Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Alexis Buehler Day/Date: Monday, December 16, 2024

Number of Clinical Hours Today: 8

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

Preceptor: Heather Lucas BSN, RN, CWON Clinical Focus: Wound __X__ Ostomy ____ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

Today, we saw three wound patients and finished colostomy teaching with a patient I met last week. The wound care team at my clinical facility had a 2-hour lunch meeting today that I went to with my preceptor. We watched an NPIAP webinar on pressure injury staging and had a short discussion afterward. We saw a patient for a chronic LLE venous ulcer and modified the plan of care. During our in-person exam, the wound was observed to have healthy, moist, pink/red granular tissue in the wound bed, indicating that the necrotic tissue previously seen in the wound was appropriately managed and removed. The wound still needed protection from contaminants but no longer required autolytic debridement with medihoney. The original order was for medihoney to the wound bed, covered with silver foam, secured with kerlix roll gauze and tape. Modifying this order was simple because the only step we eliminated was applying the medihoney gel. We cleansed the wound, applied skin protectant to the periwound, applied silver foam over the open wound bed, wrapped the area on the lower leg with kerlix roll gauze, and secured with cloth tape.

Next, we saw a patient who has been followed by the wound care team during a long hospital admission. The team is following the patient for a chronic R groin wound secondary to the removal of a cancerous tumor. Healing of the wound has been further complicated by radiation therapy and the wound has made very little progression during their hospital stay. This patient and their wound will be the focus of my clinical journal. The last wound patient that we saw for the day was a follow up for a NPWT dressing change to an abdominal surgical wound that was receiving veraflo therapy with ¼ strength Dakin's solution. We saw this patient last week and did a dressing change for. The wound had much less slough and no foul odor on our exam today, so we discontinued the Dakin's veraflo instillation and modified the plan of care to standard NPWT with continuous suction at 125 mmHg. The wound was responding very well to NPWT and the wound care team plans to do another dressing change in 48 hours and will reassess the wound and treatment plan at that time.

Types of patients: new colostomy patient, lower extremity venous ulcer, surgical wound with negative pressure wound therapy, chronic wound secondary to tumor removal with healing complicated by radiation therapy

Chart note:

This patient is a 62-year-old male with a PMHx of metastatic high-grade spindle cell sarcoma (diagnosed in Dec 2020, treated with multiple resections, radiation, and up to 6th-line chemotherapy; held after a September 2024 PET scan showed no hypermetabolic disease), severe life-threatening infections on long term PO antibiotics, poor wound healing in the right groin and left arm, PCP pneumonia, fall in 2021 with subsequent C3-7 decompression and C2-T2 fusion at an outside facility, prior cement augmentation in upper lumbar spine, myonecrosis, myositis, recurrent pleural effusions, renal stones requiring lithotripsy, atrial fibrillation on anticoagulation, IBS, OSA who was care flighted to the hospital from an outside facility on 10/19/24 with the primary complaint of acute onset, severe back pain and found to have an associated new L3 vertebral body lesion and pathologic fracture consistent with metastatic sarcoma. Admit for higher level of care and pain management. On 10/22/24 he underwent a T10-ilium posterior instrumented fusion, L3 hemilaminectomy and tumor resection with foraminotomy, with the placement of epidural catheter for pain. On 12/3/24 he returned to the OR for an I&D of his surgical spinal incision due to purulent drainage and deep undermining. Wound care team not consulted for or managing surgical spinal wound at this time, please contact neurosurgery for questions or concerns related to surgical spinal wound.

Wound care team follow-up visit for:
-Surgical wound to R inguinal fold c/b radiation therapy

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Encounter

On arrival, the patient was found lying on a pressure redistribution specialty surface with the microclimate feature turned on, and a bed extender in place due to his height. A turn and positioning system was in place, and the patient was turned to the right side at a 20-degree angle with wedges appropriately offloading his sacrococcygeal area. Pillows were observed under his upper extremities, and his heels were adequately offloaded with protective boots. The patient is welcoming to all care provided. His wife is at the bedside and has been a surgical nurse for 40 years. She is very helpful, supportive, and knowledgeable

Assessment

LOC: awake, alert, AOx4

Subjective interview: Patient reports that he is able to tolerate wound care to the R inguinal fold wound. He has chronic, acute, and neuropathic pain all secondary to his disease process and subsequent treatments. His pain management has been challenging but he is agreeable to wound assessment and care today. Reports that mobility is his current barrier and challenge. He has been able to sit at the EOB for short periods of time, but is unable to stand. His primary limiting factors are his disease process and associated pain. Due to the disease process and progression, the patient will likely require a wheelchair to mobilize for the remainder of his life.

Physical assessment: AOx4, generalized pain is 8/10, goal is 6/10. Continent of bowel and bladder. Abdomen is rounded and slightly distended. Reports constipation secondary to use of narcotics for pain control, last BM 3 days ago. BUE strength 4/5, baseline tremor in hands, sensation intact. BLE strength 2/5, reports numbness in his R leg as baseline since initial diagnosis. Trace edema in BLE. Able to eat and drink, regular diet ordered. Vital signs are stable on room air. Healed surgical incision on patients L forearm. Linear surgical incision observed on back from the cervical spine to the lumbar spine. Full thickness wound to R inguinal fold.

