Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Danielle Rising_____ Day/Date: 2/1/24

Number of Clinical Hours Today: _10___ Care Setting: _x__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __10___ Preceptor: __Janie Renaud_____

Journal Focus: _____Wound _____ Ostomy ___x___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.** This is an 81-year-old male with a past medical history of DM, dementia, malnutrition, and recurrent UTI. Patient presents to the ED with c/c of failure to thrive. Patient lives at home where his wife is his primary caregiver. She states he has decreased fluid and nutrition intake in the last couple of days. Has increased confusion for the last couple of days. Patient complains of increased weakness and fatigue. The patient's wife states that he was too weak to get up off the couch unassisted, and she has not been able to help him off the couch either. He primarily wears adult briefs due to fecal incontinence. The patient's wife states that his incontinence status has worsened since the patient's weakness has increased. Indwelling foley catheter in place. Per patient's wife, urine output has substantially decreased and on 1/31/24 she noted the urine was cloudy. Due to this, the wife called EMS and brought him to the ED on 1/31/24. Urine culture obtained and revealed current UTI with Serratia marcescens.

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.
This is the initial consultation for assessment of the patients' buttocks. The patient was rolled to the right side using maximum assistance by two WOC nurses. During assessment, attention to the Braden scale was utilized and the patient was scored at a 12. It was noted that the patient had been sitting in stool for an unknown amount of time while in the bed. There was no protective barrier paste on the patients' buttocks at time of assessment. Peri-care was provided to gently cleanse the stool away using soft premoistened disposable towelettes. Blanchable erythema was noted to the patient's sacrum and bilateral buttocks. Hyperpigmentation is noted to the patients' bilateral buttocks likely due to chronic moisture associated exposure. A fissure was

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noted to the patients intergluteal cleft, likely due to moisture exposure as well. A moist red, partial thickness wound measuring 1.8cm x 1cm x 0.1cm is present to the right perianal area. This wound is of irregular shape, completely blanchable and due to moisture associated skin damage as well as friction from cleansing. This wound is a top-down injury. There are no indicators of this wound or irritation being related to pressure to the muscle-bone interface. Protective barrier cream with zinc oxide was applied to the patients' entire buttocks and sacrum area. The patient has an indwelling foley catheter in place and is draining properly. Urine appears straw color and clear at this time. The bilateral heels were assessed while the patient was turned to his side. Assessment reveals bright red blanchable erythema. Due to his limited mobility, his bilateral elbows were also assessed and revealed bright red blanchable erythema. Heel foam borders with silicone adhesive was applied to the patients elbows to protect against friction, shearing and pressure. The patient was rolled back into the supine position. The patient was turned and offloaded to the right-side using wedges. TruVue offloading boots were applied to the bilateral heels as a pressure preventative. The bilateral elbows were also lifted off the bed's surface using pillow support. The wife stated that the patient normal defecates in the bathroom, and that his increase in weakness resulted in his incontinence. This type of fecal incontinence is likely urge incontinence. The patient and his wife were educated on calling the bedside nurse before or when episodes of fecal incontinence occur for prompt cleansing. The wife agreed to plan, however, due to patients' increased confusion related to the current UTI, the patient was unable to agree to this at this time. The patient's primary RN and PCT were in the patient's room at time of the assessment and were educated on the importance of proper peri-care. Physical therapy was consulted. Skin care ordered.

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***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
1. Fecal incontinence resulting in moisture associated skin damage.	1. Offer use of the bedpan every 2 hours. If stool is noted prior to the 2-hour mark, initiate timed voiding every 1 hour. Bedside nursing to return to bedside within 10 minutes of patient using the call bell. This patient (and wife) was educated on how to use the call bell was urge is identified. Provide peri-care within 10 minutes of fecal incontinence. This patient and his wife were educated on how to use the call bell when	1. Frequent assessment and offering of bedpan can lessen the frequency of fecal incontinent episodes. This can also lessen the amount if time that stool is exposed to the skin. Returning to bedside within 10 minutes of the patient noticing the urge can lessen incontinence episodes. This is called times toileting. Cleansing the patient within 10 minutes will reduce the length of moisture exposure.

