The NWCSP lower limb recommendations: a discussion

In 2020 the National Wound Care Strategy Programme (NWCSP) published Lower Leg Wounds – Recommendations for clinical care. In this article Annemarie Brown comments on these new recommendations puts forward question to the NWCSP.

ANNEMARIE BROWN (AB)
PhD, MSc, BSc, RN ,Lecturer University of Essex and Independent Tissue Viability Consultant

UNA ADDERLEY, DIRECTOR, NATIONAL WOUND CARE STRATEGY PROGRAMME (NWCSP)

In the wound care arena, there has been a plethora of evidence-based guidance, both national and international, published on the management of venous leg ulceration, informed by Cochrane reviews and other high quality studies (Scottish Intercollegiate Guidelines Network [SIGN] 2010; Franks et al 2016; PCDS, 2016; Wounds UK, 2019). NICE (2010) provided access to clinical guidelines for the management of chronic venous leg ulcers, hosting the SIGN document (2010) in their website. More recently, a few minor changes have been made to this guidance, particularly with reference to pain management, wound infection, and recommendations for regular monitoring of healing (NICE CKS, 2020).

The National Wound Care Strategy Programme (NWCSP) has recently published a document - Lower Leg Wounds – Recommendations for clinical care (2020); the aim of which outline a pathway of care that is underpinned by the key research evidence with lower leg wounds and foot ulcers (NWCSP, 2020).

There is no doubt that this guidance will be invaluable to health professionals caring for these patients. However, there are a number of points that I would like to draw attention to.

1. Why could existing guidelines not be updated to provide a consistent approach to care??

The guidance states:

"These recommendations do not replace existing evidence-informed clinical guidelines or replace clinical judgement and decision making in relation to the needs of the individual patient but to bring attention to such evidence and support planning for implementation into clinical practice" (page 3).

AB

The NWCSP (2020) guidance states that some of the recommendations within the document are underpinned by the SIGN (2010). However, these were published over 10 years ago and may no longer reflect the current evidence base. This new document now results in multiple sources of guidance for clinicians who may find this confusing. Furthermore, in tissue-viability related medico-legal claims, national guidance is relied on as a benchmark for assessing nursing practice in clinical negligence claims. This document will now "muddy the waters". It may have been more helpful to update current national guidelines to ensure a more consistent approach.

NWCSP response:

We agree and before developing the NWCSP Lower Limb Recommendations the NWCSP contacted both SIGN and NICE to request an update of the SIGN Guidelines and/or the development of a NICE Clinical Guideline for leg ulcers. Unfortunately, this request was unsuccessful.

The NWCSP Lower Limb Recommendations incorporate key research published after the publication of the SIGN Guideline but as the NWCSP did not have the resources to conduct a full review of the research evidence, there is still a need for a new NICE or updated SIGN clinical guideline. However, the NWCSP Lower Limb Recommendations have provided a more up-to-date set of recommendations and a basis upon which to develop the NWCSP Preventing and Improving Care of Chronic Lower Limb Wounds Implementation Case which outlined the strong economic case for improving the care of lower limb wounds. This has led to further conversations with NICE that may lead to the commissioning of a new or updated clinical guideline for lower limb wounds.

2. How will clinicians be "re-educated" to the new practice of implementing mild compression therapy at initial presentation without conducting a thorough holistic assessment (including vascular assessment) for up to 14 days?

The recommendation for immediate and necessary care in the case of patients with a lower leg wound is

"wounds on the leg to be treated with mild compression and this is based on the British Lymphology Society view that, providing people with 'red flag' symptoms (such as the symptoms of

arterial insufficiency) are excluded, the benefits of first line mild compression outweigh the risks, even for people without obvious signs of venous insufficiency" (page 18/6).

AB

This recommendation currently contradicts existing national and international guidance (SIGN 2010; NICE 2010, NICE CG147 2012; 2018; Frankks et al 2016) as it recommends the application of mild graduated compression, based solely on clinical presentation and symptoms on initial presentation, without undertaking a detailed assessment and vascular assessment. The guidance lists red flags, which is very clear and helpful and states that a detailed assessment should take place within 14 days. This recommendation is aimed at optimising healing by ensuring some form of compression therapy is initiated as soon as possible, with the expectation that the level of compression will be increased following detailed assessment. The challenge here is, how will health professionals be "re-educated" as, in the past, they have been advised not to apply any form of compression without prior detailed assessment, including and vascular status.

NWCSP response: The issue is more about the commissioning of new pathways of care that ensure patients can quickly access care from clinicians educated to have the knowledge, skills and confidence needed for lower limb assessment and the implementation of evidence-based therapeutic interventions such strong compression. Unfortunately, lack of confidence about compression therapy can itself be harmful to many patients. The recommendation to apply mild compression is simply to improve care while patients await full assessment.

The NWCSP recognises what is being proposed is a significant change in the way lower limb wound care is delivered. With this in mind, it is currently recruiting a 1st tranche implementation site in each of the seven NHS England regions to test out the assumptions of the implementation case and to inform blueprints for national roll-out. The learning from these sites will help the NWCSP understand how to best address challenges such as these.

