Cleveland Clinic

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Jaclyn Rosso Day/Date 7/29/2024

Setting: Hospital ☒ Ambulatory Care • Home Health Care • Other: _____

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 chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History

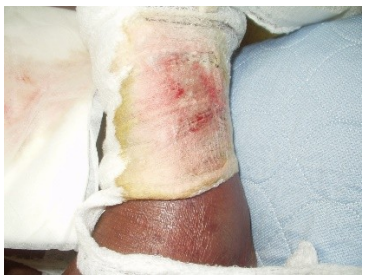
Age/sex:52-year-old female
PMH: morbid obesity, CHF, COPD, PE and lower extremity venous disease with ulcers.
CC: Presented to the ER with bilateral lower extremity edema, cellulitis and ulcers. BLE are erythematous and warm, confirmed cellulitis. Short of breath for past week & uses 4L oxygen
Meds: Currently taking Bumex 2mg BID. Has been taking Tylenol for pain but states it is not helping.
Social hx: Lives alone

Braden score

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	2
Friction/Shear	3
Total	19

Plan: IV Vancomycin. Morphine for pain. Lasix for CHF. Potassium is low at 2.7. IV potassium ordered. Troponins were normal. COVID neg. Ultrasound r/o DVT's.

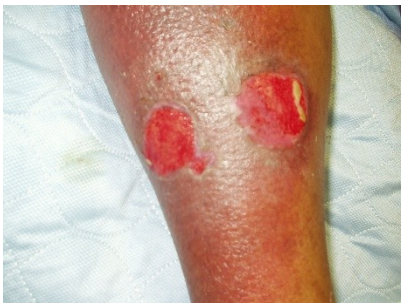
Photo: RLE on admission to ED. ABD dressing inplace



Cleveland Clinic

Assessment/encounter:
LOC: Alert, awake, & oriented.
Initial interview: Stated both legs have been swollen for a month and are extremely painful to touch. Independently wraps legs daily with ACE bandages, ankle to above wounds. Currently has been suffering with pain and was afraid to come to the hospital because she does not like hospitals, but legs are now weeping, copious amounts of clear drainage. States has not been wearing oxygen.
Wound Assessment
Location: RLE
Size & shape: Round, lateral is 1.2 x 1.3 x 0.1 cm & medial is 1.4 x 1.4 x 0.1 cm
Wound bed tissue: red tissue with small amount yellow tissue on medial wound
Exudate amount, odor, consistency: Large amount serous drainage, thin, no odor
Undermining/tunneling: None
Edges: flat & attached
Periwound skin: Erythematous, but no induration, fluctuance, maceration or denudement.
Pain: 4/10 but >10 on movement
Temperature: BLE warm to touch
Edema: Present bilateral extremities with RLE

measuring 40 cm at the calf with reference point of 12 cm from popliteal fossa, 23 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot. LLE measures 43cm at the calf with reference point of 12 cm from popliteal fossa, 25 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot.
Pulse right: Doppled on right leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable
Pulse left: Doppled on left leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable
Monofilament test R foot: All points positive
Monofilament test L foot: All points positive



Education: discuss below
Suggested consults: discuss below

Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

-No vitals are listed and vitals are a very important component of patient care. We need to explore if the patient has any signs of sepsis from the cellulitis, especially before antibiotics are administered. Also, the patient is to be wearing 4L of home oxygen but states she has not been using it. The patient needs a pulse ox reading, possibly some ABGs and then placed on some oxygen. Patients without proper oxygenation do not heal as adequately as those without hypoxemia.
-Prior to administering any medications we need to assess for allergies.
-ABIs should be done to assess ability to apply compressive wraps and it would be nice to see if the patients skin has any signs of hair growth.
- Potassium result was listed, but it is unclear if a CBC was done or any other labs. It would be helpful to see a white count as well as inflammatory markers, again to check for signs of sepsis.

-A BNP would assist with the CHF progression.
- A vancomycin peak and trough will be helpful in the coming days to be sure the patient is receiving the proper dose of antibiotics and protecting the kidneys, so a BMP should be done with those as well, especially with Lasix.
-We are given good leg measurements, but we aren't told the depth of edema and whether it is pitting or not.

