Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Meagan Ward Journal Completion Date: 01/15/2023

Setting: _____ Acute Care _x____ Outpatient _____ HHC ____ Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

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. Erythema in foot did not spread any further. Ink pen used to mark erythema edges. 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%.	

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and 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. Monofilament testing completed and noted to be positive. Band aid removed to 4th left 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

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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

Impression: Traumatic foot ulcer complicated by diabetes & peripheral neuropathy 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
- Return to clinic (RTC) in one week

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Altered skin integrity related to left foot wound	Remove previously applied dressing. Utilize NSS (normal saline solution) or wound cleanser if the dressing materials adhere to the wound to prevent unintentional mechanical trauma to the wound bed. Cleanse the wound with wound cleanser. If a commercial wound cleanser is unavailable, use NSS or tap water to cleanse the wound. Be mindful of minimizing friction when cleansing to prevent trauma to the fresh/healing tissues. Gently pat the skin dry. Open the skin barrier wipe and apply in even strokes; careful not to repeat areas as that will prolong drying times.	Removal of previously applied dressing is an essential first step, and caution must be taken to prevent any unintentional damage to the wound bed. Cleansing is imperative in wound care to allow accurate and complete visualization of the wound to assess for healing or degradation of the wound. Barrier film provides a means to protect the periwound skin from the potentially damaging effects of

		prolonged contact with bodily fluids, effluent, adhesives, and friction.
	Cut the AquacelAg sheet to fit the wound bed, cover it with a foam dressing, and secure it with a conforming dressing. Place ProCare squared shoe.	AquacelAg dressings have antimicrobial properties, which is helpful given the concern for infection. They also help promote a moist healing environment, have high absorptive capacity, and provide cushion to the wound. Conforming dressings help ensure all dressings stay where they are intended, cushion the wound, and provide an additional barrier between the wound and the outside environment. The post-op ProCare squared shoe will allow for additional protection to the wound while not having to try and inappropriately cram the foot into a traditional shoe.
	Change the dressing every other day (QOD) and as needed (PRN).	Keeping to a schedule helps the wound heal efficiently. Knowing when to change the dressing PRN (i.e., when the dressing materials are saturated) helps to ensure that further maceration of the periwound skin does not occur.
Ineffective tissue perfusion related to ABI of 0.91, TCPO2 of 13mmHg, and reports of peripheral neuropathy.	Promote active/passive ROM exercises and age, ability, and cognition-appropriate exercise as weight-bearing status and wound healing allow.	Promoting active/passive range of motion (and exercise in general, when appropriate) helps to prevent venous stasis and further circulatory compromise. An ABI of 0.9 and a TCPO2 of 13mmHg indicate peripheral artery disease. Given this information, it would warrant further exploration of the patient's history to determine any measures that could be taken to help improve profusion (i.e., managing diabetes, stopping smoking, controlling hypertension, possible referral to vascular to determine if the patient would benefit from intervention).

Identify each WOC product in use/identified	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.**

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**Skin Barrier Wipe**: Skin Barrier Film – Safe n Simple. The desirable moist healing environment for the wound bed puts the periwound skin at risk for breakdown/maceration. Skin barrier film forms a film barrier that leaves a polymer barrier over the tissue. **Disadvantages**: it has the potential to dry out the skin and can occasionally cause temporary burning/stinging sensation if periwound skin is broken/irritated. **Alternative**: DermaMed Ointment Skin protectant – Skin barrier ointment. If periwound skin is damaged/denuded or macerated, this cream can help dry out the oozing and weeping skin. It can smooth the skin and help to prevent further moisture-associated skin damage. **AquacelAg**: Hydrofiber dressing – ConvaTec. Given the concern for infection/osteomyelitis, this dressing provides the benefit of sustained antimicrobial activity for several days, which prevents microbial reformation. It is also highly absorptive, forming a gel conforming to the wound surface. **Disadvantages**: Not comparable with oil-based products, so thought must be taken when deciding on a skin barrier product. Additionally, a secondary dressing is required to ensure the placement is maintained. **Alternative**: Antimicrobial wound gel-impregnated gauze – Biakos. This gel has the benefit of being sensitive to various bacteria/biofilm microbes while being non-irritating to the wound and surrounding skin. It supports autolytic debridement and promotes a moist healing environment. Care must be taken not to contaminate the tube's opening, rendering the rest potentially contaminated and unusable. **Foam**: Allevyn Foam Dressing – Smith and Nephew. This dressing can absorb large amounts of exudate, provide some cushion to the wound, reducing pressure, friction, and shear forces on the wound, and is easy to apply. It also has a moisture-proof and bacteria-proof film back that can help protect the wound from the external environment. **Disadvantages**: Has the potential to macerate the periwound skin further if left in place too long/not changed/cared for appropriately. **Alternative**: Gauze pad (and tape) gauze dressing – Medline. Gauze comes in various sizes and is readily available and cheap to utilize. Unfortunately, once wet, they are wet and will need to be addressed so that it does not hinder wound healing and further damage periwound skin. Ensuring comprehensive education with teach-back demonstration/understanding for whoever is carrying out wound care is essential. **Conforming Dressing:** Rolled gauze dressing – Kendall. This dressing will add bulk and conform to whatever shape is needed and can secure the dressings in place. This can help cushion a wound as well. **Disadvantages**: It does not provide a barrier to the outside environment and has a greater risk of infection when used alone. Additionally, there is a greater chance that this dressing adheres to the wound, which can be painful upon removal and damage the wound bed. **Alternative**: Elastic bandage – Cardinal Health. It is crucial to ensure that the bandage is placed securely but comfortably. It should be snug enough to hold underneath dressing materials in place but not so tight that it is uncomfortable or impeding circulation. Unfortunately, if the effluent is significant once this dressing is wet, it can impede healing.

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal for this case study was to learn more about protecting periwound skin, as macerated skin adds a layer of consideration to wound healing. I achieved my goal as I was able to research different methods of protecting periwound skin.
What are your learning	I would still like to learn more about negative pressure wound therapy (wound vacs) as my

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

goals for tomorrow? **(Share learning goal with preceptor)**	experience with them are more limited.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	As a virtual student, this case study allowed me to learn more about mechanical trauma, techniques for debridement, and managing periwound skin maceration. Additionally, this case allowed me to explore antimicrobial dressing options, given the concern for infection in the case.

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.