Leg Ulcer Pathway

This local pathway is an example used in the NICE medical technology guidance adoption support resource for UrgoStart for treating diabetic foot ulcers and leg ulcers. It was not produced for or commissioned by NICE.
GUIDANCE NOTES FOR COMPLETION

If a patient has a wound to the lower limb for 2 weeks commence the leg ulcer pathway. Wound Care Assessment and Wound Care Treatment Plan must be completed weekly inclusive of all measurements. Refer to the Leg Ulcer Treatment Algorithm for guidance on treatment plans and escalation of wound care.

NB: If you have ticked any of the boxes on the Wound Assessment Chart highlighted with the following icon
- These may be significant signs of clinical infection
- These may be significant signs of osteomyelitis. You must take appropriate action to treat the wound complication.

NB: Ankle Brachial Pressure Index (ABPI) assessment to be repeated at 12 weeks, for patients with a new or first episode of ulceration, then subsequently every 6 months.
If patient has repeated stable readings and reduced risk consider yearly assessments.

Dressings & Treatment Regimens.
- Dressing regimes should only be changed based on assessment of the wound. A clear rationale must be provided to support a change.
- Do not change dressing regime < 2 weekly unless due to allergic reaction or visible signs of local infection.
- All health care professionals should make themselves aware of manufacturers guidance for each dressing product used.
- Antimicrobial dressings must only be used when signs of local, spreading or systemic infection are present. Immunosuppressed patients may not have the expected response to infection. This type of dressing must only be used initially for 2 weeks. After 2 weeks, reassess the wound to establish if longer term antimicrobial treatment is required. Consult with local TVN/Microbiologist for longer term use as per your local policy.
- Do not routinely amend the treatment plan unless required. An arrow can be drawn to indicate continuation of current treatment.
- Ensure nutritional screening using Trust screening tool, such as MUST. Refer to dietitian as appropriate.

Quality of Life Assessment
- The QoL assessment is to be completed during the first assessment and then at 4 weekly intervals.
- It is designed for the patient to complete themselves where possible.

Evidence Based Practice:
A wound (or cut, injury, ulcer) is a break to the skin that may be taking some time to heal. Please answer these questions about how you are coping with your wound.

1. Can you walk as well as you did before you had your wound?
   - Yes
   - Sometimes
   - No

2. Can you go out as easily as before you had your wound?
   - Yes
   - Sometimes
   - No

3. Do you eat well?
   - Yes
   - Sometimes
   - No

4. Are you able to have a shower or bath?
   - Yes
   - Sometimes
   - No

5. Are you able to wear clothes and shoes that you want to?
   - Yes
   - Sometimes
   - No
6. Do you get a good night’s sleep?

7. Please circle the picture to show if you sleep in a bed or in a chair.

8. Please circle a number to show how your pain has been recently.

9. What medication do you take for your pain?

10. Where do you get your support from?

11. How do you rate your overall quality of life?
   Please circle the number to show your answer
   0 =worst quality of life  100 = best quality of life
**TREATMENT ALGORITHM**

Assessment of symptoms and ABPI reading 0.8 – 1.3 or TBPI reading >0.7 Full Compression*
ABPI reading <0.8 – 0.6 Reduced Compression* following discussion with TVN (<0.6 or >1.3 refer to vascular) Refer to Leg Ulcer Management Guidelines for assessment guidance

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**Compression**
(Ankle measurements required to ensure the correct kit is used)

- **Full** Compression: 40mmHg
  - UrgoKTwo
  - Hosiery Leg Ulcer Kit
- **Reduced** Compression: 20mmHg
  - UrgoKTwo Reduced
  - K-Four Reduced Kit

*If considering JUXTA contact TVNs

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**Comorbidities**
1) Diabetes
2) COPD
3) CCF
4) PAD
5) Obesity
6) Medication
7) Rheumatoid Arthritis
8) Mixed aetiology

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**Emollients**
- Cleanse lower limb, ensuring maintenance of skin hydration, with appropriate emollient

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**Bacterial Burden**
1) Contaminated
2) Colonised
3) Local Infection
4) Spreading Infection
5) Systemic Infection

Wound swab as per Trust protocol

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**Weekly review to include completion of wound chart**

Following expected healing progression, more than 40% reduction in wound surface area at 8 week review

Yes

Continue with UrgoStart Plus as primary contact layer + Compression*
Ensure thorough reassessments considering microbial imbalance, presence of biofilms or patient concordance

No

Refer to Tissue Viability Service / Vascular if not healed within 16 weeks

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**Consider UrgoStart Plus Border & either Leg Ulcer Kits or Juxta for Wounds < 10cm**

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**Treatment:**
1) UrgoStart Plus
2) Kliniderm (if required)
3) Compression* (consider reduced compression for comorbidities)

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**Treatment:**
1) Octenilin / Oilatum Plus
2) Cutimed Sorbact / UrgoClean Ag
3) Kliniderm (if required)
4) Compression*
5) Antibiotics if spreading or systemic infection present

If no improvement at 4 week review refer to Tissue Viability Service for guidance
# Tissue Type

