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: _5/17/23_____

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	43 y/o male admitted through emergency room via EMS after a wellness check at his place of residence. Wellness check was initiated by home care aide after patient turned them away via phone for third consecutive visit. Patient is non-ambulatory and weighs a reported 680lbs per EMS and home care aide reports. EMS reported found pt alert and oriented x1 and laying in urine, feces and wound exudate. Patient with foul odor and maggots noted to large open wound on left elbow and left heel. Saturated dressing noted to left heel. Severe IAD noted to left side of body. PHM includes COVID-19 hospitalization with ICU related pressure injury to coccyx and left heel (unstageable), COPD, cellulitis to lower extremities, depression, suicidal ideation, morbid obesity, DMII and non-compliance. Patient fluid resuscitated in emergency department and admitted to medical floor for further care. Upon resuscitation patient mentation improved to alert and oriented x3.

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.

Consulted for "wound evaluation".

Patient with pleasant affect and noted resting in bariatric LAL bed watching a show on his laptop device. Dietician and occupational therapy consults completed earlier today. Entries noted. Appears disheveled with slightly sunken facial features. States he lives alone. Orders food by phone that is delivered through his condo's side window. Patient states he does not recall the last time he "ate or drank" prior to his last hospital admission a year ago. States spent an extended time in the hospital due to a COVID related illness and spent several days intubated in the ICU. He was discharged home with wounds and home care. He admits to "sometimes" turning away care. Patient commented he "favors" propping himself on his left side due to the view out his window. Denies pain. Agreeable to full assessment. All wound dressings removed with patient assistance with removal of left elbow dressing.

Assessment:
Left elbow: Stage 3 pressure injury present on admission. Area congruent with where patient props himself up. Wound measures 3.5 x 2.0 x 0.5cm. No tunneling or undermining. Wound bed dark red with some residual purulence and moderate serousanguineous drainage. Wound edges defined and regular. Periwound dry and intact. Wound cleansed with Vashe wound cleanser and patted dry. Silver alginate dressing applied and site covered with a 4x4 Allevyn foam dressing.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Left Heel: Stage 4 pressure injury present on admission. Site measures 3.0 x 3.0 x 1.0cm with 0.5cm undermining from 3-8 o'clock. Wound bed with visible bone and 50% adherent yellow fibrinous exudate, 50% pale pink granular tissue. Scant serous drainage noted. Wound edges epibolized and firm. Wound cleansed with Vashe wound cleanser and patted dry. Silver alginate dressing moistened with sterile water and placed and site covered with a 4x4 Allevyn foam dressing.

L hip: Stage 2 pressure injury present on admission measuring 2.0 x 1.5 x 0.2cm. Wound bed shallow with adherent ivory appearing layer and epithelial islets noted. Scant serous drainage. Periwound with diffuse denuded areas with resolving IAD. Wound cleansed with Vashe wound cleanser and patted dry. Periwound dusted with stomahesive powder, excess dusted away with no sting skin prep applied to create crusting. 4x4 Allevyn foam dressing applied over area.

IAD: Resolving with continence care. Patient able to verbalize when needs to urinate or defecate and is aware of urge. Area cleansed with PH balanced skin cleanser and patted dry. No drainage noted at this time. Area left open to air per patient's request. Erythemic area with raised satellite lesions noted to abdominal skinfolds on left side of body. Nystatin antifungal powder applied per order to abdominal skinfolds.

Braden scale noted to be 12 at this time. Interdry wicks placed to abdominal skinfolds. Patient educated on correct placement and verbalizes understanding of need to maintain wicks. Patient tolerated all wound care without reported pain. States understanding of plan of care and goals to discharge to a nursing facility for assistance with care.

Recommendations:
Consult to plastic surgery for evaluation / debridement of wounds.
Offload heels at all times
Continue LAL mattress at all times
Interdry wicks to body folds
Turn and reposition q2h; requires 2 people
Roll patient on and off bedpan
If dressings become dislodged or soiled, change PRN as above.
Notify WOC team with any changes, questions or concerns regarding wound care.
Social work consult
Follow nutrition recommendations
Maintain PT/OT schedule as tolerated

