Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Roxanne Britt_____ Day/Date: __3/24/25_____

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 3/24/25.

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.

3 follow up visits on inpatient medical surgical floor:

68y/o female BLE wounds and stage 2 PI to coccyx. Wounds cleansed with wound wash and gauze. Allevyn foam dsg applied to coccyx. LL ext healed and d/c dsg order placed. New order to apply Aquaphor to L lower leg BID for moisture written. RL ext Xeroform applied and secured with kerlix gauze and paper tape to gauze only.

67y/o female MASD to abd skin folds and no open lesions seen. No changes to orders. Cont with zinc oxide cream. Since zinc oxide is moist, definitely lobby for one of the silver textiles such as Coloplast Interdry AG. BLE wounds cleansed with wound wash. Adaptic applied for contact layer and calcium alginate applied to both wounds for mild serous exudate. In your own practice consider placing the alginate directly on the wound. If the wound has exudate then the alginate will gel. If the wound does not have enough to gel the alginate you can easily flush the alginate out with NSS or water! Dsg secured with gauze and paper tape to gauze only.Also consider not using gauze as the only secondary dressing as there is minimal absorption capability of this product + it is open weave & the wound can be contaminated easily. An ABD would work Tubigrip stockings applied from toe web to just below popliteal spaces for 10mmHg for light compression. This is definitely light!

88y/o female unstageable PI to coccyx with Mesalt dressing. Wound cleansed with wound wash and measured. Mesalt dressing was applied but order to be change to methylene blue foam dressing for antibacterial treatment. would be interesting to follow for success. Perfect place for collagenase though or cadexomer iodine

5 initial visits on inpatient medical surgical floor:

76 y/o male with NPWT to R heel and coccyx unstageable wound which will be main journal patient.

79 y/o male DTI just fyi, latest abbrev. is DTPI to coccyx. Blanchable deep maroon intact tissue noted. Zinc oxide applied and Allevyn foam dressing for prophylaxis. In your own practice consider no moisture under the foam as this will aid autolytic debridement & sometimes if pressure removed a DTPI resolves. Iodine applied to dorsal heads of toes 5 on R foot and 1 on L 5th toe for intact necrotic eschar. Heel boots also applied for offloading. ok

68y/o DTPI eval to L sacral area. Superficial open friction wound noted. Xeroform dressing applied and secured with foam secondary dsg. Xeroform redundant Large foam dressing also applied to bony prominence L3 to L5 for prophylaxis of pressure. Pt discharging today.

82y/o male post spinal surgery and sheaer injuries noted bilat from c-collar. Superficial wounds cleansed with wound wash and foam dressing applied. Pillows to offload heels applied. Blanchable erythematous intact skin noted at coccyx and foam dsg applied for PI stage 1. ok

L lower shin with superficial possible sheaer/friction wound. **Eto unk.**?? Wound cleansed with wound wash and xeroform dsg applied and secured with secondary kling gauze and secured with paper tape to gauze.

88y/o male L hip closed fracture with surgery this am. Post operative silver dressing clean and intact, secured with film secondary dsg in place. L elbow with superficial small open wound possible friction/sheer injury and L dorsal hand with skin tear type 2. Wound cleansed with wound wash and xeroform dsg applied and secured with secondary kling gauze dsg and secured with paper tape to gauze. Tubigrip stockings reapplied from toe web to just below popliteal spaces for 10mmHg for light compression.

Per preceptor, due to the acuity of all of the inpatient patient's health conditions, only light compression of 10mmHg is applied in this facility to avoid taxing of CV or Pulmonary status.

Case Study:

Age/sex: 76 year old male

PMH: As reported in chart:
Chest pains
Compression fracture L-7
Constipation
T2DM
Insomnia
Low back pain
Nicotine use disorder

Unspecified non-displaced fracture of sixth cervical vertebra
PVD

PSH: As reported in chart:
Cholecystectomy
Tonsillectomy
2/27/25 PICC line insertion

CC: R heel diabetic ulcer infection S/P surgical debridement 2/26/25 with NPWT.

