



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Kristin Hazel__ Day/Date: Thursday Dec 7th

Number of Clinical Hours Today: Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 8 Preceptor: Patti Harris

Journal Focus: Wound Ostomy Continence Combination Specify: Wound and Ostomy

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. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

<p>Today’s WOC specific assessment</p>	<p>WOC nursing department is consulted for pressure injury (PI) assessment on admission and colostomy care for an established colostomy. Pt is an 80-year-old female admitted less than 24hrs ago for a 2nd opinion regarding cancer treatment. PMH includes Metastatic moderately differentiated adenocarcinoma of the proximal rectum to pulmonary nodules, Stage IIIA (T3 N2 M0) adenocarcinoma of the gastric antrum, DVT of the right lower extremity (2021), chronic coccygeal wound, History of iron-deficiency anemia, Rheumatoid arthritis, Vitamin B12 deficiency. The patient is status post subtotal gastrectomy/gastrojejunostomy in 2016, diverting loop ileostomy/splenic flexure mobilization in 2016, loop ileostomy reversal in 2017, and colostomy 2021.</p> <p>Pt current medical status includes hypokalemia potassium of 2.5, Albumin 2.3 and Total protein 6. H/H. 8 &26. All other labs are essentially WNL or not significantly out of range. Chest x-ray diffuse involvement of metastatic disease in the right lung field. The left lung field was completely opacified by presumed malignant effusion.</p> <p>Current medications include antibiotics, opioid and non-opioid pain medications, heparin gtt, IV fluids. The patient’s medication list included Orenzia for treatment of her RA, but is not currently ordered. Dysphasia screening is pending for oral intake and diet. No alternative nutrition has been addressed at this time. Patient has been transferred by family for second opinion on cancer treatment options. The patient is a full code. There are consults in place for palliative care and goals of care discussion. At this time, it is unclear of what the patient/families wound care goals will be.</p>
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Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

This is an initial consult for assessment of a patient admitted with PI, present on admission (POA) and management of an establish colostomy. On arrival patient resting in the Neuro ICU, staff RN present to assist with care. The patient is very lethargic, occasional moan, VS stable on continues telemetry with pulse ox monitoring and 4L NC. The patient is currently NPO, cachectic, every boney prominence is visible. Urinary catheter in place and LLQ colostomy functioning for soft brown stool, continence is

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completely contained and managed at this time. Full head to toe, anterior and posterior assessment completed. Pt found to have 4 PIs, POA. The patient's skin is loose and shifts easily over boney prominences. Pt found to have an unstageable PI to the right of her coccyx. Wound measures 4x5cm, soft black eschar intact, remains adhered at the periphery. No edema erythema, drainage or fluctuance noted. Right ischium DTPI, measures 3x5cm non-blanching deep purple hue. Skin remains intact, loose and boggy on palpation. No surrounding erythema or drainage noted. Currently no moisture related risk factors assessed. Unsure of when urinary catheter was placed or prior urinary continence status.

Right posterior ribs proximal DTPI. Measures 2x2cm of non-blanching purple hue. Skin remains intact. No surrounding erythema. Right posterior ribs distal Stage 3 PI. Wound measures 1x0.7x0.2cm with 0.4cm of circumferential undermining. Wound bed with red, moist, clean tissue with epibole to the wound edges. No surrounding edema or erythema. Scant serosanguinous drainage on recently placed dressing. During assessment the patient was a full assist with all movement. She did not directly communicate any pain, moaned randomly, unable to determine if directly related to pain. This hospital uses the S (sensory)-K(kinetics)-I(incontinence/excessive moisture)-N(nutrition) risk assessment tool. This patient is at risk for SKN. S is limited ability to feel or communicate pain or discomfort. K, unable, unwilling or restricted to independently walk and/or adjust position; and /or is unable to prevent sliding while in bed or chair. N, determined by visual assessment of prominent skeletal structures, loose skin with minimal subcutaneous fat layer and muscle wasting.

Attention turned to colostomy care. Old pouching system removed, stoma and skin cleaned. Stoma is pink, elevated with healthy appearance. Stoma measures 32mm round, functioning for soft brown stool. Peristomal skin and mucus junction are healthy, intact and WNL. Back of old pouching system without evidence of leakage under wafer. Pt currently using Coloplast 1piece flat drainable pouching system with slim moldable ring. Patient unable to provide additional information. Unclear if this is patients regular pouching system or something place at previous hospital. No information on date last changed, family not at bedside to provide additional information. This pouching system is appropriate for an end colostomy, and no evidence of leaking identified. Re-pouched in same product, Coloplast

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</p> <p>Nutrition deficient</p> <p>Pressure Injury wound care</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Complete a dysphasia screening Consult registered dietician (RD) Discuss alternative methods of feeding that align with patient/family goals of care</p> <p>Coccyx (Right) Unstageable – assess and clean with soap and water. Monitor for changes such</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Patient should be provided nutriments safely and in line with goals of care once established. The RD can provide nutritional plan to meet patient's caloric, fat and protein needs regardless of route of administration. If the patient cannot be fed orally, other means of administering nutrition need to be considered</p> <p>We expect this wound to evolve</p>