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**

Wounds: Left elbow stage 3 PI: Left heel stage 4 PI Left Hip stage 2 PI IAD on the left side of the body	***All wounds: Soak gauze with Vashe wound cleanser. Clean wound and pat dry.*** ***Left elbow: apply silver alginate and 4 x 4 Allevyn foam dressing*** ***Left heel: apply moisten silver alginate and 4x4 Allevyn foam dressing.*** ***Left hip: dust periwound with stomahesive powder and dust away with no sting skin prep to create a crust. Apply 4x4 Allevyn over area.*** ***Consult to plastic surgery for evaluation and wound debridement pending.*** ***Follow nutrition recommendations and obtain a list of patient preferred foods to encourage protein consumption.*** ***Use offloading protocols:*** ***Offload heels at all times with heel protectors or float heels on pillows under calves as tolerated.*** ***Continue LAL mattress at all times and check functioning every shift.*** ***Turn and reposition every 2 hours, requires 2 people.*** ***IAD:*** ***Apply interdry wicks to abdominal folds.*** ***Apply nystatin powder to left abdominal folds over erythemic areas.*** ***Roll patient on and off bedpan.*** ***Continue continence care with elimination. Use a pH balanced cleaner after each elimination, ensure entire area is gently pat dried.***	Vashe (hypochlorous acid) is as safe as saline but has antimicrobial properties with a skin-neutral pH. Silver alginate is an appropriate primary dressing due to anti-microbial properties along with absorption as these wounds have drainage. Allevyn foam provides further absorptive protection and cushioning while holding primary dressing in place.. Crusting the periwound skin gives the skin a barrier when the skin is raw and denuded. This offers protection from fluids that may reach this area. A consultation with plastic surgery is needed to evaluate the need for debridement. Wound edges on left heel are epibolized which require advanced treatment. A nutrition consultation is important for recommendations to manage this patient's dietary needs. Protein consumption will help promote wound healing. Knowing the patient's food preferences promotes intake. Offloading protocols such as use of LAL mattress, turning every 2 hours, offloading heels at all times, reduce risk of further pressure injuries. Studies have shown patients have an increased risk of developing further pressure injuries in the presence of existing pressure injuries. The goal of IAD care is to promote cleanliness and dryness. Interdry will keep abdominal folds dry by wicking away moisture. Nystatin powder is an anti-fungal treatment.

Self-care deficit	***Self-care deficit:*** ***Social work consult pending – follow recommendations.*** ***Maintain PT/OT schedule.*** ***Discharge goal to a nursing facility.***	The purpose of a social work consultation is to assess and address this patient's psychosocial and lifestyle needs. PT and OT promote strengthening and offer solutions for self-care and self-independence. The patient continues to need further assistance with care. A nursing facility will be able to provide a continuum of care until he is able to go home.

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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** **Vashe: a disadvantage might be availability. Normal saline can be used for cleaning as it is cost-effective and readily available but lacks the anti-microbial properties of Vashe.** **Allevyn foam – I do not see the disadvantages of Allevyn foam at this time.** **Silver alginate – this is not appropriate for dry to scant drainage wounds, there is a risk of drying the wound bed out. Another disadvantage might be the patient has an allergy to silver, so a calcium alginate without silver or a gelling fiber dressing might be more appropriate. Medihoney could be used for anti-microbial properties.** **Interdry wicks: Not cost-effective. I once worked at a facility that would not accept this as treatment (constant battle between prescriber, insurance, and facility). A solution would be to use pillowcases or use nystatin powder alone.** **Nystatin powder – allergies to the drug are possible, an alternative would be miconazole. If a supply issue is the case, nystatin cream is an alternative but needs to be used with caution as it can add moisture to areas we are trying to keep dry.**

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

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal was to review and further understand the care of a morbidly obese patient and I think my goal has been achieved. This case reinforced to me the importance of using offloading measures. It sounds like this patient does have some mobility but may not feel motivated to turn himself. This was evidenced by a pressure injury on his left elbow where he constantly propped himself up, most likely infrequently moving himself.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My learning goal for the next and last case is the management of a patient with trauma after a fall. I do not usually work with trauma patients, so I am interested to see if any aspects of the management of an unresponsive patient would be different from an alert patient.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	For this patient, weighing nearly 700 lbs, I think including mechanical lift orders for the future (even though he might be bed-bound for now) would be appropriate to prevent transfers from causing further wounds or trauma to existing wounds. Mechanical lift orders would also help prevent injuries to staff members involved in this patient's care. I would add a psych consultation given the patient's depression and suicidal ideation. Depression can indirectly cause slow wound healing by promoting behaviors such as non-compliance and poor nutritional decisions. I don't really like the silver alginate for his heel because there is scant drainage and exposed bone. Even though it is "moistened with sterile water" the potential to dry out fast is there. I would rather try hydrogel to promote autolytic debridement.

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.