

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Sonya Kowalski Day/Date: 11/18/24

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Abbie Ware

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.

1. Hatch, J. – 68-year-old male

Admitted for: Abnormal finding on radiology exam

Wound History: Chronic sacral wound; wheelchair bound for the most part. Wound care at home once a month, and nurse visits 3x per week.

Current Wound:

Sacrum: 7 cm x 9 cm, with undermining from 9:00 to 10:00, depth 0.3-0.5 cm.

Right ischium: 1 cm x 1 cm (chronic).

Assessment:

Chronic pressure ulcer on sacrum with undermining; risk of infection, possible osteomyelitis.

Plan and Orders:

CT of sacrum to assess for osteomyelitis (as per previous order).

Wound cleaning: NS (Normal Saline) wash to cleanse the wound site.

Dressings: Aquacel AG (silver dressing) applied to the wound.

Skin protection: Skin prep around the wound to protect periwound area.

Covering: Mepilex sacral dressing for pressure relief.

Monitor: Regular assessment for signs of infection and healing progress.

Patient Education: Ensure the patient maintains pressure relief techniques (e.g., turning every 2 hours, use of pressure-reducing surface).

Home care follow-up: Continue current home care regimen as scheduled.

2. Delia, J. – 68-year-old male

Admitted for: Ascites secondary to liver disease

Wound History: Chronic sacral wound; patient with psoriatic arthritis, reports picking at buttock wounds.

Current Wound:

Sacrum: Small linear wound measuring 1 cm x 2 cm x 0.5 cm.

Buttocks: Previous healed wounds with scar tissue.

Assessment:

Chronic wound on sacrum; picking behavior contributing to skin damage.

Plan and Orders:

Wound cleaning: NS to cleanse the wound area.

Dressing: Xeroform applied for moisture control.

Covering: Mepilex dressing to provide cushioning and absorption.

Patient Education: Discuss behavior modification to reduce picking and prevent further damage.

Monitor: Regular assessment of wound healing and signs of infection.

Follow-up: Continue care and dressing changes 3x per week with home health nurse.

3. Ward, P. – 76-year-old male

Admitted for: Burns involving 30-39% of body surface area

Wound History: RT heel wound post-burn injury.

Current Wound:

Right Heel: Burn injury requiring specialized care.

Assessment:

Significant burn on heel requiring advanced burn care.

Plan and Orders:

Wound cleaning: Use sterile saline to cleanse burn area.

Debridement: Assess for necrotic tissue and perform debridement as necessary.

Burn care dressing: Apply appropriate burn care dressing (e.g., silver sulfadiazine, or Aquacel Ag) to prevent infection.

Covering: Mepilex or appropriate burn-specific dressing to heel.

Pain management: Coordinate with the pain team for burn-related pain control.

Monitor: Regular assessment of wound healing, potential for infection, and progress.

4. Mujakovic, V. – 53-year-old male

Admitted for: Septic shock, post-fall

Wound History: Multiple skin tears due to trauma; cachectic appearance.

Current Wounds:

Sacrum: 1 cm x 2.5 cm.

Right forehead: 3 cm x 2 cm.

Left arm: 6 cm x 3 cm.

Chest: 6 cm x 9 cm.

Assessment:

Multiple skin tears and wounds, likely worsened by septic shock and poor nutritional status.

Plan and Orders:

Wound cleaning: NS to cleanse all wound areas.

Skin protection: Apply non-sting skin prep around all wound edges.

Dressing for skin tears: Apply Adaptic (non-stick dressing) with Vaseline gauze to prevent further trauma.

Dressing for larger wounds: Xeroform applied to larger skin tears (chest, forehead).

Covering: Mepilex or soft silicone dressings for sacrum, left arm, and chest wounds.

Monitor: Assess for infection and progress of wound healing. Regular wound checks for any sign of infection.

Nutritional support: Ensure adequate nutrition and hydration to support wound healing.

Pain management: Address pain as needed, especially around skin tears and larger wounds.

5. Field, F. – 72-year-old male

Admitted for: CAD (Coronary Artery Disease) and ICU care

Wound History: Sacral pressure injury.

Current Wound:

Sacrum: Deep tissue injury (DTI), measuring 3.5 cm x 2 cm with purpura (non-blanching redness).

Assessment:

Suspected deep tissue injury, purpura indicates early tissue damage.

Plan and Orders:

Wound monitoring: Regular assessment of wound for any signs of progression or healing.

Pressure relief: Transition to a pulsating mattress for enhanced pressure relief.

Dressings: Mepilex for pressure injury prevention (no dressing applied directly to wound at this time to avoid causing further tissue damage).

Positioning: Continue frequent repositioning and ensure pressure relief.

Monitoring: Check daily for signs of worsening or improvement, including changes in skin color or swelling.

Patient education: Educate the patient and family on proper pressure relief techniques.

6. Hughes, C. – 67-year-old female

Admitted for: Fall on stairs, head injury

Wound History: Wound on dorsal aspect of the head.

