

Virtual Journal Entry with Plan of Care & Chart Note

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 Day/Date: 1/10/25

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

Photo:

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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.

Wound Care Management ,G-Tube Securement, Pain Management, Nutritional Support, Psychological Support, Monitoring and Follow Up, Education

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)

Plan of Care

1. Wound Care Management:

- Clean and Dress G-Tube Site:
- Cleansing with normal saline and applying a barrier film (Cavilon Durable Barrier Cream) to protect the skin.
- Using a specialized dressing (Mepilex Border Lite) around the G-tube bumper to prevent further skin breakdown and manage exudate.

2. G-Tube Securement:

- Recommend the use of a G-tube securement device (Hollister G-Tube Securement Device) to minimize movement and irritation.

3. Pain Management:

- Due to inadequate pain relief from Tylenol, consider stronger analgesics for breakthrough pain management (oxycodone or hydromorphone).
- Referral to a pain management specialist for a comprehensive pain management approach.

4. Nutritional Support:

- Consult with a dietitian to assess her dietary intake and ensure adequate nutritional support during this period of weight loss.
- Evaluate and adjust feeding regimen as needed to promote tolerance and caloric intake.

5. Psychological Support:

- Address the patient's anxiety regarding pain and potential need for G-tube replacement with emotional support and education.
- Consider referral to a clinical psychologist or counselor specializing in chronic illness to provide psychological coping strategies.

6. Monitoring and Follow-Up:

- Schedule follow-up appointment in 1 week to reassess the G-tube site, skin condition, pain levels, and nutritional status.
- Instruct the patient to contact the clinic immediately if there are any signs of infection (increased redness, warmth, fever, or

drainage).

Education

- Provided education on proper G-tube care, including the importance of keeping the site clean and dry.
- Instructed on recognizing signs of infection and when to seek immediate care.
- Discussed the importance of maintaining hydration and nutritional intake, given her recent weight loss.

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: 45 years

Gender: Female

1/11/2025

Consult Type: Initial Consultation

Reason for Consultation

The patient is being seen for evaluation and management of a painful G-tube site with significant redness and bleeding under the G-tube bumper. She has been experiencing intense pain (rated 10 out of 10) and has expressed anxiety regarding her condition. Previous G-tube placement challenges, significant weight loss, and current nutritional intake methods warrant a comprehensive assessment and updated care plan.

Subjective

The patient reports the following:

- Past Medical History: Anxiety, anemia, fibromyalgia, hypercalcemia, major depressive disorder (recurrent with severe psychotic symptoms), and history of tongue carcinoma with recent partial mandibulectomy and chemotherapy/radiation.
- Current Medications: Bumex 2 mg BID for fluid management; Tylenol for pain management (ineffective); occasionally uses narcotics for pain relief.
- Pain: Reports severe pain (10/10) at the G-tube site, with increased redness, maceration of the surrounding skin, and bleeding noted under the G-tube bumper.
- Nutritional Intake: Currently on a feeding schedule of Iso-Source 1.5 cal (four cans per day) and consuming some PO foods and fluids. She reports a significant weight loss of 25 pounds over two months (weight prior to surgery was 148 lbs, currently 123 lbs).
- G-Tube Site: No dressing under the G-tube bumper, which has a visible suture, and the bumper measures 2 inches x 2 inches; noted to be loose. No effluent drainage was observed at the time of assessment.

Objective

Physical Assessment:

- G-Tube Site:

- Redness and bleeding noted under G-tube bumper.
- Skin surrounding the bumper: macerated and friable.
- Pain on palpation extending beyond the bumper area.
- G-tube flange appears loose, contributing to irritation.

- General Health: The patient is alert but appears anxious regarding her pain and potential need for repeat G-tube placement.

Assessment

The patient's symptoms of pain and skin integrity deterioration around the G-tube site are consistent with irritation, possible infection, and inadequate securement of the tube. An interdisciplinary approach is required to manage her pain

Conclusion

This initial consultation addresses the immediate needs of the patient concerning her painful G-tube site and underlying conditions. The plan includes multiple interdisciplinary referrals and targeted interventions aimed at improving her pain management, nutritional support, and overall quality of life.

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?

The primary goal of this case is to alleviate the patient’s pain, prevent further complications at the G-tube site and enhance her overall quality of life as she migrates her cancer treatment and associated challenges. But ensuring appropriate wound management and multidisciplinary support we can stabilize her condition of provided reassurance regarding her care.

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		