Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Natalka Wiszczur___ Day/Date: 9/11/23

Number of Clinical Hours Today: ____ Care Setting: _8__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __7___ Preceptor: Jennifer Brinkman____

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.** 68-year-old female. PMH of respiratory failure status post tracheostomy, a fib, hypotension, stroke, ischemic bowel status post-end ileostomy on TPN, malnutrition, CKD on dialysis, and DVTs. History of smoking and alcohol use. Presented to Cleveland Clinic from LTAC for bloody output from ostomy. The patient is hemodynamically stable upon arrival. Hemoglobin level is 7.4, orders to transfuse below 7.0. BUN is 95 consistent with CKD. The patient has a necrotic left index finger and sacral pressure injury that was acquired on previous 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.

Initial visit for evaluation and management of left index finger and sacral wound. The patient is pleasant, alert, and agreeable to care, on trach collar at 30% O2, laying in bed, moving all extremities, fecal ostomy in RLQ draining liquid yellow brown stool with intact pouching system, urinary foley in place with moderate leakage around catheter.
Left index finger has a dry black necrotic tip without drainage or odor. Wound measures 3 x 1.5 cm. Edges and surrounding skin are intact. WOC nurse recommends the use of betadine Q daily and allow to dry, leaving it open to air.
Sacral wound is an unstageable pressure injury. Appearance is red, pink, and yellow with two areas of black necrotic tissue. Measuring 9 x 12.5 x 1.3 cm. Has scant serous purulent drainage and dry eschar. The wound was cleansed with NS and dressed with hydrogel, a contact layer (Urgotul), and an abdominal pad. Change daily and as needed. Consult placed to plastics for debridement. Periwound skin is intact

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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*** 1. Risk for peri-wound skin damage due to leaking Foley catheter and sacral pressure injury. 2. Risk for delayed healing due to comorbidities and critical care status. 3. Risk for pressure injury due to bed rest and critical care status.	**Statements should be directive and holistic relating to the problem/concern.** 1. Apply clear moisture barrier ointment (Critic-aid clear) to perineal area BID and as needed. Ensure prompt changing if foley continues to leak. Dress sacral wound with hydrogel, cover with Urgotul (contact layer), and abdominal pad. Change daily and as needed. 2. Monitor patient's electrolyte levels and replace as needed. Patient may need a nutrition consult to adjust TPN if labs continue to show levels outside of normal status. Monitor patient's hemoglobin and hematocrit and transfuse per orders. Ensure patient is receiving adequate oxygen through trach collar. 3. Utilize Tru-Vue heel protectors to bilateral lower extremities. Turn Q 2 hours with wedges to offload sacral pressure. Continue with Dolphin Immersion surface (air support bed system). Utilize Alleyvn (foam dressing) with key keyhole aperture under tracheostomy. Apply Sween cream (moisturizing lotion) to bilateral feet BID.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** 1. Prompt changing after foley leakage and when dressings are saturated helps to ensure minimal moisture-associated damage to peri wound skin. 2. Altered electrolyte levels, nutritional status, hemoglobin/hematocrit, and oxygen saturation can delay wound healing and perfusion. Close monitoring and replacement will aid in creating an optimal wound healing habitus. 3. Offloading pressure to sacrum, feet, and tracheostomy will assist in preventing further pressure injuries. Moisturizing lotion ensures skin health to deter further injury.

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</u>	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Betadine may not be an option for care if the patient is allergic to iodine. An alternative is the use of chlorhexidine. Hydrogel can dehydrate and adhere to the wound bed. An alternative product for an unstageable pressure injury with dry eschar is a nonwoven wet to dry gauze.

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should be from a different category or classification. In other words, what could be used if the product was not available?	

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?	Yes, I was able to evaluate, stage, and dress multiple pressure injuries. I was also introduced to Clevland Clinic's product formulary.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Continued wound care, evaluation, and appropriate utilization of product formulary.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	N/A
Reflection: Describe other patient encounters, types of patients seen.	My clinical day was specific to the surgical ICU. I mostly evaluated pressure injuries. One of these patients had three deep-tissue PIs acquired from a prolonged surgery. I had one patient with a wound vac that was discontinued by the surgical team for frank blood production. I saw two patients with moisture-associated skin damage.

Reviewed by: _____ Date: _____

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