Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Stacy Mariano__ Day/Date: Monday 2/6/23

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

Number of patients seen today: ___6__ Preceptor: _Aaron Fischer__

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.**
Open abdominal wound with ECF.	PMH: 31 yo female with history of Vascular Ehlers Danlos Syndrome, pneumothorax, ruptured hepatic artery, bullous emphysema, 2 cranial aneurysms, CVA, anxiety GERD, HTN, migraines and thyroid disease. Surgical history of hernia repair, surgery to repair hepatic artery rupture and pneumothorax, splenectomy. HPI: seen at OSH for abdominal pain, N/V eventually diagnosed with emboli in mesenteric vein with bowel ischemia, patient had small bowel resection with subsequent multiple bowel surgeries ending with ileostomy creation, midline incision left open due to VEDS. Patient has visible deep tissue exposure with mesh (prior surgery) and has developed an ECF in the wound with large amount of drainage making pouching difficult. Ileostomy noted on RLQ, separate from wound.

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 for evaluation of open abdominal wound with ECF. Patient has rare genetic disorder contributing to multiple medical problems which has necessitated several abdominal surgeries, the most recent of which abdominal incision had to be left open to heal by secondary intention. Patient has visible mesh supporting internal abdominal structures and has recently developed a spontaneous ECF that is draining copious amounts of brown colored, liquid drainage. Wound is a large midline surgical wound with even, open edges, pink tissue with some yellow adipose tissue noted, mesh is sutured in place and is visible in wound bed. Mesh is brown in color

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due to ECF drainage. Periwound skin intact with no maceration, slight redness noted in slim border around edges, moderate pain during wound care, patient was premedicated and was having PCA delivered towards end of visit. Patient has loop ileostomy in RLQ that is functioning and has no notable issues. Stoma is beefy red and moist with no periwound maceration noted. Wound was cleansed with mild soap and water, gently dried with gauze, unable to isolate ECF, wound pouched with Eakin fistula pouching system with Holliheasive petals applied to periwound skin, patient has skin sensitivities so minimal product was used. Seal was obtained, patient repositioned for comfort.

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*** Knowledge deficit related to wound care. Pain, acute vs chronic Fluid/electrolyte imbalance related to fluid loss. Knowledge deficit related to nutrition.	**Statements should be directive and holistic relating to the problem/concern.** Patient/caregiver will participate in learning proper wound and skin care prior to discharge. Patient/caregiver will perform hands on teach back with wound care prior to discharge. Patient will be able to verbalize pain on numerical scale to nurse and ask for pain medication prior to wound care. Patient will have tolerable pain levels during and after wound care. Encourage patient to increase po fluid intake to maintain fluid/electrolyte levels due to increased drainage. Patient/nursing to keep track of I&O to monitor fluid status and adjust treatment as necessary. Instruct patient/caregiver on adequate healthy protein intake for optimal wound healing.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Education related to self-care enables patient to regain a sense of control over their health status, improve overall outcomes and reduces risk of re-hospitalizations. Adequate pain control during wound care improves patient well being and wound healing. Fluids are lost through heavy wound drainage and ileostomy output. It is important to monitor I&O and encourage increased po fluid intake to prevent dehydration. Increased protein is necessary for wound healing at the tissue and cellular levels. Instructing the patient to make healthy protein choices is important to overall health and wound healing.

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	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Patient's current system removed using adhesive remover, skin cleaned with mild soap and water, 3M barrier film applied to periwound area, Holliheasive barrier petalled around wound edges, creases at 3 and 9 o'clock filled with holliheasive barrier strips, Convatec stoma paste applied over Holliheasive barrier, ConvaTec Eakins fistula pouching system applied to abdomen over entire midline wound.

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should be from a different category or classification. In other words, what could be used if the product was not available?	**Patient is very sensitive to adhesives so no tape or stoma paste should be used on skin. If current system is insufficient or supplies become unavailable, physician should be consulted regarding use of NPWT.

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?	Goal today was to see wound or continence patients. We were able to see this patient along with several other wound patients today. This was a challenging wound care patient with a very complex history.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	Goal for tomorrow is to see continence patients.

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	Along with today's journal patient we saw a NWPT patient to change the dressing along with several ostomy patients that had wounds complicating their ostomies which I have noticed does become a problem for many patients. If pouching seals are not maintained and leakage occurs the patients end up with skin problems which then lead to additional pouching problems and it becomes a nasty cycle. Fitting patient's properly at first is so critical to the success and positive outcome of their surgeries! For today's journal patient, I wondered why the surgeon was not considering NPWT but perhaps it was to soon after surgery. It seems to me that a wound vac would better manage this wound.

Reviewed by: _____ Date: _____

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