

**Daily Journal Entry with Plan of Care & Chart Note #3**

Student Name: Cheryl Eastmond Day/Date: 11/10/2023

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

Number of patients seen today: 6 Preceptors: Amparo Cano CWOCN/ Michelle Harris-Farrell CWOCN

**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.

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| <b>Today's WOC specific assessment</b> | <p>Forty-six y/o male patient evaluated in the MICU. He was recently transferred from SICU originally admitted for kidney transplant and is being treated for pneumonia induced respiratory failure. The wound care team is consulted due to sacral wound. He is sedated.</p> <p>PMH also includes HTN, Cardiomyopathy, s/p heart transplant 2010, Hypothyroidism, HLD, MRSA positive, ESRD.</p> <p>Medications include Albuterol inhaler, artificial tears, atorvastatin, enoxaparin, metoprolol, potassium chloride, sacubitril Synthroid, lisinopril, aspirin, prograf , IV ceftriaxone, Calcium, Ferrous, Gluconate tab</p> <p>The patient is receiving nutrition via tube feeding ( Nutren 2.0). He is followed by the ICU dietician. His weight is 115.96 lb and height is 58 inches. His BMI is wnl at 24.29</p> <p>He has a foley.</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.**

WOC nurse is consulted for pressure injury evaluation. The patient is intubated and eyes are closed . The patient is turned on his side with the assistance of the staff nurse. The sacral wound is unstageable. The wound measures 7.0 cm x 6.0 cm x.01. The wound bed is covered with adhered soft brown and tan eschar. There is moist pink tissue that bleeds easily when disturbed at the distal aspect of the wound. The wound edges are open and surrounding skin is hyperpigmented. There is no drainage or malodor. The bilateral heels are intact. The sacral wound is cleansed with normal saline and gauze. Skin prep is placed on peri-wound area. Medihoney gel is applied to sacral wound. A thin dime sized layer of triad is applied to the distal aspect of the wound. The sacrum is covered with Allevyn silicone adhesive foam dressing. The patient is off loaded and kept on his

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right-side using wedges. An air mattress and offloading heel protector boots are recommended. The Braden Score is deferred due to already existing pressure injury. He is in the critical care area and is high risk.

**WOC Recommendations:**

Initiate and maintain pressure reduction/prevention protocol.  
Foam dressing to hip pressure injury  
Consult dietician.  
Consult PT

| WOC specific medical & nursing diagnosis and concerns | WOC Plan of Care (include specific products used)                                                                                                                                                                                                                                                                                                      | Rationale (Explain why an intervention is chosen; purpose)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| Unstageable Pressure injury                           | <p>Cleanse with normal saline and pat dry.</p> <p>Apply skin prep to surrounding peri-wound area.</p> <p>Apply Medi-honey gel to eschar</p> <p>Apply Triad to distal aspect of wound</p> <p>Application of Allevyn silicone adhesive foam dressing</p> <p>Turn patient to side, reposition every 2 hrs, place heel protectors and air mattress bed</p> | <p>Keep area clean, helps to remove bacteria/eschar.</p> <p>Protects surrounding skin from adhesive, wound drainage, friction, and trauma.</p> <p>Supports the removal of necrotic tissue and promotes a moisture-balanced environment conducive to wound healing.</p> <p>Helps to maintain optimal wound healing and serves as a barrier against episodes of leakage.</p> <p>Foam dressing provide moisture, protects surrounding skin and adds a little padding preventing pressure.</p> <p>Reduces pressure and provides off loading and pressure redistribution.</p> |

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| Incontinence | <p>Dietary and PT consultation</p> <p>Check for incontinence episode every two hours; Foley care to prevent leakage and injury from tubing.</p> | <p>Provides nutrition including a protein rich diet to facilitate healing of wound. Also, PT to provide adequate movement and exercise program. Activity is essential in pressure injury prevention.</p> <p>Frequent assessment to prevent injury and incontinence leading to skin breakdown and device related skin injury.</p> |
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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</b> | <p>Normal saline was a good choice. A wound cleanser could have been used as well. No disadvantage identified.</p> <p>The skin protectant is preventative. No disadvantage identified.</p> <p>Medi-honey was a good choice. However, Santyl also known as collagenase as a means of debridement could have been used as well. Allevyn is a foam dressing that was used to isolate the wound and provide padding. A transparent dressing like Tegaderm could have been used.</p> |
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| <b>different category or classification. In other words, what could be used if the product was not available?</b> | <p>The patient was already on an air flow mattress reserved for high risk and patients in the critical care areas.</p> <p>Heel boots or pillows that elevate the heels could be used.</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.**

|                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| <b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b> | <p>My goal for today was to see patients with all types of wounds including pressure injuries, wound vacs and basically to be in the wound care setting. This case was good as this was an unstageable wound. I would say yes, my learning goal has been met because I saw two wound vacs applied. I have no experience with wound vacs, so this was a good opportunity. I saw both partial thickness and full thickness wounds.</p> |
| <b>What are your learning goals for tomorrow?</b><br><br><b>(Share learning goal with preceptor)</b>       | <p>I would like to continue to see all sort of wounds and to not limit my experience. My preceptor asks for a lot of feedback and makes me think a lot. I approach it as it if were a trivia game which is fun. At the same time, I am seeing a lot and am learning. My next rotation is on 11/14. My preceptor is eager for me to get as much experience as I can. She seems to enjoy teaching.</p>                                 |

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| <b>Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b> | <p>I got the opportunity to see patients in their busy wound care clinic as well as in the hospital setting. The wound care nurses would say, they have a vac that they are placing and asked if I would like to see it. Also, they would say there is a vascular case in the ER. The clinic is in the colorectal surgery department. There are a lot of ostomy cases but many of them are post-op so both the surgical incisions and ostomy care are addressed during the patient encounter.</p> <p>.</p> |
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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