Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Teodoro Flores Day/Date: Wednesday/ June 15th 2022

Directions: ***WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, s***select one patient each clinical day and complete ***plan of care and chart note.***. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	70 year old male with a history of Type II Diabetes, lower extremity neuropathy, peripheral vascular disease, and s/p left 5th toe amputation due to osteomyelitis 3 weeks ago. Patient states he saw his podiatrist 2 weeks ago for wound care of his left 5th toe amputation site as well as for routine foot care. Tip of left 4th toe was clipped causing a small wound. Wife performs wound care of over-the-counter triple antibiotics and a Band-aid daily. Patient states the wound continually worsened, tried to soak his foot in Epsom salt once for 15 minutes but the wound continued to deteriorate. The patient reported to the emergency room 1 week ago and was placed on Clindamycin and with instructions to continue with current wound care regimen. Patient states the wound did not improve on the antibiotics and the erythema in his foot did not spread any further. Erythema edges marked with an ink pen. The patient said the toenail on the left 4th toe has almost fallen off. The patient is seeking wound care for his injured toe. X-rays of left foot from the emergency room visit showed concern for osteomyelitis. Lower extremity arterial doppler reports from 3 weeks ago: ABI of .92 in the left lower extremity with a TCPO2 of 13mmHg. Last reported A1C: 7.8%.

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

This is the initial wound clinic visit for this 70 y/o male who presents with wounds to his left foot. Pt is Type II Diabetic and reports neuropathy to BLE. Has a history of vascular disease. Presents today for assessment and management of wound to left foot, 4th toe. Reports tip of left 4th toe was clipped x 2 weeks ago causing a small wound. Treatment includes OTC triple antibiotic. Currently on Clindamycin after ED visit x 1 week ago for what he referred to as a deteriorating wound and erythema. Reports recent history of amputation to left 5th toe x 3 weeks ago. Site being managed by podiatry. States has "stitches to site". Open to air. Wife present. Shoe and sock removed to BLE. Sutures in place to 5th toe amputation site. Erythema without induration noted to medial side anteriorly and posteriorly. Erythema extends from base of 4th toe up anterior foot x 3 cm x 2 cm wide and posteriorly 2 cm in length x 2 cm wide. Parameters noted to be marked. Pulses palpable, equal and weak bilaterally to PT and DP. Feet cool to touch. onofilament testing completed and noted to be positive. Band aid removed to left 4th toe. Entire distal tip of toe noted to be macerated with non-adherent, loose necrotic tissue covering 100% of wound. Small amount of serosanguineous drainage, no malodor. Periwound macerated. Toenail noted to be detached except for area at medial corner near root. Site cleansed with wound cleanser. Measures 0.3cm x 0.3cm. Unable to appreciate depth related to necrotic tissue except for area at tip of toe. Depth noted to be 0.5cm with palpation of bone. Pt and wife agreeable to CSWD. Written consent obtained. Time out performed. CSWD completed to loose necrotic tissue. Site cleansed with wound cleanser. Wound measurements unhanged. Denied pain, discomfort during procedure. Skin barrier wipe applied to periwound. Aquacel Ag applied to wound followed by foam dressing. Secured with conforming bandage. Fitted with ProCare squared toe post op shoe for added protection. Demonstration and explanation given. Wife and pt verbalize understanding with wife expressing ability to perform dressing change. Educated to monitor for fever, chills,

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or wound deterioration. Call PCP or go to ED if noted. Discussed POC with pt and wife. Agreeable.

Impression: Diabetic foot ulcer, s/p toe amputation to left foot 5th toe.

Recommendations:
- Wound care as described with skin barrier wipe, AquacelAg, foam and conforming dressing. Change QOD and prn
- ProCare squared shoe
- Continue antibiotic until gone
- MRI and Bone scan to r/o osteomyelitis
- ID consult coordinate with next clinic visit
- RTC in one week

