Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Yvan Fortunat Day/Date: 10/16/24

Number of Clinical Hours Today: 8

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

Preceptor: Jennifer Brinkman

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 was with the wound care team. We saw 3 patients and I participated in a nursing meeting to discuss how we can work together to decrease the prevalence of wounds a lot better. The first patient is known to the hospital, she was discharged to a long-term care facility where she was being treated for a stage 4 wound. She came yesterday with a fecal management system (FMS). We used kerlex soaked in normal saline and lightly filled the wound bed, then we covered it with foam dressing. The wound had moderate drainage, I would have used alginate or a hydrofiber like aquacel to fill in the wound and a foam as a secondary dressing. The second patient is also known to the WOC nurse. She has a big stage 4 sacral wound that was fully granulated with a small stage 2 on the right ischium and another in the process of healing stage 3, fully granulated on the lower right leg. We used kerlex soaked with vashe and covered the sacral wound with ABD pads. We used hydrogel and allevyn foam dressing on the others. Patient's son was present, we provided teaching and counselled son on the state of the wounds and why we were using certain products. Son seemed very happy with the teaching since he stated no one had explained how her mother got those wounds the way we did. The third patient was a gentleman who was refusing wound care. He appeared very belligerent and refused to let the nurses get to his wounds. But after spending over an hour coaxing him, he agreed to let us work on the wounds.

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:

This is a 60 year old female, A&Ox1, nonverbal, frail looking. She is only able to grunt and grimace when she is getting turned. Patient upper and lower extremities are contracted. She was diagnosed with autoimmune encephalitis and urinary retention. Patient as a tracheostomy, foley catheter and a Fecal

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management system on admission. Patient originally developed a stage 4 pressure injury on 8/5. She was recently in an LTACH where her wound was managed using a NPWT 2xweekly. Patient daughter informed us that she has had her FMS for a while now. Our FMS protocol is to have patient change them on admission no date is on them and every 29 days. The FMS should not be used more than 3 times. More than that, we must start thinking about alternative treatment methods for fecal incontinence. Call was made to doctor concerning FMS and our concern was communicated. We were the first to see and document the wound since patient was admitted the night before.
Patient's vitals were within normal value. Once her dressing was removed, we could observe moderate exudate of a green and purulent appearance. No smell was detected. Wound was red, yellow and white at the base. The shape of the coccyx bone was visible though it was still covered by a thin layer of tissue. Measurement taken, wound was 5.5cm Long by 3cm wide, 1.8cm in depth with undermining from 9 to 5 o'clock for a depth of 2.3 at 1 o'clock. Wound edges are rolled, a bit macerated. Periwound looked clean and normal in presentation. Wound was cleansed with normal saline, lightly filled with kerlex gauze moistened with normal saline and covered by allevyn foam.

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)

Coccyx: removed old dressing, cleanse with normal saline, lightly fill wound with kerlex moistened with vashe, cover with allevyn dressing BID.
Excange FMS if needed per MD.
Apply Desitin to perianal area BID as needed.
Keep on True-Vue heel protectors to lower extremities to offload heels
Turn and reposition patient every two hours and as needed with turning wedges to offload patient off of coccyx/ischium
Place a Iso-Tour blower on bed surface for low air loss
Assess tracheostomy daily for skin breakage
WOC nurse will continue follow up with patient. Please contact WOC sooner if wound is deteriorating.

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

The case was interesting. I would have chosen an alginate or a hydrofiber for the wound bed followed by light filling by kerlex covered by a foam dressing since the wound has moderate exudate. With that dressing we could keep it on daily instead of BID since the alginate will help with absorption of exudate as well. I was able to observe the other part of the WOC role. The person I was with really advocated for the right supply for the patient. She made sure the mattress was the one she liked for that particular wound. Most of the nurses on the floor did not know that a FMS should be changed if we have no clear understanding when it was placed.

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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? My goal was to assess different wounds and to come up with the right treatment for them
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My goal is to get familiar with the different products we can use for different wounds. Type of beds, mattresses, and some of the name available as well as direct wound supplies. In addition, if I could perform and ABI, I would really love that.

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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