Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Jennifer Lemert_____ Day/Date: 9/28/2023

Number of Clinical Hours Today: _8___ Care Setting: _____ Hospital __X__ Ambulatory Care ___ Home Care ___ Other: _

Number of patients seen today: ___20__ Preceptor: ___Kimberly Mauck_____

Journal Focus: __X___Wound ____ Ostomy _____Continence _____Combination Specify: _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.**
Total Contact Casting opportunity with TCC-EZ	CC: Post operative visit with flap/incision check and re-application of TCC. HPI: I.Y. is a 50 year old male who comes in 5 weeks post op second distal metatarsal shortening with fusion of the MTPJ followed by anterior-lateral foot free flap using lateral thigh muscle. He has pins in his second toe. At this time he is in a total contact cast to allow for 90 degree flexion at the ankle and free flap protection. He is seen by podiatry, and plastics sees him later in the visit for check as well. He is doing well. He has diabetic neuropathy and has no pain. He is still avoiding weight bearing, but admits that he does use his heel to balance when transferring. He denies fevers, chills, sweats. HE denies complaints of itching, pain , or selling related to the TCC. PMH: NIDDM, Hyperlipidemia, PAD-s/p reperfusion procedures PSH: Angiogram left leg with arterial stents Early August 2023 and mid August 2023 Left Foot wound debridement: 8/11, 8/16, and 8/2022. Left foot second metatarsal shortening with fusion of the second MTPJ and pin placement, followed by free flap closure of chronic wound. Family History: Diabetes Social History: smoker-40 pack year history, still smoking, refuses cessation. Allergies: NKDA Medications: ASA 325mg po QD Atorvastatin 40mg po QD Clopedigrel 75mg po QD

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	Cyanocobalamine 1000mcg IM Qmonth Glypizide 2.5mg po QD Januvia 100mg po QD Metformin 1000mg po BID Pantoprazole 40mg po QD XRAYS: left foot: pins stable, fusion site still visible, improved from last XRAY, no evidence of osteomyelitis or other acute change Vital Signs: T 36.8, BP 137/83, Pulse 81, Resp: 18

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, *interactions, and specific products that were used/recommended for use.*

The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit. Write in a manner others will be able to understand and be able to interpret your plan of care.

Visited with patient with technician for cast removal. The cast was removed without difficulty, discomfort or injury. Dr. Steinberg and I returned to evaluate pins, and surgical site.

Physical exam:
Gen: pleasant and cooperative
Neuro: alert and oriented x3, speck clear and appropriate. Moves all extremities well, cautious with left lower extremity, no pain in left lower extremity and patient has no protective sensation on the planar or dorsal foot. He does have sensation to gentle touch starting above the ankle.
Pulses: Left foot: DP and PT biphasic and moderate strength with doppler
Skin: plantar skin graft surgical sites are well approximated, numerous prolene sutures in place, graft is swollen, warm, capillary refil 4 seconds, no drainage, purulence, redness, odor or open wounds.

Assessment: graft doing well, pulses and circulation good, photos taken and saved to chart
Plan: replace TCC, follow up in one week for suture removal with Plastics and 2 weeks for pin removal with podiatry

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. Post op left foot 2nd metatarsal shortening and Fusion of second MTP joint immediately followed by anterior lateral foot free flap muscle graft and primary closure.	**Statements should be directive and holistic relating to the problem/concern.** Weekly post operative visits in wound care clinic alternating between plastic and podiatry. Local surgical site protection with TCC Steps for TCC: 1. Wash hands, apply gloves	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** 1. Always wash hands before and after every client to reduce risk on spreading infection. Gloves are

