Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Sheila Guzman_____ Day/Date: _10/14/24__

Number of Clinical Hours Today: __8__

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

Preceptor: _Christopher Eddun_____

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 my first day of clinicals, I had the chance to see 14 patients with my preceptor. Most of the consults stated they were for "pressure injuries," of which only 1 was a real PI. We also had a patient who had a new colostomy placed and we were asked to do the teaching. I was able to encounter patients who had diabetic ulcers, venous ulcers, debrided abscess ulcer (s/p Incision &Drain), surgical incisions, moisture associated skin damage (MASD), incontinence associated dermatitis (IAD) and even self-inflicted necrotic wounds. This patient with the self-inflicted wounds has a history of drug abuse and of biting her fingers causing areas with redness, irritation, bleeding and necrosis. She stated she didn't need us to take care of her wounds, she wants us to get her pain medication. The only consult that was truly a pressure injury was a stage II pressure injury found on the left heel of a 90yo female pt who had been admitted for surgery 4 days prior. We searched and did not find any documentation of the patient having this upon admission. We measured the size, cleansed the area and applied Mepilex. We left her feet offloaded with pillows and suggested the use of Z-flex heel protector booties. A patient with surgical incisions also has atypical necrotic ulcers that we "painted" with betadine. The patients with IAD is a female patient with an amputation below the knee of her left leg. She stated she was sitting in her recliner in urine and feces for 3 days unable to get herself up, until her niece came to her home looking for her. The patient was told to keep the area as clean and dry as possible at home, use perineal cleanser and apply triad hydrophilic dressing to the area. Primafit is currently being used for incontinence management.

I have never worked with adults so I got to see a lot of the dressings, ostomy supplies and off-loading devices used such as: foam wedges, gel mattress, Z-flex booties, among others. First time every seeing or hearing about Primafit.

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 the initial visit for this alert and oriented 55-year-old female patient on room air, admitted to us for Incision & Drainage surgical procedure to abscess on the lower left buttocks. Pt has history of diabetes and hidradenitis suppurativa, which are followed by her primary care doctor outpatient. No history of other surgeries. Medications were reviewed. Surgical team conducted an I&D procedure, however were not able to fully remove all the necrotic tissue due to patient not tolerating the sharp debridement. Morphine was to be used for local anesthesia, which the patient stated she did not want. Patient stated that she has had this chronic skin condition "forever" just that they had never been as big and infected as this one. She is only using wet to dry gauze like the

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surgery team was using post I&D. The patient agreed to allow us to remove the dressing, assess and make recommendations. The patient can position herself independently. Dressing removal was painful, noted to have scant amount of serosanguinous drainage on it. The ulcer cleansed and measured 3x3x0.5cm with approximately 70% moist, yellow slough adhered to the pale pink, moist base tissue of the wound. Cleansed area again with Vashe hypochlorous acid cleanser, applied medicinal honey gel, then used Mepilex adhesive border foam dressing. Pt tolerated the dressing change well, no signs or symptoms of acute distress or discomfort noted at this time. A new treatment plan was selected to promote autolytic debridement. Dressing changes recommended to be done every Monday, Wednesday and Friday to allow the Medi honey to work. The goal is to promote autolytic debridement, decrease pressure, swelling and pain. The treatment plan, rationale and goals explained to the patient and team. Pt teaching provided on the importance of taking medications and antibiotics to promote healing, hand washing before and after to prevent the spread of bacteria/infection. Patient verbalized understanding and repositioned self to side lying position. Agreed to follow-up visit for assessment of the wound and re-evaluation of the treatment plan if necessary.

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)

*Discontinue wet to dry gauze dressing to abscess ulcer of the lower left buttocks.
*Use adhesive remover to remove old dressing. Begin by thoroughly cleansing the area with Vashe hypochlorous acid cleanser. Pat dry with gauze. Apply Medi honey gel to wound. Cover with Mepilex adhesive border foam dressing. Change every other day and prn when soiled or highly saturated.
*Manage diabetes
*Dietician involved
*Notify WOC nurse if any questions/concerns or changes in wound status of the patient

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

I would have to say that the surgical team should have provided another option to the patient when it came to local anesthesia. I noted not only for this patient but for all the patients we saw that adhesive remover was not being used to remove the dressings. These areas are already so painful and tender, removal of the dressings doesn't make it feel any better. I noted some patients had lidocaine patches that seemed to help with the pain, something I would like to use or recommend when I am practicing.

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 the day was to learn more about the role and responsibilities of the WOC nurse in an acute care setting. On this day alone, I was able to see the WOC nurse play the roles of a consultant, educator, advocate and direct patient care provider. My preceptor is extremely knowledgeable in his area of expertise, therefore making him fast, efficient and able to mange his time appropriately with each patient.

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

For our next clinical I would like to see more advanced stages of pressure injuries. I am interested in following up with some of the patients we saw today, to see their progress or lack thereof. I would like to learn more about selecting dressings and how to choose/provide the best plan of care.

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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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