Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Tara McLane_____ Day/Date: _April 25, 2024_____

Number of Clinical Hours Today: _8___

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

Preceptor: _Erika Daigle, CWON_____

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.

I saw 4 patients with my preceptor. We discussed a fifth patient to be seen but received a message she was to return to surgery, so the follow-up was rescheduled. The patients seen were all wound-focused. ✓ ***- remember, only one of these needs detailed. A synopsis (as you provide) is great. Make sure each journal focuses on different types of patients***

Types of wounds seen: Healing Stage 4 Sacral Pressure injury, Arterial foot wound, Dermatitis – possibly psoriasis, Incontinence Associated Dermatitis – Gluteal Cleft/Buttocks, Wound of unknown etiology – suspect infiltrated IV, DTI of the heel, Stage 2 Pressure Injury coccyx

Patient #1: 68 y/o male with a healing stage 4 sacral pressure injury. He has a history of CVA and is bedbound. His wife cares for him at home. This assessment was a follow-up focused only on his sacral wound. His wound was packed with Prisma then hydrofiber Ag rope covered with a border foam dressing.

Patient #2: 76 y/o male from a nursing home. The CWON was consulted for a foot wound. He has an extensive history of arterial stenosis in multiple locations. His right dorsal foot and all his toes had an arterial wound. Vascular surgery had already been consulted on this patient. His foot was wrapped in Dermagran then Kerlix and secured with tape. He also had plaques with scales thought to be psoriasis. He did not have a history of this, so it was considered a dermatitis.

Patient #3: 72 y/o male with COPD exacerbation. He was seen in the ICU on BIPAP after a recent extubation. He was incontinent of stool with loose stools. He was also obese causing moisture in skin folds. He had mirroring partial thickness wounds to his bilateral buttocks and gluteal cleft. This was consistent with IAD. The treatment was zinc oxide. His left wrist had a wound of unknown etiology. The wound had an area of necrosis, slough, and maroon intact skin. This was possibly due to an infiltrated IV. However, the was no documentation to support this.

Patient#4 82y/o male bedbound from home. History of Parkinson's. The sacrum had areas of pink newly healed skin. Unknown what the wound type was. Now Stage 2 Pressure injury. Treated with zinc oxide.

The fifth patient had an open abdominal wound with a colostomy present in the middle of the open wound. She presented with necrosis of the peristomal skin. After a debridement and colostomy revision due to ischemia, the abdominal wound was left open. The wound measured 21x24cm. We had a lengthy discussion about how to address pouching the ostomy and containing the wound exudate with a wound vac. The discussion included how to use a wound crown or an isolator strip with the wound vac. This allows the ostomy to be pouched while the abdominal wound

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is treated with the wound vac. We also discussed how the ostomy could be isolated if the wound crown or isolator strip could not be obtained. The patient was note able to be seen because the surgical NP notified my preceptor the patient wound be returning to surgery. ✓ ***- remember wound "vac" is a brand name for the KCI product. Make sure to refer to as NPWT unless specifically mentioning that type of therapy.***

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:

Wound Nurse Initial Consultation Note

Reason for Wound/Ostomy/Continence Consult: Leg Pressure Injury
Reason for admission/Chief Complaint (CC): AMS, Leukocytosis, Urinary Retention, Sepsis
Past Medical History (PMH): Severe right knee osteoarthritis, CHF EF 30%, Type 2 DM, CAD s/p CABG, Left iliac artery stenosis, Left subclavian artery stenosis s/p stenting, Aortic valve stenosis s/p TAVR, HTN, HLD, COPD, BPH, Chronic Foley, Chronic microcytic anemia
Allergies: NKA
Braden: 14 *– consider including subscores – these are very important when considering/justifying interventions.*
Support Surface: Centrella Mattress

ASSESSMENT:

