

Daily Journal Entry with Plan of Care & Chart Note

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Day/Date: 1/13/2021

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:

<p>Initial Consult: Bilateral lower extremity cellulitis, Present on admission</p> <p>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.</p> <p>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.</p>

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WOC specific medical & nursing diagnosis	WOC Plan of Care (include specific product used today)	Rationale (<i>Explain why an intervention is chosen; purpose</i>)
<p><i>This patient has chronic, bilateral venous insufficiency ulcers. The factors that make these chronic is that they are characterized by persistent inflammation (patient states they have been this way for over a month). They are failing to close with a standard approach to wound care. The tissue has ineffective remodeling, and needs to be addressed with specific dressings, and a holistic approach from the care team.</i></p>	<p><i>The plan of care for this patient is to cleanse the bilateral lower extremity wounds daily with Coloplast wound cleanser. Aquacel AG should be used as the primary dressing on the open ulcers. Add ABD pads as secondary dressings, along with wrapping the bilateral lower extremities with Kerlix. This dressing change can be performed as needed (in addition to daily) as the serosanguinous exudate saturates the dressings. Nutrition consult, as well as physical therapy should be put on consult to address the morbid obesity. Repositioning the patient every two hours, along with friction and moisture control will reduce the risk of pressure injuries. The bariatric mattress is ordered to assist with this as well.</i></p>	<p><i>Use of Coloplast wound cleanser is a saline-based solution that works well for acute and chronic wounds. The patient does not have to rinse after using the product. It is an isotonic solution and pH balanced. Since the patient is in pain, it also has a low psi irrigation pressure, which will lessen the pain upon application.</i></p> <p><i>Aquacel AG is a good choice for a primary dressing in this patient. There are a few different types of Aquacel AG, but the foam would benefit the patient greatly. There is serosanguinous exudate noted, and the foam acts as an absorbent in this case. The hydrofiber contact layer gels on contact with the wound fluid. The use of silver in this product will also decrease the bacterial factor since silver is an antibiotic. He already has cellulitis, so any help to reduce an infection is key.</i></p> <p><i>The ABD pads and Kerlix add for more absorbent properties as well as another layer of protection. Again, the pain level of 11/10 noted is extreme, and any additional padding may be able to reduce the pain for the patient. Kerlix is also absorbent and can mold and conform to the lower legs as to hold the dressings in place.</i></p> <p><i>The tubular compression dressing applied will act as a pumping mechanism for the venous insufficiency. Hopefully this will start to improve circulation of the blood back to the heart. This will lessen the swelling, pain, inflammation, and hopefully the ulcer size as well.</i></p>

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		<p><i>This patient is at high risk for a pressure injury, so repositioning every two hours is imperative. In addition to a pressure injury, he is also at risk for moisture associated skin damage. Repositioning will also help with assessment of this, and the RN will be able to dry the skin, or add barrier cream as needed.</i></p> <p><i>The morbid obesity of the patient has been addressed with the ordering of the bariatric mattress. This special mattress redistributes pressure among all the contact surfaces of the body and the bed. This also lessens the chance of a pressure injury. In addition to the mattress, nutrition has been placed on consult. This patient needs further education on not only caloric intake, but how different vitamins and supplements will help the closing of wounds as well.</i></p> <p><i>Encouraging ambulation is also key. The legs need to pump blood back to the heart. The compression dressing only works when the body is moving. The circulatory system in the body needs a kick start, but it is up to the patient to “work out” as well. Start slow and build up just like any type of new exercise.</i></p>
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<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p>	<p><i>The disadvantage of these products is that there are a few steps involved. This patient is morbidly obese and therefore might have some mobility issues that could hinder his ability to physically change the dressings. It also states he lives home alone, so there is no one to help him. If he is unable to change the dressings, the saturated products will be a breeding ground for bacteria, and is a risk for sepsis.</i></p> <p><i>Alternatives that could be used is not really an alternative, but a supplemental intervention. Many insurances come with a home health nurse that is able to visit with a doctor’s referral. It may only be 3-4 times a week, but this could ensure that he is getting some help versus none. The RN would also be able to further educate the patient and have him learn more in the comfort of his own home. Outpatient wound care clinics are also something to look into. Normally also covered by insurance only 1-2 times a week, this in addition to the home health care nurse would take care of the majority of the days in a week.</i></p>
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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?	<i>My learning goal today of reviewing products and dressings was met. Going back to my wound course notes and lecture slides was very helpful, and allowed me to form a plan of care for this specific patient.</i>
What are your learning goals for tomorrow? (Share learning goal with preceptor)	<i>My learning goals for tomorrow (or the next journal day) are to gain more hands-on experience. I am currently on a travel nurse assignment, and have made friends with the WOC nurses that see patients. The orthopedic/urology floor I am on is amazing when it comes to putting the didactic portion of what I have learned into somewhat of a “clinical” experience. Even if it is only for 10-15 minutes with one patient.</i>

Reviewed by: _____ Date: _____

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