

Implementing SSKIN and staging PI case studies



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Declaration

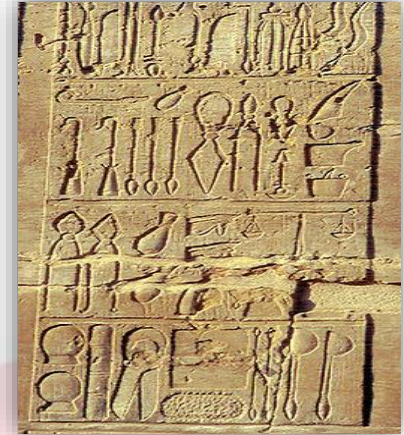
- The views expressed in this workshop are my personal thoughts and opinions on developments in Pressure Injuries and Wound Healing.





History of Pressure Ulcers

- Decubitus ulcers, Pressure sores, Bedsores
- 1940s recognition that management of urinary incontinence and turning patients reduced the number of pressure sores
- 1960s and 1970s 'Pressure Sore Books': recorded and reported to Matron
- Prevention of skin breakdown included:
 - **Softening the skin with oils & creams**
 - **Hardening the skin – methylated spirits and alcohol**
 - **Rubbing the skin to get circulation going again**



Groups at risk: Intrinsic factors

Factors related to the condition of the patient:

- Reduced mobility / Immobility
 - Sensory impairment
 - Acute illness
 - Level of consciousness
 - Extremes of age
 - Pain
 - Continence
 - Drug therapy
 - Posture
 - Previous history of pressure damage
 - Vascular disease
 - Severe chronic or terminal illness
 - Malnutrition
 - Psychological & social factors
- (CREST, 1998; NICE, 2003)*



Prevalence, Incidence and cost of pressure ulcers in Europe



Pressure ulcers are a relatively common risk among hospital inpatients and residents in long-term care whose mobility is restricted.

There are limited data on the incidence of hospital-acquired pressure ulcers in European hospitals. Point prevalence studies are more common, and these generally suggest that between one in four and one in five acute hospital inpatients has a pressure ulcer at any time.

Few studies have quantified the costs associated with pressure ulcers in European hospitals.

The cost of treating and preventing pressure ulceration in the UK across all care settings was estimated to be between £1.4 billion and £2.1 billion (€2.2–3.2 billion) at 2000 prices, which was approximately 3–4% of the total health-care spend in that year.

Bennett, G., Dealey, C., Posnett, J. (2004) Age Ageing 33: 230-235

Pressure Ulcers in USA

- Incidence:
 - » 1 – 5% in hospital
 - » 1.5 – 25% in long-term care
 - » **20% develop in nursing homes**
 - » 20% develop at home
- Associated Mortality Inc X5 (25-35%)

Avoidable or Unavoidable?

In the USA

Facility did not do one or more of the following:

- Evaluate clinical condition & risk factors
- Define/implement interventions consistent with resident goals/standards of practice
- Monitor/evaluate impact of interventions
- Revise interventions

Even though the Facility did:

- Evaluate clinical condition & risk factors
- Define/implement interventions consistent with resident needs, goals/standards of practice
- Monitor/evaluate impact of interventions
- Revise interventions

Litigation

Ayello 2005

Pressure Ulcers: Avoidable injuries?

- Is zero pressure ulcers an achievable goal?
- Pressure ulcers are everyone's business.
- Problem of 'silo' working:
 - Skin = nurse
 - Medication = Doctor
 - Mobility = Physio
- Funding aligned to performance in relation to 'Never Events'



Adverse events reported in NH

Avoidable incidents causing serious harm or death



26 facilities reporting

42 events in 2010

73 events in 2014

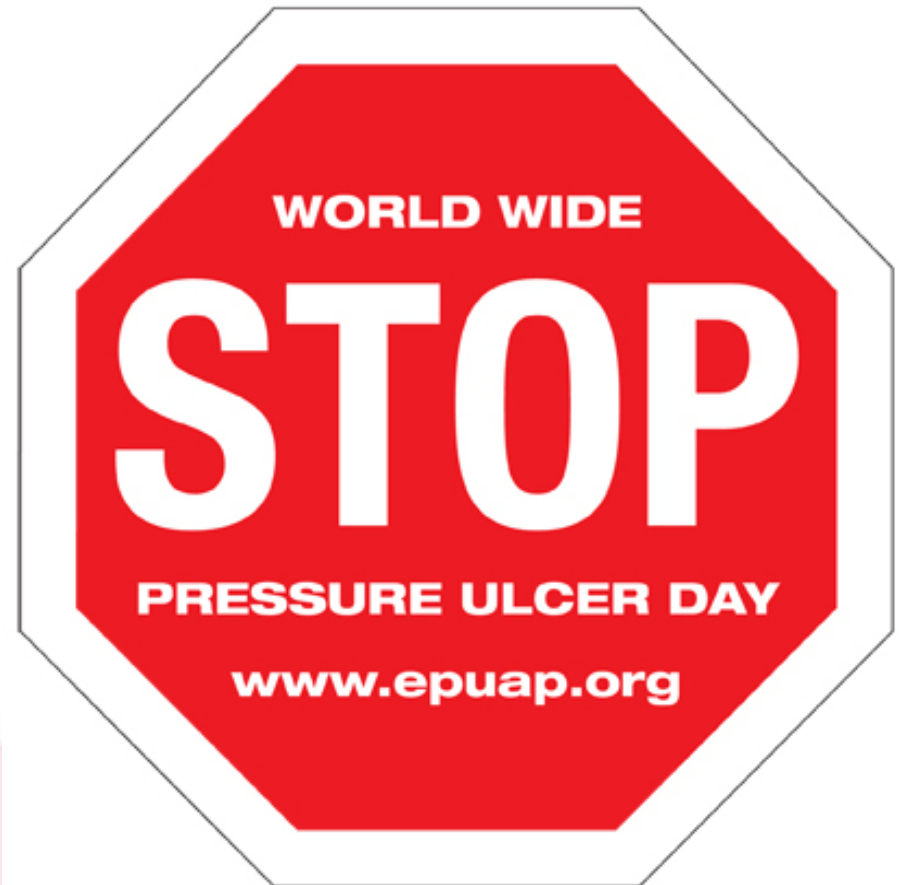
- Surgical/invasive procedure events
- Death/serious Injury Associated with a Fall
- Stage 3, 4 or unstageable pressure ulcers
- Other adverse event types



Source: NH Bureau of Licensing and Certification

International Initiatives

- Holland-Front page of Newspapers as 3rd most expensive health care problem
- Japan-Nominated Dr and Nurse in Charge for each facility
- USA-Nov 2008 No reimbursement for preventable complications
- “Superman” dies of PU



2014 International Guideline

Special Populations

- Bariatric Individuals
- Critically ill Individuals
- Older Adults
- Paediatric Individuals
- Individuals with Spinal Cord Injury

Implementing the guideline (new)

- Health Professional Education
- Patient Consumers and Their Caregivers
- Quality Indicators

247 new recommendations

60 recommendations
deleted

63 recommendation
reworded (slightly to a lot)

6 recommendations
Strength of Evidence
decreased

4 recommendations
Strength of Evidence
increased

**Approx 50% changed
since 2009**

2014 Definition of PI

A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure (including pressure associated with shear). **NB FRICTION NOW REMOVED FROM DEFINITION**

*A number of contributing or confounding factors are also associated with pressure ulcers; **the primary of which is impaired mobility.***

'A' level Strength of Evidence

Consider the pressure redistribution support surface in use when determining the frequency of repositioning.

(Strength of Evidence = A; Strength of Recommendation = 👍)

Use a high specification reactive foam mattress rather than a non high specification reactive foam mattress for all individuals assessed as being at risk for pressure ulcer development.

(Strength of Evidence = A; Strength of Recommendation = 👍)

Regularly reposition the older adult who is unable to reposition independently.

(Strength of Evidence = A; Strength of Recommendation = 👍👍)

Consider the use of direct contact (capacitive) electrical stimulation to facilitate wound healing in recalcitrant Category/Stage II pressure ulcers as well as any Category/Stage III and IV pressure ulcers.

(Strength of Evidence = A; Strength of Recommendation = 👍)

Offer high calorie, high protein nutritional supplements in addition to the usual diet to adults with nutritional risk and pressure ulcer risk, if nutritional requirements cannot be achieved by dietary intake.

(Strength of Evidence = A; Strength of Recommendation = 👍)