<table>
<thead>
<tr>
<th>Tissue Type</th>
<th>Action</th>
<th>Vigilance</th>
<th>Observation</th>
<th>Topical</th>
<th>Topical &amp; Systemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necrotic</td>
<td>Rehydrate and debride dead tissue. CAUTION: Vascular studies are required before active treatment is commenced. If poor blood supply, keep wounds dry do not aim to debride with dressings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sloughy</td>
<td>Remove dead tissue, manage exudate and prevent infection. Exudate volume will increase as dead tissue is rehydrated and autolytic debridement occurs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Remove dead tissue, manage exudate and prevent infection. Exudate volume will increase as dead tissue is rehydrated and autolytic debridement occurs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granulating</td>
<td>Promote healing and prevent infection. Cavity wounds will need to be packed to promote granulation from the base of the wound.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epithelialising</td>
<td>Protect newly formed skin. Wounds that have been covered over with a top layer of skin may not require a wound dressing and simple moisturising products may be preferred.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infected</td>
<td>Reduce bacterial burden. Disrupt biofilms and restore bacterial balance. Exudate levels are likely to increase.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Primary Dressings
- **UrgoStart Plus**: TLC-NOSF Healing Matrix and poly-absorbent fibres, bordered or pad. Use from day 0 to full healing, unless wound infection present.
- **Cutimed Sorbact**: DACC coated dressings. For moist or circumferential wounds.
- **UrgoClean Ag**: Silver poly-absorbent fibre dressing with TLC-Ag. For all levels of exudate.
- **Octenilin**: Wound Irrigation Fluid. If unable to wash leg or recurring infections.
- **Oilatum Plus**: Antiseptic Liquid Emollient. For full leg wash.
- **Kliniderm**: Absorbent polyurethane foam. Depending on exudate levels.

## Antimicrobial Dressings
(Use when bacterial burden is imbalanced)
- **Cutimed Sorbact**: DACC coated dressings.
- **UrgoClean Ag**: Silver poly-absorbent fibre dressing with TLC-Ag.
- **Octenilin**: Wound Irrigation Fluid.
- **Oilatum Plus**: Antiseptic Liquid Emollient.
- **UrgoKTwo**: Two layer compression bandage system. Full or reduced compression.
- **KFour (KSoft, KLite, KPlus, KoFlex)**: Four layer compression bandage system. Full or reduced compression.
- **Leg Ulcer Kit**: Leg Ulcer Hosiery Kit (liner + hosiery). Full compression.
- **Juxta Range**: Inelastic, adjustable compression garment. Contact TVN.

## Absorbent Dressings
- **Kliniderm**: Absorbent polyurethane foam. Depending on exudate levels.

## Compression
Remember to measure and follow manufacturers guidance for the correct selection of size.
- **UrgoKTwo**: Two layer compression bandage system. Full or reduced compression.
- **KFour (KSoft, KLite, KPlus, KoFlex)**: Four layer compression bandage system. Full or reduced compression.
- **Leg Ulcer Kit**: Leg Ulcer Hosiery Kit (liner + hosiery). Full compression.
- **Juxta Range**: Inelastic, adjustable compression garment. Contact TVN.

## Bacterial Burden

<table>
<thead>
<tr>
<th>Contaminated</th>
<th>Colonised</th>
<th>Local Infection</th>
<th>Spreading Infection</th>
<th>Systemic Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observation</strong></td>
<td><strong>Topical</strong></td>
<td><strong>Topical &amp; Systemic</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Exudate Levels
1) Dry 3) Wet
2) Moist 4) Saturated

### Wound Swabbing
Refer to MFT Infection Control Guidance.
# INITIAL LEG ULCER ASSESSMENT FORM

## Patient Details

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename(s)</th>
<th>Date of Birth</th>
<th>Address</th>
<th>Contact Number</th>
</tr>
</thead>
</table>

## Referral Source

<table>
<thead>
<tr>
<th>Consultant/GP</th>
<th>Treatment room</th>
<th>District Nurse Team</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NHS/Hospital No:</th>
</tr>
</thead>
</table>

## GP Details

<table>
<thead>
<tr>
<th>GP</th>
<th>Address</th>
<th>Contact number</th>
<th>Fax number</th>
</tr>
</thead>
</table>

## Venous / Arterial History

<table>
<thead>
<tr>
<th>Trauma</th>
<th>Cellulitis</th>
<th>Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin Graft</th>
<th>Phlebitis</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sclerotherapy</th>
<th>Deep vein thrombosis</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Vein Surgery</th>
<th>Previous ulcer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Arterial Surgery</th>
<th>History of this episode</th>
</tr>
</thead>
</table>

## Cause and Duration of Current Ulcer

<table>
<thead>
<tr>
<th>Venous / Arterial History</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rheumatoid Arthritis</th>
<th>Oedema</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Poor Circulation</th>
<th>Systemic Infection</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Inadequate Nutrition defined by the MUST tool</th>
<th>Anaemia</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Restricted Mobility (use of walking aid/loss of limb/only able to walk short distances)</th>
<th>Medication e.g. Inotropes, Steroid, Anticoagulants</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sleep disturbance</th>
<th>Smoking</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ankle leg fracture</th>
<th>Hip Surgery</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cerebral Vascular Accident</th>
<th>Hypertension</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other please state</th>
</tr>
</thead>
</table>

