Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Laura Clermont_____ Journal Completion Date: __1/20/23_____

Setting: __X___ Acute Care _____ Outpatient _____ HHC ____ Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	Patient is a 49 year old male admitted to the hospital with generalized weakness, UTI and pneumonia. He has a past medical history of chronic kidney disease, type 2 Diabetes and hypertension. Nurse noted pressure injury to left and right buttock on admission. Patient reports he has been unable to ambulate due to pain in right hip that started a few days ago. Sits in his chair most of the day. Patient reports poor appetite over the last few months with a weight loss of more than 30 lbs. Recent lab values: Albumin 1.9 g/dL, Hematocrit 22.9%, Hemoglobin 7.5g/dL, INR 1.4, Blood Glucose 226

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

Initial consult for evaluation of pressure injuries, present on admission. Patient is a 49 year old male who was admitted with generalized weakness, UTI, and pneumonia. PMH includes chronic kidney disease, type 2 Diabetes and hypertension. Medical record review notes a Stage 3 pressure injury to left buttock and unstagable pressure injury on right buttock. Pt is alert and oriented. Reports pain in bilateral buttocks a "5 out of 10" with recent pain medication with no further medications available. Voices has been non-ambulatory related to the pain and spends most time in chair. Agreeable to assessment. Pt encouraged to utilize deep breathing and ask for time outs for pain management during assessment. Verbalized understanding. Pt turned onto right side. Wound noted to left buttock. Site cleansed with wound cleanser. Wound noted to have defined edges with wound bed 85% red agranular tissue, 15% yellow slough and moist. No drainage. Wound measures 1.6 x 0.6 x 0.3cm. Periwound skin dry and intact with blanchable erythema and without induration. Cavilon barrier film applied to periwound skin. Medihoney calcium alginate sheet cut to fit wound bed and placed in wound. Site covered with Mepilex Border Sacrum dressing. Tolerated without need for time out and deep breathing. Repositioned onto left side. Wound noted to right buttock. Site cleansed with wound cleanser. Pt noted to be taking slow deep breaths during cleansing. Wound edges defined with moist wound bed, 90% yellow slough, 10% red agranular tissue. No drainage noted. Wound measures 0.6 x 0.2 x 0.1cm. Periwound skin dry and intact with blanchable erythema and without induration. Cavilon barrier film applied to periwound skin. Medihoney calcium alginate sheet cut to size of wound bed and placed in wound. Site covered with Mepilex Border Sacrum dressing. Pt tolerated dressing application without deep breathing or need for time out. Pt instructed on wound care, pressure redistribution including: need to offload areas, turn and reposition every 2 hours, limit time up in chair to 2 hour increments, utilize air chair cushion, use of chairlifts and repositioning. Pt verbalized understanding of teaching. Denies questions. Agreeable to POC.

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Assessment: Unstageable pressure injuries to right and left buttock.

Plan:

- Continue wound care of alginate and foam. Change every 2 days and prn.
- Utilize deep breathing, time outs, and medications to manage pain.
- Offload areas: turn and reposition every 2 hours, chair cushion, limit time up in chair and chair lifts
- Continue with low air loss mattress.
- Dietary consult
- Blood sugar monitoring with treatment as ordered

Will follow at intervals. Staff to notify WOC nurses for concerns, change in wounds.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Bilateral, unstageable pressure injuries to left and right buttocks.	**Daily care for each pressure injury:** **1. Cleanse with wound cleanser** **2. Cut Medihoney calcium alginate to size of wound bed and apply to wound.** **3. Cover with Mepilex border sacrum dressing.** **4. Frequency: change every 2 days and PRN.** **Offloading protocols:** **Turn and reposition every 2 hours** **Use air chair cushion when up in chair and ensure proper placement and functioning.** **Limit amount of time in chair, no more than 2 hours or at meals.** **Continue to utilize low air loss mattress and ensure proper functioning.**	**Medihoney calcium alginate will promote autolytic debridement and slough removal from wound bed.** **Mepilex border sacrum dressing provides waterproof cushioned protection of the wound and holds dressing in place.** **The patient is at a high risk for developing additional pressure injuries in the presence of two unstageable pressure injuries on his buttocks. Offloading is a preventative measure to limit pressure over bony prominences.**
Impaired wound healing related to co-morbidities.	**Consult with physician regarding abnormal labs with treatment as ordered.** **Continue blood sugar monitoring with treatment as ordered.**	**Abnormal labs need to be addressed with physician. Low albumin, low hematocrit, and low hemoglobin are factors that contribute to delayed wound healing.** **Hyperglycemia causes stiff blood vessels which slows circulation and delays wound healing.**

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	Encourage the use of nutritional supplements for added nutrients and protein. **Encourage foods the patient likes to promote further intake of nutrients and protein.** **Follow additional recommendations from (pending) dietician consult.**	**Reduced tissue perfusion also increases risk of infection.** **Nutritional supplements and consumption of patient-preferred foods lead to increased protein and nutrient intake to promote tissue healing.** **The dietician will have further recommendations on preventing weight loss and increasing protein/nutrient intake.**
Pain related to right hip and bilateral buttock pressure injuries.	**Encourage the patient to utilize deep breathing and distraction techniques.** **Provide opportunities for the patient to call a time out for pain with dressing changes.**	**Adequate pain management using techniques and time outs provides the patient with comfort and reduced stress. Promotes ambulation and self-care which contributes to wound healing.**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***		

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** **Medihoney calcium alginate – potential to dry out wounds without drainage. Use a hydrogel primary dressing instead.** **Mepilex foam – increased expense, the brand might not be available to the facility. Use an island dressing for cover as an alternative.** **LAL mattress – the added expense of using medical equipment. Turn every 2 hours, repositioning as an alternative.** **Air chair cushion – risk of injury to the patient from bottoming out. An alternative could be limited time in a chair, no more than 2 hours at a time.**

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not available?	

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	I wanted to review pressure injuries and management. I was able to meet my goal for this journal. I felt very comfortable with this wound topic.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I would like to do my next journal on NPWT. I currently have limited experience in this area.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The patient has acute pain in his right hip which prevents him from ambulating. He sits in a chair all day, which contributes to his pressure injuries. I think a PT or ortho consult is needed. I am not 100% sure the Medihoney calcium alginate was the best dressing selection. While the Medihoney does promote sloughing, I would be concerned that the alginate could make the wound(s) dry out, considering the assessment indicated no drainage for either buttock. A hydrogel might be a better option to prevent drying and promote autolytic debridement.

Reviewed by: _____ Date: _____

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