FUNDAMENTALS OF LOWER LIMB MANAGEMENT – DAY 2

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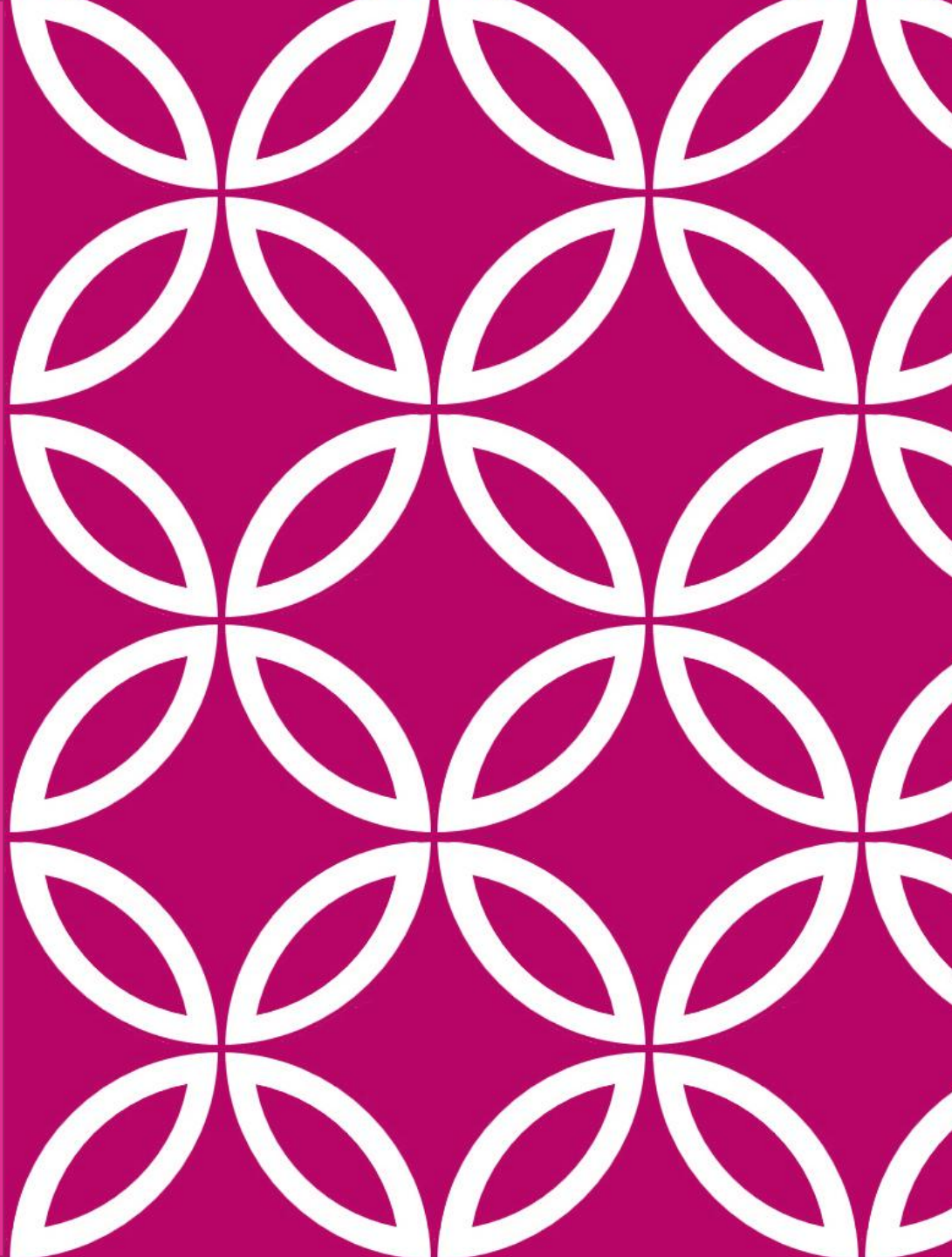


LEARNING OBJECTIVES

Learn how to undertake a manual doppler assessment, identify pedal pulse types and calculate ankle brachial pressure index.

Understand the theory of graduated compression, La Place's Law and Pascal's Law

Exploration of the benefits of compression therapy and overcoming barriers to implementation

Introduction to effective application technique of Actico, K2 and Ko-Flex with an opportunity to practice under supervision

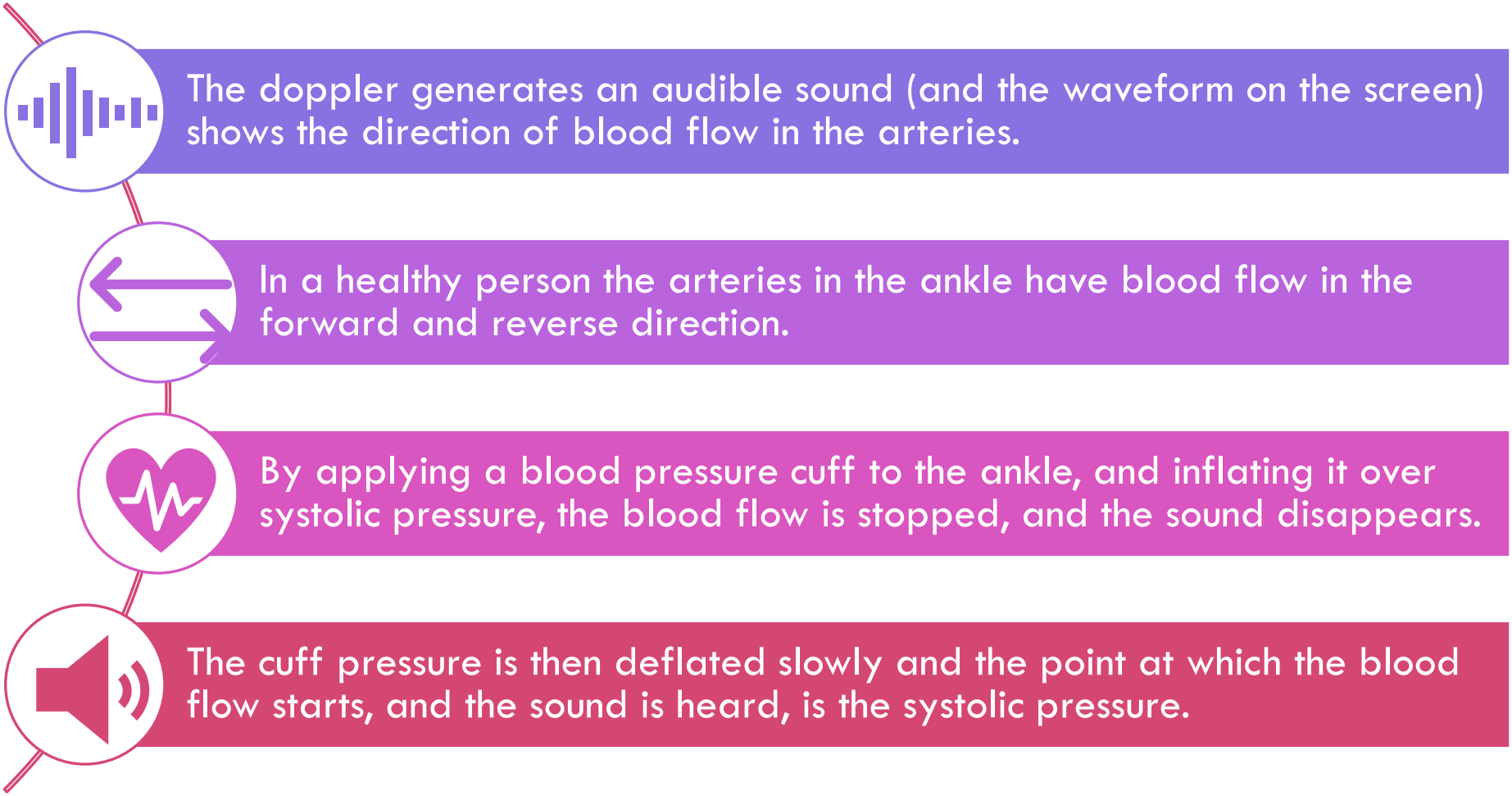
Practice effective application technique of below knee Actico, K-Two and Ko-Flex bandaging for venous leg ulceration and thigh high Actico bandaging for chronic, including stump bandaging to toes

DOPPLER

WHAT ACTUALLY IS A DOPPLER?

A lower limb doppler is like a **specialised ultrasound for leg arteries**. It uses sound waves, like a tiny radar, to assess the blood flow in the lower legs and feet.

THE PRINCIPLES OF DOPPLER ULTRASOUND



Let's improve this statistic!

40% OF PEOPLE WITH LEG ULCERS DO NOT RECEIVE AN ABPI ASSESSMENT (GUEST, 2019)

DOPPLER PROBES & FREQUENCIES

The rule of thumb is:

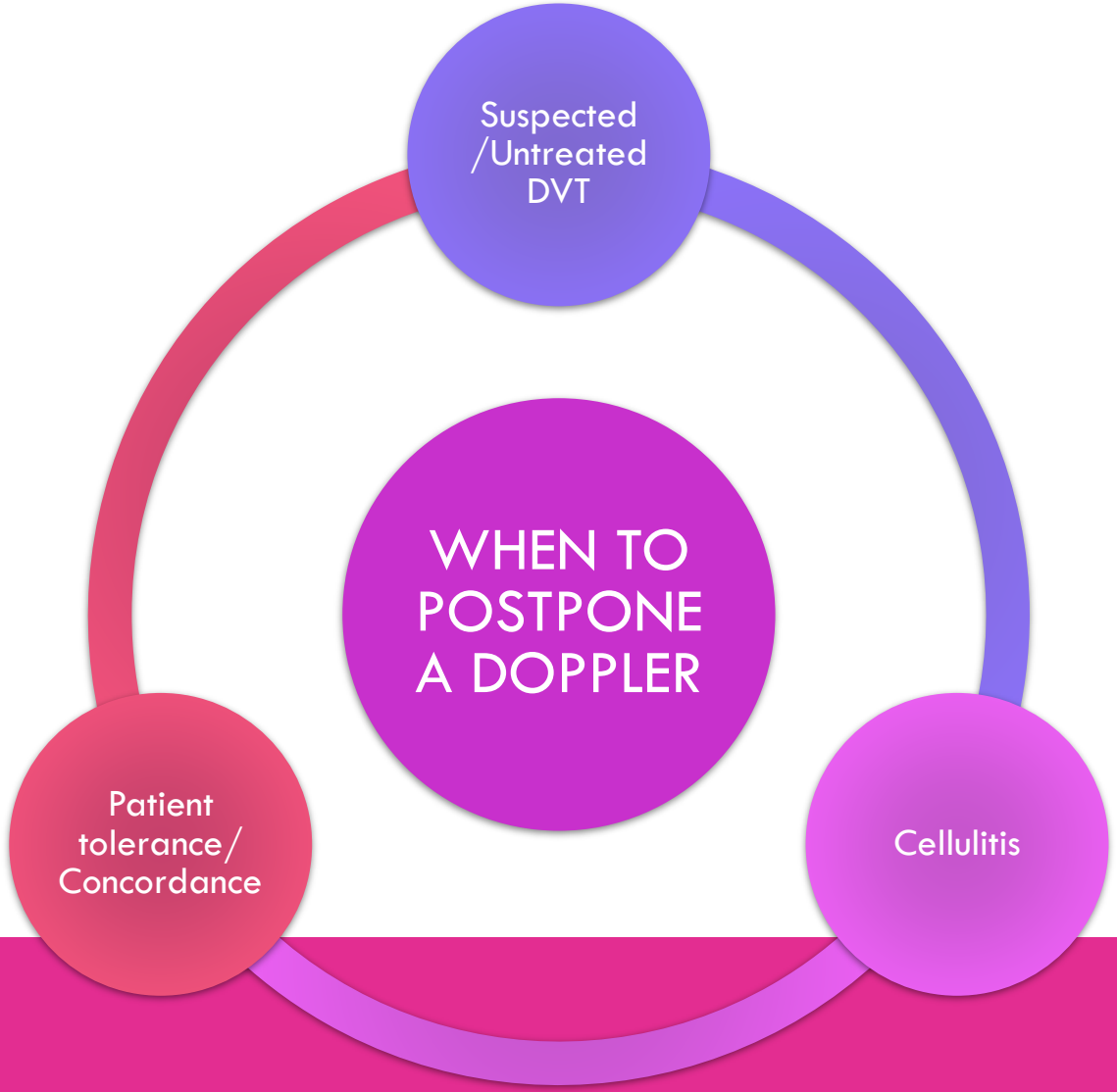
The **LOWER** the frequency

The **DEEPER** the penetration

The **LARGER** the probe head

A 5MHz Doppler probe for oedematous limbs and deep lying vessels. (35mm range – suitable for when oedema is present)

An 8MHz Doppler probe for easier detection of peripheral vessels and calcified arteries (20mm range)

