Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Cathleen Nesheiwat Day/Date: 6/28/2021

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, 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** 61-year-old patient with HX of uncontrolled DM presented to ER with complaints of abscess to left labia starting over a month ago. Patient states it drained bloody purulent drainage and started developing excruciating lower abdominal pain. CT findings compatible with necrotizing fasciitis arising from left labia majora extending along anterior and posterior aspect of abdominal wall. Surgery preformed wide debridement of necrotizing fasciitis area (debridement of skin, subcutaneous fat and fascia) leaving an extra large wound to lower abdomen and left labia. Surgery wants recommended treatment, possible Negative pressure wound therapy.

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 visit: Evaluation and management of lower abdomen surgical wound that extends to left lower labia. Possible NPWT device application

Patient alert and agreeable to assessment. Patient states she is in severe pain 10/10. RN notified and administered IV Morphine as per order. Encouraging pt to take slow deep breaths. Distracting with conversation between breathing. Surgery PA at bedside and assisting. Wet to dry packing removed from wound. Wound has full thickness tissue loss and measures approximately 28 x 40.5 x 9.2 cm with exposed muscle and tendon noted at wound base. Wound bed is pink and moist with small amounts of serosanguinous drainage noted without odor. Circumferential undermining with the largest area measuring 13 cm at the top of the abdomen. Right side of abdomen has 3 x2 cm tunneling from 12:00-2:00 and left side abdomen has 3x 3 cm tunneling from 9:00- 11:00. Periwound skin intact and normal for ethnic group. Wound determined to be appropriate for NPWT. Wound cleansed with Coloplast sea-cleans wound cleanser. Skin prep applied to periwound skin. Two pieces of KCI V.A.C. Whitefoam applied to wound to cover tendons on the left and right abdomen. Four pieces of KCI black Granufoam applied over white foam and to to wound bed. Utilized hydrocolloid adapt cera ring near labia to help fill in crease and covered with KCI drape. Connected to device set at 100mmHg, continuous therapy. Good seal obtained. Pt tolerated well with minimal complaints of pain.

Plan: NPWT dressing change q 2-3 days. Next change will be by surgery.

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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)***
Impaired skin integrity r/t wounds Infection r/t to abscess, necrotizing fasciitis Pain r/t wounds Decreased tissue perfusion, impaired healing r/t uncontrolled DM	Notify RN and administer IV Morphine as per order for pain. Encourage pt to take slow deep breaths. Distract with conversation. Cleanse wound with Coloplast Sea-Cleans wound cleanser. Apply skin prep to periwound skin. Apply two pieces of KCI V.A.C. Whitefoam to wound to cover tendons on the left and right abdomen. Apply four pieces of KCI black Granufoam over white foam and to wound bed. Use hydrocolloid adapt cera ring near labia to help fill in crease and cover with KCI drape. Connect to device set at 100mmHg, continuous therapy.	APRN pain control, and nonpharmacological methods needed prior to wound care and changing dressing of this magnitude. Infection control and increased tissue perfusion are achieved by means of wound debridement, cleansing, and NPWT. Using Coloplast Sea-Cleans helps keep the wound from further infection as it is a no-rinse, isotonic, pH-balanced formula meant for cleansing and irrigating acute and chronic wounds, removing slough, debris and infected tissue from the wound bed. Skin prep protects periwound skin from the NPWT and its adhesive dressings used. It does not compromise the seal of these dressings. KCI VAC Whitefoam: White foam is hydrophilic. It is intended to hold moisture next to structures like tendon (in this case, tendons), bone and hardware. KCI black Granufoam is hydrophobic (moisture repelling), which enhances exudate removal. Using the Hydrocolloid Adapt Ceraring near the labia is to help fill in the crease in an anatomically challenging situation. It resists erosion from any fluid, hence protecting the skin.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why?	***KCI VAC therapy runs the risk of shifting, and creating bleeding or organ damage. Considering the scope of the wound, extreme care should be taken to monitor for bleeding or any other adverse changes during VAC therapy.*** ***KCI Whitefoam White foam: Is made of polyvinyl alcohol (PVA) material. This foam must remain***

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(This is your opportunity to share your product knowledge and apply critical thinking)	***moist or it will become quite hard, and has limited ability to move moisture through it. Typically it is recommended that pressures be increased with PVA foam.*** ***Other manufacturers' white foam is polyurethane (PUA). This is soft even when dry, and does not require pressures be increased to move fluid. Use of other foam would require a change in NPWT systems; KCI "VAC" cannot be used. Some patients may be unable to tolerate higher pressures required for VAC therapy.*** ***Coloplast Sea-Clens is not cost-effective. In lieu of Coloplast Sea-Clens, normal saline, hydrogen peroxide diluted with saline, or sodium hypochlorite can be used to cleanse/irrigate the wound and gently remove eschar, etc., each of which are far less expensive than a 6-oz. bottle of Sea-Clens.*** ***The Adapt Ceraring as the filler in the labial wound might be too thick for the drape to fit properly. For the labial crease that may interfere with the seal of the NPWT, PolyMem WIC® Cavity Filler serves as a multifunctional dressing designed to gently expand to fill cavities.***

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, NPWT application and usage is a topic that is highly relevant to what I wish to be able to perform independently. Challenging abdominal wounds or hard to heal ones require more complex therapy like NPWT, and it comes with its own set of challenges that I wish to further explore.***
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I wish to learn more re: NPWT, eventually performing it with the help of my colleagues on the surgical unit who are more versed in it.

Reviewed by: _____ Date: _____

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