Does the unqualified nurse have a role to play in the active recall and follow up care of patients with healed leg ulcers?

Jenny Hindley, Tissue Viability Clinical Nurse Specialist, Surrey Community Health.

Surrey Community Health
better care for better lives

The Problem

- Ritualistic recall of patients with healed venous leg ulcers in some community areas
- Reassessment is haphazard and lacks evidence
- No capacity for frequent, lengthy Doppler assessment
- Practice review identified the need for an increased proactive approach

Current Practice in 3 Health Centres

- In the well leg clinic the trained nurse will complete the vascular assessment and the unqualified nurse will undertake a basic leg assessment only
- To give structure and guidance to the unqualified nurse a compression hosiery renewal checklist has been developed
- The checklist ensures the unqualified nurse contributes safely and effectively to patient care and is an aide-memoire for trained nurses

What do we know as clinicians? Does wearing hosiery work?

- Anecdotal evidence from experts and clinicians endorses the use of compression hosiery as part of a preventative approach

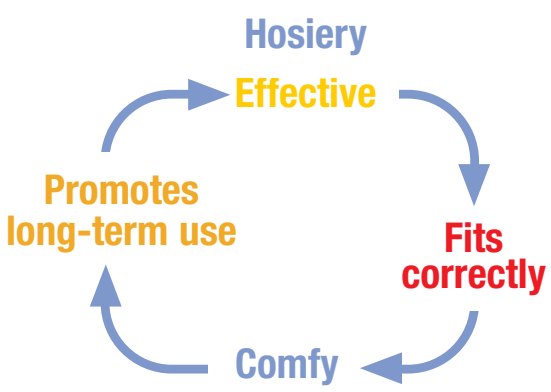
What others have found?

- Patients receiving education were nine times less likely to develop a leg ulcer (Brooks et al 2004)
- Recurrence is reduced when contact and support is maintained with health professionals (Ruane-Morris et al 1995, Fassiadis et al 2002, cited in Vowden 2005)

Well leg work pack for Community Nurses
Tissue Viability Services, Surrey Community Health 2010

The pack includes well leg clinical referral criteria and guidelines and is available from the author.

Hosiery Selection Cycle



Adapted from: Moffatt, C (2006) Compression Hosiery in Lymphoedema. In: Lymphoedema Framework. Template for Practice: compression hosiery in lymphoedema. London: MEP Ltd.

When looking at the therapeutic approach to prescribing hosiery, the clinician has to weigh; the complex needs of the patient and the diversity of compression garments, with the science of compression hosiery (Moffatt 2006). All have to be in place to achieve 'Effectiveness' and the clinician re-visits these issues at each review.

Effectiveness and concordance

Factors that affect concordance

- Patients have a poor understanding of their condition
- Difficulty in application – poor dexterity and mobility
- Discomfort or pain caused by ill-fitting garments and the inability to remove at night
- Refusal to actively engage in treatment
- Lack of belief caused by previous treatments
- Poor communication between nurse and patient

Improving concordance

- Patient information leaflets
- Application aids, layering of hosiery and education
- Correct measuring and fitting of hosiery
- Mentoring, monitoring and motivating patients with long-term conditions
- Reassure the patient that the treatment will work
- Communication and positive relationship building

Skills & Knowledge?

The correct assessment, measurement and fitting of hosiery is complex and staff undertaking this role require training to learn these skills, along with robust documentation.

The extent of the problem and Mapping progress?

- Quality initiatives around healing rates and re-ulceration rates in the author's locality are inadequate
- No audit had taken place in order to set standards and measure outcomes
- Audit is necessary in order to measure outcomes with the documentation tool

Audit - a snapshot of quantitative and qualitative data. March 2010.

Qualitative data linked to the care quality commission standards.

"Ideal Practice" this was quantified from:

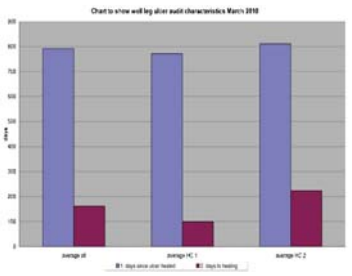
- RCN (2006) Clinical Practice Guidelines. The Nursing Management of patients with Venous Leg Ulcers. RCN. London.
- SIGN (1998) the care of patients with Chronic Leg Ulcer. A National Clinical Guideline. SIGN, Edinburgh.
- Best Practice Statement, Compression Hosiery. (2002) Wounds UK.
- A series of standards were set, with an achievement percentage allocated to each standard. The qualitative evidence was taken from the patient's nursing notes, with shared permission from the GP practice.

6 Audit questions
Based on standards set.

1. Date leg ulcer (now healed) developed.
2. Date this ulcer healed.
3. Was Hosiery Px within 3 months of healing?
4. Was there documented follow up within 13 months of Px being issued for hosiery?
5. Was there documented follow up within 13 months of ulcer healing?
   To include: ABPI? Leg measurements? Leg/skin inspection or condition. Hosiery fitting correctly? Concordance with skin care? Health Ed Leaflets/ Advice.
6. Have there been other episodes of documented venous ulceration?

Yes/No or Not /Known.

Well leg audit March 2010 - healing times.



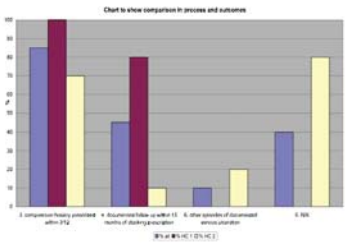
The healing rates at HC1. were practically half of those at HC2. Health Centre 2. - evidence from the documentation.

