

Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West CCAC contracted Community Nursing Agencies in the South West Local Health Integration Network.



Title	Guideline: The Management of People with Leg Ulcers
Background	<ul style="list-style-type: none"> See “Guideline: The Assessment of People with Leg Ulcers”
Indications	<p>This guideline is intended to be used by front line registered health care providers, to guide their management of individuals admitted with or presenting with a leg ulcer.</p>
Guideline	<p>NOTE: The management of a person with a leg ulcer follows either “The SWRWCP’s “Venous/Mixed Leg Ulcer Assessment and Management Algorithm” or “The SWRWCP’s Arterial Leg Ulcer Assessment and Management Algorithm”.</p> <p>Healable Wounds (venous and mixed leg ulcers where the person adheres to compression therapy and has no intrinsic, extrinsic or iatrogenic factors negatively affecting their ability to heal)</p> <ol style="list-style-type: none"> Upon completion of a thorough, holistic patient and wound assessment as per the SWRWCP’s “Guideline: The Assessment of People with Leg Ulcers”, and upon determination that the wound in question is ‘healable’, cleanse the wound as per the “SWRWCP’s Dressing Selection and Cleansing Enabler – HEALABLE” As you have previously determined that the wound is healable: <ol style="list-style-type: none"> Debride any loose, non-viable tissue in the wound and/or periwound callus, using techniques within your scope of practice (the exception is dry stable heel eschar – this should be managed in a maintenance fashion). See “Guideline and Procedures: Wound Debridement (excluding conservative sharp debridement)” and “Guideline and Procedure: Conservative Sharp Wound Debridement” Cleanse the wound again post debridement using the “SWRWCP’s Dressing Selection and Cleansing Enabler – HEALABLE”. Gently <u>pat</u> the wound dry with gauze, if required Choose an appropriate conventional moist wound dressing or combination of dressings as per the “Guideline: The Assessment and Management of Moisture in Acute and Chronic Wounds”, using the “SWRWCP’s Dressing Selection and Cleansing Enabler – HEALABLE”, unless otherwise directed by a physician or nurse practitioner. This may involve the use of topical antimicrobials if identified as a need (see “Guideline: The Assessment and Management of Bacterial Burden in Acute and Chronic Wounds”). Consider: <ol style="list-style-type: none"> How well the dressing can manage and/or control

	<p>the wound environment</p> <ul style="list-style-type: none"> ii. If the dressing will keep the wound bed continuously moist, yet the periwound tissue dry iii. If the dressing can control exudate, but not dry out the wound bed iv. A dressing that can eliminate dead space by loosely filling all cavities with dressing material v. Avoid adhesive dressings due to the increased sensitivity of people with venous disease <p>d. Choose an appropriate dressing change frequency based on:</p> <ul style="list-style-type: none"> i. Your wound assessment, including the person’s risk for infection ii. Dressing products used and their ability to manage the drainage anticipated iii. Person’s comfort and acceptability <p>e. Initiate appropriate compression therapy in collaboration with an Enterostomal Therapy (ET) Nurse or Wound Care Specialist (WCS), based on your holistic assessment of the person, their wound, and their lower leg circulation. Compression bandaging, in combination with exercise, is the treatment of choice for venous leg ulcers. NOTE: Compression bandaging is an added skill for clinicians and therefore there must be an educational component and mentoring to ensure safety and efficacy in application. Agency policy should reflect that compression bandaging is not initiated until a holistic lower leg assessment is completed and the person is assessed to be appropriate for bandaging. Agency policy should also include level of staff education and training necessary to perform compression bandaging. Although the highest degree of compression that is safe to use based on your assessment is most beneficial, if the person is unable to tolerate it, the use of lower compression therapy is better than no compression therapy at all. NOTE: in the presence of deep wound infection and/or cellulitis, reduce the amount of compression until the person shows signs that they (and their wound) are positively responding to antibiotic treatment and until the person can tolerate a resumption of the previous level of compression. Also, to prevent pressure damage in people with impaired peripheral perfusion, thin or altered limb shape, foot deformities or dependent edema, Rheumatoid Arthritis, reduced sensation, long-term steroid use, and/or loss of calf muscle pump, choose an inelastic bandaging system</p>
--	--

