WOUND CARE TODAY

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LEG ULCER ASSESSMENT

GETTING IT RIGHT FIRST TIME

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WOUND CARE TODAY

LIVE Q&A

SEND IN YOUR QUESTIONS BY COMMENTING ON THE VIDEO

URGO FOUNDATION

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GETTING IT RIGHT FIRST TIME: MASTERING THE ART AND SCIENCE OF LEG ULCER ASSESSMENT

WOUND CARE TODAY

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WHY ARE WE STILL TALKING ABOUT LEG ULCER ASSESSMENT?

- Data
- Patient stories
- National Wound Care Strategy Programme (NWCSP)
- Campaigns such as Legs Matter
- High turnover of staff

BUT – YOU are here today!

- Covid-19 pandemic
- Access to training
- Multiple skills to learn
- Leadership

WHY IS LEG ULCER ASSESSMENT SO IMPORTANT?

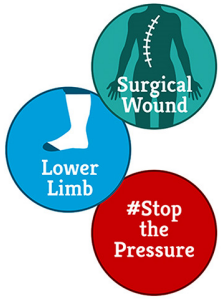
- It provides an holistic approach to looking at the condition
- It provides important information that will aid diagnosis and identify potential risks (healing and patient safety)
- It provides a platform from which a treatment plan can be formed
- It provides a baseline from which progress can be measured

How should leg ulcer assessment be carried out?

- Holistic/patient-centred — prepare your patient
- Systematic — it should flow
- Should trigger curiosity (reflection on action)
- It should make you use all your senses (touch, smell, listening, seeing)
- It should trigger ‘light bulb’ moments!
- Don’t be tempted to let the ‘what now’ little voice distract you. ***Concentrate on the here and now***
- Document as you go along, but don’t allow it to become a tick box exercise

PRE HOLISTIC ASSESSMENT — IMMEDIATE AND NECESSARY CARE

- Anyone presenting with a lower limb or foot wound
- Assess against five red flags
- Early detection of problems
- Early referral/intervention
- Start compression if red flags eliminated
- Immediate referral to a healthcare professional with additional skills in leg ulcer assessment if wound not healing (should be seen within 14 days)



National Wound Care Strategy Programme
Excellence. Every Patient. Every Time.

RED FLAGS

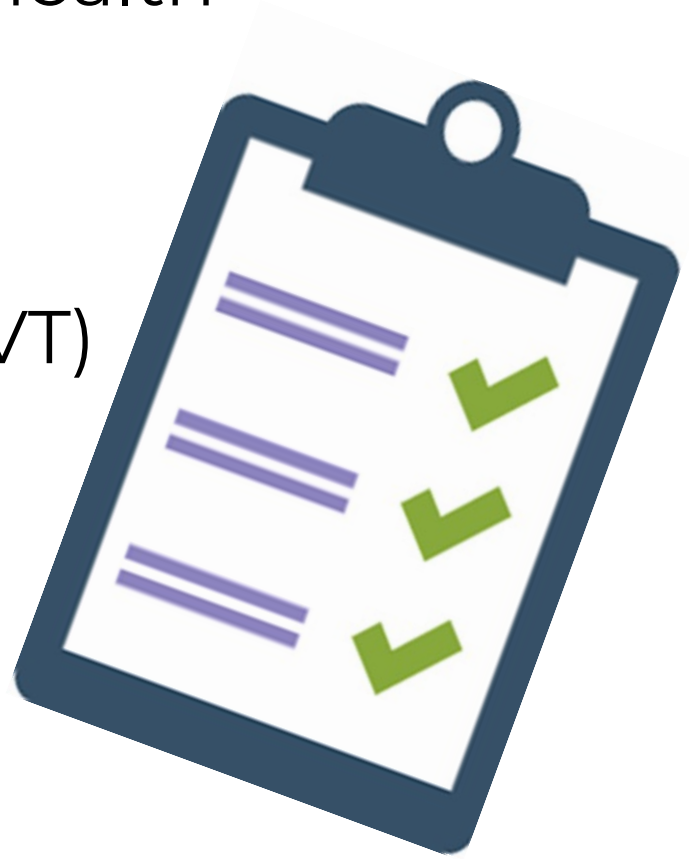
- Acute infection
- Sepsis
- Acute or chronic limb ischaemia
- Deep vein thrombosis
- Suspected malignancy

FUNDAMENTAL COMPONENTS OF HOLISTIC LEG ULCER ASSESSMENT

1. Patient assessment (intrinsic/systemic and extrinsic/external)
2. Lower limb/vascular
3. Wound

1. PATIENT ASSESSMENT — INTRINSIC/SYSTEMIC

- Status of patient's physical and mental health
- Underlying medical conditions
- Blood pathology
- Past history of surgery/trauma
- Past history of deep vein thrombosis (DVT)
- Consultations/referrals
- Medication
- Nutritional status
- Allergies
- Mobility/gait

