Cleveland Clinic

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

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name: Jen Ennyl E. Gomez Day/Date: Tuesday- November 26,2024
Number of Clinical Hours Today: 8hours

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

Preceptor: Amy Folk

Clinical Focus: Wound ✓ 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 clinical day at UPMC Shadyside Hospital, I had the opportunity to shadow a staff member in the Wound, Ostomy, and Continence (WOC) department after meeting my preceptor who happens to be the manager of the unit. The emphasis of the day's clinical experience was on wound care. We attended to a total of 3 patients, all of whom required an initial consultation for wounds that were present prior to their admission.

The first patient was an 82-year-old female residing in a senior nursing facility. She has a past medical history of Diabetes Mellitus type 2 and dementia. She presented to the emergency department via EMS with weakness and fever, and was found to be COVID-positive. The wound ostomy and continence care team were consulted because the patient had an existing stage 2 pressure injury on her left heel. Prior to entering the patient's room, we meticulously assemble all essential supplies required for wound dressing, including Vashe, dry gauze, Adaptic, and bordered gauze. We adhere to safety protocols by donning the appropriate personal protective equipment (PPE). During the initial assessment, a thorough evaluation of the patient's skin was performed, focusing particularly on areas prone to pressure injuries. Throughout the assessment, it was observed that the majority of the skin appeared blanchable, dry, and intact, indicating overall good condition. However, attention was drawn to the patient's left heel, which was noted to have a dressing in place. This dressing appeared to be somewhat loose and consisted of Medihoney and bordered gauze.

After careful consideration, we gently removed the existing dressing to inspect the condition of the skin underneath. We then cleansed the area using Vashe, a gentle solution recognized for its wound cleansing properties. Upon examination, there was no drainage present, indicating that the wound was not currently infected and was not producing exudate. The dimensions of the wound measured approximately 1.5 cm in length, 1 cm in width, and 0.1 cm in depth. The wound bed appeared red and pinkish in color. The WOC nurse applied an adaptive dressing and covered it with Gentac silicon-bordered gauze. Continuous monitoring and appropriate care such as frequent turning and off-loading are essential to ensure optimal healing and prevent further complications.

Second patient was a 43-year old male lives independent at home, He has a past medical history ESRD which he gets dialysis every MWF. He is also paraplegic with cardiac dysrryhtmia and asthma. He gets a wound care visit 2x a week for his Stage 4 in Coccyx. Patient also has an existing colostomy which was created since 2019 and verbalized that he does his own changing and emptying of his pouch. Patient came in to the ED as advised by the home health nurse as patient has increase drainage in his coccyx, fever and weakness. Patient verbalizes frustration as he feels this is never ending situation. WOC provided emotional support and education. Skin assessment were done and found to have a stage 4 on his coccyx measuring 8x21x8.5 undermining all around, with deepest portion at 9.5cm. Bone palapable with serosanguineous drainage. His moist is red and draining with semi-formed effluent. Patient also reports 10/10 pain. PRN pain meds were given prior to dressing change. Old wound dressing is gently removed and then washed with Vashe. Then packed with Kerlix with half strength Dakin's solution and then secured with abd pad and tape. Orders

(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.

for positoon changes and offloading is also ordered to the bedside rn and WOC nurse will followup 2-3x a week and as needed. Patient is following by infectious doctor and waiting for the plastic surgery consult.

Lastly, the patient was 55yo male with past medical history of Hypertension, GERD and SBO. Patient came to the ED from home and was complaining of abdominal pain. Patient was then ordered to have CT scan and was then had a skin tear on the knees after the scan. WOC was consulted as family members were upset of what happened. Skin assessment was done and patient's left knee is redenned without drainage and measuring 05x1 cm. Wound was gently cleanse with Normal Saline and then covered with gauze and secured with tape.

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:**

Patient noted to be on bed with soiled sacrum dressing with left colostomy pouch dry and intact.
*LOC*: Patient awake, alert, oriented, and frustrated.
*Interview* with patient who states

- had increase drainage output from his sacrum and complaints of fever and weakness.
- turned down ostomy education because he had the colostomy since 2019 and states that he is knowledgeable in his ostomy care.
- Refuses changes of wound dressing at home health as he feels it's not improving.
- reports frustration in his nonhealing coccyx wound and reports 10/10 pain.
- Reports decrease appetite.

*Stoma:* Moist, red with semi-formed, yellow brown effluent.
*Stoma size:* 2.0 x 2.0 in
*Shape:* round, both lumens visualized
*Coccyx:* Stage 4 measuring 8x21x8.5 undermining all around, deepest portion at 9.5 cm. Bone palpable with serosanguineous drainage.

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)**

*Treatment*

- ICU bedside nurse gave prn pain meds prior to dressing change.
- Patient is on low air loss mattress to prevent further skin injury
- Frequent turning and using of wedge to off-load pressure.
- WOC nurse changed the coccyx wound dressing by gently cleansing with vashe then packed kerlix with half strength Dakin's and covered with ABD pad. Then secured with paper tape. Orders will be provided to bedside RN for as needed change. WOC will follow every MWF.
- Patient is on IV Zosyn and infectious disease is following.
- Patient is scheduled for a plastics consult.

(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

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

| |
|---|
| The patient is being followed by the right doctor and being taken care of as of the moment. Until the recommendation of plastics, I would also consult a social worker to provide options in skilled facility for daily basis monitoring and treatment. I would also consult nutritionist for possible TPN or supplements. |

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?**<br><br>My goal is to identify the workflow of the WOC nurse in hospital setting. How they manage the care for existing or new wound and prevent potential injury in the future. |
| **What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**<br>My learning goals is to adapt and learn with how the WOC nurses manage their time and assessment in between each patient care |

| 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.