

**Daily Journal Entry with Plan of Care & Medical Record Note**

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Day/Date: 2/4/23

**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.**

<b>Today's WOC specific assessment. Include pertinent past medical &amp; surgical history and medications.</b>	<p>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 not 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.</p> <p>Recent lab values: Albumin 1.9 g/dL BAD, Hematocrit 22.9%, Hemoglobin 7.5g/dL ?, INR 1.4, Blood Glucose 226 BAD</p>
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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:**

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. Noted to have wound to left buttock. Site cleansed with wound cleanser. Wound edges defined. Wound measures 1.6 x 0.6 x 0.3cm. Wound bed noted to be 85% red agranular tissue, 15% yellow slough and moist. No drainage (Syntal). 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. Noted to have wound to right buttock. Site cleansed with wound cleanser. Pt noted to be taking slow deep breaths during cleansing. Wound edges defined. Wound measures 0.6 x 0.2 x 0.1cm. Wound bed noted to be moist, 90% yellow slough, 10% red agranular tissue. No drainage noted. 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 during process. Instructed on 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.

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

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- Dietary consult
- Blood sugar monitoring and treatment as indicated

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

WOC Nursing Problem pertinent to this visit	WOC Directive Plan of Care (Base this on the above data. Include specific products)	Rationale ( <i>Explain why an intervention was chosen; purpose</i> )
<p>Risk for infection r/t stage 3 &amp; unstable pressure injuries.</p> <p>Deficient knowledge r/t uncontrolled DM.</p> <p>Fatigue r/t to poor diet.</p> <p>Imbalanced nutrition: Less than body requirements r/t weight loss of &gt;30lbs over the last few months.</p>	<p>The nurse will,</p> <ul style="list-style-type: none"> <li>• Take Q8 VS, I/Os &amp; labs, BS checks AC/AH</li> <li>• notify MD if abnormal.</li> <li>• Q2 T/R, from reclining position to seated position and R/L side lying positioning w/ pillow support, if appropriate in relation to PIs.</li> <li>• Out of bed to chair for max of 2hrs on waffle cushion by Turnsole for meals.</li> <li>• Encourage ambulation.</li> <li>• Place bedside commode &amp; urinal for daytime, condom catheter for night.</li> <li>• Culture wound for anaerobic/aerobic bacteria for targeted ABX.</li> <li>• Reinforce EDU on the use of distraction techniques for pain management.</li> <li>• Document all Tx and finding, notify MD w/ abnormalities or concerns.</li> </ul> <p>Daily Dressing change or PRN:</p> <ul style="list-style-type: none"> <li>• Remove dressing using “push pull technique”</li> <li>• Assess and document; size, depth, odor, drainage, document (both wounds).</li> <li>• Clean wound w/ Vashe, rinse w/ NS, pat dry (both wound).</li> <li>• Prep periwound skin w/ skin-prep by Smith &amp; Nephew, let dry.</li> <li>• EDU Pt on enzymatic debridement &amp; apply Santly to base of wounds x2.</li> <li>• Lightly fill stage 3 pressure injury w/ Aquacel Ag packing strips by Medline,</li> </ul>	<p>The comprehensive treatment plan is aimed at effectively managing the patient's multiple comorbidities, including diabetes, hypertension, chronic kidney disease, and pressure injuries. The nurse is responsible for monitoring the patient's vital signs, I/Os, BS levels, and promptly reporting any abnormal results to the physician as this can stall wound healing. To prevent pressure injuries, best evidence-based practice shows that a scheduled T/R works best when coupled w/ ambulation to offload effected areas. The patient is also encouraged to sit in a chair for up to two hours, using a waffle cushion during mealtimes. To aid with elimination, the patient has access to a bedside commode or urinal during the day and a condom catheter at night to help protect the skin. To ensure proper wound care, the wound is cultured for type and sensitivity for targeted ABX that spares the kidneys. Additionally, the patient is educated on the use of distraction techniques for pain management. The nurse documents all treatments and notifies the physician of any concerning findings and to track if Tx are working or need to be changed.</p> <p>These orders are designed to deliver thorough and effective wound care for patient w/ full thickness wound compounded by their comorbidities. The daily or PRN dressing change is performed using the gentle "push</p>

