

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name: \_\_\_\_\_

Journal Completion Date: \_\_\_\_\_

 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.

<b>Today's WOC specific assessment</b>	43 y/o male admitted through emergency room via EMS after a wellness check at his place of residence. Wellness check was initiated by home care aide after patient turned them away via phone for third consecutive visit. Patient is non-ambulatory and weighs a reported 680lbs per EMS and home care aide reports. EMS reported found pt alert and oriented x1 and laying in urine, feces and wound exudate. Patient with foul odor and maggots noted to large open wound on left elbow and left heel. Saturated dressing noted to left heel. Severe IAD noted to left side of body. PHM includes COVID-19 hospitalization with ICU related pressure injury to coccyx and left heel (unstageable), COPD, cellulitis to lower extremities, depression, suicidal ideation, morbid obesity, DMII and non-compliance. Patient fluid resuscitated in emergency department and admitted to medical floor for further care. Upon resuscitation patient mentation improved to alert and oriented x3.
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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.**

Consulted for "wound evaluation".

Patient with pleasant affect and noted resting in bariatric LAL bed watching a show on his laptop device. Dietician and occupational therapy consults completed earlier today. Entries noted. Appears disheveled with slightly sunken facial features. States he lives alone. Orders food by phone that is delivered through his condo's side window. Patient states he does not recall the last time he "ate or drank" prior to his last hospital admission a year ago. States spent an extended time in the hospital due to a COVID related illness and spent several days intubated in the ICU. He was discharged home with wounds and home care. He admits to "sometimes" turning away care. Patient commented he "favors" propping himself on his left side due to the view out his window. Denies pain. Agreeable to full assessment. All wound dressings removed with patient assistance with removal of left elbow dressing.

Assessment:

Left elbow: Stage 3 pressure injury present on admission. Area congruent with where patient props himself up. Wound measures 3.5 x 2.0 x 0.5cm. No tunneling or undermining. Wound bed dark red with some residual purulence and moderate serousanguineous drainage. Wound edges defined and regular. Periwound dry and intact. Wound cleansed with Vashe wound cleanser and patted dry. Silver alginate dressing applied and site covered with a 4x4 Allevyn foam dressing.

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

Left Heel: Stage 4 pressure injury present on admission. Site measures 3.0 x 3.0 x 1.0cm with 0.5cm undermining from 3-8 o'clock. Wound bed with visible bone and 50% adherent yellow fibrinous exudate, 50% pale pink granular tissue. Scant serous drainage noted. Wound edges epibolyzed and firm. Wound cleansed with Vashe wound cleanser and patted dry. Silver alginate dressing moistened with sterile water and placed and site covered with a 4x4 Allevyn foam dressing.

L hip: Stage 2 pressure injury present on admission measuring 2.0 x 1.5 x 0.2cm. Wound bed shallow with adherent ivory appearing layer and epithelial islets noted. Scant serous drainage. Periwound with diffuse denuded areas with resolving IAD. Wound cleansed with Vashe wound cleanser and patted dry. Periwound dusted with stomahesive powder, excess dusted away with no sting skin prep applied to create crusting. 4x4 Allevyn foam dressing applied over area.

IAD: Resolving with continence care. Patient able to verbalize when needs to urinate or defecate and is aware of urge. Area cleansed with PH balanced skin cleanser and patted dry. No drainage noted at this time. Area left open to air per patient's request. Erythemic area with raised satellite lesions noted to abdominal skinfolds on left side of body. Nystatin antifungal powder applied per order to abdominal skinfolds.

Braden scale noted to be 12 at this time. Interdry wicks placed to abdominal skinfolds. Patient educated on correct placement and verbalizes understanding of need to maintain wicks. Patient tolerated all wound care without reported pain. States understanding of plan of care and goals to discharge to a nursing facility for assistance with care.

**Recommendations:**

Consult to plastic surgery for evaluation / debridement of wounds.

Offload heels at all times

Continue LAL mattress at all times

Interdry wicks to body folds

Turn and reposition q2h; requires 2 people

Roll patient on and off bedpan

If dressings become dislodged or soiled, change PRN as above.

Notify WOC team with any changes, questions or concerns regarding wound care.

Social work consult

Follow nutrition recommendations

Maintain PT/OT schedule as tolerated

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p><b>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</b></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><b>Statements should be directive and holistic relating to the problem/concern.</b></p>	<p><b>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</b></p>

<p><b>Identify each WOC product in use/identified in POC. State at least one</b></p>	<p><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p>
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<b>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?</b>	
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<b>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</b>	
<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	

<b>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b>	
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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