## Patient Consideration (please state)

<table>
<thead>
<tr>
<th>Known Topical Allergies (creams/dressings)</th>
<th>Known Systemic Allergies (medication)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Equipment In Use:</th>
</tr>
</thead>
</table>

## Referral to Other Disciplines

<table>
<thead>
<tr>
<th>Tissue Viability Nurse</th>
<th>Vascular Team</th>
<th>Stoma Nurse</th>
<th>Podiatrist</th>
<th>Other please state</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physiotherapist</th>
<th>Macmillan Nurse</th>
<th>Leg Ulcer Clinic</th>
<th>Dietitian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medication</td>
<td>Dose and Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Steroid Treatment</th>
<th>Duration</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current / Previous Compression Therapy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully mobile</td>
<td></td>
</tr>
<tr>
<td>Reduced mobility</td>
<td></td>
</tr>
<tr>
<td>Mobile with an aid</td>
<td></td>
</tr>
<tr>
<td>Immobile</td>
<td></td>
</tr>
<tr>
<td>Elevation of legs</td>
<td></td>
</tr>
<tr>
<td>Full ankle movement</td>
<td></td>
</tr>
<tr>
<td>Limited ankle movement</td>
<td></td>
</tr>
<tr>
<td>Fixed ankle joint</td>
<td></td>
</tr>
</tbody>
</table>
INITIAL LEG ULCER ASSESSMENT FORM CONT...

### Pain

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is night pain experienced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is pain relieved by hanging leg out of the bed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Severity (ask patient to rate on the scale below and clearly mark)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Pain</td>
<td>Moderate Pain</td>
<td>Extreme Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Lower Limb Assessment (Legs & Feet)

**Answer Yes / No to the observations below**

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th></th>
<th>Right</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose Veins</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Oedema</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Eczema</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Skin Condition (Dry / Flaky / Fragile)</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Induration</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Staining</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Post Medial / Lateral Malleolus Involvement</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Atrophie Blanche</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Ankle Flare</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Poor Tissue Perfusion</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Colour of Feet (Pale, Rubor, Pink, Black, Gangrene)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature of Feet</td>
<td>Normal</td>
<td>Same on both feet</td>
<td>Same as the patient’s body</td>
<td>Hot</td>
</tr>
</tbody>
</table>
ANKLE BRACHIAL PRESSURE INDEX (ABPI) ASSESSMENT

Ensure patient is in supine position and if applicable, rested for at least 15 minutes prior to performing ABPI or TBPI (Toe Brachial Pressure Index) assessment.

INITIAL ASSESSMENT

<table>
<thead>
<tr>
<th>Ankle pulses palpable:</th>
<th>Initial measurements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No please circle</td>
<td>Left Ankle: ------------------------- Right Ankle: -------------------------</td>
</tr>
<tr>
<td></td>
<td>Left Calf: -------------------------- Right Calf: --------------------------</td>
</tr>
</tbody>
</table>

Left
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Right
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Additional information:
- Any comments on position of patient:
- Calculations:

Repeat initial ABPI assessment in 12 weeks if this is a new or first episode of ulceration.

12 WEEK ASSESSMENT

<table>
<thead>
<tr>
<th>Ankle pulses palpable:</th>
<th>Initial measurements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No please circle</td>
<td>Left Ankle: ------------------------- Right Ankle: -------------------------</td>
</tr>
<tr>
<td></td>
<td>Left Calf: -------------------------- Right Calf: --------------------------</td>
</tr>
</tbody>
</table>

Left
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Right
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Additional information:
- Any comments on position of patient:
- Calculations:

6 MONTH ASSESSMENT

<table>
<thead>
<tr>
<th>Ankle pulses palpable:</th>
<th>Initial measurements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No please circle</td>
<td>Left Ankle: ------------------------- Right Ankle: -------------------------</td>
</tr>
<tr>
<td></td>
<td>Left Calf: -------------------------- Right Calf: --------------------------</td>
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Left
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Right
- Brachial
- Anterior Tibia (AT)
- Posterior Tibia (PT)
- Dorsalis Pedis (DP)
- Toe Pressure

Additional information:
- Any comments on position of patient:
- Calculations:

Routine ABPI assessment may be reduced to 6 monthly / yearly for patients with a stable reading and minimal risk factors.

GUIDANCE FOR ABPI RESULT
- ABPI / TBPI readings form part of a holistic assessment.
- If there is a difference of 15-30mmHg between the brachial systolic pressures please refer for vascular assessment as upper limb vessel disease may be present.

