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: _Unni Mary Kurian_____ Day/Date: __4/24/24_____

Number of Clinical Hours Today: 10____

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

Preceptor: _Jennifer Scheile_____

Clinical Focus: Wound __☑__ 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.

It was my first day of practicum. I saw 7 patients today. All the patients had wound issues; 5 of them had NPWT, 1 DTI, and another had a new consult for skin tear and rashes. My first patient from CVICU with gas gangrene, post-op CABG, had a non-working NPWT since midnight and was called to look into it. Pt was left with the NPWT dressing and the machine off since midnight. Removed the dressing and looked into the reasons for the nonworking NPWT. Found that the tubing was blocked with blood clots /applied wet to dry, Notified provider after taking pictures. And gave education to staff regarding removal of non working NPWT dressing within 2 hrs and application of wet to dry dressing and frequency of change.

The next patient was a patient with biventricular dysfunction, who came with leg pain and was found to have acute limb ischemia, compartment syndrome, and eventually now with an NPWT after fasciotomy. I was able to assist my preceptor in changing the same.

Next, we went to a patient who was reconsulted to a WOC nurse for worsening DTI. Patient with liver mass with multiple comorbidities and the Braden score of 11. I noticed the patient was placed on a low air loss mattress but deflated, the patient with diapers on and in a flat position with oxygen with tubings pulled off the patient. The patient was NPO for a biopsy and looked lethargic. Notified the primary RN and made sure the patient was stable.Fixed the nonworking mattress. Removed the incontinent briefs, The Patient was also noted to have loose stools. I cleaned the patient and noted that the perirectal region was excoriated and just a foam dressing over the DTI on the sacrum, which has progressed to an open wound., with the top layer peeled off. and clearly demarcated. The exudate was minimal. Cleaned with antimicrobial solution, applied nonadherent hydrofiber dressing, and covered with foam. I noticed the patient was sore over the perirectal excoriated area. Applied hydrophilic paste, a thick layer to that area.Repositioned the patient to the sideline position. My preceptor educated the staff regarding the fallouts and also the family members regarding the intake of protein supplements for the patient as ordered.

Next, we saw a patient with a history of gastric bypass, DM-2, who came with a persistent leak from GJ anastomosis and with esophageal stent placement for the fractured esophageal stent, PE s/p IVC filter. The patient has her laparoscopic sites on the left side of the abdomen infected and growing gram-negative rods; the patient was placed on an NPWT after I & D and came back just an hour ago post-drain placement on LUQ. As soon as the patient arrived in the unit, the primary nurse called my preceptor to see the NPWT as it was off. When we went and assessed, we noticed the NPWT was open on one end and brownish blood-tinged exudate on the black foam; the Periwound was macerated for both incision sites. Slough was also present inside both, cleaned with an antimicrobial solution. I did the measurements, and looked for tunneling. We noticed another opening in the middle of both wounds, which, on assessment, had brownish blood-tinged purulent exudate, which we noticed on the black foam. Took pictures. My preceptor packed the new opening with iodoform dressing, applied a small piece of nonadherent silver dressing, and did the NPWT dressing. they bridged both wounds and the trackpad was placed over the lower incision site away from and connected as per the orders. Drain sites were cleaned and redressed with silver dressing, split gauze, and Tegaderm as it was with peri-wound redness and mild drainage, showing starting signs of infection.

