TREATMENT PROTOCOL FOR ARTERIAL/NON-HEALABLE WOUNDS

Initiate Wound Record

**Confirm that patient with arterial wound has been referred to a vascular specialist for re-vascularization consult.**

- [ ] Photograph wound and file as per regional policy
- [ ] Initiate wound record

CLIENT INFORMATION:

Name:

Date:

ARTERIAL WOUND

- [ ] Date of re-vascularization consult: ______________________________________________________________
- [ ] Maintain a clean, stable wound until consult has taken place. Paint wound with Betadine or Chlorhexidine.
- [ ] Apply a protective dry gauze dressing, if required, and secure it.

** Once the limb has been successfully re-vascularized, re-evaluate the client by completing an updated Lower Leg Assessment and a new treatment plan **

** If re-vascularization is not possible, treat as non-healable wound. **

NON-HEALABLE WOUND (when moist wound healing is contra-indicated)

Wound is considered non-healable due to: [ ] Not a surgical candidate  [ ] Patient at end of life  [ ] Other

Wound is covered with **stable, hard, dry eschar or dry gangrene**

- [ ] Treatment goal: Maintain dry eschar
- [ ] Clean and hydrate intact skin
- [ ] Cleanse the wound with enough Betadine to remove any loose debris. Cleansing the wound with saline or soaking in tub/water is not recommended.

** Consult wound clinician nurse if dry eschar begins to lift or becomes moist / boggy **

- [ ] Apply a protective dry gauze dressing, if required, and secure it.
- [ ] Change dressing 3 times/week.
- [ ] Reassess the wound at every dressing change. Complete a full wound reassessment weekly, including wound measurements, and update wound record.

** Monitor change in wound depth and area. Contact wound clinician nurse for advice/reassessment if required. **

Wound is covered with **moist, boggy slough or wet gangrene**

- [ ] Treatment goal: protect and promote formation of dry eschar
- [ ] Clean and hydrate intact skin
- [ ] Cleanse the wound with normal saline or water; pat dry to remove excess moisture. Soaking in tub/water is not recommended.

** Consult wound clinician nurse if moist eschar does not dry out or if there are increased signs of infection **

- [ ] Paint open areas and intact eschar with betadine and allow to dry well.
- [ ] Apply a protective dry gauze dressing, if required, and secure it.
- [ ] Change dressing once or twice daily until a dry stable eschar is present.

** Monitor change in wound depth and area. Contact wound clinician nurse for advice/reassessment if required. **
Counseling provided

- Establish wound care goals with client: ______________________
  
- Provide client/caregiver with instructions for care & management: ______________________
  
- Risk factor reduction ______________________
  
- Address client concerns ______________________
  
- Other ______________________

CLIENT INFORMATION

Name
Date

Date

Coordination of care (arrange consults if physician/NP has not already done so)

- Vascular disease (specialist): via □ Primary care provider

- Client concerns: □ Dietician □ Social work □ Other:

- Other:

Individualized care plan

Signature: ______________________ Date: ______________________

Communications

- Provide summary of assessment and recommended treatment to referring Physician/ NP. Use LEW Pathway form “Communication with Referring Physician/NP.” Attach lower leg assessment form if appropriate.
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