Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Tori Butts Day/Date: _____1/10/22_____

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 in ICU for treatment of infective endocarditis. Hx Afib/Flutter with anticoagulant therapy (on Eliquis currently), CKD III, chronic leg ulcers. Stress hyperglycemia and post-op anemia requiring infusion of 1 unit RBCs noted on chart. Current smoker. Pt is unable to answer questions or repositions herself. Protein (Total) 4.6, albumin 2.6. DTPI of R buttock now extends to L buttock and inferior to coccyx measuring 7 x 9 x 0.2cm. Wound bed appears red/purple in appearance with scattered open areas of partial thickness. Small sanguineous drainage noted. Wound margins are irregular, dry, intact, and red. There is also area of partial thickness redness and excoriation noted to perianal area, likely IAD from fecal incontinence. Unstageable pressure injury to L heel measuring 2.5 x 3.2 x 0.3cm. Wound bed appears small pink granular tissue and large slough/eschar. Scant serous/serosanguinous drainage. Wound margins are irregular, dry, and intact. Full thickness wounds with punched-out appearance to lower extremities. R anterior LE cluster measuring 8 x 3 x 0.3cm. L anterior lateral LE cluster measures 8 x 1.2 x 0.3cm. L posterior LE cluster measures 7x 2 x 0.2cm. Wound beds appear small pink/pale granular and large slough. Moderate to large serous drainage noted. Wound margins are regular, dry, and intact. Possibly vascular in cause. Cluster of two partial thickness wounds noted to R dorsal foot. Measurements not taken at this time. Wound beds appear to be mostly pale granular tissue. No drainage noted. Wound margins regular, dry, intact. May also be vascular in cause. Scattered lesions noted to mouth and lips, particularly around the oral commissures. Measurements not taken at this time. Wounds appear to be partial thickness loss of mucosal membranes, with small sanguineous drainage. Pt is intubated but wounds do not appear to be pressure or device related. Etiology unknown.

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…,

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evaluation and management of…, etc Then, describe the visit.

Pt seen by wound care team for follow-up evaluation and management of multiple wounds. Pt's RN at bedside throughout visit. Pt has known pressure injuries to R buttock and L heel; both present on arrival to hospital. Additional wounds noted today: see below. All wounds cleansed, measured, and photographed by wound care team at time of visit. Buttock & perianal dressings applied at time of visit by wound care team, pt's RN to apply recommended dressings to all others. Unable to educated patient on wound care and offloading at this time d/t lack of response/communication.

-R buttock: DTPI now noted to extend into L buttock and coccyx. Wound bed is red/purple, with scattered areas of partial thickness openings and moderate sanguineous drainage. Surrounding erythema noted. IAD related to fecal incontinence noted to perianal skin.
-L heel: Unstageable pressure injury. Wound bed is largely slough covered with section of eschar in the middle. Small amount of pink granular tissue noted to outer margins. Scant serous/serosanguinous drainage.
-R anterior lower extremity: Scattered full thickness wounds, possibly vascular in etiology. Wound beds are largely slough with small amount of pale/pink granular tissue. Moderate to large serous drainage.
-L anterior lateral lower extremity: Scattered full thickness wounds, possibly vascular in etiology. Wound beds are largely slough with small amount of pale/pink granular tissue. Moderate to large serous with some opaque drainage.
-L posterior lower extremity: Scattered full thickness wounds, possibly vascular in etiology. Wound beds are largely slough with small amount of pale/pink granular tissue. Moderate to large serous drainage.
-R dorsal foot: Cluster of 2 full thickness wounds, possibly vascular in etiology. Wound beds are largely slough with small amount of pale/pink granular tissue, dry. No drainage noted.
-Mouth: Scattered mucosal ulcers noted to lips, especially concentrated around oral commissures. Etiology is unknown, does not appear to be pressure or device related. Wound beds appear white/pink. Moderate bloody drainage.

Recommendations:
-Buttocks & Perianal: BID and as needed. Apply Desitin (may first apply stoma-adhesive powder, being sure to brush off excess) and cover with ABD. Be sure to cleanse thoroughly and apply new protection with all soiling. Continue Q2 turns and offloading with TAP wedges.
-L heel, R & L lower extremity wounds: Clean wounds with wound cleanser. Urgotul contact layer to open areas, cover with ABD and secure with kerlix. Continue Truvue boots for offloading of heel.
-Mouth: continue oral care and moisturizer. Continue to monitor for complication from ETT.

-Continue low air loss bed for pressure reduction.
-Nutrition consult advised to promote wound healing.

Wound care team will continue to follow, please contact us if wounds worsen.

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: ***Pressure injury to multiple sites***	Continue low air loss mattress Continue Truvue boots Continue Q2 turns with TAP wedges Prompt and thorough cleansing with bowel movements Use of Desitin protective ointment for buttock wounds and IAD	Continued dispersed pressure to avoid new pressure injuries and allow blood flow to capillaries of current wounds to promote healing. Removal of caustic stool from inflamed skin and open wounds to avoid further breakdown and decrease the risk of infection. Barrier ointment to further protect

		skin from breakdown s/d fecal incontinence.
Break down of mucosa (oral)	Oral moisturizer Oral care as scheduled (Sage oral suction swabs)	Keep skin moisture barrier intact to prevent further breakdown Oral care to minimize bacteria count and minimize risk of infection and further wounds
Lower extremity ulcers of unknown etiology	Urgotul and ABD dressing Consider ABI/vascular testing with worsening of wounds	Non-adherent dressing that adds some moisture to wound bed, covered with absorptive drainage for moderate serous drainage. D/t unknown etiology with likely vascular involvement, further vascular workup may be warranted in the future. Not indicated at this time d/t severity of other illness vs severity of LE ulcers.

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)	Desitin – can hide evidence of worsening wound, can trap fecal matter to skin/wound bed if not cleansed properly before application, can be drying. An alternative option would be a bordered foam dressing (which would further protect the skin from pressure and shear as well as helping to maintain a moist wound bed) or an alternate barrier cream such as Calazime ointment. Use of a physical dressing in the case is not likely to be successful however d/t proximity to the anus and liquidity of incontinent stool. It may be beneficial to consider a fecal containment device, if there is an significant increase in the volume and frequency of stools. Urgotul – no antibacterial qualities, not strictly helpful with autolytic debridement. An alternative option would be Xeroform, which would better help to create a moist environment to encourage autolytic debridement, and contains antibacterial properties.

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. My goal for the first day was to begin to familiarize myself with the workflow of the inpatient wound nurse and look for any products or techniques that I was not already familiar with. We do not have Pick and Pluck offloading pillows or the breathable/inflatable slide sheets at my hospital, and I look forward to looking into the logistics of implementing them in the future.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I am switching over to the inpatient ostomy (WOC) team tomorrow, so my goals will be the same as today but with regards to ostomy care.

Number of Clinical Hours Today: 8

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

Number of patients seen today: _5_ Preceptor: ___Jennifer Brinkman_____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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