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: _10/15/2024_

Number of Clinical Hours Today: _10_

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

Preceptor: _Pamela Clay_

Clinical Focus: Wound ____ Ostomy ____ 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.

On 10/15/2024 We had a consult for a wound vac placement in OR, we went there but it was not necessary so the WOC nurse recommended Aquacel Ag and cover with dry dressing. We had a patient with skin irritation due to radiation on patients face, Pam applied Sonafine. Another consult for a foot ulcer on a diabetic 15y/o patient. We follow up on a patient with a wound on his knee infected with MRSA. A follow up with a patient with spinal cord injury due to a GSW. Another follow up for a fungal rash in the perineum and PEG tube peri-stomal, Pam recommended Nystatin powder and skin prep “crust” and she also stabilize the PEG tube.

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: 13 y.o. male who presents as a trauma alert via air care from Halifax s/p GSW to the anterior neck. Per report, he was brought to the ED after people heard a loud noise and then found him in a bedroom with a gunshot to his neck. Grandparents report that he was over at a friend's house when this occurred, other details are unknown at this time. He was GCS 14 at OSH on arrival. He was found to have an anterior neck injury with obvious tracheal injury and mechanical ventilation was initiated with ETT placed via the traumatic tracheostomy via the penetrating injury prior to transfer. He was transferred to APH as a trauma alert transfer for further management. Tachycardic and hypertensive and received 2 units pRBCs en route. On arrival the patient was HDS, GCS 6T on sedation, with a c-collar and backboard in place. The patient was found to have ETT in place in anterior neck penetrating injury, without evidence of expanding hematoma. Also found to have priapism. CXR demonstrated foreign body consistent with bullet in mid cervical neck region. FAST negative. ETT position low. He was taken to the OR with general surgery for exploration of penetrating wound of anterior neck, neurosurgery for cervicothoracic laminectomy and fusion with dural repair, and tracheostomy with trauma surgery and ENT.

Chart note: Initial visit to evaluate a treat developing pressure sores on sacrum and heels. Patient assessed with P. Clay, RN, CWOCN and grandmother at the bedside. Bilateral heels were assessed and found to be intact at this time. There were areas of persistent blanchable erythema noted to the right heel, tips of the toes, and where SCD cord had been against the skin. However, since these areas remained blanchable, they cannot be classified as pressure injuries. Patient was found in bed without any protective boots on and with feet touching the footboard. Patient had multiple areas where medical devices were in contact with his

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

skin and left an indention, however all areas were blanchable. Please be aware of all tubing/devices that could come in contact with the patient and lead to a pressure injury. Dr. Del Rio updated on assessment. The open area to the sacrum is unstageable pressure injury. There is a centralized island of adherent eschar in the wound opening. Additionally, there appears to be an incontinence associated skin damage component. Nursing, family, and patient reminded of the importance of maintaining a turning schedule to ensure pressure is properly redistributed and prevent additional pressure injury formation. Recommend frequent and vigilant peri-care in addition to using a barrier cream with every brief change.

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 care as follow:

1. Maintain turning schedule every 2 hours
2. Seat patient on a static air cushion when out of the bed to the chair
3. Cleanse skin promptly following episodes of incontinence.
4. Cleanse skin using a pH-balanced, nonsensitizing skin cleanser and warm water.
5. Implement individualized continence management plan.
6. Use absorbent pads (No more than 1 to 2 pads)

Peri-area care, with every brief change:

1. Cleanse with Barrier Cream Cloths (gray package)
2. Pat dry
3. Apply Stomahesive powder to the affected area then skin prep

Care to Sacrum every day or if soiled

1. Cleanse with barrier cream cloths (gray package)
2. Pat dry
3. Apply a thick layer of Triad Hydrophillic Wound Dressing
4. Cover with Mepilex

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

For the sacral wound I would done different to cleanse with Vashe, pat dry, apply skin prep to peri-wound, apply Santyl to wound bed and cover with mepilex. For the perineal area I would've add to the current treatment a moisture barrier Zinc oxide.

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 was to be able to familiarize with wound care, ostomy care in a children setting, however I was unable to see pediatric stomas but it was a really good experience.

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

My next goals will be to be the primary wound nurse for at least 3 patients, documenting on at least 3 patients, take active role in communicating with nurses, get to know how to create macros and dot phrases.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.