



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

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

S/tudent Name: \_Gina Farinacci-Nugent\_\_\_\_\_ Day/Date: 6/8/23

Number of Clinical Hours Today: \_8\_ Care Setting:  Hospital \_\_\_ Ambulatory Care \_\_\_ Home Care \_\_\_ Other: \_\_\_\_\_

Number of patients seen today: \_5\_ Preceptor: Jennifer Brinkman

Journal Focus:  Wound \_\_\_ Ostomy  Continence \_\_\_ Combination Specify: \_\_\_\_\_

**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.

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| <p><b>Today’s WOC specific assessment</b></p> | <p>77-year-old female from patient presented to OSH for evaluation of abdominal pain that radiated to back. Patient was found to have a large infrarenal AAA with concerns for rupture and therefore, transferred to Cleveland Clinic CVICU for further management. Patient was found to have ruptured infrarenal AAA. Patient went to OR on 5/28/23 for Open infrarenal AAA repair from RP approach using bifurcated Dacron graft (18x9cm Hemashield Gold). Ligated IMA. Placement of L chest tube. Patient with PMH of CAD, HTN, HLD, uncontrolled DM, morbid obesity and former smoker (quit 2002).</p> <p>Patient is anuric and is on IHD</p> <p>Patient is incontinent of stool</p> <p>Per NT note review Mild Protein-Calorie Malnutrition. TF’s Novasource Renal goal rate 40 ml per hour</p> <p>Consulted by nursing for evaluation of, erythema breast folds, skin breakdown right buttock and natal cleft. Patient seen in Vascular ICU. Nursing staff reports patient refusing to turn at times.</p> <p>Braden Score: 9</p> <p>Labs reviewed: Protein, Total: 5.4<br/> Albumin: 2.7<br/> Calcium, Total: 8.3<br/> Glucose: 192<br/> BUN/CR: 40/2.85<br/> Phosphorus: 1.9<br/> Hematocrit/Hemoglobin: 8.9/27</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.**

General: Alert and in NAD  
 Skin: Skin color light in tone. Texture and turgor normal. Bilateral breast folds with erythema, erosion, maceration, and moist skin. Scattered satellite erythematous lesions. Slight odor.  
 Musculoskeletal: Positive for weakness  
 HEENT: Corpak left nares, mucous membranes intact  
 GI: Incontinent  
 Extremities: No edema. Bilateral heels with xerosis and intact skin

Wound: Location: Gluteal crease  
 Type: MASD  
 Stage: NA  
 Exposed structure: None  
 Wound measurements (cm): 0.4 x 7 x 0.2 cm  
 Full thickness: No  
 Tunneling/undermining: None  
 Wound tissue: 100% moist red linear with partial thickness skin loss  
 Peri-wound: Macerated  
 Drainage: None  
 Odor: None

Location: Right buttock  
 Type: Pressure injury  
 Stage: Stage 2 pressure injury  
 Exposed structure: None  
 Wound measurements (cm): 1 x 1.5 x 0.2 cm  
 Full thickness: No  
 Tunneling/undermining: None  
 Wound tissue: 50% red and 50% pink  
 Peri-wound: Edges and surrounding skin intact  
 Drainage: None  
 Odor: None

**Nursing staff reports patient refusing to turn. Upon examination patient stating that she is tired and too sore to move. She would prefer not to turn. Patient has limited mobility and has been in bed for 12 days.**

| WOC specific medical & nursing diagnosis and concerns   | WOC Plan of Care (include specific products used)  | Rationale (Explain why an intervention is chosen; purpose)   |
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| 1. Impaired skin integrity related to skin breakdown<br>-Intertrigo breast folds fungal<br>-Stage 2 pressure injury right buttock<br>-MASD gluteal crease | Nursing staff treatment recommendations<br>1. Breast folds: Gently cleanse skin with bath wipe and pat dry. With clean scissors cut enough fabric to cover allowing a minimum of 2 inches to extend beyond skin fold for moisture wicking. Lay a single layer between the breast folds, keeping it flat and secure with skin fold. | Inter-dry is used to wick away moisture and has antimicrobial properties to treat fungal component. Inter-dry can be applied by ancillary staff after bathing. |

