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Background

There are currently two community ‘Look after your Legs’ leg ulcer clinics running in the Gloucester side of the county. The Gloucester clinic began in September 2003 and the clinic held at The Dilke Hospital began in April 2006. The clinics run on a weekly basis one in Gloucester and one at The Dilke Hospital in Cinderford. The clinics provide assessment and ongoing management of patients with mainly venous leg ulceration.

Within the county there are one or two shared clinics between district nurses and practice nurses. There is one established ‘Leg Club’ in Cirencester using a defined model of care. Lindsay E (2000) Leg Clubs: a new approach to patient centred leg ulcer management Nursing Health Science 2 :139-141

The ‘Look after your legs’ model (Freeman et al 2007) in Gloucester runs a monthly support group on the first Tuesday of the month. The club provides a social support network for experienced leg ulcer patients to befriend new patients and emphasise the self care ethos of small changes to every day activities to prevent a recurrence (Gibbins et al 2007).

The audit aims to collate information to match against other local and National statistics.
Audit Aims

Compare activity at leg ulcer clinics with national guidelines (RCN 1998). One clinic held at Gloucester and one at The Dilke Hospital drawing patients from GP surgeries in those areas.

- To review level of patient activity in Gloucester City clinic from 2003 and The Forest of Dean clinic from 2006.
- To identify healing rates for benchmarking against other clinics in the county or nationally.
- To identify reoccurrence rates and compliance with guidance on management of patients with healed ulcers.

Methodology

An audit tool was designed by Anna Gibbins, Lynn Davis and a member of The Primary & Community Care Audit Group to review the patients’ records of all those attending the ‘look after your leg clinics’ at Gloucester and The Forest of Dean. Community nursing teams were given two months notice of the audit to allow time for organising the notes to be available for audit. A further reminder was sent via email and telephone two weeks prior to the audit.

Pilot

8 patient records were reviewed on the 19th March 07 to assess the audit tool. A slight amendment was made to one question after the pilot.
Results

Not all the notes were available at the time of the audit.

55 sets of patients’ notes were reviewed
15 from The Forest of Dean and 40 from Gloucester.

The patients treated at the leg ulcer clinic are registered at the following GP practices.

Bartongate  29
Glevum/St. Michaels  6
Mitcheldean  6
Forest Healthcare  5
Trinity  4
Drybrook  3
Pavilion  1
Dockham Road  1

Gender

![Gender Distribution](image)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>27</td>
<td>51%</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>49%</td>
</tr>
</tbody>
</table>

n=53
The gender was not recorded on the audit forms for 2 patients, both were over 70yrs of age.
The mode of referral was not recorded in the patient record for 10 patients.

The referral date was not recorded in the patient record for 24 patients. The first treatment date was not recorded in the patient record for 9 patients. **22 patients had full referral information recorded, of those 82% were seen within 2 weeks of referral.**
Aetiology

1 Doppler assessment was not completed at patient request. The aetiology was not recorded in 13 patient records.

Difference between 1st treatment date for 1st ulcer and healed date

57% of those patients with 1st ulcer recorded were healed within 12 weeks.
Ulcer status

The ulcer status was not recorded in one patient record.

Recurrences

2nd Ulcer

7 patients had a 2nd ulcer of which:

- 3 patients had unhealed ulcers at the time of the audit
- 3 patients had healed ulcers within 12 weeks
- 1 patient had an ulcer that took over 1 year to heal

3rd Ulcer

2 patients had a 3rd ulcer of which:

- 1 patient had an unhealed ulcer at the time of the audit
- 1 patient’s ulcer had healed within 12 weeks
The compression system used for 1st ulcer where aetiology was confirmed

![Bar chart showing the distribution of compression systems used.]

- **Profore**: 13 patients
- **Profore light**: 5 patients
- **Class 1 hose**: 6 patients
- **Class 11 hose**: 8 patients
- **Jobst stockings**: 2 patients

37 patients had aetiology confirmed in their patient record.
1 patient is being treated for lymphoedema
1 patient refused compression
1 patient record did not state the compression system

**Mixed aetiology**

There were 4 patients with mixed aetiology of which:

- 1 patient was treated with profore light
- 1 patient was treated with class 1 hosiery
- 2 patients were referred to the vascular consultant.
Re-screening

32 patients had re-screening documented in their patient record
7 had no re-screen in the patient record and no reason given why not

Number of re-screen sessions attended by patients

This activity for Gloucester was between September 2003 and the audit date and for The Forest of Dean between April 2006 and the audit date.
Referral to other services

14 patients were referred to the ‘Leg Ulcer Service’ for further investigation. These patients are shared care and attended at varying intervals.

