



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

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name:     Darleen Olsen     Day/Date:     7/12/2024    

Number of Clinical Hours Today:     8    

Care Setting: Hospital  Ostomy Inpatient  Ambulatory Care  Home Care  Other

Preceptor:     Lauren Forneris    

Clinical Focus: Wound  Ostomy  Inpatient  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.**

The first patient I saw in conjunction with the Ostomy nurse was a patient who had a LAR and the end ileostomy was unmodified. When we arrived, the patient was having no leaking issues. Patient requested supplies and to try a pouching system that is less revealing under her clothes. The same pouching system recommended but as a one piece. Patient was very happy as it looked a lot thinner.

The second patient was a pediatric patient who is from Costa Rica with an ECF. The patient only spoke Spanish and the mother as well. I was able to provide care and discuss care with the patient as I am fluent in Spanish. We received a consult for a leaking pouch. The patient was utilizing a Hollister 2-piece pouch system with extended wear in which was recommended with him inpatient as hospital did not carry his home pouching system. Mother and patient preferred to return with their pouching system from home. I applied the same pouching system as home, followed by caulking per patient's and mother's preference, and applied 3M Cavilon to protect the skin before application. Patient is planned for take down of ECF on 6/15/2024.

The third patient I saw had a consult for a leaking pouch of end ileostomy of the patient. When we arrived there was no evidence of leakage. Per bedside nursing, patient had leakage at 7 am today when patient was turned to the left side. The patient has multiple sternal incisions. The pouching system was intact. We had changed the pouch yesterday and the patient had a small incision around 3 o'clock in which we had applied strip paste to fill. Discussed with bedside nursing to reconsult if leakage issues.

The fourth patient I saw had a sternal incision in which the Ostomy nurse was consulted for NPWT dressing change. The patient had a sternal incision which had been incision and drained on 7/9/2024 which was when the 3M™ V.A.C.® Ulta Therapy Unit was initially placed. The patient had hardware in the sternal wound. We applied a contact layer over the wound bed due to hardware present. The 3M™ V.A.C.® Ulta Therapy Unit was running at -50 mmHg low continuously. Preceptor and I had discussion of NPWT on very low setting and recommended is 125 mm Hg. I would have reached out to the Primary Service and inquire if there was a reason of it being at -50 mmHg low continuous, dependent on response and if appropriate, if it can be increased to 125 mm Hg to optimize blood flow to the wound.

The fifth patient had consult placed for NPWT dressing change. The patient had a midabdominal wound, right lower abdominal wound, and left lower abdominal wound with driveline present.

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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:**

Reason for Consult: Patient seen for NPWT dressing change consult for study being conducted for NPWT in wounds with drivelines intact.

Age/Sex: 74 year-old Male

LOC: Patient awake, alert, oriented. Patient laying in bed and falling asleep during NPWT dressing change.

Interview with patient who states:

- "I do not have any pain. I am not having any trouble with comfort. I like getting out of the bed on my right side."

CC: Worsening DLI with cxs + E. coli and Pseudomonas

Social hx: Denies alcohol, drug, and tobacco use.

Meds: Carvedilol 3.125 mg PO BID with meals, acetaminophen 500 mg PO PRN for pain, Lisinopril 5 mg PO once daily, Pantoprazole 40 mg PO once daily before breakfast, Warfarin 2.5 mg daily, Ciprofloxacin BID PO, Levitracem 750 mg PO BID, Oxycodone 5 mg PO PRN for pain, Atorvastatin 80 mg PO once daily at bedtime, Ascorbic Vitamin C 500 mg PO once daily, Docusate sodium 100 mg PO BID, Furosemide 20 mg once daily PRN for 2-3 pounds in 24 hours and 3-5 pounds in one week, Magnesium oxide 400 mg PO BID, and Melatonin 3 mg PRN for sleep.

Labs: WBC 6.33 k/uL, RBC 3.24 m/uL, Hemoglobin 8.7 g /dL, Hematocrit 28.1 %, Platelet count 202 k/uL, Protein 6.5 g/dL, Calcium 9.3 mg/dL, BUN 30 mg/dL, Cr 1.4 mg/dL

Patient assessed in conjunction with Ostomy nurse while patient laying in bed. Masks applied to patient, Ostomy nurse, and WOC student to decrease pathogens from entering wound. The NPWT was paused and the connection port was unplugged. Canister of NPWT was disposed of appropriately. The patient has three surgical wounds which lay horizontally with about 2 cm of space between each wound. The drape was removed with adhesive remover very gently while stabilizing driveline. Holihesive™ Skin Barrier removed from abdominal crease where abdominal deep crease at 3 o'clock of most left wound, Wound #3, where DriveLine exits. The black foam was removed from the wound beds while stabilization of Drive Line. The wounds were flushed with normal saline and cleanse with soft gauze and cotton tip applicators while stabilizing Drive Line. The peri-wound and skin where drape was going to be applied was cleanse with Hibi clens and gauze. Then washed off with normal saline and soft gauze. This was pat dry. Then 3M Cavilon no sting barrier was applied on the peri-wound and where drape was going to be applied. This was allowed to dry. Pieces of drape were cut to fit on the peri-wound and area where black foam was going to lay. Then applied over the peri-wound and where black foam was going to be applied. Black foam cut to fit shape of wounds. The black foam was cut to shape of left abdominal wound with Drive Line exiting with a slit to allow for the Drive Line to exit. Then a wedge of Holihesive™ Skin Barrier was cut to fit the deep crease at 3 o'clock and to help offload the Drive Line to prevent a pressure injury. Then strip of black foam was cut to lay over the black foam of the three wounds to bridge for suction for NPWT. Drape applied over the black foam and full seal verified. WOC student inquired on patient's preference of exiting bed and patient comfort for trac pad of NPWT to exit. Patient usually exits the right side of the bed and feels comfort of the 3M™ V.A.C.® Ulta Therapy Unit tube to exit on the right side. A slit of dime size shape on the right side

