

R. B. Turnbull Jr. MD WOC Nursing Education Program

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Lydia Agyekum

Day/Date: 3/27/25

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>:55-year-old male</p> <p><u>PMH</u>: CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities</p> <p><u>CC</u>: 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><u>Meds</u>: Unknown</p> <p><u>Social hx</u>: 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><u>Braden Score: (Post arrest)</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Sensory Perception</td><td style="text-align: center;">1</td></tr> <tr><td>Moisture</td><td style="text-align: center;">1</td></tr> <tr><td>Activity</td><td style="text-align: center;">1</td></tr> <tr><td>Mobility</td><td style="text-align: center;">3</td></tr> <tr><td>Nutrition</td><td style="text-align: center;">1</td></tr> <tr><td>Friction/Shear</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: right;">Total</td><td style="text-align: center;">8</td></tr> </table> <p><u>Plan</u>: 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
Sensory Perception	1														
Moisture	1														
Activity	1														
Mobility	3														
Nutrition	1														
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.

Though the patient is intubated, and not oriented but physical assessments including ABI, vital signs would have been checked, this patient is at high risk for pressure injury so comprehensive assessment especially the skin would be assessed

for the bony prominence for possible injuries, skin color, folds, lesions, toes, heels. Optimize comorbidities. Referrals; dietician, cardiologist, vascular specialist.

Test; full blood count, glucose levels, electrolytes, BUN, urinalysis

Education: family and care givers on heel offloading, offload boots, low air loss surface, turn and reposition

schedule, moisture management. And elevation of lower extremities.
Treatment; analgesic, TPN, IV fluids, antibiotics

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)

sacrum

Wash wound bed with wound cleanser
Cover wound bed with silver alginate dressing
Cover dressing with allevyn
Change dressing every 5 days and PRN
Assess for signs of infections

R. lateral buttock

Wash wound bed with wound cleanser
Cover wound bed with hydrocolloid
Change dressing every 7 days and PRN

- Turn and reposition patient every 2 hours on left and right rotation (CLRT)
- Offload heels with boots remove at least daily, wash & inspect the feet

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, Patient is seen in the intensive care unit on the request of wound consultation by attending physician on open wound at the sacrum and right lateral buttocks.

Physical assessment

LOC: the patient is intubated and sedated in the intensive care unit, unable to complete review of systems due to intubation

non alert, intubated on ventilator, cachexic and ill looking.

WOUND ASSESSMENT: pressure injury at the sacrum and R lateral buttocks present on admission.

Wound location; sacrum

Extend of tissue loss; stage 3

Site assessment; red moist

Shape; oval

Peri wound; moist; erythema
Wound length. 2.0cm
Wound width. 1.2cm
Wound depth. 0.2cm
Drainage type; serous
Drainage amount; moderate
Odor: none Wound location; R lateral buttock

Wound type; pressure injury
Extend of tissue loss; stage 2
Site assessment. Pink/moist
Peri wound; maceration
Wound length. 0.8cm
Wound width. 0.8cm
Wound depth. 0.1cm
Drainage type; serous
Drainage amount; scant
Odor; none

Wound washed with wound cleanser for accurate assessment and evaluation, measurement taken as charted above, photography taken to aid in visualization, wound bed covered with silver alginate on the sacrum to promote wound healing, provide moist and absorb the moderate exudate, the silver is antimicrobial to prevent bacterial growth, covered with silicone bordered foam (allevyn) to reduce pressure at sacrum. Hydrocolloid on the right lateral buttocks to provide moist to wound.

Barriers to healing; body habits, comorbid conditions, compliance with care regimen, mobility, and moisture. Education: care givers/family educated on the importance of heel boots and the 2 hourly repositioning. Pressure injury prevention; heel suspension boots, low air loss surface, moisture management, redistribution surface, and turn schedule.
Follow up, a week after the initial assessment.

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?

To be able to assess and manage pressure injury.

Reviewed by: _____ Date: _____

For instructor use only. Do not remove or edit

CRITICAL ELEMENTS	Completed	Missing
-------------------	-----------	---------

R. B. Turnbull Jr. MD WOC Nursing Education Program

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	