

Virtual Journal Entry with Plan of Care & Chart Note

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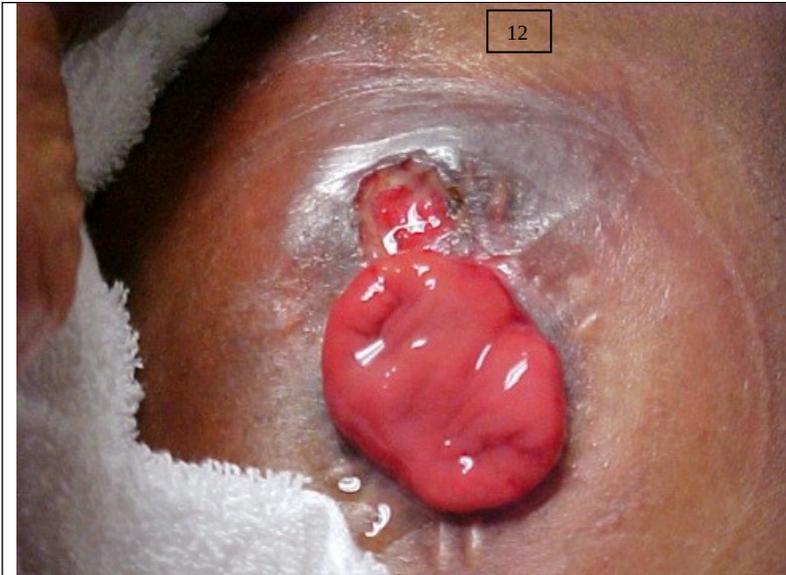
Day/Date: 1/11/2025

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>: 37-year-old female</p> <p><u>PMH</u>: Crohn's, diverticulitis, bowel resection, ileostomy placement, hypertension, rheumatoid arthritis, and depression. Patient with many reported allergies to foods and environment. Patient was experiencing symptom exacerbation related to her diverticulitis diagnosis to which she went to the ER 8 weeks ago. Work up discovered severe adhesion and patient had a RUQ loop ileostomy placed with a bowel resection.</p> <p><u>CC</u>: Pain under ostomy appliance.</p> <p><u>Meds</u>: Methotrexate, Prednisone, Sertraline, Hydralazine, Vicodin PRN, Tylenol PRN, Over the counter Probiotic</p> <p><u>Social hx</u>: Denies smoking, ETOH or illicit drug use</p> <p><u>Labs</u>: Labs drawn at last outpatient appointment and unremarkable.</p> <p>Patient had called ostomy clinic due to a new wound in her peristomal plane and was advised by the tech to come into the ostomy clinic.</p>
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<p>Assessment/encounter:</p> <p>Ostomy nurse visit today in the outpatient clinic.</p> <p><u>LOC</u>: Patient awake and alert</p> <p><u>Interview</u> with patient</p> <ul style="list-style-type: none"> • Independent in ostomy care • Had a pinpoint area that "erupted" and has been "extremely" painful with lots of drainage under her pouch • No further issues or other changes since her hospital discharge • No missed ostomy clinic appointments • Wears Convatec Sur-fit Natura 1 ¾" flat flange with drainable pouch • Empties pouch 4-5 times per day. • Appliance changes every 3-4 days • Current 1-2 day wear time due to wound drainage disrupting seal <p><u>Stoma</u>: Loop ileostomy, pink, moist,</p> <p><u>Stoma size</u>: 1.3x 1.0"</p> <p><u>Shape</u>: round</p> <p><u>Peri-stomal skin</u>: full thickness wound at 12 o'clock aspect noted with heavy serous drainage and violaceous edges.</p> <p><u>Abdominal plane</u>: semi-soft, flat, painful on palpation.</p> <p><u>Education</u></p> <ul style="list-style-type: none"> • Develop education below <p>The patient is exasperated with the pain associated with her pouch change and feel she is in a "catch 22". Patient will be returning home after this visit.</p> <p><i>What <u>specific</u> interventions would you choose as the Ostomy provider? Make sure to include below, considering both short and long term plans for this patient.</i></p> <p>Photo</p>
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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.

