

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Ruth Capp _____ Day/Date: _____ Day 1 / 11 October 2021 _____

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>Patient is a thin 67 year old male who presented with a history of diverticulitis and symptoms of a colovesical fistulas. Surgical entry was by Pfannenstiel incision on 9/27/21. Surgical findings were a colovesical fistula near the trigone of the bladder from the sigmoid colon, and an abscess of the bladder wall containing stool and purulence. The sigmoid colon was removed and the descending colon joined to the rectum. No further mention is made of the bladder (at least in the information available to me).</p> <p>Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc</p>
--	---

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

<p>Patient is seen for scheduled change of NPWT of Pfannenstiel incision. NPWT cannister has large amount of dark bloody drainage. Wound bed also has dark bloody drainage at 2-3 o'clock, next to tunneling at this location. Wound is cleaned with normal saline. Periwound skin is washed with soap and water, rinsed with water, and patted dry. Wound bed is 100% red, moist, granulated tissue measuring 2.5 x 5.7 x 2.4 cm. Tunneling at 2 o'clock and 9 o'clock measuring 3.4 cm and 2 cm, respectively. Wound edges are even and intact. Periwound skin is intact with scattered bruising superior and inferior to wound. Supportive tissue is semi-soft. 3M Cavilion skin prep is applied to periwound skin and protected with transparent adhesive drape. 1 piece of black foam from small kit is placed in wound bed and another piece on top of that. Transparent adhesive drape applied over foam and periwound. Hole cut in drape for trac pad and trac pad applied. Negative pressure initiated and seal achieved at -125 mmHg continuous suction. Next scheduled visit is 10/14 for scheduled NPWT dressing change. Patient tolerates procedure but did comment on his tailbone being sore from sitting. Coccyx area is unremarkable but a sacral foam pad with adhesive border is placed to his coccyx for comfort.</p> <p>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.</p>

WOC specific medical & nursing diagnosis	WOC Directive Plan of Care (Base this on the above data. Include specific products)	Rationale (Explain why an intervention was chosen; purpose)
--	---	---

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

<p>1. NPWT in use</p> <p>2. Tubing may cause pressure injury</p> <p>3. Coccyx is prominent and patient complains of pain at that location after sitting.</p> <p>4. Pain</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:</i></p>	<p>1. Monitor NPWT for leakage. If leakage is present repair or replace dressing until leakage stops.</p> <p>2. Monitor tubing every shift to assure it is not pressing against skin. Place foam cushion between tubing and skin prn or reposition patient to relieve pressure.</p> <p>3. Verify every shift that foam to coccyx is intact and not soiled. Change if foam is dislodged or soiled. Prior to application of foam clean area with soap and water, rinse with water, pat dry, apply skin prep to entire area.</p> <p>4. Monitor patient for pain and chart results. If pain is noted request physician for order of medication to control pain.</p>	<p>1. Value of NPWT is lost if leakage occurs and it becomes instead a source of potential bacterial infection.</p> <p>2. Patient's skin is fragile so pressure from a tube could easily cause injury.</p> <p>3. Patient received so much relief from this foam that he commented on it the following day. This area is at high risk for development of pressure injury.</p> <p>4. Pain slows healing. Patient does not appear to have pain medication ordered.</p>
--	---	---

<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p> <p>(This is your opportunity to share your product knowledge and apply critical thinking)</p>	<p>NPWT has been shown to speed up healing and the wound bed on this wound looks very good with 100% granulation. It has been 14 days since his surgery so this is a timely progression. There is potentiation for the exterior wound to heal while the bladder abscess remains infected, effectively sealing in an infected and active wound. The abscess likely contains Escherichia coli bacteria, which are anaerobic and gram negative. Studies have shown they can not grow at ≤ 3.7 pH. Studies have also shown success with treating wounds with Citric Acid. Ingestion of yoghurt, buttermilk, and/or kefir in studies have shown increase in urine acidity.</p> <p>Thus, an alternative to the NPWT therapy, should it become not available, would be citric acid ointment into the tunnels and a dressing of pouched foam placed to fit and fill the wound bed and main cavity. (Care must be taken to loosely fill the wound cavity and not to overfill it.) This could be covered with a transparent drape so as to be able to monitor the amount of exudate being absorbed (and, of course, prior to application the periwound skin being covered with skin prep). Oral intake of cultured milk product would also be recommended to raise the acidity in the bladder where the abscess is/was located.</p>
---	---

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

<p>Were you able to meet your learning goals for today? Why or why not?</p>	<p>Yes. My goal was to train at the Cleveland Clinic and the journey has begun.</p>
<p>What are your learning</p>	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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

goals for tomorrow? (Share learning goal with preceptor)	To see and do and listen and comprehend as much as possible.
---	--

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 4 Preceptor: Jessica Lawson, RN, BSN, CWOCN

Reviewed by: _____ Date: _____

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

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.