<table>
<thead>
<tr>
<th>ABPI / TBPI</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1.3</td>
<td>Indicates a falsely elevated reading. This could be due to oedema or calcification. Please request referral to vascular services.</td>
</tr>
<tr>
<td>1.0 - 1.3</td>
<td>Indicates safe to use compression. Normal arterial flow.</td>
</tr>
<tr>
<td>0.9 - 1.0</td>
<td>Indicates a mild degree of arterial insufficiency.</td>
</tr>
<tr>
<td>0.8 - 0.9</td>
<td>Indicates patient is receiving 80-90% arterial blood flow. It is safe to apply full compression.</td>
</tr>
<tr>
<td>0.6 - 0.8</td>
<td>Indicates presence of arterial disease for which reduced compression may be suitable dependant on symptoms. Consult with TVN or Leg Ulcer Specialist Nurse.</td>
</tr>
<tr>
<td>&lt;0.6</td>
<td>Indicates significant arterial disease do not apply compression therapy please refer to vascular services for further assessment.</td>
</tr>
</tbody>
</table>

GUIDANCE FOR TBPI RESULT
- >0.7 Normal, indicating no arterial disease
- 0.64 - 0.7 Borderline: Indicates presence of arterial disease for which reduced compression may be suitable, dependant on symptoms. Consult with TVN or Leg Ulcer Specialist Nurse.
- <0.64 Abnormal, indicating the arterial blood flow is inadequate for compression. Please refer to vascular services for further assessment.
WOUND IDENTIFICATION MAP

GUIDANCE FOR COMPLETION IF MORE THAN ONE WOUND PRESENT

- Please draw and label on the above diagrams each active ulceration labelling A,B,C,D etc providing clear guidance on the images which ulcer correlates to which letter
- Please note there is a separate wound assessment chart for each leg
- If required, please use the note page at the end of this booklet to record weekly wound measurements
- Include date and time and document on the assessment chart if the wound measurements are being recorded on the notes page
- Measure consistently length (north-south) and width (west-east) at weekly intervals
- Dependant on Trust protocol consider taking weekly photographs of the wound
### Wound Care Assessment Chart – Left Leg

**Wound Assessment Details**

- **ABPI**
- **TBPI**

**Date of Next Assessment**

- (due 12 weeks from last assessment)

**Tissue**

- Please state (out of 100%) percentage of tissue on wound bed:
  - Granulation
  - Necrotic
  - Slough
  - Epithelialisation
  - Over granulation
  - Other – Bone / Fat / Tendon / Muscle ▲

**Inflammation/Infection**

- Odour present – Yes / No?
- Erythema to wound margins? Yes / No
- Spreading cellulitis? Yes / No
- Wound swab taken? Yes / No / N/A
- Temperature

**Moisture/Wound Exudate**

*May indicate local or spreading infection

- Levels (Dry / moist / wet / saturated)
- Colour (Clear / blood stained ● / green ●)

**Edge**

- Please record maximum dimensions in cm
  - Length
  - Width
  - Depth
  - Ankle Circumference
  - Calf Circumference

**Surrounding Skin**

- Healthy & intact
- Macerated
- Blistering
- Fragile
- Excoriation
- Dry skin

**Pain (0-10)**

- Generally
- Frequency
- At dressing change

**Wound Status**

- Improving / Static / Deteriorating

**Signature**

**NB** ▲ May be significant signs of osteomyelitis

● May be significant signs of clinical infection

- 2 weekly review; refer to Tissue Viability Service If no improvements when using antimicrobial primary dressing.

Please complete Quality of life template at 4 weeks.
## WOUND CARE ASSESSMENT CHART – RIGHT LEG

**Date of next assessment:** ........................................

**(due 12 weeks from last assessment)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Week</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
</table>

### TISSUE - Please state (out of 100%) percentage of tissue on wound bed

- Granulation
- Necrotic
- Slough
- Epithelialisation
- Over granulation
- Other – Bone / Fat / Tendon / Muscle

### INFLAMMATION/INFECTION

- Odour present – Yes / No
- Erythema to wound margins? Yes / No
- Spreading cellulitis? Yes / No
- Wound swab taken? Yes / No / N/A
- Temperature

### MOISTURE/WOUND EXUDATE *May indicate local or spreading infection

- Levels (Dry / moist / wet / saturated)
- Colour (Clear / blood stained / green)

### EDGE - Please record maximum dimensions in cm

- Length
- Width
- Depth
- Ankle Circumference
- Calf Circumference

### SURROUNDING SKIN

- Healthy & intact
- Macerated
- Blistering
- Fragile
- Excoriation
- Dry skin

### PAIN (0-10)

- Generally
- Frequency
- At dressing change

### WOUND STATUS

- Improving / Static / Deteriorating

**Signature**

---

**NB**

- **May be significant signs of osteomyelitis**
- **May be significant signs of clinical infection**
- 2 weekly review; refer to Tissue Viability Service If no improvements when using antimicrobial primary dressing.
- Please complete Quality of life template at 4 weeks.
# WOUND CARE TREATMENT PLAN

<table>
<thead>
<tr>
<th>Week</th>
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<tr>
<td><strong>Cleansing Regime</strong></td>
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<tr>
<td>Primary (contact) layer</td>
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All dressing regimes to be reviewed at 2 weeks to determine clinical effectiveness
# Wound Care Treatment Plan

