



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Kristel Nielsen Day/Date: 10/25/2024

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Nicki Blasiolo

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 saw six patients with my preceptor and two of the patients were follow up wound vac changes. We notified their nurses so the patients could receive pain meds in advance. PD had abdominal surgery and wound care was consulted or a wound vac change. Her surgical wound was open with a layer of Strattice reconstructive tissue matrix covering the abdominal cavity. I learned the importance of using white foam under black foam when Strattice is present in a wound, because of the negative pressure and not mistake Strattice for white foam during wound vac dressing changes.

The first patient, JU, a 77 year old man was intubated and on continuous dialysis. Wound care was consulted to assess for pressure injury on his coccyx/sacrum. The patient had dark purple skin near sacrum, indicating a deep tissue injury. The area was cleaned with pH balanced skin wipes and Allevyn foam dressing applied. The patient's nurse was in the room, and she was educated to put this patient on a repositioning schedule.

We saw a patient in the ED who had skin tears on his right knee and left foot. This young man lived in a care home, was nonverbal and immobile. Wound care was consulted for wounds on his sternum, and skin tears on his toes. He was quite fearful and moaning in anticipatory pain when we came closer and he did not want us to remove his dressings. His nurse came into the room and medicated him. We were able to completed his wound cleansing and dressing quickly, The WOC nurses are gentle and reassuring, but work efficiently. I like the way they work in pairs and assist each other. We used wound cleanser on gauze to cleanse, applied xeroform, covered with gauze and wrapped with Kerlix.

We also visited an 83 year old man for a venous ulcer on his lower leg. The wound was cleaned with saline, xeroform applied and wrapped in Kerlix. The WOC nurse wanted to use ECM dressing on this wound, but did not have any with her. She ordered ECM for this patient for future dressing changes. This patient did not have any pressure injuries. An Allevyn foam dressing was applied to his sacrum/coccyx for pressure injury prevention.

We also visited a patient who had a hospital acquired mucosal pressure injury due to a medical device. This patient's case is discussed below. Today, I participated in patient care by cleansing wounds, dressing wounds, assessing for pressure injuries on the heels, repositioning patients, applying wound vac dressing.

Types of patients seen today: Deep tissue injury, hospital acquired pressure injury from medical device, surgical abdominal wound, wound vac, traumatic wounds, xerosis, healing surgical wound, infected surgical wound with copious drainage, venous ulcer, ileostomy. I also visited the HBO therapy room while a patient was receiving treatment for diabetic foot ulcer.

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

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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:

<p>EG is a 59 year old male with ETOH cirrhosis, portal hypertension, deep vein thrombosis, drug abuse, and ascites requiring frequent large volume paracentesis. The patient presented to the ED after struggling with shortness of breath for several hours. At ED, patient was confused, hypotensive low MAPs, hypothermic and with severe respiratory distress and was intubated. He remained hypotensive despite IVF resuscitation, and required vasopressors with Levophed and vasopressin. He was admitted for further evaluation. Patient was found to be in severe septic shock, likely due to spontaneous bacterial peritonitis (SBP) and required mechanical ventilation, albumin infusion, sedation and IVF resuscitation. Patient has been inpatient for two weeks and during this time a Convatec flexi-seal internal fecal management system was inserted. Wound care was consulted to assess painful wound in anus.</p> <p>At time of visit, patient is awake, alert, lying in bed, pleasant and cooperative. He complains of anal pain 8/10. FMS has been discontinued. A traumatic, pink, irregular wound was noted on the anal mucosal membrane, approximately 0.8 x 0.6 x 0.5. Periwound skin was indurated, but no drainage or odor noted. This appears to be a mucous membrane pressure injury due to a medical device. The wound was cleansed with pH balanced no rinse wipes and zinc oxide cream was applied. A seat cushion was ordered.</p> <p>Due to immobility, patient is at risk for pressure injury. Patient's heels, back and sacrum/coccyx area were inspected and no skin breakdown or pressure injury noted at this time. However, pressure injury prevention protocol should be implemented to include a low air loss surface mattress, seat cushion, redistribution surface and turn schedule. Allevyn foam dressing applied to the coccyx area.</p> <p>Patient tolerated all procedures well. Patient was educated to reposition frequently to prevent pressure injury and patient verbalized understanding. WOC service/wound care will continue to follow weekly.</p> <p>Barriers to healing: comorbid conditions.</p>	<p>Imaging: Chest xray Bibasilar opacities concerning for atelectasis or pneumonia.</p> <p>Labs WBC 23.08 HB 12.2 HCT 34.4 Na 116 K 3.7 Chlor 64 CO2 6 Anion 46 BUN 52 Creatinine 3.10 Albumin 3.1</p> <p>Current Medication: Spironolactone 50 mg daily Metronidazole 0.75% apply thin layer to face 1 to 2 times per day Buprenorphine naloxone SL ½ tablet under tongue each day Hydroxyzine 1 tablet at bedtime PRN Sertraline 50 mg daily Docusate sodium 1 cap BID PRN Furosemide 1 tablet daily Thiamine 100 mg TID Folic acid 1 mg daily Heparin 5000 unit SQ injection Q8 hrs</p>
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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)

<p>Cleanse anal mucosa gently with pH balanced no rinse wipes and apply zinc barrier cream to wound twice daily, and when soiled. Patient should avoid sitting for long periods of time and use therapeutic seat cushion when sitting.</p> <p>Pressure injury prevention: Apply Allevyn bordered foam to coccyx/sacrum. Peel down every shift to assess wound, cleanse skin with pH balanced wipes and reapply, <i>if not soiled</i>. Change foam dressing every three days and when soiled. Turn and reposition patient every 2 hours. Offload heels with boots or pillows. Decrease friction and shear. Place head of bed no higher than 30 degrees, as tolerated.</p>

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

<p>I thought this patient's care was appropriate. Because of the location of the wound, any foam dressing would get soiled frequently</p>

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which would damage skin. By using a cream, the mucosa can be protected, and the area can be cleaned and cream reapplied as needed. The only thing that I would have done differently for this patient is order numbing cream for anal pain. The WOC nurses explained mucosal pressure injuries cannot be staged. Additionally, they showed me an alternative FMS that is applied externally. The WOC nurses showed me how the external FMS could also be used to collect wound drainage.

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 is to visit the hyperbaric oxygen unit, learn more about HBO treatment, and observe ta HBO treatment if possible. Yes, I met my goal, I was able to visit the HBO unit, observe a treatment and speak with the HBO tech. HBO can be used for diabetic ulcers, radiation and failing skin grafts. I wanted information that I could share with patients who may be candidate for HBO.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
 This is my last day.

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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