1. The notes that were examined showed a delay in referral to the D/N team and, therefore a delay in commencing appropriate treatment.
2. There is evidence that delayed healing is linked with time of wound duration.
3. Treatment Room sisters are unable to perform Doppler assessment and do not apply compression therapy. Patients therefore have to wait to be referred to the D/N team.
4. Most HC2 patients were not receiving optimal compression.

Vs. Health Centre 1.

1. Led by level 3 Treatment Room Sister with Tissue Viability knowledge, who can perform Doppler assessment.
2. Patients receive Doppler assessment in a timely fashion, receiving appropriate levels of compression dependent upon their clinical findings.

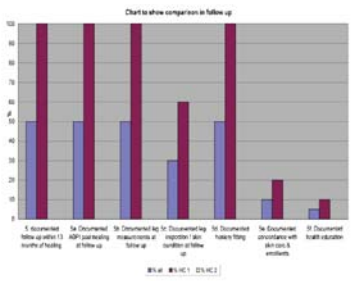
Active follow up? Recurrence rates



3. Both areas provided hosiery post healing.
4. HC1 patients receive active recall and follow up ownership for this by untrained staff (Introduced by TVN with current documentation and training). HC2 have a poor (absent!) standard of post healing and prevention care! NOT DOING IT!!
5. & 6. Not/Known - HC1. Re-ulceration rates are 0% from the audit snap shot view. At HC2 recurrence rates were found to be 20% (taken from notes randomly pulled that could provide adequate information for the audit.) Proactive follow up is not done!

Some authors predict re-ulceration rates to be as high as 50% post healing without compression hosiery. (see literature search)

Facets of follow up



HC2 (Cream colour) are absent completely and are not scoring at all in this section.

New revised documentation should correct low scoring in these fields, thus implementing a change in practice, if used!

In Conclusion

What changes can we make?

Audit becomes a powerful tool to instigate practice development by identifying best practice and proposing changes to improve practice (Fowkes 1982).

The revised guidelines acting as a protocol for untrained staff will ensure safety and efficacy of their input. Guidelines will act as an aide memoire for trained staff and, along with the Traffic lights system will ensure systematic clinical decision making and implementation of best practice.

Standardised Letter to GP informing of ABPI results/hosiery prescribed will close communication gap for prescribing accountability issues.

Untrained staff - Band 3 Health Care Assistants or Band 4 Associate Practitioners have great potential to participate in the active re-call and proactive preventative approach to chronic disease management under the supervision of trained staff; thus freeing up trained nurses limited time resources.

What did it tell us?

This audit measured the extent from which practice deviated from "ideal practice".

Need to repeat - When audit becomes cyclical, it encourages practice development and measures incrementally how much closer to the "ideal" practice has developed.

Can be a good motivator if used appropriately and introduced with information to increase staff ownership /"buy in to ideal".

The results from the audit comparing the Health Centre with the unqualified nurse working alongside the qualified nurse (HC1) to another Health Centre who were not following the protocol described above (HC2) demonstrated that in HC1 the average days to heal was 100 and in HC2 it was 224. HC1 had no ulcer reoccurrence at all and HC2 had 20% (5 patients).

This highlighted the important supportive role of the unqualified nurse in the clinic; freeing up time for qualified staff to take on a new proactive preventative approach to care.

Therefore in conclusion

Widening the audit area and repeating once others have adopted the project, will measure whether Best Practice is being assimilated.

The University of Leeds (1994) identified that the way in which guidelines are developed, implemented and monitored seemed to influence uptake.

The revised documentation, "well leg work pack" once disseminated across the locality will translate guidelines into practice, which is vital for success (Hayes 2003).

Future Aims

Experientially we know that pro-active follow up works!!

Harnessing Audit as a means to demonstrate this could capture our experiential knowledge in a meaningful way.

Education to be rolled out and hosiery companies to be involved in this. An up to date preventative approach to chronic disease management, empowering patients with knowledge and skills to manage their care, instead of the old reactive leg ulcer service.

To monitor and collect right information to inform future service provision so that we, as practitioners, can provide cost effective optimal care.

References

Brooks J, Ersser S, Lloyd A (2004) Nurse led education sets out to improve patient concordance and prevent recurrence of leg ulcers. Journal of Wound care. 13, 3 111-116.
Fowkes F.G.R (1982) Medical Audit Cycle. Medical Education 16: 228 -238.
Hayes, L. (2006) "Taking the lead in nursing … If we don't who will?" Primary Health Care 16(2), 14-16.
Jull, A. (2004) Factors influencing concordance with compression stockings after venous leg ulcer healing. Journal of Wound Care; March 13: 3 90-92
Moffatt, C. (1995) Recurrence of leg ulcers within a community ulcer service. Journal of Wound; Care Feb 4: 2 57-61
Moffatt, C. (2004b) Understanding patient concordance in the management of leg ulcers. Nursing Times; Aug 100: 32 58-60
Moffatt, C. (2004a) Factors that affect concordance with compression therapy. Journal of Wound Care; 13: 7 291-294
Senior, B. and Flemming, J. (2006) Organizational Change. 3rd Ed. Harlow: Prentice Hall.
Vowden, K, and Vowden P. 2005. Preventing Venous Ulcer Recurrence: a review.
The Authors. Journal Complilation. Blackwell. London.

The poster was supported by a educational grant from Activa Healthcare Ltd.

Activa Healthcare is a part of the Lohmann & Rauscher