

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Dyann Stewart Day/Date: 1/29/2024

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

Number of patients seen today: 5 Preceptor: Mary Montague, APRN, CNS, CWOCN

Directions: WOC nurses function as consultants and develop care plans for other caregivers 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>89 y/o male was recently admitted to the ICU unit as a transfer from OSH with a diagnosis of thrombocytopenia. The patient has multiple skin injuries present on admission. He is being managed by the primary team.</p> <p>PMH includes Arthritis, A-fib, CKD, COPD, hyperlipidemia, HTN, Hypertensive cardiovascular disease, Intermittent confusion, Prostate CA, s/p cardiac catheterization.</p> <p>Medications include Tylenol, Atrovent, Mucomyst, Proventil, Pulmicort, Lipitor, Vasopressin, Levophed, Merrem, Pepcid</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 consulted for multiple pressure injuries on the patient’s sacrum, left lateral heel, right heel, right posterior upper thigh, and left ear. The patient is lying in bed awake, lethargic, and non-communicative. He is unable to verbalize the reason for admission. The patient is currently on 5L O2 via NC. He has a foley in place, draining amber urine. The patient’s granddaughter is present at the bedside and unaware of the wounds present on the sacrum and bilateral heels. The patient was transferred from an OSH. Skin assessment reveals a wound on the left ear developed due to the presence of a pulse ox clip from an OSF, per the granddaughter. The patient has DTPI on the sacrum extending onto the bilateral buttocks measuring 7x8 cm; the surrounding epidermis is intact and dark red/purple in color. A DTPI on the left lateral heel measuring 3x3.5 cm; the epidermis is intact, dark purple/red in color, edges are diffused, the skin surrounding the wound is peeling, and no drainage or odor is present. A DTPI on the right heel measuring 3x2 cm with the epidermis intact, dark black/purple in color; edges are diffused; the skin surrounding the wound is peeling, with no drainage

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and no odor presence. Etiology for the sacrum left lateral, and right heel is due to pressure over a bony prominence complicated by thrombocytopenia. The right posterior upper thigh wound measures 2.5x5.5 cm, and the edges diffuse with an intact epidermis with purple skin, no drainage, and no odor. The etiology is unknown. A DTPI on the left ear measures 1.5x1.5 cm, device-related from a pulse ox clip used at an OSH. The epidermis is intact and dark purple in color, the surrounding skin is intact, and no drainage or odor present. Currently, on a low-air mattress, heels are elevated with offloading heel boots in place. POC reviewed with the granddaughter to maintain the Comfort Glide System, using wedges to offload pressure over the sacrococcygeal area with every Q2 hour turns. Maintain TruVue boots to offload heels. Continue skin prevention interventions. Denies any questions. The WOC consulting team will continue to follow as needed.

WOC Impression/Recommendations:

Sacrum, bilateral heels: Cleanse with NSS, pat skin dry; apply Urgo Tul contact layer; cover with Allevyn; change daily.

Right posterior thigh: Cleanse with bath wipe; apply Critic-Acid Clear moisture barrier ointment BID and PRN to keep area covered at all times.

Left ear: Apply Sween 24 moisturizing cream daily.

TruVue boots to offload heels.

Low air loss surface

Moisture management

Redistribution surface

Turn schedule Q2 hours with wedges to offload pressure over the sacrococcygeal area.

