Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lillian Kopatz Day/Date: Tuesday January 23, 2024

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

Number of patients seen today: __6___ Preceptor: Mary Montague CNS, CWOCN

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 is a 65-year-old female with a medical history of asthma, GERD, osteoperosis, vitamin D deficiency, hypertension, and chronic hypoxemic respiratory failure. Patient is in the ICU admitted for chronic respiratory failure with hypoxia. Patient is being weaned from ventilated since post-surgical procedure 05/12/2023 bilateral lung transplant. At this time patient is awake, alert and oriented, ventilated via a tracheostomy, and can answer yes/no questions appropriately via head nodding. WOC nursing has been following for a stage 4 pressure injury on sacrum and new consult for a left hand skin tear.

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.*

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.

Initial WOC nursing visit for left hand skin tear and follow-up visit for stage 4 sacral pressure injury.

Upon WOC nursing arriving to bedside, patient lying in bed awake and on ventilator via tracheostomy. This nurse explained purpose of visit and patient nodded head in "yes" motion. With patient's permission via "yes" head nod and patient's full cooperation with turning self, wound assessment completed as detailed below. Recommendations also outlined under assessment.

Assessment

Per bedside nurse, skin tear occurred when patient was reaching for side rail to reposition self in bed and misjudged distance, hitting hand on side rail. Upon assessment an Allevyn foam was in place. Allevyn foam was removed using ConvaTec Adhesive Remover wands and normal saline to prevent further tearing of epidermis. Skin tear type 3 with total flap loss measures 2.0cm x 3.2cm x 0.1cm and presents as a 100% moist, red wound bed with fragile and ecchymotic surrounding intact periwound skin. No odor present, scant amount of dried sanguinous drainage present on Allevyn Foam, and patient appears to be in pain with dressing

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change via grimacing and flinching. Emotional support provided and deep breathing encouraged; patient tolerated well. Wound cleansed with normal saline and patted dry with gauze. Applied a folded piece of Urgotul contact layer (for 2 layers) to skin tear. Wrapped with entire roll of Kerlix to secure contact layer and provide additional padding for protection of fragile skin. Secured with paper tape.

Upon assessment of stage 4 pressure injury, wound was covered with Allevyn foam and Calcium Alginate dressing. Previous dressing was gently removed. Stage 4 pressure injury measures 2.5cm x 2.0cm x 0.3cm and presents as 100% moist, pink granular tissue with flat edges. Periwound skin is clear and intact. Small amount of serosanguinous drainage with yellow slough present and soaked into previous Calcium Alginate and Allevyn Foam. No odor present and patient denies pain via head nod "no." Wound cleansed with normal saline and gently patted dry with gauze. Applied small circle of Calcium Alginate to wound bed and covered with an Allevyn Foam. Patient tolerated dressing change well. This wound has improved per decreased size, increased granular tissue present, and undermining no longer present compared to previous WOC nursing visit.

Recommendations

Left Hand Skin Tear: Gently cleanse wound with normal saline and pat dry with gauze. Apply folded sheet of Urgotul contact layer (for total of x2 layers) to skin tear. Cover with Kerlix roll and secure with paper tape. Change daily and PRN. (Do NOT use Allevyn foam or any adhesive bandage on this skin tear due to fragility of patient's skin.)
Sacrum Stage 4 PI: Gently cleanse wound with normal saline and pat dry with gauze. Apply a small circle of Calcium Alginate to cut to fit to wound bed and cover with an Allevyn foam. Change daily and PRN. Offer assistance repositioning patient as needed and utilize off-loading wedges.

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 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*** *Skin Tear, Type 3 (left hand)*	**Statements should be directive and holistic relating to the problem/concern.** *-Gently remove dressing in place (to ensure not to damage intact skin)* *-Cleanse wound with normal saline and pat dry (to clean the wound)* *-Apply folded sheet of Urgotul contact layer to wound bed (to keep the wound moist, promote wound healing, and prevent trauma with removal of Kerlix, which would potentially stick to wound)* *-Cover with Kerlix roll (to keep contact layer in place over wound and also to add extra padding for protection as patient received skin tear from accidentally hitting hand on side rail) and secure with paper tape (to keep in place)* *-Change dressing daily and PRN (to ensure wound dressing is staying clean to promote healing, also always wound to be assessed at least daily)* *-Ensure patient's glasses are bedside (visual aids within reach will allow the patient to utilize them when needed, like in the case of repositioning self using side rails)* *-Gently remove dressing in place (to ensure not*	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** *←(done in parathensis after statement d/t spacing issues in word…statement and explanation were not lining up in 2 separate columns)*

