Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Erica Crenshaw Day/Date: Day 6 6/10/24

Number of Clinical Hours Today: 8

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

Preceptor: CWOCN-APN Erica Yates

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.

My preceptor works as a Nurse Practitioner for the Wound Care team. There were challenges presented including a total of 2 out of 4 of the WCCT members being absent due to Conference attendance on Monday after a collection of wound needs and consults become requested after a busy weekend. This resulted in doubling the caseload for each of the 2 WCCT members present at work. With that being said, she and I visited a total of 5 patients admitted across units within the hospital today. The first patient had a number of patient care and documentation issues. On 6/7, the patient's wound was added as a full thickness wound to the left lateral leg however; today's assessment demonstrated that the wound had bone and tendon exposure and should have been documented as a Stage 4 PI. The wound was lightly packed with a packing strip soaked in Vashe and covered with an ABD pad. There was another large Stage 4 PI to the coccyx measuring at 20 cmX 20cmX 6cm which was also present upon admission. The patient stated that she had a Caregiver that entered into the home for 10 hours per day, 7 days per week to provide aide. The patient also stated that the Caregiver reported the wound to the coccyx was starting to heal and that she didn't have confidence that the Caregiver would be able to replicate necessary wound care upon discharge in the home. This patient is in denial as to how much her wounds have progressed. Ultimately she would benefit from reinforced education on continued use of bilateral boots to offload heels and repositioning off her wounds with the use of the wedges. The next patient, a 68-year old female is an NT intubation patient and has been recommended for a wound care consult for an abdominal wound dehiscence s/p paniculectomy surgery on 5/17. Patient presents with a full thickness wound to the left abdomen with small amounts of serosanguinous drainage. 1.5 inches of Curad packing strip moistened with Vashe has been lightly packed into the wound with an ABD pad to cover. Another full thickness wound with some moisture to the wound bed has been identified to the right abdomen towards the patient's back. A piece of Aquacel has been placed over the wound bed with Allevyn to cover the wound. Erica introduced a good point, there will be patients in need of a consult who will have wounds with an unknown etiology such as the 68 year old s/p paniculectomy patient. The full thickness wound that extended towards the back had no evidence of an incision near the site or further indication of identified trauma. The patient was non-verbal due to sedated intubation and the assigned Critical Care nurse barely had the ability to identify the location of the wounds thus, the origin of the wound will not always be easily identified. A separate Oncology patient, a 60 year-old male admitted to SICU was recommended to the WCCT for what was assumed to be an acquired DTI to the left hip and scrotum. The patient had multiple episodes of runny, bloody stool during the visit and upon turning the patient to assess the skin, the patient had a non-blanchable deep red to purple colored patch to the left hip which disbursed to the center of the back and deep red to purple colored scrotum with peeling to the scrotal sac. No sting was applied to the discolored skin and protected with wedges. The assigned nurse believed the patient was potentially mottling to the lower extremities while Erica proposed the possibility of the patient having a Kennedy Ulcer to the left hip but could not identify injuries to the scrotal sac. She presented the image to the other WCCT member and they both proposed the possibility of a vascular component being involved but the wounds could not be properly identified at the time of documentation. An 80 year-old male received a visit from WCCT for a skin tear to the left hand. The tear was wrapped in Kurlax with a contact layer over the base of the wound and measurements included 2cm x 1.5cmx 0.2cm. Erica stated that the Kurlax wrapping for such a small skin tear results in wasted material but the

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

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

old dressing was removed, a contact layer was applied to the skin tear and covered with a small Allevyn. There were small setbacks that added onto more time than anticipated being consumed on wound care needs and reinforced education. However, this doesn't minimize the accomplishments of today. Though there were fewer WCCT visits, I was able to visualize patients that don't necessarily have textbook wounds that are easily classified or easily treated.

Types of patients: MASD/ IAD, deep-tissue pressure injury, skin tear, acquired wounds, staged and unstaged pressure injuries, full thickness wound assessment and plan development

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:

50 year-old female presents with an admitting diagnosis of Sepsis of unspecified acute organ dysfunctino has a PMH of cervical spinal cord injury, hypotension and osteomyelitis of the right foot. Upon assessment, the patient is alert and oriented x3-4, follows verbal commands, bedbound, incontinent to bowel and bladder and multiple wounds. Patient presented to the hospital with a Stage 4 to the coccyx and Stage 4 to the left lateral leg. The periwound skin is firm to touch and hyperpigmented while the base of the wound is red, brown and yellow in color with small amounts of serosanguineous drainage and measures at 8 cm long, 3.7 cm wide and 1 cm deep. The wound is also positive for undermining, at 6 o'clock measuring with a depth of 0.2 cm. The wound bed is cleansed with normal saline. Starting at the area of undermining, the wound is to be lightly packed with 1.5 in of Curad packing strip. Finally, the wound base is to be covered with ABD dressing. Stage 4 wound to the coccyx has periwound skin assessed to be intact with hyperpigmented wound edges. The wound is yellow, red and tan in color with moderate amounts of yellow serosanguineous drainage and measures at 20 cm long, 20 cm deep and 6 cm deep. The wound is positive for undermining at 10 o'clock measuring at 4.5 cm in depth. Nutrition consult advised for optimized wound healing. Maintain Tru-Vue heel protectors to bilateral lower extremities to off-load heels while in bed. Continue to reinforce patient education on turning and positioning system to off-load patient's coccyx/ ischium every 2 hours. WCCT will continue to follow patient, please reconsult if wounds worsen.

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)

-Nutrition consulted for optimal wound healing

- Remove old dressings of Coccyx and left lateral leg, cleanse with NS, gently pat dry, and gently fill wounds with Vashe moistened Kerlex and apply ABDs. Change daily as needed.

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

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

- Off-load wound on coccyx while in bed. Turn and reposition every 2 hours.

-Continue skin prevention interventions based on Braden risk assessment subset scores.

-Counsel on prevention including use of heel suspension boots, moisture management, redistribution surface and turn schedule. and evaluate for effectiveness of compliance

-Call for changes in wound, wound dressing concerns or if wound worsens.

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

I thought the care provided to the patient went well. Initially upon entering the room, the MD was preparing to consult with her and we offered to perform the visit at another time so that she could focus on the consult. Again, this emphasizes the significance of the IDT working to optimize the patient's overall care. Upon returning, we were able to address the wound care needs however; her mother seemed confused about education regarding offloading. If given sufficient time, I would have not only demonstrated off-loading to her but, I would have explained the use of the wedge and how it could benefit the patient's wound.

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 identify 4 out of 5 wounds on assigned patients and apply the correct wound care intervention. I was able to correctly identify 3 out of 5 wounds on assigned patients and apply the correct wound care interventions to each patient. There were 1 or 2 patients with wounds of unknown origin or etiology that the WCCT were also unable to identify.

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

My goal is to identify the primary reason for admission as well as key elements within the patient PMH and correlate them with the WOC nursing concern.

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

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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	✓	

Reviewed by: _____ Date: _____

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

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.