Evidence-informed Leg Ulcer Care: A Cohort Study Comparing Outcomes of Individuals Choosing Nurse-led Clinic or Home Care

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Abstract
Clinicians are interested in options for delivering community-based wound care. Studies have largely focused on nurse clinics as an alternative to people receiving wound care at home. A prospective, two-arm, cohort study of individuals who requested and received their preference for community-based leg ulcer care delivered in either their home or in a nurse-led clinic was conducted to explore the relationship between choice of care location and health outcomes. Provision of care was similar—ie, care was guided by an evidence-informed protocol and a trained nursing team. Individual and system level outcomes were compared between the groups, including 3-month healing rates, 1-year ulcer recurrence rate, time free of ulcers, health-related quality of life (HRQL), satisfaction with care, and resource use. Following the baseline assessment, data were collected every 3 months until healing occurred plus a 1-year follow-up to monitor recurrence. Of the 104 participants (average age 67.5 years), 56 chose home and 48 chose clinic-based care. More than half (55%) of the participants were men, 53.8% had an ulcer <5 cm² and <6 months' duration, 84% were English-speaking, and 51.9% had a previous episode of ulceration. No significant sociodemographic, HRQL, or clinical characteristic differences were found between groups at baseline. A trend toward improved healing for those choosing clinic care was observed (3-month healing rates at home were 48.1% versus clinic care 66.7%, \( P = 0.07 \)) but neither healing outcome nor other variables, including resource utilization, were significantly different and post-hoc analysis revealed only 48% power to detect a difference in healing. The results confirm previous research indicating that the organization rather than the location of care is most important; however, observed differences in healing rates pose an important question for future inquiry regarding the potential impact of choice and whether the quality of care is standardized and delivered by the same team. The concept of providing individuals/families with the choice of care location warrants further research.

Keywords: prospective cohort study, evidence-based care, leg ulcers, patient choice, healing

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Lower-limb wounds (or leg ulcers) are among the most common chronic wounds. Epidemiological studies have shown their occurrence increases with patient age\(^1\)-\(^5\) and they can become a substantial burden to individuals, families, and healthcare systems globally.\(^6\)-\(^10\) These wounds present a complex, costly condition.\(^11\)

Managing care in the community for this patient population is challenging. These individuals typically present to primary care providers via a family physician's office or healthcare clinic, are referred to various medical specialists—e.g., dermatologists or vascular surgeons—for further assessment, and then usually are transferred back to the primary
care physician and/or home care. As a result, services often are poorly integrated.

Since the early 1990s, delivery of leg ulcer care through integrated, nurse-led community clinics has been enthusiastically endorsed in the UK.12-18 However, results of health services studies have been mixed. The groundbreaking London Riverside project consolidated five home nursing districts, one tertiary setting, and the Charing Cross Hospital in a health services arrangement for wound clinic care provision.14,19 The Riverside study revealed that healing rates improved from 22% to 69% with the new service (pre-post audit at 12 weeks). Two controlled studies of leg ulcer clinics,15,17 one of which was randomized,15 were unable to achieve the same level of improvement found in the Riverside project (24% to 34%, P = ns15 and from 26% to 42%, P = 0.00117), but this could have been due to variations in the quality of care provided. For example, evidence-informed recommendations for management of venous ulcers, particularly the use of high compression, were more consistently delivered in the UK clinics than in the home. Moreover, clinic staff was more specialized in their ability to assess wounds and apply high compression bandages than home provider teams.

A more recent Canadian study20 questioned whether there would be superior healing with care delivered in clinics if the quality of provider teams and method of leg ulcer assessment and management were held constant. Using a 1-year pre-post evaluation, the impact of evidence-informed venous leg ulcer care delivered with the usual model (home visiting) and clinics using the same specially trained nursing team was evaluated. Three-month healing rates improved from 23% to 56%. Median supply costs declined from $1,923 to $406 (Canadian dollars), and nursing visits decreased from 37 to 25 visits per case.21 Further, in the post-implementation phase, a randomized controlled trial (RCT, n = 126, 65 home care patients, 61 nurse-run clinic patients) was nested into the design to determine the relative effectiveness and efficiency of clinic-delivered versus home-delivered care by nurses for individuals who were mobile. Both the control (home care) and experimental (clinic) arms were managed by the same team of specially trained nurses and both followed the same evidence-informed protocol for care, including compression bandaging. The RCT revealed no differences in 3-month healing rates (58.3% for clinic compared to 56.7% for home care, P = 0.5) nor in secondary outcomes. Researchers concluded that when quality wound care that conforms with evidence-informed recommendations is provided by a trained nursing team, similar outcomes (healing rates, pain and health-related quality of life [HRQL]) are achieved. Wound care supplies, weeks on service, and visits per week were similar for the clinic and home care groups. From this trial, it was concluded that the organization of care rather than the location/venue of care delivery is most important.

