Protocol for Managing Leg Ulcers

A leg ulcer is a wound below the knee that is more than 6 weeks old. The only exception to this rule is pressure ulcers

For all patients admitted with leg ulcers:

1. *Remove all dressings within 6 hours of admission* to inspect, assess and record skin, leg ulcers and any pressure ulcers present on admission.
2. Identify ulcer aetiology (i.e. whether it is venous, arterial, diabetic or other).
3. Assess leg ulcer as per normal wound protocols & complete Wound Assessment form.
4. Refer to Tissue Viability Nurses if infected, MRSA, cellulitic, necrotic or severe pain is present.
5. *Compression bandaging should not usually be continued during an in-patient stay due to the increased risk of pressure ulcer development during this period.* If the patient usually has compression bandaging, remove this within 6 hours, give the patient a copy of the RUH patient leaflet 'compression bandaging' and explain the rationale behind the removal of compression. Re-refer to district or practice nurses prior to discharge so compression can be recommenced immediately post discharge.

For patients with venous leg ulcers:

1. Select an appropriate primary dressing and then apply absorbent layers according to exudate levels.
2. Complete with toe to knee Soffban (taking care to protect bony prominences) & 'K' Lite – *do not use 'K' band.*
3. Encourage / promote active mobilisation where possible.
4. Elevate affected limb. For effective elevation the ankle must be higher than the hip. This will require nursing the patient on their bed with the foot end elevated.

For arterial / diabetic ulcers

1. Refer to the vascular team if the ulcer is critically ischaemic / necrotic.
2. Dress foot ulcers with Inadine (first choice) or Urgotul (second choice) - do not use moist wound dressings unless advised otherwise.
3. Provide effective pressure relief.
4. Refer patients with diabetic foot ulcers to the Diabetic Foot Clinic.

Kate Purser, Senior Nurse, Tissue Viability
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