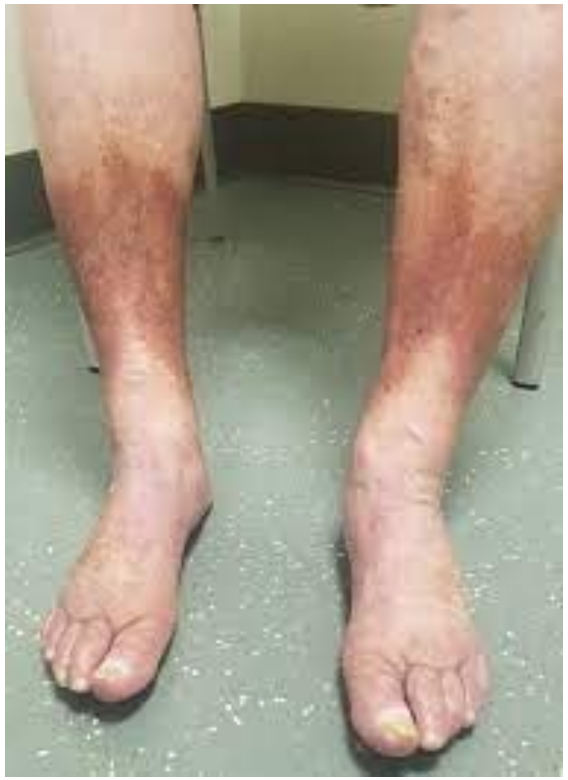


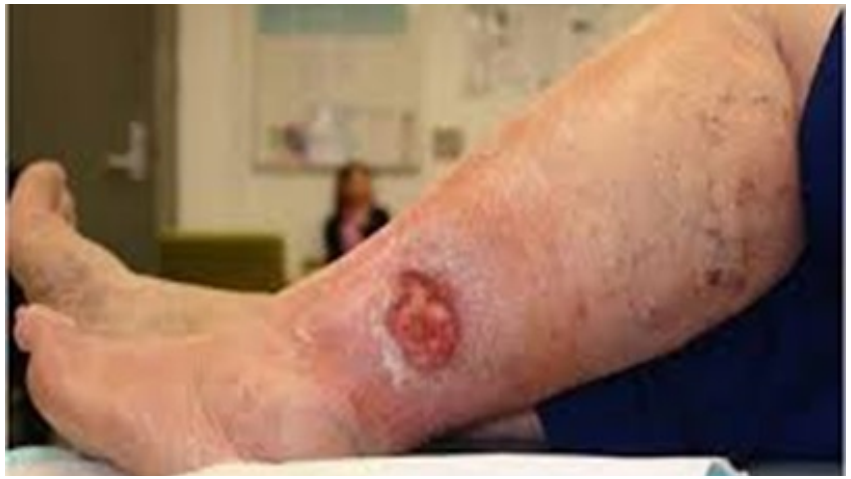
PATIENT ASSESSMENT — EXTRINSIC/EXTERNAL

- Environment
- Support network (family/friends)
- Are they a carer?
- Socioeconomic (job, pension, income)
- Lifestyle
  (smoking, drugs, alcohol, diet, exercise)
- Sleep
- Mobility/leg elevation
- Previous experiences of the health service
- Access to leg ulcer services
- Cultural factors/beliefs

2. LOWER LIMB/VASCULAR

- Skin changes
- Shape
- Swelling
- Veins
- Arterial status

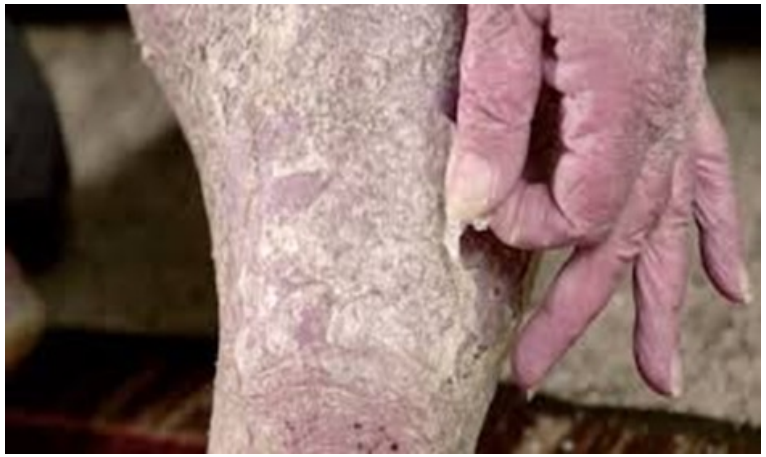


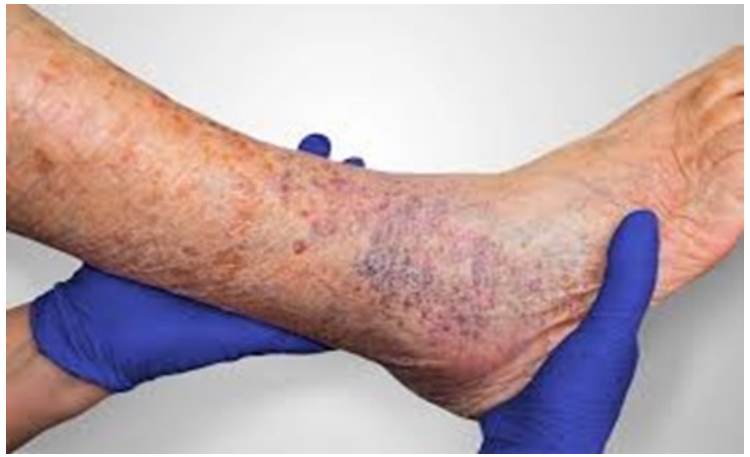


SKIN

- What does the skin feel and look like?
- Is it well hydrated or is it dry/flaky?
- Is it itchy?
- Is it weeping?
- Is it painful to the touch?
- Are there extremes of temperature (hot or cold?)
- Is the skin thin/fragile?
- Are there any lesions/spots present?
- Are there areas of scarring/previous ulcers?
- Presence of eczema
- Is the patient using any emollients/moisturisers on the legs?

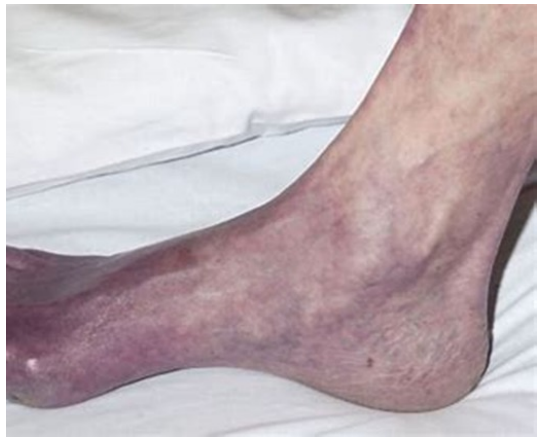
SKIN

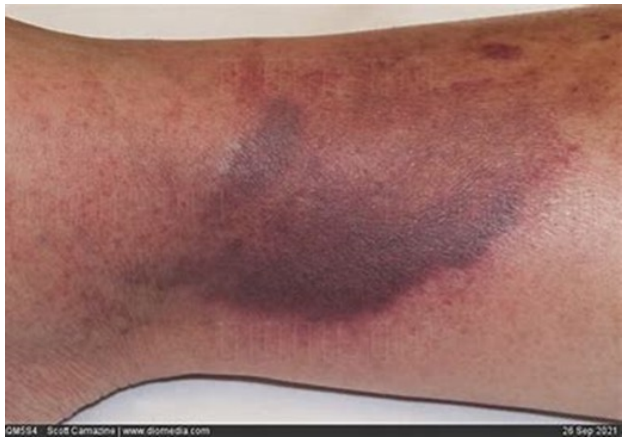


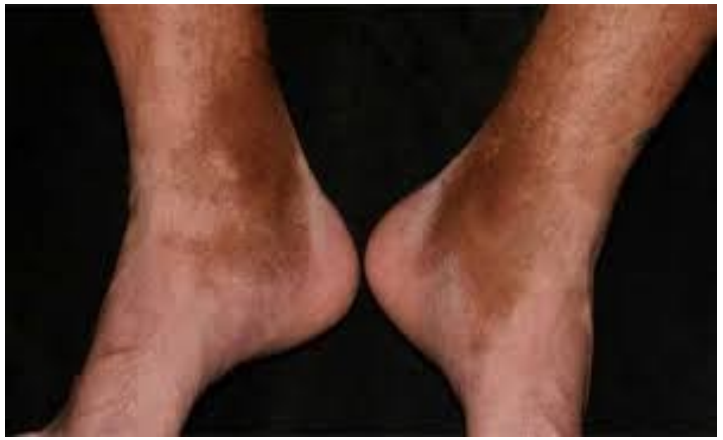


SKIN DISCOLORATION

- Is there discoloration of the skin? (red/brown staining)
- Are there purpuric marks present?
- Is there purple/blue mottling, particularly of the foot/toes?

