

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Melissa Romeo Journal Completion Date: ___1/23/23

 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	<p>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.</p> <p>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%.</p>
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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 be 0.5cm with palpation of bone. Pt

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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)
<p>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</p> <p>Non-healing wound to left foot 4th toe related to type II diabetes, neuropathy and vascular disease. Concern for osteomyelitis.</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <ul style="list-style-type: none"> -Change dressing to left 4th toe every other day and as needed. Apply Cavilon skin barrier to periwound (skin around wound). Let dry. Cut a piece of Aquacel AG to cover wound bed and apply to wound. Cover Aquacel AG with foam dressing. Wrap lightly with conforming stretch gauze dressing to secure. -Wear ProCare squared shoe at all times when ambulating. -Take antibiotic as prescribed until all remaining pills are gone -Schedule follow up MRI and bone scan as prescribed -Schedule appointment to see infectious disease. Coordinate appointment with Infectious disease during next clinic visit in one week. 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <ul style="list-style-type: none"> -Periwound was macerated. Skin barrier will provide a thin film of protection to the periwound. This helps to prevent maceration by protecting periwound from wound drainage. -Aquacel AG is a highly absorbent hydrofiber dressing. This will help to absorb wound drainage and prevent periwound maceration. This dressing also contains silver. Silver dressings provide antibacterial properties. This is indicated because the patient has periwound erythema, which can be suggestive of infection. The patient is also being treated for an active infection. The silver in the hydrofiber will work by killing and containing bacteria in the wound exudate (Weir & Schultz, 2022). -The foam dressing will help to

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		<p>absorb wound drainage. The foam dressing will also help to decrease friction, shear and pressure between the skin and the dressing.</p> <p>-the conforming dressing will be able to conform to the foot due to its stretchy quality. This dressing will help to keep the primary dressing in place.</p> <p>-The ProCare squared shoe will help the patient to offload the wound. Offloading is important for wound healing as increased or consistent pressure can lead to wound deterioration.</p> <p>-if the patient stops taking the antibiotic before the course is done, he will be at risk for developing a more severe infection that is resistant to antibiotics.</p> <p>-Osteomyelitis cannot be diagnosed by assessment only. MRI is recommended (Weir & Schultz, 2022). Underlying, untreated osteomyelitis can lead to non-healing wounds. Osteomyelitis should be ruled out. The patient's bone was able to be probed, this could be an indication of osteomyelitis in addition to the non-healing wound.</p> <p>-A consult for infectious disease is warranted if there is concern for osteomyelitis or any other complicated infectious process.</p> <p>-The wound should be reassessed in one week for signs of infection and deterioration which would require a change in the treatment plan.</p>
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<p>Identify each WOC product in use/identified 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</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>- Cavilon skin barrier is a liquid barrier that can be used to protect skin from maceration: Disadvantage: it does not easily adhere to a wet surface. Alternative: marathon liquid skin protectant</p> <p>- Aquacel AG is a highly absorptive, silver-containing, hydrofiber dressing. These dressings can help to absorb wound drainage in wounds with moderate to heavy exudate. The silver has antibacterial properties, helping to prevent infection. Disadvantage: may gel in wound so wound needs to be cleaned thoroughly to ensure all of the dressing is removed. Alternative: Medihoney alginate</p> <p>-Foam dressings will help to absorb drainage, maintain a moist wound bed, and provide protection to fragile skin or areas vulnerable to pressure. Disadvantage: Costly. Alternative: Exu-dry anti shear wound dressing</p>
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not available?	-Conforming stretch gauze roll is a stretchy, light weight dressing that can be used to secure dressings on areas such as limbs. Disadvantage: may come off with movement. Alternative: Coban
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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 was to learn more about caring for diabetic foot wounds. I was able to meet my goal and learned about dressings I wasn't familiar with as I tried to think outside the box when coming up with alternative dressings that might work for a toe wound.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	My goal for tomorrow is to learn more about osteomyelitis.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<ul style="list-style-type: none"> -I would have the patient/caregiver change the dressing daily, not every other day. It is important to assess diabetic feet and wounds every day. Changes can occur quickly, and they would likely go unnoticed due to the patient's neuropathy. -For home wound care, I would add a wound cleanser, such as Vashe, to the regimen. - Consider endocrinology consult. The pateint's A1C is elevated, adjustments may need to be made to his current treatment regimen.
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Reference:

Weir, D., & Schultz, G. (2022). Assessment and management of wound-related infections. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Core curriculum: Wound management* (2nd ed., pp. 187-213). Wolters Kluwer.

Reviewed by: _____ Date: _____

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