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: 06/13/2023

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

Number of patients seen today: _5__ Preceptor: Mary Montague McGown

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	**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:** Quadriplegia due to a gunshot wound (10/2018), vent dependent, pulmonary embolism, Acute on chronic respiratory failure with hypoxia, pneumonia, anemia, acute encephalopathy, Takyosubo cardiomyopathy (10/2018), and asthma. **Surgical History:** No documented surgeries at this time – *this patient likely had many surgeries given the picture presented. Make sure to include this as it is imperative for holistic assessment.* **HPI:** 32-year-old male who present to the Emergency Department from outpatient IR after a rapid response called for hypotension. The patient was febrile on admission.

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.

WOC Consult note

WOC team consulted regarding coccyx pressure injury.

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HISTORY OF PRESENT ILLNESS: Shedrick Harris is a 32 year old male is being seen with the admitting diagnosis of hypotension, septic shock.

The patient was alert, but had a trach in place and on a ventilator in the ICU. The patient was unable to offer much history due to the trach being in place. No family present at bedside. Patient was incontinent of stool at this dressing change. Incontinence care provided at this time and a new absorbent, breathable under pad placed.

Wound Assessments:

Pressure Injury Buttock Right (Active)
Assessment
Present on Admission during this Encounter
Pressure Injury Stage 4
Site Assessment: Red
Peri-Wound Assessment: Intact with scar tissue
Measurements: 1.3 cm x 1 cm x 1.2, 3.9 cm undermining at 12:00
Drainage Description: Serosanguineous
Drainage Amount: Small
Odor: None
Dressing: Foam- Adhesive; Vashe-moistened Kerlix
Dressing Changed at this visit

Pressure Injury Hip Left (Active)
Assessment
Present on Admission during this Encounter
Pressure Injury: Stage 4
Site Assessment: Unable to visualize wound bed – *we can not stage this wound if the depth can't be appreciated. We know it could be full thickness if obscured, but by what in this case?*
Peri-Wound Assessment: Scar tissue
Measurements: 0.1 cm x 0.1 cm, no depth – *if there is no depth, how could this be a stage 4? If Eschar or thick fibrinous exudate is present, then this would be staged as "unstageable". If reticular dermis is exposed (may appear white-ish), this could be a stage 2.*
Drainage Description: Serous
Drainage Amount: Large- *this lends to a full thickness injury*
Odor: None
Dressing: Foam- Adhesive
Dressing Changed at this visit

Pressure Injury Heel Left
Assessments
Present on Admission during this Encounter
Pressure Injury Stage 2
Site Assessment: Red
Peri-Wound Assessment: Intact
Measurements 1.7 cm x 1.7 cm x 0.2 cm
Drainage Amount: None
Odor: None
Dressing: Foam- Adhesive
Dressing Changed at this visit

Pressure Injury Coccyx (Active)

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Assessments
Hospital Acquired during this Encounter – *Make sure your charting above is clear re: when this patient was admitted. This is an important factor here when it comes to reporting.*
Pressure Injury Stage 3
Site Assessment: Pink and Tan
Peri-Wound Assessment: Intact
Measurements: 3.5 cm x 3.2 cm x 0.2 cm
Drainage Description: Serous
Drainage Amount: Scant
Odor: None
DressingFoam- Adhesive and Vashe-moistened Kerlix
Dressing Changed

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.	**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.**
1. Altered skin integrity related to quadriplegia *Incontinence (UI+FI)*	1.Turning and repositioning every 2 hours -Utilized Heel-off loading boots on the patients feet -Place preventative Allevyn to all boney prominences. *–We do not want to cover the patient in unnecessary dressings. Be specific as to sites that you want this implemented – consider indications for use for dressings, as well as facility cost here. As the specialist, it is important to implement interventions that will evidence based and beneficial.* -Place breathable, absorbent under pad beneath the patient with one transfer sheet underneath. -Assess the patient for incontinence with each turn and as needed. -Utilize an external male catheter to maintain urinary incontinence and change the device once a shift and as needed. *– unsure what is meant here.* -Avoid using an indwelling catheter to manage incontinence. – *this will not be done if the above directive is followed.* -Right buttock: Irrigate with normal saline; gently fill depth and undermining with Vashe-moistened Kerlix; cover with Allevyn foam; change daily and as needed. -Left hip: Gentle cleansing with normal saline; cover with Allevyn foam dressing; change daily	1.Turning/reposition and hell offloading boots prevents pressure injuries and maintains skin integrity. *Be careful with your verbiage here. We know it lowers risks. We know as nurses that despite ideal conditions nothing is definitive. Consider from a legal review standpoint.* -Preventative foam dressings help to prevent pressure injuries. -Placing breathable, absorbent under pads beneath incontinent patients will help maintain skin integrity, and limiting the amount of layer beneath immobile patients will help to reduce shear and friction. -An external male catheter will help to maintain urinary incontinence *??* with a decreases risk of UTI. -Indwelling catheters should only be used after surgery, to manage retention, or to divert urine if wounds are negatively impacted by urinary incontinence. -Cleansing the wound with normal saline will gentle clean the wounds

