

Daily Journal Entry with Plan of Care & Chart Note

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Day/Date: August 29, 2020

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 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	<p>Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc</p> <p>52-year-old male with a history of morbid obesity, CHF, COPD, PE and venous stasis ulcers presented to the ER with bilateral lower extremity edema, cellulitis and ulcers. He states both legs have been swollen for a month and are extremely painful to touch. He independently wraps his legs daily. He currently has been suffering with pain and was afraid to come to the hospital because of COVID-19. He states his legs are now weeping, clear drainage. B/L extremities are erythematous and warm, confirmed cellulitis. He is currently taking Bumex 2mg BID. He has been taking Tylenol for pain but states it is not helping. He lives alone and is oxygen dependent. Has been SOB this past week and normally wears 4 L of oxygen at home but admits he can be non-compliant with wearing his O2.</p> <p>Patient was started on Vancomycin. Given morphine for pain. Lasix for CHF. Potassium is low at 2.7. He was ordered IV potassium. Troponins were normal. COVID neg. Ultrasound r/o DVT's.</p>
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Initial Consult: Bilateral lower extremity cellulitis, Present on admission

Pt alert and oriented. Agreeable to assessment and dressing change. Patient states pain is 4/10 currently but will be 11/10 with moving his lower extremities. RN pre-medicated pt 20 minutes prior to this visit Morphine as prescribed. Removed saturated ACE wraps from BLE. No dressings in place. Several small congruent open wounds scattered across BLE below the knees with partial thickness tissue loss. BLE warm to touch. Moderate amounts of serosanguinous drainage with no odor noted. Periwound skin is edematous, with scant moisture associated skin damage and moderate discoloration of skin (purple/ red). LLE slightly more edematous than the right. LLE measures 43cm at the calf with reference point of 12cm from knee gatch, 25cm at ankle with reference point 2 cm above maleolous, and 20cm plantar foot. Left posterior open leg wound measures 2.5 x 4.8 x 0.1 cm, left anterior leg wound measures 3.1 x 4 x 0.1 cm. RLE measures 40cm at the calf with reference point of 12cm from knee gatch, 23cm at ankle with reference point 2 cm above maleolous, and 20cm plantar foot. Right lower posterior open leg wound measures 5.8 x 4.2 x 0.1 cm. Dorsalis, posterior tibial and popliteal pulses palpable to BLE. Patient felt very warm, temp. 99.8. RN present for assessment. BLE wounds cleansed with Coloplast wound cleanser. Aquacel Ag applied to open weeping leg wounds and covered with ABD pad and wrap with Kerlix. Tubular compression dressing applied. ABI/TBI ordered and pending. Plan to compress BLE with ACE wraps if indicated after testing.

Plan: Nursing to change BLE dressings daily and prn for saturation. Reevaluate dressing frequency with next visit. Continue to follow SKIN bundle of pressure redistribution, turn patient q 2 hours and moisture/friction control. Bariatric pressure redistribution bed ordered. Elevate BLE. Encourage ambulation. Nutrition on consult. Will continue to follow while inpatient.

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	<p>Institute low-level compression with tubular compression dressing, to increase to ACE when ABI readings are available</p>	<p>necessitates higher levels of compression (30-40mmHg) to achieve and maintain healing. It is imperative to assess the patient's perfusion status to the lower extremities, via ABI prior to initiating higher levels of compression. Failure to ensure adequate perfusion may cause the WOC nurse to miss a possible arterial insufficiency to which applying high level compression is contraindicated and could have catastrophic effects for the patient. If an arterial component does exist, depending on the degree of involvement, the patient will require further testing and possibly a Vascular Surgery consult.</p> <p>Compression supports healing in the setting of venous insufficiency by reducing the degree of incompetence in the valves of the veins over which it is applied. Compression also improves the efficacy of the calf muscle pump function by the same mechanism. By promoting venous return, the degree of hypertension in the capillary bed is reduced and inflammation decreases allowing for healing to occur. This intervention ensures the appropriate degree of compression will be instituted while taking other risk factors into account while obtaining more definitive studies of</p>
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Pain	<p>Premedicating patient prior to care</p> <p>Use of less adherent dressing materials</p>	<p>(other than wraps), which increases the risk for infection. Implementing dressing changes with topical antimicrobial action helps to reduce bacterial activity within the dressing and reduces risk of secondary infection from additional bacteria entering from the skin flora or patient environment. This combined with appropriate compression therapy and exercise will help achieve the medical goal of resolution of infection and inflammation.</p> <p>Consultant notes specifically noted patient concerns related to pain and pre-medicating the patient as an intervention prior to care. Managing the patient's pain both prior to dressing changes, as well as routinely as needed may help to achieve patient compliance with both dressing change regimen and ambulation/activity goals.</p> <p>Hydrofiber dressings have a gelling effect when saturated, this will help to reduce dressing adherence to wound base, making dressing changes more comfortable.</p>
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What are the disadvantages of using this product(s)? What alternatives could be used and why?	As drainage from wound decreases in response to therapy (IV antibiotics, compression, elevation, and exercise) the dressing material may become adherent. An antimicrobial foam dressing with a silicone contact, such as Mepilex Ag, could offer absorption for moderate drainage while maintaining antimicrobial activity and minimize product adherence to wound base.
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R.B. Turnbull, Jr., M.D. School of WOC Nursing

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. My learning goal for today was to work on a journal entry and work toward completing my course work.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	My plan for tomorrow is to work on another journal entry.

Reviewed by: _____ Date: _____

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