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	<p>leaving pigtail and document number of packing strips placed.</p> <ul style="list-style-type: none"> <li>• Cove wounds w/ Optifoam Gentle by Medline.</li> </ul> <p>Place consult w/:</p> <ul style="list-style-type: none"> <li>• Dietician to assist in selecting a diabetes-aligned diet for a patient with decreased nutritional status.</li> <li>• Endocrinologist to assist in Tx of diabetes type 2.</li> <li>• Diabetic educator to assist in EDU/Tx of DM.</li> <li>• I&amp;D to assist in Tx UTI, PNA.</li> <li>• Cardiology to assist in Tx HTN.</li> <li>• Nephrologist to assist in Tx CKD</li> <li>• PT/OT to assist w/ strength training and maintaining ADLs.</li> </ul> <p>Order:</p> <ul style="list-style-type: none"> <li>• Recliner</li> <li>• BSC</li> <li>• Sage Prevalon Heel Protector I by Stryker.</li> <li>• Condom catheter or BSU</li> </ul>	<p>pull technique" to ensure the patient's skin is not damaged further. The nurse assesses and records the wound's characteristics, including its size, depth, odor, drainage, and overall appearance. This gives insight into if the Txs are working or have stalled and need to be changed. To clean the wound, Vashe solution is used to kill topical bacteria, rinsed w/ NS. This ensures that the Santyl is not deactivated by the Vashe. The surrounding skin is prepped using Smith &amp; Nephew skin-prep, allowing it to dry before treatment for further protection. The patient is also educated on how Santyl breaks down the slough and helps prepare the wounded bed for healing. In the event of a stage 3 pressure injury, the wound is filled with Aquacel Ag packing strips by Medline and is impregnated w/ sliver which has antibacterial properties that help fight topical infection. Finally, the wound is covered with an Optifoam Gentle foam dressing by Medline to protect against pressure and friction.</p> <p>The goal of these consultations is to provide the patient with comprehensive care for their various comorbidities. To support their health, the patient is being referred to experts who specialize in their specific needs. A dietician will help the patient choose a diabetes-friendly diet to improve their nutritional status and keep their blood sugars low. An endocrinologist will offer expert treatment for the patient's type 2 diabetes. A diabetic educator will further educate and assist the patient in managing and understanding the disease process. An infectious disease specialist will help treat any urinary tract or pneumonia infections and order appropriate ABX. A cardiologist will work to manage the patient's hypertension,</p>
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		<p>while a nephrologist will offer treatment for chronic kidney disease as these two-disease processes can affect wound healing buy the medications they take or poor perfusion. Lastly, physical and occupational therapy will help the patient maintain their ADLs and improve their strength.</p> <p>The rationale behind these orders is to promote healing and prevent further injury for a patient with a stage 3 pressure injury. The use of a recliner allows the patient to be in a comfortable and relaxed position, reducing pressure on the affected area and gives them the opportunity to change positions independently. A bBSC allows the patient easy access to the bathroom without having to get ambulate far. To prevent further injury to the heels are protected w/ Sage Prevalon Heel Protector by Stryker. Lastly, a condom catheter is used at night to ensure clean and dry skin overnight.</p>
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<b>What are the disadvantages of using this product(s)?</b>	Medihoney aids and supports autolytic debridement and provides a moist wound healing environment making an optimal wound bed, but it also costs \$300 - \$400 a tube.
<b>What alternative product(s) could be used and why?</b>  (This is your opportunity to share your product knowledge and apply critical thinking)	<p>I chose to swap Medihoney for Santyl because I have been using it on a couple of Pt that have very sloughy wounds and have seen tremendous improvement over the course of week w/ the only downside to the Pt is the cost.</p> <p>I like the surfaces and T/R orders that are placed and don't know of any other way to offload the Pt as they have PIs to R/L buttocks making it difficult to offload this area.</p>

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

<b>Were you able to meet your learning goals for today? Why or why not?</b>	
<b>What are your learning goals for tomorrow?</b>	To ask the WOC inpatient team and my other colleagues when they use Medihoney over Santyl. I would also like to know some other recommendation for enzymation debridement agents as Santyl is very expensive and hard to get now.

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<b>(Share learning goal with preceptor)</b>	
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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