Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _____Sara Waggoner_____ Day/Date: __3__12/3_____

Number of Clinical Hours Today: __8__ Number of patients seen__5__

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

Preceptor: ___Erica Yates_____

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, and any additional activities.

61yo Male DTI coccyx. Wound team consulted to obtain a new scout image and f/u on medical adhesive related skin injury on abdomen and left flank.

67yo female – wound team consulted for wound staging on DTPI vs Stg. 2 and dressing orders.

76yo male – Order recommendations for old abscess that has been non-healing for a few months.

55yo female- Initial eval on stage 4 sacral ulcer for a pt. who was previously admitted last month.

50yo female- f/u on unstageable pressure ulcer that is healing and is now a stage 3. New orders for aquacel given.

Time spent with preceptor discussing wound products and ABI results and doppler results.

Attended meeting to discuss updates on products and procedures.

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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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient

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encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

CC: "I can't move my legs"

HPI: D.M a 55-year-old Caucasian female was admitted to the medical step-down floor for complaints of inability to move her legs. Patient has a history of developmental delay, paget's disease, epilepsy, and irritable bowel disease. Patient was recently admitted to the hospital a month ago for dizziness, hypotension, and right lower extremity DVT with IVC filter placement. Wound care was consulted regarding treatment recommendations for a chronic pressure ulcer to sacrum. Patient last seen by wound care team on 11/26. Patient does complain of pain at the wound site, but she is unable to describe the pain or rate it on the pain scale. Patient does complain that she feels she is leaking urine. Patient's mother is at bedside and sates they have not been doing any dressing changes at home as patient has been in and out of the hospital.

Current Facility-Administered Medications:
Heparin 5,000units Sub-Q Q12hr
Acetaminophen 1,000mg Q8hr prn
Miralax 17g packet daily prn
Clonazepam 2mg po BID
Ferrous Sulfate 325mg po Daily
Midodrine 15mg po with meals
Pantoprazole 40mg po daily

Allergies:
Amitriptyline – altered mental status

PMHx:
Developmental Delay
Epilepsy
Paget's Disease
Irritable bowel syndrome

Surgical Hx:
Cholecystectomy
Total hysterectomy

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Soc & Substance Hx: Never Smoker. Denies recreational drug use. Denies alcohol use.

Fam Hx:
Mother – HTN, cataract, Diabetes, heart disease
Father – HTN, heart disease, diabetes

ROS:
GENERAL: Denies fever and chills.
HEENT: No headache, dizziness, nosebleed, mouth pain, or sore throat.
CARDIOVASCULAR: No chest pain or heart palpitations. +1 BLE edema.
RESPIRATORY: Denies shortness of breath, coughing, or wheezing.
GI: Denies constipation or diarrhea.

O.
BP: 112/54, HR: 82, TEMP: 97.9 Oral, RR: 20 Pulse Ox 96%. HT: 5'2'', WT: 160LBS

GENERAL: A&Ox3. No acute distress.
HENT: Atraumatic, normocephalic. Mucous membranes moist.
PULMONARY: Respirations even and unlabored. No respiratory distress or audible wheezing.
SKIN: Good Turgor. Stage 4 pressure ulcer to sacrum. Wound measures 2cmX2.4cmX2.3cm. Undermining 4.5cm. Wound bed beefy red with epithelial tissue. No slough or eschar noted. Wound edges not attached. Peri-wound skin pink and intact with scarring. No erythema or induration. No maceration noted.
GU: Indwelling foley catheter present. Clear yellow urine noted.
EXTREMITIES: +1 edema BLE.

Procedures:
WCCT APRN and student completed wound care. Removed old foam dressing. Large amount of serosanguinous drainage noted. Cleansed wound with normal saline. Applied ConvaTec skin barrier to peri-wound. Aquacel cut into spiral shape and gently packed into wound using cotton tip applicator. Wound covered with foam dressing. See wound assessment above.

Most Recent Abnormal Labs:
12/3 CBC WNL

Plan:
Stage IV pressure injury to Sacrum:
Nurse to remove old dressing, cleanse wound with normal saline or wound cleanser. Apply ConvaTec skin prep to peri-wound. Spiral cut Aquacel or use Aquacel rope to gently fill wound. Do not overpack wound and be sure to gently fill undermining. Cover wound with foam dressing. Change daily and as needed.

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Braden Risk Assessment Tool

Sensory Perception	3
Moisture	4
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	2
Total	14

Moderate risk

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)

Plan:

Stage IV pressure injury to Sacrum:
Nurse to remove old dressing, cleanse wound with normal saline or wound cleanser. Apply ConvaTec skin prep to peri-wound. Spiral cut Aquacel or use Aquacel rope to gently fill wound. Do not overpack wound and be sure to gently fill undermining. Cover wound with foam dressing. Change daily and as needed.
Obtain a seating cushion for when patient is up to chair.
Limit time in chair to 1.5-2hrs at a time.

Prevention:

Order IsoTour blower for low air loss.
Off-load heels while in bed
Use Medline comfort glide sheet and turning wedge
Encourage repositioning every two hours
Nutrition consult for optimized wound healing.

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

Aquacel and a foam dressing is a good option for this wound since the wound is draining a large amount. Aquacel will help promote a healthy moist healing environment by wicking away drainage. A foam dressing will also help to soak up excessive drainage and be able to be wiped off if a small amount of stool leaks onto dressing. In this situation, instead of a daily dressing change I wound recommend dressing changes to be done three times a week and as needed since foam dressings are recommended to stay in place for longer than a day.

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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 for the day was understand when negative pressure wound therapy is appropriate to order. I was able to meet this goal by discussing patients that NPWT would be appropriate for. We also discussed contraindications to using NPWT.

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

My goal for tomorrow is to understand what all wounds classify as diabetic ulcers.

For instructor use only. Do not remove or edit:

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	

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Reviewed by: _____ Date: _____

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