

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: _____ Day/Date: _____

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	<p><u>Age/sex</u>: 52-year-old female</p> <p><u>PMH</u>: morbid obesity, CHF, COPD, PE and lower extremity venous disease with ulcers.</p> <p><u>CC</u>: Presented to the ER with bilateral lower extremity edema, cellulitis and ulcers. BLE are erythematous and warm, confirmed cellulitis. Short of breath for past week & uses 4L oxygen</p> <p><u>Meds</u>: Currently taking Bumex 2mg BID. Has been taking Tylenol for pain but states it is not helping.</p> <p><u>Social hx</u>: Lives alone</p> <p><u>Braden score</u></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr><td>Sensory Perception</td><td style="text-align: center;">4</td></tr> <tr><td>Moisture</td><td style="text-align: center;">4</td></tr> <tr><td>Activity</td><td style="text-align: center;">3</td></tr> <tr><td>Mobility</td><td style="text-align: center;">3</td></tr> <tr><td>Nutrition</td><td style="text-align: center;">2</td></tr> <tr><td>Friction/Shear</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: right;">Total</td><td style="text-align: center;">19</td></tr> </table> <p><u>Plan</u>: IV Vancomycin. Morphine for pain. Lasix for CHF. Potassium is low at 2.7. IV potassium ordered. Troponins were normal. COVID neg. Ultrasound r/o DVT's.</p> <p>Photo: RLE on admission to ED. ABD dressing inplace</p> <div style="text-align: center; margin-top: 10px;">  </div>	Sensory Perception	4	Moisture	4	Activity	3	Mobility	3	Nutrition	2	Friction/Shear	3	Total	19
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Moisture	4														
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Total	19														

Assessment/encounter:

LOC: Alert, awake, & oriented.

Initial interview: Stated both legs have been swollen for a month and are extremely painful to touch. Independently wraps legs daily with ACE bandages, ankle to above wounds. Currently has been suffering with pain and was afraid to come to the hospital because she does not like hospitals, but legs are now weeping, copious amounts of clear drainage. States has not been wearing oxygen.

Wound Assessment

Location: RLE

Size & shape: Round, lateral is 1.2 x 1.3 x 0.1 cm & medial is 1.4 x 1.4 x 0.1 cm

Wound bed tissue: red tissue with small amount yellow tissue on medial wound

Exudate amount, odor, consistency: Large amount serous drainage, thin, no odor

Undermining/tunneling: None

Edges: flat & attached

Periwound skin: Erythematous, but no induration, fluctuance, maceration or denudement.

Pain: 4/10 but >10 on movement

Temperature: BLE warm to touch

Edema: Present bilateral extremities with RLE

measuring 40 cm at the calf with reference point of 12 cm from popliteal fossa, 23 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot. LLE measures 43cm at the calf with reference point of 12 cm from popliteal fossa, 25 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot.

Pulse right: Doppled on right leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable

Pulse left: Doppled on left leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable

Monofilament test R foot: All points positive

Monofilament test L foot: All points positive



Education: discuss below

Suggested consults: discuss below

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.

-No vitals are listed and vitals are a very important component of patient care. We need to explore if the patient has any signs of sepsis from the cellulitis, especially before antibiotics are administered. Also, the patient is to be wearing 4L of home oxygen but states she has not been using it. The patient needs a pulse ox reading, possibly some ABGs and then placed on some oxygen. Patients without proper oxygenation do not heal as adequately as those without hypoxemia.

-Prior to administering any medications we need to assess for allergies.

-ABIs should be done to assess ability to apply compressive wraps and it would be nice to see if the patients skin has any signs of hair growth.

- Potassium result was listed, but it is unclear if a CBC was done or any other labs. It would be helpful to see a white count as well as inflammatory markers, again to check for signs of sepsis.

- A BNP would assist with the CHF progression.
- A vancomycin peak and trough will be helpful in the coming days to be sure the patient is receiving the proper dose of antibiotics and protecting the kidneys, so a BMP should be done with those as well, especially with Lasix.
- We are given good leg measurements, but we aren't told the depth of edema and whether it is pitting or not.

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)

- Elevate legs above heart while in bed and in chair.
- After venous duplex is resulted, if patient is without a DVT perform ABI.
- Elevate legs 30 minutes prior to dressing change and wrapping
- Cleanse wounds with 0.9%NS.
- Apply a silver alginate dressing to wound bed and cover with a nonadherent foam dressing.
- Apply compression to lower extremities, pending result of ABI.
 - *If ABI is less than 0.5 or greater than 1.3 do not apply compression, consult vascular.
 - *If ABI is 0.5-0.8 apply Low Compression (20-30 mmHG) with a three-layer compression system.
 - *If ABI is greater than 0.8 apply High Compression (30-40 mmHg) with a four-layer compression system.
- Be sure toe wrap at base of toes up around foot and up to just below knee. Wrap in a figure eight motion. Left over 1st layer padding can be applied to bony prominences before next layer is applied.
- Clean wound and change dressing and wrap every 3 days.
- Do not allow dressing or wraps to get wet or soiled, if drainage comes through or if dressing becomes soiled change dressing.
- Consult Physical Therapy to review gait and safety.
- Monitor Vancomycin Peak and Trough, pharmacy to dose.

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:

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?

Reviewed by: _____ Date: _____

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 		
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 		
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 		
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 		
<ul style="list-style-type: none"> Identifies overall recommendations/plan 		
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 		
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 		
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 		
<ul style="list-style-type: none"> Directives are written as nursing orders 		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 		
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 		
Learning goal identified		