Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: Seju Myers Date/hours: 2/24/2022 (8AM – 5PM)

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.***	This 72-year-old female is paraplegic and is wheelchair-bound. It has been for several years in this state of health from a vertebral fusion and injury with feal incontinence. She recently presented to the ER with decubitus on a CT scan. There was some air tracking from the external sacrum through and into the perirectal area. With these findings, surgical debridement and laparoscopic ostomy creation were performed on 2/18/2022. **Surgical history**: - Neuroplastic & Transpose median nerve carpal tunnel - Inguinal hernia repair **Medication**: Zosyn 3.375g IV, Miralax 17g PO, Glucagon 1mg Subcu, Heparin 5,000units Subcu, Tylenol 1,000mg PO, Coreg 3.125mg, Protonix 20mg PO, Neurontin 300mg PO, Lipitor 40mg PO, Apresoline 10mg PO, Ultram 50mg PO

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:

REASON FOR REFERRAL: Consultation for NPWT

The patient has an unstageable pressure injury on the sacrum area with a colostomy on LLQ. The size of the injury was 16x13cm, and the depth is 5.5cm. 3.5cm depth of tunnel was presented at 4~7 o'clock and necrotic tissue was debrided on 2/16/2022 in OR. The wound was red without odor and exudate, and the edge of the wound was irregular. The patient got a pain medicine before the WOC nurse visit and was worried about NPWT. The WOC nurse explained how NPWT works for her wound and encouraged her. During the assessment, she

complained of mild pain, but it was tolerable.

The wound was covered wet Kerlix and ABD with gauze. It was removed and cleaned with normal saline then pat dry. Applied transparent dressing on the sacral area and removed the center that was above the wound. Applied a long transparent dressing, which connects from the dressing on the sacral area to the front of the iliac crest for the pump connector. Wet Kerlix was applied to the tunnel area. The wound was covered by black foam then transparent drape tightly and negative pressure was achieved at -125mmhg. No leakage was found. Wedges applied under Rt. Shoulder and upper leg.

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)***
Maintain negative pressure with intact dressing	**Maintain/Reinforce dressing without air leaking**: -Apply transparent tape on the air leak if it found - Apply black foam only in inside of incision - Cover all edge of skin with transparent tape. Dressing changing schedule: Monday & Thursday **Reinforce the pump's working:** - Maintain -125mmHg pressure - Check the black foam is shrunk well in every shift (If foam is not shrunk, check air leak on the edge of the dressing and the canister tube. If filed, notice to WOC team) - If blockages found in the drainage tube, change the whole canister -Monitor bleeding with regular measuring the amount of drainage (Bleeding signs: Drainage color changes to blood, fast filling in the drainage chamber, and unstable vital signs) -If bleeding, stop the pump right	Blocking a small air leak on the dressing enables to maintain the NPWT dressing instead of changing the whole dressing. Maintaining pressure (-125mmhg) enables to remove of discharges and promote the tissue to grow healthy cell. In addition, negative pressure removes the infection source from drainage that can be a bed for bacteria. The clinical level of pressure for NPWT is between 50~150mmHg. Over 160mmHg setting showed bleeding in some cases and is not effective to improve wound healing than under 150mHg through various clinical research.

Manage pain **Maintain off-load**	away and notice to Dr. (Apply extra pressure with Kerlix or other thick dressing on the wound site. Never remove the wound dressing without an instructions or order from Dr.) -Monitor infection (mal-odor or yellow or creamy discharge, and vital sign changes) in every position change -If infection shows, notice to Dr. -Provide pain medicine before dressing change -If pain is not controlled with pain medicines, notice to Dr. -Require position change every 2 hours -Apply edges for off-loading the wound site (Hand check required after applying edges)	NPWT is covered by a tight invisible dressing, so it could be hard to find out infection. For this reason, drainage color, amount, and odor with the patient's vital signs should be monitored. Dressing change of NPWT triggers severe pain, so prior pain management before dressing change is important for the patient comfort and cooperative dressing change. For preventing further damage and maintaining the current dressing, changing position every 2 hours should be performed. Especially, the wound site should be checked with hand after changing position or reapplying edges for making sure the site is off-loaded.

What are the disadvantages of using this procedure?	The most dangerous disadvantage of NPWT is bleeding from strong suction power accidently. Constant suction power could cause constant pain.
What alternative product(s) could be	I think an alternative is regular compression dressing. This is safer but less beneficial than the NPWT dressing to heal the wound fast.

used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	

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 was able to meet my learning goal today.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Tomorrow, I'd like to see more cases of wounds.

M2-105, Chizu Sacai, 8am ~5:50pm
Reviewed by: _____Date: _____