Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Paula L. Vaughn Journal Completion Date: 2/5/2023

Setting: X Acute Care __ Outpatient ___HHC 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	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 performed 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 treatment recommendations, possible Negative pressure wound therapy.

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 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. States she is in severe pain 10/10. RN notified and administered prescribed IV Morphine. Encouraging pt to take slow deep breaths. Distracting with conversation between breathing. Surgery PA at bedside and assisting. Moist gauze dressing 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 12 o'clock. 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 white foam applied to wound to cover tendons on the left and right abdomen. Four pieces of 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 transparent film 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.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not**

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problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***		**required, unless utilized.**
Wound with full-thickness tissue loss.	• Premedicate patient with prescribed IV morphine. • Remove the moist gauze dressing from the wound. • Measure wound and record measurements. • ~~if the drape is painful to remove may utilize a adhesive remover, then please~~ Cleanse the wound with Coloplast sea-cleans wound cleanser pat dry. • S~~Next,~~ kin prep the periwound skin. Apply two pieces of white foam to the wound to cover the exposed tendons on the left and right abdomen. Place four pieces of black Granufoam over white foam in the ~~and~~ wound the bed. After the foams, place a hydrocolloid adapt cera ring near the labia to help fill in the crease and cover~~ed~~ it with a transparent film drape. ~~Lastly,~~ Connect to the device set at 100mmHg, continuous therapy. • Change NPWT dressing Q 2 days ~~NPWT dressing change q 2-3 days. The~~ The next dressing change on 2/10/2023 will be completed by surgery.	This will instruct the staff on how to provide appropriate wound care to the wound and how to reapply the negative pressure dressing appropriately and safely. Safe meaning utilizing the white foam for the tendons that are exposed. White foam is Polyvinyl alcohol-infused foam that is dense, the foam has large pores in it and it can be used safely to protect tendons, and be placed in undermining and tunnels. The tensile strength is much higher than black foam. Negative pressure wound therapy works by stimulating the blood flow, reducing edema, and encouraging the process of endothelial cell formation which will increase wound healing by utilizing negative atmospheric pressure.
Acute pain related to full-thickness tissue loss and open wounds.	• Prior to and during dressing change administer IV morphine as prescribed. • Utilize deep breathing techniques and encourage the patient to conversation to assist with pain control and distraction during dressing change.	Pain control is essential for successful wound care and dressing changes. If the patient does not have good pain control they are not going to be willing to participate in wound care and dressing changes.

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	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Coloplast sea cleanse wound cleanser: Disadvantage: does not directly eradicate bacteria. **Alternative:** Hypochlorous acid eradicates Poliovirus, H1N1, MRSA, SARS-CoV-2, E-coli, HPV, Salmonella, Staph, Strep and drug-resistant bacteria. NPWT: Disadvantage: The tape can be irritating and painful to the skin. Risk for leaving foam

different category or classification. In other words, what could be used if the product was not available?	behind in the wound. OK, but there are alternatives to this dressing. Alternative: Line the wound base with a collagen product such as Promogran or fibracol, followed by a moist to dry dressing, and change the dressing daily.

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 mini case study was to review NPWT. I did meet my learning goal because I reviewed the indications and contraindications for NPWT. This was a good review.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Continue to broaden my education in wounds.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The only thing I may have done differently is may have added collagen to the wound base prior to the foams. When collagen is added to the wound, this would add an assist in increasing the tensile strength of the fibers of the wound. Would also request the 3m dermatac drape; this drape helps take the pain out of dressing changes, it provides a protection for sensitive periwound and acts as a barrier against external contaminants. **2. OK good thought but what else can you do to minimize pain on NPWT dressing removal? 3. What can you do about the tunneling?**

Reviewed by: Patricia A. Slachta Date: 2/8/23

Hi, I have put three questions here for you to answer on this journal. You can do so below this.

1. For pain control when removing NPWT installation of normal saline is a great option.
The NPWT machine would be turned off and the tubing disconnected from the patient; saline may be infused through the wound vac tubing directly into the foam and wound or may cut the tract pad off the drape and slowly infuse normal saline within the old foam dressing to saturate the foam let this normal saline sit 5-10 minutes to assist in loosening the foam from the wound bed.

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2. For the tunneling, I would treat the tunneling of the wound by utilizing white foam. The white foam has a higher tensile strength than the black foam and is less likely to pull apart and be left behind in the wound. I would keep the white foam in one piece as much as possible attempting to decrease the possibility of leaving any behind in the wound.

3. Alternative for NPWT: Line the wound base with a collagen product such as Promogran or fibracol, followed by a moist to dry dressing, and cover with Zetuvit silicone border dressing, complete this daily.

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