Cleveland Clinic

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Nancy Benchley_____ Day/Date: __3/29/2024_____

Setting: Hospital __ __ Ambulatory Care _____ Home Health Care __x_____ Other: _____

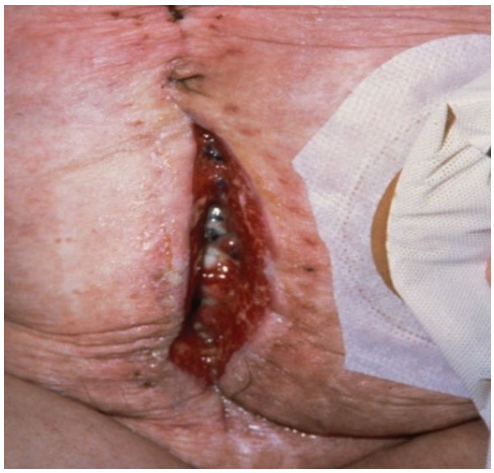
WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, a chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History	49 year old with a history of uncontrolled DM, obesity and colon cancer with descending colostomy Followed by home health care. Home health sees patient for ostomy care and teaching. Referred to wound clinic for treatment plan. States the "stitches were taken out earlier today and now I have a big hole"

Assessment:

- Serosanguinous drainage on blouse.
- Lifting of blouse finds wound dehiscence.
- Site cleansed with NS. Wound measures 25 x 10 x 5 cm with red wound bed.
- Periwound is nontender and without erythema or induration.
- Draining moderate amounts of serosanguinous drainage.
- VS within normal range.

Photo:



WOCN Library

Write a chart note giving careful consideration to the chart review information, 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 used/recommended for use. *What dressing regimen would you recommend?* Are there any further teaching points for this patient as the wound professional directing the care of this patient based on the case study? Write in a manner others will be able to understand and be able to interpret your plan of care.

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Chart note:

Initial visit for the evaluation of a wound dehiscence. Patient is a 49 year old with a history of diabetes, obesity, colon cancer, and a descending colostomy. Patient was referred by home health care after stiches were taken out earlier today from a previous surgery and patient developed an open wound. Patient presented with serosanguinous drainage on their blouse. Wound dehiscence noted. Vital signs within normal range and wound was cleansed with normal saline. Wound measurements were 25cm x 10cm x 5 cm. The wound bed was red with moderate amounts of serosanguinous drainage. Periwound without erythema or induration. A negative pressure wound therapy (NPWT) was selected as a dressing for the wound. The periwound skin was protected with transparent film. Black foam was applied to wound bed and then covered with transparent drape. Home NPWT device attached. NPWT dressing will be changed withing 48 hours for the first dressing change and then three times a week by home health nurse. If there is pain with dressing changes then an oil emulsion dressing can be applied to wound bed under the foam dressing. Patient was educated on NPWT. How the machine works. If the machine alarms it may need to be plugged in if there is a low battery, the canister may be full and need to be changed, and there may be a seal leak. If the machine suction is not working for more than 2 hours the NPWT dressing needs to be taken off and saline moistened gauze can be applied to the wound and notify either the wound clinic or home health nurse. If bleeding occurs the wound clinic or primary provider need to be notified. If it is after hours then patient needs to go to the hospital. Make sure tubing stays free from bony prominences. Patient educated that her uncontrolled diabetes is contributing to the stalling of the wound healing. A consult with a diabetes educator was initiated.

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)

*cleanse wound with normal saline between dressing changes
*Apply no sting barrier skin prep (Cavilon) to periwound, allow to dry
*Apply transparent film to periwound
*Fill wound bed with black NPWT foam
*Apply NPWT drape over foam, make slit into drape, and connect NPWT button
*Make sure pressure setting is accurate according to physician orders
*If suction is interrupted for more that 2 hours then a new NPWT dressing will need to be applied.
*Change first dressing within 48 hours, then 3 times a week

Describe your thoughts related to the information provided. What would you have done differently? Any additional information that would have been helpful?

If the patient refused NPWT, then the wound can be filled with hydrofiber dressing (Aquacel) and a secondary foam dressing will be placed over it (Allevyn). Change dressing q 3 days or if strike through is noted. The chronic conditions that are of concern for proper wound healing is the uncontrolled diabetes and obesity. The patient's diet and exercise regime would have to be assessed. A dietician or diabetes educator could address these issues and the wound care nurse could also give information about proper nutrition. The case did not provide information on the type of medication the patient is on for their diabetes, this may need to be adjusted by the primary care provider. The date the surgery was performed would be helpful information.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

Goals.

What was your goal for choosing this case?

My goal was to learn about the management of surgical wound dehiscence.

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Reviewed by: _____ Date: _____