

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Kristina Rosu Day/Date: 2/5/6/2025Number of Clinical Hours Today: 10Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Amparo Cano RN CWOCNClinical 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. samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

On Tuesday May 6 I was with CWOCN RN Amparo. We were one of 4 teams today. One nurse is assigned to the outpt clinic and the other three are rounding in the hospital on our admitted patients and new consults. Amparo and I had the inpatient unit today with five patients. Five does not sound like much, but then you take their acuity into account. Our first patient #1 I chose as my focus patient, he is an 82 year old, morbidly obese male. I will get more into his situation in the next box.

Patient #2 is a 60 y/o female admitted on tele s/p heart transplant. This is her 28th day admitted and was started in the SICU and stepdown. Primary dx for her was heart failure and cardiogenic shock. She first started to have heart problems in 2013 and had CAD with CABG. She is 14 days post op now. She was consulted to us for a possible naval cleft DTI, her spouse reports >8hour surgery. The patient was found today in good spirits and cooperative with her spouse. Both are receptive to care and education. The patient was found with a foam Allevyn in place. We removed this and per Amparo the area is improved with less color, although there is now a small tear opening that has very scant drainage, measures less than 0.2 cm and is causing no concern for the patient. Amparo is reporting this as a healing DTI. We wiped the area with NSS and covered with the Allevyn. We encouraged increased ambulation and positioning changes and patient is slowly regaining her activity and PT is consulted. Pt is to concentrate on protein intake to assist with wound healing and to change the foam dressing every three days. Pt is encouraged to keep the area clean and dry. Her consult was left open to see again later this week.

Patient #3 was a very interesting case. She was an 81 year old female with a stated history of being disabled and deformed for thirty years, although she can not name any particular diagnosis. She refuses most care directed for her. Pt was in the room to assist us and she refused them as well. Her consult was for wounds present on arrival and was in the ED obs unit for a UTI, reports she called from the SNF as she did not like the care there. She reports that she is in constant pain. Her wound was a small sacral PI. She refused to assist in her care and was resistant to being turned. It did take four of us to assist in her turning and we were able to assess the area, provide care quickly and place Allevyn foam. Pt was not forth coming about any self care measures that she takes, she refused to tell us how she goes to the bathroom. She presently has a pure wick in

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place. She has black marker writing on both her legs that state NEUROPATHY and PARALYZED to them and she states that her neighbor girlfriend did that for her. She is getting IV abx for her UTI, in which she does have chronically per the primary RN. We placed While we were in the room we had the primary nurse obtain the heel elevators and assisted in placement and encouraged nursing to practice in place protocols that are there for them to initiate preventive measure. Pt dressing to be changed every three days or as needed if soiled, she is to increase activity with PT and nursing, hydrate and participate in care.

Patient #4 is a 63 year old male in SICU who has been in the hospital for 170 days. He developed a HAPI in this time period and this is why we are seeing him. He had to have a colostomy placed to divert his stool form this now present Stage 4 HAPI. The patient is on a chronic vent via trach. His original admit was due to heart failure where he was able to have a heart and kidney transplant. He is due today for a NWPT change. The patient continues to get in room HD three times weekly and our care was arranged around this. The patient is awake although he has limited communication ability. He can participate little in his care and I am told he has no support person/family. He was medicated with IV pain meds prior to our care. His colostomy care and change was done and it is functioning well with no apparent complications. He is on TF for nutrition. After being medicated we turned him and provided care to his wound. The wound bed measured 14cm x 18cm x 2cm with undermining of 4 cm from 7 to 12 o'clock and 2cm at 12 to 6 o'clock. The wound bed is moist with yellow fibrous material and minimal granulation. I assisted with the majority of the care for this wound change. I removed the current dressing, irrigated the wound with saline and gauze, provided measurements. I applied skin protectant and draping to the area and packed it with black foam. I provided a "track" for the vacuum tubing to be placed further up the leg so that the pressure of the tubing was not near a pressure point on his backside causing more damage. I then was able to cover the wound and obtain good suction after changing the vacuum cannister. We all then helped reposition the patient.