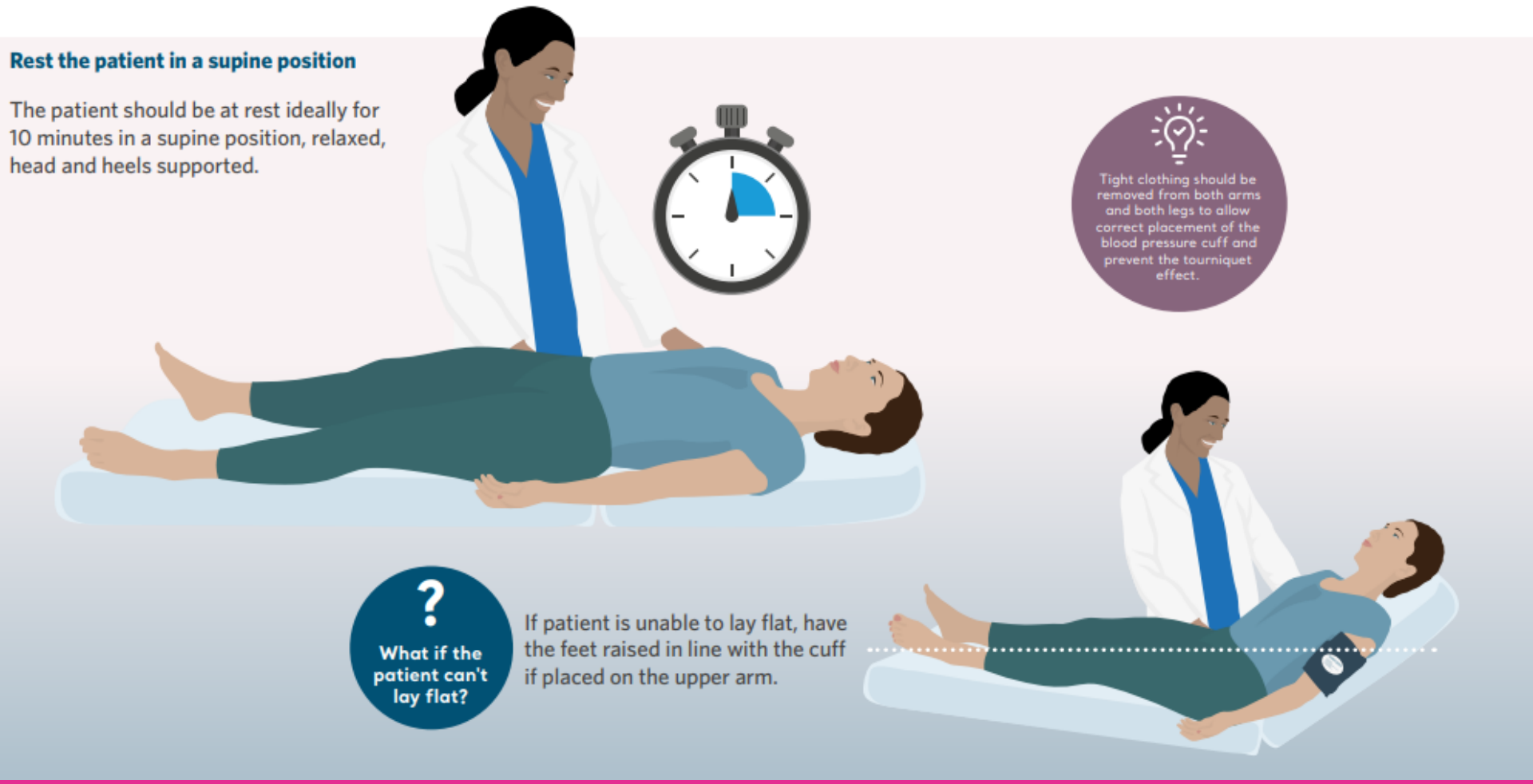


WHEN TO POSTPONE A DOPPLER

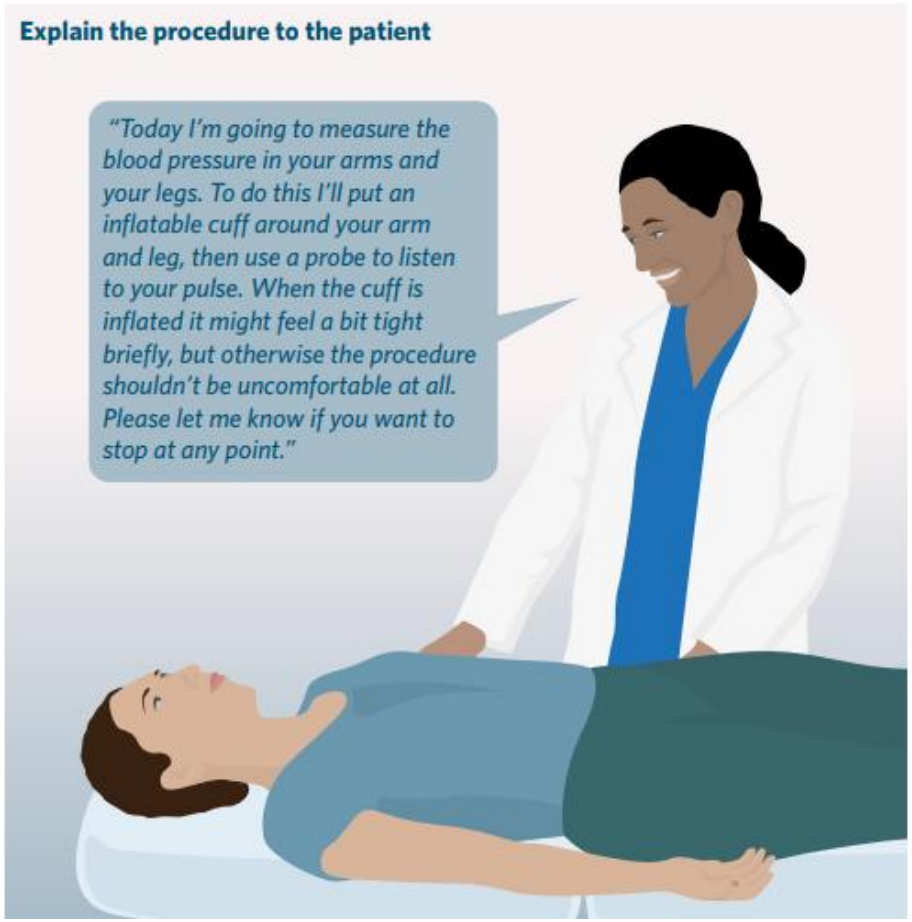
PREPARATION OF THE PATIENT

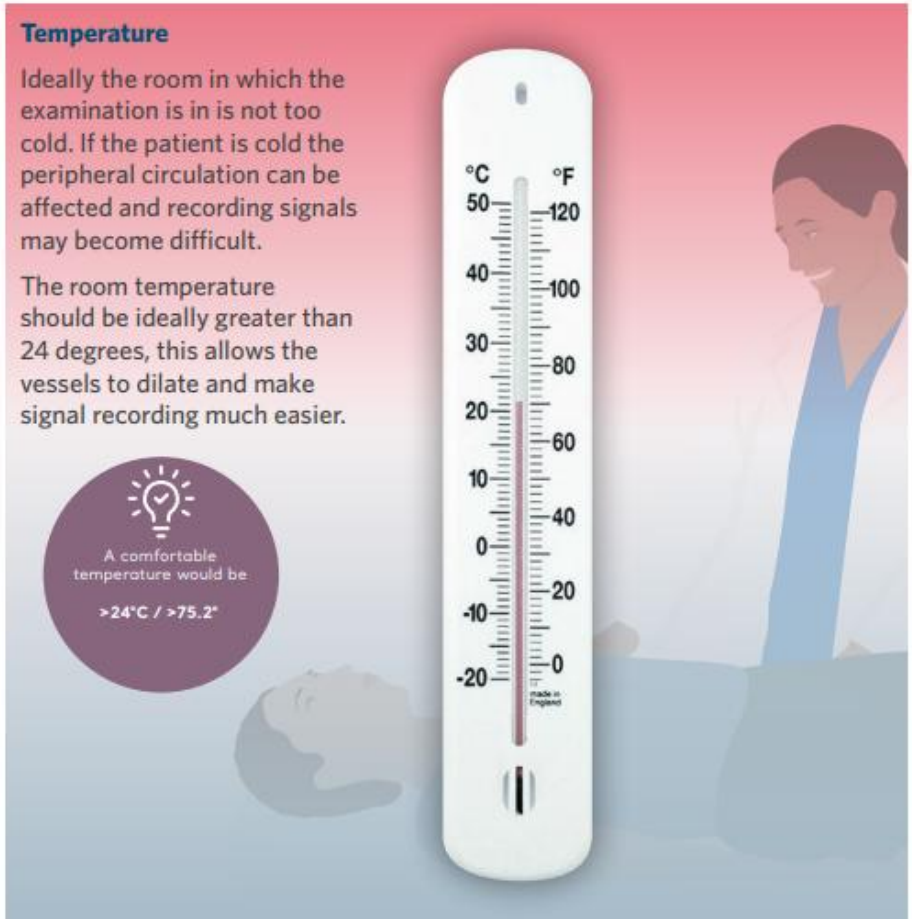
Preparation prevents incorrect readings!

- Explain and reassure patient of the procedure
- Ask the patient to refrain from smoking for 10 mins prior
- Ensure ambient temperature of the room is comfortable
- Remove any tight clothing from both arms and legs
- Cover any open lesions with a sterile field from a dressing pack
- Rest the patient in the supine position for at least 20 minutes (manual doppler)



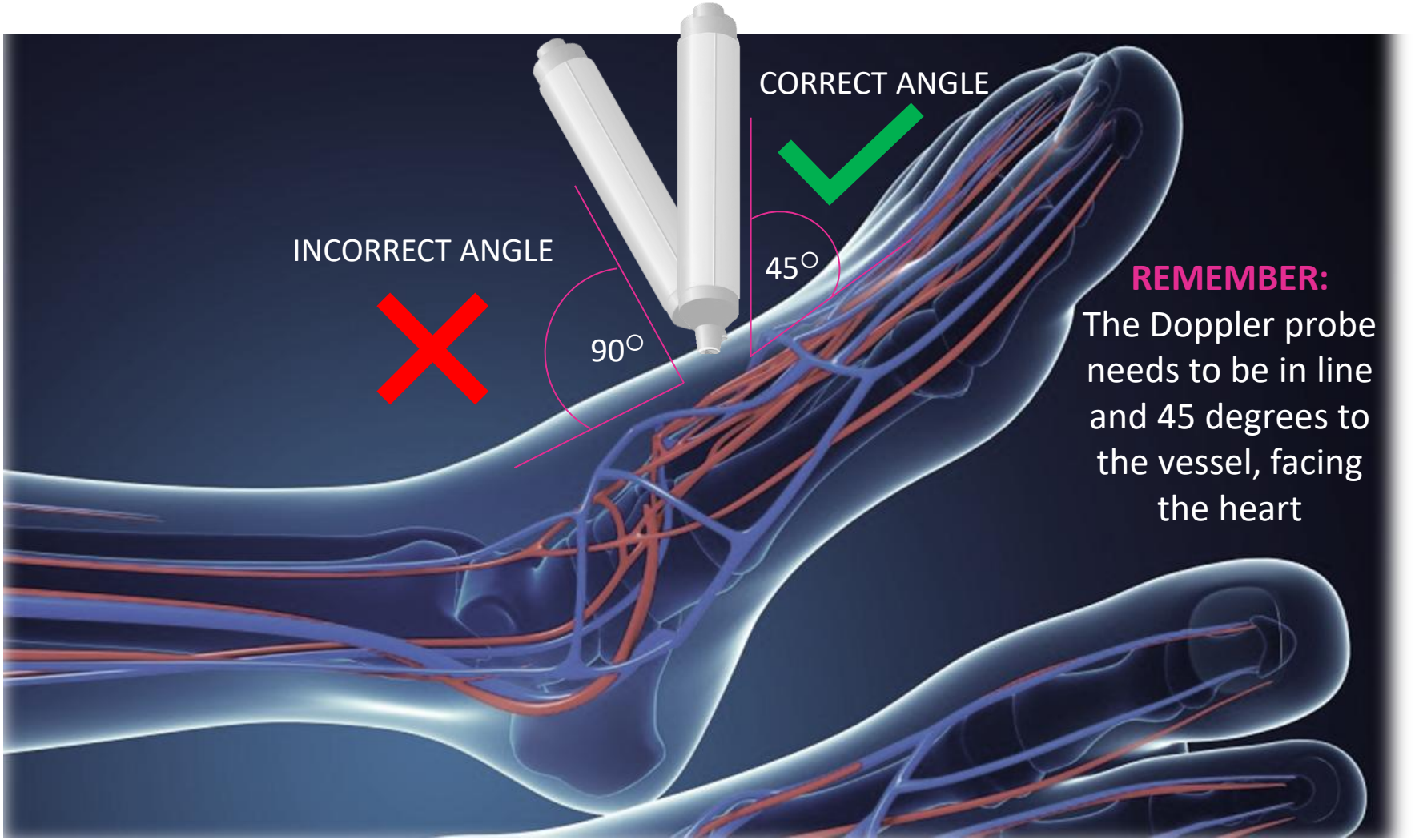
PREPARE THE PATIENT





PREPARE THE PATIENT

PROBE POSITIONING



Step 1 - Apply the Cuff

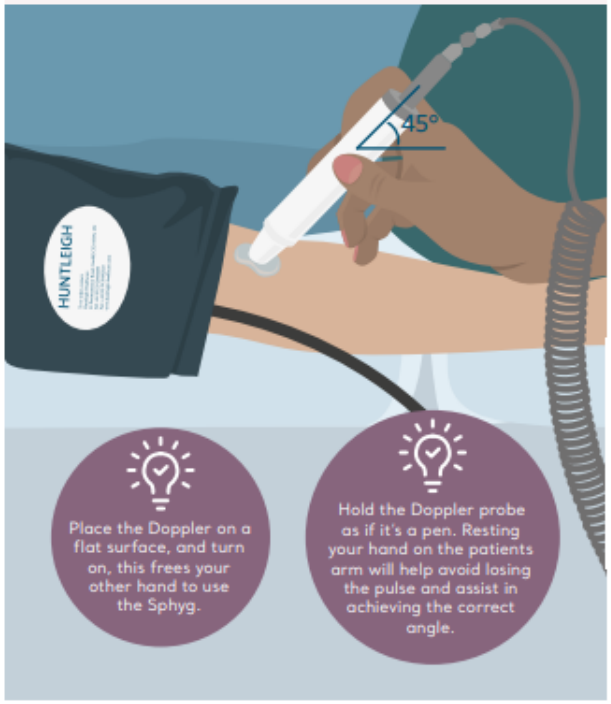
Apply the cuff to the upper arm, just above the elbow.

Step 2 - Locate the Pulse

The brachial pulse can normally be found with manual palpation.

Step 3 - Apply Gel and Probe

Apply a suitable amount of gel to the skin over the brachial artery. Apply the Doppler probe to the surface of the skin with the probe at a 45° angle to the artery, with the tip of the probe pointing towards the heart. Adjust the position of the probe to find the best signal.

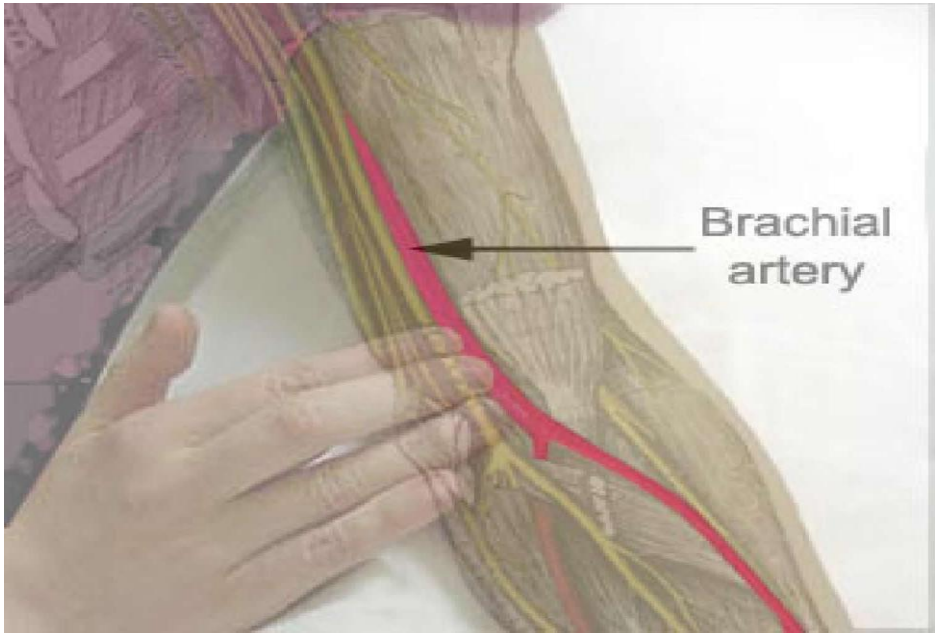


RECORDING THE BRACHIAL SYSTOLIC PRESSURE

WHERE IS THE BRACHIAL ARTERY?

1. Place two or three fingers or the doppler probe on the inner side of the person's upper arm, next to the bicep. (Do not use your thumb, as it has its own pulse).

2. Locate the brachial artery in the antecubital fossa (the crease of the elbow), along the inside of the arm between the biceps and triceps muscles, approximately 1-2 inches above the elbow crease.