Using the information from the encounter and your critical evaluation develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders. (For example: *What dressing change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

-Elevate legs above heart while in bed and in chair.
-After venous duplex is resulted, if patient is without a DVT perform ABI.
-Elevate legs 30 minutes prior to dressing change and wrapping
-Cleanse wounds with 0.9%NS.
-Apply a silver alginate dressing to wound bed and cover with a nonadherent foam dressing.
-Apply compression to lower extremities, pending result of ABI.
*If ABI is less than 0.5 or greater than 1.3 do not apply compression, consult vascular.
*If ABI is 0.5-0.8 apply Low Compression (20-30 mmHG) with a three-layer compression system.
*If ABI is greater than 0.8 apply High Compression (30-40 mmHg) with a four-layer compression system.
-Be sure toe wrap at base of toes up around foot and up to just below knee. Wrap in a figure eight motion. Left over 1st layer padding can be applied to bony prominences before next layer is applied.
-Clean wound and change dressing and wrap every 3 days.
-Do not allow dressing or wraps to get wet or soiled, if drainage comes through or if dressing becomes soiled change dressing.
-Consult Physical Therapy to review gait and safety.
-Monitor Vancomycin Peak and Trough, consult pharmacy to dose.

Write a chart note giving careful consideration to the chart review information, how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc. Then, describe the visit. Be sure to include any physical assessment, interactions, and specific products used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

Initial visit for 52-year-old female admitted after arriving to the Emergency Room with vascular wounds x2 to right lower extremity. Patient with a past medical history of morbid obesity, congestive heart failure, pulmonary embolism, lower extremity venous disease and dependent on home oxygen at 4 liters on nasal cannula. Patient, who has a Braden score of 19, presents with bilateral lower extremity edema and warmth with confirmed cellulitis. The patient also has two wounds to the right lower extremity. The lateral wound is 1.2 x 1.3 x 0.1 cm while the medial wound is 1.4 x 1.4 x 0.1 cm, both are round in shape. Wound beds are

both red, a small amount of yellow tissue is noted medially on the medial wound. Wounds are draining a copious amount of serous drainage and periwound is red, but intact. Pulses are present upon palpation and via doppler. Calf size measures 40cm to the RLE and 43 to the LLE at 12 cm from the popliteal fossa while the ankles measure 23cm to the right ankle and 25 to the left ankle at 2 cm above the malleolus.
Patient reports pain is present at a 4/10 that increases to a 10/10 with movement with a positive monofilament test. Patients only home medications are Bumex and home oxygen and patient reports no allergies. Pt lives alone and denies using her home oxygen recently, but is currently on 4L nasal cannula.
Patient is receiving vancomycin IV, potassium IV due to a potassium of 2.7, Lasix IV and morphine for pain control. Ultrasound of BLE complete and negative for a DVT. ABIs were done with 0.8 as a result.
Patient's legs were elevated and patient was educated that her legs need to remain elevated unless she is up to the bathroom or with PT. Pt also instructed that her legs should be elevated at least 30 minutes before applying a compressive dressing.
The two wounds to RLE are cleansed with 0.9%NS. Silver alginate dressing is applied to both wound beds then a foam nonadherent secondary dressing was applied. Bilateral lower extremities were wrapped with the 4-layer compressive therapy beginning at toes and wrapped to the base of the knee in the figure eight manner. Extra padding wrap was carefully applied to bony prominences at ankle prior to first compressive layer application. Pt was educated on the importance of wrapping and beginning at the toes and going up to the top of the calf. Pt states she understands.

Physical therapy consulted to measure of compression stockings with a zipper for 30-40mmHg and also to evaluate patient's gait for calf pumping failure.
Pharmacy consulted for vancomycin dosing per peak and trough results.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

4. What was your goal for choosing this case?

I saw some venous ulcers during my clinical, but we did not perform compression therapy and I did not explore a patient initially from the ER with the venous ulcers. Wounds from venous disease are so common, so I wanted to be able to work through an entire patient for my own benefit.

Cleveland Clinic

Reviewed by: _____ Date: _____

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen		
• Describes the encounter including assessment, interactions, any actions, education provided and responses		
• Includes pertinent PMH, HPI, current medications and labs		
• Identifies specific products utilized/recommended for use		
• Identifies overall recommendations/plan		
Plan of Care Development:		
• POC is focused and holistic		
• WOC nursing concerns and medical conditions, co-morbidities are incorporated		
• Statements direct care of the patient in the absence of the WOC nurse		
• Directives are written as nursing orders		
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		
• Identifies alternatives/what would have done differently		
Learning goal identified		