Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Chart Note & Plan of Care

Student Name: **Kyle Aniol** Day/Date: **Thursday, September 24th**

Number of Clinical Hours Today: **8** Number of patients seen: **5**

Care Setting: **Hospital**

Preceptor: **Colleen Baisden**

Clinical Focus: **Wound**

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters, types of patients seen, and any additional activities.

My clinical rotation today included hospital consults and an educational video on the Scout thermal imaging. The thermal imaging is used on patients considered high risk for acquiring pressure injuries. Changes in skin temperature can indicate a pressure injury up to three days before it will have visible signs. As for the patients seen, I saw 5 wound related consults. Patient A was a 56 y/o male being seen in the Surgical Intensive Care Unit. He had an unstageable wound to his left ischium, a stage 4 pressure injury to the coccyx, and incontinence-associated dermatitis in the perineum. Patient B was a 60 y/o female that had a follow up after a recent wound dehiscence of her abdominal incision. She also had an unstageable pressure injury to her mid spine. Patient C was a 72 y/o male that had a fall and was found down after an unknown amount of time. He recently had the thermal images taken in the emergency department and we were seeing him in the Cardiovascular Intensive Care Unit. He had an old neck abscess that was partially open and scabbed; this was characterized as an atypical wound. He also had an unstageable to the right elbow and a stage 2 to the coccyx. Patient D was a 40 y/o male being seen for routine care of his multiple wounds. This patient has a stage 4 pressure injury to the coccyx, a device associated pressure injury to the philtrum, and a mucosal injury of the rectum related to a recent fecal management system. Patient E was 35 y/o male being seen for routine care of his soft tissue necrotizing fasciitis of all 10 fingers, bilateral feet, and both forearms were covered with a 2 cm thick layer of brown eschar. The care for this patient took my preceptor and I working together over an hour.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	1
Total	11

Age/Sex: 35 y/o male
PMH: Patient has a history of Acute Lymphoblastic Leukemia, Graft Versus Host Disease, and Hypertension.
CC: Acute Hypoxic Respiratory Failure
Social, Family, Surgical Hx: There was no past surgical or social history on file. Family history is negative for any hereditary disease.
Medications: Pantoprazole 20 mg (Daily), Sertraline 200 mg (Daily), Aspirin 81 mg (Daily), Thiamine 100 mg (Daily), Cholecalciferol 1000 units (Daily), Sulfamethoxazole-Trimethoprim 160 mcg (M-W-F), Insulin Lispro (Q6), Buspirone (TID), Vancomycin 125 mg (BID), Gabapentin 100 mg (TID), Atorvastatin 10 mg (Nightly), Prednisone 5 mg (Daily)
Assessment/Encounter: The patient is A&Ox3, in no acute distress, able to communicate via picture/letter board, max assist for turns in bed, incontinent of stool, and anuric. There are multiple scabs to bilateral knees and necrosis affects bilateral, bilateral forearms, left shin, and all 10 fingers (hands are unaffected). The knee wounds are pink and red with intact scabs. The left foot is necrotic up to the ankle, with the right foot necrosis extending above the ankle. Eschar is thin, dry, and black with minimal sanguineous drainage. The left shin is covered with a thick, brown eschar. Bilateral forearms are also covered with a thick layer of black, brown eschar. All 10 fingers appear shriveled and black. Necrosis affects entirety of 8 digits. Both thumbs are affected only at the tip.

The patient was being seen for routine care of soft tissue necrosis to multiple areas along with bilateral knee wounds. The knee wounds were cleansed with normal saline and left open to air. Both feet were cleansed with normal saline and then “painted” with Betadine. A heel pad was made with an ABD and wrapped around the foot with Kerlix. The left shin and bilateral forearms with cleansed with a Vashe soak and then Betadine was applied. A silver impregnated contact layer was placed over all areas of eschar and then wrapped with Kerlix. The fingers were gently cleaned with normal saline and Betadine was applied; left open to air.

Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Using the information from the chart note, 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.

WOC Plan of Care (include specific products)

Bilateral Arms & Left Shin- remove old dressing gently using normal saline. Apply Vashe soaked gauze to the wounds and let sit for 5-10 minutes. Remove and dry area. Paint the wounds with Betadine and cover with a silver (Ag) contact layer. Place an ABD pad over entire area and wrap with Kerlix. Change daily and as needed.
Bilateral Feet- remove dressing and clean with normal saline. Paint the whole foot with Betadine and place a contact layer on the heel. Use an ABD to pad the heel and wrap the whole foot in Kerlix. Change daily and as needed.
Bilateral Hands- gently cleanse the fingers with normal saline and dry. Paint each finger with Betadine, do not cover with a dressing, and keep the area dry. Do this daily.
Bilateral Knees- cleanse the wound and then dry. Apply Sween cream. Do this BID and as needed.

Preventative Measures
Maintain use of Tru-Vue heel protectors while in bed
Maintain turning Q2 hours to off-load weight from coccyx/ischium

Describe your thoughts related to the care provided. What would <u>you</u> have done differently

I thought the care provided was excellent. My preceptor talked through every step of the dressing changes for the patient and his mother, and also gave them realistic expectations of what to expect moving forward with the wounds. If I had to do anything differently, it would have been more preparation of supplies before staring the wound care. The dressings changes are painful and lengthy for the patient, any consideration that can be made to shorten the hands on time should be taken.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?
My goal for today was to work with a patient that had a wound I had not seen before. This goal was met as. I saw a patient with extensive soft tissue necrosis. I have seen this in isolated spots such as the heel, but I had not seen anything to this extent. It was a great learning experience.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
This was my final clinical day.

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **<u>48 hours</u>** following the clinical experience day.

Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

For instructor use only. Do <u>not</u> remove or edit:

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: _____

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **<u>48 hours</u>** following the clinical experience day.