The solution to the problem is prevention

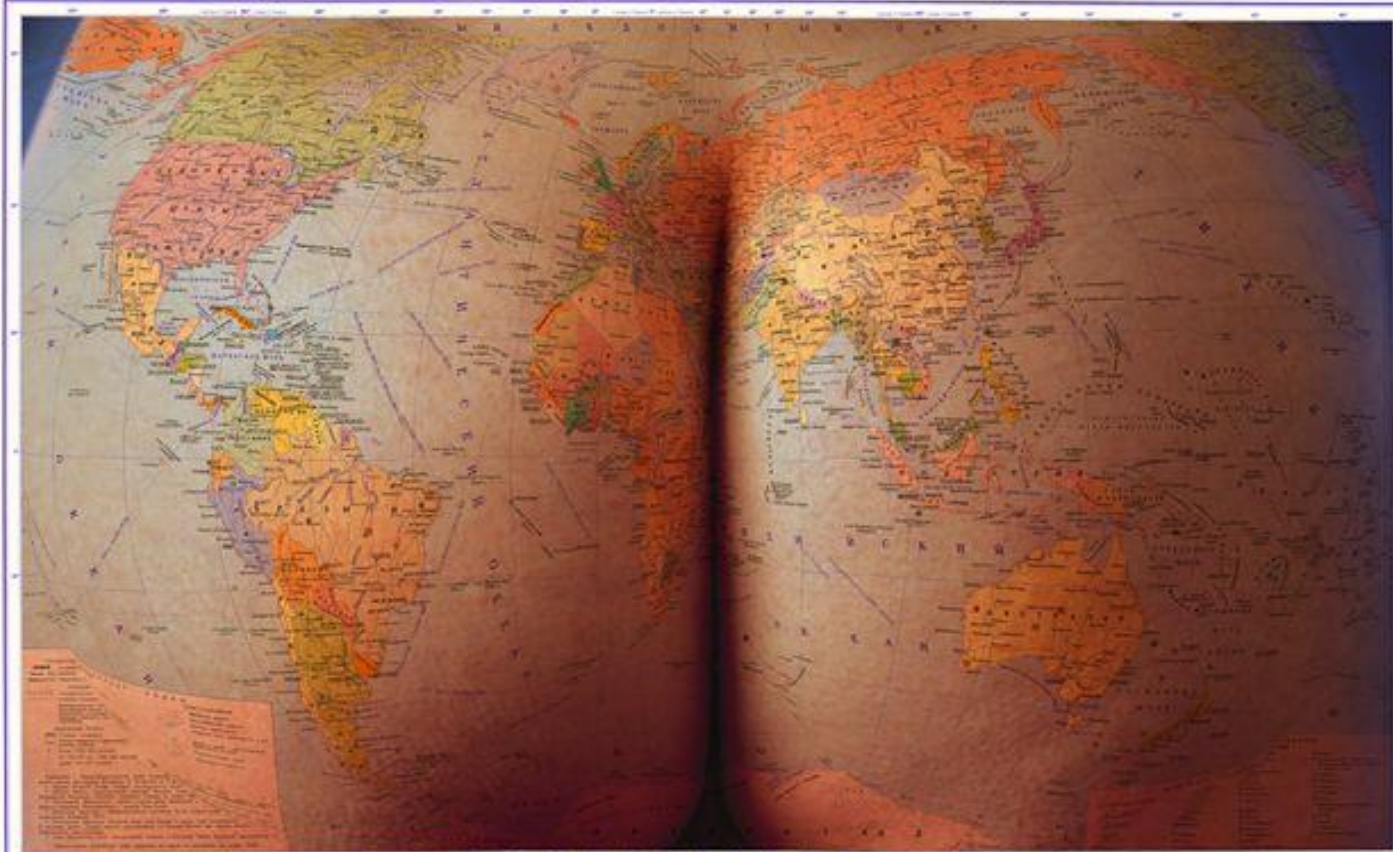
Consider the following statement:

95% of all pressure ulcers are preventable

(Hibbs 1988)

In 2010 Barbara Braden All I Ever Wanted Was a World Full of Pretty Butts...Still a way to go!

Н А Й Д И С В О Ю Р О Д И Н К У...



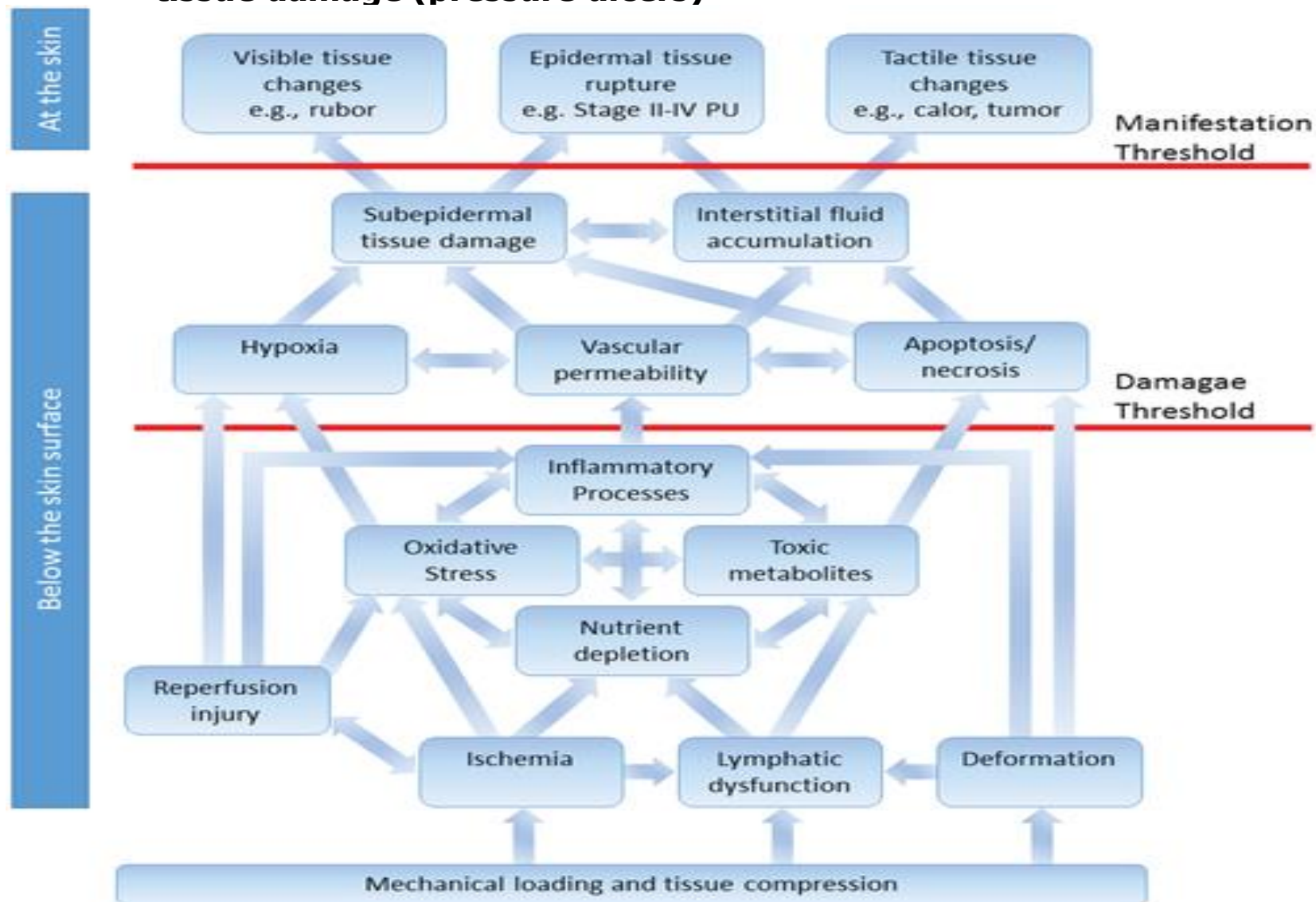
Risk Assessment Tools

- Assist but do not replace clinical judgement
- Allow some comparative measurement
- Encourage a logical and holistic process of assessment
- Encourage standardised terminology

Risk Factors and Scoring systems

Risk Factor Domains	Anderson	Braden	Modified Braden	Cubbin Jackson	Fraggmet	Douglas	Gosnell	Knoll	Norton	NHP-PUP	RAPS	Song and Choi	Suriadi	Waterlow	Total
Mobility	√	√	√	√	√		√	√	√	√ *	√	√		√	12
Activity		√	√			√	√	√	√		√	√			8
Mental state				√	√	√	√	√	√						6
Moisture (including Continence)	√	√	√	√		√	√	√	√		√	√		√	11
General Physical condition/general health								√	√		√				3
Friction and shear		√	√		√						√	√			5
Perfusion (including Haemodynamic status, diabetes or smoking)				√		√ x2							√	√ x2	4
Nutrition (including food or fluid intake)	√ dehyd	√		√		√	√	√ x2			√ x2	√		√ x2	9
Weight, (including emaciation or body build for height)	√		√	√											3
Sex														√	1

Subepidermal moisture (SEM) and bioimpedance: a literature review of a novel method for early detection of pressure-induced tissue damage (pressure ulcers)



What is the **SSKIN** Bundle of care?

Surface

- ▶ Mattress and Cushion
Include safety checks
- ▶ Sheet checks,
wrinkles *etc.*
- ▶ Reassess Waterlow
score at least daily

Keep Moving

- Reposition patient
- Inspect skin
- Encourage mobility
- Written advice for
patient and carers

What is the **SKIN** Bundle of care?

Incontinence

- Toileting assistance
- Continence products
- Seek specialist advice
- Keep clean and dry

Nutrition

- ▶ Nutritional risk tool
- ▶ Follow instructions
- ▶ Ensure optimal intake
- ▶ Use of charts if required
- ▶ Keep well hydrated

Skin assessment

As a minimum you must check

B – Buttocks (Ischia)

E – Elbows and ears

S – Sacrum

T – Trochanters(hips)

S – Spine / shoulders

H – Heels

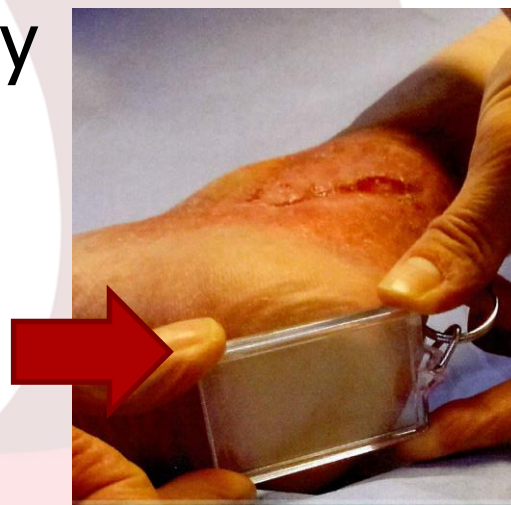
O – Occipital area

T - Toes

Clinical judgement

- Skin assessment should also form a key part of risk assessment
- If the patient has a red area that does not blanch (go white) when pressed, this is a category I pressure ulcer and they are automatically at risk!

