Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note Journal #1

Student Name: Cheryl N. Eastmond Day/Date: 10/16/2023

Number of Clinical Hours Today: 8 Care Setting: X Hospital Ambulatory Care ___ Home Care ___ Other: __

Number of patients seen today: 8 Preceptor: Amparo Cano CWOCN

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.** 79 y/o male patient consulted to wound service for buttock wound. The patient was admitted to the hospital on the med/surg floor for generalized weakness, acute onset of confusion, mental status change, and diarrhea that is resolving. The patient has mild leukocytosis with a white count of 13,000 per microliter. BUN is 24. No other laboratory abnormalities found. The patient is Spanish speaking and bedside nurse is there to assist with translation. The patient is alert and oriented x 2. It is reported that the patient prior to admission was ambulating at home with walker. He lives with his spouse who is present in hospital room at time of assessment. The wife reports that the patient is continent of urine and generally continent of stool except for a few occasional accidents. She states that she has used Depends or other diaper type products. Other considerations are mobility and nutrition. The patient was OOB to chair which was performed by physical therapy department. He is on a regular diet, and he is able to feed himself and requires minimal assistance. His wife reports that his appetite is ok. PMH significant for metastatic Lung CA to bones and brain. He is s/p gamma knife one month ago. PMH also includes Ulcerative Colitis, HTN, GERD, Gout, Anemia. Medications include Amolodipine, Famaotidine, Ferosul, Mesalamine, Allopurinol

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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The WOC nurse was consulted to assess and make recommendations for buttock wound. The patient is alert and sitting up in chair. He denies pain to buttock and is asked to stand with walker in place. The wound at this time is assessed. The wound is a MASD natal cleft with epidermal disruption. The wound base is light red, no drainage observed, no malodor. There is no pain with palpation. There is a partial thickness 2x3 cm healing superficial wound noted on left buttock. The sacrum is intact, and no pressure injury is noted. Due to the recent bouts of diarrhea and acute illness, there is a moisture associated wound to the buttock area. A Braden score of 13 is given which places the patient at moderate risk for pressure injury.

WOC Recommendations:
Moisture barrier ointment to natal cleft and surrounding skin as a barrier against moisture
Keep skin folds clean and dry as possible.
Place waffle cushion in chair to redistribute pressure.
Assist patient to turn and reposition frequently.
Provide incontinence care as prn- promptly to protect skin.
Monitor al bony prominences closely.
Ensure adequate nutritious diet and adequate hydration. BUN indicative of possible dehydration in warm South Florida climate. Re-consult if necessary.
Patient teaching to patient and his wife regarding prevention of skin breakdown.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
MASD wound	Daily skin care with ph-balanced wound cleanser and the application of barrier cream daily and prn Turn and reposition every 2 hours while in bed using wedges and pillows. Limit time up in chair to <2 hours at a time Use waffle cushion while in hospital and upon discharge. Encourage well balanced nutritious meal and adequate hydration. Assist with feeding and meal set up.	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Prevention of skin MASD wounds, frequent turn and positioning, and mobility will assist in the prevention of pressure injuries, Use of DME waffle cushion to ensure re-distribution of pressure to areas. Encourage adequate well-balanced meal necessary in healing of existing wounds. Also, hydration is important in maintaining the integrity of the skin. Continence care to keep area clean and dry and remove additional moisture. Include caregivers to help with the

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Intermittent Fecal Incontinence Discharge plan	Continence care entails meticulous skin care immediately after each incontinent episode. Plan of care should include spouse and any other caregivers. Work with discharge planner to order DMEs for ambulatory aides and pressure redistribution equipment, also consult for home skilled nursing and PT for evaluation and plan.	implementation of plan. Discharge planners to ensure that the plan of care is carried out in the home setting where there will be assessment of skin and activity to help with mobility.

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.** **Skin Barrier Cream/paste: used to protect the skin from moisture. The barrier cream includes zinc oxide which attaches to the skin preventing moisture. The skin barrier cream should be zinc paste which has healing properties that are good for the skin. The use of diapers are not recommended as it may create a moist environment. Also, the diaper and pull ups may create a false perception that frequent diaper changes are not needed. Proper hygiene is key and skin should be pat dry.**

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 learning goal was to learn and see as much as possible. I was a little nervous yet excited to be working with my preceptor as I did not know what was expected of me. Also, although my focus is not ostomy, I plan on pursing that next year, so it was great to be able to get an introduction to what the care of the ostomy entails.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My learning goals are to continue to get experience working with wounds. I want to see pressure injuries in all stages and even the unstageable.

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Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I would not have done anything different. The challenge was to identify what type of wound it was. Once it was identified, the selection of a barrier cream was implemented. Also, prevention is key and the teaching to patients and caregivers is also key. There was a language barrier as the wife only spoke Spanish. After the nurse who served as the translator left the room, I thought about it and wished she was there to emphasize to the patient's wife to avoid rubbing the skin during cleaning. I think that sometimes during cleaning people tend to rub too hard and may not gently clean the area. Also, one must look at the patient holistically and things like mobility, nutrition and social environment should be taken into consideration when implementing the plan of care and recommendations.
Reflection: Describe other patient encounters, types of patients seen.	We saw a total of 8 patients. It was a great opportunity working with a 1:1 preceptor so in I was able to ask her questions directly. My preceptor gave me the opportunity to diagnose the wound and asked what I thought prior to our discussion. I got to see a lot of Ostomy care as my preceptor is both wound and ostomy certified. We saw patients in both the clinic and hospital setting. Other patients that I saw included vascular, pressure, and post op surgical wounds with drains.

Reviewed by: _____ Date: _____

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