

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Miin Choi

Journal Completion Date: 2/3/23

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>Patient is a 15 month old male patient with extensive medical history including jejunal atresia, short gut syndrome, status post multivisceral transplant, rejection, mucormycosis, and stage 4 graft versus host disease currently in pediatric intensive care unit. Patient and parents are in from Kuwait, Arabic speaking and are residing locally, generally taking turns being present at bedside. Translator needed to communicate all medical information. Patient admitted to PICU under surgery for multivisceral organ transplant due PHM of severe jejunal atresia at birth and subsequent jejunal perforation and necrotizing infection. Pt with extensive surgical history with poor outcomes at outside hospital. Surgeon recommended transfer to this facility for second opinion and possible multivisceral organ transplant. POD 75 multivisceral organ transplant. Patient and is intubated and sedated in PICU. Prior to infection, patient with appropriate orientation to self and surroundings for age. Ileostomy nonfunctioning and patient NPO on TPN for all nutrition. Patient noted to be jaundice with generalized edema. NG tube in place with strict orders not to remove or manipulate due to s/p transplant and present mucormycosis infection. Per surgeon order, patient to maintain non-adherent foam dressing over non-functioning ileostomy, managed by bedside nursing. Due to severe immunocompromise, patient is on reverse isolation precautions. WOC nurse consulted today for evaluation of new blisters and denuded area with friable bleeding to abdomen.</p>
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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.

<p>Initial WOC nursing visit for evaluation of new open areas to abdominal skin.</p> <p>Patient well known to WOC service and has been followed previously for ileostomy and skin care. Parents at bedside and non-English speaking. Familiar with WOC nurse from previous encounters and able to communicate consent for evaluation and visit. Due to critical patient condition, reverse isolation precautions established prior to encounter per protocol and maintained throughout visit. Patient noted to be resting comfortably in bed on ventilator, sedated and non-arousable.</p> <p>Assessment of patient’s skin reveals severe jaundice and generalized weeping to abdomen. Foam dressing to ileostomy being held in place with rolled gauze. Large unroofed blister noted to patient’s left lower abdominal quadrant with serosanguineous drainage noted to have seeped onto gauze dressing. Kerlix gauze wrap carefully removed using copious amounts of normal saline. Patient tolerated with no signs of discomfort. Unroofed blister to LLQ, measures 4.5cm x 7cm x <0.1cm with defined margins. Moderate serosanguineous drainage noted. No further blistered areas noted. Nonadherent foam dressing removed from end ileostomy. No effluent noted on dressing. Mucousa noted to be pink and tacky, friable. Oozing easily controlled with gentle pressure. Has prn silver</p>
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nitrate order available and not used this visit. Surgical scars noted with no drainage. Surgical team paged to bedside for tandem evaluation per request. Abdomen cleansed with NS and gently patted dry using sterile gauze. Urgotul contact layer dressing cut to fit and placed over unroofed LLQ area. 2x2 non adherent Allevyn foam dressing placed over non-functioning ileostomy. 4x8 ABD dressing placed over abdomen. With assistance from surgical team, pt lifted and kerlix wrap gently secured completely around abdomen. Linens changed by nursing at this time due to wound exudate and weeping edema. Patient repositioned onto left side using foam wedge. No non-verbal pain cues noted and pt remained stable throughout entire procedure.

Recommendations:

Maintain reverse isolation at all times

Turn and reposition patient q2h

Maintain LAL support surface at all times

Utilize Arabic translator for all medical communication with patient parents.

WOC nurse to perform daily wound care during surgical rounds

If dressing noted to be soiled, or any changes in skin condition, change dressings as per above and notify WOC nurse and surgical team. Use only non-adherent dressings.

If acute bleeding is noted, notify surgical team.

Consult with Surgical team for tandem visits, as to minimize traffic in PICU.