Using the clear key ring allows you to see that this skin is blanching



Surface

- All of the surfaces that the patients use must be considered
 - Chair / cushion
 - Mattress
 - Shoes / bootees
 - Any devices such as oxygen delivery tubing or urinary catheters
- Seating and mattresses should be appropriate for the level of risk

Surface

- Seating and mattresses should be considered with relevance to:
 - Pressure
 - Shear and
 - Microclimate
- Do not layer incontinence pads etc. between the patient and their support surface as it blocks the effectiveness of the equipment
- Equipment must be regularly checked and maintained

Keep Moving

- Patients should be encouraged to move themselves where possible
- Make sure they understand why they need to move
- Give them examples of how much to move, simply leaning forwards in the chair for 5 minutes can be enough to redistribute the pressure off the coccyx

Keep Moving

- Patient repositioning should be individualised
- Although a turning time of 2 hours is widely quoted it is not appropriate for all patients – check their skin
- Avoid turning the patient onto their sides when in bed, instead use the 30 degree tilt to position them onto their large muscles

Incontinence and Moisture

- If the patient is incontinent it is important to determine why rather than simply managing the incontinence
- Ensure the skin is kept clean and dry, use a simple skin protectant and moisturiser
- If pads are needed smooth them of any wrinkles before use and check / change regularly

Which Pressure Injury was preventable?



What category PI is this ?



What challenges relating to grading seen here?



What Category of PI is this?



What direction of change is likely to occur?



What would be your next step in this patient?



What direction is this wound likely to take ?



**What is the likely major factor in causation of this PI?
Was it unavoidable ?**



What could be the likely outcome in this patient ?



What category of PI is this ? Is it really a PI ?



What would be your choice of treatment for this PI ?



Which Pressure Injury will not Heal ?

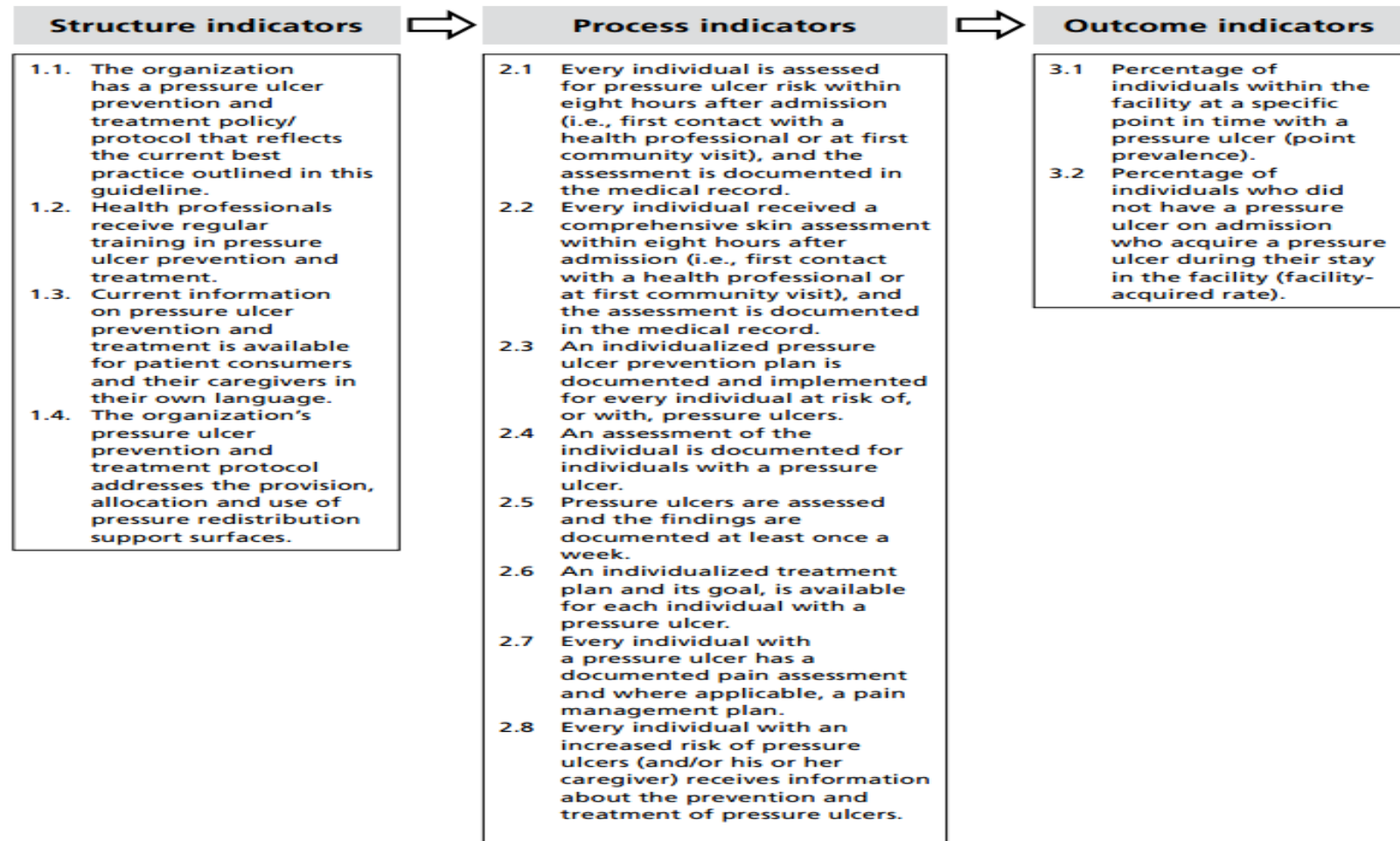


Implementing actions

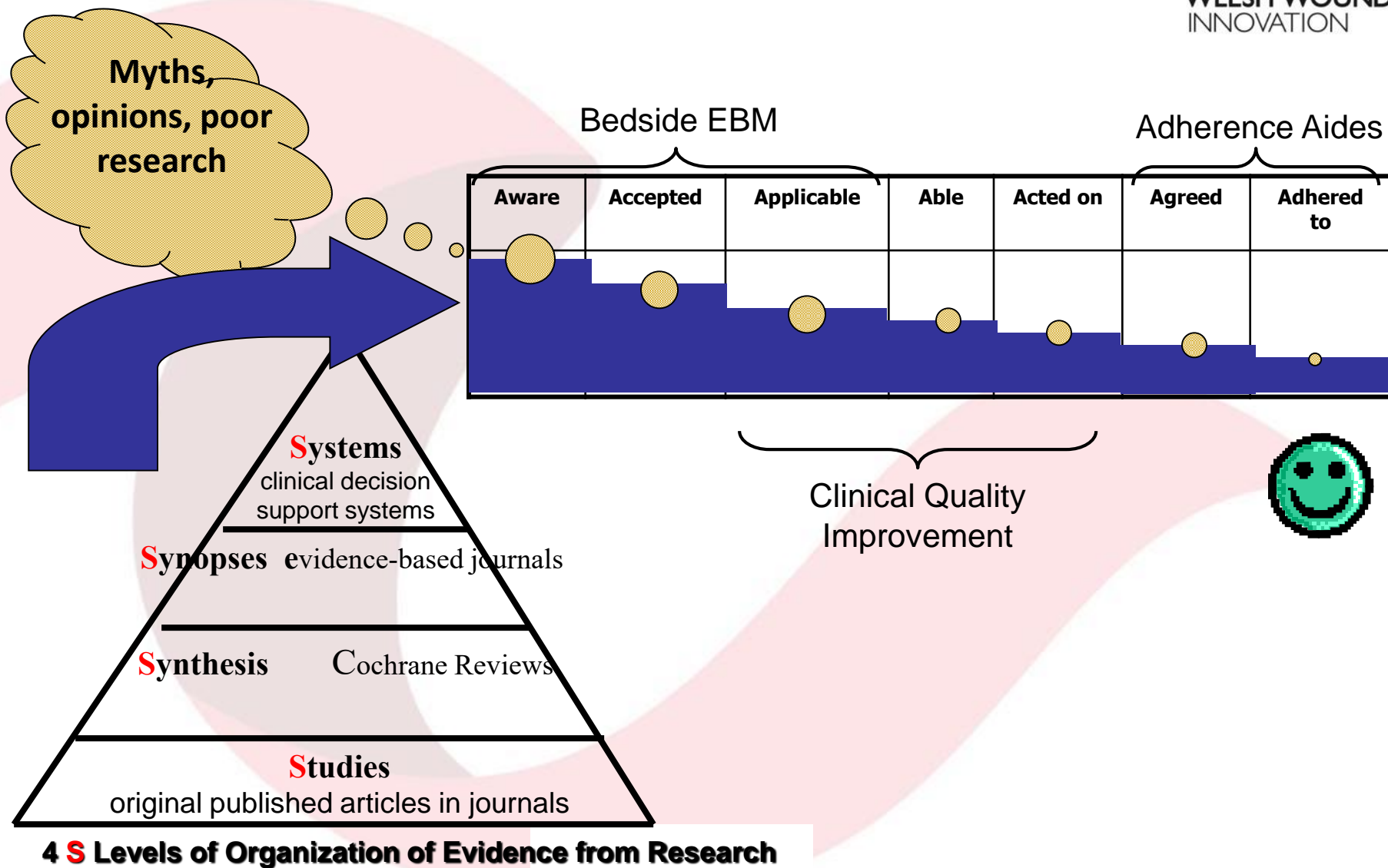
- If the risk assessment tool is identifying factors such as
 - Incontinence
 - Poor appetite
- The care plan should address these factors
- The equipment supplied in the home is suitable for use with patients who are identified as up to very high risk
- However if the patient is not at all mobile remember that they will not move enough to make the mattress air cells work properly

Implementation is always the most difficult step !

The quality indicators presented in this section of the guideline are intended to assist health care organizations to implement and monitor the strategies recommended in this clinical guideline. The quality indicators have been developed to reflect the recommendations and current best practice outlined in this clinical guideline. Specific guidance for quality improvement audits is provided in the *Clinical Practice Guideline*.



Translating Research into Practice



Adapted from Glasziou P, Hayes B. Evidence-Based Medicine 2005; 10: 4-7
From Orsted.

