Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Stacy Mariano_____ Day/Date: Friday 2/3/23

Number of Clinical Hours Today: __8__ Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __4___ Preceptor: _Mary Montegue_____

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.**
Skin assessment for multiple wounds of unknown etiology.	Patient is an 80 year old male admitted to hospital with confusion, diarrhea of unknown etiology, and increased weakness. Per patient reports he is wheelchair/recliner bound is has been unable to get himself to and from the bathroom and has no one at home to assist him. Stool and urine are in constant contact with skin, patient has Texas catheter in place draining dark urine and is noted to have large amounts of water green/yellow stool when turned. Patient reports not being able to tell he has to have a bowel movement. Labs indicate acute infection, source unknown, possible dehydration/electrolyte imbalance which may be contributing to confusion and weakness. PMH includes CAD, HTN, prediabetes, Asthma, OA of multiple joints, hyponatremia, insomnia, thrombocytopenia. No remarkable surgical history as related to consult. Patient has a stage 3 pressure injury to coccyx that was previously closed but has now reopened and was present on admission, measures 3.5 x 4.5 x 0.3. Patient has a partial thickness wound to LLE covered with pink/yellow tissue, edges intact scant serous drainage, etiology unknown, measures 2 x 1.5 x 0.1. Patient has a stage 2 pressure injury to right hip that measures 2.3 x 3 x 0.2 covered with pink/red tissue, scant serosanguinous drainage, no odor present. Patient has large areas of open excoriated skin with diffuse boarders to bilateral buttocks, bilateral posterior thighs, and groin. These areas are red/pink with scant serous drainage, no odor, tender to touch. These areas are surrounded by intact scar tissue. Etiology of wounds are incontinent associated dermatitis.

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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.

Initial visit by WOC nurse for evaluation of multiple wounds on 80 yo male. Patient has a stage 3 pressure injury to coccyx that was previously closed but has now reopened and was present on admission, measures 3.5 x 4.5 x 0.3. Patient has a partial thickness wound to LLE covered with pink/yellow tissue, edges intact scant serous drainage, etiology unknown, measures 2 x 1.5 x 0.1. Patient has a stage 2 pressure injury to right hip that measures 2.3 x 3 x 0.2 covered with pink/red tissue, scant serosanguinous drainage, no odor present.

Patient has large areas of open excoriated skin with diffuse boarders to bilateral buttocks, bilateral posterior thighs, and groin. These areas are red/pink with scant serous drainage, no odor, tender to touch. These areas are surrounded by intact scar tissue. Etiology of wounds are incontinent associated dermatitis.

Patient has bordered foam dressing soaked with stool on coccyx, bordered foam to right hip, dressings to lower extremity has non-adherent contact layer covered with abd pad and secured with roll gauze. These were removed for assessment, cleaned and replaced per POC.

Permission received from patient to photograph wounds for EMR, patient premedicated for pain prior to wound care and assessment, patient tolerated assessment and care well.

Spoke to attending MD regarding wounds as possible source of systemic infection which was determined to be unlikely however it was the recommendation of this WOC nurse that a stool culture be considered for evaluation due to liquid consistence of stool and incontinence.

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. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc.*** Impaired skin integrity, actual. Impaired self-care related to incontinence. Fluid/electrolyte imbalance.	**Statements should be directive and holistic relating to the problem/concern.** Patient to be turned every 2 hours. Maintain Comfort Glide System using wedges to offload pressure points; side to side turns only. Gentle cleansing to skin on thighs and groin. Apply Urgo-Tol contact layer to wound bed and cover with Allevyn foam on bilateral thighs, change every two days. Cleanse coccyx gently with bath wipes after each incontinent episode; apply Critic-Aid Clear moisture barrier ointment TID and as needed to	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Maintaining pressure relief/prevention measures is necessary for wound healing and to prevent further injury. Non-adherent contact layers should be used to prevent disruption of wound bed during healing, bordered foam will provide some cushioning to surface of wound while managing exudate.

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Acute vs chronic pain.	keep areas covered. LLE: gently cleanse with soap and water, apply Urgotol contact layer, cover with abd pad and secure with roll gauze and tape, change daily. Maintain TruVue boots to offload heels while in bed. Instruct care givers on incontinence care, skin care, and pressure injury prevention at home. Consult Case Management to assess for home equipment needs/home care needs vs SNF placement as appropriate prior to discharge. Encourage patient to increase po fluids to maintain adequate fluid status. Monitor labs for s/s of electrolyte imbalance. Patient to receive pain medication prior to wound care to provide optimal comfort. Instruct patient on non-pharmacological methods of pain management including deep breathing, distraction, and warm compresses.	Dressing to coccyx will not withstand constant moisture from incontinence so skin should be cleaned and moisture barrier applied after each episode of incontinence. Dressings should protect wound bed while adequately managing wound exudate. Education for caregivers will help to improve ability to maintain skin integrity if patient goes home. Case management should be consulted to determine the best arrangements for patient post discharge. Patient needs to have adequate hydration to maintain skin elasticity and integrity. Proper electrolyte levels are important to cellular health. Pain control is important to patient mental health which has been shown to improve healing and patient outcomes.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> 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.** For this patient we used non-contact layers over wound beds for protection, UrgoTul and Allevyn brand border foam. The advantage to using these types of products over something like abd pads due to the incontinence. Border foam dressings tend to be more expensive and are not appropriate for daily dressings or if there is a likelihood that incontinence will compromise the integrity. A more appropriate treatment for the IAD on the thighs would be a quality moisture barrier, one with an antifungal medication may be needed if the wounds look like they may have yeast involvement. For the patient's wound on the LLE non-contact layer and abd pads are at this point the most cost effective treatment and appropriate for this wound. Contact layers could also include Adeptic gauze or Xeroform gauze however xeroform can sometimes be drying to wound beds. The most important part of treatment is going to be the management of the patient's incontinence and pressure management.

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

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What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	My goal for the day was to see more patients with incontinence related problems which I was able to complete with the assistance of my preceptor.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I need to complete more contact hours/journals for incontinence and wounds. At this time, I believe all my ostomy hours have been completed.

Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Other patients seen today included patient's we were consulted to see to determine etiology of wounds for example moisture vs pressure related injuries. Determining the difference between the two is an area I feel a lot of clinicians need education on along with the staging of pressure injuries. I did discuss with my preceptor the possibility of using an internal bowel management system for this patient until the underlying cause of the diarrhea was determined. Further evaluation including a rectal exam would need to be completed prior to determining if this would be appropriate for this patient.

Reviewed by: _____ Date: _____

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