NHS

Bath and North East Somerset
Community Services

Leg Ulcer Pathway for Community Hospitals and Nursing Homes

Any concerns at all, please contact the Tissue Viability Service
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On identifying a lower limb wound

Complete a wound assessment, measure and photograph wound

Any patient with a lower limb wound that has failed to heal within 2 weeks must be referred to the Tissue Viability Team

A leg ulcer is a break in the skin below the knee which has not healed within 2 weeks. NICE (2013)

IMMEDIATELY ESCALATE TO THE RELEVANT CLINICAL SPECIALIST:

- Acute infection
- Symptoms of sepsis
- Acute or suspected chronic limb threatening ischaemia
- Suspected acute deep vein thrombosis (DVT)
- Suspected skin cancer
- Bleeding varicose veins.

National Wound Care Strategy Programme (2023) Leg Ulcer Recommendations Summary

Reference - NICE (2013) Varicose Veins: Diagnosis and management [CG 168].

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Cleansing and skin care for patients with leg ulcers

Skin changes are common in patients with leg ulcers and skin care is essential to prevent deterioration.[1]

Self-care

If the patient is able, at each dressing change encourage them to wash their leg in the shower using an emollient as a soap substitute.

Ask them to rinse off the emollient and dry their leg gently and thoroughly without vigorous rubbing, taking care to dry between their toes.

Ask the patient to apply the same emollient as a moisturiser in downward strokes in the direction of hair growth. Clinician to observe the legs for any skin changes, areas of dry skin and signs of pressure damage.

For those unable to self-care

At each dressing change, observe the legs for any skin changes, areas of dry skin and signs of pressure damage.

Cleanse the legs in a disposable or lined bowl using a soap substitute, rinse off and gently dry the leg taking care to cleanse and dry inbetween their toes and any crevices. Include cleansing of peri-wound skin.

Ensure the legs are dry before decanting emollient into a separate container and applying as a moisturiser in downward strokes in the direction of hair growth.

Emollient selection

Standard Care – Epimax cream

For those at risk of Infection – Dermol 500 lotion as a soap substitute

For those with very dry skin – Hydromol Ointment (Do not use on hands or face due to risk of corneal abrasion)

Emollients are highly flammable. Patients should stay away from naked flames and heat sources whilst using emollients.[2]

For patients receiving oxygen therapy ask medical team to prescribe Apoderm ointment.

References

1. Charles, H., Anderson, I. (2013) Practical tips: skin care for the lower limb affected by venous disease. Wounds UK, 9(2) p12 – 16
2. GOV.UK (2020) Drug Safety Update – Emollients. Available from https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients

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Dressing selection and bandaging lower legs

Use the pathways on the following pages to select the appropriate primary dressing for the wounds.

Use an appropriate non-adherent secondary dressing dependent on the level of exudate.

Lower legs must be bandaged from the base of the toes to the base of the knee using K-Soft and K-Lite bandages, applied in a spiral technique with 50% overlap.

Bandaging only part of the leg is not accepted practice as this can cause a tourniquet effect and swelling. If the patient declines to have toe to knee bandaging, then apply the appropriate size stockinette.

Ensure the patient's heels are off-loaded.

For further advice please contact the Tissue Viability Team.

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Wound Bed Preparation/Biofilm Management

Definition: Biofilm-a complex microbial community in which microorganisms synthesize and secrete a protective matrix that attaches itself to a surface.

All high risk patients to commence biofilm management regime

High risk are patients with the following risk factors:

BOX A **CO-MORBIDITIES**

- Diabetes
- Rheumatoid Arthritis
- Immunosuppressed
- Lymphoedema
- Factor 5 Leiden (Thrombophilia)
- Moderate to Severe Renal Disease
- Heart Failure
- COPD
- PAD

Low risk of infection

No co-morbidities

See Cleansing & Skin Care Guide on page 3

High risk of infection

With co-morbidities (see above)
OR wound present for more than 4 weeks

Use Octenilin to moisten Debrisoft and use on the wound bed and peri wound skin to disrupt and prevent biofilm.

