Challenging the “No ABPI: No Compression” rule

The clinical dilemma

Tessa presented to our multi-disciplinary complex wound clinic with worsening leg ulcerations with an original history of traumatic damage. She is 92 years old and had been managed daily at home by community nurses with support from the local TVN. Issues included:

- Severe and constant pain making Tessa’s life unbearable
- Circumferential gaiter ulceration and lower leg oedema
- Severe pain also prevented ABPI assessment
- **Community Nurses unwilling to go against nationally recognised guidance (SIGN, 2010) that an ABPI must be obtained prior to the application of compression therapy. Compression therapy was thus not commenced despite the presence of significant oedema and deteriorating ulcers.**

Adherence to guidelines had resulted in

- Extensive dermatitis from the excessive exudate
- Her ulcers deteriorating as exudate increased

Decision making

Clinical & Risk Assessments undertaken

- Doppler assessment of foot pulse sounds
- Past Medical History. DVT noted
- Analgesia review
- Podiatry assessment
    - walking heel to toe to focus on increasing ankle mobility
    - Footwear to enable tolerance of compression and provide safety

Tessa urgently required compression therapy if we were to change her awful situation. Importantly, Tessa also believed that her leg needed support. She needed hope that her situation could change.

Providing an effective care plan

Tessa’s severe pain meant that a careful plan was developed with her and her family:

- Effective analgesia to tolerate therapeutic compression
- Topical steroid to manage the erosive dermatitis
- 3A compression (Figure of 8) to reduce the oedema and control exudate
- As part of the risk assessment Tessa was reviewed in 24 hours to see how the management plan was tolerated by both Tessa and the effect on her limb.

Tessa’s experience

Tessa said that what we did was a miracle, that we changed her life overnight. The soggy bandages stopped immediately.

But is this an accurate description of what we did? We believe all we did was carefully plan and provide rational, safe and effective care.

References

NMC (2008) The Code London NMC

SIGN (2010) Management of chronic venous leg ulcers; a national guideline. Edinburgh SIGN

Goal is to heal leg ulcers with safe and effective compression therapy

Risk assessments undertaken to ensure safety of application without ABPI.

Manage pain with adequate analgesia so that Tessa can have effective management

NMC guidelines

The NMC Code (2008) advises nurses to be accountable for any omissions or deliverance of care; to be able to rationalise their actions; to provide care using best available evidence, and; to maintain openness and honesty with the patient whilst involving them in their care decisions.

The nursing challenge: Guidelines are not prescriptive, but a framework to work within. Had blind adherence to guidelines actually been a disservice to Tessa? Was the last 10 months an omission of care or an inability to rationalise safe actions?

Figure 1: a 10 month history

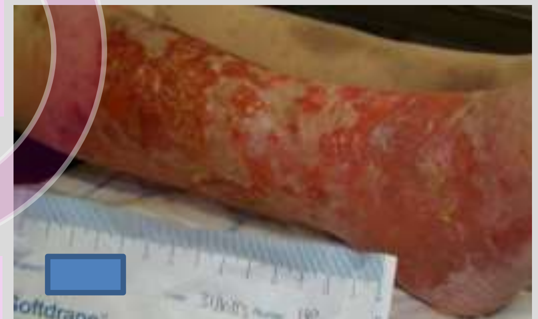
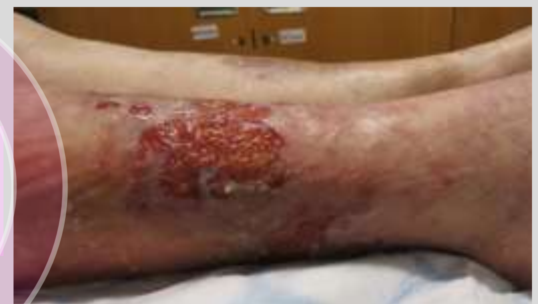


Figure 2: 2 weeks later



Outcomes and conclusions

Within 24 hours Tessa’s life was better

- Pain was better controlled
- Soft oedema decreased and guttering evident
- Erosive areas were calmer
- Exudate reduced – no strikethrough
- Immediate reduction to twice weekly dressings

Within 2 weeks

- Ulcer wound bed improvement and reduction in size.
- Erosive areas healed completely

Improved patient outcomes and experiences can be achieved whilst working outside of national guidance if simple, alternative safety strategies are applied. Nurses need to weight the risk of compression in the face of clear clinical need.

“It is not wise to violate rules until you know how to observe them” TS Elliott

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