



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

Student Name: **Grace Prazniak** Day/Date: **January 12, 2024**

Number of Clinical Hours Today: **9** Care Setting: (**Inpatient Care**) Hospital \_\_\_ Ambulatory Care \_\_\_ Home Care \_\_\_  
Other: \_\_\_\_\_

Number of patients seen today: **6** Preceptor: **Sarah Yount**

Journal Focus: \_\_\_ Wound \_\_\_ Ostomy (**Continance**) Continance (**Patient had continance and wound issues, focus of journal is on continance**) 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.

<p><b>Today’s WOC specific assessment</b></p>	<p><b>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</b></p> <p>Patient is a 14 year old male with a history of myelomeningocele status post operative repair, neurogenic bladder, bowel incontinence, eczema, osteomyelitis, seizures, and developmental delay. Last seizure was noted in July of 2024 and was in the setting of a UTI. At home patient uses intermittent straight catheterization every two hours to manage neurogenic bladder. Sensation in the lower extremities is very limited although patient is able to turn himself in the bed without assistance.</p> <p>Current hospital admission is related to development of an infected pressure injury on the left buttock over the ischial tuberosity. Current management of the wound and incontinence include IV ceftriaxone, bi-weekly and PRN NPWT dressing changes set to -125 mmHg, an indwelling 14 French Foley catheter, and body worn diapers from home. All labs are within normal limits except for WBC count, which is slightly elevated at 11 k/uL. Current home medications include levetriacetam 1000 mg BID, oxybutynin 5mg daily, and ergocalciferol 50000 units once a week.</p> <p>WOC care was consulted for help with a leaking Foley catheter and a soiled NPWT dressing needing to be changed related to the leakage.</p>
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**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 team was consulted to see the patient in hospital for a soiled NPWT dressing needing to be changed. 14 French Foley catheter is in place for neurogenic bladder management and buttock wound management. Per notes from urology, patient uses intermittent catheterization at home, and can resume intermittent catheterization once cleared by wound care. Use of indwelling

catheter and need to decrease catheter size to prevent leakage was discussed with patient and mother at bedside, who expressed a desire to return to their home routine of intermittent straight catheterization every two hours. Foley catheter was removed and supplies were provided to the patient for intermittent self catheterization. Diaper was checked for fecal incontinence and found to be clean, discussed with patient and family the need to keep a bowel diary to help predict episodes of fecal passage to ensure prompt cleaning to protect skin.

NPWT dressing was removed with adhesive remover, periwound skin was cleansed with soap and water, and wound was assessed. Wound measures 2 cm L x 2 cm W x 2.2 cm D with a tunnel at 1 o'clock measuring 5.1 cm in length. Small amount of serosanguinous drainage present, with additional small amount of purulent drainage noted after probing the tunneled section of the wound. Granulation tissue is present covering 100% of the visible wound bed. Periwound skin has small area of maceration from 11 o'clock to 1 o'clock and area of healed hypopigmentation from 4 o'clock to 7 o'clock. Wound edges are slightly rolled.

Skin was prepared with 3M no sting skin barrier. Coloplast Brava barrier sheet washer was cut to fit around the wound and placed on the barrier. Transparent drape was placed over the wound and reached up to the left hip to form a bridge. Opening was cut in the transparent drape over the wound. Black foam spiral cut to fit into wound and bridge to left hip. 1 piece of black foam was placed over the transparent drape, then covered with additional drape to create a seal. Hole was cut at the left hip bridge for the Trac pad, and seal was obtained at -125 mmHg.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p><b>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</b></p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <p>Frequent wound dressing changes related to fecal incontinence and indwelling catheter leakage. Alternative: frequent dressing changes</p>	<p><b>Statements should be directive and holistic relating to the problem/concern.</b></p> <p>Remove indwelling catheter and implement intermittent straight catheterization.</p> <p>Keep a bowel diary of times and types of food eaten as well as times and consistency of bowel movements.</p>	<p><b>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</b></p> <p>Decreasing the size of the Foley catheter could resolve the issue of leakage, however family and patient preference indicate that intermittent straight catheterization would be a more appropriate option. Without the leakage, the dressing is less likely to become soiled.</p> <p>Keeping a bowel diary helps identify how long after eating bowel movements occur and identify links between types of food and transit time as well as types of food and fecal consistency. Using this it is possible to predict when fecal incontinence will occur, allowing for prompt response and cleaning, leading to the dressing being less likely to be soiled. Knowing what foods will cause looser stools can also be used to</p>