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NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc	and as needed -Left heel, right lateral ankle, right hip: Gentle cleansing with normal saline; cover with Allevyn foam dressing; change every other day and as needed, -Coccyx: Gentle cleansing with NSS; apply Vashe-moistened gauze; cover with Allevyn foam dressing; change daily and as needed. -Utilize a fecal management system for less than 30 days to maintain fecal incontinence that is interfering with wound healing – *who is this reported to if there is an issue? You are the WOC specialist and would make this decision or collaborate to. Directive would simply be to:* *"maintain/implement the system".* *"Change every X days…"* *"contact LIP/WOC if…"* *We don't want to delegate assessment/our role* -Consider a fecal diversion if wounds are not healing. *– Remember, this is a directive plan of care. This will not be delegated, you would escalate this as the WOC professional as needed. It may be included in the note, but not the directive POC.* -Wound care team will follow up weekly to assess and measure wounds. *– what is the directive? Omit this* -Reconsult Wound care team if any new wounds develop, or if any current wounds worsen. ***Make sure your plan is holistic. You include tasks above re: wounds. Further consider:*** ***Pain management, Support surface, Nutritional needs, case management***	and covering the wounds with Allevyns dressings will help to maintain drainage and protect the wounds. -Vashe moistened gauze will help the wound environment stay moist and will contribute to autolytic debridement. -A fecal management system may help a severe wound in the perineal area heal if the patient is having a large amount of fecal incontinence. -If wounds are worsening or if they are severe enough a patient may need a fecal diversion to allow them to heal, or to give the patient a better quality of life. *– this could be an option. Mention this in your note – not the directive plan of care, as it is within the WOC profession to assess this* -Weekly assessment and measurement is important for determining if treatment is appropriate.

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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.** -Allevyn dressing-an disadvantage to this dressing is that they are not beneficial for coccyx dressing when patients are frequently incontinent. An alternative to this dressing would be an ABD absorbent pad. – *yes, Allevyn is not cost effective if frequent changes are needed.* -Normal saline-a disadvantage to this is that it not the most effective at cleaning wounds and removing bacterial form the wound. Sea-Clens is an alternative that could be used. *Consider offloading devices/boots here as well.*

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 today is to take measurements of undermining a complex wound. I saw a patient with undermining that we measured on a coccyx pressure injury.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to intubate a stoma.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I feel at thought there was more I wanted to do to provide this patient with more comfort. The patient was not verbal but was showing signs of discomfort on his face during these dressing changes. I would have asked the nurse to give the patient some pain medication before starting the wound care. – *This should be done and included in the plan of care as a directive. Non-verbal pain cues indicate a need for intervention. Formulate such when building your plan and deliver it above.*
Reflection: Describe other patient encounters, types of patients seen.	We saw another patient is the ICU that had lost so much weight and was developing a stage 3 pressure ulcer on their coccyx. We had to measure the undermining of the wound that was worsening and make appropriate recommendations.

Reviewed by: Mike Klements 6/19/23 Date: 6/19/23

Hi Jennifer – see my comments throughout this journal – I left many in green. They are meant to be constructive. The POC needs some updating prior to the satisfactory status of this submission. Continue to apply previous and current feedback- the plan of care should be directive and holistic; from the specialist to the caregiver- in this case the ICU nurse/team..

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This patient is quite complex and had many continence issues as well – this journal can count towards continence hours if you wish after necessary updates, or be split 50/50 between the two specialties – just let me know.
As usual, reach out with any questions. - Mike

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