RATIONALE

Practitioners who are managing leg ulcers in the community setting require a thorough understanding of holistic based wound care. Please refer to the current Trust Leg Ulcer Procedure. In addition to the cleansing of the ulcer, patients with underlying symptoms of venous mixed aetiology leg ulceration require a bandage regime which also requires the cleansing or soaking of the leg following the removal of compression bandaging. Soaking of the leg aids and the removal of skin accumulation can be socially beneficial for the patient. This process can only be performed in Community Leg Ulcer Clinics and patients’ homes. The holistic assessment of a leg ulcer is probably the single most important factor affecting its healing. Holistic assessment of wounds is designed to engender patient centred decision making regarding treatment options. The Practitioner must learn to see the ulcer and the factors contributing to it as inter-connected, this includes the social and psychological impact of living with an ulcer from the patients’ perspective. Consideration should be given to the impact that not being able to bathe has on wound healing and perceived quality of life. (Lindsay 2007)

TARGET GROUP

All Community Nurses who are involved in the assessment, management and ongoing care of patient’s with leg ulcers.

TRAINING

All staff in the Trust are required to comply with mandatory training as specified in the Trust’s Mandatory Training Matrix. Clinical Staff are also required to comply with service specific mandatory training as specified within their service training matrix.

Community Nurses who are required to provide in the provision of leg ulcer care will attend an in house 2 day leg ulcer training course, updated every two years.

This training is not mandatory for bank staff. When training has not been accessed, bank staff must always work within their scope of practice and competency levels in the assessment, management and ongoing care of leg ulcer patients.

DELEGATION AND SCOPE OF PRACTICE

The delegation of nursing care must be appropriate, safe and in the best interests of the patient at all times and the decision to delegate must always be based on an assessment of their individual needs (NMC 2008). Where Trust staff have the authority to delegate
clinical tasks to other members of staff, they will retain accountability and responsibility for that delegation.

Trust staff should only delegate clinical tasks to other members of staff whom they deem clinically competent and able to fully understand the nature of the delegated task and also what is required of them.

Trust staff should not delegate to other members of staff if they believe that it would be unsafe to do so or if they are unable to provide or ensure adequate supervision. It is important that the member of staff, to whom an aspect of care is being delegated, understands their limitations and when not to proceed should the circumstances within which the task has been delegated change.

When health care assistants are undertaking the role of cleansing leg ulcers, the delegating person must assess the person performing the clinical task has the competence to undertake this duty, as the delegating nurse remains accountable for the delivery of the care plan and for ensuring that the overall objectives for that patient are achieved.

Health care assistants should be encouraged to understand their limitations and recognise when it would be unsafe to proceed with a clinical task which has been delegated to them. In this instance, the member of staff should contact the Community Nursing team and liaise with the most appropriate member of staff.

RELATED POLICIES

Please refer to relevant Trust policies and procedures

CLEANSING OF LEG ULCERS

There is no difference in infection and healing rates between wounds that are cleansed with tap water compared to those that were not. (EBN Review, 2003). It has been identified that cleansing the leg with tap water has many benefits for the patient. (Lindsay 2007) Evidence supports the simple cleansing of leg ulcers with water or saline (RCN 2006). Tap water is regularly used in clinics and patient’s homes in the community as it is readily available, efficient as a cleansing agent and is also cost effective.

The removal of dry loose tissue by washing allows the growth of new epithelium and aims to prevent hard areas of tissue, scabs or hyperkeratosis building up and acting as pressure points beneath dressings as compression hosiery. Skin scales can accumulate on patients with leg ulcers due to being contained in bandages for a week and the actual process of desquamation cannot occur and consequently hyperkeratosis is a feature associated with patients who are in long term leg ulcer bandages. Cleansing of the limb has been shown to remove the accumulation of the skin cells or keratonocytes. In addition with wearing long term compression bandages, patients experience difficulty in bathing because it is important not to get the dressings wet. Wet dressings can adversely affect wound healing.

