



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Yvan Fortunat Day/Date: 10/17/24

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Jennifer Brinkman

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 I was with the wound care team. We went over two cases during huddle, and we saw 4 cases. In the huddle, different teams of nurses and WOCs were discussing a couple of cases where the documentation was not clear as the progression of the existing wounds. One patient had a wound on admission, as per documentation, but no picture was taken. After the patient got transferred to a different unit, wound was documented as healed, again no picture was taken. However, two days later, a stage 3 pressure ulcer with mixed etiology was documented by the WOC nurse during the first consult. As per patient, he had been having these wounds on and off for years, but he was adamant he did not have one upon arrival. We were discussing should the wound be classified as present on admission or not and what better way to make sure any initial documentation of wounds is associated with a picture as visual proof. We decided we may have to do an in-service to remind the staff that pictures need to be taken if a wound is detected for the first time and wound consult should be requested immediately. THE other case we discussed was a patient with kyphosis whose spinal bones are sticking out to the point where two unstageable ulcers are appearing. The discussion centered around ordering kyphotic wedges that can be stored on site, in a couple of units. That way the few patients with kyphosis will already have the right product that can help with decreasing the risk of those wounds developing. All 4 patients I saw today were pressure injuries on the sacrum/coccyx areas. The first one was a case the WOC documented on, with pictures, as a stage 2 pressure injury but which deteriorated to an unstageable pressure injury. We received the request for another consult yesterday. Patient is in the ICU, she is incontinent of bowel, foley catheter is present. The WOC nurse opted to use hydrogel and ADB pads BID. I would have liked to use TRIAD daily instead, couple with repositioning patient every two hours. For one patient, we were shadowed by a new nursing student who never done a wound before. It was a great opportunity to teach and demonstrate the proper way to clean, take the measurement and light pack a wound. The student was able to verbalize the steps and perform packing while being directed. We also consulted with another nurse who was unsure whether a patient should be turned and repositioned when Md states do not disturb patient. Nurse was educated on the importance of repositioning especially for patients who cannot move at all by themselves. Unless stated clearly not to turn the patient at all due to specific reasons and for how long, all patient should be turned and repositioned as per protocol. The other two cases we saw were also pressure injuries on the coccyx/sacral area. I was able to perform the wound care and the patient tolerated the

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treatment without complaints.

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:

Patient is a 68 yo female, A&Ox3 who was admitted on 10/11/24 due to renal failure. Patient has an unstageable pressure injury on the coccyx area. She stated that she had pressure injuries in that location before due to skin damage and scarring secondary to previous radiation. Patient stated, she thinks that her wound reopened during transport to the hospital because she was placed on a very hard chair and pulled a bit too hard. She stated she felt the pain and the shearing sensation during transport. Patient has a history of DM controlled without complications, HTN, HLD, asthma, dyslipidemia, the presence of an ileostomy that was created in early September, Cholecystectomy, and hysterectomy. Patient is very agreeable, she is on room air, vitals withing normal, she is able to turn independently in the bed to allow access to the wound. Allevyn foam dressing is removed as well as wet to dry packing, small serous and purulent drainage is observed on the dressing, no odor noted. Wound is red, with yellowish slough at the base. Edges are irregular, wound size is 1.8cm in length, 0.5cm in width and 1cm in depth, no undermining, no tunneling. Peri-wound is red, shiny, blanching scar tissue. Wound is cleansed with normal saline, Peri-wound is prep with sting-free skin barrier. AMD nu-gauze lightly packed the wound. Covered with bordered foam dressing. Patient denies pain, and tolerated treatment well.

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)

- Discontinue old dressing, cleanse wound with normal saline, apply skin sealant to peri-wound, lightly pack wound with AMD nu-gauze packing, cover with Allevyn foam dressing 3xweekly and prn if dressing comes off.
- Use seating cushion for patient when up in a chair
- Monitor patient's pain and provide relief as per order
- Monitor Blood glucose and HTN and treat as per order
- Increase protein intake within ostomy and diabetic diet limitations
- Reinforce stoma care
- Use cane or walker to encourage activity

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

This patient's wound was very interesting to look at. She has a pressure injury secondary to not only pressure but because of radiation that has permanently damaged the skin in the sacral/coccyx area. The amount of

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exudate was small, therefore I would have used some hydrogel impregnated gauze to keep that wound bed moist while packing it lightly, which could also help with the autolytic debridement. I would use a foam dressing like Allevyn to provide absorption in the event that is needed as well as some cushion for increase protection. Patient has an ostomy for less than a month, I would have recommended a dietician consult to make sure patient is following her ostomy diet and DM diet since not eating well enough can impact the healing of the wound.

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 was to have a sense of some of the products used in providing and preventing pressure related injuries. But I was able to see a different part of the WOC role. I saw how the collaboration among colleagues works to maintain the goal of keeping pressure ulcers as low as possible.

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

I would love to see some venous stasis or arterial ulcers tomorrow. I still would love to perform an ABI test.

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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