Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Romeo Journal Completion Date: 2/11/23

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	Patient is a 60-year-old male presenting to the hospital with nausea, weakness & fatigue. He lives alone. Patient has a PMH of ulcerative colitis, C Diff, HIV, depression, anxiety, drug & ETOH abuse, CKD, HLD, HPTN, Non-compliance. Previous surgery of RLQ ileostomy & non-functioning LUQ mucous fistula. Pt on Octeratide 30 minutes before meals. Admitting diagnosis is dehydration & electrolyte imbalance. Lab results reveal K 2.8, Na 128, Mg 1.5. He is admitted to telemetry for fluid resuscitation & electrolyte replacement.

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 this admission for this 60 y/o male pt who is very well known to service. Requested to see pt by PCP for ileostomy management. He has a high output ileostomy with a history of peristomal dermatitis and a mucus fistula to LUQ. Medical record indicates ileostomy output over the last 24 hours to be 1300 mL, brown in color and watery consistency. No output to mucus fistula. Pt is independent in care. He has a history of frequent pouch changes of multiple times per day as well as appliance leakage. Utilizing foam dressing to mucus fistula. Per nursing staff, his affect today is agitated, yelling at staff, and pacing the room. Upon entering room, pt addresses this practitioner by name and sits down in chair. Pt is agreeable to appliance change and assessment. Effluent in pouch is brown in color and watery consistency. Pt emptied pouch independently of 300 cc effluent. Pouch removed by pt using push pull technique. Area cleansed with warm, tap water, moistened washcloth. Stoma moist, red and protrudes above skin level approximately 2 cm. Peristomal skin is red, open and weepy from 3 to 9 0'clock. Affected area measures approximately 3 cm in length. Satellite lesions noted. Area gently patted dry. 0.25 cm wide and 0.1 cm deep mucocutaneous separation noted from 3 to 6 o'clock. Peristomal irritation and separation dusted with Miconazole 2% antifungal powder followed by skin prep wipe to create crusting effect. Area then covered with thin hydrocolloid. Moldable skin barrier ring applied around stoma. SenSura® Mio 1-piece drainable pouch applied with opening cut to fit stoma. Pt holding hand over area to enhance adhesion of pouching system. Instructed on use of antifungal powder, crusting and hydrocolloid application. Voices had been using crusting technique with Stomahesive powder. Pt inquired about use of a belt. Belt advantages and disadvantages explained. Voiced desire to try with Brava ostomy belt applied. Reinforced need for appliance to remain in place at least 3 days. Change immediately for leakage. Verbalized understanding. Foam dressing removed to mucus

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fistula. Scant amount mucus noted to old dressing. Cleansed with warm, tap water, moistened wash cloth. Stoma is red, moist, and at skin level. Peristomal skin intact and without irritation. Discussed dressing options including use of a large adhesive bandage; for example a Band aid. Verbalizes understanding. Small 2 x 2 adhesive border foam applied.

Discussed strategies for slowing down output, changing consistency to mushy or pasty. Strategies included taking medication as prescribed, drinking 30 minutes before meals with no fluids to sips during meal, foods that increase consistency (BRAT diet). Voices "I try. I'm just not that hungry." Reinforced need for frequent, small meals. Discussed fluid and electrolyte needs with ways to manage with replacement fluids such as Gatorade or Pedialyte. Pt expresses lack of desire for these fluids. Emphasized need to explore various flavors related to need. Agreeable to try other flavors. Dietician consulted to assist with food and fluid choices. Plan to continue to provide education, support, and assist in management of ileostomy.

Recommend continue ostomy care and peristomal irritation management as described. Continue with education.

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. Dehydration and electrolyte imbalance related to high output from ileostomy. Peristomal irritant dermatitis related to leaking of effluent onto the peristomal skin and frequent appliance changes. ***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.** Continue ostomy care and peristomal irritation management: -Change appliance every 3 days or if leaking/lifting -Remove appliance using push-pull technique -Clean peristomal skin with warm tap water -Gently pat dry -Apply Miconazole 2% antifungal powder to areas of peristomal irritation. Dust off excess powder -Apply skin prep to powdered area to create a crust. -Cover affected area with a thin hydrocolloid -Flatten and stretch a moldable skin barrier ring and apply around stoma -Apply Sensura mio 1-piece drainable pouch -Apply belt if desired Mucous fistula care: -Change dressing daily -Gently remove dressing -Clean peristomal skin with warm tap water -Apply 2x2 foam dressing or a large band aid To slow down output and change effluent consistency to mushy/pasty: -Take medication as prescribed -Drink fluids 30 minutes before meals. No fluids	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -Appliances are typically changed twice a week or more frequently if leaking or lifting (Carmel & Goldberg, 2022). If skin irritation is noted, the appliance should be changed as this may be a sign that effluent is leaking onto the peristomal skin, which can lead to peristomal irritant dermatitis. -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 remove any oils from the effluent that remain on the skin as they can affect pouch adhesion. -Irritant dermatitis can be treated by applying barrier powder to the affected area (Salvadalena & Hanchett, 2022). This layer of powder should be dusted off so that only a thin layer remains on the skin. To help seal the powder, liquid

