

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Michele Ramirez . Day/Date: Frisay, February 2, 2024

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

Number of patients seen today: 9 Preceptor: Erica Yates

Journal Focus: X 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.

Today’s WOC specific assessment	<p><u>Assessment:</u> 72-year-old female; with admitting diagnosis of Sepsis due to pneumonia. Patient is AAO x 3, moves all extremities with generalized weakness, assist of 2 for bed mobility. Irritant contact dermatitis related to urinary and fecal incontinence with full thickness skin loss. Left buttock wound of unknown etiology. Left thigh – purple/burgundy discoloration. Incontinent of stool, none noted during assessment. Foley in place, tea colored urine noted.</p> <p><u>Medical Hx:</u> HTN/obesity/Afib/CKD/OA/Asthma</p> <p><u>Medications:</u> Albuterol 2.5mg/3mL inhalation q4h, gabapentin 200mg cap daily, Tylenol 1,000mg tab q6h PRN, diphenhydramine-zinc acetate 2-0.1% topical cream TID PRN, anastrozole 1mg oral daily, atorvastatin 40mg tabs oral at bedtime</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.

WCCT performed a follow up visit today. The wound in the intergluteal fold remains the same since WCCT’s last visit. The wound on the left buttock remains the same. The wound on the patient’s perineum are slightly improved, but there is an area that is covered with tan/brown slough. The patient endorses 9/10 pain at the sites during cleansing. The area of purple/burgundy discoloration on the patient’s left upper posterior thigh remains the same. The patient now has an indwelling urinary catheter to divert urine away from wounds and is taking Imodium to improve diarrhea.

Intergluteal fold/perineum – 17 x 2.5 x 0.3 cm, irritant contact dermatitis related to urinary and fecal incontinence with full thickness skin loss.

Left buttock – 2.5 x 1.5 x 0.3 cm, yellow/red blanchable erythema, irregular shaped. Unknown etiology.

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WCCT will continue to follow patient. Please reconsult if wounds worsen.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p>Impaired skin integrity related to fecal/urine incontinence.</p> <p>Incontinence related to urine/feces.</p>	<ul style="list-style-type: none"> - Intergluteal fold/perineum: gentle cleansing after each incontinent episode. Perform crusting technique daily by sprinkling stomahesive powder over the area and dusting off excess then applying ConvaTec skin barrier wand over top and repeating process 3 times. - Apply thick layer of Desitin to perianal area, bilateral buttocks, and coccyx BID and as needed to keep areas always covered. - Use ONLY ultrasorb pads under patient (no diaper and no blue chux). - Continue with indwelling urinary catheter to divert urine away from wounds. - Continue with Imodium to improve diarrhea. 	<ul style="list-style-type: none"> - Keeps the skin dry and free from excessive moisture. - Crusting technique with powder provides additional protection to the skin. - Desitin creates protective barrier on the skin and helps prevent further damage from moisture and irritants. - Zinc oxide is present in Desitin which has soothing and protective properties. - Catheter helps in draining the urine effectively and maintain skin dryness to help manage IAD. - Giving anti-diarrhea medication to manage incontinence.
<p>Impaired Physical Mobility related to mobility</p>	<ul style="list-style-type: none"> - Maintain turning/positioning system to off-load patient's coccyx/ischium every 2 hours. - Maintain Tru-View heel protectors to bilateral lower extremities, to 	<ul style="list-style-type: none"> - Using TAP system helps patients with mobility issues and prevent complications associated with

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	<p>off-load heels while in bed.</p> <p>-</p>	<p>immobility.</p> <ul style="list-style-type: none"> - Regular repositioning and turning with the help of a turning and positioning system helps to reduce the pressure on specific body areas, improving blood circulation and reducing the risk of pressure ulcers. - Tru-View boots have a unique design that helps redistribute pressure away from the heels. By elevating the heel and providing cushioning, these boots minimize the pressure and friction that can lead to the development of heel ulcers. <p>-</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>Stomahesive powder – can be challenging to achieve a smooth and even application, especially in areas with skin folds or creases. Excess powder can clump, making it less effective in providing a protective barrier. Alternative: 3M Cavilon Barrier Cream</p> <p>Convatec skin barrier wand – more expensive compared to other brands. Alternative: Cotoplast Brava Protective Barrier.</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.

<p>What was your goal for the day? Were you able to meet your learning</p>	<p>Yes, my goals were met.</p> <p>My goal was to become more familiar with different ways to document wound consults.</p>
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goal for today? Why or why not?	
What are your learning goals for tomorrow? (Share learning goal with preceptor)	My learning goal is to continue seeing more patients with different stages of PI/IAD and to learn about the components of a good wound care consult documentation.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The patient had expressed a desire for other staff members to be gentler when assisting with cleansing her wounds, like Erica and myself. It is important to ensure that the patient's preferences are respected and that they receive care in a manner that makes them comfortable. Patient was encouraged to always express her needs to staff members.
Reflection: Describe other patient encounters, types of patients seen.	During our rounds, we encountered several patients who presented with multiple wounds that were specifically attributed to incontinence and immobility. One patient had a deep wound in intergluteal fold due to an abscess.

Reviewed by: _____ Date: _____

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