Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Stacy Mariano_ Full Scope Capstone Project_____ Day/Date: ___03/14/23_____

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***elect 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	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc** 44 y.o. female with Gardner Syndrome, adenomatous polyposis with desmoid tumor that is s/p multiple resections. Patient had abdominal wall reconstruction with chemoradiation (2004-2020), developed small bowel obstruction and multiple ECF which she underwent several more surgeries resulting in short bowel syndrome requiring a temporary ileostomy that was later reversed; a fistula developed from this site and functions similarly to an ileostomy with a constant drainage of liquid stool. Also present is an enterovaginal fistula that leaks liquid stool as well. Patient developed acute kidney injury due to multiple upper and lower urinary tract infections requiring indwelling catheter and bilateral ureteral stent placement for hydronephrosis. The disease course was complicated by presence of multiple bacterial strains including candida albicans candidiuria in ureteral stents, VSE faecium bacteremia, Klebsiella, e. faecium, Klebsiella pneumoniae, Pseudomonas. Patient transferred to CCF Main from Abu Dhabi for evaluation for multivisceral transplant. Patient is currently intubated and sedated, foley catheter in place, PEG tube in place but non-functional, TPN dependent. Patient has large, matured fistula on abdomen that exposes PEG tube and internal lining of stomach, multiple fistulas noted surrounding this fistula have formed in old scar tissue on abdomen and also leak liquid stool. Labs show electrolyte imbalances, anemia, declining kidney function, increased liver enzymes, and elevated glucose levels which are being treated with an insulin drip, nutritional status maintained with TPN that is managed by pharmacy.

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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? Consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit.

Patient seen by WOC nurse for evaluation and management of multiple issues including fistula care/wound care/ostomy care, pressure injury risk evaluation, and continence related issues due to foley catheter, enterovaginal fistula, and multiple ECF. Patient has large, complex matured ECF with additional multiple smaller ECFs located in scar tissue on abdomen. Fistulae are draining liquid stool and stomach contents requiring pouching system attached to gravity drainage. Current system is Convatec Eakin iron shaped fistula pouch with Mefix tape to drainage; pouching encompasses all abdominal fistulae. Fistulae located in wound bed are red and moist, erythema noted on perifistular skin. Contour of wound/periwound areas are uneven with varying sized creases at 10.2. and 5 o'clock positions along with mature scar tissue.
Patient has indwelling foley catheter for strict I&O due to critical illness and retention/hydronephrosis, catheter is secured to thigh with statlock device, draining purulent, yellow urine to gravity.
Patient has history of constipation due to multiple surgeries, opioid use for pain control, and short bowel syndrome. Colon is connected to intact rectum and anus with scant, liquid fecal and mucous output reported; likely due to long term NPO status. Patient has PEG tube that is currently non-functional with excoriated skin and ulcerations around the insertion site from migration. The internal portion of the PEG is visible in the gastrocutaneous fistula.

Recommendations/care:

Fistulae/Ostomy – Domeboro's soak to perifistular skin, pat dry with gauze, apply Stomaheasive powder and 3M skin prep to excoriated areas. Use Holliheasive skin barrier cut in wedges to perifistular skin, use multiple layers to build up creases, use stoma paste on all seams avoiding skin, apply Convatec Eakin Iron pouch to include all fistulae and connect to gravity drainage bag. Use Mefix tape to secure edges of pouching system. Goal wear time 36 – 72 hours. May leave in place up to 1 week if not leaking. Check positioning of drainage tubing every 2 hours with repositioning to ensure tubing does not kink and obstruct drainage.

Continence Care: Catheter care and pericare completed using pH balanced periwash spray, catheter tubing cleaned from urethral meatus downward, drainage bag maintained below level of bladder. Perianal area to be assessed for skin irritation/breakdown from mucous drainage, Critic-Aid moisture barrier cream applied.

Skin Care: Patient's Braden Scale score is 10 putting her at high risk for pressure injuries (see assessment sheet below). Bony prominences assessed for pressure related breakdown, elbows and heels noted to have mild blanchable redness with no open areas. Critic Aid moisturizer applied, pressure relief heel protectors in place bilaterally. Since patient has multiple lines and is intubated, face and neck areas at risk for medical device related pressure injury (MDRPI). Hydrocolloid barrier used under ET securement device; lines to be repositioned every 2 hours. Small area of MAD noted on buttocks, Critic Aid moisture barrier applied. Low air loss mattress in place, Comfort Glide system in use for patient positioning. Patient has areas of maceration and ulceration around PEG tube. This area should be kept outside of fistula/ostomy pouching system and treated separately. Dust open areas with ostomy powder, brush off excess and apply skin prep with individual wipe or spray, may complete multiple times to achieve crusting to protect skin. If drainage becomes heavier, use

Aquacel hydrofiber dressing to absorb drainage. May use split gauze to protect skin from PEG tube bumper.

