

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

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

Student Name:    Kelsi Critzer    Day/Date:    9/18/23   

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

Number of patients seen today:     Preceptor:    

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><b>Today’s WOC specific assessment</b></p>	<p><b>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</b></p> <p>3 y.o. female with history of high risk Pre-B cell ALL, diagnosed on 7/19/22. She has completed Induction (modified), Blinatumomab block 1, Consolidation, Blinatumomab block 2 and interim maintenance 2. Her therapy has been complicated and modified due to Pseudomonas infection to original port and bone marrow biopsy site, with ongoing wound complications to those areas and to allow for wound healing. S/P right chest and right back split thickness skin graft placement with plastic surgery on 1/4/2023.</p> <p>Patient being admitted for Interim Maintenance I Day 43 of treatment. Mom reports today the appearance of her labia seem redder with mild skin peeling. Last week, it was her perianal area that appeared more excoriated and at this time, that now seems somewhat improved. Mom reports alternating sensicare with the miconazole cream as directed by wound care; she reports no recent bleeding to the area. All other lesions on her legs from 2 weeks ago are all healing now and no new lesions per mom, though the one on her middle back of neck does appear slightly more red today.</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><b>Reason for Consult:</b> New consult from MD- "Please reassess diaper area; mother currently alternating barrier cream with fungal miconazole cream as directed"</p> <p><b>Wound History:</b> Patient known to the WMST service for right upper chest and right lower back wounds. Now healed.</p> <p><b>Pressure Redistribution Support Surface:</b> Standard, Accumax mattress</p> <p><b>Wound Team Summary Assessment:</b></p>
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Patient assessed with P.Clay RN, CWOCN and Mother at the bedside. Diaper change and diaper care performed. The patient presents with pink, scaly lesions noted to the bilateral vulva and bilateral lower buttocks. No open areas, no bleeding, no overt redness and no satellite lesions. Some peeling epidermis noted. The buttocks, perineal and perianal areas are pink and intact with no concerns. Overall, the diaper area is looking improved, but barrier protection will remain crucial as the patient is admitted for high dose Methotrexate. Spoke with Dr. Wright and she requested a wound culture of the diaper area lesions be obtained secondary to the patient's history of infections. The diaper area was cleansed with saline and then a culture was obtained. At this time, while the culture is pending, recommend consistent and vigilant barrier protection with Sensi-Care Protective Barrier Ointment. No further triple care antifungal cream recommended at this time. If the culture comes back as negative, will consider using No Sting Barrier Film to additionally protect the pink areas on the vulva and buttocks.

APRN from hem/onc was updated on the assessment and agrees to the plan of care. RN updated.

**Wound Team Plan:**

Continue local wound/incision care, continue to monitor skin, WOC nurse to follow as needed and supplies left for patient

Discussed With: RN, MD, APRN, Patient and Family

**Wound-Specific Plan:**

Diaper area care, with every diaper change:

1. cleanse and remove only soiled layers of cream with Barrier Cream Cloths (gray package)
2. apply a thick layer of Sensi-Care Protective Barrier Ointment to affected area

<b>WOC specific medical &amp; nursing diagnosis and concerns</b>	<b>WOC Plan of Care (include specific products used)</b>	<b>Rationale (Explain why an intervention is chosen; purpose)</b>
Altered skin integrity related to oncological interventions	<p>Frequently assess and remove/change any soiled diapers</p> <p>Utilize barrier cream clothes for cleansing as ordered</p> <p>Apply a thick layer of Sensi-Care Protective Barrier Ointment to affected area with every diaper change. DO NOT scrub off previously applied ointment, gently wipe away soiled layer before reapplying</p>	<p>Potent medication regimen known to be excreted through urine</p> <p>Gentle on skin and provide additional skin barrier</p> <p>Continuously provide barrier to skin from irritants</p>
Increased risk for nutrition deficit related to N/V	<p>Collaborate with nutrition team</p> <p>Regular diet with supplemental Pediasure Grow and Gain as ordered</p> <p>Administer antiemetics as ordered</p>	<p>Promote optimal outcomes for patient by enlisting specialist</p> <p>Provide patient with preferred snacks and meals to encourage intake</p> <p>Prevent N/V</p>

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	<p>Wound-Specific Plan: Diaper area care, with every diaper change:</p> <ol style="list-style-type: none"> <li>1. cleanse and remove only soiled layers of cream with Barrier Cream Cloths (gray package)</li> <li>2. apply a thick layer of Sensi-Care Protective Barrier Ointment to affected area</li> </ol>	
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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><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p> <p>Sensi-Care Protective Barrier Ointment: can be difficult to remove/assess skin beneath, may cause additional irritation. Additional barrier creams patient could try include Z Guard skin protectant paste and Triad hydrophilic wound dressing (cream)</p> <p>Barrier Cream Cloths: may cause irritation to the skin worsening current condition and requires wiping/friction to an already compromised area. Peri bottle with room temperature normal saline or tap water could be used to rinse area (reduce wiping required and associated damage from friction)</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.**

<p><b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b></p>	<p>My goal for the day was to care for a patient with a G-tube and create a plan of care following the assessment. However, there were no new consults for patient with G-tubes and no scheduled follow-ups. I still plan to achieve this goal as I know we have follow-up visits with several patient's that have G-tubes.</p>
<p><b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b></p>	<p>I still want to learn and perform G-tube care for patients with persistent hypergranulation tissue that have been unsuccessful with previous management methods. Additionally, I am planning on working with a SCI patient and possibly a TBI patient to truly create an effective plan of care for continence.</p>

<p><b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b></p>	<p>Patient is receiving high dose methotrexate that is known to cause skin issues specifically in her peri-area. The use of barrier creams should be maintained in between doses and when skin appears intact. A barrier should always be present to avoid as much initial breakdown as possible.</p>
<p><b>Reflection: Describe other patient encounters, types of patients seen.</b></p>	<p>Today I found a NICU patient with oxygen threaded through a tear in the diaper. This oxygen had a large hub that was just laying under the baby. We removed this device and educated the nurse who had placed it on the increased risk of pressure injury formation related to medical devices. We then encouraged this nurse to look for our previously placed orders and plan of care or to simply call us with any questions or concerns. This is something I heard was once a thing, but I had never actually seen it in practice. The rest of the day was filled with patient follow-ups mostly ileostomies (we currently have quite a few) and a new consult on a recurring irritant dermatitis.</p>

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

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