From a clinical and health services perspective, the evidence is mounting that care provision involving trained providers and use of an evidence-informed protocol is effective and efficient. The concern remains about what happens if care recipients choose where they receive leg ulcer care. During the Canadian clinic-versus-home trial, preference for where care is received was deemed an issue: 45% of individuals approached stated a strong preference for either home or clinic care and were not willing to be randomized. As a serendipitous experiment, this group was carefully followed using the exact same data collection and follow-up schedule as the RCT to evaluate the relationship between care location and health outcomes when controlling for the quality of care received.

Key Points

• When conducting a prospective, randomized, controlled clinical study comparing outcomes of evidence-based lower leg ulcer care between nurse-led clinics and home care, the authors learned that 45% of patients eligible to participate wanted to choose their site of care and did not want to be randomized.

• Patients who choose home care (56) and those who choose clinic care (48) were subsequently enrolled in the cohort study to explore the relationship between choice of location of care and outcomes.

• No significant outcome or baseline differences between the two groups were observed but, after 3 months, the proportion of patients with healed ulcers was higher in the clinic-based group.

• Studies examining the potential effects of choice on wound care outcomes are warranted.

Methods

Design and purpose. A prospective, two-arm cohort study of individuals who requested and received their preference for community-based leg ulcer care delivery (either in their home or in a nurse-led clinic) was conducted to explore the relationship between choice of care location and health outcomes. Individual and system level outcomes were compared between the home and clinic groups and included a 1-year post-healing follow-up.

Setting and sample. The study population was drawn from a large urban-rural region in Ontario overseen by two Community Care Access Centres (home care authorities) and two home nursing agencies. Mobile individuals (independently mobile or requiring minimal assistance) eligible for community leg ulcer care were included if they were: 1) admitted to home care for care of a leg ulcer (an ulcer below the knee to the foot), and 2) had a leg ulcer of venous or mixed venous and arterial etiology and were eligible for compression bandaging.
Procedures. Upon referral to the regional home care service for leg ulcer care, individuals received a comprehensive, standardized clinical assessment, including ankle brachial pressure index, by specially trained registered nurses. Mobile individuals were informed of the clinic-versus-home trial and invited to participate. Persons who expressed a willingness to participate but not to be randomized to where they received their leg ulcer care received a modified consent form for the cohort study, noting they would have their choice of location of care. Only those who chose their care were enrolled in the cohort. The same nursing team delivered care in the home and clinic settings. Care for leg ulcer management was standardized and guided by international evidence-informed recommendations. The leg ulcer care management protocol was developed using the Practice Guideline Evaluation and Adaptation Cycle, a process for evaluating and adapting existing practice guideline recommendations for local use. The process involved bringing together an interdisciplinary task force comprised of clinical leaders representing home nursing, entero stomal therapy, family practice, vascular surgery, dermatology, and hematology to systematically identify and review existing leg ulcer guidelines. The task force appraised the quality of the existing recommendations using the Appraisal of Guidelines for Research and Evaluation (AGREE) appraisal instrument; assessed content, clinical utility, and feasibility of implementing the recommendations in the local context; and produced a local care protocol adapted from the guidelines reviewed. A draft protocol was sent to home care nurses and family physicians for review and feedback; it was kept current through scheduled reviews by a task force. Agency nurses involved in the study receive additional training in leg ulcer assessment and compression bandaging application to ensure consistency with their skill and familiarity with the evidence for best practices.

Ethics and consent. Before their first visit, all cohort study-eligible clients were provided a written explanation about the need and rationale for the Cohort Study. At the time of intake assessment, an attending nurse verbally explained the study and sought written informed consent. The study was approved by the Ottawa Health Research Institute Ethics Board (#20000272-01H).

