Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Jill Jacobson, MSN, RN_____ Day/Date: _Monday, April 26, 2021

Directions: ***WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, s***elect one patient each clinical day and complete ***plan of care and chart note.***. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc** Pt is a 23 year-old man who is a paraplegic d/t gunshot wound about 5 years ago. He has a suprapubic urinary catheter and had a loop sigmoidostomy closure about 5 weeks ago. He presented to hospital with fever and tachycardia two days ago and subsequently was diagnosed with sepsis. He has multiple, chronic full thickness wounds on the bilateral ischia and left buttock as well as a stage 2 pressure injury to the scrotum. Either due to wound drainage or leakage at the suprapubic urinary stoma or combination thereof, pt has a high level of moisture to buttocks and periarea. Barriers to healing include limited mobility, current tobacco use, obesity, excessive moisture exposure, and sepsis. Only lab value that is more than slightly off is the WBC at 14.36k/uL which is commensurate with pt's sepsis status. ***Any significant PMH? If not, state such.***

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? Consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit.

Initial visit by WOC nurse for this hospital admit. Pt admitted two days ago (4/24/2021) for sepsis (with fever and tachycardia) and stage 4 decubitus ulcers. *As a WOC nurse, what is the acceptable terminology and what should you use?* Upon WOC RN arrival, pt is alert and watching TV in bed. He has a large area of drainage and/or urine on sheets and protective barrier (some of which was dried) under buttocks. *Could you observe this without repositioning the page? Statement reads as if you could.* With assistance from floor RNs, pt's bedding and underpad was changed. He is obese and paraplegic with limited mobility although he can assist with turns. Pt's bilateral ischia and left buttock show multiple irregular full thickness "Stage 4 healing" wounds apparently re-opened after being reported healed less than 2 months ago. *How do you know this? Did you remove the dressings? If so, state such as without doing so results in questioning the validity of your assessment. This, then, becomes a liability and practice issue.* Clustered wounds on the left buttock measure 13cm x 7cm x 0.3cm; on left ischium clustered 13cm x 11cm x 0.3cm; on right ischium single wound 3cm x 3.5cm x 0.3cm. The buttock and ischial wound bases are moist and red and pink with some non-slough yellow/pale tissue with serous drainage. Amount of drainage difficult to determine d/t probable concurring urine leakage from suprapubic catheter. Pt also has a smaller, Stage 2 pressure injury to his scrotum 1cm x 0.5cm x 0.2cm with a moist, red wound bed and none to scant serous drainage. His buttocks and periarea show multiple areas of scar tissue from previous full thickness wounds that have healed and matured. Wound care recommended and provided this visit: Bilateral ischia and left buttock: Remove old dressing, cleanse with NS and pat dry. Apply contact layer over wound beds, cover with ABD, and secure with silicone tape. Change dressing daily and PRN while

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hospitalized. Apply zinc-based barrier cream to scrotum and periarea BID. Consults for surgical wound and nutrition placed. Heel protectors, gliding repositioning system, and immersion surface bed ordered. Additional nursing orders placed: Turn pt q2h and moisturizing cream to bilateral feet BID. Wound Team to continue to follow patient in 10 days or sooner if there is a new wound consult for new or worsening skin alterations.

Did you apply the dressing or leave sites undressed? If you did not redress, who did or should? State this information in your note for accountability considerations and to decrease your liability.

You identify returning in 10 days. Might I suggest you do not specify specific dates are time frame as this could become a liability. What if there was an occurrence (too many pts, lack of staff, etc) which prohibited a visit on that specified day? The lack of follow through, then, can be and often is interpreted as negligence. That is, you failed to provide care as you stated. Instead, use general terms…will continue to follow, will follow at intervals, etc

