Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: Michelle Kahana Day/Date: July 13, 2018

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 you are acting as a nurse specialist;*** 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. ***Include pertinent past medical & surgical history and medications.***	KH is a 37 year old male pt admitted in the NICU for altered LOC. Pt was found unresponsive while working on a construction site. CT shows 0.8cc L parietal intracranial hemorrhage extending into the ventricles with associated obstructive hydrocephalus. Current neuro status: unresponsive Mechanically ventilated via trach. Nutrition per G-Tube with nutrition services managing. Past medical HX: sickle cell anemia, asthma. Medications: Hydrea 500 pGT Q8H, folic acid 1 mg QD GT, Iron tab 325 mg QD, Percocet 1 tab Q8h, Vit D 50,000 units Q weekly

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

This is the initial visit for this 37 y/o male who was found unconscious at work construction site. Requested to see pt for bilateral ischial ulcers. Pt is mechanically ventilated per trach and is unresponsive. Receiving nutrition through g-tube.

Turned onto left side. Dressing removed. Assessment notes right ischial ulcer measuring 4 cm round with depth of 3 cm and tunnel track noted at 3 o'clock position of 4 cm long. Turned onto right side. Left ischial wound dressing removed. Wound measures 4.5 cm round with depth 2 cm and track at 9 o'clock of 3 cm. Wound bed to both ischial sites with adherent tan and black devitalized tissue. Sites without drainage, no foul odor. Periwound areas are without induration or erythema. Coccyx/sacral area noted to have a DTI measuring 3 cm round. Will contact primary team to consult Plastic surgery for further evaluation. Indwelling catheter in place and draining amber colored urine in adequate amounts.

Assessment: Bilateral ischium unstageable pressure injuries, DTI pressure injuries to coccyx/sacral area.

Recommendations:
1. Ischial wounds: Cleanse with wound cleanser or NS. Loosely pack hydrogel impregnated gauze and cover with border foam daily and PRN
2. Coccyx/sacral area: Apply border foam and change every 3 days
3. Pressure redistribution: offloading, Q2H turns, heel boots
4. Maintain on Dolphin bed mattress
5. Nutrition services following for moderate Protein Calorie malnutrition.
6. Incontinence care: Cleanse skin with incontinence wipe after each episode. Apply Desitin barrier ointment daily and prn
7. Wound care team to follow: consult if worsens.
8. Plastic Surgery consult: Notify primary team.

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WOC Nursing Problem pertinent to this visit	**WOC specific direction for other care providers such as the bedside nurse, nurse assistants, etc. to follow.**	**Rationale *(Explain why an intervention is chosen; purpose)***
1. Impaired skin integrity of the bilateral ischium.	-Topical wound care – cleanse with wound cleanser or NS, loosely pack with hydrogel impregnated gauze and cover with border foam, change daily and PRN. -Implement fluid immersion simulation via support surface of the Dolphin bed. -Monitor for signs and symptoms of infection.	-Topical therapy encourages moist wound healing principles and autolytic debridement. -Fluid immersion therapy redistributes pressure and eliminates gradient shear forces. It helps to maintain adequate blood supply to the pressure points. It also provides a beneficial microclimate to the skin which promotes wound healing. -Identifying potential infection as it unfolds enables treatment to be implemented in a timely manner.
2. At risk for skin breakdown of the sacrococcygeal region and bilateral heels.	-Monitor the evolution of the DTI of the coccyx and sacrum; re-consult Wound Care Team if this area opens up. -Provide offloading and pressure redistribution via Dolphin bed, q2h turns, and heel boots.	-Offloading the areas that have sustained DTI through the means of the Dolphin bed and q2h turns will help prevent future tissue damage. -If the DTI opens into a wound, further assessment from Wound Care Nurse will be necessary in order to determine topical therapy. -Heel boots will offload the heels and serve as pressure injury prevention for these prone pressure points.

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3. Impaired wound healing resulting from poor perfusion related to sickle cell anemia, asthma, and mechanical ventilation.	-Administer medications as ordered. -Maintain MAP > 60 mmHg	Adequate perfusion to the tissues will promote optimal opportunity for wound healing.
4. At risk for skin breakdown related to IAD.	-Cleanse with incontinence wipe after each episode. -Apply Desitin barrier ointment daily and PRN. -Consider use of fecal management system or rectal pouch if stools become loose and frequent.	-A routine skin care regimen, including cleansing, moisturizing, and protecting, will help in the prevention/management of IAD. -Systems that contain fecal matter can also help in the prevention/management of IAD.
5. Impaired wound healing related to inadequate protein intake.	-Follow nutritional recommendations as per Nutrition Service Consult.	-1.25-1.5g of protein/kg of body weight per day is required for optimal wound healing.

What are the disadvantages of using this product(s)?	Dolphin bed is a costly therapy. The topical wound care requires a daily dressing change, which may put a strain on the staff nurses. Heel boots require proper application to be effective against pressure injury prevention of the heels.
What alternative product(s) could be used and why?	Envella bed could be used as alternative support surface. This surface provides air-fluidized therapy and is suitable for patients with multiple advanced pressure injuries. Placing one pillow lengthwise under each leg can be an alternative to the heel boots to offload the heels.

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

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Were you able to meet your learning goals for today? Why or why not?	Yes, I have gained knowledge on different support surfaces and offloading strategies.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I chose this case study because I was unfamiliar with the Dolphin bed as a support surface. I was curious to see how it would compare with surfaces I am familiar with, such as the Envella bed. Additionally, I wanted the challenge of piecing together how underlying medical diagnoses can potentially impact wound prognosis and identifying interventions to address that.

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

Reviewed: _____ Date: _____

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