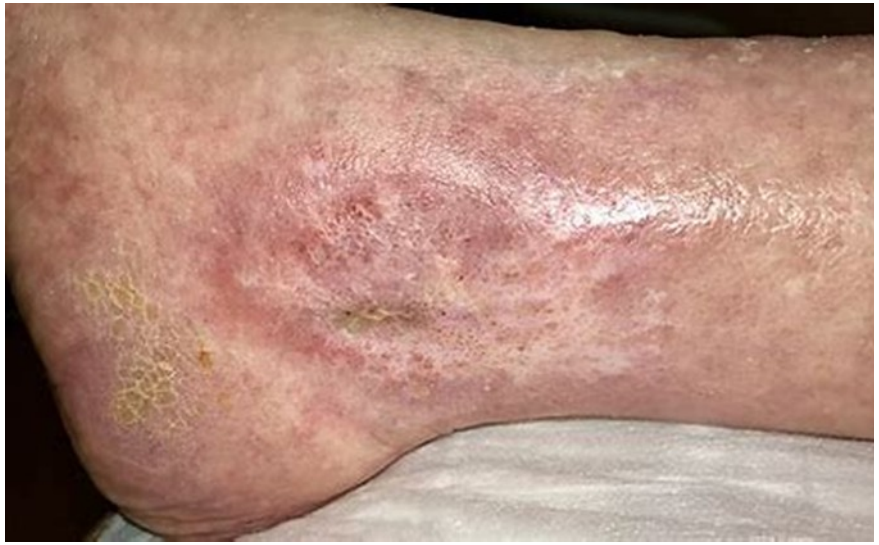


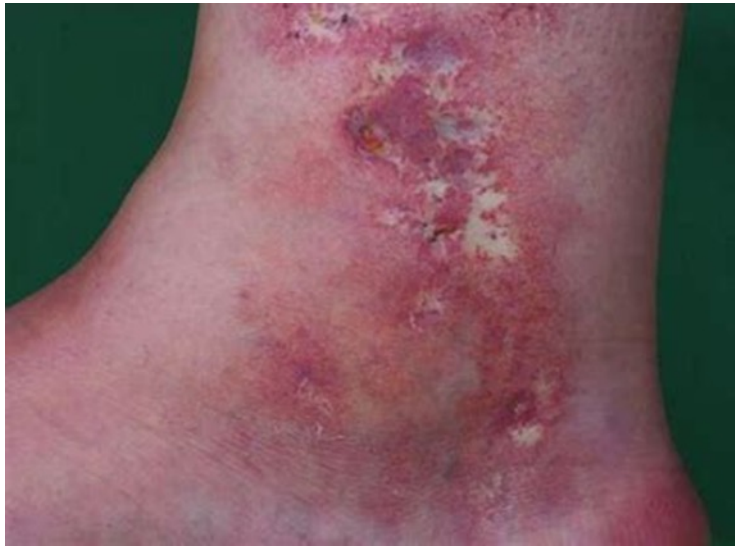




ATROPHIE BLANCHE

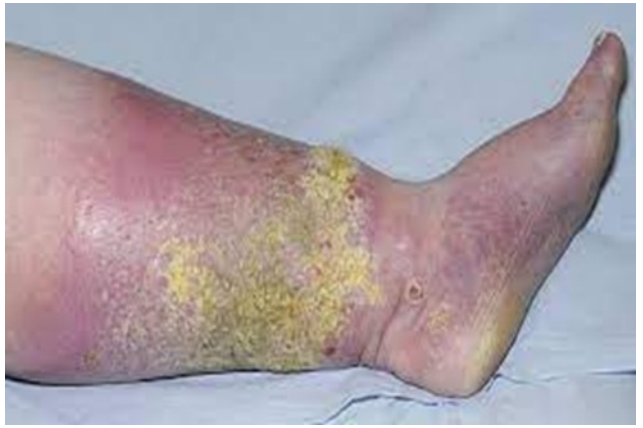
- Is there atrophie blanche?
- Can be mistaken for scarring
- Is it painful?

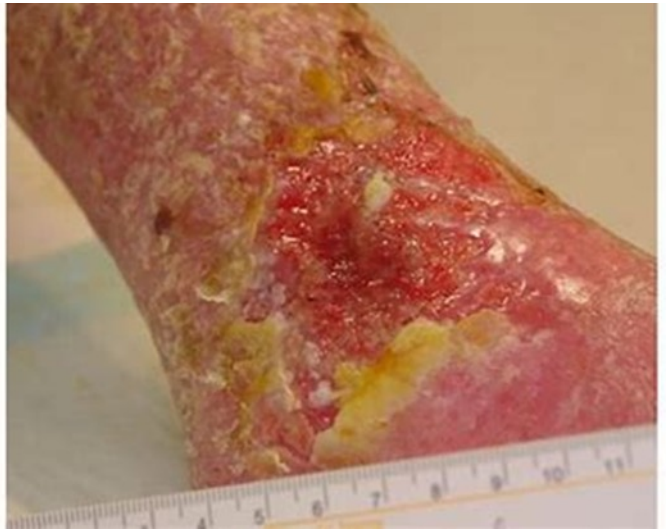


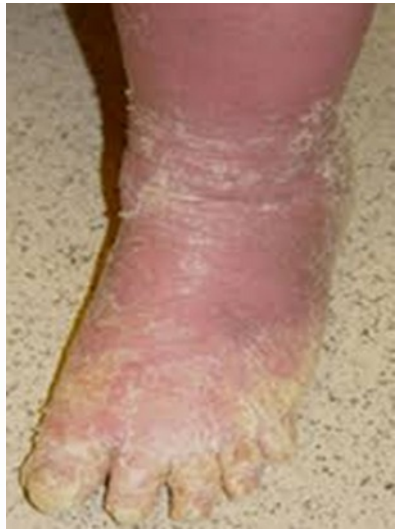


SKIN PLAQUES/HYPERKERATOSIS

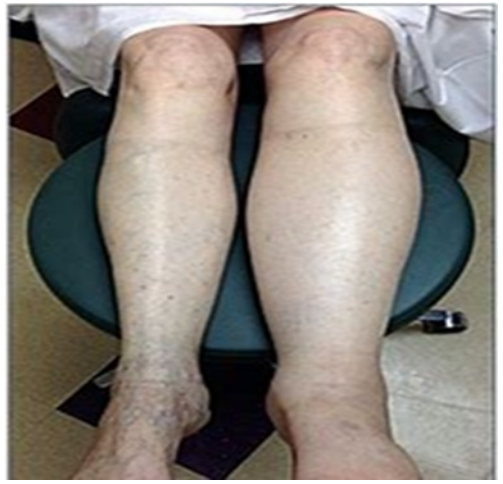
- Are there skin plaques?
- Where are they present?
- Is there any odour?
- Are they hard or soft?

