Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Elisa Weil Day/Date: 7-17-24

Number of Clinical Hours Today: 10

Care Setting: Hospital x Ambulatory Care ____ Home Care ____ Other ___

Preceptor: Janie Renaud

Clinical Focus: Wound ____ Ostomy x Continence x

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Today we say a total of 9 patients. We started the day doing a site marking for a 49 year old male admitted with an anastomotic leak. This was a very pleasant gentlemen that has had a rough few months. The patient underwent a LAR and ileostomy in May of this year with a reversal in June all done at a different hospital system. The patient was then admitted on 7/2/24 for abdominal pain, nausea and vomiting and at the time CT of the abdomen showed concern for an ileus. The patient underwent a decompressive colonoscopy which improved his symptoms. The patient was discharged on 7/9 but returned to the ER with complaints of abdominal and suprapubic pain. CT of the abdomen at the time showed a peritoneal abscess as a result from an anastomotic leak, and colonic stricture. We were consulted for stoma site marking. The patient requested that we do site marking in only the lying and sitting position as he felt to weak to stand at this time. The abdominal rectus muscle boarders were located, and sites were identified in the LR and LL quadrants. The sites were marked with skin markers and covered with Tegaderm. The patient is to be taken to the OR today.

The next ostomy patient was saw was a 77 year old female retired nurse admitted with a small bowel obstruction. The patient had a loop ileostomy created in May of this year. The patient has undergone 2 treatments of chemotherapy and the colorectal physician believes she has developed an ileus from the chemotherapy. The patient has a NG tube to the left nare, to gravity drainage. Our visit was for an appliance change. Prior to changing the pouch, 200 ml of green, watery effluent was discarded. Adhesive remover wipes were used to remove the pouch. The stoma moist and red, measured 7/8" in diameter, and was above the skin. The peri-stomal skin was denuded. Crusting technique was used when preparing the peri-stomal skin. A Cera Plus ring was applied. The patient's pouching system of choice was a Hollister 1 piece cut to fit barrier. Once applied, barrier extenders were applied.

The last ostomy patient we saw was a 66 year old female admitted for rectal cancer. The patient was POD #5 for a diverting loop ileostomy. The patient was experiencing discomfort and nausea and did not want any teaching done today. The patient had a JP drain to the RLQ with serosanguinous output. An NG tube was placed in the left nare to low intermittent suction. The patient was agreeable to a pouch change and rod removal. The patient had approximately 100 ml of green water effluent prior to pouch removal. The pouch was removed with adhesive remover spray. The area was cleansed with soft cloth and water. The stoma was 1 ¾" x 1 ½" oval, it was moist and pink. The peristomal skin was erythematous but intact. The sutures were cut and the rod was removed. Crusting technique was used around the peristomal skin and a Cera Plus barrier ring was applied. The patient was pouched with a Hollister 2 piece 2 ¼" flat cut to fit barrier with drainable pouch. A started kit of supplies was provided for patient with post operative teaching scheduled for Friday.

We saw a 64 year old male admitted on 7/10/24 to the SICU for carotid artery stenosis with cerebral infarction. This patient had an indwelling urinary catheter placed in the OR on 7/16/24. We were consulted for redness to the buttocks. Upon assessment, patient presented with hyperpigmentation and scattered maculopapular rash with fungal indicators to buttocks and groin. The patient was cleaned with bathing wipes and Miconazole powder was applied. The patient was offloaded with pillows.

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Next we say a 66 year old female admitted for Hepatic Encephalopathy. This patient is known to wound care team from previous visit with incontinent associated dermatitis. The patient is incontinent of both urine and feces. The patient presents today with healing partial thickness wounds to the sacrum and natal cleft. A female external catheter was in place however absorbent pad under patient was saturated with urine. The patient was cleaned with bathing wipes and skin prep was applied to areas of breakdown, and a foam bordered dressing was used to prevent friction damage.

We saw a 39 year old female admitted for cellulitis. The patient has a history of removal of squamous cell carcinoma and radiation to the left ear. The patient was seen by an ENT this admission with recommendations for Lotrimin and Cipro drops to the ear. The wound measures 0.8 x 1.0 x 0.2. The area had moist pink tissue, with dry flaky skin to the peri-wound. The wound was cleansed with normal saline and once dried, calcium alginate was applied. The patient also requested that we look at her previous port site. According to patient the wound was cleansed with Vashe and packed every couple of day with Hydrofera Blue Classic. Hydrofera Classic was not available at this time so the wound was normal saline. The wound bed was pink and moist and measured 2 x 3 x 1.1cm with moderate amount of serosanguinous drainage. The wound was packed with calcium alginate and covered with gauze and Tegaderm.

Next we saw an 82 year old female admitted with failed hip arthroplasty with dislocation. The patient presented with a POA DTI to the left heel. The wound measured 4 cm x 4 cm. The patient reports pain as a 10/10 and was not comfortable with repositioning. The LLE was warm to the touch, cap refill <3, and +2 pedal pulses. The wound was cleansed with normal saline and then skin prep was applied. The patient was offloaded in Tru-View Green offloading boots and stated relief once the boots were placed.

