

Daily Journal Entry with Plan of Care & Chart Note

 Student Name: Paula L. Vaughn Journal Completion Date: 2/1/2023

 Setting: Acute Care Outpatient HHC Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	<p>84-year-old male with a past medical history significant for depression, hypertension, dyslipidemia, motor vehicle accident resulting in right above the knee amputation and suprapubic catheter, TIA, cataracts, and dementia. The patient was admitted to the hospital for multi-drug resistant infections both to the sacral stage IV pressure injury and ESBL in the urine. The patient is a poor historian. The patient is known to the outpatient clinic and was seen prior to admission for negative pressure wound therapy. It was noticed that the wound was stalled, malodorous, and exhibited increased drainage. The LIP obtained a culture which indicated polymicrobial growth. Around the same time frame, the patient was seen by PCP and a urine culture was taken which grew a resistant organism. The patient was admitted for IV antibiotics and wound care. This is hospital day #4.</p> <p>Surgical history: Above the knee amputation s/p MVA 2014 Suprapubic catheter s/p MVA 2014 Left knee replacement 2011</p> <p>Medications: Vancomycin 1 Gm IV q 18 hours Unasyn IVPB 100 mg IV q 6 hours Heparin flush 20 units IV prior to discharge x 1 All other PO medications are on hold at this time (acetaminophen, lisinopril, and rosuvastatin until swallow study can be completed)</p> <p>Social hx: Smoking: never smoked ETOH: none Illicit drug use: none</p> <p>Diagnostics: Urine Culture: + E. coli, and ESBL Blood culture: negative Wound culture: +S. aureus, S.anginosus, Diphtheroids CT Pelvis w IV contrast. Report Findings: Sacral decubitus ulcer with ulceration of the underlying</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.

distal sacrum and coccyx. No evidence of focal fluid collections to suggest abscess. BUN 27 Cr. 0.58
--

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

CWOCN-AP NOTE

Follow-up visit for suprapubic catheter care

Subjective:

ROS: unable to obtain at this time. 84 y/o male poor historian.

Objective:

T: 98.9°F, HR 70 regular, RR 18 regular, BP 138/84

General: Well nourished, well developed male, who appears stated age. No distress noted. Awake, confused, non-verbal, oriented to name only.

HENT: Normocephalic, atraumatic, moist oral mucosa, no nasal drainage, no visible lesions on external ears or nose, no oral lesions

Resp: No accessory muscle use or increased work of breathing. Respirations even and unlabored, clear to auscultation.

CVS: Heart sounds are normal with a normal apical impulse. No murmurs, gallops or rubs

PVS: right AKA, BLE warm, appropriate for ethnicity, R popliteal pulse 1+, L pedal, 2+, L popliteal pulse 1+, No edema noted

ABD: Abdomen soft and round. Active bowel sounds x 4 quadrants

GU: suprapubic urinary catheter, unsecured to skin, draining clear yellow urine.

MSK: Well-healed right AKA stump noted. No visible effusion, swelling, increased warmth, erythema, or limitation of motion of major joints.

Skin: Stage IV pressure injury to sacrum. NPWT device intact to site. PICC line right upper arm. Red rash around suprapubic catheter site, no satellite lesions.

Assessment:

Suprapubic catheter, peristomal skin breakdown

Dementia

Chronic wound, stage IV pressure injury sacrum with polymicrobial growth being managed by PCP

Plan:

Swallow study to be completed as ordered, if patient is unable to take PO intake, then referral to Pharmacy for hyperalimentation dosing.

Referral to registered dietician for dietary support.

Continue low air loss mattress and turn patient every 2 hours

Continue antibiotics per ID

Secure urinary catheter with medical adhesive tape or with a commercial device; prevent dependent loops of drainage; measure I/O every 8 hours

Local skin care to suprapubic site

Monitor the patient for fecal incontinence and diarrhea while on IV antibiotics.

Patient education:

Patient unreceptive to teaching at this time

(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.

