Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Sherry Storm_____ Day/Date: Tuesday 5/30/23

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

Number of patients seen today: __13___ Preceptor: _S. Arnold_____

Journal Focus: __X__Wound _____ Ostomy _____Continence _____Combination Specify: _____

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	43 year old female with history of DMT2 was admitted to the hospital for bilateral foot wounds in March. Diagnosed with osteomyelitis Right great toe, right 2nd toe. She is now S/P Right great toe amputation, right 2nd toe partial amputation, I&D left foot on 3/2/23 per podiatry. She initially received IV antibiotics, discharged on oral antibiotics. Patient has cancelled all scheduled post-op visits with podiatry in the outpatient wound clinic, podiatry wanted her to be seen by any of the providers in the center that would work with her schedule. PMH also includes Asthma, heart murmur, fall, acute renal failure, transaminitis, DKA, PAD. Medications: Norvasc, ASA, lipitor, flexeril, metformin. Last bloodwork and imaging while admitted after surgery.

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.*

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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 presents to Wound & Ostomy Center for initial evaluation right foot wounds. Spouse present. All wounds to right foot with desiccated scabbing. Sutures still in place from surgery. Patient washing wounds with soap and water, getting them wet in the shower. Reports pain in the right foot but states it could be from her neuropathy. Denies fevers. Has not been doing dressing changes, just washing as above and leaving open to air. Patient is independent with ambulation and ADLs. She was noted to be homeless and living in her car when she was hospitalized in March. Currently living with her sister. Only checking her blood sugar 2-3 times a month, states she is compliant with her medications. Admits to not adhering to a diabetic diet. Smokes occasionally, denies illicit drug use except for marijuana, denies alcohol use. Sleeps in a bed. Does not always wear shoes and socks as they cause pain. Patient has decreased epicritic sensation in her feet. Dorsalis pedis and posterior tibial pulses not palpable, biphasic doppler signal is present at all sites. Legs, feet, and toes temperature and color are normal. No hair to lower legs, feet, or toes. Toenails not thickened or discolored, appropriate length. The scabbing to the wounds was removed as maceration can be seen around the edges. Sutures also removed. Wounds smaller than measured scabbing. Wound beds red, full thickness. No surrounding erythema, edema, cellulitis. Wounds do not appear infected. No sharp debridement to wounds as once scabbing removed wounds without slough. Left foot without open wounds, callus to 1st and 5th MTP heads.

WOC Recommendations
Paint wounds with betadine, cover with dry gauze, change daily.
Referral to diabetes educator.

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

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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***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Diabetic foot ulcers to right medial foot, right great toe amputation site, right 2nd toe amputation site, right medial foot, & right medial foot.	Daily wound care: cleanse with saline, paint with betadine, cover with dry dressing. Do this after showering.	Betadine will help to keep wounds dry which is preferred due to decreased blood flow as evidence by non-palpable pulses and that she is a diabetic. Wounds that are overly wet can lead to infection. Betadine also has antiseptic properties.
	Keep wounds protected from water when showering.	Keeping wounds dry and protected from shower water help decrease chance of infection.
	Wear properly fitted shoes when ambulating.	Wearing shoes help to protect the feet from injury that patient may not be able to feel due to known neuropathy. Shoes that are properly fitted will not rub or cause wounds to the feet that the patient may not be able to feel.
	Wear clean white socks every day.	Wearing clean white socks every day can alert the patient to drainage or bleeding that could develop due to an injury the patient may not feel.
	Monitor feet daily, look for blisters, wounds, or injuries.	Monitoring feet daily helps to detect any new injuries so a potential injury can be addressed quickly as wounds to the feet on diabetics can decline rapidly.
	Blood sugar control, twice daily monitoring of blood sugar, American Diabetic Association Diet adherence. Referral to Diabetes Educator.	Tight blood sugar control helps with wound healing. Diabetes Educator can be useful to help the patient understand her diabetes and why it is important to closely monitor her blood sugar. Educator can also help with an ADA diet education.
	Increase intake of protein with choosing foods higher in protein. Can try diabetic supplements with increased protein.	Diet with increased protein can help with wound healing as protein is crucial to the process.

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Identify each WOC product in use/identified in POC. State at least one disadvantage of the 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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Betadine is an antiseptic which will help with keeping the wound free from infection without damaging the surrounding skin or wound. Topical antibiotic ointments/creams should not be used as they could make the wound to wet. Hydrogen peroxide, alcohol, chlorhexadine can damage the wounds and surrounding skin. Gauze is used for protection from injury as it provides another layer between the wound and outside forces such as shoes or objects. It will absorb drainage but not wick it away, if the wound is draining and this is not replaced it can trap moisture close to the wound. If the gauze was to become wet by other means and not changed, again it could keep moisture close to the wound. Alginate could be an option but as the wounds are not draining a large amount this is an expensive dressing to use for this purpose.

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?	My goal for the day was to see a variety of wounds. This goal was met as I saw diabetic ulcers, arterial ulcers, venous ulcers, and pressure injuries.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To see a skin substitute placed.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The dressing for this patient was what I would have chosen as I have been taught with my prior wound care experience that diabetic foot wounds, especially with compromised blood flow, should be kept dry and treated conservatively as sharp debridements can cause worsening of the wound.
Reflection: Describe other patient encounters, types of patients seen.	All patients seen today had wounds. Mostly saw venous ulcers and compression wraps were used frequently. Many patients with venous ulcers had heavily draining wounds, mepilex-highly absorbent foam dressing was used frequently. I was able to see different choices of dressings and treatments based on the patient and the characteristics of the wounds.

Reviewed by: _____ Date: _____

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