First to dress lower leg wound pathway for Emergency Departments

Aim: This pathway should be used for all patients in ED areas with lower limb wounds.

Red Flags	Emergency Actions Required
Leg ulcer with systemic/severe infection/sepsis with (tachycardia, pyrexia, hypotension, patient feeling unwell, spreading cellulitis, creitus, significant deterioration over a short period of time).	Refer urgently to the Vascular Team via switchboard
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 a non-adherent dressing, absorbent pad (If required) and follow the Safe Soft Bandaging Pathway. Ask the managing clinician to consider if a Vascular referral is required.
Suspected acute deep vein thrombosis.	Follow the Venous Thromboembolism (VTE) - Prevention and Treatment of VTE in patients admitted to hospital - PAT/T 44 V3.
Suspected Skin Cancer.	Refer to the Dermatology Department as per the 2 week wait protocol.
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). • A non-healing wound of more than 2 weeks duration and / or gangrene on the foot.	Complete the Vascular Service – Peripheral Arterial Disease (PAD) / Chronic Limb- Threatening Ischemia Disease Referral Form 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: • Ulceration that static or deteriorating despite optimum compression therapy. • Acute venous bleeding from the leg requiring first aid treatment.	Complete the Vascular Service – Venous Insufficiency Referral Form. Send to: **dbth.vascular-admin@nhs.net**

1. Remove all dressing and bandages within 6 hours of the patient arriving in the department.
2. Undertake wound cleansing in accordance with the Wound Bed Preperation Pathway.
3. Undertake a full wound assessment on Symphony Wound IPOC.
4. **Following the wound assessment, if signs of spreading or systemic infection are identified:**
   - Take a wound swab.
   - Consult the senior clinician involved in the patient's care to follow NICE guidance and local policy for infection and anti-microbial stewardship.
   - Follow the Pathway for Wound Infection.
5. Promote good skincare by applying emollient cream to the intact skin and peri-wound skin daily as per local formulary.
6. Apply Atrauman to the wound bed, with a Kliniderm Absorbent Pad with Safe Soft Bandaging.
7. Report and reder to the Skin Integeirty team via Datix.

TOP TIPS:
- Provide analgesia as required before dressing change
- Elevate limbs using a footstool when sat out in a chair or adjust the bed and use pillows for bedbound patients.

NOTE:
- If the patient is transferred to a new ward area the admitting Nurse will need to remove the dressings, complete skin check, assess the wound and redress.

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.

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