

Medical Diagnosis: Acute or Chronic Wound Nursing Diagnosis: Skin Integrity Impaired or Tissue Integrity Impaired

Goals of Patient Care

Reduce risk factors for ulcer development and delayed healing. Prevent wound complications and promote wound healing.

Wound Assessments Observed

Wound bed/exudate

Dry-minimal moisture

Wound bed/tissue

≤ 25% necrotic tissue/fibrin slough

Assess for Clinical Signs and Symptoms of Infection (Purulent exudate and/or elevated temperature and/or peripheral induration or edema)

Depth

Superficial or partial thickness

Full-thickness

Surrounding skin

Healthy/reddened

Healthy/reddened

Wound edges

Healthy

Healthy

Undermined

Goals of Wound Care

Obtain clean wound bed

Provide moist environment

Provide moist environment/
prevent premature wound closure

Wound Care Plan

Cleanse

Cleanse Wound

Primary Dressing

Moisture Retentive Dressing

Wound Hydration

Secondary Dressing

N/A

Moisture Retentive Dressing

Patient Care Plan

Reduce risk factors for developing chronic ulcers and delayed healing, e.g.:

RISK FACTORS

Arterial ulcers: Smoking, hypertension, hyperlipidemia and inactivity. Review surgical/medical management options to improve arterial circulation.

Diabetic ulcers: Smoking, hypertension, obesity, hyperlipidemia and high blood glucose. Review surgical/medical management options and use appropriate off-loading techniques.

Pressure ulcers: Pressure, shear, friction, nutritional deficiencies, dehydration and dry skin conditions, skin exposure to moisture or wound contamination secondary to incontinence, perspiration or other fluids, e.g. skin protection.

Venous ulcers: Edema with leg elevation, ambulation and compression. If patient is not ambulatory, assure frequent ankle flexes. Review surgical/medical management options to improve arterial circulation and compression bandages if appropriate.

Mixed arterial-venous ulcers: Smoking, hypertension, inactivity, hyperlipidemia. Review surgical/medical management options to improve arterial circulation and compression bandages if appropriate.

All patients: Provide patient and/or caregiver teaching and support. Confirm and treat infection if needed. Assess and manage wound pain and odor if present.

Expected Outcomes

Wound is not infected and is healing as evidenced by a reduction in size after 2 to 4 weeks of care. No evidence of new skin breakdown.

Delayed Healing

Re-evaluate plan of care or address underlying etiology if ulcer has not reduced in size during 2 to 4 weeks of care