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: Tuesday 2/7/23

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

Number of patients seen today: ___4__ Preceptor: _Mary Montague___

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 breakdown to buttocks; PI vs IAD	Patient is an 80 year old male admitted to hospital with confusion, diarrhea of unknown etiology, and increased weakness. Patient determined to have urosepsis and is being treated accordingly with antibiotics, awaiting stool cultures to determine source of diarrhea. Patient has Texas catheter in place urine and is urine is tea colored but improving since last assessment. Patient has stool management system with rectal tube draining gravity. Stool is still very watery. Labs continue indicate acute infection, dehydration/electrolyte imbalances are being managed with IV hydration, medications and encouragement for po intake. Patient is more alert and appropriate today but is still weak and unable to manage ADLs. PMH includes CAD, HTN, prediabetes, Asthma, OA of multiple joints, hyponatremia, insomnia, thrombocytopenia. No remarkable surgical history as related to consult.

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.

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Follow up visit for wounds assessed last week, patient's Stage 3 PI unchanged from previous assessment, Stage 2 PI to right hip has closed with intact pink scar tissue. Areas of excoriation to bilateral buttocks and posterior thighs, and groin area are grossly improved with initiation of FMS and Texas catheter to keep urine and liquid stool off skin. New epithelial migration noted, wound bed is pink with scant drainage, diffuse borders. Stage 2 PI to right hip has closed with intact pink scar tissue. Per Dermatology consult wounds to BLE are due to stasis dermatitis.

Patient does report some pain during wound and skin care but this has improved as well.

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*** Bowel and Bladder incontinence Fluid/electrolyte imbalance Impaired Skin Integrity, actual Pain, acute	**Statements should be directive and holistic relating to the problem/concern.** Cleanse skin with bath wipes, apply Desitin TID and as needed to keep areas of buttocks, coccyx and bilateral thighs covered at all times. Right hip; cleanse with NS, apply UrgoTul contact layer, cover with Allevyn foam, change every other day. BLE; cleanse with NS, apply UrgoTul contact layer, cover with Allevyn foam, wrap with Kerlix, change daily. Per CC policy, flush FMS with 60-240 cc tap water every shift and as needed to keep stool liquid and flowing; ensure tubing does not kink or twist, Position tubing behind patient like a tail when side lying. If leakage occurs, check inflation balloon, ensure 35-35 cc is contained in balloon. Maintain Comfort Gluide system, wedges and TruVue boots for positioning and offloading of pressure. Complete pain assessment prior to wound care and provide pain medication as needed for patient comfort.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Products used for today's care include Desitin as a moisture barrier, MD specifically ordered a zinc based product. Other options could include Coloplast Critic-Aid Moisture Barrier which is also zinc

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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?	based and designed specifically for incontinence. UrgoTul brand contact layer was used to protect wound beds but other product options would include McKesson, Restore, Mepitel, or Profor as they all are essentially the same type of product. Allevyn bordered foam was used as a secondary dressing for the right hip and BLE; another option that may be more cost effective would be abd pads with tape on the right hip and any brand of roll gauze on the BLE. These dressings also do not necessarily need to be changed EOD since the hip and BLE wounds have minimal drainage and the moisture from the incontinence is now being managed.

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?	Today's goal was to see incontinence patient's so I was pleased to be able to follow up with today's journal patient to see the improvements and the utilization of the FMS and Texas catheter to manage the patient's incontinence.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Tomorrow I'd like to participate in more hands on care for incontinent patients or those with wounds.

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	Today we saw another patient with a pressure ulcer to her coccyx; this patient was in the process of transitioning to hospice care so her wound care POC/goals were focused on moisture and odor control along with pain control. End of life patient's don't have the physiological resources for healing so the ultimate goal is comfort. We were also consulted on a patient with a possible medical device related pressure injury which turned out to be a skin tear from triple lumen dressing change; the area was bruised from insertion not pressure. The other patients were to evaluate coccyx/sacral areas for PIs due to bed bound status in ICU. I was glad to see that the journal patient's incontinence was being managed well and his wounds were improving. I think the patient will need further evaluation to identify the underlying reasons for his incontinence to see if were acute or chronic in nature. A POC for discharge will need to be made so that re-hospitalization can be avoided and the patient's QOL is improved. For example, how did he end up in a wheelchair? What was his functional status prior to becoming septic? Does he need caregiver assistance at home? Could he regain independence if he went to rehab or does he need to consider long term care? This is where collaborating with other disciplines like therapy, case management, nursing and MD is beneficial.

Reviewed by: _____ Date: _____

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