12/4 #2

Student Name: Marina DeRosa_____ Day/Date: __Wednesday 12/4/2024___

Number of Clinical Hours Today: 12___

Care Setting: Hospital _x_ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: _Karen Francis__ APN CWON__

Clinical Focus: Wound _x___ Ostomy ____ Continence ____

This assignment should be WOC focused and approached as 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.

I saw six patients today with my preceptor. All of them were wound-focused, with one having multiple wounds one of which I performed Cross Hatching as the patient had left hip unstageable with hard black eschar over wound which is adherent . A # 5 Curette was used to perform criss cross marking to the Eschar. Other patient seen were three with stage 2 pressure injuries community acquired. Wounds were assessed and treated. Normal saline was used for cleaning. No sting barrier was applied to periwounds. Wounds were covered with 4x4 gauze dressing and secured with Allevyn Life dressing. This

is a daily change. One patient with bilateral heel DTI ’s. Wounds were cleaned and dried. Povidone iodine was then applied to the heels, and they were then offloaded in EHOB boots. Lastly one patient with stage 3 pressure injury to sacrum with GI bleed. Patient wound was cleansed with NSS pat dry. No sting barrier to periwound. Wound had minimal excudatem Hydrogel from Medline was applied, wound cover with 4x4 gauze and secured with Allevyn Life daily dressing change and PRN when soiled. A fecal pouch was also used to control the diarrhea from the GI bleed.

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:

81 y.o. female arrived from home, related to multiple pressure injuries Patient is White, Non Spanish, Latino or Hispanic and English speaking. Fitzpatrick Scale Type 2. Patient admitted for multiple pressure injuries. Patient is referred for evaluation and treatment of community acquired wound.

Patient seen at bedside awake. Patient was medicated for pain prior to wound treatment. Patient is non verbal in no distress or discomfort. Life partner was at bedside.

Past Medical History: Diagnosis

• High cholesterol • Hypertension

Date

Past Surgical History:

Procedure

Laterality Date

• HIP SURGERY

Left 8/2/2023 HIP INTERLOCKING NAIL INSERTION /GAMMA, LEFT performed by Charles Ekstein, MD at PMC MAIN OR

VITAL SIGNS:

Patient Vitals for the past 8 hrs:

12/05/24 1049 12/05/24 0932

127/52 98.2 °F 48 18 (36.8 °C)

BP

Temp

Pulse

Sp02 Height

Weight 97 %

47.7 kg 1.55 m (5'

(105 lb 1.02")

3.3 oz)

1/0 last 3 completed shifts:

In: -

Out: 518 [Urine:518]

No intake/output data recorded.

Body mass index is 19.86 kg/m'.

Review of Systems

Unable to perform ROS: Dementia

Physical Exam

Vitals and nursing note reviewed. Exam conducted with a chaperone present. HENT:

Head: Normocephalic.

Pulmonary:

Effort: Pulmonary effort is normal. Genitourinary:

Comments: Purewick in place Musculoskeletal:

Comments: Both upper and lower extremities contracted

Skin:

General: Skin is warm and dry. Multiple pressure injuries to sacrum, bilateral hips, and lower extremities.

Neurological:

Mental Status: She is alert. Mental status is at baseline.

PRN: acetaminophen

ASSESSMENT AND PLAN:

Comprehensive Problem List Diagnosis

• *Pressure ulcers of skin of multiple topographic sites

• Moderate vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (CMS/HHS HCC)

• Leukocytosis

• Paroxysmal A-fib (CMS/HHS HCC)

Date Noted

12/03/2024 12/03/2024

10/21/2024 05/06/2024 08/01/2023 08/01/2023

• Primary hypertension

• High cholesterol

Resolved Hospital Problems No resolved problems to display.

Patient received AAOx1, respiratory status is even and regular. Relevant medication which may delay wound healing ASA, Lovenox, and Lopressor. Patient is bed bound with a pressure redistribution surface in place, positioned on right side. Sacrum and heels offloaded. Patient rec's dysphagia diet with Pro-Stat for nutritional supplementation. Nutritional Status: Does not meet criteria for malnutrition at this time. Patient is incontinent of urine with a Purewick in place. Patient wounds were assessed and treated. Left hip with back thick eschar, crosshatching performed over eschar with Curette #5. Wound was cleaned. Santly applied nickel thick to wound bed. Wound was then covered with 4x4 gauze and secured with Allevyn Life dressing. Patient was left comfortable in no distress or discomfort.

Braden Scale Score:10

Wound Care Done: Removed Allevyn life dressing

Location:	Left hand 3rd digit lateral side
Type:	pressure
Stage;	2
Size:	3cm x 1.5cm x0.1cm
Wound Base	Exposed dermis
Undermining	none
Excudate	clear fluid
Periwound	intact
Inflammation	minimal
Odor	none
Pain(Pain-AD)	8

Location: Left hand 4th digit lateral side

Type: pressure

Stage; blister

Size: 3cm x 1.5cm x 0cm

Wound Base blood filled

Undermining none

Excudate none

Periwound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left hand 3rd digit

Type: pressure

Stage; 2

Size: 3cm x 1.5cm x0.1cm

Wound Base Exposed dermis

Undermining none

Excudate clear fluid

Periwound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left medial knee

Type: pressure

Stage; 3

Size: 3.2cm x 1.0cm x0.2cm

Wound Base Yellow/white subcutaneous tissue

Undermining none

Excudate minimal serous sanguineous

Periwound erythema

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left hand dorsal side

Type: ruptured blister

Stage; 2

Size: 3.3cm x1.2cm x0.1cm

Wound Base Exposed dermis

Undermining none

Excudate clear fluid

Periwound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left Lower extremity top medial aspect

