

Virtual Journal Entry with Plan of Care & Chart Note

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Day/Date: November 11, 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	<p><i>Age/sex:</i> 55-year-old male</p> <p><i>PMH:</i> CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities</p> <p><i>CC:</i> 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.</p> <p><i>Meds:</i> Unknown</p> <p><i>Social hx:</i> Homeless, denies ETOH or illicit drug use, smokes 1 PPD</p> <p>Pt desaturated and code called in ER. Pt resuscitated. Incontinent of stool. External male catheter placed.</p> <p><i>Braden Score:</i> (Post arrest)</p> <table> <tr> <td>Sensory Perception</td> <td>1</td> </tr> <tr> <td>Moisture</td> <td>1</td> </tr> <tr> <td>Activity</td> <td>1</td> </tr> <tr> <td>Mobility</td> <td>3</td> </tr> <tr> <td>Nutrition</td> <td>1</td> </tr> <tr> <td>Friction/Shear</td> <td>1</td> </tr> <tr> <td>Total</td> <td>8</td> </tr> </table> <p><i>Plan:</i> Transferred to ICU, intubated, sedated. Low air loss surface ordered.</p>	Sensory Perception	1	Moisture	1	Activity	1	Mobility	3	Nutrition	1	Friction/Shear	1	Total	8
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Activity	1														
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Friction/Shear	1														
Total	8														

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.

A validated behavioral pain tool like FACES should be used to assess the patient's pain. Education should be provided to staff regarding pressure injury prevention including turning q2h, and ensuring TAPS system is in place with wedges. Consult social work for discharge needs including possible facility placement with nursing care i.e. inpatient rehab. Consult physical and occupational therapy to work with patient once medically stable and oxygenation status improves. Suggest to provider insertion of NG/OG tube for enteral nutrition. Consult dietician to assess dietary status, and nutrition recommendations. Assess frequency, amount, and characteristics of stool and urine. Assess medications patient is receiving. Assess testing for influenza/COVID panel and need for airborne/contact precautions.

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)

- For sacral wound:
 - Cleanse wound with pH balanced skin cleanser
 - Allow skin to dry
 - Apply skin sealant to periwound skin.
 - Cut McKesson Hydrogel sheet to fit base of the wound and place on wound bed.
 - Apply 4x4 foam Mepilex dressing applied as secondary dressing over hydrogel.
 - Change q3days and PRN for strikethrough.
- For right lateral buttock wound:
 - Cleanse wound using pH balanced skin cleanser
 - Allow skin to dry
 - Apply 2x2 foam Mepilex dressing applied over wound.
 - Change q3days and PRN for strikethrough.
- Assess Braden Score q12hours per facility policy.
- Document strict intake and output q1hour while patient is in ICU per hospital policy.
- Cleanse skin gently using pH balanced wipes
- Monitor blood sugar and treat as indicated
- Increase protein intake within diabetic diet limitations
- Assess ETT at pressure points on patient's face and head, allowing two fingers width between strap and patient's neck. Ventilator circuit should be placed on ventilator's circuit holder to avoid pulling on face and neck. Change ETT holder as appropriate (i.e. when soiled). Apply hydrocolloid dressing to facial pressure points as needed to prevent medical device related pressure injuries. Discuss with RT to reposition ETT every 4 hours unless otherwise ordered.
- Turn patient q2h using TAPS repositioning system.
- Assess external urinary catheter skin integrity at least q2 h with turning patient and PRN and change external device q24hours.
- Assess lower extremities for cellulitis and skin changes considering patient's past medical history.
- Check for stool incontinence at each q2h turn and PRN
- WOC team will continue to follow
- Notify provider and contact the JHH Surgery Wound/Ostomy Care Inpatient GROUP on Epic Secure Chat with any questions or changes in patient's wounds.

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:

This is the initial visit for this 55 y/o male who has been admitted to the ICU after oxygenation desaturation and cardiac arrest in the emergency department. Patient has PMH of CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities. Patient is intubated and sedated in bed, and will require education when mental status improves. Patient is currently on low air loss support mattress. Patient appears thin and cachexic. Patient is noted to have stage 3 pressure injury on sacrum and stage 2 pressure injury on right lateral buttock. Upon assessment wounds open to air. Wounds cleansed with pH balanced skin cleanser. Sacral wound measures 2.0cm x 1.2 cm x 0.2cm. Wound base has yellow slough at the center of the wound, with granulation tissue around the edges to peri-wound skin. Moderate, serous, thin exudate noted with no odor. No tunneling noted. Periwound skin erythematous with no induration or fluctuance. Skin sealant applied to periwound skin. McKesson Hydrogel sheet cut to fit wound and placed on wound bed. 4x4 foam Mepilex dressing applied as secondary dressing over hydrogel. Change q3days and PRN. Right lateral buttock wound measures 0.8cm x 0.8 cm x 0.1cm. Scant, serous exudate noted with no odor. Skin is macerated with peeling of epidermis. No tunneling or undermining. Edges approximated. No induration noted with periwound skin. 2x2 foam Mepilex dressing applied over wound. Change q3days and PRN. Patient tolerated procedure well without oxygenation desaturation. Review nutritional factors and assess hydration status. Monitor patient's weight for significant changes (i.e. greater than 2% change in 1 week, greater than 5% in 1 month). Monitor associated signs and symptoms that impact the patient's nutritional status, including nausea, vomiting, diarrhea. Request for dietitian consult (Braden Nutrition Score 2). Monitor strict intake and output with patient's AKI and assess need for temporary dialysis and IV fluid replacement. Turn and reposition patient every 2 hours while in bed and every 1 hour while in chair to offload bony prominences. Use wedge or TAPS system while patient is in bed for positioning. Request Physical Medicine Consult for physical and occupational therapy assessment and treatment. Assess male external catheter (Purewick) skin q2hours with each turn and change external device q24hours. Connect to 40mmHg continuous wall suction canister, always using the minimum amount of suction necessary. Remove Purewick when patient is able to void in the urinal, bedside commode, or toilet. Orient device, aligning fitting towards feet of patient. Slide opening of device over penis until close to pelvic skin. Center penis within opening. Remove adhesive liner and press device against pelvic skin to adhere it. Ensure base has adhered around penis (scrotum should not be place in device). To remove device, lift top edge of device off the skin. In slow, downward peeling motion remove device. To avoid skin injury, never pull device away from patient, instead, always peel in direction from head to foot. Replace device at least every 24 hours or if soiled with feces or blood. Follow and document skin integrity q4h per hospital policy. Document intake and output q4h per hospital policy. Provider contacted regarding electrolyte replacement, nicotine replacement patch order, and suggested to order liver enzyme labs. Requested social work consult for resources regarding opioid use and discharge planning. Provided education to primary nurse on skin care. Contact the JHH Surgery Wound/Ostomy Care Inpatient GROUP on Secure Chat for further questions. WOC team will continue to follow.

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?

My goal was to practice and review best practices for pressure injuries and develop a care plan for a patient in the ICU. I was able to meet this goal as I reviewed the NPIAP guidelines and applied them to this patient.

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		