

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

Daily Journal Entry with Plan of Care & Chart Note

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Day/Date: 2/4/23

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, select 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	61-year-old patient with HX of uncontrolled DM presented to ER with complaints of abscess to left labia starting over a month ago. Patient states it drained bloody purulent drainage and started developing excruciating lower abdominal pain. CT findings compatible with necrotizing fasciitis arising from left labia majora extending along anterior and posterior aspect of abdominal wall. Surgery performed wide debridement of necrotizing fasciitis area (debridement of skin, subcutaneous fat and fascia) leaving an extra large wound to lower abdomen and left labia. Surgery wants recommended treatment, possible Negative pressure wound therapy.
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

<p>Initial visit: Evaluation and management of lower abdomen surgical wound that extends to left lower labia. Possible NPWT device application</p> <p>Patient alert and agreeable to assessment. Patient states she is in severe pain 10/10. RN notified and administered IV Morphine as per order. Encouraging pt to take slow deep breaths. Distracting with conversation between breathing. Surgery PA at bedside and assisting. Wet to dry packing removed from wound. Wound has full thickness tissue loss and measures approximately 28 x 40.5 x 9.2 cm with exposed muscle and tendon noted at wound base. Wound bed is pink and moist with small amounts of serosanguinous drainage noted without odor. Circumferential undermining with the largest area measuring 13 cm at the top of the abdomen. The right side of the abdomen has 3 x2 cm tunneling from 12:00-2:00 and the left side abdomen has 3x 3 cm tunneling from 9:00- 11:00. Periwound skin intact and normal for ethnic group. Wound determined to be appropriate for NPWT. Wound cleansed with Coloplast sea-cleans wound cleanser. Skin prep applied to periwound skin. Two pieces of KCI V.A.C. Whitefoam applied to wound to cover tendons on the left and right abdomen. Four pieces of KCI black Granufoam applied over white foam and to wound bed. Utilized hydrocolloid adapt cera ring near labia to help fill increase and covered with KCI drape. Connected to device set at 100mmHg, continuous therapy. Good seal obtained. Pt tolerated well with minimal complaints of pain.</p> <p>Plan: NPWT dressing change q 2-3 days. Next change will be by surgery.</p>

WOC specific medical & nursing diagnosis	WOC Directive Plan of Care (Base this on the above data. Include specific	Rationale (Explain why an intervention was chosen; purpose)
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	products)	
<p>Skin Integrity, Impaired r/t surgical debridement of perianal necrotizing fasciitis</p> <p>Nutrition: Less Than Body Requirements, r/t wound healing</p> <p>Pain r/t wound dressing change</p> <p>Fluid Volume Imbalance r/t impaired skin integrity</p> <p>Body Image Disturbance r/t open wound requiring NPWTchase789</p>	<p>Surgery PA will,</p> <ul style="list-style-type: none"> Order: IV fluids, PCA pump w/ morphine, PRN dilaudid to premedicate for dressing changes, A1C levels & culture wound. Place consult w/ Dietician, Endocrinologist, Diabetic Education & Psyc. Eval., PT/OT. <p>The RN will,</p> <ul style="list-style-type: none"> Take Q4 VS Insure 2 working IV Place Pt in privet room Place Pt on contact precaution Q2 T/R, right, supine, left, w/ pillow support. Out of bed to chair for max of 2hrs on waffle cushion for meals. Daily I/Os & labs notify MD if abnormal. Mark outline of infection w/ marker date/time, notify MD/WOC if infection travels beyond line, odor increases, increased drainage or skin breakdown. Place bedside commode for daytime use, Purewick for night. Culture wound for anaerobic/aerobic. <p>Order:</p> <ul style="list-style-type: none"> Hillrom P500 Bedside commode <p>Wound cleaning & NWPT change:</p> <ul style="list-style-type: none"> Get help from CNA/RN, plan for extended dressing change. Premedicate if appropriate Turn off pump Clamp all tubes and disconnect. Remove film by pulling parallel to the skin. Remove foam from wound, if stuck moisten w/ NS, check documentation for number of foams pieces in wound. Assess and measure wound dimensions & document. Clean wound w/ Vashe, rinse w/ NS, pat dry. Clean periwound w/ Cavilon Advance by 3M, let dry. Place 4in flat 7806 rings by Hollister 	<p>For a patient with necrotizing fasciitis, a comprehensive treatment plan is imperative. This plan will include the administration of IV fluids to replenish fluids lost from the wound, a PCA pump with morphine for effective pain management (pain level 10/10), PRN dilaudid for premedication during dressing changes, monitoring of A1C levels to ensure proper blood sugar control for wound healing, and a culture of the wound to determine the type of infection and select the appropriate targeted antibiotics. Additionally, consultations with a Dietician, Endocrinologist, Diabetic Education program, Psychologist, Physical Therapy, and Occupational Therapy will be arranged to provide comprehensive care. These specialists will address the patient's dietary needs, manage their diabetes, provide education and support, evaluate psychological factors, and focus on rehabilitation and wound management to support a successful outcome.</p> <p>For a patient with necrotizing fasciitis, the role of the RN is critical in promoting optimal outcomes and minimizing potential complications. The RN's actions, such as taking Q4 vital signs, ensuring functioning IVs for hydration and medication administration, and placing the patient in a private room with contact precautions, help monitor the patient's condition and prevent the spread of infection. In addition, the RN's monitoring of the patient's intake and output, wound culture, and marking of the infection outline, as well as notification of any changes to the physician, are key to tracking the patient's progress and ensuring</p>

