

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Erica Crenshaw Day/Date: Day 5 6/7/24Number of Clinical Hours Today: 8Care Setting: Hospital ☒ Ambulatory Care ☐ Home Care ☐ Other ☐Preceptor: CWOC-APN Helen ShubsdaClinical Focus: Wound ☒ Ostomy ☐ Continence ☐

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

My preceptor works as a Nurse Practitioner for the Wound Care team. She and I visited a total of 7 patients admitted across units within the hospital today. Wound care needs or follow-up treatment plans were the primary focus and reason for providing patient care to the admitted patients. The first patient, a 69 year-old female was suspected of having a Stage II or III PI to the coccyx. It could be easy for Clinicians to misidentify injury to the skin but upon further assessment, Helen and I were able to determine that the patient had MASD. Desitin cream was applied and no further intervention was performed. Not only was the skin intact, it was still blanchable and poorly distributed around the perianal area. Although some of the patient's had misidentified injuries on some of their patients, I think that it's important to note that routine skin checks are being performed and a request for follow-up treatment and intervention is being initiated. This was not always the case with injuries that have progressed or gone completely undocumented. The following patient, a 53 year-old female was in need of a reassessment of perianal mucous membrane. The patient had an existing perianal mucous membrane showing signs of healing at the edges. She noted the reasoning behind the injury being a perianal mucous membrane rather than a stageable PI. Mucosal membrane (MM) pressure injuries are found on mucous membranes and due to the anatomy of the tissue, these injuries can't be staged (Edsberg, 2022; NPIAP, 2016). The patient's wound was left open to air with no further interventions performed. Another patient, a 62 year-old female had a perinephric abscess to the left abdomen. Initially, the area was closed with erythema noted to the left abdominal region however; the surgical team opened the abscess due to fluid accumulation and is currently a surgical wound with full thickness. The wound was cleansed and packed with gauze with an ABD dressing placed over the surface. The Surgical Team is scheduled to return and determine if the placement of a wound vac would be appropriate. A separate patient visit involved a 38 year-old female with multiple wounds, 1 full thickness wound located on the left lower leg and another unstageable sacral pressure injury. While hydrogel and Aquacel were applied to the left lower leg wound bed and covered with Allevyn foam, the sacrum was gently filled with Kerlix, moistened with Vashe followed by an Allevyn foam covering. Vashe has been a wound cleanser that has gained a lot of popularity over the past years and it does seem that patients and caregivers alike have garnered a liking to its use. There was a case in which a patient had MASD to the abdomen and we discussed the significance behind the correct use of wound care dressing. A 49 year-old female had MASD to the abdomen and an Interdry layer was applied. Helen recommended to watch for instances in which the Interdry layer is folded on this wound or any other wound like a taco as this is the incorrect method of placement. The Interdry layer is meant to wick moisture away from the abdomen and this cannot properly occur if it's folded into the abdomen.

Types of patients: MASD/ IAD, mucous membrane pressure injury, venous ulcer full thickness wound assessment and plan development

References

Edsberg, L. (2022). Pressure and Shear Injuries. In J.Carmel, J. Colwell, & M.T. Goldberg. (Eds.), Wound, Ostomy and

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Continence Nurses Society care curriculum: Wound management (2nd ed., pp 373-393). Wolters Kluwer.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse 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. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

38 year-old female admitted with a diagnosis of Severe mitral regurgitation with an active unstageable pressure injury and a full thickness left pretibial wound prior to the admission date of 5/30/2024. PMH of asymptomatic gallstones, DVT, current dialysis treatment for ESRD, Hepatomegaly, Mitral regurgitation, Systemic lupus erythematosus and Rectal cancer s/p chemo 2019. Pt is withdrawn, quiet with blanket over head, follows commands. The periwound skin of the sacral PI was assessed to have maceration, moist, and pink irregular edges. The wound measures to 7.5 cm long x 7.5 cm wide and 0.3 cm deep. The wound bed is black, with yellow slough to the base. The wound bed was cleansed and the contact layer, Restore was added to the base and the entirety of the wound was covered with ABD dressing. The periwound skin to the left leg is hyperpigmented and irregularly shaped. The wound measures at 2 cm long and 0.7 cm wide. The wound bed has a small amount of slough at the base and small amounts of serosanguineous drainage. The wound bed was cleansed, hydrogel was applied to the base in addition to Aquacel, gently filled with Kerlix and the wound was covered with Allevyn foam. New dressing change was explained to patient, changing frequency is daily as needed and patient also encouraged to change and reposition every 2-4 hours for purposes of off-loading; patient shook head to demonstrate understanding.

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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 used)

- Plastics Team consulted for wound to sacrum for possible debridement
- Nutrition consulted for optimal wound healing
- Sacrum gently filled with Vashe moistened Kerlix and covered with Allevyn foam. Dressing to be changed daily and prn when soiled and with strikethrough.
- Left leg wound to be cleansed with NS. Apply hydrogel followed by Aquacel, cut to the size of the wound and cover with Allevyn foam. Dressing to be changed daily and prn with strikethrough.
- Off-load heels while in bed. Turn and reposition every 2 hours.
- Obtain Medline Comfort Glide Sheet and Turning wedge to off-load patient's ischium every 2 hours.
- Call for changes in wound, wound dressing concerns

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

I thought that it was great that the obstruction was relieved with intubation and irrigation rather than putting the patient through another procedure. The patient denied pain and was relieved of symptoms related to obstruction with such a simple procedure. I would have incorporated more patient education on fluid and solid intake suggestions to avoid obstruction and even ask the patient if she would like a Nutrition consult.

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 was to visualize and assess how the WOC APN interacts with and initiates wound care to the variety of patients admitted to

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different levels of care.

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

I would like to see more MASD/ IAD cases and learn how the WOC nurse manages the plan of care.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
● Identifies why the patient is being seen	✓	
● Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
● Includes pertinent PMH, HPI, current medications and labs	✓	
● Identifies specific products utilized/recommended for use	✓	
● Identifies overall recommendations/plan	✓	
Plan of Care Development:		
● POC is focused and holistic	✓	
● WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
● Statements direct care of the patient in the absence of the WOC nurse	✓	
● Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
● Critical thinking utilized to reflect on patient encounter	✓	
● Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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