# 50 Wound Care Goals

1. Promote complete wound healing within established timeframes.
2. Reduce wound size by 25% within four weeks.
3. Achieve full epithelialization of wound bed.
4. Maintain wound free from infection during treatment period.
5. Decrease exudate to a manageable level within one week.
6. Eliminate necrotic tissue and establish a healthy granulation bed.
7. Maintain a moist wound environment to promote cell migration.
8. Reduce wound odor within seven days.
9. Control wound-related pain during and after dressing changes.
10. Protect periwound skin from maceration and breakdown.
11. Maintain wound edges free from epibole (rolled edges).
12. Prevent further tissue damage and wound deterioration.
13. Prevent new pressure injuries from forming.
14. Improve patient's nutritional status to support healing.
15. Maintain adequate hydration to promote tissue perfusion.
16. Enhance oxygenation to wound site through improved perfusion.
17. Maintain capillary refill and tissue perfusion within normal limits.
18. Achieve and maintain blood glucose levels within target range.
19. Decrease wound drainage to minimal or none by discharge.
20. Reduce periwound erythema and inflammation.
21. Maintain stable body temperature to support cellular repair.
22. Improve patient's mobility and ability to reposition independently.
23. Demonstrate proper wound care technique before discharge.
24. Patient verbalizes understanding of wound infection signs.
25. Maintain wound dressing intact and free from leakage between changes.
26. Promote formation of granulation tissue within two weeks.
27. Maintain adequate pain control using pharmacologic and non-pharmacologic methods.
28. Prevent recurrence of healed wounds.
29. Minimize scar formation after closure.
30. Achieve control of wound odor to improve social comfort.
31. Ensure dressing changes are performed safely and aseptically.
32. Reduce edema surrounding the wound.
33. Prevent wound desiccation.
34. Promote autolytic debridement of slough tissue.
35. Maintain patient's skin integrity elsewhere on the body.
36. Prevent cross-contamination between wounds.
37. Improve patient's self-esteem and coping related to wound appearance.
38. Maintain functional mobility and prevent contractures near wound site.
39. Ensure adequate offloading of pressure areas.
40. Encourage compliance with prescribed compression therapy.
41. Prevent re-injury to fragile newly healed skin.
42. Enhance patient and caregiver confidence in wound management.
43. Maintain absence of odor and exudate in palliative wounds.
44. Achieve reduction in wound pain to a tolerable level.

45. Prevent systemic infection or sepsis secondary to wound.
46. Ensure continuity of wound care after discharge.
47. Facilitate interdisciplinary collaboration in wound management.
48. Improve patient's nutritional protein intake to >1.2 g/kg/day.
49. Demonstrate reduced anxiety regarding wound appearance.
50. Achieve patient satisfaction with wound comfort and care outcomes.

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# 50 Wound Care Interventions

1. Cleanse wound with sterile normal saline at each dressing change.
2. Apply moisture-retentive dressing (hydrogel, foam, or hydrocolloid) as indicated.
3. Perform conservative sharp or autolytic debridement to remove necrotic tissue.
4. Assess wound characteristics (size, depth, drainage) weekly.
5. Document wound progress with photos and measurements.
6. Use aseptic technique for all dressing changes.
7. Apply protective barrier film to periwound skin.
8. Reposition patient at least every two hours to reduce pressure.
9. Use pressure-redistributing mattress or chair cushion.
10. Elevate lower extremities to reduce edema in venous ulcers.
11. Apply compression bandage or stockings per protocol.
12. Offload pressure from diabetic foot ulcers using specialized footwear or boot.
13. Teach patient and family sterile dressing change techniques.
14. Apply absorptive dressing for heavily draining wounds.
15. Apply non-adherent dressing to fragile or painful wounds.
16. Administer analgesics 30 minutes before dressing changes.
17. Monitor wound for signs of infection—erythema, odor, drainage changes.
18. Obtain wound culture if infection suspected.
19. Administer systemic antibiotics as prescribed.
20. Educate patient on infection prevention and hand hygiene.
21. Encourage protein-rich diet (meat, eggs, dairy, legumes).
22. Provide nutritional supplements (Ensure, Juven, etc.) if indicated.
23. Collaborate with dietitian for nutritional plan.
24. Monitor blood glucose levels daily for diabetic patients.
25. Encourage smoking cessation to improve perfusion.
26. Promote adequate hydration (2–3 liters per day unless contraindicated).
27. Elevate head of bed to 30 degrees or less to reduce shear.
28. Provide range-of-motion exercises to enhance circulation.
29. Use negative pressure wound therapy when indicated for deep wounds.
30. Apply topical antimicrobial or silver dressing for colonized wounds.
31. Avoid cytotoxic agents (e.g., hydrogen peroxide) unless specifically ordered.
32. Inspect and cleanse periwound area during each dressing change.
33. Apply zinc oxide or barrier ointment to prevent moisture-associated damage.
34. Educate patient on importance of offloading and repositioning.
35. Refer to podiatrist for diabetic foot care.

36. Collaborate with physical therapy to enhance mobility.
37. Collaborate with occupational therapy for adaptive self-care tools.
38. Provide patient emotional support and active listening.
39. Refer to social worker for assistance with wound supplies or home care.
40. Use warm irrigation solutions to minimize pain during cleansing.
41. Apply odor-control dressings (charcoal, honey, or silver-based).
42. Reinforce adherence to dressing change frequency.
43. Assess pain levels before, during, and after care.
44. Notify provider of delayed healing or signs of deterioration.
45. Review and discontinue unnecessary medications that delay healing.
46. Encourage patient participation in care decisions.
47. Educate on proper footwear and protective garments.
48. Provide written and visual wound care instructions.
49. Schedule weekly interdisciplinary wound rounds for reassessment.
50. Arrange follow-up care and supply delivery post-discharge.