1 patient attends 2 monthly
3 patients attend 3 monthly
1 patient now to attend after 7 months
It was recorded for 2 patients ‘As requested by Leg Ulcer Service’
It was recorded for 1 patient ‘1 attendance only’

Other referrals for further investigation

1 patient was referred back to GP
1 patient was referred back to nurse led clinic recall 3 monthly
1 patient declined all recommendations for support hose and declined follow up care
1 patient was referred to the practice nurse
1 patient returned to practice nurse of own volition
1 patient was referred to the Diabetic foot clinic/ Dermatology Consultant
1 patient was referred to the Vascular Consultant
1 patient was referred to the Vascular Consultant and GP

Social support

40 patients attended a social support group at Gloucester

3 patients have declined follow up care
Discussion

Introduction

Primary care nursing is at present undergoing significant change and District nurses are being challenged to develop new ways of working and to take on Long Term Condition management (Morgan 2005). Venous leg ulceration from the patients, point of view is a chronic life changing condition. It is not currently recognised by the government as a chronic disease and yet, the literature confirms that Leg Ulcer care is a major component of the District Nursing case load and presents staff with huge challenges. The cost of Leg Ulcer treatment to the NHS is estimated to be 1.3% of the health care budget, much of this cost is caused by nursing hours within the community (Leach 2004). The plethora of literature, comparing service delivery in community leg ulcer clinics against care provided by district nurses at home, illustrates a general opinion that care provided at home was “good” but was more “specialised” in a community clinic setting. Flannigan et al (2001) further suggest that Community Nursing services often fail to identify frame works for preventative care, but this has been challenged by the Look after Your Legs approach locally and the internationally established Lindsay (2004) Leg Club model. Local research within the Look after Your Legs model identifies patient’s views via focus groups and illustrates the value of support networks that they gain from attending a community clinic that provides holistic nursing, encompassing psychological and social support which empowers and enables patients to self care.

Gender and Age

Leg ulceration affects a large number of people in the UK especially in older age groups, (Field 2004), although it can be a condition which affects younger people in particular IV drug users (Palfreyman et al, 2007). This audit reflects 66% of older people between seventy and eighty nine years who are most affected with venous disease. With 34% being below seventy years. With regards to gender, national statistics show a greater proportion of women to men however this audit shows almost a fifty, fifty split.

Referral Mode and Difference between Date of Referral and 1st Clinic Appointment

The audit showed that approximately 70% of referrals came from community staff with the remainder being referred from GP’s and Specialist Consultants with a small percentage of patients self referring. 82% of patients were seen within two weeks of referral to the clinics. This compares to an average waiting time of two-four weeks for patients with referrals to secondary care specialist Leg Ulcer services. The audit identified an overall weakness in record keeping with regards to “mode of referral” and the difference between “date of referral and 1st clinic date”. The auditors are not in receipt of any national data in relation to referral modes or waiting times.

Aetiology

There are many related pathophysiological conditions that can eventually result in lower leg ulceration, (Murray 2004). In a study by Callam et al (1985) the aetiology of leg ulceration was identified as venous in 70% of patients and arterial in 22% with the remainder being associated with other co morbidities. This audit identified that 90% of patients had ulceration of venous aetiology and 10% had mixed aetiology ulcers (a combination of arterial and venous insufficiency). The next most common cause of ulceration is arterial insufficiency at 10% according to Maloney and Grace (2004), however this audit identified no patients with clearly defined arterial disease.
The difference between first clinic date and healed date.

25% percent of patients presenting with leg ulceration were shown to be healed within four weeks, 13% within eight weeks and 19% within twelve weeks. 57% of patients over all were healed within a total of twelve weeks, this compares with a study by Edwards et al (2005) which show healing rates at twelve weeks using the Leg Club model to be 46.2 %. This was reported as a comparison with those patients treated within their own homes which showed healing rates at twelve weeks to be only achieved in 25.9% of patients. Of the remaining patients 19% healed within sixteen weeks, 6% within twenty weeks and 19% took more than twenty weeks to heal.

Ulcer Status

The audit identified that the majority of patients were referred to the clinic for ongoing management of lower leg ulceration. Thirteen patients were referred with healed ulceration and were being treated in compression hosiery and required only on going management to prevent ulcer recurrence. These patients would be entered into an ongoing programme of management to prevent recurrence. The Look after Your Legs self care prompt tool underpins self management. Patients are given the opportunity to gain insight in to the experience of living with a healed venous ulcer, and learn how to live with a chronic recurring condition, by recognising signs and symptoms of regression, and empowering them to self care, and recognise when to seek professional intervention. Flaherty (2005) supports this in her article which reviewed the views of patients with healed venous leg ulcers.

Two patients were referred on for further specialist advice, from secondary care. One patient was referred for advice only and in one set of notes the status of the patient’s ulcer was not recorded.

