Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lindsay Glorioso Journal Completion Date: 1/11/2024

Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _**VIRTUAL WOUND 1/2**

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)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Bilateral lower extremity venous ulcers - ***Complicated by comorbidities CHF and morbid obesity***	Promote Skin Integrity Daily site care: Cleanse with wound cleanser. Apply Aquacel Ag to open weeping leg wounds and cover with ABD pad and wrap with kerlix. Apply tubular compression dressing. Change daily and PRN saturation. - Apple ACE wrap toes to knee for compression. - Elevate lower extremities while at rest - Consult with PT for evaluation and plan. - Nutrition has been consulted for additional dietary recommendations. WOC will consider use of multilayer compression wraps v. ACE wrap for venous insufficiency and edema control in future, pending ABI results.	Skin cleanse was chosen for cleanse as this is nontoxic and gentle for patient. Aquacel Ag is an antimicrobial hydro fiber dressing impregnated for silver. This is appropriate for moderate to heavy exudating wounds. It is nonadherent which will help with pain control with dressing change. ABD will provide secondary absorbent layer. Kerlix for securing as condition is not appropriate for tape or direct adhesive. Multilayer compression wraps, if applicable, would assist with edema control and support ulceration healing. Leg circumference calf and ankle will provide quantitative data on response. Elevation will assist with edema control and support wound healing. Activity and ambulation is important component for management of venous ulcers, PT can identify patient specific plan and recommend interventions. Dietary can identify patient's needs for wound healing in setting of CHF and morbidly, while will likely require modifications and possible fluid restrictions.
Moisture Associated Skin Damage	**Provide daily wound care.** **Continue to monitor skin integrity.**	**Skin will be monitored. Anticipate improvement to MASD with use of local wound care, compression, and elevation. Will consider implementation of moisture barrier ointment (like Zinc Oxide) if fails to improve. Holding initially as may be irritating to skin surface and will requiring removal with cleansing.**

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Infection- Cellulitis	Administer antibiotics per provider as ordered. Monitor skin condition for worsening erythema, warmth, or pain. Monitor for vitals, blood work, and patient condition for infection.	Systemic antibiotics for the management of cellulitis will be ordered by a medical provider. WOC nurse will monitor response to antibiotic therapy; cellulitis erythema should improve throughout treatment. Any worsening or deterioration will be reported to the provider.
Pain	Administer pain medication as ordered. Coordinate pain medication administration with dressing changes. Encourage alternative pain relief measures like music, meditation or distraction.	Appropriate pain control will promote patient comfort during dressing change and positively impact compliance with local wound care regimen.
Morbid Obesity; At risk for skin breakdown	Perform full body assessment for additional PI or areas of risk for developing PI. Continue bariatric pressure redistribution bed. Continue Q2H turn and moisture and friction control measures. Consider foam dressing over the sacrum per hospital protocol for PI prevention. Provide toileting Q2H and PRN. Check for incontinence Q2H PRN. Elevate lower extremities and float heels.	Support surfaces and turning/repositioning will help reduce pressure on bony prominence and decrease the risk of developing HAPI. The patient is receiving diuretics for the management of CHF, which will increase urinary output and risk for incontinence.
Discharge plan	Consult with provider and PT re: discharge planning to determine if the patient is safe to be discharged home.	The provider will determine if the patient is stable enough to be discharged home. PT will help determine the patient's physical condition and ability is safe to return home as he lives alone and on 4L of 2, he may require discharge to rehab.

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	Educate patient on plan of care, wound care regimen, and rationale. Recommend follow-up appointment with an outpatient wound care center within one week of discharge and referral home health care to assist with wound care if discharged home. Consult with the discharge planner to assist in following up on appointments, medications, and wound care supplies.	The patient has a chronic condition that will need ongoing monitoring and management. Ideally, a caregiver would be present in the home and can assist with local wound care based on the patient's belief. If cleared by provider and PT, he would be best suited for an outpatient wound care follow-up along with home health care. Noting home health care may be limited due to lack of having a caregiver in the home. Recommend discharge planner assist with the facilitation of follow up appointments to increase compliance to follow up.

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.** - AquaCel Ag: Antimicrobial hydro fiber. - Disadvantages: 1) Possible risk of allergic reaction or sensitivity to topical application. 2) Available product size. Given the size of the RLE posterior leg wound, the patient may require more than one primary dressing. LLE with two wounds requiring two primary dressings. 3) Risk of maceration with heavily exudating wounds. - Alternative in a different category: 1) nonadherent antimicrobial gauze (Xeroform containing 3% bismuth). Alternative 2) Calcium alginate Ag - Alternative for secondary dressing ABD: Optilock Nonadhesive Super Absorbent Wound 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 choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal for this patient is to manage the damage and prevent further skin deterioration and MASD. While assessing the patient, I would begin to educate the patient on venous insufficiency, specifically related to lower extremity edema and the development of ulcerations. Education needed to include management of ulcerations. Education will be done in small increments at each subsequent visit to avoid overwhelming the patient, as the goal is to promote health literacy and knowledge.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Review ABI results for this patient and determine if multilayer compression wraps / ACE wound benefit this patient. If so, we will need to consider adjustments to local wound care related to the absorbency of secondary dressing and frequency of dressing change.

Reflection: Identify/describe thoughts	I think the initial plan was well developed, especially with plans to re-evaluate for

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related to the mini case scenario, anything you might have done differently, etc	frequency. I would consider transitioning to multilayer compression wraps to BLE upon discharge. I am aware these wraps are not typically utilized in the inpatient setting, but from experience, ACE wraps tend to lose their elasticity quickly, and patients are prone to wrapping with inconsistent pressure to the lower extremities. I noted consideration for additional a skin barrier ointment like zinc oxide to the LE along with wound care to assist with MASD; however, I am uncertain if this a common practice by WOCN and would like to learn about their further. The patient will need follow-up with PCP and specialists' cardiology and pulmonary re: chronic diseases. If ABI is abnormal or suspect, consult with vascular. May benefit from lymphedema therapy in future once euvolemic.

Reviewed by: _____ Date: _____

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