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of the work

and apply extra padding or foam over bony prominences, the Achilles tendon, and the tibialis anterior tendon. Benefits of compression therapy include:

- i. Simulation of fibrinolysis
- ii. Removal of sodium from subcutaneous tissue and a reduction in edema
- iii. Facilitation of fluid movement due to the pressure gradient
- iv. Creation of an environment suitable for wound healing

***Elastic bandages** provide compression with high pressures at rest but less with muscle contraction, i.e. Profore™, Surepress™, Coban™ Self-Adherent Wrap. Ankle circumference must be more than or padded to equal 18cm (measure ankle circumference 2.5cm above the medial malleolus)

***Inelastic bandages** provide support and resistance, i.e. high pressures with exercise and minimal pressure at rest, i.e. Viscopaste and kling wrap, Circaid Boot®, short stretch Comprilan®, Coban 2™, Coban 2 Lite™

Interpretation of ABI and Recommended Compression Therapy	
ABI & Description	Recommended Therapy
ABI >1.2 or unable to compress (Abnormal)	Referral for further vascular assessment required, i.e. segmental compression studies, toe brachial pressure index. No compression. Arterial etiology assumed
ABI 0.8 – 1.2 in the presence of signs of PAD, rheumatoid arthritis, diabetes, or systemic vasculitis	No compression. Further testing required before initiating high compression. Arterial etiology assumed
ABI 1.0 – 1.2 (normal) ABI 0.8 – 0.9 (acceptable) with an ankle circumference > 18cm	High compression (30-50mmHg), i.e.: <ul style="list-style-type: none"> • Profore (Smith & Nephew) • Surepress™ (Convatec) – long stretch, elastic • Comprilan® (BSN) – Peter Staudinger method, inelastic • Coban 2™ (3M)
Venous disease	
ABI 0.5 – 0.8 (abnormal) Mixed disease	Modified compression bandaging with physician agreement, i.e.: <ul style="list-style-type: none"> • Profore Lite (Smith & Nephew) – ABI 0.6-0.8 • Coban 2 Lite™ (3M) – ABI 0.5-0.79 • Viscopaste (fan-folded) (Smith & Nephew) and kling (figure of 8) - ABI 0.5-0.79 • Comprilan® (BSN) - Parkwood method, ABI 0.6-0.8 with no ischemic S+S • Tubigrip (Molnlycke) Consider further medical assessments, i.e. segmental compression studies, toe brachial pressure index

	<p>ABI <0.5 Arterial disease</p>	<p>No compression. Urgent vascular surgery consult</p>
<ul style="list-style-type: none"> f. Compression therapy should create a pressure gradient extending from the ankle to the knee: <ul style="list-style-type: none"> i. Must overcome the gravitational effects ii. Highest pressure must be at the lowest aspect and progressively diminish as it extends up the leg iii. The combined effect of the graduated compression plus the calf muscle pump moves the fluid towards the heart g. Compression bandages MUST be applied according to manufacturer’s recommendations h. Compression hosiery should be measured and fitted by a certified fitter i. TEDS DO NOT provide therapeutic compression for the treatment and management of venous stasis disease, and should not be used for that purpose <p>3. If woody fibrosis and induration are present in the periwound area or in the leg at the initial assessment, speak to the person’s physician/primary care nurse practitioner re a trial of pentoxifylline 400mg TID to relieve the symptoms and improve the rate of wound closure</p> <p>4. Teach the person to:</p> <ul style="list-style-type: none"> a. Elevate their legs above the level of their heart when they are at rest, and 2-3 times per day for up to 30 minutes, and to elevate the foot of their bed on 5cm blocks or risers if congestive heart failure is ruled out b. Avoid applying sensitizing products like lanolin, latex, perfumes, cetylsteryl alcohol and topical antibiotics to their lower legs c. Protect themselves from insect bites d. Eliminate restrictive clothing e. Sit without their legs crossed and to avoid sitting/standing for long periods f. Walk and perform active range of motion exercises of ankles regularly to increase calf muscle pump function – you may need to refer to Physiotherapy 		
<p>Maintenance/Non-Healable Wounds (People with venous ulcers who are not adherent to their compression therapy or who have intrinsic/extrinsic/iatrogenic factors negatively affecting their ability to heal; or people with arterial leg ulcers)</p> <p>1. Upon completion of a thorough, holistic patient and wound assessment as per the SWRWCP’s “Guideline: The Assessment of People with Leg Ulcers”, and upon determination that the wound in</p>		

