



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

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Nancy Ndamukong Day/Date: 09/17/2024

Number of Clinical Hours Today: 9

Care Setting: Hospital yes Ambulatory Care Home Care Other

Preceptor: Helen Shubsda

Clinical Focus: Wound Yes Ostomy Continence

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Today we had five patients on our list, but we could only see four because one of them refused to be seen today. My preceptor and I spent the first two hours of the morning attending meeting on pressure injury (PI) prevention. The first patient had a healing stage 3 pressure injury (PI) on the left ischial tuberosity. No drainage, no pain. Area was cleaned with NS, measurement and photo taken. A protective dressing (Allevyn gentle border 4x4) applied. Patient instructed to keep the area protected since the epithelia tissue still has a decrease tensile strength. Pt understood that the skin in that area is still fragile and could easily breakdown or open if rubbed against anything with pressure. The second patient had a stage 2 PI to sacrum, with a minimum amount of drainage and accidental episodes of loose stool. Patient complains that it “feels raw” around the groin area. Area cleaned with NS, measurement and photograph taken. Destin powder applied and left open to air. The third patient was seen for two open wounds in the posterior part of the scrotum, caused by shear/friction force as the patient is been moved up and down and side to side in bed. He had a swollen and painful scrotum due to hydrocele. Desitin powder was applied to help prevent the scrotum from rubbing against the skin. A scrotal support was placed under the scrotum to help prevent the scrotum from rubbing against the bed pad when sliding up in bed. The fourth patient was paraplegic with multiple PIs. Stage 3 in the coccyx with minimal drainage, a stage 4 in the right ischium with undermining from 1-5 o’clock and a max depth of 3cm. Moderate drainage. Then, a stage 2 PI to the right heel, moderate drainage. All the wounds were cleaned, measured and photo taken. Aquacel and Allevyn applied to the coccyx, ischial wound was lightly packed with alginate to wick the drainage from the undermining. Aquacel and allevyn was also applied to the left heel. An order for a dolphin mattress was place.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse’s absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. 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. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

A follow-up visit for a 70 y/o female patient who was admitted to the hospital due to other diagnoses including fluid overload and CKD. History of cardiac insufficiency, CAD and hyperlipidemia. Labs look good, nothing significant that could affect wound healing. Patient was admitted seven days ago with full thickness tissue loss stage 3 Pressure injury wound to left ischium. Initial assessment reveals visible subcutaneous fat with some slough as was reported. Patient seen today for a healing stage 3 PI. On

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assessment, the left ischium has pink scar, no pain, no drainage. Assessment was done when patient was sitting up in the chair. Patient refused to lay down in bed. She preferred standing up and leaning forward on a walker for assessment to be done. Wound was cleaned with 4x4 gauze soaked with normal saline and photo taken. No measurement obtained because there was no open spot, except for a pink discoloration over the scar. A protective cover (Allevyn gentle border 4x4) was placed on the scar. Patient was educated to keep the area protected since the epithelia tissue still has a decrease tensile strength. Pt understood that the healed skin is still fragile and could easily re-open if pressure is applied to it. She verbalized understanding.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products used)

- o Clean wound with normal saline, gently dry, apply allevyn gentle bordered foam 4x4.
- o Change dressing daily
- o Turn and reposition every two hours to off-load patient’s coccyx/ ischium.
- o Obtain Medline comfort glide sheet (oracle number 1112852) and turning wedges (oracle number 1062865) to off-load patient’s coccyx/ischium every 2 hours.
- o Nutrition consult advised for optimized wound healing.
- o Maintain Isotour blower to Stryker bed, to maintain low air loss.
- o Please order a seating cushion, Oracle # 1066990, for patients when up to a chair.
- o No further visit planned by WCCT at this time. Please re-consult wound care, if wound re-open or non-blanchable erythema noted to the healed pressure area.
- o Assess pressure points daily and notify the WCCT for non-blanchable erythema..

Describe your thoughts related to the care provided. What would you have done differently?

On assessment, the wound was opened to air. Patient stated that “it is all healed up”. The healing stage 3 PI was then covered with a protective foam. My recommendation will be for the patient to implement the above plan of care. So as to prevent the recurrence of wound in future.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?

My goal for today was to learn how to write a better plan of care. Goal was met because I discussed with my preceptor about writing a plan of care and she educate me on how to critically think of a patient’s care plan.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

My goal for tomorrow is to see patients with more complicated wound.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	

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• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	
• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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