Cleveland Clinic

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Jen Ennyl E. Gomez Day/Date: 11/26 - Tuesday

Setting: Hospital ☒ Ambulatory Care • Home Health Care • Other: _____

Chart Review/History	*Age/sex: 43*-year-old male *PMH* ESRD on dialysis, DVT, GERD, Cardiac dysrhythmia, Paraplegia and asthma *CC: P*resented in the ED yesterday with fever, fatigue, and increase in drainage output in his coccyx. *Social hx:* Patient lives by himself from home, *C*hronic ETOH abuse, regular smoker and denies illicit drug use. The patient is paraplegic and develops coccyx injury from being incontinent and had colostomy since 2019 and has home health nurse visit every Monday and Thursday. *Labs*: WBC – 17.7, Hgb-7.5, Hct 24.1, Na- 130, K – 3.2 Colostomy output: 300 in the last 12 hours, yellow brown in semi-formed consistency

Assessment/encounter:

Patient noted to be on bed with soiled sacrum dressing with left colostomy pouch dry and intact.
LOC: Patient awake, alert, oriented, and frustrated.
Interview with patient who states

- had increase drainage output from his sacrum and complaints of fever and weakness.
- turned down ostomy education because he had the colostomy since 2019 and states that he is knowledgeable in his ostomy care.
- Refuses changes of wound dressing at home as he feels it's not improving.
- reports frustration in his nonhealing coccyx wound and reports 10/10 pain.
- Reports decrease appetite.

Stoma: Moist, red with semi-formed, yellow brown effluent.
Stoma size: 2.0 x 2.0 in
Shape: round, both lumens visualized
Coccyx: Stage 4 measuring 8x21x8.5 undermining all around, deepest portion at 9.5 cm. Bone palpable with serosanguineous drainage.

Education

- Patient has poor knowledge in the importance of wound dressing.
- Patient refuses home health visit and has poor support group.
- Patient is frustrated and with resistance in education.
- Agreeable to dressing change after pain medicine.
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Treatment

- ICU bedside nurse gave prn pain meds prior to dressing change.
- Patient is on low air loss mattress.
- WOC nurse changed the coccyx wound dressing by gently cleansing with vashe then packed kerlix with half strength Dakin's and covered with ABD pad. Then secured with paper tape. Orders will be provided to bedside RN for as needed change.
- Patient is on IV Zosyn and infectious disease is following.
- Patient is scheduled for a plastics consult.

- WOC nurse will follow every MWF.

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Photo

Patient refuses to have a photograph taken.

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 differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

The patient is being followed by the right doctor and being taken care of as of the moment. Until the recommendation of plastics, I would also consult a social worker to provide options in skilled facility for daily basis monitoring and treatment. I would also consult nutritionist for possible TPN or supplements.

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)

Since the patient is paraplegic, preventing another pressure injury is essential. I would recommend to have an off-loading devices such as boots and wedges.
WOC will coordinate with the bedside RN for frequency of dressing change and provide a detailed wound dressing change for the patient.

1. Gently remove the soiled dressing by using adhesive remover.
2. Soaked a dry gauze with Vashe and gently cleanse the area.
3. Using a cotton tip applicator, gently packed the sacrum cavity using kerlix with half strength Dakin's solution covered with ABD pad.
4. Secured with paper tape with date and time.
5. Change every other day or as needed.
6. Call WOC extension for any questions.

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 of the WOC nurse since the patient just arrived the day before the encounter. WOC assessed the patient in cephalocaudal manner giving importance to the pressure points such as the patients heels and hips. Patient is in 10/10 pain and bedside RN provided prn pain meds. Patient is then cooperative with the dressing change however verbalizjng frustration. WOC nurse provided encouragement and emotional support to the patient and explained the importance of dressing change. Patient verbalized understanding. WOC changed the dressing and provided wound orders to the bedside RN.

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?

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The patient is still young without good support system and I feel like he has a lot of opportunities to get better with proper coordination of resources available for the patient.

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		