Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Belinda Chapa Day/Date: 8/9/24

Number of Clinical Hours Today: 12

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

Preceptor: Jennifer Scheile

Clinical Focus: Wound X Ostomy ____ Continence ____

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 I saw 5 patients with my preceptor. The first patient of the day was a consult for a 37 y/o male who was having redness under his pouch for his esophagostomy aka “spit fistula”. The patient informed us that he came from another hospital that did not teach him much about peristoma care or pouching. He has been using a pouch with an adhesive border and has been replacing frequently due to leakage. With this patient we demonstrated and educated on proper cleansing and drying, crusting technique for the reddened and moist area, and extended wear barriers and barrier rings to provide better seal and leak less. The patient in fact has an adhesive allergy and was informed to discontinue tape border products. The patient was also using baby wipes to clean peristoma area and was advised to discontinue due to residue from the wipes that can leave skin moist and interfere with adherence and cause moisture under barrier. We also provided UOAA information and pouch product booklet where he can try other products. The second patient we saw for the day was an 86 y/o male who underwent a pelvic exenteration and had a consult for day 1 ostomy education. With day 1 education we made sure to have the patients wife and daughter who will be helping with the patient care and ostomy care. We educated patient by providing educational booklet with included accessible videos and writing/drawing the steps of pouch removal, perisomal cleansing, and repouching on a large “chuk” and the products over each step. We first demonstrated all steps on the patients sigmoid conduit on the right side and had him and his wife participate on changing the left side, his end colostomy. Once all supplies were gathered, the steps included: 1: Remove pouch from top to bottom using adhesive remover and dispose. 2: Using washcloth or paper towel clean peristoma with warm water. 3: Dry peristomal area and or apply crusting if needed. 4: Measure stoma for the following 6 weeks or until stoma has kept its size. 5: Cut skin barrier to fit size needed for stoma. 6: Ensure peristoma is dry and apply skin barrier to peristoma. 7: Apply pouch to skin barrier and close the end. Informed the patient to change every 3 to 4 days and as needed if there is leakage. The third patient we saw is a 41 y/o paraplegic male with a stage IV pressure injury to the sacrum who was being discharged with negative pressure therapy and needed it placed. My preceptor and I cleansed the wound with vashe cleansing solution and gauze, applied a topical skin protectant to the intact skin, window draped the periwound with hydrocolloid and draped to his left side to create a bridge using black granufoam. The wound measured 15cm x 13cm x 4cm with undermine from 10 o’clock to 3 o’clock and max depth of 6cm. Black foam was cut into a spiral or cinnamon roll fashion and applied into the wound and covered with dermatac drape. The connector was applied at bridged area and therapy was turned on to 125 mmhg matching the physician orders. Seal was achieved and patient was ready for discharge. The fourth patient we saw was a 64 y/o female who needs a wound vac change from her left upper chest where a pacemaker was removed and debrided due to infection. We removed the present wound vac dressing with adhesive remover as patient has much pain with removal of drape. The wound bed was cleaned with vashe cleansing solution and gauze. The wound measured 8cm x 7cm x 3.3 cm with no undermine or tunneling. The periwound was window draped with hydrocolloid to protect the periwound and help with seal of the vacuum. The black granufoam was cut in an oval shape to fit the size of wound. The foam was placed over the wound and draped with dermatac drape. A hole was cut and connector placed on top. The wound vac was turned on and suction was placed at 75 mmhg per physician order. The fifth patient we saw was a 68 y/o male who had an abdominal wound vac that needed to be changed. The wound came from a PEG tube site pressure injury that became infected. The wound was cleaned, debrided and PEG tube removed previously. The wound was cleansed with vashe cleansing solution and gauze. The wound

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measured 6cm x 5cm x 3 cm and no undermine or tunnel. Black foam was cut to fit the oval size of the wound and dermatac drape was placed over the black foam. A hole was made where connector was placed on top and wound vac was turned on at 75 mmhg as physician order is stated.

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:

Initial visit was with 41 y/o paraplegic male who needs wound vac placement for his stage IV pressure injury to his sacrum. On assessment the patient is alert and oriented x 4. He is laying in bed and is pleasant in introducing himself and talking to us about his journey with his wound. He has been paraplegic since 2016 and has hypertension. The patient has informed us that he has been dealing with his wound for almost two years and every few months comes to the hospital due to infection. The patient has chronic osteomyelitis and is in the process of having an orthopedic surgeon resect the infected bone. The patient is currently employed as a teacher but is on leave due to his injury. He will be going home with IV antibiotics and home health services. His wound vac will need to be changed 2x per week on Tuesdays and Fridays. Upon assessment the patients skin assessment was clean and clear with exception of his sacral wound which measured 15cm x 13cm x 4cm with undermine from 10 o'clock to 3 o'clock and max depth of 6cm. The wound was window draped with hydrocolloid and black foam was cut into spiral shape. The wound was cleansed with vashe and gauze and periwound was prepped with cavilon skin protectant. The black foam was placed in the undermine and across the wound to cover. Dermatac vac drape was used to create bridge and black foam was placed over drape to create bridge. Dermatac drape was used to cover over wound and bridge and hole is created over the end of bridge where the connector was placed. The wound vac was turned on and setting is at 125 mmhg continuous. The orders were verified and the patient and repositioned.

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)

Wound vac dressing change is Tuesday and Fridays.
Upon removal of dressing adhesive removed may be used if necessary.
Cleanse wound using vashe wound cleanser and gauze and let sit in wound for 5 minutes.
Apply topical skin protectant to periwound and let dry.
Using hydrocolloid cut strips ½ inch to 1 inch and apply to edges/perimeter of wound.
Using dermatac drape cut into long 4 inch x 10 inch strip to apply to end of hydrocolloid and bridge to left or right lateral area away from bony prominence.
Using black granufoam cut into spiral shape.
Apply black foam to undermine in spiral fashion and continue to cover the entire wound and a strip over the bridge.
Using dermatac wound vac drape apply over wound and bridge.
Cut a hole at the end of the bridge and apply connector.
Turn wound vac on and ensure settings are at 125 mmhg continuous and is fully charged.
If wound vac is alarming leakage assess for area that is open by listening for sound of hissing sound and use fingers to feel over

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difficult draping areas and apply extra drape over leak until alarm stops.

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

I believe that the care provided was all done in a timely manner. We were able to see several patients in the morning half then finish up computer charting, then have lunch. After lunch the next set of patients were seen and again after the care was provided we were able to chart on the patients that were seen. My preceptor did take note on the time and pictures of all the patients we were able to see and feel that is very effective to keep the charting consistent and correct. I would not have done differently but learned to keep track of time when care is provided.

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 for today was to assist in the consultation, assessment, and application of a negative pressure wound therapy device with my preceptor.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
My goal for next clinical day is to provide teaching and care for new ostomy patients.

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	✓	

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Reviewed by: _____ Date: _____

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