

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Sommer Saddler _____ Day/Date: Monday, 1/16/2023

Number of Clinical Hours Today: ____ Care Setting: 7 Hospital 2 Ambulatory Care ____ Home Care ____ Other: _____

Number of patients seen today: 7 Preceptor: Megan Hincapie

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	<p>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</p> <p><i>Pt. is a 54-year-old with a PMH of metastatic breast cancer, HTN, T2DM, depression, bowel perforation, AKI. Pt. is present on the nursing floor with a surgical midline wound. Pt. stated she had been having abdominal pain for about 2 weeks, pt. was volume resuscitated and lactate acid improved. Upon exam and ED arrival, pt. had abdominal pain, and was + for peritonitic sign. Plan was for pt. to have a ex lap. The goal is for the pt. wound to be managed with a NPWT dressing and homecare will manage the NPWT 2x/week and PRN.</i></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.

Initial assessment, the pt. incision is midline of the abdomen, the wound bed is light red with moist tissue, wound edges are regular and intact, the peri wound skin is also dry and intact; the contour of the pt. abdomen is round with some creasing present at the site of the wound at 3 and 9 o’clock, palpable, with some mild tenderness due to wound.

Recommendations are from WOC nursing and should be performed by the home care agency nurses. Remove the old NPWT tegaderm dressing with an alcohol pad and soak black foam with normal saline to easily remove from wound bed. The wound should be cleansed with a pH balanced wound cleanser, lightly pat with a gauze, apply Skin prep to peri wound skin followed by transparent drape. Assess the wound bed, and gently fill the wound bed space with 4 pieces of black foam and one additional piece of black foam for the Trak pad. Cover all black foam with Transparent drape, apply Trak pad and seal with a goal achieved of 125 mmHg low continuous suction. NPWT should be changed on Tuesday and Friday’s. If the wound vac malfunctions, apply a moist to damp gauze dressing to the wound bed, and cover with a ABD pad, and secure with tape.

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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>Surgical wound incision</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>In the Home Health Care setting, home care would be provided twice a week and PRN for management of the NPWT, and if there is a caregiver present in the home, they would be educated on what to do if malfunctions of the NPWT occurs and how to apply a wet to dry dressing until a nurse is available to reapply the NPWT and further evaluate.</p> <ol style="list-style-type: none"> 1. Remove the previous NPWT dressing, removing the Transparent dressing with an alcohol prep pad will help loosen the edges and prevent pulling of the skin or any loose hairs. 2. Then instill normal saline solution to the black foam for easy removal, as the black foam can stick to the wound bed, and pull at the wound and cause pain for the pt. 3. Cleanse/irrigate the wound with pH balanced wound cleanser. 4. Lightly pat with gauze. 5. Apply 3M Cavilon Skin prep to peri wound skin followed by transparent drape. 6. Gently fill the wound bed space with 4 pieces of black foam and one additional piece of black foam for the Trak pad. 7. Cover all black foam with Transparent drape, apply Trak pad and seal with a goal achieved of 125 mmHg low 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Removing the old dressing and cleansing the wound with a wound cleanser/pH balance cleanser will assist in removing debris from the wound or bacteria, exudate residual which can build up and reduce the ability for the wound to heal and is safe to use on wounds. Using normal saline solution to easily remove black foam from the wound will minimize any pain or discomfort upon removal. 3M Cavilon Skin prep will secure a seal and prevent possible leakage from the NPWT system. Filling the wound with black foam aides and promotes wound healing by also removing excess exudate, and tissue debris. Covering the wound and dressing will protect the wound and allow assessment of drainage or wound changes.</p>

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	<p>continuous suction.</p> <p>8. NPWT should be changed on Tuesday's and Fridays, and PRN for malfunctions.</p> <p>9. If the NPWT system malfunctions the caregiver if one is available and or the home care agency should apply a moist to damp gauze dressing to the wound bed, and cover with a ABD pad, and secure with tape.</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 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> <ul style="list-style-type: none"> • Alcohol pad wipes- disadvantage is the alcohol could have a burning or tingling sensation to the pt. skin if the area is tender. Alternate option is to use adhesive remover wipes. • Normal Saline- is typically very safe, some pt. might say they feel a burning if used directly onto a wound, an alternate would be using sterile water. • pH balanced cleanser- disadvantage is the cleanser could cause a sensitivity or irritation to the surrounding skin (very rare). An alternate would be using a sterile water or normal saline solution. • Black foam- disadvantage, the foam can stick to the wound bed, therefore applying a non-adherent dressing such as a Vaseline gauze or Adaptic to the wound bed then filling with black foam will minimize any disruption of granulated tissue. • 3M Cavilon No-sting prep: disadvantage could be skin irritation to the surrounding skin, an alternate is to not use any barrier if the peri wound is intact, and ensure surrounding skin is thoroughly dry before placing dressing on. • Clear Transparent dressing included with NPWT- disadvantage, if the pt. wound is draining a moderate to large amount the Transparent dressing may not hold large amounts of drainage, so using an a no sting prep along the edges of the Transparent dressing can secure that seal and prevent leakage or NPWT malfunction.
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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 the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>Goal for today was to encounter patients with wounds and continence concerns. That goal was fulfilled during clinicals today and I got to apply the NPWT system independently with no complications and the pt. tolerated the procedure well.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>Goal for tomorrow is to encounter and manage continence conditions, and treatment options for the pt. with continence concerns/issues.</p>

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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	There were a lot of pts. requiring lesson #2 on the schedule, so an additional pt. seen was a 43-year-old female requiring a lesson #2 for LLQ end ileostomy teaching and management. Pt. was present with her mother, but pt. was not feeling well. Pt. has a PMH of HTN, Pancreatitis, Crohn's disease, and legally blind to the right and left eye. Lesson #2 was talking out how to perform the stoma change and incorporating the pt. and or family support. I would have implemented teachings and education when the pt. was feeling a little better as her current state could be a distraction for her and despite her mother being a support for her, the pt. will still need to know and understand how to manage her ostomy.
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Reviewed by: _____ Date: _____

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