



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: 10/07/24

Number of Clinical Hours Today: 10

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Patti Grossnickle

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.

Today's patients presented with a variety of wounds, the first patient has a stage 4 pressure injury to the sacrococcygeal region that will be the focus of today's journal. The next patient had a wound to the left arm that occurred after scraping the arm on a door frame about one month prior. The wound was full thickness and cleansed with a vashe soak, Mepilex AG foam was applied and covered with alleevyn foam dressing. The next patient presented with a right leg that had undergone a rotationoplasty 18 years prior and was now experiencing a pressure injury to the right foot hallux from a prosthetic leg that is too large since recent weight loss. The patient's wound has slough present to the entire wound bed with blanchable erythema noted to the peri-wound. The wound was cleansed with normal saline and lidocaine 4% applied topically. The wound was then debrided by the provider and a red and pink wound bed revealed. The wound was then cleansed again, and off-loading felt was applied to the periwound, pre-moistened promogran was applied to the wound bed and covered with hydrofera blue classic. The patient was arranged to have home health do the dressing changes, and provided with the contact information for prosthetic fitting. The next patient was one that was seen previously for a tunneling left breast wound that developed after radiation and a lumpectomy were performed for breast cancer. The patient was complaining of an expanding rash that was previously thought to be caused by a fungal infection. The rash had spread and was causing more discomfort. The patient was assessed by the provider and determined to have a possible drug reaction to the previously prescribed Diflucan. The patient was instructed to discontinue taking Diflucan and hydrocortisone cream was applied. The wound recommendations remained the same and the patient's wound was packed with gentamicin impregnated ¼" plain packing gauze, it was then covered with an alleevyn foam dressing. Follow up appointments were made for Wednesday and Friday in-clinic for closer monitoring. The last patient presented with a skin tear to the left lower arm that occurred while grocery shopping and was hit on a freezer door. The edges were observed to be approximated, and a vashe soak was performed. The wound was then dried, xeroform was applied and covered with dry gauze and secured with kling and tape.

A hurricane is predicted to cause closures of this clinic this week and each patient was provided with extra supplies and education regarding the care of their wound. Many patients were told that their dressing can remain in place for a slightly longer period of time and to follow up once the storm has passed if closures occur.

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

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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:

The patient is a 64 year old male who presented to the clinic for a dressing change and wound assessment with the provider. The patient developed a stage 4 pressure injury to the sacrococcygeal area in 2021. The patient is a paraplegic with a chronic indwelling foley catheter and colostomy appliance in place. The patient has a history of surgical debridement and VAC placement to the wound. Today the wound presents with a pink and yellow wound base with an intact peri-wound with scarring noted. There is no odor noted, and the patient stated that home health typically does the dressing changes but that he had changed the dressing this morning after noticing it had saturated through. Current measurements of 5.9x3.9x1.9 with undermining noted at 1-4 o'clock with the deepest measurement of 1.4 cm noted at 4 o'clock. The wound was cleansed and lidocaine 4% was applied. The wound was debrided by the provider using a 5 mm disposable dermal curette, and a red and bleeding wound bed was exposed. The wound was cleansed again with vashe and Coloplast collagen hydrogel was applied to the wound bed. Hydrofera blue classic was lightly packed into the wound bed, and the area was covered with dry gauze, and ABD pad, and secured with primapore tape. The patient was instructed to utilize a Dakins wet to moist dressing if he needed to change it himself. Patient has home health care arranged for dressing changes every Mon/Wed/Fri.

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)

Mon/Wed/Fri: Cleanse wound to sacrococcygeal area with vashe soaked gauze, allow vashe to sit on wound bed for five minutes. Pat dry. Apply generous amount of hydrogel to wound bed. Cut hydrofera blue classic to exact size and shape of wound then activate hydrofera by soaking in normal saline; allow to sit for one minute then squeeze out excess saline. Apply hydrofera to wound bed only, do not overlap on healthy intact skin. Cover with dry gauze, secure with tape.

Patient may change dressing as needed if soiled with Dakins wet to moist dressing.

Continue to avoid water to wound

Offload and reposition at least every two hours when in bed and every one hour when in chair

Continue to monitor for fevers, increase in pain/tenderness and/or redness/swelling, purulent drainage/odor

Follow up in clinic in 1.5 weeks, call for any concerns before then

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

I thought the care provided was great and the wound is decreasing in size when compared to previous assessments. I also appreciated that a simpler dressing was recommended for the patient to apply if needed as it is difficult for him to reach the area and needed to be less complicated. They ensured that the patient had enough supplies to last through the hurricane, and were able to ensure the patient that even if the dressing needed to stay in place for longer than planned it would be okay. I would've focused more on prevention measures as this patient has had this wound for over two years and no seat cushion was observed on his wheelchair. The patient stated he is getting a new wheelchair soon and will get a cushion then but I believe he should be more proactive in prevention and understanding why even a temporary cushion can help the healing process and prevent further breakdown.

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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 see patients that I had seen previously, such as the woman with a tunneling wound in her breast who developed a drug reaction rash, as this helps to understand why frequent assessment is so beneficial even for wounds that wouldn't typically warrant close follow-up with the wound care team.

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

My goal for tomorrow is to better see the facilities process for preparing patients for the hurricane as home health and follow up appointments may all need to be delayed.

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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