WOC specific medical & nursing diagnosis	**WOC Plan of Care (include specific product used today)**	**Rationale *(Explain why an intervention is chosen; purpose)***
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: 1. Impaired Skin Integrity, potential vs actual. 2. Knowledge deficit related to fistulae/ostomy care. 3. Nutritional deficit 4. Electrolyte imbalance 5. Impaired urinary Elimination: retention, indwelling catheter. 6. Pain, acute vs chronic	1. Assess skin each shift and with each repositioning. Use Critic Aid moisture barrier to areas of MAD, Stage I PIs, and superficial breakdown. Cover any areas of deeper breakdown with bordered foam and re-consult WOC nurse. Reposition patient every 2 hours, maintain heel protectors, continue use of low air loss mattress for pressure relief, and continue Comfort Glide system for positioning. Use Duoderm for areas of pressure on face related to intubation equipment. Pad areas on neck, shoulders and chest where lines and tubes are located with soft towels. Use Ph balanced periwash cleanser to perianal area and apply Critic Aid moisture barrier to protect skin. Assess linens for dampness and change each shift and as needed. **Evaluation:** patient should remain free from any new PI/MDRPI and IAD/MAD. Redness on elbows should improve within 24 hours with interventions, IAD/MAD on buttocks and in perianal area should show improvement within 2-4 days with interventions. 2. Assess pouching system with every repositioning for leakage, ensure drainage tubing is not twisted, kinked, or pulling, empty gravity collection system when 1/3 full. Measure and document output for fluid balance evaluation. If system leaks, patch with Mefix tape and enter consult	1. Patient is at risk for skin breakdown and pressure injuries based on Braden Scale (Borchert, 2022) and includes compromised nutritional status, immobility, and exposure to moisture from fistulae, ostomy, anal leakage, and perspiration. Patient is likely to have a difficult time modulating body temperature and presence of equipment in room can cause fluctuations in room temperature causing perspiration. 2. This pouching system and geography of patient's abdomen, along with frequent repositioning make maintaining a seal difficult. System needs to be assessed after movement and due to skin moisture/effluent for product erosion and leakage. It is likely to complicated for nursing staff to do a complete change effectively so patching with Mefix tape and consulting WOC team

	for WOC nurse. Clean surrounding skin of drainage with mild soap and water. May use abd pads for drainage checking frequently for need to replace. Do not use bath wipes due to moisturizers. **Evaluation:** caregivers should be able to demonstrate proper assessment of system integrity and documentation each shift. The pouching system should maintain seal from 36-72 hours without leaking. 3,4. Continue with TPN administrations per pharmacy/PMD orders. Monitor labs for electrolyte imbalances, kidney and liver functions, signs/symptoms of infection, dehydration (dry oral mucosa, dry eyes, decreased urine output, temperature changes, etc.). Notify pharmacy and PMD of abnormal lab values so adjustments can be made. **Evaluation:** patient labs should reflect adequate fluid and electrolyte levels, and show improvement in dehydration symptoms 24-48 hours with interventions. 5. Perform indwelling catheter care and pericare every shift. Use pH balance cleansing cloth and periwash to clean peri area from front to back. Clean catheter from meatus down catheter to avoid contamination. Ensure catheter securement device is intact, empty drainage bag when 2/3 full and ensure it is always maintained at a level below the bladder to prevent reflux. Record output in patient's chart and report to PMD any decrease in output, change in color, presence of foul odors, or mucous.	is the best option. 3,4. Nutritional status and needs change constantly and need to be monitored by lab values so adjustments in TPN formulations can be made in a timely fashion. Hydration status also needs to be closely monitored due to the high-volume output from the patient's fistulae/ostomy. Maintaining nutritional and hydration status are critical to wound healing and overall stability (Friedrich et al., 2022). Since this patient is NPO monitoring TPN via lab work and accurate I&O is the only way to ensure status. 5. Patient has impaired urinary elimination related to hydronephrosis and is at risk for CAUTI. Catheter care needs to be routinely performed to reduce the risk of further infection. Peri care should be performed at least once per shift but may be addressed with each repositioning. Drainage bag should be emptied when ¾ full and maintained below level of bladder to prevent reflux. Color and output should be documented

