Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Sheila Guzman___ Day/Date: ___10/23/24_____

Number of Clinical Hours Today: _8___

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

Preceptor: ___Christopher Eddun____

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.

This morning, I attended skin/wound rounds on a step-down unit with the Skin Care Champion RN and my preceptor. There was a total of 29 patients to be seen, only 3 of them were listed as having HAPIs. One of those PIs was previously stage 2 HAPI, now noted to be completed healed upon assessment. Another 34yo male patient laying in gel bed, with history of cystic fibrosis and renal transplant surgery, came in for placement of trach and current medical goal is to wean off the ventilator. He was noted to have a sacral DTPI, which I measured to be 5.5x2x0.1cm. Area was cleansed with Coloplast no rinse perineal solution and covered with Mepilex silicone adhesive border foam. Repositioned to offload, Z-flex booties in placed.

Our next patient, a 66 yo female orally intubated and connected to ventilator, admitted for chest pain was awake and laying in gel bed. History of hypertension, allergies to Heparin. S/p stent placement in left carotid, using anticoagulant Argatroban. Being followed by Nutrition due to strict I&Os and Nephrology for oliguric AKI. Patient had healing DTPI of both heels, right was measured to be 3x2cm and left 2.5x2cm. My preceptor had consulted this patient 2weeks prior and stated that there was notable improvement, evidenced by lightening of the color of the heels from dark maroon to lighter yellow, pinkish purple. This is a result of optimal offloading with the use of Z-flex boots. We recommend continuing cleansing with NS and patting dry with gauze, covering the heels with Mepilex silicone adhesive border foam. Changing the Mepilex 3 times a week or if soiled.

We were later consulted to see a 36yo female s/p lung transplant and tracheostomy, awake, AAOx3 sitting in chair with a necrotic ulcer on lateral side of her right forearm. This necrotic ulcer was noted to have dry and stable eschar and peri wound noted to be red. Chart reviewed. Medi honey was being used. I suggested that the Medi honey be discontinued and paint the wound with betadine instead. Covering the wound with Mepilex. When reviewing the chart, I noticed that this patient was being discharged within the next 2 days. Her immune system was very suppressed, and debriding was only going to open way for bacteria to get in. When I explained the new treatment plan to the patient with the rationale, she stated the Medi honey was causing the wound to be painful, rating it 3 or 4 out of 10 on the pain scale. She stated that Betadine felt more soothing. ← *consider need for debridement eventually here if goal is healing. This sounds like a complex picture. Necrotic tissue itself has danger for infection.*

The most interesting/complex patient we saw was a 41yo male s/p I&D of wound on right wrist and chronic wounds on left and right legs from IV drug abuse. He refused us touching him because he was in pain and requested pain medication first. When asked he said his pain was a 20 on a scale of 10. We notified the nurse, and she came to give him some pain meds. The patient states that his legs hurt but he can walk.

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

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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 consult for 41-year-old male with a h/o IV SUD (heroin, cocaine), untreated Hep C, anemia, type 2 DM, who came to ER for diarrhea, vomiting, fever and loss of appetite at shelter, found to have significant R wrist/hand swelling, anemia, and AKI with hyperkalemia /uremia /metabolic acidosis. R wrist swelling and pain, he denies recent IVDA into the RUE, most recent IVDA in L foot 3 days ago. States swelling/pain has become progressively worse today. He reports a similar episode of R wrist swelling/pain approximately 4 months ago. I&D done by Ortho at bedside of R wrist, approximately 75cc of pus expressed through incision. Wound wic placed in incision to maintain a patent opening. Ketamine and propofol used to sedate pt for procedure. WOC nurse was consulted by Ortho team to assess and recommend dressings. We cleansed each wound with Vashe hypochlorous acid cleanser, applied Aquacel AG, then wrapped with Kerlix gauze. The leg ulcers were noted to be dressed with gauze, abd pad, cling gauze wrap, tape and blue chucks. This made the dressing change extremely painful and it is not evidence-based practice. ← *good call. What was changed at this visit? Make sure to chart what you did , and direct what you need done.* The medial calf area of the lower right extremity noted to have large amount of purulent exudate and foul smell. After cleansing we measured it to be 10.6x5.5x1cm. The medial gaiter area of the lower left extremity measured 6x4.5cm after being cleansed. Pt was repositioned and left asleep in bed. Siderails up x4 for safety. Bedside nurse and medical team updated.

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)

*Remove and discontinue all old dressings.
For the RUE wound:
-Thoroughly cleanse the area with Vashe hypochlorous acid cleanser. Pat dry with gauze. Apply Aquacel AG to wound. Wrap with Kerlix gauze wrap. Change every other day and prn when soiled or highly saturated.

#For LLE wound:
-Thoroughly cleanse the area with Vashe hypochlorous acid cleanser. Soak 4x4cm gauzes with Vashe, apply it to the wound and remove it gently but firmly after letting it sit for at least 3 mins to loosen and remove slough and necrotic tissue. Cleanse peri wound and surrounding area also with Vashe soaked gauzes. Pat dry with gauze. Apply Aquacel AG to wound. Wrap with Kerlix gauze wrap. Change every other day and prn when soiled or highly saturated.

For RLE wound:
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-Order Citadel 200 Specialty bed for active alternating pressure redistribution and enhanced microclimate management.
-Turn and reposition the patient to offload pressure points every 2 hours as patient condition permits
-Use one incontinence pad underneath the patient to minimize moisture and humidity, which can lead to skin breakdown.
-Utilize AirTap positioner and wedges to ensure offloading of the sacrum.
-Apply Cavilon Barrier Film to all bony prominences and vulnerable areas including heels, elbows, and ears every 24 hours.

***Notify WOC nurse with any questions and/or concerns about the dressings or changes in status of wounds.

Make sure to address pain in this plan. This pt will likely not be tolerant of these directed orders without management of pain per order.
Consider nutrition consult.
Consider social consult as patient is from a shelter

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

I would have consults with Social worker, Nutrition, Psych, Pain Management, Outpatient Wound Clinic and Detoxification Program. ← *direct this in your POC* For this patient I would have called the nurse to premedicate before we saw him. It would have prevented the patient from experiencing pain and aggravation. I would have placed fall precautions on this pt because he was sedated for the procedure that was performed on his RUE and noted to be drowsy. These wounds are a result of daily IVDU, uncontrolled DM, and poor wound care. This patient has been referred to primary care doctor, diabetes and wound clinics and fails to follow-up. The goal here is to teach the patient how to keep the wound as clean and dry as possible to prevent further damage and infection.

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?
Our goal was to see more complex cases, practice and or /review Monofilament testing, ABI and fistula management. The goal was for me to continue seeing patients with my preceptor but independently recommending the treatments and educating the patients and staff.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
The goal will be to do the monofilament testing on a patient, see a patient who has a fistula and practice how to manage it. Selecting a patient and gathering information for my complex journal.

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	Make sure to incorporate all feedback in your final submission	
• 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	✓	

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• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Hi Sheila – see my comments throughout. Continue to make sure all feedback is considered in your plan of care. Apply all feedback to your complex care plan submission – reach out with any further questions.

Reviewed by: Mike Klements 10/28/24 Date: 10/28/24

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