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 _ 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 EmSorb Max superabsorbent 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.

Developed by the Skin Integrity Team. Update September 2026 v4. Review by July 2029