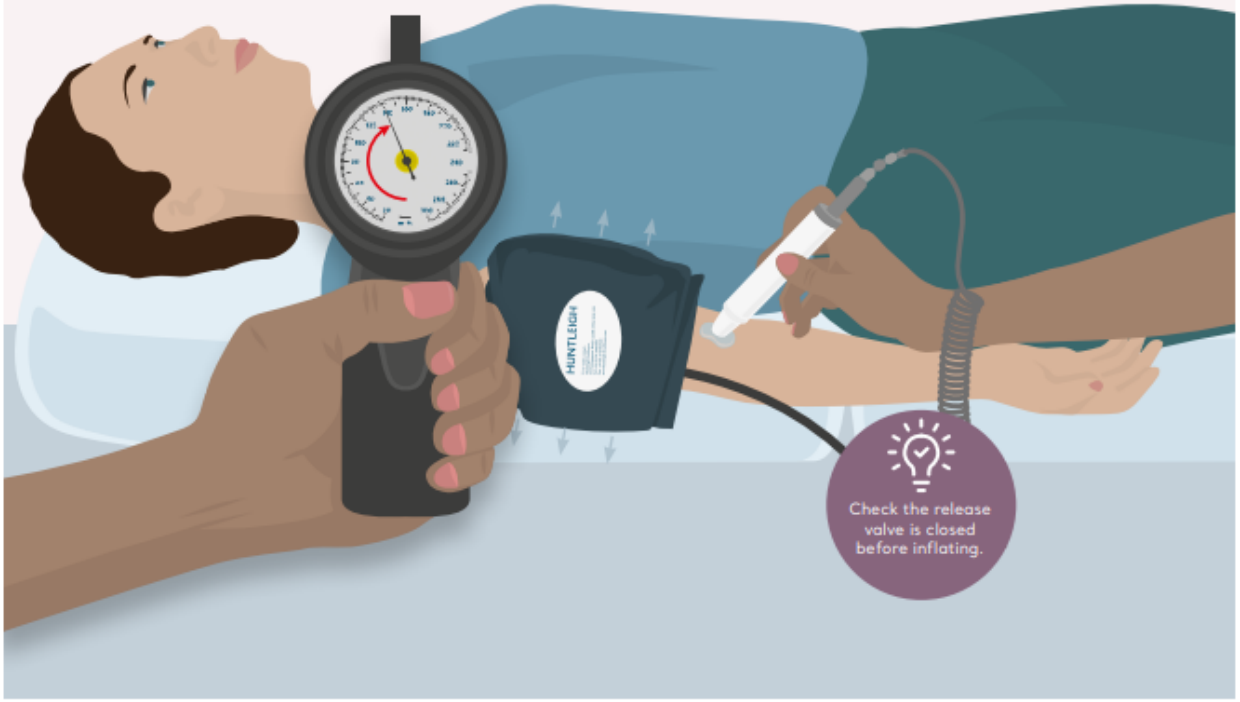


LOCATING THE BRACHIAL ARTERY

Step 4 - Inflate the Cuff & Read the Pressure

Watching the pressure gauge, inflate the cuff until you stop detecting a pulse with the Doppler. Keep inflating to a pressure that is 20 mmHg higher than the pressure was at the time when you heard the last pulse.

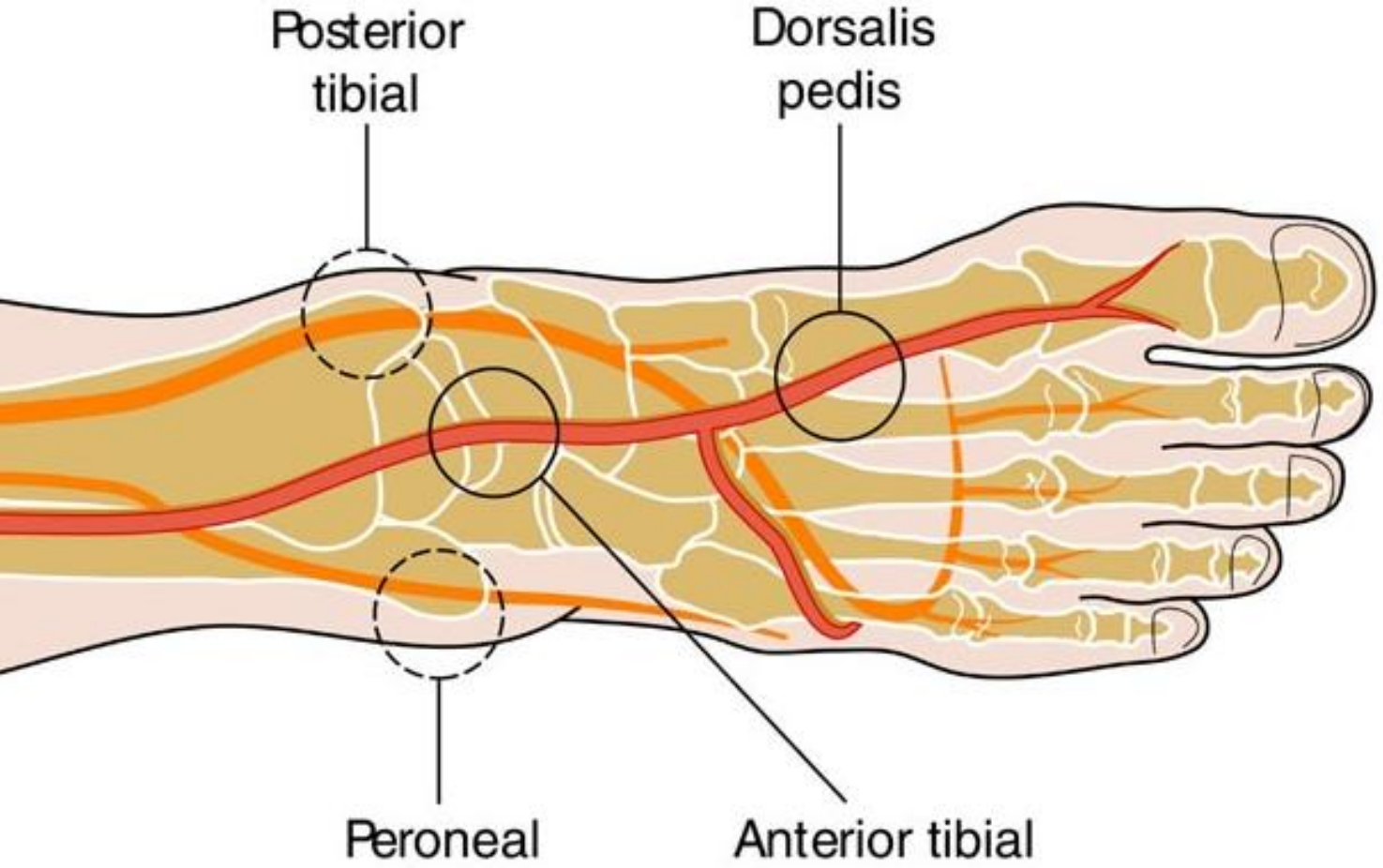
Slowly release the pressure from the cuff whilst maintaining the probe position. Record the pressure when the pulse returns, this is the brachial systolic pressure.



Step 5 - Repeat

Repeat these steps to obtain and write down the brachial pressure of the other arm. The highest brachial pressure (from the left or right arm) is the denominator for the ABPI ratio equation.

RECORDING THE BRACHIAL PRESSURE



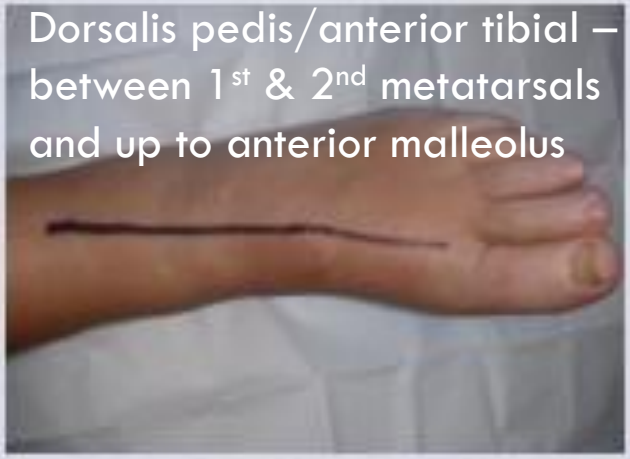
All guidelines concur that at least 2 pulses should be assessed for each foot.

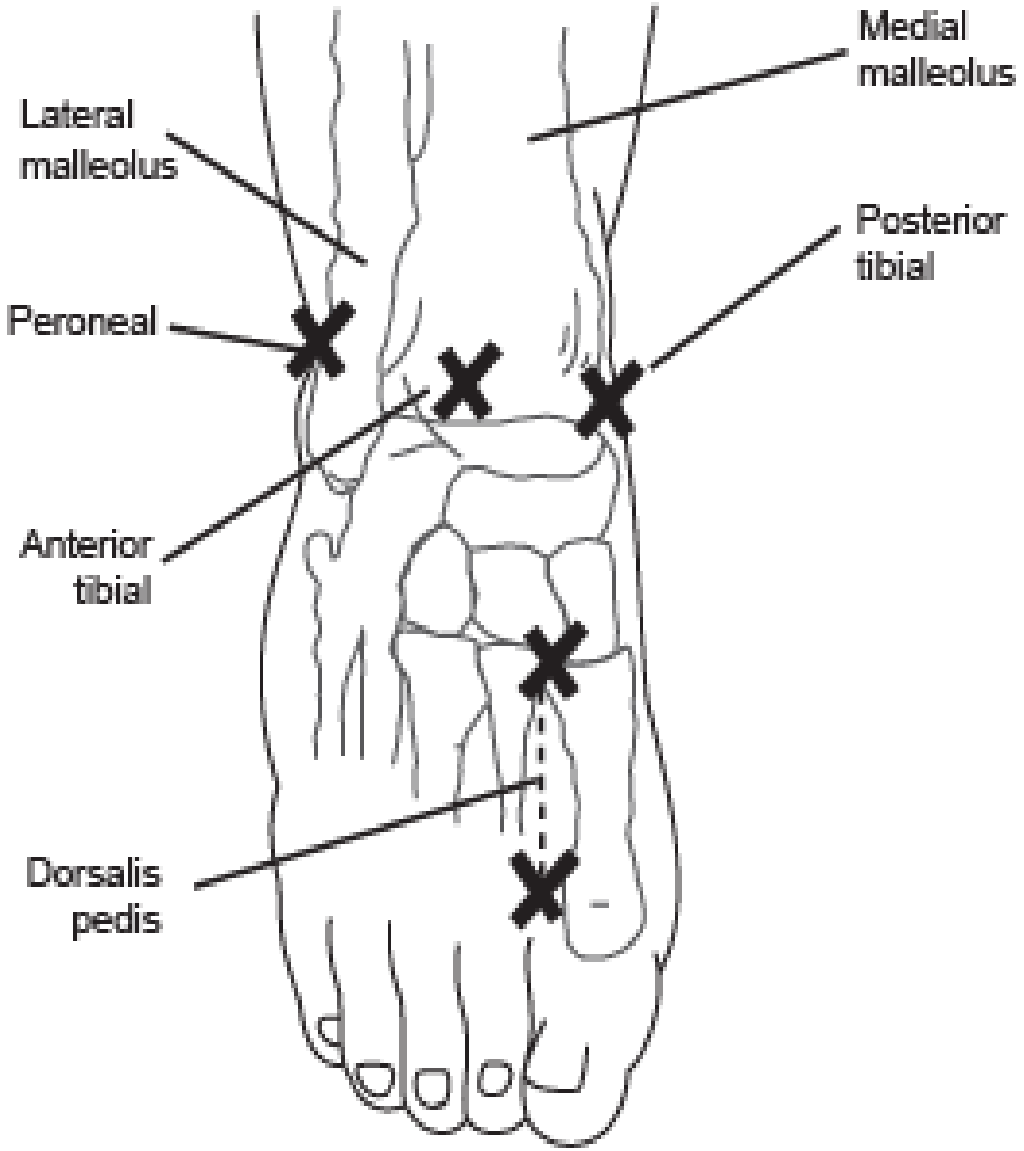
Please note the peroneal artery can be the most challenging to find.

10% of the population do NOT have a dorsalis pedis pulse

ARTERIES OF THE FOOT

POSITIONS OF THE PEDAL PULSES





Step 1 - Apply the Cuff

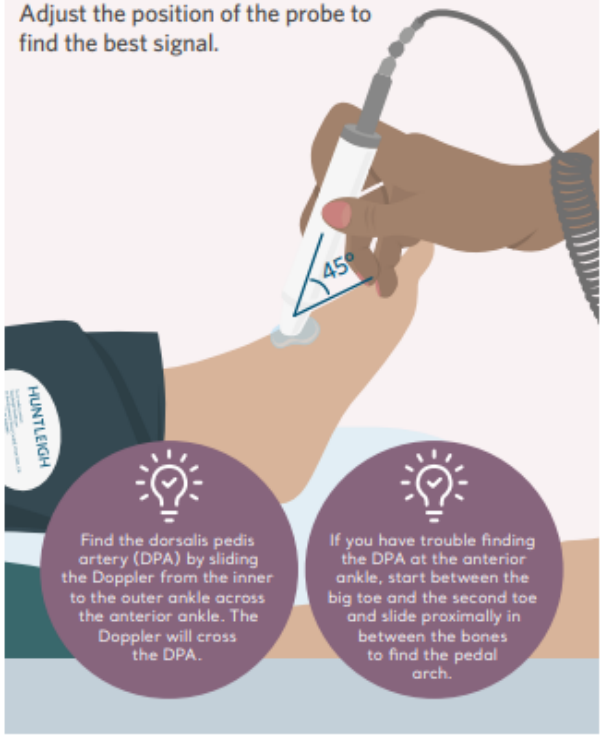
Apply the cuff to the ankle just above the malleolus.

Step 2 - Locate the Pulse

The Pedal pulses can sometimes be found with manual palpation

Step 3 - Apply Gel and Probe

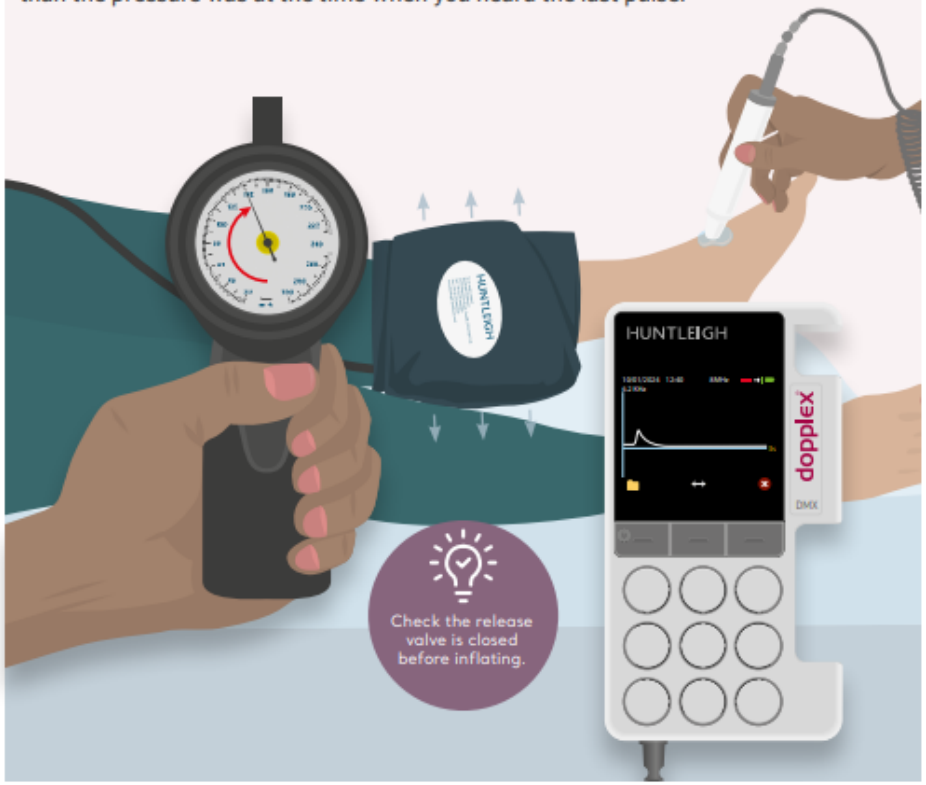
Apply a suitable amount of gel to the skin over the Dorsalis Pedis. Apply the Doppler probe to the surface of the skin with the probe at a 45° angle to the artery, with the tip of the probe pointing towards the heart. Adjust the position of the probe to find the best signal.