Medications:
Melatonin 6mg PO qHS
Polyethylene glycol 17-gram packet PO mixed in fluid of choice daily
Ampicillin-sulbactam 3 Grams IV piggyback in NaCL 0.9% 100mL IV Q 6 hours
Insulin lispro subcutaneous with meals and HS per sliding scale
Dextrose 15 gram/32 mL give 15 grams oral PRN
Daptomycin 500 mg in NaCL 0.9% 50 mL Q 24 hour
Haloperidol lactate 2 mg IM Q6 hours PRN
Acetaminophen 650 mg PO Q4 hours PRN
Morphine 2 mg IV Q3 hours PRN injection
Dextrose 5% in NaCL 0.9% 75mL/hr IV continuous
Social History: Nicotine use disorder history per chart

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2
Activity	1
Mobility	1
Nutrition	2
Friction/Shear	1
Total	9

Plan: Continue to provide wound care, treat infection, and further stabilize patient on medical-surgical unit with wound care in goal to discharge back to his residential facility.

Assessment/encounter:
LOC: Conscious but non-alert male in bed with NPWT on and draining sero-sanguinous drainage. No scratch hand mittens in place.

Wound Assessment:
Location: R heel
Wound type: DFU
Extent~~tsive~~ of tissue loss: Wagner Grade 3- healing

Size and shape: 3.2cm x 3.6cm x 1.3 cm Round
Wound bed tissue: Red granular tissue 70% Pink 30%
Exudate amount, odor, consistency: Scant sanguinous without odor
Undermining/tunneling none
Edges: flush with skin surface
Peri-wound skin: intact and pink in color

Location: Sacrum
Wound type: Unstageable pressure injury
Size and shape: 6.2cm x 4.7cm Irregular
Wound bed tissue: Black 20% Red granular 40% Pink 40%
Exudate amount, odor, consistency: None
Undermining/tunneling: - unstageable
Edges: flush with skin surface
Peri-wound skin: Pink, blanchable, warm, and dry

Pain: Pain unable to be assessed

Chart note:

76-year-old male nonverbal and confused consider describing behavior vs. just making a statement as the description is more helpful to our colleagues lying in hospital bed this am with no scratch mitts on hands. He initially presented to hospital for readmission of chief complaint right heel diabetic ulceration with new onset of increased exudate of the wound with purulent discharge per his residential care facility. He was admitted to inpatient medical-surgical unit on 3/22/25 with R heel diabetic ulcer debridement performed for osteomyelitis. Last hospitalization 2/26/25 for right heel debridement. At that time, patient was discharged after hospitalization to LTC facility with NPWT.

Wounds assessed and dressings changed. R heel DFU, Wagner Grade 3 is healing with beefy red granular tissue present. Clean, round wound bed measuring 3.2cm x 3.6cm x 1.3 cm. Scant sanguinous exudate amount without odor noted No undermining or tunneling noted. Wound edges are flush with skin surface and peri-wound skin is intact supple, dry, and pink in color. Sacrum with irregular unstageable pressure injury measuring 6.2cm x 4.7cm. Wound bed tissue with 20% eschar, 40% red granular tissue and 40% pink granular tissue noted with no exudate or odor noted. Wound edges flush with skin surface and peri-wound skin pink, blanchable, supple, warm, and dry. One thing to keep in mind about ‘beefy’ red tissue. IF the tissue is friable & bleeds easily this is usually indicative of bioburden. In those cases, some debridement & antimicrobial dressings can be very effective. Under NPWT one of the antimicrobial dressings that allows the transfer of exudate can be beneficial. One example is Acticoat Flex.

Pain: Pain unable to be assessed don't forget that we can get some indication of pain if pt grimaces or pulls away quickly when we are doing the wound care

Chart reviewed with pertinent medical history includes:

2/20/25 US Arterial PVR lower extremities obtained and reason for procedure stated PVD.
Impression: Resting right ankle brachial index 1.89.
Right toe brachial index 1.12.
Non-compressible vessels.
Resting left ankle brachial index 2.42.