Stage 4 Pressure Injury (sacrum)	*to damage intact skin)* *-Cleanse wound with normal saline and pat dry (to clean the wound)* *-Apply a small circle of Calcium Alginate to cut to fit to wound bed (to continue to absorb the drainage coming from the wound, while also maintaining a moist wound environment to promote wound healing)* *-Cover with an Allevyn foam (Allevyn foam holds alginate in place while also protecting wound and by covering wound it keeps the wound temperature warmer (since skin and tissue are missing here) increasing blood flow and promoting healing)* *-Change daily and PRN (to ensure wound dressing is staying clean to promote healing, also always wound to be assessed at least daily)* *-Provide frequent repositioning reminders, utilize off-loading wedges and assist patient PRN for repositioning (patient independently turns self in bed, but providing reminders to do so may be helpful in ensuring the repositioning is occurring frequently enough. Also assisting as needed and offering use of off-loading wedges/using them for patient will be helpful in off-loading pressure to sacral area.)* Consider less frequent dressing changes since Allevyn & alginate are used to absorb any drainage & wound can remain at same temperature for 48 hours. Also this will decrease the cost of the dressing. If using Allevyn foam you can use skin prep to surrounding skin here & on hand	

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an alternative to the product. <u>Alternatives should be from a different category or classification</u>. 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.** **Disadvantages:** <u>Urgotul contact layer:</u> keeps wounds moist, sometimes may keep wound too moist if having more drainage. <u>Allevyn foam:</u> being an adhesive there is still a risk for damage to skin, especially for this patient with extremely fragile skin Are you using the silicone bordered foam? <u>Calcium Alginate:</u> absorbs wound moisture, but may dry out wound too much if not having as much drainage **Alternatives:** <u>Skin tear:</u> Apply Cavilion 3M No Sting Skin Barrier to intact periwound skin and allow to dry completely. Then apply hydrogel to wound bed and cover with a Cardinal Health Tefla “Ouchless” Non-Adherent Dressing. Secure with kerlix and paper tape. Change daily and PRN. Good plan <u>Sacral PI:</u> Apply Aquacel hydrofiber to wound bed base and cover with a Coversite dressing. Change daily and PRN. If there is not a lot of drainage this may not need to be changed daily

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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 goal for the day was to select an appropriate dressing for a wound I have no experience with. (Have experience with incisions, negative pressure wound therapy, and some experience with pressure injuries; therefore, wanted to pick something different from these wounds.) I did achieve my goal for the day! I selected an appropriate dressing for a skin tear (type 3, total flap loss) and additionally I got to see an improving stage 4 pressure injury. It was rewarding to see how far this stage 4 has come in less than a week just from the WOC nurse's dressing recommendations. Its empowering to think what a difference we can make for these patients!
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to correctly identify an unstageable pressure injury and select an appropriate dressing after discussion with my preceptor. I am starting to feel more confident in my wound identification and dressing selection. As I am becoming more familiar with the dressings, I think my next goal is to become more familiar with how certain dressings address debridement and an unstageable pressure injury would be a good wound for that learning experience.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I know one thing I would have done differently for sure: laid down a blue absorbent pad under the patient's hand for the skin tear assessment. We had laid down some gauze, but that did not cut it as we ended up requiring more adhesive remover and normal saline with the removal of the Allevyn Foam that was placed over the skin tear and the skin tear had started to adhere to. It was tender for the patient and we therefore continued using normal saline and adhesive remover to loosed the dressing without pulling or causing further damage to her already very fragile skin. Her pillow was soaked (not the end of the world, we changed the pillow case) which could have been prevented if we had placed a chux down first. Lesson learned! Yes, you are correct!
Reflection: Describe other patient encounters, types of patients seen.	Other patients I saw today included: a patient with bilateral lower extremity cellulitis (closed, no open wounds), a patient with a tongue medical device related pressure injury (due to intubation), a patient with a superficial scrotal wound from scrotal edema and swelling, and a patient with closed deep tissue injuries to left heel, left shoulder, and left ear. The bedside nurse offered the WOC nurses an interesting idea to the scrotal edema patient that I had never heard before: using inter dry as a scrotal sling. My preceptor and I recommended moisture barrier cream on this wound and thought this was an additional good idea that may help with wicking moisture and providing comfort for the patient.

Reviewed by: Patricia A. Slachta Date: 1/24/24

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