Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Cimarron Smith Day/Date: July 17th

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	30 year old caucasian male in MVA, restrained passenger. Weight 189.5 Kg. EMS reported heavy damage to the vehicle. Noted to have deformity to LLE. Tetanus and Ancef given in trauma bay. Consulted orthopedic for open fracture to lower extremity. I&D left femur, closed reduction left hip, and left knee. Left hip arthrotomy and removal of foreign bodies performed two days later. Wound debridement with removal of external fixator and fixation of the left tibial plateau performed 4 days after initial surgery. Patient has history diabetes, HTN, obesity, asthma and venous stasis ulceration. CT Angio Abd/pelvis: pneumoperitoneum with gas and blood in pelvis concerning for rectal injury.

Write a chart 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 30 y/o male who is being seen for evaluation and management of LLE wound following a MVA. Pt has undergone surgery to extremity including I&D left femur, closed reduction left hip. Left hip arthrotomy and removal of foreign bodies performed two days later. Wound debridement with removal of external fixator and fixation of the left tibial plateau performed 4 days after initial surgery. Dressings dry and intact to all LLE surgical sites. Patient is on a Hill-Rom 1000. Voices being sore and needing assistance to reposition. Braden Scale completed and noted to be 13. Sensory impairment to BLE feet. Skin is often moist and requires a linen change a few times each shift. Requires moderate to maximum assistance in moving and transferring to chair. Non-weight bearing to LLE. Pt agreeable to dressing change. Pre-medicated by nursing staff. Dressing removed to left hip. Scant sersosanguinous drainage noted on old dressing. Staples in place to incision line, well approximated and without erythema or induration. Mepilex border foam dressing applied. Dressing removed to LLE knee/tibia of NS moist dressing. Pt voices discomfort. Time out taken and encouraged pt to deep breath. Wound measures 10 cm wide x 25 cm long and 7 cm deep. Wound bed red with visible bone. No undermining or tunneling noted. Moderate amount serosanguinous drainage noted to old dressing. Discussed clinical findings with surgeon. Site dressed with NPWT device. Adaptic contact layer dressing of 8 layers applied over exposed bone followed by one piece

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black foam. Dressing secured with transparent film. Connected to 125 mmHg continuous suction and seal obtained. Utilizing deep breathing and distraction to manage pain along with time outs when requested. Tubing tracked up LLE to prevent fall hazard. Discussed dietary needs for wound healing and staying within diabetic diet needs. Agreeable to dietician consult to assist with meal planning. Head to toe assessment completed. Blanchable erythema on sacrum and bilateral heels. Patient states often does not call for assistance. "Hurts to move." Discussed need for repositioning. Verbalizes understanding. Discussed POC with pt and agreeable. Questions answered to pt satisfaction.

Plan: Continue pressure redistribution and moisture control strategies
Continue wound care of border foam to hip with every 3 day dressing change. Peel back to assess daily
Continue NPWT to LLE knee/tibia. Dressing change 3xwk
Increase protein in diet, manage blood sugars/diabetes
Begin discharge planning with NPWT device

Will follow at intervals.

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
1. ***Impaired wound healing*** 2. ***Impaired skin integrity*** 3. ***Increased risk for infection*** 4. ***Pain***	1. ***NPWT therapy initiated – troubleshoot therapy per guidelines. If therapy discontinued for more that 2 hours remove dressing and pack wound lightly with NS moistened gauze, cover with ABD and secure with tape; contact WOC nurse immediately*** ***Change all dressings per wound care order*** ***Nutrition consulted: re-educate patient on need for maintaining diabetic diet and increased protein*** ***Assess labs for signs on malnutrition, anemia and electrolyte imbalances; alert MD to abnormal labs for changes to care; administer medication for order*** ***Accuchecks ac/hs; administer antidiabetic medication per MD order; follow established hypoglycemia/hyperglycemia protocols.*** 2. ***Order bariatric bed and obtain a low air loss surface feature*** ***Perform daily skin checks*** ***Turn patient every 2 hours or more frequently as needed*** ***Place foam dressing and sacrum/coccyx, and heels and elbows*** ***Float hells off bed***	1. All staff nurses should be aware of how to troubleshoot NPWT treatment. If therapy can't be restarted with 2 hours dressing should be removed and keeping them in place could increase infection risks; Maintaining normal blood glucose levels and increasing protein in the patients diet will aid with wound healing by decreasing the inflammatory stage that can be cause by increased blood glucose and increasing protein needed for tissue development; assessing labs for signs of anemia and electrolyte abnormalities if also important for wound healing ad wound need

	Perform daily skin care and PRN peri-care ***Change linens daily and more frequently when wet*** ***3. Assess vital signs and labs for risk of infection; contact MD with abnormalities for needed changes in treatment*** ***4. Premedicate patient before NPWT dressing changes*** ***Administer scheduled and PRN medication per MD order*** ***Use non-pharmacological strategies for pain control such as, limb elevated, repositioning, relaxation methods, distraction, guided imagery, etc.***	oxygen and electrolytes for healing. 2. These interventions are skin intervention strategies. Keeping the skin moisturized prevent breakdown from friction share forces and offloading decrease pressure injury risks; low air los mattresses help with pressure redistribution and also air flow to keep the patient's skin dry. 3. Infection prolongs a wounds inflammatory stage slowing the wound healing process. 4. Pain control will help patient to comply with care intervention for wound healing and skin breakdown prevention.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	***NPWT treatment*** • ***Pros: remove excess fluid from wound; improving circulation to wound; increasing granulation tissue formation*** • ***Cons: pain with therapy and dressing changes; increased bleeding risks*** ***Mepilex foam*** • ***Pros: atraumatic removal; absorptive dressing; offload pressure from wound; doesn't require frequent changes; dressing is replaceable aiding assessments daily without needing to change the dressing.*** • ***Cons: set sizing; adhesive may cause irritation to skin or trauma if not properly removed*** ***Adaptic contact layer*** • ***Pros: helps to protect bone during NPWT treatment; provides atraumatic removal; allows for even negative pressure redistribution for wound healing with NPWT treatment*** • ***Cons:***

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?	Yes; I continued to learn about using NPWT treatment and non-pharmacological ways to aid with pain.
What are your learning goals for tomorrow? **(Share learning goal with**	Learn about the different support mattresses and the availability for use

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preceptor)	

Number of Clinical Hours Today:

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

Number of patients seen today: __ Preceptor: _____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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