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>Delayed surgical healing</p> <p>Impaired skin integrity</p> <p>Impaired communication</p> <p>Pain</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Maintain reverse isolation at all times.</p> <p>Notify surgical team if acute bleeding is noted to the abdominal area.</p> <p>Maintain patient on low air loss mattress.</p> <p>Turn and reposition patient Q2h using foam wedge.</p> <p>Do not use adhesive dressings. Use only non-adherent dressings.</p> <p>Dressing change to be performed by WOC nurse daily.</p> <p>If the dressing becomes soiled or if there are any changes in skin condition, notify the WOC nurse and change the dressing as follows:</p> <ul style="list-style-type: none"> - Remove the old dressing by moistening it with normal saline. - Cleanse the abdomen with normal saline and pat dry with sterile gauze 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Risk of infection is high. The patient is immunocompromised due to recent organ transplant, current infection, and history of chronic disease. Reverse isolation precautions must be maintained to minimize exposure to potential pathogens that may exacerbate the patient's current condition and further delay surgical healing.</p> <p>Acute bleeding to the abdomen may indicate intra-abdominal bleeding related to the surgical sites (post-operative hemorrhage) that warrants immediate attention from the surgical team. If the ileostomy is bleeding and manual compression cannot control the bleeding, the silver nitrate may be needed for hemostasis.</p>

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	<ul style="list-style-type: none"> - Apply Urgotul contact layer dressing cut to fit over the unroofed blister on LLQ. - Cover non-functioning ileostomy with 2x2 non-adherent Allevyn foam dressing. - Place 4X8 ABD dressing over the abdomen. - Gently secure dressing by wrapping Kerlix gauze wrap completely around the patient's abdomen. <p>Use Arabic translator using hospital language service for all medical communication with the patient's parents.</p> <p>Use FLACC pain scale to assess the patient's pain level.</p> <p>Administer pain medications PRN per orders.</p>	<p>The patient is at increased risk of pressure injuries due to immobility, constant moisture (related to weeping edema), and their critical condition and immunosuppression. Repositioning Q2h and keeping the patient on a LAL mattress will ensure pressure redistribution to prevent pressure injuries.</p> <p>The patient has delicate skin at 15 months old and is also at high risk of friction and shear injuries including skin tears. Utilizing non-adhesive dressings can prevent MARSIs.</p> <p>The old dressing must be moistened before removal to minimize trauma to the skin. Urgotul contact layer dressing is non-adherent, promotes moist healing of the unroofed blister, and protects the wound from further trauma.</p> <p>The patient's primary caregivers, the parents, are at risk of deficient knowledge due to the language barrier. Using a certified medical translator through the hospital's language services will ensure the parents receive adequate education and information about the patient's plan of care.</p> <p>The patient is 15 months old, and is intubated and sedated, limiting their ability to express normal pain cues. The FLACC scale can be used to assess the patient's pain level and the bedside nurse should administer pain medications as needed per orders. Promoting patient comfort is integral for wound healing.</p>
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<p>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Normal saline</p> <ul style="list-style-type: none"> - Disadvantage: may not be readily available in community setting, i.e. in patients' homes
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<p>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>	<ul style="list-style-type: none"> - Alternative: sterile water <p>Urgotul contact layer dressing</p> <ul style="list-style-type: none"> - Disadvantage: contains latex (potential allergy) - Alternative: petrolatum gauze <p>Non-adherent Allevyn foam dressing</p> <ul style="list-style-type: none"> - Disadvantage: predisposes to periwound maceration if saturated. In this case study, the thickness of the foam dressing may lead to MDRPI if the Kerlix is wrapped too tight - Alternative: in this case study, may possibly use non-adherent gauze pad to protect stoma (e.g. Telfa) if foam dressing is not available <p>ABD dressing</p> <ul style="list-style-type: none"> - Disadvantage: may not be available in community setting - Alternative: non-woven gauze (more absorbent and softer than woven gauze) <p>Kerlix wrap</p> <ul style="list-style-type: none"> - Disadvantage: may be wrapped too tight, leading to unwanted compression - Alternative: tubular elastic retention netting
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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>I chose this mini case study because although I do not anticipate working with pediatric patients in the future, I will undoubtedly encounter patients with complex surgical procedures resulting in a stoma with peristomal wounds. I was able to meet my learning goal because I was thoroughly challenged and had to think critically as a WOC nurse specialist.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>My learning goals moving forward are to continue to practice how to formulate plans of care as a WOC nurse specialist throughout additional case studies and reviewing the course material.</p>

<p>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>This case study was very challenging because I do not have any pediatric nursing experience or much exposure to extensive abdominal surgeries, and had to research a lot of the conditions and the surgical procedures performed. This case study made me realize that as a WOC nurse I may be exposed to complex cases where I myself may have deficient knowledge in regard to the patient's conditions. However as a WOC nurse specialist I will need to be able to see the big picture regarding the dermatological manifestations of the patients conditions and their relationships to wound healing.</p>
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Reviewed by: _____ Date: _____

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