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Daily Journal Entry with Plan of Care & Chart Note

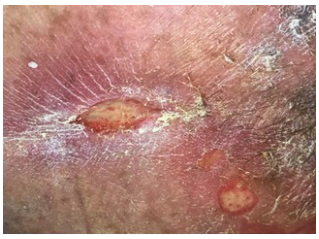
Student Name: ___Nancy Benchley_____ Day/Date: __4/1/2024_____

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 chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History	55-year-old homeless male presented to the ER accompanied by pt friend with severe flu-like symptoms and severe shortness of breath 2 days ago. Per patient friend's report, Pt is a 1ppd smoker and "uses oxygen when he has it". Patient friend provided limited history, states patient has been "sick for a few days" and has been "unable to get out of his chair". Denied any known recent ETOH or illicit drug use from patient. Pt is reported ambulatory at base line and noted unable to transfer self due to SOB and fatigue in ER. Pt desaturated and code called in ER. Pt resuscitated and transferred to intensive care unit, intubated, and sedated. Flu+ COVID-19 negative. Patient remains intubated in ICU. Incontinent of stool. External male catheter in use. No skin assessment noted in ER. History of CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities. Patient is on a low air loss surface. Braden Scale noted to be charted "11" per bedside nurse charting. Medications include vasopressors and a diuretic.

Assessment:

- Intubated and sedated in the intensive care unit.
- Thin, with cachexic appearance, and unkept.
- Bedside RN reports noting a Stage 3 pressure injury to sacrum and buttock during incontinence care this morning. No previous documentation available on injury.
- Sacral foam dressing removed.
- Copious amounts of Desitin barrier cream to area.
- Small amount of fecal incontinence.
- Sacral and buttock area cleansed. Mineral oil used to clean off Desitin noted.
- Open area to sacrum and left upper buttock area.
- Scant serous drainage noted from both open areas.
- Sacral wound shallow with reticular dermis layer visible. Epithelialization. Wound measures 2.0 cm x 1.2cm x 0.2cm.
- Left upper buttock wound measures 0.8 x 0.8 x 0.2cm.
- Photographs taken and placed in chart.



Write a chart note giving careful consideration to the chart review information, how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse consultant/specialist note should begin with why you are seeing the

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pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit. Be sure to include any physical assessment, interactions, and specific products used/recommended for use. *What dressing regimen would you recommend?* Are there any further teaching points for this patient as the wound professional directing the care of this patient based on the case study? Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

Initial visit for the evaluation of a 55 year old male with stage 3 pressure injury to the sacrum and buttock. Patient has a history of CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities. Patient was sedated and intubated in the ICU upon presentation. Patient is thin, unkempt, and cachexic. The patient was turned to side, foam dressing was removed. Desitin barrier cream to sacral area was removed using mineral oil. Small amount of fecal incontinence cleaned. Sacrum wound measurements were 2.0cm x 1.2cm x 0.2 cm. Left upper buttock wound measurements were 0.8cm x 0.8cm x 0.2cm. Scant amount of serous drainage noted from both wounds. Reticular dermis layer and epithelization noted. Both classified as stage 2 pressure injuries. Applied no sting barrier film (Cavilon) to periwound skin and allowed to dry. Applied hydrogel adhesive sheet dressing (Aquaderm) to be changed q 3 days. Patient was on a low air loss mattress. An alternating pressure surface will be used in combination with the low air loss surface to facilitate pressure distribution changes as well as managing temperature/humidity. No patient education performed at this time due to sedation level.

Since the wound had the reticular dermis present it would be classified as a stage 2 pressure injury. The reticular dermis is the bottom layer of the dermis so this would not be a stage 3 pressure injury since it is a partial thickness wound. Educated nursing staff on the difference between stage 3 and stage 2 pressure injuries. Braden was scored at an 11 by nursing staff. The Braden score would be a 7 (sensory 1 completely limited, moisture 2 very moist, activity 1 bedfast, mobility 1 completely immobile, nutrition 1 very poor, friction & shear 1 problem). The presence of epithelization suggests this is a healing wound, it should have been documented in the ED or upon admission to the ICU. Nursing education provided about Braden scores and importance of skin assessments.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products used)

*Cleanse wound with normal saline
*Apply no sting barrier skin protectant (Cavilon) to periwound skin
*Apply hydrogel adhesive sheet dressing (Aquaderm) to both wounds, change q 3 days or when soiled
*Q2 hour turning schedule keeping patient from supine position.
*Low air loss and alternating pressure surface mattress ordered
*Diabetic consult ordered for nutritional assessment since patient is sedated and possibly malnourished
*Once patient is able to receive education, smoking cessation education will be provided
*Consultation to case manager regarding homelessness/insurance coverage and resources in the community such as finding adequate nutrition and housing.

Describe your thoughts related to the information provided. What would you have done differently? Any additional information that would have been helpful?

It says the patient is incontinent of stool but the severity of this is not indicated such as how often the patient has bowel movements and the amount. If the wound cannot stay clean and the stool is liquid then a fecal management system (Dignishield) would be considered.
There is no information on the assessment of the bilateral lower extremities. It says he has a history of cellulitis and it is unknown if it is currently active. Also, any arterial leg ulcers present? What is the appearance of the skin for the lower extremities? The dorsalis pedis pulses present? Any edema in the lower extremities?
The case says the patient is homeless but “cannot get out of his chair”, how does he have a chair if he is homeless? Maybe he is staying with his friend?

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You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

Goals.

What was your goal for choosing this case?
I choose this case study because the patient had a more complex case due to extrinsic/intrinsic factors influencing wound healing.

Reviewed by: _____ Date: _____