



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Stacy Mariano Day/Date: Tuesday 1/24/23

Number of Clinical Hours Today: 8 Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 5 Preceptor: Jessica L.

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. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. 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 by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

Today’s WOC specific assessment	Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.
NPWT Vac dressing change and wound assessment	<p>40 y.o. male PMH of Major Depressive Disorder IV drug use (cocaine and heroin) in recovery with Suboxone. Hepatitis C, prior Hep B infection Osteomyelitis of right foot s/p great toe amputation s/p Right BKA due to osteomyelitis (continued), wound treatment is NPWT presented to hospital with acute respiratory failure leading to ARDS leading to intubation w/sedation and admission to ICU.</p> <p>Recent Labs indicated likely sepsis: Sputum CS = + Strep pneumonia, Serratia M. w/mixed flora. Urine CS = Legionella AG, Strep pneumo MRSA in nasal swab Elevated WBC’s consistent with infectious process/sepsis Thrombocytopenia noted (plt 69) Elevated BUN 83, CREAT 3.69 indicating AKI</p> <p>Chest X-ray showed bilateral pneumonia</p> <p>Patient has NG in place for feeding, IV fluids and antibiotics.</p> <p>WOC nurse consulted for NPWT management and ongoing assessment of open wound to R BKA healing process.</p>

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Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

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. Write in a manner others will be able to understand and be able to interpret your plan of care.

Follow up visit for wound vac dressing change to right BKA wound. Patient is s/p R BKA due to osteomyelitis. Patient wound has bone exposure, intact periwound skin, and good beefy, red granulation tissue covering 95% of wound bed. Minimal yellow colored slough noted in spots, some epithelial migration beginning. Patient was premedicated with Fentanyl prior to wound care visit but still had pain throughout treatment requiring frequent breaks. Dressing removed carefully with adhesive remover and saline, gently washed/irrigated with mild soap and water, pat dry. Periwound skin protected with skin prep and transparent drape to wound edges, petrolatum gauze applied to bone, Urgotul non-contact layer applied to wound bed followed by 2 pieces of black foam, covered with drape and trac pad, seal achieved at 125 mmHg continuous suction. Wound photographed and uploaded to patient chart, measurements taken for comparison to previous measurements as method to monitor wound healing. Patient tolerated wound care poorly in spite of premedicated state and frequent breaks. PMD did stop in during care to discuss pain control plan with patient and stated that medications were being adjusted for better pain control. Plan to change wound vac dressing again on Friday 1/27/23. WOC nurse to call primary RN to premedicate patient prior to visit.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <ol style="list-style-type: none"> Acute vs Chronic pain Alteration in skin/body structure s/p R BKA. Active infection- multiple organisms Active bleeding in wound d/t Thrombocytopenia Nutritional deficits 	<p>Statements should be directive and holistic relating to the problem/concern.</p> <ol style="list-style-type: none"> Patient to be premedicated with Fentanyl 1 hour prior to wound care/dressing changes to provide pain control. NPWT dressing changes Tue/Fri: remove using Convatec adhesive remover and saline to loosen foam and drape. Gently wash with mild soap and water, pat dry, apply 3M Cavillon skin prep to periwound area and apply drape to periwound skin. Cover exposed bone with petroleum gauze, Urgetol to wound bbed, black foam to wound bed, cover with transparent drape and trac pad. Goal: obtain seal at 125 mmHg continuous suction. Monitor progression of healing, looking for signs of wound stalling indicating possible biofilm or infection with each dressing change. Monitor patient for 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <ol style="list-style-type: none"> Pain control and patient comfort should be a priority during wound care. Uncontrolled pain can interfere with healing. Specific instructions for dressing changes will ensure continuity of care and provided optimal healing environment. Ensures subsequent clinicians will have adequate supplies. Careful monitoring of wound progression can indicate need for change in POC. This patient is at high risk for wound

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	<p>s/s of infection including fever, increased pain, redness spreading outward from wound, periwound induration. Report s/s of infection to primary nurse or MD.</p> <ol style="list-style-type: none"> 4. Monitor wound for active bleeding with each dressing change, alert primary RN or MD of uncontrolled bleeding, monitor labs for worsening Thrombocytopenia, instruct nursing staff to monitor cannister for frank sanguineous drainage. Stop NWPT and page WOC nurse team if large amounts of blood found in canister. 5. Monitor labs including albumin, prealbumin and protein levels. Patient currently receiving protein supplements with tube feedings along with IV fluids. Consult nutritionist if labs indicate decline. 	<p>declining due to presence of multiple infectious organisms and smoking history which is known to impair wound healing. Patient also has compromised venous perfusion per H&P notes which can also impair wound healing. Exposed bone has the potential to lead to recurring osteomyelitis. All the above are reasons for close monitoring of wound status.</p> <ol style="list-style-type: none"> 4. Patient has diagnosis of Thrombocytopenia which has been noted to be causing bleeding problems with wound. Vascularized wound bed is good for healing but excessive bleeding is not. Cannister should be closely monitored by nursing in the event the vac starts pulling blood. 5. Monitoring labs and nutritional status is important. Proper protein intake is vital to tissue profusion and building. Adequate hydration ensures proper fluid balance.
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<p>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>For this patient we are using KCI NPWT equipment and products, along with Convatec adhesive remover and 3M Cavillon skin prep. There are multiple equipment suppliers that could be used by patient upon discharge depending on availability and insurance including DeRoyal, Convatec, Cardinal, and Apria to name a few examples. The adhesive remover and skin prep may be ordered from companies such as Hollister.</p> <p>If the NPWT is unsuccessful other wound care options could include simple wet to dry dressings however these would be labor intensive as they are a BID dressing change. Hydrafera Blue would be</p>
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used if the product was not available?	another option especially due to the risk of developing a biofilm along with a secondary dressing such as ABD pads covered with light compression such as an ace wrap. In any instance the bone would need to be protected with some form of occlusive dressing and the periwound skin would also need some form of barrier cream or skin prep to protect it from exudate and moisture. Since the wound bed is beefy red and mostly filled with granulation tissue, no enzymatic debridement product is indicated.
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Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	Goal for today was to participate in urostomy care/system change. We were able to see a patient that had both a urostomy and a colostomy in which both systems needed to be changed. Patient has had ostomies for some time and was well educated on care but required system reevaluation due to recent changes to abdominal geography.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	Wed. 1/25 I will be in outpatient GI clinic. Goal is to see/participate in preoperative stoma marking and preoperative education.

Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<p>Other patients seen today included an new ileostomy patient requiring discharge education for self and spouse along with supply order form. Couple were very engaged and eager to learn, asked lots of questions, spouse was very hands on. Another NPWT patient was seen for initial application of wound vac to debrided wound in left groin area. Education on therapy was provided and patient tolerated application of wound vac well.</p> <p>Of considerable notation has been the observation of patients with positive vs negative outlooks and attitudes. Patient mind set seems to make such a difference in the healing process. The patients with positive outlooks seem to have better managed symptoms which I feel will ultimately lead to better outcomes.</p>
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Reviewed by: _____ Date: _____

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