

LIVE ON FACEBOOK:

Compression therapy the safe way: what to look out for in vascular assessment



Wednesday, 4th December
19:30

Presented by **Leanne Atkin**, *vascular nurse consultant, Mid Yorkshire NHS Trust*;
Dawn Stevens, *medical education manager, Essity*

Compression therapy the safe way: what to look out for in vascular assessment

The webcast will begin in..

06.00

Q&A session
To post a question,
comment on this
video



Compression therapy the safe way: what to look out for in vascular assessment

Learning objectives

1. Leg ulceration — how much time do we spend looking after legs?
2. GIRFT approach to leg ulcers (Getting it right first time)
3. New guidance on starting compression without a Doppler — let's not waste time
4. Understanding what is involved in vascular assessment to make it safe to start compression
5. Where is the evidence to support bandaging versus leg ulcer kits?
6. How does compression actually help our patients?
7. Live Q&A with Leanne and Dawn

Cost of wound care to the NHS

- Managing patients with wounds and their associated comorbidities is estimated to cost the NHS £5.3bn per annum
- For providers/commissioners, the delay in wound healing relates to resources being consumed inappropriately
- A recent study was conducted looking at the true extent of managing and healing chronic wounds – Burden of Wounds Study



Burden of wounds — nursing time

- Wound management is a nurse-led discipline
- Two-thirds of wound care is managed in the community setting
- Cost of wound management is higher than the cost of managing obesity of over £5bn per annum
- **10.9m community nurse** visits recorded to manage wounds per annum
- **18.9m practice nurse clinic** visits recorded to manage wounds per annum



Health economic burden that wounds impose on the National Health Service (NHS) — Guest et al, 2015

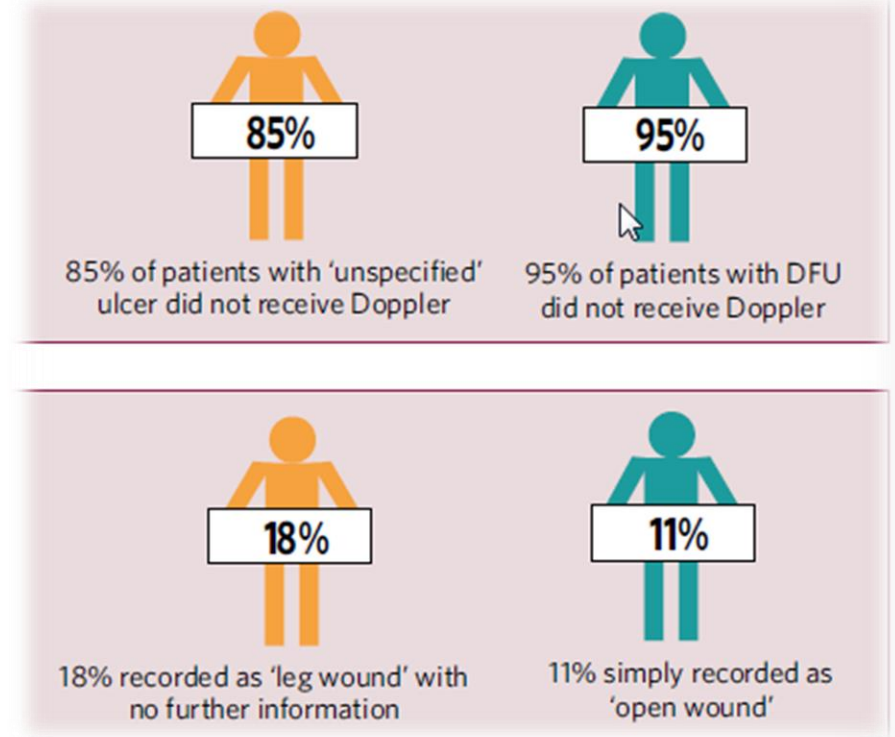
Cost of leg ulceration

- Leg ulceration is thought to affect 3% of the adult population worldwide
- During 2012/13, the NHS managed an estimated 278,000 patients with a confirmed venous leg ulcer (VLU)
- The annual cost of managing these VLUs and associated comorbidities was estimated to be £941.1 million
- The NHS also managed 420,000 patients with an ulcer of the lower limb without a differential diagnosis costing between £539.5 and £778.9 million



Compression without a Doppler

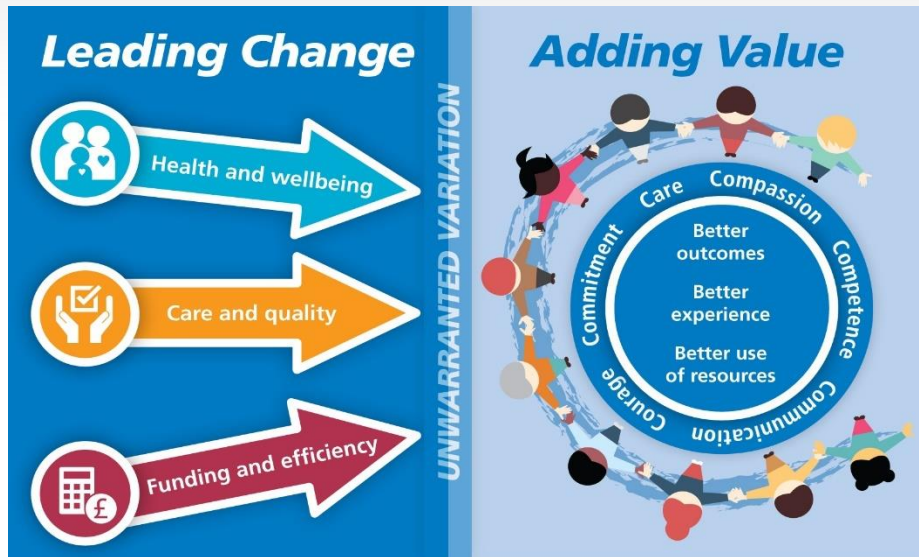
- Lack of holistic assessment
- 41% of all wounds were on the lower limb
- Doppler (ankle brachial pressure index [ABPI]) was NOT performed on 84% of patients with lower limb ulceration, but 46% of those patients were in compression therapy



- Dawn introduces Leanne

Effective care?





January 2017

NHS RightCare scenario:
The variation between standard and optimal pathways

Betty's story: Wound care

January 2017

<https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/02/nhs-rightcare-bettys-story-app1.pdf>

Financial information

Analysis by provider	Sub-optimal	Optimal
Acute	£1,703	£0
Ambulance service	£466	£0
Community teams	£2,167	£12
Primary care	£1,334	£346
Pharmacist	£3	£3
Leg ulcer pathway	£0	£144
Grand total	£5,673	£505

In the suboptimal scenario:

- Dressings represent £1,353 (24%) of the total costs versus £88 in the optimal pathway.
- Clinical time represents £2,139 (38%) of the total costs versus £195 in the optimal pathway.



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Whole system change



National Wound Care Strategy Programme

Excellence. Every Patient. Every Time.



Navigation tool

DRAFT NWCSP Lower Limb Clinical Navigation Tool (V10 12.08.19)

Initial Care

RED FLAGS - Immediately escalate

- Spreading infection of leg or foot
- Limb threatening ischaemia
- Suspected skin cancer
- Red hot swollen leg or foot
- Suspected DVT

Discuss with relevant specialist:

- Acute cardiac failure
- Last few weeks of life

Diabetes - Care for patients with a foot ulcer and confirmed (or suspected) diabetes should follow NICE Guidance for diabetic foot⁵

All patients with a lower limb wound should have:

- Wound and skin cleaning¹
- Simple low-adherent dressing with sufficient absorbency¹
- For wounds on leg, first line mild compression (14-17mmHg)
- Within 24 hours of initial presentation arrange escalation to designated clinician/ service with responsibility for diagnosis and treatment.**
- Wounds due to pressure damage due to immobility or medical device: Report using local incident reporting system.

