Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Karen Rovinsky_____ Day/Date: Wednesday, October 4, 2023

Number of Clinical Hours Today: __8_ Care Setting: __x Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __6__ Preceptor: __Helen Shubsda_____

Journal Focus: __x___Wound _____ Ostomy _____Continence _____Combination Specify: _____

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	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** D. F. 64 year old male with admitting diagnosis of interstitial lung disease being managed by the primary team. PMH: Chronic respiratory failure, Coronary artery calcification, COVID infection x2 (09/22, 01/23), GERD, Hypersensitivity pneumonitis, Liver cirrhosis (d/t short telomere syndrome), Portal hypertension, Thrombocytopenia, HIV test positive (4th generation reactive but confirmatory tests negative), Supplemental O2 dependent. Current Hospital Administered Medication: Senna-docusate, Bisacodyl, Tenofovir alafenamide, Hydralazine (PRN), melatonin, Polyethylene glycol, Ondansetron (PRN), Lidocaine patch, Prochloroperazine (PRN), Rosuvastin, Zinc oxide cream, Aspirin, Prednisone, Sodium chloride nasal spray, Pantoprazole, Insulin lispro, Azithromycin, Glycerin 35% mucosal oral spray, Insulin NPH human, Trazadone, Metoprolol, Albuterol, Pentamidine, Acetaminophen (PRN), Tacrolimus, Acyclovir, Ferrous sulfate, Ursodiol. Allergies: Perflutren Lipid Mi Patient presented to WCCT on 08/10/2023 for evaluation of Left foot bulla. Per Podiatry note, patient suffered significant bilateral lower extremity edema, at which time 2 serous blisters presented on the dorsum of the Left foot and the lateral aspect of the Left foot. Approximately 4 days later the bullae filled with blood and appeared larger and denser. At that time the blisters were extremely painful. Pt does not have history of previous foot wounds or lower extremity neuropathy. Pt able to ambulate. Patient denies calf pain in legs at rest bilaterally. Patient presented to WCCT on 08/17/2023 for evaluation of skin tear to Right buttock. Subsequent encounters for bilateral buttock friction wounds assessed on 09/06/2023 and 09/11/2023.

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.*

(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

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. Write in a manner others will be able to understand and be able to interpret your plan of care.

The patient is seen for a follow-up visit for a hematoma/bulla to the Left foot and friction/shearing injuries to bilateral buttocks at the request of Dr. Unai.

Review of Systems:

General: denies fevers
Respiratory: Patient has a trach with intermittent trach collar at 6 liters
Cardiovascular: denies chest pain
GI: denies nausea
GU: denies dysuria
Skin: friction and shearing to buttocks and hematoma to left dorsal/lateral foot

Physical Exam:

BP 109/59 | Pulse 67 | Temp 97.9 (oral) | Resp 20 | Ht 5' 11.181" | Wt 215 lb | SpO2 100% | BMI 29.83 kg/m^2
O2 Therapy: Nasal Cannula, 1 Liter, FIO2: 28%
General Appearance: alert, no distress, cooperative, sitting in chair, stood for assessment of buttocks
Musculoskeletal: positive for weakness
Neuro: alert, oriented X3, follows verbal commands
Skin: Dorsal foot: brown, red, dry, peri-wound skin intact, round, 3.6 x 4 cm, no drainage, no odor.
Bilateral buttocks: blanchable erythema, excoriated, peri-wound skin intact, irregular shape, no drainage, no odor.
Last Braden score: 19

Left foot: Old dressing removed. Site noted to be dry with brown and red tissue and peri-wound skin intact. There was no drainage from the wound and no odor from the wound. A photo of the wound was taken and placed in the patient's chart.
The wound was cleansed with normal saline and gently dried. The wound was measured and noted in the chart. Restore contact layer was placed over the wound and covered with dry gauze. The dressings were secured with Kerlix rolled gauze.

