Bristol Community Health

Integrated Care Pathway
Lower limb Care Pathway Form

Name:

Address:

General Patient Assessment

Past Medical History:	**Current medication & dose:**

Known drug allergies:			
Allergies to dressings / topical preparations including latex.			
Evidence of Neuropathy	**No**	**Yes:**	
BP:	**P:**	**HB:**	**Glucose:**
Other bloods:			

Venous Related Risk Factors									
	Left		**Right**			**Left**		**Right**	
Deep vein thrombosis	Y	N	Y	N	**Thrombophlebitis**	Y	N	Y	N
Past surgery	Y	N	Y	N	**Varicose veins**	Y	N	Y	N
Past venous surgery	Y	N	Y	N	**Prior venous ulceration**	Y	N	Y	N
Lower leg fractures	Y	N	Y	N	**Orthopaedic surgery**	Y	N	Y	N
Multiple pregnancies (3+)	Yes		No		**Any prolonged periods of bed rest**	Yes		No	
Venous Related Signs / Symptoms									
	Left		**Right**			**Left**		**Right**	
Varicose veins	Y	N	Y	N	**Pigmentation** (brown staining)	Y	N	Y	N
Induratation (hard woody feeling in skin)	Y	N	Y	N	**Varicose eczema** (wet or dry)	Y	N	Y	N
Atrophie blanche (white with red dots)	Y	N	Y	N	**Ankle flare** (broken capillaries)	Y	N	Y	N
Oedema	Y	N	Y	N	**Itching over varices**	Y	N	Y	N
Ulcer over malleolus	Y	N	Y	N	**Ulcer with gaiter area**	Y	N	Y	N
Aching or heaviness in legs	Y	N	Y	N					

Arterial Related Risk Factors						
Peripheral vascular disease	Yes	No	**Arterial surgery**		Yes	No
Rheumatoid arthritis	Yes	No	**Intermittent claudication**		Yes	No
Diabetes mellitus	Yes	No	**Angina**		Yes	No
Ischaemic heart disease	Yes	No	**Myocardial infarction**		Yes	No
Trans ischaemic attack	Yes	No	**CVA (Stroke)**		Yes	No
Smoker	Yes	No	**Amount & duration**			

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Arterial Related Signs / Symptoms									
	Left		Right			Left		Right	
Capillary refill time >3s	Y	N	Y	N	**Dusky skin colour on foot**	Y	N	Y	N
Foot / toes blanche when foot raised	Y	N	Y	N	**Cold foot**	Y	N	Y	N
Loss of hair on leg	Y	N	Y	N	**Atrophic, shiny skin on shin**	Y	N	Y	N
Muscle wasting in calf / thigh	Y	N	Y	N	**Thickened toe nails**	Y	N	Y	N
Ulcers on toes	Y	N	Y	N	**Gangrene on toes**	Y	N	Y	N
Loss of pedal pulses	Y	N	Y	N	**Pain in lower leg / foot when raised**	Y	N	Y	N
Is there any family history of above?									

Mobility:	Full mobility	Partial mobility	Mobile with aids	Immobile			
Does patient walk heel to toe?	**Yes**	**No**					
Ankle movement: Left	Mobile	Reduced	Fixed	**Ankle movement: Right**	Mobile	Reduced	Fixed
Is patient able to elevate legs?	Yes	No	**Does the patient sleep in bed?**			Yes	No
Please provide comments re patient mobility issues / sleeping difficulties:							
If mobility is affected consider referral to Physiotherapy							

Pain Assessment

Does the patient have pain?	Y	N	**At night**	Y	N	**At rest**	Y	N	**On movement**	Y	N	
Is sleep disturbed	Y	N	**Patients own description of pain: Creeping / Pins & Needles / Heaviness / Gnawing / Aching/Shooting/sickenin/punishing/Cruel/Splitting/Burning/stinging/stabbing. Other patients own words;**									
What helps to relieve pain?												
Current pain relief?												
What makes pain worse?												

