Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note for Wound and Fecal Incontinence

Student Name: Dyann Stewart Day/Date: 1/30/2024

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

Number of patients seen today: 4 Preceptor: Mary Montague, APRN, CNS, CWOCN

Directions: WOC nurses function as consultants and develop care plans for other caregivers 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	63 y/o male was admitted on 1/28/24 complaining of shortness of breath and anxiety, with a diagnosis of acute hypoxia exacerbation. The patient is being treated by his primary care team. PMH includes s/p Lung transplant (12/23), lung disease, CABG, CKD Stage 3, HTN, Hyperlipidemia, HFpEF, Type 2 DM, and A-fib. Medications include Acyclovir, Amiodarone, Aspirin, Eliquis, Inhaler, Insulin-sliding scale, Levaquin, Lipitor, Prednisone, Tacrolimus.

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.*

WOC nurse consulted for potential DPTI on the right heel and a Stage 2 pressure injury on the natal cleft. The patient is alert and oriented X3, sitting up in bed and talking with his primary nurse. He can turn independently for the skin assessment of the natal cleft, revealing unformed liquid soft stools and some soft brown stool present perianally. The right inner buttock appears red, with semi-moist partial thickness skin loss; the surrounding skin is intact. Respirations became labored with this activity. The patient is currently on 4L oxygen via NC. The natal cleft is clean, dry, and intact. Bilateral heels are clean, dry, and intact. The patient is currently on a low-air-loss mattress, heels offloaded with pillows. The plan of care was shared with the patient with recommendations to continue skin prevention measures, offload the heel when lying in bed, utilize the chair cushion when sitting up in the chair, and frequently shift positions. The patient denies pain during the assessment. No additional questions were asked by the patient during this visit. There is no family at the bedside. The WOC consulting team will continue to follow as needed.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

WOC Impressions:
Bilateral heels: Skin clear and intact; no skin discoloration
Natal cleft: Skin intact and pink.
Right inner buttock: Area of red, semi-moist partial thickness skin loss present; surrounding area intact; no drainage or odor noted. Etiology is likely MASD.
Left inner buttock: An area of intact pink dry skin was noted.

Recommendations:
Bilateral heels: Elevate heels off the mattress when in bed.
Provide a seating cushion when up in the chair.
Bilateral buttocks, perineal area: Thorough cleansing with a bath wipe and warm water after each toileting episode; apply Critic-Aid clear moisture barrier ointment BID and as needed to keep the areas covered at all times.
Continue skin prevention interventions based on the Braden risk assessment subset scores. The total Braden score is 15.
Low air loss surface
Skin prevention intervention measures are in place at all times.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Stage 2 Pressure Injury Right inner buttock	Perform daily skin assessment of the sacrum and buttock area.	Frequent skin assessments allow for early identification of skin damage, thus encouraging early intervention to prevent skin tears and pressure injuries.
	Apply a moisture barrier ointment to the area BID and PRN to the buttock using Critic-Aid Clear.	Applying a moisture barrier forms a covering over the skin to protect it from skin irritants and moisture.
	Encourage turning and repositing Q2 hours and offloading the heel off the bed or using pillows while in bed.	Turning/repositioning will help to alternate pressure off boney prominences.
	Encourage using a waffle cushion when sitting up in a chair to offload pressure of the sacrum and buttocks.	Using specialty devices such as (cushion, mattress, heel boots) will also help to reduce pressure.
	LAL mattress to bed	Helps to keep the skin dry as well as relieving pressure by providing a constant airflow to the skin.
Altered Skin Integrity related to Moisture-Associated Skin Damage	Clean vulnerable skin with warm water, a soft washcloth, or a disposal wipe using minimal rubbing after each incontinent episode.	Cleansing helps keep skin clean and dry, free from irritants, to prevent skin breakdown resulting in a pressure injury.
	Apply a skin barrier to the skin after each bowel movement, such as Desitin cream.	Skin barrier creams coat the skin and form a barrier against skin irritants, protecting the skin from excessive moisture.
	Conduct hourly rounding to offer frequent toileting breaks.	Frequent toileting breaks prevent retaining moisture on the skin, thus keeping the skin clean and dry.

Discharge planning	Consult the Social Worker and Case Manager to assess any specific needs before discharge.	Early assessment engages the patient in the discharge process and identifies specific needs prior to the discharge date. This will prevent discharge delays.
	Consult the discharge planner to assist with returning to the facility and securing pressure redistribution devices.	The discharge planner can work with the facility to secure items for when the return visits.

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. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	Critic-Aid Clear and Desitin are skin barrier ointments protecting skin from irritants. A disadvantage of using the product is that it can sometimes cause redness or itching in the area where the ointment is applied. An alternative would be to keep the skin clean and dry by offering frequent bathroom breaks. Also, allowing the skin to be open to air while lying in bed. LAL mattress is an added expense. An alternative would be a waffle overlay or creating a frequent turning schedule, Q2 hours, and offloading with foam wedges.

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 was to see wounds requiring dressing changes performed at the bedside with the primary nurse to ensure the recommendations were clear and any questions could be answered at that time. My goal was met. I was able to see a one-piece pouching system placed on a patient s/p an esophagectomy.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I would like to perform a dressing change on a Stage 3 or 4 pressure injury.

Reflection: Describe other patient encounters, types of patients seen.	We saw a total of four wound consultations involving wound

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **<u>48 hours</u>** following the clinical experience day.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	recommendations. Two of the consults were to validate a Stage 3 sacrum pressure injury and DTI on the left ear. After assessing the patient, both patients were free of a skin injury. After visiting our patient, we attended a Listen and Learn In-Service with Coloplast.

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.