Cleveland Clinic

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

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Bernadette Fulweiler_____ Day/Date: ___3/25/24_____

Number of Clinical Hours Today: ____

Care Setting: Hospital ___x_ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: __Niki Blasiole_____

Clinical Focus: Wound _x__ Ostomy ____ Continence ____

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Types of patients seen: Diabetic foot ulcer (2), coccyx pressure injury stage 2 (2), unstageable heel pressure injury, sacral DTI, necrotizing fasciitis of the groin, abdominal wound dehiscence

Patient Encounters:
We saw a total of 9 patients, 8 of whom had been admitted over the weekend and not yet evaluated by wound care. These visits were all wound focused and included thorough examinations as the majority were new patients. The one known patient had an abdominal wound dehiscence and required wound vac dressing changes. For both of the diabetic foot ulcers, we measured the wounds, cleansed with saline, and applied sodium chloride impregnated gauze with a secondary foam border dressing. Both coccyx pressure injuries were measured, cleansed with saline, and covered with sacral foam border dressings. The unstable heel pressure injury was cleansed with saline, covered with sodium chloride impregnated gauze and a foam border dressing. The sacral DTI was measured, cleansed with saline, and covered with a sacral foam border dressing. The necrotizing fasciitis was status post surgical debridement the day prior, and is currently being managed with wet to dry dressing changes prior to an additional surgical intervention later this week. We removed the previous dressing, irrigated the wound with saline, applied normal saline soaked gauze lightly packed into the cavity, and covered the wound with ABD pads and secured with paper tape. The abdominal wound was managed with a bedside NPWT change (see detailed encounter below).

Focused Encounter: Patient X, a 75 year old female with an abdominal NPWT dressing. We spent 25 minutes with this particular patient performing a wound assessment and NPWT dressing change.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to 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 were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

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Patient X is a 75 year old female with an abdominal surgical dehiscence. Wound care was consulted at admission for evaluation and management of the abdominal surgical wound. X's history is significant for acute on chronic diastolic heart failure, enter-cutaneous fistula, and anemia. Past surgeries include Whipple procedure in 9/2022. Medications reviewed. Significant labs include H/H of 7.8/25 as well as platelet count of 116. X had undergone attempted closure of her enters-cutaneous fibula with VICRYL mesh on 2/29/24. On 3/22/24 a NPWT dressing was placed due to surgical wound dehiscence.

NPWT dressing changed at the bedside at 9 AM on 3/25/24. We took down the old dressing, and proceeded to take detailed measurements of her wound, and noted tissue, exudate, and peri-wound characteristics. The wound was located in the lower medial abdomen. Measurements were 4x3x1 cm. Wound bed pink with roughly 10% slough. Drainage moderate, brown, and malodorous. We then irrigated the cavity and dried with sterile gauze. We prepped the peri-wound skin with a liquid skin barrier and applied a window around the wound with clear NPWT drape. We utilized white foam due to surgical mesh which was visible in the wound bed, as well as a layer of black foam over top. We covered the foam with clear tape, cut a hole over the foam, and applied the NPWT at 100 mmHg. Patient tolerated dressing change without pain or complaint. Discussed need for dressing changes every other day. Discussed the importance of nutrition with the patient with an emphasis on protein and iron to aid in wound healing and anemia. We discussed turn schedule and low air loss bed with nursing staff and patient. Patient demonstrated understanding and all questions were answered.

Using the information from the chart note, 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.

WOC Plan of Care (include specific products used)

- Remove existing NPWT dressing and gently irrigate the wound cavity with normal saline. Dry peri-wound with gauze and apply liquid skin protectant. Apply window dressing to peri-wound with clear drape. Cut white foam and place in wound bed, then cut black foam and apply over white foam. Cover with clear drape, cut quarter sized hole in the tape and apply NPWT at 100 mmHg as per order.
- Monitor output and change NPWT canister every 48 hours or as needed.
- Dressing to be changed by wound care every 48 hours.
- If the NPWT malfunctions or is off for two hours, remove dressing completely and apply normal saline wet to dry dressing and call wound care to notify.
- Continue turn schedule and low air loss/redistribution surfaces.
- Continue to encourage healthy proteins, iron rich foods and heart healthy diet.
- Call the WOC Team with questions or concerns regarding wound.

Describe your thoughts related to the care provided. What would you have done differently?

I would have questioned the drainage pattern over the past several weeks utilizing chart review and potential contact with the surgical team. This patient does have a known fistula, but it was unclear if the drainage had been consistent. It is important to understand the change in the drainage status - for example if it was initially sero-sanguineous and then became increasingly more brown and malodorous this could be a sign that the known fistula is expanding.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

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What was your goal for the day?
My goal for the day was to identify the commonly encountered wound types in the inpatient adult setting. This goal definitely met, as we were able to see almost ten patients. After rounding on the patients and discussing with my preceptor, we identified the most common wound types seen at this hospital, which include coccyx/sacral pressure injuries, diabetic foot ulcers, heel pressure injuries, venous insufficiency ulcers, and venous insufficiency ulcers.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
My goal for tomorrow would be to identify product and dressing change recommendations for dry diabetic foot ulcers.

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		
*Includes pertinent PMH, HPI, current medications and pertinent 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		
*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		

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Reviewed by: _____ Date: _____

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