Cleveland Clinic

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

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.***	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 Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
Impaired skin integrity related to bilateral ischium unstageable pressure injuries	• Perform wound care to bilateral ischial wounds o Cleanse wounds with wound cleanser or normal saline o Loosely pack hydrogel impregnated gauze in wounds and areas of tunneling o Apply border foam over wound • Perform wound care daily and when needed due to removal or dressing saturation • Assess wound progression/regression with each dressing change o Measure and photograph wounds weekly and when significant changes noted • Consult WOC nurse for recommended dressing protocol changes and with signs of wound regression • Remove excess moisture at earliest notice o Change linens daily and as needed o Check for incontinence Q2 hours and with turns and cleanse according to instructions later in plan	• Cleanse wound of debris and exudate to promote continued wound healing • Fills dead space while providing necessary moist environment conducive to wound healing and cell regeneration. Also assists with debridement of eschar • Absorb exudate while conforming to ischium shape • Change schedule allows for optimal wound healing time as well as prevention of peri-wound maceration and further breakdown (could occur if saturated dressing were left on longer than ordered) • Continued assessment addresses whether correct dressing is being used for current state of wound. WOC is then able to adjust treatment plan for patient based on presenting changes. Photographs and measurements help maintain documentation regarding progress/regression • Excess moisture leaves skin more susceptible to breakdown and can inhibit wound healing – weakens tensile strength of the skin layers
Impaired skin integrity related to coccyx/sacral area DTPI	• Perform wound care to coccyx/sacral area DTPI o Apply border foam	

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	• Perform wound care Q3 days and when needed due to dressing removal or saturation • Assess wound with dressing changes and notify WOC nurse and surgical team of any changes o Measure and photograph wound weekly and when significant changes noted • Refer to plastic surgery recommendations for further care • Avoid pressure to area at all times – maintain right or left side-lying positions when turning	• Cushion area from pressure, shear, and friction forces. Protect area to facilitate tissue healing • Change frequency allows for scheduled assessments while remaining in place for time needed for tissue healing • Continued assessment addresses whether correct dressing is being used for current state of wound. WOC is then able to adjust treatment plan for patient based on presenting changes. Photographs and measurements help maintain documentation regarding progress/regression • Plastic surgery is consulted and will come up with any further instructions for care • Help to redistribute pressure from the coccyx/sacral area to allow for tissue healing and decrease chances or further damage
Risk for inadequate perfusion for wound healing due to sickle cell anemia	• Consult primary team for underlying disease treatment and pain control strategies • Apply compression wraps to BLE upon waking o Perform ABI to rule out arterial insufficiency (0.9 or less) – if noted, compression wraps contraindicated • Avoid venipunctures to BLE • Perform full skin assessment Q4 hours for signs of impaired skin integrity (breakdown, erythema, induration, etc.)	• Treatment of sickle cell anemia requires disease management. The patient is taking Hydrea 500 pGT Q8H for this. Sickle cell crises can cause severe pain, so pain management is crucial for these patients. If pain is unmanaged, this can also affect wound healing by decreasing blood flow and oxygen to the healing tissues • ABI must first be performed to determine if arterial

Risk for impaired skin integrity due to indwelling catheter placement, trach placement, g-tube placement, and decreased mobility	• Track urinary catheter tubing down leg out from under patient's legs
	• Perform catheter care daily
	  o Cleanse tubing with soap and water
	  o Cleanse perineal area with incontinence wipe after each episode
	  o Assess catheter site Q4 hours with full skin assessment
	• Apply Desitin ointment daily and as needed to perineal area
	• Cleanse neck and stoma site daily with soap and water
	• Secure trach with neck ties
	• Cleanse g-tube site daily with soap and water
	• Avoid manipulation of g-tube – secure with cath-grip if needed
	• Perform pressure redistribution and turning schedule Q2 hours – right side-lying and left side-lying – avoid supine
	  o Maintain heels in boots at all times
	  o Maintain patient on Dolphin mattress
	• Consult WOC nurse for any signs of impaired skin integrity
		disease is present. If it is not, compression wraps will help promote blood return to the heart (patients with sickle cell anemia often have vascular disease)
		• Prevention strategy to avoid LE wounds
		• Continued frequent assessments helps to note any changes to skin integrity and any needed skin care to treat changes
		
		• Prevents pressure and skin breakdown from tubing laying under leg
		• All cleansing measures remove irritants from skin to prevent breakdown from moisture. Assessment allows for continued visualization of insertion site and notification if impaired skin integrity is present
		• Protective barrier for the skin from irritants and moisture
		• Cleanse debris and remove any moisture or exudate from stoma site
		• Decrease trach manipulation to avoid stoma irritation and breakdown
		• Cleanse debris and remove any moisture or exudate from stoma site
		• Decrease g-tube manipulation to avoid stoma irritation and breakdown
		• Redistribute pressure away from bony prominences to maintain adequate blood

		flow and avoid impaired skin integrity. Avoid turning supine to relieve pressure placed on coccyx/sacral DTPI. Boots redistribute pressure placed on heels when lying on bed (heels are especially susceptible to pressure because of limited tissue present between skin and bone • Combat heat and humidity build up on the skin while facilitating pressure redistribution and envelopment as well as decreasing friction present • Alerts WOC for change in skin integrity and when treatment may be needed

What are the disadvantages of using this product(s)? **What alternative product(s) could be used and why?** (This is your opportunity to share your product knowledge and apply critical thinking)	**Hydrogel impregnated gauze**: may dehydrate and stick to the wound bed making for painful removal, require secondary dressing, can macerate periwound skin **Alternatives**: hydrogel with normal saline dampened gauze. This options donates moisture to the wound for an adequate healing environment as well as promote autolytic debridement **Border foam**: may cause maceration to periwound skin from absorbed moisture **Alternatives**: transparent film covering. The film maintains the moist environment and facilitates autolytic debridement of the devitalized tissues my providing a non-occlusive seal **Border foam**: can become saturated from incontinence episodes requiring frequent change **Alternatives**: silicone border foam (allevyn 4x4) This option may help to alleviate possibility of saturation from other sources.

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, today I learned a lot about the reasons different dressings are chosen and how they each can affect a wound's healing and progress.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Tomorrow I would like to learn more about compression therapy

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

Reviewed: _____ Date: _____

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