



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jasmine J. Lee Day/Date: Monday December 30, 2024

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Candance Beeghley

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.

Patients seen to today are wounds and ostomy. Ostomy teaching perform as well as some pouch changes. One of my patients with tan ostomy also had a wound vac change as well. Which took up some time to perform even with help

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:

Follow up visit for wound vac change

S.C. 31y.o. M

Pmhx: Homeless, HIV, DM2, Protein calorie malnutrition, medical noncompliance, Hidradenitis Suppurativa. S/p debridement to bilateral buttocks and perineum on 11/19/2024

Patient came to ED 12/10 with complaints of worsening pain, swelling, and drainage to buttocks wound. Patient denies fever and chills. CT A/P reveals new tissue swelling, subcutaneous edema and increased skin thickening involving the left thigh and gluteal regions with extensive subcutaneous gas concerning for necrotizing soft tissue infection. Gen. Surgery consulted for necrotizing fasciitis- Surgery not concerned for Necrotizing fasciitis, signed off. Wound MD consulted recommended wound care follow up at wound clinic and possible SNF placement. Infectious disease consulted who then reconsulted surgery. Labs upon admission: Lactic acid 3.4, CRP 29.74, WBC 20.6 Albumin 1.4, Max temp 101.3. Blood cultures collected. Empiric antibiotics started. Sepsis protocol started.

12/13- Incision to Left buttock 24x20cm, right buttock 30x18cm, and left hip 20x12cm, per surgery. Orders given for Dakins 0.125% wet to dry performed daily by nursing.

12/15- Creation of diverting loop colostomy in order to maintain a clean environment during wound healing.

12/ 16- Ostomy teaching started by wound care nursing. Patient was instructed to help pouch emptying, and WOCN nurse continues with pouch changing.

12/26- Wound vac ordered then started, ostomy appliance changed.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

12/30- Prior to arriving to the floor, nurse was asked to premedicate the patient and was given Roxicodone and Ativan nurse was also asked to turn off wound vac approximately one hour prior to WOC nurse and CWOCN arrival as well. Once in the room, this nurse reintroduced herself to the patient, and explained what was going to happen. Patient in agreeance with the plan and already lying prone in bed. Patient asked about the level of pain that might occur during the dressing change and he was made aware that there will be some discomfort, patient then asked for as needed pain meds prior to the start of the removal. Prior to removing of the drape and foam, the line to the track pad was cut with siccors and saline inserted through the line in order to further moisten the foam and to facilitate easier removal. Adhesive removal spray was utilized in order to release the draping, and to help in the removal of the Eakin that was used to protect the peri wound prior to draping.

Removal of the foam and drape was very difficult and required that the patient be administered intravenous pain medications three separate times and benzodiazepine administered once as well. Multiple messages sent to surgical MD requesting medications for better pain management. Patient had a heart rate of 130's-180's throughout the dressing change. During the early stages of removal, patient expressed major discomfort and WOC nurse stopped removal to allow the patient to composed himself in order to continue. Normal saline was continuously applied to the foam to aid with removal. Although the patient complained of pain, with gloved hand he helped in the removal of some of the foam dressing in order to have some control of the amount of pain felt. Patient understood the need for the wound vac and was willing to undergo the uncomfortable process.

Once foam dressing was removed after about 2.5 hours of attempting to remove it, the full wound bed was visualized. Wound bed is pink, moist, no signs of non-viable tissue noted. Total wound measurement 57.5x 49.5x 0.8cm. Some undermining noted, to right ischial edge of the wound measuring 0.4 cm at 6 o'clock, Edges are slightly rolled along the transverse incision line across the lower lumbar. Serosanguinous drainage noted throughout. Excess hair around the perineal was shaved in order to help with adherence of transparent dressing and to aid in less painful removal. The last dose of pain medication was given, and patient was given time to rest before reapplying foam and drape. Cavilon no sting spray applied to peri wound and allowed to dry. An Eakin block was cut into strips and the strips applied along the edges of the wound to protect the skin. Contact layer applied to wound bed, to help with removal with next change, then black foam layer was placed and covered with transparent dressing. I then made very shallow cuts to the transparent dressing in order to make a hole that is a quarter in size, this will facilitate proper suction, without any blockage. Tubing was connected. Ensured ordered vac setting was in inputted on the machine. Once started, suction was noted to the dressing, and no air leak was noted.

Because the ostomy appliance was very soiled, the appliance was then changed. Appliance was removed and peristomal skin cleaned. Upon inspection, multiple macro papule lesions noted adjacent to the stoma, and then patient started to complain that the skin is very itchy. Light dusting of nystatin powder applied along with a light dusting of stomaheise powder and was sealed with Cavilon no sting spray. Once dry, stoma was measured. 2" Eakin barrier ring applied along the stoma. Patient preferred a one piece cut to fit appliance, and opening was cut appropriately, and placed onto the skin. Brava strips (curved barrier extender strips) applied to collar and hand placed above the appliance in order to maintain a better adhesive to the skin.

