

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Oluremi Fawole _____ Day/Date: 12/7/2023

Number of Clinical Hours Today: 10 Care Setting: Hospital

Number of patients seen today: 6 Preceptor: Cano, Amparo.

Journal Focus: Wound

	<p>Patient is 48-year-old male being seen in IMCU with his wife at the bedside. He is alert and oriented status post Left Ventricular Device (LVAD) implantation with heartmate 3 on 8/11/2022. LVAD device and monitor at bedside, he has a glucose monitor device attached to the left chest. He reports being continent of both urine and stool. He reports that his wound developed into a boil. He reports that his wound developed into a boil and was lanced recently and admits to significant decrease in drainage each day, he admits to significant decrease in drainage each day. There is evidence of IV antibiotics at bedside.</p> <p>He is ambulatory, able to provide maximum assistance in repositioning for assessment.</p>
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Chart Note:

<p>Initial Consult: Draining healed surgical scar, present on admission</p> <p>Pt alert and oriented. Agreeable to assessment and dressing change. No c/o pain. Temperature of 97.7f. RN present for assessment. Healed surgical scar located on the midchest with the wound at the distal aspect measuring 0.2cm by 0.2 by 0.1, wound base red, moist with mild serous drainage, peri wound intact, odorless surrounding skin shows evidence of medical adhesive related skin injury (MARSIS) from tape borders used from home. Pt was asked of the source of materials, patient reported that dressing material are self-acquired. Heels intact, sacrum, groin and pannus folds intact. Adhesive remover (Hollister Adapt) used to remove existing old dressing (old dressing covers the entire healed scar longitudinal heal scar measuring 4cm by 1cm), cleansed with normal saline, light gauze and silicon foam (Allevyn) dressing applied. Pt tolerated intervention with no complaints of pain.</p> <p>Plan: Nursing to change dressing every other day and PRN for saturation. Reevaluate drainage and dressing frequency with next visit. Actions: Adhesive remover (Hollister Adapt) used to remove existing dressing, educate patient and wife on care of the wound to include skin prep and adhesive remover. Adhesive remover wipes left at the bedside.</p>
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WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen, purpose)
<p>infection</p>	<p>Remove old dressing, clean wound with normal saline, pat dry, assess for drainage amount, color and odor, apply Allevyn foam dressing. Change dressing every other day or PRN</p>	<p>A clean wound surrounding will lessen the risk of wound contamination. Wound cleaning reduces the risk of infection and aid the healing process.</p>

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

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impaired skin integrity	<p>Use alternative wound dressing material in this case the home-applied tape dressing material, is replaced with an atraumatic silicon foam</p> <p>Teach/encourage patient's compliance with medications and physician's prescribed antibiotics</p>	<p>A soft atraumatic foam covering will help the MARSI wound already created heal, also prevents further damage or irritation to the surrounding skin/peri wound.</p>
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Identify each WOC product in use/identified in POC with the disadvantage and an alternative	<p>Silicon foam dressing is opaque and due to its high absorptive capacity, the silicon tape might dry out the wound. If it becomes saturated it could also cause maceration to the peri wound.</p> <p>Hydrocolloid dressing is an alternative to silicon 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.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	<p>My goal is to be able to use wound VAC materials and to change a wound VAC dressing, I was able to change a wound VAC under supervision.</p>

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<p>It was interesting to me that while a wound (a suture line) was healing, another wound is being created on the edges of the wound because of the materials and techniques of changing the wound dressing.</p> <p>Patient reported boil-like protrusion at the base of the wound was lanced at home and has been draining since, this strongly suggests an infection to the wound.</p>
Reflection: Describe other patient encounters, types of patients seen.	<p>I saw preventable cases of amputation due to infection, poor management and noncompliance (by patients) to care plans. Patients had rectal tubes, I participated in changing and emptying existing ostomy bags. I participated in applying a silver nitrate swab on a temporary stoma with curled wound edge and slow healing.</p>

Reviewed by: Kelly Jaszarowski Date: 12/14/2023

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