	Evaluation: patient should remain free from skin breakdown in periarea and show no new signs of new infections in 24-48 hours with interventions. Caregivers should be able to demonstrate proper catheter care and documentation based on interventions. 6.Assess patient for non-verbal signs of pain due to sedation including grimacing, frowning, and moaning. Premedicate patient with pain medicine prior to wound care or ADLs that are expected to include excessive movements and positioning such as bathing and head to toe assessments. Monitor patient for recovery time after activity. Notify PMD if patient seems to be responding poorly to current pain treatment plan. During wound care, use Domboro soaks to soothe irritated skin, adhesive removers to loosen adhesives prior to removal. Avoid ostomy products containing alcohol. **Evaluation:** patient should demonstrate improved pain and activity tolerance with in 24 hours with interventions. Caregivers should be able to demonstrate assessment of pain based on non-verbal cues and behaviors. Documentation should reflect completion of proper pain management interventions.	as means of assessing hydration status. Cloudy, purulent urine may indicate infection. Drainage bag should be changed out per hospital policy (Newman, 2022). 6. Pain should be assessed prior to wound care and patient should be premedicated at least 30 min prior. Use of products to minimize pain during wound care include Domboro's soaks to denuded skin and adhesive remover to remove pouching system. Pain can negatively impact systemic response to healing leading to poor patient outcomes. (Snelgrove, & Baileff, 2019).

What are the disadvantages of using this product(s)? What alternatives could be used and why?	Pouching all fistulae together in a single large pouch leaves periwound skin exposed to acidic gastric/GI content that could result in additional breakdown. These products are very expensive and can be cost prohibitive for long term management. This patient has had trials using individual pouching systems with little success however so it was decided that protecting periwound/perifistular skin as best as possible with hydrocolloids, skin prep, and stoma powder was the best option for attaining a seal that would last for the goal wear time. Holliheasive is a Hollister product, but any hydrocolloid skin barrier could be used, while there are many skin prep products available 3M Cavilon skin prep is alcohol free and hypoallergenic. Smith and Nephew skin prep is latex free for those with allergies. The major disadvantage of these products is the cost. Moisture barrier creams come in many different varieties including those with zinc and antifungal medications. Desitin A & D ointment can be used as a moisture barrier in place of the Critic Aid but often requires an MD order in the hospital setting. It is however more readily available OTC in the outpatient setting. For pericare and catheter care mild soap and water can be used instead of periwash or bath wipes and is more cost effective. The advantage of the periwash products is that they are pH balanced which will help maintain the proper pH balance of the skin in that area reducing likelihood of yeast or bacterial growth, bath wipes can also be gentler to the skin than wash cloths (Colwell & Hudson, 2022).

Braden Scale Assessment (Borchert, 2022).	Sensory – 2 – Very Limited-patient is intubated and sedated, responds to deep pain and repositioning with moans and grimacing. Moisture -2- Very Moist- patient has poor control over body temperature and is often sweaty, pouching system leaks frequently exposing skin to moisture and effluent, moisture often detected in perianal/vaginal area from mucous and fistula drainage. There are areas of weeping IAD from before the foley was placed. Activity- 1- Bedfast- patient is unable to ambulate or be up in a chair d/t intubation with sedation. Mobility- 1- Completely immobile r/t sedation. Patient is unable to make meaningful movements; only sporadic, unconscious, light movements of extremities are noted. Nutrition- 3- Adequate- patient nutrition is maintained with TPN however therapy is contributing to declining renal and liver function. Patient has become insulin dependent due to increasingly unstable glucose levels. Studies have shown long term dependence on TPN can lead to liver and kidney failure. (Hamden & Puckett, 2022). Friction/Shear – 1- Problem- patient requires full assistance with repositioning. Lifting and sliding in bed is a constant problem. 2 or more people are required to turn patient due to presence of multiple medical devices, lines, and tubes.

Total Score 10

References

Borchert, K. (2022). Pressure injury prevention: implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 396-424). Wolters Kluwer.

Colwell, J., & Hudson, K. (2022). Selection of pouching system. In J., Carmel, J., Colwell, M., Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 172-188). Wolters Kluwer.

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Snelgrove, H., & Baileff, A. (2019). A review of interventions to reduce pain in chronic wounds. *British journal of community nursing*, *24*(Sup12), S12–S17. https://doi.org/10.12968/bjcn.2019.24.Sup12.S12

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What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	

Number of Clinical Hours Today:

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

Number of patients seen today: __ Preceptor: _____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals