Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Lynette Gorniak_____ Day/Date: Thursday, September 14, 2023

Number of Clinical Hours Today: ___ Care Setting: _8_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __7__ Preceptor: __Helen Shubsda_____

Journal Focus: __X__ Wound _____ Ostomy _____Continence _____Combination Specify: _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** Patient was admitted to the hospital for abdominal pain and atrial flutter with rapid ventricular response. Past medical history including CHF, Atrial fibrillation (not on anticoagulants d/t falls), pulmonary embolism, chronic respiratory failure, diabetes mellitus type 2, morbid obesity s/p laparoscopic Roux-en-Y gastric bypass in 2009, and chronic lymphocytic leukemia. Significant lab results that can affect wound healing on admission are WBC 16.16, hemoglobin 9.3, lactic acid 2.1, glucose ranging 221, albumin 3.0, total protein 5.7, and last A1c 7.4 in March 2023. The WOC team was consulted on 8/28/23 for wounds on the sacrum, right heel, right ischium, and right great toe. It was found the patient had an unstageable pressure injury to the sacrum and right ischium, a stage 2 pressure injury to the right heel, and a diabetic ulcer to the right great toe. Patient was followed up with WOC team today to re-evaluate wounds. The sacrum pressure injury is unstageable with yellow slough attached to wound bed with intact, hyperpigmented peri-wound. Sacrum measuring 11cmx9cmx0.8cm and has moderate drainage. The right ischium pressure injury is unstageable with yellow slough attached to wound bed with intact hyperpigmented peri-wound. Right ischium measuring 5cmx5cmx0.2cm with minimal drainage. The right heel pressure injury is a stage 2 with red wound bed and dry, intact peri-wound. The right heel wound measuring 1.2cmx0.5cmx0.2cm and minimal, serosanguineous drainage. The right great toe diabetic ulcer is brown, dry, and intact with no drainage present. The wound is measuring 0.8cmx0.5cmx0.1cm. The patient reports 7/10 pain to sacrum and increased pain with turning or repositioning.

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, *interactions, and specific products that were used/recommended for use.*

The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit

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for…, evaluation and management of…, etc. Then, describe the visit. Write in a manner others will be able to understand and be able to interpret your plan of care.

Patient was followed up with WOC team today to re-evaluate present wounds. The sacrum pressure injury is unstageable with yellow slough attached to wound bed with intact, hyperpigmented peri-wound. Sacrum measuring 11cmx9cmx0.8cm and has moderate drainage. The right ischium pressure injury is unstageable with yellow slough attached to wound bed with intact hyperpigmented peri-wound. Right ischium measuring 5cmx5cmx0.2cm with minimal drainage. The sacrum and right ischium wound were dressed with saline soaked gauze to the wound bed covered with Allevyn sacral foam border. The right heel pressure injury is a stage 2 with red wound bed and dry, intact peri-wound. The right heel wound measuring 1.2cmx0.5cmx0.2cm and minimal, serosanguineous drainage. Restore contact layer applied to wound bed and covered with 4x4 Allevyn dressing. The right great toe diabetic ulcer is brown, dry, and intact with no drainage present. The wound is measuring 0.8cmx0.5cmx0.1cm. Betadine applied to right great toe diabetic ulcer and left open to air. The patient reports 7/10 pain to sacrum and increased pain with turning or repositioning. Patient received pain medication prior to wound assessments and dressing changes.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen, purpose)**
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.***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Pain due to sacrum wound	Administer pain medication as ordered. • Pain medication should be given if patient is in pain and prior to dressing changes. • If patient's pain is uncontrolled, then nursing should notify the provider to discuss other pain medication options. Coordinate pain medication administration with dressing changes. • WOC nurse should coordinate with the patient's nurse on a time to administer pain medications. Giving appropriate amount of time for pain medications to provide relief while dressings are being changed. Offload of sacrum to relieve pressure and pain to sacrum wound.	Patient should take pain medication when having pain from wounds or frequent repositioning to lower the body's stress response which can delay wound healing. By coordinating pain medication administration with wound dressing changes, this can keep help the patient tolerate the interventions and decrease the pain. Frequent repositioning and offloading of the wounds can help reduce patient's pain when pressure