RECORDING THE DORSALIS PEDIS ARTERY PRESSURE

Step 4 - Inflate the Cuff

Inflate the cuff, watch the pressure gauge, and listen for the point at which you stop hearing a pulse from the Doppler. Keep inflating to a pressure that is 20 mmHg higher than the pressure was at the time when you heard the last pulse.



Step 5 - Read the Pressure

Slowly release the pressure from the cuff while maintaining the probe position and record the pressure. When the pulse returns, this is the Dorsalis Pedis systolic pressure.

DOPPLER TROUBLESHOOTING

Gravity & Perfusion

- If you cannot hear pulses, ask the patient to sit upright with legs hanging over the edge of the bed – gravity may assist perfusion

Find Pulses Sitting Up

- Find pedal pulses when the patient is sitting up, mark them with a pen and then try again when the patient is laying flat

Sounds of normal artery

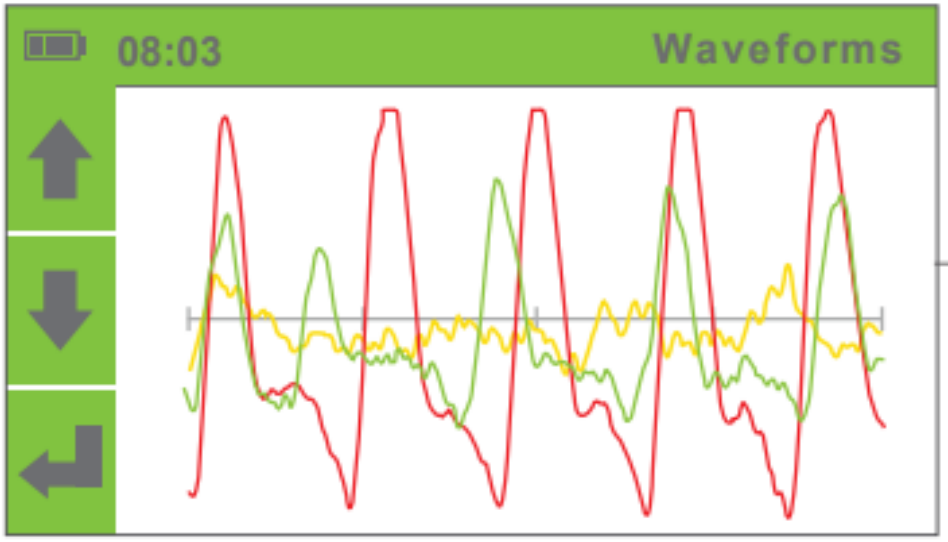
Sounds of normal vein

NORMAL ARTERY VS NORMAL VEIN SOUNDS

INTERPRETING PEDAL PULSE SOUNDS AND WAVEFORMS

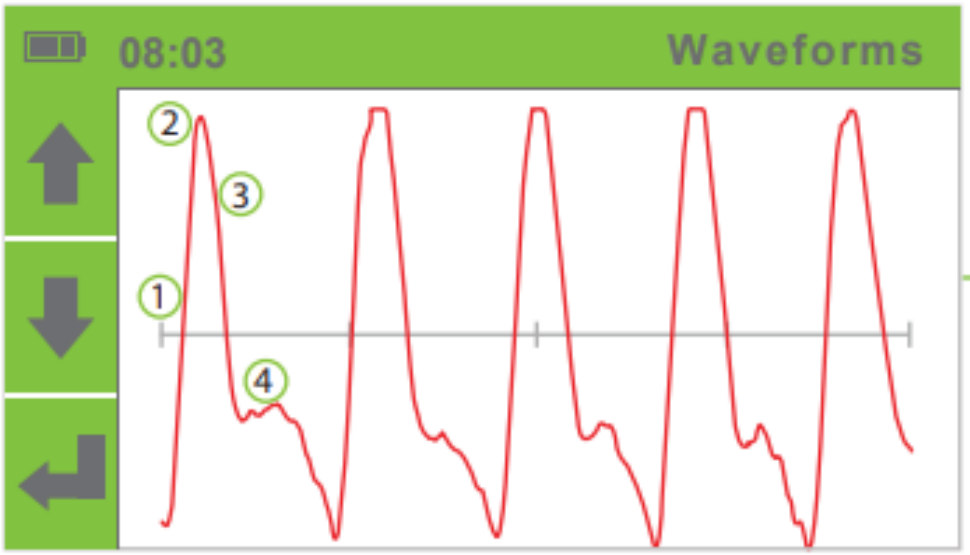
ABPI readings alone can be unreliable or inaccurate. Sometime it is not always possible to obtain an ABPI reading.

Pulse sounds/waveforms can help to support your assessment alongside completion of a lower limb assessment form.



Pulse Volume Recording is an essential addition to ABI measurement. The waveforms are interpreted by pattern recognition and determine the severity of Peripheral Arterial Disease.

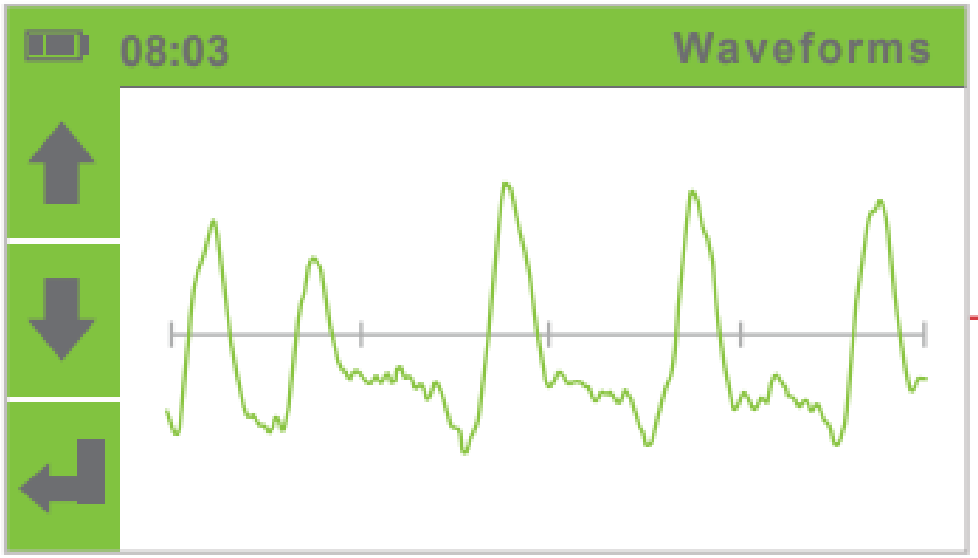
PVR WAVEFORMS



Normal PVR will display:

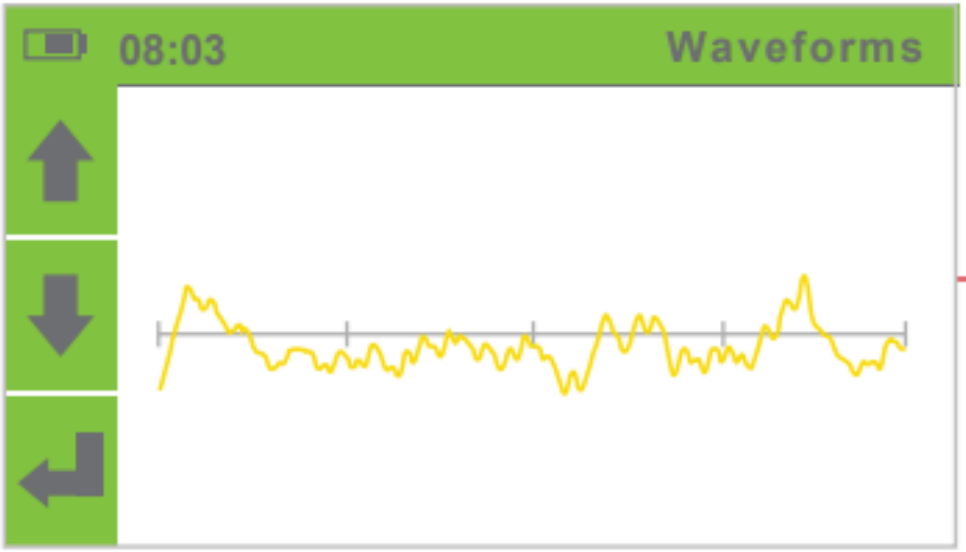
1. A rapid rise in the upstroke during systole
2. A very sharp peak
3. A gradual downstroke
4. A presence of dichrotic notch

NORMAL PULSE VOLUME READING WAVEFORM & SOUNDS – TRIPHASIC - 3 PHASES



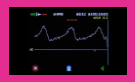
An absence of the dichrotic notch, a smaller amplitude, decreased slope and rounding of the systolic peak are the initial signs of a possible abnormality - measured ABI value is lower than the one with normal PVR.

LOW PULSE VOLUME READING WAVEFORM AND SOUNDS – BIPHASIC - 2 PHASES



A flattened PVR waveform or a PVR without the typical shape is an indicator of severe PAD. The absence of the pulsations caused by occlusions in the artery makes it impossible to calculate the ankle pressures. Instead of ABI value, the device will display a "PAD" result, indicating severe disease. The result is confirmed with non-typical, flattened PVR waveform, similar to the picture on the left.

SEVERE PULSE VOLUME READING WAVEFORM AND SOUNDS – MONOPHASIC - 1 PHASE



BEFORE USING AN AUTOMATED ABPI MEASUREMENT DEVICE

There is not enough evidence to recommend routine adoption of the automated ankle brachial pressure index (ABPI) measurement devices to detect peripheral arterial disease in people with leg ulcers (NICE, 2023).

However, NICE (2023) agreed that the automated devices already purchased by the NHS and implemented within a care pathway can continue to be used, so long as bases using automated measures educate the users on the NICE (2023) recommendations and collect data to show their impact on people with leg ulcers.

National Institute for Heath and Care Excellence (2023). Diagnostic guidance (DG52): Automated ankle brachial pressure index measurement devices to detect peripheral arterial disease in people with leg ulcers.

NOW IT'S YOUR TURN – DOPPLER PRACTICE!

WHAT ARE WE CALCULATING?

ABPI stands for Ankle Brachial Pressure Index

A ratio of the systolic blood pressure at the ankle to the systolic blood pressure in the arm

HOW TO CALCULATE ANKLE BRACHIAL PRESSURE INDEX (ABPI)

To calculate the ABPI, you need to measure the ankle systolic pressure and the brachial systolic pressure in millimetres of mercury (mmHg).

The ABPI should be calculated per limb, by dividing the highest systolic pressure at the ankle by the higher of the two brachial systolic pressures, giving an ABPI per lower limb.

$$\text{ABPI} = \frac{\text{Highest ankle systolic pressure (for each leg)}}{\text{Highest brachial systolic pressure}}$$

ABPI CALCULATION EXAMPLE

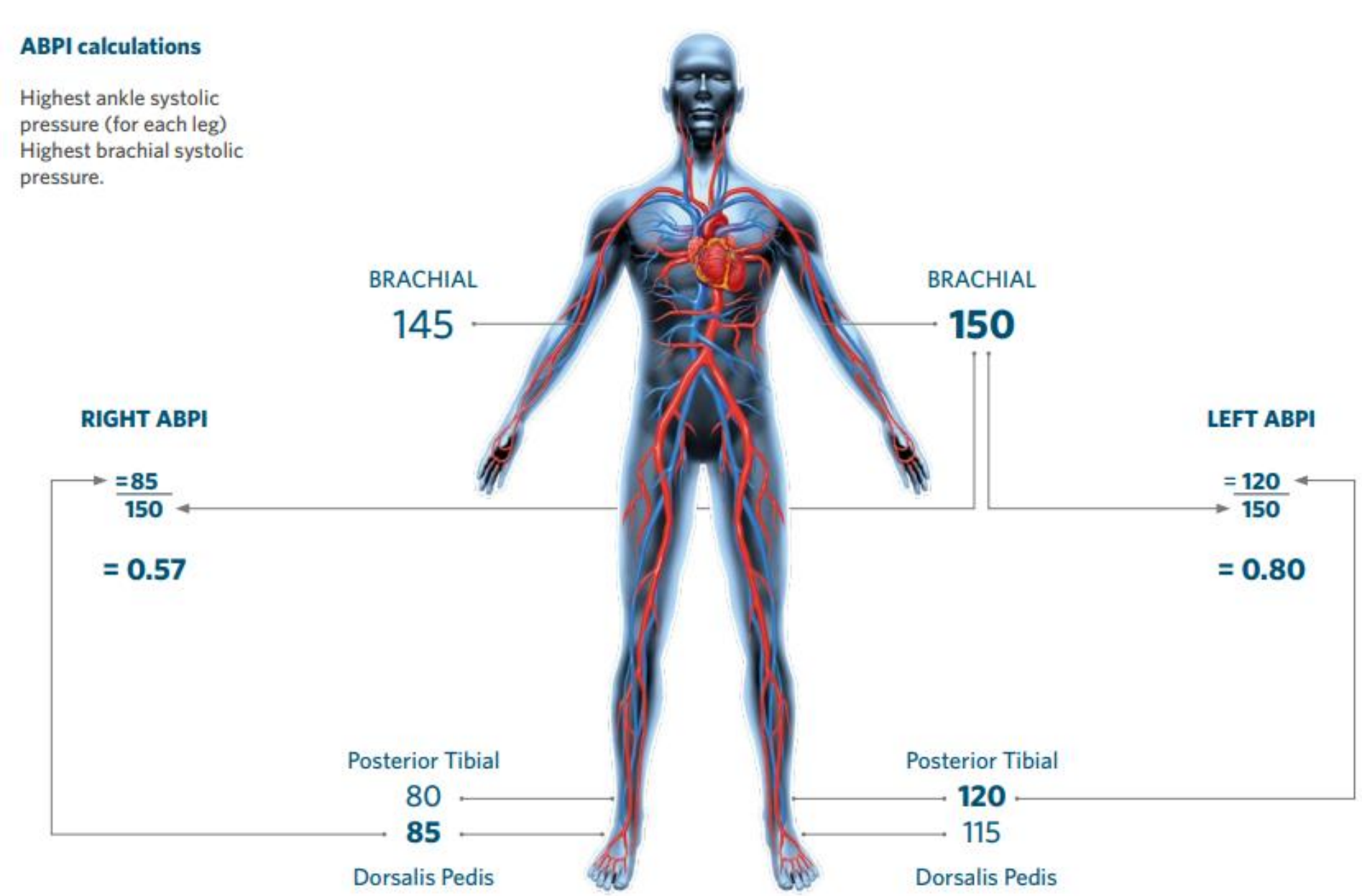
	Brachial	Dorsalis Pedis	Posterior Tibial	Peroneal	ABPI
Right:	145mmHg	85mmHg	80mmHg	80mmHg	?
Left:	150mmHg	115mmHg	120mmHg	117mmHg	?

