Best practice in leg ulcer care: is there a role for healthcare assistants?

Although epidemiological data may vary, it has been documented that the prevalence of venous leg ulcers may increase with age. However, as O’Meara et al (2012) stated, UK data in recent surveys indicates a reduction in prevalence, which may be explained by improvements in treatment or a narrow set of selection criteria being used in studies.

About 1% of the western population will develop a venous leg ulcer during their lifetime (O’Meara et al, 2012); the Scottish Intercollegiate Guidelines Network (2010) suggests that approximately 0.1–0.3% of the population has an active venous leg ulcer at any one time. We also know that the cost to the NHS – mostly through primary care treatment of these patients – is significant; figures of up to £400m annually have been recently postulated (Martin, 2014). It is therefore imperative that these patients receive evidence-based, clinically competent care that is provided by the most appropriate practitioners. This is the only way we can be sure they will have the best possible outcomes.

As Martin and Duffy (2011) indicated, the majority of venous leg ulcer care has traditionally been provided by community nurses in primary care. We know that if these nurses correctly diagnose the underlying aetiology, enabling a treatment plan to be commenced, the duration of the ulcer and human costs can be reduced (Day, 2015). However, as Anderson et al (2013) suggested, there is often a chance that compression therapy might be carried out by the least qualified and accountable member of the team, which can then put the patient at risk.

Changes in primary care

Primary care nursing within the NHS has been undergoing immense change over recent years, and demand for services has never been greater. We are seeing an increase in healthcare assistants in all areas of healthcare and particularly within community nursing and primary care.
The role of the HCA has been in the spotlight following the Francis Report (Francis, 2013) and aspects of it are currently under review. This includes the introduction of the compulsory Care Certificate – a set of minimum standards that should guide health and social care staff in their day-to-day work – and an exploration of a more robust career development framework (Cavendish, 2013).

Despite these new requirements, posts for HCAs are increasing in numbers, particularly in GP practices where people undertaking these roles are often very new to healthcare. Many have undertaken additional university-based education, which may include had the Care Certificate, but others have been trained ‘in house’ and, at present, HCAs are an unregulated workforce.

Regardless of the level of qualification of individual HCAs, the responsibility for assessing and planning care remains with the registered nurse. This has raised some concerns about accountability due to a lack of consistency in the structure of different GP practices. The Nursing and Midwifery Council (2015) requires registered nurses to be accountable for their decisions to delegate, and to be sure that the ‘other person’ has a scope of competence, is adequately supervised and supported, and that the outcome of any task meets the required standard. If this is applied to leg ulcer management, there are many areas that might be questionable (Box 1). This raises issues that may need to be highlighted within a clinical setting.

### Box 1. Leg ulcer management: accountability and the HCA

- Is it in the patient’s best interest to receive care from the healthcare assistant?
- Has the HCA been suitably trained to perform compression bandaging?
- Have full records of the HCA’s training been kept?
- Has evidence of competence assessment been documented?
- Are these skills within the HCA’s job description?
- Does the HCA have appropriate levels of supervision?
- Is ongoing development in place to ensure competency is maintained?
- Has the process been assessed for the degree of risk?

Source: Adapted from Royal College of Nursing (2015)

To date, there has been a lack of research around the provision of leg ulcer care within GP practices, and in particular the experience of the HCA. In our current political environment there is a great variance in the services GPs provide with respect to wound care and, indeed, which services they are actually commissioned to provide. As such, it is not surprising that there is confusion around best practice in this field.

Some nurse specialists have been happy for HCAs to apply compression bandages, but this does not ensure that all patients receive a safe service. There are also occasions when the staff accountable for these HCAs do not have the skills either, or perhaps do not understand the complexities of the skills they are delegating (Anderson et al, 2013).

