Wounds UK debate: Rethinking lower limb cleansing in leg ulcer care

Lower limb cleansing has long been regarded as a basic, even routine, aspect of wound care. Yet, as highlighted in the new International Wound Infection Institute consensus document on wound cleansing, it is far more than a simple hygiene task, it is a therapeutic intervention with direct implications for healing, comfort, infection prevention, and long-term skin health. Despite this, cleansing remains inconsistently delivered across community services, often competing for time and priority against what are perceived as more technical interventions. For patients with leg ulcers, the act of cleansing extends beyond wound bed preparation. It includes holistic lower limb care, removing debris, controlling odour, maintaining skin integrity, and applying emollients, all of which contribute to comfort, dignity, and quality of life. When neglected, the risks of recurrence, delayed healing, and skin breakdown increase, placing further strain on already stretched services.

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This debate asks us to reconsider the value we place on cleansing within ulcer care. If we acknowledge its therapeutic benefits, how should practice change? Are clinicians supported with the training, time, and resources needed to deliver cleansing consistently? And crucially, how do we ensure that fundamental aspects of care, such as limb hygiene, are prioritised and protected as essential components of ulcer prevention and management?

1. The International Wound Infection Institute (IWII, 2025) consensus document emphasises the importance of therapeutic cleansing. In your view, what are the key take-home messages from this guidance for clinicians working with patients with leg ulcers?

KP: It is great to see that the importance of cleansing is now recognised as being required not only for the wound bed and wound edges but also for the periwound skin and surrounding skin. Therapeutic wound cleansing is now being recognised as a fundamental component of the process to prepare the wound bed for healing. It is set out with several other steps being required as part of the wound care process to achieve wound bed preparation, which is easy to follow, with images to visualise each of these zones to enable understanding of the different areas. This procedure will support clinicians to undertake the recommendations to ensure the whole lower limb is considered and not just the wound.

ER: The guidance emphasises that wound cleansing in leg ulcer management should be regarded as a purposeful therapeutic intervention rather than a routine task. Effective cleansing should address not only the wound bed, but also the wound edge, periwound, and surrounding skin. Given that venous leg ulcers are particularly susceptible to inflammation, dermatitis, and hyperkeratosis, comprehensive cleansing is crucial for supporting healing and maintaining skin integrity. In my view, a key message from this guidance is the importance of assessing the periwound and surrounding skin, with the findings informing cleansing strategies, including the choice of solution and the degree of mechanical force required.

HR: Therapeutic cleansing is not just routine; itis strategic. The guidance redefines cleansing as a therapeutic intervention, not a habitual or non-purposeful task. It should be performed meticulously and purposefully, using appropriate techniques, solutions and sequences to support wound healing.

2. Why do you think lower limb cleansing is still inconsistently applied in community settings, despite its recognised importance?

KP: The element of time will be one factor due to the large size of district nursing caseloads, with multiple tasks. Some patient slots are only 15 minutes to complete a full wound assessment and dressing change, which makes all the requirements needed to provide optimal wound bed preparation challenging. However, some barriers, like moving and handling difficulties, infection control protocols,and time pressures, can be overcome by using

products that are multidimensional or fast-acting and that will provide therapeutic wound cleansing. This, along with other elements of wound bed preparation, would help ensure they can be achieved in the timeframe they have. Furthermore, having clinical pathways in place for healthcare professionals can speed up the process, as they set out a step-by-step process for them to follow, which is aligned to evidence-based practice.

ER: Within my area, community nursing teams are under significant staffing pressure, with urgent care responses for patients requiring end-of-life care, catheter care, or PICC line issues often taking priority. As a result, time management becomes a constant challenge, and for patients requiring leg ulcer care, the focus is frequently limited to removing a saturated dressing and applying an antimicrobial and dry dressing. The patients on my evaluation reported that cleansing and skincare is brief—typically a quick wipe-over, followed by application of emollient. Community nurses are not always allocated sufficient time to perform thorough cleansing and skincare regimes.

HR: Despite long-term recognition of wound cleansing in wound healing and leg ulcer care, it is inconsistently applied in the community due to time pressure, limited access to appropriate products, knowledge gaps, fragmented care and misconceptions about skin fragility. Without clear pathways or guidance, cleansing is often undervalued or treated as a basic task rather than a skilled, therapeutic intervention. This leads to lack of standardisation in practice and missed opportunities to improve outcomes (Guest et al, 2017; Atkin et al, 2020; IWII, 2025). Empowering clinicians with training, resources and evidence-based guidelines is essential to standardise care and maximise the clinical impact of cleaning.

3. Do you think enough clinical time is currently allocated for thorough lower limb hygiene as part of wound care routines? If not, what changes are needed to support this?

KP: As a whole, no, and this is why this element of wound care is often missed or overlooked. This could be addressed by ensuring standard operation processes or contacts include 'time to care' factors to ensure you have an adequate amount of time to deliver optimum evidence-based care. Within our local area, we have a contact in place with the integrated care board and general practices that practice nurses have a minimum allocation of 30 minutes per patient or per limb to provide wound care.

