A recent Nursing Times webchat on leg ulcer management highlighted three frequently asked questions. Members of the Leg Ulcer Forum Executive provide the answers.

## FAQs on leg ulcer care

### In this article...

- The role of healthcare assistants in leg ulcer management
- Why reporting adverse events in leg ulcer care is important
- Dressings to use under compression bandaging

### 5 key points

1. **The prevalence of leg ulcers has not decreased since the 1980s**
2. **A lack of improvement in healing rates may be due to patients’ age and increasingly complex needs**
3. **Recurrence rates are high and maintaining healing is cost effective**
4. **The National Patient Safety Agency has highlighted 158 incidents of patient harm from compression bandaging**
5. **There is anecdotal evidence that inappropriately low compression is being used for some patients**

### What is the role of healthcare assistants?

Compression bandaging is an integral part of leg ulcer care, and its ubiquity means there is a risk compression therapy may become a task carried out by the least qualified and accountable member of a team.

Although it is possible to teach the mechanics of applying a bandage from toe to knee, that application must be tailored according to the previous application of the bandage, oedema, limb-shape changes, vulnerability of tissue, marks on the skin that indicate risk of tissue damage, and feedback from the patient. This means applying compression bandages is far from a simple task: all these signs must be assessed and therapy adapted as a result. If clues about effectiveness and safety are ignored, there is a real risk of damage.

Nurse specialists and managers have been heard to say they are happy for particular healthcare assistants (HCAs) to apply compression bandages and, worryingly, that they would have these people bandage in preference to their qualified staff. This approach does not ensure all patients receive a safe and equitable service and, of even greater concern, is the fact that the practitioners responsible for supervision and safe patient care do not have the appropriate skills. It often appears that senior staff making decisions about who delivers this care are unaware of the complexities of leg ulceration management and the consequences of inappropriate care. This is compounded by a lack of reporting of bandage damage.

The National Patient Safety Agency (2011) cited a sample incident in which compression bandages applied by staff who were not competent to do so caused patient damage. The notice highlighted 158 incidents reported between 2004 and 2010 in primary and secondary care, eight of which resulted in “severe harm to the patient”. As the recording of such incidents is not compulsory, it is likely many more occur every year. The notice states healthcare staff must be competent to “assess patients and apply the bandages” – this recognises that ongoing assessment and compression therapy are interlinked.

HCAs do have an important role in leg ulcer management. One key aspect of this is ongoing maintenance of healed limbs through skin care, patient support and the application of compression hosiery, under the supervision of the qualified practitioner. Recurrence rates for leg ulcers are high (Moffatt et al, 2007a) and recurrence presents considerable costs for health services, so maintaining the healed state is extremely cost effective.

In leg ulcer clinics, HCAs are under direct supervision of a nurse with specific leg ulcer qualifications and experience, which may enable them to take a more extended role under direct supervision. However, translating this into solo working in a patient’s home loses the direct supervision aspect and does not acknowledge that patients requiring care at home are likely to be more vulnerable than those able to get to a clinic, making the assessment process more complex.

There is also a growing body of anecdotal evidence that, in some areas, patients are given reduced levels of compression because staff fear inflicting damage through high-compression therapy. If this is because the staff applying the therapy have neither the skills nor the confidence to apply therapeutic levels, this is not only a disservice to patients, but also will prolong healing times and add to healthcare costs.

### How can compression damage be avoided?

Studies on the prevalence of leg ulcers show reasonably consistent figures (Graham et al, 2003), with no significant fall in prevalence or increase in healing rates since the 1980s. This reflects the ageing population and the complex clinical needs of people who experience leg ulceration (Moffatt et al, 2007b).

Ever more vulnerable patients need compression therapy in order to control lower-limb oedema, skin condition and pain, and to maximise wound healing. Therapy therefore requires more skill, and competence in assessment and management is crucial to safe and effective care (Anderson, 2012). If leg ulcer care is left to practitioners who do not have the relevant...

