Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Tatiane Abud Pimentel_____ Day/Date: 01/19/2024

Number of Clinical Hours Today: __12__ Care Setting: __x_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __7___ Preceptor: ____Candace Beeghly_____

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.**
	Patient with a history of poly-substance abuse disorder and hypertension presented on January 16, 2023, to the ED with complaints of scrotal swelling and pain that began the day prior to admission. The patient was found to have septal shock secondary to necrotizing fasciitis. Wound culture positive for strep progenies, and blood culture 1 of 2 also positive for strep progenies. Patient was taken to the OR with urology and general surgery for extensive debridement of the anterior pelvic soft tissue, debridement of the penile soft tissue and scrotal tissue, skin, and soft tissue of the inner thighs. Patient was intubated intra-operatively and remained intubated post-op for repeat I&D the next day. On January 17, 2024, the patient underwent excisional debridement of penile skin, scrotectomy, and implantation of the testicles in the inner thigh pocket. Patient was extubated on January 18, 2024, after he completed TEE (negative for thrombus or vegetation) and physical assessment per MD note patient was alert, and was able to follow commands. Same day, during night

(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.

	shift, patient had one episode of generalized seizures that lasted approximately 2 minutes. An MRI of the brain showed a small acute infant in the frontal lobe. Neurology was consulted and recommended KEPPRA 1000 mg twice daily. Today, on 01/19/2024 patient remains in the ICU with urology and general surgery on board. General surgery placed WOC nurse consultation for placement of negative pressure wound therapy in pubis area down to scrotum. PMH: hypertension, anxiety, and poly-substance abuse. Surgical history of hand surgery (2012).

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.*

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.

Patient resting in bed, alert, oriented in place and person, somewhat confused in time, able to follow all commands, no signs of distress, mother at bedside. Upon arrival, the patient stated, I am anxious; I don't know what happened down there. The WOC nurse educated patient on all steps of NPWT dressing placement. Patient stated, "Go ahead; I want to see how bad it is." The surgical dressing was removed. Upon wound evaluation, the WOC nurse assessed a triangular-shaped wound with visible blades, ligaments, fascia, tendons, adipose tissue and muscles, penis body visible connective tissue and muscle (glans, corona, and neck of penis intact), and surgical removal of testicules and scrotal sack tissue. Peri-wound skin is red; there is no warmth, no induration, and light maceration on the perineal area. Wound length is 17.6 cm, wound width is 19 cm, and depth is 4.2 cm. There is no undermining or tunneling. Patient stated, "This is not real; I can believe this is happening; I need to fix my (coursing word)" and started crying. The WOC nurse was able to comfort the patient.

Management: Patient was pre-medicated for pain as prescribed. Cleansed and gently irrigated wound with Antiseptic Wound Cleanser solution and gauze to remove debris. Patted dry peri-wound skin and prepped wound margins with skin protectant and Eakin Barrier Seal to help prevent leaks and protect penile remaining skin. Applied Mepitel atraumatic wound dressing to the wound bed. Cut the white foam dressing to size and place it into the wound (white foam is placed as the first layer to decrease intensity and be less adherent to the tissue). Above the white foam, cut and apply black foam to the size of the wound. Cut the clear occlusive dressing to size, peel back one side of layer 1, and place the adhesive side down over the foam. Removed the remaining side of layer 1 to ensure that a tight seal was created and secured. A hole was cut on the left anterior superior pelvic area into the clear dressing about the size of a quarter (2.5cm). The adhesive pad was connected to the pump, placed directly over the hole, and affixed to the clear dressing. The pad tubing was connected to canister tubing. NPWT wound vac dressing was turned on with pressure settings at 125 mmHg continuously. Labeled dressing with date, time, initials, and number of foam pieces placed in the wound. Visual assessment confirmed that NPWT was working properly with clamps open and foam shrinking down. The patient tolerated the procedure well. Documented all pieces of foam and gauze used on the dressing.

