Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Kelsi Critzer_____ Day/Date: 9/13/23

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

Number of patients seen today: __8___ Preceptor: ___P.Clay_____

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.** 51 y/o female who presented to the ED due to concern for vulvar abscess. The patient reports that a week ago she felt a small bump externally near the left labia, she reported the bump went away. Additionally, she added the bump occurred on the same day that she shaved and had intercourse. Then a few days later she suddenly developed fevers, chills, and myalgia. She had no other associated symptoms at that time. A few days following that occurrence, she woke up and noticed that her left vulva was extremely swollen, red and painful. Patient saw her primary care doctor who started her on doxycycline and Flagyl for suspected infection. Patient reports the pain and swelling did not improve so she called her gynecology provider who advised her to come to the emergency room. Pt assessed and admitted prior to wound care consult due to uncontrolled pain, 101.4 F, elevated WBC's (22.9), fluid collection identified by perineum ultrasound, and abscess centered within the left vulvar region measuring 4.6 x 3.4 x 5.9 cm confirmed by MRI. Cultures were obtained during surgery and results are still currently pending. IV antibiotic therapy was initiated. The patient was admitted for surgical I&D of left labial abscess. Pt was admitted following I&D, wound care was requested to be at the bedside for initial packing removal by the gynecology team. Additionally, wound care was requested to assist with dressing recommendations and discharge education. PMH: 2 C-sections and a rhinoplasty.

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

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and be able to interpret your plan of care.

New consult for patient with concerns to the vulvar area, dressing recommendations and discharge education. Patient assessed with P.Clay RN, CWOCN, MD, and patient's son at bedside. The patient was properly premedicated (IV analgesic) prior to wound care. The patient presents with a new wound to the left labia after I&D of a labial abscess on 9/11/23. The current (surgical) Kerlix packing was removed, a large amount of serosanguinous drainage is noted. The wound was gently probed with a cotton-tipped applicator and measurements were obtained. The left labia presents with a 1.5 cm L x 0.5 cm W x 2 cm D open area. Undermining is noted at 6 o'clock and extends 3 cm. The periwound skin is intact but significantly indurated and swollen. Faint erythema is noted. The wound was irrigated with 0.9% sodium chloride (orders for Dakins solution placed after assessment). The wound was then packed with one long strip of Aquacel Ag. WMST will return to bedside tomorrow to evaluate the need for additional dressing changes and the products efficacy. MD agrees with plan of care. RN updated.

WOC Recommendations:
Following tomorrow's assessment of the wound and how the dressing preformed, the WOC team will determine if Aquacel Ag becomes too saturated and requires increased dressing changes or if another product may perform better. The WOC team will then enter orders for wound supply DME and a home health referral to be completed by the DC coordinator. Additionally, tomorrow pt should be premedicated with PO medication as this will be the available medication for dressing changes once discharged. Due to the location of the wound, it is recommended that prior to packing the wound, the area should be irrigated with Dakins solution (provided by pharmacy). No cover dressing is recommended due to the location of the wound and current foley catheter placement.

Wound care to left labia:
1. Irrigate wound with Quarter Strength Dakin's Solution
2. Cleanse periwound skin with Dakin's moistened gauze, pat dry
3. Using ONE long strip of Aquacel Ag gently pack wound, starting at the undermined area at 6 o'clock
4. Should the packing come out, re-irrigate the area and pack wound with new piece of Aquacel Ag

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Pain related to dressing changes	Administer pain medication prior to dressing change as ordered Coordinate pain medication with dressing changes as ordered Utilize topical Benzocaine spray as ordered	Controlled pain promotes comfort and cooperation from patient during dressing changes
Adherence to antibiotic therapy	Complete all antibiotic therapy as prescribed	Completing antibiotic therapy ensures bacteria is effectively treated and helps prevent antibiotic resistances
Discharge planning	Consult DC coordinator Educate son on POC and dressing changes	Assist with setting up of home health agency and wound supply DME Son can change dressing incase home health is unable to show or if

		dressing comes out when home health is not there Provides a backup plan to ensure care is provided to patient

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.** Aqucell Ag: this product is expensive and becomes very slippery once saturated, not ideal for a wound with no cover dressing. Also, may require more frequent dressing changes if saturated too quickly. However, removal of dressing is less painful because it does not stick to the wound bed. Another alternative could be Mesalt ribbon. This product does not become slimy and should stay in place a little better. Dakins solution: effective antimicrobial, however, is also cytotoxic. Normal saline may be utilized to irrigate wound.

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 pack a wound in a difficult area without using a cover dressing. Due to this wound being located on the patient's labia, a cover dressing would have been painful and likely soiled every time the patient used the restroom. I feel I met this goal and confidently created a backup plan in case the original dressing proved to not be effective.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to independently pouch an ileostomy on a NICU patient with a hernia and prolapsed stoma.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Coordinating better with the patient's nurse to administer PO pain medications instead of IV to better assess if the patient's pain will be effectively managed once discharged.
Reflection: Describe other patient encounters, types of patients seen.	Other patients seen today included a baby with diaper rash who responds well to the "crusting" technique as opposed to marathon. Multiple premature infants with ileostomies that are due to be changed tomorrow and currently intact.

Reviewed by: _____ Date: _____

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