Bilateral buttocks: Patient was able to stand for assessment of buttocks. Site noted to have blanchable erythema and some excoriation. The peri-wound skin was intact. There was no drainage or odor from the wound. A photo was taken of the wound and placed in the patient's chart.
The wound was cleansed with normal saline and patted dry. Zinc oxide (Desitin) was applied to the area for skin protection.

Plan:

Left dorsal foot: apply Urgotul contact layer to blister. Cover with dry gauze and wrap with Kerlix.
Bilateral buttocks: apply Desitin to perianal, coccyx, and bilateral buttocks as needed.

Prevention:

True-Vue heel protectors to bilateral lower extremities to off-load heels while in bed.
Maintain Air Turn and Position System. Turn patient every 2 hours using the TAP wedges, avoiding pressure over the coccyx/sacral region.
Maintain low air-loss bed/redistribution surface.
Moisture management.
Seat cushion.

Barriers to healing: Body habitus, comorbid conditions, medications, mobility, and moisture.

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	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should**

(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.

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***		**be followed. References are not required, unless utilized.**
Impaired skin integrity: foot	Clean bullae gently with normal saline, using caution to prevent excessive friction to the surface of the wound.	Keeping the surface of the blister intact will provide a natural barrier for the deeper tissue layers to block bacteria and other pathogens from invading the wound and causing infection.
	Apply non-stick contact layer on surface of the blister.	It is desirable to keep the surface of the blister intact. Use of a non-adherent contact layer will prevent trauma to the surface of the blister during dressing changes.
	Apply dry gauze over the contact layer.	Dry gauze will provide a layer of protection to the wound to prevent trauma. Dry gauze will also absorb fluid from the blister should it start to drain.
	Apply Kerlix around the foot to secure the dressings in place.	Kerlix is a readily available dressing choice to secure dressings in place while providing additional padding to the wound to protect it from trauma. Kerlix can hold the dressing in place without applying additional pressure of compression to the wound.
	Keep lower extremities elevated when seated or in bed.	Elevation of lower extremities can help relieve edema and aid resorption of extracellular fluid in lower extremities. This wound appeared after the patient experienced marked edema of the lower extremities, secondary to medications administered in the ICU. Prevention of edema can help to prevent additional blisters from forming.
Impaired skin integrity: bilateral buttocks	Apply Desitin to perianal, coccyx, and bilateral buttocks as needed.	Desitin will provide a skin barrier to protect the buttocks from injury due to friction, shear, and moisture.

(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.

	Use air Turn and Positioning wedges to offload pressure from coccyx and sacral regions.	Pressure points are vulnerable to additional breakdown on fragile or damaged skin. This patient's skin has healed, but it is important to continue measures to prevent regression of his wounds by preventing pressure to sensitive bony prominences.
	Provide seat cushion that redistributes pressure from the ischium, coccyx, and sacrum.	As this patient has regained mobility his seating surfaces should be addressed to prevent excessive pressure at the ischium, coccyx, and sacrum.
Calorie/protein deficiency, r/t prolonged illness and hospitalization.	Encourage patient to choose meal options that offer optimal protein and calories.	Sufficient calories and protein are required for tissue repair and healing.

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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Urgotul contact layer: extra step in wound dressing, might not be necessary if non-stick foam dressing or other silicone dressing used to cover the wound. The purpose of the dressing contact layer is to prevent the gauze layer from sticking while preserving moisture balance in the wound. Dry gauze: can promote bacterial infection for highly exudating wounds if not changed frequently. This dressing choice is intended to protect the wound from further trauma by providing extra padding. Foam dressings or ABD pads can provide protection from trauma for this wound. Kerlix can become bulky when used to secure the dressing to the foot. This can cause issues when the patient ambulates if it changes the contours of the sole of the foot, causing an increased fall risk. Coban could be used to secure dry dressings, but care should be taken to prevent compression of this wound. Stockinette could also be used to hold the dressing in place on the top of the foot without adding bulk to the contours of the foot. Desitin (Zinc Oxide): Can be difficult to remove with regular hygiene, making visualization of the wound difficult. Clear skin barriers and ointments without zinc oxide could be considered to protect the skin from friction and shearing without obstructing the view of the wound.

