Cleveland Clinic

Daily Journal Entry with Plan of Care & Chart Note

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Miranda Prawdzik Day/Date: 11/12/24

Setting: Hospital • Ambulatory Care ☒ Home Health Care • Other: _____

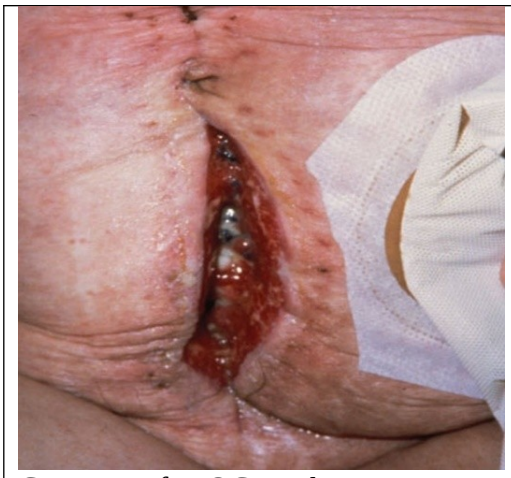
WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, a chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History	*Age/sex*:49-year-old female *PMH*: Uncontrolled DM, obesity, colon cancer with descending colostomy. *CC*: Came to ER for dehisced surgical wound *Meds*: Unknown *Social hx*: Lives alone *Plan:* Referred to wound clinic for treatment plan.

Assessment/encounter:
LOC: Awake, alert, oriented x 3
VS: 98.7°F P 688 R 26
Initial interview: States the "stitches were taken out yesterday at the surgeon's office and now I have a big hole"
Wound assessment:
Location: Mid abdomen
Wound type: Dehisced surgical wound
Extent of tissue loss: Full thickness
Size & shape: 25 x 10 x 5 cm oblong
Wound bed tissue: Red
Exudate amount, odor, consistency: Moderate amount of serosanguineous drainage, no odor. Also noted exudate on blouse
Undermining/tunneling: None
Edges: Attached
Periwound skin: No erythema, induration, fluctuance, denudement. Non-tender
Pain: 8/10 when moving

Photo:

Cleveland Clinic



Courtesy of WOCN Library

Education: Discuss below
Suggested consults: Discuss below

Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

- Something I would have done differently is collect/assess more of the patient's medical/surgical/social history. The information stated above is fairly limited.
- I also would have dug deeper into the surgical site. What recent surgery was performed (assuming it is from colostomy creation) and when was the surgery.
- I may have obtained a set of lab work, including a BMP, CBC, Hbg A1C, etc.
- More physical assessment could be performed as well including a current weight, a full set of vitals, and more thorough abdominal assessment.
- I would have assessed the patient for social concerns. Patient claims to live alone. Are they fully independent? Would they be able to care for wound independently? Is the patient able to afford care and travel to and from appointments?
- I would also be sure to consult multiple other services including endocrinology, nutrition, WOC/ostomy team, surgical team that performed previous procedure, and acute pain management team

Using the information from the encounter and your critical evaluation 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. (For example: *What dressing change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

- Apply and initiate negative pressure wound therapy (*3M ActiV.A.C. Therapy Unit with 300mL canister*). Change NPWT dressing every 3-5 days.

- Cleanse wound with normal saline irrigation and gently pat dry with each dressing change.
- Apply adhesive transparent film barrier/drape to the peri wound skin
- Apply petroleum impregnated gauze to the base of the wound bed.
- Lightly pack black foam into the wound bed, covering the wound in its entirety to the edges, ensuring the foam does not extend to the intact peri wound skin.
- Apply transparent film barrier/drape overtop of black foam and peri wound skin.
- Cut small opening in the top of transparent film to fit the size of the suction tubing device. Place tubing at cut site and attach tubing and canister to the NPWT system.
- Ensure system seal by powering on system and programing to the ordered settings (continuous therapy, -125 mmHg)

