

**Daily Journal Entry with Plan of Care & Chart Note**Student Name: **Jason Gray** Day/Date: **Friday 7/18/2025**Number of Clinical Hours Today: **8**Care Setting: **Hospital X** Ambulatory Care  Home Care  Other Preceptor: **Jennifer Mullins**Clinical Focus: **Wound X** Ostomy  Continence **Reflection: Describe your patient encounters & types of patients seen.**

I rounded with Jennifer Mullins, CWON and Lisa Pirro, APRN

We saw 8 patients today, 6 of which were new consults. Types of wounds included: post-surgical, pressure injuries (stage 2, stage 3, unstageable, and deep tissue injury), and lower extremity arterial disease-related ulcer.

As you mentioned in my previous entry for 7/17/2025, the dressing choices and care received were not my choice but what was done. Example: Mesalt on wounds that had no to light exudate which would promote wound desiccation. This care was directed by the CC rounding team.

When I asked questions about treatment decisions, the answer was that many choices made in the acute side of care differ from home care simply by the nature of the milieu. This is not meant to be criticism of the care team in Akron, to be clear. However, there are things that I witnessed that did not make much sense to me. There was generally a lack of education with patients and families, they had about six dressing choices we used on every patient, they were still ordering and verbally referring to wet-to-dry dressings and had to soak gauze out of wounds, the real-life documentation for care does not comport with the expectations for this assignment, and there was a focus on me documenting pictures in Epic when that time could have been better spent in specific wound care activities. I do not use Epic on the home care side and learning that technology had very little benefit to my progress as a wound care provider.

**Chart note:****Focused History**

- 58-year-old male with I&D of left lower extremity medial thigh wound.

**Chief Complaint**

- Left lower extremity wounds (see below).

**History of Present Illness**

- Mr. Carpenter underwent angiogram and revascularization on 5/14/2024 with a femoral-popliteal bypass graft. Additionally, patient underwent a left fifth toe amputation on 5/24/2025. Patient reports being a former smoker with a 47.4 pack year history having quit May 2025. Patient presented to the emergency department on 7/15/2025 with a chief complaint of left lower extremity redness, swelling, and drainage starting one week prior. Patient was receiving wound care for his left lower extremity calf wound in outpatient clinic when redness and swelling was noticed by Dr Masterson. Patient was encouraged to be evaluated at that time which

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is when he presented to the emergency department. Patient reported fever and chills on arrival. X-ray demonstrated nonspecific soft tissue swelling and the patient had incision and drainage of his left lower extremity thigh wound. Though distant from his Fem-Pop Bypass, this was attributed to the surgery in clinical documentation from all sources. Of note, the patient was receiving negative pressure wound therapy for his left lower extremity lateral calf wound and was able to change his dressing independently at home.

**Primary Medical History:**

- Hyperlipidemia
- Hypertension
- Peripheral arterial disease
- Nicotine dependence
- History of CVA

**Evaluations:**

## Lab Work-Up:

- Sodium = 135
- Potassium = 2.9
- Creatinine = 1.49
- Serum glucose = 114
- hemoglobin = 11.6
- hematocrit = 35.9
- Otherwise, within normal limits.

## Medications:

- vancomycin IV – dose per pharmacy protocol for wound infection
- piperacillin-tazobactam IV 3.375 grams IV Q 6 hour for wound infection
- morphine 2 milligram IV Q4 PRN (per order) for pain
- oxycodone IR 5-10 milligram PO Q 4 hour PRN (per order) for pain
- apixaban 5 milligram tablet PO BID for PAD/LEAD
- aspirin 81 milligram tab PO Q day for PAD/LEAD

