WOUND MANAGEMENT OF LEG ULCERS

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WOUND MANAGEMENT OF LEG ULCERS

Introduction
A leg ulcer is a long-lasting sore on the leg or foot which can take more than four to six weeks to heal. They most often develop on the inside of the leg, just above the ankle. A leg ulcer can develop after a minor injury if there is a problem with the circulation of blood in the leg veins. If this happens, the pressure inside the veins increases. This constant high pressure can gradually damage the tiny blood vessels in the skin and make it fragile. As a result, the skin can easily break and form an ulcer after a knock or scratch.

Aim
Sunlight Care aims to provide excellent care to minimise the risk of a resident having leg ulcers, and to provide effective and appropriate management and treatment of leg ulcers.

Leg Ulcers
Varicose leg ulcers can develop as a result of a chronic venous insufficiency and poor circulation. This causes a lack of oxygen and nutrients being distributed to the leg which can result in skin ulceration.

The main causes of leg ulcers include:

- poor general circulation
- obesity
- standing for long periods
- injury

These are the factors, which contribute towards strain being placed on both the veins and the valves in the legs.

Most venous leg ulcers will heal within three to four months if they are treated by a healthcare professional trained in compression therapy for leg ulcers. However, some ulcers may take longer to heal, and a very small number never heal.

Treatment usually involves cleaning and dressing the wound and using compression bandages to improve the flow of blood in the legs. Antibiotics may also be used if the ulcer becomes infected, but they do not help uninfected ulcers to heal.

However, unless the underlying cause of the ulcer is addressed, there is a high risk of a venous leg ulcer recurring after treatment. Underlying causes could include immobility, obesity, or varicose veins.

The symptoms of a venous leg ulcer include pain, itching, and swelling in the affected leg. There may also be discoloured or hardened skin around the ulcer, and the sore may produce a foul-smelling discharge.

Assessment
All residents should undergo a comprehensive assessment upon admission. This assessment should:

- identify the resident's level of risk of developing a leg ulcer and preventative measures needed to reduce that risk
- identify any existing leg ulcers and the cause of them.

The assessment should be repeated on a regular basis so that any developing leg ulcer will be identified as early as possible.

It is essential that the cause of the ulcer is determined, whether it is venous or arterial, and the use of a Doppler ultrasound will be used as part of the assessment process to enable the cause to be established.

A tracing and/or a photograph of the ulcer should be taken and entered in the notes to help to provide an illustration of the extent of the ulcer before and after treatment began.

Holistic Assessment
The healing process of a leg ulcer can be complex and can be affected by numerous general and local factors. It is essential to treat the resident as a whole and not just wound in isolation. The resident must be assessed to identify any factors which may affect wound healing.

Factors which can affect wound healing can include disease processes such as cardiovascular issues, diabetes, immunosuppressant conditions, cancer, medication, age, dehydration, and the nutritional status of the resident.

The provision of appropriate and effective pressure relief is essential for any pressure ulcer or wound.

Where possible a detailed Care Plan should be prepared and agreed with the resident and /or his or her relative to address or improve each of the identified issues which may affect wound healing.

Wound Assessment
All wounds will be assessed using evidence-based methods to optimise wound healing. The details from wound assessments will be completed at every dressing change.

The wound assessment must:

- Be resident centred
- Be accurate and precise
- Detect the presence of complications
- Detect general patient factors which may delay healing such as nutritional status, diabetes, chronic infection, and medications such as steroids
- Provide a framework to monitor the stages of wound healing
- Evaluate the effectiveness of any treatment.

- Consider the resident's smoking history
- Have the resident's compliance

Time stands for:
T – Tissue
Nature of the wound bed - healthy, unhealthy, granulation tissue, epithelialisation tissue, sloughy or necrotic tissue or eschar. This should be recorded as a percentage of the wound bed.

I – Infection/ Inflammation
Colonisation/infection - suspected, confirmed (specify organisms)
Odour - offensive, some/none.
Pain - specify site, frequency, continuously/intermittent, only at dressing change and severity.

M – Moisture
Exudates - colour, type, approximate amount/extent of strike through onto primary and/or secondary dressings or bandages.

E – Edge
Wound dimensions - length, width, depth, sinus formation and undermining of surrounding skin.

Tracing of the wound may assist with wound measurement. Incorporating a rule or tape into the photograph will provide a scale. The written consent of the resident must be obtained prior to any photographs being taken.

The wound margins should be identified - oedema, colour, erythema (measure extent), and maceration.

The general condition of surrounding skin should be noted - dry, eczema, fragile, macerated, or inflamed.