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
1. Delayed wound healing related to high glucose levels	• Educate the patient on the importance of achieving blood glucose control. • Instruct the patient to monitor their feet daily for any changes such as cuts, redness, and swelling. • Provide instructions and educate patient on how to use a self-monitoring blood glucose device.	• The patient's last reported A1C was 7.8%. High blood glucose prevents wounds from healing. For diabetic foot ulcers, immune cell activity is suppressed, which causes delayed wound healing. The nurse must educate the patient on ways to control their blood glucose levels by incorporating exercises into their daily routine, staying hydrated with water, eating a high fiber diet, getting enough quality sleep, and managing body weight. • The patient has a history of Type II Diabetes and lower extremity neuropathy. Neuropathy can cause numbness or decreased sensation to lower extremities, which makes the patient vulnerable to not sensing cuts or any other abnormal changes. The nurse must instruct the patient in monitoring their feet daily and use a mirror

		if he cannot fully see the bottom of his feet. • The nurse must educate the patient on the importance of monitoring their blood glucose to help prevent delayed wound healing. Uncontrolled or high blood glucose levels prevents the immune system from functioning efficiently, increases inflammation in the body, and prevents nutrients/oxygen from energizing cells. The nurse can provide the patient with a handout on how to self-monitor their blood glucose levels using a blood glucose monitoring device and demonstrate how to use the blood glucose monitoring device.
2. Infection related to impaired skin integrity on the left fourth toe	• Perform wound care every other day (QOD) and PRN. -Cleanse site with Anacept wound cleanser -Apply Cavilon no sting barrier film (skin barrier wipe) to peri-wound -Apply Aquacel Ag cut to fit in wound bed -Apply Optifoam gentle lite to cover wound -Apply Kling Rayon conforming bandage around the patient's toe -Secure Kling Rayon conforming bandage with Hypafix tape • Order MRI and bone scan for patient to check for osteomyelitis. • Order ID consult for the patient.	• It is important for the nurse to perform wound dressing changes every other day or PRN to help prevent further infection Proper wound care helps speed up the healing process and prevent further complications. • The patient presents with erythema without induration, 100% of wound bed covered with loose necrotic tissue, and an x-ray that showed concern for osteomyelitis. An MRI can best confirm osteomyelitis, since it produces detailed images of bones and the soft tissues that surround them. • It is important for infectious disease to consult with this patient to help evaluate which antibiotic is best if needed, evaluate the patient's

		symptoms of infection and review their latest scans and lab results.
3. Impaired blood circulation related to the narrowing of vessels in the lower extremities	• Assess for signs of decreased tissue perfusion every shift. • Review laboratory data (ABI, TCPO2, A1C). • Assist the patient with position changes and promote active/passive range of motion exercises every shift.	• It is important for the nurse to assess the patient's lower extremity dorsal pedal pulses, posterior tibial pulses, and capillary refill every shift to evaluate if the patient shows any signs of decreased tissue perfusion. • The patient presents with an ABI of 0.92 of the left lower extremity, which is considered "borderline" in developing complications such as increased risk for peripheral arterial disease and critical limb ischemia. TCPO2 or transcutaneous oxygen pressure is a non-invasive method to quantify skin oxygenation. The patient presented with an A1C of 7.8% which indicates that the patient's average blood sugar levels over the past 3 months has been high. High blood glucose levels cause fatty deposits to form inside blood vessels. • The nurse can assist the patient with repositioning and exercises as tolerated every shift to help prevent further circulatory compromise.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	• Instead of using a Procare squared shoe, I recommend using a DARCO off-loading shoe. Procare squared shoe may not necessarily help offload the toe area. The DARCO shoe is designed to off load the toes and can speed up the wound healing process. Customizable inserts or PegAssist insoles can be added to the DARCO off-loading shoe as well. • The current wound care regimen is to use Aquacel Ag, foam, and a conforming dressing. After CSWD and cleansing with Anacept wound cleanser, I recommend using Promogran prisma onto the wound, hydrofera blue, optifoam gentle lite (low profile), Cavilon no sting barrier film applied to peri-wound conforming dressing, and hypafix tape to secure. • The current dressing change frequency is QOD and PRN. I recommend the next dressing change will be in one week, since Promogran Prisma can last up to 7 days. Also, PRN if

	dressing gets soiled.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	• Yes, I was able to meet my learning goal this week of learning the commonly used products at the wound clinic I currently work at. I printed out a list of the commonly used products for the clinic and have been making notes as to why each product is used on a patient.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	• My goal is to become more confident and comfortable suggesting wound care products to patients and the provider to help increased wound healing.

Number of Clinical Hours Today:

Care Setting: Hospital __X_ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __ Preceptor: _____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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