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| <p>2. Fecal incontinence</p> <p>3.High risk for skin breakdown based on Braden Score</p> <p>4.Anxiety: . Patient stating that she was hesitant to move because she has arthritis and was fearful of pain and discomfort. Expressed about having been in bed for days and not able to move around.</p> | <p>Change every 5 days or if soiled. Remove fabric before bathing. <b>Do not use cream or ointments with Inter-dry.</b></p> <p>-Right buttock: cleanse wound and peri-wound with NS or wound cleanser. Apply Duoderm Hydrogel wound gel to wound bed and cover with foam dressing.</p> <p>-Gluteal crease: Cleanse with NS, apply Critic-Aid moisture barrier cream BID.</p> <p>2.Fecal incontinence: Cleanse promptly with perineal cleanser of bath wipes and apply barrier cream to buttocks, perineum, and groin after each episode of incontinence, dry under pad</p> <p>3.TruVue heel boots</p> <p>-Turn patient every 2 hours offloading with wedge pillows placed back of thigh</p> <p>-Maintain low air loss bed while in ICU</p> <p>-Nutrition to optimize wound healing</p> <p>4. Educate patient importance of turning and pressure injury prevention measures.</p> <p>Patient provided with education and reassurance and was able to turn and reposition. Discussed interventions including PT and OT to perform ROM exercises and spiritual care consult to help with coping and decrease anxiety.</p> | <p>Right buttock stage 2 pressure injury wound bed is dry. Adding moisture to wound bed will facilitate healing and foam dressing to absorb drainage and protect wound.</p> <p>MASD increases risk for pressure injury. Prompt attention to incontinence in key. Treat with barrier cream to protect skin.</p> <p>Prevention of further skin breakdown is critical. Initiating a prevention bundle has been shown to be effective in preventing skin breakdown.</p> <p>Interventions chosen to meet the holistic needs of the patient</p> |
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| <p><b>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?</b></p> | <p>Inter-dry with silver moisture wicking fabric between skin folds. One disadvantage of this product is that if is not properly applied with approximately 2 inches extending beyond the fold then it is ineffective in wicking away moisture. An alternative product would be an antifungal powder such as Nystatin 100,000 units per gram 2 times daily to skin folds. Nursing staff should be educated against the use of antifungal powder in conjunction with inter-dry.</p> <p>Critic-Aid moisture barrier cream. Alternatives include Destin cream for management of incontinence. Heel boots are a better alternative for offloading heels. If patient is refuses heel boots a pillow behind the calf and elevating heels off bed is another option. Wedge pillows are good for offloading. If not properly placed, then offloading is not achieved.</p> |
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

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| <p><b>What was your goal for the day? Were you able</b></p> | <p>Goal for this day was to observe a patient with pressure related skin injury. This patient was also positive for fecal incontinence. I was able to meet my learning goal for today in addressing this</p> |
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| <b>to meet your learning goal for today? Why or why not?</b>   | patient with pressure related skin injury and also fecal incontinence. I also addressed pressure injury prevention, increasing mobility, and decreasing patient's anxiety. |
| <b>What are your learning goals for tomorrow?</b><br><br><b>(Share learning goal with preceptor)</b> | I am scheduled in outpatient ostomy clinic. Goals stoma marking and performing pouch change  |

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| <b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b> | One of the things that I thought about numerous times I have had patients state that they would rather not be bothered with moving or repositioning. It is important to acknowledge that patient's feelings, be patient and give the patient time to think thing through. Most often, as in this case, patients will come around and do what they need to do. I made sure to share this with the bedside nurse. Explaining that with education and support we were able to get the patient to move. |
| <b>Reflection: Describe other patient encounters, types of patients seen.</b>                                      | Other patient encounters include a 40-year-old patient with multiple pressure injuries including stage 3 and stage 4. A 75-year-old critically ill patient in CVICU with multiple deep tissue pressure injuries, on CVVHD, multiple pressors, GI bleeding and liver failure. 68-year-old male patient, ventilator dependent on pressors with necrotic fingers and toes.   |

Eir concerns

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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