

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

Daily Journal Entry with Plan of Care & Chart Note Journal #2

Student Name: Cheryl N. Eastmond Day/Date: 10/17/2023

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

Number of patients seen today: 6 Preceptor: Amparo Cano CWOCN

Journal Focus: Wound Ostomy Contenance 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>70 y/o obese female patient consulted to wound service for buttock wound. The patient is a patient in the observation unit. She came to the hospital due to a sudden onset of left lower back pain that started in the middle of the night. She states that the pain is excruciating. She states that she was able to walk with assistance of a cane up to three days ago. She reports that she is continent of both urine and stool with occasional accidents from urine. She has a Promofit external urinary drainage device in place. She required minimal assistance to reposition for assessment. Assistance is provided with an additional nurse during assessment. She complains of minimal pain to her buttock wound area.</p> <p>PMH significant psoriatic arthritis, osteoporosis, five back lumbar surgeries.</p> <p>Medications include Amlodipine, Mesalamine, Fosamax, Estrogen hormone replacement, Vancyclovir, Morphine, chlorpromazine.</p> <p>She states that she lives alone. Her diet is good. Her mobility is limited at this time.</p> <p>Weight 218 lbs, Height ‘5 2”</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

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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.

The WOC nurse was consulted to assess and make recommendations for buttock wound. The patient is pleasant, alert, and oriented x 3 and is lying in the bed. She is able to move to her side with minimal assistance. The wound at this time is assessed. The wound is a fissure located in her natal cleft. It is a linear shape wound measuring 4.0 cm. It is light red with no drainage. The peri-wound is intact. There is also herpetic dried resolving lesions to her right mid buttocks that have no drainage, and are painless per patient. She has occasional outbreaks. Her sacrum and heels are intact. Also the groin and pannus folds are intact.

A Braden score of 17 is given which places the patient at risk for pressure injury.

WOC Recommendations:

Cleanse area with saline

Apply skin prep daily to natal cleft during hospitalization.

Keep skin folds as clean/dry as possible.

Apply Critic-aid clear moisture barrier ointment to natal cleft and surrounding skin as a barrier against moisture

Offload heels and sacrum with pillows

Turn and reposition frequently.

Elevate HOB 30 degrees or less unless contraindicated.

Provide incontinence care as prn.

Adjust Primofit urinary device prn to prevent leakage.

Re-consult if necessary.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
Fissure to natal cleft	<p>Daily skin care with a wound wash or normal saline to perineal area and to wound and pat dry.</p> <p>Apply skin prep to peri-wound area.</p> <p>Apply skin Critic-aid clear barrier cream to area.</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Keep area clean and dry, fissure most likely related to moisture.</p> <p>Skin Prep protects surrounding skin from moisture.</p> <p>Protects area from moisture and helps heal.</p>

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(Share learning goal with preceptor)	
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Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	As stated above, I would have used the barrier cream to protect the surrounding skin, emphasize the importance of keeping the area clean and dry but I would have put a little salve to the actual fissure to help soothe the area as well. Also, I would include patient teaching regarding incontinence pads.
Reflection: Describe other patient encounters, types of patients seen.	We saw a total of 6 patients. I got to see ostomy care as the wound care clinic is situated in the colorectal department. I saw patients in both the clinic and hospital setting. I also saw a deep tissue injury patient, a surgical incisional wound, vascular wound, and a skin rash. There was an in-service on new barrier skin products that the hospital is purchasing.

Reviewed by: _____ Date: _____

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