Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Jennifer Lemert_____ Day/Date: 9/19/2023 Instructor: Kimberly Mauck, WOCN at Georgetown

Number of Clinical Hours Today: ____ Care Setting: _8__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __10__ Preceptor: ___Kimberly Mauck_____

Journal Focus: ___Ostomy

Wound _4_ Ostomy __3____Continence ___0__Combination Specify: __W&O-3_____

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 **Peri-stomal skin irritation around ileostomy**	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** ***See following chart note***

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.*

The WOC nurse 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. Write in a manner others will be able to understand and be able to interpret your plan of care.

See following chart note

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.** ***See assessment in chart note***	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**

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NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc	***See assessment in chart note***	

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. 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 not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** **See plan in chart note**

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?	See a combination of various wounds and or ostomy patients choose an ostomy patient with a current concern and complete a case study. We saw three inpatient stoma patients, four inpatient wounds, and three patients with both wounds and stomas. Case study was completed on the 2 yo ileostomy patient who is pending intestinal transplant.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Continue to see inpatients with wounds. Focus on wound assessment and PI assessment. Discuss plans of care for all patients seen. Wound assessments under observation with active involvement of preceptor, but start to make recommendations as opposed to just observing.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I have never participated in care for an individual who is a candidate for an intestinal transplant. Compared to some of the other patients I saw this day, He was in incredible condition. All of his nutrition needs were being met with oral feedings into a short gut and TPN to complete needs. I was impressed the aggressive push to get his HGB to 18 with Venafer and Procrit
Reflection: Describe other patient encounters, types of patients seen.	This is a fantastic exposure to a large hospital with a large community of chronically ill patients. Compared to my practice in a rural area, the patients in this system come in with more risk and more medical instability. The result is a concentration of stoma and wound problems all in the course of an 8 hour day, when in my practice I may see this sam mix of patient complications in a 6 month period of time. Great opportunity to cement learning. I was anxious about product selection, but the facility formulary does not have 900 products available, so it helps to have only 1-2 products available for choice.

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Reviewed by: _____ Date: _____

Chart note
9/18/2023
Patient: R.L.
39yo Male
V.S.: Temp: 36.6, HR: 63, RR: 18, BP: 121/73, SaO2: 97%, 6'2", 190 pounds

Chief Complaint: WOC consult for irritation around ileostomy

History Present Illness:
"R" is a 39 year old male admitted for treatment of iron deficiency anemia in anticipation of intestinal transplant.

His difficulties began in 2014 with rectal bleeding. He had colonoscopy and Familial Adenomatous Polyposis was discovered. Additionally, he had numerous desmoid tumors. APC gene mutation was confirmed at Mayo. Total Proctocolectomy with end ileostomy was completed as a first stage procedure for Ileal Pouch Anal Anastomosis (IPAA), which was completed in 2015. Desmoid tumors were treated with chemo: 6 cycles of doxorubicin, imatinib and sulindac. Unfortunately, thereafter, he had recurrent small bowel obstructions. One was managed surgically with desmoid tumor and segmental small bowel excision and re-anastomosis of small bowel; the others were medically treated and improved. In 2021, the day after the birth of his first child, he experienced severe lower abdominal pain and emergent evaluation revealed peritonitis with perforated viscus caused by desmoid tumor impingement on his J-Pouch. 2021 laparotomy, washout and diverting ileostomy was completed. Dense pelvic fibromatosis prevented reversal of his j-pouch. A Stent was placed in the rectal/j-pouch perforation site. This stent remains. He has ongoing issue with duodenal polyps and has surveillance EGD annually. He has had a duodenal tubular adenoma polyp, but none of his duodenal polyps have been malignant.

In November of 2022, he developed acute acalculous cholecystitis and bacteremia. He required hospital admission, IV antibiotics, and percutaneous cholecystostomy tube-now out. He recovered. During that hospital admission, he was found to have large rectal and small bowel mesenteric masses. As per surgery team note, the small bowel mass extends into the SQ soft tissue around his current ileostomy.

