



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Sherry Storm Day/Date: 7/6/23 7:45a-4:30p

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

Number of patients seen today: 17 Preceptor: Sally Arnold

Journal Focus: Wound Ostomy X 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.

<p>Today’s WOC specific assessment</p>	<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>73 year old male with history of hemiplegia due to CVA and buttock wounds.</p> <p>PMH: CVA, HTN, urinary incontinence, Sleep apnea, HLD, morbidly obese, PE.</p> <p>Medications:ASA, vicodin, lisinopril, meclizine, simvastatin, tamsulosin.</p> <p>No labs since 2021</p>
---	--

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.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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.

Patient presents to Wound and Ostomy Center for initial evaluation of buttock wounds. Reports he has had these off and on to the buttocks and hips since 2012. Thinks current wounds have been open for about 2.5 years, chart review shows these wounds likely opened in 12/2022. Patient has a motorized wheelchair, has a Roho type cushion for the seat. Unable to stand, sits in wheelchair from when he wakes up until about 1 or 2 am. He is incontinent of urine, gets enemas for stooling. He sits in the wet depends for most of the day. He bought an air mattress in January of this year, but has not used it because it is not bariatric. Thinks he paid for this out of pocket. Has not ever had wheelchair mapping. He is getting a new chair, it is actually in his garage, he is waiting on cushions for the chair. He is eating and drinking per his usual. No nausea, vomiting, diarrhea. Denies pain. No recent fevers. Denies history of diabetes. Non-smoker. Has HHC 3 times a week.

Assessment: Bilateral buttocks, thighs, coccyx, sacrum with areas of denudement, peeling skin, undefined borders, serosanguinous drainage present. Right buttock wound 1.8 cm X 0.6 cm X 0.1 cm, wound bed is red without necrotic tissue or slough. Left buttock wound 3.2 cm X 3.9 cm X 0.2 cm, wound bed is red without slough or necrosis. No debridement to either wound, mechanically debrided with gauze.

WOC recommendations:

Apply thick layer of calmoseptine to buttocks, thighs, sacrum, and coccyx.

Aquacel Ag to wounds, cover with ABD pad

Change brief frequently

Condom catheter

Bladder training/voiding program

Wheelchair mapping

Mattress support surface

Update blood work

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
---	---	--

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

<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>Incontinence associated dermatitis</p> <p>Altered skin integrity as evidenced by wounds on buttocks</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Cleanse buttock wound with saline, pat dry. Apply calmoseptine to the periwound. Apply Aquacel Ag to wounds and cover with ABD pad. Change dressing daily, more often as needed for soiling/saturation. Wipe off visible areas of soiling on the calmoseptine but do not remove down to the skin, calmoseptine should only be removed from the skin once a day with bathing. Reapply calmoseptine as needed throughout the day. Do not wear incontinence brief in bed, use moisture wicking fabric chux pads. Change brief frequently throughout the day.</p> <p>Do not sit in a chair for more than 1-2 hours at a time. Change position when lying in bed every 2 hours, use pillows to prop up in a side lying position. Continue using Roho type cushion in chair. Have your wheelchair mapped, you were provided a written prescription and directions on getting this completed. You will be contacted by a company to evaluate you for a support surface for your bed/mattress at home.</p> <p>Begin using condom catheter for containment of urine. Begin a toileting/bladder training program by holding a urinal and trying to urinate in it every 2 hours while waiting on condom catheter.</p> <p>Have blood work drawn per order, ok for HHC to draw and fax to Wound and Ostomy Center.</p> <p>Increase intake of higher protein containing foods such as meats, fish, nuts, yogurt, greek yogurt. Look for yogurt with live active cultures.</p> <p>Dietician consult, schedule an appointment in the next week or as soon as appointment available.</p> <p>Watch wounds for signs of infection such as redness, swelling, pus-like drainage, fever, flu like symptoms, nausea/vomiting, body aches. Call wound center if these develop.</p> <p>Follow up with wound center in one week.</p>	<p>Using saline for wound cleansing as opposed to tap water, tap water can have bacteria that could lead to infection. Calmoseptine is a moisture barrier and will protect the skin from further moisture damage. Frequent changing of the brief will decrease length of time the skin is exposed to urine which will decrease the risk of breakdown. Moisture wicking fabric chux pads will draw moisture from the stool away from skin and as no brief is on there is better air flow.</p> <p>Frequent position changes and offloading of high pressure areas will help to prevent pressure injuries from developing and aid in healing existing wounds. Patient has hemiplegia and with his history of pressure ulcers, he will likely qualify for a support surface for his mattress at home. Will also need to be bariatric so patient is able to use the support surface.</p> <p>Condom catheter can be used for incontinence of urine, it will drain into a bag and protect the skin from moisture damage. Bladder training program may be beneficial and decrease the amount of time the patient is incontinent of urine.</p> <p>Increasing protein intake helps to heal wounds, even in someone with normal levels of protein, extra protein will help with wound healing. Dietician consult is helpful with educating patient on foods to choose that are higher in protein. Can also discuss reducing calories for weight loss as patient is severely morbidly obese. Once labs are resulted, this will give a clearer picture of protein and glucose status.</p> <p>Close monitoring of signs of infection and new wound is important as this will require quick action to decrease risk of worsening.</p>
---	---	--

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Calmoseptine/Moisture Barrier disadvantage is difficulty to remove fully, alternative is powder for absorbing of moisture.</p> <p>Aquacel Ag disadvantage is can be to drying and adhere to wounds causing difficult removal, alternative is foam dressing.</p> <p>ABD pad disadvantage is it could potentially hold to much moisture to be held close to the skin, alternative would be a SAP.</p>
---	---

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	Seeing patients with variety of wound, skin, ostomy concerns. To see different types of wound and skin care treatments to build my familiarity with the various products.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	I have not seen many fistulas yet, I would like to see some fistulas to gain some experience with those.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This patient came in due to concern for pressure injury but upon gathering information for patient history and the physical exam, his wounds are due to IAD. He is at risk for developing pressure injury and this was addressed in the care plan.
Reflection: Describe other patient encounters, types of patients seen.	I am seeing a lot of repetition in the patients. Many of the ostomies are routine visits for re-ordering of supplies. As for the wound patients, many of these are also repetitive. Repetition is good for me with needing to gain experience. It is good for me to see what is "normal" so I will be able to identify what is abnormal.

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.