Left ABPI = (highest ankle systolic pressure of the **left** lower limb) ÷ (highest brachial pressure).

Right ABPI = (highest ankle systolic pressure of the **right** lower limb) ÷ (highest brachial pressure).

Remember 'leg over arm'

ABPI CALCULATION EXAMPLE



INTERPRETATION OF ABPI

<0.6	0.6 – 0.8	0.81 – ≤ 1.3	>1.3
• Severe peripheral arterial disease • Do **NOT** apply compression therapy • Urgent referral to Vascular for arterial duplex scans and possible intervention • Re-doppler every 3 months	• Suspected mixed disease • Apply mild 20mmHg compression • Routine referral to Vascular & TV • Re-doppler every 3 months (sooner if ischaemic symptoms develop)	• Suspected venous disease • If no red flags present, apply high 40mmHg compression • Routine Vascular referral • Re-doppler every 12 months (sooner if ischaemic symptoms develop)	• Consider arterial wall calcification • Assess pulses/ waveforms • Apply mild 20mmHg compression • Routine referral to Vascular & TV • Re-doppler every 3 months

FAQS

How many pedal pulses do you measure

A minimum of two arteries on each foot

e.g. dorsalis pedis or anterior tibial and posterior tibial or peroneal

Which probes should you use to take ABPI measurements?

8MHz for general use

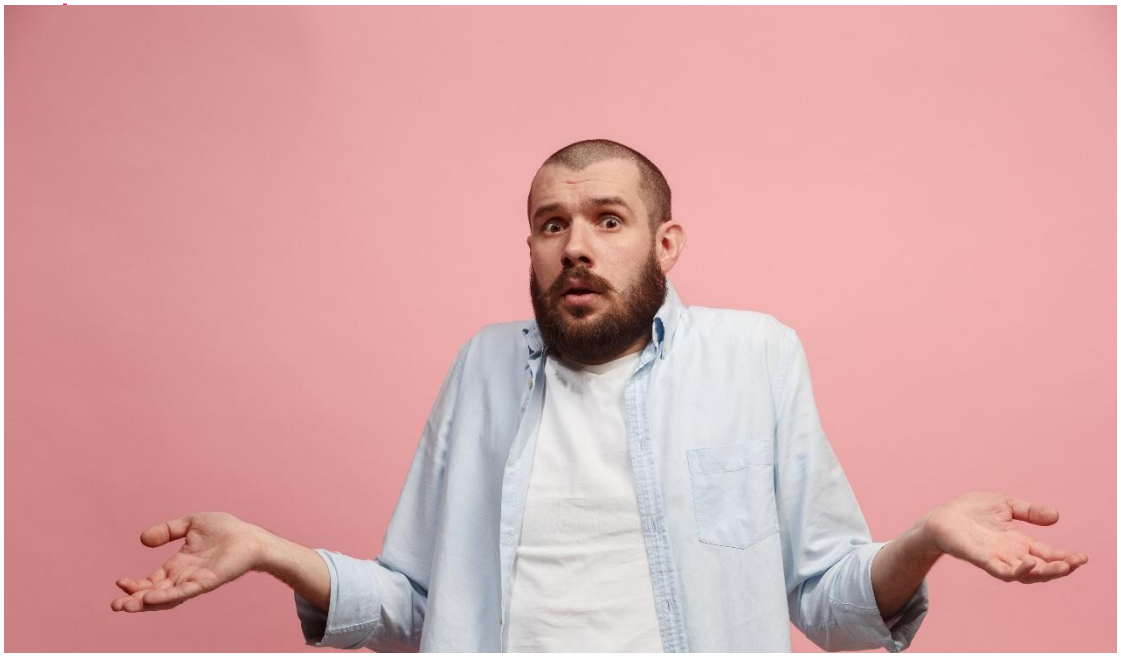
5MHz for obese patents and oedematous limbs

Why measure pressure in both arms and take the highest reading?

This ensure that the systolic pressure is closest to the systemic pressure, especially is arterial disease is present

Why do you use the higher of the two measurements in the foot?

This will determine whether there is adequate blood flow to the foot from one of the arteries



HELP! I CAN'T GET A DOPPLER!

Focus on clinical assessment, rather than relying on an ABPI alone.

Ignoring the symptoms or delaying treatment while awaiting an ABPI may lead to a deterioration of the condition.

Provided vascular status has been thoroughly assessed ABPI measurements for patients who present with lymphoedema are not necessarily required.

If there are concerns in terms of reduced arterial flow, complete a referral for further vascular assessment through both the TV team and vascular.

WHY SHOULD I CARRY OUT DOPPLER?

To establish if arterial disease is present, the severity and monitor deterioration over time (objective method of assessing arterial blood supply to the legs)

To assess suitability for compression therapy to prevent arterial occlusion and ischaemia

To gain information on healing protentional

95% of leg ulcers develop due circulation issues - to understand what is going on with the vascular system

To help diagnose aetiology

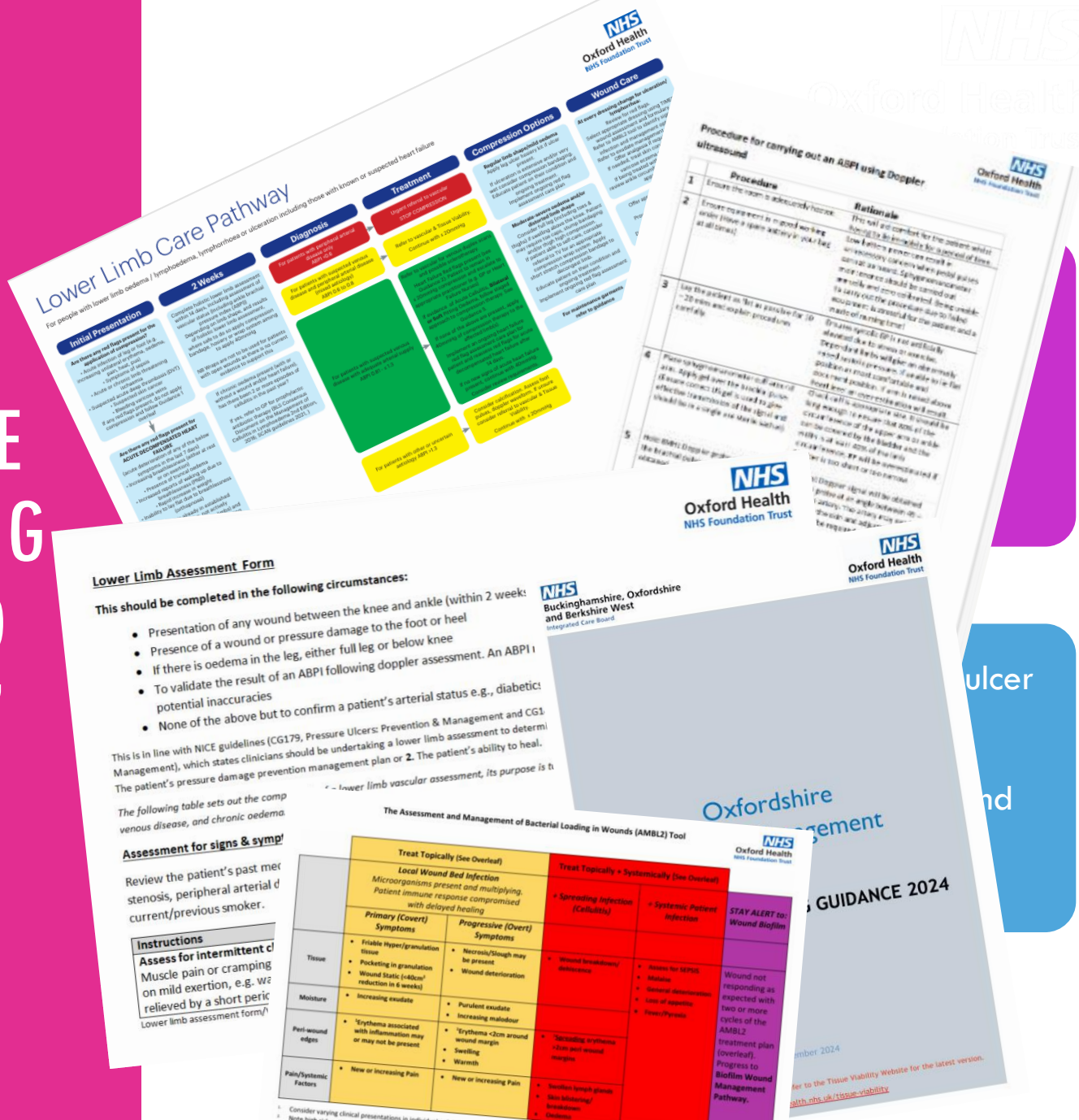
Palpation of foot pulses is not sufficient

To address underlying issues and identify correct treatment

To establish if there is a good blood supply before undertaking debridement

Best practice – supported by NICE guidelines, NWCSP and written in local policy

“WHAT’S THE WORST THING THAT COULD HAPPEN…”



ulcer

nd

QUICK QUIZ!

Question 1	How often should you repeat a doppler assessment if an ABPI is 0.7?
Question 2	What does an ABPI of 0.85 indicate?
Question 3	Who should you send a referral to if an ABPI is <0.6?
Question 4	Is compression therapy advocated in patients with an ABPI of >1.3 as an interim measure?
Question 5	What ABPI range suggests mixed disease?
Question 6	How many mmHg can be applied if an ABPI is 1.2?


GUESS WHAT?
IT'S TIME FOR LUNCH

ROBUST EVIDENCE SUGGESTS COMPRESSION THERAPY CAN **DOUBLE** THE CHANCE OF VENOUS ULCERATION HEALING WITHIN **12 WEEKS** BUT VARIATION IN CARE MEANS ONLY **47%** OF THOSE AFFECTED HEAL WITHIN **12 MONTHS**

IMPACT OF COMPRESSION THERAPY

Lymphatic system

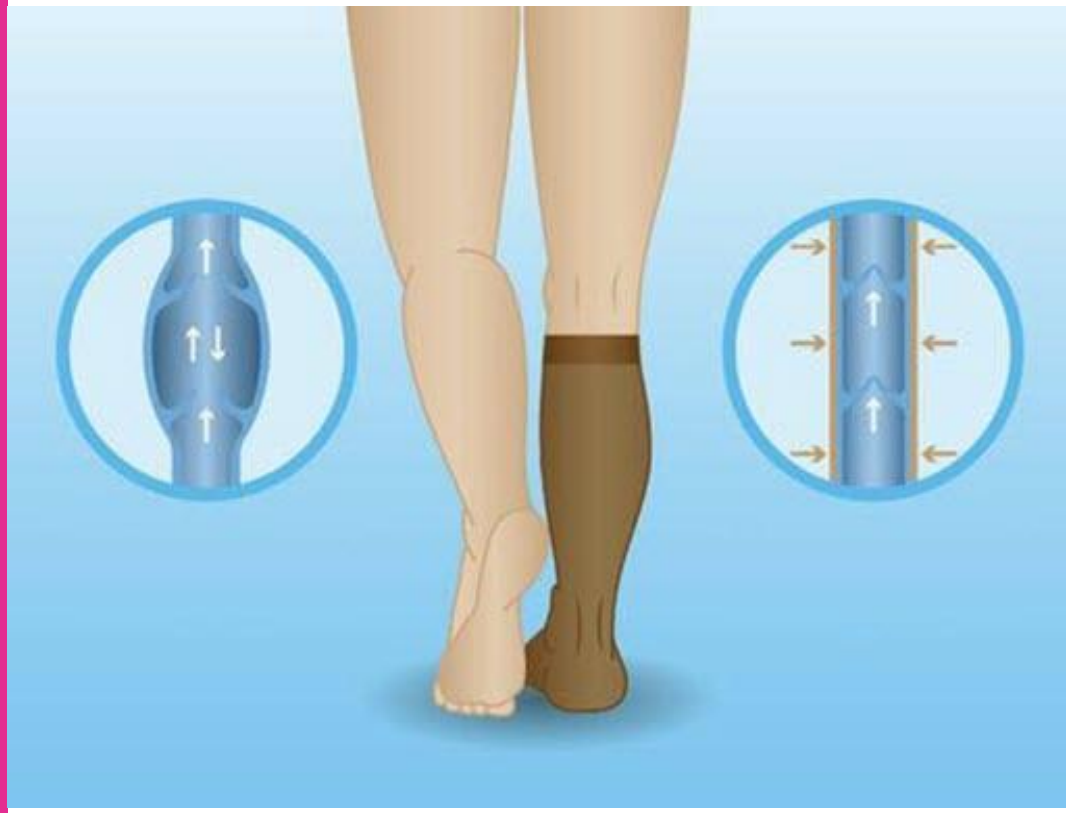
- Breakdown of fibrosis
- Decreased fluid filtration from capillaries into tissue
- Decreased formation of excess interstitial fluid
- Decreased lymphatic load
- Enhanced muscle pump
- Increased frequency and amplitude of lymph-collector contractions
- Shifting of fluid into areas with better lymphatic function

Venous system

- Improved venous return
- Maximised calf muscle pump
- Reduced matrix metalloproteinase (MMPs) levels
- Reduced venous reflux
- Reduces venous hypertension
- Improve symptoms of lipodermatosclerosis and papillomatosis
- Restores valve function

COMPRESSION THERAPY

- The key to healing a venous leg ulcer and preventing recurrence is the use of strong compression therapy.
- This is essential to restore normal return of venous blood flow back to the heart and is achieved by applying an external force or support to the limb.
- This support allows damaged valvles in the leg veins to close and reduces pooling in the veins by directing venous blood in the right direction back towards the heart.



THE LAWS OF COMPRESSION

La Place's Law

This law frequently used to calculate sub-bandage pressures of compression systems and is summarized as: pressure (mmHg) = tension (Kgf) x number of layers x 4620 circumference (cm) x bandage width (cm)

Pascal's Law

"Pressure at a point has infinite direction, and thus a pressure change at any point in a confined incompressible fluid is transmitted throughout the fluid such that the same change occurs everywhere."

LA PLACE'S LAW

The pressures exerted by a compression bandage are influenced by four factors:

1

Tension

↑ tension = ↑ pressure

↓ tension = ↓ pressure

2

Number of layers

↑ layers = ↑ pressure

↓ layers = ↓ pressure

3

Limb circumference

↑ limb = ↓ pressure

↓ limb = ↑ pressure

4

Bandage width

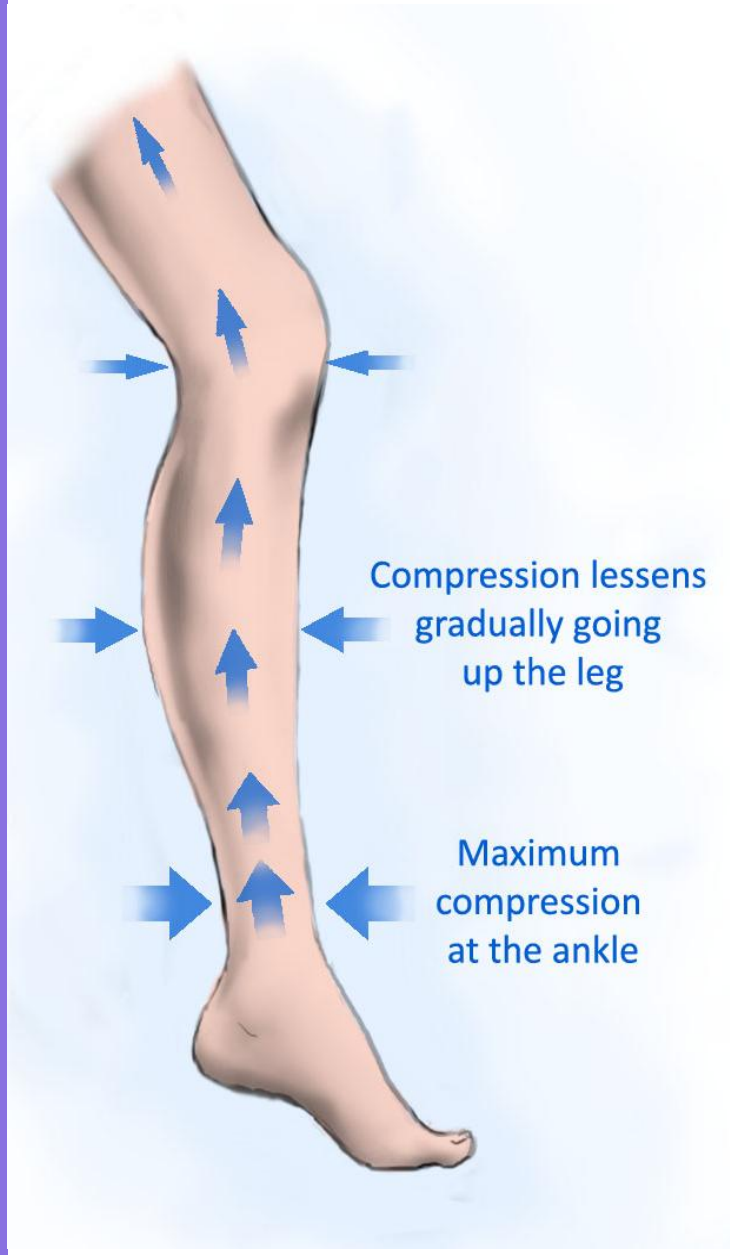
↑ width = ↓ pressure

↓ width = ↑ pressure

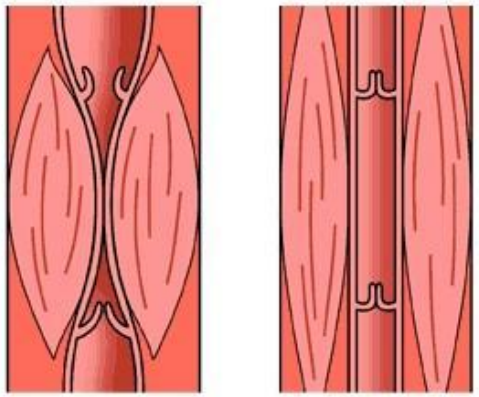
FOLLOW MANUFACTURER'S INSTRUCTIONS

GRADUATED COMPRESSION

- Graduated compression is when the bandages are applied at the correct compression up the leg.
- The pressure falls as the circumference of the leg increases (Le Place's Law).
- Maximum compression is at the ankle as it is furthest away from the heart.
- There should be an 8-10cm increase in calf circumference compared to the ankle circumference to ensure efficient venous return (La Place's Law).
- This is why correct limb shaping/padding is SO important!



WORKING & RESTING PRESSURES



Working Pressure

When the muscle pump is active and expands it presses against the bandage. The resistance of the bandage 'presses back' against the muscle

When the muscle pump relaxes it is not pressing against the bandages. There is no resistance from the bandages.

Resting Pressure

SHORT STRETCH VS LONG STRETCH BANDAGING

Inelastic (short stretch) bandage

- High working pressure (100% stretch when mobilising)
- Low resting pressure
- Suitable for mobile patients with good calf muscle pump

Elastic (long stretch) bandage

- Maintains a constant pressure all of the time by 'squeezing' the muscle, even when resting
- Suitable for less mobile patients with no calf muscle pump

OXFORD HEALTH COMPRESSION BANDAGING

	Clinistretch	K-Two	K-Two Reduced
Elastic or inelastic?	Inelastic	Elastic	Elastic
Short or long-stretch?	Short-stretch	Short and long-stretch elements	Short and long-stretch elements
Working pressure	High	Constant	Constant
Resting pressure	Low	Constant	Constant
mmHg	40mmHg (20mmHg for ankle circumference >25cm)	40mmHg	Mild 20mmHg
Single or multi-layer?	Single or double layer can be	Multi-layer	Multi-layer

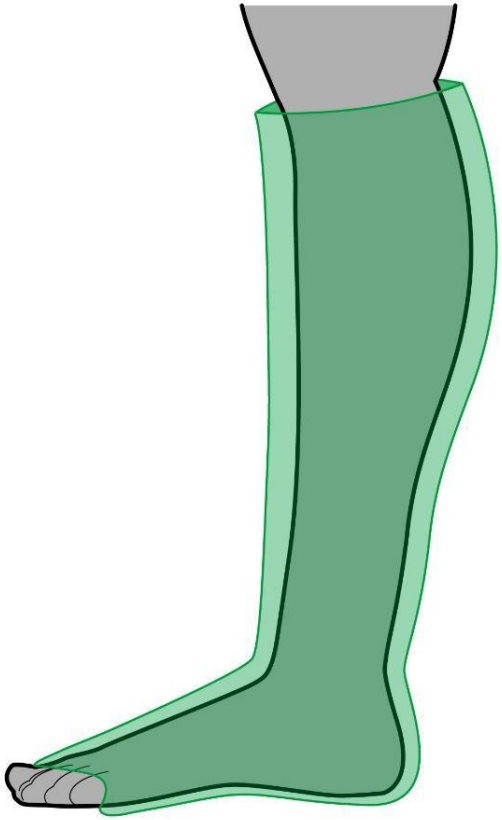
COMPRESSION PRESSURE

Compression pressure is the dosage of our treatment and should be adjusted to individual needs. The ideal compression device should provide a tolerable resting pressure and a pressure high enough to counteract gravity in an upright position

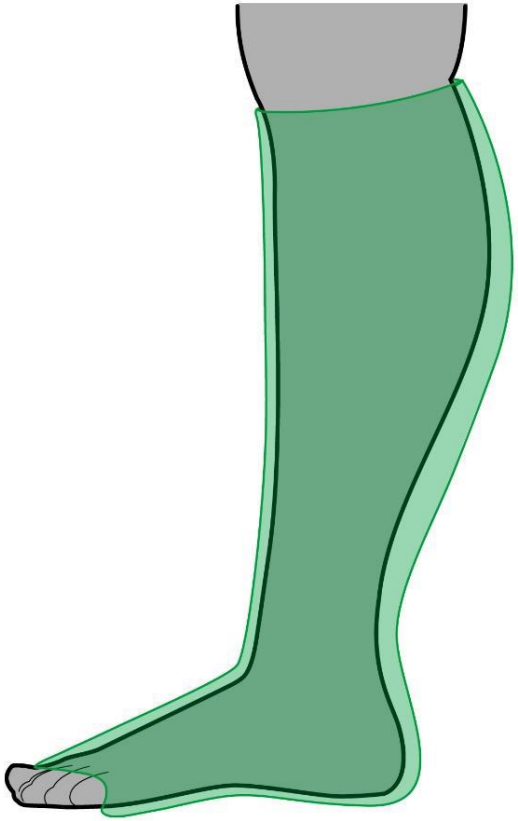
(Partsch and Mortimer, 2015)

SUB-BANDAGE PADDING

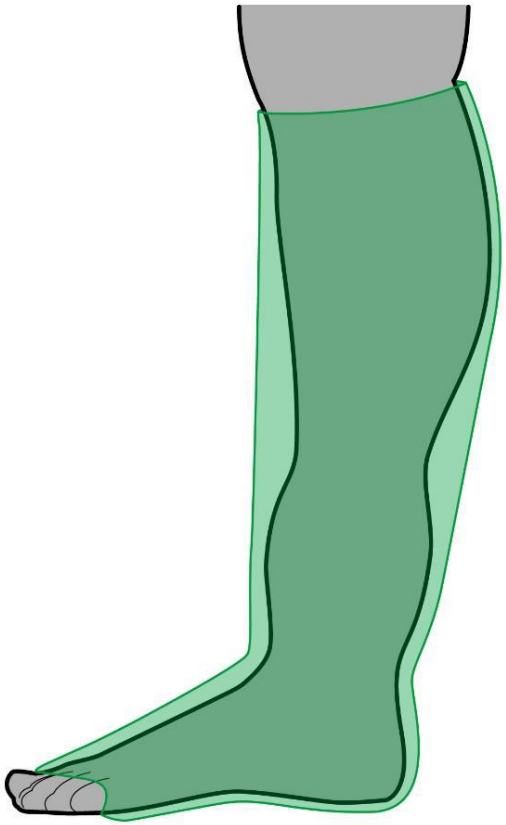
SUITABLE PADDING FOR DIFFERENT LIMB SHAPES AND SIZE



'NORMAL' LEG



PRONOUNCED CALF MUSCLE



FIBROSIS OF THE ANKLE

PRESSURE DAMAGE CAUSED BY INSUFFICIENT PADDING

DO NOT OVER-PAD WITH WADDING




INCORRECT PADDING APPLICATION

YOUR TURN! COMPRESSION BANDAGE DEMONSTRATION AND PRACTICE FOR VENOUS ULCERATION

Patient factors

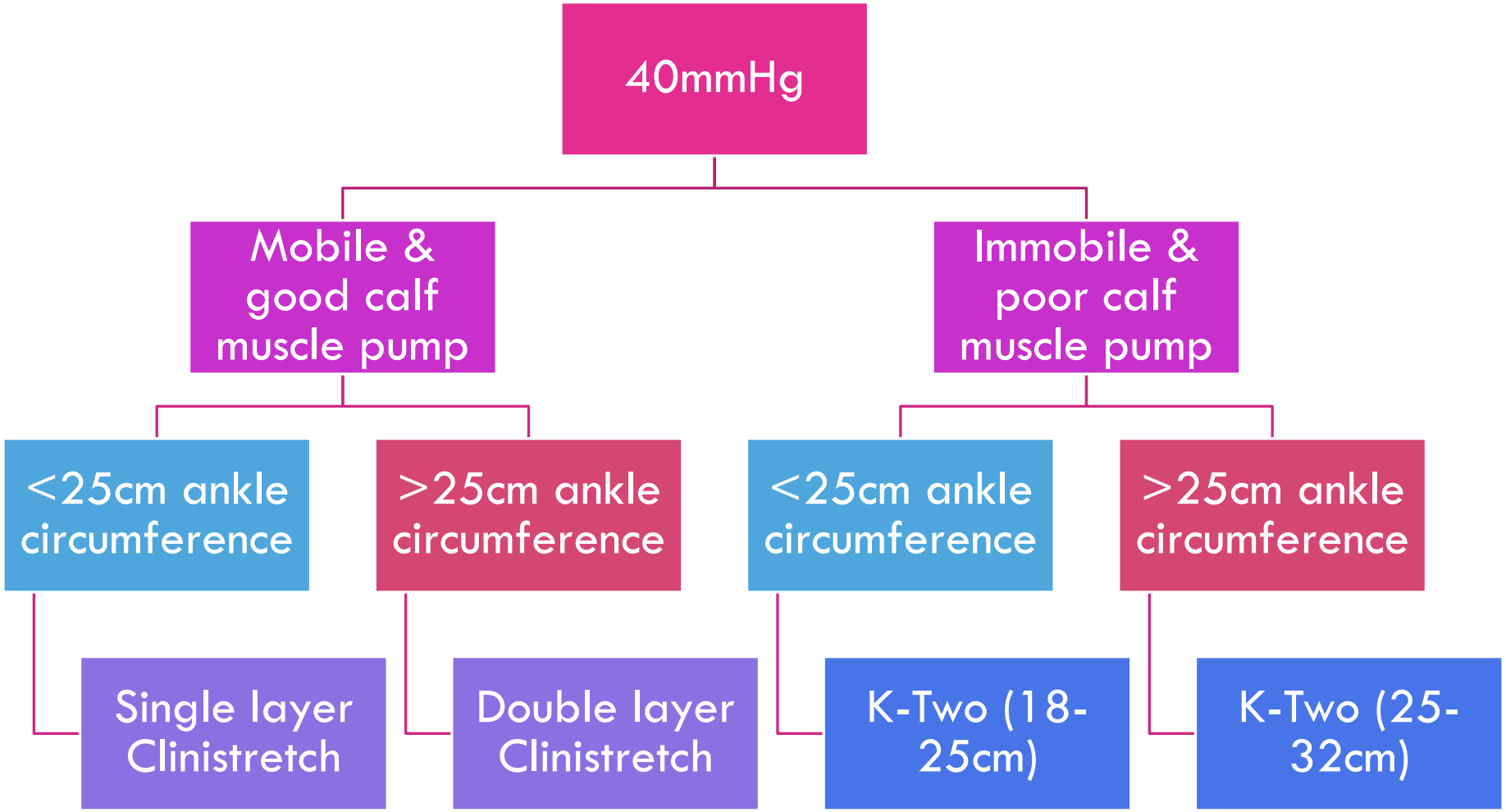
- Activity level
- Ankle circumference
- Dexterity
- Disease pathology
- Lifestyle
- Mobility
- Skin texture (hard/soft)
- Wound size, duration and complexity

Compression factors

- Compression strength
- Consistency of pressure over time
- Durability
- Dynamic profile (elasticity or stiffness)
- Ease of application
- Slippage
- System type

HOW DO I DECIDE WHICH COMPRESSION BANDAGING TO USE?