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?	For my final day with the wound care consult team, I hope to see deep tissue pressure injuries vs. stage 3-4 pressure injuries and compare the differences in treatment modalities. I also want to learn more about the types of pressure-relieving devices and mattresses that are typically used for patients at Cleveland Clinic. Today I saw pressure injuries at various stages of healing. Some of these were unstageable during assessment due to necrotic tissue or slough present. The biggest difference in treatment of the wounds was dependent on whether the wound was open or closed. Open wounds with high exudate were treated with absorbent products to maintain appropriate moisture balance while preventing maceration of intact skin. Wounds that were closed were treated with skin barrier products to prevent breakdown of the epidermal layers. If the wound was due to deep pressure, protective products were included in the plan of care to cushion and off-load pressure from those sensitive areas.
What are your learning	For my first day with the inpatient ostomy team, I hope to learn about stoma assessment, pouching,

(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.

goals for tomorrow? **(Share learning goal with preceptor)**	patient teaching and general observation of the role of the stoma team. If possible, I would like to see a patient treated with NPWT with instillation to learn more about this treatment modality, such as why it is implemented and how it is applied.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This patient has been in the hospital for approximately 2 months prior to this visit. His wound to the left foot is slowly improving. He had similar blisters to his lateral left foot that have resolved. Per the patient "the scabs from the blisters just fell off" without any additional drainage or tissue injury evident. The large blister has been left intact with protective measures implemented to preserve the epidermis and prevent exposure to outside pathogens that could lead to infection. The patient does complain of pain at the site of the blister when touched. The blister is not draining any fluid and the peri-wound skin is intact without erythema. This wound reminds me of the treatment for eschar to the heels, where the damaged tissue is left intact to protect deeper tissues under the eschar. The difficulty with this wound is that it is best left alone, where the initial instinct might be to "do something" to accelerate the healing process. When the scab from the blister does come off I would be curious to see the condition of the newly exposed skin and any treatment recommendations at that time. The patient's other wound to his bilateral buttocks has also shown significant improvement since it was first assessed by the WCCT. Measures to assist in healing this wound included offloading of pressure using a low air loss mattress and turning the patient every 2 hours. At the time of this visit the patient was no longer in the ICU, and his mobility was improved from the time of the initial injury. Patient mobility is another factor that can assist in the progression of a wound to the coccyx/sacral region. During this visit the patient was concerned that the wound had worsened after he was positioned on a surface that did not offload and redistribute pressure for a bronchoscopy exam the day prior to the visit. This illustrates the value in providing patients with pressure relieving devices that can travel with the patient to other areas of the hospital to prevent the recurrence or worsening of wounds after showing marked improvement.
Reflection: Describe other patient encounters, types of patients seen.	Today we saw 6 patients. 3 of these patients had wounds located on the buttocks. These wounds were in various stages of healing. One of these wounds was still open and required treatment with hydrogel and foam dressings. Another patient had a blister on their calf that was likely of venous origin. There was a patient with an old abscess (drained in February?) to her scapula that still had purulent drainage. This patient would likely need a wound culture to identify the infectious agent causing purulent drainage to optimize healing. One other patient had an area from a bone biopsy that required Stat Seal to be applied to control bleeding from the site. When she was assessed, the Stat Seal disk was gently removed and there was no evidence of active bleeding. The area was covered with a foam dressing to provide protection to the area. The patient was cautioned to be careful with the area to avoid re-opening the wound and causing excessive bleeding again. If the bleeding had not subsided, the plastic surgery team would have been notified to apply another Stat Seal disk or to cauterize the area with silver nitrate.

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.