

Barnsley tissue viability team

Community - 01226 645180

BHNFT - 01226 736126

Barnsley Podiatry Team

Community Podiatry - 01226 644315

BHNFT (Diabetic Foot Clinic) - 01226 435678

Legs must be washed at every dressing change. For housebound/inpatients, line a bowl with a plastic bag or use a disposable bowl, use warm tap water and an emollient to wash the leg. Dry skin scales and hyperkeratosis can harbour bacteria. Good hygiene is an essential part of leg ulcer management.

*Confirmed diabetic foot ulcers and ischaemic foot ulcerations to be thoroughly cleansed with prontosan/ saline.

Lower limb care

All patients who have a lower leg wound

or weeping legs should have a Doppler test and leg ulcer assessment no later than 2 weeks from onset.

Please follow the Leg Ulcer Care for Nurses guidance poster or the Chronic Oedema and Wet Legs Management Plan.

Aids in the management of wounds on lower legs

Ensure patients can maintain personal hygiene. Use wound care protectors such as Sealtight or Limbo. Special footwear can be an issued to enable the patient to mobilise safely, reducing the risk of falls. Debridement pads are effective in removing sloughy tissue and dead skin scales when washing legs.

Pressure ulcer classification









Category 1	Ca	tegory 2	Catego	ry 3	Category 4
		Pressure ulcer		Moisture lesion	
Cause		Pressure and/or shear		Moisture; shining wet skin	
Location		Usually over a bony prominence		May be over bony prominence, in skin folds, and cleft, peri-anal redness/skin irritation	
Shape		Circular or regular shape, limited to one spot. Exclude possible friction		Diffuse superficial spots or irregular shape	
Depth		Partial – full thickness, from grade 2 – grade 4		Superficial – partial thickness skin loss	
Necrosis		Present in full thickness pressure damage		No necrosis or eschar present	
Edges		Distinct edges demarcation	with clear	Diffuse, irregular edges	
Colour		Red, yellow, green, black		Redness that is not uniformly distributed	

Protocol 1

Melolin Softpore Tegaderm + Pad 365 Film Island Dressing (BDGH)

Protocol 2

Lomatuell Pro Duoderm extra thin Tegaderm transparent film

Protocol 5

Protocol 6

Actiform Cool Biatain Fibre

Protocol 3

Algivon Plus Algivon Ribbon Activon Tube Actilite Flaminal Forte/Hydro

Protocol 4

Algivon Plus Algivon Ribbon Activon Tube Actilite Flaminal Forte/Hydro

Protocol 7

Suprasorb P sensitive Urgo Absorb border – Skin Tear Pathway only

Zetuvit, Zetuvit +Silicone Biatain Silicone foam border/ non border

Protocol 8

Moderate to high levels exudate Eclipse – Non backed Convamax superabsorbent / adhesive

Protocol 9

Tissue viability

Tissue Viability TNP – Activac or Avelle Aguacell Ag+ Extra Larrvae therapy Medi Derma Pro range

Podiatry

Acticoat flex 3 and 7 Aquacel Aq+ extra Tegaderm Foam Adhesive Inadine

Dermatology

Hidrawear range

Malodorous wounds

Refer to protocol 3 and 4 Refer to Posies pathway

Cleansing and debridement

Follow Wound Cleansing pathway

Moisture associated skin damage

Follow MASD pathway

If you require a copy of this information in any other format or language please contact your line manager.

Wound management flow chart Community - Refer all Is the patient Is the wound diabetic foot ulcers to SPA diabetic? on a foot? BDGH - Refer all diabetic foot ulcers to High risk No foot team. Community - refer to community podiatry team. See Barnsley Podiatry BDGH – undertake routine wound care, if department foot any concerns regarding deterioration during referral pathway admission, refer to high risk foot clinic. Follow guidance for heel pressure ulcers Is there any ischaemia? Refer to Tissue Viability or Podiatry for review No before debriding If critical limb ischaemia refer urgently to vascular Take a swab and Are there any signs or A&E Yesrecord clinical of infection? observations, inform Doctor/ GP. Confirmed No infection from results /clinical Is there any sloughy Nosigns of infection? Is the wound No → necrotic tissue? clean? Yes Yes Yes Is the wound flat? **Protocol 3** Protocol 5 if the wound is shallow if the wound is shallow **Protocol 4 Protocol 6** Yes f the wound is if the wound is deep deep No If the wound is malodorous, additionally consider the use of odour reducing **Protocol 7 Protocol 1** dressings if the wound is if the wound is dry shallow and wet **Protocol 2** Refer to the **Protocol 8** beginning/seek if the wound is if the wound is advice deep and wet moist

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