Cleveland Clinic

R. B. Turnbull Jr. MD WOC Nursing Education Program

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: H. Alexis Seris Espinal Day/Date: 6/20/25 (journal for 6/18/25)

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

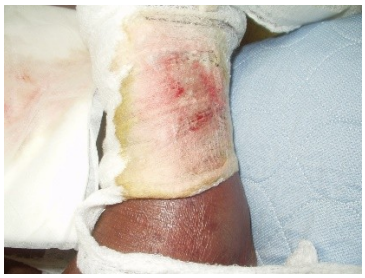
Age/sex:52-year-old female
PMH: morbid obesity, CHF, COPD, PE and lower extremity venous disease with ulcers.
CC: Presented to the ER with bilateral lower extremity edema, cellulitis and ulcers. BLE are erythematous and warm, confirmed cellulitis. Short of breath for past week & uses 4L oxygen
Meds: 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



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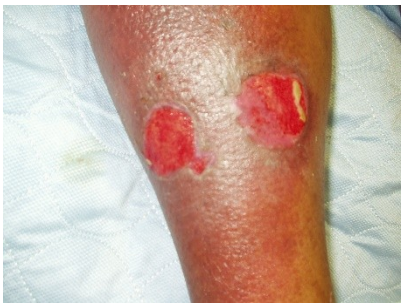
Assessment/encounter:
LOC: Alert, awake, & oriented.
Initial interview: Stated both legs have been swollen for a month and are extremely painful to touch. Independently wraps legs daily with ACE bandages, ankle to above wounds. Currently has been suffering with pain and was afraid to come to the hospital 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.

In this case, we may perform ABI To assess for qualification for compression therapy. I would also follow up with this patient's cardiologist or consult cardiology. As this patient has congestive heart failure. This condition can also be a contraindication to compression therapy and can also be revealed through ABI. If approved by cardiology We may continue with compression therapy.

Due to the patient's admitting diagnosis and preexisting co-morbidities, I would involve Many other disciplines in their plan of care. The first consult may be cardiology if this patient does not have a cardiology consult. The next would be the vascular team just to follow up and see if the patient needs any of their

intervention. Though this patient may not need their services as they have palpable pulses. They may also need to have an infectious disease, and a pharmacy consulted. These disciplines can help with systemic antibiotic management and dosing. Wound care should follow this patient for recommendations on dressings. Given the patient's admitting diagnosis Existence of wounds and other co-morbidities Nutrition should be consulted. The patient would be seen by a registered dietitian for diet teaching and or supplements for wound healing. Lastly, the patient may also benefit from a physical therapy consult as according to their Braden scale their mobility may be slightly less than their baseline.

For all the recommendations, we would educate the patient on why they are in place and how they will help in wound healing. Who would educate about the dressing and that we want to contain and control drainage. If able to provide compression therapy we would explain that we Want to promote good circulation. As well as the other interventions that promote circulation and wound healing.

Lastly, I did not see it listed but I would ask the patient if they have any Known drug allergies or food allergies. I would also ask more assessment questions such as if they remember how they got the wound.

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)

1. Right medial and lateral venous ulcer: Cleanse with NS. Apply cadexomer iodine gel to the wound bed. Cover with ABD pads x2 and lightly secure with Kerlix cling gauze. Change daily or as needed for soilage.

2. Apply Elastic ACE bandage to the BLE, wrap snuggly from the foot and ankle up below the knee. May be removed for bathing and wound care, then reapplied.

3. Elevate BLE with pillow support or with the footrest of the recliner chair.

4. Obtain and apply an air cushion to the chair, please send home with Pt upon discharge.

5. Obtain and apply a low-air bed pump.

6. Nutrition Consult for diet teaching and supplements to promote wound healing.

7. Wound Care Consult will follow up with this Pt in a week and can be reconsulted for additional concerns.

8. Vascular Team Consult to assess needs.

9. Pharmacy and Infectious Disease Consult for antibiotic therapy and dosing.

10. Physical therapy consultation to promote mobility and activity.

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 Assessment:

In to see a 52-year-old female, who lives at home alone for right lower extremity venous ulcers x2 per consultation order. Pt presented to ER with BLE edema, cellulitis, and ulcers. PMH of CHF, COPD on 4L of O2, morbid obesity, history of PE, and LEVD. Pt on IV Vancomycin, Morphine, and Lasix. Reviewed H&P. NKDA listed for this Pt. Pt is alert and oriented x4, able to explain the reason for hospital admission. Explained the role and reason for the visit. Pt agrees to dressing change and wound assessment. Follow up with the primary RN prior to visit to ask if they can provide pain medication before dressing change.

Bilateral popliteal, dorsalis pedis, and posterior tibial pulses palpable and audible via Doppler.

R medial LEVD ulcer: round, partial thickness, 95% red, 5% yellow with intact, red erythema to surrounding skin. No tunneling or undermining noted. Large amount of serous exudate was noted with no odor. No fluctuant or induration noted. Area is warm to the touch. Measured as 1.4 x 1.4 x 0.1 cm in size. Gently removed previous dressing. Cleansed with NS. Applied cadexomer iodine gel to the wound bed. Covered with ABD pads and lightly secured with Kerlix cling gauze.

R lateral LEVD ulcer: round, partial thickness, 100% red with intact, red erythema to surrounding skin. No tunneling or undermining noted. Large amount of serous exudate was noted with no odor. No fluctuant or induration noted. Area is warm to the touch. Measured as 1.2 x 1.3 x 0.1 cm in size. Gently removed previous dressing. Cleansed with NS. Applied cadexomer iodine gel to the wound bed. Covered with ABD pads and lightly secured with Kerlix cling gauze.

BLE were wrapped snugly with an ACE bandage from foot and ankle up to below the knee.

Pt tolerated dressing change well without pain. Discussed dressing change recommendations, provided education on why recommendations are in place, and how they will aid in wound healing. Repositioned Pt in bed to semi-Fowler position with legs elevated with pillow support. Bed in a low and locked position. Call given to Pt. Updated Primary RN on POC.

Time spent with Pt 35 minutes for dressing change, interventions, and education.

H. Alexis Seris Espinal BSN, RN WOC nursing student

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?

My goal in choosing this case study was to gain a better understanding of LEVD and venous ulcers. I see these wounds often in the facility I work in. I've had difficulty in differentiate them with arterial ulcers and the wholistic treatment for these wounds. I hoped to gain a better understanding of topical treatment, dressings, And other preventative measures. As well as other holistic measures and disciplines that may need to be involved to aid in healing.

I was able to meet this goal. There were key points that I was able to take away from this case study. Venous ulcer wounds are more shallow, weepy, have copious amounts of drainage. They also require compression therapy to aid in circulation and promote wound healing. These wounds require Absorptive dressings such as alginate or a cadexomer iodine gel to absorb the exudate. These characteristics differ from arterial ulcers in which they are dry, deeper and compression therapy here would be contraindicated.

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	