Reducing harm in leg ulcer management

OR

How to improve the lives of patients and clinicians

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2019
Do you see HARM as a common experience for people with leg ulcers in your area?

- ☐ All the time
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Not sure what you mean
- ☐ Never
What we know: we have a problem

- Wound care estimated to cost £5.3 billion per annum
- 66% of costs within the community
- 50% community nursing time
- Cellulitis due to lymphoedema and infected leg ulcers? £246m for 2018/19
Leg ulceration [ref Guest et al 2016]

- 1.5% of the population will have lower leg wound*
  - suggests 4500 people per annum within 300k population
  - Venous leg ulcer point prevalence 150 residents. Incidence per annum unknown

- 30% have no diagnosis

- *includes all lower limb trauma, lacerations, haematoma, surgery, various leg ulcer aetiologies.

- Infection rates unknown
Lymphoedema or chronic swelling

- 1.3-3.9 per 1000 will have lymphoedema
  - If 2.5 suggests 750 people within 300k population

- 20% have cancer. With a comprehensive service this adjusts to 10% due to the overlap with venous disease

- 30% of new referrals will have had ≥1cellulitic episode

- 15% of new referrals will have had ≥1admission.
Speaking out: using the H Word

- Naming it: some of our system creates **harm**
- A **Patient Safety** issue
- Challenging the status quo
- Challenge what is accepted as the norm
- It can be considered **preventable harm:**
  - **Identifiable cause**
  - *Can be avoided with reasonable adaptations to a process or adherence to guidelines*
What creates non-healing?

- Inadequate knowledge and skill
- Pain
- Age
- Disinterest by GPs
- Lack on GPN management
- Delay in diagnosis, access to ABPI
- Non-compliance
What patient’s would say

• Poor assessment and no help in the early stages
• The inability to cope with bandaging due to the pain from the ulcer
• The dreadful itch from the bandages
• Inconsistent care and bandage application, poor technique
• The problems with footwear and getting on with life
Cumulative healing rate by duration

- a. < 1 year
- b. 1-8 years
- c. > 7 years

Healing rate for patients who reached this point on the pathway:
- 38% at 6 Weeks
- 50% at 12 Weeks
- 60% at 24 Weeks
- 78% at 40 Weeks
- 92% at 100%
- 100% at 40 Weeks
Pain Management and Plan B

Mean of pain scores over pathway
Mean and actual values by pre-pathway wound duration

Duration
- a. < 1 year
- b. 1-6 years
- c. > 7 years

Score

Admission 4-6 Week Visit 12 Week Visit 24 Week Visit 40 Week Visit

partners in wound and lymphoedema care
Therapeutic compression
Infection and soggy legs

![Bar chart showing infection levels]

- Recurrent infection at assessment: High
- Antibiotics during care: Low
The 50% workload

- An immediate saving in nursing time of 34% from assessment which increases to 46% by week 6.
- This is a result of appropriate assessment with therapeutic intervention.
Makes sense

Total financial analysis

£5,979

“Doing it right first time” presents 89% potential saving or opportunity to treat more cases.

£748
The need to advocate for a better system

The system for patients will not improve if:

- The nurses have more education in evidence based leg ulcer management
- That patients were educated and their ‘lack of compliance’ was tackled
Addressing the culture

- Average pre-pathway cost
- Average cost on pathway to heal

Cost

- £8,000
- £7,000
- £6,000
- £5,000
- £4,000
- £3,000
- £2,000
- £1,000
- £0

n = 64

n = 35

Working Age

Older Adult
They just need decent care
Tackling the narrative

• Leg ulcers are chronic and many are Complex

• Management of symptoms is progress for many

• That patients do not like high compression or Light compression is better than none

• They are in high compression

• Non-compliance

• The need to create controls for dressing expenditure
5 easy steps to reduce HARM

1. Ensure that management is based on the cause
2. Stop the wound progressing down the route to non-healing
3. Ensure compression is therapeutic
4. Spotting the complex early
5. Seeing the bigger picture and challenging the norm
Therapeutic compression

1. **Tall men need more**


2. **The issue of ulcer site**


Ulcer site

2 weeks later
Case Studies – Mrs A

- Patient has been on the district nurses case load since 2011 following an admission for cellulitis
- Patient has mental health issues and severe pain that prevented ABPI assessment by the district nurses
- Extensive dermatitis and circumferential ulcers and high exudate ulcers deteriorating as exudate increased.
- Effective analgesia to tolerate therapeutic compression
- Topical Steroid to manage the erosive dermatitis reduced compression (figure of 8) to reduce the oedema and control exudate
- Doppler performed and compression increased to 40mmHg
## Case Studies – Mrs A

**Community Nurse Patients Mrs A bilateral circumferential leg ulcers (Left leg healed)**

<table>
<thead>
<tr>
<th></th>
<th>Prior to Leg Ulcer Service Intervention</th>
<th>After Leg Ulcer service intervention</th>
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</thead>
<tbody>
<tr>
<td><strong>Time History</strong></td>
<td>312 wks</td>
<td>31 wks</td>
</tr>
<tr>
<td><strong>Visit frequency average</strong></td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Nursing time cost in total</strong></td>
<td>£54,600</td>
<td>£3,875</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Non -healed</td>
<td>Healed (Left leg)</td>
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</tbody>
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Prevention of harm

- See the world differently.
- Datix lack of assessment, poor access to diagnostics, delayed care
- Support a Plan B where evidence is lacking
- Challenging the narrative and words we use.
- Not accepting the ‘way things are’
- Collect the data
- Create a system that addresses need