Excess wound exudate can also have a detrimental affect on the surrounding skin causing maceration and excoriation. To prevent this type of damage cleansing should be kept simple. Immersion of the limb in water removes the build up of exudate and slough. It cleanses the affected area without damaging granulation or epithelialising tissue.
WASHING LEGS

All Practitioners are responsible for identifying and recording the risks that are specific to their individual practice and in the environment in which they work. Prior to considering washing a patient’s leg a full risk assessment should be made of the environment where this practice is to take place i.e. in a leg ulcer clinic or in a patient’s home. A bucket must be cleansed and lined with a suitable plastic bag (orange bag for clinic). This enables heavy soiling from soap scale and skin scale to be disposed of easily and also aids in the disposal of the water following cleansing. Once lined, the bucket can be filled with tap water. The majority of wounds are colonized with bacteria, a status that does not affect healing. Increased exposure can increase the bio-burden, which may give rise to wound infection. This is more likely to occur through the use of poor infection control techniques, than the exposure to water. One of the most important ways to prevent infection is to observe a correct hand – washing technique (Hampton & Collins 2003). The risk of back injury whilst carrying a full bucket of water must be considered. Where there is doubt concerning the task, weight of the load or the nurses capability then the task should be considered hazardous and if it cannot be avoided then a full risk assessment must be performed. The Manual and Handling Operations Regulations 1992 set no specific requirements such as weight limits. However, familiarization with the following recommendations may be beneficial.

- Ensure correct lifting and handling techniques are employed. Equipment must be carried in a correct and safe manner at all times, i.e. using the legs to lift and deposit the weight, taking care not to flex the spine and keeping the load close to the body during lifting and lowering of the load.

- All practitioners are responsible for attending the Trust’s mandatory manual handling updates

- All practitioners must have access to and be aware of the content of local health and safety policies for reference

- Reduce spillage by providing a vehicle to transport the full bucket from the filling point to the clinical area. In leg ulcer clinics, Trust buckets have wheels to aid transfer from point A to point B.

- Ensure the floor is dry at all times and mop up any spillages.

- Ensure water is directed into a floor level sluice (where able to do so) in a safe manner after use. The plastic liner can be held to direct flow of the water for safe disposal

- Have a bin available for the direct disposal of clinical waste.

- Water must be at the correct temperature (37°C) to prevent patients being at risk of scalds as well as any wound and tissue damage.

- A bath thermometer is recommended to provide a guide when filling buckets
• Soak the leg in a clean bucket of warm water lined with a polythene orange bag at each treatment.

• Remove dry loose skin/scabs if they can easily be removed, to allow epithelialisation of the wound.

• Clean interior of buckets in between patients as per infection control guidelines.

• To assist removal of dead skin cells, emollients may be added to water or applied to the dry skin surrounding the ulcer in the form of cream or ointment. Any product that is applied to the area surrounding the wound must contain no chemicals capable of sensitising the skin.

• Examples of satisfactory products include arachis oil – caution should be taken with peanut allergy sufferers as arachis oil contains peanut oil, Epaderm (Medlock Medical), 50/50 (refer to Trust risk assessment for use of topical products containing paraffin) or hydromol ointment. For skin that is already sensitised or damaged, the use of chemically inert products is of utmost importance. Products that contain preservatives and perfumes are not acceptable for the treatment of skin around a leg ulcer.

• Close inspection of the feet and skin is very important, especially for people with diabetes. When washing patient’s feet it is important to check the heel for hard skin and cracks or fissures. This can be very painful and a focus for infection.

Cleansing should never involve scrubbing the wound with gauze or cotton wool balls as this may damage granulating and epithelialising tissue. Always clarify with patient/family or carers if there are any known allergies, prior to adding any emollients to the water. Emollients/ointment must only be used on a named patient basis / the person it has been prescribed for, not for multi patient use. This is essential for best practice in infection control procedures. It is recognised that communal use of products are linked to outbreaks of infection. Please refer to the Trust’s Policy for the Safe handling and Administration of Medicines as this refers to the legal requirements associated with sharing prescribed products.

