

PROTOCOL FOR: Venous Stasis Ulcers: Care of the Patient with

DESIRED PATIENT

OUTCOMES: Patient will exhibit signs of improvement, e.g.: decreased swelling; decreased pain; decreased signs/symptoms of infection.

CLINICAL
ASSESSMENT
AND CARE:

1. Circulation:
 - a. Check vital signs every 8° or as per MD order.
 - b. Check CSM (color, sensation and movement) in affected extremity/extremities every 8° or per LIP order. Check palpable and doppler pulses every 8° and document. Inspect and palpate for: color, temperature, blanching, sensation, flexion/extension of affected extremity and edema.
 - c. Maintain elevation of affected extremity.
 - d. Maintain bedrest as ordered.
 - e. Obtain labs as ordered.
2. Fluid Volume Status:
 - a. Monitor IV infusion as ordered.
 - b. Monitor I + 0 as ordered.
 - c. Monitor edema to affected extremity/extremities.
3. Wound Care:
 - a. Observe and document the characteristic of ulceration: location, size, shape, configuration, color.
 - b. Assess ulcer site for S/S of infection: redness, heat, edema, pain, drainage, and odor.
 - c. Change dressings to ulcer as per LIP order.
 - d. Place patient on versacare bed or specialty bed as ordered by LIP

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4. Pain Management:

- a. Initiate appropriate Pain Protocol (Adult and/or Acute).
- b. Assess and document patients' report of pain: location, type, duration and severity. (Use pain scale: 0-10: 0 = no pain, 10 = worst pain).
- c. Medicate for pain as needed and assess and document patient's response to medication regimen.
- d. Premedicate appropriately prior to dressing changes, mechanical debridements and/or whirlpool treatments per LIP order.
- e. Institute comfort measures as needed: repositioning, relaxation and reassurance.

5. Notify House Officer if:

- a. Vital Signs are outside LIP parameters.
- b. Ulcer site shows signs of infection or change in characteristics.
- c. Unmanageable pain.
- d. Change in circulation, sensation and movement of affected extremity extremities.

PATIENT TEACHING: 1. Provide patient/significant other with the following information:

- a. Signs and Symptoms of infection - redness, heat, edema, pain, drainage and odor.
- b. Review supplies needed for dressing changes and instructions for dressing changes per LIP order.
- c. Health Education:
 - a. avoid sitting or standing long periods of time
 - b. elevate legs on a chair 5 minutes out of every 2°
 - c. elevate legs above the level of the heart by lying down 2 - 3 times daily
 - d. raise foot of bed 6 - 8 inches at night
 - e. apply lotion (e.g. Lubriderm or Aquaphor) to prevent scaling and dryness of skin

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- f. avoid constricting bandages
- g. wear elastic stockings to prevent edema
- h. avoid injury, bruising, scratching and/or other trauma to skin of leg and foot.

APPROVAL: Medical-Surgical Standards Review
ICU Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 4/93

REVISION DATES: 1/95, 12/97, 3/00, 11/03, 12/05