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In a webchat on leg ulcer management issues, hosted by Nursing Times, participants raised three key areas of care: the role of healthcare assistants in compression bandaging; reporting and investigating damage caused by compression therapy; and recommendations for dressings to be used under compression. This article discusses each of these in turn.

**Practice educator**

**Wound care**

This article discusses each of these in turn.
increased exudate and a higher risk of limb damage caused by high sub-bandage pressures or because application techniques are not recognised at initial or ongoing assessment, limb caused by high sub-bandage pressures ranging from a small blister under a dressing to a large ulcer. As discussed in the “Healthcare assistants” section, this leaves patients vulnerable to delayed healing, poor symptom control and a risk of complications such as wound infection, increasing oedema and increased pain.

Care would be improved by better clinical reporting of adverse events and of the levels of compression applied to patients. This would highlight the quality of care patients receive, the problems they experience and any deficits in the competence and skills of staff.

The NHS Safety Thermometer initiative (Harm Free Care, 2012) is highlighting pressure ulcers, but it seems iniquitous that the hundreds of thousands of people who experience leg ulcers and chronic oedema necessitating compression therapy do not benefit from the same emphasis on the quality of tissue-viability care. However, any similar initiative for leg ulcer care would need to focus on accurate data and meaningful ways of recording and investigating, without losing clinical time to administration, thereby impacting negatively on patient care.

A major challenge would be recognising bandage damage in order to report it, especially if practitioners do not have the knowledge and experience to conduct effective assessments of patients. Bandage damage ranges from a small blister under a bandage to an exposed tendon on a limb caused by high sub-bandage pressures because arterial deficits are not recognised at initial or ongoing assessment, or because application techniques are not aligned with the condition of the leg.

Which dressing should be used? Which dressing should be used for leg ulcers? The short answer is: keep it simple,atraumatic and of a low enough profile not to cause pressure damage under compression therapy. A bulky dressing under a compression bandage alters the pressure exerted on the leg and may lead to localised oedema, increased exudate and a higher risk of limb trauma (Hopkins, 2006). Effective compression therapy is the key to venous ulcer healing and the dressing is part of symptom control. For example, if the wound is producing excess exudate, the dressing should offer absorbency with minimal thickness to ensure the bandages around the leg maintain an even pressure; if the wound is dry, a dressing that promotes moisture may be needed to optimise the wound-healing process, which slows in the absence of moisture (Jones et al, 2006). Care must be taken to ensure moisture does not become excessive, leading to skin irritation.

Dressings may also be required to help with infection prevention and control, protect the skin surrounding the wound from exudate, control pain and minimise malodour – sometimes all of these things will be required simultaneously. A systematic review of 42 randomised controlled studies of dressings under compression therapy concluded the type of dressing used did not influence healing and that patient preference should be taken into account (Palfreyman et al, 2006). Dressing choice must therefore be supported not only by performance under compression therapy, but also by clear treatment objectives and evidence of the clinical and cost-effectiveness of the dressing for specific wound objectives.

Conclusion
The webchat was an interesting opportunity to consider experiences coming directly from practitioners. In leg ulcer care there is increased pressure to involve staff at a lower band or those who are qualified but not suitably knowledgeable and skilled in the therapies and diagnostic tests that are essential to patient assessment.

The professional nature of leg ulcer care and the direct impact of treatment and clinical decisions on patient safety must be the prime concern in healthcare. Leg ulcer care does have an evidence base and there are many examples of excellent practice within structured and specialist nurse-led services. It is important that practitioners enable patients to experience the highest-quality care and staff are not put into situations for which they are not qualified or supported. Effective treatments make a huge difference to patients so practitioners making decisions on therapy need to know the modalities being used and their benefits and risks – and they must be able to monitor effectiveness and safety; NT

References


Harm Free Care (2012) NHS Safety Thermometer. tinyurl.com/harmfree-thermometer


