

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Candace Beeghly _____ Day/Date: 10/6/2020

Directions: *WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, select one patient each clinical day and complete **plan of care and chart note**.* This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. **Journals should be submitted to your dropbox by no later than 48 hours following the clinical experience day.**

Today's WOC specific assessment	<p>Assessment: 78 year old male admitted for altered mental status. He is currently being treated for a urinary tract infection and proctitis for which this is a readmission admission for as he stopped taking his antibiotics for 3 days prior to admission for an unknown reason. Alert, follows commands but with periods of confusion. Per patient he is normally mobile than his current state, at present he is bed bound, but can turn with minimal assistance. He has wounds to his bilateral feet, reddened scrotum and diarrhea present. Overall very thin appearance.</p> <p>Medical Hx: type II diabetes, CAD s/p CABG, CHF, ef of 35-39%, atrial fibrillation, HTN, GERD, diabetic neuropathy, obstructive sleep apnea, COPD on 2L NC O2 at baseline, and had COVID related pneumonia in February 2020 for which he had a lengthy hospitalization of greater than 60 days.</p> <p>Surgical Hx: CABG</p> <p>Medications: eliquis, ertapeneum, triple care anti fungal, thiamine, multivitamin, aldactone, lasix, sliding scale insulin, fludrocortisone, metoprolol, midodrine, pepcid, docusate, albuterol/ipratropium nebulizer, potassium chloride, Regular dysphagia pureed cardiac ADA diet with 1500 ml fluid restriction.</p>
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

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Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? 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.

Initial visit with patient to evaluate him for an internal fecal management system as well as assess his bilateral feet, and scrotum. Patient was lying in bed, alert, able to follow commands did demonstrate some moments of confusion throughout visit. Patient has an overall thin appearance, almost cachectic. Lunch tray is at bedside, has not been touched, patient states he isn't hungry. Per patient he is normally more mobile at his nursing facility but currently has been more bed bound. Patient is on a standard pressure redistributing therapeutic mattress.

While assessing his feet noted to have hammer toes to bilateral feet. The anterior aspect of his toes have evidence of small scabbing from possible trauma with his shoes. He has dry black, non fluctuate eschar to the plantar aspect of his R great toe ~ 1.5 x 1.5, Anterior aspect of his 2nd metatarsal joint ~ 1 x1, distal 5th toe near end of nail bed ~ 0.3 x 0.3 as well as on his L foot to his 3rd metatarsal head ~ 1 x1. These areas present as arterial ulcers. Recommendation is to keep them dry and clean, will enter black eschar protocol order which consistent of daily cleaning with chlorprep and keep these areas uncovered. Patient's heels are also noted to be pink, but blanchable. Currently using static air heel suspension boots, recommend continuation of this item.

Turned patient with minimal assistance. Patient noted to have a moderate amount of liquid brown stool. He is currently continent of both stool and urine, but is utilizing a condom catheter to manage his urine. Patient was cleansed with bath wipes. Patient's scrotum noted to be reddened with slight denuding. Small opening to R side of scrotum ~ 0.3 x 0.3, shallow pink with macerated edges. Another small opening noted within the R groin, ~ 0.2 x 0.1 again pink with macerated edges. Recommendations is to apply a barrier cream to these areas that will help heal the openings as well as protect it from the stool irritant. No irritation noted to inner thighs or groin areas.

Patient has evidence of friction to the sacrum, superficial flaking noted. Recommend use of a mepilex sacral dressing to help protect this action from friction forces. Other than superficial flaking of skin sacrum, coccyx, buttock and posterior thighs are in tact, no irritation noted. Because of episode of stool incontinence, patient at risk for chemical irritation from stool exposure, applied barrier cream to buttock, perineal area and posterior thighs. Noted that patient had covidien incontinence pad folded up between his legs, and also had 3 layers beneath him as well as a fitted sheet. This is too may layers and can contribute to heat and moisture trapping which can cause additional skin damage. Recommendation is to limit layers to no more than 2 to allow to air to passthrough and promote a cool dry environment for patients skin.

Per documentation review patient had 4 episode of stool incontinence within a 24 hour period of time, currently skin remains intact and not irritated from exposure of stool. Patient does not have any history of trauma or colon surgery within the last year, is currently being treated for proctitis. At this point in time do not believe patient requires and meets criteria for internal fecal management system.

Assessed all other bony prominences, unremarkable.

WOC specific medical & nursing diagnosis	WOC Plan of Care (include specific product used today)	Rationale (Explain why an intervention is chosen; purpose)
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<p>Arterial ulcers to Bilateral Toes</p> <p>Incontinence associated skin irritation to scrotum and groin</p> <p>friction injury to sacrum</p> <p>at risk for poor wound healing secondary to PMhx decreased tissue perfusion, as well as suboptimal nutrition</p> <p>at risk pressure injury due low braden score, 13</p> <p>poor nutrition as evidence by cachectic appearance, poor appetite, low albumin levels</p> <p>Incontinence associated dermatitis to scrotum</p> <p>Moisture associated skin damage to scrotum and groin, at risk for further damage due to excessive layers</p>	<p>Chloraprep clean bilateral toes daily to help keep clean and dry and maintain the dry eschar</p> <p>Clean and dry scrotum, groin and perineal area. Application of calazime barrier cream for protection and prevention of further skin breakdown. Continue to use covidien incontinence pads.</p> <p>Application of sacral Mepilex dressing to sacrum. Reduce number of layers beneath patient to no more than 2, continue to use incontinence pads and frequent checks on patient for episodes of incontinence</p> <p>Continue with use of static air heel suspension boots</p> <p>Recommend consultation with hospital dietician to address nutritional needs</p>	<p>For arterial ulcers with dry stable eschar it is better to maintain this clean and dry eschar to protect the patient from developing an infection as well if removed patient is at risk for poor and delayed wound healing.</p> <p>Patient is moisture associated and incontinence associated skin damage to scrotum and groin the application of calaziem cream will help heal these areas as well as protect it from coming into contact with the stool irritant. Reducing the number of layers beneath the patient will prevent heat and moisture trapping which can put skin at risk for MASD as well as make it more susceptible to injury from friction, shearing and pressure.</p> <p>Due to patient's thin appearance, suboptimal nutrition and poor vasculature patient is at risk for pressure injury to Bilateral heels, static air boots help offload pressure from the heels.</p> <p>Dietician may be able to help promote dietary alternatives to better optimize the patient's nutritional status and help with wound healing.</p>
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<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p>	<ul style="list-style-type: none"> - Chorprep can be substituted with betadine to the bilateral feet arterial ulcers as this would also provide the same affect of maintaining the stable eschar and eliminating microorganisms. - If the static air boots are not preferred by the patient or are not staying in proper position and are twisting an alternative would be the prevalence boots as they would also provide offloading of the heels but are made of a softer material than the plastic static heel boots. - If the use of incontinence pads is not sufficient for the incontinence episodes a stool pouching system could be utilized. It would help contain the stool, as well as help measure the amount of stool to keep more accurate I/O's and help protect the skin from the exposure of the stool irritant. - A low air loss mattress overlay could also be implemented to help promote a cool dry microclimate.
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Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	Yes, goal for today was to successfully manage 3 patients with assistance from preceptor.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	To be more confident in my approach with patients as the lead WOC Nurse.

Number of Clinical Hours Today: 8

Care Setting: Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: 3 Preceptor: Cynthia Cisneros

Reviewed by: _____ Date: _____

****References are not generally required for daily journals**

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