



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Mindy Wong Day/Date: September 23, 2024

Number of Clinical Hours Today: 10 hours

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Geronimo Fuentes

Clinical 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.

Today, my preceptor, wound care nurse, and I saw a total of 8 patients during our rounds. The majority of the patients were wound or incontinence related injuries, but there was one patient that was a severely neglected elderly lady brought in by family during the weekend. It is to our understanding that the ED staff have filed a report with the Department of Social Services – Adult Protection Services (APS) sector. She was noted to have multiple pressure sores on both sides of her body, somnolent, malnourished, unable to respond, and with necrotic toes. We did spend a generous amount of time with this patient due to the number of injuries on her body and performing a full assessment with severe contractions of all her extremities. The other patient cases we had assessed were of similar conditions from being in one position in prolonged periods of time and developing stage 2 PIs or unstageable DTIs. Those with the stage 2 PIs that had open wounds were given an autolytic debridement ointment (Medihoney) to help with faster healing and for anti-inflammatory properties. These wounds were then covered with a foam dressing (Mepilex border) to protect open wounds from bacteria, and to provide a flexible yet moist environment that is ideal for healing wounds. The remaining patient that was seen by us was a follow up per the request of the daughter of the patient. The patient was bedbound, incontinent x 2, and had moisture related dermatitis due to incontinence. The family member was insistent on having a dressing placed at the coccyx to protect the skin from further irritation. We endorsed that applying a dressing would further cause more skin breakdown and would actually retain the urine/feces against the skin. We educated the family member that a perineal cleanser would help remove excrements from the skin after each incontinence episode, and a moisture barrier ointment be applied to assist with skin protection and further breakdown.

Types of patients: stage 2 open wound PIs, unstageable DTIs, G-tube moisture related dermatitis, necrotic toes, stage 4 PIs, moisture related fungal dermatitis, assessment and treatment planning

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: Minday, a question...is the info below what you would write in a chart? Not a problem but I just wanted to make sure that is how you are writing.

Initial assessment of 96 y.o. female BIBA from home for weakness, change in mental status, lethargy, open pressure wounds, and necrotic toes. Daughter claimed that the patient became weaker, stopped eating/drinking and seemed more confused. Patient is typically AOX4, self-independent, ambulatory but requires assistance with most ADLs. No known allergies. PMH of hypertension and neuropathic pain but of unknown origin. Patient was admitted into the hospital 09/21 for acute metabolic encephalopathy due

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to sepsis likely UTI vs. skin and soft tissue infections (SSTI), dry gangrene of the left foot toes, pressure injuries of the left hip and iliac crest, right hip and iliac crest, left shoulder, severe protein and calorie malnutrition, physical deconditioning, and eventually peripheral artery disease (PAD). Upon assessment, the patient was lying on the left side in a fetal position, alert but nonverbal.