Consults: PT and Nutrition

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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<p>DTPI – Sacrum, bilateral heels</p>	<p>Daily site care: Cleanse with wound cleanser Apply foam dressings.</p> <p>Turn and reposition Q2 hours, offloading with foam wedges. Apply heel protectors when in bed.</p> <p>LAL mattress to bed</p> <p>Encourage intake of protein. Assist with feeding as needed.</p> <p>Encourage families to bring in foods patients like.</p> <p>Consult dietician for additional dietary recommendations.</p> <p>Encourage intake of dietary protein supplements of Beneprotein</p> <p>Consult PT for evaluation and plan.</p>	<p>Foam is appropriate for superficial wounds and promotes moist wound healing.</p> <p>Turning/repositioning will help to reduce pressure on boney prominences. Using specialty devices (cushion, mattress, heel boots) will also help to reduce pressure.</p> <p>Protein intake is necessary for normal body function and to help heal skin breakdown. Dieticians can assess nutritional deficits and identify patient’s specific need and make recommendations to enhance healing. Protein supplements encourage wound healing.</p> <p>Activity is an important component of pressure injury prevention. PT can identify a patient specific plan.</p>
<p>Foley Catheter care</p>	<p>Provide daily perineal care and continence care:</p> <p>Clean the perineal area using warm water and a clean washcloth or disposable wipes, cleaning the tip and shaft of the penis and scrotum.</p> <p>Clean skin immediately after each incontinent episode using pH balanced, no rinse cleanser.</p>	<p>Frequent assessment allows for earlier intervention.</p> <p>Cleansing helps to keep skin clean and dry, free from irritants, to prevent skin breakdown resulting in a pressure injury.</p> <p>Establishing a toileting program and offering the toilet helps to prevent incontinence episodes.</p>

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<p>Discharge plan</p>	<p>Assess the patient’s support system and demonstrate correct dressing change techniques with a return demonstration. Keep skin clean and dry with daily moisturizer.</p> <p>Perform wound dressing recommendations as required.</p> <p>Home Health Services for dressing changes.</p> <p>Educate granddaughter on plan of care and rationale.</p> <p>Consult discharge planner to assist with return to the facility and securing pressure redistribution devices.</p>	<p>Understanding the rationale for performing dressing changes as recommended increases compliance and promotes wound healing.</p> <p>Performing dressing changes as order promotes compliance and encourages wound healing.</p> <p>Home Health Services for wound dressing changes if the granddaughter is not available.</p> <p>The granddaughter can intervene on the patient’s behalf and participate in care.</p> <p>Pressure redistribution measures should be continued to the next provider of care.</p> <p>The discharge planner can work with the facility to secure items for when the return visits.</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>Urgo Tul, a mesh dressing used as a contact layer containing hydrocolloids and petroleum jelly, is designed to keep the area moist for wound healing. A disadvantage of using Urgo Tul is that it is associated with wounds with a high exudate. An alternative would be to use a Vaseline-impregnated with white petroleum.</p> <p>An Allevyn foam dressing is indicated for a small amount of exudate and is designed to keep the wound moist, absorb fluid, and protect the wound. Removing the dressing can be painful if it dries out; thus, a contact layer dressing would be ideal. A disadvantage of using this foam dressing would be if Dakin’s or hydrogen peroxide is used because it could break down the components of the dressing. An alternative would be to use Mediplex foam dressing if Allevyn is not readily available.</p>
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	<p>Critic-Acid Clear moisture barrier ointment to keep the skin moist. A disadvantage is this product is very expensive. An alternative inexpensive moisture barrier ointment is Remedy Essential barrier ointment.</p> <p>Sween 24 moisturizing cream daily cream. A disadvantage is that the product is expensive and an added expense and the alternative is to use Cerve moisturizing cream using BID. daily to keep the skin moist and decrease itching and flaking.</p> <p>TruVue boots to offload heels and reduce pressure injuries. A disadvantage is an added expense. An alternative would be using a Prevalon boot or offloading the heels with pillows.</p> <p>LAL mattress is an added expense. An alternative would be a waffle overlay or creating a frequent turning schedule, Q2 hours, and offloading with foam wedges.</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?	My goal for today was to see how the Wound Care Consult team manages the flow of their patients and to see patients with complicated wounds. My goal was achieved as most of my patient's wounds were Stage 3 and multiple DTIs.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	I would like to see wounds requiring dressing changes performed at the bedside with the primary nurse to ensure the recommendations are clear and any questions can be answered at that time.

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	We saw five patients today who had wounds. We spent the afternoon reviewing each patient's etiology, pressure injury prevention measures, and treatment recommendations. One of the consultations was for a patient with a labia surgical wound. Interestingly, the recommendation to care for the wounds was to cleanse the area with Vashe instead of Dakin's solution. Vashe is a wound cleanser containing pure hypochlorous acid produced by our body's immune system and is thus very gentle on the wounds.
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Reviewed by: _____ Date: _____

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