Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Michele Ramirez Day/Date: Thursday, February 2, 2024

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

Number of patients seen today: ___7__ Preceptor: _Jennifer Brinkman___

Journal Focus: __**X**___Wound _____ Ostomy _____Continence _____Combination Specify: _____

Directions: WOC nurses function as consultants and develop plans of care 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) that directs care.

This assignment should be WOC-focused and approached as 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 data 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 the course to assist you with this assignment.

Today's WOC specific assessment	Unable to obtain, patient in the ICU with a tracheostomy and on ECMO. A 62-year-old female with an admitted diagnosis of End Stage Heart Failure is being managed by the primary team. The patient is known to WCCT for right buttock extending onto the coccyx and left buttock pressure injury that is hospital-acquired. Also seen for left upper anterior thigh (old trialysis catheter site). Last seen on 1/26 by WCCT with a plan of care placed. On 1/31/24, the patient developed a perianal injury, and WCCT was consulted back to evaluate.

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 patient is being seen at the provider's request for a WCCT opinion regarding a new perianal injury. The skin was assessed, and the following was noted:

- Right buttock extending onto coccyx and left buttock: stage 3 pressure injury. The wound is 4 x 14 x 0.3 cm with red, yellow tissue in the base and brown, dead epidermis on the outer periphery. Edges are intact and irregular. Surrounding skin is intact. The injury was previously unstageable and appeared to have evolved to stage 3 at this time.
- Left upper anterior thigh Trialysis/Apheresis catheter site: ? Fungal rash. The catheter was previously removed. The area is now red, brown, dry, crusty, peeling tissues. Edges are very irregular and intact. Surrounding skin is intact and clear. The area is much improved when compared with the previous photo taken on 1/26. Will discontinue antifungal cream and now use moisturizing cream.
- Perianal: device-related mucous membrane pressure injury. Wound is 1 x 1.5 x 0.2 cm with red tissue in the base. Edges are intact and linear on the bilateral sides. Surrounding skin is intact. Etiology is likely pressure from the current FMS.

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

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- Right groin incision did not evaluate this visit.
- GI: FMS to GD draining brown liquid stool.
- GU: Foley to GD draining clear yellow urine.

Plan:

- Right buttock extending onto coccyx and left buttock: Remove old dressing, cleanse wound with normal saline and then gently dry. Prep surrounding skin with Sting-free skin barrier. Allow to dry. Apply Hydrogel to wound bed and with ABD.
- Right groin wound: Remove old dressing, cleanse wound with normal saline and then gently dry. Apply Urogtul to open portion of wound and cover with dry dressing. Change dressing daily.
- Left anterior thigh: Remove old dressing, cleanse wound with normal saline and then gently dry. Apply Sween cream to dry skin only and cover with ABD. Perform care BID.
- D/C 2% miconazole cream.

WCCT will continue to follow up on patient status. Please re-consult WCCT sooner if wound worsens.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Impaired Skin integrity related to critical care status, prolonged immobility, and moisture.	- Right buttock extended onto the coccyx and left buttock: Right buttock extending onto coccyx and left buttock: Remove old dressing, cleanse wound with normal saline and then gently dry. Prep surrounding skin with Sting-free skin barrier. Allow to dry. Apply Hydrogel to wound bed and with ABD. - Right groin wound: Remove old dressing, cleanse wound with normal saline and then gently dry. Apply Urogtul to open portion of wound and cover with dry dressing. Change dressing daily. - Left anterior thigh: Remove old dressing, cleanse wound with normal saline and then gently dry. Apply Sween cream to dry skin only and cover with ABD.	- Sting-free skin barrier protects skin from irritants and other harmful substances. Creates a protective layer on the skin. - Hydrogel provides a moist environment that promotes healing and prevents infection. - Urogtul provides a moist environment that promotes healing and helps prevent infection. - Sween cream is used in the management of dry, cracked, or irritated skin. It helps restore moisture to the skin and prevent further dryness and

Maintain skin integrity to prevent further skin breakdown	Perform care BID. - D/C 2% miconazole cream. - Desitin to perianal area BID and as needed. - Tru-Vue heel protectors to bilateral lower extremities. - Maintain TAP System, turn patient every 2 hours using the TAP wedges avoiding pressure over the coccyx/sacral region. - Sween cream to bilateral feet BID. - Maintain low air-loss bed while in the ICU.	irritation. - Desitin is a type of skin protectant used in the management of skin integrity. Active ingredient is zince oxide, helps to soothe and protect the skin. - Tru-Vue heel protectors designed to prevent and treat pressure injuries in patients who are bedridden or have limited mobility. - Low air-loss bed provides patients with a comfortable and therapeutic environment that promotes healing and prevents the development of pressure ulcers. Designed to distribute the patient's weight evenly and reduce pressure on bony prominences.

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	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Convatec Sting-free skin barrier – may not be as effective as traditional barriers at preventing skin breakdown. Can also be expensive—alternative: Coloplast Moisture Barrier Cream. Hydrogel (DuoDerm) may require frequent changing, which can be time-consuming and costly. Alternative: UrgoTul. Sween cream can cause stinging/redness/burning/irritation to skin. Alternative:

used if the product was not available?	Coloplast Moisture Barrier Ointment.

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?	Yes, I met my goals. My goal was to assess different types of wounds, their causes, and appropriate wound care practices.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To learn about different strategies to prevent wound complications and products used at this facility.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Reinforce teachings to bedside nurses to ensure all measures are in place to treat and prevent PI.
Reflection: Describe other patient encounters, types of patients seen.	I had the opportunity to work with patients who presented with complex surgical wounds, pressure injuries, and instances of incontinence-associated dermatitis (IAD).

Reviewed by: _____ Date: _____

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