



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

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

Student Name: \_\_\_\_\_ Amanda Walker BSN \_\_\_\_\_ Day/Date: 10/20/23

Number of Clinical Hours Today: 8  *Please clarify how many hours were done this day* Care Setting: \_\_\_ Hospital \_\_\_ Ambulatory Care \_\_\_ Home Care \_\_\_ Other: \_\_\_

Number of patients seen today: 10 Preceptor: Mitzi Finn, BSN, CWOCN

Journal Focus: 10 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.

<b>Today’s WOC specific assessment</b>	RD a 60 year old man admitted to hospital for acute organ dysfunction without septic shock, due to an unspecified organism. DKA, an insulin drip, started on admission. Multiple wounds on various parts of the body. Blood cultures pending. PMH: CVA, HTN, CHF, Back pain, Syncope, HLD, DM, Wounds on sacral and lower extremities Labs: NA 135, K. 4.6, Calcium 8.0, WBC 16.5, BG 350 BUN 8 Creat: 0.58 Hemoglobin 10.3, Albumin 2.4 Currently is dependent on trach oxygen, peg tube feeding, foley catheter. Wounds located on bilateral legs, knee, buttocks
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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 Nursing consult outcome: Assessment completed.Wound care provided to bilateral lower extremities, Right knee, buttocks. Patient incontinent of urine and stool, Foley in place CHG bath given. Notified NP of wound care recommendations and orders received.

WOC next scheduled visit/**plan:**  *include this component in the directive plan of care below.* Bedside RN/LPN to complete wound care. Re-consult if any changes in wound condition.

Wound location: Left medial leg Size: 4x4x0.3cm Right leg size: 3x5x0.3cm

Undermining: N/a tracking: N/a

Wound type: **Venus leg ulcer**

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Wound bed: Purple/maroon discoloration

Draining: Serous

Periwound skin: masd

Therapeutic surface: envella

Intervention/Recommendations:

Irrigate with normal saline or wound cleanser.

Pat dry

Apply no sting skin prep (Cavilon) to periwound

Apply single layer of aquacel dressing

Cover with abdominal pad

Wrap with kerlix

Change every day and as needed

Wound Location: Right lateral Knee 2x2x0.2

Undermining: n/a Tracking: n/a

Wound type: Friction/pressure injury

Wound bed: Red, pink

Draining: n/a

Periwound skin: intact

Therapeutic surface: Waffle bed surface

Intervention/Recommendation:

Irrigate with normal saline or wound cleanser.

Pat dry

Apply no sting skin prep (cavilon) to periwound

Apply xeroform dressing

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Cover with mepilex border dressing

Change every other day and as needed.

Wound location: coccyx/sacral area Size 4x4x0.4cm

Undermining: n/a Tracking: n/a

Wound type: Mixed etiology with evolving DTI and MASD/irritant contact dermatitis due to fecal, urinary or dual incontinence

Wound Bed: Purple/Red/Pink

Draining: Serosanguinous

Periwound skin: Masd

Therapeutic surface: Envella

Intervention/Recommendations:

Irrigate with normal saline or wound cleanser

Pat dry

Apply no sting skin prep (cavilon) to periwound

Apply single layer of aquacel dressing in wound bed

Cover with mepilex border dressing

Change every other day and as needed.

While in bed the patient should only be on a sheet and one chux. Please do not use briefs while the patient is resting in bed. Elevate heels off the bed surface at all times. Turn and reposition at least every 2 hours

Thanks for the consultation, while inpatient please contact with questions or changes in condition.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.	Statements should be directive and holistic relating to the problem/concern.	Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.

