**Venous Ulcer Interventions**

**Assessments Completed**

- **Normal skin? Thin? Fragile? Dry?**
- **Previous ulcer site**

**Partial-Thickness**

- **Exudate? Dry wound? Necrotic? Odor? Periwound skin at risk or impaired?**

**Full-Thickness**

- **Exudate? Dry wound? Necrotic? Odor? Depth or undermining? Periwound skin at risk or impaired?**

**Healed or at Risk**

- **Protect intact skin: skin protectant**
- **Moisturize intact skin: skin protectant (cream or ointment)**

**Monitored**

- **Healed Venous Leg Ulcer or Skin at Risk**

A healed wound is epithelialized with adequate strength to maintain closure. Skin at risk is tissue exposed to potential injury or tissue that is in a weakened condition (e.g., dry, thin).

**Goals of Care:** maintain intact skin and improve tissue tolerance.

**Wound and Skin Care Objectives:** protect and moisturize intact skin.

**NOTE:** Appropriate skin care is performed in combination with compression therapy.
**VENOUS ULCERS**

**BACKGROUND INFORMATION:**
Venous ulcers account for approximately 90% of ulcers found in the lower limbs. The underlying etiology involves vein damage or an incompetent calf muscle pump action which leads to venous hypertension. As a result, dead pools in the lower extremities causing edema and leakage of fibrinogen and other blood products into the tissues. Trauma to the area or increased pressure within the tissues results in ulceration.

- **Venous leg ulcers** typically share the following characteristics:
  - Located above the medial malleolus and below the knee (“gaiter” region)
  - Beady, red wound base
  - Wound edges intact without undermining
  - Irregular shaped borders
  - Shallow
  - Moderate to heavy serum exudate

The ulcer is staged as partial or full-thickness. Partial-thickness ulcers involve the epidermis and dermis, whereas full-thickness ulcers extend into deeper tissue which may involve subcutaneous tissue, muscle, bone or other supporting structures.

- The **periwound and lower leg skin** may have evidence of the following changes:
  - Hyperpigmentation (brown/black discoloration)
  - Dryness
  - Erythema
  - Weeping dermatitis

The algorithm on the reverse side provides a general path of decision-making for assessment, management and treatment of venous leg ulcers. Below is detailed information which is designed to assist health care providers. This tool should be used along with the consultative services of a wound care specialist such as a WOC/ET nurse, physical therapist, clinical nurse specialist or physician when indicated.

**NURSING ASSESSMENTS:**
- **Goals of Care:**
  - Restore skin integrity and avoid infection.
  - Manage pain.
  - Optimize venous return:
    - Elevate legs above the level of the heart; compression therapy (stockings, bandages, pumps);
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    - Manage pain.
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    - Manage pain.

- **Partial-Thickness Venous Leg Ulcer**
  - A full-thickness wound extends into deeper tissues which may involve subcutaneous tissue, muscle, bone or other supporting structures.
  - Goals of Care: restore skin integrity and avoid infection.
  - Wound and Skin Care Objectives: protect intact periwound skin, cleanse wound, manage wound exudate, debride wound, hydrate wound and manage wound odor.
  - NOTE: Appropriate wound and skin care is performed in combination with compression therapy.

- **Full-Thickness Venous Leg Ulcer**
  - A partial-thickness wound involves the epidermis, dermis or both. It is a superficial wound and may present as an abrasion, blister, or shallow crater.
  - Goals of Care: restore skin integrity and avoid infection.
  - Wound and Skin Care Objectives: protect intact periwound skin, cleanse wound, manage wound exudate, debride wound, hydrate wound and manage wound odor.
  - NOTE: Appropriate wound and skin care is performed in combination with compression therapy.

**GENERAL NURSING INTERVENTIONS:**
- **Optimize venous return:** elevate legs above the level of the heart; compression therapy (stockings, bandages, pumps); exercise (walking); weight management (reasonable eating to avoid being overweight); smoking cessation.
  - **Treat and prevent infection:** debridement, cleansing.
  - **Debridement:** This is based upon condition of the wound and patient. Methods of debridement include autolytic, mechanical, sharp and enzymatic.
  - **Peri-wound skin inspection and care:** This may include cleansing, moisturizing and use of protective barriers.
  - **Provide adequate nutritional intake.**
  - **Manage pain.**