Cleveland Clinic

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

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name: Tina Garcia Miller Day/Date: 02/25/21

***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, s***elect 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.

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| **Today's WOC specific assessment** | **Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc**<br><br>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.<br><br>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. |

**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 malleolus, 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 malleolus, 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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| **WOC specific medical & nursing diagnosis** | **WOC Plan of Care (include specific product used today)** | **Rationale *(Explain why an intervention is chosen, purpose)*** |
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| Impaired skin integrity as evidenced by venous stasis ulcers to bilateral lower extremities due to peripheral vascular disease. | Continue to change dressings to BLE daily and PRN for saturation.<br>• Clean legs with Coloplast wound cleanser<br>• Apply Aquacel Ag to open and weeping leg wounds<br>• Cover the Aquacel Aq with an ABD pad and wrap with Kerlix.<br>• Cover with tubular compression dressing. | Coloplast (Sea-Clens®) wound cleanser is a commercially-available saline-based cleanser that is safe to use on acute and chronic wounds as it is not cytotoxic and does not add or remove moisture from the wound bed.<br><br>Aquacel Ag is highly absorbent hydrofiber dressing that is impregnated with silver ion to kill bacteria and yeast in the wound bed and most yeast. When this dressing come into contact with wound exudate, it creates a gel that adheres to the wound bed and promotes autolytic debridement.<br><br>The Kerlix and ABD pad are used to hold the Aquacel Ag in place and to add another absorbent layer.<br><br>The tubular bandage offers additional support to the dressing and may offer a minimal amount of compression. |
| | Elevate the feet to at least the level of the heart for 30 minutes 3-4 times daily. | Elevation of the legs can improve venous return but is ineffective if the legs are below the level of the heart. |
| | ABI/TBI ordered and pending. Plan to compress BLE with ACE wraps if indicated after testing. | Compression therapy for venous ulcer management works by compressing the distended superficial vessels and increasing the level of pressure in the interstitial space resulting in a reduction of edema. Before initiating compression therapy, it is important to review the ABI/TBI to ensure that there are no contraindications for the type of compression being used. |

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| | | Static compression as provided by compression stockings and compression bandages is usually 30-40 mm Hg and is generally contraindicated for individuals with an ABI ≤ 0.5. For patients with an ABI that is between 0.5-0.8, a compression of 23-30 mm Hg is appropriate.<br><br>For the patient that requires frequent dressing changes, ACE bandages can be used. |
| Acute pain related to dressing changes | Premedicate the patient for pain 20 minutes prior to dressing changes (if intravenous) and up to 60 minutes prior if oral medication. | Controlling the patient's pain will reduce anxiety associated with dressing changes and promote healing. |
| Infection (cellulitis) | Patient is on Vancomycin | The first line drug of choice to treat cellulitis is vancomycin. |
| Impaired mobility due to body habitus, acuity of illness, and co-morbid conditions. | Continue to follow SKIN bundle of pressure ulcer prevention:<br>• Bariatric low air loss bed ordered<br>• Turning and repositioning q2 hours<br>• Moisture control<br>• Nutrition consult ordered<br><br>Control moisture in skin folds with absorptive linen, moisture wicking products, or absorbent padding.<br><br>Reinforce the importance of small shifts in position and ambulation with the patient. | This patient may be of higher risk of skin injury due to impaired mobility, increased weight, and reduced tissue oxygenation (related to COPD). As a result, it is good practice to provide an appropriate support surface and implement skin protective measures.<br><br>Areas with deep skin folds can trap moisture and become breeding areas for bacterial and fungal growth. |
| Imbalanced nutrition more than body requirements – the patient is morbidly obese | A nutrition consult has been ordered.<br>Explore patient's access to food and eating habits upon his return to home. Verify that he has access to nutritionally dense foods and fresh produce. Encourage making healthy choices and provide information on lifestyle changes and weight loss. | The patient needs to consume a diet that is adequate in protein to meet the needs of adequate wound healing. |

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| Deficient knowledge as evidenced by poor compliance | Provide education on nutrition, compression therapy, and venous insufficiency and venous ulcers. | Management of the patient with venous insufficiency is ongoing to prevent the recurrence of venous ulcers and will require a combination of compression, weight management, and increased physical activity. Continued teaching and reinforcement may facilitate adherence which will then improve outcomes. |

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| **What are the disadvantages of using this product(s)? What alternatives could be used and why?** | Coloplast (Sea-Clens®) wound cleanser is an additional cost. Sterile normal saline may be less expensive.<br><br>Aquacel Ag may adhere to the wound bed. An alternative option would be the application of Hydrofera Blue foam with a secondary dressing to secure it.<br><br>The plan after the ABI/TBI is to use an ACE bandage for compression. An ACE bandage will not provide enough or equal compression in cases of venous insufficiency. As the individual has wounds that require frequent/daily surveillance. Molynlyke Tubigrip can provide minimal compression, secure dressings, and can be washed and reused. |

**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

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| **Were you able to meet your learning goals for today? Why or why not?** | This case was chosen because this is a common scenario or type of patient that is often seen in the wound clinic. |
| **What are your learning goals for tomorrow?**<br><br>**(Share learning goal with preceptor)** | Continuing in explore different modalities and ways to treat patients with chronic lower leg wounds |

Reviewed by: ___ _____ Date: _____

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