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<p>Impaired skin integrity</p> <p>Uncontrolled diabetic</p> <p>Dressing changes</p> <p>Nutritional deficit</p> <p>Pain control</p> <p>Education</p> <p>laboratory values for possible underlying conditions</p> <p>Culture of wound</p> <p>BVAS testing and/or ABI testing</p>	<p>Daily Site care with cleaning of wounds using soap and water or wound cleanser, apply foam</p> <p>Use heel protectors while in bed</p> <p>Pain assessment for patient to assess for any dull or aching feeling or throbbing and cramping or neuropathic pain which can further indicate the type of ulcer. Elevating the legs whenever available to do so can assist to alleviate pain.</p> <p>Assessment of skin BID or as needed for early breakdown prevention to assess possible sites of pressure, new breakdown of skin or non-healing wounds.</p> <p>Use a waffle device if sitting in a chair with legs elevated for physician recommended length of time or patient preference.</p> <p>Consult dietician for additional dietary recommendations for supplements/peg feedings and diabetic control/understanding</p> <p>Monitor blood sugars with each meal/feedings and night time with insulin adjusted sliding scale per physician order</p> <p>Keep skin clean and dry. Moisturize daily with fragrance free lotion.</p> <p>Bedside RN/LPN to change dressing per physician order.</p> <p>Education with patient about ulcer healing and how it can correlate to blood sugar control</p> <p>Monitor laboratory value's for continued elimination of possible causes that can present similar to vaculitis ordered by Physician</p> <p>Monitor culture of wounds pending to possibly assist in the pathological investigation of ways to potentially treat wound.</p> <p>Perform Birmingham Vasculitis Activity Score (BVAS) that can be used to guide treatment options . ( Should this be referenced if I got it out of book?)</p>	<p>Cleansing skin helps to keep it clean and dry, free from irritants to prevent skin breakdown.</p> <p>Nutritional supplements in peg tubes are necessary for enhancement of wound healing.</p> <p>Monitoring and assessing for pain can assist with decreased stress level and frequency of medications used.</p> <p>Pressure redistribution with Q2 hr turns, offloading, heel boots can allow circulation to affected area</p> <p>Monitoring blood sugars help assist in improving the body's health promotion in ways of skin growth, improves the amount of oxygen and nutrients and allows the immune system to function properly giving the wound necessary functions to heal.</p> <p>Education about the importance of blood sugar control in wound healing can help the patient understand why eating a balanced diet and gentle exercise or movement can improve wound healing.</p> <p>Certain laboratory values can contribute to the possible treatment plan of leg ulcers. It can indicate other autoimmune issues that prevent ulcer healing.</p> <p>Cultures of wounds can guide choices in antibiotics and improve the healing process.</p> <p>The BVAS can suggestive disease process severity. Further more another non-invasive testing for lower extremity blood flow can</p>
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	ABI testing for further assessment for arterial blood flow in lower extremities. Testing for lower-extremity Arterial disease (LEAD).	give advanced indication of disease process.
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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. <u>Alternatives should be from a different category or classification.</u> In other words, what could be used if the product was not available?</b>	<p>Aquacel: Used to absorb exudate from Lower leg wounds.- Alternative could be to use an alginate and foam dressing. A cheaper alternative could be to use honey based products or hydrophilic with abdominal pad and kerlix dressings. A moisture barrier ointments or liquid barrier film with low level compression can be alternated.</p> <p>Xerofoam can be replaced with a hydrophilic cream or honey based product and covered with foam 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.**

<b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b>	<p>Yes, goals are met and learning goals are achieved.</p>
<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	<p>Incontinence</p>

<b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b>	<p>The patient was from a nursing home and had a trach with a peg tube. It was unknown how much he was able to provide his own ADL's. The high blood sugar could have also been from the stress on the body from other illnesses this patient was trying to heal from. Focusing on the blood sugar control, it was surprising he came from a facility and had maintained such a high level of blood glucose for so long. Providing education became a challenge because he was not in his best cognitive ability and there was no family present when changing dressings.</p>
<b>Reflection: Describe other patient encounters, types of patients seen.</b>	<p>Several wounds, NPWT, Stoma evaluations. Learning the departments ways of reaching out to each floor for education and prevention of wounds in the ICU.</p>

Reviewed by: Mike Klements received 11/13/23 Date: 11/14/23

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Hi Amanda – please review my comments closely throughout this journal and apply all feedback to future submissions/your 5<sup>th</sup> wound submission. Your note reflects what was done, your directive plan should read as complete directions (nursing orders) for those caring for the patient after you as the specialist. ... also, let me know how many hours were completed with this journal via e360. If you have any further questions regarding enzymatic debriding agents, let me know, I'd be happy to review. Reach out with any further questions.  
-Mike

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