Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Karen Lachowski Day/Date: Thursday 1/19/2023; wound journal

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** **76 yr. old male admitted to the hospital with cardiogenic shock, infective aortic valve endocarditis presumed origin from renal calculi with urosepsis. He is s/p aortic valve replacement, aortic root patch, CABG x 1, cystoscopy, laser lithotripsy, bilateral stent placement. During peri-hospital stay, a CT was obtained for confusion which confirmed a right frontal subarachnoid hemorrhage. The patient is being followed by the Wound team for a 1" deep –** *make sure this is mentioned below or if it is no longer present, mention that it was a "healed stage X".* **pressure injury to coccyx, noted and most likely acquired following a 9-hour surgical case.** *– be careful, although this may seem obvious to us as professionals, we don't want to chart presumptions.* **PMH: DM, MI with cardiac stent placement 01/2022, Rheumatoid Arthritis, hypothyroid, gout** **PSH:** **cholecystectomy,** **tracheostomy 1/3/2023,** **gastrostomy 1/3/2023** **LABS:** **WBC 30.1** **Albumin 3.2** **protein 5.7** **glucose 109**

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Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

The WOC nurse 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. Write in a manner others will be able to understand and be able to interpret your plan of care.

A wound care consult was placed by the inpatient intensivist for concerns of purulent drainage around gastrostomy tube in LUQ. Arrived at bedside. Patient is alert, focus' on speaker, does not attempt to communicate. He grimaces and becomes resistant with turning and repositioning. He is on ventilator support and gastrostomy tube is clamped for CT scan today. Patient followed by dermatology for generalized dry exfoliative rash from reaction from antibiotic. Dry, flaky skin noted to trunk, arms, legs with abdomen with papular rash, non-draining noted. Noted a new 4 cm x 1.3 cm device related injury to left mid flank adjacent to location of chest tube connector stop cock attaches to water seal container. area left open to air, stop cock covered with gauze/tape. a healed midsternal incision noted. Gastrostomy tube site evaluated. *Depth?- if this is a pressure injury, an intervention should be implemented.* **A small amount of creamy yellow drainage noted on gauze pad. Bumper in place with skin intact beneath. No drain tube secure device was noted, and tube was clamped. Insertion site appears to be enlarged from the tube eroding the skin. Intensivist at bedside for further evaluation. Area cleansed with saline at gastrostomy insertion site, allowed to dry, Desitin applied to skin, drain sponge gauze applied and loosely taped down. Secure device Hollister was placed and the tube was secured. The perirectal area was evaluated with fecal management system in place x 16 days. An open wound is noted posterior anus and is measured at 3 cm x 0.8 cm x 0.2 cm within the anal canal. It is red, partial thickness open area, scant serosanguinous drainage noted. Area cleansed and Desitin applied. The fecal management system was then removed. Dermatology recommendations for full body rash, dry skin is ordered as follows:**

Make sure note is complete

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. **Alteration in skin integrity due to placement of fecal management system** **Ulceration around gastrostomy tube placement, unsecured device**	**Statements should be directive and holistic relating to the problem/concern.** **Perianal area:** 1. **Remove internal fecal containment system.** *– this was completed by you per the note*. 2. **Apply desitin ointment to perianal area twice daily and as needed following soiling.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** 1. **Internal fecal containment systems are placed in bedbound, critically ill patients to contain stool and protect perirectal skin from Moisture associated**

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Alteration in skin integrity	**<u>PEG tube site:</u>** **1. Apply Desitin lightly around site and cover with split gauze twice daily as needed.** **2. Apply drain tube attachment device to PEG tube.** **Sacral Deep pressure injury, healing:** **1. Critic-aid ointment to sacral, coccyx region daily and as needed.** *– if this is a 1" deep wound, this is not an EBP intervention.* **Skin/Wound Care:** **-maintain bilateral heel protectors** **-maintain low air loss bed** **-Sween cream to bilateral feet and heels twice daily** **- turn patient every 2 hours utilizing Turn & Position system** **Skin Recommendations:** **-continue with dermatology orders for drug rash: triamcinolone acetonide 0.1% ointment twice daily to all affected areas; do not use on the face, groin or axilla** *Non-verbal pain cues are mentioned – make sure intervention is in place.*	**skin damage. While external pouching is the first line approach, the internal device that is inserted into the rectum is often chosen for the critically ill, especially those who are hemodynamically unstable. Removal should take place within 29 days. In this case, perianal skin is beginning to breakdown due to presence of the tube. He is no longer having diarrhea so the tube should be removed.** **2. Desitin ointment is a skin barrier which will offer protection of the perirectal skin ulcer** **PEG tube site:** **1. The skin surrounding the insertion site was deemed not infected but had erosion due movement of the tube at the insertion site. There was a failure to secure the gastric tube to the skin upon insertion. Area is cleansed and desitin was lightly applied as a skin**

