Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Yuhan Kao _____ Day/Date: _____1/11/2023_____

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, s***elect 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 no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment **Abusalah, 6942897**	61 year old male with metastatic medullary thyroid cancer s/p total thyroidectomy, neck dissection, mediastinotomy (~2010) now with recurrent metastatic disease, hypothyroidism, glaucoma who presents with tachypnea and hypoxia. Patient was recently admitted for pneumonia and failure to thrive at another hospital and G-tube was placed at that time and started on tube feeds. During the OSH hospitalization, imaging was done and showed spread of cancer to the left lung. Patient was treated with zosyn while inpatient and discharged on levofloxacin. Was at home for 2 days and presented to UCLA ED with hypoxia and tachypnea. Stage 2 pressure injuries and DTI at the coccyx area were identified when patient first admitted to the hospital. On the day of wound care assessment, patient was trached with trach collar at 28% 6L. Alert and oriented x 4, able to mouth words with daughter at the bedside. Patient had a foley catheter for output management and g-tube with continuous tube feeding. Both the family and patient knew about the pressure injuries since patient had had the skin issue prior to hospitalization and the daughter was very aware of the current wound care plan of applying Traid cream to the wounded area and covering with Mepliex Lite.

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

On the day of assessment (Day 25): Patient was alert and orientated with moderate weakness at both upper and lower extremities. Patient as on trach collar at 28% 6L with O2 saturation above 95%. Patient's daughter was also at the bedside and engaging in wound care conversation. Introduced myself to both the patient and daughter and both agree it was a good time. Patient was turned to his left side first with moderate assistance and was able to hold himself in the side position with minimal support. Dressing on the coccyx was removed and a stage 2 pressure injury was noted with TRIAD cream around the site. Cleaned the wound with Baza Cleanse and noted the pressure injury started to resurface with granulation tissue with the measurement of 3.5cm x 3cm. Surrounding skin was all blanchable, intact and dry. Both the patient's daughter and bedside nurse also shared that he had been having more stable bowel movement so his perianal skin had been looking better. Based on the wound progression and surrounding skin condition, decided to change the treatment plan to cleaning the wound with Vashe, then apply Collagenase (Santyl) ointment to the wound bed and protected with Mepliex Lite. Since the surrounding skin was intact and all blanchable, and based on the patient's daughter's feedback regarding bowel movement, Critic-Aid Clear barrier cream was recommended to protect the perianal area.
Patient had been malnourished and his spine had been visibly apparent, recommended to place Mepliex Lite along the spinal area to protect the bony prominences. Patient tolerated the dressing assessment and change well and did not experienced any discomfort. Patient's vital signs were stable throughout the process. Treatment was reiterated to the patient and family again and all questions were answered before exiting the room.

RECOMMENDATIONS:

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Wound Care Plan

Wound: Coccyx DTI and stage 2 pressure injuries
Treatment: Continue gentle cleanse with Baza Cleanse to remove the residual TRIAD cream.
Clean the wounds with Vashe and apply nickel thick Santyl to the open wounds.
Cover with Mepliex Lite. Protect rest of the perianal area with Critic-Aid Clear.
Change Daily and as needed.

Back skin is intact with no redness, continue to cover with Mepliex Lite to protect bony prominences. Change q2days as needed.

Support surface recommendations: Continue IsoAir mattress
Continue pressure ulcer prevention interventions per Pressure Ulcer Prevention Guidelines

Yuhan Kao
01/11/2023

WOC specific medical & nursing diagnosis	**WOC Plan of Care (include specific product used today)**	**Rationale *(Explain why an intervention is chosen; purpose)***
Fragile skin condition due to severe deconditioning and malnourishment prior to admission. Hospitalization was complicated with hemodynamic instability and respiratory distress that resulted in tracheostomy and finally liberation from mechanical ventilation.	Wound: Stage 2 pressure injury at coccyx area. Treatment: Cleanse with Vashe and pat dry. Apply nickel thick santyl ointment to the wound. Covered with mepliex lite, cut to fit. Change BID and as needed. Support surface recommendations: IsoAir Mattress Nutrition: Continuous tube feeding of Peptamen AF at 70ml/hr x 22 hrs (hold 1 hr before and after Levothyroxine). Daily goal is 1848 kcal and 117gm protein. Moisture and incontinence management: apply a thin layer of Critic-Aid Clear Barrier Cream to perianal area after each pericare and as needed. Avoid use of adult brief or additional chuck under the patient.	Vashe is a wound solution that is saline base wound cleaner that contains hypochlorous acid that inhibits microbial contamination and effectively clean and debriding the wound. Santyl is an enzymatic debrider that help remove devitalize tissue. The goal is to clean the wound and promote new tissue development. IsoAir Mattress is a low pressure mattress that has active sensor technology to help control patient pressure distribution and also has a breathable endurance cover to assist in moisture management. Nutrition: Goal is to maintain adequate nutrition to increase muscle and fat percentage and

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		promote wound healing. Maintain electrolyte and blood glucose balance. Electroyle imbalance are managed through IV/PO supplement as needed. Nutrition update at least weekly by in hospital dietitian. Critic-Aid Clear Barrier Cream is clear moisture barrier ointment that supports the skin against irritants and helps avoid maceration.

What are the disadvantages of using the product(s)? What alternatives could be used and why? **Identify each WOC product in use. This is an opportunity to communicate product knowledge and critical thinking.**	Vashe – it is more expensive than normal saline. Does has a strong smell. May sting the wound bed. May not be available after discharge. Alternative: Normal saline Santyl - More expensive. May not be available after discharge depending on insurance and personal economic constraints. Alternative: Medical honey, hydrogel, or products that contain surfactant (i.e. Aquacel Ag Advantage and polymen). Mepliex Lite - May not be available after discharge depending on insurance. Alternative: thin, non-broader foam dressing. Critic-Aid Clear Barrier Cream- Not much disadvantage found (low cost, covered by insurance and available for purchase online). Alternative: Medline barrier cream, or Aquaphor advanced therapy healing ointment, or other over then counter moisture barrier cream.

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?	Yes, Continue to assess/consult on various patients with different style of wound and started to make recommendation and change wound care plan based on wound progression.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Continue to evaluate different type of patient wounds and continue to assess and consult on patients with different ostomy.

Number of Clinical Hours Today: __6__

Care Setting: ___Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: 6 Types of patients seen: Acute and chronic wound Assessment and treatment and ostomy management. (Peds: Ostomy assessment and management. Adult: Stage I to complex unstageable pressure injuries assessment and management. Consult on moisture related dermatitis and self inflecting wounds and provided treatment. Wrote wound care consult notes).

Preceptor: Thanuttha (Tak) Tiensawang

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Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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