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of the work

	<p>question is ‘maintenance’ or ‘non-healable’, cleanse the wound as per the “SWRWCP’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE”</p> <p>2. As you have determined that the wound is maintenance/non-healable:</p> <ol style="list-style-type: none"> a. DO NOT DEBRIDE, especially if the circulation is severely impaired, revascularization surgery is not possible or has been unsuccessful, and/or if the wound is covered with hard, dry eschar b. Paint and/or cleanse the wound with antiseptics as indicated on the “SWRWCP’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE”, and allow the antiseptic to air dry c. Choose an appropriate dry gauze based non-adherent dressing or combination of dressings, as per the “Guideline: Assessment and Management of Moisture in Acute and Chronic Wounds” using the “SWRWCP’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE”, unless otherwise directed by a physician or nurse practitioner. NOTE: Application of a moisture retentive dressing in the context of ischemia and or dry gangrene can result in a serious life or limb threatening infection. Choose an appropriate dressing that will: <ol style="list-style-type: none"> i. Promote a dry wound environment ii. Minimize bacterial contamination iii. Prevent strike through of exudates, while wicking moisture away from the wound surface iv. Is cost effective, i.e. do NOT use conventional dressing products for daily dressing changes! v. Comfortable to wear, and do not causing increased pain during wear time or on removal d. Choose an appropriate dressing change frequency based on: <ol style="list-style-type: none"> i. Your wound assessment - goal is to keep the wound clean, dry and free of infection ii. Dressing products used and their ability to manage the drainage anticipated iii. The person’s comfort and acceptability e. If the wound is venous in nature and ‘maintenance/non-healable’, you may wish to consider low compression therapy to help manage edema and keep the wound from getting any larger f. If the wound is arterial in nature: <ol style="list-style-type: none"> i. Consider a referral to a vascular surgery to see if the problem with the arterial circulation can be
--	--

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of the work

	<p>corrected</p> <ul style="list-style-type: none"> ii. Support the person to eliminate restrictive clothing and to access a supervised exercise program as tolerated – you may need to refer to Physiotherapy iii. Teach the person to: <ul style="list-style-type: none"> 1. Protect their extremities from heat, cold, and trauma 2. Elevate the head of their bed 10-15cm to maintain lower limb position below the level of the heart for ischemic pain 3. Use a bed cradle to elevate bedding off their limbs, for pain management 4. Avoid constrictive activities, i.e. nicotine, caffeine, tight shoes/socks <p>Management Guidelines for ALL Leg Ulcers, Regardless of Healability</p> <ul style="list-style-type: none"> 1. Treat the cause: <ul style="list-style-type: none"> a. Modify any identified intrinsic, extrinsic, and iatrogenic factors affecting wound healing to increase the chance of preventing leg ulcers, to promote the healing existing leg ulcers (or stabilization if healing is not the goal), and to prevent limb loss through infection and amputation b. For heel ulcers, have the person elevate their heels completely off the bed surface and other pressure causing surfaces, using pillows or a wedge, to remove pressure when lying (even when on a therapeutic surface) 2. Person centered concerns: <ul style="list-style-type: none"> a. Manage pain using the SWRWCP’s “WHO Pain Ladder with Pain Management Guidelines”. Consider: <ul style="list-style-type: none"> i. Coordinated pre-dressing change analgesia ii. Regular dosing of pain medications iii. Use of appropriate medications to manage neuropathic pain iv. Use of topical analgesics (i.e. morphine) or anesthetic (i.e. EMLA or lidocaine) if pain during dressing changes b. Consider non-pharmacological methods of pain management, i.e. appropriate dressing choice, distraction, guided imagery, pressure redistribution, music, time-outs during dressing changes, less frequent dressing changes, etc. c. Consider surgical management of ischemic pain, i.e. revascularization. Also consider elevation of the head of the person’s bed 10-15cm to position their lower limbs below the level of their heart, using a bed cradle to
--	---