WHICH COMPRESSION BANDAGING SHOULD I CHOOSE FOR… LEG ULCERATION



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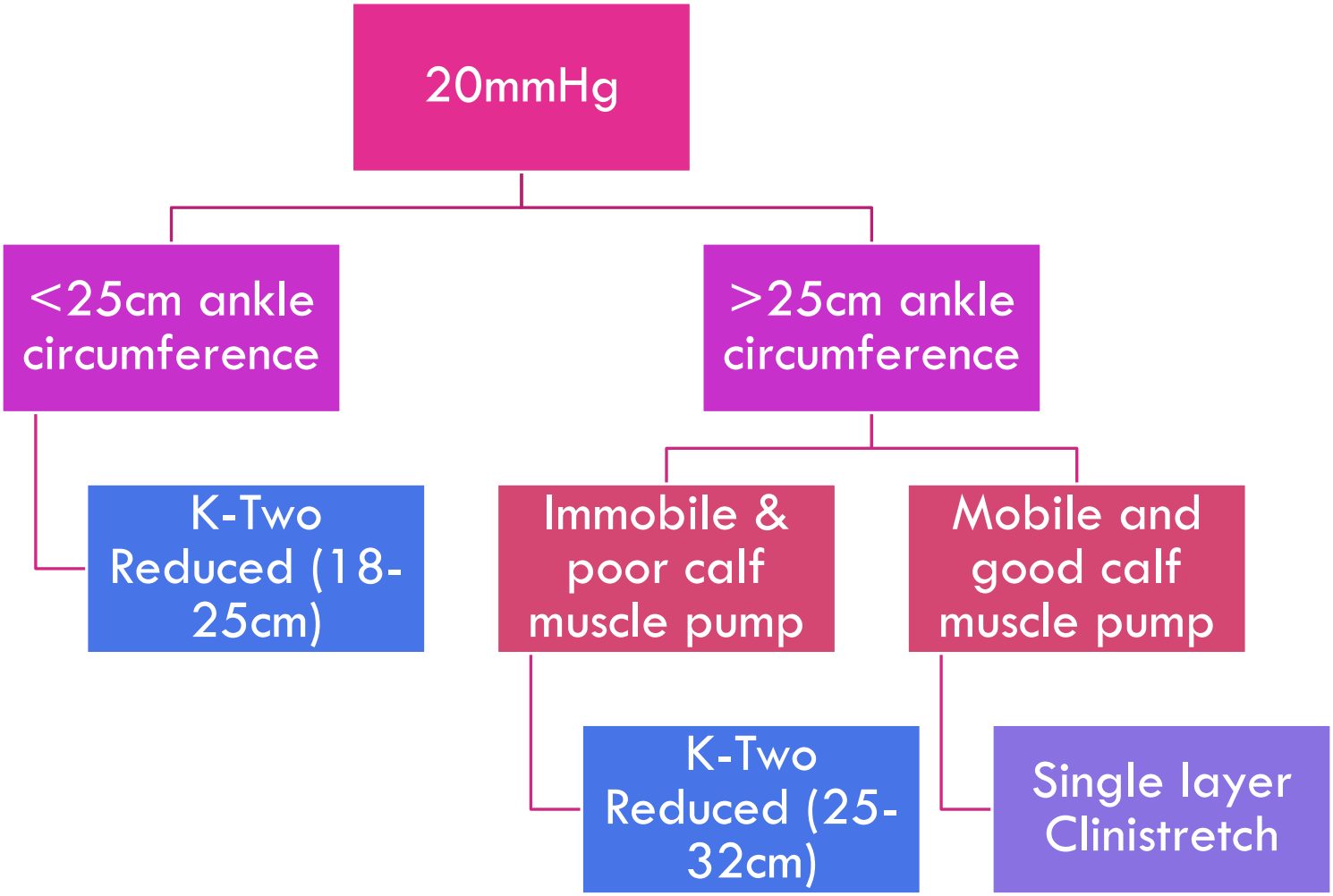


Ever seen a giraffe with oedema?

Always opt for a SHORT-STRETCH compression bandaging system to manage chronic oedema

STATIC STIFFNESS INDEX (SSI)

ASSESSING THE SEVERITY OF OEDEMA HELPS TO DETERMINE OUR TREATMENT

Where is the oedema? (toes, ankles, calves, knees, thighs, hips)

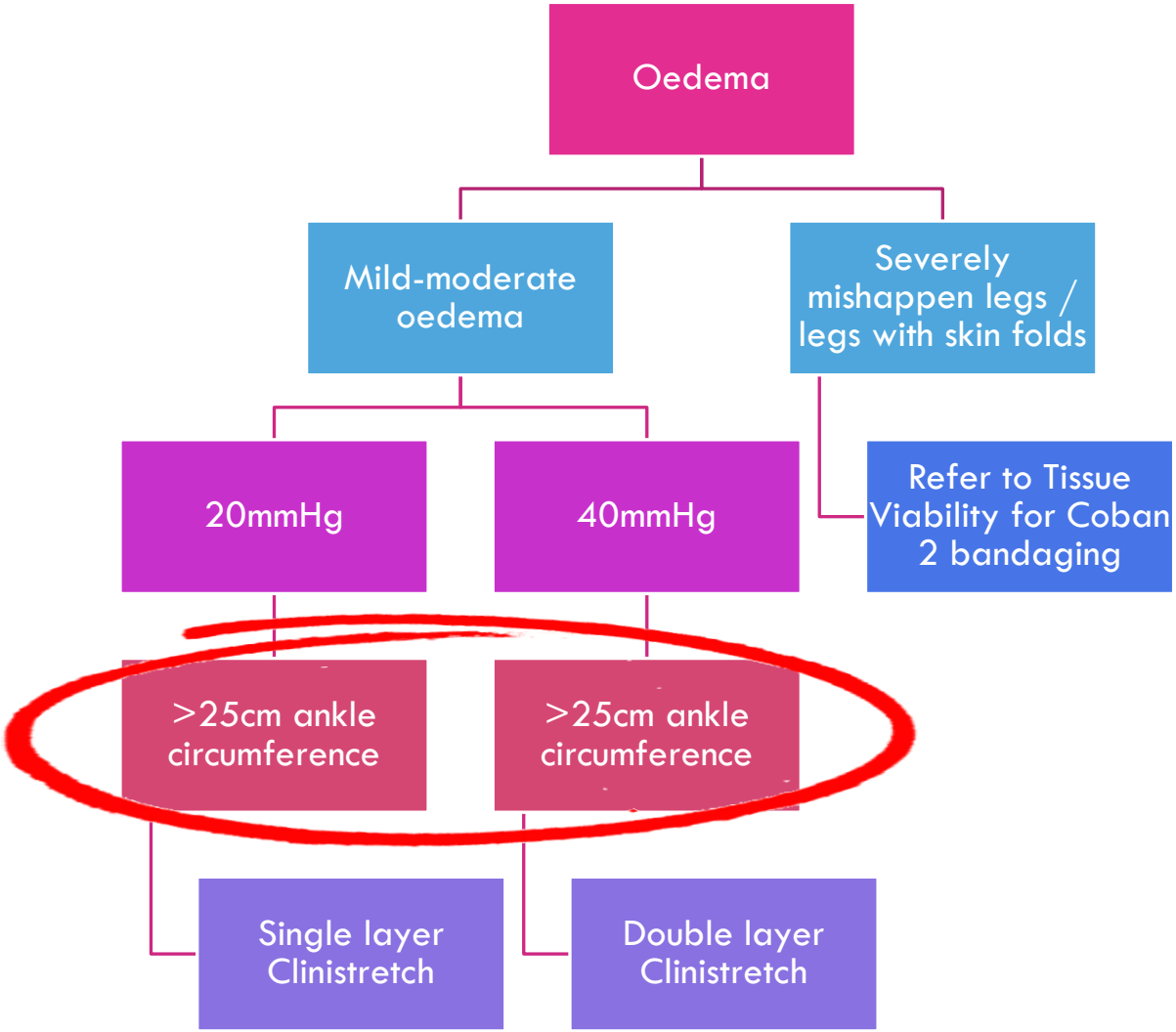
What does the oedema feel like? (Soft, pitting, firm, fibrotic)

Skin changes? (hyperkeratosis, ulceration, papillomatosis, lymphorrhoea – refer to the CHROSS checker tool)

Positive Stemmer sign?

Skin folds? (minor, moderate, severe)

WHICH COMPRESSION BANDAGING SHOULD I CHOOSE FOR…CHRONIC OEDEMA?



SEVERE OEDEMA, MISSHAPEN LIMBS AND SKIN FOLDS

Refer to Tissue Viability for Coban bandaging.

Lauren Frost (3M rep) to support with Coban application

Coban compression bandaging is ordered via Tissue Viability

IS THE COMPRESSION THERAPY EFFICACIOUS?

BASELINE LIMB MEASUREMENTS

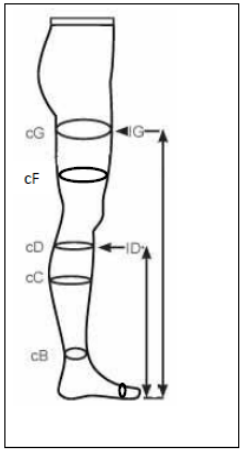
Misshapen legs with skin folds - Take photograph of leg and mark on photograph where to measure

Patient label

NHS
Oxford Health
NHS Foundation Trust

Please measure the limb before each application of compression bandaging - **LEFT / RIGHT LEG** (delete as appropriate)

DATE									
cG									
cF									
cD									
cC									
cB									
Circumference around base of toes									



Lower Limb measurement form/Tissue Viability/V3/Nov2019

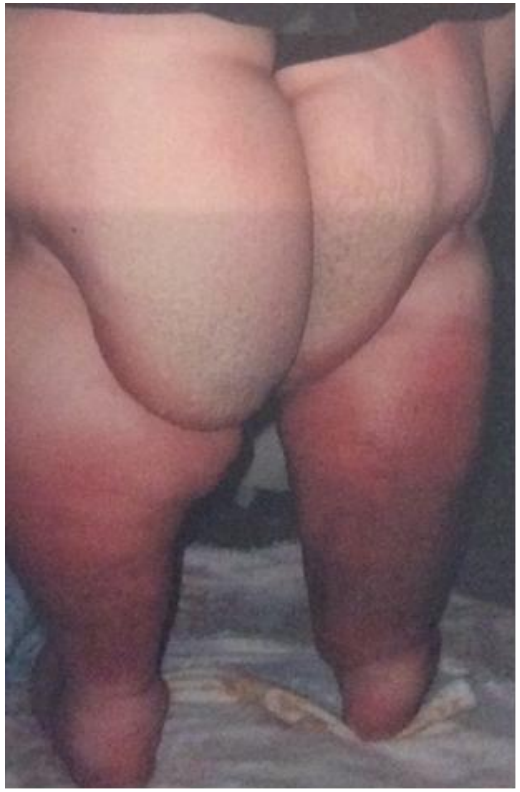
QUICK COMPRESSION QUIZ!

Question 1	Sandy is 42 years old, fit, visits the GP practice for wound care, has an ABPI of 1.1 and an ankle circumference of 24cm. Which compression bandaging wound you choose?
Question 2	Fred has an ankle circumference of 30cm. Your colleague applies a single layer of Actico. How many mmHg is being applied to Fred's leg?
Question 3	Dorothy has an ankle circumference of 22cm and Adam has an ankle circumference of 29cm. They are both wearing single layer Actico. Who has a higher amount of compression on ther leg?
Question 4	Bev is 94 years old, has to be hoisted in and out of bed, has an ankle circumference of 27cm and is suitable for high 40mmHg compression. Which compression bandaging wound you choose?
Question 5	Arthur has an ABPI of 0.97 and an ankle circumference of 31cm. Should you apply 1 or 2 layers of Actico?

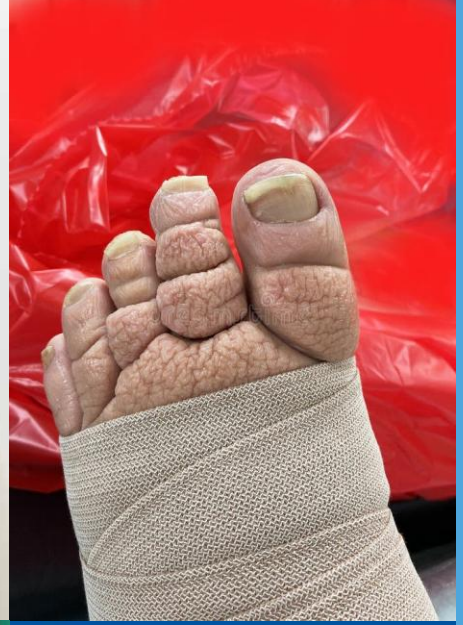
BANDAGING FOR CHRONIC OEDEMA

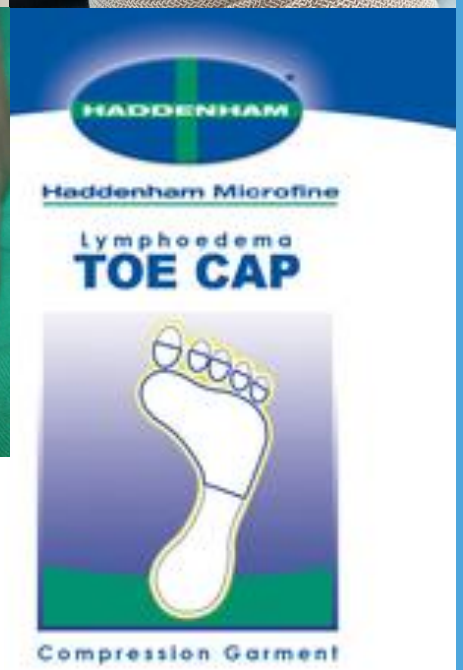
- Decongestion of limb
- Aid healing of ulcers
- Help mobility
- Reduce discomfort/pain
- Actico bandaging (using chronic oedema technique)

OEDEMA DECONGESTION SUCCESS! JANUARY 2014 (BEFORE)



OEDEMA DECONGESTION SUCCESS! FEBRUARY 2015 (AFTER)





DON'T FORGET THE TOES!

1. Stump bandaging

For weeping or very deformed toes

2. Toe garments – Haddenham microfine toe caps

Off the peg – measure circumference at ball of foot	Use under bandages	Trim to fit – seams on outside

CHALLENGES!

- Washing and drying
- Fungal infections!
- Toe sandwiches
- Toe creases

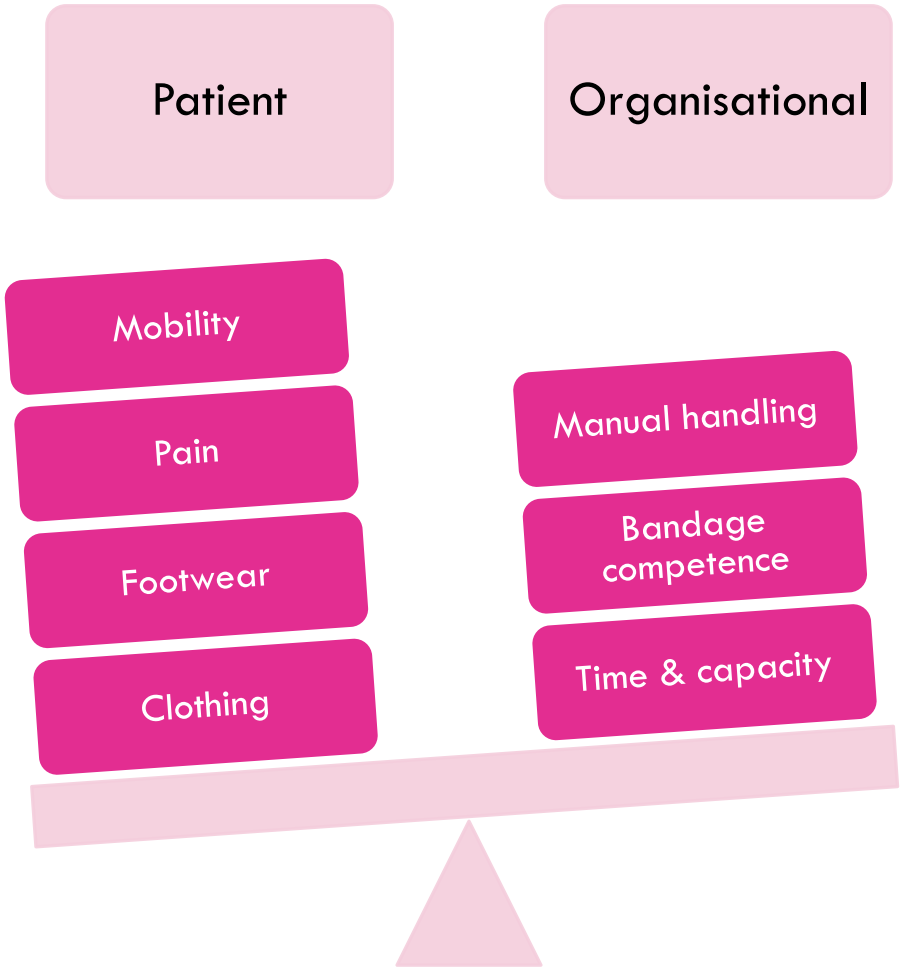
TECHNIQUE – DEMONSTRATION & THEN YOUR TURN!

