

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Day/Date: _____

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.**

<p>Today's WOC specific assessment</p>	<p>Information obtained from medical record</p> <p>HPI: The patient is a 72-year-old female who was in a nursing facility for a fracture of her right shoulder. During this stay, she fell and sustained a hematoma to her left medial anterior shin. The patient developed anorexia, fatigue, and malaise during her stay. She was brought to the emergency department and was found to be in atrial fibrillation with rapid heart rate and, was admitted 4 days ago. Rapid atrial fibrillation being treated with a Cardizem drip. She receives hemodialysis on Tuesdays, Thursdays, and Saturdays for kidney failure. Hematoma to left shin opened. Vascular Surgery was consulted. Vascular Surgery noted the patient to have multiphasic pedal signals and adequate perfusion and necrotic debris to the wound base. Took to OR for debridement of devitalized skin border and necrotic fat and muscle down to the level of the tendon. Surgicel was placed in the wound bed and pressure was held until adequate hemostasis was achieved. Wound was irrigated. NPWT placed at 125 mmHg continuous suction.</p> <p>PMH: COPD, sleep apnea, CKD Stage 3 requiring hemodialysis, cirrhosis, atrial fibrillation, lung cancer, GERD, depression, gastroparesis, erosive esophagitis, lethargy, peripheral vascular disease NOS, anxiety disorder, and glaucoma.</p> <p>Medications: ampicillin-sulbactam (Unasyn) IV, budesonide (Pulmicort Respules), Cardizem, digoxin, insulin glargine, insulin lispro, metoprolol, midodrine, multivitamin, pantoprazole, miralax, sertraline. PRN medications: acetaminophen, bisacodyl, hydromorphone IV, ondansetron, and oxycodone PO.</p> <p>Allergies: Phenergan, Motrin, and diphtheria-tetanus toxoid.</p> <p>GFR 30-59 ml/min</p>
---	---

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

This is the initial wound consult for a 72-year-old female **admitted for atrial fibrillation and traumatic left leg wound** which she sustained as a result of a fall. The wound initially presented as a hematoma on admission 6 days ago and ruptured yesterday. **Vascular surgery debrided wound including necrotic fat and muscle down to the level of the tendon.** Homeostasis was achieved and NPWT applied **@ 125 mmHg (lower sucking lvl) continuous suction.** Significant PMH includes **long term anticoagulant use for a-fib, CKD requiring dialysis.** Nursing staff requesting **consult related to "frank blood in tubing" of NPWT device.** Device turned off at time of discovery. **100 cc bright red exudate noted in canister.** Canister has not been changed since

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

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

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

application of NPWT. Pt pre-medicated with IV hydromorphone 30 minutes prior to visit. Received oxycodone 2 hours prior. **Vashe wound cleanser was utilized to moisten and saturate foam dressing to ease removal.** Pt c/o **pain at 8/10 during removal.** Multiple time outs along with deep breathing utilized to manage pain. One piece black foam and Surgicel removed. No other dressings visible to wound bed. **Wound bed cleansed with Vashe. Wound base easily friable with scattered, scant amounts of bright red bleeding noted.** Wound measures 12 cm x 8.5 cm x 2 cm with 2 cm undermining from 11 o'clock to 1 o'clock. No structures visible. Periwound without irritation, erythema, induration. Treatment options discussed with pt. **Agreeable to reapplication of NPWT. (?)** White foam applied to area of undermining. **Surgicel applied (sliver nitrate?)** to remaining wound bed followed by one piece black foam. **No sting skin barrier wipe applied to periwound.** Area covered with transparent film drape. Connected to NPWT device @ 125 mm Hg continuous suction. Seal obtained. Tubing direction is up the leg to allow for increased mobility and to decrease fall risk. Pt continued to utilize deep breathing during dressing application. No additional time outs were necessary.

Assessment: S/P debridement of traumatic wound to left anterior medial anterior shin

Recommendations:

- Continue with NPWT, unless contraindicated for increased bleeding, uncontrolled pain
- Pre-medicate prior to wound care
- Turn off NPWT device 30 minutes prior to planned dressing change
- Consult PT
- Continue with fall risk precautions

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)
<p>Impaired skin integrity r/t large open wound on LLE.</p> <p>Nutritional deficit less than body's requirements r/t decreased PO intake and anorexia.</p> <p>Fluid volume deficit r/t impaired skin integrity.</p> <p>Poor oxygen perfusion r/t sleep apnea/COPD.</p>	<p>The nurse will,</p> <ul style="list-style-type: none"> • Take Q8 VS, labs (HnH), BS checks AC/AH, notify MD if abnormal. • Check cainser for frank red blood for 1st 15 min after dressing change, then Q2 hrs, stop if bleeding is noted. • Q2 T/R, from R/Land supine w/ pillow support. • Out of bed to chair for max of 2hrs on waffle cushion by Turnsole for meals. • Encourage ambulation. • Place bedside commode for daytime, Purwick at night. • Culture wound for anaerobic/aerobic bacteria for targeted ABX. • Reinforce EDU on the use of distraction techniques for pain management. • Document all Tx and findings, notify MD w/ abnormalities or concerns. • Consult MD team on the appropriateness of Pt medication and if contraindicated 	<p>The treatment plan for a patient with A.Fib, CKD, COPD, and DM all have specific Tx plans and Pt should be Tx as a whole. The patient's VS (Q shift) and BS (AC?HS) with immediate notification to MD to prevent infection. To minimize bleeding risk, the wound will be inspected for frank red blood after dressing change and every 2 hours thereafter to insure there is no bleeding. To prevent bed sores and promote mobility, the patient will be repositioned every 2 hours, encouraged to ambulate, and seated on a waffle cushion for meals. A bedside commode and Purwick will be used for daytime and nighttime use, respectively. The wound will be cultured to guide targeted antibiotic therapy, and pain</p>