Patient #5 was a 69 year old male admitted for weakness into the ED obs unit. He was in his room, AAOx3 and getting a blood infusion. He was consulted for a darkened sacral area. The patient was able to tell us that he has a healed wound to his backside and upon assessment there was a small area with a healed scar from a previous PI. The patient history includes cirrhosis, and will be getting a paracentesis later in the day. He reports he gets them every few weeks. His abdomen is distended and skin is jaundice. The patient plans on returning home after his procedure later. He is reminded to continue to change his positions regularly to alleviate pressure to his backside and concentrate on his diet especially with dx cirrhosis. Increasing his protein intake is important for his skin related to loss through his liver disease. This patient was very receptive to education and pleasant.

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 beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects

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all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

Chart note: Patient #1 82 year old male who is morbidly obese with various skin wounds.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	1
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	1
Total	10

The hospital charting has this patient scored as a 15, mild risk on the Braden scale. I scored him a 10.

Patient #1 is my focus patient. This is an 82 year old male who is morbidly obese with a BMI >50, his weight is >300lbs. He was admitted to the med surg unit 4/22/25 for wounds, arriving from SNF. Additional history includes HTN, HLD, MRSA, OSA with CPAP, chronic lymphedema BL, DVT & PE on coumadin, various bone fractures healed. His labs included a positive blood culture on 04/22 with MRSA and Proteus Mirabilis and on 4/22 were negative. His urine culture was negative. His INR on 5/5 was 2.2 and HGB of 9.3. His last protein taken was 5/2 and was 4.9 and albumin at 1.9. The patients glucose has been WNL. The patient is in his room and resists most care that is attempted. The patient does not help with any care. He is AAOx3 and provides little information regarding his medical conditions and care. The patient denies having anyone at home who is able to care for him and has been refusing discharges previously attempted. Today the patient had his d/c appeal denied and will be d/c to home today with HHC for wound care and IV abx therapy and coumadin management. Case management has attempted several admit transfers to facilities for rehab and care and they have all refused him. In regards to his wounds and skin, it is constantly moist due to his size and refusal of care. Today he is in bed and he is incontinent of his stool and urine and both are pooled in the specialty bed he is in. It is caked to his lower legs and backside. His backside is covered in a fungal rash, as well as the many skin folds. He has multiple skin tears to his upper back, upper arms and lower back. We had a team of three nurses, one PT and one PCT to provide the care to the patient. Although the patient can move he refuses to participate in the care and assist. He was cleaned of the urine and stool and rolled. There was little time to clean the patient properly due to patients refusal so anti fungal powder was placed all over his backside. Assessment is that the rash is improved with this treatment. The tears were wiped with NSS and gauze and we placed Mepilex Ag foam to these areas on his back and upper arms. The patient has Interdry wicking cloths with silver placed to his skin folds. The patients BL lower extremity lymphedema is calloused dry and leathery, flaking and cracking. Pt refuses any type of compression for treatment. One area on his left calf is slightly cracked open and red and we placed another silver foam with rolled gauze here. The patient was repositioned in the bed and not receptive to any education attempted. He will be going home on his home meds he was taking. He takes coumadin, protonix, tamsulosin, Tylenol, his vitamins and senna. He is to continue IV abx through a PICC line, Unasyn and Cubicin and PO Minocycline. He will be getting an Rx for antifungal PO and topical.

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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)

Position change to patient every two hours with offered toileting
Offload pressure points with pillows, wedges and prophylaxis foam dressing
Maintain specialty air mattress bariatric bed support LOS
Offer periods of hydration and high protein diet, consult nutrition
Continue to offer physical therapy and assist OOB daily
Provide hygiene to skin folds every shift and change Silver wound cloth dressing every three days
Provided skin care to tears with silver foam dressings changed every three days
Utilize safe and effective lifting devices to avoid shearing

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

In my 20 years of nursing I have seen so many of these patients that I am not sure that there was anything else that could be done. We had to be as quick as we could be with what he allowed us to do. This patient was resistant to any care, education and instruction that we tried to provide. He even stated that he would not use the call bell to call for when he needs to go to the bathroom and will just continue to soil the bed. I do not have much hope for this discharge as he has no support at home and the HHC he will be ordered will not be able to provide the care he needs. The patient was instructed to hire private duty care as well. I see him being readmitted in the near future.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

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Goals

What was your goal for the day? I was not able to do a stoma marking today, as these are scheduled in the clinic, rarely do they get one on the floor to do.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
 Tomorrow I will get to do a stoma marking, as I will be following the outpatient clinic CWON RN and there are two scheduled.

For instructor use only. Do not remove or edit:

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	

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R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Reviewed by: _____ Date: _____

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