

Lower Limb Assessment Essential Criteria

The Lower Limb Assessment Essential Criteria has been compiled using all the criteria from the NHS England [Leading Change Adding Value Framework Minimum Data Set](#)¹ (Table 4 p 235) and the assessment criteria from the [SIGN Guideline for Venous Leg Ulcers](#)². These criteria are the **minimum** that should be documented in a Lower Limb assessment.

The following should be assessed and recorded in the patient record:	
Domain	Data Item
General Health Information ^{1, a}	Risk factors for delayed healing ^b
	Allergies
	Skin sensitivities
	Impact of the wound on quality of life (physical, social & emotional)
	Information provided to patient and carers
Wound Baseline Information ¹	Number of wounds
	Wound location
	Wound type/classification ^c
	Wound duration ^d
	Treatment aim ^e
	Planned re-assessment date ^f
Wound Assessment Parameters ¹	Wound size (maximum length, width and depth)
	Undermining/tunnelling ^g
	Category (pressure ulcers only) ^h
	Wound bed tissue type ⁱ
	Wound bed tissue amount ^j
	Description of wound margins/edges ^k
	Colour and condition of surrounding skin ^l
	Whether the wound has healed ^m
Wound Symptoms ^{1,2}	Presence of wound pain ⁿ
	Wound pain frequency
	Exudate amount ^o
	Exudate consistency/type/colour
	Odour occurrence ^p
	Signs of systemic infection ^q
	Signs of local wound infection ^r
	Whether a wound swab has been taken ^s
Lower limb specific ²	Signs of venous disease ^t
	Lower limb oedema (including ankle circumference) ^u
	Joint mobility ^v
	Assessment of arterial supply ^w

¹ Coleman, S., Nelson, E. A., Vowden, P. et al 2017. Development Of A Generic Wound Care Assessment Minimum Data Set. *Journal Of Tissue Viability*. 26 (4) 226-40

<https://www.sciencedirect.com/science/article/pii/S0965206X17300529?via%3Dihub>

² SIGN. 2010. Management of chronic venous leg ulcers - a national clinical guideline.

<https://www.sign.ac.uk/sign-120-management-of-chronic-venous-leg-ulcers.html>

Explanatory Notes

- a. *General Health Information*: These items should be recorded in the wound assessment record if not already recorded in the wider patient record.
- b. *Risk factors for delayed healing*: Including diseases and conditions that affect wound healing (e.g. diabetes, auto-immune conditions), systemic and local blood supply to the wound, susceptibility to infection, medication affecting wound healing, skin integrity and other factors that affect healing such as obesity.
- c. *Wound type/classification*: Wounds should be classified by the dominant cause of wounding and/ or non-healing e.g. diabetic foot ulcer, venous leg ulcer, pressure ulcer etc
- d. *Wound duration*: The date of initial injury/ wound appearance
- e. *Treatment aim*: For most wounds, the overall aim will be healing within a specified time frame but there may be other intermediate aims which should also be recorded such as reduction in pain, odour etc. In a few cases, wound healing may not be a viable option in which case an alternative treatment aim (along with underpinning rationale) should be noted.
- f. *Planned re-assessment date*: As a minimum, wounds should be re-assessed 4 weekly. More frequent re-assessment may sometimes be appropriate.
- g. *Undermining/tunnelling*: Undermining and tunnelling is unusual on leg wounds but should be noted in documentation if present.
- h. *Category (pressure ulcers only)*: NICE³ requires NHS Trusts to report skin pressure damage of Category / Stage 2 or above. It is important to differentiate between pressure ulcers on the leg and leg ulceration due to other causes. A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence primarily as a result of unrelieved pressure due to immobility in combination with shear³. Some leg ulcers have an element of pressure as part of the aetiology. When all individual clinical and non-clinical factors pertaining to the patient are considered and the predominant factor of cause is pressure, then the wound should be considered a pressure ulcer and reported as such. When the predominant factor is disease related (e.g. diabetes, neuropathy, arterial disease) as the NICE definition of a pressure ulcer³ relates to static pressure not ambulatory pressure, the wound should not be considered a pressure ulcer in patients who are independently mobile, unless the pressure damage has been caused by a prescribed orthosis or cast.
- i. *Wound bed tissue type*: Granulation tissue, epithelial tissue, slough etc
- j. *Wound bed tissue amount*: Commonly reported as % of different tissue types covering wound bed.
- k. *Description of wound margins/edges*: e.g. steep edged, presence of callus, macerated, rolled etc
- l. *Colour and condition of surrounding skin*: e.g. healthy, inflamed, swollen, macerated etc
- m. *Whether the wound has healed*: Defined as full epithelialisation across 100% of wound bed along with date of healing.
- n. *Presence of wound pain*: Recorded with information about level of pain using a validated visual analogue scale and description
- o. *Exudate amount*: Exudate amount is difficult to measure accurately so an estimate (e.g. low, moderate, high) is usually adequate.

³ NICE (2014) Clinical Guideline - Pressure ulcers: prevention and management
Clinical guideline [CG179] <https://www.nice.org.uk/guidance/cg179>

- p. *Odour occurrence:* It is normal for there to be some odour when a stale dressing is removed but significant odour should be noted and described.
- q. *Signs of systemic infection:*
- r. *Signs of local wound infection:* The clinical signs of wound infection can include cellulitis, pyrexia, increased pain, rapid extension of area of ulceration, malodour, increased exudate². Venous ulcers are commonly associated with varicose eczema which is characterised by erythema, weeping, scaling and pigmentation, and may be misdiagnosed as infection.
- s. *Whether a wound swab has been taken:* Bacteriological swabs should only be taken where there is clinical evidence of infection (local or systemic). In the absence of clinical signs of infection (as above) there is no indication for routine bacteriological swabbing of venous ulcers. All ulcers will be colonised by micro-organisms at some point, and colonisation in itself is not associated with delayed healing².
- t. *Signs of venous disease:* The leg should be assessed for signs of venous disease, in particular, varicose veins, venous dermatitis, haemosiderin deposition, lipodermatosclerosis and atrophie blanche. A venous duplex scan may aid assessment of the leg.
- u. *Lower Limb Oedema:* Oedema should be assessed, and non-venous causes of unilateral and bilateral oedema ruled out.
- v. *Joint Mobility:* Joint mobility, particularly that of the ankle, is an important component of calf muscle pump function and should be carefully recorded.
- w. *Assessment of arterial supply:* It is important to assess arterial supply with respect to safety of compression therapy, which is the standard treatment for venous leg ulcers. Palpation of pulses alone is not adequate to rule out peripheral arterial disease. Measurement of the ankle brachial pressure index (ABPI) of both lower limbs using a Doppler device is the most reliable way to detect arterial insufficiency in a community setting.