ER: No. While our team delivers a 2-day leg ulcer course and a half-day wound care course, my evaluation across the county and within leg ulcer clinics revealed that, although clinicians are competent in performing ankle–brachial pressure index assessments and applying compression, there was minimal focus on cleansing and skin care. This highlighted a gap in our training provision. In response, we have restructured both courses to include a comprehensive assessment of the whole lower limb, rather than focusing solely on the wound bed. A pathway has also been developed to provide specific guidance on assessment and management of the wound bed, periwound skin, and the wider limb. Published clinical evidence and current recommendations support and reinforce this change.

HR: In the community, lower limb hygiene is often deprioritised due to time constraints, high caseload numbers and workforce shortages. This limits the ability of clinicians to deliver comprehensive wound care during restricted visit times. (Ford, 2018). In my experience, some nurses underestimate the importance of cleansing, viewing it as a low-priority or comfort-based task rather than a therapeutic intervention. As clinical leaders in this space, we should be providing effective, strong clinical leadership and promoting the importance of therapeutic cleansing and lower limb hygiene. We need to be providing education, role modelling best practice and ensuring that it is seen as a core element of wound care that directly impacts healing outcomes and patient wellbeing.

4. How does routine cleansing and the use of emollients fit into the broader strategy of prevention for patients at risk of recurring ulcers or skin breakdown?

KP: Therapeutic wound cleansing of the periwound and surrounding skin of healed ulcers, along with the application of emollients, aims to maintain the skin health by preventing dryness and cracking. The cleansing will reduce any bioburden present, whilst the emollient will keep the skin hydrated.

ER: The midpoint review of my evaluation suggested that cleansing alone, regardless of the method, has limited long-term impact without broader skin care management. Following a 2-week trial, follow-up visits were

adapted to place greater emphasis not only on cleansing, but also on comprehensive skin care, including debridement and hydration. An oil was applied to areas of hyperkeratosis, which were then gently debrided using a debridement pad. By investing an additional 15 minutes during these visits, skin conditions were optimised and subsequently required only maintenance at later reviews. This approach demonstrated that, by selecting efficient products and techniques, patient outcomes can be improved while overall nursing time is reduced – aligning with recent recommendations on therapeutic wound and skin cleansing, which emphasise holistic care of the wound bed, edge, periwound and surrounding skin (International Wound Infection Institute, 2025).

HR: Routine cleansing and use of emollients are essential preventive strategies for patients at risk of recurring leg ulcers or skin breakdowns, as they help maintain skin integrity, reduce microbial burden, and support healing. The IWII (2025)consensus statement on therapeutic cleansing emphasises the importance of skin cleansing, including the wound bed, periwound and surrounding skin, removing all debris and contaminants to lower infection risk and improve skin condition. Emollients restore the skin barrier, preventing dryness and irritation and maintaining a healthy skin pH, therefore reducing the likelihood of skin damage and ulcer recurrence (Probst et al 2022). Using regular emollients can alleviate itching, improve patient comfort and increase adherence with compression products.

5. There is a growing need to protect and ringfence time for fundamental care. How can we raise the profile of cleansing as a therapeutic intervention deserving protected time and attention?

KP: By measuring outcomes based on interventions, we can share and present the importance of this in practice to local organisations, integrated care boards and even nationally to enable this fundamental component to be recognised with the importance it needs in the aim to heal wounds and prevent recurrence, while reducing the risk of infection and hospitalisation. By evidencing the impact cleansing as a therapeutic intervention has on wound outcomes, which reduces time and saves money, it will provide resources to develop business plans, policies and commissioning contacts that have a minimum time frame that is required for wound care to be provided effectively. For standardisation, having a national clinical pathway in place for therapeutic cleansing for healthcare professionals to utilise, as we do the national pressure ulcer clinical pathway, can make the process faster and more achievable and enable evidence-based practice to be implemented.

ER: The community tissue viability team in Cornwall is working to raise the profile of cleansing as a therapeutic intervention by incorporating it into a formal care pathway and carrying out a county-wide evaluation. By demonstrating positive patient outcomes across community teams and leg ulcer clinics, we can evidence its value and strengthen its position as a therapeutic practice. In addition, embedding clinical recommendations within our training ensures that cleansing is recognised as an essential component of treatment rather than a routine task, deserving of protected time and attention.

HR: Therapeutic cleansing needs to be reframed as a clinical priority rather than being considered a basic task. We need to embed cleansing into clinical protocols and pathways and educate staff on the value of therapeutic cleansing. To justify the dedicated time for this intervention, link it to measurable patient outcomes such as infection rates and improved healing rates. Promoting cleansing as a skilled, evidence-based practice also supports professional recognition by validating the expertise of our nursing workforce and enhancing patient safety.

Conclusion

The debate highlights that lower limb cleansing can no longer be dismissed as a "basic" task but must be recognised as a therapeutic intervention that underpins wound healing, recurrence prevention, and patient quality of life. The IWII (2025) consensus has reframed cleansing as a structured, evidence-based practice that requires the same professional attention as compression, debridement or infection management. Yet, for this to be achieved, time, training, and resources must be safeguarded within overstretched services. Standardising cleansing pathways, embedding education, and linking practice to measurable outcomes are essential steps to ensure consistency and impact. By protecting and prioritising cleansing, clinicians can deliver not only more effective patient care but also more dignified, holistic care, helping patients to live well with, and ultimately move beyond, lower limb ulceration.

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