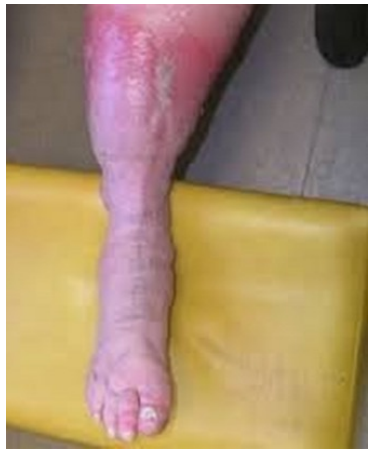




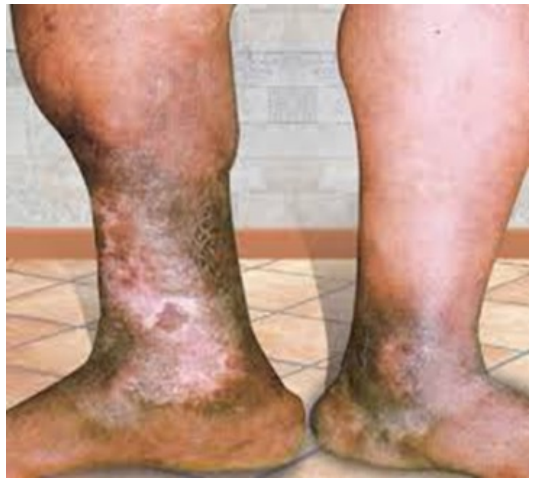


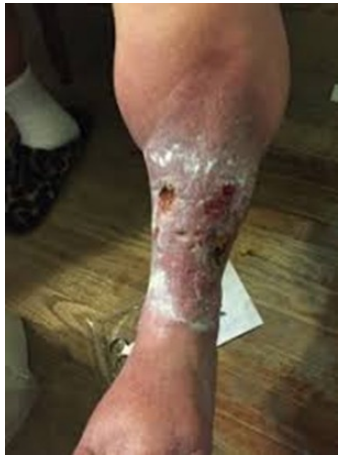
LIMB SHAPE





- Compare the two limbs — are they different?
- Has the limb got a significant shape deformity? Why?
- Is there a foot deformity? Why?
- How does this affect mobility?

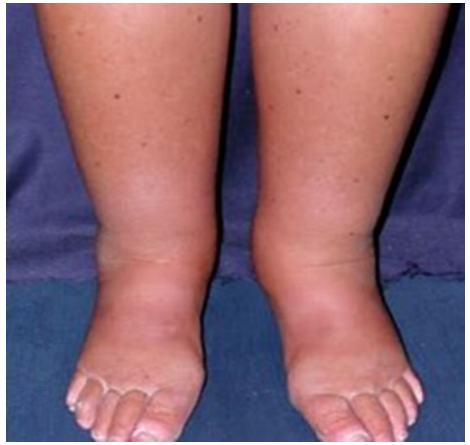


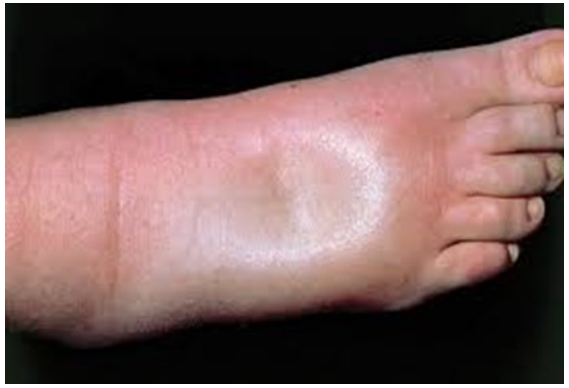


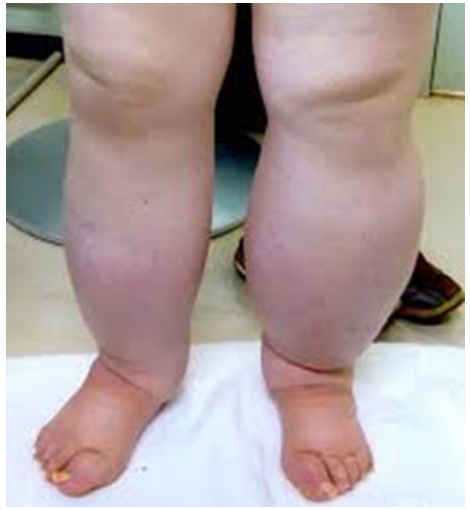
SWELLING

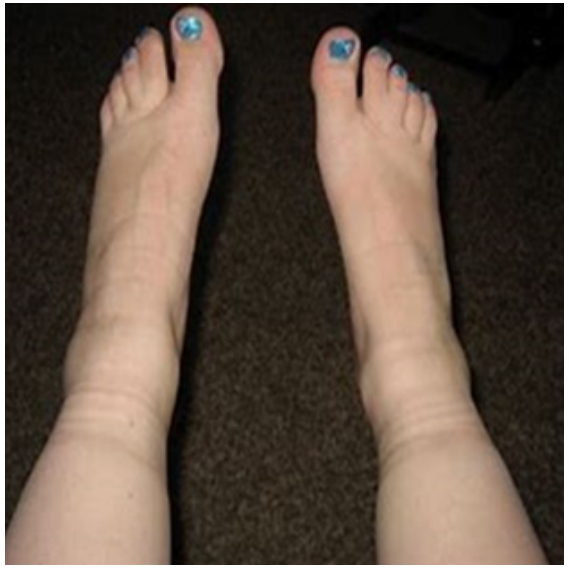
- Where is the swelling?
- Does it include the foot, below the knee, above the knee?
- What does it feel like?
- Is it soft or fibrotic?
- Is it painful when pressed?
- Is it leaking/weeping?
- Does it resolve at all over night?
- For how long has the patient had swelling?

