Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Mikaela Dillon **Day/Date:** Monday, Oct 14, 2024

Number of Clinical Hours Today: 8

Care Setting: Hospital

Preceptor: Erica Yates, APRN

Clinical Focus: Wound Care

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.

During this clinical day, I worked with the wound APRNs in the morning to go over patient consults to be seen for the day. We also looked over thermography images taken by nursing staff for patients in the ICU setting. This was beneficial to see which areas were of interest, those more often being areas of hypoperfusion or sites of inflammation.

After getting supplies set for the day and looking through the charts and notes for the patients to be seen (5-6 patients per nurse), we saw the first couple of patients for the morning and followed up with charting. WCCT consults included looking over the patient charts to see which area they were consulted for, as stated by the ordering provider, and sifting through any previous images of the wounds and any pertinent medical history including reason for admission.

We saw 5 patients for the day, including a patient with 2 ischial wounds connecting to a sacral wound with skin bridges, another patient with symmetrical peripheral gangrene secondary to toxic shock syndrome, DIC, and long-term use of vasopressors. The other patients that we saw were more straight forward pressure injuries and minor wounds caused by removing surgical bandages on delicate skin.

Ok – sounds like you were able to see a good variety of types here. If you are able to follow up on the toxic shock syndrome patient or PI patient, they could be a good topic for your complex care plan journal later.

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:

Wound care was consulted to see a 55-year-old male patient for management and assessment of documented pressure injuries to his sacrum and ischium. The patient is wheelchair bound at baseline due to bilateral AKAs secondary to PVD and chronic osteomyelitis secondary to diabetic ulcers, as well as a spinal cord injury at T12. He has an extensive PMH, including HTN, T2DM, HFrEF, CKD, and sensory deafferentation syndrome. This patient presented to the ED for admission for a UTI with a suprapubic catheter in place, but is a known patient to the WCCT due to chronic wounds, that the patient states he has had for more

than 2 years. He admits to spending many hours a day in his wheelchair and states that he is "not good about turning or offloading", causing his chronic wounds to sustain further pressure and damage.

The patient is currently receiving meropenem 500mg in 100mL NaCl 0.9% Q6h, as well as baclofen 40mg BID, oxycodone ER 110mg BID, and enoxaparin 40mg Q24h.

Lab work is WNL, lactic acid is 1.0, Hgb 7.9, HCT 26.3, WBC 7.47, BUN 22, Cr 1.34.
An additional lab that should be ordered is a HbA1C as T2DM can inhibit wound healing. Close glycemic control is necessary for this patient's healing, and orders should be placed to ensure the patient is receiving insulin before meals and before bed if needed.

Upon initially speaking with the patient, his chief complaint was the odor that was coming from his wounds, as well as the increased pain. The floor nurse was able to give him his PRN pain medication before we started to work at removing and replacing the dressings. The patient is followed by home-health nurses who have been managing his wounds with use of NPWT. The patient states that the vac was not removed when he presented in the ED, and it has been without active suction for over 2 days at this time. ← *this is concerning. Definitely need an intervention/change of plan here*. The patient noted that the wound vac was pulling out a lot of blood, which might have been the reason the vac was discontinued due to increased risk of hemorrhage.

After removing the wound vac dressing, a copious amount of tan and serosanguineous fluid was puddled inside of the wound bed. The wound was incredibly malodorous. The WCCT assessed his wounds, noting that the 3 wounds he states have been chronic, have now developed into one large wound that is attached by skin bridges. The periwound skin is intact, scarred, and pink, whereas the wound bed is pink, red, and bleeding.

The patient currently has a stage 4 pressure injury, measuring 15x22cm, and 8cm deep. There is significant undermining of 6cm at 11 o'clock. From previous admission until the day of consult, the healing percentage of the wound is currently -3567%.

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)

It is imperative that this patient's wounds are kept from further pressure and that his sacrum and ischia are offloaded. Nursing staff is to continue to turn the patient Q2h, and to utilize supportive and offloading materials including foam wedges and pullsheets/ComfortGlide Repositioning Sheets as friction and shearing forces can also inhibit healing. This patient should not be allowed to spend more than an hour in his wheelchair as he is unable to offload pressure to his wounds on his own.

For dressing changes, the patient's wounds should be packed with Vashe soaked kerlix with ABD pads placed over to ensure efficacy of the Vashe. ← *of note, consider this an off label use of this product. As far as I know Vashe is approved as a cleanser, not a dressing component.* Silicone tape or paper tape may be used to affix the ABD pad to the patient's skin. The kerlix should be placed under the section of skin bridges to fill all dead space, but should not be so packed as to cause unnecessary pressure. Skin prep should be applied to the periwound skin to prevent from damage from routine dressing changes and incontinence. The dressings are to be changed BID and PRN to ensure that they remain clean from stool or urine.

