Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Kelsi Critzer_____ Day/Date: 9/14/23

Number of Clinical Hours Today: _8___ Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _12__ Preceptor: _P.Clay RN, CWOCN_____

Journal Focus: _____Wound _X____ Ostomy _____Continence _____Combination Specify: _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. 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. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** Patient is a male 7 w.o. premature infant born at 22 weeks gestation. At 1 w.o. the patient was found to have pneumoperitoneum and underwent an exploratory laparotomy in which two perforations were noted and a portion of the small intestines was necrotic. Patient underwent a small bowel resection with ileostomy creation.

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, *interactions, and specific products that were used/recommended for use.*

Reason for consult: Follow-up visit for patient with new ileostomy.

Assessment:
Patient assessed with RN and P.Clay RN, CWOCN at bedside. The patient presents with a new RLQ ileostomy. The current pouching system appears to be intact, however a routine pouch change was initiated. The stoma is dark red, moist, and prolapsed. Today the stoma appears more prolapsed, including the peristomal fistulas. There also appears to be 3 os. Of note, there remains a possible area of stricture at the mid-aspect of the stoma. Recommend monitoring stoma and output closely. The peristomal skin is intact. A peristomal hernia remains noted. A wide strip of eakin dough was used to provide a flat pouching surface due to the hernia and irregular stoma shape. The prolapsed stoma was carefully lifted with gauze to ensure the eakin dough was closely placed at the base of the stoma to prevent the exposure of any peristomal skin. The wafer of the Incutech preemie pouch was cut and offset as much as possible due to limited pouching surface area. The prolapsed stoma was carefully guided into the prepared pouch without allowing the adhesive portion of the wafer touch anything until the stoma was contained in the pouch. Pouch change provided. Patient was re-swaddled and left in the care of the primary RN.

Wound Team Plan:

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Continue ostomy care, continue ostomy instruction/education, continue to monitor skin, WOC nurse to follow as needed and Supplies left for patient

Ileostomy care: Change pouch every 3 days or PRN for leakage
Ileostomy Supplies: Incutech Preemie Pouch, Stomahesive Powder, Cavilon No-sting barrier film, Eakin dough, scissors, saline wipe, gauze
1. gather supplies and cut wafer to size
2. gently remove the old pouch, may use the adhesive releaser wipe
3. cleanse skin with saline wipe only, dry thoroughly
4. dust any reddened/open areas with Stomahesive powder, then dab/spray with No Sting Barrier Film to form a protective crust.
5. place a ribbon of Eakin dough on the skin, around and snug to the base of the stoma, lift prolapsed stoma if necessary.
6. apply the wafer/pouch, be sure to incorporate the entire stoma into the pouching system and offset the wafer to avoid any skin folds
7. cover the pouch with hand for at least 2 minutes to better activate adhesive

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.	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Possible stricture formation in mid-aspect of stoma	Closely monitor and document stoma output and immediately report any changes in output to the neonatologist such as little to no output or deviations from their baseline.	Early identification of improperly functioning stoma can receive early interventions to be corrected.
Peristomal skin breakdown related to effluent leakage	Assess pouch for leakage with each diaper change and provide pouch change if found to be leaking	Frequent monitoring allows for early detection of leakage and quick correction
	Thoroughly assess the skin with each pouch change and document findings	Provides evidence of changes in skin condition between pouch changes
	Incorporating each os and fistula into the pouching system Provide pouch change when leaking or every 3 days. 1. gather supplies and cut wafer to size 2. gently remove the old pouch, may use the adhesive releaser wipe 3. cleanse skin with saline wipe only, dry thoroughly	Ensures all effluent is going into the pouch system and not beneath the barrier

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	4. dust any reddened/open areas with Stomahesive powder, then dab/spray with No Sting Barrier Film to form a protective crust. 5. place a ribbon of Eakin dough on the skin, around and snug to the base of the stoma, lift prolapsed stoma if necessary. 6. apply the wafer/pouch, be sure to incorporate the entire stoma into the pouching system and offset the wafer to avoid any skin folds 7. cover the pouch with hand for at least 2 minutes to better activate adhesive	

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. <u>Alternatives should be from a different category or classification</u>. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Incutech Preemie Pouch: smallest pouch we have access to, but wafter is maxed out when cutting to fit prolapsed/irregularly shaped stoma. A Hollister newborn 2-piece could be used and trimmed to avoid the groin fold and umbilicus. Eakin dough: can lift the wafer and not allow for proper adhesion requiring more frequent pouch changes. The only other product approved to be used in our NICU is the Eakin paste that does not contain alcohol. There is very limited product approved for patients in the NICU due to ingredients being easily absorbed by the neonates underdeveloped skin.

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 the day? Were you able to meet your learning goal for today? Why or why not?	My goal for the day was to independently change an ileostomy pouch on a NICU patient with a hernia, fistula, and prolapsed stoma. I did meet my goal and successfully pouched a very difficult stoma on a fussy neonate.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	For my next clinical experience, I want to assess and identify an appropriate plan of care for complex wound.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	Overall, I feel I provided excellent care to the patient. I did have his primary nurse at bedside due to the patient being intubated and easily upset with hands on care. I feel I truly prepared for the pouch change prior to initiating any hands on care.
Reflection: Describe other patient encounters, types of patients seen.	Additional patients I was consulted on included a child with a discolored foot, currently ruling out IV extravasation vs. blood clot, an infant with an open chest and poor perfusion receiving nitro paste to his toes in hopes of restoring perfusion, and an infant with a DTI following surgical procedure.

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Reviewed by: _____ Date: _____

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