

12/14/2024 # 6

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Marina DeRosa Day/Date: 12/4/2024Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Karen Francis, APN CWONClinical 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 the course Resource area to assist you with this assignment.

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

My preceptor and I saw seven patients at bedside today. Two patients' s/p new colostomy creation. Continued teaching on care of colostomy, including diet, signs of symptoms of colostomy problems. This included when to seek medical attention. Both patients had accounts created with our Colostomy product distributor. All products were ordered for these patients and confirmation was received. Appointments were also set up for follow up care at our local Wound Care Center. Two weeks of product was given to each for hold over till delivery was received from the distributor. Other patients seen were one patient with vascular wounds to bilateral lower extremities. Wounds were cleansed, an oil emulsion dressing was used over the open wound and secured with rolled gauze. (daily change or PRN soiled). Three patients with multiple stage two pressure injuries both from nursing home facilities. Patients wounds were identified, measured, cleansed with Vashe cleansing solution (Urigo Medical), no sting barrier to periwounds. Allevyn Foam was then used over the wounds and secured with Allevy Life dressing.(Daily change). Lastly one patient from a long term facility with multiple stage four pressure injuries to sacrum and ischium bilaterally

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 that 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:

WOC Services:Wound management

40 y.o. Black /African American, Not: Spanish Hispanic Or Latino, English speaking, Fitzpatrick Scale Type 4, female. She arrived from Complete Care at Harborage, related to Anemia. The patient was admitted for the same. The patient is referred for evaluation and treatment of community-acquired wounds. Medical records were reviewed.. The patient was seen at the bedside. awake alert in no distress or discomfort.

INTERVAL HISTORY:

Past Medical History:

Diagnosis Date

• Anemia

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- Ascites due to alcoholic cirrhosis (HCC)
- Chronic kidney disease
- Cirrhosis (HCC)
- Congestive heart failure (HCC)
- COVID-19
- Dependence on renal dialysis (HCC)
- ESRD (end stage renal disease) (HCC)
- ESRD (end stage renal disease) (HCC)
- GERD (gastroesophageal reflux disease)
- Hyperlipidemia
- Hypertension
- Muscle weakness
- Paraplegia (HCC)
- Persistent mood disorder (HCC)
- Protein calorie malnutrition (HCC)

No past surgical history on file.

ROS:

Review of Systems

Skin: Positive for wound.

VITAL SIGNS:

Patient Vitals for the past 8 hrs: VSS Stable 140/50 97.5 °F (36.4 °C) 82 18 —

Temp (24hrs), Avg:97.9 °F (36.6 °C), Min:97.2 °F (36.2 °C), Max:100.1 °F (37.8 °C)

I/O last 3 completed shifts:

In: 720 [Blood:720]

Out: -

No intake/output data recorded.

Body mass index is 26.86 kg/m².

EXAMINATION:

Physical Exam

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

HENT:

Head: Normocephalic.

Mouth/Throat:

Mouth: Mucous membranes are dry.

Pulmonary:

Effort: Pulmonary effort is normal.

Abdominal:

General: There is distension. Abdomen is firm, positive bowel sounds

Musculoskeletal:

Left lower leg: bilateral pitting +4 edema to lower extremities

Comments: Right subclavian PermCath (tunneled)

Skin:

General: Skin is warm.

Findings: Lesion present.

Comments: Stage 4 Pressure Injuries to sacrum, left ischium, left lateral malleolus

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Neurological:

Mental Status: She is alert and oriented to person, place, and time.

Psychiatric:

Behavior: Behavior normal.

INPATIENT MEDICATIONS:

Scheduled:

- pantoprazole 40 mg Oral Daily (6 AM)
- pneumococcal vaccine 0.5 mL intraMUSCULAR Prior to discharge
- ascorbic acid 500 mg Oral Daily
- atorvastatin 20 mg Oral Nightly
- docusate sodium 100 mg Oral Daily
- [START ON 5/12/2024] ergocalciferol 50,000 Units Oral Q Sunday
- QUetiapine 37.5 mg Oral Nightly
- sevelamer 800 mg Oral TID - WC
- zinc sulfate 220 mg Oral Daily
- gabapentin 300 mg Oral TID
- folic acid 1 mg Oral Daily
- melatonin 3 mg Oral Nightly

PRN:

acetaminophen, lactulose, traMADol, HYDROmorphine

DIET RENAL

Comprehensive Problem List

Diagnosis

- *Anemia - asymptomatic
- GERD (gastroesophageal reflux disease)
- Major depressive disorder
- Constipation
- Diabetic neuropathy (HCC)
- Pressure ulcer of sacral region, stage 4,
- ESRD (end stage renal disease) on dialysis (HCC)
Chronic
- Essential hypertension
Chronic

Resolved Hospital Problems

No resolved problems to display.

