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: 9/27/2023

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

Number of patients seen today: __8___ Preceptor: ___Kimberly Mauck_____

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.**
Continued ostomy teaching-second session with patient and his brother	CC: Desires additional stoma care education. Surgery requesting WOC consult perianal wound. HPI: J.C. is a 78-year-old male with Prostate Cancer who had pelvic exenteration on 9/8/2023. His post operative course was complicated by acute respiratory failure with aspiration pneumonia, and pulmonary embolism on 9/12/2023, and ileus. This acuity prevented early post operative stoma teaching. His respiratory failure and ileus have resolved. His NGT has been out for 36 hours, he is passing gas through his colostomy. He has not passed stool. Pouch changes were initially reviewed with family and patient on 9/13/2023, again on 9/25/2023, and today we will review it again. His brother has studied the stoma care information we provided last week. They are both interested in a repeated learning opportunity today. He has both an end colostomy and an ileal conduit. WOC was consulted as well for a perirectal wound. As part of his exoneration, his anus was closed. The wound now present is at the closure site, is wet and is oozing. PMH: Prostate cancer with local invasion of rectum, no distant metastasis, Erectile dysfunction, Anemia, Hemorrhoids, Diverticulitis, Lymes disease PSH: Sigmoidoscopy, Colonoscopy, Left inguinal hernia repair, Tonsillectomy Medications: Pantoprazole 40mg IV QD Lovenox 60mg SQ Q12 Duoneb QID PRN Fentanyl 25 mcg prn pain

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	Nutrition: on TPN, but NGT is out, so likely he will start eating shortly and will remain in hospital until his TPN can be stopped. Last T.Protein and albumin were done on 9/24/2023 and were 5.1/2.7 respectively. Labs: stable, PT/PTT/INR slightly elevated on lovenox for PE, H/H stable 8.2/28.2, BMP normal. Mg/Phos normal, Calcium slightly low at 7.8 consistent with low albumin. Allergies: NKDA SH: Married, wife and brother visiting frequently.

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.

WOC visited with JC today. He is interested in repeated teaching for both his colostomy and his ileal conduit. His brother has a cheat sheet for stoma care that helps him remember supplies needed and steps in care. JC is pleasant, smiling and cooperative, but can not really remember any detail regarding his stoma care. Precise simple instructions like his brother has written out will assist him in gathering supplies and following the care steps as he improves and progresses with less dependence.

PE:
GEN: pleasant, smiling, interactive, ready to learn.
Neuro: alert answers questions in the moment correctly, has no memory of most of hospitalization. Oriented to person and place and knows family and his regular nursing staff. Is markedly weak and requires some assist with getting in and out of bed. Ablt to shift weight and move in bed today.
Resp: even and unlabored
Abd: soft and non-tender, + bs hypoactive, minimal gas in pouch left colostomy, no stool. Right ileal conduit noted. Both pouching systems are intact without leak.
Right upper abdomen Ileal conduit pouch is removed using adhesive remover, peristomal skin is intact and cleaned using water, stoma is well budded, sits above skin, is red and well perfused with some persistent edema, but less so over the last two days. The stoma sizes 1 ¼ inches at the stoma skin junction with the stoma itself being a bit larger and swollen. The aperture is central. The stoma barrier has no erosion. A Hollister Premier 2 inch, Cut-to fit soft convex Flextend extended wear barrier is cut to 1 ¼ inch and placed on clean, dry skin, urostomy drainage pouch is attached. Patient can assist in pouch change, following simple instructions. He is not able to predict supplies or steps, but his brother is.

Attention is then directed to the colostomy. Left colostomy sits slightly lower than the right ileal conduit. The pouch is removed using adhesive remover, the peristomal skin is cleaned with water. The 1 5/8 inch colostomy, which sits well above the skin, is red and well perfused, some swelling present. A Hollister flat Flextend extended wear barrier is cut to size and placed on clean, dry peristomal skin, lock and roll drainage pouch. Patient is encouraged to cover each of his pouches with his hands for 30 seconds to warm the barrier to encourage adherence

Perianal surgical site is 3cm x 0.5cm without depth. The skin is poorly approximated, but not widely gaping. There is some serous to milky discharge. The wound is otherwise without slough, redness, pain, or induration. Wound is cleaned with saline soaked gauze, will order Vashe and Aquacel AG strips- 2 cm x 45 cm. In the meantime Allevyn 4x4 dressing is applied.