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of the work

	<p>offload the pressure of the blankets on the person’s lower limbs, and avoiding constrictive clothing and activities</p> <ul style="list-style-type: none"> d. For venous ‘heaviness/limb tiredness’, encourage adherence with compression therapy, limb elevation above the level of the heart when resting, calf-muscle pump exercises, and walking (not standing still) e. Ensure the plan of care is created with input of the person with the wound and/or their caregiver, including their concerns, motivations, abilities and preferences for treatment <p>3. Debridement:</p> <ul style="list-style-type: none"> a. Determine if debridement is appropriate for the person and the wound b. Prior to debriding wounds on lower extremities, ensure a complete vascular assessment has been conducted to rule out vascular compromise c. If debridement is appropriate, select the appropriate method of debridement considering: <ul style="list-style-type: none"> i. The goals of treatment, i.e. healability ii. The person’s overall health condition iii. Type, quantity and location of necrotic tissue iv. Wound depth and amount of drainage v. Availability of resources. NOTE: Lower extremity ulcers with dry eschar in people who are acutely palliative should NOT be debrided if they do not have edema, erythema, fluctuance or drainage d. Consider referrals to an ET or WCS for conservative sharp debridement of non-viable tissue, using sterile instruments e. Consider requesting a referral to a general surgeon for surgical sharp debridement in the presence of necrotic tissue in a wound that requires debridement secondary to the presence of advancing cellulitis/sepsis, increased pain, exudates and odor, or for debridement that is beyond the scope of practice/competency of primary care providers f. Ensure adequate pain management with wound debridement <p>4. Infection control:</p> <ul style="list-style-type: none"> a. Teach that new onset or worsening pain is a sign of infection and requires immediate medical attention b. Treat bacterial burden as per the “Guideline: The Assessment and Management of Bacterial Burden in Acute and Chronic Wounds”, using the “Bacterial Burden in Chronic Wounds” tool. NOTE: Topical antimicrobials can be used to reduce bacterial burden in the presence
--	---

	<p><i>of superficial wound infection, but <u>never</u> take the place of systemic antibiotics when those are needed for deeper infections</i></p> <ul style="list-style-type: none"> c. If you are not sure of the nature of the infection, choose a non-occlusive dressing as the secondary dressing. Dressing frequency for infected leg ulcers should be increased until the symptoms of the infection are progressively improving d. Implement strategies to prevent infection, i.e. proper hand washing and infection control measures e. Systemic antibiotic therapy is needed for cellulitis. Trace any areas of cellulitis with a soft-tipped indelible marker to monitor the resolution/worsening of the cellulitis f. The person may find high compression, especially elastic systems, too painful to tolerate until the infection starts to respond to the antibiotic therapy. Do not stop compression entirely because the edema will increase as a result of the cellulitis. Instead reduce compression. Leg elevation is important g. Consider a referral to an Infectious Disease Specialist in the presence of a wound complicated by bacteremia, sepsis, advancing cellulitis or osteomyelitis <p>5. Management of venous stasis dermatitis:</p> <ul style="list-style-type: none"> a. Resolution may take 2-4 weeks b. Avoid the use of known sensitizers in persons with venous disease, i.e. products that contain perfume, latex, dyes, lanolin or wool alcohols, balsam of Peru, cetylsterol alcohol, parabens, colophony propylene glycol, neomycin, rubber, adhesives, framycetin, or gentamycin, as these may contribute to dermatitis c. Systemic antibiotic therapy is not needed for acute contact dermatitis d. Cleanse the person's skin gently with tap water using a mild soap, i.e. Dove Soap, and rinse well e. Discomfort can be soothed with a compress of Burosol solution or Burrow's solution x 15-20 minutes f. Use moisturizers such as Glaxal Base, Cliniderm, Moisturel lotions (not creams), or plain Vaseline petrolatum to keep the skin healthy and free of dry scales. Reserve products containing urea, i.e. Uremol or Attractain, for severely dry, scaly skin, and stop if dermatitis occurs g. Apply prescribed steroidal cream or ung. to all affected areas. Only use topical corticosteroids for two weeks at a time if being applied more frequently than 2x/week as this may contribute to skin breakdown or rebound dermatitis. The addition of Menthol 1/4 – ½% to the
--	---

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP's website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of the work

