Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Sommer Saddler _____ Day/Date: Tuesday, 1/17/2023

Number of Clinical Hours Today: ____ Care Setting: ___ Hospital ___ Ambulatory Care 10___ Home Care ___ Other: _____

Number of patients seen today: __13___ Preceptor: __Kathy Tavernilli_____

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.** Pt. is an 80-year-old female with a PMH of CVA, obesity, COVID-19, Diabetes Mellitus, Neurogenic bladder, urinary retention, UTI, and Hemiplegia affecting left dominant side. Pt. is a long-term resident in a facility, and currently has an indwelling urinary catheter due to neurogenic bladder and urinary retention; pt. also has been experiencing loose bowel movements for quite some time, tests have been done to r/u C-diff, and pt. primary has assisted in making adjustments to some medications, and implementing some supplements to assist in bulking the pt. stool.

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 assessment the pt. has an indwelling catheter present, the stat lock to assist with keeping the catheter in place was not present, pt. was also soiled during assessment of loose brown stool. Pt. peri area is discolored from previously healed areas, scar tissue present, and a few very small, scattered opened areas of incontinence dermatitis/redness, no drainage once stool was wiped from area, no odor or s/s of infection, no pain or discomfort. Pt. has an abdominal hernia as well, abdomen is slightly distended, soft, and palpable, pt. denies any pain or discomfort to abdomen.

Recommendations are to cleanse the peri skin with a pH balanced wound cleanser or cleansing wipes, lightly pat skin dry, apply Stomahesive barrier powder to irritated skin areas/reddened areas, then apply 3M Cavilon Skin prep spray over powder, cover with a Foam dressing. Pt. should be frequently repositioned and offloading pressure, frequent incontinence care and changing adult briefs when soiled or damp.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen, purpose)**

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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*** ***Dermatitis due to moisture from stool incontinence***	**Statements should be directive and holistic relating to the problem/concern.** Is pt being discharged from LTC? I am a little confused about where you saw this patient period So sorry for any confusion, I saw this pt. in a nursing home/facility, and below is an error, the facility staff will be providing the management of Dermatitis based upon my recommendation in treatment. Home health Care Nurses will be assessing the area 1-2/week and PRN, and Caregiver or family will be providing care and treatment for pt. every day and with each episode of incontinence. 1. Cleanse the peri area and provide catheter care as well and surrounding peri skin with pH balanced cleansing solution and gently wipe with a cleansing cloth/wipe. Pat dry thoroughly. [2.] ~~Then~~ apply Stomahesive barrier powder to the peri wound/irritation and surrounding peri skin. [3.] ~~Then~~ spray over the Stomahesive barrier powder with 3M Cavilon Skin prep spray. 2.[4.] Cover with a Foam dressing can alternate with an Island dressing as well. 3.[5.] Place an extra absorbent adult brief under pt. and leave unfastened. 4.[6.] Complete daily and with interruption of dressing or incontinence.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Cleansing the skin with a pH balanced cleansing solution are basic/safe and appropriate methods to safely remove biofilm pH balanced cleansers or NSS for that matter do not really remove biofilm. Biofilm is best removed by conservative sharp debridement or cleansing with a rough gauze or fiber pad., debris. Stomahesive barrier powder will protect the skin, and free the symptoms of skin irritation, redness, itching, and the urge to scratch skin, and absorb moisture. The 3M Cavilon Skin prep will increase the benefits of the stomahesive powder; will provide a light crusting over the irritated skin and protect with a seal. This is true but there are so many other things to use that will not be quite so difficult to remove and time intensive to apply. Keeping the area covered with a Foam dressing and adult brief can maintain application of the products applied and absorb incontinence. Glad the brief is under the patient and not fastened around the patient. Changing a phone dressing daily is expensive. Further evaluation we opted out of the foam dressing and using only an underpad. The area had improved tremendously.

moisture

Identify each WOC product in use/identified in POC. State at least one disadvantage of the	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** • pH balanced cleanser- (possible) disadvantage is the cleanser could cause a sensitivity to the

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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?	skin (which could be rare). An alternate would be using a just a gentle mild soap difficult to remove soap residue and water. It is rare that people have an allergy to these cleansers but it's not impossible. As informed from previous journal feedback, a pH balanced cleanser has a surfactant that will assist with gathering stool and urine and allowing it to become easier to cleanse with a cloth. • ConvaTec Stomahesive powder- disadvantage is over usage, skin irritation, alternate is using non-sting barrier or no product if skin is intact. • 3M Cavilon No-sting prep: disadvantage could be skin irritation to the surrounding skin, an alternate is to not use any barrier if the peri wound is intact, and ensure surrounding skin is thoroughly dry before placing dressing on. • Adult brief- disadvantage, the brief could increase skin breakdown, the other option is to leave the brief unsnapped, or only use breathable chux pads for better absorption, and decreased risk of skin breakdown. • Foam Allevyn- Disadvantage, the dressing could dry the wound out or if there becomes an increased amount of moisture, can break skin down. Options are to leave area open to air.

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 for today was met, my goal was to assess the patients seen and determine if treatment plan was appropriate and how long the treatment has been active. In this case the treatment plan is one of the best, as we have tried, various creams or ointments, Alginates, and the key for this pt. is keeping the area dry, despite the stool incontinence, and there has been great improvement to her peri area with the treatment discussed.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Goal for tomorrow is to implement a treatment plan for a continence pt. or pt. with a wound, and perform the assessment care independently.

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	An additional pt. assessed was an 82-year-old female with a PMH of acute respiratory failure with hypoxia, Multiple Sclerosis, Pneumonia, Pressure injury of Coccygeal region stage 4, and obesity. Pt. has a chronic wound and various treatments have been implemented in the long-term care facility, but there are some barriers that are prohibiting the wound from healing. The patient is bedbound, and when assisted in the wheelchair, the pt. does not like to go back to bed during the day because it is a lot of work, and stays in the wheelchair the entire day until bedtime, also the pt. is incontinent of bladder and bowel, and the urine primarily gets on the wound, and through the dressing. The current treatment is lightly filling the wound with Calcium Alginate with Silver and covering with a Foam dressing daily. I believe the current treatment is appropriate and in addition, trying a Stomahesive barrier paste to an area of the wound that has a depression and filling that area in with the paste could function as a barrier in preventing urine leakage from getting into the wound, and affecting healing.

Reviewed by: Patricia A. Slachta Date: 2/8/23

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.