

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Julia Hurst _____ Day/Date: 9/25/23

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

Number of patients seen today: 5 Preceptor: Aaron Fischer

Journal Focus: ___ Wound ___ Ostomy ___ Continence ___ Combination Specify: Wound & Continence

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>PMH: 23-year-old with a past medical history of asthma and anoxic brain injury</p> <p>Surgical history: No past surgical history on file</p> <p>HPI: This is a 23-year-old male with a past medical history significant for asthma. Patient recently had sudden cardiac arrest at home shortly after complaining of dyspnea. Family performed CPR. Upon EMS arrival, patient had ventricular fibrillation. In the ED, patient was in PEA. ROSC was achieved after 30 minutes. Etiology of cardiac arrest was determined to be status asthmaticus associated with acute hypercapnic and hypoxic respiratory failure. His urine toxicology was positive for THC. Findings from the CT of his brain indicate severe anoxic brain injury. Since then, the patient has not made purposeful movements, responded to speech, or followed commands. A family meeting with the multidisciplinary team was held to review treatment options. The patient is no status post tracheostomy and PEG tube placement. Patient has experienced some complications during this admission, requiring cholecystectomy. Additionally, he developed DVTs in his left calf and left upper extremity. He has now completed an extended course of steroid medication with taper for asthma exacerbation.</p> <p>Medications: Heparin 1400 units/hr IV continuously Chlorhexidine gluconate 0.12% 14 mL PO QID Nystatin 5mL PO QID Verapamil 60 mg PO q6h Acetaminophen 650 mg PO q4h PRN</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.

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.

Reason for referral: Assessment and NPWT initiation to mid-abdomen wound.

Assessment: Patient was awake with his eyes open upon our arrival; however, he remains unresponsive. Primary nurse presented to the bedside. She had recently cleaned and turned the patient with the PCNA. Turn & Position system and offloading boots in place. The nurse reports that the patient has an unstageable pressure injury to his sacrum. He was having liquid stool, warranting placement of a fecal management system that has leaked occasionally. She states that the patient's indwelling foley catheter was removed earlier for a voiding trial. Male external catheter is currently in place. The nurse reports that if it appears that he is retaining urine, patient will require re-insertion of foley catheter for neurogenic bladder. The wound to the patient's mid-abdomen is a dehisced surgical incision. The proximal part of the incision is well-approximated with staples. The wound measures 3.8 cm x 1.5 cm x 1.3 cm. There is a 7 cm tunnel at 12 o'clock. The wound bed consists of 100% red granulation tissue.

Treatment: The NPWT dressing was applied without issue. The mid-abdomen wound and the surrounding skin were cleansed with soap and water. After the peri-wound skin was dried, transparent drape was applied to the wound edges. One piece of spiral-cut black foam nestled within a contact layer was placed in the wound bed. The vacuum pump was programmed according to the provider's order of -125 mmHg continuous suction pressure. Patient has existing wound care recommendations for the sacral wound.

Teaching: Patient is ICU status. Teaching is not appropriate currently due to patient's clinical condition. The primary nurse had questions regarding NPWT and wound care which were all answered. She was advised to continue following the wound care orders for the sacral region. Informed her that the NPWT dressing will be changed by a WOC nurse every Monday and Thursday.

Patient response: Patient is not responsive to verbal prompts. He remained awake and calm for the entirety of today's care. Bedside nurse was appreciative and very responsive to education and teaching.

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> <ul style="list-style-type: none"> -Impaired skin integrity -Delayed healing of wounds from corticosteroid use -Altered nutrition 	<p>Statements should be directive and holistic relating to the problem/concern.</p> <ul style="list-style-type: none"> -Document amount and characteristics of drainage. If frank blood is noted in the tubing or canister, immediately stop V.A.C. ® Therapy and notify the provider. -Change the V.A.C. ® Therapy canister when it is full. -Do not leave the NPWT dressing on without suction for more than two hours. In this case, remove the dressing and apply a moist dressing. -Consult WOC nurse if additional needs arise prior to next scheduled visit. -Assess FMS device at regular intervals to 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>NPWT is indicated for this patient as this type of treatment is the most appropriate choice for faster granulation and wound healing. A FMS is indicated for this patient because he is incontinent of liquid stool and he has an unstageable pressure injury to the sacrum. Condom catheters are not recommended for those with a</p>

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<p>-Altered elimination</p>	<p>ensure tubing is not beneath the patient and that there is no tension on the device. Monitor insertion site as patient is at risk for damage to the rectal mucosa.</p> <p>-Record number of days that the FMS is in place and reevaluate daily whether it is needed. Discontinue it as soon as possible.</p> <p>-Apply moisture barrier ointment to intact skin, such as Critic-Aid ® Clear, after performing peri-care and as needed.</p> <p>-Change the condom catheter every 12 hours.</p> <p>-Turn the patient every 2 hours</p> <p>-Maintain Turn & Position system and offloading heel boots.</p> <p>-Consult Nutrition.</p>	<p>cognitive impairment. In this case, however, the patient is incontinent of urine and a voiding trial was ordered. Use of a condom catheter during this period will allow for containment and accurate measurement of urine.</p>
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<p>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>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>If the patient's condition does not improve and he continues to exhibit neurogenic bladder dysfunction, other treatment options can be considered. These include re-inserting an indwelling catheter; however, long-term use of this device is not advised and is associated with many adverse consequences, such as urethral trauma and CAUTI. Depending on the situation, the patient might be eligible for a suprapubic catheter for long-term management of neurogenic bladder. Another option to contain stool and/or urine is the use of absorbent products, such as a brief. When used appropriately, a brief is appropriate for moderate to heavy urinary and/or fecal incontinence. This is not the most ideal product for this patient considering he has a wound to the sacrum. An alternative to the NPWT dressing is to lightly pack the wound with gauze that is moistened with a wound cleansing solution or normal saline. This dressing can be changed daily or BID, depending on the amount of exudate.</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>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>My goal was to practice stoma intubation and/or irrigation. Yes, I was able to meet this goal. I discussed this with my preceptor. We chose a patient together that needed stoma irrigation. Conveniently, I was familiar with the patient because I had intubated his stoma last Friday.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>My goal for tomorrow is to perform a pressure injury assessment.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>I appreciated seeing a patient in the initial stages of management of bowel and bladder incontinence from neurological damage.</p>
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Reflection: Describe other patient encounters, types of patients seen.

I assisted with a NPWT dressing to a leg, performed a pouch change for a NICU patient, removed a stoma foley and performed stoma irrigation.

Reviewed by: _____ Date: _____

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