Has the pain become worse in the last 2 weeks	**Yes**	**No**
Does the patient experience night pain in the lower limbs	**Yes**	**No**
Does hanging legs down help relieve the pain?	**Yes**	**No**
Has the pain affected the patients' activities of daily living?	**Yes**	**No**

Pain analogue scale 0 = No pain / 1- 2 = Mild pain /3 - 4 = Moderate pain / 5 - 6 = Severe pain / 7 - 8 = Very severe pain / 9 - 10 = Worst pain ever

	0	1 – 2	3 – 4	5 – 6	7 – 8	9 – 10	Constant	Intermittent
Day								
Night								
At dressing change								

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Doppler Assessment

Doppler Assessment Date: **Headphones used: yes/no**

Position of patient for readings: Supine / sat with legs raised / sat - legs downward angle (delete as appropriate)

Ideally patient should be lying supine for 15 minutes prior to commencing Doppler Assessment. Take the systolic brachial pressure in both arms and 2 of 4 of the following points

(**Key** – Tri – Triphasic / Bi – Biphasic / Mono – Monophasic

Use of Doppler for all pulses including brachial	**Strength**	**Sound**	**Left**	**Right**	**Sound**	**Strength**
Brachial						
DPA						
ATA						
PTA						
Pero						
A.B.P.I						

Calculation: $\frac{\textbf{Highest Ankle Pressure}}{\textbf{Highest Brachial Pressure}}$ **= A.B.P.I**

If A.B.P.I is equal to or greater than 0.8 and venous disease is determined to be the underlying aetiology, then compression is indicated.
If A.B.P.I is greater than 1.3 and monophasic consider referring the patient for vascular assessment
If A.B.P.I is less than 0.6 refer patient for vascular assessment
NB If the patient is diabetic possible calcification of medial artery wall may give a high reading

* Ankle brachial pressure index

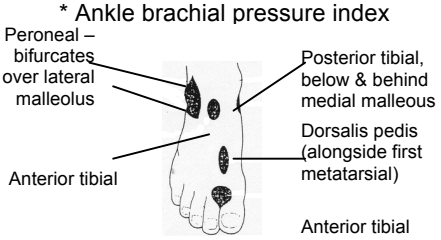
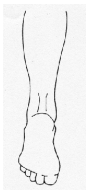
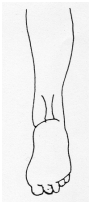


Diagram of Ulcer Position

	Left Medial View	**Posterior View**	**Anterior View**	**Left Lateral View**
Left Leg				
	Right Lateral View	**Posterior View**	**Anterior View**	**Right medial View**
Right Leg				

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Name:

Address:

Ulcer assessment

Date – Day / Month / Year						
Ulcer Number						
Site of ulcer						
Measurements in cms (width x length)	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**
Depth (superficial, dermal, deep dermal, tendon exposed, bone exposed etc)						
Wound Decreasing:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Nature of Wound: Healthy Granulation (Red) % /Epithelialisation						
Slough (Yellow) %						
Black Necrotic Tissue (Black) %						
Exudate: Colour						
Amount: Heavy / Med / None						
Odour: None						
Some						
Offensive						
Pain (site): Wound						
Check heels for pressure damage and advise						
Pain Frequency: D- Day / N – Night None						
Dressing changes only						
Intermittent						
Continuous						
Pain Severity**:** see assessment sheet for pain scale						
Condition of Surrounding Skin: Healthy intact						
Dry / Flaky						
Erythema						
Eczema**:** D – Dry / W - Wet						
Maceration						
Signs of infection (redness, inflammation, purulent discharge, pyrexia, patient unwell)						
Has wound been traced (T) or photographed (P)						
Ankle & Calf circumference						
Compression Therapy Applied	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Treatment Pathway						
Type of Compression System Used:						
Skin Care:						
Dressing used:						
Wound Assessed by: Initial / Sign						

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Lower limb Care Pathway Form

Name:

Address:

Date – Day / Month / Year						
Ulcer Number						
Site of ulcer						
Measurements in cms (width x length)	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**	**W –** **L –**
Depth (superficial, dermal, deep dermal, tendon exposed, bone exposed etc)						
Wound Decreasing:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Nature of Wound: Healthy Granulation (Red) % /Epithelialisation						
Slough (Yellow) %						
Black Necrotic Tissue (Black) %						
Exudate: Colour						
Amount: Heavy / Med / None						
Odour: None						
Some						
Offensive						
Pain (site): Wound						
Check heels for pressure damage and advise						
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Intermittent						
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Condition of Surrounding Skin: Healthy intact						
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Erythema						
Eczema**:** D – Dry / W - Wet						
Maceration						
Signs of infection (redness, inflammation, purulent discharge, pyrexia, patient unwell)						
Has wound been traced (T) or photographed (P)						
Ankle & Calf circumference						
Compression Therapy Applied	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Treatment Pathway						
Type of Compression System Used:						
Skin Care:						
Dressing used:						
Wound Assessed by: Initial / Sign						

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Consent for use of photographic material

At Bristol Community Health CIC we occasionally use photographs taken in hospitals, GP surgeries, health centres and other health authority funded locations to illustrate our leaflets, our annual report and for exhibitions to explain our role in the community. We might also want to use them as illustrations on out internet website in the future.

