Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jaclyn Rosso Day/Date: 7/15/2024

Number of Clinical Hours Today: ____

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

Preceptor: _Jennifer_____

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, my preceptor, the APRN and myself saw seven patients, plus one that declined care due to being discharged and having outpatient wound care already set up. The first patient we saw had a left diabetic heel ulcer, and right BKA done in April with which had a healing incisional site. After checking all of her skin and pulses the wound to the left heal was rinsed with a commercial cleaner and a Mesalt dressing was applied and wrapped, the same was completed for the RBKA incisional site as well, it was rinsed with commercial cleaner, a small amount of Mesalt was applied to the small wound site then a Allevyn dressing was applied to decrease friction. Pt states the site is much less red and the area with red skin is much less than the marked area on the skin.

Second, we saw a patient with squamous cell cancer to her vulva. The wound was extensive and deep. According to wound staff, her wound will likely not heal and her care is merely palliative at this time. Her wound did have an odor and it was stated by my preceptor that it was the odor of a malignant wound. We unpacked the wound and rinsed it with vashe. A wet to dry was then done. The patient also presented with excoriation to her groin and inner thigh, with the greatest of pain to the right inner thigh. ABDs were applied in the groin, but I thin I would have possibly added some barrier cream to the area to protect it from drainage. A wound culture may have been helpful as well because some green drainage was noted when removing the dressing. Lastly, we learned that wet to dry dressings are not preferred, so maybe packing the wound lightly with some alginate dressing may be more beneficial. The patient preferred to not move, so we made sure to reposition and offload her heals as well.

Third, we had a patient with Berger's disease. He had wound to his right thumb and 1st and 2nd fingers. He recently lost his left first finger due to the same type of wounds becoming infected. The fingers and wounds were black and scabbed over. The APRN did debride and removed some dried skin to the right middle finger to the palmer aspect of the knuckle. Patient denied pain with skin removal. Patient is on Xarelto, but aggressive removal was not done. Alginate was applied to moist areas then it was wrapped around the fingers. This patient also had a left lower leg vascular wound that patient states it stays there continuously from hitting it on his bed. He also has multiple wounds (3) to his left foot from prior amputation sites. Xeroform was applied to sites then a gauze and his entire for and leg was wrapped for compression. Lastly, the patient did have a sacral wound. He states he has had a cyst there chronically and states it drains about monthly and was told by physicians there is nothing more they can do due to scar tissue. A silicone protective dressing was removed and drainage was seen. The area was cleaned and a new silicone dressing was applied.

The next patient was a simple wound vac dressing change. The site was just under the sternum and from a surgical site from an infection from a pacer wire. The site was packed with dense white foam and then the black foam was placed on top and the wound vac was applied. I learned to increase the mmHg to 150 due to the denser white foam. Patient tolerated well and we set up his wound vac settings for home.

Next was a patient that had excoriation and moisture to his groin. Antifungal cream was applied. He had a left lower leg wound. The leg was red and edematous and the wound was noted to have slough covering the wound bed. The periwound was macerated as well. It was decided to use medihoney to the wound bed with alginate covering then wrapping. The patient also had a left hip wound that also had some slough to the site with redness and induration and warmth. The wound was open to air upon arrival so medihoney was also used for this wound then a silicone dressing. Lastly, we checked under a preventative silicone dressing to the

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sacrum and reapplied one to ensure the skin was not breaking down there.
The seventh patient was a parkinsons patient with some soreness to his buttocks and a left heel and palmar wound due to charcot foot. The heel wound was unstageable due to some eschar. He also had some reddish/purple areas on his toes that were blanchable. A silicone dressing was placed to the foot wounds for protection. His sacrum was macerated so triad cream was applied to the site then a foam dressing on top.
The last patient we saw was another wound vac change. This patient had a wound to the left heel. Upon removal, he was noted to be macerated and moist anywhere the tape was. It was decided to change the site of bridging to the opposite side of the foot to give the skin a break. The site was then wrapped with gauze to protect it from the vac cord from rubbing.

Types of patients: venous stasis ulcers, squamous cell malignant wound, wound vac changes, charcot foot heel wound, and diabetic heel ulcers, monitoring of sacrum skin

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:

Initial visit for a patient with a history of Berger disease, diabetes, atrial fibrillation and hypertension. Patient with a history being wheelchair bound and with an ostomy and BKA due to becoming septic from diverticulitis as well as a left index finger amputation from a wound developed from the Bergers disease becoming infected. The patient presents with wounds to the thumb, index and middle fingers. The areas on the fingers are blackened and dry. An open area was noted to the palmar aspect of the middle finger at the knuckle site measuring 2x4x0.6cm and the index finger measuring 1.3x5x0.5cm. Dried skin was debrided to the middle finger by the APRN via a scalpel, but gently due to the patient being on Xarelto. Patient tolerated well and denies pain throughout care. Alginate was then applied to open areas and fingers were wrapped in gauze. The patient also presents with an open vascular wound to the left lower leg. Pt states wound is from hitting his shin on the bed over and over. Toes are amputated to the left foot and three wounds are noted to foot on the top. And lateral side of foot. Leg and foot wounds were covered in xeroform and then wrapped with gaze, then wrapped with an elastic wrap. Lastly, the patient's silicone protective dressing was removed from his sacrum with noted serosanguinous drainage on the dressing. Patient states he has a cyst that drains about monthly and the surgeon informed him due to all the scar tissue there nothing else can be done with it. Area is dry at this time, no active drainage noted. A fresh silicone dressing was applied. Patient was instructed on the importance of following up with an outpatient wound care facility.

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)

-Apply alginate to moist, open wounds on fingers then wrap with gauze daily.
-Apply xeroform to left lower leg and foot wounds then wrap with gauze. Then wrap patient's legs with an elastic bandage or apply own stockings.
-Monitor silicone boarded foam dressing, change every 3-5 days. If becomes soiled or rolled, remove and reapply a new one.

Consult for outpatient wound care upon discharge for follow up and see if patient can qualify for home care for dressing changes.

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

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I thought the team worked very well together and were very efficient. They knew the patients very well and we able to answer the patient's questions. I would have considered using a barrier cream on our excoriated labial patient as well as being careful using the wet to dry dressing on her.

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 for today was to get in and get comfortable to understand my role as a student and a potential wound nurse.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Tomorrow, I want to continue to see some interesting wounds and learn about different products. I also want to continue to learn the 'why' with their thought process for some of the dressing choices.

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: _____

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