Outcome measurement. The primary outcome for the cohort was healing at 3 months (≤91 days). Other healing outcomes were decrease in ulcer size and sustainability of healing. These measures were clinically feasible and allow comparisons to other leg ulcer studies in the literature. The 3-month timeframe to healing continues to be used in many studies and is encouraged by international practice guidelines.

Ulcer size was assessed by calculating ulcer area (cm²). The line of epithelium was traced on acetate with an indelible pen and the ulcer area calculated using computer planimetry. This method to serially measure ulcer size has been shown to be reliable and valid. Sustainability of healing was assessed by calculating the time (in days) to first recurrence during the 12-month follow-up after healing.

Pain and HRQL measures were selected based on the experience of the authors’ previous work and that of Walters et al. Pain was assessed using the McGill Short Form Pain Questionnaire (SF-MPQ). The SF-MPQ is designed to assess the multidimensional nature of the pain experience and has been demonstrated to be a reliable, valid, and consistent measurement tool. Importantly, it has been used in studies of individuals with leg ulcers and other chronic wounds and found to be a sound approach for clinically assessing the quality of pain with this population. HRQL was assessed with the widely used Medical Outcomes Trust SF-12, which measures eight self-reported aspects of HRQL, including physical function, role physical, bodily pain, general health, vitality, social function, role emotional, and mental health. The SF-12 generates a Physical Component Summary (PCS) and Mental Component Summary (MCS) that are standardized to a mean of 50, with a score above 50 representing better-than-average and below 50 poorer-than-average functioning. Canadian population-based normative data are also available for this measure.

Satisfaction with care was assessed through two surveys administered at the 3-month point. Developed with frontline clinicians, the 12-item questionnaire provided data on individual perception of care continuity, information about prevention and self-managing the leg ulcer themselves, and satisfaction with care received in either the clinic or home setting.

Data.

Collection and management. Baseline data collection began at the time of initial assessment. Data were gathered through interview, clinical assessment, and chart review. Sociodemographic and clinical assessment, as well as measurements of primary and secondary outcomes, were collected at baseline. Ulcers were measured at 3-month intervals until complete healing (defined as reepithelialization of all ulcers) or until 12 months post study entry, whichever came first. If healing occurred between measurement intervals, this was recorded and the next full assessment carried out according to the schedule.

Quality assurance procedures ensured the integrity of the trial. A detailed protocol manual for the study team outlined data management. A log record was maintained to track the status of participants throughout the duration of the study. Once recruited, participants were assigned a code number used on all subsequent documentation to ensure confidentiality. Withdrawals from either arm of the study were monitored and reasons documented. Data were analyzed using SPSS (version 18, SPSS, Chicago, IL) software. Case records (10%) were randomly selected to assess data entry accuracy every 3 months.

Analyses. The primary data analysis sought to describe healing, recurrence, HRQL, pain, and resource use by persons receiving care in the clinic versus those receiving care in their homes. The proportion of individuals in each group...
who healed at 3 months (91 days) was compared using chi-squared tests. Recurrence rates were analyzed using a t-test. Mean differences in health status outcomes (SF-12, pain) were compared between the two groups using the independent t-test of either the pooled or separate variance estimates as appropriate. Variables with a nonnormal distribution were analyzed with the appropriate nonparametric procedures—Mann-Whitney for unpaired data and Wilcoxon for paired data. Factors associated with healing also were assessed using a multivariable logistic regression to control for clinical and demographic variables as well as location of care.

Results

Over a 28-month recruitment period, 759 individuals were referred for home care and screened for the Clinic versus Home RCT and Cohort Study (see Figure 1). Of the presenting group, 44% were assessed as mobile and able to travel outside their homes and as such eligible to receive clinic care; of these, 69% (upon clinical assessment) presented with venous disease or mixed venous and arterial etiology and were eligible for compression bandage treatment. Of these, 45% of leg ulcer patients indicated they were willing to participate in a study to evaluate healing but declared a strong preference for receiving care in either the home or clinic setting. This cohort of 104 individuals forms the study sample reported here.