If compression is applied incorrectly, there is a risk of tissue necrosis or exacerbation of underlying conditions. The National Reporting and Learning System database from 2004 to 2010 revealed 158 incidents relating to compression bandaging, reported from both primary and secondary healthcare settings, in which issues around poorly applied compression and staff competency were highlighted (National Patient Safety Agency, 2011). These severe potential consequences are often not recognised by staff if they have not had the initial training before they start treating patients. It is also recognised that the true extent of tissue damage may not be reported or, alternatively, that nurses might apply reduced compression to minimise the risks when, in reality, they are delaying the healing process (Anderson et al, 2013).

### The role of the HCA in wound care

Due to the increase in responsibilities for HCAs, particularly in primary care and GP surgeries, there has been much debate in recent years about the role of unqualified nursing staff in wound care. Indeed, it has been suggested that nurses and HCAs involved in tissue viability are expected to be competent but, at present, there is little agreement around how we define competence or the expertise required by people filling different roles within wound care (Maylor, 2012).

Wounds UK (2013) has been clear that HCAs and associated professionals may have a role in leg ulcer management with specialised training, but the registered practitioner remains responsible for the care of the patient when delegating. Maylor (2012) also recognised that many elements of wound care are delegated to HCAs and that they, therefore, require a level of competence. This is also supported by Guy (2010) who specified that registered nurses need to ensure that clinical support workers undertaking wound care have had adequate training in the wound care task and have demonstrated competence.

However, as Jones (2014) stated, front-line staff cannot be expected to manage venous leg ulcers without having received appropriate leg ulcer management and training, and should be provided with guidelines, protocols and pathways, which are lacking in some clinical areas. HCAs may not recognise that they are accountable in law, regardless of title, qualification or rank, for any actions or omission of actions that directly result in harm caused to patients in their care (Guy, 2010).

### Best practice in leg ulcer management

It is already known that compression therapy is the cornerstone of venous leg ulcer management – it improves healing and prevents recurrences (Harding et al, 2015). However, due to a multitude of factors, patients do not always receive this treatment, applied correctly and in a timely fashion. As Harding et al (2015) suggest, some health professionals view all forms of compression therapy as the realm of a specialist and beyond their scope, while others have not received the appropriate training and therefore might apply the bandages with sub-optimal pressure.

At present the gold-standard practice followed in many clinical areas is adherence to SIGN’s (2010) guideline, which states that:

> “... compression bandaging should be routinely used for the treatment of venous leg ulcers [but] should only be applied by staff with appropriate training”.

However there is no national guidance to indicate which staff members this might include, the format the training should take, or who it should be provided by. In concordance with this, in their review of guidelines, Franks et al (2016) found there were no recommendations on the nature or extent of training and education required for effective management of venous leg ulcers.

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### Quick Fact

1% Estimated percentage of people in the west who will have a venous leg ulcer
Effective venous leg ulcer management requires a correct diagnosis and treatment plan.

It is questionable that we are asking an unqualified workforce without pathophysiology training to undertake tasks when they may not have the knowledge to understand the consequences of their actions. We also need to remember that, while it may be optimum for patients to be referred to specialist services for their leg ulcer management, these are often not available or the waiting list is extensive. With this in mind, it appears then to be appropriate to equip other nurses working in general practice with the relevant skills as the practice nurse may be the first health professional with whom the patient consults (Brown, 2016). This will also enable nurses to feel confident that they are making the right treatment decisions with and for patients, which is based on the best available evidence, as Guy (2010) has identified.

Defining a role for unregistered nursing staff

If it is recognised that leg ulcer management can be provided by appropriately trained health professionals, and there is no current stipulation around what their qualification might be, one must explore whether there is a role for HCAs in applying compression bandages independently if they have attended an accredited course. Indeed as the nursing workforce has expanded to include associate practitioners, and will soon accommodate nursing associates, we need to be proactive in identifying how their role within chronic wound care and leg ulcer management might develop.

Nursing associates will have a unique position that differs from other unregistered assistant roles. Those trained in the new role will supplement, augment and complement the care given by registered nurses but will have higher skills that have been set by the NMC, along with a more defined career progression pathway (Health Education England, 2016).

