Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Stefanie Edgar_____ Day/Date: _____2-15-2023_____

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. Peristomal 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

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)***
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:		
Pain related to peristomal skin break down	Coordinate pain medication administration with pouch changes Give pain medication as ordered by PCP	Reduced pain increases patient physical functionality and ability of patient to concentrate on education allowing patient to be more involved in self care
Impaired skin integrity	Clean and dry stoma and peristomal tissue with warm water at each pouch change Pat dry Assess peristomal skin and stoma at each pouch change Notify the surgeon if the stoma continues to darken and/or stoma does not have an output Check the back of the barrier wafer for evidence of leaking	Healing denuded skin decreases fluid loss and reduces pain and discomfort -promotes a healing environment by regulating moisture balance in the wound. Large amounts of exudate can cause the periwound tissue to break down becoming inflamed or infected and increases the time to heal by slowing epithelial cell migration
Deficient Knowledge ***Disturbed body image***	Apply stoma powder and skin prep wipe to peristomal skin, creating a crusting effect Fit and apply Hollister 2-piece Ceraplus appliance cut the opening of the barrier to 1/8” larger than the stoma diameter Instruct/ educate Patient on stoma care - How to measure and fit appliance - How to empty - Signs/Symptoms of dehydration - Effluent characteristics - Stomal care	Darkening of the stoma is a sign of stoma necrosis and surgical intervention may be needed -correct sizing of barrier opening dimensions (1/8’ larger) allow enough space between stoma and cut edge and limit the amount of peristomal skin in contact with drainage Providing education promotes

	- Allow time for questions and set up multiple sessions/ leave educational packet for the patient to review -Give support through active listening -Instruct/educate the patient on stoma care and appliance application Answer questions about patient satisfaction Create a follow-up scheduled Look for signs of emotional withdraw	understanding verbal affirmation of education promotes patient compliance in self-care WOCN provided reassurance and support lessen patient anxiety. Allowing patient time to adjust to new circumstances and encouraging self-care will increase adaptation physically and psychologically.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	Stoma powder - Stoma Powder- pectin or karaya is used to protect the mucocutaneous separation and aid in healing, absorbing moisture and exudates prior to placing the skin barrier for added protection. **Disadvantage** – messy, difficult to control Skin prep wipe - protects intact skin from mechanical breakdown, moisture, and friction, can seal antifungal powders -**Disadvantages**- may not adhere to weeping skin, may cause an allergic reaction if pt is sensitive to ingredients, some contain alcohol and sting sensitive skin, they can interfere with the adherence of some barrier wafers Hollister 2-piece Ceraplus appliance - A two-piece system is easier to clean out for reuse or to remove and change with less damage to the skin especially if using closed pouches. Two-piece systems are more discrete to empty while in public restrooms. **Disadvantage** – two-piece systems are bulkier and less discrete under clothing, the pouch can detach, and they emit odors **Alternative** - Coloplast filtered ostomy pouch flat two-piece system with a close end ***A new colostomy would have serosanguinous drainage but I would instruct the patient and floor nurse to alert the surgeon if output increases in amount or becomes more bloody.***

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?	Awareness of the emotional impact of ostomy surgery is important for the WOC nurse in helping the patient to adapt to a productive lifestyle with the ostomy.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue with my plan of care refinement.

Number of Clinical Hours Today:

Care Setting: <u>X</u> Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __ Preceptor: _____

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **<u>48 hours</u>** following the clinical experience day.

Cleveland Clinic

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

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.