SWELLING

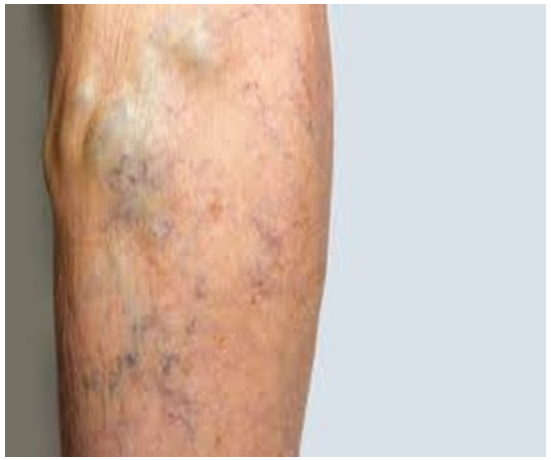


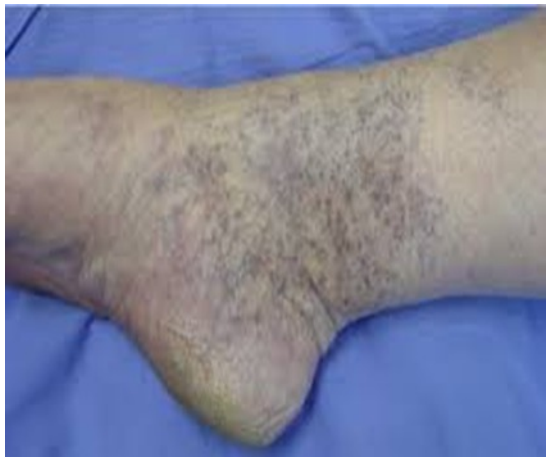


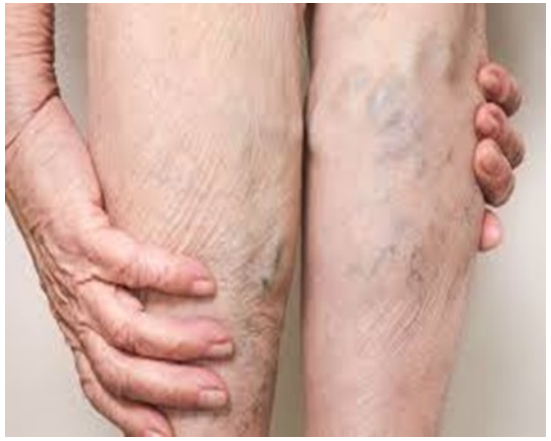




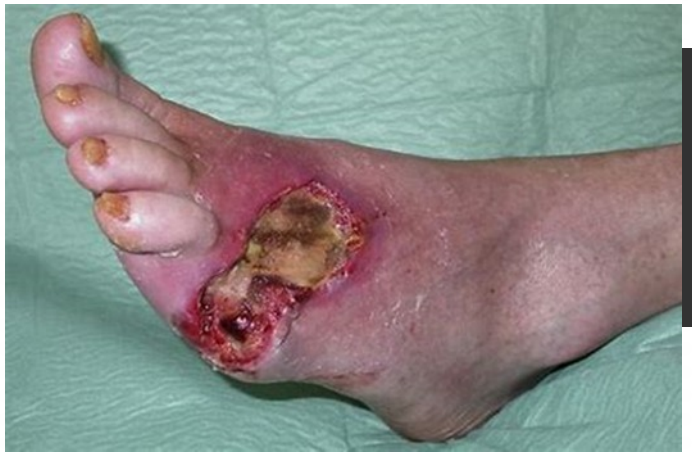
VEINS

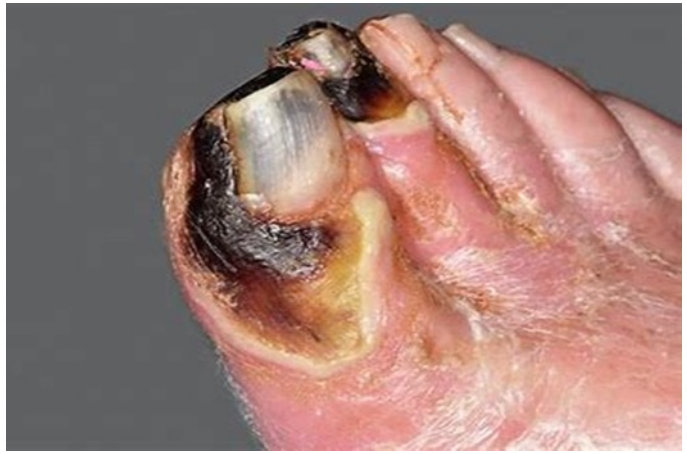


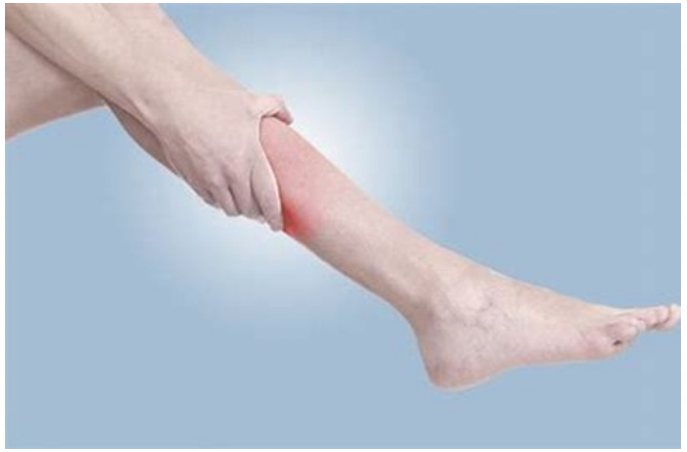




- Varicose veins — where?
- Are they painful?
- Spider type veins
- Ankle flare







ARTERIAL STATUS — LOOK FOR:

- Cool limb
- Pale skin
- Purple/blue mottled skin
- Evidence of gangrene (toes/feet)
- Pain on leg elevation
- Calf pain when walking
- Changes in skin colour when elevating and lowering the limb

ANKLE BRACHIAL PRESSURE INDEX (ABPI) DIAGNOSTIC

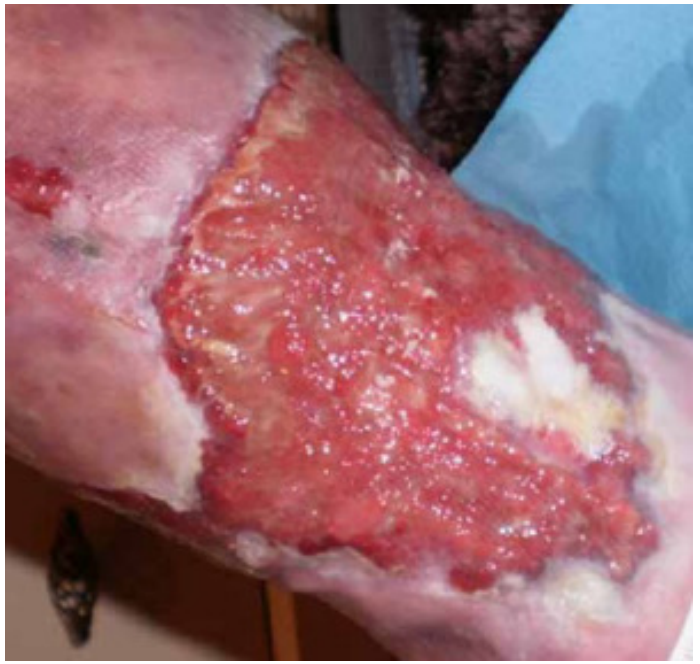
- To determine whether arterial disease is present
- Should be undertaken before applying compression therapy
- Hand-held or automated devices
- Listen to the sound waves (pulses)

