Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Vanessa Rittle Day/Date: 9/20/2021

Today's WOC specific assessment	This is a 77-year-old female with a history of diverticulitis, bowel resection, ileostomy placement, hypertension, rheumatoid arthritis, and depression. Patient was experiencing symptom exacerbation related to her diverticulitis diagnosis to which she went to the ER. Work up discovered part of her bowels had fused together. Patient had a RUQ loop ileostomy placed approximately 8 weeks ago along with a bowel resection. Independent in ostomy care with appliance changes every 3-4 days. Using a Hollister two-piece cut to fit, flat skin barrier wafer with throw away pouches. No additional accessories in use. Patient's incision line to midabdominal region, superior to the umbilicus, non-healing with progression to a large abscess/wound. Within the last 7 days, patient has a newly formed fistula inferior to the abscess/wound. Pt performs daily wound care with home health care following. Home care nurse expressing concern for progressive abscess and fistula with request for evaluation and reevaluation of ileostomy. Requested consult from WOC nurse.

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

This is an initial assessment for the evaluation and management of a progressing abdominal abscess with a fistula and reevaluation of loop ileostomy. A joint home visit was made with the home care nurse. Dressing removed from abdominal abscess. Wound measures 8.2 cm x 9.3 cm with protruding 4 cm beefy red tissue. Appears to be hypergranulation tissue. Moderate effluent drainage with 80% of dressing saturated. Periwound skin to abscess intake and without irritation. No change from previous nurse visit. Stomatized fistula inferior to abscess measures 1 cm x 1 cm. Fistula with small circumferential erythema, moderate foul-smelling exudate. Pain noted with palpation to perifistular area. Reports as 10/10. Patient denies fevers or chills. Patient changing dressing daily. Discussed option to pouch wound and/or fistula. Pt declined. Abscess wound cleansed with NS. Wound and fistula dressed separately with xeroform gauze followed by abdominal pad as per current orders. Paper tape utilized to secure dressings. Patient verbalizes ability to care for wound and fistula with daily dressing changes. Explained need for daily temperature checks, signs and symptoms of an infection including changes to wound and fistula (increase drainage, foul smelling, redness, heat to palpation). Notify MD of any changes to site. Verbalized understanding. Pt has follow-up visit with physician in 2 weeks. Encouraged to call MD and request earlier appointment. Patient verbalizes understanding.

Loop ileostomy with appliance inplace and without leakage. Skin barrier wafer noted to be window taped. Pt states "I feel better with the extra tape". Stoma opening noted to be cut larger than stoma. States "been cutting appliance to 2 ¼". Appliance removed. Back of skin barrier wafer assessed and without evidence of drainage/leakage. Stoma measures 1 1/4". Protrudes with centrally located os. Beefy red in color. Stoma effluence dark brown, liquid stool noted in pouch. States empties pouch about 6 times per day. Peristomal skin denuded, weepy clear exudate from 1 to 4 o'clock and 7 to 9 o'clock. Patient denies pain to area. Patient currently using Hollister two-piece *Ceraplus* skin barrier wafer, cut-to-fit with closed end pouch. No additional accessories in use. States wear time of 2-3 days. Denuded skin crusted using stomahesive powder and Cavalon skin barrier wipe. Two layers applied. Demonstration and explanation given to patient. Verbalized understanding of how to perform and need to do with each appliance change until areas resolved. Skin barrier wafer opening cut to 1 ¼" with patient instruction to do same. Verbalized understanding. Discussed appliance options. Patient unwilling to utilize drainable pouch. "I can't stand the odor". Discussed methods of odor control. Verbalizes understanding and states "I'm good with what I am doing". Discussed diet and fluid needs with need to increase fluid intake including electrolyte replacement fluids such as Gatorade or Pedialyte. Patient verbalizes understanding of importance. Patient informed of plan for nursing to call physician regarding clinical findings today with request management changes and sooner office visit. Patient verbalizes understanding and plan to call office for new appointment.

