Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Romeo Journal Completion Date: 2/4/23

Setting: _X____ Acute Care _____ Outpatient _____ 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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	37 y/o female admitted for respiratory distress. Pt has a PMH of Gardener's syndrome resulting in multivisceral transplant (stomach, small intestine, and pancreas), immunosuppression therapy, small bowel enterectomy, creation of jejunostomy, chronic kidney disease with right nephrostomy tube, short gut syndrome, TPN dependent, pancytopenia, subdural hematoma, neurogenic bladder, ureteral obstruction with left side stent, recurrent pyelonephritis. Medications affecting wound healing: heparin, insulin, prograf, prednisone Pt presents with headache, nausea, dry heaves. Ct showing subdural hematoma. Also positive for UTI. Stay complicated by respiratory failure due to aspiration pneumonia. Left shin has a nonhealing wound. Wound cultures negative for bacterial infection and fungal infection. 6/26 punch biopsy performed by dermatology to rule out invasive fungal infection. Labs: 6/27 WBC 3.2, H&H 7.9/24.4, Plts 24.4, alb 2.7, TProt 5.8, BGL range 122-210 At this time, the patient CXR shows ongoing aspiration pneumonia. Pt is on Meropenem. Infectious disease is following.

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

This is the initial visit for this 37 y/o female for evaluation and management of jejunostomy, nephrostomy, and open leg wound to left shin area. PMH significant for Gardener's syndrome resulting in multivisceral transplant (stomach, small intestine, and pancreas), immunosuppression therapy, small bowel enterectomy, creation of jejunostomy, chronic kidney disease with right nephrostomy tube, short gut syndrome, TPN dependent, pancytopenia, subdural hematoma, neurogenic bladder, ureteral obstruction with left side stent, recurrent pyelonephritis. Presented this admission with headache, nausea, and dry heaves. CT scan positive for subdural hematoma. Urinalysis positive for UTI. Medical record indicates ambulates with a stand by assist, able to turn independently. Husband provides stoma care at home. Receiving TPN for nutrition with dental soft diet for comfort feeds. Is on a fluid immersion specialty mattress and noted to be in place. Pt noted to be alert and oriented. Agreeable to assessment and care. Pouching system in place to jejunostomy, no dressing or securement device to right nephrostomy tube, and no dressing on LLE wound. Jejunostomy pouch with effluence of light brown loose stool with partially digested food. Appliance removed using push pull technique. Back of skin barrier wafer without

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evidence of leakage. Site cleansed with warm, tap water. Stoma is red, moist, and flush with skin. Skin creases at 3 and 6 o'clock. Mucocutaneous junction intact. Peristomal skin intact and without irritation. Moldable skin barrier ring applied followed by Coloplast Mio 2 piece appliance with deep convexity, and high output pouch. Right nephrostomy with intact peritubular skin. No leakage noted. Applied tube securement device and gauze drainage sponge around tube. LLE anterior shin has an open wound. Dermatology performed punch biopsy to upper aspect of wound at the 1 o'clock position yesterday. One stitch in place to punch biopsy site and covered with tape. Site cleansed with NSS. Wound measures 6 cm x 4.5cm x 0.2cm Wound bed is mostly red granular tissue with 10% thin, brown soft eschar in the upper and lateral areas of the wound. Edges attached. Periwound skin chronic brown discoloration, no erythema or edema present. Palpable pulses and equal to BLE. Pt voices has had large amounts of drainage. Noted to be draining serosanguinous drainage. Zinc barrier cream 5% applied to periwound skin. Exufiber Ag applied to wound bed and covered with silicone border foam. Explanation provided with care and pt verbalized understanding. Agreeable to POC.

Assessment: jejunostomy, nephrostomy, non-healing LLE wound

Recommendations:
-Maintain pouching system to jejunostomy. Change every 3 days and prn
-Change gauze to nephrostomy tube daily. Keep tube secured with securement device
-Change dressing to LLE QOD and prn
-Pressure redistribution measures

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. Delayed wound healing related to disease process and polypharmacy ***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.** -Jejunostomy care: change pouching system (Coloplast Mio 2 piece with deep convexity high output pouch) every 3 days or more frequently if lifting/leaking. -Remove appliance using push-pull technique -Clean peristomal skin with warm tap water -Flatten and stretch a skin barrier ring and apply to peristomal skin. -Cut wafer opening to the size of stoma and apply. -Apply pouch - Nephrostomy tube care: apply gauze drainage sponge around tube. Change daily. Continue use of securement device. -LLE wound care: Change dressing every other day or more frequently if soiled. Clean gently with NSS. Apply zinc barrier cream to periwound skin. Apply Exufiber AG to wound bed. Cover with silicone border foam dressing. -Continue use of fluid immersion specialty mattress	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -Patient is at high risk for peristomal moisture-associated skin damage as jejunostomy effluent contains enzymes that erode the epidermis (Stricker, et al., 2022). Due to this, the appliance should be changed every 3 days, even if it is still intact, so the peristomal skin can be visualized. -The use of convexity can help to flatten abdominal creases, providing a flat and even surface for the appliance (Colwell & Hudson, 2022). Convexity can also be used to push or press the skin directly around the stoma to cause it to protrude more when it doesn't protrude or is flush with the skin. -High volume output pouches are commonly used for patients with jejunostomies as they contain less than 200cm of small bowel to the stoma and are prone to have high