## Physical Assessment:

- General: alert and oriented, no apparent distress, pleasant, and cooperative
- Respiratory: even excursion, unlabored
- Cardiovascular: bilateral dorsal pedal pulses and posterior tibial pulses palpable
- Extremities: heels intact and firm
- Integumentary: coccyx intact. Wounds (see below)
  - Left Lower Extremity Medial Thigh - Surgical Wound (related to LEAD)
    - L 8 x W 2.2 x D 3.2 cm + Undermining 7:00 to 11:00 D 3.5 cm (Surface Area = 17.6 cm<sup>2</sup>) (Volume = 56.3 cm<sup>3</sup>)
    - Scaphoid shape, wound base 65% yellow adherent slough, induration extending >4 cm around wound, serosanguinous exudate saturated to outside of ABD, no odor
  - Left Lower Extremity Lateral Calf – Surgical Wound (related to LEAD)
    - L 8.4 x W 2.4 x D 0.2 cm (Surface Area = 20.2 cm<sup>2</sup>) (Volume = 4.0 cm<sup>3</sup>)
    - Scaphoid shape, wound base pink to red with approximately 30% granulation tissue, <25% epithelization, light exudate, no edema, no induration

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**Interventions (this is what was done)**

- Lower Extremity Medial Thigh Wound:
  - Removed gauze packing
  - Cleaned with normal saline
  - Primary Dressing – Filled the wound with antibiotic-impregnated foam (Hydrofera Blue Traditional - cut into rope)
  - Secondary Dressing - Covered with ABD
  - Secured with gauze roll and paper tape
    - Patient tolerated this poorly due to 10/10 pain
- Lower Extremity Lateral Calf Wound:
  - Removed gauze dressing
  - Cleaned with no-rinse wound cleanser (Sea Clens), can substitute with any no-rinse wound cleanser like Medline Skintegrity or Dermarite Clean and Free
  - Primary Dressing - Covered with impregnated gauze (Xeroform)
  - Secondary Dressing – Covered with gauze 4x4
  - Secured with gauze roll and paper tape
    - Patient tolerated this well with no complaints of pain

**Interactions**

- Review of Systems:
  - Pain 0/10 at rest; Pain 10/10 with wound care (see note above regarding wet-to-dry). Denies shortness of breath, chest pain, nausea, vomiting, and fevers
    - In my opinion, we should have stopped what we were doing to have the patient medicated for better tolerance to treatment. The patient asked for this during treatment, as well, but we continued.
    - The only ROS and History questions asked throughout the week to each patient were: Do you have chest pain, shortness of breath, nausea, vomiting, or fevers?
      - An example of this was when we discovered the patient was drinking Juven, he volunteered the information to query if he could stop due to taste.
- Patient quizzed about how he managed NPWT at home for lower extremity lateral calf wound. Patient reported that he managed his own NPWT with no Home Health support – per patient this was ordered but they never arranged for visits to assist with therapy or assess his wound. He did not get supplies delivered in a timely fashion and his NPWT dressing was not changed until his first outpatient wound clinic visit, which was seven days after placement. Of note: this was a peel-and-place dressing and these can stay in place for up to seven days.
  - In my opinion, this should have been escalated to Care Coordination or Case Management to ensure the patient had the support needed for wound healing in his home setting
  - New wound (medial thigh) covered in slough (approximately 65% - see assessment above) and not ready for NPWT until infection and slough better managed.
    - As reported to patient, the CC policy is less than 25% of wound bed covered in slough to qualify for NPWT.
    - I queried rounding staff about instillation capability of NPWT to encourage debridement but was told this was impossible/impractical in the acute setting. We cannot do this on the home care side. If we can't utilize this therapy in either setting, this seems like a redundant feature of NPWT.
- Patient was instructed to cut Hydrofera Blue Traditional in its dry state into a rope shape, then hydrate it, then fill the wound.