Pressure Ulcer SI reporting – the story



Chapter 1 – 2012 - 14

A survey identified that pressure damage was being recorded in Welsh Hospitals (Tier 1 target), **BUT:**

- No standardisation
- Variation in the Root Cause Analysis
- Lack of consistency regarding the measure



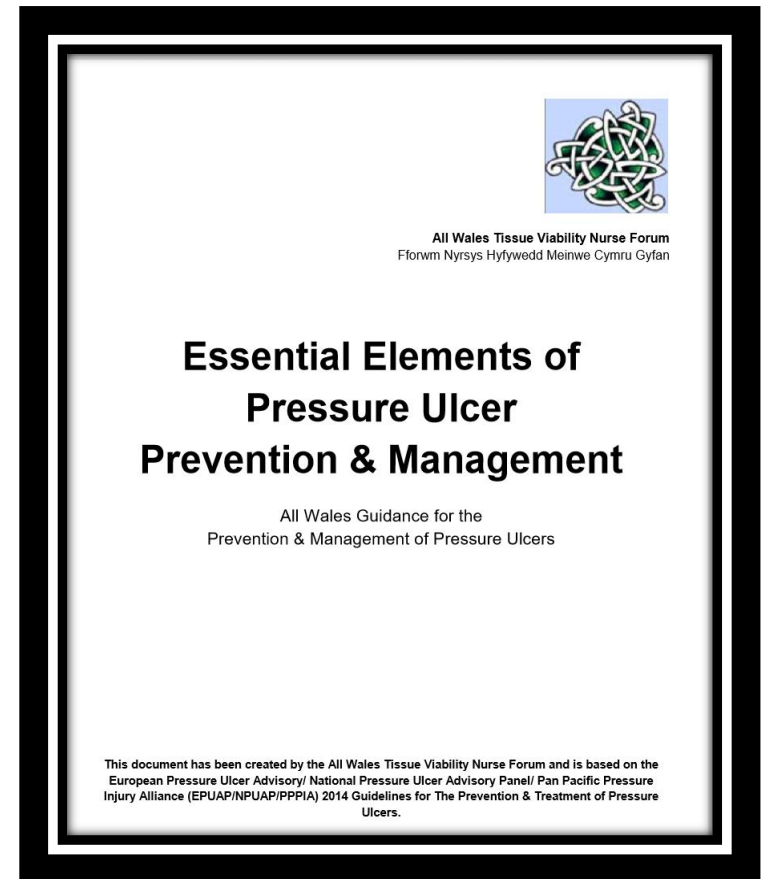
If you can't measure it consistently, you can't improve it!

2014: All Wales TVN Forum and Adult Protection collaborated to determine a standard approach. First guidance issued.

Chapter 2 – 2014

Did it make a difference?

- Provided a platform to gather data and *Report* it in a *Consistent* way
- Encouraged a *standardised approach* to the RCA investigative process
- Promoted *collaboration*
- Led to a *degree of scrutiny at WG level* in terms of incident reporting



Chapter 3 – the Data

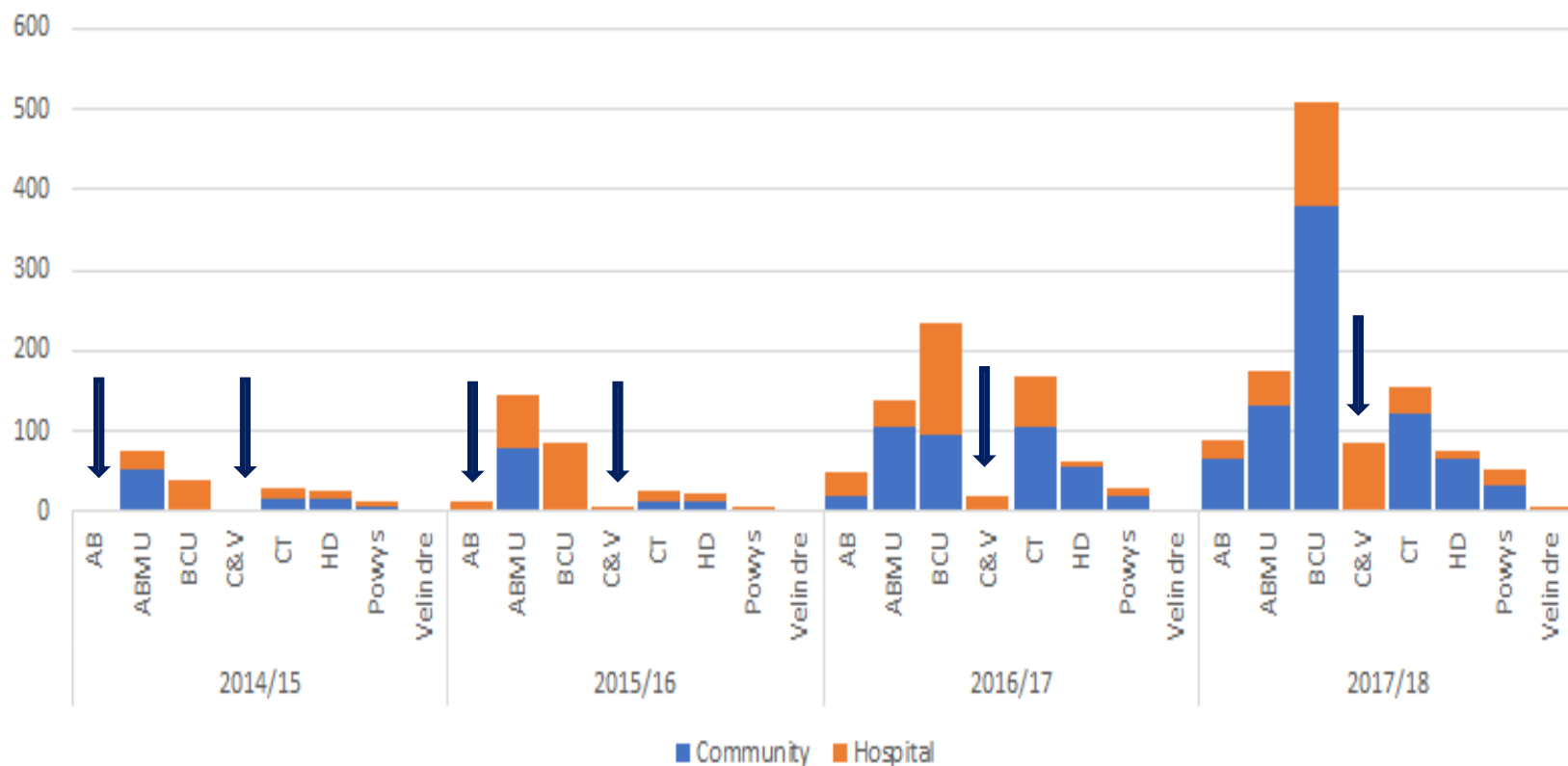


2013/14 Hospital Data

ALL WALES	57
Abertawe Bro Morgannwg	20
Aneurin Bevan	0
Betsi Cadwaladr	28
Cardiff & Vale	0
Cwm Taf	3
Hywel Dda	0
Powys	6
Velindre	0

PU Reporting Community/Hospital - 2014/15 - 2017/18

By Year & uHB



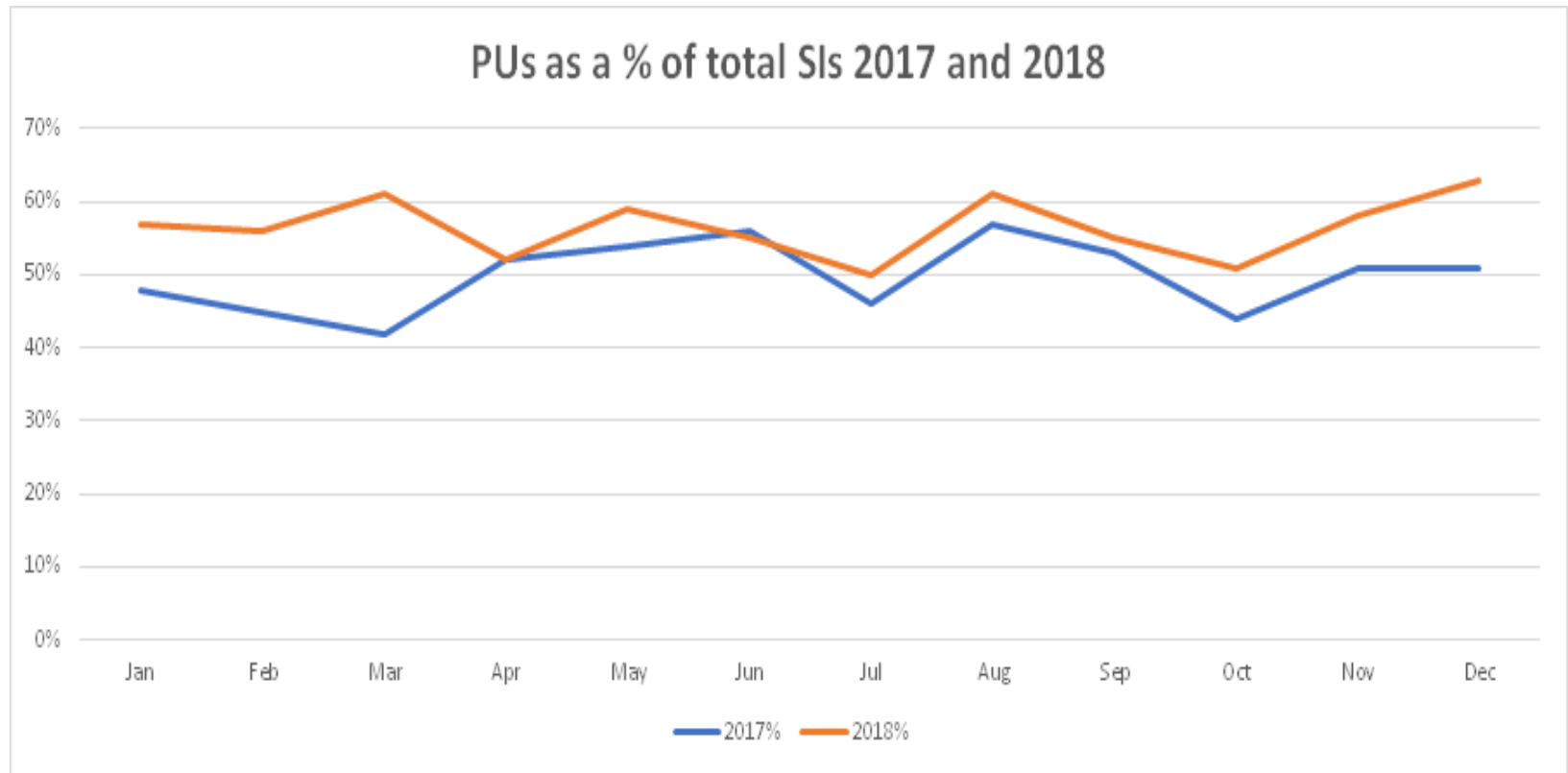
2017/18 Data – A shift in reporting.....