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was made by WOC student. Then trac pad of suction with hole of suction was placed over the open slit of the drape for suction. Then secured with trac pad transparent drape built in. New canister placed in 3M™ V.A.C.® Ulta Therapy Unit. Tube of canister of 3M™ V.A.C.® Ulta Therapy Unit connected to trac pad tube of 3M™ V.A.C.® Ulta Therapy Unit. Discussed with patient of 3M™ V.A.C.® Ulta Therapy Unit being turned on and of sensation of suction. 3M™ V.A.C.® Ulta Therapy Unit turned on and checked for leak. Black foam compressed. No leak detected during seal check. Verified settings on 3M™ V.A.C.® Ulta Therapy Unit at -125 mm Hg low continuous suction. History verified of 3M™ V.A.C.® Ulta Therapy Unit. No issues noted other than one low battery alarm at 02:03 on 6/11/2024. 3M™ V.A.C.® Ulta Therapy Unit connected to outlet. Patient tolerated procedure well with no pain. Discussed with nursing to attempt to maintain 3M™ V.A.C.® Ulta Therapy Unit connected to outlet unless patient is ambulating. Bedside nursing in agreement. Please see assessment below of wounds.

Assessment:

**Wound #1**

Wound Type: Surgical

Location: Right lower abdomen

Wound bed color and tissue: Visible tissue is 25% red and moist, 75% yellow and moist- drive line is visible at base of wound

Wound measurements: 0.5 cm x 3 cm x 3 cm

Wound Edges: flat, open

Peri-wound: pink scarring at 12 o'clock slightly macerated circumferentially

Peri-wound contour-Concave-sits at base of abdominal crease

Supportive tissue: Soft

Wound drainage: Serosanguinous, small amount

Current management system: NPWT; -125 mm hg low continuous, black foam

Current Management: twice weekly

**Wound #2**

Wound Type: Surgical

Location: Midline lower abdomen

Wound bed color and tissue: Visible wound bed 25% red and moist, 75% moist, yellow tissue

Wound measurements: 1 cm x 1.5 cm x 2 cm

Wound edges: flat, open

Peri-wound skin: pink and intact

Peri-wound contour: Concave sits at based of abdominal crease

Supportive tissue: Soft

Wound drainage: Serosanguinous, small amount

Current management system: NPWT; -125 mm hg low continuous, black foam

Current Management: twice weekly

**Wound #3**

Wound Type: Surgical

Location Left lower abdomen

Wound bed color and tissue 75% red and granular, 25% slough, drive line in place

Wound edges: flat, open

Peri-wound: pink and intact

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Peri-wound contour: concave-sits at base of abdominal crease  
Supportive tissue: soft  
Wound drainage: serosanguinous, small amount  
Current management system: NPWT; -125 mm hg low continuous, black foam  
Current Management: twice weekly

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)

-Monitor 3M™ V.A.C.® Ulta Therapy Unit for any alarms. If alarms for low battery, please plug to outlet. For any issues or leaking with 3M™ V.A.C.® Ulta Therapy Unit, please consult Ostomy Nurse. If alarm of no seal or NPWT has been off for an hour and not working appropriately, please pack the wound beds with wet to dry dressings with Normal Saline Moistened Kerlix Gauze, then cover with soft gauze and secure with gentle skin tape following TID and PRN for strike through. Then consult Ostomy Consult after packed.

-Monitor CBC for hemoglobin and hematocrit for deficiency as a sign of bleeding. Monitor CBC for increase in WBC for indication of infection. Monitor 3M™ V.A.C.® Ulta Therapy Unit canister for increase change in a larger amount of drainage. For any of these changes please contact Primary Service and notify.

-Please monitor patient for fever as this may be an indicator of infection. Please contact Primary Service if patient develops a fever.

-Patient to ambulate TID.

-Optimize patient nutritionally by consulting Registered Dietician for wound healing.

-Pain management adequately within patient's goal for comfort.

-Monitor albumin and prealbumin. If any of these are lower than within normal limits, please notify Primary Service to help manage for optimal wound healing.

-Keep 3M™ V.A.C.® Ulta Therapy Unit plugged in at all times except when ambulating or patient not close within outlet. If patient's 3M™ V.A.C.® Ulta Therapy Unit is not plugged, assure battery is not low.

-Monitor INR for therapeutic range. If not within therapeutic range notify Primary Service for management.

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

Reflecting back on care for the patient, I would have placed the trac pad tube to exit on the left side of the patient as the patient's Drive Line is on the left side. The Drive Line being on the left side was require stabilization. This would facilitate and prevent from tugged on the Drive Line or the NPWT tube. It would have been better to put both on the same side for patient's comfort during mobility and repositioning. I will be more mindful of this next time I see patient with NPWT with a Drive Line in place.

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 for the date was to work with NPWT as Ostomy nurses are the only ones that really work hands on with NPWT not the Wound nurses per the Ostomy nurse. I was able to apply one, change the canister, and how to bridge. I had not heard of bridging until didactic. It was wonderful to have these experiences and learn from them as this is great for certain wounds to heal.

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

My learning goal for Monday (next clinical day) on 7/15/2024, is to assess a wound and determine the etiology of a wound. Then implement a management plan.

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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