

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

illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that was **done** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	19

41-year-old female being seen and examined at the bedside for evaluation and treatment recommendations of “slow healing blisters to right forearm and groin”. Patient has a past medical history of coronary artery disease (CAD), chest pain, myocardial infarction (MI), end stage renal disease (ESRD), polycystic ovary syndrome (PCOS), right coronary artery stent placement, uncontrolled type 2 diabetes, and peripheral arterial disease. Patient greeted in bed and WOC role explained. Patient agrees to examination. Right lower abdomen with irregularly shaped pink, yellow, and black wound. Wound bed with large amount of necrotic yellow tissue and small amount of black necrotic tissue scattered within the wound bed; small amount of serous drainage, no odor noted. Wound edges poorly defined; periwound with no fluctuance or induration. Right posterior forearm with irregularly shaped area of dry necrotic black tissue surrounded by a ring of pink epithelialized skin. Wound bed unable to be visualized; no drainage, no odor. Wound edges poorly defined; periwound is dry with no fluctuance or induration. Wounds cleaned with Vashe, Medihoney sheet (cut to fit) applied to the wound, and wounds covered with Mepilex border foam. Patient tolerated dressing changes. Patient made aware of recommendations and agrees. Recommendation then communicated to bedside RN.

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)

- *Remove old dressing noting type, color, consistency, and amount of exudate
- *Clean wounds with Vashe antimicrobial solution
- *Assess wound bed, wound edges, and periwound
- *Apply Medihoney sheet (cut to fit) to wound
- *Cover wound with Mepilex border foam
- *Dressing change Q3 days and PRN for increase drainage
- *Notify WOC for any noted deterioration of the wound

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

I was able to see many wounds today and I did change up from my normal way of doing dressing. I used many dressing that I would not use normally. There is nothing that I would have done differently but I would like to be able to follow up on these patients to see the outcome of the dressing I selected for wound care.

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 today was to treat wounds with a variety of dressings.

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

My next clinical is at the Ostomy Clinic, so I hope to do a stoma marking

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For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 	✓	
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 	✓	
<ul style="list-style-type: none"> Completes Braden Scale for inpatient encounter 	✓	
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 	✓	
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 	✓	
<ul style="list-style-type: none"> Identifies overall recommendations/plan 	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 	✓	
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 	✓	
<ul style="list-style-type: none"> Braden subscales addressed (if pertinent) 	✓	
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 	✓	
<ul style="list-style-type: none"> Directives are written as nursing orders 	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 	✓	
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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