Type: pressure

Stage; 3

Size: 3cm x 1cm x0.2cm

Wound Base yellow subcutaneous tissue

Undermining none

Excudate minimal serosanguinous

Prewound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left lower extremity medial aspect

Type: pressure

Stage; 3

Size: 2cm x 1.cm x0.2cm

Wound Base. yellow subcutaneous tissue

Undermining none

Excudate minimal serosanguinious

Preowned erythema

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left lower extremity medial mid leg

Type: pressure

Stage; 3

Size: 6cm x 3cm x0.2cm

Wound Base yellow subcutaneous tissue

Undermining none

Excudate minimal serosanguinious

Periwound erythema

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left heel

Type: ruptured blister

Stage; 2

Size: 1cm x 1cm x0.1cm

Wound Base pink

Undermining none

Excudate minimal clear fluid

Periwound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left heel

Type: pressure

Stage; DTI

Size: 1cm x 1cm x0cm

Wound Base. Purple

Undermining none

Excudate none

Periwound intact

Inflammation minimal

Odor none

Pain(Pain-AD) 8

Location: Left heel

Type: callous

Size: 3cm x 1.5cm x0cm

Wound Base yellow hard skin

Undermining none

Excudate none

Periwound intact

Inflammation. None

Odor none

Pain(Pain-AD) 8

Location: Left hip

Type: pressure

Stage; unstageable

Size: 8cm x 4.5cm x0cm

Wound Base black hard eschar

Undermining none

Excudate none

Periwound erythema 0.7 cm circumferentially

Inflammation moderate

Odor none

Pain(Pain-AD) 8

Location: sacrum

Type: pressure

Stage; 3

Size: 2cm x 1.5cm x0.2cm

Wound Base subcutaneous tissue white

Undermining none

Excudate none

Periwound erythema

Inflammation moderate

Odor none

Pain(Pain-AD) 8

Location: right medial malleolus

Type: ruptured blister

Size: 2cm x 1.5cm x0.2cm

Wound Base pink

Undermining none

Excudate clear

Periwound intact

Inflammation moderate

Odor none

Pain(Pain-AD) 8

WOC Plan of Care (include specific products used

Left Hand and digits

Cleanse wounds with NSS and pat dry

Cover wounds with Oil Emulsion dressing (Medline)

Change oil emulsion 5-7 days

Change rolled gauze q 2-3 days

Left Hip

Cleanse wound with NSS daily pat dry

Apply no sting barrier to periwound let dry 60 seconds

Apply Collagenase to wound base

Cover with dampened NSS 4x4 gauze

Secure with Allevyn dressing

Change daily

Bilateral heels

Cleanse with NSS and pat dry daily

Apply no sting barrier to periwound let dry 60 seconds Keep patient in EHOB boots

Left medial knee,

Cleanse wound with NSS daily pat dry

Apply no sting barrier to periwound let dry 60 seconds Apply hydrogel to wound base

Cover with 4x4 gauze

Secure with Allevyn dressing

Change daily

Left medial lower extremity

Cleanse wound with NSS daily pat dry

Apply no sting barrier to periwound let dry 60 seconds Apply hydrogel to wound base

Cover with 4x4 gauze

Secure with Allevyn dressing

Change daily

Right lower extremity, right heel, right malleolus Cleanse with NSS and pat dry daily

Apply no sting barrier ot periwound let dry 60 seconds Cover with Allevyn foam

Secure with Allevyn life dressing

Change q 48 hours

3. Support surface: Hill Rom Centrella, while admitted to med/surgery, follow

Recommendations include a nutrition consult with the primary care team regarding possible nutritional supplements as per their recommendation. Infectious disease consult. The patient needs a pain medication order before any dressing changes. The patient needs wedges for offloading every two hours, and positions change. EHOB boots for offloading heels. Contact WOC services if wounds become malodorous.

Social services to possibly contact the APS , patient who has only an elderly life partner who may not be able to facilitate care, as there has been a significant deterioration of her condition since her last stay at the facility less than one month ago. Education on wound care plans was provided, and an opportunity was given to the significant other to ask questions. He did explain to this WON that he is not the power of attorney or health care proxy, and her daughter is the one to speak to. A call was placed to the patient's daughter, who said her mother would be discharged to her home. Visiting nurse services were suggested to both the social worker and the daughter. The patient may also benefit from a hospital bed at home. The patient does not have Medicaid, so she is not eligible for home aid services. The patient is

not a candidate for sub-acute services. She has dementia, is unable to follow commands, and is bedbound.

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

This patient has a very interesting case from the perspective of; I am not sure what I could have done differently. As per her history, she has had multiple admissions in the last two months. She has significant skin breakdown suddenly. The patient's mental status has deteriorated and now is contracted in both upper and lower extremities. WOC services did not see her on her previous visit but did have a single-digit Braden scale, and even though the nurses do a 2 RN skin check, maybe a WON should see the patient. At this point I feel continued prevention from further skin breakdown would be my goal

Goals

What was your goal for the day? Today's goal was to crosshatch on a patient's unstageable left hip pressure injury with black hard eschar; all policies and procedures were followed at the facility.

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

The goal of my next clinical is for marking for a ostomy

CRITICAL ELEMENTS

Complete Missing

- 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

See my comments

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:_____