

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Kelly Goch Day/Date: Friday, 1/19/24

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

Number of patients seen today: 4 Preceptor: Jennifer Brinkman, APRN, CNS

Journal Focus: X 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.

<p>Today’s WOC specific assessment</p>	<p>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</p> <p>History of anxiety, aortic dissection, cardiomyopathy, chronic kidney disease, diabetes, hypertension, limb ischemia, obesity, pacemaker, pulmonary embolism, umbilical hernia. For the past 2 weeks pt has had intermittent low- grade fevers leading him to follow up with PCP. Blood cultures taken and revealed Candida parapsilosis at which point was admitted to CCF. Once admitted to CCF echocardiogram obtained and showed mobile echo density attached to aortic valve and placed on IV micafungin for infection. Pt already on WCCT caseload for management of Stage 4 pressure area to sacrum but staff now reporting additional open areas to back and flank areas and are requesting additional consult for these areas.</p>
---	--

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.

<p>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.</p> <p>Pt currently admitted with Fungemia and has Stage 4 sacral pressure wound present on admission. Currently on caseload for management of sacral wound. Staff reporting new open areas to flank and lower back regions and has been seen today for those areas. Assessment findings include new Stage 2 pressure injury measuring 1.4 x 2 x 0.2 cm to R upper lateral flank region with pink wound bed and scant amount of serous drainage without odor. Wound margins defined with peri wound skin pink. No other new areas found. New treatment orders provided. N.O. - cleanse wound to R upper lateral flank apply skin prep to peri wound skin and allow to dry top with petrolatum contact sheet cut to size top with foam dressing change daily. Stage 4 sacral wound changed and redressed using treatment of cleansing wound, pack with Vashe moistened gauze packed into wound topped with foam dressing. Pt tolerated dressing applications with discomfort. Turned and repositioned to R side using wedge cushions. Noted incorrect wedge pillows in use, new wedge pillows ordered. Staff education provided</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.

on new wedge pillows and proper positioning when using on pt. Call bell remains within reach.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</p> <p><i>NANDA diagnosis does not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <p><i>Risk of skin breakdown related to stage 4 sacral pressure injury and stage 2 right lateral upper flank injury</i></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Communication provided to nursing and supervisory staff regarding new wound areas. Staff educated on importance of keeping pt turned side to side q 2 hrs. using wedge cushions supplemented with bed pillows. New wedge pillows ordered.</p> <p>Wound care: Stage 4 sacral pressure ulcer - apply skin prep to peri wound skin and allow to dry pack with Vashe moistened gauze and top with large foam dressing change daily. Stage 2 R upper lateral pressure injury cleanse wound apply skin prep to peri wound skin allow to dry top with petrolatum contact sheet cut to size and top with foam dressing change daily.</p> <p>Ensure hospital gown is open on back and smoothed not bunched under pt shoulders</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Side to side turns redistributes weight off posterior boney prominences. Use of wedge pillows prevents pt from rolling off side onto the back area and may promote skin integrity</p> <p>Completing dressing and treatments may promote pt comfort and add physical barrier protecting wounds and promoting skin integrity</p> <p>Consultation with Dermatology for advanced treatment and management of wounds of unknown etiology may result in improved treatment and increase positive pt outcome</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.

<p><i>Impaired physical mobility related to muscle weakness and inability to self-turn</i></p>	<p>Low air loss mattress</p> <p>Bilateral heel suspension boots and float heels. Nursing to check placement q shift and ensure in place.</p> <p>Placement of new wedge pillows as ordered. Use with each turn and repositioning.</p>	<p>Specialty mattress aids in redistributing body weight and may help to reduce future pressure areas</p> <p>Reducing pressure on boney prominences of the feet may help to prevent skin breakdown in these areas</p> <p>Correct wedge pillows not in use. Ordered proper wedge pillows for pt use to assist with adequate side to side positioning</p>
<p><i>Impaired comfort related to fever and infection</i></p>	<p>Nursing staff to administer anti-pyretic medication timely per MD order</p> <p>Maintain fan safely secured to bedside rail to promote comfort</p> <p>Keep bed linens and warming sheet off pt per his request</p>	<p>Reducing fever, promotes normal body temperature and may help promote comfort and healing</p> <p>Reducing fever, promotes normal body temperature and may help promote comfort and healing</p> <p>Reducing fever, promotes normal body temperature and may help promote comfort and healing</p>

<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</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p><u>Stage 2 Pressure Injury to R upper lateral flank: apply skin prep to peri wound skin allow to dry. Apply petrolatum contact sheet cut to size and top with foam dressing. Advantage of this dressing is that it offers a protective barrier to wound site that will stay in place. Disadvantage of this dressing is that it is more expensive over another type of dressing and offers no</u></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>should be from a different category or classification. In other words, what could be used if the product was not available?</p>	<p>antimicrobial protection. Alternative: Apply skin prep to peri wound skin and allow to dry top xeroform gauze cut to size and can top with foam dressing or ABD with silicon tape. This dressing still offers protective barrier but at a lessor cost in addition to antimicrobial component related to the Bismuth in the Xeroform gauze. However, both dressing selections offer a non-adherent approach for the wound.</p> <p>Stage 4 Pressure Injury to Sacrum: cleanse wound, apply skin prep to peri wound skin and allow to dry. Pack wound with Vashe moistened ribbon gauze top with foam dressing change daily. Advantage of this treatment offers microbial properties found in the Vashe moistened ribbon gauze and the foam dressing offers absorptive capabilities and added padded protection. Disadvantage of this treatment is Vashe moistened gauze could cause maceration to localized skin if too moist or tail left too close to peri wound skin. Alternative: Apply skin prep to peri wound skin and allow to dry apply Dakins ¼ strength ribbon gauze packed into wound topped with foam dressing. This treatment still offers microbial effects by using Dakins Solution and foam dressing or ABD pad taped with silicon tape both offer absorptive capabilities while silicon tape is just as gentle on skin as adhesives of foam dressing. Dakins may be more readily available over Vashe wash.</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 goal for the day was focus on wound care needs in acute care.</p> <p>Yes – I was able to see various ICU patients all with different wound care needs.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>Friday is my last day with this preceptor and I look forward to more pressure and deep tissue injury related wounds.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>Veshe moistened ribbon gauzed was ordered for a pressure ulcer. I was unfamiliar with this product and had to look it up.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<p>Seen a total of 4 ICU pts today. All pts presented with pressure injuries or deep tissue injuries as it is the role of APRN on the WCCT team to see these types of wounds that are not receiving negative pressure therapy. One note I have made is supplies may not be readily available at the bedside, especially if the order has changed. It can be time consuming to run to supply area to retrieve necessary treatment supplies and may be easier if keep with the provider.</p>

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.



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

(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.