Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Romeo Journal Completion Date: 2/25/23

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	14 year old female patient with a history of severe ulcerative colitis. PMH of UC, rectal bleeding, malnutrition and failure to thrive. Patient is amenorrheic. No further significant history. Patient active in sports previously and has been unable to participate this year. Reported unmanageable symptoms x2 years at home that were beginning to affect her schooling as well. Reported up to 20x bm per day and "unmanageable" abdominal pain. Medical management of UC unsuccessful and patient and parents agreed upon surgical intervention to try to regain quality of life. Pt received pre-operative education and marking in outpatient clinic prior to surgery for IPAA. 3 step surgery indicated due to present severe malnutrition. Underwent laparoscopic 1st step of 3 step IPAA total colectomy with end ileostomy. Post op day 2.

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.

Consulted for post-operative evaluation of ileostomy and to begin education.

Patient sleeping in bed upon with parental figure, Mother, at bedside. Agreeable to visit at this time. Patient aroused easily reporting 10/10 pain to abdomen. RN to bedside and patient medicated per PRN order. Patient laid supine and exposed abdomen. Laproscopic sites noted to be intact with surgical glue. Coloplast Sensura post operative drainable ostomy appliance in place to RLQ with dark green effluent in pouch. Pouch emptied and effluent measures 200 ml. Patient declined participation, but watched closely. Patient educated on need to monitor and empty pouch when 1/3 of the way full. Mother states ostomy appliance leaked overnight and patient has "retaped the side". Buckling noted to flange congruent to hip, no leak noted. Pouching system removed using push pull technique and no sting adhesive remover. Peristomal skin cleansed with water and patted dry Pt tolerated with wincing. Stated she was "ok" and to proceed. Using deep breathing. Mother attentive to change, asked no questions.

Ileostomy stoma red and edematous, budded, measured 1 ¼" in right lower quadrant. Mucocutaneous junction intact. Peristomal skin smooth, even and unremarkable with diffuse tenderness. Patient moved to seated position and limited space noted between right hip and peristomal plane. Microcreases also noted to peristomal plane. Abd changes accommodated with fitting of a smaller profile system. Coloplast Sensura cut to fit one piece light convex drainable pouch with no accessory products applied. Patient instructed to gently hold hand over the pouching system for a few minutes to allow for adhesive to "melt" to contours. Patient requesting WOC nurse return at a different time for further "practice". She states she is confident she can care for her stoma and likes her new pouching system more than "the huge one after surgery". Encouraged patient and Mother to write down questions and actively participate in

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care.

Recommendations:
Change pouching system q3d and PRN
Have patient participate in all ostomy care as tolerated
Continue dietary education
Encourage ambulation
Will follow to continue teaching
Notify WOC nurse for persistent leaks or questions

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. Acute pain related to surgical incision and tissue trauma. Disturbed body image related to new ileostomy. Need for education prior to discharge related to new ileostomy. ***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.** -Have patient empty the pouch and participate in appliance changes as tolerated. Emptying the pouch: -Patient to empty pouch when it is 1/3 full and before appliance changes. Sit on the back end of the toilet with the appliance opening facing the toilet. Squeeze the ends of the pouch together over the toilet bowl. Clean the inside of the spout with toilet paper or a wipe. The appliance can be emptied in the bathroom, over the toilet or into a measuring container. Removing and changing the appliance: - Change appliance every 3 days or if leaking/lifting. -Remove appliance using push-pull technique and no sting adhesive remover if preferred -Clean peristomal skin with warm tap water -Measure the stoma. -Cut wafer opening to 1/8" larger than stoma -Apply Coloplast Sensura cut to fit one piece light convex drainable pouch - Hold hand over the pouching system for a few minutes to allow for adhesive to "melt" to contours Medication and dietary considerations: -Avoid enteric coated and extended release medications. -Avoid foods that may cause a food blockage such as popcorn and nuts. Fibrous foods should be consumed in moderation. Drink 500-1000 ml of fluid per day. Avoid tea, coffee, sugary drinks, and juice. Eat absorptive food such as bananas,	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -Learning how to empty the pouch is an important skill for the patient to learn. The patient or caregiver needs to demonstrate that they are able to empty the pouch independently prior to discharge from the hospital. It is also a sign that the patient is adjusting to the ostomy. -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. Adhesive remover can help to dissolve the adhesive of the wafer, making it easier and less painful to remove. -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. -If the stoma is new, it should be measured prior to pouch changes for

	bread, and rice prior to drinking. -Have patient ambulate at least three times per day as tolerated. -Notify WOC nurse for persistent leaks or if questions arise.	four to six weeks due to edema (Carmel & Goldberg, 2022). The stoma can be measured using a measuring guide. This can be provided by the WOC nurse or ostomy supply manufacturers. After the initial six weeks, the patient may use a pre-cut template for appliance changes. This may need to be adjusted at times. -the skin barrier opening should be cut 1/8" larger than 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 (if it is a 2-piece appliance). -Holding warm hands over the appliance following application will help to facilitate a better seal as the adhesives are activated by body heat. -A person with an ileostomy has a shortened length of bowel available to absorb medication (Carmel & Scardillo, 2022). Enteric coated or extended-release medications will likely not be absorbed properly for the medication to be effective, so they should be avoided. The person with an ileostomy should discuss medications that are easily dissolvable and absorbed with their doctor or pharmacist. -Due to the shortened length of bowel available with an ileostomy, it can be more difficult to digest foods that are high in fiber, or a large amount of food eaten at one time (Carmel & Scardillo, 2022). This can lead to a food blockage. If there is no output from the stoma and the food blockage is complete, the patient should notify their doctor and go to the emergency department as soon as possible. -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. Eating absorptive foods prior to drinking fluids can help to bulk the stool as well as increase absorption of liquid in the bowel. -Ambulation in the post operative period is important as it facilitates intestinal peristalsis. Decreased or no ambulation following surgery can lead to constipation, gas pain, deconditioning and increase the risk of infection, deep vein thrombosis or post operative ileus. -If leaking of effluent is noted from the edges of the pouching system, the pouching system should be changed (Carmel & Goldberg, 2022). A leak should not be reinforced with tape or other adhesives. If the effluent is in contact with the peristomal skin, this can lead to irritant dermatitis. Persistent leaking may require pouch modification or further education, so the WOC nurse should be notified.

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.** Adhesive remover- Disadvantage: can leave oils on the skin causing adhesives to not stick. Alternative: clean skin with pH balanced cleanser after using to remove excess oils - Coloplast Sensura cut to fit one piece light convex drainable pouch- Disadvantage: may not accommodate high volume output from ileostomy. Alternative: Hollister one-piece high output ostomy pouch with soft convex skin barrier and filter.

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not available?	

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 for today was to learn more about choosing an appliance for the pediatric patient in the post operative period with abdominal surface challenges. I met my goal as I learned more about convexity.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about food blockages and how to manage them.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	-I would recommend a nutrition consult as the patient has a history of malnutrition and failure to thrive. Patient now with new ileostomy and is at increased risk for dehydration. -I would recommend a physical therapy consult to initiate and assist with post operative ambulation.

Reviewed by: _____ Date: _____

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