

A guide to assessing, preparing and dressing venous leg ulcers and skin tears

The Department of Veterans' Affairs (DVA) Wound Identification and Dressing Selection website has just been updated. It consists of a:

- **Wound Identification and Dressing Selection Chart** that includes a quick reference guide to identifying and treating wounds
- **DVA Wound Care Module** that includes information about different types of wounds and methods for treating and dressing them.

Visit the website at:

www.dva.gov.au/woundcare

Assessing the wound using TIME^{1,2}

Tissue

- presence of devitalised, granulated or necrotic tissue
- deeper tissues visible, including bone, tendon, muscle or subcutaneous fat
- presence of foreign material or debris

Inflammation / Infection

- signs of local clinical infection including redness, heat, fever, swelling, delayed wound healing, new or increasing pain and exudate
- abnormal granulation tissue, including bleeding or dark coloured tissue
- increasing malodour
- extent of infection (local, spreading or systemic)

Moisture

- amount, colour and type of exudate

Edge of wound

- the wound edge is clean, dry or macerated
- condition of the wound edges, including sloped, undermined, callused or heaped up skin at the edges
- condition of the peri-wound skin, including hydration level, inflammation, excoriation, oedema or presence of a sinus track.

Venous leg ulcers

Assess the ulcer, peri-wound skin and the patient's legs, feet, mobility and gait, and document findings.^{3,4} Use the systematic approach of TIME (**T**issue, **I**nflammation / **I**nfection, **M**oisture balance and **E**dge of wound) to assess and prepare the wound bed.^{2,3} Reassess the wound regularly using TIME to summarise aspects of the wound bed, note any changes since the last assessment and to adjust wound management accordingly.¹ Assessment of the ulcer location, dimensions (length, width and depth), clinical appearance of the wound bed and the edges are particularly important in determining the cause of the ulcer and healing status.^{1,4,5} Photographing or tracing the outline regularly is helpful to note changes over time and demonstrate improvement.^{1,4,5} Address the effects of odour and leakage

from the wound, and social isolation felt by the patient because of their wound or treatment.^{5,6}

Venous leg ulcers are often painful.⁷ Wound pain can have an impact on the patient's quality of life, including sleep, mood, relationships and activity, and it can increase healing time by decreasing concordance with treatments, including compression therapy.^{1,5} Aim to identify if the pain is dressing change-related, wound-related or due to other issues, to treat adequately.¹

The decision on when to change a dressing depends on the type and location of the wound, type of dressing used, wound bed, volume of exudate and patient factors.⁸ Wound dressings available on the RPBS can be accessed at: www.pbs.gov.au/browse/rpbs?initial=d

Preparing the wound bed and dressing a venous leg ulcer

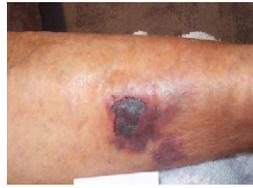
- Clean the wound and peri-wound area using water, saline or an appropriate pH-balanced skin cleanser.^{5,9} Don't use alkaline soaps or cleansers as they cause dry, flaky and irritated skin.^{1,9}
- Debride slough, non-viable or necrotic tissue.⁵ Some types of dressings, including hydrogels, aid debridement.³
 - Provide adequate pain relief during debridement.⁵
- Choose a simple non-adherent dressing to protect the wound and absorb excess exudate.^{3,8} **No specific dressing is superior for reducing healing time.**^{2,5} Select a dressing based on its function, the wound bed status, amount of exudate and patient preference.⁵ When choosing a dressing to use under compression therapy, choose one that:
 - maintains a moist wound healing environment, but is able to manage varying levels of exudate⁸
 - absorbs and retains fluid without leaking under external compression
 - helps maintain the wound core temperature within a normal body temperature range
- is comfortable for the patient and suitable for fragile skin
- conforms to the wound bed to prevent pooling of exudate and does not damage the wound or peri-wound skin on removal⁹
- is easy to remove and remains intact on removal.³
- Patients with venous leg ulcers often have skin problems that affect the surrounding skin and lower leg.^{3,5} Implement a skin care regimen to reduce odour, promote healthy skin and minimise the risk of future ulcers.^{5,7} Encourage the patient to wash and dry the affected leg and apply an appropriate moisturiser at each dressing change.^{5,7}
- Usually antibiotics are not required. Confirmation of an infection by clinical signs and symptoms and microbiological investigation, will guide whether or not an antibiotic is needed.^{5,7,8}

Skin tears

The STAR Skin Tear Classification System* facilitates assessment of skin tear injury.



Category 1a: A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened.



Category 1b: A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is** pale, dusky or darkened.



Category 2a: A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened.



Category 2b: A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is** pale, dusky or darkened.



Category 3: A skin tear where the skin flap is completely absent.

* Adapted from Skin Tear Audit Research (STAR), Silver Chain Nursing Group Limited, Curtin University, Revised 4 February 2010. Reprinted August 2012. Reproduced with permission.

Preparing the wound bed and dressing skin tears

- Clean the wound with saline or water. If the wound is dirty, clean with a surfactant wash product, for example Prontosan® wound irrigation solution, or apply a low strength povidone iodine solution, leave for three minutes, then wash off.⁸
- If the wound is bleeding, apply gentle pressure using a non-stick dressing. If bleeding does not stop, apply a haemostatic alginate dressing.^{1,8,10} Remove any blood clot adhering to the flap before gently replacing a viable flap.¹
- A dressing that minimises the number of dressing changes is ideal.¹⁰ There are two dressing types advocated to achieve this:
 - apply a soft silicone mesh over the flap and cover it with a simple absorbent secondary dressing, for example a silicone foam dressing.^{1,11} The silicone mesh dressing adheres gently to the skin flap and surrounding skin, but not to the wound surface and allows exudate to pass through the holes to the secondary dressing.¹¹ The mesh can be left in place for up to 14 days and changing the secondary dressing as needed leaves the skin flap in place to heal undisturbed.^{11,12}
 - alternately, if there is a major separation of the skin edges, apply a few Steristrips® to hold the tear together without tension and leave in place until they fall off or can be removed in the shower when the wound has healed.⁸ Cover the Steristrips® with a silicone-coated foam dressing which can be left in place for up to seven days.^{4,8} The use of Steristrips® is not advocated in people with cognitive impairment or at risk of removing them incorrectly.
- To prevent damaging the wound on removal, draw an arrow on the outside of the dressing to indicate which direction to pull when removing.¹³
- Hold in place with a non-adhesive lightweight cohesive bandage or lightweight tubular bandage. Do not apply any adhesive tapes.
- If the flap is pale or dusky when the dressing is applied, reassess within 24 to 48 hours, as debridement may be required if the flap is non-viable.¹⁴
- Ensure the clinician knows the correct way to remove the dressings before doing so.
- Consider a surgical review if there is full thickness skin injury, significant bleeding or haematoma formation.¹⁴

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