In the meantime, the NWCSP has published a free-to-access online learning resource for venous leg ulcers that is based on the NWCSP recommendations. This learning resource will be complemented by further free-to-access online learning resources and a recommended lower limb curriculum to support those tasked with implementing the NWCSP recommendations.

.

3. Is it possible that the standard of care will deteriorate if patients are not able to be fully assessed within the 14 days post implementation of compression therapy?

AB: As a result of the NWCSP (2020) guidance, it may become common and acceptable practice to apply light compression hosiery or bandaging as a first-line treatment for all leg wounds as a "one size fits all" management strategy. In addition, the recommendation that the patient is fully assessed within 14 days may not be realistic to achieve due to increasing workloads, particularly in the community. As a result, the patient may receive sub-optimal compression therapy for much longer periods, resulting in a scenario expressed in Wounds International guidance (2013) "Compression therapy is often used sub-optimally in practice because of a lack of knowledge and confidence in relation to assessing patients using Doppler ankle brachial pressure index (ABPI) measurement and applying compression bandaging. As a result, patients may not always receive the full benefits of the treatment" (2013: page 1). Young et al (2013) concurred with this view also. It may have been more appropriate, therefore, to recommend that "For leg wounds, first line mild graduated compression should be considered".

NWCSP response: We agree that undertaking full clinical assessment within 14 days is a challenge in the current delivery model. However, this is being achieved in organisations that have chosen to go ahead with service redesign to enable implementation of the NWCSP recommendations. These organisations are being rewarded by much faster healing rates and greater levels of patient self-care leading to significant reductions in community nursing workload.

Had the NWCSP only recommended 'considering' first line mild graduated compression, we suspect that relatively few patients would be offered a therapy that is likely to be beneficial and which carries minimal risk. However, focussing on the application of first line mild graduated compression is something of a 'red herring' as the real improvements in care will only come from ensuring that there is a service model that can ensure quick assessment and implementation of appropriate evidence-based therapeutic care.

4. The guidance uses the term "leg wound" defined as "originating on or above the malleolus (ankle bone) but below the knee". It may have been helpful to provide more specific guidance on the different types of leg wounds, such as skin flap lacerations.

AB: Within this definition, lower limb skin flap lacerations would be included. The recommendation here is to apply a simple, low-adherent dressing and mild graduated compression. While compression therapy may be appropriate following full assessment, as a TVN, applying this type of dressing to very friable skin, would not be my first choice as it may cause further trauma on removal. Also, there is no specific guidance on whether compression should be applied bilaterally in these cases, despite the possibility of there being no signs of chronic venous insufficiency?

NWCSP response: The NWCSP Lower limb workstream (which included very experienced tissue viability nurses) took the view that it was not helpful to attempt to give highly detailed information for every type of leg wound. The recommendations note that people with leg or foot wounds usually only present to a clinician if healing is problematic or anticipated to be problematic. If such people are able to swiftly access assessment, diagnosis and treatment planning from a multidisciplinary team with appropriate levels of knowledge and skill, then such clinicians should be able to use clinical judgement to adjust the NWCSP recommendations to the needs of the individual. Having said that, the NWCSP lower limb workstream was strongly of the view that, providing there is no significant arterial disease, compression therapy is likely to beneficial to many patients. The extensive stakeholder consultation supported this view.

CONCLUSION

Overall, this document is to be commended as the aim is to provide a simply care pathway and encourage a more consistent approach to the management of venous leg ulceration, which is currently subject to variations in the standard of care delivered. Guidelines and recommendations are dynamic and subject to change as more robust research evidence emerges. It is hoped that the questions posed here, and the resultant debate will feed into future versions of the guidance when it is updated.

REFERENCES

Franks P, Barker J, Collier M et al (2016) Management of patients with venous leg ulcer: challenges and current best practice A EWMA Position Document. *J Wound Care* 25(6 Suppl):1–67. https://doi.org/10.12968/jowc.2016.25.sup6.s1

NICE CKS (2020) Leg ulcers – Venous. https://cks.nice.org.uk/leg-ulcer-venous#!changes (accessed 30 May 2021)

National Wound Care Strategy Programme (NWCSP) (2020) Lower Limb. Recommendations for Clinical Care. https://tinyurl.com/5e8hh7xy (accessed 30 May 2021)

Primary Care Dermatology Society (PDCS) Leg ulcers and disorders of venous insufficiency. Lhttps://tinyurl.com/4pf2beva (accessed 2 June 2021)

SIGN (2010) Management of chronic venous leg ulcers - a national clinical guideline. https://tinyurl.com/m5r5xutt (accessed 30 May 2021)

Wounds UK (2019) Best Practice Statement:Addressing complexities in the management of venous leg ulcers. *Wounds UK*. https://tinyurl.com/35upv369 (accessed 30 May 2021)

Wounds International (2013) Principles of compression in venous disease: a practitioner's guide to treatment and prevention of venous leg ulcers. *Wounds International*. https://tinyurl.com/zt33a4ff (accessed 30 May 2021)

Young T, Connolly N, Dissemond J (2013) UrgoTwo® Compression Bandage System. Made Easy. *Wounds International* 4()1):1–6. https://tinyurl.com/53yabxsn (accessed 30 May 2021)