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> <p>Nutritional deficiency related to nutritional intake below metabolic needs.</p> <p>Impaired tissue integrity related to sacral stage IV pressure injury.</p> <p>Impaired skin integrity resulting in damage to the skin allowing bacteria to enter and cause infection evidenced by wound that is stalled, malodorous, and exhibited increased drainage. With a culture that indicated polymicrobial growth.</p> <p>Impaired physical mobility secondary to above the knee amputation, TIA, cataracts, and dementia.</p> <p>Altered urinary and fecal excretion evidence by suprapubic catheter in place.</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Swallow study to be completed as ordered, if patient is unable to take PO intake, then referral to Pharmacy for hyperalimentation dosing. Referral to registered dietician for dietary support for dietary supplements to ensure patients caloric needs are met.</p> <p>Continue low air loss mattress and turn patient every 2 hours. If low air loss mattress is not available be sure bony prominences are not resting on each other and are cushioned with pillows, be sure to have the body in the most neutral position possible. Float heels as much as possible.</p> <p>Continue antibiotics per ID.</p> <p>Continue low air loss mattress and turn patient every 2 hours. Reposition patient focusing to keep patient off bony prominences.</p> <p>Secure urinary catheter with medical adhesive tape or with a commercial device; prevent dependent loops of drainage; measure I/O every 8 hours. Local skin care to suprapubic site. Cleanse the area with soap and water. Monitor the patient for fecal incontinence and</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Having a swallow eval with evaluate the ability to take PO medications and diet, if the patient fails then the pharmacy will be notified to calculate TPN for the patient.</p> <p>Offloading mattress and repositioning the patient will assist with preventing further pressure injury and assist with the current pressure injury to heal.</p> <p>Will assist in clearing infection to help with wound healing.</p> <p>Offloading mattress and repositioning the patient will assist with preventing further pressure injury since the patient has dementia, history of TIA, and amputation he may not remember to reposition.</p> <p>Securing the catheter will prevent potential damage, pain and irritation, accidental dislodging of a catheter. Local skin care will help prevent infection and injury.</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

<p>Impaired urinary elimination with urinary tract infection present.</p>	<p>diarrhea while on IV antibiotics.</p> <p>Secure urinary catheter with medical adhesive tape or with a commercial device; prevent dependent loops of drainage; measure I/O every 8 hours.</p> <p>Local skin care to suprapubic site, assess the catheter site a few times a day assessing for redness, pain, swelling. Wash the area around the catheter daily with mild soap and water pat dry, do not use creams, powders, or sprays near the site.</p> <p>Continue antibiotics per ID.</p>	<p>Securing the catheter will prevent potential damage, pain and irritation, accidental dislodging of a catheter.</p> <p>Local skin care will help prevent infection and injury.</p> <p>IV antibiotics will assist in clearing the UTI.</p>
---	---	---

<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 used if the product was not available?</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Continue low air loss mattress; Disadvantage: can be poor temperature control, can cause the patient to have poor body alignment, patient slides down easily. Alternative: Alternating pressure pad - inflatable low air loss mattress topper.</p> <p>IV antibiotics; Disadvantage: can cause diarrhea, can cause Clostridioides difficile. Alternative: No alternative.</p> <p>Suprapubic cath: Disadvantage: may cause trauma, infection, or pain. Alternative: No alternative secondary to patient with large pressure injury and dealing with dementia.</p>
--	---

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

<p>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</p>	<p>My goal for choosing this case study was to learn more about urinary tract infections with resistance, reading about the different methods to secure SP catheters and the different antibiotic therapies for wound infections.</p> <p>Yes, I feel I was able to meet my goal, because I studied and learned about MDR UTIs and wound infections.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>To continue working on journals and broadening my knowledge and skills for wound, ostomy, and continence.</p>

<p>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>For this case study I would recommend someone to assist the patient for meals TID secondary to him having dementia along with having a high caloric need due to a large wound and with infection.</p> <p>Another suggestion is a physical and occupation therapy referral for mobility and strengthening.</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

	Ongoing reminders for him about the importance of repositioning. Even though he has dementia he stills needs to be attempted to be educated and reminded.
--	---

Reviewed by: _____ Date: _____

(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.