	<p>steroidal cream may aid in soothing and has an anti-itch effect. Keep the cream/ungt. in the refrigerator</p> <ul style="list-style-type: none"> h. Consider the application of an Unna’s Paste Boot in a fan-fold method to help soothe the irritated skin, followed by Kling and <u>appropriate compression</u>. Compression is the main treatment for venous eczema. NOTE: Contact dermatitis may occur with Viscopaste. You may wish to patch test prior to fully implementing the product i. Teach that rubbing or scratching even through a bandage will make the rash last three more days than it would have <p>6. Consider referrals to (see “Criteria for Interdisciplinary Referrals”):</p> <ul style="list-style-type: none"> a. Registered Dietician (diet, nutrition, supplementation, weight control). NOTE: To be most efficient, the following blood work could be ordered on the results obtained before making a dietician referral: serum albumin, CBC (if anemic, proceed to checking Serum Iron, Total Iron Binding, Ferritin, Transferrin, B12 and Red Blood Cell Folate Level), BUN, Creatinine, and Potassium b. Speech Language Pathologist (presence or risk of developing a swallowing impairments) c. Physician/Primary Care Nurse Practitioner (poorly controlled co-morbid health conditions, smoking cessation, medication adjustments) d. Physiotherapy (mobility/exercise plan, mobility/gait/range of motion assessment, adjunctive therapies for wound healing and/or neuropathic pain management) e. Occupational Therapist (assistive devices, modifications to activities of daily living, fall risk assessment and recommendations) f. Orthotist/Pedorthist/Podiatrist (appropriate footwear/offloading device, professional foot care) g. Social Work (psychosocial and economic/community supports) h. Vascular surgeon (vascular assessment +/- surgical correction) i. Infectious Diseases (for wounds complicated by bacteremia, sepsis, advancing cellulitis or osteomyelitis) j. ET or WCS for wounds that have one or more of the following FUN criteria: <ul style="list-style-type: none"> i. F (Frequency) – frequency of dressing changes has not decreased to three times per week or less by week three ii. U (Unknown) – the cause (etiology) of the wound is unknown, or the nurse is unsure of best
--	---

	<p>practices</p> <ul style="list-style-type: none"> iii. N (Number) – the surface area of the wound has not decreased 28.79% at four weeks, as this predicts complete venous leg ulcer closure by 24 weeks⁷, or a minimum of 20-30 in 3-4 weeks of treatment, or there is not an ongoing decrease or reduction in wound surface area k. Dermatologist (for patch testing for people with suspected sensitivity reactions) <p>7. Teach the person and/or their caregiver, using adult education principles, the importance of the following (you may need to consider interdisciplinary referrals):</p> <ul style="list-style-type: none"> a. To wash their legs and feet daily and moisturize their dry skin (not between the toes) daily, using non-scented, mild, pH balanced soap. If the person is wearing compression socks, have them apply moisturizers after the socks have been removed for the day b. To wear proper fitting shoes and orthotics (if they have been prescribed), indoors and out c. The value of quitting smoking and avoiding the consumption of caffeine d. To exercising regularly and eating a well-balanced diet e. To change their socks daily (no tight shoes or socks) f. To protect their legs and feet from heat/cold/injury (no ice packs/heating pads) g. The signs and symptoms of infection/complications and when and how to seek IMMEDIATE help h. Chronic diseases and how they affect the healing process and the importance of adhering to the treatment plan i. The wound dressing technique if they or their caregiver are going to be changing dressings j. Strategies for improving nutrition k. Strategies for managing pain during and between dressing changes, i.e. use of a bed cradle, elevating the HOB on 4-6" blocks to keep the persons heart above their feet, avoiding leg elevation l. The need for ongoing follow-up with a health care provider at regular intervals m. The importance of professional foot care for those with arterial leg disease n. The benefits of compression therapy and daily leg elevation and the need for lifelong compression (if this is part of their plan of care) o. Exercises to promote calf muscle pump function p. How to care for and apply/remove compression stockings, including the need to replace stockings every
--	---

