**BASIC VENOUS LEG ULCER CARE PLAN**

Patient label

**Date/time commenced ……………………………..**

**Implemented by ……………………………………..**

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| **This patient has LEFT / RIGHT / BILATERAL leg ulcer(s)** |
| Goal to:   * Avoid infection * Manage pain * Manage exudate * Prevent deterioration |
| **INTERVENTIONS/ACTIONS:**  Assess patient’s pain prior to redressing; administer analgesia prior if required  Establish any allergies/sensitivities |
| **Surrounding skin preparation / protection:**  Wash leg(s) & feet using Aqueous cream as a soap substitute removing as much dry skin, detritus as possible without causing patient further harm; dry well.  Liberally apply Cetraben\*, or patients preferred emollient to legs, dorsum of feet and heels in downward strokes.  Apply Derma S cream or film to peri wound skin  \* Patients may prefer an alternative emollient; avoid those that are highly scented |
| **Wound bed preparation:**  Granulating/epithelializing – Apply Atrauman  Sloughy & dry – Apply Actilite\*, cut to size of wound  Sloughy & wet – Apply Aquacel Extra, with at least 1cm margin around wound  Dry, necrotic or eschar – Apply Duoderm/Comfeel  Infection localised to wound, wet – Apply Aquacel Ag, with at least 1cm margin around wound. Reassess efficacy after 2 weeks, if improvement noted continue for a further 2 weeks then cease use; if no improvement noted cease use and reassess  Infection localised to wound, dry – Apply Actilite, cut to size of wound  \* Actilite is not suitable for people with allergies to bee venom; blood sugar levels should be monitored in patients with diabetes. |
| **Exudate management:**  Low to moderate – dressing pad  Moderate to high – Biatain non-adhesive |
| **Retention:**  If patient is sensitive to Soft ban dressings can be secured with Actifast blue/yellow prior to bandaging  Apply Soft ban: apply two turns around base of toes; over lapping by 50% apply further turn around foot if required; ask patient to ‘point their toes towards their nose’ and continue spiralling with 50% over lap up to two fingers width below the back of the knee(s)  Apply crepe bandage in same manner; tape in place |
| **Frequency of redressing & reassessment:**  Redress every 3 – 4 days; this depends on how much the wound is exuding and may require redressing more often  The entire care plan to be reviewed every two weeks and updated as necessary |
| **Additional needs:**  Ensure MUST assessment completed and referral made to dietician as required; patient to be encouraged to take meals high in protein, vitamins and minerals to aid wound healing  Avoid patient sitting with legs dependent for long periods of time, encourage bed rest after meals. If a foot stool is used ensure heels are suspended to avoid pressure damage  Encourage patient to mobilise to support calf muscle pump |
| **Person/Team Responsible:**  All ward staff; doctor(s); physiotherapy; occupational therapy; clinical nurse specialist(s); dietician; pharmacist |