Daily Journal Entry with Plan of Care & Chart Note

Student Name: Tammi (Titania) Watkins Day/Date: Tuesday November 30,2021

Directions: ***WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, s***elect one patient each clinical day and complete ***plan of care and chart note.***. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc** HPI: pt is a 67 yoa female pt admitted to the hospital on 11/22 from her home due to abdominal pain and distention. Her PMH is significant for RA, GERD, depression, HTN, chronic pain, frequent abscess requiring I&D, prior colectomy with ostomy formation (2019). She was recently admitted to the hospital at SLHS in October for an infected hematoma s/p I&D. On 11/19 she was seen in the ED of this hospital for sxs of constipation and abdominal pain. A CT scan revealed LLQ and a colostomy with an ill-defined mesenteric edema around the ileocolic junction and large amount of colonic stool. She was offered observation to determine is edema was r/t infection or inflammatory process but the pt chose to go home instead. She returned on 11/22 due to increased abdominal pain and still no output from her ostomy. A new CT revealed large amount of stool through the colon extending to the level of the L abdominal ostomy sites; it was concerning for ostomy site obstruction. The CT also showed a LLL nodule measuring up to 8 mm. Her WBC was 12.6, lactic acid 1.3. her temp was 101.5, UA was negative, and her oxygen saturation on RA was in the 80's. On 11/23 she had a subtotal colectomy for stomal obstruction and has a midline abdominal incision. The incision remains loosely approximated with spaced staples and telfa wicks were placed in surgery but have fallen out. She has 2 JP drains to RLQ and LLQ with serosanguinous drainage and an ileostomy to her L

	abd. Pt also has an open wound to her R lateral thigh from an I&D performed on an abscess in October

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? 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.

Follow up visit for wound assessment and dressing change.

Abdominal wound: midline abdominal incision loosely approximated with spaced staples. Telfa wicks had been placed during surgery and they are no longer in place. The length of the incision is approx. 14 cm with 4 small open areas surrounding the staples. The areas are approx. 0.5 cm x 0.5 cm x 0.2 cm in size with small amount of serosanguinous drainage. The surrounding skin is pink, no warmth or odor noted from the wound.

JP drains: bilat to the abd wound to the R and L LQ with moderate amount of serosanguineous drainage

R posterior-lateral thigh wound: incision wound from I&D performed in October of this year. It measures 2.2 cm x 0.6 cm x 1.6 cm with undermining from the 5 –7 clock position. The wound has epibole edges, small amount of serosanguineous drainage, no odor is noted from the wound. Pt denies any pain to the wound bed during the dressing change. Her husband is at the bedside and reports the undermining has improved and the wound is getting smaller. The surrounding skin is pink, no warmth noted to the wound.

Coccyx: healed pressure injury that was present upon hospital admission. Skin is intake, no open area, scarred darker pink skin tone noted. No drainage.

Dressing orders:

Abdominal incisional wound: cleanse the surrounding skin with normal saline and dry completely. Pack open areas with ribbon gauze moistened with NS, leave a tag out that is taped to the skin for placement, cover the incision with ABD pad and secure with tape. Change 2 x a week and PRN is soiled

JP drains: placed split 4x4 gauze around the drains and secure with tape, change 2 x a week and PRN if soiled

R posterior- lateral thigh wound: cleanse the surrounding skin with hibclens and allow to dry. Irrigate the wound bed with NS and then pack with ribbon gauze moistened with NS, end of ribbon gauze is taped to adjacent skin to stop migration into the wound bed, covered with foam dressing. Change 2x a week and PRN if soiled.

Coccyx healed wound: cleanse the skin with hibclens and allow to dry. Apply skin protectant and cover with foam dressing. Change weekly and PRN if soiled.

Wound team to perform dressing change next on 12/7

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care** **(Base this on the above data. Include specific products)**	**Rationale** ***(Explain why an intervention was chosen; purpose)***
Infection	a. Continue with current IV ABT b. Continue with current dressing orders and change 2 x a week and PRN if soiled c. Assess for sxs of worsening infection ie temperature, change in WBC, change in wound appearance, drainage, or odor. If any of the above is noted notify physician of the changes and alert the wound team in wound appearance changes, drainage or odor.	systemic IV ABT secondary to surgery and in response to WBC count Dressing order will promote healing of the tissue Full assessment is required to assess for sxs of infection. Any changes will need to be addressed by either change in ABT, ID consult, and WOC nurse assessing effectiveness of the wound dressing protocol

