Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Roxanne Britt_____ Day/Date: __3/25/25_____

Number of Clinical Hours Today: _8___

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

Preceptor: ____K. Nicki Blasiole_____

Clinical Focus: Wound __x__ Ostomy ____ Continence ____

Inpatient hospital wound rounds 3/25/25.

All patients have orders in place for turning and rotation schedule every two unless otherwise specified for pressure redistribution.

All beds at Akron General/Cleveland Clinic Hospital are low air loss and have weight redistribution properties for pressure redistribution and pressure injury prevention per preceptor's report.

Patient encounters:

63 y/o female stage 4 PI to coccyx, unstageable PI to heels bilat, bliat ischial stage 4 PI with R side tunneling to bone. Stage 4 PI washed and packed with vashe applied to gauze and secured with secondary silicone foam dressing. DTI to spine with silicone foam dressing. Heels with mesalt dsg and secured with kelix gauze wrap and paper tape to gauze. EHOB TruVue heel boots in place for offloading.

92y/o female with L ankle lateral wound venous in nature. Xeroform applied. Natal cleft with friction wound possibly from adult brief and MASD. Mesalt dsg applied and secured with silicone foam dressing. Abd fold with moisture and yeast but skin intact. Miconazole powder ordered. EHOB TruVue heel boots in place for offloading.

81y/o female with open wound to L lateral leg sustained from fall. Wound bed clean with granular tissue after prior debridement before admission to ICU yesterday. Silicone foam dressing applied and NPWT to be resumed this afternoon. Her NPWT device was non-operational.

59y/o male L BKA 3/24/25 due to osteomyelitis. NPWT with black foam on at 100mmHg. R lower leg with 3 small wounds venous/DM mixed in nature. Wounds treated with xeroform and secured with secondary silicone foam dressing. R foot cool to the touch. Negative sensation up to mid leg. Negative proprioception. No DP or PT pulse appreciated and cap refill 3 seconds. EHOB TruVue heel boot in place for offloading.

71y/o female with intra-abdominal infection post-surgical procedure. Stage 2 PI to coccyx. Will be journal case study.

45y/o female admitted for UTI to med/surg unit but known to wound care for stage 4 PI with tunneling to R ischium. Mesalt packing applied and secured with secondary silicone foam dressing. Prior surgical history with L hip open friction wound at old surgical scar site. Pt cannot report eto but agrees friction from wheelchair possible cause. Silicone foam dressing applied.

72y/o male with traumatic wound to buttocks. Zinc oxide applied and large sacral silicone foam dressing applied. L ankle healing stage 2 PI. Xeroform and secured with secondary silicone foam dressing. EHOB TruVue heel boots in place for offloading.

67y/o male with L DFU and Charcot foot. Hx of R Foot osteomyelitis with BKA. Wound was moist so dressed with mesalt dressing and secured with kelix gauze wrap and paper tape to gauze. Macerated pinpoint DM ulcer found between 4th and 5th toe. Mesalt gauze weaved between toes and dressed with above.

Case study

Age/sex: 71-year-old female

PMH:
Abdominal wall fistula
Anemia
Calculus of gallbladder without cholecystectomy without obstruction
Edema
Unspecified history of echocardiogram left ventricular ejection fraction, 60% normal systolic function -moderate mitral regurgitation
History of left leg deep vein thrombosis
Malignant neoplasm of right ovary
Muscle weakness (generalized)
Neoplasm of uncertain behavior of unspecified ovary cancer
NSTEMI 2024
Plural effusion, not elsewhere classified

Presence of other vascular implants and grafts
T2DM diet controlled
Sacral wound
Stercoral colitis
Vitamin D deficiency
PSH: abscess drainage, renal/perirenal
Percutaneous thrombectomy
Thoracentesis
Ultrasound abdomen/rectoperineal mass biopsy- CT guided

CC: Her long-term care facility brought her to the ED for increased drainage from her incision site. She presented with hx of ovarian endometrioid carcinoma status post laparotomy with drainage of left paracolic gutter inclusion cyst and biopsy/ excision of the intrabdominal fistula tract on 3/11/25. She was admitted to hospital 3/24/25 with CT findings concerning for intraabdominal abscess.

