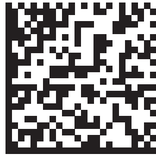
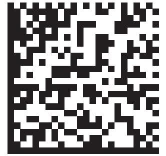
File within 3rd spine

Place patient sticker **within** this box

NHS
Royal Cornwall Hospitals
NHS Trust



Lower Limb Pathway - Checklist and Care plan



Lower limb pathway checklist					
	Yes	**No**	**Date**	**Time**	**Sign / Print / Designation**
On arrival to Emergency Department (ED)					
1. Complete top to toe skin assessment within one hour of arrival. Document on skin bundle					
2. Film dressing to be applied to vulnerable skin areas including heels and elbows along with additional form of protection ie. offloading with pillows					
3. Request air mattress and heel protection from the Equipment library.					
If none available commence hourly repositioning and undertake skin assessments until a mattress is available.					
On arrival to Trauma ward (Orthopaedic Unit)					
1. Patient already nursed on air mattress or ensure one has been requested					
2. Place slide sheet at the patient bedside for single patient use					
3. Skin assessment to be completed within 4 hours of transfer by a Registered nurse					
Registered nurse to record the frequency of skin assessment and care rounding					
4. Apply Hydrofilm if not already insitu					
5. Lower limb pathway stamp to be completed on patient admission					
On arrival to recovery					
1. Top to toe skin assessment to be completed following surgery and recorded in skin bundle					
Post-operative care (Return to ward)					
1. Top to toe skin assessment within 4 hours of return to ward. Record the frequency of skin assessments that are to be continued.					

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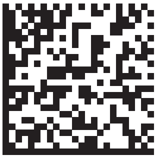

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Care plan commenced by: Date: Time:	Care plan reviewed by: Date: Time:

Practice statement: All patients with hip or femur injuries are at increased risk of developing pressure damage.

Practice goals

- To minimise pressure ulcer risks to patients who have sustained a hip or femur injury
- To ensure patient assessment and documentation continues as per pressure ulcer prevention policy

Practice expectations

- SSKIN assessment and care rounding to be completed as per identified level of risk. Reassessment to be completed if patients condition changes.
- Continued assessment of patient including Nutrition (MUST), hydration, mobility and pain as per trusts guidance.
- Patients to be repositioned according to skin tolerance and encouraged to mobilise at an early stage. Air mattresses and heel protection to be in place until the patient can mobilise independently or their level of risk reduces.
- Any pressure ulcers that are present on admission must be documented on the admission nursing care record and SSKIN bundle assessment tool and reported via RCHT incident reporting process.
- Ensure effective communication with all members of the multi-disciplinary team involved in caring for the patient at risk of pressure damage to ensure prompt recovery and optimum management of pressure areas across care settings.

Other individual interventions	Sign, Designation Date and Time

Care plan activated ☐ Initial:	Sign Print Designation	Care plan shared with patient ☐ Initial:	Sign Print Designation