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<thead>
<tr>
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<th>6</th>
<th>7</th>
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All dressing regimes to be reviewed at 2 weeks to determine clinical effectiveness.
Date of next assessment: ..........................
(due 12 weeks from last assessment)

| Date of next assessment: .................................  |
| (due 12 weeks from last assessment)                      |

<table>
<thead>
<tr>
<th>Date</th>
<th>Week</th>
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**TISSUE** - Please state (out of 100%) percentage of tissue on wound bed

- Granulation
- Necrotic
- Slough
- Epithelialisation
- Over granulation
- Other – Bone / Fat / Tendon / Muscle ▲

**INFLAMMATION/INFECTION**

- Odour present – Yes / No? ●
- Erythema to wound margins? Yes / No ●
- Spreading cellulitis? Yes / No ●
- Wound swab taken? Yes / No / N/A
- Temperature

**MOISTURE/WOUND EXUDATE** *May indicate local or spreading infection*

- Levels (Dry / moist / wet / saturated)
- Colour (Clear / blood stained ● / green ●)

**EDGE** - Please record maximum dimensions in cm

- Length
- Width
- Depth
- Ankle Circumference
- Calf Circumference

**SURROUNDING SKIN**

- Healthy & intact
- Macerated
- Blistering
- Fragile
- Excoriation
- Dry skin

**PAIN (0-10)**

- Generally
- Frequency
- At dressing change

**WOUND STATUS**

- Improving / Static / Deteriorating

**Signature**

**NB** ▲ May be significant signs of osteomyelitis

● May be significant signs of clinical infection

- 8 week review, calculate 40% healing rate and follow treatment algorithm.

- Please complete Quality of life template at 8 weeks and 12 weeks.
## WOUND CARE ASSESSMENT CHART – RIGHT LEG

<table>
<thead>
<tr>
<th>Date of next assessment: ......................... (due 12 weeks from last assessment)</th>
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</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td><strong>TISSUE</strong> - Please state (out of 100%) percentage of tissue on wound bed</td>
</tr>
<tr>
<td>Granulation</td>
</tr>
<tr>
<td>Necrotic</td>
</tr>
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<tr>
<td>Other – Bone / Fat / Tendon / Muscle</td>
</tr>
<tr>
<td><strong>INFLAMMATION/INFECTION</strong></td>
</tr>
<tr>
<td>Odour present – Yes / No?</td>
</tr>
<tr>
<td>Erythema to wound margins? Yes / No</td>
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<tr>
<td>Spreading cellulitis? Yes / No</td>
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<tr>
<td>Wound swab taken? Yes / No / N/A</td>
</tr>
<tr>
<td>Temperature</td>
</tr>
<tr>
<td><strong>MOISTURE/WOUND EXUDATE</strong> <em>May indicate local or spreading infection</em></td>
</tr>
<tr>
<td>Levels (Dry / moist / wet / saturated)</td>
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<td>Colour (Clear / blood stained / green)</td>
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<tr>
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<td>Calf Circumference</td>
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<tr>
<td><strong>SURROUNDING SKIN</strong></td>
</tr>
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<td>Healthy &amp; intact</td>
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<tr>
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<td><strong>PAIN (0-10)</strong></td>
</tr>
<tr>
<td>Generally</td>
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<tr>
<td>Frequency</td>
</tr>
<tr>
<td>At dressing change</td>
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<tr>
<td><strong>WOUND STATUS</strong></td>
</tr>
<tr>
<td>Improving / Static / Deteriorating</td>
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<tr>
<td>Signature</td>
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</tbody>
</table>

**NB** ▲ May be significant signs of osteomyelitis

▲ May be significant signs of clinical infection

8 week review, calculate 40% healing rate and follow treatment algorithm.

Please complete Quality of life template at 8 weeks and 12 weeks.
# Wound Care Assessment Chart – Left Leg

**PATIENT LABEL**

<table>
<thead>
<tr>
<th><strong>LEFT ABPI</strong></th>
<th>Date of next assessment:</th>
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<tr>
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<td>(due 12 weeks from last assessment)</td>
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<table>
<thead>
<tr>
<th><strong>LEFT TBPI</strong></th>
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<table>
<thead>
<tr>
<th><strong>Date</strong></th>
<th><strong>Week</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>TISSUE</strong></td>
<td>Tissue (out of 100%) percentage of tissue on wound bed</td>
<td>Granulation</td>
<td>Necrotic</td>
<td>Slough</td>
<td>Epithelialisation</td>
<td>Over granulation</td>
</tr>
<tr>
<td><strong>INFLAMMATION</strong></td>
<td>Odour present – Yes / No?</td>
<td>Erythema to wound margins? Yes / No</td>
<td>Spreading cellulitis? Yes / No</td>
<td>Wound swab taken? Yes / No / N/A</td>
<td>Temperature</td>
<td></td>
</tr>
<tr>
<td><strong>MOISTURE/WOUND EXUDATE</strong></td>
<td><em>May indicate local or spreading infection</em></td>
<td>Levels (Dry / moist / wet / saturated)</td>
<td>Colour (Clear / blood stained / green)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EDGE</strong></td>
<td>Please record maximum dimensions in cm</td>
<td>Length</td>
<td>Width</td>
<td>Depth</td>
<td>Ankle Circumference</td>
<td>Calf Circumference</td>
</tr>
<tr>
<td><strong>SURROUNDING SKIN</strong></td>
<td>Healthy &amp; intact</td>
<td>Macerated</td>
<td>Blistering</td>
<td>Fragile</td>
<td>Excoriation</td>
<td>Dry skin</td>
</tr>
<tr>
<td><strong>PAIN (0-10)</strong></td>
<td>Generally</td>
<td>Frequency</td>
<td>At dressing change</td>
<td></td>
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</tr>
<tr>
<td><strong>WOUND STATUS</strong></td>
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</table>