	with meals. -Consume frequent, small meals. Eat absorptive food such as bananas, bread, and rice prior to drinking. -Drink oral rehydration fluids such as Gatorade or Pedialyte -Dietician consult	skin barrier may be applied on top of the powder layer. This two-step process may be completed several times until a layer of crust is formed. This technique is called crusting. The presence of satellite lesions is indicative of a fungal infection. Miconaozole 2% antifungal powder can be used as a substitute for stoma powder to treat both the denuded skin and the fungal infection. -The hydrocolloid acts as a barrier strip to create a better seal and it provides a layer of protection for the denuded peristomal skin and the mucocutaneous separation. -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. -This patient has an established stoma, so it does not need to be measured. The pre-cut wafer eliminates the need for the patient to cut the wafer. -A belt can be used to create a better seal by applying pressure to the pouching system. -The mucous fistula has little to no output, so it does not need to be pouched. The mucous fistula can be covered with a dressing to contain any output. -Octreotide should be taken before meals and as prescribed. Taking this medication with food decreases the absorption and efficacy of the drug. This medication can be used to control diarrhea. -Drinking liquid with meals can cause the effluent to be more of a liquid consistency. Avoiding drinking liquids with meals can help the effluent to be more of a mushy/pasty consistency. If the effluent is bulkier, the pouching system is less likely to leak and may stay on longer. -People living with ileostomies are at increased risk of dehydration

		(Carmel & Scardillo, 2022). The bowel's ability to absorb liquids is compromised because the person may have had the rectum, anus and colon removed. A person living without the colon may lose twelve hundred milliliters of fluid a day. A person with a healthy, functioning colon may only lose up to two hundred milliliters. The loss of the colon can also lead to electrolyte imbalances. To prevent dehydration, a person with an ileostomy should drink between five hundred and one thousand milliliters of fluid a day. Oral rehydration drinks such as Gatorade and Pedialyte can help to decrease dehydration and replenish electrolytes lost. Eating absorptive foods prior to drinking fluids can help to bulk the stool as well as increase absorption of liquid in the bowel. -A dietician can help this patient to manage and decrease the risk for dehydration caused by high output from the ileostomy more effectively. They can provide suggestions for meals and fluid and electrolyte replacement drinks that may be more effective than drinking water alone as it is contraindicated to increase liquid intake as this may cause high volume output from the ileostomy.

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	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** -Miconazole 2% antifungal powder- Disadvantage: may be ineffective. Alternative: nystatin powder -Skin prep- Disadvantage: may burn or sting. Alternative: Cavilon no sting skin barrier -Thin hydrocolloid- Disadvantage: this may deteriorate more quickly from the high output from the ileostomy. Alternative: Skin barrier strip paste -barrier ring: Disadvantage- may deteriorate with moisture and lose shape. Alternative: stoma paste -Sensura mio 1 piece drainable pouch- Disadvantage: may not accommodate high volume output. Alternative: Hollister one-piece high output ostomy pouch with flat flextend barrier and filter -Ostomy belt- Disadvantage: if worn too tightly, they can cause pressure injuries. Alternative: elastic skin barrier strips

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not available?	-foam dressing- Disadvantage: not cost effective to change daily. Alternative: large band aid

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 choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal was to learn more about caring for patients with peristomal skin complications. I met my goal as I learned how to treat peristomal irritant dermatitis and how to use antifungal powder in place of stoma powder for fungal infections.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about stoma complications and how to treat them.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	-I would use cavilon no sting barrier instead of skin prep. -I would recommend a high output appliance due to the high output of the ileostomy.

References:

Carmel, J., & Goldberg, M. T. (2022). Postoperative education for the patient with a fecal or urinary diversion. In J. Carmel, J. Colwell, & M. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 189-200). Wolters Kluwer.

Carmel, J., & Scardillo, J. (2022). Adaptations, rehabilitation, and long-term care management issues. In J. Carmel, J. Colwell, & M. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 201-222). Wolters Kluwer.

Salvadalena, G., & Hanchett, V. (2022). Peristomal skin complications. In J. Carmel, J. Colwell, & M. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 250-269). Wolters Kluwer.

Reviewed by: _____ Date: _____

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