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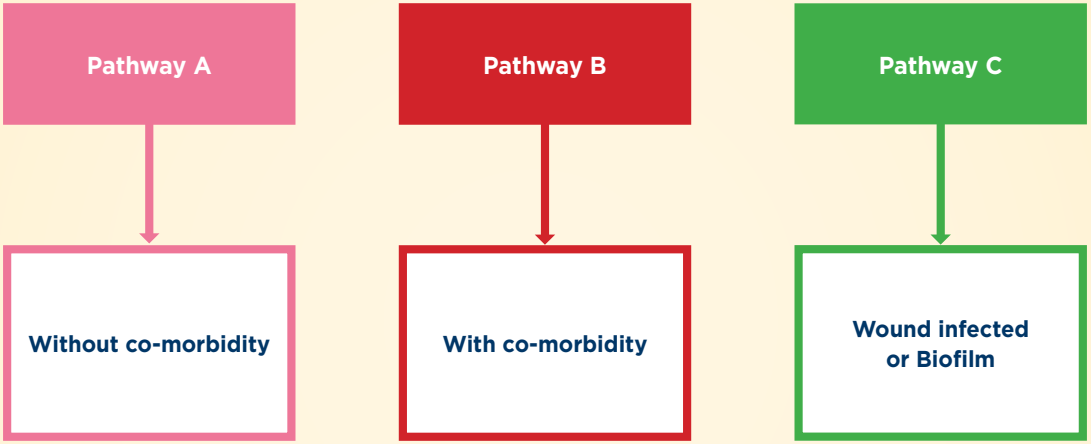
Dressing Selection Pathway



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Pathway A: without co-morbidities

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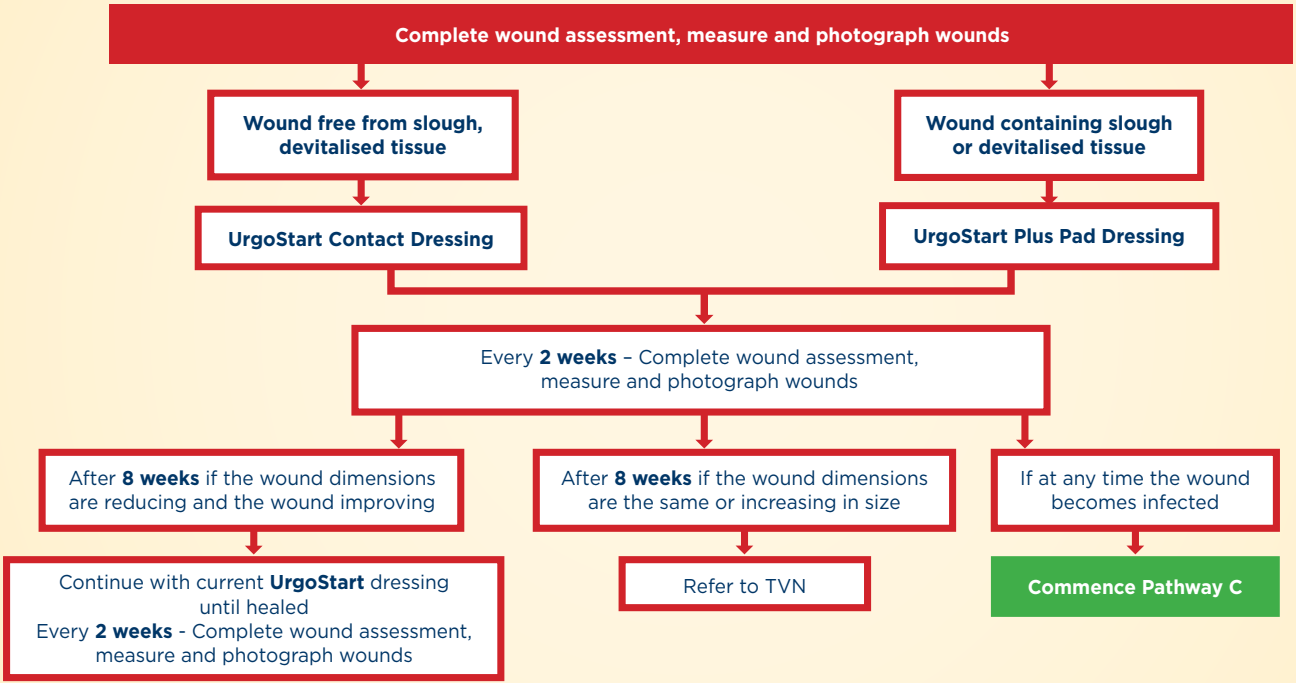
Reference: 1. Flanagan, M. (2003) Wound measurement: can it help us to monitor progression to healing? Journal of Wound Care: 10(5).