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	<p>around periwound, allow for 5cm gap from wound edge.</p> <ul style="list-style-type: none"> • Cut Hydrofera BLUE ComfortCEL strips to fit tunneling x2 lightly fill. • Cut to fit Hydrofera BLUE ComfortCEL and place to base of wound. • Cover wound w/ drape dressing, apply pressure to 4in flat 7806 ring to catch seal. • Cut hole at superior section for intake and cut larger hole inferior for vac placement. • Connect tubes • Turn on set pressure to 100mmHg and listen for leaks. • If leaks, apply Tegaderm until no leaks. • Change Q 2-3 days. • Document Tx, products used and number of foam placed in wound. • Follow up w/ WOCRN outpatient when DC. 	<p>appropriate treatment. The use of a bedside commode and Purewick for hygiene also helps reduce the risk of infection and promote healing. Overall, the RN's actions are specifically designed to address the unique needs of a patient with necrotizing fasciitis, with the goal of achieving the best possible outcome.</p> <p>The steps outlined for wound cleaning and NWPT change aim to create a safe and effective wound care process that supports an optimal wound healing environment. Involving a CNA or RN and preparing for a potentially lengthy dressing change ensure the proper resources and preparation are in place. Premedication, if necessary, helps manage pain and prevent traumatic removal of the dressings.</p> <p>To prevent backflow of old drainage into the wound bed, it is important to turn off the pump and clamp all tubes before removing the film and foam from the wound. Careful assessment and documentation of wound dimensions and progress are crucial in tracking healing. Cleaning the wound and periwound with appropriate products such as Vashe and Caviol Advance reduces the risk of infection and supports healing.</p> <p>Proper wound coverage and protection are provided through the use of Hydrofera BLUE ComfortCEL strips, 4in flat 7806 rings, and a drape dressing, creating a warm moist wound environment. Connecting the tubes, setting the pressure to 10mmHg, and checking for leaks are important steps in ensuring the proper functioning of the NWPT. Regular dressing changes every 2-3 days and documentation of the treatment, products used, and number of foam pieces placed in the wound helps</p>
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		ensure a comprehensive wound care plan.
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<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p> <p>(This is your opportunity to share your product knowledge and apply critical thinking)</p>	<p>When it comes to wound cleaning, I highly recommend using Vashe wound cleanser instead of Coloplast sea-cleans. Although Coloplast is suitable for simple wounds, Vashe is a better choice for wounds that are at risk of or recovering from necrotizing fasciitis. Vashe effectively reduces bacterial contamination and promotes debridement, which is critical in supporting wound healing. To take it a step further, I suggest using an antibacterial foam dressing like HFB ComfortCel. This dressing is infused with gentian violet and methylene blue, which provide optimal support for wound healing.</p>
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Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

<p>Were you able to meet your learning goals for today? Why or why not?</p>	
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>I am looking to gain more hands-on experience with wound vacs. They are not a commonly used in my current role at the outpatient wound clinic, but I have a desire to become proficient in their use. To achieve this goal, I have reached out to the inpatient WOCRN and expressed my interest in tagging along on their rounds to observe and assist with wound vac cases. This opportunity will provide me with the hands-on training I need to enhance my skills and knowledge in this important aspect of wound care.</p>

Reviewed by: _____ Date: _____

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