Left toe brachial index 1.22.

Non-compressible vessels.
Hooray that TBIs were done!
MRI 2/22/25 impression: cutaneous ulcer at the right posterior heel with mild underlining calcaneal osteomyelitis.

Surgical report from 2/26/25 for osteomyelitis and R heel debridement. Post operative diagnosis confirmed of heal ulcer right foot with underlying osteomyelitis. Post operative wound measurements 4.5 X 3.5 x2 cm.

WOC Plan of Care:

NPWT order: Cleanse wound with wound wash and gauze prior to NPWT application. Apply skin prep to peri wound skin. Apply transparent film dressing to peri-wound skin in windowpane fashion to protect peri-wound skin. Apply black foam that has been cut to shape/size of wound to the wound bed. Secure with transparent film dressing. NPWT dressing change 3 times a week. Setting 125mmHg continuous section. Roxanne, for your own practice you may or may not use the drape on the periwound area. I have many colleagues that do not do this (but they do skin prep) as they learned NPWT before this was taught! The thought among those that do not do this is two fold…you have to use more product & there were probably instances where the dressing was not applied well & the peri-wound skin became macerated. BUT, if you are careful w the foam & it is not on the skin, you skin prep, & you have drape on at least one inch of good skin, this extra step is usually not necessary.

Also, glad to see these orders are 3X/wk as that is the IFU

Change canister once a week and PRN when full. If NPWT wound vac malfunctions and bedside RN unable to correct, call wound care center. If still unable to correct and wound vac is malfunctioning or off for two hours, bedside RN must remove wound vac, dressing and foam.
Apply normal saline wet to dry dressing BID. In your own practice consider saying a moist

saline dressing or better yet applying amorphous gel to the wound surface & filling dead space w opened, fluffed, moist saline gauze! -Call physician and wound care to notify. Upon discharge, if patient is going home, connect wound vac dressing to home wound vac. If patient is going to skilled nursing facility, remove wound vac dressing and apply NS wet to dry dressing. Same here

I have put some references at end re why no wet to dry as well as a link for the VAC IFU that I can find although they are not 2025.

Coccyx dressing order: Cleanse wound with each dressing change. Apply mesalt dressing to coccyx wound and secure with Allevyn silicone foam dressing daily to the coccyx and prn if soiled or dislodged. Changing Allevyn daily is very expensive so consider another secondary dressing & writing order for no back lying except at meals.

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

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

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

I have no suggestions for what could have been done differently and agree with current management and treatment plans of the case study patient. This was truly the first from start to finish NPWT I had witnessed and assisted with and why I chose this case. Unfortunately, our patient is confused and non-verbal, so no patient teaching took place with this mini-case patient encounter. His sister consented for his treatment after the surgeon had provided education on risk versus benefits of the debridement and further treatment. If his sister had been visiting, that would have been an opportunity for family education concentrating on wound care and NPWT use and benefits.
Overall, there is much less knowledge of the inpatient's nutritional intake and hydration status for optimal healing. Two patients were able to tell me if they had eaten and taking PO fluids. We the students do not have access to the EMR to assess CNA flowcharts for diet and I&Os. We were in and out without seeing many or any CNAs at times to have verbal report for assessment of nutritional intake. Preceptor stated she wishes we had EMR read only ~~assess~~access. I will know how to access this in the future for "what would you have done differently" in effort to ensure adequate intake for optimal healing.

What was your goal for the day?

I had requested more orientation with products. I also have had no prior NPWT experience and was able to assist in the application of the dressing and to have hands on experience with one NPWT device. I also learned a few very valuable tips for NPWT use so goals met for the day.

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

To learn standard of care with how often the follow up patients are seen depending on admission status. More product learning and use.