ANKLE BRACHIAL PRESSURE INDEX (ABPI) DIAGNOSTIC CONTINUED

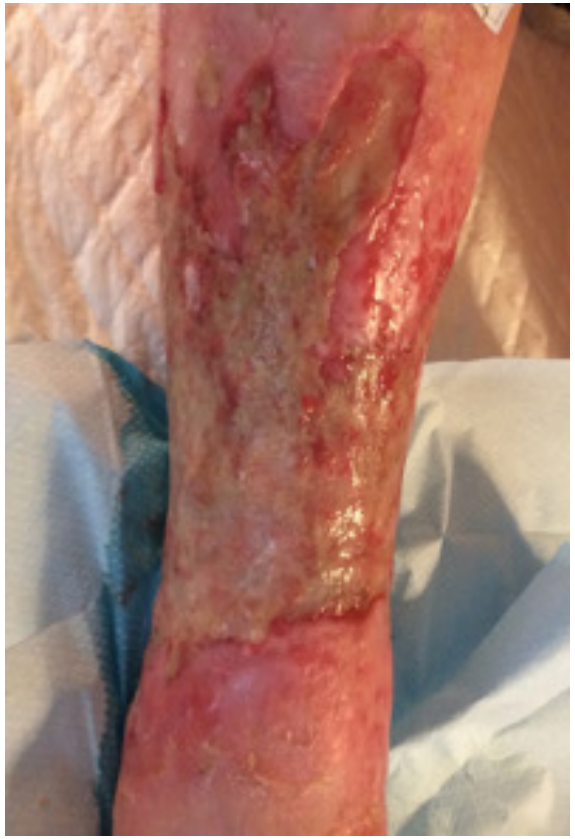
- Record result:
  - 1–1.3 = normal
  - 0.8–1 = mild arterial disease
  - 0.6–0.8 = moderate arterial disease
  - Under 0.6 = significant arterial disease
  - 1.3 and above = may suggest arterial calcification

3. WOUND ASSESSMENT

- Document where the wound is on the leg
- Take a measurement (cm^2 surface area or length/width)
- Photograph
- Does the wound look unusual?
  - Raised
  - Bleeding
  - Itchy
  - Use TIMES to assess



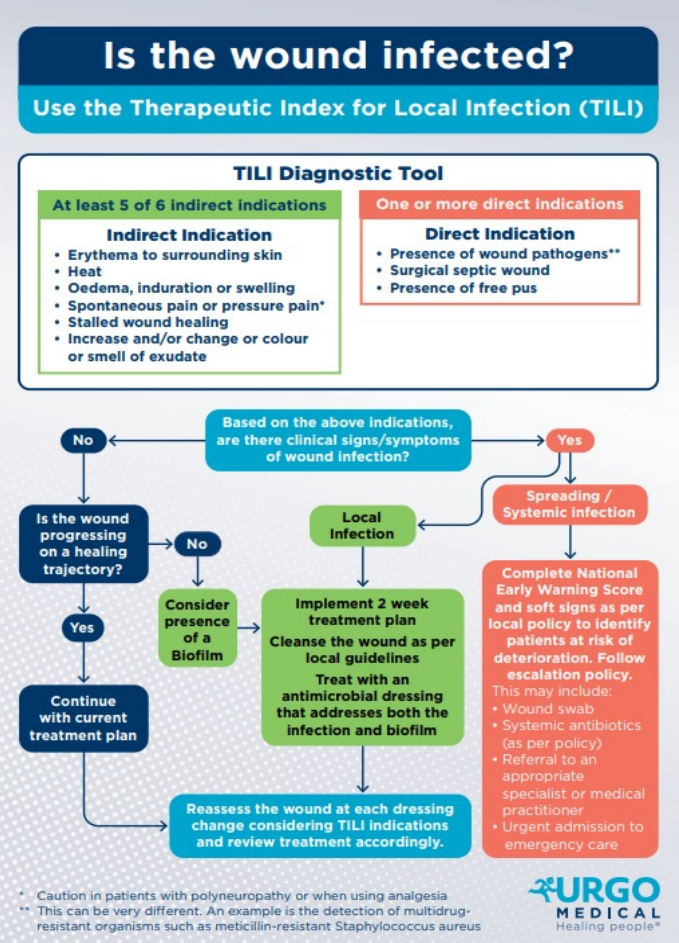
T = TISSUE TYPE



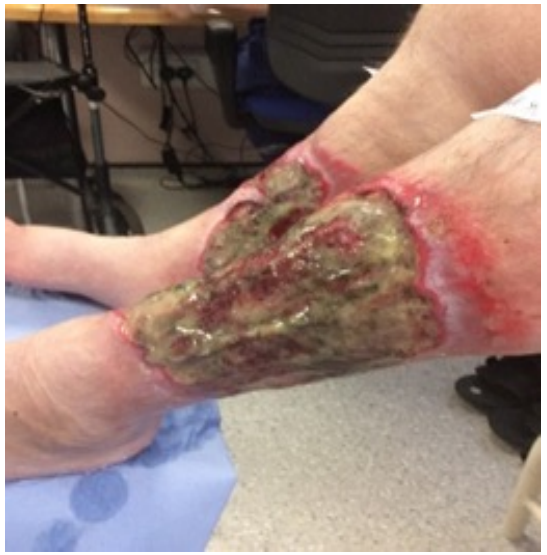
- Epithelial tissue
- Granulation tissue
- Slough
- Necrosis

- Can you work out the percentages of the tissue types?
- Photographs will capture this baseline

I = INFECTION/INFLAMMATION



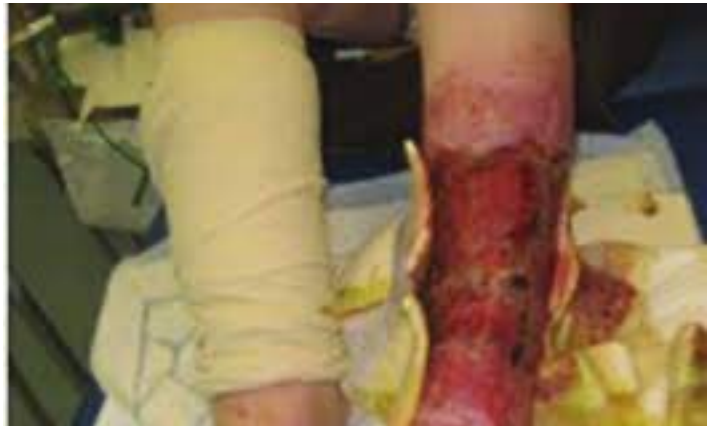
How can you tell?