No significant differences were found on admission regarding sociodemographic, circumstance of living, HRQL, or clinical characteristics between the two care location groups (see Table 1). Mean age of the cohort was 67.5 years (14.5); 55% were men and the majority (84%) was English-speaking. Approximately half (51.9%) had at least one previous episode of ulceration and 53.8% had a current ulcer measuring ≤5 cm² for 6 months or less on admission. The SF-12 PCS was poor, with baseline scores much lower than the Canadian norm (36.4 versus 51.7). The SF-12 MCS was more similar to the Canadian norm (49 versus 50.5). No differences were found in key aspects of care (ankle brachial pressure index and use of compression) received by the two groups (see Table 1).

Healing. Healing rates differed between groups at 3 months (66.7% of the clinic care group healed, compared to 48.1% of the home care group), but this fell just short of statistical significance (P = 0.073). A multivariable logistic regression of healing at ≤91 days, controlling for site, gender, age, previous ulcer, ulcer onset, ulcer size, and SF-12 physical component score (PCS), yielded similar results. The effect of home (reference value) versus clinic care fell short of significance (odds ratio 2.4, 95% CI 0.9–6.8, P = 0.09), with no previous ulcer (OR 4.4, 95% CI 1.5–12.7, P = 0.01) and ulcer size ≤5 cm (OR 3.2, 95% CI 1.1–9.4, P = 0.04) the only two significant variables in the model. No significant difference was noted in recurrence rates within 1 year between the two groups (22.7% in the clinic compared to 16.3% in the home group, P = 0.6) (see Table 2). Mean time free of ulcers after healing was 158.3 days (SD 106.7) for the home care group and 166.7 days (SD 93) for the clinic care participants.

Pain and HRQL. At 3 months, the number of participants reporting no pain was higher in the clinic group (65%) than in the home care group (54.8%) (see Table 2). HRQL mental component scores (MCS) were not statistically different between the groups but bordered on significance with the PCS. The clinic group reported a PCS of 43.0 compared to 37.4 (P = 0.048) in the home care group. Although the clinic and home care groups were almost identical at baseline, the clinic group improved more on the PCS (from 37.4 to 43) than the home care group (35.6 to 37.4).

Individual satisfaction with care. Overall, the majority of individuals were very or quite satisfied (~96%) with the care they had received in the past 12 weeks and >95% would recommend it to others (see Table 3). Only waiting time satisfaction was significantly different between groups: 16.7% of the home care group waited 30 to 60 minutes compared to 8.9% of the clinic care group.

Figure 1. Clinic and home leg ulcer cohort study recruitment.
Discussion

In this community-based study, 104 mobile people with leg ulcers received care either in their homes or in a nurse-led clinic according to their choice. Care was delivered by the same specially trained
team of nurses in both settings and guided by an evidence-informed protocol for assessment and management. Healing at 3 months favored the clinic group (66.7% compared to 48.1%) but fell short of statistical significance \((P = 0.073)\); recurrence was comparable and not statistically significantly different between the clinic and home care groups. No differences were found in quality-of-life, pain, or resource-use outcomes. The PCS is bordering on significance, with lower scores in the home care group at 3 months. This may be associated with lower healing rates in the home care group. The sample size is not powered for this level of subanalysis, but this is clearly an area worthy of further study.

Both groups had relatively high healing rates at 3 months compared to what has been reported in the literature, which is likely due to consistency in delivery of evidence-informed care in both settings. In comparison to the authors’ previous RCT on clinic versus home delivery,22 persons in the home care group fared worse (48% compared to 57% healed) than the RCT/home group regarding healing at 3 months, but they had a lower ulcer recurrence rate within 1 year (16% versus 22%). The choice/clinic group had higher proportions healed at 3 months than the RCT/clinic group (67% versus 58%), but this group had slightly higher 1-year recurrence rates (23% versus 24%).

