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: Tuesday, September 23rd

Number of Clinical Hours Today: **8** Number of patients seen: **6**

Care Setting: **In-Patient Wound**

Preceptor: **Colleen Baisden**

Clinical Focus: **Wound Care**

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

Today was spent rounding the hospital for patients with wound related consults. Patient A was a 76 y/o male with a chronic venous ulcer on the left shin and left foot. This was new patient being seen for initial wound care and orders for nursing staff. Patient B was a 74 y/o male with a wound on the left flank. The patient had a surgical procedure that resulted in a hematoma in his armpit; thoracic surgery removed the hematoma leaving an open wound. The wound care team is performing care every couple days to monitor progression and change orders as needed. Patient C was a 81 y/o female with an unstageable pressure injury to the left heel. The wound is a round PI on the back of the heel covered in black eschar. Patient D was a 77 y/o female with a new wound to the RUE. Nursing staff had noted it may have been IV infiltration but it presents as a skin tear. The initial dressing change was performed and updated wound care orders were placed. Patient E was a 66 y/o female with a stage 4 pressure injury to the coccyx and a wound under the right breast. Both dressings were changed, and positive improvement was noted for both wounds. Patient F was a 78 y/o male with an unstageable pressure injury to the sacrum. Preventative measures were discussed with nursing staff and orders to turn patient and float heels were added to the chart.

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 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.

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Chart Review, Assessment, Encounter

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	3
Nutrition	2
Friction/Shear	2
Total	16

Age/Sex: 74 y/o male
PMH: Patient is type 2 diabetic managed with insulin, history of renal calculus, GERD, osteoarthritis, gout, neuropathy, atrial fibrillation, HTN, recurrent pneumothorax, spinal stenosis of lumbar region, sleep apnea on CPAP.
CC: Purpura and healing L flank wound
Social Hx: Former smoker 2 packs a day for 34 years (quit in 1995), consumes 3-4 alcoholic beverages (mixed drinks) per week, no illicit drug use
Family/Surgical Hx: Arthritis, ischemic heart disease, and prostate, uterine and ovarian cancer
Knee arthroscopy x4(1990), Cataract extraction bilateral (2018), Gastric bypass (2008), right hand cyst removal (1999), verticle sleeve gastrectomy (2014), Lumbar decompression laminectomy and fusion (2014).

Medications: Buspirone 10 mg (BID), Atorvastatin 10 mg (Nightly), Senna-Docusate 8.6-50 mg (BID), Insulin Lispro (w/ meals & HS), Pregabalin 75 g (BID), Famotidine 20 mg (Nightly), Prednisone 60 mg (Daily), Heparin infusion 25,000u (Continuous), Ipratropium-albuterol 3 mL (9 am & 9 pm), Torsemide 60 mg (Daily)

Assessment/Encounter: The patient is in no visible distress and is pleasant. Braden score is 18, requires no assistance to move in bed, 1 person assist to walk with a walker, and BLE edema is present. The patient is continent to both bowel and bladder. The wound is located below the left armpit. The skin around the wound is intact but tender on palpation. Adhesive removed easily with no skin breakdown present. The wound bed appears red and moist with yellow slough around the edges. Pt states that left flank pain has decreased and does not require pain medication for dressing changes. Wound measurements are the same as previous assessment, wound gel not required this dressing change as moisture is present. Improvements in undermining noted. Sutures were noted at 11 o'clock inside the wound, follow up with thoracic surgery recommended to remove sutures.
Length: 7 cm Width: 4.5 cm Depth: 3 cm
Undermining: 5.5 cm at 12 0'clock
Drainage: Moderate amount of serosanguineous exudate

The patient was seen for routine wound care for a healing wound below the left armpit. The wound has been present for 3 months and had negative pressure therapy initially. The old dressing was removed and the wound was cleaned with normal saline, the skin cleansed with soap and water. Saline soaked Kerlix was used to pack the wound and an ABD pad was placed over and taped with cloth tape.

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.

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WOC Plan of Care (include specific products)

Remove adhesive and old dressing
Use a saline flush to clean the wound (spray flush around all areas of wound and gently dry with gauze pad)
~~**Cleanse the skin around the wound with soap and water and allow time to dry**~~
Cleanse the skin with wound spray or NS and dry completely with gauze pad
Apply 3M Skin Barrier to peri wound skin and allow time to dry
~~**Soak Kerlix in normal saline (am) or Dakins solution (pm)**~~
~~**Pack lightly with soaked Kerlix to the level of the skin (use a cotton tip applicator to push Kerlix into undermined area)**~~
Pack the wound with Calcium Alginate sheets (Aquacell or Algisite), using a cotton tip applicator to pack sheets into undermined areas (do not moisten dressing prior to packing)
Place a contact layer over the wound
Placed an ABD pad flat onto the flank and tape on all sides with paper tape
If areas of skin are irritated, move the ABD slightly to avoid taping the same areas of skin
Dressing should be changed every night, or when the ABD pad is saturated
~~**Dressing should be changed BID (morning and evening)**~~
~~**Morning dressing change will use normal saline soaked Kerlix**~~
~~**Evening dressing change will use Dakins solution soaked Kerlix per thoracic surgery note**~~

~~**Elevate legs for 2 hours per day while sitting in the chair or bed**~~
Implement and maintain use compression stockings during the day when the patient is out of bed
Implement and maintain use of Sequential Compression Devices (SCD's) during the day when in bed
Use Interdry strips for abdominal and breast creases (change EOD or if moisture is present)
Maintain use of low air loss mattress
Encourage patient to turn Q2H during the day (Right, Left, Supine)
Implement use of foam dressings for any erythema or tenderness over bony prominences
Implement use of heel protector boots at night for any erythema or tenderness to heels

Describe your thoughts related to the care provided. What would you have done differently?
I would have talked to thoracic surgery to get their opinion on resuming negative pressure wound therapy for the patient discussed above. The patient will either be going home with care or to an acute rehab facility. The wound vac system is easier to manage than twice daily dressing changes. Also, the output of the wound has increased. More frequent dressing changes or negative pressure wound therapy could be indicated if the wound continues to increase drainage. Kyle, glad to see the depth was measured this time. However, I am not sure why you are not addressing several things….1. soap & water cleansing when rinsing is a challenge (why can't he wash it in the shower? 2. The use of wet gauze dressings that are still not evidence based! You are not using what you have learned. And again, you are not addressing the low Braden subscales in your what would you have done differently as it appears the wound nurse did not address this in her care.
The Braden subscale areas of moisture, mobility, and friction/shear need to interventions added to the plan of care. An alginate dressing is more appropriate for this wound than wet gauze dressings. The alginate sheets will absorb the moderate drainage and turn into a gel. They do not cause any trauma when removing, promote autolytic debridement, and maintain a healthy, moist wound bed.

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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 be proficient with any wound care supplies that were needed. This goal was met as I was able to identify the necessary materials and use them appropriately with minimal guidance.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My goal for tomorrow is to do a dressing change on an arterial ulcer or a wound with heavy exudate.

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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: <u>Patricia A. Slachta</u> Date: <u>10/9/25</u>

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