Pressure injury prevention: This patient is high risk for pressure injury development due to limited mobility. No evidence of skin breakdown was observed over bony prominences, including the patient's bilateral heels, iliac crests, coccyx, sacrum, scapula, and occiput. All pressure injury prevention interventions available are currently in place, and the patient has been agreeable to repositioning Q2 since his initial day of admission. He is presently on a specialty mattress that accommodates his height and has additional protective measures, including a microclimate function, to help manage moisture and temperature between the patient and the mattress.

Wound assessment: The wound measures 2 cm x 1 cm x 0.8 cm and is round and well-defined with epibole at the edges. Visualization of the wound bed is limited due to the size of the wound but there is evidence of moist, pink/red non granular tissue. There is a 0.9 cm tunnel at 9 o'clock, traveling along the trajectory of the inguinal fold. Peri-wound is intact with circumferential hyperpigmentation and scar tissue. Medium amount of tan drainage, no odor.

Wound treatment: R inguinal wound was found with an intact bordered foam dressing in place. Strikethrough noted on dressing prior to removal. Upon removal, foam dressing with medium amount of tan drainage. No purulence or odor. A single piece of Opticell Ag silver rope was easily removed from the wound bed. The Opticell Ag was noted to be gelatinous, as is expected with Opticell Ag on removal, and is due to absorption of wound exudate. Wound gently cleansed with gauze moistened with Vashe antimicrobial solution. Vashe moistened gauze and then soaked over the wound bed for 5 with minutes to decrease the bioburden and further cleanse the wound. A cavilon skin protectant wand was applied to the peri-wound skin and allowed to dry. Wound bed gently filled with a single, cut piece of Opticell Ag rope with a tail exiting the wound for easy retrieval. Covered with dated bordered foam. Due to the increase in drainage noted on the dressing and packing removed from the wound for today's assessment and care, the frequency of the dressing change has been modified, as outlined below.

WOC Plan of Care (include specific products used)

To Right inguinal wound (located with skin fold):

- Gently remove the dressing in place, note the amount of exudate observed upon removal, and document findings in the wound LDA flowsheet
- Gently cleanse the wound with a piece of 4x4 gauze moistened with Vashe antimicrobial solution; attempt to wipe away any necrosis, exudate, or crusting as able
- Apply a new piece of 4x4 gauze moistened with Vashe over the wound and allow to soak for ~5 minutes. Remove gauze and allow the area to dry
- Apply Cavilon skin barrier film to intact periwound skin, allow to dry
- Using a cotton tip applicator, gently fill the wound bed with a ***single*** piece of Opticell Ag rope; ***include the tunnel located***

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at 9 o'clock to a depth of 0.9 cm; leave a tail of the rope outside of the wound bed for easy retrieval

- Cover with a dated Allevyn 2 x 2 bordered foam dressing
- Change the dressing every other day, or as needed if the dressing becomes saturated, soiled, or dislodged
- Document dressing change in the wound LDA flowsheet

**patient's wife is able to assist with this dressing change and has been thoroughly instructed by the wound care team on the steps and plan of care*

Please notify the wound care team and the primary team if there are any acute changes to the wound, including bleeding or signs of infection, such as foul or purulent odor, increased drainage, patient with a temperature greater than 38.5 Celsius, or if the patient develops acute pain associated with the wound.

Do not place ice packs over the R inguinal fold, as this can cause vasoconstriction and impede wound healing.

Please maintain all pressure injury interventions, including:

- The patient is on a specialty pressure redistribution mattress with a microclimate function and should be on this surface until discharge.
  - For this bed to operate as intended, limit the number of layers between the patient and the mattress surface and *use only a single flat sheet, a turn and positioning system (TAPS) sheet, and a single chux pad*
- Turn patient Q2 hours with TAPS sheet and wedges, ensure sacrococcygeal area is adequately offloaded by sliding a hand under the draw sheet between the wedges – the sacrococcygeal area should be palpable if patient is properly turned
- Maintain HOB less than or equal to 30 degrees, ensure hips are flush with the bed or the chair to reduce sacral shearing
- Use a waffle cushion when up in chair and limit sitting to 1 hour
- Offload heels with heel lift boots, assess for proper heel placement Q2 hours. Heel should be palpable through opening in the bottom of the boot.
- Ensure any tubing is not in contact with patient's skin, reposition any medical devices applying pressure to the skin Q2 hours

Perform two-person skin assessments during bedside shift reports and document per policy.

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

We modified the plan of care based on the change in the amount of exudate and how the specific properties of Opticell Ag work. The dressing was initially ordered to be changed every 3 days, but there was a strikethrough noted on the removed dressing, so we needed to improve moisture management. The Opticell Ag is effective with highly exudative wounds and the dressing can be changed more or less frequently than every 3 days if needed. We decreased the frequency of dressing changes to improve the management of wound exudate—ideally, the cover dressing won't become saturated or have evidence strikethrough if changed every 2 days rather than every 3 days. I do think that the wound doesn't have much depth and could also be managed with medihoney alginate and as a possible consideration for future treatment options.

Goals

What was your goal for the day?

I wanted to discuss pressure injuries further and was able to reinforce a lot of information regarding pressure injury prevention during the NPIAP webinar and discussion that took place today.

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

I honestly just want to continue to see a variety of wounds and applications of wound care products. I have enjoyed seeing the same patient more than once to assess wound progression and consider POC modification.

CRITICAL ELEMENTS	Completed	Missing

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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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