**NB**  
May be significant signs of osteomyelitis  
- May be significant signs of clinical infection  
- Please complete Quality of life template at 8 weeks and 12 weeks.
# WOUND CARE ASSESSMENT CHART – RIGHT LEG

<table>
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<th>PATIENT LABEL</th>
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<table>
<thead>
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<table>
<thead>
<tr>
<th>TISSUE - Please state (out of 100%) percentage of tissue on wound bed</th>
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<tr>
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<td>Necrotic</td>
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**NB**  ▶️ May be significant signs of osteomyelitis

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Please complete Quality of life template at 8 weeks and 12 weeks.
# Wound Care Treatment Plan

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## Cleansing Regime
- Bucket wash Oilatum Plus Irrigation with Octenalin. Specific individual patient requirements

## Treatment Aim
- State objectives of treatment. Healing/maintenance/symptom control

## Dressings Selected
- **Primary (contact) layer**
- **Secondary (outer) dressing**
- **Compression level used** 20mmHg / 40mmHg / awaiting or declined Doppler
- Please state type of compression bandage selected (Refer to Leg Ulcer Pathway)

## Special Considerations
- May include patient advice provided, particular patient requests, e.g. leg elevation
- Skin care regime, emollients/topical steroids/barrier creams
- Specific leaflets given – NICE/Trust guidelines

## Frequency of Dressing Change
- For example: daily/twice weekly

## Treatment Evaluation Due
- Frequency of planned evaluation for potential change in treatment
- Date of treatment evaluation due

## Signature

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All dressing regimes to be reviewed at 2 weeks to determine clinical effectiveness.
## WOUND CARE TREATMENT PLAN

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<tr>
<td>Secondary (outer) dressing</td>
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</tbody>
</table>

*All dressing regimes to be reviewed at 2 weeks to determine clinical effectiveness*
# Wound Care Assessment Chart – Left Leg

**Manchester University**

**NHS Foundation Trust**

**Wound Care Assessment Chart – Left Leg**

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>LEFT ABPI</strong></td>
<td>.........................</td>
<td>Date of next assessment: .........................</td>
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<tr>
<td><strong>LEFT TBPI</strong></td>
<td>.........................</td>
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</table>

<table>
<thead>
<tr>
<th>Week</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TISSUE</strong> - Please state (out of 100%) percentage of tissue on wound bed</td>
<td></td>
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<tr>
<td>Granulation</td>
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<tr>
<td>Necrotic</td>
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<tr>
<td>Slough</td>
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<td>Epithelialisation</td>
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<td>Over granulation</td>
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<tr>
<td>Other – Bone / Fat / Tendon / Muscle ▲</td>
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</tr>
</tbody>
</table>

| **INFLAMMATION/INFECTION** |
| Odour present – Yes / No? ● |
| Erythema to wound margins? Yes / No ● |
| Spreading cellulitis? Yes / No ● |
| Wound swab taken? Yes / No / N/A |

| **MOISTURE/WOUND EXUDATE** *May indicate local or spreading infection* |
| Levels (Dry / moist / wet / saturated) |
| Colour (Clear / blood stained ● / green ●) |

| **EDGE** - Please record maximum dimensions in cm |
| Length |  |
| Width |  |
| Depth |  |
| Ankle Circumference |  |
| Calf Circumference |  |

| **SURROUNDING SKIN** |
| Healthy & intact |
| Macerated |
| Blistering |
| Fragile |
| Excoriation |
| Dry skin |

| **PAIN (0-10)** |
| Generally |
| Frequency |
| At dressing change |

| **WOUND STATUS** |
| Improving / Static / Deteriorating |

| Signature |

**NB** ▲ May be significant signs of osteomyelitis

● May be significant signs of clinical infection

16 week review; refer to Tissue Viability Service if not healed at 16 weeks or has not achieved 40% wound reduction.

