Wound Care

By

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When I arrived at the Wound care clinic, a patient who I'll call R, was being brought in to see how her pressure ulcer on the bottom of her foot was healing. R has neuropathy in both feet which I learned was why the wound went so long without being noticed. The nurses proceeded to take the dressing that was on off and inspect the wound. The used a ruler to measure the width and length of the wound and then used a cu-tip looking thing to measure the depth. The nurse then let me don gloves and proceed to poke R's bone with the stick.

After that I was then taking on rounds with Cindy. Her routine started out first in the office organizing the patients that she was to see that shift. Then she would go to the different floors to see new referrals to the wound care clinic or to check up to see if the recommendations she had made on a previous visit to a patient were improving the area that was affected. After seeing a patient, she would make notes on the computer as to what the general assessment was done. She would also make new recommendations if they were needed. After entering it in the computer she would have to rewrite it on a slip of paper and attach it to the outside of the patient's chart. She would do this each time she seen a patient for her shift.

With my special experience we went and saw a total of 10 different people on all the floors at mercy. The first lady had a reddened coccyx/buttocks area, and also had fragile dry skin. For this woman some things that were recommended were a lotion for her dry skin and also a pressure overlay. This wouldn't be as expensive as a pressure mattress but would work just as well. The second woman we saw has a right hip pressure ulcer. The nurse told me she had favored this side. When I walked into the room I discovered why someone would favor a right hip with a pressure ulcer on it. The woman had Cerebral Palsy and was all allergic to all anti-seizing medication so her muscles were contracted in a way that it made her put pressure on her right hip. This woman was recommended an ointment that she had used before and the family said had worked well. She was also on a pressure mattress to help with this contraction of her body. The third person we saw was a man with a left foot diabetic ulcer. Again

this is due to neuropathy and the patient having no feeling in their feet so they have no way of feeling pressure. This person was just having dressing changes. The fourth person we saw was a man that Cindy just had to check to make sure their ostomy bag was holding. She just had to check to make sure the patient had supplies in his room so that the nurse on the floor wouldn't have to go far if she needed to change the ostomy bag. The fifth person was a woman who was obese and therefore the skin folds of her groin and under her breasts had become excoriated. Cindy saw what she knew to be a fungus /rash starting to spread. For this Cindy made a recommendation to wash the affected area at each shift and to administer a nystop powder and also Interdry AG. She said that since this area doesn't see light and always that skin is not allowed to breathe it becomes moist with sweat and therefore fungus/rashes can begin to spread. The sixth and seventh patient was a male and a female both with ostomy bags that again just had to be checked to make sure they were holding nicely and also take note of what substance was in the bag if any. And also to make sure the patient had supplies in their room on hand. The eighth patient was a female who had a scab skin tear on her left shin. This was caused at home when her dog jumped up and caught her with one of its nails and tearing the fragile dry skin. This had started to heal already so Cindy just recommended an ointment to keep the area hydrated so it could heal properly. The ninth person I saw was a little old woman who had a right lower leg wound. This was also due to a problem caused at home. The woman actually had ointment that she had used before so she offered to bring supplies from home instead of getting new ones. And the last patient, number ten, which I saw was a female with, blisters on her buttocks. Cindy had already seen this patient and since the patient had immediate family in the room, and a nurse had just checked she continued with current treatment which was a decubitus would care ointment.

With the patients that I saw there wasn't much teaching going on because I only had 4 patients who were A & O X 3. There rest of the patients were patients who were unconscious or had a mental illness so they were not able to convey. And all four of the other patients could or would provide their

own care and do their own dressing changes. The role of the nurse in this setting was to catch pressure ulcers and to help deter the possibility of pressure ulcers forming. Nurses are in charge of caring for the overall well-being of skin integrity in patients that are at risk. Also the nurse is in charge of seeing if progress has been made with the patient that had recommendations made.

Overall I like this experience, however I enjoyed the OR experience more. Dealing with wounds up close and person made me a little sick but it was okay. And I know for a fact I would never want to work in the ICU/CCU. I just couldn't get past the fact that some of these people were unconscious and couldn't say anything. It was almost as if they weren't even in the room just like a body was lying in the bed. I felt horrible that I couldn't do anything for these people. Especially the lady who was allergic to almost all pain killers/narcotics and anti seizing medications, I could see the pain in her eyes and I felt helpless not being able to do anything. Overall though, I could see the benefits and the perks of the job but also the downfalls. I just don't think it's my area that I would want to get into.