	Community	Hospital	Total
ALL WALES	787	332	1119
Aneurin Bevan UHB	64	21	85
ABMU	126	40	166
Betsi Cadwaladr UHB	371	126	497
Cardiff & Vale UHB	4	79	83
Cwm Taf UHB	127	34	161
Hywel Dda UHB	65	11	76
Powys tHB	30	16	46
Velindre	0	5	5

PU reporting as a proportion of Serious Incidents:



PU reporting as a % of SI's - you decide:



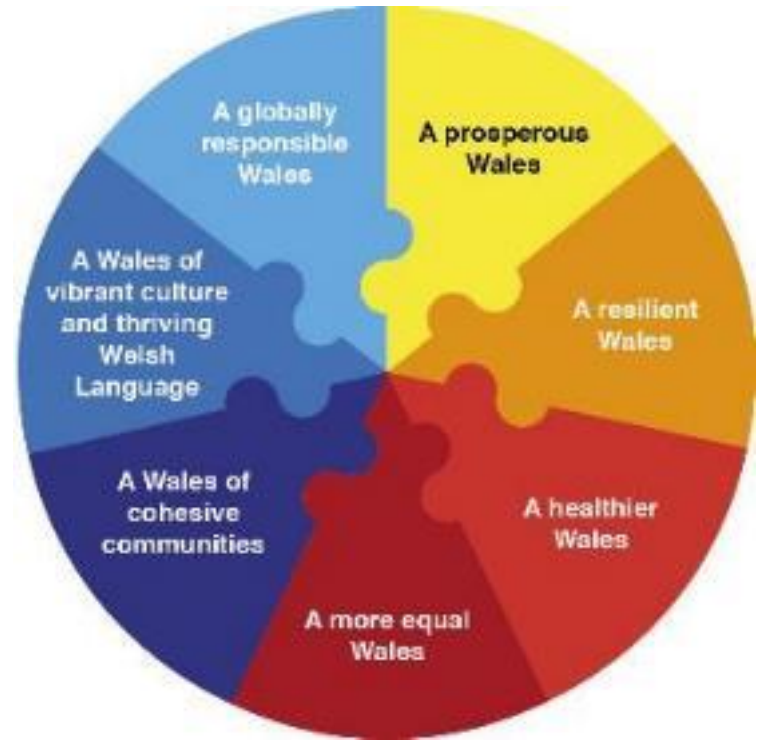
Chapter 4 – What else was happening in Wales?

2014: Andrew's Report –

- Q&S in relation to aspects of care and practice at PoW and Neath Port Talbot Hospital

2015:

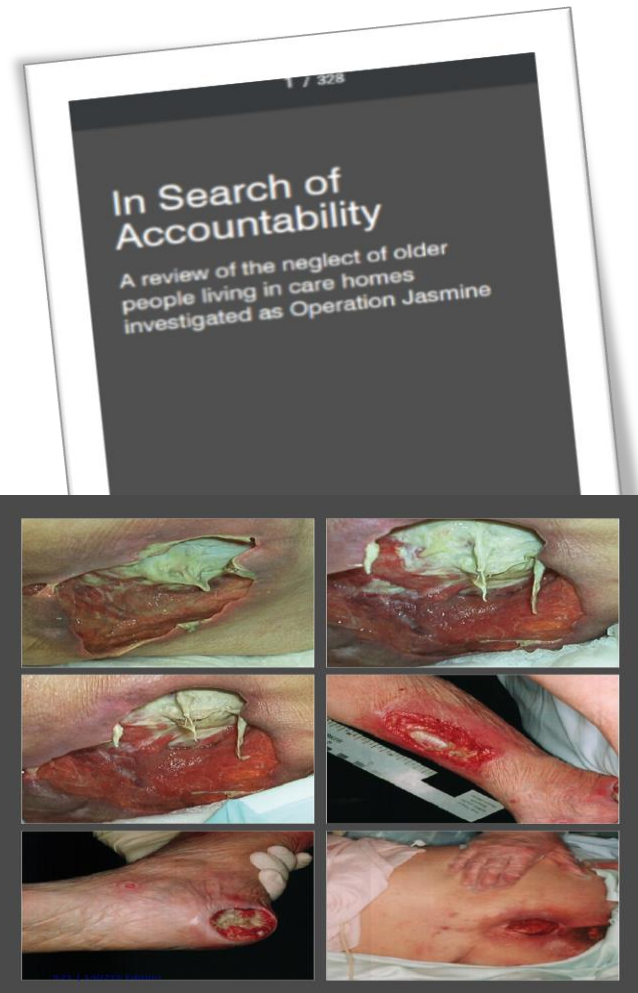
- Well-being of Future Generations Act
- Flynn Report
- National Wound Audit – CNO commissioned
- Estimating the cost associated with chronic wound management



2015: Levers for change

Investigation of 63 deaths in care homes and nursing homes in S.E Wales

- How can we prevent anything similar happening in the future?
 - Making Pressure Ulcers a notifiable disease
 - Training and registration
 - Regulation and inspection of social care
 - Accountability – safeguarding adult boards should ensure the POVA process
- NHS accountable for investigating major conditions in the Care Home sector



National Wound Audit 2015

495.5 person days

- Strong collaborative effort – NHS, Industry and WWIC

8365 patients –

- 5165 (patients lacking capacity/refusing consent)

8.9% prevalence rate

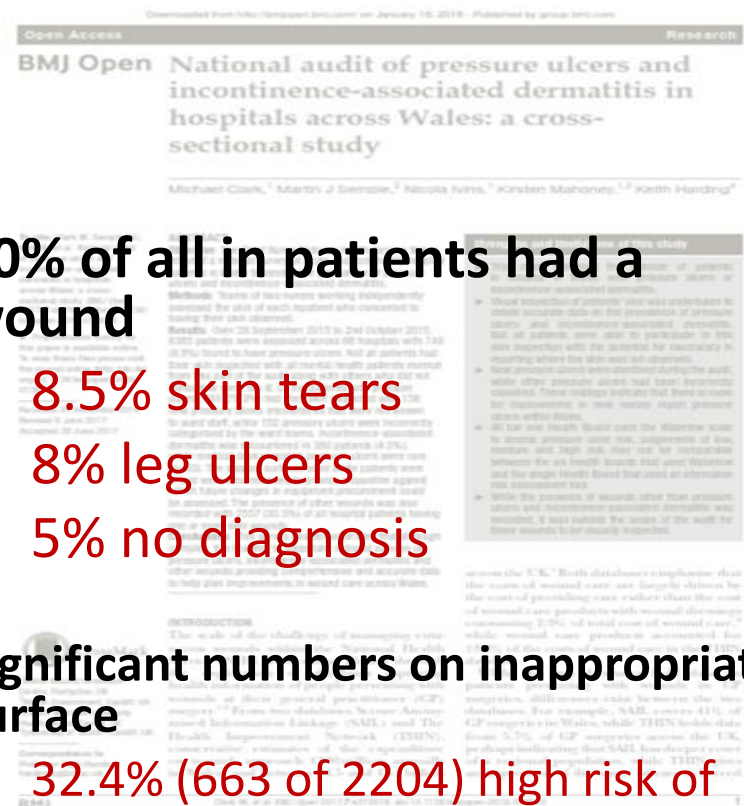
- 50% hospital acquired
- 18% Not recorded
- 18% Incorrectly classified

30% of all in patients had a wound

- 8.5% skin tears
- 8% leg ulcers
- 5% no diagnosis

Significant numbers on inappropriate surface

- 32.4% (663 of 2204) high risk of developing a PU nursed on a Foam Mattress
- 8% (161 of 2080) low risk of PU on a high cost Dynamic Mattress



Costs of Wounds in Wales



ORIGINAL ARTICLE

Estimating the costs associated with the management of patients with chronic wounds using linked routine data

Ceri J Phillips, Ioan Humphreys, Jacqui Fletcher, Keith Harding, George Chamberlain, Steven Macey

First published: 26 March 2015 | <https://doi.org/10.1111/iwj.12443> | Cited by: 30



Resource utilised	Number in cohort	Unit cost (£)	Cost (£)	Cost at all-Wales level (£)
Initial GP visit	78,090	45	3,514,050	8,570,854
Subsequent GP visits	1,249,809	13	16,247,517	★ 39,628,090
Number of dressings	2,344,930		3,964,537	★ 9,669,602
Number of district nurse attendances	703,479	35	24,621,765	60,053,085
Number of out-patient attendances	68,662	120	8,271,711	★ 20,174,905
Number of in-patient episodes	14,697		78,204,577	190,742,871
Total expenditure			134,824,157	328,839,408
Average cost per pt				1726.53