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<p>Colostomy Care</p>	<p>as drainage, surrounding erythema, increased pain, and warmth and febrile status. Monitor WBC while admitted. Assess for eschar separation at wound edges. Protect wound and provide padding with Allevyn silicone bordered foam dressing. May be used for 72hours. Assess under dressing Qshift. Turn and reposition every 2hours using pillows and foam positioning wedges Re-consult wound care nurse if wound becomes worse. Consider plastic surgery consult for debridement if in line with goals of care.</p> <p>Right ischium and posterior ribs DTPIs - Protect wound and provide padding with Allevyn silicone bordered foam dressing. May be used for 72hours. Assess under dressing Qshift. Turn and reposition every 2hours using pillows and foam positioning wedges</p> <p>Right posterior ribs distal Stage 3 – clean with MicroKlenz antimicrobial wound cleanser. Fill space with saline moistened Nugauze packing strips. Apply no-sting skin prep to peri-wound skin, cover with Gentac silicone island dressing. Change daily</p> <p>Place order for immersion mattress at time of transfer from ICU</p> <p>Provide routine colostomy care biweekly Q3-days or immediately if leaking. Remove old appliance, clean skin. Inspect stoma and peri-wound skin for abnormalities. Prepare new Coloplast 1 pc drainable appliance by cutting opening for stoma to 32mm, apply moldable ring around stoma and land new appliance. Re-consult ostomy nurse for leaking issues or assessment finding that are not WNL.</p>	<p>and is at high risk for infection. Until goals of care and nutrition is addressed, protecting and monitoring the PI is appropriate. There are no current sign or symptoms of infection, pt is afebrile, WBC is WNL, and wound assessment does not reveal localized infection. At this time, it is stable eschar that should be protected and monitored closely.</p> <p>These 2 PIs have the potential to resolve or evolve. A foam dressing and offloading provide protection from shearing, reduction of pressure and padding to the boney prominence.</p> <p>The saline moistened Nugauze fill dressing creates a moist environment for wound healing and fills dead spaces of the wound. The Gentac cover dressing is gentle on fragile skin and aids in the moist wound healing, but provides absorption for excess exudate. The skin prep to the peri-wound skin protects against maceration.</p> <p>Patient is on a Linet ICU bed with automated bed tilt and pressure redistribution automatically customized to patient weight.</p> <p>Routine colostomy is managed by nursing staff. If there are educational deficits, leaking issues or challenging appliance applications, the Ostomy nurse can follow more closely or provide additional guidance.</p>
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<p>Identify each WOC product in use/identified in POC. State at least</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US. Allevyn silicone bordered foam dressing – highly absorptive gentle adhesive cover dressing being</p>
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<p>one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</p>	<p>used as padded protection to a dry wound bed. The disadvantages are it is very expensive and not providing any topical treatment. Alternative could be an ABD and tape or hydrocolloid dressing <u>MicroKlenz</u> - a non-cytotoxic antimicrobial wound cleanser. Disadvantages are likely not covered in the outpatient setting, and 2 products are being used on 1 wound. Alternatively saline solution is appropriate to both clean and moisten the Nugauze. <u>Nugauze</u> - tightly woven packing strips. Disadvantages are can be over packed, over or under moistened, no topical healing properties, minimal absorption if wound is draining. Alternative can be a silver imbedded hydrofiber is wound is draining more than initially assessed. Triad, zinc-oxide based hydrophilic paste can be used. The wound is small Triad is appropriate for light-to- moderate amounts of exudates. The zinc would also protect the peri-wound skin from maceration and eliminate the use of the skin prep. Since the dressing had been recently changed, amount of exudate was hard to determine. Coloplast 1 pc drainable pouching system this basic pouching system can be replaced with any other brand of 1pc flat CTF unless the patient has a known allergic reaction adhesive property in other brands</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>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>I didn't have any specific goals for today, just to make a positive impact on a patient's day and learn as much as I can from my preceptor I had hoped to observe/participate in NPWT dressing change, but there were none scheduled for the day as they are typically ordered Monday/Wednesday/Friday for this hospital/Wound care dept. Look forward to that on M/W/F clinical day.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>I hope to get experience with ostomy care teaching for new ostomy patients and an opportunity to pre-op stoma mark and education a patient.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>This was another very challenging patient case. While most of the wound and ostomy care seemed straight forward, there were several elements of patient care that still needed addressed before more definitive recommendations could be made. With the patient admission only being a few hours, several very important decisions still needed to be made by the patient/family. Specifically, goals of care and alternative nutrition options if oral intake is not appropriate. Plastic surgery was not recommended or consulted during this visit. I understand the rational for not, but can also rationalize why they should have been.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<p>My preceptor observed application of 2layer compression wraps to bilateral lower extremities. This patient was a follow-up visit who need routine week wrap changes, no active open wounds that needed care at this time. Several of the other patients were consults for PI assessment that were determined to have moisture/incontinence skin breakdown. Topical treatments such as zinc barrier, zinc barrier with anti-fungal and calmoseptine were ordered with low air loss microclimate support mattresses were ordered as appropriate.</p>

Reviewed by: _____ Date: _____

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