Research indicates that it is imperative that evaluating the peripheral arterial circulation of the lower limbs, including ankle brachial pressure index, is an essential step in the decision-making process involved in the use of compression therapy (Harding et al, 2015). Are we then suggesting that this must also be part of role of unregistered nursing staff so they have the underpinning knowledge to provide safe, effective clinical care?

Franks et al (2016) have stated that health professionals should meet the qualification, registration and/or licensing requirements of their geographic region before undertaking a role in assessing patients with venous leg ulcers but, again, this is extremely generalised and can be left open to interpretation. This does not provide any guidance around the training that would be essential for this important element of patient care.

At present HCAs do have an important role in leg ulcer management, much of which is orientated around skin care and the application of hosiery. In clinics they often have direct supervision, which can enable them to extend their role safely but, as Anderson et al (2013) indicated, this does not translate into transferring these skills to independent working within a patient’s own home where HCAs are likely to be more vulnerable, or in a GP surgery where they may not be on duty with a registered nurse.

It might be preferable in time, to consider other ways in which unregistered nursing staff can be involved in compression therapy whereby the registered nurse only needs to be involved during the initial stages. More modern systems – such as wraparound compression systems and compression hosiery – can then be monitored further by other health professionals and even carers, when provisions for accountability have been put in place. However, the risks should never be underestimated and consideration of a change in patient condition and suitability must always be reviewed.

It is necessary, therefore, to explore how we move forward to ensure patients receive the best care for their venous leg ulcers, administered by the most suitable practitioner, in the appropriate environment and in adherence with evidence-based guidelines. There have been some scoping studies on the use of assistant staff in the delivery of community nursing services in England, where the role of the band 4 associate practitioner has been explored (Spilsbury et al, 2013).

To date, the shape of the associate practitioner role has been determined by the

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organisational context in which associate practitioners work; this creates variations across England in how these roles are operationalised to support service needs. However, in determining suitable roles for associate practitioners, there has been some discussion around managing the risks associated with the work of the unregistered workforce and negotiating the scope of practice for these roles with registered practitioners. As discussed, this has also been an issue previously with HCAs in terms of the delegation of particular nursing activities.

As Glasper (2016) indicated, there has been an interest in addressing skill-mix deficiencies in the HCA workforce following the failures in care exposed by the Francis inquiry into care failings at Mid-Staffordshire Foundation Trust. With the formal introduction of the new nursing associate role in prospect next year, there may be some scope to develop it into a role that can have a more thorough contribution to complex wound care, including leg ulcer assessment and compression bandaging. Concerns have already been raised around scope of practice and accountability for this new role (Coley et al, 2016), and it was recently announced that nursing associates will be regulated by the NMC.

There is a lot of evidence to suggest these new roles would need careful planning to ensure they are successful and we would not wish HCAs and associate practitioners – who are already undertaking roles in wound care – to feel undervalued and overlooked. However, as Rosser (2016) has stated, more positively, the new role has been identified as one that might be equipped with a sound and specific knowledge base that can expand the delivery of care by nursing teams. This suggests there is potential to shape the identity of new nursing associates in the clinical area in which they work. However, some consideration of where accountability will lie and how these new roles will be supervised will still be necessary.

Conclusion
It is evident that the management of venous leg ulcers brings forth significant challenges, particularly in a primary care setting, and that gold-standard treatment often involves compression bandaging. At present, unregistered unqualified nursing staff may have a role in leg ulcer care, but this varies depending on the clinical area; as yet there are no national guidelines to suggest which format their training should take. With this, comes the question of delegation and accountability, but there may be the potential to reduce some of the identified risks with the introduction of the nursing associate role. Exciting times may be ahead but there needs to be further scoping work to ensure the safety of patients is maintained.

Further resources
- Scottish Intercollegiate Guideline Network guideline on venous leg ulcer management
  - www.sign.ac.uk/pdf/sign120.pdf
- Skills for Health Care Certificate
  - B1t.ly/SHCareCertificate
- Royal College of Nursing guide on accountability and delegation
  - Bit.ly/RCNAccountability
- Cavendish review into healthcare assistants and support workers
  - Bit.ly/DHCavendishReview

References

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