Please complete Quality of life template at 16 weeks.
**WOUND CARE ASSESSMENT CHART – RIGHT LEG**

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<thead>
<tr>
<th>Date</th>
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<th>17</th>
<th>18</th>
<th>19</th>
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</thead>
<tbody>
<tr>
<td><strong>RIGHT ABPI</strong></td>
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<tr>
<td><strong>RIGHT TBPI</strong></td>
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<tr>
<td>Over granulation</td>
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<tr>
<td>Other – Bone / Fat / Tendon / Muscle ▲</td>
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<tr>
<td><strong>INFLAMMATION/INFECTION</strong></td>
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<tr>
<td>Odour present – Yes / No? ●</td>
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<tr>
<td>Erythema to wound margins? Yes / No ●</td>
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<tr>
<td>Spreading cellulitis? Yes / No ●</td>
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<tr>
<td>Wound swab taken? Yes / No / N/A</td>
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<tr>
<td>Temperature</td>
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<tr>
<td><strong>MOISTURE/WOUND EXUDATE</strong> <em>May indicate local or spreading infection</em></td>
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<tr>
<td>Levels (Dry / moist / wet / saturated)</td>
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<tr>
<td>Colour (Clear / blood stained ● / green ●)</td>
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<tr>
<td><strong>EDGE</strong> - Please record maximum dimensions in cm</td>
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<td>Length</td>
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<td>Depth</td>
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<tr>
<td>Ankle Circumference</td>
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<tr>
<td>Calf Circumference</td>
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<tr>
<td><strong>SURROUNDING SKIN</strong></td>
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<tr>
<td>Healthy &amp; intact</td>
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<tr>
<td>Macerated</td>
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<tr>
<td>Blistering</td>
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<tr>
<td>Fragile</td>
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<tr>
<td>Excoriation</td>
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<tr>
<td>Dry skin</td>
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<tr>
<td><strong>PAIN (0-10)</strong></td>
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<td>Generally</td>
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<td>Frequency</td>
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<tr>
<td>At dressing change</td>
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<tr>
<td><strong>WOUND STATUS</strong></td>
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<tr>
<td>Improving / Static / Deteriorating</td>
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<td>Signature</td>
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**NB** ▲ May be significant signs of osteomyelitis
● May be significant signs of clinical infection
16 week review; refer to Tissue Viability Service if not healed at 16 weeks or has not achieved 40% wound reduction.
Please complete Quality of life template at 16 weeks.
WOUND CARE ASSESSMENT CHART – LEFT LEG

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<tr>
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<tr>
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<table>
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<tr>
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<th>24</th>
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**TISSUE** - Please state (out of 100%) percentage of tissue on wound bed

- Granulation
- Necrotic
- Slough
- Epithelialisation
- Over granulation
- Other – Bone / Fat / Tendon / Muscle

**INFLAMMATION/INFECTION**

- Odour present – Yes / No?
- Erythema to wound margins? Yes / No
- Spreading cellulitis? Yes / No
- Wound swab taken? Yes / No / N/A
- Temperature

**MOISTURE/WOUND EXUDATE** *May indicate local or spreading infection*

- Levels (Dry / moist / wet / saturated)
- Colour (Clear / blood stained / green)

**EDGE** - Please record maximum dimensions in cm

- Length
- Width
- Depth
- Ankle Circumference
- Calf Circumference

**SURROUNDING SKIN**

- Healthy & intact
- Macerated
- Blistering
- Fragile
- Excoriation
- Dry skin

**PAIN (0-10)**

- Generally
- Frequency
- At dressing change

**WOUND STATUS**

- Improving / Static / Deteriorating

**Signature**

**NB** ▲ May be significant signs of osteomyelitis

▲ May be significant signs of clinical infection

24 week review, refer to Tissue Viability Service if not healed or previously referred at 16 weeks.

Please complete Quality of life template at 24 weeks
**WOUND CARE ASSESSMENT CHART – RIGHT LEG**

<table>
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<tr>
<th>Right ABPI</th>
<th>Date of next assessment:</th>
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<tbody>
<tr>
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<tbody>
<tr>
<td>Week</td>
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</table>

**Tissue** - Please state (out of 100%) percentage of tissue on wound bed

<table>
<thead>
<tr>
<th>Granulation</th>
<th>Necrotic</th>
<th>Slough</th>
<th>Epithelialisation</th>
<th>Over granulation</th>
<th>Other – Bone / Fat / Tendon / Muscle</th>
</tr>
</thead>
</table>

**Inflammation/Infection**

<table>
<thead>
<tr>
<th>Odour present – Yes / No?</th>
<th>Erythema to wound margins? Yes / No</th>
<th>Spreading cellulitis? Yes / No</th>
<th>Wound swab taken? Yes / No / N/A</th>
<th>Temperature</th>
</tr>
</thead>
</table>

**Moisture/Wound Exudate** *May indicate local or spreading infection*

<table>
<thead>
<tr>
<th>Levels (Dry / moist / wet / saturated)</th>
<th>Colour (Clear / blood stained / green)</th>
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</table>

**Edge** - Please record maximum dimensions in cm

<table>
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<tr>
<th>Length</th>
<th>Width</th>
<th>Depth</th>
<th>Ankle Circumference</th>
<th>Calf Circumference</th>
</tr>
</thead>
</table>

**Surrounding Skin**

<table>
<thead>
<tr>
<th>Healthy &amp; intact</th>
<th>Macerated</th>
<th>Blistering</th>
<th>Fragile</th>
<th>Excoriation</th>
<th>Dry skin</th>
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</thead>
</table>

**Pain (0-10)**

<table>
<thead>
<tr>
<th>Generally</th>
<th>Frequency</th>
<th>At dressing change</th>
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</thead>
</table>

**Wound Status**

<table>
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<tr>
<th>Improving / Static / Deteriorating</th>
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24 week review, refer to Tissue Viability Service if not healed or previously referred at 16 weeks.

