Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lindsay Glorioso Day/Date: 2/9/24

Number of Clinical Hours Today: 8-4:30_ Care Setting: X Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: 6 Preceptor: Kristine Woodsworth

Journal Focus: 4 Wound 1 Ostomy Continence Combination Specify: 1 (Wound/ Continence)

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.** 53 year old female PMHX vitamin B12 deficiency, pancytopenia, anemia of chronic disease, history of gastric bypass, hyponatremia, hypertension, hypokalemia, thrombocytopenia due to prior alcohol abuse, suspected alcoholic fatty liver, anxiety, depression, morbid obesity, mixed urinary incontinence with recurrent UTI presented to ED for complaints of abdominal pain. Patient denies fever, nausea, vomiting. Reports abdominal pain with urinary frequency without dysuria or hematuria. She presented to ED because she felt symptoms were like previous UTI. On ED evaluation patient was afebrile, blood work with pancytopenia WBX 2.1, Hbg, 9.4, PLT 93, Lactate 4.8 with repeat 3.3, Albumin 2.4, Bun/creatinine 8/0.67, Mg 1.5pregnancy test negative. UA obtained via straight catheter- consistent with UTI (3+ leukocytes, positive nitrates, >50 WBC, many bacteria). Blood cultures pending. CT Abdominal/ pelvis revealed mild increasing ascites with anasarca, hepatosplenomegaly, right greater than left atelectasis versus pneumonia. In ER patient received 2.5 L of LR IV fluids, was given one dose of Zosyn prior to urine sensitivities. Urine culture reviewed >100,000 cfu/mL E. Coli. Dietary has been consulted, receiving Ensure Compact with lunch and dinner meals. WOC was consulted today for evaluation of wounds to right calf, under abdominal folds, and urinary incontinence.

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.
Patient seen at bedside today. Verbal consent obtained for evaluation. The patient is morbidly obese, has diffuse anasarca throughout the body, and is resting in bed and eating breakfast. Reports she lives at home with her husband, who works during the

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day. Reports she is mostly homebound, does not regularly follow with PCP. Reports recurrent UTI and urinary urgency, frequency with incontinence. She reports due to urinary symptoms, she is unable to make it to the toilet, is incontinent in bed, and usually changes her sheets herself unless her husband is home. She reports difficulty cleaning herself and does not aware of wiping front to back. Patient has PuraWick incontinence management device in place with clear dark yellow urine in cannister. Abdominal wounds chronic, scattered open areas down to subcutaneous tissue along skin fold, tissue moist red granular to hyper granular tissue, no induration or signs of bacterial or fungal infection, has been applying cream at home, but unclear of name. She does clean her skin folds daily. RLE lateral aspect wound without clear etiology, suspect trauma complicated by pressure in setting of pancytopenia. On physical exam discoloration purple consisted with ecchymosis bruising 5.5x 6 x 0.1cm with scattered partial thickness wound down to dermal layer with most red tissue, mild tenderness on palpation without induration or cellulitis streaking, no active weeping noted to BLE.

Assessment: Mixed urinary incontinence with retention urgency and frequency; MASD to abdomen, RLE lateral aspect traumatic ulcer

Plan:

- Toilet routine Q2H with post void bladder scan for urinary retention.
- Perform bladder scan Q6H per physician order
- Perform straight Cath procedure for residuals over 300mL per physician order
- Abdominal- wound care- Cleanse with wound cleanser or soap and water, pat dry. Apply InterDry to abdominal skin folds. Change Q3D PRN soiling.
- RLE- wound care- Cleanse with Coloplast wound cleanse or soap and water, pat dry. Apply Allevyn bordered foam to wound. Change Q3D PRN soiling. Utilize the offloading 'Heels Off' device to float heels. Avoid pressure to open the wound
- Reconsult WOC if deterioration or concerns are noted.

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.	**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.**
Mixed urinary incontinence with retention and recurrent UTI	Toilet routine Q2H with post void bladder scan for urinary retention. If PVR greater than 400 straight Cath per physician order. Avoid indwell foley catheters due to risk of infection. PT to evaluate and formulate plan. Administer IV antibiotics per physician order. Educate patient on proper toilet hygiene- wiping front to back, toileting schedule, hand hygiene post void. Recommend establishing with urology post discharge	Mixed UI with retention. Patient has PureWick in place now, however toileting schedule is recommended to initiate. Do not anticipate D/C with purawick. Educated on proper toileting hygiene provided to prevent additional contamination risk of UTI. However given mobility and body habitus anticipate some difficulty with this.

