Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Unni Mary Kurian_____ Day/Date: __5/29/23_____

Number of Clinical Hours Today: _10__

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

Preceptor: __Ms.Jennifer .S_____

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.

We started the day with rounds with WCP. The first patient was with a left pretibial venous stasis ulcer. The patient had an adherent necrotic tissue to the wound and needed bedside sharp debridement, which was done by WCP. In our hospital, the policy doesn't allow WOC RNs to do bedside sharp debridement, even though it is allowed in Texas. I could assist my preceptor and make reminders about the care. The second patient was a paraplegic, homeless patient who was not willing to a placement in an LTAC or inpatient rehab, Patient had an unstageable pressure injury in the perianal coccyx region with an adherent eschar at the center, with indurated peri-wound and scattered full-thickness ulceration to buttocks and left tuberosity with yellow slough, which needed debridement. Since the patient was unwilling and not agreeable to follow the treatment plan discussed, did dressing with hydrogel(silvasorb) and covered it with a foam dressing. The patient also had a flush colostomy(established), which she was managing herself, but she had issues with leakage due to the skin fold and creases, and she was using a flat pouch.Peristomal skin was denuded at the 3 o' clock position where the skin fold was present. We could do it with a light convex pouch, crusting over the denuded periwound area, and fill the creases with strip paste, and secure the ostomy.

The next patient was one with spina bifida, paraplegic, Stg 4 PI to sacral region, neurogenic bladder with an SPC and IAD around the SPC, B/L nephrostomy tubes, with double barrel ostomy, and a parastomal hernia. It was a follow-up. Patients' wounds remained the same. The ostomy had good output, and we changed the ostomy appliance with the postop pouch, as it was a wide stoma. The IAD site around the SPC is covered with moistened hydrofera blue split gauze and foam dressing. There was still leaking from the drain site even though the urologist changed the SPC. Earlier, they tried pouching around the SPC site but failed as it didn't stick due to the deformed anatomy of the patient's body. L nephrostomy sites were on the skin fold due to the weird anatomy of the patient with the deformity. They were with stage 2 injury worsened from moisture-associated injury, which we used silver-cel as the primary dressing. This patient took almost 2 hours to complete the care.

Then, we went to another follow-up patient with an L chest NPWT.I changed the NPWT and learned another easier method of cutting the Dermatac and fixing the NPWT over the surgical wound. It was interesting to learn the different ways to do it and even save time.

After lunch, we visited a patient with a new colostomy on 5/18/24. The patient with a distended abdomen and a red rubber was inserted the previous day along with the surgery provider. The patient was unstable with chest discomfort, tachycardia, and still abdomen grossly distended with scant output in the ostomy. We notified the primary RN to notify the provider and explained we will come back once she is stabilized. We had to see a few more patients; one had a skin tear at the back and was referred to a WOC RN. It was a simple one, and we placed a contact layer and foam dressing and recommended primary RN continue the care.

Our next patient was an obese bariatric patient with MASD to skin folds and friction tear to the thigh. Recommended contact layer with foam dressing for the skin tears and wicking cloth (Interdry) to the skin folds. The patient stated the floor nurses push in the interdry and don't remove it for days together even though it starts to stink. Taught the primary RN how to place the wicking cloth and the due time for removal and placed orders with clear instructions. Then we went back to the ostomy patient whom we left as she was unstable. The patient discussed hospice and comfort care options with the provider and family. We stayed with the patient as we felt she wanted us to listen to her and the provider. She refused further interventions now, So we had to leave and stated we

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would come to her the next day.
Compared to my previous clinical days, this was a calm day. We were able to finish the work within the planned time.
Cases handles: Venous stasis ulcer with sharp debridement:; pt with double barrel ostomy, AD, STG4 PI, Drain site care; Unstable PI and flush colostomy; skin tear; NPWT; MASD, friction tear; New colostomy with follow up