<p>Pressure injury related to impaired sensation. Alternative: pressure injury recurrence and poor healing</p>	<p>Use body-worn products to contain fecal incontinence.</p> <p>Monitor wound dressing for soiling.</p> <p>Institute a q2hr turning schedule for the patient.</p> <p>Make sure that lines and tubes are not placed beneath the patient.</p> <p>When possible, use pressure redistribution products when patient is sitting for extended periods, such as when using a wheelchair.</p> <p>Monitor skin of high risk areas for breakdown, focusing on coloration and temperature changes.</p>	<p>help keep stool formed and thus less likely to contaminate the dressing.</p> <p>Body worn products such as diapers and pull ups do not absorb stool, but they can be used to contain it and keep it away from the wound dressing.</p> <p>Monitoring the wound dressing on a regular basis – such as every two hours when straight catheterization is performed – will identify issues with the dressing rapidly and allow them to be addressed promptly for optimal wound healing.</p> <p>Having the patient turn at regular 2 hour intervals prevents injuries caused by pressure from developing and helps prevent current injuries from worsening.</p> <p>Keeping the area under the patient free of tubes and drains prevents the medical devices from causing pressure injuries, especially in patients who are unable to feel the devices underneath them.</p> <p>Using pressure redistribution products such as gel cushions for wheelchairs helps prevent pressure injuries from developing on bony prominences (such as the ischial tuberosities as in this case) by spreading the patient’s weight out over a greater area – in the case of sitting this often includes the greater trochanter and the femur.</p> <p>This particular patient has a dark skin tone as well as impaired sensation, so monitoring for erythema or pain is not going to be sufficient. Hyperpigmented areas of skin and temperature differences in skin are signs of injury and should be monitored for so that any pressure injuries can be identified early and interventions initiated.</p>
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<p><b>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an</b></p>	<p><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p> <p>14 French Intermittent Straight Catheterization kit – intermittent catheterization has the potential to introduce more bacteria and trauma to the urethra and bladder, and requires a significant amount of</p>
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<p><b>alternative to the product. <u>Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</u></b></p>	<p>time on the part of the bedside staff to complete every two hours. Alternative: indwelling Foley catheter (of smaller size due to previous leakage, attempt 12 French first)</p> <p>Diapers (home provided, brand unknown) – Diapers are not able to absorb the feces, instead only contain it and keep it away from the NPWT dressing to prevent soiling. Doing so poses a risk to the skin cover by the diapers if they are not checked and changed frequently enough. Alternative: absorptive pads</p> <p>3M No Sting Skin Barrier – skin barrier needed to be applied to a wide range of skin, and the wipes are not the easiest way of applying barrier to that large of an area. Alternative: 3M Cavilon No Sting Spray Skin Sealant</p> <p>Coloplast Brava barrier sheet – barrier sheet is a hydrocolloid meant to protect the skin, but may not be appropriate for overhydrated skin. Alternative: remove, only using skin barrier/skin sealant</p> <p>Transparent Drape/Black Foam/Trac pad/3M NPWT device – these products are bundled together as they are the only NPWT options available at the Cleveland Clinic. With this patient as the tunneling in the wound was thin, the black foam was less than ideal as it could not be cut small enough (and still be expected to remain in one piece for removal) to fit all the way to the back of the tunnel. Alternative: 3M Whitefoam dressing for areas of undermining</p>
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<p><b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b></p>	<p>My learning goal for the day was to work with NPWT. Goal was met and two patients with NPWT were seen and had their dressings changed.</p>
<p><b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b></p>	<p>Monday (next clinical day) will be in the inpatient setting again. If any patients I saw the previous week are still present, I would like to be able to follow up with them. I also plan to attend a class in the early morning being led by my preceptor. With patient care I would like to assess and change a dressing for at least one fistula.</p>

<p><b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b></p>	<p>This patient presents a series of challenges because of the location of the wound with the patient's incontinence and neurogenic bladder. In this case, I felt like our adjustments to the plan of care today were appropriate. While I might have been tempted to try a smaller size catheter to see if that would stop the leakage, family was clear that they wanted to return to intermittent straight catheterization instead of attempting another indwelling catheter. I felt like the NPWT portion of the encounter went much more smoothly and I would not have changed anything there, although since we were merely performing a dressing change due to soiling and assessing the wound for changes rather than altering the plan of care, I didn't feel like there was really any room for input or improvement in that area.</p>
<p><b>Reflection: Describe other patient encounters, types of patients seen.</b></p>	<p>Other patients seen today included a patient with an ileostomy in close proximity to multiple pinpoint fistula openings along the abdominal midline which posed a challenge to pouching. A patient with an enteroprostatic fistula with significant drainage that went through mesh that had been placed during previous abdominal surgeries. A patient with an almost-circumferential leg wound that was receiving NPWT and needed a dressing change and assessment. A pre-operative patient who needed to be marked in four sites for a possible ileostomy or colostomy for an upcoming surgery. A patient consulted for a leaky ileostomy pouch whose pouch was not leaking but did need to be changed, and was given a lesson on changing</p>

	and management with familial caregivers at bedside. Two other patients were briefly seen to give a second opinion on site markings for upcoming surgeries that were expecting to have either an ileostomy or colostomy.
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_