Wound Location : Sacrum
Type : Pressure
Stage : 4
Size : 6cm x 10cm x 1cm
Wound base : Red muscle with fat, palpable bone
Undermining/ : 1 to 4 o'clock 2 cm

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Exudate	: large sero sanguinous colored
Periwound skin	: Macerated red with white epibole
Edema	: moderate
Odor	: none
Pain	: none
Wound Location	: Left ischium
Type	: Pressure
Stage	: 4
Size	: 7cm x 12cm x 4 with 5cm tunnel between 1 o'clock and 2 o'clock
Wound base	: muscle pink tissue, Palpable bone chipped
Undermining/	none
Exudate	: large sero sanguinous
Periwound skin	: macerated
Edema	: moderate
Odor	: none
Pain	: none
Wound Location	: Left ankle lateral malleolus
Type	: Pressure
Stage	: 4
Size	: 2cm x 2cm x 0.3cm
Wound base	: yellow slough, cream colored devitalized tissue
Undermining/	: none
Exudate	: moderate sero sanguinous colored
Periwound skin	: Macerated red with white epibole
Edema	: moderate
Odor	: none
Pain	: none

Patient received AAOx3. Respiratory status is even and regular. The patient has no relevant medication that may delay wound healing. Patient was premeditated by the primary nurse before the exam. Patient is resting on the left side of her bed, with a pressure redistribution surface in place. Patient was moved to the middle of the bed for evaluation. Patient rec's renal diet. She receives Hemodialysis 3 times a week M/W/F. Patient is anuric. Patient is incontinent of stool with a large soft yellow stool on exam. Patient was cleansed and changed. Wounds were evaluated, cleansed and treated. Patient was left comfortable in no distress or discomfort.

Braden Scale Score:10

Patient education was provided on the wound care plan. Patient is usually found with both her legs hanging off the bed and on her left side. Teaching was reinforced on the importance of staying on the bed as much as possible to decrease the risk of falling. t The patient verbalized understanding.

Wound dressing removed; Left Malleolou Xeroform dressing with rolled gauze. Sacrum and left Ischium packed rolled gauze removed covered by an abdominal pad which was secured with a border dressing.

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.

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WOC Plan of Care (include specific products used)

Discontinue Xeroform to malleolus and plain packing to sacrum and Ischium. Both sacrum and left Ischium have moderate to large amounts of serosanguinous drainage, both wound dressing changed to Aquacel Hydrofiber daily with rolled gauze in the sacrum and 4x4 gauze used in the left Ischium. Continue to monitor blood sugar. Refer to Nutrition for follow up on patient diet to improve nutritional intake. follow up with the primary care team for possible Podiatry consultation.

Wound Care Orders

Sacrum,

Cleanse wound with NSS pat dry

Apply Aquacel sheet over wound bed

Gently pack wound with rolled gauze

Apply no sting skin barrier to periwound let dry 60 seconds

Cover wound with Allevyn Life 21cm x 21cm dressing

Change daily

Left Lateral Malleolus

Cleanse wound with NSS pat dry

Apply no sting skin barrier to periwound let dry 60 seconds

Cover with 4x4 gauze

Cover wound with Allevyn Life dressing

Change daily

Left Ischium

Cleanse wound with NSS pat dry

Apply Aquacel sheet to wound bed

Apply Cavilon skin barrier to periwound let dry 60 seconds

Gently pack with rolled gauze

Cover wound with Allevyn Life dressing Change daily

Therapeutic surface ordered Envella bed (Hill Rom) low air loss surface

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

Goals

What was your goal for the day? My goal for today was to learn how to finish up teaching my new colostomy patients. Which included setting the patients up for success with ordering supplies, making sure the family and patient are comfortable with what they were taught and answering any question they have. confirming appointments, and securing all supplies they need. Even my patient who said his colostomy was gross had a positive attitude upon his discharge.

What is/are your learning goal(s) for tomorrow? Marking for a new colostomy or ileostomy patient. Follow up on all NPWT patients. My preceptor has already received a new NPWT referral for 11/16 my next clinical dat from surgery which was excision of a mass in the patient's thigh. 11/16 will be the follow up on this patient

Reviewed by: _____ Date: _____

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

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