- [1.] Left shoulder with deep tissue injury, full thickness loss of dermis with bright pink tissue, dry wound, dark maroon discoloration with erythema surrounding the periwound, 7cm x 7cm in size. A foam dressing (mepilex border 4 x4) was placed ~~to redistribute pressure and prevent any shearing that could result in compromising skin integrity.~~
- 1.[2.] Right flank extending to iliac crest found to have deep tissue pressure injury, intact skin with dark purple discoloration, dry, no drainage, 4 cm x 2 cm in size, erythema in surrounding periwound area. A foam dressing (mepilex border 4x4) was placed to minimize and redistribute shear, pressure, friction, and prevent skin tear.
- [3.] Right hip with evolving deep tissue injury, full thickness loss of tissue, dry black eschar scab with surrounding dark purple discoloration, slight moist drainage, 6cm x 6cm in size, erythema in surrounding periwound area. A foam dressing (mepilex border 4 x 4) was placed to minimize possible dislodging of eschar and surrounding tissue in wound bed, as well as to provide optimal healing environment while protecting wound bed. An autolytic debridement ointment (medihoney) was applied onto wound ~~to help debridement of dead tissue layers and promote new tissue growth.~~
- 2.[4.] Left iliac crest with unstageable pressure injury, full thickness loss of dermis, wound bed pink/red tissue, moist purulent drainage, 7cm x 7cm in size, moist black eschar tissue covering 80% of wound bed, red tender erythema in surrounding periwound area. A **moderate amount of autolytic debridement ointment (medihoney) was applied to promote new tissue growth and debridement of dead eschar tissue.** Depending upon the situation, minimize the amount of rationale in your note. Also, just state that medi honey ointment was applied and give a millimeter of thickness perhaps vs saying a moderate amount. See strike-thrus above too. If you believe this should be in a note, consider writing. A few statements to describe the rationale for your dressing choices at the end of your note... Foam used on all DTPIs in order to minimize shear and redistribute pressure. Honey used on necrotic open wounds in order to provide environment for autolytic debridement and keep wound bed moist.
Great wound descriptions in your note!
- [5.] Left hip with evolving deep tissue pressure injury, dark purple discoloration with scattered areas of partial thickness tissue loss, slight moist drainage, pink wound bed, erythema in surrounding periwound area with some hyperpigmentation, 7cm x 7cm in size. Covered w A foam dressing (mepilex border 4 x 4) ~~dressing was placed to prevent dislodging of eschar tissue and to redistribute pressure at boney prominence.~~
- 3.[6.] Sacrum/coccyx, bilateral gluteal folds/cleft, perineal/perianal area with moisture associated skin damage causing partial thickness tissue loss, pink erythema and maceration throughout perineal area and gluteal cleft, no drainage but slightly moist due to incontinence and scant soft fecal matter. Unable to define approximate size. Moisture barrier cream gove the brand here applied onto skin to prevent further maceration of tender skin. No dressing needed.
- [7.] Left knee with stage 1 pressure injury with dry intact skin blister if there is a blister & you think it is pressure then it is stage 2. Pink erythema surrounding periwound, 2cm x 2cm in size. A foam dressing (mepilex border 2 x 2) was ~~placed to prevent opening of blister and friction. Pillows were also placed between legs at knees to prevent further evolution of pressure injury.~~
- 4.[8.] Right heel with deep tissue injury, skin intact, diffuse purple color discoloration, dry, 3cm x 3cm in size. No dressing needed. Open to air, elevate heels with pillows to offload
- 5.[9.] Left heel with deep tissue injury, skin intact, diffuse purple color discoloration, dry, 3cm x 3cm in size. Open to air, no dressing needed. Heels elevated with pillows for offloading
- 6.[10.] Left foot with dry gangrenous toe (big toe), s/p amputation with pinkish tissue, dry gangrenous necrotic tissue surrounding periwound and remaining portion of toe. Betadine swabs for treatment at amputation site, open to air, no dressing needed.
- 7.[11.] Left foot with dry gangrenous second toe (index toe), dry necrotic tissue, black in color, brittle. Potential to auto amputate. Open to air, no dressing needed.

No family at bedside. Pt unable to participate in care and treatment plan. Unable to address any questions/concerns. Spoke with primary RN regarding plan and recommendations. No questions/concerns indicated.

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)

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Intact skin: Clean wounds-skin with NS ~~or Vashe~~ why Vashe if skin intact?. Pat dry with gauze. Apply mepilex border dressing to wounds-areas with dry intact skin that are deep tissue injuries - left shoulder DTI, right flank/iliac crest DTI, left knee with dry intact blister. Change dressing every ~~2 to~~ 3 days or PRN if soiled/misplaced.

Partial/Full thickness loss of dermis: clean wounds with NS or vashe. Be prescriptive. What do you want the nurse to do when you are not there Pat dry with gauze. Apply medihoney onto wound base and cover with mepilex border dressing to protect wounds and allow for autolytic debridement – right hip with full thickness loss and evolving DTI, left iliac crest with full thickness loss and DTI, left hip with partial to full thickness loss and DTI. Change dressing q3 to 4 days or PRN if dressing soiled/saturated with exudate/removed.