	<p>four - six months, if compression therapy is part of the persons plan of care</p> <ol style="list-style-type: none"> 8. Provide the person with the SWRWCPs “My Venous Leg Ulcer” or “My Arterial Leg Ulcer” pamphlet and the “Importance of Nutrition in Wound Healing” pamphlet, and review the pamphlet contents with them 9. Re-evaluate (see “Guideline: Wound Re-Assessment and Consideration of the Use of Adjunctive/Advanced Therapy”): <ol style="list-style-type: none"> a. Regularly and consistently measure the ulcer, weekly at a minimum, using the same method b. Conduct a comprehensive reassessment to determine wound progress and the effectiveness of the treatment plan, i.e. Using the NPUAP PUSH Tool 3.0”, weekly at a minimum (see “Procedure: NPUAP PUSH Tool 3.0” c. Calculate the % reduction in wound surface area to ensure that the wound has closed 28.79% by four weeks as this is a predictor of complete wound closure by 24 weeks. If the wound is not closing at an expected rate, reassess for additional correctable factors, vascular status, infection, and adherence d. Repeat Doppler ultrasound measurement of ABI when: <ol style="list-style-type: none"> i. A leg ulcer deteriorates ii. An ulcer is not fully closed within three months iii. Person has a leg ulcer recurrence iv. There is a sudden increase in pain v. The color and/or temperature of the foot changes e. If the wound is not healing at an expected rate despite the implementation of best practice interventions, you may need to consider: <ol style="list-style-type: none"> i. A referral to a WCS or ET nurse for assessment ii. Diagnostic testing to rule out the presence of underlying infection/osteomyelitis +/- a referral to an Infectious Diseases Specialist iii. Adjunctive therapies, i.e. therapeutic ultrasound, intermittent pneumatic compression, hyperbaric oxygen therapy, or electrical stimulation therapy iv. A request for a wound tissue biopsy to rule out underlying malignancy, if suspected v. Barriers to concordance f. Reassess pain at EVERY dressing change and more frequently as reported by the person, using the same pain tool/scale each time. Report pain management issues to the person’s primary care physician or primary care nurse practitioner, using the SWRWCP’s “Comprehensive Assessment of Chronic Pain in Wounds” form (see “Procedure: Comprehensive Assessment of Chronic Pain
--	--

	<p>in Wounds” tool)</p> <ul style="list-style-type: none"> g. Reassess the person’s quality of life using the “Cardiff Wound Impact (Quality of Life) Questionnaire” if the person reports alterations in their quality of life or if their caregiver verbalizes that they suspect as much [see “Procedure: Cardiff Wound Impact (Quality of Life) Questionnaire] <p>10. Notify the primary care physician or primary care nurse practitioner immediately if the following occur:</p> <ul style="list-style-type: none"> a. Acute onset of pain or increasing pain b. Wound probes to bone (if this is a new finding) c. Gangrene develops or worsens d. Rest pain develops in the foot e. Previously palpable peripheral pulses are diminished or absent f. Signs of localized and/or systemic infection develop <p>11. Documentation:</p> <ul style="list-style-type: none"> a. Document initial and ongoing assessments as per your organizations guidelines b. Document care plans, implementation strategies, and outcome measurements as per your organizations guidelines <p>12. Discharge Planning:</p> <ul style="list-style-type: none"> a. Discharge planning (if it is anticipated) should be initiated during the initial encounter with the person. Timely discharge should be supported along with optimal person independence b. If the care of the person is being transferred across sectors, ensure that the receiving site/facility/service is provided with a care plan that outlines the current care and wound management strategies, and copies of: <ul style="list-style-type: none"> i. Initial Wound Assessment Form ii. Interdisciplinary Lower Leg Assessment Form
<p>Outcomes</p>	<p>1. Intended:</p> <ul style="list-style-type: none"> a. The wound closes and drainage ceases, if the wound is deemed ‘healable’ (this may require revascularization of arterial wounds), i.e. surface area reduction of 28.79% at four weeks⁷ or a minimum of 20-30% in 3-4 weeks of treatment. OACCAC Venous Leg Ulcer Outcome-Based Pathway (OBP) outcome intervals (September 2013 release): <ul style="list-style-type: none"> i. Interval 2 (28 days) – 20-30% reduction in wound surface area ii. Interval 3 (84 days) – Wound is closed <p>OACCAC Arterial Leg Ulcer OBP outcome intervals (September 2013 release):</p> <ul style="list-style-type: none"> iii. Interval 2 (28 days) – 20-30% reduction in wound

