

Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: Christine Pennington

Day/Date: 9/18/22

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
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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:

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.

WOC Nursing Problem pertinent to this visit	WOC Directive Plan of Care (Base this on the above data. Include specific	Rationale (Explain why an intervention was chosen; purpose)
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	products)	
1) Deep tissue injury to coccyx	1) Cover deep tissue injury with mepilex dressings, change q3 days and when soiled a) pull down mepilex dressing to assess deep tissue injury site Qshift	1) covering DTI's with foam dressings can help put a protective layer between the injured area and the injuring area a) daily assessment of wounds is crucial to assess if proper wound healing is occurring
2) Unstageable pressure injuries to BL ischiums	1) Cleanse bilateral ischial wounds with normal saline moistened gauze. - Fill bilateral ischial wounds with skintegrity (hydrogel by medline) moistened gauze and cover with Bordered Gauze dressing - Change daily and PRN/when soiled	1) hydrogel will help to keep wound beds moist and will help to moisten and remove devitalized tissue with dressing changes. Bordered gauze will help to keep these gauze dressings in place.
3) Immobility	1) Turn and reposition q2 hours off coccyx and ischial wounds using wedges behind back and behind thighs 2) Apply preventative measures - Apply prevalon offloading boots to bilateral lower extremities. Remove daily to assess skin - Utilize Z-flow fluidized positioner pillow under patient head to prevent occipital injuries. - Lift patient head and reposition pillow under head q2 hours unless contraindicated by neurosurgery team. - Utilize dolphin bed specialty surface	1) Repositioning every 2 hours will prevent additional deep tissue injuries over bony prominences 2) Preventative products such as offloading wedges and boots will help to prevent hospital acquired pressure injuries a) Occipital pressure injuries are common in high risk skin breakdown patients in ICU. Offloading pillows can help to prevent occipital injuries. b) Dolphin beds are an excellent air loss surface that help prevent pressure injuries in high risk populations.

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3) incontinent of stool	1) Cleanse perineal skin daily with Theraworx cleansing wipes after each episode of stool incontinence PRN and as needed. - Apply Desitin barrier cream to perineum daily and as needed	1) Theraworx is a pH balanced gentle skin cleanser which is beneficial for incontinence-impacted skin. Deisitin cream helps creates a gentle skin barrier which can help with incontinence dermatitis.
5) nutrition deficit related to critical illness	1) follow nutrition recommendations	6) Nutrition promotion and increase in protein will promote wound healing

<p>What are the disadvantages of using this product(s)?</p>	<ul style="list-style-type: none"> • Bordered dressings are an appropriate dressing for holding a wound-filling product, but they do little to nothing to protect bony prominences from excess pressure. • Hydrogel impregnated gauze is good for keeping ulcerated wounds filled, but the increased moisture can macerate surrounding tissue. They also require more frequent dressing changes than some other products. Some intensive care unit patients may not be able to tolerate turns without becoming hemodynamically unstable.
<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>To better protect bony prominences, foam dressings such as mepilex foam dressings can be utilized and can hold wound willing products in place.</p> <p>Instead of a hydrogel impregnated gauze, a manuka honey impregnated gauze (Therahoney by Medline) can be utilized to help promote autolytic debridement.</p> <p>A skin protectant can be placed around the peri-wound skin as a moisture barrier to prevent maceration which will promote healing – such as cavilon advanced skin protectant (3M) or Sureprep no sting barrier wipes (Medline)</p> <p>To prevent maceration of peri-tube skin and dislodgement of the G-tube, a tube stabilizer such as a Hollister horizontal/vertical tube stabilizer can be utilized.</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>Yes. I learned the different utilizations for pressure injuries that are used for the intensive care patient population, and how different services can help to promote skin and wound healing such as nutrition.</p>
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What are your learning goals for tomorrow?

(Share learning goal with preceptor)

I want to learn more about how using barrier creams and ointments prevent worsening of incontinence dermatitis vs. using a topical barrier product such as Cavilon advanced.

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

Reviewed revision: Patricia A. Slachta

Date: 10/3/22

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