In summary, several implications can be drawn about evidence, venues of care, and patient choice. In the authors’ first study\(^{21}\) that implemented and evaluated best practices using a pre-post design, the feasibility and acceptance of using an evidence-informed protocol from provider and patient perspectives were demonstrated. The results indicated that implementing evidence-informed care with a specially trained team was related to improved healing (more than double the rate) at 3 months, along with reduced expenditures for nursing time and supplies. In the subsequent study, a randomized health services trial provided the first comprehensive evaluation of clinic versus home wound care in a Canadian context. Unlike UK studies, clinics were not found to be superior in terms of healing, HQRL, pain, or patient satisfaction. Given these findings, health service planners and decision-makers could offer community leg ulcer care in either a clinic or home setting and expect good results if the team follows an evidence-based protocol and is specially trained. Practically, clinic care has the advantage of readily available supplies. Not only could care be initiated without delay once a comprehensive assessment is completed, but it also would provide nurses the advantage of changing the treatment immediately if an allergic reaction to a dressing or bandage occurred.

Currently, nursing hours are considered a limited resource, especially with increasing pressure on home care resources. As such, authorities might consider offering mobile, able clients the option to attend clinics to access care. Having the option is important in the Canadian context. Factors such as the size and distribution of the population, varying urban-rural mix, and the feasibility of setting up clinics differ across regions in any one province.

In this study, the authors sought to describe the treatment outcomes of individuals who chose to receive their care either in a nurse clinic or their home. The results suggest that preference for one or the other is common because 45% who were approached to participate expressed strong preference for where they received their care (54% preferring home delivered care and 46% preferring clinic care). To date, no studies examining outcomes when recipients of care have their choice of where to receive care have been published. Consequently, for planners basing decisions on population profiles and available resources, if efficiencies are to be gained by health authorities offering one or both options, it will be vital to understand if real differences exist regarding consumer choice of healthcare. Including the patient perspective in addition to considering

### Table 2. Study population healing, quality of life, and pain outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Home care group ((n=56)) (n (%))</th>
<th>Clinic group ((n=48)) (n (5))</th>
<th>(P) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing(^{a})</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 3-month (≤91 days)</td>
<td>26 (48.1)</td>
<td>32 (66.7)</td>
<td>0.07</td>
</tr>
<tr>
<td>• Recurrence rate in one year(^{b})</td>
<td>8 (16.3)</td>
<td>10 (22.7)</td>
<td>0.60</td>
</tr>
<tr>
<td>Pain at 3 months(^{c})</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No pain</td>
<td>23 (54.8)</td>
<td>26 (65.0)</td>
<td>0.63</td>
</tr>
<tr>
<td>• Mild/Discomfort</td>
<td>14 (33.3)</td>
<td>10 (25.0)</td>
<td></td>
</tr>
<tr>
<td>• Distressing/horrible/excruciating</td>
<td>5 (11.9)</td>
<td>4 (10.0)</td>
<td></td>
</tr>
<tr>
<td>SF-12 scores at 3 months(^{d})</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>• Mental component</td>
<td>52.2 (9.5)</td>
<td>52.8 (12.7)</td>
<td>0.82</td>
</tr>
<tr>
<td>• Physical component</td>
<td>37.4 (12.9)</td>
<td>43.0 (11.3)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

\(^{a}\) Two clients in the home group were not included in the analysis because of loss to follow-up after baseline.

\(^{b}\) Clients who were lost to follow-up after baseline or never healed were not included in the analysis (home group \(n=49\), clinic group \(n=44\)).

\(^{c}\) Missing 14 cases in the home group and eight cases in the clinic group.

\(^{d}\) Missing 15 cases in the home group and 10 cases in the clinic group.

Note on missing cases: at the 3-month point, cases are missing on the survey data (SF-12 and pain) due to individuals not being willing to complete forms. The patients agreed to have their clinical data collected but were not willing to complete any forms.
It might be considered a limitation that nurses who provided care also were involved in the data collection. Obviously, blinding the nurse to the care setting was not possible and once bandages were applied it would have been excessively intrusive (and immensely expensive) to remove them solely for the purpose of an outcome assessment. On the other hand, the small team of dedicated, specially trained nurses guaranteed expert, quality outcome assessments by measuring healing in a rigorous and consistent manner regardless of setting. Lastly, as a caution, the study was conducted as a descriptive cohort of common indicators of community leg ulcer care (healing, resource use). As such, it was not powered to determine factors associated with receiving care in either of the settings, prohibiting conclusions to be drawn. However, the results should be useful to those planning a larger future study.

