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| Objective Data:  
- Gangrene infected left foot  
- Open wound  
- Wet to dry dressing  
- Pain upon movement, grimacing, shaking  
- She immediately requests Morphine  
- She needs assistance when ambulating, even to sit up in bed | #1: Impaired tissue integrity r/t wound, presence of infection. | Patient will:  
1. Report any altered sensation or pain at site of tissue impairment during January 23 and 24.  
2. Demonstrate understanding of plan to heal tissue and prevent injury by 1/24.  
3. Describe measures to protect and heal the tissue, including wound care by 1/24. | 1. Monitor color, temp, edema, moisture, and appearance of surrounding skin; note any characteristics of any drainage.  
2. Monitor site of impaired tissue integrity at least once daily for signs of infection. Determine whether patient is experiencing changes in sensation or pain. Pay attention to all high risk areas such as bony prominences, skin folds, and heels.  
3. Monitor status of skin around the wound. Monitor patient’s skin care practices, noting type of soap or other cleansing agents used, temp of water, and frequency of cleansing. | 1. Systematic inspection can identify possible problem areas early in infection.  
2. Pain secondary to dressing change can be managed by interventions aimed at reducing trauma and other sources of wound pain.  
3. Individualize the plan according to patient’s skin condition needs and preferences. Avoid harsh cleaning agents, hot water, extreme friction or force, and too frequent cleansing. | 1. Surrounding skin remained intact and w/o inflammation.  
2. Wound did not have signs of added infection.  
3. Educated patient on technique of cleansing and putting on dressing. Had her watch while I did it so she could understand. She stated she would try to do it herself when she is discharged. |

Subjective Data:  
- Patient said the pain is worse when ambulating & turning  
- She said she dreads physical therapy  
- She said she wishes she did not have to be in this situation |Medical Diagnoses:  
- Diabetes foot ulcer  
- Diabetes Mellitus Type 2  
- PVD  
- Infection |
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<td>4. Experience a wound that decreases in size and has increased granulation tissue.</td>
<td>4. Select a topical treatment that maintains a moist wound –healing environment but also allows absorption of exudate and filling of dead space.</td>
<td>4. Choose dressings that provide moist environment, keep skin around wound dry and control exudate and eliminate dead space.</td>
<td>4. Used wet to dry dressing, which was changed twice a day.</td>
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<td>5. Achieve functional pain goal of zero by 1/24 per patient’s verbalizations.</td>
<td>5. Assess patient’s nutritional status; refer to nutritional consultation.</td>
<td>5. A good diet with nutritional foods and vitamins may help promote wound healing.</td>
<td>5. She was on a clear fluid diet but still has little appetite. Continued consultation with nutritionist before discharge would be beneficial.</td>
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