General:
The patient's nurse, Judy, was notified the CWON was going to see the patient for a wound care consult. – *Make sure to write this from the standpoint of the specialist*. The nurse advised it was okay to see the patient at this time. The patient was sitting semi-fowlers in the bed. He was alert to self, confused. CWON explained the reason for the wound care consult. The patient was very hard of hearing and need to be told multiple times the reason for the consult. The patient gave permission for the assessment. A full skin assessment including all bony prominences was performed. The following was found:
Right foot: Red and black irregular partial thickness arterial wound with areas of necrosis noted. The wound starts at the toes and extends down the dorsal side of the foot. Moderate serous exudate noted. The foot is edematous with mild pain. Cleansed with wound cleanser. Dermagran was applied to the entire foot. Kerlix was wrapped around the foot and ankle and secured with tape.
Right heel: Fissure noted. Cleansed with wound cleanser. Wound included in the right foot wound dressing.
Bilateral legs: Scattered areas of red, raised plaques with scaling, and areas of flat red patches noted. When asked the patient says they occasionally itch. This could possibly be psoriasis. The patient has no history. Assessed only. Recommendation for topical steroids to the active areas of flare.
Bilateral arms: Scattered areas of flat red patches. This could possibly be psoriasis. The patient has no history. Assessed only.
Left hand: Red, raised plaques with scaling and edema noted. This could possibly be psoriasis. The patient has no history. Assessed only. Recommendation for topical steroids to the active areas of flare.
Left heel: Fissure noted. Remedy Moisturize Skin Cream applied. Will recommend A & D ointment.
Penis: Abrasion noted on the anterior side. Applied Remedy Prevent Silicone Cream.

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Forehead: Abrasion noted. Assessed only.

No other wounds were noted. A preventative foam dressing was in place to the sacrum. This was replaced after assessing the area. The patient was repositioned in the bed. The nurse was advised of the assessment findings and wound care plan.
Ok- make sure to include how patient tolerated procedure.

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)

RECOMMENDATIONS/PLAN:

Right foot -
Cleanse with wound cleanser. Pat dry. Apply Dermagran. Wrap with Kerlix. Secure with Tape. Change daily and PRN if soiled.

Left heel -
Cleanse with soap and water. Apply A & D ointment BID. Leave open to air.

Bilateral lower legs/ Left hand -
Cleanse with soap and water. Pat dry. Apply Triamcinolone Topical 0.1% to raised red plaques with scales BID. Leave open to air.

Skin Care Protocols -
For all patients with a Braden score of 18 or less unless there are specific orders addressing the plan of care.

- Turn and reposition patient q 2 hours, use pillows/repositioning aides PRN
- Limit layers of linens/pads under patient to maximize microclimate management of surface
- Keep skin clean and dry
- Float heels off surface; keep plantar surfaces free from bed. *– how is this to be done? You are the directing specialist.*
- Monitor skin under/around medical devices with each assessment, reposition devices as needed to redistribute pressure/avoid injury. *– what is done with this assessment? When we direct to monitor in a plan of care, an associated action is always needed.*
- Apply Barrier cream Silicone (Blue - Before open)/ Zinc Oxide Paste (Orange - Open wounds) to affected areas q Shift and PRN.
- Preventative foam dressings as needed over bony prominences (unless there are specific orders addressing a different plan of care); to be changed weekly and PRN if loose/soiled. Assess skin daily and reinforce dressing during assessments.

Referrals/Consults: Nutrition, Vascular - Both already consulted – *direct to follow up with these facets if questions/issues arise under their umbrella.*

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IPOCs Ordered: Pressure Injury Prevention

Wound care to follow up weekly, as time permits- *don't write this in the MR. Make sure you are direct and specific in your writing. Consider all WOC documentation from a legal review standpoint.*

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

The nurses did not have a dressing on the right foot prior to the wound care nurse seeing the patient. They have protocols in place for what dressing can be used until wound care can see the patient. This could have been reinforced to the staff. Other than that the treatment was appropriate. A nutrition and vascular consult was already placed. The wound care consult was placed within the appropriate time frame. Camera capture was done according to the hospital's protocols. He was on an appropriate bed surface. *– make sure to include in the POC above*

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

What was your goal for the day?
My goal was to start learning more about the use and application of wound care products.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

My goal is to be able to apply the wound crown or isolator strip with the wound vac to successfully address the wound for the patient that could not be seen today.

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 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: Mike Klements 4/29/24 received Date: 4/29/24

Hi Tara – it looks like you are off to a good start with your clinical journals. See my comments throughout – meant to be constructive and help you build future plans/journals. Reach out with any further questions! This qualifies your first 8 hours of the wound specialty.
-Mike

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