WOC specific medical & nursing diagnosis	**WOC Plan of Care (include specific product used today)**	**Rationale *(Explain why an intervention is chosen; purpose)***
1. Excessive moisture that may lead to MASD and contribute toward formation of pressure injury.	1. Bedding changes daily and PRN ~~and~~ use the wicking Xtra-sorb underpad. 2. Address possible leaking urinary stoma site. (This will be addressed by the Ostomy team.) ***Be specific and address care. Ostomy team to address …..*** 3. Wash and dry abdomen, periarea and buttocks daily per standard method. Wounds washed every bandage change with normal saline and pat dry with clean gauze. ***Reads as what you did as opposed to being directive. Cleanse wounds with NS and pat dry.***	Overly moist skin leads to skin breakdown and contributes to infection. Washing and drying the skin daily, especially if actively draining or leakage, will help prevent infection and control odor.
2. Limited mobility due to partial paralysis and obesity that may contribute to pressure injury.	1. Using Comfort Glide Patient Repositioning System and Turning Wedge Oracle #1062865, turn/reposition patient every 2 hours to off-load coccyx/ ischia. 2. Place patient on Dolphin Immersion Surface bed for pressure redistribution. 3. Apply Tru-Vue heel protectors bilaterally while in bed to off-load heels.	The Comfort Glide system will help prevent skin tears as turning/positioning pt without system is very difficult. Immersion bed, heel protectors, and wedges used in conjunction with q2h turning will help prevent pressure injuries.
3. Multiple pressure injuries.	1. Ischia and left buttock wounds: Daily and as needed, remove old dressing, cleanse with normal saline and pat dry. Apply Urgotul Contact Layer over wound beds and cover with ABD pad with silicone tape to secure. Change Urgotul Contact layer at least every seven days or if dislodged or soiled. 2. Twice daily apply thin layer of Desitin 30% to perianal and posterior scrotum.	Affordable, effective bandaging during patient's hospital stay with frequent, at-least-daily bandage changes. Wound care orders will likely change to something that is more effective and changed less frequently as wounds become less exudative and/or when patient is discharged from hospital.

NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: **Chronic wounds with high bacterial loads, complicated by suprapubic catheter leakage and occasional diarrhea d/t recent loop sigmoidostomy closure.** **Insufficient caregiving: Substandard hygiene; Inappropriate repositioning/offloading techniques and tools/equipment.** ***I am uncertain about this information in terms of why you identified such. This would not be something to have on your POC. This is especially true of the last statement as this indicates negligence.***	May remove Desitin with baby oil and gauze before cleaning skin.	

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why?	**Disadvantages to NS wash, contact layer and ABD pad dressing change – easily dislodged, must be replaced daily or more frequently.** ***See below.*** **Alternatives include using alginate or hydrofiber with silver in wound beds to absorb drainage and help mitigate bacterial load and cover with foam silicone bordered bandages.** ***Ok*** **Cleaning wound beds with wound wash may also reduce bacterial load. Xeroform at wound beds covered with foam silicone bordered bandages would also help lessen the bacterial load and promote healing.** ***Identify each product separately along with a disadvantage of it as opposed to as one unit. NS…, Contact layer…., ABD pad.*** **Disadvantage to Desitin – high zinc content can be drying. Alternative would be to use barrier cream such as Remedy Hydra Guard on the area to promote healing by protecting the skin from moisture and urine/feces.** ***Good***

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	Yes, today was productive. I was able to practice identifying risks and assess/accurately stage or identify wounds, especially DTIs. The preceptor reviewed with me many different topical treatments and we debated the pros/cons of different wound care techniques. She also taught me about Dolphin beds and briefly reviewed other types of bed/chair surfaces. I was able to see very unique skin alterations in a patient with COVID on ECMO – blisters/bullae and strange, large petechiae. ***Good***
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I'd like to see another nurse's technique and approach to wound care and their rationale for chosen treatment plan. I'd like more practice at identifying skin alterations. Also, I need to simulate compression therapy with my preceptor as it is unlikely I will have opportunities during this practicum to practice this skill in person. ***Good***

Number of Clinical Hours Today: ___8 hours_____

Care Setting: <u>X</u> Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

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Number of patients seen today: _5_ Preceptor: _Jennifer Brinkman_____

Reviewed by: _Kelly Jaszarowski_____ Date: __4/27/2021_____
You are off to a good start. Be sure to provide strategies which are directive and identify what care should be done in your absence. Note my feedback regarding WOC products as each one should be identified separately.

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