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: __2-9-2023____

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	**Information obtained from medical record** **HPI:** The patient is a 72-year-old female who was in a nursing facility for a fracture of her right shoulder. During this stay, she fell and sustained a hematoma to her left medial anterior shin. The patient developed anorexia, fatigue, and malaise during her stay. She was brought to the emergency department and was found to be in atrial fibrillation with rapid heart rate and, was admitted 4 days ago. Rapid atrial fibrillation being treated with a Cardizem drip. She receives hemodialysis on Tuesdays, Thursdays, and Saturdays for kidney failure. Hematoma to left shin opened. Vascular Surgery was consulted. Vascular Surgery noted the patient to have multiphasic pedal signals and adequate perfusion and necrotic debris to the wound base. Took to OR for debridement of devitalized skin border and necrotic fat and muscle down to the level of the tendon. Surgicel was placed in the wound bed and pressure was held until adequate hemostasis was achieved. Wound was irrigated. NPWT applied at 125 mmHg continuous pressure. **PMH:** COPD, sleep apnea, CKD Stage 3 requiring hemodialysis, cirrhosis, atrial fibrillation, lung cancer, GERD, depression, gastroparesis, erosive esophagitis, lethargy, peripheral vascular disease NOS, anxiety disorder, and glaucoma. **Medications:** ampicillin-sulbactam (Unasyn) IV, budesonide (Pulmicort Respules), Cardizem, digoxin, insulin glargine, insulin lispro, metoprolol, midodrine, multivitamin, pantoprazole, miralax, sertraline. PRN medications: acetaminophen, bisacodyl, hydromorphone IV, ondansetron, and oxycodone PO. Allergies: Phenergan, Motrin, and diphtheria-tetanus toxoid.	

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.

This is the initial wound consult for a 72-year-old female admitted for atrial fibrillation and traumatic left leg wound which she sustained as a result of a fall. Wound initially presented as a hematoma on admission 6 days ago and ruptured yesterday. Vascular surgery debrided wound including necrotic fat and muscle down to the level of the tendon. Hemostasis was achieved and NPWT applied @ 125 mmHg continuous pressure. Significant PMH includes long term anticoagulant use for a-fib, CKD requiring

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dialysis. Nursing staff requesting consult related to "frank blood in tubing" of NPWT device. Device turned off at time of discovery. 100 cc bright red exudate noted in canister. Canister has not been changed since application of NPWT. Pt pre-medicated with IV hydromorphone 30 minutes prior to visit. Received oxycodone 2 hours prior. Vashe wound cleanser was utilized to moisten and saturate foam dressing to ease removal. Pt c/o pain at 8/10 during removal. Multiple time outs along with deep breathing utilized to manage pain. One piece black foam and Surgicel removed. No other dressings visible to wound bed. Wound bed cleansed with Vashe. Wound base easily friable with scattered, small spots of scant amounts, bright red bleeding noted. Wound measures 12 cm x 8.5 cm x 2 cm with 2 cm undermining from 11 o'clock to 1 o'clock. No structures visible. Periwound without irritation, erythema, induration. Treatment options discussed with pt. Agreeable to reapplication of NPWT. White foam applied to area of undermining. Surgicel applied to remaining wound bed followed by one piece black foam. No sting skin barrier wipe applied to periwound. Area covered with transparent film drape. Connected to NPWT device @ 125 mm Hg continuous pressure. Seal obtained. Tubing direction is up the leg to allow for increased mobility and to decrease fall risk. Pt continued to utilize deep breathing during dressing application. No additional time outs were necessary.

Assessment: S/P debridement of traumatic wound to left anterior medial anterior shin

Recommendations:
-Continue with NPWT, unless contraindicated for increased bleeding, uncontrolled pain
-Pre-medicate prior to wound care
-Turn off NPWT device 30 minutes prior to planned dressing change
- Consult PT
-Continue with fall risk precautions

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Chronic kidney disease D.M. II Pain 8/10 Compromised skin integrity due to traumatic wound and surgical debridement	-hemodialysis M-W-F - insulin administered per order - blood glucose checks before meals -Oxycodone and/or with IV hydromorphone given as needed per order -Vashe wound cleanser was utilized to moisten and saturate foam dressing to ease removal -Multiple time outs along with deep breathing utilized NPWT: -Clean wound with Vashe -Apply White foam to undermining at edge of wound running from 11 O'clock to 1 O'clock -Apply Surgicel to rest of wound bed	-Reduces toxic levels of chemical buildup in body causing: altered mental status acute metabolic encephalopathy - controlled blood glucose promotes wound healing and overall health. Increased blood sugar decreases blood flow and oxygen to wound and reduces functionality of both red and white blood cells leading to decreased infection control … -Prophylaxis for infection – by reducing the presence of microbes in system and allowing the immune system to concentrate on the function of healing -For pain control, to promote wound healing – lowering pain