		volume output (Stricker, et al., 2022). -The push pull technique can help to protect the peristomal skin from traumatic damage during pouch removal. -the peristomal skin should be cleansed with warm water prior to new pouch application to removal any oils from the effluent that remain on the skin as they can affect pouch adhesion. -When applied around the stoma, moldable skin barrier rings can help to improve the seal by helping to create a flatter surface around the stoma. The skin barrier applied prior to the pouching system can help to increase convexity for this patient. -the skin barrier opening should be cut to the size and shape of the stoma. The barrier should stop the effluent from coming into contact with the peristomal skin. Once the correct size is cut, the barrier should be applied followed by the pouch. -Nephrostomy tubes should be stabilized to prevent accidental removal, pulling or kinking (Fellows & Rice, 2022). A gauze drainage sponge around the tube can help to protect the peristomal skin from drainage. -Zinc oxide skin barrier ointment will help to protect the Periwound skin from maceration and breakdown from the large amount of wound drainage. -Exufiber AG is a highly absorbent fiber dressing. This will help to absorb the wound drainage as the patient reports a large amount of drainage. This will also help to prevent Periwound maceration. The AG provides antimicrobial properties to prevent infection. -the foam dressing can stay in place for several days and will absorb wound moderate to high amounts of wound drainage. -an air immersion support surface works by redistributing pressure and

		providing a fluid like surface for the patient (Mackey & Watts, 2022). These mattresses are beneficial to patients with multiple pressure injuries, burns and skin flaps. This patient is likely at moderate risk for pressure injuries using the Braden scale. This mattress will help to prevent pressure injuries.

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 should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Coloplast mio 2 piece with deep convexity high output pouch: Disadvantage- the pouch can detach from the barrier causing leakage of stool. Alternative- Hollister one-piece high output ostomy pouch with soft convex skin barrier -moldable barrier ring: Disadvantage: may deteriorate with moisture and lose shape. Alternative- stoma paste -gauze drainage sponge: Disadvantage- if the gauze becomes wet, it can cause maceration. Alternative: Sorbex sterile absorbent dressing Securement device: Disadvantage- adhesive may cause sensitivity; not always available. Alternative: Mepitac tape NSS: Disadvantage- no antimicrobial properties. Alternative: Vashe -Zinc oxide: Disadvantage- adhesive may not stick to this. Alternative- marathon -Exufiber ag: Disadvantage- can adhere to dry wounds. Alternative: maxorb silver alginate -foam dressing: Disadvantage- may increase the risk of Periwound maceration. Alternative: mepore absorbent island dressing

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal for today was to learn more about jejunostomies. I was able to achieve my goal as I learned that jejunostomies typically have high output and the effluent is corrosive to the peristomal skin.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about convexity.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	-I would recommend the use of Cavilon skin barrier after cleansing the peristomal skin to provide another layer of protection. -I would recommend changing the nephrostomy tube dressing twice a week or if soiled as long as it is after the initial 2 week postoperative period (Fellows & Rice,

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	2022). -I would recommend cleaning the lower extremity wound with Vashe instead of NSS. The patient is on immunosuppressive medications so she is more at risk for infection and Vashe has antimicrobial properties. -I would recommend applying Cavilon to the Periwound skin instead of zinc-oxide as the dressing will likely not stick well to the zinc oxide ointment. -Though the patient is likely at moderate risk for pressure injuries, an air immersion surface is not necessarily indicated. The patient can ambulate with stand by assist and turn independently, pressure injuries can be effectively prevented with a q2 hour turn schedule, routine skin assessments and moisture management. The need for a support surface can be re-evaluated as needed if the patient starts to deteriorate or shows signs of skin breakdown.

References:

Colwell, J., & Hudson, K. (2022). Selection of pouching system. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 172-188). Wolters Kluwer.

Fellows, J., & Rice, M. (2022). Nursing management of the patient with percutaneous tubes. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 304-315). Wolters Kluwer.

Mackey, D., & Watts, C. (2022). Therapeutic support surfaces for bed and chair. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management (2nd ed., pp. 425-445). Wolters Kluwer.

Stricker, L.J., Hocevar, B., & Shawki, S. (2022). Fecal and urinary stoma construction. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 131-142). Wolters Kluwer.

Reviewed by: _____ Date: _____

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