**Lower Limb Assessment Form**

**This should be completed in the following circumstances:**

* A new wound less than 4 weeks old between the knee and ankle
* Presence of a wound or pressure damage to the foot or heel
* If there is oedema in the leg, either full leg or below knee
* None of the above but to confirm a patient’s arterial status eg; diabetics or those with symptoms of claudication

This is in line with NICE guidelines (CG29, Pressure Ulcers: The management of Pressure Ulcers in Primary & Secondary Care and CG147, Lower limb Peripheral Arterial Disease: Diagnosis & Management), which states clinicians should be undertaking a lower limb assessment to determine the presence of disease that may impact on: **1.** The patient’s pressure damage prevention management plan or **2.** The patient’s ability to heal.

***The following table sets out the components of a lower leg vascular assessment***

|  |  |  |
| --- | --- | --- |
| **Assessment criteria** | **Rationale** | **Comments** |
| **Assess skin colour** in both limbs to determine any differences:  With patient supine, elevate the leg and note any colour changes. If it becomes pale within 30 seconds this is indicative of severe chronic arterial insufficiency.  Assess for areas of skin erythema (redness).  Does this blanch on pressure?  How quickly does the colour return? | When ischaemic, the dependant limb becomes red due to the chronic dilatation of the microcirculation distal to the arterial occlusion. Pallor on elevation and dependant rubor is known as Buerger’s sign.  Healthy limbs maintain their colour on elevation  Areas of skin erythema that do not blanch on pressure are likely to have damage to the micro circulation. This will be classed as category 1 pressure damage. | Nurse signature: Date: |
| **Assess for any changes in the skin including:**  Hair loss  Scaling  Thickening (Atrophy) of the subcutaneous tissue  Thickening of nails/ slow nail growth  Use the CHROSS checker tool to identify signs of lympho-venous disease; such as induration, skin folds, papilomatosis, ankle flare | Poor tissue nutrition/ oxygenation caused by chronic reduction in arterial blood supply results in skin changes.  Chronic oedema and venous hypertension cause certain skin changes which if present can be used to diagnose venous insufficiency. **Early intervention with compression will prevent long term complication such as leg ulceration.** | Nurse signature: Date: |
| **Assess for signs of skin damage,** particularly from injury.  Ulceration or necrosis may be present, particularly over pressure areas such as heels, dorsum of foot and metatarsal heads. | Poor tissue nutrition/ oxygenation caused by chronic reduction in arterial blood supply results in skin changes. | Nurse signature: Date: |
| **Assess for oedema.**  Examine for size, symmetry and presence of oedema.  Press the skin firmly for 5 seconds to identify whether it is pitting.  If oedema is present, has it been present for 3 months or more?  Do they have a positive stemmer sign? | Pitting oedema may indicate congestive cardiac failure or renal failure. Ischaemic rest pain may cause the patient to hold the limb dependant with associated oedema in the leg. The patient may sleep in the chair or hang the leg out of bed to gain relief.  Oedema which is present for 3 or more months is diagnosed as chronic oedema. This indicates some venous and/or lymphatic disease. This is not curable and will progress without a management plan, including compression | Nurse signature: Date: |
| **Assess skin temperature**  Ensure room temperature is not too cool.  Check both limbs for skin temperature – both limbs should be warm.  Start with the toes and work up the leg feeling symmetrically.  Note any changes in temperature and whether there is a gradual or abrupt change. There may be an obvious demarcation in temperature.  Assess for areas of the limb that have a rise in skin temperature | Severe arterial insufficiency will result in a cool limb.  A rise in skin temperature may indicate inflammation and/ or infection | Nurse signature: Date: |
| **Ankle Brachial Pressure Index (ABPI)**  Also known as Doppler test.  Refer to ABPI procedure for step by step instructions for carrying out this test. | This is a method of assessing the arterial blood supply to the legs.   |  |  | | --- | --- | | 1.0 – 1.3 | Normal | | 0.8 – 1.0 | Mild arterial disease | | 0.6 - 0.8 | Significant arterial disease | | < 0.6 | Severe arterial disease | | >1.3 | Medial wall calcification | | Nurse signature: Date: |
| **Pain/ sensation**  Assess for pain both at rest and on walking/ movement.  Assess where in the limb they experience pain. Ask patient to describe it.  What relieves the limb pain?  Assess for sensation. Is the limb/ foot numb? | Patients with peripheral arterial disease will commonly complain of intermittent claudication, described as calf pain brought on by exercise and relieved with rest.  Muscle groups distal to (Lower than) the arterial obstruction will become painful with a cramp like sensation, usually affecting calves first.  Rest pain caused by chronic arterial occlusion will limit mobility due to the severity of the pain. Sitting and sleeping in a chair at night may relieve discomfort, as gravity will assist the perfusion of blood into the foot.  In acute arterial occlusion, the limb may be numb and virtually paralysed. This is an indication of severe advanced ischaemia and rapid intervention is required. | Nurse signature: Date: |
| **Ankle movement**  Assess whether patient can flex and extend the foot/ toes.  Non ischaemic reasons for poor movement need ruling out such as arthritic conditions, oedema, and lack of use. | In chronic arterial insufficiency, muscle group function may be reduced by a compromised arterial blood supply. The ability to flex and extend foot maybe diminished. | Nurse signature: Date: |