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: 2/9/2023

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 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

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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)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc*** ***Impaired skin integrity secondary to fall.***	**Statements should be directive and holistic relating to the problem/concern.** • Continue with NPWT, unless contraindicated for increased bleeding or uncontrolled pain. • Premedicate prior to wound care. • Turn off NPWT device 30 minutes prior to planned dressing change.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** • NPWT promotes wound healing by sub-atmospheric pressure to reduce inflammatory exudate and promote the tissue to granulate. NPWT also provides a moist wound environment, assists with removing wound exudate, decreases soft tissue edema, and draws the wound edges together. It also stimulates the wound bed, increases blood flow to the wound edges, promotes angiogenesis and

Physical mobility disorder related to atrial fibrillation with rapid beats.	• Consult PT • Continue with fall risk precautions. Yes, I totally agree	contributes to the creation of granulation tissue. • Turning off the NPWT system 30 minutes prior to changing the dressing can allow the foam to loosen from the wound base. • Will help manage and improve patient's balance, strength, and mobility with possibility to decrease the fall risk.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> 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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** NPWT: Disadvantage: bleeding from the wound. Alternative: Promogran Prisma (this may go to the base of the wound and to the undermining) followed by a non-adherent dressing such as adaptic or Silflex and cover with ABD,OK but if wound large then you need to fill dead space with something moist (& of course, not a NSS dressing)! Yes I would not just cover a large pocket, I would have Promogran at the base, then could line the wound with polymem WIC. Of course not a NSS dressing. roll gauze, then tubular compression (If the ABI's are appropriate). I do not understand this? Is this a copy/paste from something else? My apology, I believe I was working on two things at once. This is misplaced. :-/

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 refresh myself on the usage of Vashe and Surgicel. I did meet my goal because I learned Vashe works against bacteria and fungus. I thought it was only bactericidal so that is what I learned about Vashe. I learned that Surgicel stimulates thrombin and fibrinogen production and those facilitate coagulation of the blood which helps stop the bleed. I would hold the wound vac for a day or so and allow the wound to calm down and gain hemostasis. So, would provide an alternate dressing, then in a couple days may return to NPWT.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue strengthening my education in WOC.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	For the removal of the wound vac may instill normal saline and allow it to soak prior to removal. I would place a non-adherent layer prior to the foam, that will decrease the pain, protect the friable areas, and hopefully decrease the chance for bleeding. For removal of the dressing, utilizing Coloplast Brava adhesive remover spray to assist with drape removal will decrease the patient's discomfort greatly. I would order venous reflux ultrasounds and ABIs secondary to the patient having CKD puts her at risk for PAD.

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normally we are looking for the whole NPWT procedure to be written out. I will accept this because you did a previous NPWT journal with revision and discussion.

Thank you, Patricia 😊

Reviewed by: Patricia A. Slachta Date: 2/14/23

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