Recurrences

Venous ulcer recurrence rates are generally reported as between 26 and 33% (Moffet and Franks 1995). This audit identified that 13% of patients presented with recurrence of second ulcer and of those 35% presented with a third ulcer. 13% from this audit represents a significant decrease in recurrences in comparison with professional literature. Poore, et al. (2002) endorses that regular follow up in a clinic setting has been shown to reduce recurrence rates and compliance with wearing compression hosiery and patient education also impact on this ( Flaherty 2005) . Lindsay 2006 shows a correlation between delivering care in a community setting as opposed to a home setting in relation to a reduction in recurrences.

Compression systems used with confirmed aetiology.

The RCN (1998) and Scottish Intercollegiate Guidelines network (SIGN) (1998) are the national guidelines that endorse compression therapy as the most effective treatment for confirmed aetiology venous leg ulcers.

The audit shows that 91% of patients suitable for compression had compression therapy applied for their first episode of ulceration. The remaining 8% yielded one Lymphoedema patient who needed specialist intervention, one patient who refused compression and one set of nursing records did not state type of compression used.

Of the 91% a proportion of patients were treated in the Profore and Proguide systems which reflect the use of the PCT wound care formulary guidelines. The remaining were treated with a range of compression hosiery.
Off those who had identified mixed aetiology leg ulcers one was treated with Profore light compression, one with class 1 hosiery, and two were referred to the Vascular Consultant.

Re Screening

Current RCN (1998) guidelines suggest that Ankle Brachial Pressure Index (ABPI) should be repeated every three months, this is supported by Pankhurst (2004). The audit results show that 62% of patients were re screened three monthly, this reflects national guidelines. In seven sets of patient records there was no re screen entry or reason given as to why no re screening activity was undertaken. At the time of the audit 12% of patients had not reached an initial three month re screen date. 12% were non compliant with re screening, i.e. did not turn up on the day.

Number of attendance for re screen

Gloucester clinic commenced in September 2003 and the audit was undertaken in April 2007, results include all attendances for re screening over those forty four months. The Forest of Dean clinic commenced in April 2006 and represents twelve months of re screening activity. Re screening activity shown in patient records, recorded thirteen patients had attended for between one to five re screening sessions in Gloucester and six patients in the Forest of Dean. Six patients attended for between six to ten re screening sessions and three had attended for between eleven to fifteen re screening sessions in Gloucester.

Referral to other services

A total of fourteen patients were referred to the Leg Ulcer Service in secondary care for further investigations. The audit results don’t however identify the reasons for referral, but it is expected that the main reason would be that patients’ ABPI fell outside nationally recognised normal ranges, (RCN 1998). This is supported by Field (2004). These patients care then became “shared” with secondary care with patients attending the community leg ulcer clinics on a regular basis with follow up care being provided by the secondary care leg ulcer service as indicated by the patient’s leg ulcer status. Patients were also referred to the Vascular Consultant, Dermatology consultant/ GP/ Diabetic foot clinic, Practice Nurse and one patient declined all treatment.

Social Support

Attendance numbers at a social support group refers to the Gloucester support group only, there is no support group attached to the Forest of Dean clinic. 40 patients attend the Gloucester group on a monthly basis and three patients have declined attendance. Hawkins and Lindsay (2006) acknowledges that participation in a regular support group meeting encourages patients to be better informed and actively involved in their care with a growing willingness to share with one another their experiences of living with a leg ulcer. Radley (1994) claims, relationships in which we live and the groups, to which we belong, have a strong bearing on the maintenance of good health.
### Clinical Audit Action Plan

<table>
<thead>
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<th>'Implement By' Date</th>
<th>Staff Member Responsible</th>
<th>Review Date</th>
</tr>
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<tbody>
<tr>
<td>To set up further community based leg ulcer clinics in Gloucester and the Forest of Dean</td>
<td>Gloucester September 07, Forest of Dean January 08</td>
<td>Identified leads for clinics</td>
<td>Gloucester January 08, Forest June 08</td>
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<tr>
<td>To recommend the Forest of Dean (Dilke) clinic is relocated into a community setting</td>
<td>Jan 08</td>
<td>Forest of Dean clinic lead and team</td>
<td>September 08</td>
</tr>
<tr>
<td>The development of a social support for the Forest of dean clinic</td>
<td>April 08</td>
<td>Forest of Dean clinic lead and team</td>
<td>October 08</td>
</tr>
<tr>
<td>Sustaining of local leg ulcer two day training and one day up dates.</td>
<td>On going</td>
<td>Joint primary and secondary care leg ulcer training team</td>
<td>Annual September 08</td>
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<tr>
<td>Re audit all established clinics</td>
<td>Spring 09</td>
<td>To be arranged</td>
<td>Autumn 2009</td>
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Signature of Project Lead: ............................................ Name (in print): .................................................. Date: .........................

Signature of Manager: .................................................. Name (in print): .................................................. Date: .........................
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