound with soaked gauze to facilitate removal of surface debris and contaminants, biofilm, and devitalised tissue.	Does not promote bacterial resistance Shelf life of eight weeks after opening bottle No refrigeration required Mixing product with other wound cleansing soaps, lotions, ointments, oils or enzymes may lower efficacy.

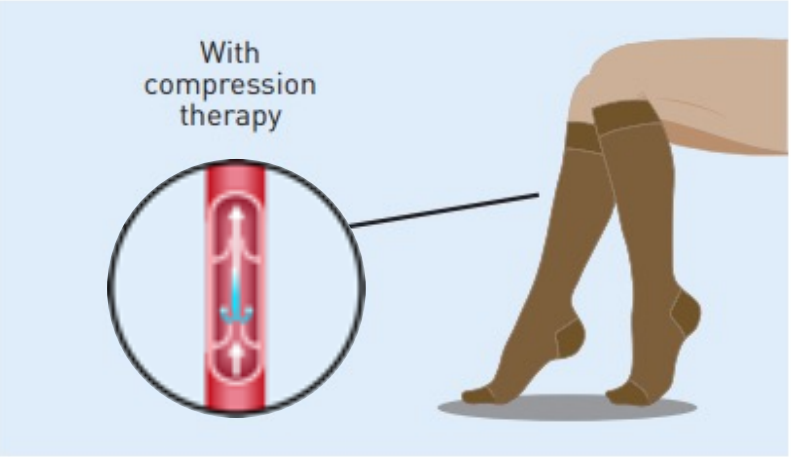
TOPICAL MANAGEMENT GUIDE

- If light exudate present, apply a simple absorbent pad or for moderate to high exudate volume, select a super-absorbent dressing
- An adhesive dressing may be considered if hosiery is used, and exudate can be contained within the dressing
- Secure non-adhesive dressings with tubular stockinet applied toe to knee or a leg ulcer hosiery kit liner if using a kit
- Respond to local infection
- Respond to spreading infection.

LEG ULCERS AND COMPRESSION THERAPY

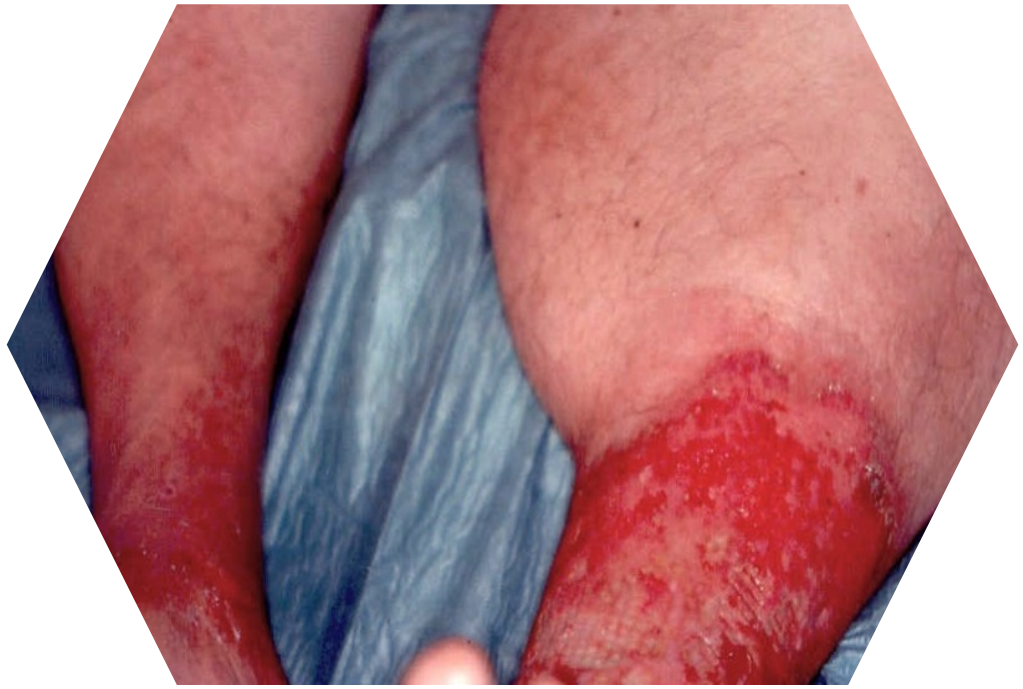






LEG ULCERS AND COMPRESSION THERAPY

- Oedema
- Exudate
- Limb shape
- Pain management
- Post-thrombotic changes
- Height of the individual
- Obesity
- Psychosocial or lifestyle issues
- Availability of product on formulary (Wounds UK, 2016).



