Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Stefanie Edgar_____ Journal Completion Date: _01-30-2023__

Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	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 he does not like them 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.

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and 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 with Morphine 20 minutes prior to this. 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 scattered 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 and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
Hypokalemia - K+ 2.7	IV potassium replacement	Electrolyte balance
BLE scattered partial thickness wounds and Venous stasis ulcers moderate amount of serosanguinous drainage BLE edema painful to touch	Daily site care: - wounds cleansed with Coloplast wound cleanser - (keep periwound skin dry and protect from moisture damage - use a barrier cream like Calmoseptine), - Aquacel Ag applied to open weeping leg wounds - covered with ABD pad and wrap with Kerlix	To reduce microbial load and promote a healing environment To protect periwound tissue from MASD Manage exudate and provide antimicrobial action
Cellulitis	Aquacel Ag and IV Vancomycin	Antimicrobial action
BLE edema painful to touch	Lasix and morphine Tubular compression dressing applied until	Pain control Edema of LE and periwound tissue
Vascular assessment	ABI/TBI then prescribe compression dressing	To better prescribe amount of compression
Chronic wounds	Nutrition on consult	ptimal nutrition for wound healing
Nursing plan	Nursing to change BLE dressings daily and prn for saturation. Continue to follow SKIN bundle of pressure redistribution, turn patient q 2 hours moisture/friction control. Bariatric pressure redistribution bed ordered. Elevate BLE. Encourage ambulation.	Measures to promote healing and prevent additional skin damage through moisture or mechanical means. To keep skin profusion optimal

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Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	Aquacel Ag – manages exudate and provides means of microbial control in adjunct to systemic ABX, Xeroform antimicrobial could be used as an alternative. Coloplast wound cleaner – saline based wound cleaner, An alternative that can be used is Normal saline solution. Calmoseptine - protects periwound skin from moisture breakdown an alternative would be coloplast baza skin protectant ABD pad – means to absorb/control exudate. Alternative to this would be 4X4's Kerlix – gauze wrap that holds dressing in place, provides protection without adhesive trauma to the skin Tubular compression(What degree of compression) – helps to control dependent/periwound edema, provides protection to dressing and keeps it from displacement. If the patient was at home an clean tube sock could be used as an alternative ACE wrap – elevate leg before binding, binds extremity and provides support and compression to reduce edema. Cobane 2 layer dressing is an alternative.

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal for choosing this case was to get familiar with the documentation process since it is familiar to past experience.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Goal for tomorrow is to cover NPWT.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc.	Ask patient what alleviates the leg pain. - Communicate to PCP that pain regimen may need adjustment. Patient states that he wraps his legs at home - inquire about products used. Consider having patient perform task to see technique used to assess ability and if needed educate /demonstrate proper technique.

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	Assess sensation in Feet. Provide a moisture barrier to peri-wound skin to prevent maceration and possible enlargement of wound area.

Reviewed by: _____ Date: _____

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