During this change the patient asked questions regarding future vac dressing changes. Patient was made aware by MD that a graft would be needed in the future and the patient inquired to CWON about where graft would be coming from. Recent MD note suggested the need to add vitamin D and zinc supplements for the patient, as well as to change their diet. Patient placed on an HS diet consisting of No beef, no dairy, and no yeast, high protein, high calorie diet. Juven was also added to diet. Patient was previously on a low air loss mattress and was ordered an Envella air fluidized bed due to the patient spending a lot of time on his right hip due to the wounds on his left hip and bilateral buttocks. The bed allows for cooler microclimate and helps to relieve pressure off the boney prominences.

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)

Removal:

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

Ensure that Wound VAC machine is turned off and tubing between the patient and the machine is disconnected. Remove transparent dressing with adhesive remover around the edges so that patient experiences less pain. Foam should lift up with transparent dressing, if there is difficulty, flood the foam with normal saline in order to help it release from the skin.

Clean/ Prep:

Clean the wound bed with normal saline.

Prep the skin:

Prep the peri wound by spraying Cavilon no sting prep spray to the peri wound and allow to dry. Apply Eakin barrier strips to the edge of the wound encircling the wound.

Apply:

Contact layer applied in order to aid with dressing removal at the next dressing change. Cut the black foam as needed to ensure that foam only touches the wound and is not laying on healthy skin. Be mindful of the number of pieces of foam used to fill the wound space. Apply Transparent dressing over the foam and ensure that all edges have been covered. Carefully cut a quarter-sized hole to the transparent dressing at the area of the lateral left thigh and apply trackpad to the area ensuring that the hole in the track pad is touching foam, this help to facilitate adequate suction.

Connect:

Connect the tubing connected to the patient to the tubing connected to the machine and turn on machine. Allow machine to fully turn on. Set the desired therapy suction and start therapy. Monitor for suction at the wound. Foam should appear to shrivel under the transparent dressing.

Trouble shooting:

- Pump and dressing should be assessed once every shift and as needed to ensure that pump is working properly. If beeping at the machine occurs, check for kinks in the tubing, check track pad to assess for blockage, check canister to ensure that it is not full, check dressing to ensure that there are no air leaks, and ensure that machine is plugged into the wall.
- Wound VAC therapy should not be interrupted for more than two hours within a 24-hour period. If this occurs, 1. Inform the physician. 2. start moist to dry dressing by wetting gauze with saline, fluffing the gauze, and applying it to wound bed and cover with a dry dressing twice daily, until evaluated by wound physician.

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

Due to the amount of pain the patient exhibited I was surprised that he was willing to follow all the way through with the dressing change. With this patient, I would have, and I did put in a request to the physician for pain medications that are to be ordered only for wound vac changes. The physicians were trying to limit the amount of intravenous pain medications both because patient was exhibiting behaviors that would suggest drug seeking and also because the patient would be transferred to a skilled nursing facility in the next week. Also, because there is very little depth to the wound, it became how small movements can cause excruciating pain. The only thing I would have done differently if I had known was to ensure that patient was better medicated for the procedure. This is the first VAC change

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

1. Experience a wound of that extent and the complexity that comes with vac changes. With all my previous vac changes I have never experienced such an intense reaction by the patient due to the removal of the foam, as well as the difficulty in removing the dressing. I learned the little tricks that can make dressing removal easier on the patient. Using the tubing to flood the foam, as well as consistent saturation with saline to assist in removal would not have been a trick I would have thought for removal.
2. This is the first time I have been in contact with a patient with Hidradenitis Suppurativa. This was something told my preceptor some weeks ago, and I was mentioned that the department does not get consulted for these as much as they would like. Unfortunately, I was only able to experience the result of severe HS, the patient's body still exhibited large pores

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

through the back. What appears to be nodules were found to the nape of the head. Scars to the axilla noted and cystic scars noted throughout the cheeks. I understand that not all patients will present this way but having an idea of what I am looking at really helps to be able to identify what you are observing.

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

My goal for the next wound day is to be better prepared for pain or discomfort experienced by the patient, by anticipating the patients' needs better.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 		
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 		
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 		
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 		
<ul style="list-style-type: none"> Identifies overall recommendations/plan 		
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 		
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 		
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 		
<ul style="list-style-type: none"> Directives are written as nursing orders 		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 		
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 		
Learning goal identified		

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.