**LEG ULCER CLINIC**

Risk assessments will comprise of the following factors that need to be considered:

• Environmental factors – identifying hazards such as: couch safe height and is it adjustable

• Flooring

• Lighting

• Shelving and cupboards for storage of products

• Sluice and accessibility to remove waste products
- Vinyl covered furniture to allow for effective cleaning and reduce the risk of cross infection
- Cleansing and soaking process involved
- Filling and emptying of buckets
- Disposal of waste water and dressings
- Hand washing facilities
- Privacy and dignity for the assessment process and reassessment of patients
- Cleansing of buckets, what liners to use and availability
- Manual handling of the patient and the leg involved including the removal of bandages and the bandaging of the leg
- Protective clothing for staff including aprons with reference to Infection Control Policies

Following a risk assessment staff will need to estimate the level of risk i.e. how likely is it that something will go wrong. The risk assessment must include the work tasks performed by staff associated with the level of risk encountered whilst performing these tasks. Following completion of the risk assessment, forms identifying levels of risk control measures should be implemented. The risk assessment must be displayed on the clinical wall for all staff involved in the Leg Ulcer Clinics to access. This must be reviewed following changes to environment and every 6 months and documented accordingly.

MANAGING LEG ULCER PATIENTS IN THEIR OWN HOMES

An environmental risk assessment must be carried out prior to commencing leg ulcer care to ascertain manual handling and cross infection issues. This may include:

- Removal of bandages by the Health Care Assistant/Auxiliary
- Cleansing of leg ulcer
- Disposal of waste infected products (only if specifically needed)
- Manual handling including removal of bandages and bandaging of leg

Advise patient / family / carers to have a supply of suitable plastic liners for the bucket or bowl.

1) **Removal of bandages by the Health Care Assistant.**

Following removal of the bandages by the Health Care Assistant, the registered nurse who has been trained in leg ulcer management must plan to attend to the patient within ½ hour of the removal of the dressings and bandages. Problems with attendance must
be communicated as soon as possible to the caseload manager or alternative practitioner to attend.

2) Cleansing of the Leg Ulcer

Patients in compression bandaging can benefit from having their legs soaked or immersed in warm water with added bath emollient (following manufacturer’s instructions). A full risk assessment must be undertaken to ascertain the risks with performing nursing tasks associated with the cleaning and washing of the legs in the patient’s home. This will include the following:

- Filling and emptying of buckets or bowls.
- Infection control issues with cleaning of the bowl.
- Dedicated bowl for the use of washing patients legs
- Protective clothing with reference to Infection Control Policy.
- Disposal of water and dressings.
- Environmental factors i.e. lifting and transferring within the patient’s home, the size of the wound and other obstacles within the patient’s environment.

Manual handling issues associated with access to patient i.e. safe working heights, associated activities i.e. kneeling, standing and transfer of equipment. If following a risk assessment, the estimate of hazards is such that the cleaning of the leg ulcer using a bucket or bowl is unsafe both for the staff and patient, on that basis the task would not be performed and this would need to be documented and kept within the patient’s records. An alternative plan of care must be put in place to meet the patients’ needs, if required contact Tissue Viability Specialist Nurse for advice.

WERE TO GET ADVICE FROM

Trust staff should contact their own Line Manager if further advice is needed. When more comprehensive advice is required, please contact the Tissue Viability Service.

INCIDENT REPORTING

Clinical incidents or near misses must be reported and a Trust Incident Form must be completed via the Trust’s incident reporting system.

SAFEGUARDING

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.

EQUALITY ASSESSMENT

During the development of this protocol the Trust has considered the clinical needs of
each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.

If staff become aware of any clinical exclusions that impact on the delivery of care a Trust Incident form would need to be completed using the Trust’s incident reporting system and an appropriate action plan put in place.

REFERENCES


Royal College of Nursing (2006) Clinical Practice Guidelines
### CONTROL RECORD

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