Principles
- To ensure a comprehensive assessment of health needs, in relation to wound care, is undertaken
- To ensure that continuity of care takes place when different nurses or carers may be called upon to meet the needs of the resident
- To ensure that a standardised approach to wound care takes place
- To ensure the appropriate wound management product is utilised for optimum wound management and patient comfort
- Where palliative care is being provided healing is not the primary aim. The goal is to ensure comfort, freedom from pain, itch, malodour and haemorrhage
- To ensure that wound management products are used cost-effectively thereby minimising waste and inappropriate usage

Procedures
The Care Plan should identify the actual and potential issues which the resident has or may have, and this should include the following:

- facilitating rest and elevation
- taking a wound swab
- applying a non-stick sterile dressing
- administering preparations to relieve pain (if present)
- administering antibiotics if prescribed
- applying appropriate dressings.

Wound Cleansing

- The aim of wound cleansing is to remove gross contamination with minimal pain to the patient and minimal trauma to the tissues.
- For a healthy wound, irrigation with either a sterile solution of 0.9% sodium chloride or sterile water is appropriate.
- The irrigation fluid used should be close to body temperature, and care should be taken to avoid trauma to tissues or splash back.
- If wiping is necessary, a non-filamented swab should be used. The wound bed itself should not be dried, only the surrounding skin. Wiping the wound
- bed may leave fibres that could be a focal point for infection or may damage newly formed tissues.
- The general use of antiseptics/disinfectants and dyes is not recommended as these are cytotoxic to fibroblasts

Routine bacteriological swabbing is unnecessary unless there is evidence of clinical infection such as inflammation/redness/evidence of cellulitis, increased pain, purulent exudate, rapid deterioration of the ulcer, or pyrexia.

If a compression dressing system is prescribed, then this should be applied by a trained practitioner.

In the case of multi-layer bandages these layers are left in place for seven days and then removed and the progress of the ulcer is reassessed, and the procedure is repeated until healing of the ulcer has taken place.

The resident's weight should be monitored regularly, at least weekly.

Past History of Venous Ulcer
Information relating to a past history of ulcers should be recorded with as much information as possible as to:

- when a previous ulcer occurred
- the exact location of the ulcer and of any previous ulcers
- the treatment received
- the length of time it took to heal

- previous operations on venous system
- previous and current use of compression hosiery

Staff should seek a referral of the resident to a tissue viability specialist if the leg ulcer does not improve.

Factors Which can Affect Wound Healing

Medical history

- Past and current medical condition and general health
- Drug history and current prescribed medications and alternative therapies
- Smoking and alcohol history
- Allergies, including reactions to dressings, topical applications and natural rubber latex
- Nutrition and hydration level, weight, height and Body Mass Index (BMI)
- Mobility
- Temperature, pulse and blood pressure, respirations, blood sugar level, blood results, urinalysis
- Previous planned investigations or procedures, venous, arterial duplex, X-rays, surgery

Nutritional assessment

All residents should have a nutritional screen, which proceeds to full assessment if any deficit is suspected.

Protein, Vitamins C, B, and A, Zinc, Iron, and Copper are essential for wound healing. In addition to these nutrients, it is essential that adequate energy (calories) is obtained from fats and carbohydrates to prevent tissue protein being used as a source of energy.

- Nutritionally compromised residents who have wounds may have an increased dietary need and a referral to a dietician should be considered for further assessment, advice and supplementation.
- Resident's weight, height and body mass index (BMI) should be recorded at initial assessment and then weekly.

Adequate Fluids

It is important that each resident has an adequate fluid intake of 1800 – 2100mls to prevent skin dehydration.

Psychological and Social Assessment

The following aspects should be considered during the resident's assessment:

- Stress levels, depression, and ability to sleep.
- Ability to understand the cause of the wound and the ability to participate in care.
- Factors which may affect compliance with treatment, such as residents with dementia, or a lack of mental capacity, or cognitive impairment, or learning difficulties.
- Drug or Alcohol dependency

Pressure Relief
The provision of appropriate and effective pressure relief is essential and will contribute to healing.

Training
Sunlight Care recognises the importance of educating and training its staff on the issue of wound management. All new staff will be instructed and encouraged to read this policy on leg ulcer prevention and management as part of their induction process. Existing staff will be offered training covering basic information about current evidence-based treatment and basic dietary advice. Only staff trained in wound management should dress the leg ulcer in accordance with the resident's care plan.

Audit
Sunlight Care will monitor the effectiveness of the Wound Management Policy.

Regular audits will be undertaken to review wound management, to include wound dressing product combinations, appropriate dressing selection and wound healing rates.