Diagnosis and Treatment

FOOT (i.e. below malleolus) Within 48 hours of original presentation

- Assess and ID contributing causes of non-healing by undertaking an assessment that includes:
 - Comprehensive assessment including clinical and psychosocial needs;
 - Wound assessment documented using wound minimum data set.
 - Lower limb assessment that includes vascular, neuropathy and biomechanical assessment³
- Formulate treatment plan
 - Patients with confirmed or suspected diabetes
 - o Follow NICE Guidance for diabetic foot⁵
 - Patient without confirmed or suspected diabetes
 - o Follow principles of NICE Guidance for diabetic foot

References

- SIGN. 2010. Management of chronic venous leg ulcers - a national clinical guideline. <http://www.sign.ac.uk/guidelines/fulltext/220/>
- NICE (2013) Clinical Guideline - Varicose Veins: Diagnosis and Management. <http://www.nice.org.uk/guidance/cg166>
- Gohel, M. S., Heasley, F., Liu, X. et al. (2018) A Randomized Trial of Early Endovenous Ablation in Venous Ulceration. *New England Journal of Medicine*.
- Ashby, R. L., Gabe, R., Ail, S. et al. 2014. VenUS IV (Venous leg Ulcer Study IV): Health Technology Assessment.
- NICE. (2016). Clinical Guideline - Diabetic foot problems: prevention and management. <http://www.nice.org.uk/guidance/ng19>

LEG

Within 2 weeks of original presentation

- Assess and ID contributing causes of non-healing by undertaking an assessment that includes:
 - Comprehensive assessment including clinical and psychosocial needs;
 - Wound assessment documented using wound minimum data set.
 - Lower limb assessment including ASPI ("Doppler") or other vascular assessment
- Formulate treatment plan
 - Leg wounds with and without signs of venous disease where no other aetiology is suspected:
 - o Refer for venous surgical interventions
 - o Simple low-adherent dressing
 - o Minimum 40mmHg graduated compression
 - o Consider oral pentoxifylline
 - Leg wounds with signs of arterial disease:
 - o Refer for vascular surgical interventions and advice on compression
 - o Pending vascular opinion:
 - Simple low-adherent dressing
 - If limb is oedematous and ASPI 05.-0.79 continue with mild graduated compression (14-17mmHg)
 - Consider oral pentoxifylline
 - Leg wounds of other or uncertain aetiology:
 - o Refer to appropriate specialist for symptoms
 - o Pending specialist opinion
 - Simple low-adherent dressing
 - Continue with mild graduated compression (14-17mmHg)
 - For **all** types of leg wound:
 - o Review medicines
 - o Consider analgesia needs
 - o Offer advice on skin care, footwear, exercise, rest and limb elevation and self-care

Ongoing Care and Review

FOOT (i.e. below malleolus)

- At each dressing change:**
- Wound and skin cleaning
 - Review effectiveness of treatment plan and escalate any concerns
- At weekly intervals**
- Review effectiveness of treatment plan and escalate any concerns

LEG

- At each dressing change:**
- Wound and skin cleaning
 - Review effectiveness of treatment plan and escalate any concerns
- At 4-week intervals:**
- Assess for reduction in wound size;
 - Assess for reduction in limb swelling;
 - Assess condition of skin
 - Assess pain/ discomfort
- If not improving escalate for specialist advice
- At 12 weeks:**
- If unhealed, escalate for specialist advice.
- Following healing of venous leg ulcer:**
- Maintenance compression hosiery;
 - Advice regarding prevention of recurrence

Compression Therapy for those with no significant arterial disease

At each dressing change:

- Review effectiveness of treatment plan
- Wash leg and foot
- Remove old dry skin
- Apply hypo-allergenic emollient to leg and foot
- Apply simple, low-adherent dressing¹
- Review analgesia needs
- Consider 2-layer compression hosiery kit (40 mmHg)⁴ unless:
 - Very swollen ankle or increased swelling not reduced by elevation, or
 - Abnormal limb shape, or
 - Copious exudate, or
 - Very fragile skin
 Consider need for application aids
- If not suitable for compression hosiery, offer multi-component compression bandaging (40 mmHg or equivalent)¹.

Continue with therapeutic compression and at 4-week intervals (or less)

Assess:

- Ulcer size
- Swelling in lower limb
- Surrounding skin
- Pain / discomfort

Improving: Continue with care

Not improving or not healed by 12 weeks: Refer to Lower Limb specialist service which should tailor care to the individual using bespoke or advanced treatment or compression techniques; if effective, this care should be continued by the local care team under the supervision of the specialist team.



Clinical navigation tool

Initial Care



Red flags — immediately escalate

- Spreading infection of leg or foot
- Red, hot swollen leg or foot
- Limb-threatening ischaemia
- Suspected deep vein thrombosis (DVT)
- Suspected skin cancer

Discuss with relevant clinical specialist:

- Acute cardiac failure
- Last few weeks of life

Diabetes — Care for patients with a foot ulcer and confirmed (or suspected) diabetes should follow NICE guidance for diabetic foot

Spreading infection of leg or foot

- Systemic features:
 - Fever (30–80% may be afebrile)
 - Tachycardia
- Redness — clear edge
- Skin can resemble orange peel
- Pain
- Warm to touch
- Oedema — resulting in elimination fine wrinkles
- General malaise — flu-like symptoms
- Develops rapidly



Annually NHS spends £172–254 million on the admission and treatment of patients with cellulitis — accounts for 400,000 bed days per year (Curtis, 2011)

Red, hot swollen leg or foot



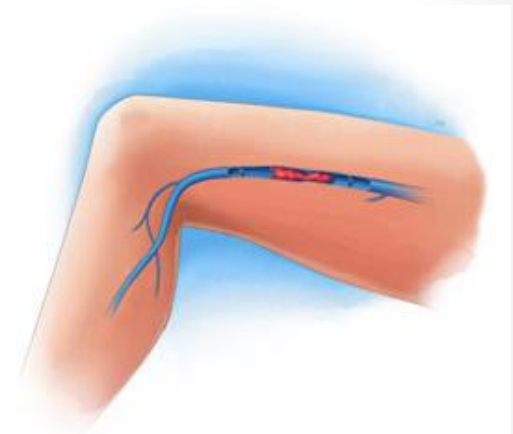
Limb-threatening ischaemia

- Dependent rubor
- Red sunset foot
- Induration reduces on elevation
- Associated with severe pain (unless patient has diabetes)
- If revascularisation not timely, tissue loss will follow
- Often on background of claudication
- No need for urgent admission
- Requires urgent referral



Suspected DVT

- Limb congestion
- Sudden onset oedema over 12 hours
- Pain on flexing of ankle
- Red/purple discoloration
- Warm to touch
- Often preceding event: surgery, flight, period of immobility



Suspected skin cancer

- Lump, blemish or mark which changes
- Crusty, oozing or bleeding
- Itchy, tender or purple
- Lower tolerance for biopsy
- Clinical pathways with red flag time points



Discuss with relevant specialist

Chronic heart failure

- Shortness of breath
- Fatigue
- Lower limb oedema
- Rapid or irregular pulse
- Persistent cough or wheeze with white/pink blood-tinged phlegm
- Swelling of abdomen
- Gradual weight gain from fluid retention
- Lack of appetite and nausea

Acute heart failure

- Symptoms similar to chronic, but start to worsen suddenly
- Sudden fluid build up
- Palpitations
- Sudden shortness of breath — coughing up pink, foamy mucus
- Rise in B-type natriuretic peptide (BNP)

Discuss with relevant clinical specialist

Last few weeks of life



the **gold standards**
framework

Diabetes

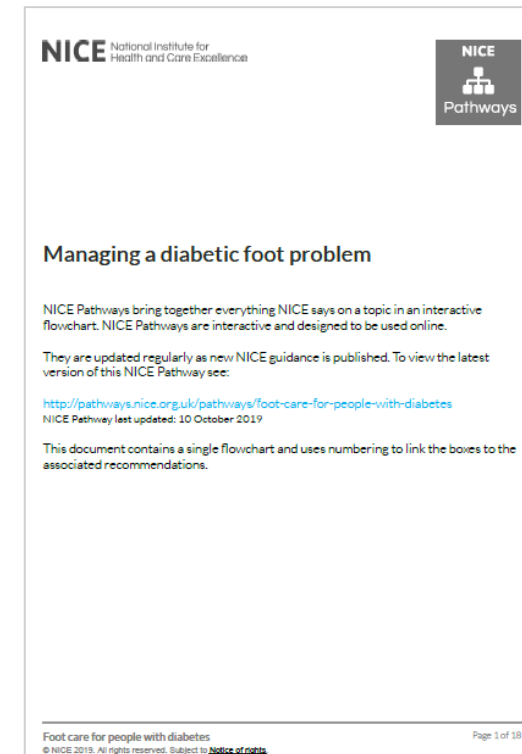
Diabetes - Care for patients with a foot ulcer and confirmed (or suspected) diabetes should follow NICE Guidance for diabetic foot

2 When to refer

If a person has a limb-threatening or life-threatening diabetic foot problem, refer them immediately to acute services and inform the multidisciplinary foot care service (according to local protocols and pathways; also see [principles of care](#)), so they can be assessed and an individualised treatment plan put in place. Examples of limb-threatening and life-threatening diabetic foot problems include the following:

- Ulceration with fever or any signs of sepsis (see what NICE says on [sepsis](#)).
- Ulceration with limb ischaemia (see what NICE says on [lower limb peripheral arterial disease](#)).
- Clinical concern that there is a deep-seated soft tissue or bone infection (with or without ulceration).
- Gangrene (with or without ulceration).

For all other active diabetic foot problems, refer the person within 1 working day to the multidisciplinary foot care service or foot protection service (according to local protocols and pathways; also see [principles of care](#)) for triage within 1 further working day.



The screenshot shows the top portion of a NICE Pathways document. At the top left is the NICE logo (National Institute for Health and Care Excellence). At the top right is the 'NICE Pathways' logo, which includes a small icon of a person with a plus sign. The main title is 'Managing a diabetic foot problem'. Below the title, there is a paragraph explaining that NICE Pathways are interactive flowcharts. Another paragraph states they are updated regularly and provides a link to the latest version: <http://pathways.nice.org.uk/pathways/foot-care-for-people-with-diabetes>, noting it was last updated on 10 October 2019. A final paragraph mentions that the document contains a single flowchart and uses numbering to link boxes to recommendations. At the bottom left, it says 'Foot care for people with diabetes' and '© NICE 2019. All rights reserved. Subject to [notice of rights](#)'. At the bottom right, it says 'Page 1 of 18'.



Clinical navigation tool

Initial Care



Red flags — immediately escalate

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Discuss with relevant clinical specialist:

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Diabetes — Care for patients with a foot ulcer and confirmed (or suspected) diabetes should follow NICE guidance for diabetic foot



Clinical navigation tool

Initial Care



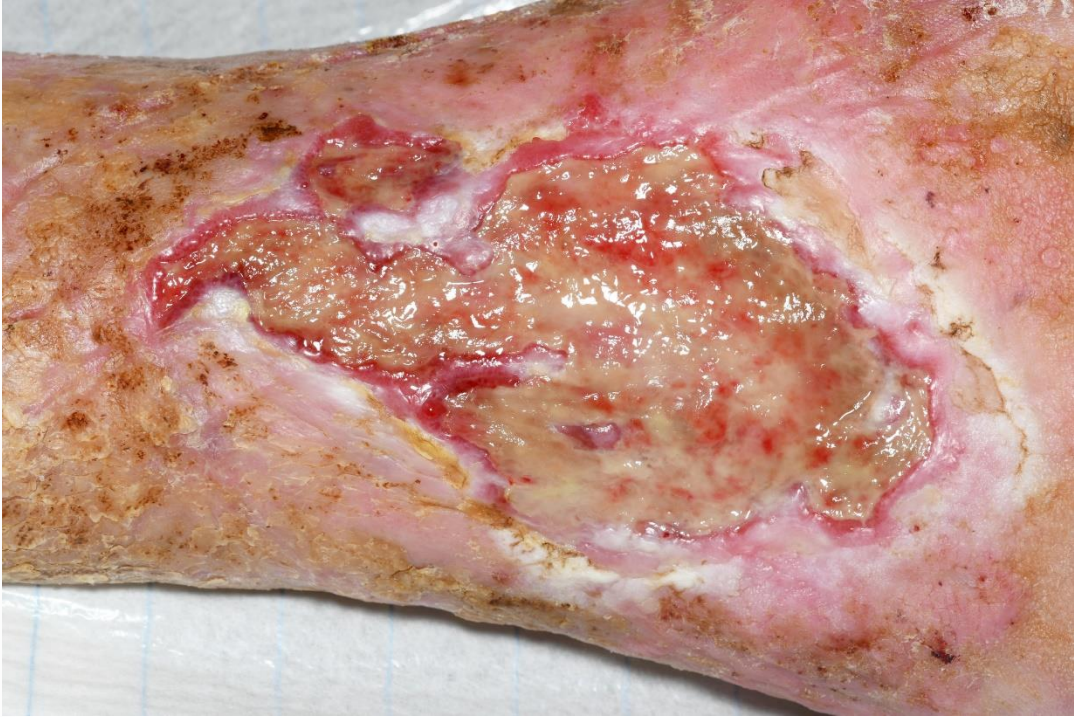
All patients with a lower limb wound should have:

- Wound and skin cleansing
- Simple, low-adherent dressing with sufficient absorbency
- For wounds on leg, first-line mild graduated compression (≤ 20 mmHg)

Within 24 hours of initial presentation escalate for an assessment for diagnosis and treatment undertaken by a clinician with advanced wound care capabilities/competencies working with a multidisciplinary team system

- Wounds on foot should be assessed within 48 hours of initial presentation
- Wounds on the leg should be assessed within 14 hours of initial presentation
- **Wounds due to pressure damage due to immobility or medical device:** report using local incident reporting system and the revised definitions and measures

Wound and skin cleansing



Simple, low-adherent dressing with sufficient absorbency

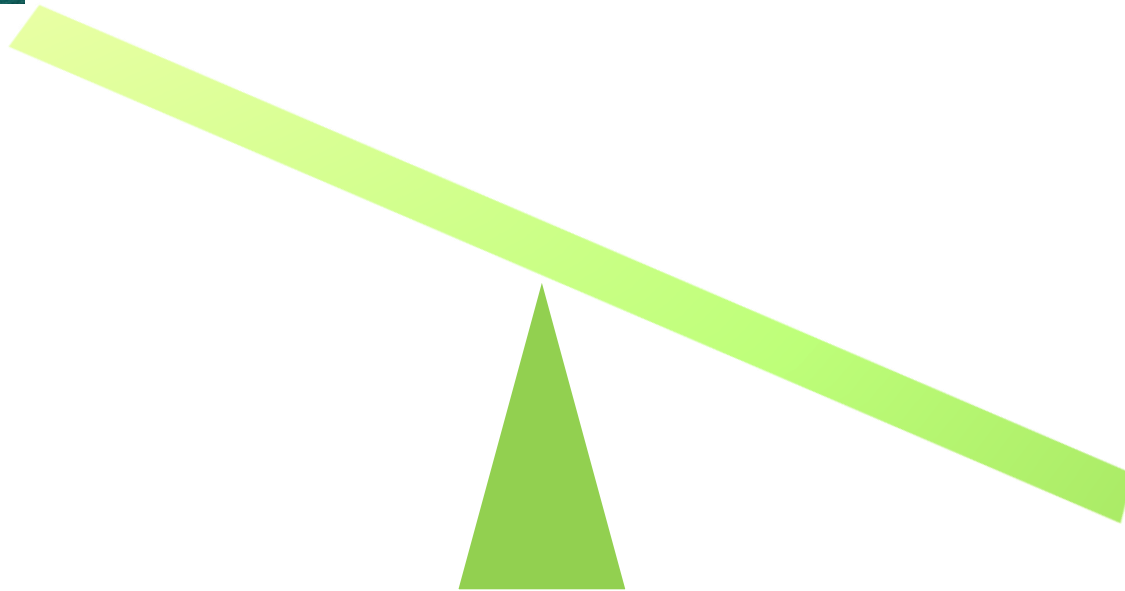


For wounds on leg, first-line mild graduated compression (≤ 20 mmHg)

- Without any formal vascular assessment
- Simple assessment of red flags
- Delays in compression = harm
 - 420,000 leg ulcers without a diagnosis
 - The older the ulcer, the harder to heal
 - 47% healing at six months
 - 10% chance of healing from 6–12 months
- We are causing harm if delaying assessment/compression



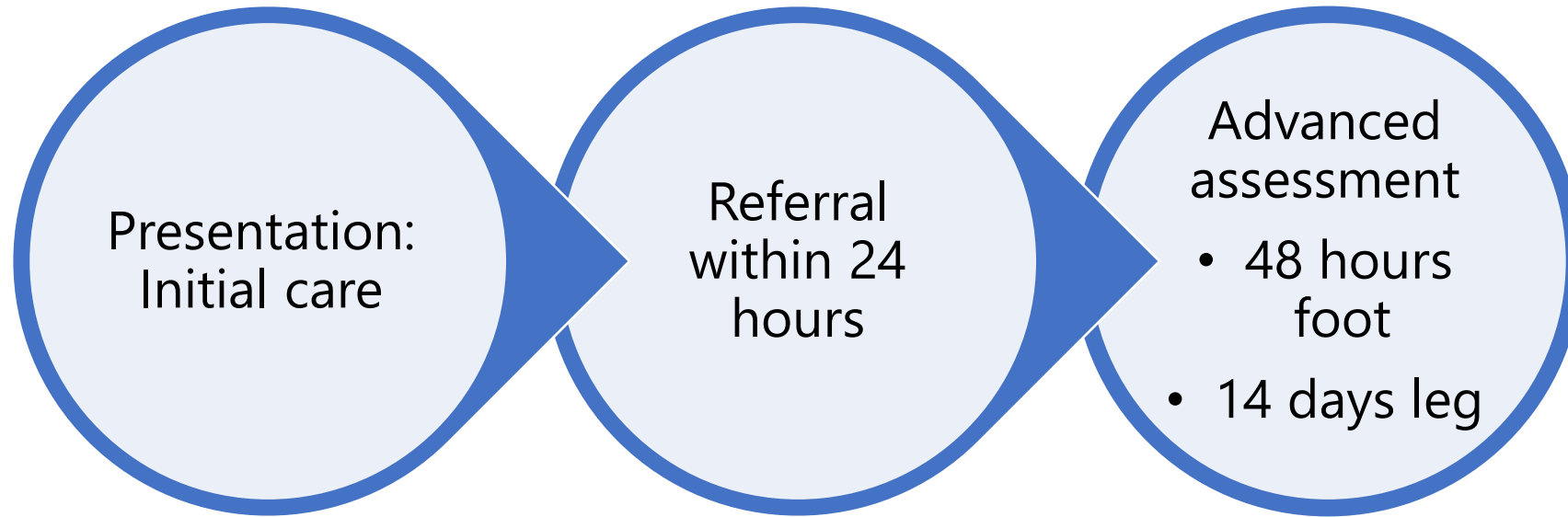
Risk harm balance



Benefits of compression

- Venous incompetence and oedema will reduce arterial flow
- Venous hypertension reduces the intravascular pressure gradient — reducing perfusion pressure
- Oedema pushes blood capillaries apart — increasing distance between blood capillary and cells — impeding nutrient transportation
- Compression increase aids all these factors

Timeline



Within 24 hours of initial presentation escalate for an assessment for diagnosis and treatment undertaken by a clinician with advanced wound care capabilities/competencies working with a multidisciplinary team system.

- Wounds on the foot should be assessed within 48 hours of original presentation.
- Wounds on the leg should be assessed within 14 days of original presentation



Clinical navigation tool

Leg — diagnosis and treatment



Within 14 days of original presentation:

Assess and ID contributing causes for non-healing by undertaking an assessment that includes:

- Comprehensive assessment including clinical and psychosocial needs;
- Wound assessment documented using wound minimum data set ²² and wound photography
- Lower limb assessment including assessment of ankle brachial pressure index (ABPI) using handheld vascular Doppler or other vascular assessment

Formulate treatment plan

Patients diagnosed with **venous disease** should be offered referral for venous surgical interventions.

For leg wounds **with and without signs of venous disease with an adequate arterial supply and where no other aetiology is suspected** care should be in line with the SIGN clinical guideline for venous leg ulcers.

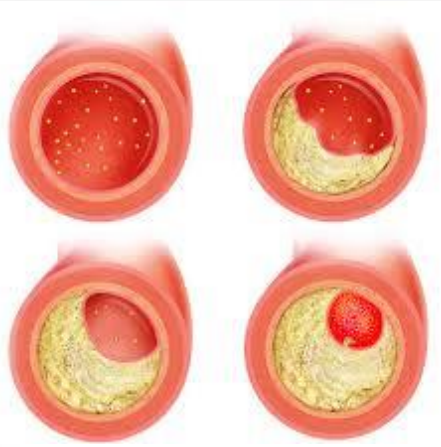
This should include:

- Information about the benefits of compression therapy;
- Compression therapy (minimum of 40 mmHg)

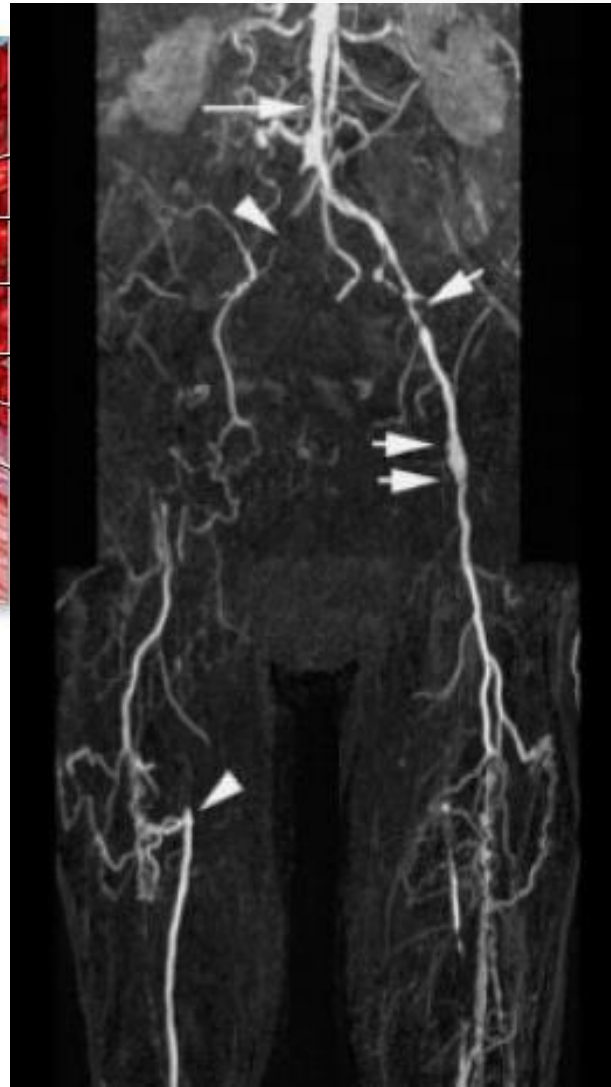
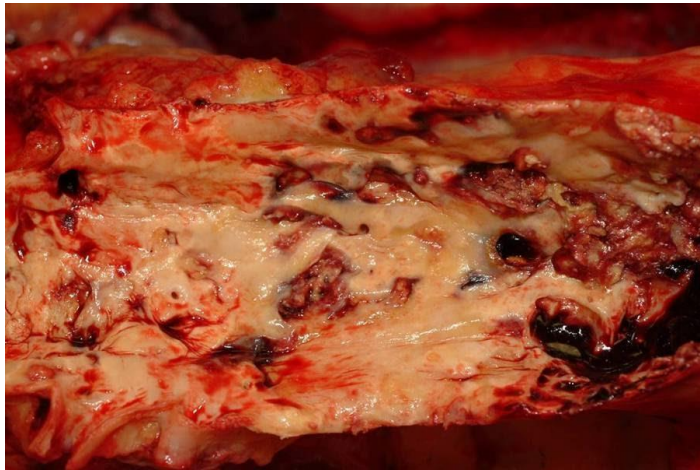
Advanced assessment

Diagnosis: how do you diagnose the aetiology of a leg ulcer?

- Detailed history
- Vascular risk factors
- Physical examination
- Ulcer presentation
- ABPI assessment — remember, ABPI assessment can only confirm or deny presence of arterial disease, NOT diagnose venous ulceration



Cut-section of artery



Doppler assessment

ABPI = ankle brachial pressure index

Simple vascular assessment using a Doppler device


Determines the ratio of the ankle to the brachial systolic pressure



Abnormal ABPI

- If ABPI out of normal range onward referral recommended
- Advanced skills needed
- That could be you?

NHS
Health Education England



Multi-Professional Advanced Capabilities Framework for Lower Limb Viability

The COLLEGE of PODIATRY

Skills for Health



Clinical navigation tool

Leg — diagnosis and treatment



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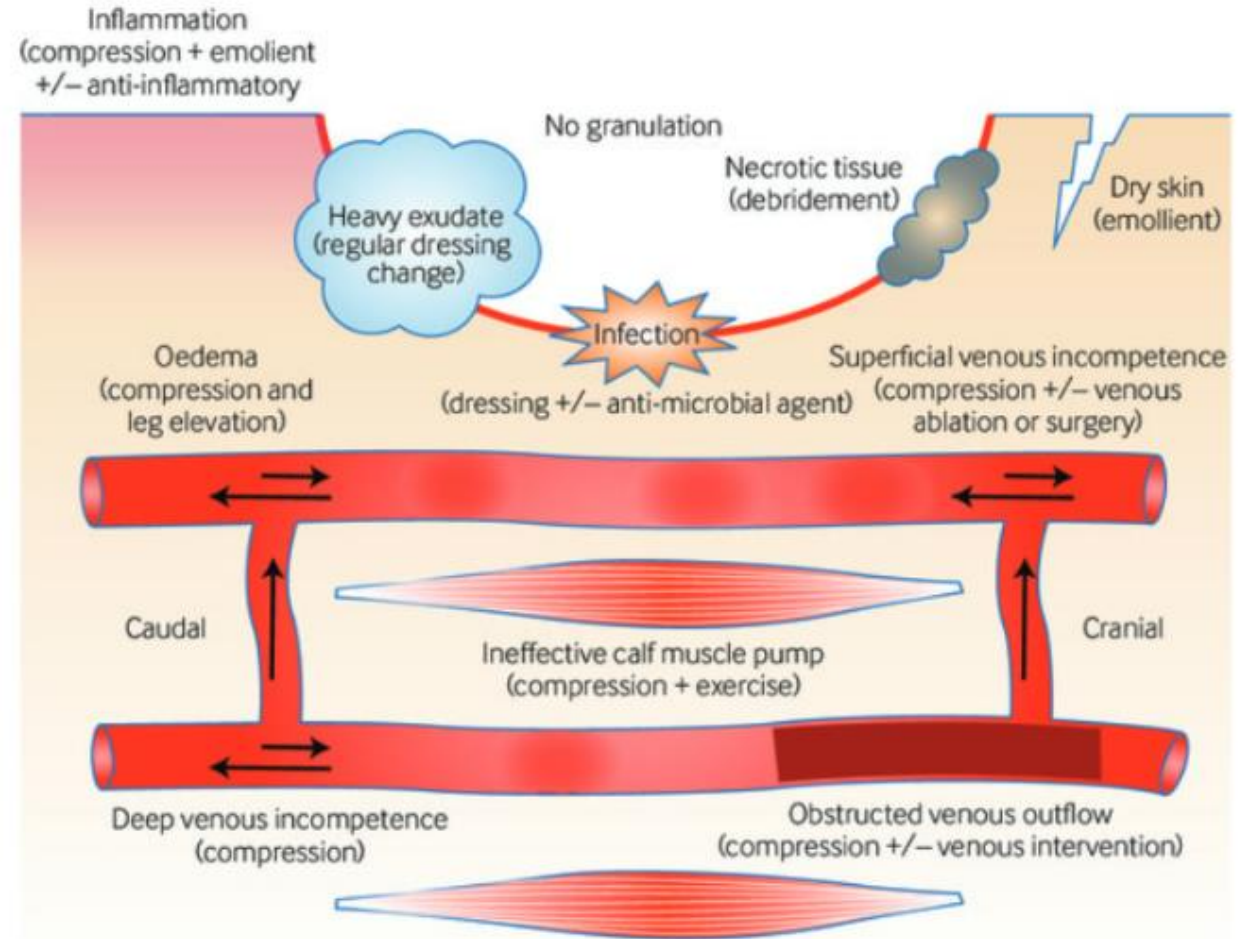
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This should include:

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- Compression therapy (minimum of 40 mmHg)

Leg ulcer — ‘a weed’