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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/concern	**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.**
New Ileal Conduit in need on ongoing stoma care education	Patient will verbalize understanding of steps in ileal conduit care as we repeat them. His brother will as well, but his brother will gather supplies and predict steps in ostomy care as I supervise patient and brother in helping each other Steps are as follows: Gather supplies	Moving toward interdependence in stoma care between patient and his brother prepares both for discharge. Gathering supplies ensures everything the patient needs is at their fingertips. Laying out supplies in order of use according to brother's cheat sheet triggers patient and brother to complete care in appropriate and effective order.
	Wash hands	Hand washing is necessary before care of ileal conduit.
	Remove ileal conduit pouch only, leaving colostomy pouch intact. Use adhesive remover. May cover stoma with 4x4 to absorb any leaking urine. Check skin side of barrier for erosion that is evidence of a leak	Using adhesive remover prevents stripping of skin with barrier removal. Leaving colostomy pouched prevents contamination of ileal conduit with stool.
	Size stoma, use provided size guide	This is a new stoma and will shrink over the first 6-8 weeks post operatively. I recommend sizing stoma with every pouch change, or at least once a week. Sizing regularly allows for better barrier fit, and better skin protection.
	Cut convex Hollister 2 ¼ convex flexwear barrier to size	Using an convex barrier cut to size, no larger then 1/8 inch greater than size of stoma protects peristomal skin and discourages urine leakage.
	Clean and dry peristomal skin with tap water	Water is appropriate for cleaning peristomal skin, soaps or lotions reduced adherence. Alcohol is not

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		appropriate as it dries skin out and can increase risk for skin stripping and MASD
	Attach urostomy pouch and attach to drainage leg or overnight bag as appropriate	A urostomy pouch is needed as they include urine antireflux technology that prevents urine from backflowing from the drainage tube back into the bag. A colostomy drainage pouch is not indicated and cannot be substituted. A leg bag is used during the day in an ambulatory patient, a regular urine drainage bag for overnight is often better for bed ridden patients or for over night use.
	If wear time is less then 48 hours or leaks are a problem, check for MASD and crust with stoma powder and skin barrier film. May try stoma ring to protect skin if cut barrier to big, or barrier adheres better with ring. Consider a belt.	DO NOT use paste, it is contraindicated with urostomy. If bag leaking or wear time is reduced, crusting dries and protects skin from urine. A ring may improve adherence or allow for longer barrier wear time. A belt secures the pouching system. Caution pressure of belt against skin, may cause injury, fit to accommodate two fingers under belt comfortably.
New colostomy	After ileal conduit pouch system is changed, proceed with same steps to change colostomy pouch system. The colostomy output can be wiped away with toilet paper. Adhesive remover should also be used. The colostomy is currently outfitted with a flat wafer, point out this difference to the patient as the size of the wafers for his ileal conduit and colostomy are the same, but cut to fit for customization. Tap water wet and dry gauze are to be used to clean skin. Remind patient that at home he can use paper towels or soft clean cloths. Size stoma with pouch changes or at least once a week. Apply new cut to fit barrier to clean dry skin. Change pouching system twice a week or more frequently for leakage or blow outs.	The steps for pouch change are similar for ileal conduit and colostomy, but the barrier shape is often different. With ileal conduits, urine leakage is often worse then stool leakage from colostomy. A convex barrier with a stoma ring and/or a belt reduces leakage and increases wear time. All of these steps can be overwhelming for the patient, so focus on less is best. For discharge planning, ensure outpatient follow up in stoma clinic is planned.
	Additional colostomy teaching information. Some patients prefer to use a thin ring of paste on the barrier to encourage adhesion. This can be used with the colostomy pouch, but not the ileal conduit. Less, however is more. Stool has a much stronger odor then urine, but both will have odor if eating certain foods like eggs,	As patient becomes mor independent with stoma care, reviewing additional information can prepare them for future trouble shooting. I would also recommend showing pictures of MASD with

