

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Mara Michalski RN Day/Date: 1/12/8/2025

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.

In regards to data collection, a more comprehensive history should have been obtained in the ER, including a head to toe skin assessment and Braden Scale where the nurse could have obtained information from the patient or the friend on when this wound formed, his level of mobility outside of the hospital, the medications he is taking, allergies, and how he cares for himself at home. If the patient is homeless then he likely does not have access to oxygen tanks frequently or may not take medications consistently as prescribed. Obtaining a skin assessment right when the patient arrived in the ER allows for the nursing team to implement earlier interventions in regard to the wound care. As a WOC I would also have wanted to see labs ordered that might indicate if wound healing would be impaired such as a CBC, CMP, HbA1c, and albumin. If the patient's diabetes is not controlled, hyperglycemia may delay wound healing. A nutrition consult should have been placed right away to put patient on a diet that would correct any malnutrition and give him the nutrients he needs for optimal wound healing. If the ER had done a head-to-toe assessment, a wound care consult could have been placed sooner and treatment of the wound could have begun earlier. Once finding out that the patient was homeless, a social work consult should also have been placed to help start the process of connecting the patient with resources once he is discharged. Once the patient is no longer sedated the WOC nurse will need to return to gather more information from the patient and provide education of smoking cessation and how to care for his wounds outside of the hospital.

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)

-To ensure proper pressure redistribution, reposition the patient every 2 hours using wedges and offloading bony prominences. Cleanse patient of incontinence with each episode with Ph balanced soap and water.

-Place patient on a P500 pressure reducing mattress.

-Consult dietary for a nutrition workup

-Consult social work to evaluate wound care resources for discharge

-Order CBC, CMP, Albumin, and A1C levels

Stage 3 pressure injury on sacrum:

1. Cleanse with Vashe moistened gauze, allow the gauze to sit for 5 minutes on the wound bed.
2. Apply thin layer of Triad cream to periwound
3. Apply Aquacel Ag cut to size of the wound bed and pack lightly fluffed gauze into open wound space.
4. Cover with Mepilex silicone bordered gauze
5. Change every 3 days or as needed if drainage leaks through dressing

Stage 2 pressure injury on right lateral buttock:

6. Cleanse with Vashe moistened gauze, allow the gauze to sit for 5 minutes on the wound bed.
7. Wipe with Cavilon no skin barrier wipes to periwound.
8. Cover with a hydrocollid dressing such as DuoDerm
9. Change every 3 days or as needed if drainage leaks through dressing

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 for present sacral stage 3 and stage 2 pressure injury evaluation and management. 55 year old patient, with a history of CHF, COPD, AKI, cellulitis and arterial disease, seen in the ICU. Patient is intubated and not currently oriented to answer questions. Patient is homeless and a smoker. The patients present pressure injury and history indicates consults to dietary for nutrition management, and social work for resources upon discharge including how the patients will care for his wounds when outside of the hospital. The stage 3 sacral pressure injury was assessed and measured 2.0X1.2X0.2 cm, the wound bed has slough present, the edges are undefined, granular and in some areas hypergranular. This WOC placed silver nitrate on the hypergranular areas of the wound wedges. Moderate serous drainage is noted. The wound was dressed with Aquacel Ag to the wound bed and packed with fluffed gauze and a Mepilex. The periwound had Triad placed around it. The stage 2 right lateral buttock pressure injury was assessed and measured 0.8x0.8x0.1 cm. The wound bed is red, granular with slough noted. Periwound is red. Scant serous drainage is noted. Cavilon skin barrier wipes were used on the periwound to protect the skin and DuoDerm was placed on the wound. The Braden scale is low with a level of 8. Sensory perception and activity is low due to patient being intubated. Incontinence of stool is being monitored by Q2hr repositioning and urine is being managed by a male external catheter, where staff will cleanse patient of incontinence when needed. The patient's low nutrition score is addressed by a dietary consult, to ensure patient is receiving adequate sources of nutrition to optimize wound healing. It is recommended that patient is transferred to stretcher when necessary, with a Hoyer lift or slide sheet to avoid shear and friction on the skin. The patient is to remain on a P500 pressure redistribution mattress.

Braden Score: (Post arrest)

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

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 a case study on pressure injuries because they are very common in the hospital and outpatient setting (where I currently work). Pressure injuries are a frequent issue and being comfortable identifying pressure injuries, the treatment of them, and appropriate products that can aid in healing these injuries will help me feel more confident as a wound nurse and educate floor nurses to help prevent HAPIs. I feel like I met this goal and expressed a wide range of recommendations apart from dressings to be used.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li data-bbox="154 380 711 420">Identifies why the patient is being seen 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 420 829 531">Describes the encounter including assessment, interactions, any actions, education provided and responses 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 531 899 604">Includes pertinent PMH, HPI, current medications and labs 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 604 938 642">Identifies specific products utilized/recommended for use 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 642 719 680">Identifies overall recommendations/plan 	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> <li data-bbox="154 718 558 756">POC is focused and holistic 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 756 862 829">WOC nursing concerns and medical conditions, co-morbidities are incorporated 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 829 727 867">Braden subscales addressed (if pertinent) 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 867 932 940">Statements direct care of the patient in the absence of the WOC nurse 	✓	
<ul style="list-style-type: none"> <li data-bbox="154 940 704 978">Directives are written as nursing orders 	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li data-bbox="154 1016 862 1089">Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	