		appropriate PPE, may want to use disposable gown as well to protect from cast removal biproducts
	2. Cut stockinette at superior anterior cast in line with demarcation on anterior cast. Remove cast using a cast saw, cutting over anterior line on TCC, cut a perpedicular line over the toes. Usse cast spreader to loosen cast, cut white leeve and pull out anterior padding, and then slip out foot out of cast.	2. The cut line is one of the areas on a TCC where the case padding is quite thick and injury with cast saw is unlikely.
	3. Remove and discard all padding and dressings.	3. All old padding and dressings cannot be re-used.
	4. Remove gloves, wash hands, replace gloves	4. Avoid contamination of wound or new dressing with dirt or debris related to cast and removal of cast.
	5. Using PH balanced skin cleaner, wash leg and foot, and pat/blot dry	5. Washing surgical site between cast changes reduces peri-incisional surface bacteria.
	6. Apply skin cream to ankle and foot avoiding the incision. Paint incision with gentian violet and cover incision with non-adherent foam dressing. May secure dressing with tape. Wash hands and re-apply gloves NOW APPLY TCC ACCORDING TO PACKAGE INSTRUCTIONS—This TCC is "TCC-EZ". Maintain ankle in 90 degrees. Position patient in a prone position to allow cast placement with ankle in 90 degrees.	6. Keeping the peri incisional skin healthy under a cast is achieved with emollients and protection. The incision is protected from surface microbes with gentian violet, non-adherent foam will accommodate and wick away drainage, and protect suture line. Keeping ankle at 90 degrees keeps layers of casting material from bunching up after fiberglass layer is placed and molded. If patient is prone with knee and ankle at 90 degrees, the patients support their own leg the cast is easier to place correctly.

	7. Apply stockinette from just beyond toes to just above the knee	7. Stockinette protects skin and wicks away sweat
	8. Apply protective felt padding, start below the knee, and continue down the anterior lower leg, ankle, dorsal foot, around the toes (accommodating the pins), plantar foot and posterior ankle. Position the circular flaps over the malleoli. Secure padding with plastic tape at the dorsal foot, arch and behind heal.	8. This padding protects bony prominences, incision site, and allow for cutting the cast off along the mid anterior lower extremity without injuring the skin. Securing padding prevents it from bunching up or folding under cast.
	9. Cut off overlapping, folded, or excessive padding. There should be no folds or wrinkles and posterior padding should end 1-3 inches proximal to the heel. Make sure there is room to accommodate pins, toes, and posterior heel	9. Rationale as above
	10. Roll white sleeve in two-inch donut shape and unroll over padding allowing for 2-4 inches of white sleeve beyond the toe and up to knee leaving 2 inches of stockinette exposed. Loosely fold white sleeve up over toes and tape to secure	10. This white sleeve holds padding secure so fiberglass layer can be placed without displacing padding
	11. Open cast material and using a 2-inch fold, roll material into a donut shape.	11. Rolling casting material allows the material to be rolled onto the lower extremity without displacing the padding or bunching up the casting material.
	12. Soak casting material in cool water (70-80F). Lightly squeeze out excess water.	12. Using warmer water will cause casting material to set faster, heat up hotter and can injure patient or weaken cast. Cooler water can slow the casting material set time.
	13. Unroll casting material over toes leaving 2-3 inches of casting material beyond the pins. Continue unrolling material up towards knee. Fold back excess casting material so that it ends at widest porting of calf muscle, then fold back stockinette to protect skin from	13. Follow product specific instructions for place cast appropriately. Protect skin, toes and pins.

	casting material. At toes, fold casting material up and over toes/pins to dorsal foot. 14. Ensure ankle is at 90 degrees for foot and ankle in neutral position to unload pressure for the plantar mid and distal foot. Rub casting material firmly to mold it to the shape of the foot and leg. This rubbing molding should last for 3-5 minutes until the casting material is initially set. Then let cast sit to dry until the toe is cool and firm (15-20 minutes) 15. Put patient in cam boot for cast protection. Weight bearing as per surgeon. This patient can weight bear on his heel. Patient Teaching: Use protective boot if able to weight bear at all. If cast is loose, rubbing, painful or gets wet, call clinical asap, the cast will need to be changed. Instruct patient in where the cast should be cut for removal in case the cast needs to be removed in and urgent care clinic or ED. TCC padding is anterior and over toes so cut is anterior and over toes, not “bi-valved”. Cast change initially is in 2-3 days, and then weekly as per surgeon. For individuals putting casts on: Indications: 1. Post operative care in charcot foot, delayed primary closures, and as per surgeon. 2. Neuropathic non infected foot ulcers with no exposure of bone, joint capsule or tendon. 3. Charcot neuropathy 4. Pre-ulcerative foot conditions. Contraindications: 1. Infection 2. Wounds with exposure of tendon, bone or joint capsule 3. Foot ulcers that are deeper then they are wide 4. Ischemic vascular disease 5. Allergy to casting components	Casting material should be dry and set before placing cam boot or cast may mold inappropriately causing pressure over bony points or allowing ankle to leave 90 degree angle.

