Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

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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***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	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc** 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. 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

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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.

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
1. Chronic venous hypertension with ulceration to bilateral lower extremities – i87.313 2. Venous insufficiency – i87.2 3. Hemosiderin staining – L81.8 4. Cellulitis of bilateral lower extremities - L03.119	1. I would agree with above the plan of care. I would make sure that the wounds and periwounds (i.e., the bilateral lower extremities) were washed with pH balanced cleanser any time after the saturated dressings have been removed (I assume Coloplast® wound cleanser is adequate). 2. I would agree that Aquacel® Ag^+ is an appropriate primary dressing choice. 3. An abdominal pad is also an appropriate secondary dressing choice. 4. Securing the primary and secondary dressings with Kerlix™ and tape is an appropriate method of securement. 5. Appropriate sized tubular compression with a light-moderate degree of compression is adequate for this patient. 6. Elevate the lower extremities three times per day for an hour. While in bed, make sure that his lower extremities are above the level of his heart. 7. Low sodium/cardiac diet as well as increase of protein intake 8. Routine oxygen use to ensure peripheral oxygen saturations remain above 92%. 9. I would also make sure this patient has proper DVT/PE prophylaxis, which isn't stated in his medical record. He has a PMH of PE so I would hope he was sufficiently anti-coagulated at this hospital visit. 10. Proper SKIN bundle/pressure injury prevention is adequate. 11. Make sure patient is set up with outpatient follow-up at a wound care center	1. Wash with a pH balanced cleanser to maintain skin's acid mantle as well as to remove any non-viable tissue/try skin with gentle cleansing of the wounds and periwounds. Cleansing the wounds and periwound skin is an appropriate method of mechanical debridement for the WOC nurse to perform. 2. Aquacel® Ag^+ is an antimicrobial dressing due to the silver cation present. It also is a hydrofiber, thus the vertical wicking technology will be sufficient to absorb the moderate amount of serosanguinous dressing the patient has. 3. Abdominal pad is a necessary secondary dressing to absorb the excess fluid these wounds may exude through the Aquacel® Ag^+. 4. The Kerlix™ also adds a layer of absorptive quality. 5. Tubular dressings of a light to moderate compression are appropriate in this case. For the patient has palpable pulses bilaterally on DP & PT surfaces. I would not increase compression until after his ultrasound to r/o DVT as well as ABI/TBI has been completed. This is so the clot, if present, isn't dislodged and could possibly travel upwards in the body to the lung or brain. As well as, if ABI is below 0.8, this could affect his circulation to lower extremities if compressed to to high of a pressure. It's unlikely this patient has peripheral artery disease based on the current assessment, but obtaining ABI/TBI is best practice prior to start of higher compression. 6. I would make sure this patient is

		elevating his lower extremities, as frequently as possible, above the level of his heart. This will decrease the edema in his BLE and reduce the amount of drainage that would result if his legs were in a dependent position. However, this patient might not like to elevate his legs for with COPD, most individuals prefer sleeping in a chair with extremities dependent so adequate lung expansion can occur. So it's important to stress this leg elevation, especially until the DVT is ruled out and the ABI testing comes back. 7. A low sodium cardiac diet is pertinent to this individual. For the decrease in salt content in his diet will help to decrease his BLE swelling. Higher protein intake will aid in repairing his wounds and assist in proper functioning of his organ systems. 8. Routine oxygen use will help with adequate lung ventilation and assist oxygen and the appropriate elements to get to the tissues for repair of wounds. 9. Proper DVT/PE prophylaxis is pertinent for this patient. For if the patient has a DVT in his left leg (it has an increase in circumference) it will not dislodge and travel to his lung or brain. 10. This patient is obese and is more immobile due to his increase in SOB. So a bariatric pressure redistributive surface, q2 turn schedule, moisture/friction control is definitely appropriate. As well as proper cleansing and drying under skin folds and in perineal areas are essential to maintain intact skin integrity. Patient is obtaining IV diuretics and may be experiencing incontinence. 11. Ensuring patient has a follow-up appointment with a wound care center after discharge is essential. This will help maintain patient's compliance with continual

		compression wear, thus decreasing his cellulitis episodes, and further hospital readmissions.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	Disadvantages of using Aquacel® Ag^+ is that it can dry and stick to wound beds as the wound bed begins to dry out. This can cause significant increase in pain for patient. One could use a wound contact layer under the Aquacel® Ag^+ to keep the wound more hydrated, but this decreases the effectiveness of the autolytic debridement this dressing can provide. So, another antimicrobial that can be used is Hydrofera Blue® Ready *Transfer*. It does not have the film backing the Hydrofera Blue® Ready has (this eliminates the extra trapping of fluid from the film and possibly macerating the periwound skin) and it does not have to be moistened like the Hydrofera Blue® Classic does (this eliminates the pain of removing the Hydrofera Blue® Classic when the product hardens as the wounds begin to decrease in drainage), and it provides absorption for moderately draining wounds this patient has. It has to be used with a secondary dressing such as an abdominal pad, so that piece of the plan should not change. Hydrofera Blue® products contain methylene blue and gentian violet which are bactericidal and trap bacteria as exudate is absorbed.

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 believe I was able to meet my learning goal for this virtual clinical day. I was able to see a current treatment plan, make modifications and additions where appropriate, and display knowledge of my own experience, critical thinking, and education to add to the treatment plan. This patient will hopefully heal quicker with the additions made, which will increase patients quality of life, as well as patient satisfaction.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Learning goals are to holistically view the patients plan of care with further addition of a multi-disciplinary care team members (i.e. add in physical/occupational therapy to increase patients safety at hospital and eventually at home).

Reviewed by: ___ _____ Date: _____

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