Impaired Skin Integrity	d. Abdominal incisional wound: cleanse the surrounding skin with normal saline and dry completely. Pack open areas with ribbon gauze moistened with NS, leave a tag out that is taped to the skin for placement, cover the incision with ABD pad and secure with tape. Change 2 x a week and PRN is soiled e. R posterior- lateral thigh wound: cleanse the surrounding skin with hibclens and allow to dry. Irrigate the wound bed with NS and then pack with ribbon gauze moistened with NS, end of ribbon gauze is taped to adjacent skin to stop migration into the wound bed, covered with foam dressing. Change 2x a week and PRN if soiled. f. Coccyx healed wound: cleanse the skin with hibclens and allow to dry. Apply skin protectant and cover with foam dressing. Change weekly and PRN if soiled.	Choice of packing with ribbon gauze will promote healing of the open wounds between the staples. The packing will promote the wound to heal from the bottom up and help it not to close from the top first. It will also help with absorbing any drainage. Irrigating the wound bed will clean the wound and use of irrigation with NS will decrease cleansing trauma to the wound bed. Choice of the packing with ribbon gauze will promote the healing of the wound from the bottom to the top. With the goal of the wound to heal from the bottom and not close at the top.

	g. Assess pt's w/c for w/c cushion to promote further skin breakdown. h. Ask pt/family where she spends most of her time during the day esp with her impaired mobility r/t her RA	Keeping the skin clean is very important with maintaining good skin integrity, applying a skin protectant will help to shield the scarred tissue from breaking down and the foam dressing will provide protection Pt has a J cushion in her w/c
	Discussed options of care services after hospitalization ie acute rehab, SNF, or going home with HH services	Pt has an area on the couch; husband states she can lie on the couch in different positions to relive pressure to her coccyx area. Promoting not to have the pt in a 30 degree or more angle will help with continuing to support the healing of the coccyx wound
	Evaluate pt's mobility devices to make sure they do not impede the patients healing. Recommend to MD to order OT to eval pt's mobility devices	Improving her impaired mobility r/t her RA and her new abdominal wound will help in decreasing her high risk of further wounds esp to her coccyx area.
	Made a referral to discharge planner for appropriate next steps in care services based on pt's ability to participate and her own decision	Immobility reduces the blood circulation and in turn reduces wound perfusion and impairs healing.

Impaired Mobility		Her mobility devices need to promote healing with cushions. Her devices also need to be accessible for her to use secondary to her RA. OT focuses on areas the pt will need to promote her mobility Discharge planning will be able to provide next step care services to the pt

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	Ribbon Gauze Packing: The ribbon gauze chosen was not impregnated with any type of antimicrobial. If there was concern for infection from the abdominal wound it may have been prudent to pack the wound with a iodoform ribbon gauze Another disadvantage of this product is nursing staff with limited wound knowledge understanding the importance of not saturating the packing gauze. Too wet can decrease the effectiveness of the healing action of the packing gauze. Normal saline for cleansing: it is not an antimicrobial so it does not help decrease bacteria. I do believe though for this type of wound normal saline is the best because of the location of the wounds it would be difficulty to cleanse all of an antimicrobial as in hibiclens from the wound bed. Hibiclens: is an antimicrobial, it is important to make sure you clean it thoroughly from the skin; if a residue is left it could cause breakdown.

	Foam dressing: disadvantage is the cost but it can stay in place for up to 7 days and it is gentle on the skin when removed Abd pads: not as absorbent as foam dressings, make require more usage of this product and can increase the cost spent on the wound care. Also, must be secured with tape increasing the risk for further skin damage

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	We had 1 patient I have seen almost every clinical so it has been great to see the progression of his wounds. We also had a patient with a wound vac!!!! YES! That was amazing—actually it was my first wound vac I have ever seen placed. I am usually at the other end of wound vacs when they are being removed and changed to a different type of dressing for EOL. Between the wound vac patient and the other two they really took a lot of time but we did have time to go over all of the wound care products they have at the hospital and she clarified questions I had about some of them. I also brought with me pictures of the products used at my agency and asked her questions about products I was unsure of their role in wound healing. An example is Elasto-gel and we had good discussion about the wound products. I have also been jotting down questions as I study to ask my preceptor and we had time to discuss them also.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Continue to grow in my confidence is choosing the appropriate topical products. I did have a pt come on service this week at work with a huge abd surgical wound r/t his metastatic colon cancer. He had a large wound pouch placed and I went to the home to eval the effectiveness, answering questions for the family, and I felt confident in my answers. I told myself just to channel Carolyn vibes and I would be okay. I felt

	confident because we had a patient with a similar wound and pouch a few clinicals prior.

Number of Clinical Hours Today: 8

Care Setting: _x_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _3_ Preceptor: Carolyn Crumley

Reviewed by: _____ Date: _____

**References are not generally required for daily journals