Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Danalyn N. Clemente Day/Date: 11/4/22

Directions: ***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, s***select one patient each clinical day and complete ***plan of care and chart note.***. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	60 year old Caucasian female in MVC, restrained driver, weight 179.5 Kg. EMS reports heavy damage to the vehicle. Patient had GCS of 8 on the scene and improved to GCS 12 on arrival to the trauma bay. C-collar in place, trachea midline. In trauma bay patient began vomiting, became disoriented. Patient was intubated for airway protection. A-line placed, BP initial 100/58. Fluid and blood initiated. Tetanus and Ancef given in trauma bay. Underwent emergent exploratory laparotomy, possible bowel resection, possible ostomy, possible abthera, rigid sigmoidoscopy, then admit to ICU for further resuscitation. Medical History obtained from previous hospital admission: Diabetes type 2 x 15 yrs, hypothyroidism, hypertension, obesity, asthma, and RLE DVT.

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 the initial visit for this 62 y/o female who is being seen for evaluation, management and teaching related to new colostomy. Pt admitted after a MVA. Has history of Diabetes type 2 x15 yrs, hypothyroidism, hypertension, obesity, asthma, and RLE DVT. Pt resides in an assisted living facility and did not require assistance prior to this admission. Sitting up in chair at present. Agreeable to appliance change and assessment. States "I am a little sore all over, but I just had something for pain so I should be ok." Encouraged to speak up if in pain and call for a time out. Noted to have scattered abrasions over her body including her face. Small amount serosanguinous exudate noted in ostomy pouch. Appliance removed to LLQ. Back of skin barrier wafer assessed and noted to have moisture to bottom half. Peristomal skin and stoma gently cleansed with warm water and patted dry. Peristomal plane noted to have weepy, erythematous skin scattered throughout adhesive surface. Etiology appliance leakage vs abrasions from accident. Stoma moist, edematous, and protruding. Noted to be translucent, red in color except for area from 6 to 9 o'clock noted to be dark red to black. Test tube inserted in stoma. No discoloration noted within. Mucosa red. Mucocutaneous junction intact. Peritomal skin irritation crusted using powder and skin barrier wipe. Cut to fit two piece Hollister Ceraplus appliance fitted to stoma and applied. Demonstration and explanation given during appliance change. Demonstration of opening and closing of pouch given. Pt able to return demonstration. Extra pouch and teaching packet left at bedside. Pt encouraged to practice and to review colostomy packet. Write down questions for next visit. Surgeon notified of clinical findings. Will continue to

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monitor stoma with staff. Staff aware of need to notify surgeon immediately if stoma increases in dark coloring and/or without output. Pt tolerated appliance change without c/o pain discomfort. Noted to be deep breathing at intervals. Stated "I am ok. Just anticipating the worse and trying to adjust to what I am seeing." Support given. All questions answered to pt satisfaction. Will continue to follow at intervals.

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)***
Pain related to recent trauma from MVA	-encourage the patient to speak, timeouts and proper breathing techniques when in pain -instruct patient to take medication 30 mins to 1 hr. prior to dressing change/clinic visit	"I'm a little sore all over, but I just had something for pain so I should be ok"
Risk for infection due to possible stomal complication as evidenced by the following symptoms: -"small amount serosanguineous exudate in the ostomy pouch" -stoma is dark red to black from 6 o'clock to 9 o'clock	-refer the patient to Home Health services -teach the patient and caregivers from assisted living to monitor any signs and symptoms of further deterioration of the stoma and report to the surgeon any abnormal findings such as further discoloration of the stoma, no output, increase exudate in the pouch, flaccid, and malodorous drainage -make a follow-up appointment with the surgeon	-Home Health will be able to monitor the patient's overall health and continue education about ostomy management -the amount of stomal necrosis determines the severity and the treatment (if necrosis is superficial, the top layer may slough off leaving a viable tissue, if malodorous and flaccid, may need debridement if indicated by the surgeon, and if deeper than fascia level, may need urgent surgical intervention)
	-refer the patient to RD for management of DM and weight management -instruct patient on the importance of monitoring blood sugar with a goal of fasting blood sugar between 80-120, following a diabetic diet -increase fluid intake to prevent constipation (at least 1L-1.5L per day of water) -measure the size of the stoma every appliance change and change the convexity and aperture of the appliance skin barrier if needed	-patient with type 2 DM and h/o obesity -if the patient's DM is uncontrolled, there's a higher chance of stomal necrosis d/t impaired blood flow from diabetes, and obesity d/t tension in the bowel wall -constipation may increase the chance of blockage and impede circulation further -level of the stoma above the skin may diminish as the necrotic tissue sloughs off
Impaired skin integrity	-monitor blood pressure daily and notify	-hypotension can cause further deterioration of the

due to peristomal skin irritation as evidenced by "peristomal plane noted to have weepy, erythematous skin scattered throughout adhesive surface"	MD for any blood pressure less than 90/60 -cleanse peristomal skin and stoma with warm water and pat dry -apply cut-to-fit 2 pc. Hollister Ceraplus appliance -crust peristomal area with stoma powder and skin barrier wipe	stoma d/t poor circulation -Ceraplus skin barrier is an extended-wear skin barrier that contains ceramide and protects the skin from skin damage/dryness -crusting would create a film over the denuded area to prevent further irritation from the effluent and provides a better seal from the skin barrier when applied

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)	Pt's stoma is moist, edematous, and protruding. The patient could use Hollister 1 pc cut-to-fit flat Softflex for a more flexible and soft skin barrier protecting the stoma and the skin. Stomal necrosis may need additional moisture and so adding petrolatum to the necrotic area may help, making sure not to spread to the peristomal area and have issues with adhesion. Hollister Adapt paste ring may be added to the bottom half of the barrier. Moisture noted to the bottom half may suggest some leakage towards that area and so the ring may provide an additional seal and fill in the gap between the barrier and the skin. Patient could also use Adapt barrier extenders to the bottom part of the appliance to push down the barrier and create a better seal. Since the patient has a colotomy, a charcoal-filtered appliance is also recommended.

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, stomal necrosis symptoms need to be identified if it occurs. As a wound care nurse, this is an important skill when evaluating a stoma. It is very uncommon that we see this kind of complication in home health as usually, patients that we see are more stable and have gone through rehab or long hospitalization stays.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My learning goal is to be able to identify other stomal/peristomal complications and provide a plan of treatment including other interdisciplinary teams.

Number of Clinical Hours Today:

Care Setting: X Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __ Preceptor: _____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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