Current Wound:

Dorsal head wound: 3.5 cm x 2 cm x 1.5 cm, foul odor with serosanguinous and mucoid drainage.

Assessment:

Head wound with concern for infection due to foul odor and drainage.

Plan and Orders:

Wound cleaning: Cleanse with normal saline to remove debris and exudate.

Dressing: Apply Aquacel AG for antimicrobial properties and to absorb excess drainage.

Covering: 4x4 gauze over the wound site, then secure with Mepilex for cushioning and additional absorption.

Monitoring: Monitor for signs of infection (increased drainage, redness, or warmth).

Pain management: Address any discomfort from the wound and fall.

Follow-up care: Reevaluate wound every 2 days for any signs of healing or infection.

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:

WOC Nurse Consultant/Specialist Note

Patient is a 67 yr old female who was admitted for: Fall on stairs, head injury. Wound care team consulted for head wound. Initial evaluation and management of a dorsal head wound following a fall. The patient has a 3.5 cm x 2 cm x 1.5 cm wound located on the dorsal aspect of the scalp. Upon assessment the patient had matted hair covering part of the wound. Hair parted away and cut back. The wound presents with a foul odor and exhibits serosanguinous and tan colored, mucoid drainage. There is concern for a potential infection due to the malodor and drainage characteristics. Although there is no acute redness or warmth to the surrounding tissue currently, the presence of purulent drainage and the size of the wound warrant careful monitoring. Given the patient's history of a recent fall, the possibility of foreign body contamination or additional trauma is considered. The wound care nurse contacted MD to assess wound also and place order for general medicine and surgery team to assess. Wound care. The wound was cleansed with normal saline to remove any debris, exudate, or foreign material. Aquacel AG (silver-based antimicrobial dressing) applied to the wound. Aquacel AG will provide antimicrobial properties to reduce bacterial load and help manage the wound's drainage while maintaining a moist wound environment. This product is appropriate given the potential for infection. A 4x4 gauze was placed over the wound after the Aquacel AG dressing in place. The gauze will absorb excess drainage and protect the wound from external contaminants. Secure the dressing with Mepilex for added cushioning and absorption. Mepilex will also reduce friction and pressure on the wound site, which is particularly important for scalp wounds that may be exposed to mechanical stress from head movements. Reevaluate and change dressing 2-3 x per week and PRN for increased drainage or compromised dressing. The wound will be reassessed for changes in drainage, wound size, and the surrounding tissue condition. Monitor the wound closely for any signs of infection, including increased drainage, redness, warmth, or change in the wound's odor. The presence of foul odor will be particularly important to assess for worsening infection.

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)

Dorsal head wound - Cleanse with normal saline, pat dry. Cut Aquacel Ag (silver-based antimicrobial dressing) to fit wound bed. Apply a 4x4 gauze over the wound after the Aquacel AG dressing in place. Cover and secure the dressing with Mepilex for added cushioning and absorption. Mepilex will also reduce friction and pressure on the wound site. Reevaluate and change dressing 2-3 x per week and PRN for increased drainage or compromised dressing.

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

The care plan provided for this patient with a dorsal head wound appears thorough and appropriate, particularly given the patient's age, recent fall, and the potential for infection. Here are my thoughts on the care provided and considerations for what could have been done differently or improved: Since this is a traumatic wound from a fall, there may be an increased risk of foreign body contamination (dirt, hair, or debris). While the initial cleaning with normal saline is appropriate, I would want to make sure an x-ray was ordered to assess for any foreign body or other damage, if it was not already ordered. In addition, Aquacel AG provides antimicrobial coverage, if there is strong suspicion of infection, especially with a persistent foul odor and unusual drainage, I might have recommended a more aggressive course of antimicrobial therapy (topical or systemic antibiotics) to further reduce the risk of systemic infection. Additionally, culturing the wound for bacterial pathogens could have been considered to guide further treatment, particularly if there was concern for resistant organisms. The location of the wound on the scalp presents a few unique challenges too; hair can complicate dressing applications and make it harder to ensure the dressing is securely in place. Ensuring that the hair around the wound is effectively managed (trimmed, or using a non-stick dressing like a telfa pad in addition to Mepilex) may help with comfort and improve dressing adherence. The scalp is an area subject to friction and pressure from hats, bed linens, and head movement. Extra attention could be given to minimizing pressure and friction, potentially with additional padding or repositioning strategies, particularly in bed-bound patients.

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 evaluate the wound, choose appropriate dressings, and anticipate potential complications, such as infection or delayed healing, while also preparing for follow-up care to ensure ongoing monitoring and reassessment.

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

My learning goal is to deepen my understanding of advanced wound care strategies, particularly in the management of infected or high-risk wounds, such as the one on this patient's head. I want to explore different antimicrobial dressings, such as silver-based or iodine-based products, and understand when to escalate treatment to systemic antibiotics or other interventions based on wound culture results.

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: _____