Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Audra Belden Day/Date: 09/16/21

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***select 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	***Patient is an 88 yo female admitted on 9/7/21. Initial hospital course 8/5-8/13, appears L1 lesion with compression fracture dx at this time. SNF 8/13 – 9/6 with dc home. While at SNF patient presented to ER 9/2 for worsening abdominal and BL hip pain (no notes available – not admitted) Patient returned to ER 9/7/21 C/O worsening pain, decreased mobility due to pain, no BM in 5 days, worsening urinary incontinence. Pain unrelieved with Tylenol. Poor appetite. Denies "saddle paresthesia but acknowledges BL foot numbness. CT performed with pathologic comp[ression fracture noted to L1, mod canal stenosis, distended urinary bladder. 2L urine straight cath. Fleet enema unsuccessful. Tyleno and Toradol with min pain improvement.*** ***MRI: 5mm posterior displacement of bone fragments into spinal canal with encroachment of cauda equine and distal conus without significant spinal canal stenosis. Follow up biopsy ordered*** ***PMH: DMII, HTN, Stress incontinence, glaucoma, hyperlipidemia, enlarged lymph nodes (self resolved), major depressive disorder – mild single episode, malignant neoplasm of female breast (bil mastectomy 1995), thyroid nodules, pseudophakia, osteopenia, hysterectomy for dysfunctional uterine bleeding, lung adenocarcinoma (being followed).*** ***All: Gabapentin - Rash***

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

Patient was seen as a follow up for fungal rash to BL buttocks, groin, intertriginous folds. Rash was initially thought to be related to medication gabapentin, however has been dx for >1 month and rash persisted. Current WCCT treatment recommendations are as follows: Cleanse area with no rinse bathing wipes, air dry, apply thin layer of baza 2% miconazole cream BID to affected areas. Skin remains intact with dry scaly skin resolving. Skin is red/ warm to touch. No dressings. Continue Q2H turns with offloading using reposition system (Current braden risk <18). Offload heels with boots, nutritional consult for optimal wound healing, staff nurse braden risk assessment daily and with any change in patient condition. No further visits planned for WCCT unless change in patient condition or additional orders needed. Patient has indwelling foley, no report of bowel incontinence.

WOC specific medical & nursing	**WOC Directive Plan of Care**	**Rationale** ***(Explain why an***

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

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

Cleveland Clinic

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

diagnosis	**(Base this on the above data. Include specific products)**	***intervention was chosen; purpose)***
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: 1. ***Risk for skin breakdown*** 2. ***At risk for PI due to limited ability for positional changes*** 3. ***Pain*** 4. ***Nutrition deficit*** 5. ***Risk for Catheter Aquired Urinary Tract Infection*** *These are both not active problems, however the patient is certainly at risk.*	1. ***Keep skin CDI, avoid moisture retentive dressings, change moist linens promptly*** *(How often + PRN?).* ***Bathe patient with no rinse bath wipes daily to remove dry flaky skin.*** 2. ***Q2H positional changes with offloading. Use boots to protect heels from pressure****(how often?).* ***Perform skin assessment Q shift.*** *(Document this!)* ***Report any change in condition to WCCT.*** 3. ***Maintain pain medication regimen as ordered by physician, if pain management protocol is inadequate - patient experiences break through pain, or rates pain >5 1-2 hours after pain medication administered. Contact physician for additional orders.*** 4. ***Order nutrition consult –*** *you as the WOC professional will likely be doing this* 5. ***Follow hospital protocols to reduce risk of CAUTI. Using the ABCDE CAUTI prevention bundle the WOC nurse and staff nurse may reduce CAUTI and subsequent comorbities.*** *Anything to consider re: diet? You mention this in your diagnoses.* A- Adherence to infection control principles/ procedures/processes and supplies (Hand hygiene, Aseptic insertion, proper maintenance/care/education and surveillance) B- Bladder ultrasound (used proactively to reduce unnecessary catheterization) C - Catheter alternatives (Use of intermittent catheterization, external catheter, pouches/other containment devices, absorbent pads[collection], toileting program) D-Do not use indwelling foley unless	1. Skin care to prevent Moisture Associated Skin Breakdown 2. Limited mobility increases risk for PI 3. Uncontrolled pain limits patient ability to tolerate positional changes, increasing risk of PI. 4. Poor appetite increases risk for malnutrition increasing risk of PI 5. Female gender, urine stasis due to blockage or failure to drain, migration of bacteria from the skin into the urethral opening during catheter manipulation, migration of bacteria from inside the bag/tube, damage to the mucosa during insertion, breaking aseptic technique during insertion, lapse in care protocol all place patient at higher risk for CAUTI *(is any of this known in this case?)*

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

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

	medically necessary E-Early removal - implement protocol for automatic stop orders in plan of care (Newman, 2022 p.418). *Make sure this is included in the rationale section. As the POC directive is part of the medical record, we want to make sure it does not contain anything that can be interpreted as nursing education. Only directive, closed communication.*	

What are the disadvantages of using this product(s)? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	***Patient may have allergic reaction to topical cream. Skin condition may not respond to treatment. Patient may need a stronger medication or use of systemic anti-fungal. Fungal infection is not a confirmed dx and rash / skin irritation may not in fact be fungal. A consult with dermatology for a KOH (Potassium hydroxide solution) would confirm dx.*** *This should be included in your POC* *What about other products? Consider continence products and support surface/offloading devices.*

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?	1. Yes - Although I do still have a question re: one of the stage 4 wounds from today that I will ask about tomorrow. 2. No new suspected DTI on schedule
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	1. Observe / Assess Suspected DTI and accurately diagnose 2. Ask why NPWT is not being used on Stage IV PI from yesterday *Good question – there may be several reasons*

Number of Clinical Hours Today:

Care Setting: _x_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _6_ Preceptor: _Suzanne Janson__

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

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

Cleveland Clinic

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

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

Hi Audra, See my notes on this one. You provide some nice directives here, however we want to used closed communication the best we can (minimizes room for error). With your next submission, focus on "what, for how long" when giving your directives. Consider these holistically.. Additionally, make sure you are listing and finding alternatives for all products. Doing so allows you to "flex" your WOC muscles and demonstrate critical thinking in regards to patient situations.
I'm interested to see the etiology of this situation. As this was a patient without a wound and continence devices in place, I have counted it towards one of your continence journals.
-Mike

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

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