Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Amanda Walker BSN_____ Day/Date: 9/19

Number of Clinical Hours Today: _8.5___ Care Setting: ___ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __10___ Preceptor: ___L.C_____

Journal Focus: ___6__Wound ___2__ Ostomy _____Continence _____Combination Specify: _____1_____

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 Wound/Incontinence	**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: GSW resulting in paraplegia, CKD, DM, Sleep apnea, GERD, HTN. HPI: Kidney dysfunctions Labs: WBC 14, K 4.3, NA 134, BUN 35, Creatinine 2.0 Multiple wounds on sacral, scrotum, bilateral knees

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.

Mr. M consulted for multiple wounds. Treatment inpatient for kidney dysfunction.
Woc nurse consult outcome: Assessment completed, Wound care provided to sacral/coccyx, scrotum and bilateral knees.Patient incontinence of urine and stool, care provided. Male purewick in place. Additional supplies left in the room. Notified NP of wound care recommendations and orders received.
WOC next visit/plan: Bedside Rn/LPN to complete wound care. Re-consult if any changes in wound conditions.
Wound Location: Right sacral size 3x4x2.5cm
Undermining: 2 cm at lower base and right side Tracking: N/a
Wound type: Mixed etiology with MASD/Irritant contact dermatitis due to fecal, urinary or dual incontinence. Full thickness Red with slough appearance
Wound Bed: Red/Yellow discoloration
Draining: Serous
Periwound Skin: MASD
Therapeutic Surface: Versacare

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Intervention/Recommendation:
Irrigate with normal saline or wound cleaner. Pat dry. Apply No sting skin prep to periwound. Apply single layer hydrablue dressing. Cover with Mepilex dressing. Change every day and as needed.
Wound location: Posterior Scrotum MASD/ Irritant contact dermatitis Size 5x3x0.2cm
Undermining: n/a Tracking: N/A
Wound type Mixed etiology with evolving MASD/Irritant contact dermatitis due to fecal urinary or dual incontinence.
Wound bed: Pink/White discoloration
Draining: Moist
Periwound Skin: masd
Therapeutic surface: Versacare
Intervention/Recommendation: Cleanse with bathwipes, or soap and water. rinse well and pat dry. Apply Triad cream. Change three times a day or as needed.
Wound location: Left knee 2x2x.5 Right Knee 2x3x.5
Undermining: N/a tunneling: N/a
Wound type: Full thickness red
Draining: Serous
Periwound Skin: Intact
Therapeutic Surface: Versacare/ prevention wedges
Intervention/ Recommendations: Irrigate with normal saline or wound cleanser. Pat dry. Apply no sting skin prep to periwound. apply a single layer of xerofoam dressing. Cover with mepilex dressing. Change every day and as needed.
While in bed, the patient should only be on a fitted sheet and one chux. Please do not use brief while the patient resting in bed. Elevate heels off the bed surface at all times. Turn and reposition at least every 2 hours.
Thank you for this consultation, While inpatient please contact WOC department with questions or changes in condition.

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*** Nutrition deficient, Fluid/electrolyte imbalance and noncompliance of treatment plans without discussions of other alternatives.	**Statements should be directive and holistic relating to the problem/concern.** Options to move frequently. Encourage movement with every commercial break if watching television. Using bed for maximum protection of skin surfaces, for example sand bed. Monitoring the leg positions frequently to eliminate pressure on bilateral knee ulcers.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Patient is relatively young and can improve the wound healing process to enhance quality of life by moving himself in bed, monitoring nutritional supplements that can increase healing and frequently monitoring knee placement in bed and chair.

Identify each WOC	**This section helps to communicate your product knowledge and critical thinking skills.**

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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?	**Products should be available in the US.** **Hydrofera blue dressings are antibacterial foam dressings. This product is expensive. Using a hydrofiber dressing could also be used to absorb and maintain an optimal healing environment.** **Triad cream used to protect contact dermatitis irritants on skin. Triad cream and calmoseptine are skin protectants creams.**

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?	Learning goal for the first day was to become familiar with the process and assessment of wound/ostomy. Yes goals were met because there were several interesting and challenging situations that were observed with preceptors.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	See the outpatient clinic with Linda for ostomy needs.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This patient has several difficult situations to manage. While inpatient there can be several ways to monitor his oral intake, nutrition and therapy. Patients have to be able to follow these requests and specific needs outside of inpatient settings. Possibly consider where the patient lives and ask if there is anyone that helps the patient if from home. Or how often the patient monitors issues of skin protection to prevent further breakdown of other areas on the body.
Reflection: Describe other patient encounters, types of patients seen.	There were numerous new experiences for me while watching and helping Linda and Mitzi on the first day. Observing different ways to dress NPWT devices, Wound consults for lower extremity blisters or ulcers from heart failure and diabetes. Being introduced to new intervention programs set forth by the WOC department for improvements of pressure injuries was informative.

Reviewed by: _____ Date: _____

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