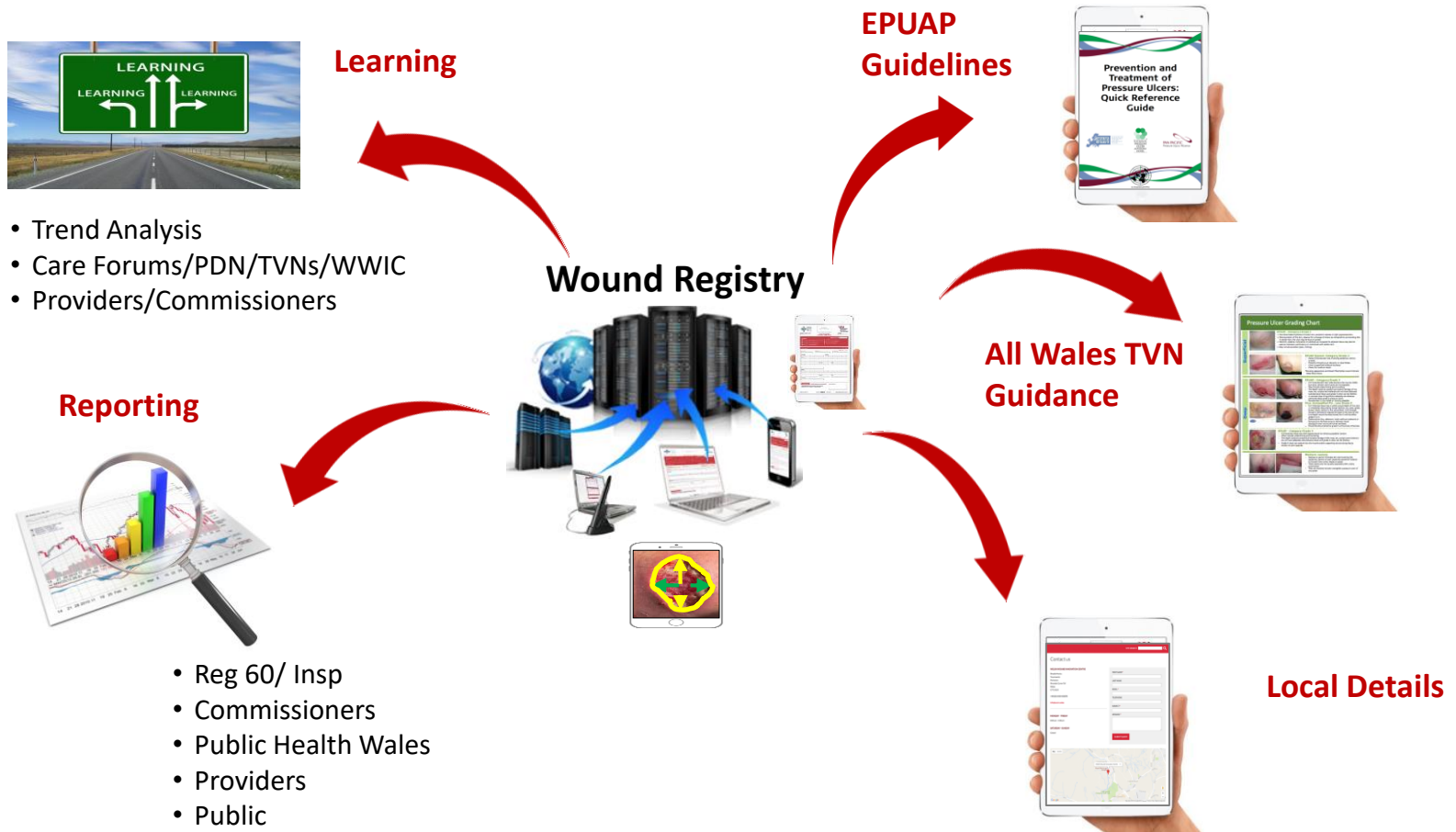
6% Budget -
£328m

Chapter 6: Learning for improvement 2017/18



Move from measurement for judgement to a learning for improvement culture.....

Integrated Education, Recording & Reporting Portal



Perceived Benefits:

Education

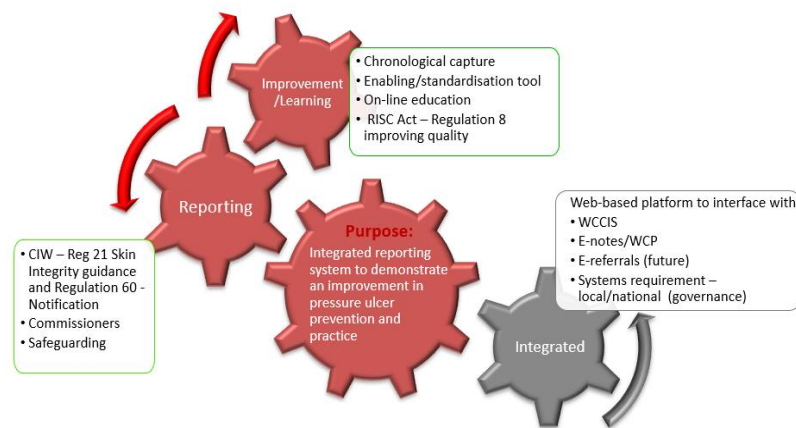
- Learning at the bedside
- Passport/certification
- TVN Guidance – include PU prevention training

Recording

- Chronological account (PDSA approach)
- Picture (measurement)
- Systematic
- Potential for e-referral in the future

Reporting

- Standardisation
- Automatic Trigger
- Interface with other systems/processes



A Healthier Wales: Vision



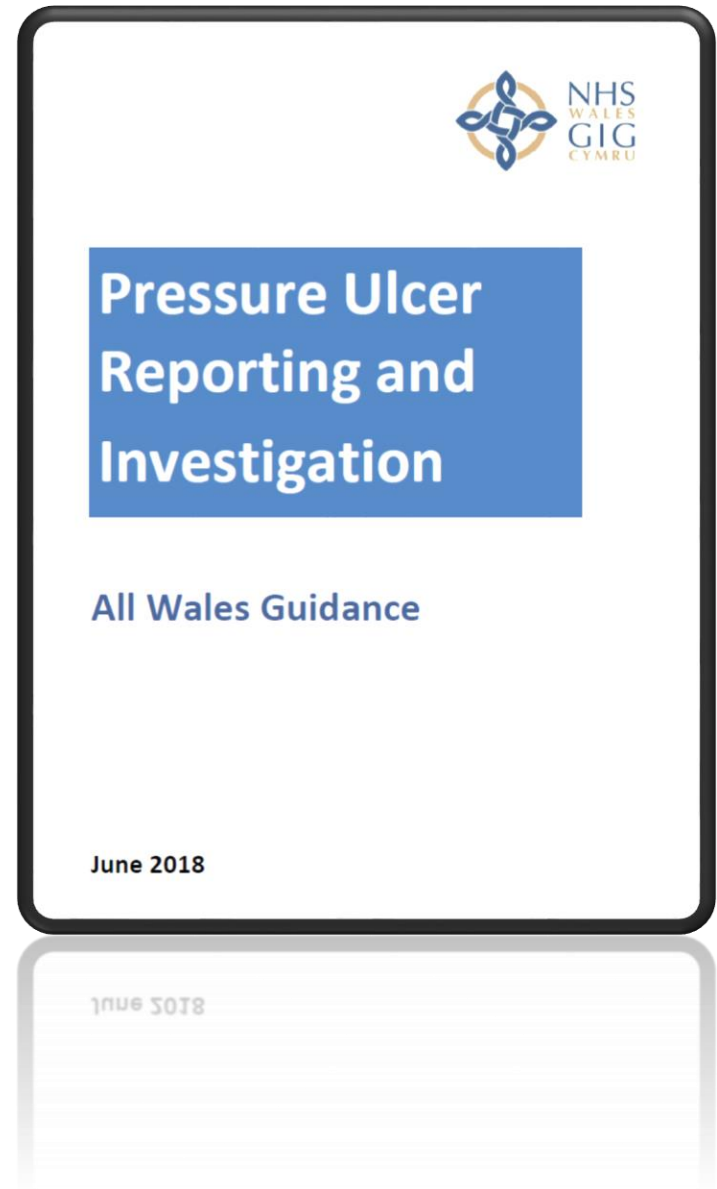
2018

We will build on the philosophy of Prudent Healthcare, and on the close and effective relationships we have in Wales, to make an impact on health and wellbeing throughout life. We will have a greater emphasis on **preventing illness**, on supporting people to **manage their own health and wellbeing**, and on enabling people to live independently for as long as they can, **supported by new technologies** and by **integrated health and social care services** which are **delivered closer to home**.

Chapter 7 - 2018

Adopting an integrated approach this guidance includes:

- Standardisation in reporting across health and social care (to include the Care Home sector)
- PU Passport
- Changes to SI reporting




Epilogue- 2019

- Shift in reporting –
 - Based on 5 years of data WG adopted an 80:20 approach to SI reporting with a focus on the 20% 'avoidable'
- This shift represents the change in 'reporting for judgement' to 'reporting for improvement'
 - Primacy is learning at the organisation level

WMC (2018) Rev1 / Number 025

CYLCHLYTHYR IECHYD CYMRU
WELSH HEALTH CIRCULAR



Defnyddio Cylchlythyr Iechyd 2018
Issue Date: 26 July 2018

SEATON TWYTHREDD / ER GWYBODAETH
RESULTS - ALL HEALTH ORGANISATIONS

CATEGORI CYLID / LLYWODAETH / PERFFORMAD / CYFLANN
CATEGORY: FINANCE / GOVERNANCE / PERFORMANCE / DELIVERY

Tiddio: Gwaith Iechyd, Iechyd Ddiwydiol, Ddiwydiol a Thdiwydiol, Ffynwedd Ailwedd / Cefnogi, Gwaith
Occupational Health, Health Ailwedd / Ddiwydiol, Ffynwedd Ailwedd / Cefnogi, Gwaith
Productive & Technical Efficiency: A Financial Framework to Support Secondary Health Services that
to Community/Primary Health Services

Defnyddio (d) / Iechyd / Ailwedd / Cefnogi
Date of Entry / Health / Ailwedd / Cefnogi

Ffynwedd Ailwedd / Cefnogi / Ailwedd / Cefnogi
For Action by: Health / Ailwedd / Cefnogi

Argymhellwedd Ailwedd / Cefnogi / Ailwedd / Cefnogi
Action required by: Health / Ailwedd / Cefnogi

Ailwedd / Cefnogi / Ailwedd / Cefnogi
Author: Health / Ailwedd / Cefnogi / Ailwedd / Cefnogi

