Cleveland Clinic

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

12/9/24 #4

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Marina DeRosa Day/Date: Monday, 12/9/2024

Number of Clinical Hours Today: 12

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

Preceptor: _Karen Francis__ APN CWON__

Clinical Focus: Wound _x___ Ostomy ____ Continence ____

This assignment should be WOC focused and approached as 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.

My preceptor and I saw seven patients today. They are listed as follows: The first patient is male with stage 3 and DTi to the sacrum and right hip. The second male patient has a fungus infection to the sacrum, bilateral buttock, and upper thigh. This patient is dark pigmented skin, and staff stated he had a DTI which was IAD with fungus Lotrisone was ordered. Third was a male with a new colostomy, and colostomy teaching continued. The patient and his family were very receptive and eager to learn. the fourth was male with right heel stage 3. The fifth patient is a young male with right neck IJ, Left AV fistula, and a stage 4 pressure injury malodorous Dakins 0.5 % bid and collagenase were ordered along with a specialty bed. The sixth patient was a long-term patient from a nursing home with a sizeable unstageable sacrum wound with hard black eschar, which was crosshatched. After crosshatching, Santyl (collagenase) was applied to the wound, and damp 4x4 gauze was placed over the wound and secured with Allevyn live *"life"* dressing. The seventh patient, also a long-term resident with multiple wounds, was referred to Hospice.
ok

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:

73 y.o. Female arrived from Complete Care at Harborage, related to a decreased level of consciousness. The patient is White and English. Fitzpatrick Scale Type 2. The patient was admitted for Hypovolemic shock. The patient is referred for evaluation and treatment of community-acquired wounds. The patient was seen at the bedside awake in distress or discomfort. ← *make sure your charting is clear.*

Past Medical History:

Diagnosis	Date
• Anemia	
• Anxiety	
• Bacteremia	10/10/2024
• Dementia (CMS/HHS HCC)	
• DVT (deep venous thrombosis) (CMS/HHS HCC)	
• GERD (gastroesophageal reflux disease)	

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- Insomnia
- Weakness

History reviewed. No pertinent surgical history.

VITAL SIGNS:
Patient Vitals for the past 8 hrs:

BP	Temp	Pulse	Resp	SpO2

Temp (24hrs), Avg:97.3 °F (36.3 °C), Min:97 °F (36.1 °C), Max:97.7 °F (36.5 °C)

I/O last 3 completed shifts:
In: 2120.7 [I.V.:1980.5; IV Piggyback:140.1]
Out: 1000 [Urine:1000]
No intake/output data recorded.
Body mass index is 15.55 kg/m².

Review of Systems
Unable to perform ROS: Acuity of condition
Physical Exam
Vitals reviewed. Exam conducted with a chaperone present.
HENT:
Head: Normocephalic.
Mouth/Throat:
Mouth: Mucous membranes are dry.
Pulmonary:
Comments: Oxygen via NC
Genitourinary:
Comments: IUC
Musculoskeletal:
Comments: Hemosiderin staining bilateral lower extremities
Skin:
Findings: Lesion present.
Neurological:
Mental Status: She is alert. Mental status is at baseline.

INPATIENT MEDICATIONS:
Scheduled:

nystatin	500,000 Units	Swish & Swallow	BID
cefTRIAXone	2 g	Intravenous	Q24H int
ferric gluconate	125 mg	Intravenous	Three times weekly (Mon-Wed-Fri) 10 pm
pantoprazole	40 mg	Intravenous	Daily
vancomycin	750 mg	Intravenous	Q24H int
hydrocortisone sodium succinate	100 mg	Intravenous	Q8H sch
folic acid	1 mg	IV Push	Daily
ipratropium-albuterol	3 mL	Nebulization	Q6H (Resp)
atorvastatin	40 mg	Oral	Nightly
mupirocin		Topical	BID

Infusions:
- D5W 75 mL/hr (12/10/24 0845)
- norEPINEPHrine Stopped (12/09/24 1900)

PRN:
acetaminophen

DIET NPO
Nutritional Status: Severe malnutrition

ASSESSMENT AND PLAN:

Comprehensive Problem List

	Diagnosis	Date Noted
•	*Hypovolemic shock (CMS/HHS HCC)	12/07/2024

Resolved Hospital Problems
No resolved problems to display.

