Lower Limb Wound Pathway

NHS
Bradford District Care
NHS Foundation Trust

Immediate Care

Patient with a wound on the lower limb

RED FLAG ASSESSMENT
- **Spreading infection**
- **Red hot swollen leg**
- **Limb threatening ischaemia**
- **Suspected DVT**
- **Suspected skin cancer**

YES →
- If patient a diabetic and wound on foot refer urgently to local diabetic foot MDT service
- If patient has limb threatening ischaemia - refer urgently to your Vascular Service
- Any other concerns discuss with GP urgently

Consider:
- Acute heart failure
- End of life
- Concordance and capability. *Discuss with wider MDT

NO ↓

Within 24 hours of presenting with wound, commence the following:
- Wound and skin cleansing
- Simple low adherent dressing with sufficient absorbency **(SEE LOCAL FORMULARY FOR DRESSINGS)** https://www.bdct.nhs.uk/services/woundformulary
- Advise patient reasons for compression
- Apply ≤20mmHg of compression to the lower limb if no signs of arterial insufficiency are present (e.g. Class 1 Activa® hosiery)
- Assess level and type of pain and document in SystmOne
- Assess by using lower limb template on SystmOne

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Refer for/arrange full lower limb holistic assessment

Leg Ulcer Assessment

In order to prevent further harm to the patient and to comply with CQUIN requirements, the below MUST be completed within 14 days
- Patient medical history
- Limb assessment
- Ulcer history
- Wound assessment
- ABPI or other vascular assessment
- Assess, manage and document pain

ABPI <0.5
Urgent referral to vascular centre. STOP compression

ABPI 0.5-0.8
Mixed Disease. Refer to Tissue Viability Team.
Refer to Vascular if arterial signs and symptoms present.
Continue with ≤20mmHg

ABPI >1.3
Consider calcification
Assess foot pulses, Doppler waveform and toe pressures.
If unsure refer to Tissue Viability team for further advice and guidance.
Continue with ≤20mmHg compression

Consider for vascular referral following diagnosis and care plan

ABPI 0.8-1.3
Patient requires compression of at least 40 mmHg

Signs of venous disease, oedema, skin staining, ankle flare, eczema or varicose veins

No evidence of significant arterial disease, safe to compress - **Do not delay compression** refer to vascular nurse specialist - consideration of venous intervention if 1) Patient is independently mobile and 2) BMI is under <35 or BMI over >35 give weight loss advise and refer for consideration.

Ongoing Treatment

Is the exudate controlled within topical dressing?

NO →
Step 1: Remove barriers to healing from the wound.
Step 2: Manage exudate with a superabsorbent dressing.
Step 3: If oedema present apply Actico® inelastic compression bandage. If no oedema present, apply K Two® system or Actico®.

*Re-assess weekly

YES ↓

Is there a large amount of reducible oedema / limb distortion?

NO →
Step 1: Remove barriers to healing from the wound.
Step 2: If no oedema apply British Standard Leg Ulcer Hosiery Kit e.g. Activa®.
Step 3: If oedema present apply European Class Hosiery Kit e.g. ActiLymph®.

YES ↓
Step 1: Remove barriers to healing from the wound.
Step 2: Apply Actico® inelastic bandage or contact TVN for advice regarding adjustable wrap system e.g ReadyWrap®. If severe limb distortion, contact Tissue Viability Team for advice.

When oedema and limb distortion controlled, change to European Class hosiery kit e.g. ActiLymph® or continue with wrap system e.g. ReadyWrap®

Once leg ulceration is healed
To prevent recurrence; prescribe compression hosiery e.g. Activa® British Standard if no oedema present or ActiLymph® European Class if oedema is present. Consider referral to vascular services to assess need for venous intervention to reduce the risk of recurrence, as per NICE guidelines CG168 (2013). Ensure patient has info leaflet "what to do next".

Assessment and Reflection
After four weeks of treatment if there is no reduction in ulcer size or limb volume refer to vascular / tissue viability service for review. If the wound does not heal in 12 weeks refer to vascular / tissue viability service for review

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