Foot Ulcer Pathways - Secondary Care

Work down the pathway to guide you through the assessment, management and onward referrals required for Foot Ulceration. A Foot Ulcer is defined as skin loss that originates below the malleolus (ankle).

Red Flags	Emergency Actions Required
Clinical evidence of acute limb ischaemia (acute pain, pallor, pulseless, perishingly cold, paraesthesia / acute sensory change, paralysis / acute motor dysfunction for <2 weeks).	Refer urgently via switchboard to the Vascular on call Consultant. Cover the area with either a Biatain Silicone, Softpore or Atrauman and Safe Soft Bandaging.
Suspected Foot Ulcers with spreading infection (cellulitis).	Obtain a wound swab and arrange for antibiotics to be commenced. Dress with an anti-microbial, absorbent pad (If required) and follow the Safe Soft Bandaging Pathway. To follow DBTH Cellulitis guidance and consider a referral to the Vascular on call Consultant .
Suspected Charcot and/or Diabetic Foot Wound.	Refer urgently via switchboard to the Vascular on call Consultant. Cover the area with either a Biatain Silicone, Softpore or Atrauman and Safe Soft Bandaging AND Refer urgently to Podiatry rdash. podiatryreferrals@nhs.net. Title to email 'a diabetes in-pt', and provide the following information: NHS number, name, ward, the foot problem and the initiated plan.
Suspected Skin Cancer.	Refer to the Dermatology Department as per the 2 week wait protocol.
Amber Flags	**Urgent action Required**
Do you suspect poor arterial blood supply because the patient has either: • Constant pain in the foot (typically relieved by dependence and worse at night). • A non-healing wound of more than 2 weeks duration and / or gangrene on the foot.	Complete the Vascular Service – Peripheral Arterial Disease (PAD) / Chronic Limb- Threatening Ischemia Disease Referral From Send to: **dbth.vascular-admin@nhs.net**

Factors that will impact the healing process

- Vascular/ neurological deficit
- Co-morbidities such as Diabetes, Auto-immune diseases, Chronic Kidney Disease, Stroke,
- Peripheral Arterial Disease and Organ transplant.
- Lifestyle factors such as smoking, alcohol intake, nutrition, work/social activities and mobility
- Pressure from footwear, mattresses/ bed due to patient inability to reposition. Refer to the Pressure Ulcer Product Selection Pathway.

Assessment and Treatment

1. Follow the Pathway for Wound Cleansing and undertake and document a wound assessment.
2. Apply E 45 emollient to intact skin.
3. Identify the suspected Foot Ulcer type using the Foot Ulcer Diagnosis Guidance and follow below guidance
4.

A Foot Ulcer caused by Pressure WITHOUT Diabetes, Neuropathy, Ischemia or Infection.	**A Foot Ulcer NOT caused by Pressure. For example, Diabetic, Neuropathic, Ischemic, Traumatic**		
	50% or more granulation WITHOUT active infection:	**50% or more slough and necrosis AND/or at high risk of infection WITHOUT active infection:**	**Active infection:**
Follow the Pressure Ulcer Product Selection Guide.	UrgoStart Plus Pad and Cosmopore OR UrgoStart Plus Border	UrgoClean AG with either Cosmopore OR Biatain Silicone 3D	Acticoat Flex 3, with either Biatain Silicone 3D fit OR Kliniderm Pad and Safe Soft Bandaging.
	Change as per exudate either 3 days or 7 days.		Change every 3 days.

5. Off load the heels (heels off bed, heels off stool) and consider a HeelPro
6. Refer all wounds to the Skin Integrity Team
7. Complete Datix form if the patient has a pressure ulcer.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

National Wound Care Strategy Programme 2020, Lower Limb Recommendations for Clinical Care.
Developed by: Tissue Viability and Lymphoedema Service, The Skin Integrity Team, Vascular Nurse Specialist 2021. Updated December 2022. For Review June 2024.