**Mixed aetiology leg ulcer pathway decision tree**

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| **Assessment** | **Diagnosis** | **Peripheral vascular disease (PVD)** | **Diabetes** |
| Has a full leg ulcer assessment, including a Doppler been carried out?  **If no**, This should be done within 2 weeks of admission to caseload.  Do not apply compression until arterial status has been established.  **If yes** | Have you established an ABPI?  **If yes**, is this between 0.6 – 0.8?  **If yes**, were the sound waves (pulses) monophasic or ‘dampened/ sluggish’?  **If yes**, speak to the GP or contact tissue viability for advice before applying compression.  **If no…** | Has the patient got a diagnosis of PVD?  **If yes**, is the patient known to the vascular service?  **If yes**, do not apply compression before discussing with GP or vascular service.  If not known to vascular, discuss with GP before applying compression. | Has the patient got diabetes?  **If yes**, is the disease well managed and Hba1c within the accepted range?  **If no**, refer patient to GP/ Diabetes specialist nurse for review. |
| Is the patients ABPI greater than 1.3?  **If yes**, contact tissue viability for advice BEFORE applying compression. |
| Has Doppler not been possible because of patient related factors (Pain, anxiety, unable to occlude arteries)?  **If yes**, carry out a lower limb assessment, review medical history (i.e. has patient got PVD?) to establish arterial status.  Contact Tissue viability for advice if unsure. | Has the patient ever had an angioplasty or arterial bypass graft?  **If yes**, do not apply compression without discussing with GP or vascular service first. Refer to vascular letter/ report for information. |
| Is the patient known to the vascular service?  **If yes**, Is compression therapy indicated as part of treatment plan?  **If unsure,** discuss with GP, vascular service or tissue viability before applying compression. |

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| **Pain** | **Compression** | **Progression** | **PSAG** |
| Does the patient have pain?  **If yes**, is the pain worse on walking and eases at rest?  **If yes**, discuss with GP. This may be intermittent claudication and patient will require a referral to the vascular service.  **If no**, establish type of pain by carrying out a pain assessment and asking patient to describe the pain.   * Neuropathic * Nociceptive   Discuss pain with GP and put in place a pain care plan.  Monitor/ re-assess at each visit. | Is the patients ankle circumference less than 25cm?  **If yes**, use Ko Flex as the reduced compression bandage option | Have you taken a baseline measure of the ulcer/s using flexigrid and worked out surface area in cm²?  **If no,** this needs to be done and recorded in patient’s notes. | Following assessment, If not contraindicated, commence patient on mixed aetiology treatment pathway. |
| Has the patient been added to the PSAG board?  **If no**, ensure they are added.  Is all the information complete?  **If no,** ensure details are added. |
| Is the patient’s ankle circumference greater than 25cm?  **If yes**, use K – Two **reduced** as the reduced compression bandage option.  **Remember** – Due to the reduced arterial flow in mixed aetiology disease, bony prominences may be more susceptible to pressure.  Ensure areas such as the malleoli and tibial plateau (shin bone) are well padded with wool.  Contact tissue viability if you require any advice/ support. |
| Have you entered a 6 week reassessment date in Care Notes diary?  **If no**, this needs to be entered.  **Remember:** Surface area in cm² and percentage reduction needs to be worked out every 6 weeks.  If a 15% reduction has not been achieved, contact tissue viability for advice. |
| Has the patient been added to the purple section of the case load review tool?  **If no**, ensure this is done.  **Remember**: Once a patient has healed, the date they healed needs adding to the case load review tool immediately in order for us to capture accurate healing rates.  If the patient is removed for another reason, use the drop down box to state the reason why. |