		barrier for protection. **Sacral deep Pressure injury:** **1. The skin was not open and was unblanchable at initial assessment 2 weeks prior. It is currently in a healing stage. Could possibly be a shear injury in transferring in the bed. Application of a skin barrier will protect the skin along with other measures such as off-loading, turning every 2 hours, and a low air loss bed.** **Skin care:** **1. A pressure injury prevention plan is best defense against pressure injury occurrence.** *– make sure this is followed in POC.* **This is utilized especially in critically ill patients who are unable to verbalize pain or are hemodynamically unstable. The use of a turn and position device minimizes shear injuries. Basic skin moisturizers and skin barriers protect the epidermal layers of the skin and allow**

		for wound healing. Low air loss bed provides airflow to manage moisture accumulation to prevent skin damage. It also allows for even distribution of pressure.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** **-Coloplast Critic-aid Clear ointment/ Desitin: a barrier ointment that protects and treats most skin irritations due to incontinence. Alternatives could be Baza Clear which is zinc oxide 20%. Overuse of these products can cause a drying affect to skin whereas moisture is needed for skin healing. An alternative could be A&D ointment.** **-split gauze: covers drain sites effectively. Disadvantage is when used and sealed up tightly with tape, unable to visualize the site. –** *alternative?* **-Coloplast Sween Cream: skin moisturizer for prevention and maintaining integrity of skin. Alternatives could be Hollister Restore Skin conditioning cream. –** *this is a brand alternative, but not a product alternative.* **-FlexiSeal Protect Plus fecal management system: one disadvantage was noted with this patient, skin breakdown at perianal site. This is contraindicated with patients who have suspected proctitis or rectal surgery within the last year. Alternatives would be Hollister drainable fecal collector. –** *yes if skin is intact* **-Sage Turn & Position (TAP) system - assists in repositioning patient. One disadvantage is creating a shear injury if not utilized correctly by pulling by oneself. An alternative is utilizing draw sheets on a low air loss bed. Pillows are more cost affective but should always assess if sacral area is free from contact with bed.** **-Low Air loss bed: provides airflow to manage moisture accumulation to prevent skin damage and allows for even distribution of pressure. Disadvantage is the patient's inability to reposition oneself. Bed entrapment can occur with an air loss bed.**

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

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	**Absorb as much information as possible from the Wound Care team and how they stage new wounds and their care. I was able to meet my goal and thoroughly enjoyed the wound care experience. It was interesting but disheartening to see a brand-new placement of a G tube without the staff securing the device. The breakdown happened so quickly around the G tube insertion site. –** *make sure this is always included in your directive plan! Unfortunately this is something common we see as WOC professionals.*
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	**To complete my requirements for the journals and to collect information during the day for my Seek and Find Wound.**

Number of Clinical Hours Today: _8___ Care Setting: _x__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____
Number of patients seen today: __5___ Preceptor: __Jennifer Brinkman_____

Clinical Reflection: Identify/describe other patient encounters, clinical experiences from today, thoughts	**Had a great day again with Jennifer. She allowed me to evaluate and come up with plan of care for all patients. Five patients seen today with Jennifer. We were to see 6 patients today however, one patient that was scheduled for evaluation of new coccyx stage 2 had expired prior to arrival.** **Other patients seen today:** **-79 yr. old female s/p takedown of enterocutaneous fistula. post operative respiratory distress, intubated. Seen today to evaluate newly acquired coccyx stage 2 PI.** **-78 yr. old female admit for cardiac workup. Seen today for evaluation of newly acquired coccyx stage 1 PI.** **-52 yr. old female s/p NSTEMI, CHF, evaluate coccyx region for pain, history of prior healed stage 2 coccyx in 2021, no new PI noted. low air loss bed ordered.** **-62 yr. old male, transferred from Abu Dhabi for advanced heart failure, stage 2 pressure injury to coccyx newly acquired.**

Reviewed by: ____Mike Klements 1/30/23 received_____ Date: _1/31/23

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Hi Karen – This sounds like it was a good day! see my notes throughout. Make sure that all notes that address wounds clearly and orderly organize information. Include present assessment data, measurements (when applicable), staging (if applicable) and intervention methodically to avoid confusion. Reach out with any further questions!
-Mike

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