Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Paula L. Vaughn Day/Date: 1/29/2023

Setting: _____ Acute Care _____ Outpatient __X___ HHC ____ Other _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

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.	

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and 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 which appears to be hypergranulation tissue. Moderate amount of 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.

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Loop ileostomy with intact pouching system. 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.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**

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Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. **NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc**	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Impaired skin integrity related to presence of a fistula with small circumferential erythema, moderate foul-smelling exudate. Pain noted with palpation to perifistular area. Reports as 10/10 pain; abdominal abscess present measures 8.2 cm x 9.3 cm with protruding 4 cm beefy red tissue which appears to be hypergranulation tissue. Moderate amount of drainage with 80% of dressing saturated.	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. 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.	This will assist in protection of the peristomal skin and protect from the constant effluent from the fistula, the fistula output will keep the skin raw and irritated if the skin is not protected. Keeping the wound and fistula clean and monitoring for worsening illness/infection.
Nutritional deficiency related to nutritional intake below metabolic needs secondary to the presence of fistula with the loss of nutrition, fluids, and electrolyte.	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.	Depending on the volume of output the fistula is the patient is high risk for major fluid and electrolyte imbalances.
Knowledge deficit evidence by appliance being cut to 2 ¼"; stoma measures 1 1/4" and patient states "I am goo with what I am doing."	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.	If the patient does not follow the recommendations of cutting to a smaller size, they will have continued irritation and skin complications.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an alternative to the product. Alternatives	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Cavalon skin barrier wipes: Disadvantage: At times with denuded skin the patient may report burning and discomfort. Alternatives: No sting skin wipe which is alcohol free, fragrance free.

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should be from a different category or classification. In other words, what could be used if the product was not available?	Hollister two-piece *Ceraplus* skin barrier wafer, cut-to-fit with closed end pouch; Disadvantages: Must remove the entire bag and reapply a new one every 2-3 days. Alternative: New Image FormaFlex ostomy barrier, 2-Pc - Adhesive Tape, Flat, Shape to Fit, Extended Wear.

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

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	My goal of the day was to refresh my mind on fistulas and fistula output, and I did meet my goal because I refreshed my memory of the different locations of fistula and the structures involved.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue to broaden my education in ostomy education.

Number of Clinical Hours Today: ____ Care Setting: ___ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _____ Preceptor: _____

Clinical Reflection: Identify/describe other patient encounters, clinical experiences from today, thoughts	This patient could possibly benefit from an ostomy visitor or support group for therapy to deal with her situation, but I know she has a lot going on so her PCP and the rest of her team members need to keep that in mind.

Reviewed by: _____ Date: _____

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