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 48y/o female patient with a past medical history of lupus, scleroderma, sinus tachycardia, acute liver failure, hepatitis, pancreatitis, and a prior history of lower extremity cellulitis who presented on 5/15/24 with increased wound drainage to lower extremity with pain and confusion. Patient was followed up at home with home health who did dressing with Xeroform. She has a previous history of multiple hospitalizations in multiple facilities, and it is unclear when the wound started. Dermatology is following the patient and has taken a biopsy to rule out the reason for the ulcer whether it is related to vasculopathy secondary to SLE.WCP was referred as the patient needed debridement of the necrotic tissue on the wound bed (due to the hospital policy for sharp debridement).
Based on the assessment, the patient has a Braden score of 16. Lab review shows Albumin-1.5, Hb-7.2, Wound cultures (taken earlier today) awaiting results, and skin biopsy(by dermatology) awaiting results. The patient has a dietician consult placed on admission and is seen by PT/OT. The goal of the treatment is healing.
The patient is resting on the bed with their left leg elevated over a pillow. The patient is agreeable to assessment and treatment. Pre-medication is given by the primary RN (Inj. Dilaudid IV). Head-to-toe assessment done. Pulses are not palpable on the left lower extremity. On Doppler assessment, feeble pulses were detected. Foot warm and 2+ pitting edema noted. The previous dressing was gently removed. There is a moderate amount of serous exudate draining from the ulcer. The wound bed was tender to touch, had pink granulation, and had slough. Necrotic tissue is estimated to be present in approximately 10% of wound beds. The ulcer bed also has exposed subcutaneous tissue and tendon. Measurements done 19.5*11.4*0.4cm). Explained to the patient the need for debridement of the necrotic tissue and WCP, which is available for the procedure. She was agreeable and requested to numb the area with lidocaine gel. Explained the risks and benefits of the procedure and informed consent obtained in the presence of WCP. Time-out was done to verify the right patient, procedure, and site. The area was gently cleaned with a hypochlorous acid solution (Vashe) and draped. The procedure was performed by the WCP in a clean field. I applied the lidocaine gel to numb the area (WCP debrided the wound's necrotic edges sharply with the scissors). The necrotic tissue was deeply adherent toward the center. Bleeding was minimal and hemostasis was achieved using pressure. The eschar was crosshatched due to the adherence. Applied Xeroform over the wound bed.Covered with roll bandage (Kerlix). The patient refused to apply an alternative dressing as she stated Xeroform had been comfortable for a long time. Explained the need for alternate dressing application to remove necrotic tissue and wound healing; patient refused. Explained to the patient, if the Xeroform doesn't work better and does not show any change, it is essential to think about the change in dressing products, or else may end up in worsening of wound situation or need sharp debridement in theoperating room.

The following was my preference for the patients wound:
{Applied Santyl(collagenase) over the necrotic tissue, covered with a contact layer (Adaptic touch), and alginate (Silvercel) was used to cover the entire wound bed. Applied gauze and secured with gauze bandage (Kerlix).}

The patient tolerated the procedure and dressing change well. Explained to the patient the frequency of dressing changes and the follow-up plan. Explained the need to take the protein milkshakes provided to the patient as prescribed by the dietician. The patient was reluctant to move out of bed with therapy, as per PT/OT notes. Explained the need for mobilization for better healing. Clarified all questions. The patient is placed in a low air loss mattress.

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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)

- Ensure pain is managed for the dressing change as per provider orders.
- Remove the dressing (if adherent to the wound bed, soak with normal saline prior to removing the primary dressing). Cleanse the wound with an antimicrobial solution (Vashe). Apply collagenase (Santyl) over the necrotic tissue (a thin layer over the necrotic tissue with a Q tip). Cover the entire wound bed with a contact layer (Adaptic Touch). Apply alginate (Silvercel). Place a layer of gauze to absorb the excess exudate. Wrap with roll gauze (Kerlix). Change dressing daily and prn.
- Monitor for bleeding and signs of infection.
- Monitor LE pulses with Doppler each shift and notify and document for any concerns.
- Ensure adequate nutritional intake as per dietician recommendations.
- Ensure the patient is mobilized as per PT/OT recommendations.
- Ensure the patient continues to sleep on a low-air-loss mattress and uses a heel-offloading device(True Vue).
- Notify provider/WOC RN (office hours)for worsening or concerns with wound/dressing.
- WOC RN Plan of Care (follow up): Twice weekly(Monday & Thurday)

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

I would have preferred to have had the chance to do the sharp debridement, but unfortunately, as per hospital policy, it is not allowed. The patient was not agreeable to the alternate dressing product use for wound debridement and healing. A more intense teaching on the need for dressing change was essential. Also should have involved family or PHI , to convince the need for better healing. Even though the patient has no confusion now, when she was admitted, she came with an altered mental status.

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 see a complex wound and how it is managed, identify pressure injuries, and select appropriate products.I was able to meet this goal partially.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
I need to concentrate more on ostomy patients and find a patient to complete the complex wound/ostomy journal assignment.

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,		

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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: _____ Date: _____

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