Recommendations:

- Avoid placing the tube over bony prominences, creases, folds, and weight-bearing surfaces to prevent tubing-related pressure ulcers.
- Provide education on signs of concern: a significant change in the color of the drainage (cloudy or bright red); signs of infection such as fever, redness or swelling of the wound, warmth, purulent exudate, or foul-smelling drainage.
- Confirm that the unit is on and set to the appropriate negative pressure, that the foam is collapsed, and that the NPWT device is maintaining the prescribed therapy and pressure. Be sure that the seal is not broken or leaking.
- Address and resolve alarm issues as soon as possible, such as a full canister, a leak in the system, and a low battery.

(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.

- Do not leave the device off for more than 2 hours. While the device is off, apply a wet-to-dry dressing and notify the prescribing clinician and WMST immediately, document amount of foam pieces removed from the dressing and time of removal.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)

(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

Identify specific problems or concerns. "Risk" concerns should be 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*** 1. ***Knowledge deficit, lack of exposure and unfamiliarity with the subject: precautions with negative pressure wound therapy use*** 2. ***NPWT and nurse education***	**Statements should be directive and holistic relating to the problem/concern.** • Educate nurses on precautions and additional support for NPWT usage. • Educate nurses to avoid placing the tube over bony prominences, creases, folds, and weight-bearing surfaces to prevent tubing-related pressure ulcers. • Provide education on signs of concern: a significant change in the color of the drainage (cloudy or bright red); signs of infection such as fever, redness or swelling of the wound, warmth, purulent exudate, or foul-smelling drainage. • Teach nurses to confirm that the unit is on and set to the appropriate negative pressure, that the foam is collapsed, and that the NPWT device is maintaining the prescribed therapy and pressure. • Educate nurses on how to identify that the seal is not broken or leaking. • Educate nurses to address and resolve alarm issues as soon as possible, such as a full canister, a leak in the system, and a low battery. • Teach nurses not to leave the device off for more than 2 hours. While the device is off, they must apply a wet-to-dry dressing and notify the prescribing clinician and WMST immediately. • Educate about the importance of documentation, such as the amount of foam removed from the dressing and the time of removal. White foam can easily be mistaken for tissue when soaked in blood, for example.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Patient will maintain intact skin integrity underneath bony prominences. NPWT will be performed correctly, and patient safety will be achieved. Nurses will enhance their knowledge on how to manage problematic vacuum pumps and monitor the efficacy of dressing clamps open and foam shrinking down. Patient will remain free of infection. Patient will experience a timely healing of the wound without complications or further deterioration. Accurate documentation will help to monitor if any pieces were left inside the wound.

(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

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.** White foam can be difficult to visualize and retrieve from the wound bed during dressing changes. Hydrofera Blue Comfortcel - Methylene Blue Gentian Violet foam minimizes adherence to the wound bed and can augment the clinical benefits of NPWT by increasing antimicrobial treatment since it absorbs and transfers bacteria-laden exudate out of the wound bed. According to the manufacturer, there is no urgent visit related to loss of seal; staying in the wound bed for up to 7 days (Hydrofera-Blue, 2021).

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?	My learning goal was to learn more about complicated wounds. Developing this POC helped me research necrotizing fasciitis and increase my understanding of how to manage this issue, as well as my critical thinking skills in how to apply foam dressing to difficult-shaped and uneven areas.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I would like to continue to learn about complex wounds settings.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This case helped me realize the lack of familiarity bedside nurses can have with NPWT dressings. Even though we have had this dressing around for a while, most of the nurses during my lunch break did not know precautions or issues related to leaving foam in the wound. I feel that this is an opportunity to promote education and train nurses on how to handle NPWT

(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.

	issues.
Reflection: Describe other patient encounters, types of patients seen.	1. Colostomy patient 2. RLE venous ulcer 3. Flexseal placement 4. Supra-pibic exchange 5. HAPI 6. Follow up with skin failure patient

Reviewed by: _____ Date: _____

References:

Hydrofera Blue. (2021). Hydrofera Blue ComfortCel® Interface Antibacterial Foam Dressing: Pull your patients into the comfort zone. Manchester, Connecticut, USA: tradmarks hydrofera blue.

(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.