HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

Surname:	First Name:
CHRIS #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

WOUND-VENOUS LEG ULCER CLINICAL PATHWAY

Venous Leg Ulcer (VLU): Characterized by edema of the legs with shallow irregular shaped wound(s) typically occurring on the medial or lateral distal lower leg. The ulcer is usually red but can also contain slough, yellow film or fibrin. Etiology of VLU is chronic venous hypertension. The failure of valves in the veins and/or ineffective calf muscle pump results in inadequate venous return from the legs

To be completed at least once weekly and/or with change in patient condition **This tool is used only as a guide and does not replace clinical judgment* Date/Initial:	✓ **where applicable; (N/A) where not applicable**			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including: wound, age of wound, previous history of wound, comorbidities, medications, immune status, vascular status and nutritional status.				
Perform and document weekly a comprehensive wound assessment identifying wound dimensions, wound bed appearance (need for debridement), exudate (amount and type), peri-wound appearance and calf circumference. Record percentage of weekly healing.				
Assess wound for signs/symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri-wound erythema greater than 2cm and report to PCP.				
Complete lower leg assessment including **ABPI**, with initial assessment, every 4-6 months and with wound deterioration, forward to Home and Community Care Support Services – North East. Inaccurate ABPIs may occur in patients with diabetes, renal failure or edema. Contact primary care provider (PCP) for referral for arterial dopplers if indicated by ABPI/assessment.				
Inspect skin for signs of breakdown. Identify causative factors at each visit and with any change in wound status.				
Perform and document a complete pain assessment.				
Complete nutritional assessment screening tool.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit, monthly and with wound deterioration.				
GOALS				
Wound will progress through the healing process.				
Wound will be protected from further complications.				
Patient factors contributing to infection will be addressed and mitigated (i.e. nutritional support, glycemic control, restoration of balance between host resistance and microorganisms).				
Patient will understand importance of lifelong compression therapy.				
Patient will have acceptable pain management.				

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COMPREHENSIVE ASSESSMENT				
Encourage patient/caregiver participation in developing individualized treatment plan and exploring self-management.				
WOUND TREATMENTS				
Apply compression dressing (do not compress patients with arterial insufficiency, refer to vascular specialty).				
Cleanse wound with potable water and wash lower leg with mild soap.				
Clean & pat peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated.				
Select dressing to manage moisture and bacterial load, control exudate and meet targeted frequency of dressing changes.				
WOUND TREATMENTS				
Wound with bioburden: Manage with antimicrobial dressing, filling dead space, undermining and tunnels loosely Options for exuding wounds include but are not limited to silver calcium alginate, silver hydrofiber, sustained release iodine, PHMB. Apply cover dressing i.e. foam or absorbent. Options for non-exuding wounds include but are not limited to nanocrystalline silver mesh moistened with water or hydrogel, cadexomer iodine, silver gel, PHMB. Apply cover dressing i.e. thin foam, hydrocolloid, transparent film. **Non-exuding wound without bioburden:** Apply primary dressing i.e. acrylic, hydrocolloid or hydrogel. Apply cover dressing if indicated i.e. foam, absorbent. **Exuding wound without bioburden**: Apply primary dressing may include calcium alginate, gelling fiber (hydrofiber). Apply cover dressing i.e. foam, absorbent.				
Manage bleeding in an exudating wound ie: calcium alginate, silver nitrate.				
Change dressing every 3-7 days depending on type of dressing used and amount of exudate.				
If chronic inflammation is suspected, consider protease inhibitor and/or NSWOC consultation.				
Consider if the wound meets the definition of a Chronic Maintenance wound: Wounds that fail to progress normally through the repair process (are present for at least 12 weeks and have not responded to wound specific pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue or patient lifestyle choices. These wounds fail to close in a timely manner or fail to result in durable closure. Please refer to Chronic Maintenance Clinical Guideline.				
Document variance if deviation from Clinical Pathway ie: frequency greater than every 3 days.				
MEDICATIONS				
Complete medication reconciliation.				

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COMPREHENSIVE ASSESSMENT				
Initiate systemic antibiotic/topical therapy as per PCP order.				
PAIN				
Support use of pre-procedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				
If patient complains of burning pain consider use of a thin layer of hydrogel onto wound bed.				
SELF-MANAGEMENT & EDUCATION				
Review with patient/family the pathophysiology of venous disease and leg ulcer development and promote choices that reduce incidence of recurrence including: Elevate legs whenever possible to reduce edema Do not cross legs, avoid scratching or damaging skin Keep active – walk in a heel-toe gait and do ankle exercises regularly to activate calf muscle Check skin regularly and moisturize daily using unscented products				
Promote importance of compression, and of adhering to lifelong compression therapy.				
Encourage daily intake to meet recommendations of Canada's Food Guide with focus on regular balances meals and adequate fluid intake (1.5-2L/day) unless contraindicated.				
Involve patient and family in care planning.				
REFERRALS				
PHYSIOTHERAPY: Request consult for Physiotherapist to initiate an effective exercise program that will maximize calf-muscle pump action, mobilization and ambulation techniques, fall prevention if appropriate.				
OCCUPATIONAL THERAPY: Request consult for Occupational Therapist to assess positioning and/or transfers to make appropriate device recommendations.				
DIETETICS: Request consult for Dietitian assessment if nutritional status implicates delayed wound healing and/or energy-protein malnutrition and/or identified need for diabetic diet teaching/monitoring.				
NURSES SPECIALIZED IN WOUND, OSTOMY & CONTINENCE: Refer according to wound/ostomy escalation process, which includes initial escalation to SPO Wound and Ostomy Care Champion PRIOR to NSWOC referral.				

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COMPREHENSIVE ASSESSMENT				
SOCIAL WORK: Request consult for socioeconomic challenges such as ineffective coping, financial issues, assistance with resources.				
DISCHARGE PLANNING				
Provide appropriate patient handbook and review appropriate teachings to support wound healing. Facilitate community referrals as indicated & provide education for lifelong compression where appropriate.				