Improving venous leg ulcer care in community services

**Key points**
- Delays in lower-limb assessments can result in inappropriate treatment of venous leg ulcers
- An assessment algorithm and a treatment pathway can help to standardise venous leg ulcer care
- Newly qualified nurses taking on community roles need adequate training in leg ulcer care
- In leg ulcer care, aftercare and prevention are as important as assessment and management
- Virtual clinics can give community nurses easy access to the tissue viability team

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**Abstract** In 2017, Staffordshire and Stoke-on-Trent Partnership NHS Trust, a community trust with 44 nursing teams, embarked on a project to improve care of patients with venous leg ulcers. Lack of staff confidence in leg ulcer management and problems with clinical capacity resulted in patients not always receiving timely and appropriate care. A lower-limb assessment algorithm and a venous leg ulcer treatment pathway were introduced, staff training was updated, a tissue viability clinical educator role was created and clinic capacity to conduct initial lower-limb assessments was increased. Outcomes have been positive and more changes are under way, including virtual clinics and a training course in chronic wound management for third-year students.

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**What was the situation?**

In early 2017, we conducted an audit of venous leg ulcer care in a sample of 80 patients with a lower-leg wound on our community caseload in the Newcastle-under-Lyme area. This revealed variations in care and delays that could result in incorrect diagnoses, inappropriate management, complications and delayed healing. This was, in turn, increasing referrals to the specialist tissue viability team.

The audit showed that 51% of patients had had an ulcer for six months or longer. Furthermore, between 2012 and 2017, a large number of experienced community nurses retired and were replaced by newly qualified staff, so many nurses were now inexperienced in leg ulcer assessment and management.
always received when required. In some cases dressings arrived after patients’ wounds had changed and were no longer appropriate.

We also found that lower-limb assessments were carried out more promptly in the clinic than in patients’ homes, partly because Doppler assessments planned at home were often cancelled as nurses had to prioritise other patients, such as those receiving end-of-life care.

**What were our aims?**

In March 2017, we embarked on a journey of transforming leg ulcer care across the organisation. Our aims were to:

- Increase clinic capacity so more patients would be initially assessed in clinic, rather than at home;
- Improve the timeliness of assessment;
- Standardise initial assessment and management;
- Improve nurses’ knowledge and competence;
- Standardise referrals to the specialist tissue viability team;
- Start collecting data on healing rates.

The trust’s transformation team was working on a project around clinic use so we started a collaboration. In April 2017, the 2017-19 Commissioning for Quality and Innovation (CQUIN) framework was announced and included ‘improving the assessment of wounds’ as a national indicator (NHS England, 2016). From then on, the focus became the CQUIN target.

**What did we do?**

In October 2017, we introduced tools that are now embedded in practice. To standardise assessments, we introduced a lower-limb assessment algorithm based on the best-practice statement on the management of venous leg ulceration (Wounds UK, 2016). We also reviewed the assessment documentation and started using a quality-of-life consultation template (Green et al, 2015).

To standardise management, we introduced a 24-week venous leg ulcer treatment pathway. Every four weeks, community nurses assess patients to check that their ulcers are progressing as per the healing trajectory. If not, they contact the tissue viability team for support. If referral to other specialties is needed, the tissue viability team liaises with GPs. If patients have not healed after 24 weeks, they are managed on a maintenance care plan, often with a modified approach. Common reasons why ulcers may not heal as expected include comorbidities, non-adherence to treatment and lifestyle issues.

**What have we achieved?**

These various measures allowed the trust to meet its improvement target based on the CQUIN framework. At the end of the project’s first year, an audit was conducted on 110 patients with a lower-limb wound. The proportion having a lower-limb assessment (and ABPI measured by Doppler) within four weeks of coming onto our caseloads had risen from 34% in March 2017 to 98% in March 2018.

Between January and August 2018, of 50 patients (16 with simple and 34 with complex venous leg ulcers) who had entered the pathway in the Newcastle-under-Lyme clinic, 48 had healed by the end of 24 weeks (100% of patients with simple ulcers and 94.1% of those with complex ulcers). Among the 16 patients with simple ulcers, 14 had healed by the end of the 12th week. The mean healing time in all patients was two months (60.6 days for simple ulcers and 60.0 days for complex ulcers). From patient surveys, the quality-of-life tool and thank-you cards, we also know that patients’ satisfaction and quality of life have improved.

**What are we working on now?**

We have piloted virtual clinics where the community nurse, while with the patient, speaks to a tissue viability nurse via Skype to review a wound that is not healing as expected. With the help of our IT team and digital champions, we are looking to spread this new way of working.

In June 2019, we held our first Student Wound Care Academy training course. The 13 trainees were students in their final 16-week sign-on placement at Midlands Partnership NHS Foundation Trust, where most will soon start in their first community nurse role. Initial feedback was positive. The course lasted two days and we are planning to extend it to five next year.

**What are our plans for the future?**

Our project focused on one aspect of the patient journey but our ambition is to improve the whole journey, including initial referral, aftercare and prevention. Aftercare and prevention, which harbour potential for long-term cost savings, are not currently commissioned in our area and we are working with commissioners on this. NT

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**Box 1. Advice for setting up similar projects**

- Build a strong vision and ‘sell’ it by highlighting the benefits for patients, staff and the trust
- Use a shared-ownership approach so other services will want to help
- Change trust-wide practice if needed
- Encourage staff to get on board and thank them for their involvement
- Listen to all ideas – even small changes can make a big difference
- Learn from the problems you face to identify areas in need of improvement

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**References**