Pathway B: With co-morbidities



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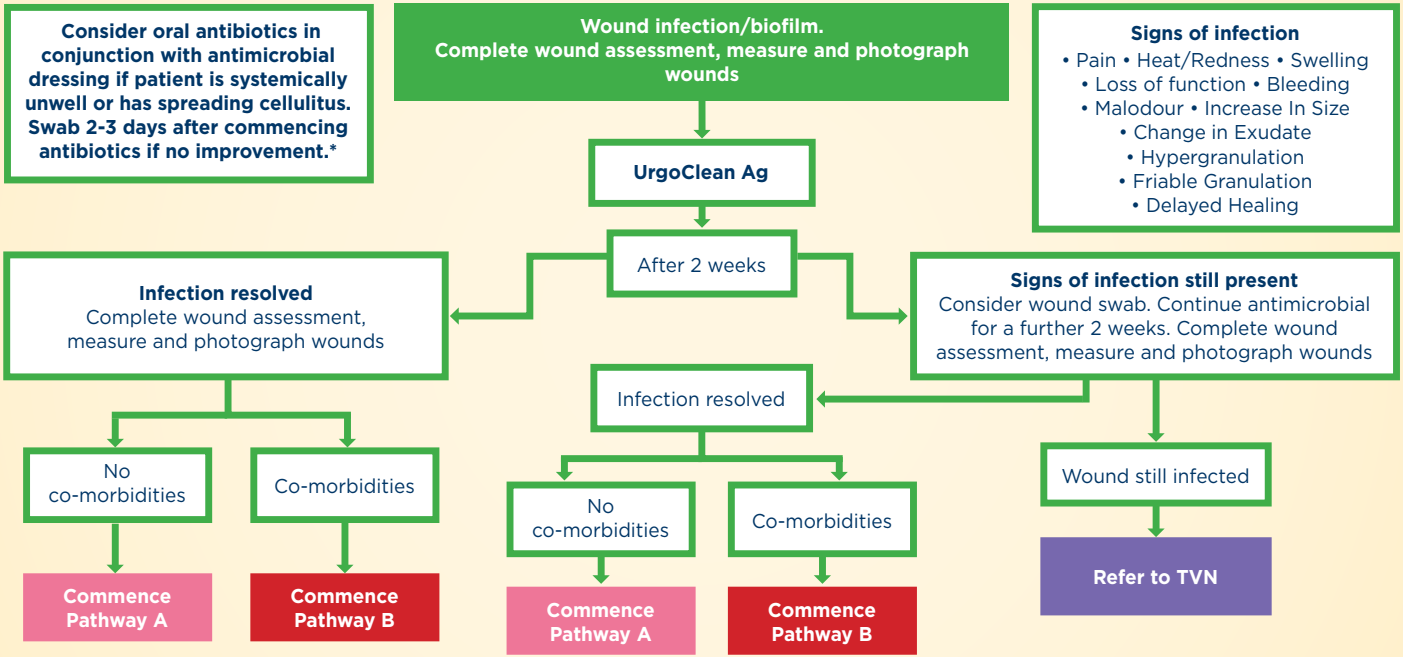
Pathway C: for INFECTED wounds



Minimum requirement is to take wound dimensions and photograph every 2 weeks

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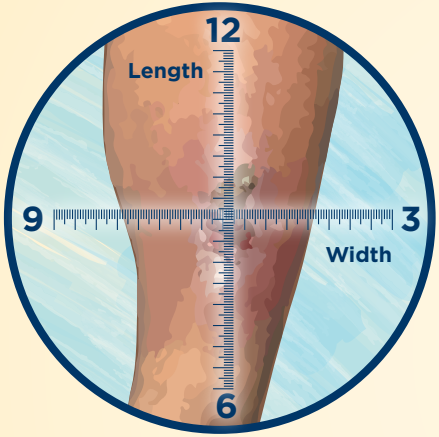
Reference: *NICE Guidance NG152

Measuring Wounds



Document all measurements in centimetres, as L x W x D. Remember—sometimes length is smaller than width.

When measuring length, keep in mind that:

the head is always at 12 o'clock

the feet are always at 6 o'clock

your ruler should be placed over the wound on the longest length using the clock face.

WHEN MEASURING WIDTH:

measure perpendicular to the length, using the widest width place your ruler over the widest aspect of the wound and measure from 9 o'clock to 3 o'clock.

WHEN MEASURING DEPTH:

Place a probe into the deepest part of the wound bed.

We also need to measure undermining and tunneling. Measure undermining using the face of a clock as well, and measure depth and direction. Tunneling will measure depth and direction.

TO MEASURE UNDERMINING:

Check for undermining at each "hour" of the clock.

Measure by inserting a probe into the area of undermining back to the wound edge.

TO MEASURE TUNNELLING:

Insert a probe into the tunnel. Grasp the probe at the wound edge (not the wound bed) and measure.

Document tunnelling using the clock as a reference for the location as well.

On the feet, the heels are always at 6 o'clock and the toes are always 12 o'clock.

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