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

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

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

	<p>for wound healing, find alternatives, replace fluids.</p> <p>Order:</p> <ul style="list-style-type: none"> • IV fluid replacement from MD. <p>Consults:</p> <ul style="list-style-type: none"> • Respiratory to Tx sleep apnea. • Cardiac, to insure there are no contraindication w/ the medication and wound healing. • Nephrology, to ensure the kidneys are being protected. • Endocrinology, Tx DM 2. • Dietary, dietary orders that promote wound healing and appropriate for DM 2 Pt. • PT/OT, to help w/ ADLs and strength training. 	<p>management will be reinforced through education on distraction techniques. All treatments and findings will be documented, and the physician will be consulted on medication appropriateness and alternative options if necessary. Adequate fluid replacement will also be monitored.</p> <p>The patient is currently facing a challenging situation with an open wound and a decrease in PO intake, leading to potential fluid loss. To address this concern, it is important to implement measures to replace lost fluids & electrolyte replacement to ensure proper hydration, which is essential for the wound healing process.</p> <p>Consulting with various healthcare professionals is crucial in providing comprehensive care to Pt with various medical conditions. For instance, a respiratory therapist can help treat sleep apnea by providing therapy and equipment such as continuous positive airway pressure (CPAP), resulting in higher O2 levels. It is also important to have a cardiologist evaluate the patient to ensure that there are no contraindications with the medications used to hinder wound healing and to make appropriate changes PRN. A nephrologist is consulted to evaluate the Pt kidney function and to prevent any kidney-related complications in relation to the medication changes and dietary orders. Endocrinologists, specialists in treating diabetes, can help manage the Pt BS levels to ensure proper wound healing and prevent complications as well as providing education on the disease process and was to manage DM. A dietitian can provide dietary recommendations that promote wound healing and are appropriate for a patient with type 2 diabetes as</p>
--	--	---

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

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

	<p>Dressing changes daily/PRN:</p> <ul style="list-style-type: none"> • Premedicate prior to dressing change & reforge education on timeouts and distraction techniques. • Get assistance from another staff member. • If dressing it stuck on, loosen w/ Vashe. • Clean wound & periwound w/ Vashe & rinse w/ NS. • Wipe skin prep by Smith & Nephew around the wound, let dry. • Use Surgicel to stop bleeding in wound bed. • Place UrgoTul Ag Silver to base of wound. • Cut to fit white and black foam, place white foam to undermining of wound and black to cover/fill, document number of foam pieces placed. • Drape w/ transparent dressing and press firmly on the periwound area to catch a seal. • Cut hole at inferior portion of wound vac dressing, paper tape to secure tube out of way. • Connect tubes, turn on, set pressure to 100 mmHg intermittent suction. Wait w/ Pt for suction to form seal and wait 15 minutes for bleeding, If bleeding turn off pump and notify MD and WOCRN for consult. 	<p>evidence by new diagnosis of anerxia. PT/OT can help with ADLs and provide strength training to help the Pt regain strength and mobility. Overall, consulting with these healthcare professionals provides a comprehensive approach to Pt care.</p> <p>The comprehensive approach of these wound care orders serves to optimize wound healing and minimize the potential for infection and other complications. Prior to the dressing change, premedication helps to alleviate pain and discomfort, while education on timeouts and distraction techniques can assist in managing the patient's stress and anxiety. Having assistance from another staff member ensures the safety and stability of the patient during the procedure. If the dressing becomes stuck, it should be moistened w/ Vashe to remove the dressing and to avoid skin tears. The wound and periwound area are thoroughly cleaned using Vashe and rinsed with normal saline, effectively removing debris and bacteria to reduce the risk of infection. Smith & Nephew skin prep is used to protect the periwound skin and prepare it for dressing placement. Surgicel is used to control bleeding in the wound bed, and UrgoTul Ag Silver provides an antimicrobial barrier and promotes non-traumatic dressing removal. The use of foam not only protects the wound, but also creates a warm and moist environment that helps to draw away excess moisture and exudate. The transparent dressing serves as a barrier to the environment and helps to secure the foam in place, allowing for visual monitoring of any extent of bleeding. The hole in the inferior portion of the wound vac dressing facilitates proper suction, and the paper tape secures the tube out of the way to prevent</p>
--	---	--

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

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

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

		fall risks during ambulation. The pressure is set to 100 mmHg intermittent suction to promote wound healing and decrease the chances of bleeding and increases the chances of clot formation. Regular monitoring for bleeding after turning on the pump and waiting for 15 minutes is important to detect any adverse reactions and prompt action by the medical team if needed.
--	--	--

<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>	Although a wound vac can be a helpful tool for wound healing, it is important to exercise caution when using it on patients taking anticoagulation medication. Close monitoring is crucial to ensure the prevention of uncontrolled bleeding, which could potentially lead to adverse outcomes. In the event of persistent bleeding, I will take swift action by utilizing silver nitrate to control the bleeding and covering the wound with a combination of UrgoTul Ag Silver to base, Hydrofera Blue ComfortCel to fill, and a large tegaderm by 3M to cover. This will not only provide a protective barrier but also aid in the healing process while being monitored closely for any further bleeding.
---	---

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>	I am eager to expand my knowledge on wound vac therapy to ensure that I make informed decisions when it comes to patient care. It is essential to understand any potential contraindications and associated risks to ensure that the therapy is used in the safest and most effective manner possible for the patient.
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	

Number of Clinical Hours Today:

 Care Setting: Hospital Ambulatory Care Home Care Other: _____

Number of patients seen today: ___ Preceptor: _____

Reviewed by: _____ Date: _____

****References are not generally required for daily journals**

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

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