

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lisandra Santos del Castillo Day/Date: 01-11-2021

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, 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	<p>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.</p> <p>Patient has history diabetes, HTN, obesity, asthma and venous stasis ulceration.</p> <p>CT Angio Abd/pelvis: pneumoperitoneum with gas and blood in pelvis concerning for rectal injury.</p>
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

<p>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 serosanguinous 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 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 do not call for assistance. "Hurts to move." Discussed need for repositioning. Verbalizes understanding. Discussed POC with pt and agreeable. Questions answered to pt satisfaction.</p> <p>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</p>

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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)
<p>LLE Wound</p> <p><u>Need to consider PI prevention strategies—so the diagnosis would be increased risk for PI (Braden 13). In the POC, what measures would you specifically take to help in this prevention? Clues can be found in the scenario for areas that he shows himself to be at high risk.</u></p>	<p>Wound care Cleanse the wound with NS and change the linen dressings three times a day. <u>I do not understand; there are no linen dressings with NPWT. Your current recommendation is use of NPWT to this deep (7cm) wound with a bone visible. Why are you thinking to change it to something else now?</u> Apply Adaptic contact layer dressing and Mepilex border foam dressing and change them once in a day. <u>See comments in rationale.</u> Apply the Negative Pressure Wound Therapy (NPWT) device when the serosanguinous drainage increases. <u>That is what is currently happening and why the NPWT is ordered.</u> Offer the pt. assistance to reposition for every two hours. <u>Okay. What else would you do for the moisture control/blanchable erythema?</u> Integrate time outs, distractions, and deep breaths to help pt. manage pain and discomfort during the application of the dressing. <u>Okay.</u></p>	<p>The frequent linen change is necessary for the moist skin around the wound. <u>I am confused; the linen change is referring to the bedsheets secondary to excessive moisture. He is 189.5 kg (417 lbs), so I am thinking that is part of the reason he is sweating. Additionally, one wonders if his pain is under control—may need to ask for pain med consult to manage pain meds (secondary to added tissue, wonder if “standard” dosages are helping—it needs evaluated.</u> Additionally, NS is not toxic and it cannot damage the healing tissues, as well. Adaptic contact layer dressing will offer the management of heavy exuding that might arise from the LLE wound. <u>No, it has no absorptive capacity; it is a contact layer to prevent pulling on the underlying tissues and prevent the suction directly on the bone.</u> On the other hand, the Mepilex border foam dressing usually creates the moist environment and enhance the debridement of the slough. <u>There is no slough to be debrided. The Mepilex is used on the closed incision to absorb drainage, maintain a moist environment, and cut down on daily dressing changes, which will assist with wound healing at the surface as well as optimize nursing staff time.</u> The use of the NPWT device will place pressure on the LLE wound to reduce the serosanguinous drainage. <u>It helps to pull fluid from the tissues so that it better manages.</u></p>

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		<p><u>the fluid; it does not exactly decrease the drainage.</u></p> <p>The occasional repositioning of the pt. will reduce any discomfort that might arise from lying on one side for a longer time. <u>It helps to prevent PIs.</u></p> <p>At the same time, the extreme pain that arises from the repositioning or dressing process might require time outs, deep breaths, and distractions. <u>Yes. May also need to evaluate effectiveness of the pain med.</u></p>
	<p>Consult with diabetic educator</p> <p>Dietary needs – arrangement of meal planning that can initiate significant wound healing.</p> <p>Create a dietary intake log that captures all the key nutrients. <u>Okay to all.</u></p>	<p>The patient has a history of diabetes. Therefore, the assessment of various diabetic complications that might interfere with the wound healing process should be a priority. In this case, the dietary needs will ensure that the patient has adequate nutrients that will facilitate the wound healing. <u>Okay.</u></p>
	<p>Consult with bariatrician</p> <p>Weight loss arrangements – improvement of nutritional status. <u>Do you want to do this now while he is recovering from a major accident with severe injury?</u></p> <p>In-depth illustration on the complicated anatomy of capillary diffusion, fat lobules, oxidative stress, and decreased vascularity in obese patients. <u>I would postpone that until he is improved. Does need to be addressed eventually.</u></p> <p>Explore appropriate measures to reduce the risk of infection. <u>These would be what?</u></p> <p>Suggest ways that pt. can use to initiate self-management of LLE wound. <u>More specific.</u></p> <p>Assess circumstances that might need compression therapy. <u>What would this be? You need to tell staff what they need to do specifically for any identified problems.</u></p>	<p>Even the patient’s higher BMI and history of obesity shows that some of these factors might interfere with the healing process. <u>True, but I question your timing. He is in the middle of a crisis, and I am not sure weight loss at this time should be the goal. Appropriate nutrition to meet bodily needs and provide for management of diabetes would be the goal.</u> As such, the bariatrician will portray the underlying issues that might undermine the healing. <u>I do not understand the use of the word “portray” in this instance.</u> In this regard, the bariatrician will pinpoint other suggestions that are necessary for implementing appropriate clinical measures. <u>I think this would be a good future consult, just not at the moment.</u></p>

<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p> <p>(This is your opportunity to share your product</p>	<p>At times, the infrequent dressing changes of Mepilex border foam dressing might result in the ingrowth of new tissues into the dressing. <u>Rarely happens, but could I suppose. It has a silicone outer layer.</u> Hence, the nurse might shift to Allevyn Adhesive as an alternative since it does not stick to the wound. <u>Okay.</u></p> <p>If the Adaptic contact layer dressing is used as a primary layer, exudate might pass freely through its mesh. Hence, JELONET paraffin gauze dressing can act as an alternative to Adaptic due to its retention options and presence of secondary dressings. <u>You do not want to hold moisture next to the primary wound.</u></p>
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<p>knowledge and apply critical thinking)</p>	<p>In some instances, the use of the NPWT device might be associated with painful dressing changes or even skin irritation. Nurses might use the sealed gauze dressing as an alternative to the NPWT device. <u>If the NPWT does not do its job correctly (and pain is one of the problems) you could switch to something else. For pain with NPWT, you can look at the type of contact layer that is used and perhaps switch to something else, use continuous suction versus intermittent, or decrease the suction on the device. For skin irritation, prophylactic use of a skin sealant on the intact periwound skin is appropriate; you could also “window frame” or Picture frame the periwound skin with drape or a thin hydrocolloid.</u></p>
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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>Yes. The session has portrayed how to incorporate technological intervention in facilitating appropriate wound care. For instance, the use of the NPWT device showed the need to place pressure on the wound in order to minimize the serosanguinous drainage. <u>See above comments. Review why NPWT is chosen for wound healing.</u></p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>To understand the importance of each type of dressing and the application to different forms of wounds or pressure injuries. <u>Good.</u></p>

Care Setting: Hospital

This plan of care will need to be redone. You have made some strides in the right direction, but your technical information about management methods is a bit off. Additionally, you need to include PI prevention.

Reviewed by: Barbara J. Hocevar, MSN, RN, CWOCN; January 11, 2022

****References are not generally required for daily journals**

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