Cleveland Clinic

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Daily Journal Entry with Plan of Care & Medical Record 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 you are acting as a nurse specialist;*** 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. ***Include pertinent past medical & surgical history and medications.***	37 y/o female admitted 6/1 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 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 pna, pt is on meropenem. Infectious disease is following.

Write a comprehensive and understandable medical record 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 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. Back of skin barrier wafer noted to be without evidence of leakage. Site cleansed with warm water. Stoma is red, moist, and flush with skin. 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 noted to have open wound. Dermatology performed punch biopsy to upper aspect of wound at the 1o'clock position yesterday. One stitch in place 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

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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 Nursing Problem pertinent to this visit	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
Impaired skin integrity	<u>Jejunostomy</u> Remove appliance Cleanse with warm water Assess peristomal skin Apply moldable skin barrier Apply Coloplast Mio 2-piece appliance with deep convexity and high output pouch *How often / when is this done?* *What is needed to be done if there are issues?* *Jejunostomy output is quite damaging to the skin.* *This is a complex case. Consider other facets to involve in the holistic plan.* *Dehydration is a dangerous risk with this patient- what should be done monitor/prevent?* fluid immersion specialty mattress <u>Right Nephrostomy</u> Apply tube securement device	-Cleansing skin reduces the chance of infection A moldable skin barrier reduces the chance of effluent leakage onto peristomal skin, reducing the chance of peristomal skin breakdown -deep convexity will decrease effluent leakage onto peristomal skin and provide a better seal fro a stoma that is - correct sizing of barrier opening dimensions allows enough space between stoma and cut edge and limits the amount of peristomal skin in contact with drainage but limits the amount of peristomal skin exposed to protect from damage usually the space is 1/8” specialty mattress reduces pressure on patients skin and reduces the chance for pressure injury formation -The securement device protects the placement of the tube and reduces the chance that the tube will be pulled from the skin

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Plan of care	Cleanse the peritubular site with normal saline	-Cleansing skin reduces the chance of infection to open skin where tube has been placed
	<u>LLE</u> Clean wound with NS Apply zinc barrier cream 5% on periwound skin Apply Exufiber Ag to the wound bed Cover with silicone border foam	-Cleansing of periwound skin can reduce the number of microorganisms on the skin and in the wound bed. -Application of silver hydrofiber absorbs exudate and applies silver ion to wound bed which is an antimicrobial Promotes wound healing by reducing bioburden – Which Reduces the chance of biofilm production taxing the immune system and reducing the chances of healing in a timely manner causing the wound to become chronically infected Border foam absorbs exudate to help regulate excess moisture promoting optimal moisture level for healing, protects wound from mechanical damage and holds in body heat creating optimal wound healing by creating an environment that allows epithelial cells to migrate across wound bed.
	Explain care to the patient and pt's husband Maintain pouching system – change every three days and prn Change gauze to nephrostomy tube daily Keep the tube secure with a securement device Pressure redistribution measures Change dressing to LLE QOD and prn	-Providing education promotes understanding verbal affirmation of education promotes patient compliance in self-care -Changing pouching system allows for care and assessment of peristomal skin reduces chance if skin breakdown and infection -Securement device protects peritube area from mechanical damage and displacement od tube -Pressure redistribution measures

		protects patient form pressure injury formation -changing wound dressing allows for assessment of wound care plan and reduces chance of further skin breakdown and infection

What are the disadvantages of using this product(s)?	Moldable skin barrier - Conforms to irregular skin folds and prevents leakage by increasing the seal to the skin or improving the fit of the barrier to peristomal skin can be stacked and stretched to fit **Disadvantage** – added cost and steps in application, manual dexterity is needed for use **Alternative** – Hollister Adapt filler paste, pectin or karaya-based paste can be squeezed from tube is quick to apply Coloplast Mio 2-piece appliance with deep convexity and high output pouch - A convex pouching system is commonly used if the stoma is flush or retracted and/or Peristomal skin is concave, but can be used for protruding stoma if flat barriers constantly leak. Firm convexity is rigid and provides support around stoma to help it stick out this type of convexity is usually used on softer abdomens **Disadvantage** – 2-piece appliance has a higher profile, and may need an ostomy belt to enhance the seal with peristomal skin, can lift away from skin if it is too rigid. **Alternative** - Marlen Ultralite one-piece deep convex precut transparent drainable pouch w/skin shield barrier Gauze drainage sponge – absorbs drainage and reduces chance of MASD and irritation and excoriation from the tube. **Disadvantage** – does not stay in place unless taped down **Alternative** - Allevyn bordered foam dressing can be cut and placed around the tube and will protect from tube-caused pressure injury Exufiber Ag –The high absorption and retention capacity may reduce the risk of leakage and maceration. Absorbs exudate and forms a gel that is easy to remove from wound bed. **Disadvantage** - Frequent or prolonged use may cause permanent discoloration of the skin **Alternative** – Aquacel Ag - hydrofiber dressing that contains 1.2% ionic which acts as an antimicrobial. The hydrofiber absorbs exudate controlling the moisture level of the wound creating optimal healing environment and removal is atraumatic. Zinc barrier cream – protects periwound skin from maceration and further damage **Disadvantage** – can rub off onto bandage, lessening therapeutic effect, possible allergic reaction **Alternative –** Coloplast Brava Strip paste conforms to periwound tissue and can be used on sensitive skin or broken skin, reducing pain during dressing changes Normal saline – it is safe with lowest toxicity and physiologic factors to patient **Disadvantage** - it does not cleanse dirty, necrotic wounds as effectively as other solutions, does not contain any surfactants which are more effective in removing biofilm **Alternative** – BIAKŌS™ antimicrobial wound cleanser disrupts extracellular polymeric substances to help eliminate biofilm.

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	fluid immersion specialty mattress - simulates the effects of immersing the patient in a fluid medium, reduces incidence of pressure injuries **Disadvantage –** Is expensive, **Alternative** - EHOB Waffle overlay redistributes pressure at bony prominences to reduce PIs
What alternative product(s) could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	

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?	Wound care for this patient is difficult and multi-faceted. For example; the patient has symptoms that can have multiple etiologies. The symptoms of nausea and vomiting can be due to the subdural hematoma or possibly the patient can be suffering from infection due to the prograf. Learning to navigate all aspects is challenging.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I will continue to study this case for alternatives in care.

Number of Clinical Hours Today: _

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

Reviewed by: _____ _____ Date: _____

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