Source: *BMJ* 2018; 362: k3115

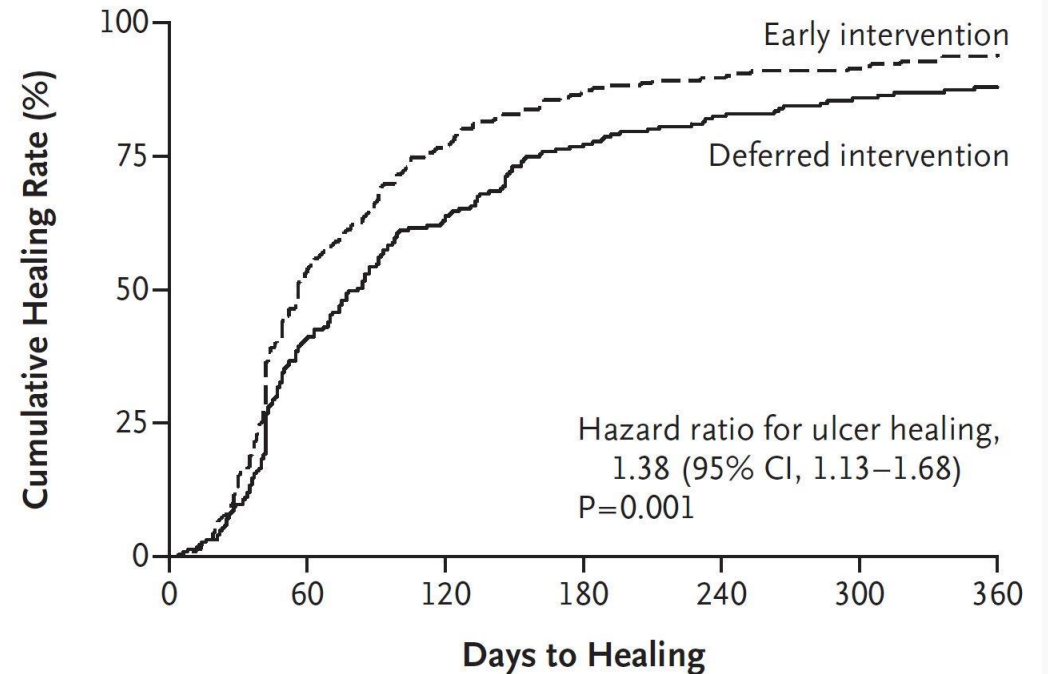
Early venous reflux ablation (EVRA) ulcer trial

- Multicentre
- Parallel group
- Randomised trial
- 450 patients
- Superficial venous reflux
- Venous leg ulcers

Source: Gohel MS , et al (2018) A randomized trial of early endovenous ablation in venous ulceration. *N Eng J Med* **378(22)**: 2105–14

EVRA results

- Early venous intervention aids healing
- Healing times reduced from 82 days in control group, (compression) to 56 days (compression and venous intervention) (P=0.001)
- Rates of healing at 24 weeks was 85.6%





Clinical navigation tool

Leg — diagnosis and treatment



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Clinical navigation tool

Leg — diagnosis and treatment



- Patients with very swollen ankle, or increased swelling not reduced by elevation, or abnormal limb shape, or copious exudate, or very fragile skin should be offered multi-component compression bandaging (minimum 40mmHg) and escalated for expert diagnosis and advice about lymphoedema
- Patients without the above symptoms should be offered compression in the form of two-layer compression hosiery kits as first-line treatment. The need for application aids should be considered

Cochrane

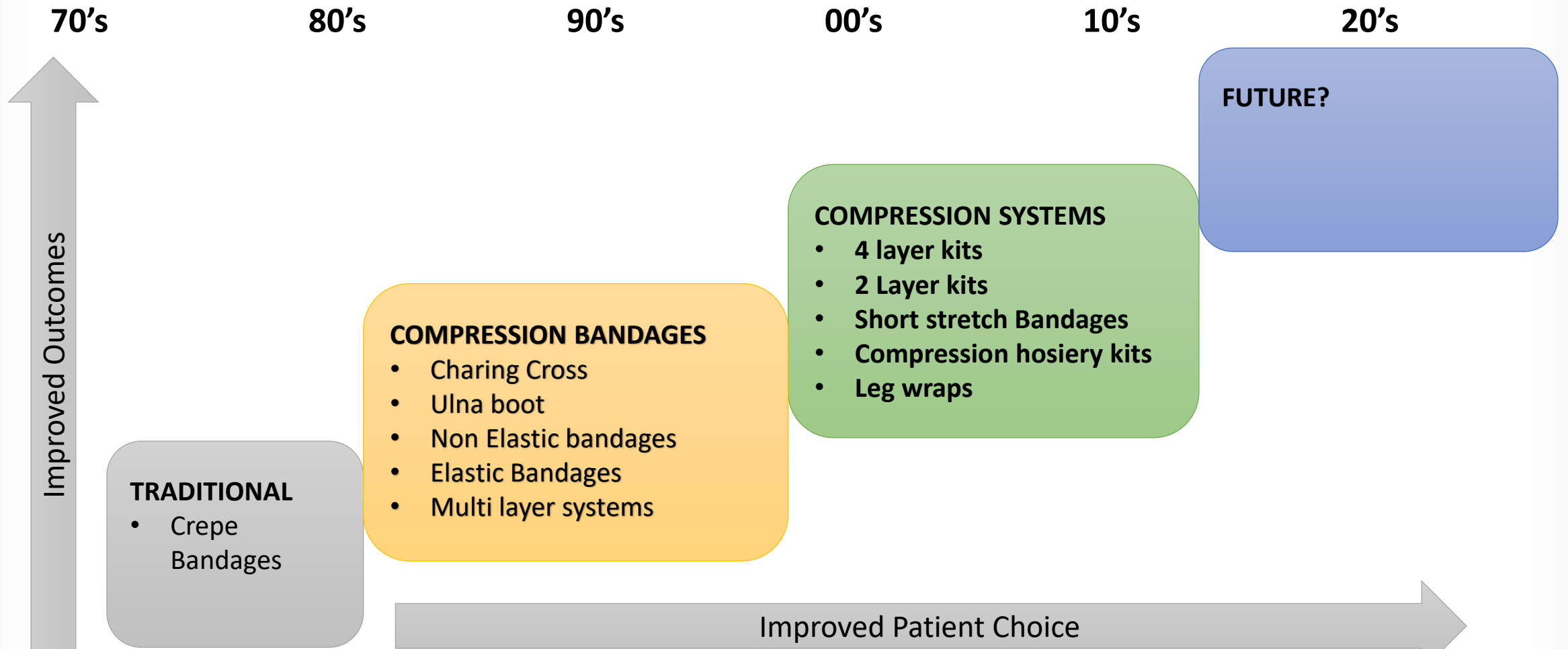
Conclusions:

Compression increases ulcer healing rates compared with no compression. Multi-component systems are more effective than single-component systems. Two-component bandage systems appear to perform as well as the 4LB



Source: O'Meara S, et al (2012) *Cochrane Database Syst Rev* **11**: CD000265

Evolution of compression therapies



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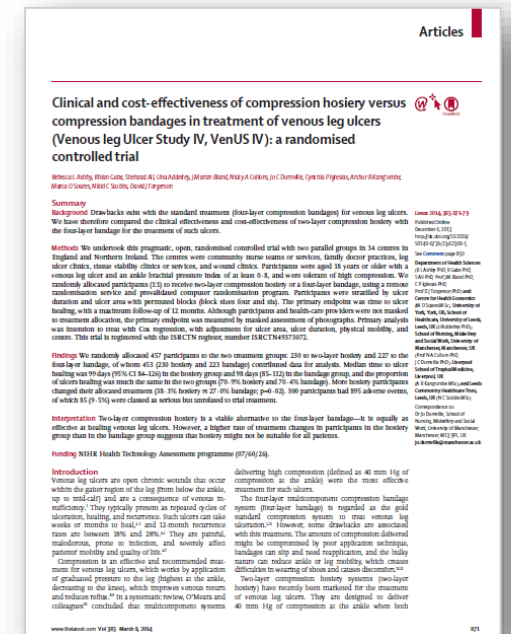


VenUS IV

VenUS IV (Venous Leg Ulcer Study IV): a randomised controlled trial of compression hosiery versus compression bandaging in the treatment of venous leg ulcers

- 34 centres (UK), 457 patients
- Maximum follow-up time of 12 months
- Cost
- Healing
- Quality of life
- Patient concordance

Source: Ashby RL, et al (2014) *The Lancet (British edition)* 383(9920): 871–9



VenUS IV results

	4-layer bandage	2-layer hosiery kit
Median time to healing	98 days	99 days
Ulcers healing	70.4%	70.9%
Ulcers recurring	23%	14%
Mean annual cost	£1,795	£1,494

'Increased use is likely to result in a substantial saving for the NHS with improved quality of life for people with venous ulcers.'

