

Daily Journal Entry with Plan of Care & Medical Record Note

Student Name:

Day/Date:

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.	Patient is a 49 year old male admitted to the hospital with generalized weakness, UTI and pneumonia. He has a past medical history of chronic kidney disease, type 2 Diabetes and hypertension. Nurse noted pressure injury to left and right buttock on admission. Patient reports he has not been unable to ambulate due to pain in right hip that started a few days ago. Sits in his chair most of the day. Patient reports poor appetite over the last few months with a weight loss of more than 30 lbs. Recent lab values: Albumin 1.9 g/dL, Hematocrit 22.9%, Hemoglobin 7.5g/dL, INR 1.4, Blood Glucose 226
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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:

Consulted to see pt for evaluation of pressure injuries, present on admission. Staff identified a Stage 3 pressure injury to left buttock and unstagable pressure injury on right buttock. Patient is a 49 year old male who was admitted with generalized weakness, UTI, and pneumonia. He is alert and oriented. Reports pain in bilateral buttocks a "5 out of 10". Has had recent pain medication with no further medications available. Agreeable to assessment. Plan to utilize deep breaths and time outs for pain management. Pt turned onto right side. Noted to have area to left buttock measuring 1.6 x 0.6 x 0.3cm. Site is moist, 85% red agranular tissue, 15% yellow slough. Unable to appreciate full wound depth. No drainage. Edges defined, periwound skin dry and intact with blanchable erythema. Site cleansed with normal saline and patted dry. Cavilon barrier film applied to periwound skin. Medihoney calcium alginate sheet cut to size of wound bed and placed in wound. Site covered with Mepilex Border Sacrum dressing. Repositioned onto left side. Noted to have area to right buttock measuring 0.6 x 0.2 x 0.1cm. Wound bed moist, 90% yellow slough, 10% red agranular tissue. No drainage noted. Edges defined. Periwound skin dry and intact with blanchable erythema. c

Pt tolerated dressing changes well. Recommend continue wound care with dressing changes every 2 days and prn. Utilized deep breathing and no time outs. Pt is able to turn independently. Pt instructed on importance of turning and repositioning at least every 2 hours. Remain off buttocks. Instructed to use air-inflated seat cushion when up to chair. Time limit of 2 hours, use of chairlifts and repositioning. Pt currently on a low air loss mattress.

Patient in agreement with plan of care. RN updated

Assessment Conclusion: Unstageable pressure injuries to right and left buttock. Present on admission.

WOC Nursing Problem pertinent to	WOC Directive Plan of Care	Rationale (<i>Explain why an</i>
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this visit	(Base this on the above data. Include specific products)	intervention was chosen; purpose)
<p>Wound nurse consulted for initial evaluation of preexisting pressure injuries of buttocks and pressure injury treatment recommendations. 49 year-old male patient with past medical history of chronic kidney disease, Type 2 Diabetes and hypertension admitted to the hospital for generalized weakness, UTI and pneumonia. Lab values significant for Albumin 1.9, Hematocrit 22.9%, Hemoglobin 7.5, INR 1.4, Blood Glucose 226. History of wound: Staff nurse noted Stage 3 pressure injuries to left and right buttock on admission. Patient reports he has not been unable to ambulate due to pain in right hip that started a few days ago. States sits in his chair most of the day. He is unable to provide history regarding wounds. Wound measurement and characteristics: Noted to have area to left buttock measuring 1.6 x 0.6 x 0.3cm. Site is moist, 85% red agranular tissue, 15% yellow slough. Unable to appreciate full wound depth. No drainage. Edges defined, periwound skin dry and intact with blanchable erythema. Noted to have area to right buttock measuring 0.6 x 0.2 x 0.1cm. Wound bed moist, 90% yellow slough, 10% red agranular tissue. No drainage noted. Dressing application and site care: Site cleansed with normal saline and patted dry. Cavilon barrier film applied to periwound skin. Medihoney calcium alginate sheet cut to size of wound bed and placed in wound. Site covered with Mepilex Border Sacrum dressing. Repositioned onto left side. Patient response to dressing change: Tolerated dressing changes well, by utilizing deep breathing and no time outs. Pt is able to turn independently. Verbalized understanding of importance of turning and repositioning at least every 2 hours, and remaining off buttocks. Time limit of 2 hours, use of chairlifts and repositioning. Therapeutic support surface used: Low air loss mattress and air-inflated seat cushion</p>	<p>For dressing change:</p> <p>Cleanse site with normal saline and pat dry with soft towel.</p> <p>Apply Cavilon barrier film to periwound skin.</p> <p>Cut to size Medihoney calcium alginate sheet and place inside of wound.</p> <p>Cover with Mepilex Border Sacrum dressing.</p> <p>Continue wound care with dressing changes every 2 days and PRN</p> <p>Turn and reposition patient at least every 2 hours to remain off buttocks. Use air-inflated seat cushion when up to chair. Time limit of 2 hours. Continue use of low air loss mattress for duration of hospital stay.</p>	<p>Cleansing the wound with normal saline removes dirt, feces, and other cytotoxic material that may cause infection and hasten wound healing time.</p> <p>Protecting periwound skin is as important as protecting the wound itself. Cavilon barrier film is non-stinging, and will not interfere with healing.</p> <p>Medihoney contains active <i>Leptospermum</i> (Manuka) honey that helps to promote a moist wound environment that aids and supports autolytic debridement</p> <p>The <i>Leptospermum</i> species demonstrates significantly faster healing when compared with conventional dressings. The osmotic activity pulls fluid to the surface of the wound, maintaining a moist wound environment</p> <p>Mepilex sacral dressing holds the dressing underneath in place while preventing further injury and a worsening wound. Foam dressings help to reduce the vertical pressure, shear, and friction of the skin, of which the bedbound patient is at risk, and effectively preventing the occurrence of pressure damage.</p>

