Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Jennifer Wyrock_____ Day/Date: 06/1/2023

Number of Clinical Hours Today: __10__ Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _8_ Preceptor: _Aaron Fischer_____

Journal Focus: _____Wound _**X**____ 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	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** **PMH:** diabetes mellitis type 2, essential hypertension, hyperlipidemia, gout, and chronic kidney disease stage 4. **Surgical History:** 5/8/2023 Debridement of left perineal wound 5/10/2023 Debridement of Left groin and Left gluteus 5/15/2023 Debridement of left gluteal, perineum, and groin wound. 5/17/2023 Debridement of left gluteal, perineum, and groin wound. **HPI:** Patient is a 53-year-old male admitted to the outside hospital on 5/2/2023 with malaise and confusion. The patient was diagnosed with septic shock, mild rhabdomyolysis, superimposed diabetic ketoacidosis, and acute kidney injury. Patient was transferred to current hospital on 5/6/2023 for further management for left thigh necrotizing soft tissue infection. Patient was admitted to the ICU with concern for Fournier's Gangrene.

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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ET/WOCN Nursing Consult
Topic: ET/WOCN Consultation Note – *these terms are quite dated/incorrect. "WOC nurse" or "CWOCN" should be used (WOCN is legally protected acronym for the professional society. ET has not been current since the 1990's in the USA, as a bachelors degree is not needed. The term ET is still used internationally; however an ET does not/did not need to be a nurse. It is important to be change agents with this evolving verbiage.*

Outcome: WOC team consulted to assess the patient's negative pressure wound therapy (NPWT) dressing. The bedside nurse reported that the wound vac started to leak overnight, and a seal could not be obtained. Patient expressed some concern about having the wound vac dressing changed again because it was changed the day before. The patient was educated that a wound vac should not be left on without suction for more than two hours and that the wound vac would need to be removed and replaced to prevent infection and worsening wound condition. The patient verbalized his understanding.

The patient stated that "he wants to be under" for the dressing changes. The patient was educated that this would not be possible to do at the bedside at this time and the patient agreed to allow this team to take the previous wound vac dressing off. There were no pain medications available to give at this time and a request for pain medications for the dressing change was made to the surgical team. Patient declined for this team to reapply the NPWT dressing at this time but did agree for a Wet-to-Dry dressing placed at this time. *– be very careful of this verbiage. A wet to dry dressing is a no selective mechanical debridement method (can be quite painful) and not EBP in this case. A Moist gauze dressing may have been used. Consider this verbiage and its implications from a legal review standpoint. This is a commonly misused term.* The patient was educated on the benefits of using NPWT dressing for wound healing, patient verbalized understanding, but further declined the NPWT dressing.

This team will follow up in 3 days to evaluate the wound and assess patient willingness for the team to redress the wound with NPWT dressing after allowing some time in-between the dressing removal. The primary care team notified of patient's decision to not re-apply the NPWT dressing. The bedside nursing team can change the dressing twice a day and as needed utilizing the recommendations listed below.

Wound assessment
Wound bed: yellow tissue present at the base of left thigh. A moderate amount of granulation tissue present, but the wound is pink and moist at this visit due to stall in therapy.
Wound edges: Open and flat, no epibole, and some jagged borders.
Periwound skin: scattered areas of denuded skin around the wound.
Drainage: Moderate amount of mildly malodorous tan drainage.
Odor: Mild after flushing.
Current methods of management: NPWT dressing at –125 mmHg at low, continuous suction.
Consider a measurement, as you are seeing weekly per your plan below.
Recommendations
Skin care:
Cleanse the skin and wound with normal saline and pat the skin dry.
Apply no-Sting barrier to periwound skin.
Dressing:
Use saline moistened gauze x 2 -*good, see my comment above* to light fill the wound.
Cover the Kerlix gauze with ABD pads and secure with paper tape.
Change Schedule: Twice a day and needed
Premedicate?

Time increment: 2 hours – *this is used for a charge capture in some institutions, however, is not needed for these journals.*

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*** Altered body image Pain related to open wound – *no interventions noted.* *Include the wound here*	**Statements should be directive and holistic relating to the problem/concern.** -Nutrition consult -WOC evaluation of wound once per week -Use saline moistened gauze x 2 to light fill the wound. *– how often?* -Cover the Kerlix gauze with ABD pads and secure with paper tape. *Pain control?* *This is an ICU patient – support surface?* *Pt/Ot Indicated?* *Any further collaboration here with other teams? This patient has a likely need for further surgical intervention or reconstruction.* *When would you need to be reconsulted outside of weekly? Is the plan to just D/C NPWT indefinitely here?* *This patient is diabetic – we know this directly affects outcomes, how do you suggest it is managed?* *Make sure this POC "covers all of your bases", so to speak. We want this to be thorough plan of care directions to the bedside caregiver .*	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -nutrition consult would help to evaluate a patient's nutritional status and optimize the patient's nutrition to facilitate wound healing. -A weekly WOC evaluation of the wound to obtain photos, measurements, and assess the wound will help to observe for improvement or deterioration of the wound *- is there a directive for this?* -Utilizing a Wet-to-dry dressing with normal saline soaked gauze will help keep the wound environment moist and help facilitate wound healing. Paper tape is used to prevent skin tears.

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. <u>Alternatives should be from a different category or classification</u>. 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.** Kerlix Gauze-if not changed consistently the patient could form an infection. An alternative could be utilizing foam gauze and negative pressure therapy. *NPWT uses a reticulated foam, not gauze typically.* Normal Saline-can be expensive to obtain. An alternative to normal saline is Vashe Wound Solution. ABD pads-they may be too large for some smaller wounds or may be too absorbent to provide an appropriate moist environment. An alternative to this would be an Allevyn cover dressing. *– any foam would work* Paper tape-they may not adhere to the skin well. An alternative would be 3M medipore medical tape.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

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What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	My goal for tomorrow is to participate in wound care and work with my preceptor on changing the wound vac. I was unable to obtain this goal as we did not reapply the wound vac due to patient preference.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to perform a wound vac application with my preceptor.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I felt like this was a very interesting case. The patient has a very large wound on their left thigh and perineum area that can be very uncomfortable for the patient. I think we could have called ahead to ensure that the patient received some pain medication before arriving to see the patient. *– this is a good plan! As the WOC nurse directing wound care here, make sure that this is communicated to all who will be doing dressing changes.*
Reflection: Describe other patient encounters, types of patients seen.	We did see an infant patient with four stomas. This patient's bowel was broken into multiple stomas due to the short length of the bowel. The patient was being refed their mucous fistulas. We had to re-intubate the two mucous fistulas that became dislodged during the pouch change. *– this sounds like an interesting and complex case!*

Reviewed by: ____Mike Klements 6/2/23 received_____ Date: __6/2/23

Hi Jennifer – see my notes throughout this journal. Try to apply the holistic approach to your future journals – see my specific comments regarding terminology as well. Reach out with any further questions!
Looking forward to next submission.
-Mike

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