

**Daily Journal Entry with Plan of Care & Chart Note**

**Virtual Journal Entry with Plan of Care & Chart Note**

Student Name: \_\_\_\_\_ Day/Date: \_\_\_\_\_

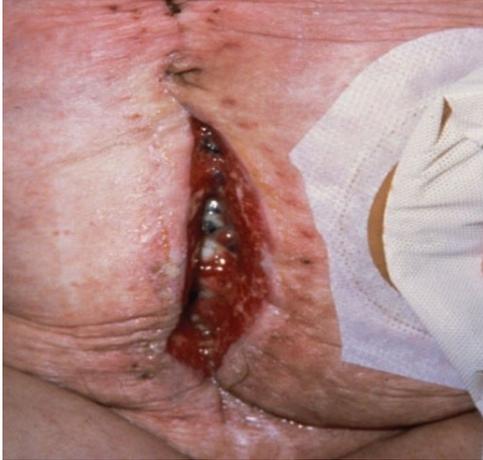
Setting: Hospital • Ambulatory Care  Home Health Care • Other: \_\_\_\_\_

**WOC nu**

reses 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.

<b>Chart Review/History</b>	<p><u>Age/sex</u>: 49-year-old female</p> <p><u>PMH</u>: Uncontrolled DM, obesity, colon cancer with descending colostomy.</p> <p><u>CC</u>: Came to ER for dehisced surgical wound</p> <p><u>Meds</u>: Unknown</p> <p><u>Social hx</u>: Lives alone</p> <p><u>Plan</u>: Referred to wound clinic for treatment plan.</p>
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<p><b>Assessment/encounter:</b></p> <p><u>LOC</u>: Awake, alert, oriented x 3</p> <p><u>VS</u>: 98.7°F P 688 R 26</p> <p><u>Initial interview</u>: States the “stitches were taken out yesterday at the surgeon’s office and now I have a big hole”</p> <p><b>Wound assessment:</b></p> <p><u>Location</u>: Mid abdomen</p> <p><u>Wound type</u>: Dehisced surgical wound</p> <p><u>Extent of tissue loss</u>: Full thickness</p> <p><u>Size &amp; shape</u>: 25 x 10 x 5 cm oblong</p> <p><u>Wound bed tissue</u>: Red</p> <p><u>Exudate amount, odor, consistency</u>: Moderate amount of serosanguineous drainage, no odor. Also noted exudate on blouse</p> <p><u>Undermining/tunneling</u>: None</p> <p><u>Edges</u>: Attached</p> <p><u>Periwound skin</u>: No erythema, induration, fluctuance, denudement. Non-tender</p> <p><u>Pain</u>: 8/10 when moving</p> <p><b>Photo:</b></p>
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Courtesy of WOCN Library

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.**

Thorough documentation comprehensive documentation of the patient's complete medical history should have been gathered during the visit including details on diabetes management last A1c information on her colostomy care surgical history. Pain assessment a more detailed pain assessment using a standardize pain scale to evaluate patient's discomfort level could have been it have added in determining appropriate pain management strategies. Wound assessment while the wound was assessed additional characteristics may warrant deeper investigation assessing for signs of infection more thoroughly such as any increased warmth or look like swelling would be appropriate given that the stitches were removed shortly before presenting to the emergency room. Things that could be done differently; immediate pain management administer an analgesic immediately to address the report pain of 8 out of 10 especially since the patient has indicated difficulty moving. Education on wound; care provide the patient with detailed education I won't care management at home including how to change dressings recognize signs of infection manage her diabetes optimally to facilitate healing. Dietary considerations considered the patient's obesity and diabetes dietary consulting Tatian she'd have been recommended to facilitate weight management not optimal nutrition crucial for Wound healing. Social service support considers the patient lives alone and require assistance with Walter refer to social worker community resources could offer to Portland or home health services for ongoing care. Laboratory test: assessing laboratory tests including blood glucose levels and complete blood count could be beneficial in evaluating the diabetes control status and overall health which and significantly affect wound healing. In this case self-management and educating the patient on the importance of regular follow up including blood sugar monitoring and potential signs that necessitate emergency medical evaluation. Providing written material on wound care and diabetes management along with home care strategies may improve management of her conditions more effectively after the discharge

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)

Wound management

Cleanse wound with NSS pat dry

Apply no sting barrier to peri wound let dry 60 seconds.

Gently fill wound with Aquacel Hydrofiber

Cover Aquacel Hydrofiber with 4x4 gauze to absorb excess exudate

Secure with Allevyn Life dressing.

Change daily

Pain management.

Recommend scheduling pain manager prior to dressing change discussed the use of acetaminophen or NSAIDs as appropriate to alleviate discomfort

Diabetes management: recommend consultation with patient's primary care physician or Endocrinologist for a comprehensive diabetic management plan as improved blood glucose control can facilitate Wound healing.

Follow up Care: schedule follow up visits at the wound clinic weekly for ongoing assessment of wound healing dressing changes and adjustments to the treatment plan as necessary

Patient education: educate the patient on signs of infection including increased redness warmth or purulent drainage and emphasize the importance of keeping the area clean and dry

Nutritionists refer patient for nutrition consultation to help manage her diabetes. Good glucose control facilitates wound healing.

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:

49-year-old female

Diagnosis:

Uncontrolled diabetes obesity colon cancer with the sanding colostomy post operative wound care

Reason for visit:

This is an initial visit for evaluation and management of a post operative surgical wound patient presents with a full thickness wound mid abdomen that was recently assessed at the general surgeon's office where the stitches were removed the patient reports significant pain and has concerns about the size of the wound.

**Assessment;**

Patient was a evaluated in emergency room and is currently alert and oriented aware of her surroundings

**Vital signs**

Temperature 98.7°F

Pulse 88 bpm

Respirations 26

Pain assessment 8 out of 10 when moving

**Wound assessment:**

Location: mid abdomen

Size: 25cm x 10cm x5cm

Shape: oblong

Drainage: moderate amount of serous drainage no older but noted soiling on the blouse

Edges intact with no undermining or tunneling

Surrounding tissue: mild induration, non-fluctuant, nontender

**Problems identified**

1. Post operative dehiscence of surgical wound
2. Uncontrolled diabetes which may impair wound healing
3. Pain management needs especially during movement
4. Increased risk of infection due to serous drainage potential exposure

**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?**

The primary goal of this case is to consolidate the healing of the surgical wound through proper management enhance the patient's quality of life by managing pain effectively and to educate her on preventative strategies and the importance of controlled diabetes which are critical for postoperative recovery.

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		

<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>		
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>		
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>		
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>		
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>		
Learning goal identified		