Medications:
Polyethylene glycol 17 g packet daily Administer in fluid of patient choice
Senna-docusate 8.6-50mg tabs take 2 tabs PO BID
Zinc oxide ointment 20% topically to coccyx BID
Lactated ringer's IV infusion 100 mg an hour
Promethazine 25 mg oral Q4 hours PRN
Metoclopramide 10mg Intravenous qQ hours PRN injection
Melatonin 3 mg oral at that time PRN
Tylenol 650mg PO q 4hrs
Morphine intravenous Q4 hours PRN injection
Zosyn 3.375 Grams piggyback IV Q6 hours in dextrose 50Ml
Insulin lispro subcutaneous with meals and HS per sliding scale.
Dextrose 15 gram/32 mL give 15 grams oral PRN

Allergies: strawberry- GI upset

Social history:
Negative for smoking
Negative for vaping
ETOH not currently
Drugs not currently

Chart note and physical exam:

VS 93/43 74-97.3-16. Height 5' 5 Weight 123.9lb Po2 96% on RA Glucose 203 on am labs
General appearance: Alert and orientated female, thin and frail, lying in hospital bed. She states she does have some pain but stated it is tolerable, and she has had pain medication this morning.
Respiratory: no SOB or cough noted
Cardiovascular: Palpable pedal pulses bilaterally
Extremities: Heels intact bilaterally. Positive sensation noted at great toes
Integumentary: Stage 2 PI to sacrum

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	2
Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	13

Plan: Continue to provide wound care. NPO For anticipated Interventional Radiology drainage of absence on 3/26/25. Will follow up after procedure for assessment of drain site and new surgical site wound management.

Wound assessment:
Location: Sacrum bilaterally
Wound type: Sacral wound pressure injury and noted as present upon admission during this encounter
Extent of tissue loss: Stage 2- Superficial skin loss
Size and shape: 5cm x 2cm x 0.1 Scattered
Wound bed tissue: red 10% pink 90% and fragile
Exudate/amount: Scant sanguineous
Consistency: Thin
Odor: None
Undermining/tunneling: None
Edges: Flush with peri-wound skin
Peri-wound skin: dry and peeling
Site assessment: Clean

Wound Location: Midline abdomen surgical with staples

Extent of tissue loss: minimal/surgical site
Closure: Staples

Size and shape: 17.5cm x 0.1cm

Exudate/amount: Serosanguinous with small amount of drainage

Consistency: Thin

Odor: None

Undermining/tunneling: None

Edges: Flush with periwound skin
Peri-wound skin: intact, warm, pink, and supple
Site assessment: Clean

Wound location: Surgical dehisced abdomen, right, mid, lower
Size and shape: 7.5 cm x 0.6 cm x 2.1 cm Transverse open incision
Exudate/amount: Moderate to large amount of serosanguinous purulent drainage
Consistency: creamy
Odor: None
Undermining/tunneling: 12 o'clock tunneling 2.6 cm
Edges: slightly raised edges with some erythema
Peri-wound skin: intact pink
Site assessment: Red and painful

Photographs obtained for documentation in the EHR

Wound care plan:

Sacrum: Cleanse wounds with each dressing change using NS and gauze. Apply an Allevyn sacral dressing to sacrum/coccyx every 3 days and as needed for soiling or non-adhesion. Peel back a corner to assess skin each shift daily.

Abdominal wounds: Cleanse wounds with each dressing change using NS and gauze. Dry 4X4 gauze fluffed and covered with ABD pad to midline abdominal incision.

R mid, lower abdominal wound: Pack loosely right abdominal wound incision site with mesalt ribbon leaving tail and cover with ABD pad and secure with paper tape.

Change abdominal wounds BID and PRN for excessive drainage.

Apply skin prep to wound boarders prior to application of paper tape.

Turning and repositioning q 2 hours utilizing wedges to float coccyx.

EHOB TruVue heel boots in place for offloading when in bed.

1. I am a novice to wound care and this was a draining abdominal wound which had a surgical management plan in place. While in the room I did count staples and there was no record in EMR that I was provided to compare but it appeared as one may have dislodged.
My preceptor had placed ABD pads over the wounds and at that moment I asked about skin prep before taping as a suggestion and she passed a Calvion swab. That is what I did do at the time to advocate and not have to say next time what I would have done differently when it was needed to protect the patient's intact skin from all of the paper tape needed to secure her dressings.

2. Goal from yesterday was met with more familiarity of products. Two of the WOC staff members took out the bag they use for new floor nurse education to wound care products and further gave more product as a hands on presentation.

I also learned they follow up on the NPWT patients every three days and see the follow up patients weekly or as needed.

3. Learning goals for the last day are to assess any gaps preceptors have identified and identify any other sources of learning materials they wish to pass on.