Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Jill M Jacobson, MSN, R_____ Day/Date: ____Wednesday, May 5, 2021_____

Directions: ***WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, s***select one patient each clinical day and complete ***plan of care and chart note.***. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc** Pt is a 52 year-old Arabic-speaking only male from Kuwait with PMH including morbid obesity (admit wt 589 lbs), HFpEF, OSA, GERD, chronic right ventricle systolic dysfunction, HTN, chronic Stage 3 lymphedema, and depression. Presented from LTAC 4/3/2021 with hypoxia/hypercarbic respiratory failure, septic shock, and AMS likely in the setting of HCAP, requiring admission to the MICU for mechanical ventilation. Pt extubated 4/9/21. Also suspected to have HSV temporal encephalitis, s/p 10-day course IV acyclovir. HCAP treated with 7-day course of IV mero/zosyn. Currently pt has sacral wound being followed by wound care and pt has reported to MD a rash at his scrotum that wound care was requested to assess/treat. No recent labs were made available although previous labs indicated consistently low H&H and low serum albumin levels. Overall, pt doing well now and working on disposition and return to Kuwait.

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? 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.

Follow-up visit by WOC RN to re-assess sacral wound and address new scrotal rash. Bilingual Arabic-English speaking unit CNA acted as translator. Pt is grossly morbidly obese (>550 lbs at this time) and sat straddled over his bariatric bed on an absorbent pad and was unclothed other than having a thin blanket covering his front lower pannus area. Each lower leg was wrapped in ACE bandages and hung low in a dependent position on either side of the bed.

The pt refused to have this female WOC RN assess his scrotal rash but stated he will show the male MD. Pt leaned forward to give WOC RN access to his sacral area wound which was found open to air. The sacral wound is a HAPI, an unstageable pressure injury which developed earlier this admission after pt laid supine in ICU and for tests/scans when acutely ill.

Since last WOC assessment six days ago, the wound has slightly increased in size and depth to 3cm x 6cm x 1.5cm with new malodor. An approximate 1cm x 1cm x 1cm depression near the center of the wound has developed. The wound bed is slightly moist with a small amount of serous drainage. The wound bed is covered by approximately 25% moveable brown slough and 60% adherent tan/grey slough with spots of pink, viable tissues nearer the wound edges. After cleansing with wound wash and gauze, the wound edges were shiny and pink. The periwound skin was dry and slightly edematous.

The wound care previously provided was Triad cream and foam dressing cover daily. To address dirty wound bed, malodor/high

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bacterial load, and need for debridement, Medihoney gel was applied to devitalized tissue. The wound bed was filled with fluffed, NS moistened continuous roll gauze wet-to-dry with intent for mechanical debridement with bandage changes. Liquid No-sting skin barrier was applied to the periwound skin and the wound was covered with an Allevyn foam. A verbal consent was obtained from the pt and a photo was taken of the wound. The image was downloaded to the pt's electronic chart to optimize pt's medical care and allow a visual aid to their wound evaluation and progress. The attending MD was contacted and notified re: pt's refusal to allow female WOC RN to assess scrotal rash and pt requesting male MD to assess/treat.

(In this case the floor nurses manage the ACE wraps on the pt's lower legs although in my practice compression of any sort would be directed by the WOC RN. Compression in inpatient situations is often not indicated as the patient is lying in bed and frequently experiences a reduction in edema due to not spending significant time in dependent positions. Compression under these circumstances can lead to HAPIs. Severe edema, lymphedema, or similar may warrant inpatient compression but it should be monitored by the wound team who can assess for vascular disease and have the knowledge to properly wrap extremities with correct stretch, correct overlap.)

Barriers to healing:
Circulatory insufficiency, poor mobility, morbid obesity, malnutrition AEB chronic low levels of serum albumin and H&H.