	incontinence is noted.	
	Apply protective barrier cream with zinc oxide (Triad) BID and PRN due to episodes of incontinence.	Ensuring that the patients buttocks is protected using barrier paste with prevent from additional moisture breaking down the epidermis.
	Remove only the soiled areas of the Triad barrier paste during times of incontinence. This can be done using an adhesive remover.	Removing only the soiled areas is all that is needed during cleansing. Reapply another layer after cleansing. Barrier paste can be easily removed using an adhesive remover. This will prevent friction and shearing.
	Avoid the use of briefs while in bed. This is only appropriate when the patients is ambulating.	Briefs trap in moisture causing damage to the epidermis.
	Assess the patient's buttocks BID at the start of each shift. Remove Triad barrier paste using adhesive remover or mineral oil. Notify WOC nursing of any alterations noted to the skin. Document assessment.	Assessing the patients' buttocks BID promotes aid in identification of additional breakdown, worsening areas or new areas of concern. Removing the barrier paste using adhesive remover will prevent stripping the skin during cleansing.
2. Limited mobility related to recent increase in weakness.	Use a pressure redistribution mattress such as a Hilrom P500 low air loss mattress.	This specialty mattress is designed to prevent against pressure injuries. This mattress promotes an increase of airflow beneath the patient, aiding in the treatment in his buttocks.
	Only apply one chuck beneath the patient.	Additional layers beneath the patient decrease the airflow to the affected area. Additional layers also increase the extent of pressure to the area.
	Physical therapy consulted for muscle strengthening.	Muscle strengthening promotes resumption of ambulation. This promotes patient independence in toileting. Strengthening muscles can also aid to decrease incontinence.
	Turn and reposition the patient every 2 hours while in bed.	Scheduled turned promotes a decrease the risk of developing a pressure injury.

	Turn and reposition the patient every 1 hour while sitting up in the chair. Use a chair cushion.	More frequent turning is needed due to the angle/pressure increased in the buttocks while sitting up. A chair cushion can provide additional prevention against pressure injuries.
	Use TruVue pressure redistribution boots.	These boots are designed to lift the patient's heels off of the beds surface, decreasing to risk of pressure injuries.
	Assess the patient's pressure points BID and notify WOC nursing of alterations in the patients skin. This includes the patients' heels, sacrum, coccyx, spine, elbows, scapula, and posterior head.	Each of these areas are at increased risk of skin breakdown related to pressure when laying supine in the bed. The buttocks is at an increased risk related to the already damaged epithelium due to moisture.

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.** Adhesive remover: can aid to easily remove barrier paste for assessment. Barrier paste can be removed without rubbing or stripping the skin, avoiding friction. This may not be readily available. Alternative: warm water and mild soap. Mineral oil or baby oil. This can aid for ease in removal of barrier paste. TruVue offloading boots: lifts the heels off the bed surface to prevent prolonged pressure to the area. This will decrease the patients' risk of developing a pressure injury on the heel. Patients may find these pressure reduction boots to be hot or bulky. Alternative: offloading the heels using pillow support. Be sure to use a fluffier pillow to maintain pillow support. Hilrom P500 low air loss mattress: A pressure redistribution specialty mattress that pumps airflow throughout the mattress. This airflow will aid in allowing the patients buttocks to heal. This specialty bed is added to the patients insurance bill. Alternative: isogel bed pump. This bed pump is readily available in the hospital and can be applied to the standard bed. This air pump mimics the same specialty features as the P500. Triad: a hydrophilic barrier paste that protects the skin from moisture and can adhere to wet skin. Disadvantage: this specific barrier paste may not be available at every facility. Alternative: a barrier paste that contains zinc oxide.

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 today was to see a continence patient. Today I was able to see many patients who were affected by incontinence associated skin damage. Some of these patients were cognitive and were able to comprehend education, however, other patients were not able to comprehend education due to severe dementia. This factor placed emphasis on nursing interventions and provided me the knowledge of emphasizing this to the nurses.

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What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My learning goal for next clinical day is to care for a wound patient.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	During this encounter, the patient showed severe dementia and was unable to properly learn interventions that could benefit the patients well-being. A family member was present and was able to participate in education. I wish this patient was able to comprehend the education so that the WOC team could follow up on this patients knowledge progress.
Reflection: Describe other patient encounters, types of patients seen.	Today, we saw a patient with a stage 4 pressure injury that was 100% covered with fibrinous slough. There was no odor present, however, patient has a diagnosis of osteomyelitis related to this wound. General surgery was consulted, a VASHE wet to dry was placed, Dakins wet to dry was ordered BID and the primary RN was at bedside. The physician was also at bedside and was able to assess the wound while we talked about the plan of care. This was a great interdisciplinary care experience!

Reviewed by: _____ Date: _____

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