Ashby et al, 2014



Clinical navigation tool

Leg — diagnosis and treatment



For leg wounds with **signs of arterial disease**

Refer for vascular surgical interventions and advice on compression;

Pending vascular opinion:

- Simple low-adherent dressing
- If limb is oedematous with an ABPI ≥ 0.5 and
- ≤ 0.79 with no signs of limb-threatening ischaemia, continue with mild graduated compression (≤ 20 mmHg)

For leg wounds **of other or uncertain aetiology**

Refer to appropriate specialist for symptoms:

Pending specialist opinion

- Simple low-adherent dressing
- Continue with mild graduated compression (≤ 20 mmHg)

Patients with suspected lymphoedema should be offered care in line with the International Lymphoedema Framework (ILF)



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Compression in arterial disease

Compression therapy in mixed ulcers increases venous output and arterial perfusion

Giovanni Mosti, MD,^a Maria Letizia Iabichella, MD,^a and Hugo Partsch, MD,^b *Lucca, Italy; and Vienna, Austria*

Objectives: This study was conducted to define bandage pressures that are safe and effective in treating leg ulcers of mixed arterial-venous etiology.

Methods: In 25 patients with mixed-etiology leg ulcers who received inelastic bandages applied with pressures from 20 to 30, 31 to 40, and 41 to 50 mm Hg, the following measurements were performed before and after bandage application to ensure patient safety throughout the investigation: laser Doppler fluxmetry (LDF) close to the ulcer under the bandage and at the great toe, transcutaneous oxygen pressure (TcPO₂) on the dorsum of the foot, and toe pressure. Ejection fraction (EF) of the venous pump was performed to assess efficacy on venous hemodynamics.

Results: LDF values under the bandages increased by 33% (95% confidence interval [CI], 17-48; $P < .01$), 28% (95% CI, 12-45; $P < .05$), and 10% (95% CI, -7 to 28), respectively, under the three pressure ranges applied. At toe level, a significant decrease in flux of -20% (95% CI, -48 to 9; $P < .05$) was seen when bandage pressure >41 mm Hg. Toe pressure values and TcPO₂ showed a moderate increase, excluding a restriction to arterial perfusion induced by the bandages. Inelastic bandages were highly efficient in improving venous pumping function, increasing the reduced ejection fraction by 72% (95% CI, 50%-95%; $P < .001$) under pressure of 21 to 30 mm Hg and by 103% (95% CI, 70%-128%; $P < .001$) at 31 to 40 mm Hg.

Conclusions: In patients with mixed ulceration, an ankle-brachial pressure index >0.5 and an absolute ankle pressure of >60 mm Hg, inelastic compression of up to 40 mm Hg does not impede arterial perfusion but may lead to a normalization of the highly reduced venous pumping function. Such bandages are therefore recommended in combination with walking exercises as the basic conservative management for patients with mixed leg ulcers. (*J Vasc Surg* 2012; 55:122-8.)

Compression Therapy in Mixed Ulcers: Search for a Safe Pressure Range not Affecting Arterial Inflow

G. Mosti^a and H. Partsch,^b The Clinica MD Barbantini, Lucca, Italy,^a and private practice, Wien, Austria.^b

Background: About 15% to 20% of patients with venous leg ulcers have a reduced ankle brachial pressure index (ABPI) causing retarded healing. Compression is able to improve venous hemodynamics in mixed ulcers but needs to be applied with caution in order not to reduce arterial inflow. This study aimed to define a safe range of compression pressure that does not impede arterial flow.

Methods: In 25 patients with mixed ulcers (ten males, 15 females aged 76.4 ± 10 years), presenting with a mean ABPI of 0.57 ± 0.09 mm Hg and a systolic ankle pressure of 91.8 ± 18.3 mm Hg, skin flow was assessed in the peri-wound area and in the plantar surface of the first toe by means of laser Doppler flowmetry, and toe pressure was measured simultaneously. The measurements were carried out in baseline conditions and after inelastic bandage from the base of the toes to the popliteal area, applied with different pressure ranges of 20 to 30, 30 to 40 and 40 to 50 mm Hg. The pressure exerted by the bandage was continuously measured by a pneumatic device with its flat probe placed next to the laser Doppler probe. The flat, peri-wound laser Doppler probe remained under the bandage, whereas the toe probes were placed distally to the bandage.

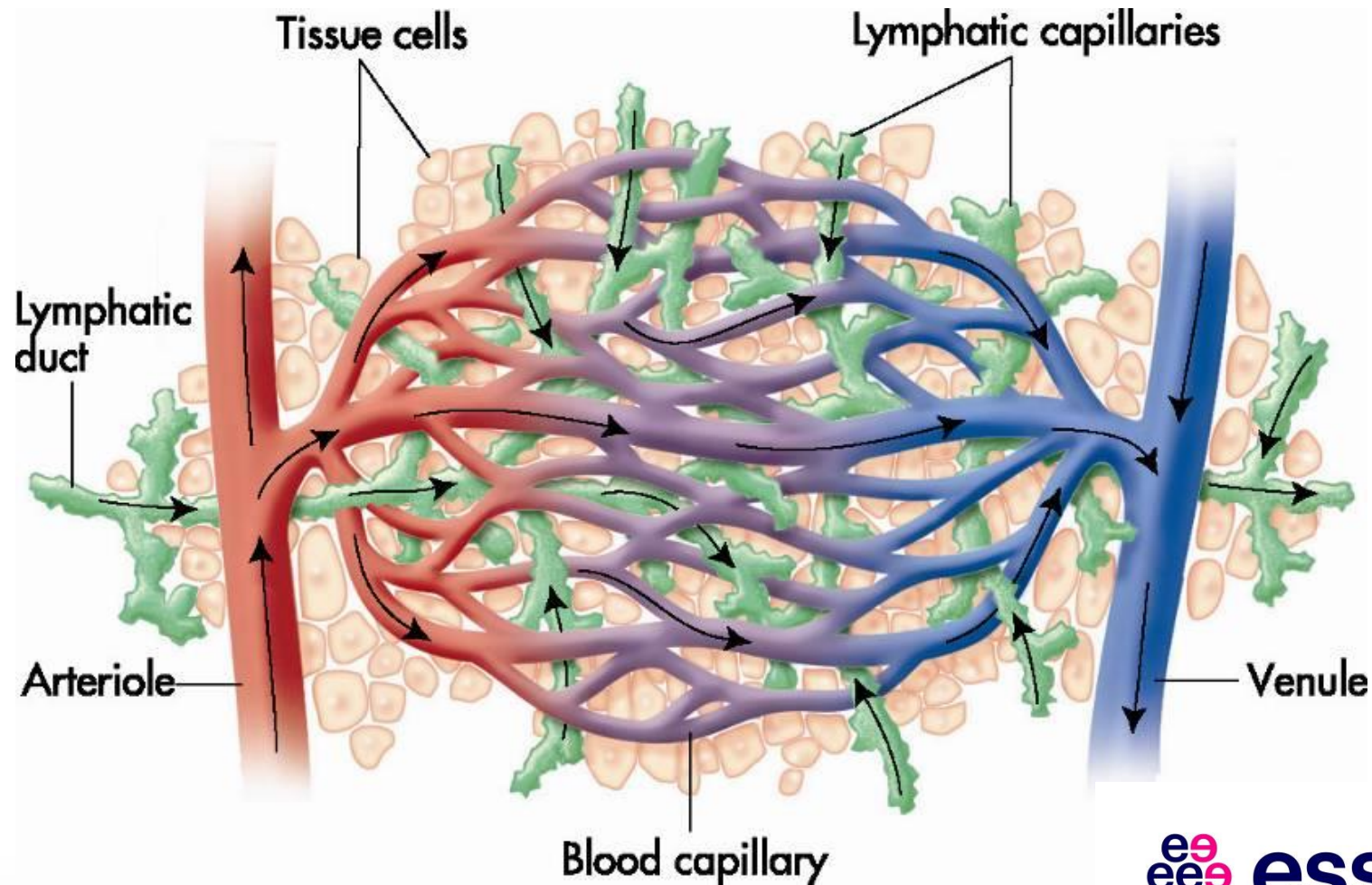
Results: Compared with baseline conditions, skin perfusion increases significantly with a bandage pressure of 20 to 30 and 30 to 40 mm Hg, and returns to the baseline level with 40 to 50 mm Hg (Fig 1A). Toe perfusion shows a minor, not significant, decrease with 20 to 30 and 30 to 40 mm Hg, but a significant reduction with 40 to 50 mm Hg (Fig 1B). Toe pressure increases with every pressure step, showing significant differences compared with baseline with 30 to 40 and 40 to 50 mm Hg (Fig 1C).

