



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Doris Elliott Day/Date: 09/23/24

Number of Clinical Hours Today: 10

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Janie Renaud

Clinical Focus: Wound 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.

The patients seen today varied from med-surg to critical care patients with a wide array of comorbidities. Each patient who was consulted for possible skin break down to the perineum was interviewed about toileting habits and mobility capabilities prior to the physical assessment to help determine possible causes of skin break down.

The patient reflected on in this journal was admitted due to shortness of breath with the admitting diagnosis of acute on chronic heart failure with preserved ejection fraction, and acute on chronic respiratory failure with hypoxia. She has a medical history of pulmonary hypertension, lupus, CHF, CKD Stg 3, OSA not on CPAP, asthma, and fibromyalgia. Her baseline dependency is 2-3 L of oxygen via nasal cannula. Patient typically takes 20 mg furosemide BID at home, and is prescribed IV Lasix while inpatient. Unable to complete VQ scan at time of admittance to rule out pulmonary embolism due to patient being unable to lay flat. Antibiotic prescribed empirically until infection is ruled out due to cough.

Most recent labs:

Sodium: 137
Potassium: 4.2
Chloride: 100
CO2: 22
BUN: 64
Creatinine: 2.59
Glucose: 91
Protein, total: 6.0
Calcium: 9.0
Magnesium: 2.0
Phosphorus: 3.8
Albumin: 2.9
Bilirubin, total: 0.6
Alkaline Phosphatase: 64
ALT: 18
AST: 21
Anion gap: 15
eGFR: 19

With noted blood count abnormalities of:

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Hemoglobin: 7.1
Hematocrit: 22.1

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:

Wound, ostomy and Continence care team consulted for "lesions near rectum". Upon assessment patient noted to have female external catheter in place with leakage contained by disposable under pad. The patient was observed with a nasal cannula in place on 5L, with frequent desaturation observed during position change into supine and side lying. The patient was experiencing frequent coughing with sputum production, and stated she can feel leakage of urine during moments of coughing and sneezing. Patient stated she typically does not have problems with incontinence, but is being treated with IV Lasix and urine production has increased, and coughing has been severe. Sacral assessment revealed a fissure to the intergluteal cleft with exposed dermis, external hemorrhoids of the rectum with no open areas, and blanchable erythema. Triad hydrophilic wound dressing applied. Patient educated on the products used, and proper placement of external catheter confirmed to prevent further leakage. Patient previously prescribed calmoseptine to be applied as needed, order modified to be applied twice daily and as needed after bowel movements. Patient also prescribed immodium as needed for diarrhea, patient denies diarrhea at this time and has not taken immodium during this admission. Patient encouraged to change positions frequently to prevent further skin breakdown, and encouraged to use the bedside commode to promote movement and bladder emptying. Patient encouraged to follow up with continence care nurse if incontinence continues past hospitalization and once baseline health is obtained.

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)

Calmoseptine to be applied routinely twice daily and utilized as needed to promote wound healing and prevent further breakdown. External catheter and absorbent under pad to be used to promote patient comfort and contain urine during periods of incontinence. Toileting schedule using the bedside commode will allow patient to be oxygenated, will promote movement, and will help to empty the bladder at routine intervals. This can be implemented at scheduled turning times, as urinating every two hours will be needed while receiving IV Lasix. Optimize respiratory status to improve mobilization, patient is at an increased risk for skin breakdown due to needing to sit at a near 90 degree angle to be comfortable. Continued support and treatment will gradually allow for the patient to be able to change positions more comfortably and place less pressure on the sacrococcygeal region.

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

I believe that optimizing the patient's respiratory status by continuing to supplement oxygen and utilize IV Lasix is appropriate and that the external catheter and absorbent underpad should continue to be used while the incontinence continues. Ideally the continence will cease to occur once IV Lasix is discontinued and the patient is coughing less frequently. I agree with the recommendation to modify the orders placed previously for calmoseptine to be used twice daily rather than as needed, as the product will then be offered more frequently and less reliant on the patient asking for it. I think the patient should be encouraged to urinate on a routine schedule using the bedside commode to both promote movement and ensure bladder emptying.

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 the day was to better understand the assessment and treatment process of this facility and staff. By understanding how consults are placed, who is responsible for assessment and treatment recommendations and how orders are placed I can better implement the knowledge gained and understand the work flow of my preceptor.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
 Learning goal for tomorrow is to better familiarize myself with the products used and available to help promote skin healing and prevent skin breakdown in the incontinent patient.

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	✓	
• 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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