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<tr>
<td>Date/Time</td>
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</tr>
<tr>
<td>Cleansing Regime</td>
<td></td>
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</tr>
<tr>
<td>Bucket wash Oilatum Plus Irrigation with Octenalin. Specific individual patient requirements</td>
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<tr>
<td>Treatment Aim</td>
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<tr>
<td>State objectives of treatment. Healing/maintenance/symptom control</td>
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</tr>
<tr>
<td>Dressings Selected</td>
<td></td>
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</tr>
<tr>
<td>Primary (contact) layer</td>
<td></td>
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<td>Secondary (outer) dressing</td>
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<td>Please state type of compression bandage selected (Refer to Leg Ulcer Pathway)</td>
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<tr>
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<tr>
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<tr>
<td>Date of treatment evaluation due</td>
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</tr>
</tbody>
</table>

**Signature**

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All dressing regimes to be reviewed at 2 weeks to determine clinical effectiveness
A wound (or cut, injury, ulcer) is a break to the skin that may be taking some time to heal. Please answer these questions about how you are coping with your wound.

1. Can you walk as well as you did before you had your wound?
   - Yes
   - Sometimes
   - No

2. Can you go out as easily as before you had your wound?
   - Yes
   - Sometimes
   - No

3. Do you eat well?
   - Yes
   - Sometimes
   - No

4. Are you able to have a shower or bath?
   - Yes
   - Sometimes
   - No

5. Are you able to wear clothes and shoes that you want to?
   - Yes
   - Sometimes
   - No

Name……………………………Date…………

Date of birth........................... NHS number

clear communication by Asist Illustrations by Laura Green
6. Do you get a good night’s sleep?

- Yes
- Sometimes
- No

7. Please circle the picture to show if you sleep in a bed or in a chair.

- Bed
- Chair

8. Please circle a number to show how your pain has been recently.

- No Pain
- Worst Pain

9. What medication do you take for your pain?

- Dependant on type of pain

10. Where do you get your support from?

- Social Support

11. How do you rate your overall quality of life?

- Please circle the number to show your answer

- 0 = worst quality of life
- 100 = best quality of life

For information please contact Julie Green at j.green@keele.ac.uk © 2017 Keele University. All rights reserved. This checklist has been developed by Nurses, Service Users and other stakeholders for use with adults with wounds. Development has been supported by the RCN Foundation Funding. Review date: February 2020
Quality of Life Wound Checklist

A wound (or cut, injury, ulcer) is a break to the skin that may be taking some time to heal. Please answer these questions about how you are coping with your wound.

1. Can you walk as well as you did before you had your wound?
   - Yes
   - Sometimes
   - No

2. Can you go out as easily as before you had your wound?
   - Yes
   - Sometimes
   - No

3. Do you eat well?
   - Yes
   - Sometimes
   - No

4. Are you able to have a shower or bath?
   - Yes
   - Sometimes
   - No

5. Are you able to wear clothes and shoes that you want to?
   - Yes
   - Sometimes
   - No

Name........................................Date..........  
Date of birth.......................... NHS number

Please answer these questions about how you are coping with your wound.
Name……………………………Date…………

Date of birth……………………… NHS number

6. Do you get a good night’s sleep?

7. Please circle the picture to show if you sleep in a bed or in a chair.

8. Please circle a number to show how your pain has been recently.

9. What medication do you take for your pain?

10. Where do you get your support from?

11. How do you rate your overall quality of life?
   Please circle the number to show your answer
   0 =worst quality of life  100 = best quality of life

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TREATMENT ROOM LEG ULCER PATHWAY

Aetiology

Is it mixed? (ABPI <0.8–0.6)

Yes

Can the patient apply a compression stocking?

No

2 x Compression Stocking Liners

British Class II or RAL (European) Class 1 (18 - 24 mmHg) Compression Stockings

Yes

Can the patient apply a compression stocking?

British Class II or RAL (European) Class 1 (18 - 24 mmHg) Compression Stockings

Yes

Measure for Leg Ulcer Kit

UrgoStart Plus Border under chosen compression

WOUND HEALED
Follow pathway for a healed leg ulcer

Is it venous? (ABPI 0.8–1.3)

Yes

Can the patient apply a compression stocking?

No

Refer to vascular

Is it arterial? (ABPI <0.6)

Yes

Measure for adjustable compression garment (ie Juxta wrap)

If there is local, spreading or systemic infection present please follow treatment algorithm for appropriate management and antimicrobial dressings
## RECURRENCE PREVENTION FOR HEALED ULCER:
### Compression Hosiery Details

<table>
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<tr>
<th>Date of review</th>
<th>Healed Date: ABPI/TBPI reading</th>
<th>ABPI / TBPI review date (at 3, 6, 12 months)</th>
<th>Hosiery</th>
<th>Class</th>
<th>Size + Colour</th>
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