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when up to chair.		
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What are the disadvantages of using this product(s)?	<p>Advantages of Medihoney listed are retrieved from healthline.com (https://www.healthline.com/health/honey-on-wounds#effectiveness): Acidic pH promotes healing. Honey has an acidic pH of between 3.2 and 4.5. When applied to wounds, the acidic pH encourages the blood to release oxygen, which is important to wound healing. An acidic pH also reduces the presence of proteases that impair the wound healing process.</p> <p>Sugar has an osmotic effect. The sugar naturally present in honey draws water out of damaged tissues in turn reducing swelling and encouraging the flow of lymph to heal the wound. Sugar also draws water out of bacterial cells, which can help keep them from multiplying. The enzyme glucose oxidase, produces gluconic acid and minute amounts of hydrogen peroxide when in contact with the wound surface.</p> <p>Antibacterial effect. Honey has been shown to have an antibacterial effect on bacteria commonly present in wounds, such as methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) and vancomycin-</p>
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	<p>resistant Enterococci (VRE). Part of this resistance may be through its osmotic effects. Anti-odor. Helpful for chronic, exudative wounds.</p> <p>A disadvantage to this dressing is that it is not readily available in most hospitals and needs to be special ordered prior to dressing changes. It is moderately costly, with dressing change frequency Q48 hours. Some patients experience stinging pain after the application of medical honey to the wound. Because of this, treatment with medical honey has to be stopped. Additionally, a patient may also have allergic reaction to the honey, which contraindicates its use. Medihoney is not an antiseptic; it does not have a fast onset of activity, as it does not seem to produce the desired reduction of bacteria and fungi in 1–10 min. (Simon, et al., 2009).</p> <p>Simon, A., Traynor, K., Santos, K., Blaser, G., Bode, U., & Molan, P. (2009). Medical honey for wound care--still the 'latest resort'?. Evidence-based complementary and alternative medicine : eCAM, 6(2), 165–173. https://doi.org/10.1093/ecam/nem175</p>
<p>What alternative product(s) could be used and why?</p> <p>(This is your opportunity to share your product knowledge and apply critical thinking)</p>	<p>For periwound protection: Application of a thin layer of zinc oxide cream. For inside of the wound: Gauze impregnated with hydrogel to place inside of the wound in order to maintain a moist wound bed. Hydrogel is moisturizing and removes any necrotic tissue. Or, Mepilex Ag dressing in place of the Medihoney dressing. These are more economical than Medihoney products.</p>

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

<p>Were you able to meet your learning goals for today? Why or why not?</p>	<p><i>n/a</i></p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>I aim to learn more about cost-effective dressing options for advanced pressure injuries such as this case.</p>

Reviewed by: _____ Date: _____

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