		UTI abx management per physician There is no current urology consult, and WOC is unable to make orders for referral; only recommendations recommend she establish urology given recurrent UTI. May benefit from urodynamic testing in the future.
Impaired Skin integrity – Abdomen and RLE	- Wound care: - RLE- Cleanse with wound cleanser or soap and water. Apply Allevyn bordered foam QOD - Abdomen- cleanse with wound cleanser or soap and water, pat dry. Apply Interdry to abdominal skin folds. Change Q3D PRN. Skin folds will keep Interdry in place, no additional tape or dressing required. - Elevate lower extremities while at rest in bed or chair. - Q2H turn and repositioning. - Float heels on pillows or supportive wedge while in bed. - Consult with PT for evaluation and plan - Continue recommendations by dietary for management of malnutrition. - Continue WOC if patient develops additional skin breakdown, concern for deterioration or new wounds.	Skin cleanse is a gentle, nontoxic choice for this patient; soap and water are the second option. RLE is stable without infection, bordered foam will allow drainage control, and silicone backing will be atraumatic to skin—no additional creams or dressing recommendations due to the risk of maceration or trauma. Patient condition places her at high risk for PI (obesity, anasarca, malnutrition) so offloading interventions are needed as preventative strategy. Ultimately, healing will depend on anasarca edema management, avoidance of pressure, and optimal nutrition. PT can identify patient-specific plans and recommend interventions. Dietary can identify patient's needs for wound healing in setting of malnutrition, morbid obesity, and anasarca.
Discharge planning	Discharge planning per attending and PT evaluation.	Anticipate D/C to rehab prior to home.

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. <u>Alternatives should be from a different category or classification</u>. 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.** No products were utilized today regarding incontinence. Will continue with PureWick at this time We recommend avoid diapers and folding disposable chucks by patient due to moisture and possible infection. Abdominal skin fold wounds: Interdry- disadvantage- none in inpatient setting. Patient with minimal activity therefore low risk that will become dislodged. Outpatient setting is not typically covered by insurance, can be costly.

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used if the product was not available?	RLE- Allevyn bordered foam- disadvantage- absorbent qualities only, no antimicrobial coverage. Alternative: oil emulsion ABD rolled gauze

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?	Goals were to see a continence patient. We had one on our assignment. I provided good education to this patient re: anasarca, moisture associated skin lesions, hygiene. We also spent time doing some photo validations and had in-depth discussions as a team for reperfusion v. pressure injury
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Next week I plan to spend more time with ostomy and continence patients as well as explore additional urodynamic testing procedures.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Urology was not consulted on this patient at this time. I do believe she should follow up with urology once discharged and may need outpatient cystoscopy to determine etiology of retention and recurrent UTI. However, WOC cannot make this referral, will likely need to come through PCP. Wounds complicated by obesity, limited mobility, pancytopenia.
Reflection: Describe other patient encounters, types of patients seen.	NICU Baby Full time- WOC consult subcutaneous fat necrosis back and buttock. Patient evaluated to have no open wounds, but small area of subcutaneous necrotic fat was noted no intervention other than to monitor. Additionally, patient had Mongolian spot over lower lumber region, no intervention. LE wound- 60 yo obese male hx crush injury to LLE 2017 with lateral aspect residual wound that required NPWT and failed STSG attempts. Wound did heal in years prior with local wound care and multilayer compression wraps, but has residual lymphedema for which he wears compression stockings at home, unable to tell me strength. Works as forklift driver. One week ago redeveloped pain and swelling to medial aspect of leg to the point he did not walk on it. LLE lateral aspect reopened in setting of increased edema and cellulitis. Now with full thickness wound approximate 1.5x 2 x0.3cm with slough over granular tissue and active weeping. Currently without dressing or compression, peri wound without induration, tenderness or erythema. Erythema to medial aspect with tenderness, no cellulitis streaking. Venous U/S negative DVT. CT LLE without drainable fluid collection, consistent with soft tissue cellulitis. WOC recommends aquacel ag with mepilex bordered foam QOD PRN. Continue elevation. Abx per ID. Will need long term compression. ED consult for worsening PI. Patient was discharged 2 hours prior to readmission. Sacral ulcer chronic due to reperfusion injury complicated by pressure. Patient was admitted 12/203 re: cardiogenic shock secondary to A. Flutter with RVR. Hx of prolonged hospitalization 2017 re: ARF and ARTS requiring ECMO, subsequent trach and peg, complicated by pneumoperitoneum requiring exploratory laparotomy with anterior gastric wedge resection and left sided VATS and Afib. Patient left

	hospital AMA during this admission. On admission for cardiogenic shock patient PEA cardiac arrest and required aortic valve replacement. PI stable, receiving local wound care with medihoney and bordered foam everyother day. Patient had discharge orders as WOC evaluated. Patient will follow up at outpatient WCC Reviewed suspected PI post op CABG x 6, versus reperfusion. Wound was on lateral aspect of left heel, patient has GSV harvested from LLE. Team was questioning if there was it was reperfusion due to occlusion from position device under knee. However, I suspect leg was external bent rotated to harvest GSV and may be inadvertently experienced pressure. ED consult – leaking loop ileostomy. Plan for reversal in upcoming weeks. Reports leaking over last week, HHC came out to change last night, patient reports unable to change himself due to LUE neuropathy limited dexterity. On exam non obese patient with loose flabby abdomen, using two piece with hard plastic attachment ring, had creases as 7 and 3 oclock. HHC was using duoderm, stomapaste and two piece pouching. We applied stoma powder and skin barrier sealant and used a one piece firm convex with belt. No issues with application. Patient was sent home with two additional pouches and contact number for Ostomy Clinic if additional help is needed.

Reviewed by: _____ Date: _____

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