COMPRESSION THERAPY SELECTION GUIDE

COMPRESSION THERAPY SELECTION GUIDE FOR LEG ULCER TREATMENT

Always consider applying toe support using bandaging or toe caps, where there is risk or presence of toe oedema in patients with no clinical signs of arterial disease

No clinical signs of arterial disease ABPI 0.8–1.29 or TBPI → 0.7	No clinical signs of arterial disease ABPI 0.8–1.29 or TBPI → 0.7	No clinical signs of arterial disease ABPI 0.8–1.29 or TBPI → 0.7	No clinical signs of arterial disease ABPI 0.8–1.29 or TBPI → 0.7
• Exudate is contained within dressing and • Leg shape is 'normal' or 'near normal' and • Skin on leg is otherwise healthy and • There is no reducible oedema	• Exudate is contained within dressing and • Leg shape is 'normal' or slightly distorted and • Reducible oedema is minimal • Applying hosiery kit is difficult	• Exudate is not contained well within dressing and/or • Oedema needs reducing and/or • Leg shape is poor and/or • Skin on leg is in poor condition and • Trained healthcare professionals are available to reapply as needed	• Exudate is contained within dressing and • Leg shape is distorted and/or • Oedema has been reduced as much as practicable and/or • Skin condition on leg needs improving and/or • Circular knit hosiery kit is not comfortable • Seek specialist advice if needed
Offer compression hosiery kit (40mmHg)	**Offer inelastic compression wrap (40mmHg)**	**Offer compression bandage system (40mmHg)**	**Offer flat-knit hosiery or inelastic compression wrap (40 mmHg)**

NB: The criteria for selecting different types of compression i.e. hosiery, wraps or bandages, above can also be applied if using reduced compression of 20mmHg

PATIENT EMPOWERMENT, PATIENT CONCORDANCE

APPENDIX B

SUPPORTED SELF-CARE

Management for those patients who are identified as appropriate for supported self-care:

- The patient has consented to a supported self-care arrangement at this time
- All treatment decisions have been made in collaboration with the patient to achieve the patients' preferred outcomes
- The patient or carer has been assessed and is considered to have mental capacity and physical ability to self-care with support
- Provide the patient with the following 4 documents:

1. ***My Leg Ulcer Treatment Plan:*** A simple written treatment plan that lists the required dressings and the order in which they are to be applied and any other treatment or advice to follow. This is signed by both the patient and HCP
2. ***My Leg Ulcer Care Journal:*** A record sheet for the patient/carer to document when dressings were changed, the progress of the wound and any possible concerns or deterioration
3. ***How to Care for Your Leg Ulcer at Home:*** Written practical instructions on how to change their dressing at home
4. ***Patient Information Leaflet:*** Provides additional practical advice and health education

- It must be ensured that the patient has the necessary wound dressings and compression therapy that is needed for the length of time required
- Follow-up appointments (via phone or in person) must be arranged and agreed with the patient and/or carer to review the wound, to ensure that they remain able and motivated to continue self-care and to prescribe any additional or alternative supply of dressings
- Ensure that the patient/carer are aware of possible **Red Flags** to look out for which are all listed on How to Care for Your Leg Ulcer at Home leaflet
- Ensure that the patient has details of a HCP that they can contact should they have any concerns or questions.

REFERENCES

- Guest JF, Ayoub N, McIlwraith T, et al (2017) Health economic burden that different wound types impose on the UK's National Health Service. *Int Wound J* **14(2):** 322-330
- Guest JF, Fuller GW, Vowden P (2018) Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *Int Wound J* **15(1):** 29-37
- National Institute for Health and Clinical Excellence (NICE) (2023) *Leg Ulcers – Venous*. Available online: https://cks.nice.org.uk/topics/leg-ulcer-venous/
- National wound care strategy programme (2023) Lower limb wounds: leg ulcer recommendations. Available online: https://www.nationalwoundcarestrategy.net/wp-content/uploads/2023/08/NWCSP-Leg-Ulcer-Recommendations-1.8.2023.pdf
- Philips C, et al (2020) Cost of managing patients with venous leg ulcers. *Int Wound J* **17:** 1074–82
- Wounds UK (2016) *Best Practice Statement. Holistic management of venous leg ulceration*. Wounds UK, London. Available online: www.wounds-uk.com