Leg Ulcer Pathways

Definition: A Leg Ulcer is defined as skin loss that originates between the knee and malleolus (ankle).

Red Flags	Emergency Actions Required
Leg ulcer with systemic/ severe infection / sepsis with (tachycardia, pyrexia,hypotension, patient feeling unwell, spreading cellulitis, crepitus, significant deterioration over a short period of time).	**Secondary Care:** Refer urgently to the Vascular Team via switch board. **Practice Nurses** – Transfer urgently to the Emergency Department **OR** Refer urgently to the Emergency Surgical Assessment Centre (ESAC). **District Nurses** - Transfer urgently to the Emergency Department **OR** Contact TVALS or GP to arrange admission to ESAC.
Clinical evidence of acute limb ischaemia (acute pain, pallor, pulseless, perishingly cold, paraesthesia / acute sensory change, paralysis / acute motor dysfunction for <2 weeks).	
Leg Ulcers with spreading infection (cellulitis).	Obtain a wound swab and arrange for antibiotics to be commenced. Dress with an anti-microbial, absorbent pad (If required) and follow the Safe Soft Bandaging Pathway. **Secondary Care:** Refer urgently to the Vascular Team via switchboard. **Primary Care:** Contact TVALS or GP to arrange the admission to ESAC.
Suspected acute deep vein thrombosis.	**Secondary Care:** Follow the Venous Thromboembolism (VTE) – Prevention and Treatment of VTE in Patients admitted to hospital. **Primary Care:** Refer urgently to the Ambulatory Care Unit.
Suspected Skin Cancer.	Refer to the Dermatology Department as per the 2 week wait protocol, either via the GP or **dbth.dermatologyteam@nhs.net**
Amber Flags	**Urgent action Required**
Do you suspect poor arterial blood supply because the patient has either: Constant pain in the foot (typically relieved by dependence and worse at night) OR A non-healing wound of more than 2 weeks duration and / or gangrene on the foot.	Complete the https://www.dbth.nhs.uk/wp-content/uploads/2024/01/Appendix-21-Vascular-Service-PAD-Referral-Form-Digital-eform-v2.pdf Send to: **dbth.vascular-admin@nhs.net**
Does the patient have any risk factors or visual signs for venous disease on the lower limb including with either of these: Ulceration that Static or deteriorating despite optimum compression therapy Or Acute venous bleeding from the leg requiring first aid treatment	Complete the https://www.dbth.nhs.uk/wp-content/uploads/2024/01/Appendix-20-Vascualr-service-Venous-Disease-Referral-Form-Digital-eform.pdf Send to: **dbth.vascular-admin@nhs.net**

Assessment and Treatment

1. Follow the Wound Bed Preparation Pathway

2. Complete and document accordingly a Wound Assessment using TIMES, and complete clinical photography

3. Identify the suspected or confirmed Leg Ulcer Type, using the Lower Leg Wound Guidance

Venous or Mixed Leg Ulceration		Arterial Ulcera
50% or more granulation WITHOUT active infection:	**50% or more slough or necrosis present AND/OR an active infection:**	**All Tissue Types**
UrgoStart Plus pad, with a Kliniderm Super Absorbent Pad is required.	UrgoClean Ag, with a Kliniderm Super Absorbent Pad is required unless specified differently by the Vascular Service.	**4C.** Acticoat Flex 3 or 7 to broken skin, Kliniderm Super Absorbent if required, Bandages as per the Pathway for Safe Soft Bandaging. Unless specified differently by the Vascular Service
4 . Diagnosis confirmation		
Venous or Mixed Diagnosis Not Confirmed	**Venous or Mixed Diagnosis Confirmed**	
Bandage as per the Pathway for Safe Soft Bandaging *(until a lower limb assessment has been undertaken by a Tier 3 or 4 service).*	Compression Bandages/ Stocking/ Hosiery/ Wraps as confirmed by a Tier 3 or 4 service. *If you don't have competencies for compression follow the Diagnosis not confirmed plan.*	

5. Onward Referrals:

Secondary Care: Refer all patient to Skin Integrity. Skin integrity will arrange a Lower Limb assessment for any leg ulcers without a confirmed diagnosis. For new arterial ulcers refer urgently to the Vascular Team.

Primary Care: Refer all leg ulcers with no confirmed diagnosis to a Tier 3 or 4 service or District Nurse to arrange a Lower Limb assessment. For new arterial ulcers refer urgently to the Vascular Team.

Primary Care: Provide seal-tight waterproof dressing protector (Limbo) and if required a compression stocking application aid appliance. Both are available on FP10.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document

National Wound Care Strategy Programme 2020, Lower Limb Recommendations for Clinical Care.
Developed by: Tissue Viability and Lymphoedema Service, The Skin Integrity Team, Vascular Nurse Specialist 2021. Updated July 2024. For Review June 2027.