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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 not available?	TCC-EZ product was used. This product is easy to apply. It is more expensive. One advantage/disadvantage is that it does not come with a CAM boot. With this patient, it is unnecessary to replace the cam boot with every TCC change, so not including the boot is an advantage. Another advantage of the TCC-EZ is the fiberglass component is a sleeve of material that is perforated to allow for the cast to have ventilation. Other TCC fiberglass is in rolls and cools more slowly and can be warmer to wear. An option to the TXX-EZ are the TCC with similar padding, but the addition of soft roll over padding and then layers of plaster and fiberglass casting material, as well as a foot plate. Each of the TCC systems is a bit different, so it is important to follow the manufactures guidelines. TCC choice will be dependent on who is prescribing the TCC and for what reasons.

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 the day? Were you able to meet your learning goal for today? Why or why not?	1. Shadow again in wound clinic. Specifically, I will follow Dr. Steinberg in wound care limb clinic. He is a Podiatrist. I reached this goal. I saw 20 patients with him. 11 had wounds, 6 were diabetic foot checks, 1 was a non diabetic neuropathic foot, 6 were candidates for podiatric surgery, one was postop free flap with good healing. 2. Participate in replacing a compression wrap in a patient with LEVD. I had hoped to do another LEVD associated compression wrap, but none of the patients required wraps today. 3. Observe TCC placement. I was able to complete this goal. The post op free flap patient had a TCC, so I was able to shadow the tech in removing and re-placing the TCC-EZ system. The purpose of the TCC was to offload and protect the plantar foot. This is accomplished with padding and positioning within a fiberglass sleeve (cast). The fiberglass sleeve has stretch, whereas orthopedic fiberglass does not have stretch. 4. Protective padding and positioning of the ankle in 90 degrees of flexion allows for offloading of plantar diabetic wounds or post op free flaps. 5. See am many LE wounds as possible and determine when they need debridement, what kind of debridement, selective versus non-selective and office based versus surgical. This goal was accomplished. I was able to identify confirm choices for dressings. The surgeons in this clinic often use gentian violet painted on periwound skin edges, mepitel contact layer and mepilex foam or hydrofera blue foams. In some circumstances they use iodosorb in deeper parts of the wound. If heavily exudating, they will use drytex over a contact layer. This is not a complete list of what is used, but illustrates what they use commonly.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Shadow in lymphedema clinic with Mick, who is an Occupational Therapist who specializes in lymphedema and wound management. I hope to see lymphedema care including Manual Lymph drainage and application of compression wraps as well as discuss garments, physical therapy plans, and pneumatic compression devices.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	It was great to see a TCC. The tech that applied the cast did a great job of explaining the steps and importance of each layer of product used and why it was used as well as how to avoid complications of TCC. He applied the TCC with the patient reclined, as the patient could not lie on their stomach. I would have supported the extremity a bit differently to make sure the TCC did not mold with pressure on the posterior surface of the distal leg, as the patient did report pressure

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	on the back of his leg with a prior TCC. I have applied numerous orthopedic casts, so I was able to understand the differences in the products used and how they are used. I am already comfortable using a cast saw. I feel that after seeing this, I could apply a TCC.
Reflection: Describe other patient encounters, types of patients seen.	Since I followed a plastic surgeon last week, I had an idea of what I would see with another surgeon in this wound care clinic. However, with the podiatrist, there were more possible podiatry surgical patients. Where the plastic surgeon emphasized circulation to avoid amputation or prepare for skin graft, free flap or reconstruction, the podiatrist saw a bigger variety of foot problems and emphasized pressure on the foot and ankle related to gait changes or structure problems in the feet. It was with this opportunity that the filament testing was illustrated. Of course, I have done both filament and vibratory testing for neuropathic feet. This is just part of advanced practice, but it was interesting to see it related to other structural changes like Charcot) and then see where the wounds had occurred. His explanations of structure problems, gait changes and wound development was fascinating and I learned quite a lot

Reviewed by: _____ Date: _____

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