You will need:

- Wadding bandage
- Clinistretch (8cm x 6m) - foot
- Clinistretch (10cm x6m) – lower leg
- Clinistretch (12cm x6m) – thigh
- Scissors

DISCUSSION:
WHAT ARE THE BARRIERS TO COMPRESSION THERAPY AND HOW CAN WE RESOLVE THEM?

CHALLENGES WITH APPLYING BANDAGING



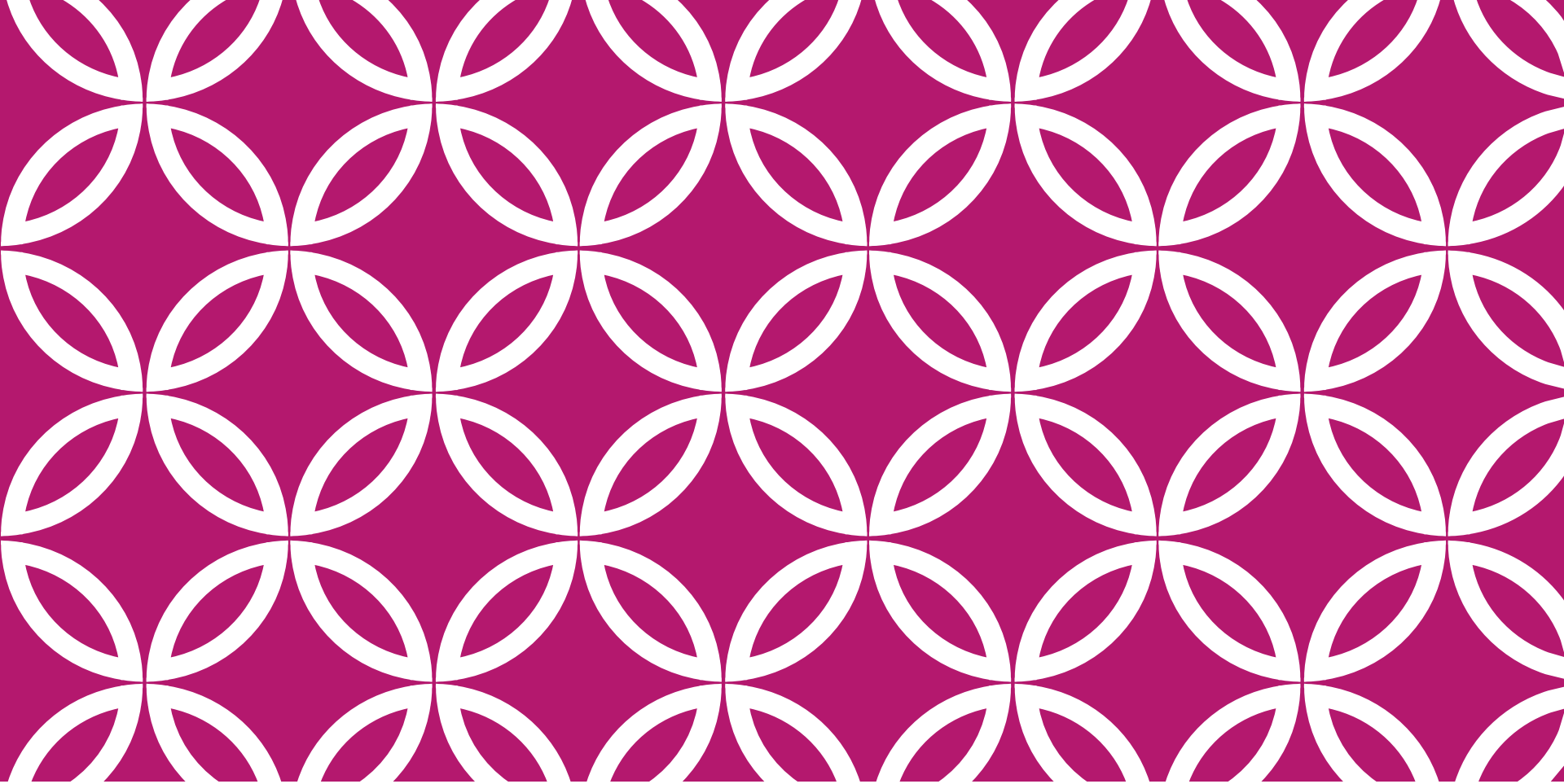
CHALLENGES WITH APPLYING THIGH-HIGH BANDAGING

Patient

- Clothing & Footwear - check appropriate clothing and footwear prior to commending bandaging
- Pain - Explore reasons for pain and consider use of analgesia
- Mobility – consider use of alternative compression therapies
- Continence – consider continence assessment and management, consider alternative compression therapies

Organisational

- Time/Staffing capacity - Plan to start decongestion bandaging when there is enough staff capacity to see it through until the end
- Competency - Where possible consider joint visits to get staff who are not used to using Actico get an opportunity to do this skill under supervision
- Manual Handling - Consider patient's environment, allow plenty of space, consider double-up visits for very large limbs to reduce twisting/stretching.



MAINTENANCE

STANDARDS?

The two main standards of compression hosiery used in the UK are:

British Standard	European Standard
British standard compression garments are made from fine, light fabrics and are circular knit. In limbs with a graduated shape, British standard compression garments provide effective compression to prevent ulceration, heal venous leg ulcers and prevent recurrence. However, they are only suitable for patients without oedema.	If oedema is present, European standard compression hosiery can be used. European standard hosiery is also circular knit but delivers a greater level of compression (mmHg) and is made from a stiffer fabric than British Standard circular knit hosiery. It can be used to prevent ulceration, heal venous leg ulcers and prevent recurrence in a limb with oedema. It can also be used to manage chronic oedema in a limb that has previously been decongested with multi-layer bandaging.

CLASS?

Class	British Standard	European Standard	Class
1	14–17 mmHg	18–21 mmHg	1
2	18–24 mmHg	23–32 mmHg	2
3	25–35 mmHg	34–46 mmHg	3

BUT IT'S NOT ALL ABOUT THE CLASS!

Circular knit garments

- (E.g. Activa, Actilymph)
- Circular knit garment has a horizontal stretch
- Suitable for patients with very mild chronic oedema
- NOT suitable for patients with moderate-severe chronic oedema
- No seam
- Off-the-peg sizes
- Stretched horizontally so rings of fabric can cause a tourniquet effect

Flat knit garments

- (E.g. Actilymph MTM, Jobst Elvarex)
- Flat knit garments offer a 'stiffness' which circular knit garments don't have – this helps to 'hold the oedema'
- Suitable for patient's with moderate-severe chronic oedema
- Has a seam up the back where garment has been stitched together
- Made to measure – contour to your patients so no uncomfortable digging in/rolling down/tourniquets

CHROSS CHECKER TOOL

Prevention	Spider veins ☐	NO ☐	Activa® British Standard hosiery† Mild: Class 1 (14–17mmHg) ☐ Moderate: Class 2 (18–24mmHg) ☐
	Ankle flare ☐		
	Mild/moderate hyperkeratosis ☐	YES ☐	ActiLymph® European Class hosiery†† Mild: Class 1 (18–21mmHg) ☐ Moderate: Class 2 (23–32mmHg) ☐
	Mild/moderate varicose veins ☐		
	Hyperpigmentation ☐		
	Venous dermatitis ☐		
Early/medium intervention	Varicose eczema ☐	NO ☐	Activa® British Standard hosiery† Moderate: Class 2 (18–24mmHg) ☐ Severe: Class 3 (25–35mmHg) ☐ Activa® Leg Ulcer Hosiery Kit ☐
	Atrophie blanche ☐		
	Induration ☐		
	Moderate/severe varicose veins ☐		
	Moderate/severe hyperkeratosis ☐		
	Healed ulcer*/** ☐	YES ☐	ActiLymph® European Class hosiery†† Moderate: Class 2 (23–32mmHg) ☐ Severe: Class 3 (34–46mmHg) ☐ ActiLymph® Hosiery Kit ☐
	Recurring ulcer/open ulcer*/** ☐		
	Cellulitis*** ☐		
Intensive management	Lipodermatosclerosis (acute or chronic) ☐	NO ☐	Activa® British Standard hosiery† Severe: Class 3 (25–35mmHg) ☐
	Chronic oedema/lymphoedema ☐	YES ☐	ActiLymph® European Class hosiery†† Moderate: Class 2 (23–32mmHg) ☐ Severe: Class 3 (34–46mmHg) ☐ ActiLymph® Hosiery Kit ☐ ActiLymph® MTM Ease or MTM Dura Moderate: Class 2 (23–32mmHg) ☐ Severe: Class 3 (34–46mmHg) ☐
	Severe hyperkeratosis ☐		
	Skin folds ☐		
	Papillomatosis ☐		
	Lymphangiomata ☐		
	Lymphorrhoea (wet legs) ☐		

Compression Hosiery & Wraps

Treatment

First Line:
Leg ulcer hosiery kit

Second Line:
Bandaging

Maintenance

First line:
Hosiery

Second Line:
Wraps

MEASURING TIPS FOR MTM HOSIERY

- Include all the oedema in your garment (E.g. if knee is oedematous opt for a thigh-high garment)
- Measurement charts differ between brands and types of hosiery so always check you are using the right one!
- Take measurements early in the day where possible
- Measure both legs
- Check positioning
- Measuring tapes – accuracy is important!
- Open toe or closed toe?
- Garments should be replaced every 6 months – prescribers are responsible for reassessing and remeasuring


actiglide


SIGVAR


Kerra

Choosing shoes

1. Fastening (lace or Velcro)
2. Sturdy heel counter
3. Rocker sole that bends where your foot bends

Top tips

- ☑ Choose a shoe with a removable insole for extra room
- ☑ Leave a thumb width gap at the end of the shoe to allow your toes to move
- ☑ Shoes with a wide opening allow for easier access for your feet

APPLICATION BY FORMAL CARERS

If the patient is unable to apply the hosiery independently and there is no relative, friend or informal carer available to assist, formal care can be applied for via a Delegated Health Care Tasks form.

If the application is successful, the shared care team will source and fund the care.

A referral should be made even if there is an existing care package, as carers will need the funding and the time allocated to deliver this care.

The referrer will be responsible for providing the training to the carers and for ongoing monitoring of the care.

The Shared Care Team can be contacted:
By phone on 01865 904201
By fax on 01865 261754
By email: shared.care@oxfordhealth.nhs.uk

LIFESTYLE CHANGES - HELP WITH FOOTWEAR

- Personal independence payment
- Adult disability payment
- VAT relief on certain goods if you have a disability
- Shoe Aid
- Talk to patient about lower cost shoes

ACHIEVING COMPETENCE

PRACTICE

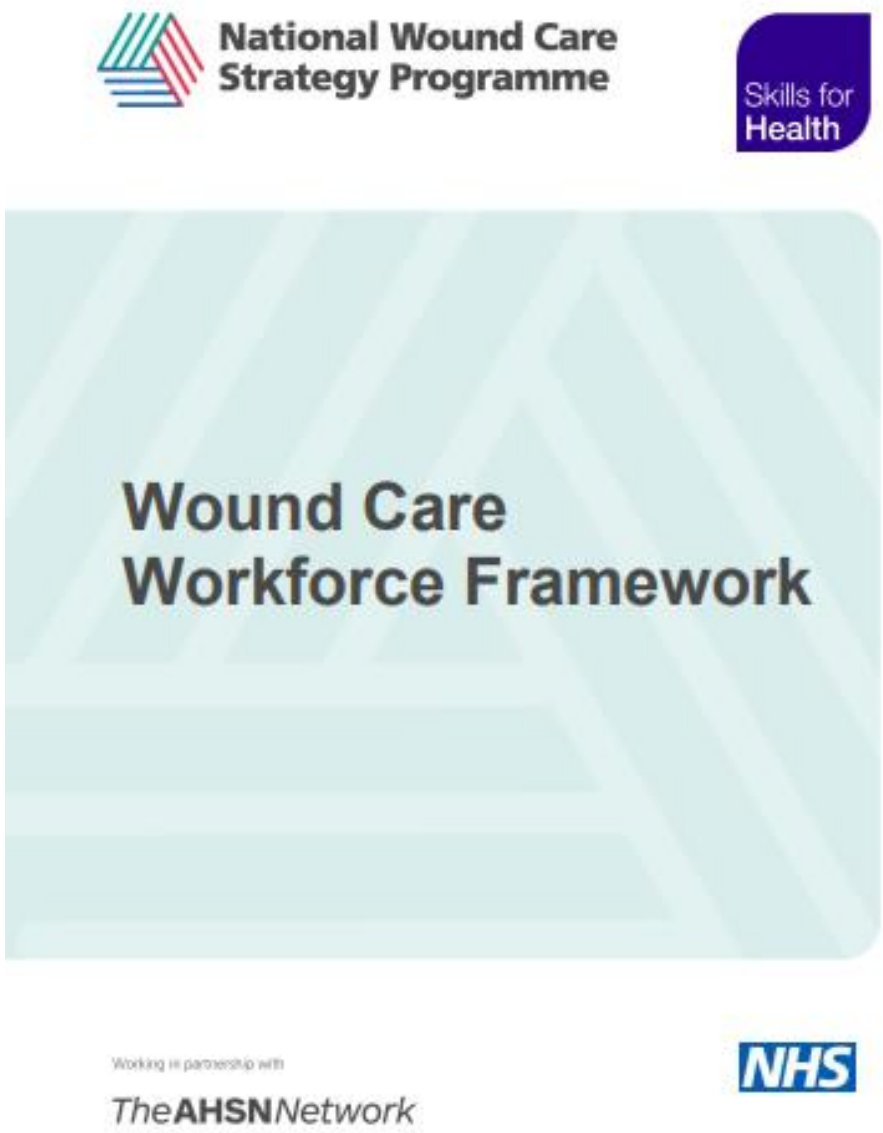
FURTHER TRAINING

CONTACT L+R AND URGO REPS

ACHIEVE COMPETENCY SIGN-OFF

SELF-EVALUATE

MONITOR COLLEAGUES



NWCSP CORE CAPABILITIES FRAMEWORK


ESCAPE
ROOM

QUESTIONS?

YOUR FEEDBACK IS IMPORTANT TO US!

PLEASE SCAN THE QR CODE AND COMPLETE THE EVALUATION