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	

Patricia A. Slachta 4/2/25

3M. (2021). *3M V.A.C.® therapy: Clinical guidelines.* https://multimedia.3m.com/mws/media/2028885O/3m-v-a-c-therapy-clinical-guidelines-clinicians-reference-source.pdf (as of June 2024, per sales person, 2021 is the most recent booklet 3M says they have; see page 23 for changing dressings) which say "Wounds being treated with the 3M™ V.A.C.®, Therapy System should be monitored on a regular basis. In a monitored, non-infected wound, 3M™ V.A.C.® Dressings should be changed every 48-72 hours but not less than three times per week, with frequency adjusted by the healthcare practitioner as appropriate."

Consequently, a planned twice a week dressing change does not follow the instructions for use. This would be a great research project though & 3M might be interested in it (although it does mean using less of their supplies)!

Kim, P. J., Attinger, C. E., Constantine, T., Crist, B. D., Faust, E., Hirche, C. R., Lavery, L., Messina, V. J., Ohura, N., Punch, L. J., Wirth, G. A., Younis, I., & Téot, L. (2020). Negative pressure wound therapy with instillation: International consensus guidelines update. *International Wound Journal, 17*, 174-186. https://doi.org/10.1111/iwj.13254

Netsch, D. S., & Nix, D. P. (2024). Negative pressure wound therapy. In R. A. Bryant & D. P. Nix (Eds.), *Acute & chronic wounds: Intraprofessionals from novice to expert* (6th ed., pp. 488-500). Elsevier.

Rossato, M., Ryrie, M., Robinson, M., Searle, R., & Murdoch, J. (2021). Use of NPWT as part of a Hospital @ Home wound management service. *Journal of Community Nursing, 35*(4), 50–57.

Strugala, V., & Leaper, D. J. (2018). The benefit of PICO™ single use NPWT system to reduce surgical site complications: Summary of a meta-analysis with implications for clinical practice. *Wounds International, 9*(4), 28-33.

Webber, L., Cornish, W., Cummins, A., & Henshaw, F. R. (2022). Portable negative pressure wound therapy (NPWT) is an effective therapy for hard-to-heal-wounds in the community: A case series. *Wound Practice & Research, 30*(2), 108–111. https://doi.org/10.33235/wpr.30.2.108-111

In wounds, use gauze that you have **moistened**, **opened and fluffed**, to fill dead space. Great to do in wounds where there is amorphous hydrogel or honey over the wound surface, but the wound is deep and needs dead space filled.

If a large wound is profusely draining, consider an alginate in the base, & **filling the dead space w fluffed, opened, dry gauze.** (Using package after package of alginate is not in the least cost-effective)! The secondary dressing can be an ABD if you want the dressing changed daily (foam is an expensive daily dressing but that does not mean it cannot be used).

Another point about gauze…use rolls such as Kerlix gauze if there is a large area to be lightly filled as it comes out in one piece and a random piece of gauze is not left behind.

If there is an article you cannot find, check the resource area but if not there contact me!

Alterescu, V. (1983). Toward a physiologic approach to the topical treatment of opened wounds. *Journal of Enterostomal Therapy, (10)*3, 101-107.

Dale, B. A., & Wright, H. D. (2011). Say goodbye to wet-to-dry wound care dressings. Changing the culture of wound care management within your agency. *Home Healthcare Nurse, 29*(7), 429-440. https://doi.org/10.1097/NHH.0b013e31821b726e

Ermer-Seltun, J. M., & Rolstad, B. S. (2022). General principals of topical therapy. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 136-156). Wolters Kluwer. Check out page 149 for wet to dry.

Ovington L. G. (2001). Hanging wet-to-dry dressings out to dry. *Home Healthcare Nurse*, *19*(8), 477–484. https://doi.org/10.1097/00004045-200108000-00007

Ramundo, J. (2022). Principles and guidelines for wound debridement. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 172-186). Wolters Kluwer. Check out page 180 for wet to dry.

Ovington, L. G. (2002). Hanging wet-to-dry dressings out to dry. *Advances in Skin & Wound Care, 15*(2), 79-84.