Conclusions: External compression of 20 to 30 or 30 to 40 mm Hg increases the arterial flow, even in patients with very low ABPI and does not affect the toe pressure as long the individual systolic ankle pressure is not exceeded. Absolute ankle pressure values are more reliable than ABPI to assess the individual risk concerning compression pressure.

Sources: Mosti G, Partsch H (2011) *J Vasc Surg* **53**(1): 255–255;
Mosti G, et al (2012) *J Vasc Surg* **55**(1): 122–8



Relationship of the lymphatic system





Clinical navigation tool

Leg — diagnosis and treatment



For **all types of leg wound**

- Review medicines
- Consider analgesia needs
- Offer advice on skin care, footwear, exercise, rest and limb elevation

Patients should be provided with written information about their diagnosis and treatment plan, and opportunities for self-care should be identified, discussed and incorporated into treatment plans as agreed with the patient



Clinical navigation tool

Leg — ongoing care and review



For **all types of leg wound:**

Each dressing change should include:

- Wound and skin cleansing
- Review of effectiveness of treatment plan and escalation of any concerns

At four-week intervals (or less):

- Assess for reduction in wound size and document using wound photography
- Assess condition of skin
- Assess pain/discomfort

In addition, for leg ulcers being treated with compression therapy:

- Assess for reduction in limb swelling



Clinical navigation tool

Leg — ongoing care and review



Wounds that are not improving:

- Escalate to the local specialist service, which should tailor care to the individual using bespoke or advanced treatment or compression techniques. If effective, this care should be continued by the local care team under the supervision of the specialist team

At 12 weeks, wounds that are not improving:

- Escalate to the local specialist service, which should tailor care to the individual using bespoke or advanced treatment or compression techniques. If effective, this care should be continued by the local care team under the supervision of the specialist team

Following healing of venous leg ulceration:

- Care should be in line with the SIGN clinical guideline for venous leg ulcers, which includes ongoing maintenance in compression hosiery and advice regarding prevention of recurrence

Workforce

Initial care

- All

Assessment

- Practitioners with advanced assessment skills

Care providers

- HCA/self/family

Care reviewer

- Registered professional

Specialist Clinic

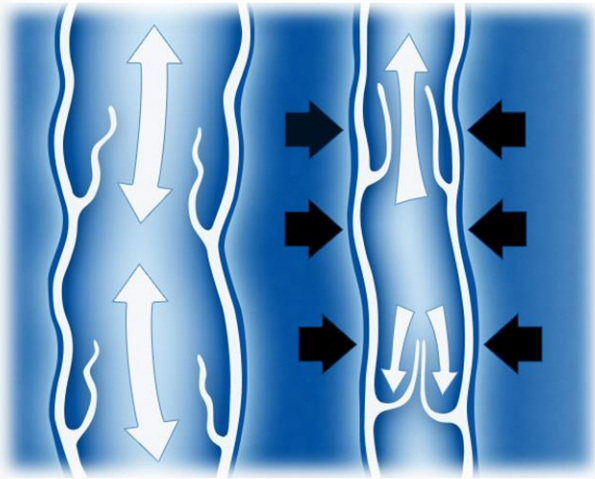
- Specialist/consultant

Getting it right



**Hand back to Dawn and I would start
the Q&A between me and Leanne**

JOBST® Compression solutions



Essity added value service

- Essity is a global health and medical solutions company that supports therapy areas that include: continence, wound care, vascular, orthopaedics and lymphology
- A team of strategic Healthcare partners dedicated to helping you and your local CCG / trusts to implement long term strategies to improve the clinical and financial outcomes of the trust.

Leukoplast[®] Actimove[®]

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TENA

Cutimed[®] Delta-Cast[®]

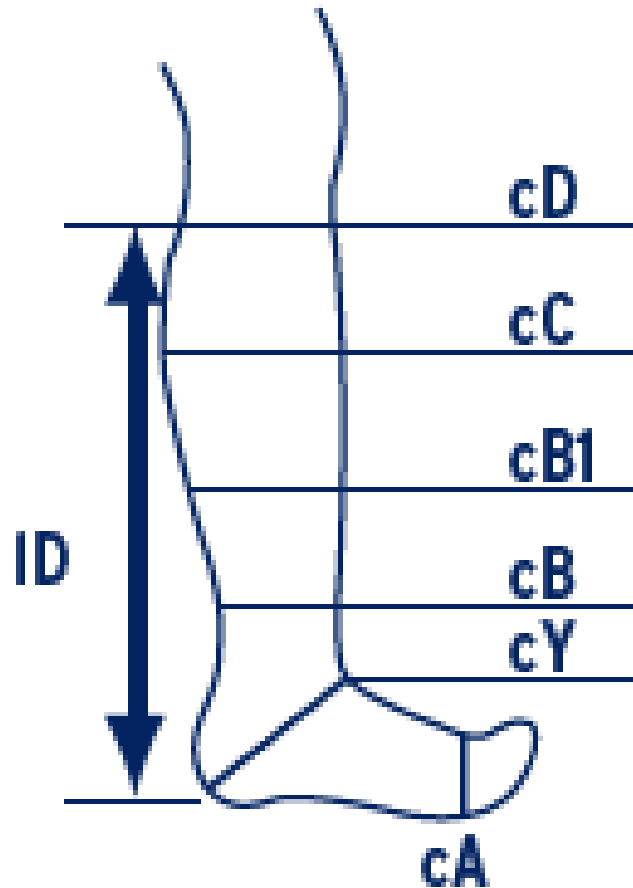
 **essity** 

Essity added value service

- Request your own JOBST® Ultrasheer or JOBST® *for*MEN knee high compression garment by **contacting the Essity Concierge with your measurements**
- Request a copy of the **clinical pathway** presented during the presentation by contacting us
- Simply download your **certificate** and contact Essity for more details on 01482 670177 or email conciierge.service@essity.com



Measuring points for JOBST® compression



D: Fibula head (two finger-widths below patella)

C: Maximum circumference of calf

B1: Transition to calf (Achilles tendon)

B: Narrowest circumference at ankle

Y: Heel / ankle flex with maximum dorsiflexion

A: Metatarsal joint of toe

Your opinion

- We would love your feedback/comments
- Open to amendments
- We want this to work for all
- Register for Stakeholder council

www.nationalwoundcarestrategy.net



Q&A session
To post a question,
comment on this
video



Contact Essity

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