Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lynette Gorniak Journal Completion Date: 11/29/23

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 serosanguineous 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.

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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 verbalized 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)**
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.**
Knowledge deficit on nutritional needs	Teach back importance of nutrition recommendations.	It is a concern that the patient was unable to recall last meal prior to hospitalization and that his meals were ordered for delivery. Patient should be able to verbalize

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		understanding and teach back the importance of nutrition and the changes that need to be made.
	Document daily food intake.	The patient's oral intake should be documented to monitor that nutritional needs are being met and if changes need to be made to diet.
	Encourage intake of meals greater than 50%.	Patient should consume greater than 50% of each meal to meet nutritional requirements for wound healing.
Knowledge deficit on importance of wound care and dressing changes	Teach back importance of wound dressing changes and cleansing of wounds.	The patient should be able to teach back and understand the importance of caring for their wounds and know the plan of care for dressing changes.
	Cleanse all open wounds with Vashe wound cleanser and pat dry.	Vashe wound cleanser helps with cleaning the wound bed and prevent microbial contamination.
	Left elbow: Apply Silver alginate dressing to clean wound bed cover with a 4x4 Allevyn foam dressing.	Silver alginate dressing will absorb the moderate serosanguineous drainage from wound bed and may help remove any residual purulence to promote granulation and healing. The Allevyn foam provides cushion and is an absorbent.
	Left Heel: Moisten Silver alginate dressing with sterile water and place to clean wound bed cover with a 4x4 Allevyn foam dressing.	Moistening the silver alginate will provide moisture to the wound bed. There is scant amount of drainage with moderate yellow fibrinous exudate. The silver alginate could promote autolytic debridement for the fibrinous exudate to be removed from the wound bed. The Allevyn foam provides cushion and is an absorbent.
	L hip: Apply stomahesive powder to clean periwound, dust away excess and apply no sting skin prep to create crusting. Cover with 4x4 Allevyn foam dressing over wound.	The crusting method with stomahesive powder and skin prep provides a moisture barrier preventing further breakdown over the denuded periwound area. The Allevyn foam provides cushion and is an absorbent.
	IAD: Cleanse area with PH balanced skin cleanser and pat dry. Area left open to air.	The pH balanced skin cleanser gently removes irritants like urine

		and feces from the skin. Pat drying the area removes any excess moisture to the compromised skin area.
	Apply Nystatin antifungal powder to abdominal skinfolds per order.	Nystatin antifungal powder should be applied to areas where fungal growth is occurring. It should not be used as moisture absorbent powder as it is specific to fungal infections.
	Apply Interdry to abdominal skinfolds.	Interdry wicks moisture away from abdominal skinfolds to prevent fungal growth or skin breakdown.
	Change dressings as needed if dislodged or soiled.	Any dressing that becomes soiled or dislodged from the wound bed should be cleansed and replaced to prevent infection and delayed wound healing.
Lack of pressure relieving techniques when in bed	Reposition in bed every 2 hours to left and right side.	Repositioning in bed every 2 hours is the standard for pressure relief and wound healing.
	Elevate heels off bed with pillows. Elevate elbows on pillows.	Elevating heels off the bed with pillows promotes pressure relief. The heels should not be directly on the pillows.
	Use LAL mattress at all times.	The LAL mattress provides airflow to allow for pressure relief and keeping the skin dry.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> 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 Wound Cleanser-This is an appropriate cleanser to use for the wound beds but may not be readily available at some hospital facilities. An alternative cleanser to use would be normal saline to cleanse the wound beds. Silver alginate dressing- If the wound bed becomes dry, then a silver alginate dressing would not be appropriate for it absorbs moisture. Which could offset the moisture balance of the wound bed further and delay wound healing. An alternative dressing to use for moisture control would be an impregnated gauze like xeroform. 4x4 Allevyn Foam- May need more frequent changes if there is an increase in drainage. An alternative dressing to use would be an ABD pad secured with paper or medipore tape. Stomahesive powder & no sting skin prep- The crusting method using stomahesive powder and no sting barrier prep can provide a moisture barrier over the skin, but excessive moisture could get through easily. An alternative product to use would be zinc oxide moisture barrier cream. Nystatin powder- This product is a good absorbent for moisture and fungal infections, but if there isn't

	a fungal infection present, then nystatin powder would not be needed. An alternative product to use would be Coloplast moisture absorbent all body powder. Interdry- Product is used to wick moisture away from abdominal skinfolds but should not be used if skin breakdown occurs in abdominal skinfolds. An alternative product to use would be abdominal pads.

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 choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal with this mini case scenario was to be able to view the plan of care for a bariatric patient and to think of alternative wound products that could be used if the hospital did not have certain products available. My learning was met because other products could be used in place of what is in the wound plan of care and further assessment may be needed at a follow up visit.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	N/A.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc.	There is not much I would have changed to the plan of care. I would have added for the patient to get Prevalon pressure relief heel boots. If the hospital did not have the product, then offloading with pillows would be fine. However, sometimes the pillows can flatten which places the heels back on the bed or the pillows get positioned directly under the heels which adds pressure. Another thing, I would have assessed the reasoning that the patient had for refusing home health care visits. I would want to know this in case the patient starts to refuse cares while in the hospital and provide further education on the importance of his wound care plan.

Reviewed by: _____ Date: _____

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