Moisture associated skin damage with maceration: clean areas with ~~NS or~~ perineal cleanser (pH balanced). Pat dry with gauze. Apply moisture barrier cream/ointment what exactly to sacrum/coccyx, bilateral gluteal cleft/area/folds, perineal/perianal area. Apply thin layer of antifungal ointment if fungal rash is detected. No dressings needed. Open to air. Avoid using diapers or multiple layers underneath patient. Cleanse promptly after every incontinence episode. Do not rub vigorously. Utilize external urine management system (Primofit/PrimaFit) to maximize incontinence management.

Elevate bilateral heels off mattress with pillows or pressure injury devices. Provide routine repositioning q2 or PRN to relieve pressure.

Left toes with dry gangrene: Apply betadine soaked swab and brush gently onto big toe and index toe. Place betadine soaked gauze onto both toes, wrap with rolled gauze dressing (kerlix) loosely. No compression dressings or coban dressing. Change dressing daily.

Utilize air pressure distributing mattress. Routine repositioning q2 or PRN. Provide prompt incontinence management: prompt cleaning with pH balanced perineal cleanser, moisture barrier cream, antifungal ointment if needed. Minimize underlayers between patient and mattress; (1) incontinence pad.

Dietician/Nutritionist consult needed to determine adequate intake and nutrition to promote tissue growth and healing. Follow up with WOC team for dressing concerns.

Describe your thoughts related to the care provided. What would you have done differently? See comments below for future journals

We were content with the dressings applied to the wounds prior to our assessment by the staff nurses of that unit. The patient was routinely repositioned, and pillows were used to help support the bony prominences to lessen pressure. We did find that the left foot was not dressed and was opened to air, which could have compromised the second toe from breaking off. The sacrum/coccyx area had a mepilex border dressing for pressure prevention due to the bony prominence, however, it was retaining fluids from urine/feces up against the skin that would further cause skin breakdown and maceration. The mepilex border would not have been necessary, and an incontinence external urine system would have assisted in minimizing moisture related skin breakdown. As for the left toes, pending surgical consult to determine if surgery would be needed. Otherwise, loose gauze dressing to prevent accidental loss of digits. So, you would not have done anything differently? Mindy, in your own practice, consider using a low air loss bed if a patient is elderly, has multiple body surfaces with pressure injuries or deep tissue pressure injuries, and consider using heel protection devices versus leaving the heels off the bed with pillows, which is risky if pts. move. For a patient with every body surface affected by pressure, consider making the turn schedule hourly instead of Q2. Time intensive, but more effective for managing pressure points. In your plan for staff, be specific about which products you want to be used for a patient. For intact heels that are compromised, consider applying a skin protector such as Marathon or 3M Advanced Cavilon to protect the area at the very least along w a heel boot to ensure elevation. DTPI on heels may also be dressed w RCT foams (Mepilex or Allevyn) but if protected w skin prep & elevated this may not be necessary.

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?

Today, my goal was to see how many patient wounds I was able to identify and provide plan of care. My goal was met as I was able to learn from my preceptor and the fellow WOC team nurses on how to properly identify and stage wounds that were not exhibiting

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the 'textbook' characteristics of a stageable wound. I also was able to learn how to distinguish hyperpigmentation vs. DTI vs. unstageable wounds. Even though there were only 8 patients, the amount of time it took to assess them all thoroughly took more time than I was expecting, but was extremely grateful that we could take the time to be thorough. [8 pts is very reasonable in a 10 hr day](#)

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

For the next clinical day, I would love to be able to assess a patient for stoma site marking prior to surgery. My preceptor informed me that typically, prior to surgery, the WOC team is consulted to interview the patient in pre-op to complete a stoma site marking, provide education for expectations and maintenance, and for product applications. [Great!](#)

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		See notes in this section
Learning goal identified	✓	

Reviewed by: Patricia A. Slachta Date: 9/26/24

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