Cyfrifwedd Ailwedd / Cefnogi / Ailwedd / Cefnogi
IFSS Welsh Government Contact (0)
Cathy White - Primary Health Services, Yn Iechyd Ailwedd / Cefnogi, Yn Iechyd Ailwedd / Cefnogi
Head of Localities and Communities, Primary Care Groups, Directorate of Primary Care & Prevention
Health and Social Services Group, Welsh Government, Telephone number 0300 300 300

Epilogue- 2019

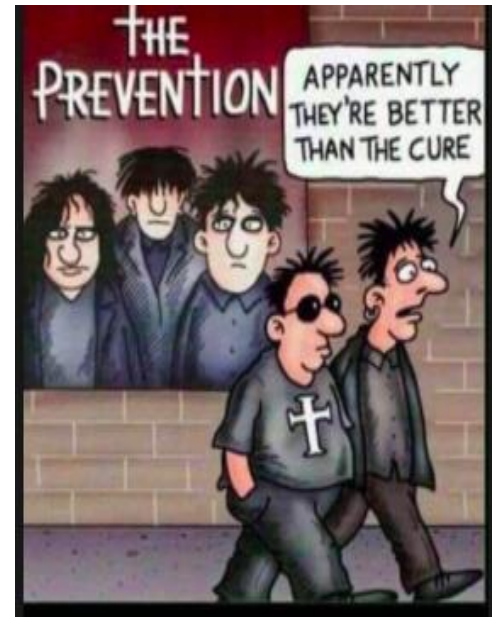
- ‘Adopt to scale’ integrated wound portal application in ABUHB to enable a *citizen* overview of PU harm
- Innovative E-learning PUP collaboration (WAST; WWIC; Hywel Dda UHB) for First Responders and Paramedics
- ‘Once for Wales’ approach to risk assessment – Purpose T as part of e-nursing documentation toolkit



In Summary

Data = Understanding. 'The goal is to turn data into information, and information into insight'.

- Our story depicts this journey, starting in 2013 with hospital reporting to 2019 having an integrated approach to PU reporting across health and social care
- Our challenge however centres on *continuous learning to **delivering improvement*** for the people that we serve



Always look at your patient's bottom !



Unlike Baboon's, its not normal
for humans To have Red bottoms !!!

Resource utilisation

Resource utilised	Number in cohort	Unit cost (£)	Cost (£)	Cost at all-Wales level (£)
Initial GP visit	78,090	45	3,514,050	8,570,854
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Wounds in Wales DN data 2014

- In one year in Cardiff & Vale UHB
- 4,790 wounds
- 2,543 open for more than 6 months
- 1,960 patients had 3 or more wounds
- 3,488 DN visits for wounds



**All Wales Tissue
Viability Nurse Forum**

Fforwm Nyrsys Hyfywedd
Meinwe Cymru Gyfan



National Wound Audit 2015

Preliminary Results



National Wound Audit



28th September 2015 to October 2nd 2015

495.5 person days

Strong collaborative effort – NHS, Industry and WWIC

8365 patients

748 with pressure ulcers (8.9%)

95% Confidence Interval 8.29% to 9.51%



Demographic data

Health Board/NHS Trust	Patients	Gender (M:F; %M)	Age (mode age band)	Pressure ulcer risk (mode risk group)	Number of Medium and High risk patients (n, % of all patients)
Abertawe Bro Morgannwg UHB	1611	720:891 (44.7%)	80-89	Low	687 (42.6%)
Aneurin Bevan UHB	1597	671:926 (42.0%)	80-89	Low	726 (45.7%)
Betsi Cadwaladr UHB	1363	632:731 (46.4%)	80-89	Low	709 (52.1%)
Cardiff & Vale UHB	1650	752:898 (45.6%)	80-89	High	992 (60.5%)
Cwm Taf UHB	982	416:566 (42.4%)	80-89	High	666 (67.9%)
Hywel Dda UHB	969	450:519 (46.4%)	80-89	Not at risk	372 (38.0%)
Powys Teaching Health Board	167	53:114 (31.7%)	80-89	High	118 (70.7%)
Velindre NHS Trust	26	12:14 (46.2%)	50-59	Low	12 (46.2%)
TOTAL	8365	3706:4659 (44.3%)	80-89	Low	4282 (51.7%)

Pressure ulcers and moisture lesions

Number patients with pressure ulcers	748/83	Pressure ulcer maximum severity	
	65	I	219
	(8.9%)	II	330
		III	81
		IV	36
		Unstageable	51
		Deep Tissue Injury	17

Pressure ulcers and moisture lesions

Number of patients with skin inspected	5178/8065 (64.2%)	Body site where most severe pressure ulcer occurred	
Reason no skin inspection		Sacrum	287
Mental Health Patient	1004	Heel	193
Declined	684	Buttock	128
Off ward	576	Other	140
Too ill	390		
Unable to consent	233		

Pressure ulcers and moisture lesions

Number of patients with new pressure ulcers found during the audit	165 (18.2%)	Origin of most severe PU Inherited: Incident Unknown III IV Unstageable	331:337 80 27 10 22
Number of patients with incorrect classification of pressure ulcers Category III reported II Category II reported I Cat.II reported moisture Classification missing	165 (18.2%) 11 7 5 107	Number of medical device related pressure ulcers	33



**All Wales Tissue
Viability Nurse Forum**

Fforwm Nyrsys Hyfywedd
Meinwe Cymru Gyfan



Support surfaces - risk

	Risk of pressure ulcer development			
Product type	None	Low	Medium	High
Foam mattress	1198	1665	862	663 (32.4%)
Other static mattress/overlay	40	223	299	533
Low Air Loss/Specialty bed	0	1	7	15
Hybrid product	2	7	22	70
Dynamic overlay	4	23	40	119
Dynamic replacement	36	161	323	644
TOTAL	1280	2080	1553	2044

Support surfaces - severity

	Pressure ulcer classification						
Product type	I	II	III	IV	Deep Tissue Injury	Unstageable	Unknown
Foam mattress	68	84	11	1	1	8	7
Other static mattress/overlay	58	80	10	9	1	5	1
Low Air Loss	0	4	0	3	0	0	0
Hybrid product	7	11	4	6	0	2	0
Dynamic overlay	8	14	9	1	0	2	0
Dynamic replacement	49	93	26	12	8	22	4
TOTAL	190	286	60	32	10	39	12



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Other wounds

**2537/8365 of
patients in
study had a
wound (30.3%)**

Wound aetiology	Number of patients
Closed surgical wound	841
Other surgical wound	55
Infected surgical wound	43
Dehisced surgical wound	35
Skin tear	215
Leg Ulcer	196
Diabetic Foot Ulcer	56
Traumatic wound	40
Lymphoedema	37
Wound diagnosis or location unknown	115



Key messages

Pressure ulcers affected 748 **(8.9%)** of all surveyed patients with 168 patients having full thickness pressure ulcers.

This survey was the first national audit of pressure ulcers across the devolved nations of the United Kingdom.



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Key messages

- 165 pressure ulcers were found during the audit although not reported by clinical staff. This represents **18.2%** of all pressure ulcers encountered during the survey and illustrates the value of conducting detailed skin inspection to ascertain robust data upon wound occurrence.

Key messages

One hundred and sixty-five pressure ulcer classifications were incorrect although data upon these errors was only reported in one-third of all cases.

Further work on pressure ulcer classification may help improve the reporting of pressure ulcers within Wales.

Key messages

In 80 (**10.7%**) patients with pressure ulcers it was unknown whether the wound had developed pre- or post- admission.

Focus should perhaps be given to the importance of reporting pressure ulcer origins during assessment at A&E or on admission to the ward.



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Key messages

64.2% of all patients had their skin inspected during the audit. Where skin was not seen during the audit, over 1000 mental health patients had been excluded from skin inspection with 684 patients declining to give consent for their skin to be seen.

Future detailed audit work may wish to consider the use of patient information to help explain the purpose of wound audits.