Wound Location	: right heel
Type	: pressure
Stage	: dti
Size	: 2cm x2cm x0.0cm
Wound base	: Purple
Undermining/Tunneling	: none
Exudate	: none
Periwound skin	: intact
Inflammation	: moderate
Odor	: none
Pain	: 10

Wound Location	: left heel
Type	: pressure
Stage	: dti
Size	: 1cm x 1cm x0.0cm
Wound base	: Purple
Undermining/Tunneling	: none
Exudate	: none
Periwound skin	: intact
Inflammation	: moderate
Odor	: none
Pain	: 10

Wound Location	: right buttock
Type	: pressure
Stage	: dti

Size : 5cm x 5cm x0.0cm
Wound base : Purple
Undermining/Tunneling : none
Exudate : none
Periwound skin : intact
Inflammation : moderate
Odor : none
Pain : 10

Wound Location : Left buttock
Type : pressure
Stage : dti
Size : 7cm x 8cm x0.0cm
Wound base : Purple
Undermining/Tunneling : none
Exudate : purulent
Periwound skin : intact
Inflammation : moderate
Odor : none
Pain : 10

Wound Location : coccyx
Type : pressure
Stage : stage 3
Size 2cm
Wound base : subcutaneous tissue yellow
Undermining/Tunneling : none
Exudate : none
Periwound skin : purple erythema
Inflammation : moderate
Odor : none
Pain : 10

Wound Location : left shoulder
Type : pressure
Stage : stage 3
Size : 1cm x 1
cm x0.2cm
Wound base : subcutaneous tissue yellow
Undermining/Tunneling : none
Exudate : none poor blood supply
Periwound skin : purple erythema
Inflammation : moderate
Odor : none
Pain : 10

The patient received AAOx2, and the patient's respiratory status was on oxygen via NC. Relevant medications that may delay

wound healing include Hydrocortisone, Rocephin, and Rocephin. The patient is bed bound with low air loss surface in place. She is positioned on her left side with pillows. Sacrum and heels offloaded. The patient rec's dysphagia diet. Nutritional Status: Severe malnutrition. Patient is incontinent of urine with an IUC in place. The patient was seen and treated at the bedside. The patient was left comfortable and in no distress or discomfort. The patient has been referred to Hospice *– you mention that the patient had "10" pain but no intervention, make sure there is noted intervention here. Should this charting come under review, it is not clear what was done to manage patient pain.*
Braden Scale Score:11

Wound Dressing: Allevyn life with Allevyn foam dressing removed

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)

PLAN
1. Continue pressure injury prevention interventions per policy
2. Wound care:

Bilateral Heels
Cleanse gently with NSS pat dry
Apply Povidone Iodine to heels
QID and PRN
Keep Patient in EHOB boots and offloaded on pillows

Bilateral buttock and coccyx, and Left shoulder blade
Cleanse wounds with NSS daily pat dry
Apply No sting barrier to periwound let dry 60 seconds
Apply Allevyn Foam to wound bed
Secure with Allevyn Life dressing
Keep patient offloaded
Turn q 2 hours

At this point, my goal is to keep the patient pain free and comfortable as possible. The state POA was called and the patient wound care plan was explained. State POA agreed with the plan

This section should be your direction to those working under your direction – nursing orders. These should include directions for dressings and holistic measures (cosnults are fine). You mention much that was done above. What is your directive to other caregivers? Please revise this section to reflect this direction.

Examples: "change dressing X Y times using Z" "Consult with hospice…" "Administer pain medication PRN per order for…" etc.

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

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This patient has been readmitted several times in the last several months. Per her chart, she is a long-term local nursing home resident. The patient has declined significantly in the past few months with AMS and decreased appetite. I think Hospice should have been introduced at her last visit. Now, she is suffering and has significant skin breakdown, contributing to her deterioration. Per this patient chart the patient has only a nephew who is not involved in her care. She does have representation with NJ state POA.

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 today was to see how a WOC nurse assesses and develops a care plan for a patient who is going into hospice.

What is/are your learning goal(s) for tomorrow?
Find a patient for who silver nitrate sticks can be used and also mark a patient for ileostomy.b

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	Components noted in note but not POC.	x
● WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
● Statements direct care of the patient in the absence of the WOC nurse		x
● Directives are written as nursing orders		x
Thoughts Related to Visit:		
● Critical thinking utilized to reflect on patient encounter	✓	

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● Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: Mike Klements 12/10/24 received Date: 12/12/24

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