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- What was demonstrated to the patient was hydrating the product, then cutting foam in a spiral shape, then filling the wound, then trying to hold it in shape in the wound bed prior to placing an ABD pad onto it to contain the Hydrofera Blue.
- My concerns with this approach:
  - The rounding team decided to use this to promote autolytic debridement, but this approach did not promote a good interface with the wound bed. I have seen Hydrofera Blue ordered in conjunction with other products to fill the wound like alginates. Additionally, there is a bordered version of Hydrofera Blue, which would have been less helpful as it would have had no contact with the deeper wound bed (see assessment for medial thigh wound above).
  - This was then covered with an ABD pad which would absorb the exudate (see assessment above of large amounts of exudate saturating to the outside of the ABD pad). My concern was that all of the exudate was being absorbed away from the wound, which would not support autolytic debridement.
    - When I asked about using a skin barrier (like Cavalon), filling the wound with a silver alginate, and then covering the wound with a bordered silicone foam to contain exudate, I was told that silver alginate would obscure the wound bed for future assessments while inpatient due to residue and this approach would not work in the acute setting.

**Identify any specific products used or recommended for use (this is what was used and some of my thoughts on alternatives):**

- Gauze roll (Kerlex) – this patient was very mobile and up ad lib. This could have been replaced with a stretch gauze like Dynarex Conforming Stretch Gauze or Lotfancy Conforming Stretch Gauze, which may have stayed in place better for a mobile patient. Additionally, a more affordable choice could have simply been a conforming elastic bandage (Ace Bandage)
- Paper tape – could be replaced with another type of tape, like easy tear plastic tape (Transpore) or fabric tape (Medipore), as its sole purpose was to secure the gauze roll (Kerlex). This step could have been replaced entirely if Ace Bandage was used to secure the primary and secondary dressings.
- Impregnated gauze (Xeroform) – this could have been replaced with NPWT, which the patient was already applying in his home setting (see above assessment for lateral calf wound, specifically granulation tissue, epithelial tissue, and lack of evidence of infection). If this was not deemed appropriate in the acute setting, it could have been replaced with a skin barrier (Cavalon or Mastasol) with a hydrocolloid pad, which is consistent for a wound with light to moderate exudate.
- Foam dressing (Hydrofera Blue Traditional) – the medial calf wound was 3.2 cm deep (see assessment for medial thigh wound above). Traditional Hydrofera Blue could have been cut and placed to conform to the sloughy tissue with an alginate product filling the wound and then covered with a bordered foam dressing to contain exudate and promote autolytic debridement.
- Normal saline – could be replaced with an anti-microbial cleanser like hydrochlorite (Dakins 0.025% solution) or hydrochlorous acid (Vasche)
- No-rinse wound cleanser (Sea Clens) – could be replaced with any brand of no-rinse wound cleanser that isn't going to be discontinued by the manufacturer like Medline Skintegrity or Dermarite Clean and Free

**Braden Risk Assessment Tool**

Sensory Perception	4
Moisture	4
Activity	4
Mobility	4

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Nutrition	3
Friction/Shear	3
Total	22

**WOC Plan of Care (include specific products)**
**Pain Management:**

- Apply topical lidocaine (gel product like GelCaine Sterile or spray product like Salonpas) may substitute for topical lidocaine on hospital formulary
- Pre-medicate with oxycodone IR 5 – 10 mg tablet per order 45 – 60 minutes prior to wound care
- Pre-medicate with morphine 2 mg IV per order on arrival if unable to pre-medicate with PO medication

