Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Laura Clermont_____ Journal Completion Date: ___5/12/23_____

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.

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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)**
Wound to left anterior medial shin **Falls**	**Steps for dressing change:** **1. Turn NPWT device off 30 minutes before dressing changes.** **2. Remove dressing, beginning with top adhesive drape. As dressing is removed, apply 60 cc of saline to foam if it sticks to wound bed. Check prior documentation to note what pieces of dressing should be present (surgicel, white foam, black foam).** **3. After the dressing is removed, gently clean the wound bed with Vashe wound cleanser.**	**Turning off the NPWT device allows for exudate to absorb into the foam, allowing for increased ease of removal and prevention of wound bed adherence to foam.** **Utilizing saline during a dressing change helps remove foam that might be stuck to the wound and helps to minimize tissue damage and pain. Checking previous documentation ensures all parts of the dressing are removed and nothing is left behind.** **Prevents infection and ensures wound debris is removed for better visualization during**

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Pain **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***	**4. Assess the wound: size, undermining, wound bed characteristics, exposed structures, odor, color, and drainage type. Be sure to include this information in wound care documentation.** **5. Apply white foam to the undermining site.** **6. Apply surgicel to the remainder of the wound bed.** **7. Cut black foam to match the remaining wound bed size and shape, and apply on top of the surgicel.** **8. Apply adhesive drape to the entire wound bed, ensuring full wound coverage. Ensure that a small hole is cut in the drape (but don't cut foam) so that NPWT can be applied.** **9. Set the NPWT device to run at 125 mm HG continuous pressure.** **Turn the NPWT device off and notify the provider and WOC nurse for increased bleeding and uncontrolled pain. Report any changes in color or amount of drainage.** **Instruct the patient to change positions slowly when standing up.** **Monitor vital signs.** **Continue to utilize facility fall precautions.** **Consult with PT**	**assessment.** **Ongoing assessment is needed to monitor progress of the wound and to direct the treatment plan.** **White foam is less porous and when applied to undermining and underlying exposed structures offers less adherence and increased protection.** **Surgicel (or other contact layers) lies between the wound bed and foam, offers protection to the wound bed and underlying structures from ingrowth and adherence to foam.** **Black foam is very porous and promotes granulation. A properly cut foam piece helps ensure a good seal.** **Adhesive drape is the top layer of dressing and full wound coverage ensures a proper seal. This is where the suction is applied.** **Studies have shown that NPWT has the greatest effect on wound granulation and regrowth at this setting.** **Bleeding is a complication of NPWT and can indicate hemorrhage and damage to wound tissue. Changes in drainage could indicate possible fistulae, infection, or lymph node involvement. Further evaluation is needed in these situations.** **Several of the patient's medications have the potential for side effects such as dizziness and bradycardia, which can contribute to falls.** **Fall precautions should be utilized**

	Pre-medicate prior to wound care per provider orders. **Utilize deep breathing and time-outs during wound care.** **Statements should be directive and holistic relating to the problem/concern.**	**at all times to prevent further injury to the patient and to protect the wound that has already been sustained.** **Because safe ambulation is a concern, PT can recommend a plan tailored to this patient.** **Adequate pain management using medication, breathing techniques, and time outs during wound care provides the patient with comfort and reduced stress. Promotes activity and participation in self-care which contributes to wound healing.**

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 system – disadvantages to using the NPWT system are expense, portability, problems with obtaining a seal, potential machine malfunction, and trauma to the wound bed with foam adherence. Dressing with collagen products or other active wound therapies might be an option.** **Black foam – black foam is very porous, and this can be painful for the patient. Use a different foam or switch to a gauze system. A gauze system has disadvantages of adherence as well. If discontinuing NPWT, as an alternative, standard dressing with a wick and filler can be used.** **Surgicel brand hemostat layer. This may not be part of a facility's wound care formulary or be an added expense to the patient depending on insurance coverage. There are other options for contact layers such as silicone-fenestrated dressing (Mepitel), emollient-impregnated dressing, or ionic silver-fenestrated dressing.**

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	My goal was to learn more about NPWT. I achieved this goal by completing this journal. I watched

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choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	videos on application techniques, and I feel confident that I will be able to do this. I noticed that one of the main problems of NPWT is the adherence of foam (or gauze) and how important it is to prevent damage to the wound bed and exposed underlying structures.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My next learning goal is wound management of a bariatric patient.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Because of this patient's history of long-term coagulation and frank bleeding in this case, I wonder if NPWT is still the best choice for her. Even though the case does not mention any anti-coagulant medications specifically, I still have a feeling NPWT will be discontinued sooner rather than later. Because of the wound size and amount of drainage, NPWT does seem to be the correct choice for now, even though that could change. I was unable to locate any literature to justify a rationale for turning off the NPWT device 30 minutes prior to a dressing change. Literature would say to do it but nothing regarding the "why". I am amazed at the science involved with NPWT and advanced wound care in general. I am looking forward to seeing what the future holds for wound therapy.

Reviewed by: _____ Date: _____

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