Providers should be notified if this patient has an increase in temperature, redness, warmth, or other signs of wound infection, as he is at an increased risk for recurrent osteomyelitis.

This patient is not currently appropriate for a NPWT due to the increased bleeding and lack of viable tissue in the wound bed. When the wound bed is able to further epithelialize, it might be acceptable to change to NPWT to further heal these wounds. ←*good plan.*

In general, consider almost all of the above as part of your note. Your note should detail what you did as the specialist. The plan of care (POC) is then your direction/nursing orders to be continued after the visit to maintain care. This should be

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pointed/specific/written as nursing orders. See the assignment example if helpful. There may be some repetition between the note actions and your POC direction, or, as in this case you direct a different dressing type. Make sure this is clear and applied to all future submissions.

Further consider holistic measures/further consults. Social work is indicated here, as is pain management, nutrition, mobility and other consults.

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

This case was frustrating as the patient knew what the consequences were for sitting in his wheelchair all day and not offloading his sacrum or ischia, and continued to do just that. Working with patients, I think it is important to show them the photos of their wounds, especially when they have digressed so far. Erica did a wonderful job working with him and explaining why the wound vac was not appropriate at this time, and the need to change his wound care routine. ←*this is an unfortunately familiar situation for many wound care nurses. We can only best set our patients up for success. Good to hear you and Erica were able to work with this patient.*

The nurse working with the patient for the morning was unable to assess his wounds thoroughly due to the demands of other patients on her assignment, but I do think that it is integral to patient care and safety to communicate any current therapies or dressings on the patient at time of admission. This is especially important in this case as his wounds were sitting in bacteria and fluid for the past few days without any mention to the oncoming team of nurses. This patient had gone through at least 5-6 nurses at this time and an assessment was never completed. ← *this indicates a serious moment for educational intervention. While nurses at the bedside may be more task oriented than the specialist, it is imperative that a collaborative approach is used. This patient sounds like he was in the hospital for this reason and it should be well documented to protect all involved-even if it is simply using a validated assessment tool. Never include nursing education in a note or plan of care, but make separate record as the specialist of situations such as this and intervene as necessary with staff education.*

After taking the wound care class through this program, I am leery about utilizing wet-to-dry dressings for any patient simply because of the lack of protection gauze provides from bacteria. It was important to utilize a secondary dressing in this case not only to keep the kerlix in his wound, but also to protect the wound bed from further contaminants. Because this wound did have slough, dressings that may also benefit this patient would include using a hydrogel impregnated gauze as packing, with a secondary dressing applied like a foam border or ABD. ← *great! Wet to dry is non-selective and considered a traumatic debriding agent. There are other options available as a primary dressing nearly every time. If there is high exudate and odor indicating serious bioburden, consider a silver hydrofiber/alginate as a primary dressing until bioburden can be controlled.*

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 become more knowledgeable in the products that are commonly used in wound care in the hospital setting, and to better understand the rationales for working with patients who are also being seen by a larger interdisciplinary team, in the case of vascular surgery for the patient with gangrene. *<-good. Include this collaborative approach/consulting in your plan of care for patients as the directing WOC specialist.*

I believe the goal for the day was met, especially since the range of patients we saw allowed for use of many wound care dressings. It was also beneficial to talk through why each dressing was being chosen, as well as some alternative that may be available for patients that were returning home shortly. This was especially helpful in the case of the patient with BLE gangrene. Her family was taking care of her wound care at home, and while Erica was using Urgotul on the junction between the healthy tissue and necrotic tissue, the family was able to purchase Adaptic at home for when they ran out of Urgotul and were awaiting more supplies to be delivered. In these instances, it was helpful to work with patient's families on supplies, as starting a patient on a specific wound care

plan may be helpful while in the hospital, but if they are unable to access necessary resources, then it is overall not beneficial for the patient as that treatment will stop.

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

My goal for tomorrow is to continue to ask questions about the complex patients we see, and to become more familiar with the role of the WOC nurse as an APRN. This includes further investigating prescribing topical medications and understanding the process of ordering supplies for patients when they return home as a treatment may be working for them in the hospital, but how does that plan change when access to resources may be more difficult.

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	See my comments .	
Plan of Care Development:		
• POC is focused and holistic	See my comments	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Statements direct care of the patient in the absence of the WOC nurse	See my comments	
• Directives are written as nursing orders	See my comments	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Hi Mikaela – see my comments throughout this first journal submission. I left many and they are meant to be constructive and assist you in building your future journal submissions. Make sure to apply feedback to future journals. See example journals in the course resources as needed. This qualifies as your first 8 hours of wound!. Make sure your note details what you did at your visit (documented from the standpoint of the WOC provider) and your POC details what is needed to be done after your visit to maintain care (written as directives/nursing orders).

Reach out with any further questions. Looking forward to the next submission.

Reviewed by: _____Mike Klements 10/16/24 received_____ Date: __10/16/24

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