Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing
Daily Journal Entry with Plan of Care & Chart Note

Student Name: Colleen Baisden Day/Date: Thursday, January 12, 2023

Number of Clinical Hours Today: 8 Care Setting: ___ Hospital _X_ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: 7 Preceptor: Sarah Yount

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

This 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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

Today's WOC specific assessment	RC is a 52 year old male admitted to the medical surgical unit. Patient present to the ED with a c/o chest pain and SOB, diaphoretic, and concerns for a right foot infection. Past medical history: Asthma, Bronchitis, DM, HTN, Morbid obesity, OSA, Hx of PE Medications: Coreg, Topamax, Lipitor,, Norvasc, Wellbutrin, protonix, IV Zosyn, Breo Ellipta, Admeloa, Lyrica, Flexeril, DuoNeb, Lantus, Heparin gtt, Percocet, Tylenol, coumadin Labs: Glucose 290, Cr 1.24, RBC 3.78, Hgb 10.5. Hct 33.5 Images: MRI- Right foot- no evidence of OM or septic arthritis . No drainable collection Assessment: Right lateral foot wound measures 6cm X 4cm with a depth of 2.2cm and tunneling of 2cm at the 12 o'clock position. Wound bed with 90% red and moist granulation tissue in the wound bed, 10% tendon visible at the 6 o'clock position. Wound edges flat without epibole. Small amount of serosanguinous drainage with small amount of active bleeding when foam removed that was easily controlled with small amount of pressure, denies pain with dressing change. Long term plan: The long term plan for this individual is to get the wound to begin healing and eventually remove the NPWT and have a daily dressing change done to the area.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, *interactions, and specific products that were used/recommended for use.*

Reason for consult: Dressing change for NPWT with Veraflow to the right lateral foot

RC is a 57 y/o male with a right lateral 5th toe wound that was recently debrided by Podiatry and a NPWT with Veraflow of NS placed on the wound.

Right lateral foot measures 6cm X 4cm with a depth of 2.2cm and tunneling of 2cm at the 12 o'clock position. Wound bed with 90% red and moist, wound bed with granulation tissue, 10% tendon visible at the 6 o'clock position. Wound edges flat without epibole. Small amount of serosanguinous drainage with small amount of active bleeding with foam removal that was easily controlled with small amount of pressure, denies pain with dressing change.
Gently removed drape with no sting adhesive and gently remove foam from wound bed. Slight bleeding from wound, gentle pressure applied and bleeding stopped. Wound be and tissue gently cleansed and irrigated with NS. Application of no sting barrier to the peri-wound skin and allowed to dry. Cut to fit Coloplast Brava barrier wedges around the wound and covered the suture area. Gently fill wound with tunnel with 1 piece of black foam. Form a bridge to the dorsal aspect of the foot (drape under bridge). Trac pad applied to dorsal aspect of the foot, and seal obtained. ACE wrap to RLE-gauzed applied under tubing. Negative pressure applied at 125 mmHg, low continuous pressure, with 10mL of NS instilled for 10 minutes every 3 hours; adequate suction was achieved, no leaks detected. Podiatry managing orders for the NPWT. Wound is improving and the off label dressing change schedule is working well for this individual.

Recommendations

1. Right foot wound: Wound care as above. Change every Tuesday and Friday, and PRN
2. Maintain heel off-loading while in bed, and off-load patient's coccyx/ischium every two hours
3. Nutrition consult advised for optimized wound healing
4. Wound care team to follow: re-consult if changes in wound or wound worsens.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Change of NPWT to the right lateral 5th toe	1.) Gently remove drape with no sting and removed foam 2.) Gently cleanse and irrigate wound with NS and gently dry 3.) Apply no sting barrier to the peri-wound skin and allow to dry 4.) Cut to fit around the wound Coloplast Brava barrier wedges (cover the suture area) 5.) Gently fill wound and tunnel with 1	No sting barrier and Coloplast Brava barrier to the peri-wound skin to prevent any breakdown or maceration to intact tissue from the NPWT with Veraflow of NS. Ensure to fill the tunnel with foam to allow instillation of NS and for the wound to heal from inside out. Bridge Trac

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

	piece of black foam. 6.) Form bridge to dorsal aspect of foot (draper under bridge). 7.) Trac pad applied and seal obtained 8.) ACE wrap to RLE-gauze applied under tubing. 9.) Maintain heel off-loading while in bed, and off-load patient's coccyx/ischium every 2 hours 10.) If the area worsens reconsult wound care for further evaluation	pad dorsal foot to prevent a pressure injury. For this wound the instillation of NS is good to help cleanse the tissue and debris out of the wound, this will not need to be continued for too long.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. 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?	The products that we used for the NPWT change was the Coloplast Brava barrier wedge, transparent drape and black foam. One disadvantage of the Coloplast Brava barrier is that it may pull slightly at the skin even if you are using adhesive remover and gently removing the barrier to not create trauma and ensure that the sutures are not pulled with removal, which could happen, because you cannot visualize them under this barrier. An alternative if the Coloplast Brava barrier is not available is to use skin prep and cover the peri-wound skin with the transparent drape. This will still give the tissue protection form the NPWT and Veraflow from maceration the intact tissue.

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 the day? Were you able to meet your learning goal for today? Why or why not?	The goal for today was to see and individual with a wound around their stoma and how the WOC RN was able to care for this wound and still be able to acquire a proper seal to the pouching system. We did not encounter a peri-stomal wound on this day. We did see patients with stomas, and got to see ways that WOC RN built up areas with creases to help and get the pouch to have a good seal.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	The learning objective that I have for tomorrow is to potential find an individual with continence issue and see how the WOC RN can approach this issue to determine the consult service they may need referral to.

Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Today we say a patient with a NPWT to the LLE that was removed from Veraflow and change to regular NPWT. POD #1 ileostomy with leakage and peristomal irritation, Domeboro soak and new pouch system applied. POD #1 of a colostomy with leakage, rods still in place, new system applied. Loop ileostomy patient with a leaking pouch d/t crease in abdomen, filled and new high output pouch applied. POD #1 patient with an ileal conduit, sizing and fitting with a

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

	new pouch.

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.