

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Patricia Weimer Day/Date: Monday 9/30/2024Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Helen ShubsdaClinical 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.

Patient 1: 55-year-old female with history of breast cancer. Right breast fungating lesion. No odor. Patient asked if she could pour hydrogen peroxide on her wound. Explained hydrogen peroxide is cytotoxic and will kill all cells including healthy skin cells and it would be painful. Vashe soak applied, covered with an ABD pad secured lightly with 3M Micropore S tape. Vaste soak will be applied twice daily. Braden score assessed at 18. Patient is ambulatory, alert, oriented and actively participated in her care. Examined heels bilaterally which were intact without hyperpigmentation. Examined coccyx. Hyperpigmentation. Patient was currently on a redistribution mattress with the capability to add an Isotour blower to the Stryker mattress to create a low-air-loss mattress. Order for blower was placed.

Patient 2: 67-year-old female with blanchable erythema to coccyx. Patient was currently on a redistribution mattress with the capability to add an Isotour blower to Stryker mattress to create a low-air-loss mattress. Order for blower was placed. Bilateral heels intact. Braden score assessed at 19. Patient is alert and oriented. She ambulates without assistance. Teaching related to offloading her coccyx every two hours while in bed was received well with patient stating "I just need to move my butt every two hours."

Patient 3: 80-year-old female with recent left above-the-knee amputation. Staples are present and intact. Edges approximated, clean and intact. Left lateral thigh with unstageable wound created by an ace wrap. Hydrogel and gauze applied. Coccyx wound unstageable, Desitin to ABD and placed loosely over coccyx wound. Wounds to thigh and coccyx were not secured because she is incontinent of stool and needs 5 to 6 changes per day. Both dressings will allow nursing staff to replace quickly during each incontinent episode. Patient is bed bound, has cognitive impairment, and is incontinent of stool. Braden score assessed at 11. Patient was currently on a redistribution mattress with the capability to add an Isotour blower to Stryker mattress to create a low-air-loss mattress. Order for a blower was placed. She is a DNR and is currently refusing to take medications orally.

Patient 4: 81-year-old female with sacral wound acquired at last admission. Unstageable. Allevyn Life Foam Dressing to coccyx. Patient contracted, with flexion of upper and lower extremities. Remains in a fetal position at all times. Braden score assessed at 8. Will only stay in left or right lying position, which naturally offloads her sacrum area. Right ischium is intact with hyperpigmented, left ischium is intact without discoloration. Skin at bilateral hips and shoulder are intact with right hip hyperpigmented. Bilateral ears assessed with hyperpigmentation to the left lobe. Bilateral heels with Tru-View Heel Protectors in place. These were removed, heels were assessed, and protectors replaced. Patient was currently on a redistribution mattress with the capability to add a blower to create a low-air-loss mattress. Order for a blower was placed.

Patient 5: 69-year-old female with history of Acute Lymphoblastic Leukemia. (See Chart Notes below)

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WOC nurses function as consultants and develop plans of care (Allevyn Life Foam DressingPOC) 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:

68-year-old female admitted for sepsis. History of Acute Lymphoblastic Leukemia. Stage 2 skin tear, wound bed is purple, peri-wound skin is dry and fragile. Patient states this occurred when an IV was being placed. Sacral wound is a stage 3 pressure injury. Full-thickness tissue loss with subcutaneous fat visible. Granulation and epibole present. Documentation in patient's chart records this wound being present 61 days.
Bilateral heels were assessed and are intact.
Patient is ambulatory and can reposition herself but needs to be reminded to offload sacrum to facilitate healing. She requested a seating cushion for when she is up to a chair. Braden score assessed today at 19.

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)

Tru-View heel protectors to bilateral lower extremities or pillows under each calf to off-load heels.
Reposition patient every two hours to off-load coccyx/ischium.
Medline Comfort Glide Sheet (Oracle #1113852)
Turning wedge (Oracle #1062865)
Attach and maintain Isotour blower to Stryker mattress
Nutrition consult for optimized wound healing.
Seating cushion Oracle #1066990
Sacral Wound – Cleanse with normal saline, pat dry, apply Aquacel cut to size of wound and cover with Allevyn foam. Change every two days and as needed.
Left Arm- Cleanse with normal saline, pat dry. Apply Restore contact layer and wrap with Kerlix. Change every two days and as needed.

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

I was excited to learn Vashe can prevent the odor normally associated with a fungating lesion.
I realize Patient 3 was not moving in bed, and I understand the concept that the dressings would be changed frequently due to frequent incontinent episodes, however (especially with the left lateral thigh wound) I would want the dressing secured to prevent stool from leaking into the wound. I would also question the etiology of the diarrhea and determine if that could be managed more effectively. However, while cleaning the patient, she complained of nausea frequently. I asked the nurse if she had something ordered for nausea and the nurse said the patient had refused to take the ordered Zofran.

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 today was to see wound and continence patients and I was able to see 5 wound patients today. My ongoing goal with wound care is to learn the products and their appropriate indications. I was able to achieve some of this today.

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

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See a variety of wound and continence patients and continue learning the wound products and appropriate applications.

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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