



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Tatiane Abud Pimentel _____ Day/Date: 01/30/2024

Number of Clinical Hours Today: 11 Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 5 Preceptor: _____ Beeghly _____

Journal Focus: Wound Ostomy Continence 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.

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

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment

Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.

Patient with a history of hypertension and advanced Alzheimer's dementia who is bedbound was brought in by her daughter for foul-smelling bilateral hip wounds. Her presentation was consistent with sepsis secondary to bilateral pressure injuries wounds of the hip with superinfection, and therefore the patient was started on IV vancomycin and piperacillin/tazobactam (abx. empiric). Upon admission, she was noted to be severely malnourished, and she was also found to have hypernatremia and hypokalemia. D5 was initiated for hypernatremia, and Infectious diseases and general surgery were consulted for wounds. On the same day, upon general surgery evaluation, the team did not recommend debridement of wounds given her comorbidities and likely approaching the end of life. General surgery signed off and palliative care was consulted. Infectious Diseases team requested wound cultures. Next day upon results, labs revealed mild neutrophilic leukocytosis, AST of 89, albumin level of 1.8, and an elevated CRP of 10.71. X-ray of the right hip revealed a large soft tissue wound lateral to the greater trochanter without bony erosion or periosteal reaction. Bilateral wound cultures showed growing Klebsiella pneumoniae. ID orders were to continue IV piperacillin/tazobactam 4.5g/q8h for susceptible K. pneumoniae and E. faecalis coverage while inpatient. ID also initiated probiotic therapy to reduce the risk of antibiotic-associated diarrhea, and a Wound Care Management consultation was placed to dressing recommendation while awaiting the transition to hospice care.

Last vitals recorded

BP 106/58 (BP Cuff Location: Left arm, Patient Position: Lying) | Pulse 90 | Temp 36.4 °C (97.5 °F) (Axillary) | Resp 15 | Ht 1.651 m | Wt 38.6 kg | **BMI 14.14 kg/m²**

Last Labs recorded

Date	Value	Ref Range
01/30/2024	10.2	4.4 - 10.5 x10(3)/uL
01/30/2024	309	139 - 361 x10(3)/uL
01/30/2024	0.63	0.60 - 1.10 mg/dL
01/30/2024	89 (H)	5 - 34 U/L

Component	Value	Date
Blood Culture	No growth at this time	01/29/2024
Blood Culture	No growth at this time	01/29/2024
MRSA, PCR	Negative	01/29/2024
Wound Culture	Klebsiella pneumoniae (A)	01/29/2024
Wound Culture	Enterococcus faecalis (A)	01/29/2024
Wound Culture	Klebsiella pneumoniae (A)	01/29/2024
Wound Culture	Pseudomonas aeruginosa (A)	01/29/2024
Wound Culture	Enterococcus faecalis (A)	01/29/2024

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

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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 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.

Patient lying on bed in fetal position, pleasantly confused, bedbound, no signs of distress, daughter, the primary caregiver at bedside. The patient's daughter reports that the wounds started a couple weeks ago and quickly evolved to the current stage. Patient skin shows indications of skin failure a non-pressure-related injury and unavoidable skin breakdown manifested as skin color, turgor, and integrity for quickly necrosis and rapid progression despite appropriate preventive interventions. Given the low probability of wound healing, wound care plan recommendations are for comfort, drainage control, odor control, and antimicrobial coverage. Upon assessment, WMST noted a left hip (trochanter) wound, presenting a wound bed of a mix of slough and necrotic tissue and draining a small amount of green and malodorous exudate. The peri-wound area was boggy, moist, and pale, with unattached and undermined wound edges. Wound Length: 10 cm, Wound Width: 11 cm, Wound Depth (cm): 0.3 cm, and Undermining: 1.6 cm range from 6 to 11 o'clock, with the deepest position at 7 o'clock. Also, a right hip (trochanter) wound with a wound bed presenting slough and necrotic tissue, draining a moderate amount of green, purulent, and malodorous exudate. The peri-wound area was boggy, moist, and pink, with unattached and undermined wound edges. Wound Length: 5 cm; Wound Width: 3.5 cm; Wound Depth: 4 cm; undermining: 1.3 cm around the clock; and tunneling: 6 cm at 3 o'clock.

Management of bilateral trochanter wounds:
 Cleansed wound and peri-wound area with Dakin's solution and gauze; gently pat dried; applied Aquacel Ag to the wound to absorb exudate; covered with ABD and secured with Medipore tape. I instructed the patient and caregiver dressing changes, and implemented pressure-reducing surfaces such as seat cushions, offloading boots, and a specialty surface LAL mattress to promote a cool, dry microclimate. I answered all patients' questions to their satisfaction. WMST dietitian consultation, patient BMI 14, she is having eating problems.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
---	---	--

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

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

<p>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <p><i>Altered skin integrity related to skin failure</i></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Nurses are to perform skin assessments every shift using the Braden skin assessment scale to determine the patient’s risk for PI’s.</p> <ul style="list-style-type: none"> • Every 2 hours, reposition the patient to maximize comfort, based on risk and mobility level. • Nursing to do every 72h (<i>Aquacel Ag states that silver dressing can stay in place up 7 days, however patient has moderate amount of exudate</i>) dressing changes or if soiled. Instructions: Remove the old or loose dressing. Clean the area with Dakin's solution and gauze. Apply antimicrobial foam dressing skin to absorb exudate while inhibiting the growth of bacteria, then cover CarboFlex odor control dressing and secure with tape. • Nursing continue to maintain preventive practices. (pressure-reducing surfaces such as seat cushions, offloading boots, and a specialty surface LAL mattress, cleansers and moisturizer) • Assess skin and document findings every shift. 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <ul style="list-style-type: none"> • Patient will feel comfort measure during process of dying. • Although preventive measures is to avoid pressure injuries, patient will have the best practice of care during end of life. • Assessment and accurate documentation will provide description and help the continuum of care. This is not only to provide physiological description of skin changes in the process of end life, it is also for legal purpose.
---	---	--

<p>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product.</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Antibacterial dressings have a special role in bioburden control and wound healing. Within the class of antibacterial dressings, Gentian violet and methylene blue (Hollister Hydrofera Blue) foam dressings are lower-</p>
---	---

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

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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

<p>Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</p>	<p>cost alternatives to silver antibacterial dressings. This type of dressing has similar effectiveness against a wide spectrum of microorganisms and the absorption of excess exudate. As I stated before, the wound care for this patient centered most on comfort and controlling symptoms, which we can find at a lower cost with this option.</p>
--	--

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

<p>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>My learning goal was to learn more about complicated wounds, and I had the great opportunity to learn about skin failure and how hard is to differ from PIs, specially the initial color that is usually purple or maroon which can easily be confused with DTI. This set us apart from a regular nurse, as an expert, we should be able to see the entire scenario and try to find if patient has perfusion and inflammatory issues.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>I would like to continue to learn more about peri-stoma skin problems.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>Sincerely, this week was hard to find a issue with the scenario, the only thing that I would take into account was the cost of dressing choice, since is comfort I would change for one with similar effectiveness however that would cost less.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<ol style="list-style-type: none"> 1. Colostomy teaching 2. Stoma Marking attempted 3. POA evaluation 4. NPWT

Reviewed by: _____ Date: _____

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

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.