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Virtual Journal Entry with Plan of Care & Chart Note

Student Name:_____Chloe DeJonge_____ Day/Date:____July 3rd, 2024 ____

Setting: Hospital ☒ Ambulatory Care • Home Health Care • Other: _____

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	*Age/sex*: 61-year-old female *PMH*: Uncontrolled DM *CC*: To ER w complaints of abscess to left labia starting > 1 month ago. States it drained bloody purulent drainage and now has excruciating lower abdominal pain. *Meds*: Insulin daily *Social hx*: Lives alone; denies alcohol, tobacco, or street drug use *Labs/Diagnostics*: CT findings compatible with necrotizing fasciitis arising from left labia majora extending along anterior and posterior aspect of abdominal wall. *Plan*: To OR for wide debridement of necrotizing fasciitis area (debridement of skin, subcutaneous fat and fascia) leaving an extra-large wound to left labia & groin area. Consult to WOC team for possible NPWT.

Assessment/encounter:
LOC: Awake but groggy post IV Morphine pre-dressing
VS: 100[2] 92 28; 150/86
Initial interview: Pt. in pain, groggy & does not want to converse. Surgery PA at bedside to assist.

Braden scale

Sensory Perception	4
Moisture	2
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	4
Total	18

Wound assessment:
Moist saline dressing removed.
Location: Left labia/groin/perineal/gluteal areas
Wound type: Post op surgical
Extent of tissue loss: Full thickness
Size & shape: 28 x 40.5 x 9.2 cm
Wound bed tissue: pink and moist with no exposed muscle and tendon noted at wound base

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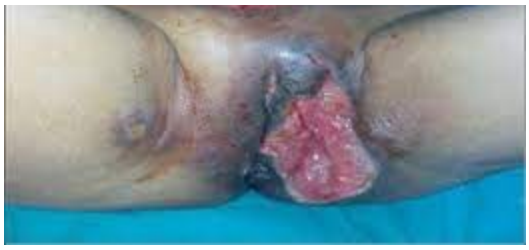
Exudate amount, odor, consistency: small amounts of serosanguineous drainage with no odor
Undermining/tunneling: None
Edges: Attached
Periwound skin: Intact
Pain: 10/10

Plan: Wound appropriate for NPWT.

Photo:



Education: Develop education below
Suggested consults: None at this time

Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

Due to the patient's past medical history of uncontrolled diabetes, I would obtain a HbA1c and consider a consult to diabetic educator pending results. I would also obtain another CT post-operation to ensure all gas accumulation has resolved… this is because necrotizing fasciitis often requires multiple debridements. As the wound has been deemed appropriate for NPWT, I would confirm with the surgical PA at bedside that the vagina is not involved as to prevent development of a fistula. ***Good***

Using the information from the encounter and your critical evaluation 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. (For example: *What dressing change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

NPWT with normal saline instillation (KCI/Solventum VeraFlo) change 3x week.

1. Cleanse wound with normal saline.
2. Apply Skin Barrier Prep to peri-wound with stoma paste around edges near perineum.
3. Place drape from wound bed onto anterior thigh for placement of trac pad.
4. Apply gray contact layer (layer with holes) to edges of wound bed.
5. Fill inside of wound bed with thin and thick gray foam.
6. Cut foam in the shape of a circle with tail to extend from wound bed to anterior thigh (for trac pad).
7. Secure all pieces with drape and attach trac pad.
8. Hook up instillation tubing and canister tubing.

9. Set VeraFlo settings to 100 mL of NS for 2 mins alternating with 2 hours of NPWT @ 125mmHg then turn on and ensure seal. (These settings are based on current patient with identical circumstances, she has leaked with more than 100mL instillation or longer than 2-minute soak.)
   There is no mention of the plan for VeraFlo. What is your rationale for this? VeraFlo has proven to reduce the number of required surgical debridements by closing wounds twice as fast, lowering bacterial counts, and reducing overall length of therapy time by more than half (3M, n.d.). It is also 43% faster than traditional VAC therapy at granulation tissue formation (3M, n.d.).