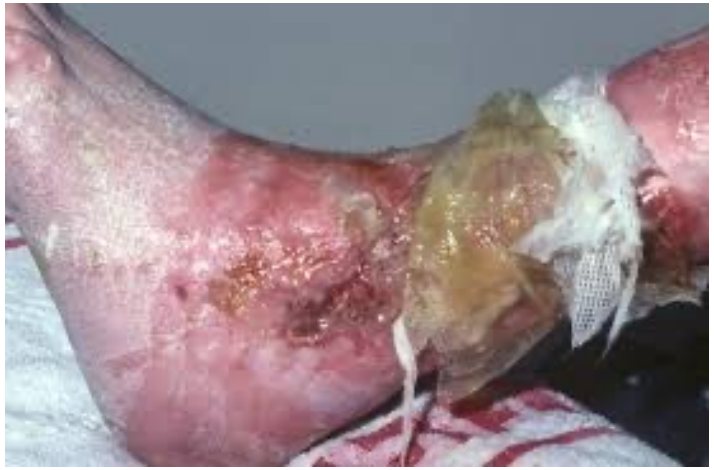


- Consider using an assessment tool
- Static or deteriorating wound
- Slough — colour
- Pus
- Increase in exudate — colour
- Increase in pain
- Odour
- Dull/dark granulation tissue
- Bridging
- Bleeding
- Bright red/shiny tissue can indicate inflammation
- Sepsis screening, e.g. NEWS (the deteriorating patient)

M = MOISTURE/EXUDATE

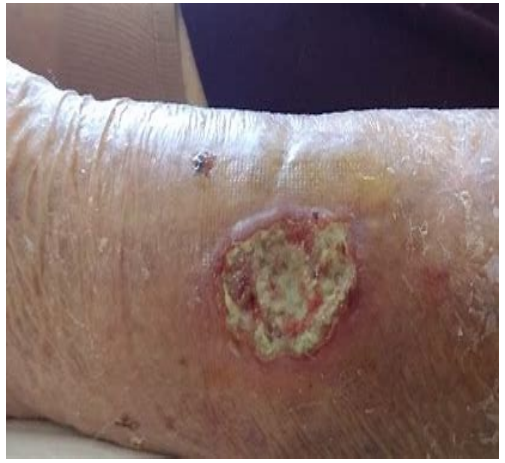
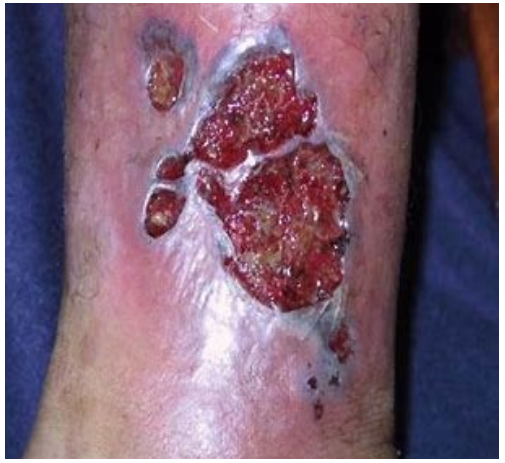
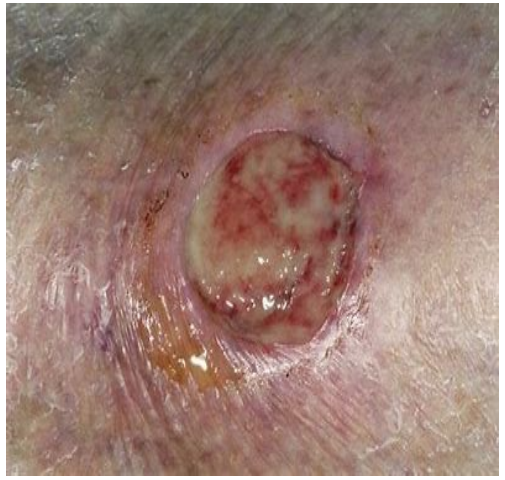
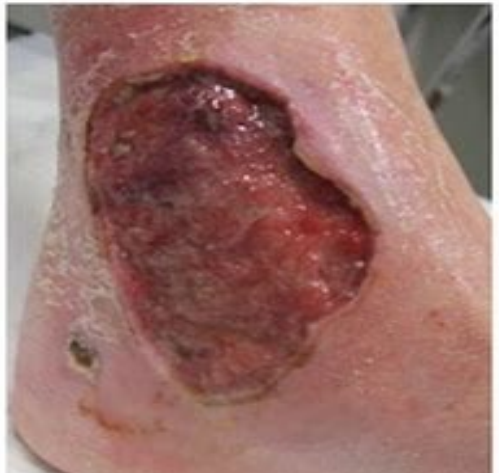
- Amount
- Is it normal for stage of healing?
- Colour
- Consistency
- Odour