We would like to have your permission to take photographs of you/your relative so that we can publicise our work in this way. Your/your relative's name will not be used in any publication.

Please sign below if you are willing to give your permission to be photographed and for us to use the photograph.

Important notes: (tick if applicable)

Photographs to be used to support treatment		Photographs to be used for other specified purpose	
Photographs to be used for the education of health professionals			

Name			
Signature		Date	

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Nutrition

Does the patient eat a well-balanced diet (i.e. food from each of the following food groups: bread / cereals, fruit & vegetable, meat / alternatives, dairy products)					Yes	No
Does the patient have a reduced appetite					Yes	No
Does the patient appear: (please circle see BMI	Frail		Underweight	Normal	Overweight	
Is the patient well hydrated	Yes	No	**Is weight loss deliberate**		Yes	No
How much weight loss in last 3 months			**Over what period of time**			
Is this significant for the patient? If weight loss is significant, Nurse to do a nutritional assessment and refer to dietician. NB overweight patients may also benefit from dietician referral for weight reducing advice.	Yes	No	**Dietician referral indicated**		Yes	No

Podiatry

Does the patient receive Podiatry treatment	Yes	No	**If Yes where**	
Does the patient need Podiatry care?	Yes	No	**If Yes refer**	
Condition of Feet / Toes / Nails: L				
Condition of Feet / Toes / Nails: R				
Include details of previous amputations:				
Number of toes:	**Left Foot**		**Right Foot**	

Psychological Assessment

Consider details of the following in this section: Motivation, embarrassment, anxiety level, indifference, depression, coping strategies and any psychological impairment that may affect compliance with treatment e.g. dementia, learning difficulties. Also detail any behavioural problems that may impact on treatment and drug / alcohol dependency.

Consider Support & Social Network i.e. Family structure, carers, ability to assist with patient care, hobbies, interests, Social Services. Detail any attitudes and any avoidance of social activities due to leg ulcer.
Consider Patient goals and expectations Consider safe guarding, mental capacity and Non concordance.
Does the patient need to be referred to WCS **Yes/no**
Is the patient aware of the treatment plan and outcomes **Yes/No**
Have they received an information leaflet **Yes/No**

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Measuring For Compression Hose or Juxta

Date										
Leg Measurements	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**
Ankle circumference										
Calf circumference										
Below knee circumference										
Thigh circumference										
Below knee length *										
Thigh Length										
Foot length *										
Style *										
Open / Closed toe										
Size										
European / British										
Class 1 / 2 or 3										
Juxta/or similar appliance										
Date of renewal										
Manufacturer ready made										
Manufacturer made to measure										

Key

Style +	**BK** – Below knee	**TH** – Thigh high	**OT** – Open toe	**CT** – closed toe

NB – All boxes marked with * most patients will require below the knee stockings, they are as effective as thigh length, prescribe thigh length for patient choice or if they have varices above the knee. Foot length and below the knee length measurements are only needed for very tall or short people.

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Name:

Address:

Doppler Reassessment

Refer to Leg Ulcer Care Guidelines June 2016 if concerned as to how often this should occur.

Date:		Assessment completed by:		Position		
Use of Doppler for all pulses including brachial	Strength	Sound	Left	Right	Sound	Strength
Brachial						
DPA						
ATA						
PTA						
Pero						
A.B.P.I						
Ankle Circumference						

Date:		Assessment completed by:		Position		
Use of Doppler for all pulses including brachial	Strength	Sound	Left	Right	Sound	Strength
Brachial						
DPA						
ATA						
PTA						
Pero						
A.B.P.I						
Ankle Circumference						

Date:		Assessment completed by:		Position		
Use of Doppler for all pulses including brachial	Strength	Sound	Left	Right	Sound	Strength
Brachial						
DPA						
ATA						
PTA						
Pero						
A.B.P.I						
Ankle Circumference						

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Name:

Address:

Progress Notes

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Name:

Address:

Integrated Care Pathway

Lower limb Care Pathway Form

Date	Notes	Signature