Cleveland Clinic

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Amy Harlan Day/Date:_____

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:*45-year-old female *PMH:* anemia, anxiety, fibromyalgia, hypercalcemia, major depressive disorder recurrent with severe psychotic symptoms, and tongue carcinoma. Partial mandibulectomy and chemoradiation last year *CC: R*ecurrent tongue lesion with metastasis to the lung, altered mental status. *Meds:* Currently taking Bumex 2mg BID. Has been taking Tylenol for pain but states it is not helping. *Social hx:* Denies recent smoking, ETOH or illicit drug use *Labs*: Na 133, K 4.3, Cl 101, BUN 20, Glu 125, WBC 7.0, Hgb 9.7, HCT 30.2 %, PLT 245

Assessment/encounter:
Ostomy nurse consulted for painful G-tube site. Being seen with HHC nurse.
LOC: Patient awake and alert,
Interview with patient who states

- Pain is "10/10"
- Redness and bleeding under her new G-tube bumper for "weeks"
- No dressing placed under g-tube bumper; has a suture in place.
- No tube securement device used.
- Takes liquid Tylenol to manage pain. "Sometimes" uses ordered narcotics to "take the edge off".
- G-Tube replaced last month
- Tube feeding schedule of Isosource 1.5 cal; 4 cans per day
- Does take some PO food and fluids.
- Weight loss of 25 lbs in 2 months. Weight 148 lbs. before surgery and 123 lbs. at present
- Followed by dietary and a pain management specialist.

Stoma: not visible
Stoma size: N/A; tube bumper 2.0 x 2.0 in.
Tube bumper: - one suture noted, loose. No effluent drainage noted.
Peri-stomal skin: skin friable and macerated under bumper. Painful. Beyond bumper is dry and intact.
Abdominal plane: Flat
Education

- Develop education below

The patient is anxious regarding her pain to the area and is worried about needing another tube replacement. She is open to trying new interventions.

What specific interventions would you choose as the Ostomy provider? Make sure to include below, considering both short and long term plans for this patient.

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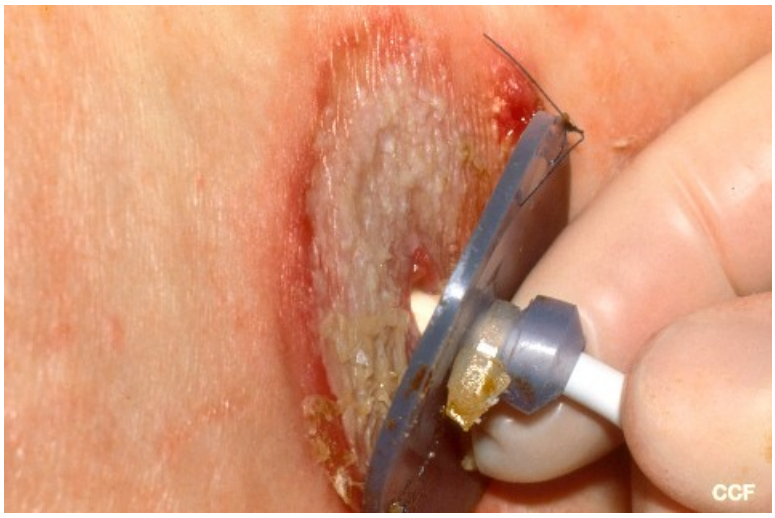
Photo: 12



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.

Explore nutritional intake further to determine what is taking in orally and how she is tolerating her Isosource feedings. Having any diarrhea or nausea? Educate on good diet choices to optimize nutritional intake. Dive deeper into mental health history and what medications she takes/ has taken in the past. Educated on relaxation strategies to help improve anxiety levels. Look further into oncology history and treatments, if any, she is currently on. Educated on tube site care- cleaning, stoma powder and using drainage sponges under bumper for excess moisture underneath. Explore further into what she has tried, what has worked and not worked for her G-tube. Educated and demonstrate use of tube stabilization device to help keep tube from being tugged on tube not sagging to avoid extra pressure applied to tube site. Educate on what to do if tube becomes clogged or falls out. Do blood work to check kidney, liver, and inflammatory marker levels. Do a blood toxicology screen, UA, and urine culture to determine cause of AMS and if she has any infection.

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 ostomy pouch change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

- Clean G-tube site daily with saline, pat dry, apply thin layer of Hollister Adapt stoma powder, sprinkle with Cavilon barrier film, brush off excess and create a crusting to denuded skin. Cover with McKesson Split Gauze 4x4s gauze and secure with 3M Medipore H tape.
- Secure tube using Medline tube secure device. Change every 2 day and PRN if it loses its integrity or becomes soiled.
- If tube becomes clogged- flush with 60mL of lukewarm water using push-pull method. If no resolution, use pancreatic enzyme tablet and sodium bicarbonate tablet crushed and mixed with 5-10mL of water. Avoid using cranberry juice or soda as this may cause tube to become more obstructed.
- Keep an extra low-profile Gastrostomy tube (MIC-KEY G by Halyard Health) on hand. If tube comes out, it must be replaced immediately, as the tract and opening in skin will start to close fast.
- Stoma nurse to check in with HH nurse in a week or two for update on skin condition, may re-consult for any worsening problems.

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 initial visit on a 45-year- old female consulted for painful G-tube site. Previous medical history consists of anemia, anxiety, fibromyalgia, MDD and tongue carcinoma. Previous surgical history includes partial mandibulectomy, gastrostomy and chemoradiation last year. Chief complaints are recurrent tongue lesion with metastasis to lung and AMS. Patient is currently taking Bumex BID and Tylenol to manage pain with occasional narcotic use to "take the edge off." Patient has social history of smoking, illicit drug and ETOH use; patient has not abused any of these recently. Patients G-tube was replaced last month, has been having redness and bleeding from G-tube bumper ever since. Patient has suture in place but no tube securement or dressing under bumper. Current feeding schedule of Isosource 1.5 cal, 4 cans per day. Patient is able to take in some PO fluids and foods. Patient has lost 25 lbs. in the last 2 months. Patient under the care of pain management and dietary. Patient reporting pain a 10/10. Patient has a flat abdominal plane, tube bumper measuring 2 x 2 in., one loose suture under bumper, no effluent present, and peri-stomal skin denuded/friable and painful. Skin beyond bumper is CDI. Peristomal skin cleansed with mild soap and water, dried gently, applied thin layer of Hollister Adapt Stoma Powder, dipped Cavilon skin barrier onto powder, brushed off excess. And formed a crusting. Placed 2 McKesson 4 x 4 split gauze under bumper and secure with 3M Medipore H tape. Applied Medline tube securement device with tube inside to LLQ to stabilize tube. Will fill out supply form and fax to home medical supplier to obtain needed supplies. Will be available to patient PRN and HH nurse to call with any worsening skin condition or other concerns. Plan to contact HH nurse in 2 weeks to check on status of pain and peristomal skin.

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 for choosing this case is to learn more about how to manage peritubular skin problems and better ways to secure tubes. I saw very few patient with tubes and have had plenty of them in my current role as a HHC RN case manager.

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		