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 26, 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.

Today I was able to see 4 patients with my preceptor. Unfortunately, the patient who was supposed to be seen for the wound vac placement with the use of the wound crown passed away overnight. The goal I had for today was not able to be met because I was not able to experience using the wound crown to isolate the ostomy while using the wound vac. – *this would have been a good and uncommon experience, sorry to hear this patient passed away.*

Types of wounds seen: Pressure injury – Stages 2,3 & DTI, & healing stage 1, large blister, MASD, intertrigo

Patient #1 79 y/o male with a history of prostate cancer who has been bedbound for several months. Consult placed for an ingrown toenail. The left great toe was noted to have an ingrown toenail with pus coming from the area. The wound was cleansed with wound cleanser. Betadine was applied and the wound was left open to air. IAD of the coccyx & buttocks was also found during the head-to-toe assessment. The area was cleansed with soap and water. Remedy Zinc Oxide Paste Skin Protectant. Heel protector boots and a foam wedge were obtained. The boots were placed, and the patient was turned to the left side. He was educated on frequent turning and repositioning.

Patient #2 This was a follow-up assessment for hospital acquired pressure injuries. The CWON wanted to check the progression of the wounds. 25 y/o male. Hospitalized since 12/2023 for encephalopathy and seizures. After extensive work up it is believed the patient is in a prolonged postictal state. He is not alert. He has a trach and is ventilator dependent. He is on a specialty immersion mattress. He has Stage 2 pressure injuries to the right ear from laying on the ear and the right earlobe from the pulse ox probe. The left ear has an unstageable pressure injury from laying on the ear. The left heel had a healing stage 1 pressure injury. The ears had Betadine applied and were left open to air. The heels were off loaded. The nurse reported the patient's mother takes the heel boots off the patient but does not put them back on.

Patient #3 65 y/o male admitted for a dislodged foley catheter. Consult was placed for a sacral pressure injury. The patient was obese creating multiple areas of moisture trapping in skin folds. The abdominal pannus was noted to have intertrigo. The area was cleansed with wound cleanser and thoroughly dried. Remedy Antifungal Ointment Miconazole Nitrate 2%. The coccyx had MASD. The bilateral buttocks had scattered DTI pressure injuries. These were cleansed with wound cleanser and Remedy Zinc Oxide Paste Skin Protectant was applied. The left posterior thigh had a large fluid filled blister. This was covered with a bordered foam dressing for protection. The left heel and medial ankle had DTI pressure injuries. The patient was not agreeable to wearing heel boots. Heel bordered foam dressings were applied in lieu of the boots.

Patient #4 This was a follow-up assessment for hospital acquired pressure injuries. The CWON wanted to check the

progression of the wounds. 87 y/o male admitted after cardiac arrest from choking. The patient recently received a trach and PEG. He is ventilator-dependent. He is not alert. CT shows anoxic brain injury. The provider has documented the patient has skin failure related to multisystem organ failure (heart, lung & neuro). The coccyx wound started as IAD but had progressed to a stage 3 pressure injury. The initial treatment was Remedy Zinc Oxide Paste Skin Protectant. After 2 weeks, the wound did not show any progression in healing. The treatment was changed to Vashe moist gauze. The wound was cleansed with Vashe. Vashe moist gauze was placed to the area and covered with a bordered foam dressing. *– sounds like a good variety of patients.*

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 Care Follow-Up Note

Objective/Assessment:
Since the previous assessment, the provider has documented skin failure in the setting of multiorgan failure (heart, respiratory, and neurologic).

Patient's nurse, Alice, was notified CWON was going to see the patient for a wound care follow-up of the sacral wound. The nurse advised it was okay to see the patient at this time. The daughter and another visitor were at the bedside. WC RN explained the reason for the follow-up wound care visit. The daughter gave permission for the assessment. The daughter and other visitor stepped out of the room for the assessment. The nurse came into the room to assist. The patient was unable to be turned yesterday due to hypotensive episodes while attempting to turn. She adjusted the vasopressors prior to turning to try to prevent hypotension. The patient was sitting semi-fowler's in the bed. He was not alert. He remains on a ventilator via trach. A focused skin assessment of the sacrum was performed. Stage 3 pressure injury combined with IAD. Not present on admission. Irregular, Red/Maroon, and yellow in color. 50% yellow slough, 50% epithelization. The wound remains similar in measurement to the previous assessment, 8cmx0.8cmx0.4cm. Peri-wound has erythema and is macerated. Minimal serosanguinous exudate noted. The daughter came back into the room during the assessment to see the wound. She asked if correcting the third spacing would help with wound healing. She was educated that wound healing would be complicated by several comorbidities, nutritional status, moisture level, and the ability to turn and reposition. She verbalized understanding. The wound was cleansed with Vashe. Vashe moist gauze was applied then covered with a bordered foam dressing. The scrotum was severely edematous with serous fluid weeping noted. The skin was dried and Remedy Protect Zinc Oxide Paste Skin Protectant was applied. The nurse was made aware to continue the current wound care plan. Continued other wound care as ordered. *– make sure to indicate how patient tolerated the procedure in the note, this patient doesn't sound very stable.*

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:

Sacrococcygeal -

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

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Cleanse with wound cleanser. Apply Vashe moist gauze. Cover with bordered foam dressing. Change BID and PRN if soiled. – *consider a dressing here that isn't a gauze dressing – this can be traumatic with removal. A dressing that promotes autolytic debridement (such as an aliginate or hydrofiber) could be considered for a primary dressing. Cost-wise, consider an alternative to foam if changing BID – this type of dressing is usually indicated for up to a week.*

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 *– how specifically? You're the specialist here - make sure it is known.*
• Float heels off surface; keep plantar surfaces free from bed. *– how specifically, consider product.*
• Monitor skin under/around medical devices with each assessment, reposition devices as needed to redistribute pressure/avoid injury.
• 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.

Referral/Consult: Nutrition – Ensure continued monitoring of adequate intake of tube feeding. Total protein 5.5 and albumin levels 2.6.

Wound care to follow up T/F, as time permits. *– what would warrant a re-consult?*

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

Due to the maceration of the peri-wound skin, I would have considered changing the Vashe moist gauze to a hydrofiber. The maceration shows there is already too much moisture. The wound may need to have moisture absorbed. The question was asked. Due to the recent change in treatment, the Vashe was continued to see if there would be wound healing given time because the Vashe was only started a few days before.

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 is to be able to apply the wound crown or isolator strip with the wound vac.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
I would like to see some ostomy patients and possibly a new ostomy patient to be able to see teaching done.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:	✓	

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• 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	✓	

Reviewed by: _____Mike Klements received 4/29/2024_____ Date: _4/29/2024

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 second 8 hours of the wound specialty.
-Mike