- Assess NPWT system daily for adequate seal, signs of leakage, signs of blockage or clogging
  - With leakage alarm: assess for leakage site in the seal/drape and patch site with adhesive transparent film. If still unable to obtain a full seal, remove dressing and replace as detailed above.
  - With blockage or clogging alarm: check tubing for kinks or physical blockage, place system at or below wound site, and ensure clamps are open. If alarm continues, replace system tubing and canister.
- Measure wound output daily. Replace vac canister when full.
- Consult endocrinology team for diabetes management, adjustment of medications, and routine monitoring of lab work and treatment adherence.
- Consult nutrition services/dietician and PT/OT for weight management recommendations.
- Notify provider if NPWT is disrupted for more than 2 hours.
  - Remove vac dressing and apply a normal saline moistened gauze dressing to the site until NPWT can be replaced. Seek medical attention/contact provider immediately.
- Notify provider of signs of wound worsening, possible fistula formation, or infection.
  - Increased wound output, change in output characteristics/appearance, increased pain at wound site, exudate malodorous, erythema, edematous, fever, etc.
- Refer to WOC team for colostomy management.
- Refer to social work team for any social concerns, any needed financial support, or concerns for independence with wound care.

Write a chart note giving careful consideration to the chart review information, 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 used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

The patient is a 49-year-old female with a past medical history of poorly controlled diabetes mellitus, obesity, and colon cancer with creation of descending colostomy. Unknown surgical history beyond colostomy creation. Patient history obtained via verbal conversation and medical record review, information limited.

The patient presents to the ambulatory wound clinic for initial visit regarding a mid-abdominal surgical wound dehiscence. The patient states having surgical site stitches removed the day prior, and the wound

opening. On assessment, full thickness wound found mid-abdomen with moderate exudate and patient reporting 8/10 pain at the site with movement. The patient first visited the emergency department and was then referred to the wound clinic for wound care treatment plan.

Physical Assessment:

- Patient seen in ambulatory wound clinic.
- Patient is awake, alert and oriented, and follows commands on assessment.
- Patient reports 8/10 pain at the wound site with movement.
- Review of systems deferred.
- Abdominal assessment performed. Abdominal contour rounded, soft, non-tender. Descending colostomy present in the LLQ, pouching system in place.
- Full thickness abdominal wound present along midline. Moderate amount of drainage, with exudate seeping through clothing.
- No other evidence of skin breakdown to the abdomen, peri wound skin intact.
- Photos obtained, see media.

Wound Assessment

- Wound type- Surgical incision dehiscence
- Location- mid abdomen
- Tissue loss- full thickness
- Measurements- 25cm x 10cm x 5cm, oblong in shape
- Appearance- tissue red, moist
- No evidence of undermining or tunneling
- Exudate amount and characteristics- moderate drainage, serosanguineous, no odor
- No dressing in place, exudate seeping through to clothes
- Edges- intact, attached
- Peri wound skin- intact, no erythema, non-tender
- Pain- 8/10 with movement

Social History:

- Medical non-compliance/poorly controlled
- Patient lives alone/independently
- No reported drug or alcohol use
- No reported smoking

Current Medications:

- Unknown, unable to obtain

Most Recent Testing/Vitals:

- No recent testing or imaging available for review at time of visit
- Latest vitals are as follows:
    - Temperature 98.7 F, HR 68, RR 26
- No recent lab work to review at time of visit

Reviewed WOC Patient Education:

- Causes of surgical wound dehiscence, current patient comorbidities that increase risk

- Signs of wound infection and when to contact provider
- NPWT treatment, how to manage system, possible complications and trouble shooting
    - Secondary dressing options
    - What to do in case of system failure/loss of suction
- Diabetes education, importance of treatment adherence
- Weight management for wound healing

Recommendations:

Initiate negative pressure wound therapy to the wound site. (see care plan for detailed dressing plan)
***Secondary dressing option if NWPT contraindicated: Antimicrobial foam dressing (Mepilex AG Foam) secured in place with gauze sheets and tape.*
Measure wound output daily.
Initiate alternative dressing option in case of infection, NPWT failure, or heavy exudate volume.
Continue to follow-up with WOC team and surgical team for wound management.
Follow-up with endocrinology team and nutrition services/dietician.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

4. What was your goal for choosing this case?

I chose to explore this virtual clinical situation as I had limited experience with surgical dehiscence during in-person clinical hours. I also have little experience with surgical incision site care in general. I wanted to review dehiscence treatment options and possible causes related to present comorbidities. I feel I was able to do so through reviewing notes, the textbook, and up to date research articles.

Reviewed by: _____ Date: _____

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		