**Conclusion**

The authors have been studying the implementation of best practices within community leg ulcer care for more than a decade. In the authors’ experience, this patient population embraces the opportunity to partake in studies and contribute to practice and health services decisions that may affect care and outcomes. Local providers and decision-makers also have welcomed formal inquiry in order to make better decisions. This cohort study opened another decision-making door—ie, of providing individuals/families the choice of where care is received. Delivering quality wound care (following evidence-informed recommendations) using a well-trained nursing team and allowing individuals to choose the care venue (nurse-led clinic or home care) resulted in wound healing at 3 months in more than two out of three (67%) of the clinic group and almost one half (48%) of the home group. Although not statistically significant, it is an administratively and clinically important finding. In a post-hoc analysis, given this difference and the current sample size, only 48% power was available to detect differences as significant (a sample size of ~106 per group would be required for a 20% difference to be statistically significant). The impact of choice, given that quality of care is standardized and delivered by the same team, is an administratively and clinically important finding. In a post-hoc analysis, given this difference and the current sample size, only 48% power was available to detect differences as significant (a sample size of ~106 per group would be required for a 20% difference to be statistically significant). The impact of choice, given that quality of care is standardized and delivered by the same team, is an important area of inquiry. If, in a fully powered study, this difference is significant, why do those receiving their preference heal more quickly? Hypothesis could be generated around their ability to self-care or possibility they have fewer other burdens at home. Based on current cohort results, further evaluation of the outcomes when individuals can choose or be assigned to where care is received is clearly warranted. Ideally, the next study would involve two arms: assigned care and preference. The data from this study provide a foundation for research.

### Table 3. Leg ulcer-related personal issues and satisfaction after 3 months of care

<table>
<thead>
<tr>
<th>Ulcer-related personal issues (n = 80)</th>
<th>Home care group (n=42)</th>
<th>Clinic group (n=38)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some problems walking about</td>
<td>22 (52.4)</td>
<td>17 (44.7)</td>
<td>0.51</td>
</tr>
<tr>
<td>Some problems with washing, dressing self</td>
<td>9 (21.4)</td>
<td>5 (13.2)</td>
<td>0.39</td>
</tr>
<tr>
<td>Some problems performing my usual activities</td>
<td>27 (64.3)</td>
<td>17 (45.9)</td>
<td>0.12</td>
</tr>
<tr>
<td>Not anxious or depressed</td>
<td>30 (71.4)</td>
<td>26 (68.4)</td>
<td>0.96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care and service survey results (n = 80)</th>
<th>Home group (n=43)</th>
<th>Clinic group (n=37)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less than 30 minutes</td>
<td>35 (83.3)a</td>
<td>37 (100.0)</td>
<td>0.01</td>
</tr>
<tr>
<td>• Waiting 30 minutes – 1 hour</td>
<td>7 (16.7)b</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Very/quite satisfied with information</td>
<td>42 (97.7)</td>
<td>36 (97.3)</td>
<td>1.00</td>
</tr>
<tr>
<td>Very/quite satisfied with treatment last 12 weeks</td>
<td>39 (95.1)c</td>
<td>35 (97.2)d</td>
<td>0.64</td>
</tr>
<tr>
<td>Very/quite satisfied with nurses’ skill</td>
<td>41 (95.3)</td>
<td>37 (100.0)</td>
<td>0.50</td>
</tr>
<tr>
<td>Recommend/highly recommend care you receive to others</td>
<td>39 (90.7)</td>
<td>36 (100.0)d</td>
<td>0.12</td>
</tr>
</tbody>
</table>

a Missing one case (n=37); b Missing one case (n=42); c Missing two cases (n=41); d Missing one case (n=36)

Local contextual factors and planning issues will contribute to an ethical health-services decision.

**Study Limitations**

The choice cohort study design has some limitations. First, participants in this study were drawn from a convenience sample of people who stated a preference before being randomized into a trial. This group may not be representative of the population receiving community leg ulcer care. Also, both the trial and the cohort study were conducted in two regions within southeastern Ontario. These populations may not be representative of other areas, given the sociogeographic diversity between Canada and the US.
Pressures on community-based care are increasing in most developed countries with the aging of populations and chronic disease management shifting more to primary rather than institutional care. Common, complex, costly populations such as those requiring chronic wound care deserve full attention from researchers, community planners, health service managers, and decision-makers to fully understand the factors that impact health and resource outcomes including patient preference.

Acknowledgments

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