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WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
Hypovolemia/electrolyte imbalance d/t high output stoma Altered skin integrity r/t incision site and fistula development Pain	Inspect stoma and peristomal skin with each pouch change. Note any signs of skin breakdown. Identify cause of skin breakdown and correct. If cause is unknow or unable to correct, notify WOC nurse. If related to leakage, add a barrier ring or stoma paste around stoma. Continue to use Hollister two-piece Ceraplus skin barrier wafer, cut to fit with closed end pouch per patient preference. With each appliance change, clean skin around the stoma with warm water and pat dry. Apply stomahesive powder and Cavalon skin barrier wipe to create a 2 layer crusting to denuded skin around ileostomy stoma. Change appliance every 2-3 days or immediately, if leaking is noted. Cut skin barrier wafter opening to 1 ¼". Measure stoma size monthly for 6 months and cut the wafter barrier no more than 1/8" larger than stoma. Use the push/pull method of appliance removal. Empty pouch when it becomes 1/3 to ½ full. Measure and record amount of stool from ileostomy. If greater than 1000 ml/24 hour or signs of dehydration noted. (increased thirst, lethargy, muscle cramps, dry mouth, abd cramps and decreased urine output,) add foods high in sodium, potassium and complex starches to diet. Avoid sugary drinks, including fruit drinks. Items to add to diet include canned vegetables, tomato juices, banana, potatoes, pepper, chicken, beef and spinach. Drink diluted sports drink (2/3 sports drink/1/3 water). Consider foods to slow transit time, such as the BRAT diet (bananas, rice, apples and toast). Take medication, if prescribed, to slow stool transit time, if other measures are not effective. If symptoms persist, call physician or proceed to the ED. Take pain medication 30 minutes to an hour	Inspection will help identify any areas for concern or need for further evaluation or interventions, if changes are noted. Early intervention can help prevent complications. The patient should be educated on different products, but should have the right to choose what they ultimately want, when possible. Keeping the skin around the stoma clean, will help prevent skin breakdown and help avoid leaks. The crusting will help protect the help prevent further skin breakdown. The stoma can change in size, so measuring will help ensure a proper fit for the skin barrier. Measuring stool output will help monitor for potential risk for dehydration, so interventions can be initiated early to prevent complications. Slowing transit time will help avoid dehydration and promote absorption of nutrient and electrolytes. Fluid replacement helps prevent dehydration. Adequate pain control will promote patient comfort during wound care

	prior to wound dressing changes, as needed. Use alternate pain relief measures (distraction, essential oils, music….). Incision midabdominal region: Clean wound with NS, apply xeroform gauze and an ABD pad. Change BID, or more often if dressing is saturated. Stomatized fistula inferior to abscess: Clean wound with NS, apply xeroform gauze and an ABD pad. Change BID, or more often if dressing is saturated. Physician consulted. Take temperature daily, if fever greater than 100.4 F(38C), or any increase in pain, changes to the wound/abscess/fistula, new wound odor or chills, contact physician immediately . If after hours, proceed to the ED.	and enhances healing. Changing dressing more often and when saturated, will help present hyper granulation tissue from forming. The physician should be notified of any changes for possible interventions. Catching signs of infection early will allow for early intervention to avoid further complications or sepsis.

What are the disadvantages of using this product(s)? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	The disadvantage of using stoma adhesive powder and cavalon skin barrier wipes, to create a crusting effect, is that the powder can clump and prevent the skin barrier wafer from sticking. The disadvantage of using the Hollister two-piece *Ceraplus* skin barrier wafer, cut-to-fit with closed end pouch is that the patient has loose stool, so it could easily leak, if not closed properly. A better alternative would be to use a drainable pouch. The disadvantage of using the xeroform gauze and ABD pad is that the wound bed has hypergranulation tissue, so it may not be absorbing enough moisture. An alternative would be to use aquacel ag (absorptive layer) and a charcoal cover dressing as a secondary.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	Yes, my learning goal was met by being able to apply knowledge learned in this class to a patient scenario.
What are your learning goals for tomorrow?	My goals for tomorrow are to continue to apply knowledge learned in this class to create individualized care plans.

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Reviewed by: _ _____ Date: _____

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