Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Rachel Pierre-Chery__ Day/Date: 12/18/2023

Number of Clinical Hours Today: _8___ Care Setting: ___ Hospital __X_ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: 20 Preceptor: __Jennifer Onorato, FNP-BC, CWNCN

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.

Chief Complaint	Sacrum pressure injury F/U
HPI:	78 years female patient wheelchair bound with history aphasia due to CVA. Patient is here today for sacrum pressure injury follow up. Patient is here accompanied by twin sister. Patient is poor historian sister reports new wound event. 3 days ago, patient and sister went to Sedona. It was a long 3 hours' drive. At Sedona they were there a little early and they had to wait 2 hours before they were able to be checking at their hotel. Patient spent about 6 hours sitting in total on that Saturday. Sister reports has noticed a worsening of the pressure injury since Saturday. Reports pain and has been taking pain medication more often for the 2 days. Reports scant drainage.
Allergies:	NKDA
Medications:	Oxycodone 5mg, Amiodarone 100mg, Levothyroxine 88mcg, Losartan 100mg, Miralax, clopidogrel 75mg.
WOC-specific assessment	
Sacrum Stage 3 Pressure Injury	Upon assessment, a stage 3 pressure injury was identified on the Sacrum area, measuring approximately 8 X 6.5 cm. The wound care plan includes the continuation of treatment with hydrocolloid gel. Prior to application, the wound was meticulously cleansed with a wound cleanser and covered with a foam dressing to maintain a moist wound environment conducive to healing. The patient is currently utilizing a low air mattress at home to minimize pressure on vulnerable areas. To further alleviate pressure, the patient will continue to utilize heel boots for offloading. Additionally, the patient has an indwelling catheter in place, and it was emphasized to the caregiver the importance of maintaining cleanliness around the wound site, particularly to prevent contamination from feces. Education was provided to the patient and caregiver regarding the significance of regular repositioning while seated and the importance of avoiding prolonged periods of sitting. The patient was encouraged to change positions regularly to relieve pressure on the sacral

(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.

	area and reduce the risk of further skin breakdown.

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.*

Make sure you include a narrative note. You mention some points above that were addressed and important to include. – consider your charting from a legal review standpoint. What did you do at the visit? Did the patient tolerate? Were further interventions needed? Did you make any consults/referrals? Did the patient have further questions/were they addressed?

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
WOC Recommendations Sacrum Stage 3 Pressure injury Nutrition	Daily dressing change: Wash the site with wound cleanser then covers with foam dressing.	Wound cleansers often have antimicrobial properties that help reduce the bacterial load within the wound. By cleansing the wound site, the risk of infection and subsequent complications is minimized, promoting optimal healing conditions. Foam dressings provide a protective barrier over the wound site, shielding it from external contaminants and mechanical trauma. The soft and cushioning properties of foam dressings help distribute pressure evenly across the wound area, reducing the risk of further tissue damage.

(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.

	Encourage to self or with the help of someone else to reposition every 2 hours when in bed. If you are chair avoid sitting no more than 2 hours Keep using your chair cushion for pressure relief. .	Repositioning enhances circulation to the tissues, promoting nutrient delivery and waste removal. Improved circulation helps maintain tissue health and function, reducing the risk of tissue damage and necrosis associated with prolonged pressure.
	Pain medication prior to dressing change.	Pain can be a significant barrier to compliance with wound care regimens. By addressing pain proactively with medication, patients are more likely to adhere to their treatment plans and undergo dressing changes as prescribed, which is crucial for promoting wound healing and preventing complications.
Discharge Plan	Include in your diet 3-4 servings daily of foods such as meat, eggs, fish, beans, and nuts. Include good sources of fat: cooking oils, meats, cheese, yogurt, and milk. Eat at least 5 servings a day of fruits and vegetables.	Important to stay hydrated which can help with defecation. Protein helps repair damaged tissue. Fat from dairy products is essential for wound healing. Vit A and C from fruits and vegetables help fight off infection and control inflammation. Protein intake is necessary for normal body function and to help heal skin breakdown. Dietician can identify patient's specific need and make recommendations to enhance healing.
	Educate sister on the watch on signs and symptoms of UTI since patient has an indwelling catheter.	Adequate fluid intake is essential for maintaining urinary tract health and

	Encourage on adequate fluids intake .	preventing UTIs. Encouraging the patient to consume ample fluids helps promote urinary flow and flush out bacteria, reducing the risk of catheter-related infections. Advising individuals to aim for a specific number of cups or ounces of fluids per day, such as 8-10 cups (about 2-2.5 liters), is based on general hydration recommendations that support optimal health and well-being
	What would prompt a return to the ED or follow up with W care nurse?	New symptoms associated with the pressure injury, such as fever, chills, nausea, vomiting, or changes in mental status, may indicate systemic infection or other complications requiring medical attention. These symptoms should not be ignored and should prompt a visit to the ED or follow-up with a healthcare provider. With the presence of an indwelling catheter patient is prompt to have UTI. Important to seek medical advice on a any change of LOC.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the	In place of Hydrogel, we could also use Collagen gel since the wound did not have too much drainage. In place of foam dressing, we could also use Transparent film dressing

product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	

Develop one learning goal for each clinical day, document that on this form then share your goals with yur preceptor.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	It was my last day today at the clinic I feel that I have learned a lot during those 40 hours. Since I am already working 40 hours a week, my goal is to try to find a PRN wound care job to practice my wound care skills.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal on the last day was to be able to work with NPWT. Unfortunately, we did not have one today, but still I feel that day was filled with a lot of good knowledge. - *NPWT is a good skill to have, I do recommend seeking out this experience. With your topic for journal #4 if you choose not to revise it, I can provide a NPWT simulated experience if needed to fill the gap from the repetitive submission, let me know.*

Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Today I had the chance to see patients with surgical wound dehisce of the abdomen, pressure injury, on HBO, LLE veinous ulcer disease.

Reviewed by: _Mike Klements_ received__2/23/24__ Date: 2/26/24

Hi Rachel – see my notes throughout this journal. A thorough note is needed prior to qualification as a satisfactory submission. Please update and return to the dropbox. Reach out with any further questions. -Mike
/

Reviewed:

(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.