Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Yoselyn Soto_____ Day/Date: _10/1/2024_

Number of Clinical Hours Today: _10_

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

Preceptor: _Candace Beeghly_

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.

On 10/1/2024 we had a consult for dressing recommendation for a left forearm non-healing wound, we follow up on a patient with an EC fistula, we checked for stoma appliances seal (was change 9/30/2024) and it was intact. We follow up on a patient with a new Ileostomy but we were unable to teach since patient was confused no family member available. We were able to provided Colostomy day 2 teaching on different pouches system and step by step appliance changes. Also, we had a consult to evaluate and treat a skin tear that was dry, we signed off on this one. We evaluate treatment on a patient with skin failure that has been on Venelex for 2 days.

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:

Medical History: 35 y.o. male with h/o polysubstance abuse (history of IV drug abuse, cocaine, heroin, tobacco), hypertension (not on maintenance medications), hepatitis C (did not receive treatment), history of pulmonary embolism (diagnosed in 2022, not on anticoagulation) who presents to the ORMC ED with left forearm ulceration and suicidal ideation. Patient has multiple recurrent admissions at Advent health and Orlando health for left forearm ulceration, most recently admitted to Advent health, CT forearm performed concerning for possible osteomyelitis, however patient continues to leave AGAINST MEDICAL ADVICE.

He now presents to ORMC, with suicidal ideation and thus psychiatry evaluated and patient Baker acted. Patient with persistent complaints of left forearm pain at ulceration site. He mentions associated purulent drainage and unable to extend his arm. Patient states he was involved in a motor vehicle accident 1 year ago and wound has not healed since. He reports that he no longer abuses IV drugs, only snorts cocaine and heroin. In the ED vital signs stable, patient currently does not meet sepsis criteria. IMG consulted to admit for forearm infection/ulceration, rule out osteomyelitis. Psychiatry following due to suicidal ideation and, patient Baker acted. He was started on empiric antibiotics and infectious disease was consulted. He was also evaluated by opioid counselor and

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initially declined starting on treatment for opioid withdrawal. MRI was done of the left forearm without any evidence of osteomyelitis, infectious disease recommended holding off on antibiotic therapy as patient's wounds are granulated and does not appear infected, he has no fever or leukocytosis and MRI is without evidence of fluid collection/osteomyelitis. In discussion with patient, he is not interested in any surgical revision/flap coverage of the wound at this time. On 9/29, his withdrawal symptoms worsened and after lengthy discussion he was interested in starting treatment and buprenorphine was started. Wound consult was placed for dressing recommendations for his left upper extremity. Opioid counselor was recalled for titration of buprenorphine regimen and additional outpatient resources. Psychiatry is still recommending inpatient psych at this time. Patient continues to refuse lab draws.

Chart note: Initial visit for dressing recommendation for a non-healing wound on patient's left forearm. Patient resting in bed, alert and oriented, no s/s of distress at this time, call light and personal items within reach, sitter at bedside. Left arm assessed today redness, hypergranulation, moist, small serosanguineous drainage 8.4 cm x 3.9 cm x 0.3 cm. Wound culture positive for MRSA. Dressing recommendations for this wound will be Hydrofera blue READY to provide antimicrobial coverage, absorb drainage, reduces hypergranulation tissue, dressing has extended wear time, an alternative dressing would be Mepilex AG, it is also an antimicrobial and help reduce hypergranulation tissue. Intended to complete a head-to-toe assessment but patient refused turning, able to assess heels unremarkable and intact. Educated patient on the importance of frequent turning and repositioning, he verbalized understanding of instructions. Patient report he does reposition and walk to the bathroom. Nursing to continue skin monitoring every shift. Patient would benefit from a referral for a wound care clinic, epic chat sent to Dr Fotso with above dressing recommendations and referral, patient reports he has not followed up with anyone and performs his own wound care "alcohol and dry dressing". Due to cost also discussed with Dr Fotso Iodosorb optional alternative for discharge dressing.

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)

Nursing to continue wound care to Left arm every other day
Instructions
1) Cleanse wound with anasept wound cleanser and gauze;
2) Gently pat dry;
3) Apply hydrofera blue the wound to provide protection, manage exudate, and address bacteria/yeast
4) Wrap with kerlix, secure with tape

Note: Hydrofera blue READY can be left on wound for up to 7 days. Apply hydrofera blue to the wound to provide wound protection and address bacteria/yeast. #When blue violet dressing foam turns white in color, it is an indication that dressing needs to be changed.

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

This situation is further complicated by the patient's inadequate wound care and existing chronic diseases. The medical history indicates that this wound originated a year ago, but it may have persisted for almost two years (according to AVATAR, 701 days). We provided three recommendations for this patient, considering his condition and inadequate follow-up history. We seek dressing that does not require frequent changes and is inexpensive and easily accessible. Unfortunately, this patient may not seek follow-up care.

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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? Be able to handle the ascom/rover by myself. Make initial and alternative dressing recommendations, participate in ostomy teaching.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Continue making initial and alternative dressing recommendations, be able to complete documentation on more than 2 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	✓	

Reviewed by: _____ Date: _____

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