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: 10/18/24

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 we saw three patients. They all had pressure injuries on the coccyx and heel. One case was extremely challenging for the term skin failure was attached to her condition. The patient was in the ICU, she came to us the night before from a different hospital. Patient went through a few surgeries in the past 8 months for a knee replacement and back surgery. The knee replacement kept getting infected, patient went into septic, now they sent her to us. Patient had open wounds on her torso, on both upper and lower extremities, and on her sacral area. Patient had skin tears, blisters filled with blood and fluid, non-stageable pressure injuries on her heels, necrotic toes, stage 4 pressure ulcer on her sacrum, right patella exposed and necrotic, purpura all over her body, vaginal bruising where foley is, and fissure on the anal area where blood is oozing when patient is moved. For close to 2 hours, we painstakingly documented over 25 wounds, took pictures, and measured all of them. We conferred with the attending physician and the nurse manager who did not see the full condition of the patient yet. A meeting was set up already with the family. The care team will be discussing later during the day what comes next. Vascular and podiatry were requested for consult. The wound care we did was removing, Mepitel non adherent transparent dressing, the old dressing that came from the previous hospital to Urgotul, a non adherent contact layer as well. On the sacrum, we used kerlex soaked in vashe to pack the wound and we lay the patient on a large ABD. For the lower extremities we did not wrap the legs since they were oozing large amount of serous fluids. We just left the ABD pads loosely positioned on top of the legs. I personally would have preferred using xeroform which is non-adherent but stays on the kin better than the Urgotul with ABD pads as secondary dressing, wrapped with kerlex BID. My goal would be to not let all those wounds open to air since patient is at high risk of infection. The other 2 cases were dressing changes where hydrogel was used with Allevyn to cover unstageable pressure injuries on the coccyx.

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.

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Chart note:

Patient is a 57 year old, A&Ox3, dark sin woman. She was able to give us consent to talk to her spouse who was in the room during our intervention. Patient has a history of ESRD (end stage renal disease, she is on dialysis), HTN and Pre-eclampsia, stroke. Past surgical history of AAA repairs. Patient was air lifted to us from a different hospital for heart attack as per husband. As per husband, patient was at the other hospital for just over a week, she went to the hospital without a pressure injury. In the previous hospital she was not moved much, and they did not promptly clean her after a bowel movement. Patient is on room air, with a NJ tube in place. Wound is an unstageable pressure injury, located on the sacral/coccyx area. No odor when dressing was removed nor after cleansing with wound cleanser. Wound is dry with brown and tan adherent tissue in the center which covers about 75 percent of the wound. 25 percent of the wound is granular tissue on the outer periphery. Edges are irregular, peri-wound is darker than the rest of the body and tender. Wound size is 8x9x0.2 cm, with small amount of serosanguineous exudate. Peri-wound treated with skin sealant, hydrogel is used on as primary covered by Allevyn foam dressing. Patient, grimaced a few times during dressing change, she did not verbalized pain level. Patient tolerated treatment well. Spouse was educated on what usually is the cause of these types of wound, the role of pressure in breaking down tissue, how they usually get healed and the wound care plan we are implementing. Spouse expressed appreciation for the care provided.

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 care order: Remove old dressing, cleanse with wound cleanser, prep peri-wound with skin barrier sealant, allow to dry, apply hydrocolloid over wound every other day. Contact wound care team with any deterioration in the wound.
-Turn and reposition patient every 2 hours and as needed with turning wedges to offload patient off the sacrum/coccyx
-Change patient promptly after fecal incontinence
-Place iso-Tour blower on bed surface for low air loss
-Keep patient's heel elevated off the bed to prevent formation of pressure injuries
-Monitor patient pain and provide relief as per order
-Consult nutritionist for optimized dietary intake

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

The care provided what good I think. We provided some information to the family as to how to manage the pressure injury. More of that will need to be done before discharge. For the actual wound care part, I chose the hydrocolloid instead of the hydrogel plus foam because I think the hydrocolloid gives us a better layer of protection against fecal matter since it is waterproof. In addition, the wound is not leaking a lot, the exudate level is small. The hydrocolloid will be able to keep the moisture in the wound to soften the slough while enhancing autolytic debridement. Furthermore, it does not need to be changed that often.

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

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Goals

What was your goal for the day? My goal was to perform and observe some different types of wounds like venous stasis or neuropathic wounds or possibly perform a ABI. However, I was able to see a case I never saw before, that is a case where the patient's skin is totally failing and is breaking apart at every possible junction.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My goal for next week is to observe and learn more about how to manage and care for some complex ostomy cases as well as some incontinent related cases.

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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