

**Daily Journal Entry with Plan of Care & Chart Note**

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 Setting:  Acute Care  Outpatient  HHC  Other  Wound Care

**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.

<b>Today's WOC specific assessment</b>	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
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**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.

<b>WOC specific medical &amp; nursing diagnosis and concerns</b>	<b>WOC Plan of Care (include specific products used)</b>	<b>Rationale (Explain why an intervention is chosen; purpose)</b>
Weight loss/ low H & H Impaired wound healing/ difficulty ambulating  High blood glucose levels  Pain  Stage III pressure injury to left hip and unstageable pressure injury to right hip	-Encourage foods high in iron, low in sugars - Encourage Protein supplements -Encourage Pt intake and reinforce importance of proper nutrition -Dietician consultation for additional education and recommendations  -Blood sugar monitoring with treatment as ordered  - Coordinate pain medication with dressing changes - Utilize deep breathing, time outs, and medications to manage pain.  -Cleanse with wound cleaner -Apply Cavalon barrier film to periwound skin -Cut Medihony calcium alginate to fit wound bed -Cover with Mepilex border sacrum dressing - Change Dressing every 2 days and prn  -Offload areas: turn and reposition every 2 hours, chair cushion, limit time up in chair and chair lifts -Continue with low air loss mattress -Nursing to monitor wound and alert WOC to a need for change in the plan of care	-Provides education on optimal nutrition that will promote healing  - Controlled blood glucose promotes wound healing and overall health  -Pain control optimizes healing environment for patient <i>What role does pain play in wound healing?</i>  -Cleans wound bed and removes microbe and debris -Prevents periwound skin breakdown -Promotes wound healing by reduction of bioburden in wound bed - dressing provides thermoregulation of the wound as well as protection from trauma  -Turning, repositioning and limiting time in chair helps to reduce pressure to skin. <b>Ok</b> Chair cushions also help to reduce pressure and prevent further skin breakdown. <b>ok</b>

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<p><b>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. 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 not available?</b></p>	<p>-Medihoney calcium alginate sheet - Supports removal of necrotic tissue and aids in wound healing. <u>For wounds with moderate to heavy amounts of exudate</u> or when light packing is needed. Osmotic potential draws fluid through the wound and helps to liquefy necrotic tissue preserving wound environment to acidic pH levels helps to promote healing. Disadvantage- can cause desiccation and dressing will stick to wound bed</p> <p>Alternative - PolyMem WIC silver cavity filler it will not dry wound bed and provides moisture, it helps to reduce wound pain and can be cut to fit wound bed. For wound with little to no drainage.</p> <p>-wound cleanser – does not specify – Cardinal Health wound cleanser is a non-irritating gentle wound cleanser Disadvantage- availability, cost, patient sensitivity Alternative- normal saline can be used to clean the wound is available</p> <p>- Mepilex border sacrum – for use on medium to high exudate, painful wounds appropriate for pressure injuries Disadvantage- inappropriate size, Mepilex has sizes that are more appropriate to wound size and would be more cost effective and the moisture absorption is more appropriate.</p> <p>Alternative – 3M Tegaderm foam adhesive is adaptable and can be used for wounds with low to high exudate, partial- and full-thickness dermal wounds, including: pressure injuries, venous leg ulcers, abrasions, superficial partial-thickness burns, donor sites, arterial ulcers, skin tears, and neuropathic ulcers.</p> <p>-Cavilon barrier film by 3M – moisture barrier and protects from medical adhesive related skin injury, friction skin damage Disadvantage- Skin irritation</p> <p>Alternative - <u>StingFree</u> alcohol liquid skin prep and shield, non-irritating and quick drying</p>
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<p><b>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</b></p>	<p>My learning goals are to go through the case studies and learn how to document the wound and how to write a plan of care for them.</p>
<p><b>What are your learning goals for tomorrow?</b></p> <p><b>(Share learning goal with preceptor)</b></p>	<p>Continue to refine writing skills.</p>

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<p><b>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b></p>	<p>I would want to give patient pain medication before changing dressings.          Use a waffle air mattress to bed for further protection.          The dressing choices that I would use <u>(for left stage III pressure ulcer)</u> since the periwound tissue on this wound has blanchable erythema - PolyMem WIC silver cavity filler will not dry wound bed and provides moisture, it helps to reduce wound pain and can be cut to fit wound bed.          Cover all with a transparent dressing like (Cardinal Health transparent/ 3M tegaderm) to monitor periwound tissue, protect periwound tissue with a barrier film.</p> <p>For the unstageable on the right hip – apply barrier film to periwound tissue, Santyl to debride necrotic tissue and solosite and covered with Mepilex Border Flex Lite foam dressing for non to moderately exuding wounds, or if that is not available, 3M Tegaderm foam adhesive is adaptable and can be used for wounds with low to high exudate..</p> <p>Medihoney calcium alginate sheet is not appropriate for this wound, can cause desiccation and dressing will stick to wound bed</p> <p>Mepilex Border Flex Lite foam dressing <u>instead</u> of the sacral dressing. More appropriate size for this wound The sacral dressing is \$18.90 per dressing the Mepilex Border Flex Lite foam dressing 1.6”x2” is \$2.39 per dressing.</p>
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 Reviewed by:  Kelly Jaszarowski  Date:  2/9/2023 

POC development does contain directives for care. Rationales do not support the directives. Product development should address disadvantages and alternatives as opposed to explain the products in use. Note my comments throughout.

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