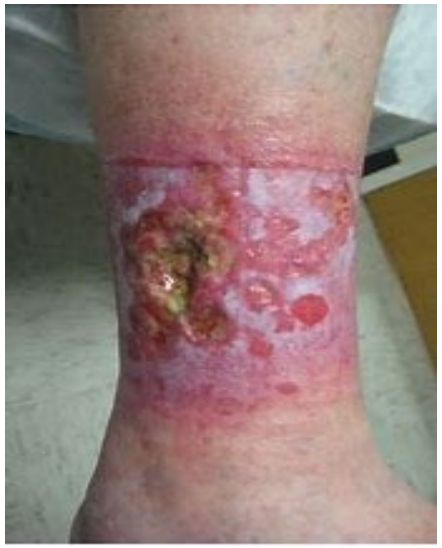
E = EDGE OF THE WOUND

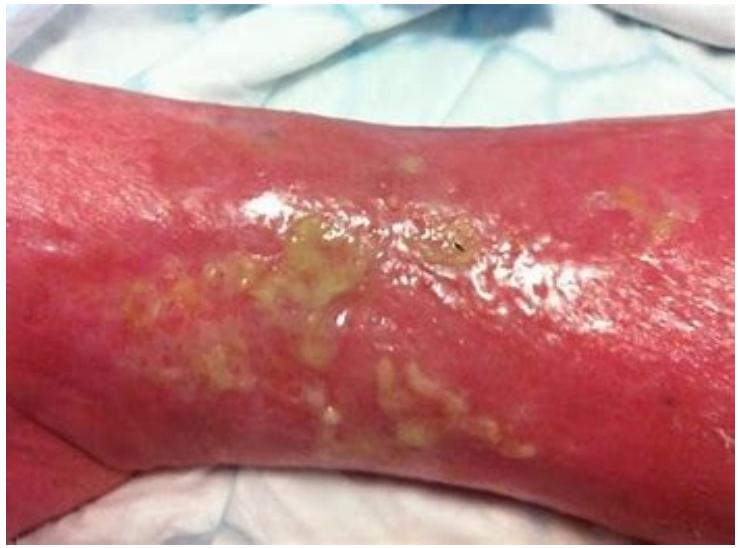
- Rolled — may be malignancy
- Fragile — need to protect with atraumatic dressings
- Dark (ischaemic)
- Purple (could be *Pyoderma gangrenosum*)

S = SURROUNDING SKIN

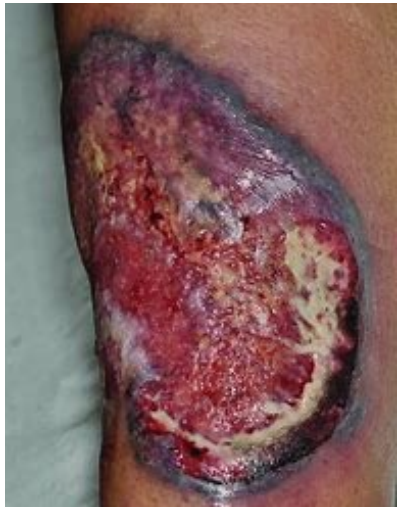
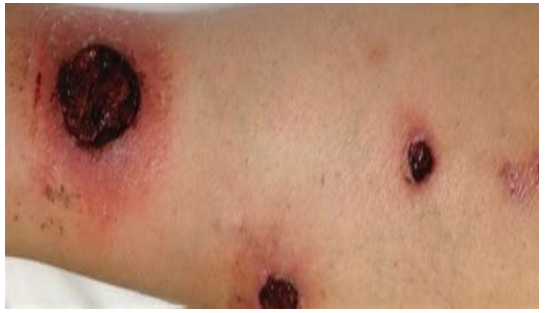
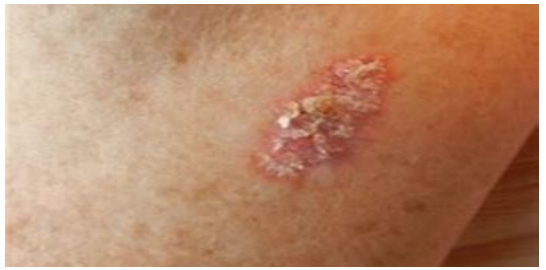
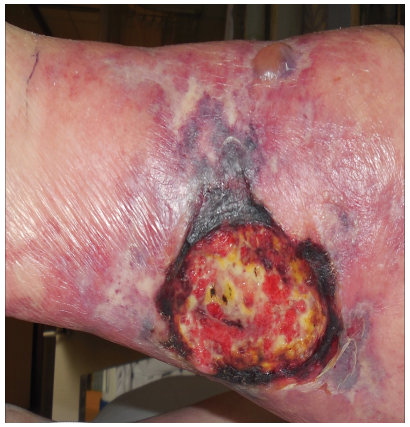
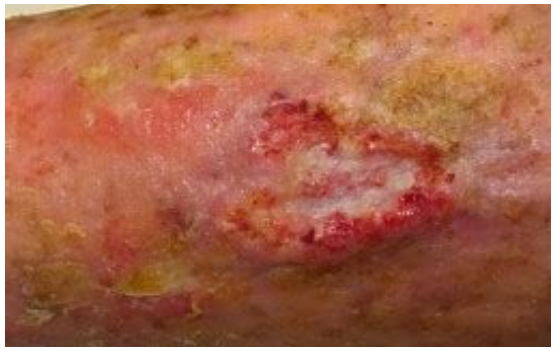
- Maceration — secondary to unmanaged exudate. Will impact on new epithelial cells migrating from the edges
- Excoriation — secondary to harmful exudate containing elevated matrix metalloproteinases (MMPs) and bacteria





IS IT WHAT YOU THINK IT IS?

- Consider the presentation
- Is it typical of ‘normal’ ulceration?
- Hypergranulation is unusual for leg ulceration
- Is the wound failing to progress despite best practice?
- If in doubt — REFER IMMEDIATELY

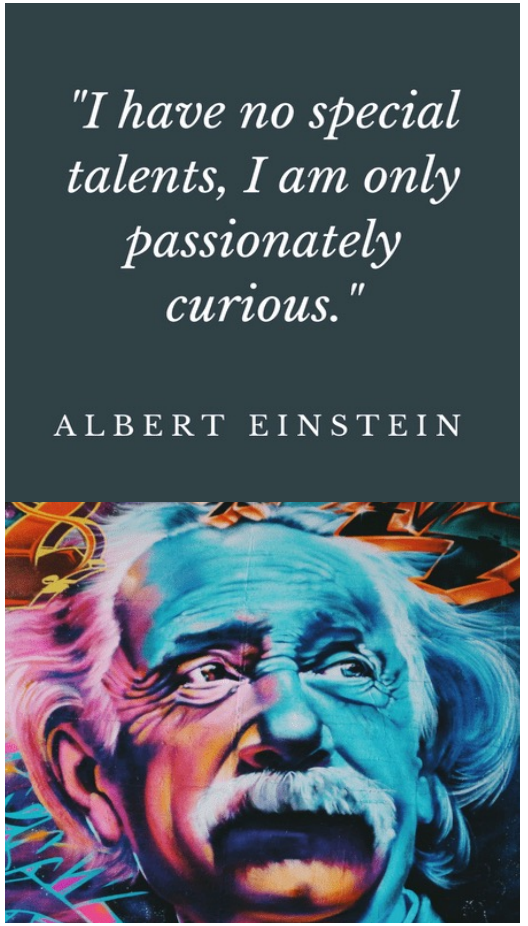






WHAT NOW?

- Collate all the information
- What is this information telling you?
- Are you able to make a diagnosis?
- What are your next steps?

IN SUMMARY

- Robust, holistic leg ulcer assessment is essential to aid correct diagnosis
- Adequate time should be allocated and the activity prioritised
- Don’t allow it to become a tick box exercise
- Be curious about what you are seeing
- Document your observations/findings
- Seek advice if unsure
- Involve your patient actively in this process
- Be confident



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