WOC specific medical & nursing diagnosis	**WOC Plan of Care (include specific product used today)1**	**Rationale *(Explain why an intervention is chosen; purpose)***
1. Pt has pressure injury, hospital-acquired, at sacrum.	1. A. DAILY perform following wound care for sacral wound: a. Remove old dressing over site. b. Cleanse with wound cleanser and gauze, then pat dry. c. Apply thin layer of Medihoney gel to wound bed then fill with fluffed, NS moistened continuous roll gauze. d. Cover with Allevyn foam. B. Wound care team will continue to follow patient with weekly assessments. Notify wound care team for new or worsening wounds.	Drier wounds and high bacterial loads hinder wound healing. Medihoney will donate moisture and reduce bacterial load and help create a healing environment and hinder further deterioration or necrotic processes. The wet-to-dry NS soaked gauze may provide additional mechanical debridement when it is removed during dressing changes after it dries out.
2. Pt requires consistent skin integrity support to prevent skin alterations and pressure injuries.	2. A. Apply Sween cream to pannus daily. B. Apply Atract-Tain cream to BLE BID.	Sween cream is used to treat or prevent dry, scaly skin and minor skin irritations. The skin of the pannus is likely thin and compromised d/t stretching. Atract-Tain cream exfoliates and softens dry, calloused skin. Due to lymphedema, the skin on the pt's legs is similar in appearance to lipodermatosclerosis.

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	C. Maintain Compella bariatric bed.	The pt size requires the additional support of a bariatric bed to help prevent pressure injuries.
	D. Attempt to achieve offloading benefits by q2h turns/repositioning.	Although the pt has been non-compliant thus far, the nursing staff should continue to try to help him adjust/reposition to achieve any amount of offloading possible.
3. Pt is morbidly obese but malnourished as evidenced by chronically low levels of serum albumin and H&H.	3. A. Submit consult for Dietitian/nutrition evaluation and follow Dietitian recommendations.	A dietitian will provide a more thorough nutrition assessment and identify deficiencies in specific macro- and micronutrients.
	B. Offer high protein PO food choices TID such as eggs, ground poultry, and peanut butter, in congruence with the dietitian's recommendations.	Sufficient serum protein levels support skin integrity and repair.
	C. Offer iron-rich PO food choice TID such as peas, fortified bread/pasta, or ground poultry, in congruence with the dietitian's recommendation	Low tissue oxygenation due to anemia will impede skin integrity and repair. Pt's hx of episodes of severely impaired respiratory function may negatively impact pt's ability to oxygenate blood so extra attention to optimize pt's iron levels is warranted.
4. Pt lacks mobility due to bodily habitus/morbid obesity and lymphedema which impedes his circulation.	4. A. Submit consult for Physical Therapy, Occupational Therapy, and Lymphedema Specialist/Therapist (if available).	Safely getting out of bed and any PT- led strengthening exercises or ROM may help increase circulation.
	B. Follow PT/OT, Lymphedema Specialist recommendations.	

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why?	MediHoney Gel – Disadvantages: can sting when used, contraindicated for bee allergies. Alternative: SilverSorb wound gel, Iodosorb. Normal Saline – Disadvantage: Does not affect bioburden and dries out quickly. Alternative: Hydrogel. Continuous roll gauze – Disadvantage: Indiscriminate debridement when dried into wound bed. Alternative: Per the WOCN® Wound Management textbook, deep dry (or drier) wounds can be filled with fluffed gauze dampened with saline or wound gel. Deep wet wounds can be filled with alginate, hydrofiber, copolymer, or gauze. Allevyn foam bandage – Disadvantage: Expensive. Per text, not good alone for dry wounds. Alternatives: ABD pad or gauze secured with tape.

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	Sween cream – Disadvantage: Prevents silicone bandages or tape from adhering well to the skin. Alternative: skin moisturizers of different formulas – although they too will probably prevent silicone/tape adherence. Atract-Tain cream – Disadvantage: creams with urea are not supposed to be used on open wounds. Alternative: zinc-based cream.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	I did receive some more instruction on support surfaces. I informed my preceptor that I would need to have either actual or virtual instruction on support surfaces and compression to complete my clinical skills check off list. Although it does not seem actual clinical experience for compression therapy will be available at The Cleveland Clinic, I have had very good instruction from my mentor/co-worker Cathie Potts, BSN, RN, CWOCN at our place of employment – we do A LOT of compression wraps at the HOD (hospital outpatient department).
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Support surfaces, compression therapy instruction.

Number of Clinical Hours Today: 7

Care Setting: X Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _6_ Preceptor: _Elizabeth Lieberman_____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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