Then we saw an 84 year old male admitted for a TAVR. The patient has a history of CAD and DM. Wound care was consulted for wound to the patient's right great toe and right plantar. The patient reported recent treatment by Podiatry outpatient in which the right toe nail was removed. The skin is dry and intact, however there is a kissing/friction like lesion to the 2nd toe, also dry and intact. The plantar aspect of the right foot presented with a small 1cm x 2cm wound covered with stable eschar. The patient had palpable pedal pulses, skin was warm, and cap refill was <3 seconds. The patient was allergic to iodine so the area was cleansed with Vashe wound cleanser and skin prep was applied to all wound areas. The toe was wrapped with dry gauze and secured with tape to prevent friction. The plantar surface was covered with bordered foam dressing to prevent friction damage.

The last patient was an 86 year old male also admnitted for a TAVR. We were consulted for wounds to patients RLE in which the patient had skin cancer removed. The wounds had a moderate amount of serosanguinous drainage. Measurements were 1.5 x 1.5 x 0.2 medial wound, and lateral wound measuring 2 x 1.5 x 0.2. The medial wound bed was moist and pink with yellow edges. The lateral wound was pink and moist. The wounds were cleansed with normal saline. Calcium alginate was applied to wound bed and the wounds were covered with a bordered foam dressing.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. 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. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

C.J., a 66 year old female was admitted to for hepatic encephalopathy. Per chart review, patient's spouse brought patient to the ED yesterday because she had poor oral intake and increased somnolence. The patient has a past medical history significant for chronic hepatic failure, liver cirrhosis, diabetes mellitus, autoimmune Hepatitis, and chronic kidney disease. The patient is s/p TIPS procedure and is on the list for liver transplant.

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Pertinent lab values include Na 132, albumin 2.8, WBC 1.49, Hgb 8.9, and platelet count 45.

The patient is received 40mg of Lasix daily, 100mg of Spironolactone, and lactulose given 3 times per day.

The patient is seen in bed with husband at bedside. Patient is agreeable to assessment. Ascites is noted to the abdomen with a scheduled paracentesis and thoracentesis scheduled for today. Patient is on a pressure redistribution surface with absorbent pad underneath patient. A Purewick female catheter is in place, however leakage is noted. Patient presents with healing scattered partial thickness wounds to sacrum and natal cleft, likely due to incontinence associated dermatitis. Per husband, patient is incontinent of both urine and feces at home. He has been working on keeping the patient clean at home and skin does show improvement from previous admission on 7/8. Buttocks were cleansed with bathing wipes and skin prep was applied to wound. A bordered foam dressing was applied to the coccyx to prevent friction and shearing. Dressing care orders were placed.

With the patient's clinical status and a Braden score of 14, this patient is more susceptible to skin breakdown. Please continue with pressure injury prevention measures to include ensuring patient is clean and dry. The patient should be turned and repositioned every 2 hours. A waffle cushion should be used while patient is up in the chair. The waffle cushion can also be used while patient is in bed. Preventive foams can be placed on heels, and heels should be offloaded with pillows.

Thank you for including me in the care of this patient.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products used)

- Dressing care- Every 3 days or PRN if soiled sooner, apply skin prep wipes to buttocks, natal cleft, and sacrum. Allow to dry completely. Apply small Allevyn bordered foam dressing to sacrum. Be sure to lift to assess skin under dressing Q shift.
- Ensure patient is clean and dry after episodes of incontinence. Only one absorbent pad should be placed under patient.
- If patient is having loose stools, a Flexi-Seal fecal management system is recommended.
- Purewick External female catheter in place to be changed each shift. Make sure lines are not placed under the patient and assess the skin around the catheter at each change.
- Nutrition consult
- Q2 turn, repositioning, and offloading.
- Every 3 days, place bordered foam heel dressing on patient to prevent friction and shearing damage. Be sure to assess skin under dressing every shift
- Offload heels with pillows or place in True-view Offloading boots.
- Waffle Cushion under patient when patient is up in chair (may also be used when patient is in bed).
- If patient is able to ambulate, patient should be taken to the restroom every 2 hours on a toileting schedule while awake to help prevent episodes of incontinence.

Describe your thoughts related to the care provided. What would you have done differently?

I always find it interesting how you can have several wound care nurses look at the same wound but each come up with a different dressing choice. I believe all of the interventions and dressing we put into place are correct. On this patient, I would have used the Triad cream to help protect the skin and dry out the excessive moisture, and I would not have placed the bordered foam dressing due to her incontinence and the possibility of more moisture being trapped under the patient. I love the Purewicks when they are positioned correctly in a patient that is not moving around much, however I do find that the nurses and care technicians rely to

heavily on them and forget to check their patients for leakage.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?
My goal today was to work with more incontinent patients and I was glad that we did have several on the schedule!

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

Tomorrow is wound vac day here, so I would like to get more experience dealing with peri-wound complications.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	
• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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