Cleveland Clinic

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Belinda Chapa Day/Date: 10.26.24

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:55-year-old male
PMH: CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities
CC: Presented to the ER accompanied by friend. C/o severe flu-like symptoms and severe shortness of breath that started 2 days ago. Friend provided limited history. States patient "uses oxygen when he has it, has been sick for a few days and has been unable to get out of his chair". Unable to transfer self in ER as short of breath & fatigued. Appears thin, cachexic & unkept.
Meds: Unknown
Social hx: Homeless, denies ETOH or illicit drug use, smokes 1 PPD

Pt desaturated and code called in ER. Pt resuscitated. Incontinent of stool. External male catheter placed.

Braden Score: (Post arrest)

Sensory Perception	1
Moisture	1
Activity	1
Mobility	3
Nutrition	1
Friction/Shear	1
Total	8

Plan: Transferred to ICU, intubated, sedated. Low air loss surface ordered.

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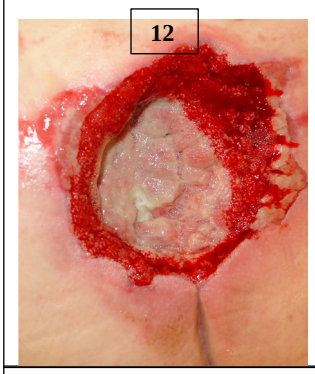
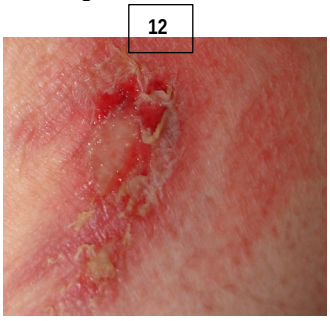
Assessment/encounter:
LOC: the patient is intubated and sedated in the intensive care unit; no initial interview able to be done
Wound assessment:
Location: Sacrum
Wound type: Pressure injury
Extent of tissue loss: Stage 3
Size & shape: 2.0 cm x 1.2cm x 0.2cm
Wound bed tissue: see image & discuss in note
Exudate amount, odor, consistency: Moderate serous, thin, no odor
Undermining/tunneling: None
Edges: see image & discuss in note
Periwound skin: Erythematous with no induration, fluctuance see image & discuss in note
Pain: pain unable to be assessed



Location: R lateral buttock
Wound type: Pressure injury
Extent of tissue loss: Stage 2
Size & shape: 0.8 x 0.8 x 0.1cm
Wound bed tissue: see image & discuss in note
Exudate amount, odor, consistency: Scant, serous, no odor
Undermining/tunneling: None
Edges: Attached
Periwound skin: No induration, fluctuance, maceration see image & discuss in note
Pain: pain unable to be assessed



Education: None at this time as patient is not alert & oriented.

Suggested consults: discuss in note

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.

Assessment data that is pertinent to the patient and his treatment plan includes labs, cultures, diagnostics, in and out of hospital medications, vital signs, oxygen levels.

I would try and expedite the low air loss delivery in order to relieve the pressure areas. While waiting I'd ensure that now the patient is using wedges and being repositioned.

I would ensure that bowel and bladder are being addressed such as the Purewick male catheter being on and also a fecal bag in place to keep urine and feces away from the wounds.

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Treatment recommendations would include the low air loss mattress, repositioning q2 hrs, offloading bony prominences, daily dressing changes, a nutritionist consult, PT/OT eval and treat consult, an infectious disease consult, a pulmonologist consult, a nephrologist consult, a smoking cessation intervention, and pressure injury/offloading education.

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)

Dressing change orders for sacrum:

- **Frequency of change: Every other day and as needed if soiled.**
- **Cleanse wound using non-cytotoxic wound cleanser such as Vashe and 4x4 gauze.**
- **Let Vashe and gauze soak in wound for 5 minutes.**
- **Apply 3M Advanced Cavilon skin protectant to periwound area and let dry. (could be reapplied once or twice a week)**
- **Apply Medihoney Alginate dressing to wound. (cut to fit size of wound)**
- **Apply 3M Tegaderm Silicone Bordered Foam sacral dressing to sacral wound.**

Dressing change orders for right lateral buttock:

- **Frequency of change: Every other day and as needed if soiled.**
- **Cleanse wound using non-cytotoxic wound cleanser such as Vashe and 4x4 gauze.**
- **Let Vashe and gauze soak in wound for 5 minutes.**
- **Apply 3M Advanced Cavilon skin protectant to periwound area and let dry. (could be reapplied once or twice a week)**
- **Apply Cutimed Sorbact with hydrogel dressing to wound. (cut to fit size of wound)**
- **Apply 3M Tegaderm Silicone Bordered Foam 4x4 dressing to wound.**

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 is for 55 y/o male who came to the ED accompanied by his friend for SOB and flu-like symptoms. The patient desaturated in the ED and was resuscitated. The patient is now in the ICU, sedated, intubated, and unable to respond. From initial arrival to the ED it was noted that the patient is homeless and most-likely is not compliant with his medical care and is nutritionally compromised as it is seen by his cachectic appearance. With the assistance of the primary nurse we are able to turn the patient on his left side to assess his sacral wound. The wound bed appears healthy pink and red, granulation tissue present with a small amount of slough in areas. The wound margins area attached and there is no tunneling or undermining. The

drainage visible is serous and is moderate amount with no odor. The wound measures 2cm x 1.2cm x0.2. Every other day dressing change with Medihoney Alginate will help with healing and help clean up the slough areas. Cavilon Advanced will help the periwound from preventing any further damage to the tissues. The right buttock wound appears red, pink, granulating and epithelizing. A scant amount of serous drainage is noted. Wound margins are attached. The wound measures 0.8cm x 0.8cm x 0.1cm. Every other day dressing change using Cutimed Sorbact with hydrogel will help promote moist wound bed and assist with healing. Upon the patient improving his health status and before discharge the patient should be evaluated for assisted housing if unable to provide a safe discharge to a temporary home (friend). The patient should be set up with home health services for wound care and PT/OT at home. Transportation should be set up for appointments with outpatient wound clinic. Oxygen therapy should also be set up if need be for home use.

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 chose to study this case because in clinic we see many patients with pressure injuries and I wanted to explore deeper into different treatment options available for pressure injury wounds. I feel I was able to research different options and the reasoning and differences of each and therefore met my goal in learning different treatment options for different wound presentations.

Reviewed by: _____ Date: _____

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		