Currently, he is known to have 200cm of small bowel beyond the ligament of Trietz. He has short gut syndrome. He is eating, but also is on TPN 14 hours out of each day. He has iron deficiency anemia from short gut syndrome and is a Jehovah's witness, he is not a candidate for transfusion, so his HGB will be optimized to 18 with Venafer and Procrit in anticipation of intestinal transplant

STOMA: He is a left mid abdominal ileostomy. This is his second ileostomy and was created in 2021. He passes thick stool without blood. He does have a high output stoma, see medication list. He uses a 2 ¼ 2 piece Hollister soft convex pouching system. For the last 2 months, he has had skin irritation around his stoma and his pouch system is requiring change every 1-2 days. He is not using powder to crust, as doing this seems to cause his bag to fall off more easily. His current pouch was placed yesterday and is not leaking. He does not desire a change today.

Past Medical History: FAP/APC gene mutation, Small bowel mesenteric desmoid tumor, Pelvic desmoid tumor, Portal vein thrombosis-resolved, Arthritis

Past Surgical History:
2014: Total Proctocolectomy with end ileostomy
2015: J-pouch with IPAA
2021: Exploratory Lap with washout, diverting loop ileostomy and rectal/jpouch-tumor stent

SH: Married, non-smoker, no ETOH, Jehova's Witness—no blood products
FH: No family history of pancreatic of intestinal cancer
Function history: independent in ADL's and self care

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Nutrition: normal weight and normal labs with oral diet as tolerated and TPN 14 hours a day

Medications:
Lomotil 5/0.5mg po BID
Clarithromycin 500mg po BID
Gabapentin 300mg po TID
Pantoprazole 40mg po QD
Venlafaxine XR 150mg po QD
Doxycycline 100mg po QD
Ergocalciferol
Loperamide 4mg po BID
Melatonin 5mg po QHS
Venafer/Procrit: dosing as per Bloodless Medicine Team to Hgb goal of 18
Enoxaparin SQ 40mg QD
Oxycodone 5mg 1-2 po Q34 prn pain
Zofran 8mg po TID prn nausea

Labs:
CBCD: wbc-4.82, h/h-11.7/35.9 (decreased), platelets-221, MCV&MCH decreased-80.9/26.4
CMP: Na 139, K 4.3, Cl 4.3, CO2 29, BUN/Cr 15/0.89, Glucose 82, T.Prot 0.9, Globulin 2.1, T.Bili 0.9, AST/ALT 60/122
PT/INR: 13/1.0
Allergies: NKDA

Physical Exam:
Gen: Pleasant and appropriate male, no distress, independently ambulating at bedside. Well nourished and well groomed in hospital gown and shorts.
Neuro: alert and oriented x 3, Moves all extremities well and equally, Ambulates with steady gait. CN 3-12 intact, speech clear and appropriate
Head: normocephalic, atraumatic
Eyes: extra ocular movements intact, conjunctiva with out erythema
Resp: even and unlabored
CV: VSS
Abd: soft, flat
Ext: no edema
Skin: other then stoma, skin is intact without lesions, rashes.

Stoma: Hollister- Soft Convex 2-piece 2/1/4" intact pouch system without leak. Stoma is visible in pouch and red without bleeding or injury, it is an ileostomy with central opening. It sits 1 cm above the level of the skin. Appears to be a round stoma, 2-2.5 cm in diameter. Flange aperture appears to be well sized. Picture of peristomal skin taken by patient at last stoma pouch changes shows ½-3/4" circumferential pink-moist skin maceration. No partial or full thickness skin loss, no satellite lesions. No evidence of infection. The appearance of the skin is consistent with Moisture Associated Peristomal Skin Damage (MAPSD).

Assessment: Peristomal MASD

WOC Decision making: MASD has failed crusting, seal of appliance is limited to 2 days, no secondary infection, likely this is not worsening, but not improving. The duration and unchanging nature of the dermatitis along with the history that one of his dermoid tumors is infiltrating the SQ tissue around his stoma increases my index of suspicion of malignancy having an adverse effect on his skin, but the current appearance is not consistent with a tumor infiltrating the skin.

Plan:

1. Reviewed correct sizing technique with patient to reinforce importance of cutting flange aperture to size of stoma
2. Patient to call WOC team with next pouch change so we can observe and instruct on crusting as appropriate
3. Soft Convex system is appropriate
4. Add belt to pouching system to see if keeping it more secure to the skin reduced leakage-Adapt medium stoma belt provided
5. WOC team available as needed, we will follow through the intestinal transplant for services as needed.
6. Options to above plan would be switch to Marathon instead of Cavilon for crusting. This is the only other skin barrier available in this facility.

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