	<p style="text-align: center;">surface area</p> <ul style="list-style-type: none"> iv. Interval 3 (84 days) – Wound is closed b. The wound is maintained and infection free if the wound is deemed ‘maintenance or non-healing’ c. The person indicates that pain is resolved or manageable (less than 3/10) with appropriate use of analgesia/adjunctive/alternative methods d. The person understands and acts on their role in preventing further tissue damage and incorporates recommended activities and interventions to treat risk factors e. The persons commits to lifelong compression therapy (if this is part of their plan of care) f. Exudates and odor are effectively managed g. The person can identify signs and symptoms of infection, and can describe how, when and whom to call when problems occur h. The person becomes independent in self-management of their wound <p>2. Unintended:</p> <ul style="list-style-type: none"> a. The wound dose not close, if the wound is deemed ‘healable’ b. The wound becomes infected c. The person develops gangrene d. The person requires an amputation where one was not anticipated e. The person expresses concerns about poorly managed pain f. The person does not understand and/or act on their role in preventing further tissue damage and does not incorporate recommended activities and interventions to treat risk factors g. The person does not commit to life-long compression therapy (if this is in their plan of care) h. The person does not understand the signs and symptoms of infection/complications, and when, how and whom to seek help from i. The person does not become independent in self-management of their wound
References	<ol style="list-style-type: none"> 1. Harrison MB, Graham ID, Friedberg E, Lorimer K, Vandervelde-Coke S. Assessing the population with leg and foot ulcers. <i>Canadian Nurse</i>. 2001;97(2):18-23. 2. Callam MJ, Ruckley CV, Harper DR, Dale JJ. Chronic ulceration of the leg: Extent of the problem and provision of care. <i>British Medical Journal</i>. 1985;290(6485):1855-1857. 3. Baker S, Stacy M, Jopp-McKay A, et al. Epidemiology of chronic venous ulcers. <i>British Journal of Surgery</i>. 1991;78(7):864-867. 4. Nelzen O, Bergquist D, Lindhagen A. The prevalence of chronic lower-limb ulceration has been underestimated: Results of a validated population study. <i>British Journal of Surgery</i>. 1995;83:255-258.

	<ol style="list-style-type: none"> 5. Zink M, Rousseau P, Holloway JA Jr. Lower extremity ulcers. In R. Bryant (Ed.), Chronic wounds: Nursing management. 2000:64-212. St. Louis: Mosby. 6. Price P, Harding K. Measuring health-related quality of life in patients with chronic leg ulcers. Wounds: A Compendium of Clinical Research and Practice. 1996;8(3):91-94. 7. Kantor J, Margolis DJ. A multicenter study of percentage change in venous leg ulcer area as a prognostic index of healing at 24 weeks. Br J Dermatol. 2000;142:960-964.
<p>Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP's website: swrwoundcareprogram.ca)</p>	<ul style="list-style-type: none"> • The SWRWCP's Venous/Mixed Leg Ulcer Assessment and Management Algorithm • The SWRWCP's Arterial Leg Ulcer Assessment and Management Algorithm • Guideline: The Assessment of People with Leg Ulcers • SWRWCP's Dressing Selection and Cleansing Enabler – HEALABLE • Guideline: Wound Debridement (excluding conservative sharp debridement) • Guideline: Conservative Sharp Wound Debridement • Guideline: The Assessment and Management of Moisture in Acute and Chronic Wounds • Guideline: The Assessment and Management of Bacterial Burden in Acute and Chronic Wounds • SWRWCP's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE • Criteria for Interdisciplinary Referrals • WHO Pain Ladder with Pain Management Guidelines • Bacterial Burden in Chronic Wounds Tool • Procedure: Bacterial Burden in Chronic Wounds Tool • My Venous Leg Ulcer pamphlet • My Arterial Leg Ulcer pamphlet • The Importance of Nutrition in Wound Healing pamphlet • Guideline: Wound Re-Assessment and Consideration of the Use of Adjunctive/Advanced Therapy • NPUAP PUSH Tool 3.0 • Procedure: NPUAP PUSH Tool 3.0 • Comprehensive Assessment of Chronic Pain in Wounds • Procedure: Comprehensive Assessment of Chronic Pain in Wounds • Cardiff Wound Impact (Quality of Life) Questionnaire • Procedure: Cardiff Wound Impact (Quality of Life) Questionnaire • Interdisciplinary Lower Leg Assessment Form