3M. (n.d.). Veraflo therapy. https://www.3m.com/3M/en_US/medical-us/products/negative-pressure-wound-therapy/veraflo/?utm_term=hcbg-msd-icuroh-en_us-pa-cwc-cpc-google-na-learn-brandedveraflo-apr24-00000&gad_source=1&gbraid=0AAAAAC-CtZ0Iq1Bdde3TyRyy6miRkVC6j&gclid=CjwKCAjwtNi0BhA1EiwAWZaANPlFlRniR-D8EBMADde4g7G59XdUwFbZpR4jvuXXph788T_m_zyzxhoCBokQAvD_BwE

10. Plan for 3x/week dressing changes in collaboration with surgical team to ensure wound bed stays healthy/clean and does not show signs of further necrotizing fasciitis. ***Is this your plan as the WOC nurse? These orders should be written for those caring for the pt in your absence. Will bedside staff do dressing changes? If WOC nurses are doing NPWT dressing changes, then the dressing change procedure would not be a component of the POC.***
    Sorry for the confusion! Our patient charts contain NPWT dressing orders (for homecare and other facilities) as well as alternative dressing orders. Here would be a dressing change order written for bedside nurses:
    1. Cleanse wound with normal saline.
    2. Apply Skin Barrier Prep to peri-wound.
    3. Cut Hydrofera Blue Classic into spiral, wet with normal saline, and squeeze out excess.
    4. Gently pack normal saline moistened Hydrofera Blue Classic into wound bed.
    5. Secure with ABD pad and tape.
    6. Change daily and as needed.
11. Document thoroughly and place orders for alternative dressing if NPWT fails during night shift: normal saline moistened Hydrofera Blue Classic, ABD pads, and tape - change daily. Consider fecal management system and/or urinary catheter if NPWT fails due to incontinence. ***This also does not read as directives for your absence.***
    POC is not holistic.
    Patient will need infectious disease consult for best antibiotic regimen. Patient will need social work and care management consults for resources if she returns home after discharge or transitions to SNF for continued wound care. Patient needs diabetic educator consult for uncontrolled diabetes. She will need follow-up appointments – most likely with general surgery, wound care, diabetic education, and infectious disease. She may desire chaplain consult to discuss her experiences throughout this admission. Registered dietician consult needed for protein intake recommendations regarding wound healing. Further imaging recommended to ensure no other gas pockets are visible, suggest abdominal and pelvic CT. Educational videos and/or reading should be provided to the patient for better understanding of necrotizing fasciitis and the road to recovery, as explanation through physician or nurse can be hard to grasp. Patient also needs low air loss mattress for low-risk Braden score and OT/PT evals as deemed necessary by internal medicine team.

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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 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. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

Initial visit for wound assessment and potential NPWT application per request of surgery team. Patient status post OR debridement of the left labia/groin/perineal/gluteal areas for necrotizing fasciitis with no undermining or tunneling. Wound bed 28 x 40.5 x 9.2 cm; clean with no structures present. Patient has past medical history of uncontrolled diabetes. 10/10 pain requiring IV morphine prior to dressing change. VeraFlo/NPWT with instillation applied – 100mL of normal saline for 2 mins alternating with 2 hours of NPWT at 125 mmHg, change 3x/week. ***You are missing integral components of this note. It is task focused. What else should be included in the note of a specialist consultant?***
Further imaging via CT recommended. Consults to infectious disease, care management/social work, diabetic education, chaplain, RD, and possible OT/PT pending. Discharge home vs SNF. Reading materials/videos needed. Surgery team following, continue collaboration at next dressing change.

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?

4. What was your goal for choosing this case?

I selected this case study because it is relevant to my current job. I am managing NPWT with instillation on a 48-year-old woman with necrotizing fasciitis of the perineum/left buttock and left abdomen, who has gone to the OR for 4 surgical debridements. It's important to understand the bigger picture of patient care as I change her dressings, even if my medical director is covering those bases. Nurses can bring small details to light that that may have a larger impact. I was able to meet the goal of deeper thinking by identifying further tests, consults, and education I would have suggested for this patient. ***This is limitedly noted above and is not noted in your POC nor note.*** I believe this was better covered after review!

Reviewed by: Kelly Jaszarowski Date: 7/5/2024
This journal is missing key elements. Note my feedback throughout. This journal needs to be resubmitted.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen		
• Describes the encounter including assessment, interactions, any actions, education provided and responses		
• Includes pertinent PMH, HPI, current medications and labs		
• Identifies specific products utilized/recommended for use		
• Identifies overall recommendations/plan		

Plan of Care Development:		
• POC is focused and holistic		
• WOC nursing concerns and medical conditions, co-morbidities are incorporated		
• Statements direct care of the patient in the absence of the WOC nurse		
• Directives are written as nursing orders		
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		
• Identifies alternatives/what would have done differently		
Learning goal identified		