



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

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

Student Name: Gina Farinacci-Nugent \_\_\_\_\_ Day/Date: 6/23/2023

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

Number of patients seen today: 8 \_\_\_\_\_ Preceptor: Helen Shubsda APRN CNP

Journal Focus:  Wound \_\_\_\_ Ostomy \_\_\_\_ Contenance \_\_\_\_ 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.

<p><b>Today’s WOC specific assessment</b></p>	<p>D.L. is a 44 year old male is being seen with the admitting diagnosis of Leukocytosis. Per note review patient reports 1 week of dysphagia and odynophagia. Wound care was consulted to assess a wound to the perianal/groin area present on admission. PMH: Patient was diagnosed with anal SCC in May 2020. Chemotherapy and radiotherapy 6/29/20-8/14/20. s/p intestinal perforation requiring emergency lower midline laparotomy and right hemicolectomy July 2021. Scans January 2023 revealed recurrent tumor. Diverting colostomy 1/4/23. History of PE in 1/2023, not currently on Elixquis.</p> <p>Patient states that wife has been managing wound care (wife not a bedside during visit). Aggravating factors include cancer, debility, malnutrition, and moisture. Patient reports pain associated with wound. Relieving factors for wound pain include pain medication per nursing, wound care, and positioning. Treatments at home include alginate and dry dressing. Patient denies fever or chills, Denies nausea and vomiting.</p> <p>Regular diet. Patient reports appetite good. NT on consult.</p> <p>Labs:  WBC: 14.51  Hemoglobin: 8.7  Hematocrit: 27.4</p> <p>Glucose: 102  BUN/CR: 4/0.64  Sodium: 133  Potassium: 3.5  Magnesium: 1.4</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.**

**Physical Exam:**  
 BP 104/48 | Pulse 73 | Temp 97.9 (Oral) | Resp 17 | SpO2 97%  
 O2 Therapy: Room Air  
 Weight: 155 lbs.

**General:** Alert, no distress, cooperative  
**Skin:** Skin color light in tone, texture and turgor normal  
**Musculoskeletal:** Positive for weakness  
**Abdomen:** Colostomy LLQ with liquid brown effluent  
**Wound: Location:** Left perianal groin  
**Type:** Atypical POA  
**Stage:** NA  
**Wound measurements (cm):** 16 x 4 x 0.3  
**Tunneling/undermining:** None  
**Wound tissue:** Wounds raised and nodular in appearance 50% red, 20% pink, 15% yellow and 15%  
**Peri-wound:** Pink  
**Drainage:** Large amount of serosanguineous  
**Odor:** None  
**Extremities:** No edema

**Braden Score** 15

**Recommendations:** Perianal/Groin: Wet gauze with Vashe solution , wring to remove excess solution, apply gauze to wound bed. Allow a soak-time of 3-5 minutes. Remove the gauze. Gently dry. Apply calcium alginate Ag, cover with ABD and secure with underwear. Change Daily and PRN if drainage.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen, purpose)
Impaired tissue integrity perineal/groin atypical wound	<ul style="list-style-type: none"> <li>-Carefully remove old dressing.</li> <li>-Apply gauze saturated with Vashe directly to wound bed soak for approximately 3-5 minutes</li> <li>-Remove the gauze</li> <li>-Gently pat dry</li> <li>-Apply calcium alginate Ag to wound bed and cover with ABD and secure with underwear.</li> <li>-Change Daily and PRN if heavily soiled</li> </ul>	<ul style="list-style-type: none"> <li>-Cleansing wound removes exudate, bacterial and devitalized tissue from wound bed. Wound cleanser with hypochlorous is pH balanced and is used to clean, moisten, irrigate, and debride wound bed.</li> <li>-Drying wound removes any debris</li> <li>-Calcium alginate Ag is used to absorb the large amounts of drainage from wound and provide antimicrobial/antibacterial benefits</li> <li>-ABD is used as secondary dressing to absorb the discharge from this heavily draining wound.</li> <li>-Dressing should be changed daily to assess wound, remove bioburden and decrease infection or more often when heavily draining to</li> </ul>

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		protect surrounding skin from moisture
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<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>	-Vashe wound cleanser: <b>Disadvantage:</b> Vashe can be costly for patient and may not be available or covered by some insurances. <b>Alternative:</b> Rinsing with potable water is an alternative cleanser that is both effective at removing debris and is cost effective for the patient. -Calcium alginate Ag: <b>Disadvantage:</b> Not useful for dry wounds. Excessive moisture absorption may cause wound to dry out. <b>Alternative:</b> Hydrofiber with secondary dressing such as foam -ABD: <b>Disadvantage:</b> May cause peri-wound damage if not changed regularly. <b>Alternative:</b> Silicone adhesive foam dressing as secondary dressing
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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 the day? Were you able to meet your learning goal for today? Why or why not?</b>	My goals for today were to see patient with pressure injuries and staging.
<b>What are your learning goals for tomorrow?</b>  (Share learning goal with preceptor)	Learning goals for next clinic day include ostomy care, stoma marking and pre-op care and NPWT

<b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b>	-I would advise the patient not to apply tape to surrounding skin and to monitor for wound changes including the development of odor or bleeding. -The amount of drainage from the wound is large amount. I would have also included in my plan protection of the peri-wound with a skin barrier such as Critic-Aid clear or zinc oxide. -Adding a non-adherent dressing may be beneficial to reducing trauma with dressing removal and reduction of cutaneous pain. -I would have advised patient to report any odor or bleeding to nursing staff. This would require change in treatment.
<b>Reflection: Describe other patient encounters, types of patients seen.</b>	Other patient encounters seen today include scrotal wound s/p I&D, traumatic facial wound, coccyx and ischial deep tissue pressure injuries, bilateral heel unstageable pressure injuries, lower extremity venous stasis ulcers

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

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