**Wound Specific: (this is my assessment of what could have been done)**

- Lower Extremity Medial Thigh Wound (following a similar path as what was chosen by the inpatient wound care provider):
  - Pre-medicate patient for wound care as described above
  - Undress wound daily
  - Clean periwound and wound bed with hypochlorite solution (Dakin's 0.025% Solution) as a less expensive choice or alternatively hypochlorous acid (Vasche) if expense and availability are not as great a consideration
    - In addition, we could have provided selective sharp debridement with a curette to remove yellow, loosely adherent slough.
  - Apply skin barrier (Cavalon No-Sting or Mastasol) to periwound – would recommend Cavalon No-Sting due to patient discomfort
  - Primary Dressing – Silver alginate (Aquacel Ag or Mepilex Ag) – to fill wound bed (rope products might work better to fill the wound bed in this case, though pad products would likely be effective)
  - Secondary Dressing – Silicone bordered foam (like Mepilex or Comfortfoam – which is consistent for use with wounds with moderate to large exudate) to contain exudate and promote autolytic debridement
  - Gauze roll (Kerlex) to hold primary and secondary dressings in place or alternatively a conforming stretch product like Ace Bandage, Dynarex Conforming Stretch Gauze, or Lotfancy Conforming Stretch Gauze
  - Tape (paper tape, plastic tape, or fabric tape) applied to roll product to secure if self-closure/Velcro not a component of manufactured product
- Lower Extremity Medial Thigh Wound (the path that I prefer):
  - Undress wound and provide the following care daily:
    - Clean periwound and wound bed with hypochlorite (Dakin's 0.025% Solution) as a less expensive choice or alternatively hypochlorous acid (Vasche) if expense and availability are not as great a consideration
    - Apply collagenase (Santyl) in a nickel-thick layer to slough on wound bed to promote enzymatic debridement
      - Of note: collagenase (Santyl) are not on formulary at the Cleveland Clinic. We attended an in-service during this week by the collagenase (Santyl) sales person to brainstorm ways we could work around this limitation, including collaborating with patients' outpatient care team to order this medication, have a family member or other

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person involved in patients' care pick it up at outpatient pharmacy and then deliver it to the hospital, and then go through the procedures through inpatient pharmacy to approve it for inpatient use. We did not discuss what that process is at Cleveland Clinic, so I have limited visibility into this as a potential solution.

- Fill wound bed with calcium alginate product.
  - All calcium alginate products appear to be compatible with collagenase (Santyl) based on the compatibility chart on the collagenase (Santyl) website (Smith + Nephew, 2025).
- Apply silicone bordered foam (Mepilex or Comfortfoam or alternatively Allevyn, which is widely used at Cleveland Clinic – Akron General)
- Secure dressing with conforming stretch bandage (Ace Bandage)
- Lower extremity lateral calf wound:
  - Undress wound and provide the following care every three days:
    - Clean periwound and wound bed with no-rinse wound cleanser like Medline Skintegry or Dermarite Clean and Free.
    - Primary Dressing – Hydrocolloid pad (DynaDerm) to maintain wound moisture, which is consistent for a wound with light to moderate drainage/exudate
      - Consider collagen pad like if wound stalls (<8-12% closure) in two weeks
    - Secure dressing with conforming stretch bandage (Ace Bandage)

**Nutrition:**

- Continue Juven supplement PO BID

**Support Surface/Mobility:**

- Patient up ad lib

**Referrals:**

- **Case Management/Care Coordination** to assess discharge planning and provide support to patient for transition to home care
- **Registered Dietician** to assess nutritional status and make recommendations to support wound healing

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

This visit could have focused more on comfort. Perhaps it is my hospice background, but the patient was immensely uncomfortable as soon as we started removing Wet-to-Dry gauze; it was indeed very dry. We could have instilled saline and let it soak while we were waiting for pain medications, even if that meant returning to provide care.

NPWT on lateral calf wound worked well (see above assessment for lateral calf wound). The depth of the wound, presence of approximately 30% granulation tissue, and <25% epithelial tissue suggested to me that we could discontinue NPWT and transition to other care. This was never discussed with either the patient or internally with the rounding wound care staff. This wound was now shallow (0.2 cm depth) and with light drainage. The focus instead was on restarting NPWT after discharge, which begged the question for me about why we would delay or withhold a beneficial treatment while inpatient.

Please see above for my thoughts on treatments and alternatives.

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**Goals**
**What was your goal for the day?**

- I would like to discuss testing strategies that worked for the WOC Nurses in preparation for certification.

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

- NA – returning home
- Possibly working on other practicum coursework at the airport while waiting to board, etc.
  - Probably won't happen because I hate traveling and get nervous I will miss my flight (last minute gate changes, etc.)

## References

Smith + Nephew. (2025). *SANTYL® Ointment compatibility*. What is collagenase Santyl ointment?  
<https://santyl.com/hcp/compatibility>

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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	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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