Consideration for referrals to involve a dietitian for nutrition management, especially to assist with proper hydration and output management given her history of Crohn's disease.

Consider Current pain medications may need reviewing for effectiveness and adjustment, as the patient continues to struggle with pain related to pouch changes. Wound Assessment:

A comprehensive wound assessment noted the characteristics (size, drainage, edges). Clear documentation of the situation is crucial for follow-up.

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)

Wound Care Plan

Nursing Order

1. Wound Management

- Clean the wound with normal saline.

- Apply a foam or hydrocolloid dressing (Mepilex or Duoderm) to manage drainage and maintain a moist healing environment.

- Apply a skin barrier (Cavilon No Sting Barrier Film) to protect peristomal skin from further irritation.

2. Ostomy Appliance Management:

- Recommend using a highly absorbent drainage pouch system (ConvaTec Esteem) a larger flange size (2" flange) that may provide better skin coverage and a secure seal.

3. Pain Management:

- Evaluate Vicodin dosage and consider adjusting for better pain control. If ineffective, consult with the prescribing physician for alternative pain management options. Reinforce the use of Tylenol for breakthrough pain.

4. Dietary Consult:

- Refer to a registered dietitian for dietary management tailored to her condition, including hydration strategies to reduce stoma output.

5. Education:

- Provide detailed education on proper ostomy care, signs of infection, and how to effectively change the pouch without causing pain.

- Teach the patient how to recognize signs of skin breakdown and proper wound care techniques.

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:

Name: [Patient Name]

Age: 37 years

Gender: Female

1/11/2025

Consult Type: Initial Ostomy Clinic Assessment

Reason for Consultation

The patient is being seen today due to the recent emergence of a painful parastomal wound and exacerbated drainage under the ostomy appliance. She is also being seen to receive support for managing her ostomy care. She has expressed frustration and pain associated with her pouch changes and is currently experiencing frequent changes (1-2 days) due to heavy drainage.

Summary of Encounter

Subjective

-Chief Complaint: Severe pain under the ostomy appliance, particularly at the wound site, where pain is described as a pinpoint area that has erupted and is draining excessively.

Current Medications:

- Methotrexate

- Prednisone

- Sertraline

- Hydralazine

- Vicodin PRN

- PRN Tylenol

- Over-the-counter probiotics

- Social History: Denies smoking, alcohol use, or illicit drugs.

Objective

- Vital Signs: Stable; general appearance alert and awake.

- Physical Assessment:

- Stoma: Loop ileostomy, pink and moist; size measured at 1.3 cm x 1 cm; shape round.

- Peristomal Skin: Notable full-thickness wound at 12 o'clock with heavy serous drainage and violaceous edges. The surrounding skin is erythematous and has some maceration due to moisture. Pain was reported as

moderate to severe upon palpation.

- Abdominal Assessment: Soft but tender upon palpation, specifically around the stoma.

This initial ostomy clinic visit was prompted by the patient's increasing pain associated with an erupting wound under her ostomy appliance, which she describes as severely painful and has caused her pouch changes to become frequent due to significant leakage.

Assessment:

Upon assessment, the loop ileostomy appears pink and healthy, but a full-thickness wound with heavy drainage at the 12 o'clock position and violaceous edges has created challenges in her ostomy care.

Rationales for the Plan

The plan of care focuses on effective wound management to facilitate healing, optimizing her ostomy appliance to minimize further irritation, and addressing her pain through proper medication adjustments and education. These measures aim to improve her overall quality of life while also enhancing her capacity to manage her ostomy with confidence.

Conclusion:

A multidisciplinary approach, including wound care, dietary management, pain control, and patient education, is essential to address her immediate needs while fostering long-term management strategies for her ostomy care.

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?

Educate the patient on the importance of maintaining a moisture balance at the stoma site to prevent skin breakdown and excessive drainage: Ensure the patient understands how to perform pouch changes with minimal discomfort and what signs indicate the need for medical attention. Collaborate with the patient to create a sustainable care plan that effectively manages pain and promotes healing at the stoma site.

Reviewed by: _____ Date: _____

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 		
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 		
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 		
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 		
<ul style="list-style-type: none"> Identifies overall recommendations/plan 		
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 		

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