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Plan of care	-Cut black foam to fit wound without overlap to periwound tissue -protect periwound tissue with no sting skin barrier -Cover wound with transparent drape -connect to NPWT with tubing running up leg to promote ambulation -Check for intact seal -Adjust pressure to 125Hg -Continue with NPWT, unless contraindicated for increased bleeding, uncontrolled pain - monitor wound for uncontrolled pain, hemorrhaging and excess drainage - in case of increased bleeding or excess drainage : Discontinue NPWT immediately, stop source of bleeding/drainage and call for medical assistance - in the event of increased pain check pressure settings, contact WOC/PCP -Administer pain medication per order prior to wound care -Turn off NPWT device 30 minutes prior to planned dressing change - If NPWT device stops working or unable to maintain seal 1. Apply drape to leak in dressing, if that does not work 2. Remove dressing, replace Surgicel and loosely pack with gauze soaked in normal saline 3. Cover dressing with ABD pad and secure 4. Contact WOC/surgeon -Continue with fall risk precautions - Consult PT	levels in patient allows the patient to relax causing the blood pressure and the chance of ischemia to the wound to lower. It also allows the patient to be able to participate in their wound care which increases the chances of compliance in the patient -Non-cytotoxic solution to clean, irrigate, moisten and debride wound, and provide antimicrobial action. Helps reduce pain by irrigating wound to loosen black foam. -Promotes wound healing by reducing bioburden – Which Reduces the chance of biofilm production taxing the immune system and reducing the chances of healing in a timely manner causing the wound to become chronically infected -Reduces dead space in wound & decreases chance of abscess and - provides continued hemostasis in wound bed - decreases the time healing time and the chance of infection bye reducing exudate it promotes a healing environment that promotes the formation of granulation tissue - protects periwound skin from mechanical damage from adhesive and moisture associated breakdown -Tube placement reduces falls risk and promotes ambulation which reduces the chance of DVTs and weakness ***Rationales mainly general statements and do not explain why or how. Need to resubmit to correlate with directives in POC*** ***I don't understand this direction.***

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		It says in the header: **"Rationale (Explain why an intervention is chosen; purpose"** ***For this section we want to explore past "what" an intervention does. For example: IV antibiotic is a prophylaxis for infection…. But why is this important to the WOC plan of care? What is the intervention accomplishing?*** ***Take rationale "one step further"… Consider if a beside caregiver asked you "why?" a directive was given. The evidence backing the action should be explored. We know IV ATB treats infection… the WOC rationale is that infection can impair healing and so on…*** ***I hope this helps clarify.***

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?	NPWT - contraindicated in malignant wounds, untreated osteomyelitis non-enteric and unexplored fistulas or necrotic tissue that exceeds 20% of wound. Vashe® wound cleanser – is used for cleansing, irrigating, moistening and debriding acute and chronic wounds, non-cytotoxic Do not use for patients with known sensitivity Disadvantage – cost Alternative - Bionix AlphaCleanse™ it is an antimicrobial wound cleaner used to irrigate, clean, and debrid wounds. It also is used to moisten and lubricate absorbent wound dressings. Surgicel – sterile cellulose based thrombogenic material used for hemostasis originating from delicate and/or friable tissues it is sheer to visualize site is bactericidal Disadvantage – in presence of swelling, regardless of the type of surgical procedure, pressure exerted by dressing can result in paralysis and/or nerve damage. Alternative- BloodSTOP iX " absorbable, bioresorbable, lipophilic, animal-free hemostat, made of etherized oxidized regenerated cellulose. It is designed to feel and handle like gauze, giving it the ability to conform to different types of wounds, reduces bleeding time and accelerates blood coagulation by activating the intrinsic clotting pathway, non-irritating woven matrix, No sting skin barrier - StingFree alcohol liquid skin prep and shield, non-irritating and quick drying moisture barrier that protects from medical adhesive related skin injury, friction skin damage many different brands to choose from. Disadvantage- painful on sensitive or abraded skin Alternative - Safe-n-simple skin barrier (hydrocolloid sheets) which are cuttable, conform to wound and go directly on skin. Can be used on sensitive skin or broken skin, reducing pain during dressing changes.***Good***

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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?	There were many factors to consider with this case. The patient had multiple comorbidities which affect wound healing (the use of anticoagulants, Diabetes and CKD which causes buildup of toxicity in the body) I continue to build skills in holistic wound healing through assessment and review of patient history and medication reconciliation.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To become proficient in writing a POC

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	To reduce pain and bleeding on dressing change, sponge can be soaked with xylocaine and epinephrine solution. This will reduce pain at dressing change and reduce bleeding irrigation with wound cleaner would clear out excess solution. IV pain medication could have been requested and given 30 minutes prior to dressing change. Instruct nursing to be vigilant with exudate output and character so NPWT can be discontinued in the event of hemorrhage. Will the use of Surgicel increase damage to wound bed at dressing changes? ***No it does not as it helps to stop the bleeding. It should be used minimally and discontinued as soon as possible.*** Thank you, I have never used this

Reviewed by: Kelly Jaszarowski Date: 2/9/2023

This is journal #4 for wounds. Overall, the journal does not support transition to the specialist. Note my feedback throughout and the sample journals. Edit this journal to reflect a directive WOC POC with supporting rationales to encourage others to follow your POC as well as utilize your critical thinking related to products. Then resubmit.

Re-sub reviewed by Mike Klements 2/10/23

Hi Stephanie – see my comments throughout this journal. I have left many comments in green throughout, specifically in the rationale section. In our reasoning for our actions, we want to be through in explanations. Your rationale above should reflect the reasoning behind why an intervention is chosen. The role of the WOC professional is to explore past the "task" level of interventions and formulate POC and reasoning reflective of recent evidence, physiology and the "big picture" for the patient. I left an example above. Reach out if you have any further questions.
-Mike

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