

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lynette Gorniak Day/Date: Friday, September 15, 2023

Number of Clinical Hours Today: Care Setting: 8 Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 5 Preceptor: Helen Shubsda

Journal Focus: X 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.

<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>Patient admitted to the hospital initially for left ankle and foot wound concerning subacute osteomyelitis on 8/22/23 and was later transferred to ICU on 8/28/23 for concerns of acute hypoxic respiratory failure and septic shock. Patient’s past medical history includes schizophrenia, iron deficiency anemia, tobacco use, and substance abuse disorder. Significant labs on admission are WBC 26.6, hemoglobin 8.4, and albumin 2.5. WOC team consulted to manage pressure injury on coccyx. The wound was first evaluated on 9/7/23 and staged as a deep tissue pressure injury to the coccyx. Today, the wound was reassessed, and dressing selection changed. The coccyx wound is now unstageable with a burgundy wound bed with yellow slough attached with minimal serosanguineous drainage. The peri-wound is blanchable erythema. The wound is measuring 3cmx2cmx0.2cm.</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.

<p>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.</p> <p>WOC team consulted to manage pressure injury on coccyx. The wound was first evaluated on 9/7/23 and staged as a deep tissue pressure injury to the coccyx. On today’s WOC team follow up, the wound was reassessed, and dressing selection changed. The coccyx wound is an unstageable pressure injury with a burgundy wound bed with yellow slough attached with minimal serosanguineous drainage. The peri-wound is blanchable erythema. The wound is measuring 3cmx2cmx0.2cm. The dressing applied to the wound is hydrogel to the wound bed covered with a 4”x4” Allevyn foam border. The patient tolerated the wound dressing well and reported no pain. WOC nurse provided education on frequent repositioning to offload coccyx while in bed. WOC team will continue to follow up with patient while in the hospital until ready for discharge. Please consult WOC team if there is an</p>
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increase in drainage or wound bed appears to worsen.

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>Statements should be directive and holistic relating to the problem/concern.</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p>
<p>Delayed wound healing due to osteomyelitis infection</p>	<p>Monitor WBC level.</p> <p>Administer appropriate antibiotics as prescribed.</p> <p>Monitor for worsening signs and symptoms of infection such as fever, increasing WBCs, increased lactic acid, or change in wound drainage.</p>	<p>Monitoring WBC level is important to make sure the present infection is not getting worse and to see if current antibiotic use is working.</p> <p>Administering appropriate antibiotics will get the infection under control and eliminate further complications.</p> <p>With infection present, there is a possibility of it developing into sepsis. Being aware of the signs and closely monitoring them will protect the patient. The nurse and patient should notify the MD of any worsening changes.</p>
<p>Nutrient deficit</p>	<p>Consult the dietician on appropriate diet and protein supplementation for the patient.</p> <p>Monitor albumin level.</p>	<p>Consulting the dietician will help determine what nutritional diet and supplementation is best for the patient. The patient will need a higher protein diet to facilitate wound healing.</p> <p>Monitoring the albumin level will show if protein levels are increasing appropriately or if the patient needs further protein supplementation.</p>
<p>Impaired skin integrity due to decrease in mobility</p>	<p>Reposition every 2 hours while in bed.</p> <p>Utilize seat cushion when up in the chair.</p>	<p>Frequent repositioning helps relieve pressure to vulnerable bony prominences that are prone to pressure injuries.</p> <p>Using a seat cushion will help redistribute pressure while sitting up in the chair.</p>

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	Promote early mobilization if possible.	Promoting early mobilization will decrease pressure, but also promote increased circulation. Optimal circulation is important to wound healing.
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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>Hydrogel- A disadvantage of hydrogel is that it does not absorb a lot of drainage. An alternative product to use if the drainage does increase would be a hydrofiber dressing like Aquacel ag.</p> <p>Allevyn- A disadvantage of Allevyn foam borders is the foam part of the dressing. It has adhesive so that can stick to the wound bed easily creating more damage when removed. An alternative product that can be used if unavailable, then use of a Mepilex foam border or Comfortfoam border dressing.</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.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	My learning goal for tomorrow is to learn more on pressure injury staging and what are the steps for WOC nurse with unstageable pressure injuries such as additional consults for debridement or dressing selections to assist with autolytic debridement. I was able to meet my learning goals today. I discussed additional steps that can be taken with unstageable pressure injuries like recommending consult for surgical debridement or use of hydrogel to promote autolytic debridement of slough in wound beds.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	My learning goal for Monday is to learn more on appropriate alternative ostomy appliances and how to select them.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc.	I would not have done anything differently. The deep tissue pressure injury had opened into an unstageable pressure injury. The wound bed needs a dressing to promote debridement of the slough that is attached. Hydrogel is a good choice and the wound needs to be covered by a foam border. The patient should reposition to decrease pressure to the area and to avoid pressure to other vulnerable bony prominences.
Reflection: Describe other patient encounters, types of patients seen.	<p>One patient we saw was a consult for a possible pressure injury to their heel. When assessed the area was dry and not open. It appeared to be a callused area on the heel. The patient denied any pain to the area. No sting barrier film was applied to bilateral heels to protect the skin.</p> <p>Another patient was being discharged to another facility and needed follow up for wound care orders. The patient had a stage 3 pressure injury to their buttocks. Barrier cream was applied. The WOC nurse provided additional education on repositioning when in bed and to utilize a seat cushion when up in the chair to relieve pressure to wound.</p>

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Reviewed by: _____ Date: _____

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