Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Kathleen Fetters Day/Date: Monday 7/1/24

Number of Clinical Hours Today: 8

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

Preceptor: Jordan Prieto

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 with Jordan who is also the hospital's pressure injury preventionist. We saw three wound consult, one NPWT dressing change, chart reviews on patients that were on predictive analysis list that are high risk for pressure injury development/seeing one in person, attended meeting regarding pressure injury risk tool, and did photo validations of suspected pressure injuries. First patient was a patient who had MASD and friction injury to posterior pelvis area. He also had purple discoloration to his posterior pelvis, and we found out he typically is sitting in a recliner so related this to chronic tissue injury as there was photos in chart from 6 months ago with same discoloration which has not improved or worsened. He was incontinent of bowel and bladder so we ordered zinc oxide cream and discussed with nursing to attempt to use external urinary collection device as he would meet criteria. Second patient was a RLE wound. He was lethargic and unresponsive so was note able to get a history on wound, but it was necrotic on lower lateral leg and he is wheelchair bound. He had no history of vascular disease in the legs and distribution and location of wound did not appear consistent with that nature. There was blistering to edges with scarring also noted but covered in soft yellow slough, no fluctuance or crepitus, drainage was serous no odor. I ordered medihoney gel and allevyn life foam dressing, we put etiology of the wound unknown due to not having a clear story and could be related to trauma from wheelchair as he is wheelchair bound or pressure from wheelchair. Third patient was skin tears (type 1 and 2) from ETT tube securement device related to patient agitation and thrashing in the bed from edges of securement device. This occurred over the weekend and the bedside RN placed mepilex lite due to patient having sensitive skin and we saw at bedside and peeled back dressing agreed with continuing that to protect areas from securement device. We also recommend if/when extubated to switch to bacitracin ointment and leave open to air. Next I attended a meeting with Jordan for a HAPI prevention predictive analytic list that is a pilot study for the Braden score and other topics such as patients with targeted temperature management, previous pressure injury, CRP, low pulse ox, surgical positioning/bedtime/procedure count, patient refusals, end of life, bed rest order, IABP, impella, ECMO, CentriMag, vasopressors, ventilator/oxygen devices, NG/OG tube, dark skin tone. The are using an AI program that reviews this and sends a list to the WOC clinical leader and pressure injury preventionist of patients that are at high risk for pressure injury development based on the above and rounding by the unit CNS and pressure injury preventionist is done to assess for pressure injury prevention interventions are in place and educate staff and patient/family if applicable. This is the hope that we start the conversation earlier and ensure adequate offloading/equipment/etc. is implemented for high-risk patients. Next we had a NPWT to change for right forearm and left elbow surgical wounds. Patient was found down in road was pedestrian struck. Found significant wounds to BUE which required surgical debridement and they recommend NPWT. Wounds had granulation tissue appeared improved. Next we reviewed chart for two patients that were on the high risk for pressure injury development predictive analysis list. This was interesting to see the deep dive into the charts my preceptor performs and different cues that can put them at higher risk. We then went up and saw one of the two patients and discussed with nursing importance of proper offloading/equipment and incontinence management. We then had an additional NPWT to apply for a right TMA wound due to gas gangrene. Patient had severe pain at baseline so was premedicate by unit RN prior to arrival and we explained how NPWT works and answered all his questions. He did well with application. We discussed importance of tight glycemic control and increased protein intake to help with wound healing.

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Patients seen: MASD/friction injury wound assessment, RLE wound patient, skin tear patient, HAPI prevention meeting, chart review on high risk patients with rounding on one, NPWT surgical wounds to BUE, NPWT to TMA wound

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:

WOC nurse consulted for NPWT dressing changes to left elbow and right forearm. Patient admitted as trauma code related to being found down in the road secondary to be struck by a motor vehicle as a pedestrian. Patient with documented past medical history of TBI, schizophrenia, and seizures. Per chart review patient was found to have significant wounds related to trauma to the left elbow and right forearm and required orthopedic surgery intervention for a debridement of right open ulnar fracture down to bone, closed treatment of right open ulnar fracture with manipulation, debridement of right open forearm wound bed down to muscle and fascia 6 cm x 10 cm with drainage of right elbow deep hematoma, application of negative pressure wound therapy to right upper extremity 6 cm x 10 cm, debridement of left elbow wound 6 cm x 7 cm down to muscle and fascia and application of negative pressure wound therapy to left upper extremity 6 cm x 7 cm on 6/23/24. Patient currently non-verbal and unresponsive, intubated and sedated. NPWT cannisters with small amount of serosanguineous drainage and dressings appear clean, dry, and intact. Alarm history reviewed on NPWT machine; no alarms noted since last dressing change. Dressings removed. Left elbow wound base with granulation tissue noted. Undermining noted from 0400-0800 for 1.5 cm. Wound measured 5 cm length x 1.5 cm in width x 0.4 cm in depth. Serosanguineous drainage noted, no odor. Periwound intact- no induration/fluctuance/purulence/erythema/edema noted. Promogran prisma applied to undermining per order, 1 piece of black foam packed into wound, drape and trac pad placed. Suction resumed at -125 mmHg, no leak noted from device. Right lower forearm wound with granulation tissue noted, no undermining or tunnelling. Exposed tendon noted. Serosanguineous drainage, no odor. Periwound intact- no induration/fluctuance/purulence/erythema/edema noted. 1 piece of Promogran prisma placed on exposed tendon per order, 1 piece of black foam packed into wound, drape and trac pad placed. Suction resumed at -125 mmHg, no leak noted from device. Patient tolerated well, no non-verbal signs and symptoms of pain noted during dressing change, scheduled for next NPWT change on Wednesday 7/3/24 by WOC nurse. Discussed plan of care with unit RN.

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)

-NPWT dressing change M/W/F by WOC nurse with black foam and promogran prisma to undermining of left elbow wound and promogran prisma to exposed tendon of right forearm wound
-Gather supplies (2 packs of 3M V.A.C. Granufoam Dressings (Small), 3M barrier prep pads, new cannister, scissors, gauze, NSS)
-Pause machine
-Remove dressing account for amount of material being removed from wound
-Assess wound (measure weekly per guidelines)
-Cleanse wound and periwound with NSS
-Pat dry and apply 3M barrier prep pads to periwound to protect intact skin
-Window pane wounds with drape to protect periwound

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-Apply promogran prisma to undermining of left elbow wound at 0400-0800 and to exposed tendon on right forearm wound per order
-Lightly pack appropriate size of black granufoam that fits the base of wound and secure with drape
-Cut quarter size hole into drape and apply trac pad
-Connect to cannister and resume machine at -1255 mmHg
-Assess seal ensure in the green if alarming troubleshoot accordingly
-Fill out packing log accordingly and ensure packing bracelet on patient
-Change NPWT cannister at least weekly and when 75% full per CMG guidelines
-Record output in IVIEW per I&O record order
-Monitor NPWT cannister output if large amount of frank red blood noted, pause device and alert provider for next steps
-Dressing assessment and assessment under device tubing every two hours per Braden scale assessment
-If device leaking or dressing integrity compromised, unit RN should assess dressing and device for alarms and troubleshoot accordingly, page WOC if unable to troubleshoot
-If therapy remains off for greater than 2 hours, a rescue dressing of saline-moistened gauze should be applied. Please reference WOC website on portal page for troubleshooting NPWT.
-If any new deterioration noted prior to WOC follow up, please alert the attending service and contact WOC via Vocera pager

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

It was nice to see an improving wound from NPWT. This patient is young, and nutrition is optimized so appear to be healing well. His situation is sad though he is full code, but nurse said he would have to live on ventilator and tube feeds the rest of his life as he has severe brain damage so are waiting for goals of care discussion. I am not sure he needed the promogran prisma on the exposed tendon we could have maybe just used a contact layer of mepitel one or adaptic.

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?
Be exposed to more advance wound therapies

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Have the chance to do more advance wound therapies on more complex wounds

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	✓	

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• 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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