Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Amelie Penberthy_____ Day/Date: 2/8/23

Number of Clinical Hours Today: _8___ Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __7___ Preceptor: ___Mary Montague-McCowan_____

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.** **Patient admitted for weakness, dizziness, SOB, palpitations. Patient had a CABG procedure performed. Patient has a history of AFib, HTN, CAD, and history of falls. Patient is on blood thinners. Consult requested for possible pressure injury in mucous membrane and ear lobe. Patient was drowsy with minimal engagement during visit. Patient had two mediastinal chest tubes in place and a Foley catheter draining urine. Left Ear: Stage 1 pressure injury measures 0.9 x 0.5 cm. Epidermis is intact, red and nonblanching. Edges are not defined. No drainage, no odor. Right upper lip: Mucous membrane pressure injury, device pressure injury from ETT. Measures 0.4 x 0.3 cm. Wound is red, edges not defined, skin on surrounding skin is intact, no drainage, no odor.**

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.

Patient is a 73 year old female admitted for weakness, dizziness, SOB, palpitations. Patient had a CABG procedure performed. Patient has a history of AFib, HTN, CAD, and history of falls. Patient is on blood thinners and vasopressors. Consult requested for possible pressure injury in mucous membrane and ear lobe. Patient was drowsy with minimal engagement during visit. Patient had two mediastinal chest tubes in place and a Foley catheter draining urine. Left Ear: Stage 1 pressure injury measures 0.9 x 0.5 cm. Epidermis is intact, red and nonblanching. Edges are not defined. No drainage, no odor. Right upper lip: Mucous membrane pressure injury, device pressure injury from ETT. Measures 0.4 x 0.3 cm. Wound is red, edges not defined, skin on surrounding skin is intact, no drainage, no odor.
Recommendation:
Mucous membrane: Open to air, Vaseline once a day

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Stage 1 pressure injury device related: Open to air, Sween 24 moisturizing cream once a day
Apply Braden Risk score every shift for preventative measures.

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 sensation and impaired perfusion.** **Stage 1 pressure injury on ear and mucous membrane pressure injury.**	**Statements should be directive and holistic relating to the problem/concern.** **Apply Sween 24 cream to stage 1 pressure injury on ear every day and other dry areas as needed.** *– make sure you offload devices!* **Vaseline lips every day.** **Assess skin head to toe every shift. Ensure tubing/drains is not under patient. – *what is done with this assessment?*** **Use Medline ReadyWet Bath wipes for bed baths. – *when?*** **Turn Q 2 hours.** **Use Sage AirTAP system to move patient.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Sween 24 cream moisturizes dry skin. *– why is this indicated?* Moisture helps the mucous membrane to heal. Every bedside provider needs to assess the skin to ensure there is no skin breakdown and treat any signs of impairment at the first encounter. Wipes are pH balanced and non-drying. *– why is this indicated?* Turning allows a relief for the part of the skin that was laid on and follows current recommendations – *consider pathophysiology, – why is this indicated?* The Sage AirTAP system allows for air to be pumped into sheet under the patient in order to allow for easy movement of the patient that prevents caregiver back injury. It also prevents shear injury during patient adjustments in bed.

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	Apply wedges to offload pressure. For this patient, two wedges are used.	Soft wedges that work with the Sage AirTAP system do no slide off in order to allow for relief from pressure of the sacral area and can be applied at either side. One goes on top portion of body and other goes under the thighs. .
	Apply the Braden Risk Assessment for every shift: HOB no greater than 30 degrees, InterDry Moisture Wicking Fabric, Patient has difficulty moving self and difficulty communicating discomfort. *Be directive here. What do you want done? What is done with braden scores?*	This encourages reassessment of pressure injury risk per facility protocol and as per nursing. – *why is this indicated? What does it do to help this patient? What is formulated based on braden scores?*
	Low air loss mattress for offloading pressure.	This mattress pumps air around the skin so excess moisture is not touching the skin. The mattress also has settings that can redistribute pressure. *– why is this indicated?*
	Assess for any blancheable erythema during repositioning. If this reoccurs often, the turning schedule and/or support surface bed should be reevaluated.	This measure can assist to prevent pressure injuries, especially since the patient has difficulty moving self.
	TruVue boots while patient is in bed.	Prevents heel injuries. *– how?*
	Consult with dietician regarding the patient's oral feeding per G-Tube.	Ensure adequate protein and micronutrients for healing. - *– why is this indicated?*
	Consult physical therapy for appropriate exercises.	Movement helps to prevent pressure injuries and this patient has a history of falls.

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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.** **Bath wipes- These can be more expensive because there is the potential of going through many a day. An alternative would be soap and water, which are easily accessible. However, this can be drying and rough on the skin.** *Be specific on brand names* **TruVue boots-These boots can be an expense that not all patients can benefit from. An alternative would be a pillow for under the heels.** **Sween 24 cream - This may not be available at all locations or may be an added expense. An alternative could be any off-label moisturizer. The important focus is to add moisture back to the impaired skin.** *You are the professional directing care here – what do you recommend?* **Vaseline: This can be thick and taste bad. Any off-brand lip balm is sufficient as long as it's moisturizing.** **Sage AirTAP system- This is an expensive system that is not widely available and it requires training to know how to use it effectively. An alternative would be a draw sheet to be under the patient and moving with a 2-person assist while the bed is flat.** **Wedges- These are part of the Sage AirTAP system, so may not be available/expensive and the caregiver needs to know to put the wedge on the black strip on the sheet. An easy alternative would be to use pillows to allow for relieving pressure and using maneuvers, such as the 30 degree lateral position.**

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?	I wanted to see a stage 3 or 4 pressure injury and differentiate the staging. There were none but did get to identify a stage 2 pressure injury that was not found by the bedside staff.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I would like more practice with a wound vacuum dressing change.

Reflection: Describe other patient	There were a lot of device-related pressure injuries. There was a slew of ETT

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encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	injuries coming from the OR that the unit staff noted was a recent pattern. There may need to be a discussion with the OR team in order to implement a preventative measure to stop the ETT injuries. – *yes, this sounds like a good opportunity for education*

Reviewed by: ____Mike Klements 2/10/23 received____ Date: ___2/10/23

Hi Amelie – as this is your 5th wound focused journal, it does need some updates prior to qualification as completed. See my previous notes regarding the rationale section. Please address my comments and questions throughout. Make sure to elaborate on rationale. Direct care as the specialist in the POC – be as specific as you can. Updates can be done right in this journal.
Reach out with any further questions.
-Mike