The next 2 patients were of lower extremity NPWTs again. One of the patients was very particular with his care. I observed how

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she changed the NPWT, which had it placed on her heel, and had an external fixator after orthopedic surgery. Another patient with a lower extremity diabetic foot, where they amputated where the middle toe and ring toe were amputated and with NPWT.It was due for a change, and I assisted my preceptor with the change. Over exposed bones we placed a contact layer and applied the foam. Next was a new referral patient with skin tears and rashes. For skin tears, a contact layer dressing was applied, and for shin rashes, which were fungal, the provider requested antifungal powder and educated the patient and primary nurse to keep the area dry and use a wicking cloth over skin folds.
Types of patients seen today: worsening DTI, MASD, fasciotomy wound requiring NPWT, Lower extremity arterial ulcer with nonworking NPWT, Diabetic foot ulcer for change of NPWT, Infected abdominal wound requiring NPWT and drain site care, Orthopedic surgery wound over heel, requiring NPWT due to dehiscence, Skin tear and fungal rashes

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:

This is a consult received for a 65-year-old patient who has been admitted to CVICU for a nonworking NPWT since midnight. The patient has a history of ESRD on HD, DM-2, Hypertension, CAD, Pulmonary Hypertension status post-ROSS procedure, CABG on 4/2/24, complicated by RV failure, cardiogenic shock needing ECMO, gas gangrene left foot status post trans metatarsal amputation on 4/17/24. The patient was placed on NPWT postoperatively and called for troubleshooting the nonworking NPWT.On assessment, the patient was on CRRT at the bedside, NPWT device with the dressing, connected to the patient and kept off. The patient is lying down on the bed with the left foot elevated. Blood clots were noted on the NPWT tubing. The patient is agreeable to the assessment of the wound. Requested primary RN to premedicate for pain. The patient was made to be in a comfortable position. Removed the NPWT dressing with adhesive remover spray. The wound is moist and has bleeding sites and clots noted. Previously, surgical was applied to a few spots to stop bleeding, which was overlooked. Notified the ICU provider regarding the concern of bleeding. Took pictures of the wound. The Peri wound was observed to be macerated with the non-working NPWT and skin lifting up over the plantar surface. Exudate over the wound was serosanguinous and bloody. My preceptor did not measure the wound this time. It was decided not to reapply NPWT due to the concern of bleeding after a discussion with the provider. Cleaned the wound with an antibacterial wound cleanser. Applied wet to dry dressing using gauze soaked in wound cleanser(Vashe), covered with ABD pad, and gauze bandage. The patient tolerated the procedure well. Educated the staff to review the orders with NPWT, reinforced on removal of the dressing and application of wet to dry, to prevent maceration and worsening of the wound. Wound care orders were entered by the preceptor for wet-to-dry dressing twice daily and as needed, with special mention of wringing out the wet gauze and applying fluffed gauze to the wound. I explained to the patient the change in dressing. Discussed the nutritional intake including protein intake and blood sugar control. The patient verbalized understanding. Notified the podiatrist and plastic surgeon involved in the case regarding the new concern and changes with dressing. Plan of care to be reassessed on Friday (4/26/24)

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.

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WOC Plan of Care (include specific products used)

- Remove the dressing and observe for bleeding. Cleanse with wound cleanser (Vashe). Apply wet to dry dressing using wound cleanser (Vashe). Wring out and apply fluffed gauze to the wound. Cover with an ABD pad and use a gauze bandage as a secondary dressing. Change the dressing twice daily and as needed.
- Monitor for bleeding
- Increase the protein intake within the diabetic diet and cardiac diet limitations.
- Call the WOC nurse for additional concerns.

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

The NPWT dressing was kept on the wound for more than 6 hours since midnight after it was found to be not working. Even though the primary RN was notified to review the NPWT orders and carry them out as ordered, I would have also notified the unit in charge, being in an ICU setting, and the patient's condition, where the retained dressing caused maceration to the peri wound and also with the presence of bleeding with clots. This can be a learning point for all staff in the unit to remove the nonworking NPWT and apply a wet-to-dry dressing to monitor the bleeding. I also would have requested the provider for a repeat of labs to check the hemoglobin in the setting of bleeding from the site.

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 today was to get to know how a WOC nurse manages a day, what kind of patients are seen, and how the cases are prioritized.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Since it was mostly the NPWT wounds we saw today, I would like to see ostomy patients and how education is provided for a patient with a new ostomy. Also how to do NPWT with instillation

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		

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*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: _____ Date: _____

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