Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Darleen Olsen Day/Date: 7/15/2024

Number of Clinical Hours Today: 8

Care Setting: Hospital ____ Ambulatory Care ____ Home Care ____ Other x Inpatient Wound

Preceptor: 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.

The first patient I saw had a deep tissue injury that was reconsulted for worsening of the deep tissue pressure injury on the sacrum. The sacrum was concave and had slough present. He also had a new deep tissue injury on the right ischium. The patient was found laying on his back supine ant not offloaded. We turned him at the end of our visit to help offload. The second patient I saw has a Stage 3 Pressure Injury healing on the sacrum. It was almost healed. There was a Wound Consult for the patient for this. There was a very small area partial thickness that was almost closed. There was scar tissue present on the peri-wound and scar tissue on areas near the partial thickness open area. The third patient I saw was a pediatric patient, 3-year-old with ascites who does not walk. He is bedridden. There was a Wound Consult for a concern for a pressure injury. My preceptor and I assessed it to be incontinence associated dermatitis. It was mirror like and irregular. It was superficial as well. We recommended Critic-Aid Clear Moisture Barrier Ointment. The other patient I saw was a Wound Consult for the patient for a pressure injury on the Coccyx. This wound was previously a Stage 2 Pressure Injury but today we staged it as Unstageable Pressure Injury. Above this, he had a new deep tissue pressure injury on the sacrum. We discussed offloading with the staffing.

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:

Age/sex: 70-year-old Male
LOC: Intubated and nonresponsive per bedside RN this has been the patient's condition with the anoxic brain injury
PMH: No known past medical history, patient unresponsive
Hospital Course: Patient presented with abdominal pain, nausea, vomiting. Patient had been experiencing abdominal pain for 3 days and was seen by his PCP who ordered 2V KUB on 6/21/2024, found to have severe colonic distension and was advised to go to the ED. Patient has sever fear of needles and did not present to the ED until 6/24/2024. While in the ED waiting, patient arrested in the bathroom, received 10-15 minutes of CPR with 3 rounds of epi, 2 amps bicarb, and calcium chloride. Intubated, emergent femoral and Left radial line place. Severe lactic acidosis post ROSC. Dark emesis witness during resuscitation c/f blood

(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.

vs. feculent emesis, received 2 unit of PRBC. Evaluated by general surgery and taken to the OR for emergent ex lap. Patient is now in the SICU with anoxic brain injury.
CC: Worsening coccyx pressure injury wound per Primary Service, reconsult-Patient nonresponsive
Social hx: No known social history, patient unresponsive
Meds: Carvedilol 6.25 mg PO BID, acetaminophen 1000 mg PO PRN for pain, Lisinopril 10 mg PO once daily, Pantoprazole 40 mg PO once daily before breakfast, Warfarin 3 mg daily, Atorvastatin 80 mg PO once daily at bedtime, Docusate sodium 100 mg PO BID, Furosemide 40 mg PO once daily, Magnesium oxide 400 mg PO once daily, and Rosuvastatin 10 mg PO once daily.
Labs: WBC 14.53 k/uL, RBC 3.12 m/uL, Hemoglobin 8.1 g /dL, Hematocrit 26.3 %, Platelet count 461 k/uL, Protein 6.4 g/dL, Calcium 9 mg/dL, BUN 42 mg/dL, Cr 1.4 mg/dL, GFR 54, Glucose 99 mg/dL

The patient was assessed in conjunction with two APRN-CNS Wound Care Practitioner. The patient was laying in the ICU intubated on his back with the four side rails up. One side rail from each side lowered down to assess patient and turn. Patient turned to the left side to assess sacral wound. The Allevyn Sacral Dressing Smith & Nephew was removed and reveal the wound as concave and measures 5 cm x 8 cm x 0.8 cm. The Unstageable Pressure Injury on the Sacrum was verified by two APRN-CNS Wound Care Practitioner's. The wound was cleansed with Vashe wound cleanser and soft gauze, then pat dried with sterile gauze. There was slough appearing gray and yellow in the wound. Then DuoDerm Hydroactive Gel was applied on a plain packing strip. The wound was lightly packed and covered with Abdominal Pad dressing. The right ischium was assessed and a new deep tissue injury was noted. This deep tissue injury took the shape of the male external urinary catheter tubing. The patient most likely laying over this tube when he was supine. This measured 1.5 cm x 5 cm and was maroon in color. There was mild induration noted in this deep tissue injury. Desitin was applied to this area and perianal area. The perianal area was for prevention. The Desitin was added on the right ischium for moisture protection as the patient has bowel incontinence about once a day. The backs side of the patient's body was assessed. Wedges applied to offload and turn to the left side. Assessment of the anterior body completed. No other skin concerns. Heels offloaded with Tru-Vee heel protectors. Pillows applied underneath arms to help elbows. Discussed with bedside nursing of worsening of Sacrum Pressure Injury now Unstageable and new Deep Tissue Pressure Injury on the Ischium most likely due to external catheter tubing. Discussed with bedside nurse to offload the patient every 2 hours and avoid the back at all times when possible as well as assure no lines or medical devices are not underneath patient to avoid other pressure injuries. Bedside nurse in agreement. During assessment WOC student discussed care being provided and plan for wounds. The patient does have barriers to healing which are critical care status, very limited mobility, and comorbid conditions.

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)

-Sacrum Unstageable Pressure Injury: Discontinue Allevyn Smith & Nephew Sacral dressing. Begin cleansing with Vashe by soaking gauze in Vashe for 2-5 minutes and placing directly over the wound bed. Pat dry. Apply 3M Cavilon skin sealant skin barrier on the peri-wound. Allow to dry. Apply DuoDerm Hydroactive Gel on the plain packing strip with cotton tip applicator, Curity Plain 1" and lightly fill the wound bed. -Apply abdominal pad dressing and secure with Kind Tape. Change BID and PRN for strike through, soiling, or wet.
-Right Ischium: Cleanse with Vashe wound cleanser with soft gauze. Pat dry. Apply Allevyn Smith & Nephew Gentle border

(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.

dressing. Change every 3 days and PRN for strikethrough, soiled, or wet.
-Monitor blood sugars and treat as indicated per Primary Service.
-Reconsult Wound Care for worsening.
-Nutrition Consult for Pressure Injury needs for nutrition optimization.
-Turn patient and offload every 2 hours the Sacrum and Right Ischium
-Assure medical devices and lines of patient are not underneath patient with any repositioning.
-Monitor patient's CBC, BMP, and protein labs and notify Primary Service with any concerns and for management.
-Continue skin prevention interventions based on Braden risk assessment subset scores.
-Continue utilizing HillROM ProgressaA+ for pressure offloading and moisture management

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

My plan of care for the patient of the right ischium deep tissue injury would have been to pad and protect instead of applying the Desitin. This patient was not having much incontinence in contact with his skin as he had an external urinary catheter that was working well and if he had any bowel incontinence, it was only about once a day. I would have used the Allevyn Smith & Nephew dressing, in which I included for the plan of care for the patient. Sometimes deep tissue injuries do not open and resolve on their own. The hope is that this resolves on its own and with padding and protecting, I think this could be accomplished.

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 the day was to identify wounds etiology and management of wounds. I did accomplish this goal today. I was able to correctly identify the etiology of the wounds as well as appropriate treatment for the wounds.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
I would like to identify a continence wound issue and create a management plan for this. I discussed with my preceptor of trying to identify a continence issue and management plan for this. My preceptor is in agreement and plan to work on this tomorrow.

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	✓	

(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.

• 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.