	• Patient should be repositioned every 2 hours on their left or right side while in bed. • If patient requests to be on their back, then placing pillows under both their hips to provide offloading to sacrum. Limiting the time on their back to 1-2 hours, then reposition to the patient's side.	is on their wound. Also, it can assist with wound healing by removing pressure.
Potential infection risk to sacral wound due to frequent incontinent stools and urine	Cleanse wound with each incontinent stool or urine and apply new dressing. • Utilize wipes and a gentle perineal cleanser when patient has an incontinent episode. • Nursing to apply new dressing to wound following wound care orders if dressing becomes soiled. Monitor WBC level. • Nursing and WOC nurse to monitor WBC levels for sign of infection. • If WBC level is elevated, then the patient's provider should be notified for further evaluation. Monitor wound exudate for purulent, malodorous drainage. • Nursing should notify the WOC nurse if they notice a change in drainage that is purulent and malodorous. • WOC nurse should reassess wound to determine if there are signs of infection, then notify the patient's provider.	Immediately removing stool or urine from the wound bed reduces the risk of infection. The area should be cleansed with a perineal cleanser and normal saline gauze to clean the wound bed. Monitoring WBC levels to make sure they don't become elevated will help catch if infection is present. It is important to monitor what the wound drainage looks like with each dressing change. If purulent, malodorous drainage is present, then this can indicate the sign of infection.
Nutrient deficit due to poor appetite and evident by low albumin and total protein levels	Consult dietician to recommend appropriate protein supplement. • Patient needing higher protein intake diet. • Patient may need oral supplementation such as a protein drink (ensure or juven) or Prostat. • If patient is having decreased oral intake such as eating less than 50% of each meal, then consult the dietician for recommendations on improving patient's oral intake. Educate and encourage patient to eat higher protein foods such as eggs, Greek yogurt,	A dietician can recommend appropriate protein supplements for patient that is low in carbohydrates and sugar. Increasing protein intake can help with wound healing. Providing education on what meals and food have higher protein levels can give more options for the

	chicken breast, fish, etc. Nursing should encourage patient to eat smaller meals throughout the day.	patient. Since the patient is having low appetite, encouraging the patient to eat frequent smaller meals. This would benefit patient in getting their daily nutrients to heal.
Wound healing delay due to uncontrolled blood sugars	Monitor blood sugar levels with each meal and bedtime. • Nursing staff should follow provider orders on blood sugar checks and should notify the provider of greater than 250-300 blood sugars that are not controlled by hyperglycemic medications. Follow hyperglycemic and hypoglycemic orders as prescribed. • Nursing staff should follow protocol orders if patient become hyperglycemic or hypoglycemic. Educate patient on dietary modifications such as monitoring carbohydrates to 60 grams a day and lower sugar content foods such as nuts, certain fruits, whole wheat breads, and legumes.	Monitoring blood sugar levels with each meal and bedtime will help the patient know if additional hyperglycemic medications are needed to control their levels better. Following hyperglycemic and hypoglycemic orders will help get blood sugar levels under control to reduce delayed wound healing. Another way to help control blood sugar levels is if a patient follows a low-moderate carbohydrate diet. Providing education on maintaining carbohydrates to 60 grams a day and substituting high sugar content foods with lower sugar options can help patients make better food choices.

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.** **Normal saline soaked Kerlix-** A disadvantage with normal saline soaked kerlix is that it only provides moisture to the wound bed. It does not provide any antimicrobial or debridement benefits. Another alternative that could be used for the sacrum wound is medihoney or hydrogel. Both have antimicrobial factors and can promote autolytic debridement which would benefit the wound bed with slough. **Allevyn-** A disadvantage is too much moisture can become trapped under the dressing especially if the patient is incontinent or the adhesive may be too abrasive. An alternative dressing that could be used is gauze and light paper tape. Paper tape can be gentler of the skin. If the hospital carries a non-adhesive Allevyn or a foam with no border, then this may be another alternative. **Restore contact layer-** The disadvantage to Restore contact layer is if the wound bed becomes dry, then the contact layer might stick to the wound. An alternative product that can be used if products are unavailable are Adaptic contact layer or Xeroform gauze to wound bed.

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	Betadine- A disadvantage to betadine is it can cause irritation. Another alternative since the wound bed is dry would be to use a no sting skin barrier wipe and leave open to air.

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 the day? Were you able to meet your learning goal for today? Why or why not?	My learning goal for today was to be able to observe a new wound consult to learn how the education is provided to patient and bedside nurse, learn to determine which products and dressings to use, and learn the follow up after consultation. I was able to meet my learning goal and ask questions during the process. It was beneficial to me to see the education, assessment, and critical thinking process firsthand.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My learning goal for tomorrow is to learn more on pressure injury staging and what are the steps for WOC nurse with unstageable pressure injuries such as additional consults for debridement or dressing selections to assist with autolytic debridement.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc.	The dressing selections for each wound were appropriate. I might would have used medihoney alginate or continued hydrogel for further slough debridement to the sacral and right ischium wounds. There is still quite a bit of slough attached to the wound beds which may need surgical debridement in the future.
Reflection: Describe other patient encounters, types of patients seen.	A few other patients seen today were new consults to determine if a pressure injury was present or not. One of the patients did end up with a stage 3 pressure injury to their sacrum that was not present on admission. My preceptor explained since it was not documented on admission, then the hospital would be responsible for the new wound and its cares to heal it. This made me realize the importance of documenting wounds and performing a thorough skin assessment on admission. Another patient had a dry, discolored area on her foot which was callus buildup. A podiatry consult was recommended. There was not an open wound to that patient's foot, but assessing the callus it did feel soft which could mean there is an open wound under the callus.

Reviewed by: _____ Date: _____

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