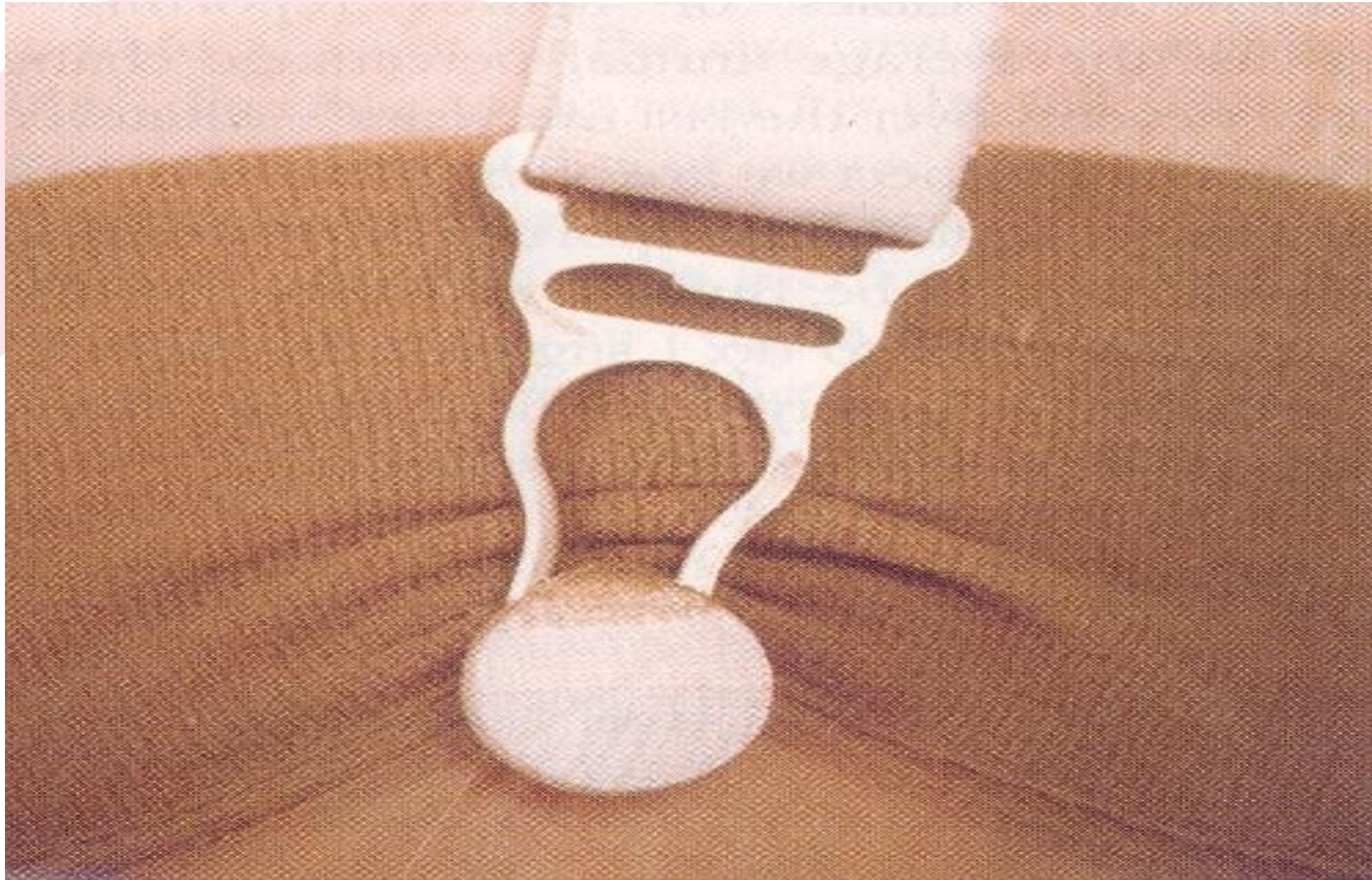


Key messages

Just over **30% (n=2537)** of all patients surveyed had a pressure ulcer, a moisture lesion or another wound type (surgical wounds, skin tears and leg ulcers being the most common). The high prevalence of wounds within NHS Wales is likely to lead to increased staff time given to wound healing, increased demands upon the tissue viability services and additional cost for each Health Board.



What is the Relevance of this ?

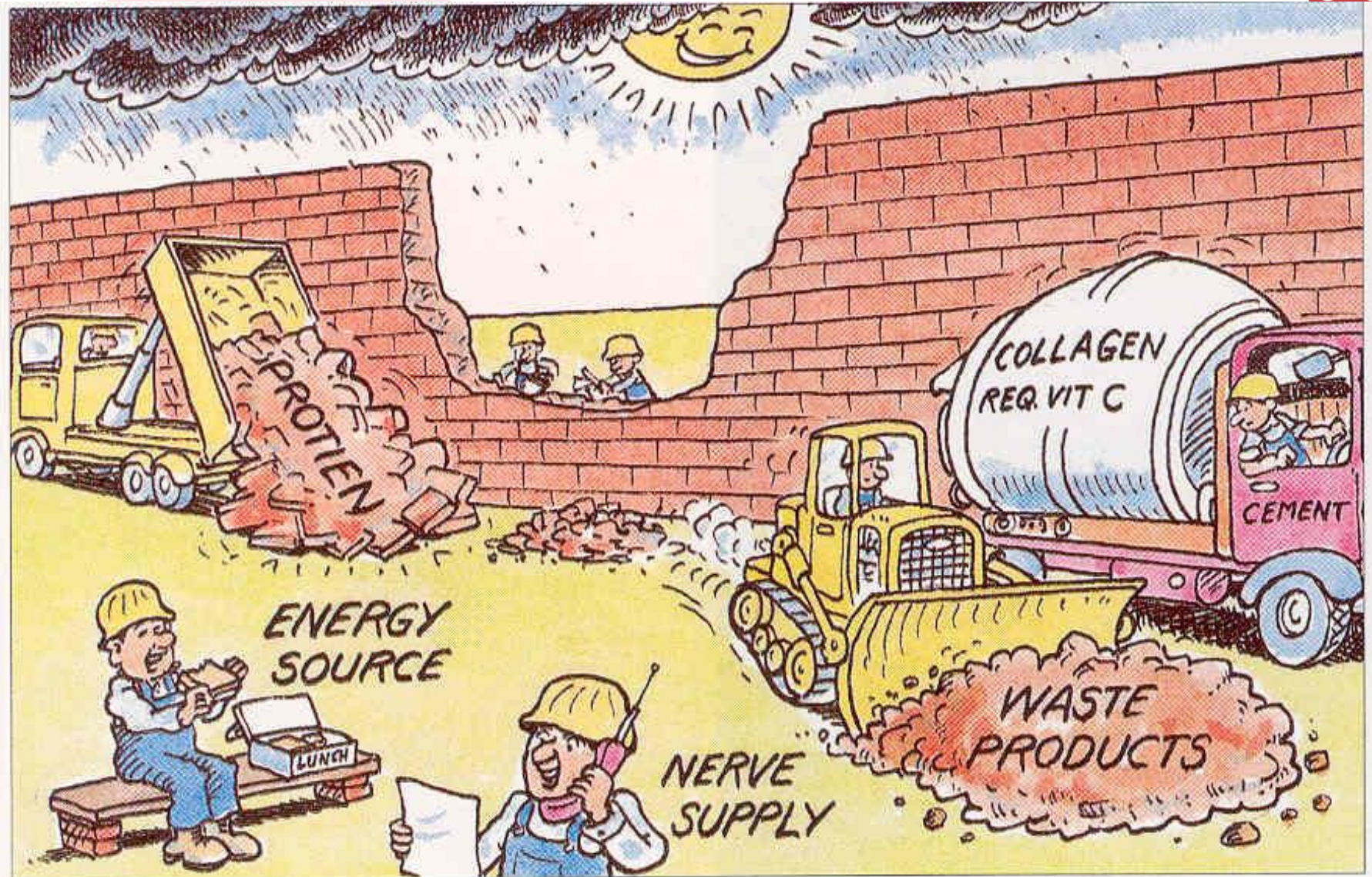


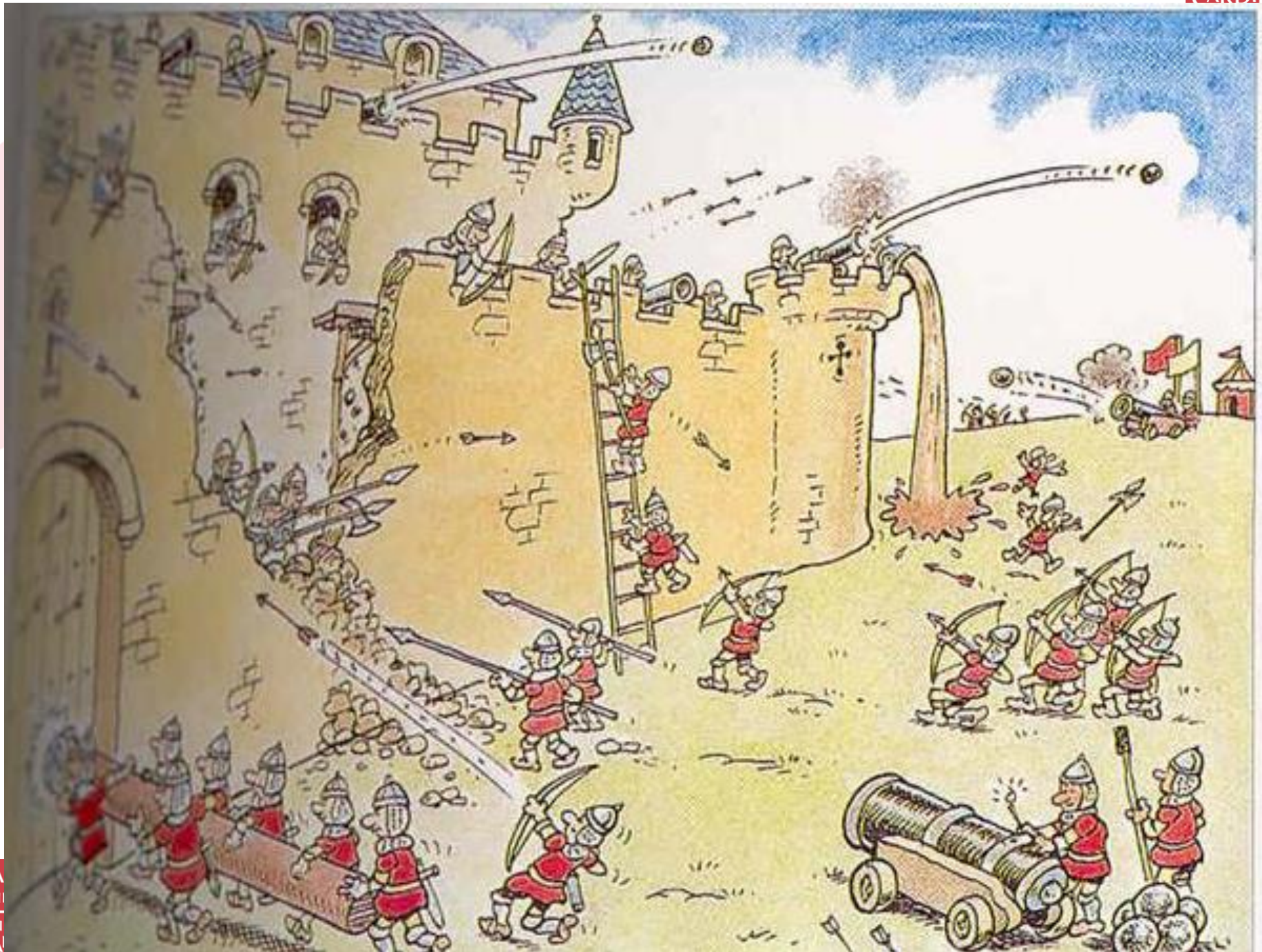
The Real World

- A 92 year old lady attended the elderly care day unit and was prescribed diuretic tablets for heart failure. **On her next visit we were pleased to see that the tablets had been put to excellent use in holding up her stockings.** This unusual route of administration had no apparent ill effects.

BMJ 2002: 325; 1489







Some Peoples View II

