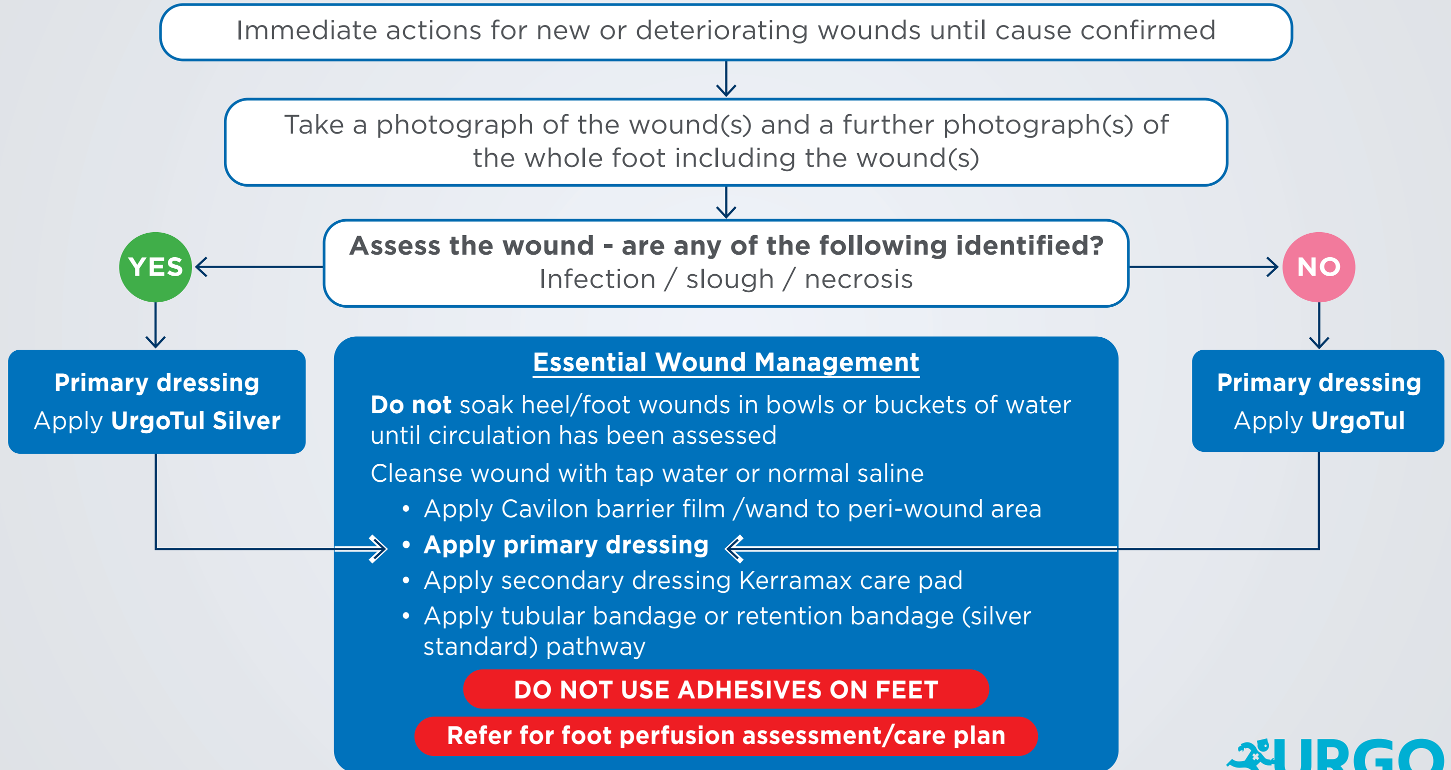
Heel/Foot Pressure Ulcer - Clinical Pathway

NHS
Great Western Hospitals
NHS Foundation Trust



See overleaf for guidance on infection and escalation process for pressure ulcers/ diabetic foot ulcer and ischaemic limbs.

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Infection guidance

One or more of these signs

- Redness/ Altered pigmentation (darker skin tones)
- Heat (surrounding skin)
- Increase in exudate
- Change in exudate colour/thickness
- Odour
- Change in granulation tissue: bleeding/friable/ unhealthy
- Increase in slough or necrosis
- Swelling
- Signs of systemic infection

Actions

- NEWS2 score
- Escalate to caseload holder/GP
- Take wound swab - if systemic antibiotics required

Actions and escalation process

Pressure Ulcers

- Renew risk assessment (Waterlow)
- Reassess MUST
- Complete aSSKINg bundle
- Complete Datix
- Complete PU categorisation template
- Complete Wound Assessment template

Add or increase interventions to reduce harm e.g. equipment

- **ESCALATE TO CASEHOLD HOLDER**
- **REFER TO TVN IF CAT 3/4 DTI OR UNSTAGEABLE**

Diabetic Foot Ulcer

Any new ulcer or chronic ulcer review (with any of the below):

- Erythema <2cm
- Bone/tendon involvement
- No acute cellulitis
- Dry gangrene

Refer to gwh.diabetesfootref@nhs.net

Foot Attack (with any of the below):

- Wet gangrene
- Erythema >2cm
- Cellulitis
- Hot swollen foot (with or without wound)

Out of hours: ADMIT A&E.

In hours: ADMIT SDEC &/or CALL GWH BLEEP 2614 (foot coordinator)

Ischaemic limb

Acute Ischaemic limb

- White cold
- Pulseless leg/foot

0300 422 2222 for On- call Vasc Blue Light to Gloucester Royal

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