	garlic, fish, asparagus. There are foods that will reduce odor: tomatoes, parsley (cranberry juice with urine). A lubricant deodorizer with or without odor is an option for odor associated with the colostomy but is not appropriate in the ileostomy pouch.	ileal conduit so that if this occurs after discharge, the patient knows they need to be re-checked and change their stoma care routine.
Perianal surgical wound poorly approximated at the skin	Wash perianal wound with sterile saline and pack with Aquacel a AG strip cut to length and secure in place with 4x4 Allevyn. Change every three days or when saturated or dirty	Even though patient is not incontinent and will no develop IAD, this perineal wound needs to be protected. It did have some milky purulent drainage with some minimal reddened edges, no cellulitis was present. Silver will reduce microbial load, washing will reduce biofilm, hydrofiber will absorb drainage without drying wound too much. Allevyn will protect.

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.** Urostomy pouching system: Initial choice was Hollister soft convex extended wear barrier with urostomy pouch and a foley drainage bag in the hospital. No accessories otherwise were needed as peristomal skin was intact without MASD or other abnormalities. Alternative pouching systems would be a Hollister flat barrier. The advantage of the flat barrier is that it is available, and possible less expensive. The disadvantage is that ileal conduit leaks can be avoided with a convex skin barrier only, without other accessories. The foley night drainage bag is good for the hospital, but if patient is ambulating during the day, a leg bag is an alternative. Last but not lease if frequent pouch emptying. Adhesive remover used was single use, it also comes in an aerosol that some patients prefer. The disadvantage is cost (in Alaska, aerosol can not be shipped in the us mail, so aerosol is shipped as freight to some clients-making it cost prohibitive). If MASD is occurring, may crust with stoma powder and cavilon or marathon if MASD is worsening. Marathon is more effective at protecting skin and lasts longer then cavilon, but is more expensive and not always covered by insurance. To extend wear time a stoma ring may be used, but stoma paste should be avoided. For the colostomy, a flat barrier is used. A soft convex barrier can be used instead. The disadvantage is cost and not needed at this time. The advantage, may produce longer wear time. For MASD, all options mentioned above can be exercised. Paste in a thin layer immediately around aperture of barrier-skin side, is often helpful if MASD is minimal or a small mucocutaneous separation or suture related wound occurs. In those situations, I would crust and then apply thin ring of paste. Regarding his perianal surgical wound, an alternative dressing would be hydrofera blue. This would absorb exudate while limiting bacterial load in the wound. Hydrofera blue is more expensive as one

	piece of foam is will not last as long as 45cm of stripping.

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 today was to do my last ostomy journal, and again repeat stoma teaching. None of the ostomy patients currently in the hospital have ostomy related compications. I achieved my goal and feel comfortable with ostomy teaching. In figuring out how to complete the journal columns, the charting that I will need to do to explain stoma care for nursing staff is becoming quite obvious. Today I added to my goals looking at more of the WOC charts and how they chart to direct nursing care. I had been paying more attention to the MD notes. Learned a lot by doing this.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Shadow again in wound clinic. Participate in compression wraps and TCC. I applied a 2-layer wrap on a hospital patient, so I would like to do a 4-layer wrap. I have placed and removed orthopedic casts, so I am looking forward to seeing how a TCC unloads the diabetic foot and understand how the application of a TCC is different. I would like to see more wounds on areas other than lower extremities and hope to accomplish this goal with the NP in the wound center as I followed the limb surgeon last week.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I considered using this patient for my Capstone, however, his continence issues were solved with his Pelvic exenteration. Solved other then his ileal conduit. So, I decided to do a case scenario instead and will choose a different patient or possibly a case study for the capstone. The origin of the perineal wound was a bit of a mystery. To my evaluation, the wound appears to be a poorly approximated surgical site, but the WOC consult was only requested and completed yesterday and today. The consult request was simply for a perineal wound. In my own hospital, I would have clarified the origin of the wound with the patient's surgeon and I would have been more familiar with the EHR and able to find the operative report and all of the MD and RN notes. The wound care, however, would have remained the same either way.
Reflection: Describe other patient encounters, types of patients seen.	I was able to independently apply NPWT. This is something I am very familiar with. The wound however was not the typical wound I see. It was a Stage 4 sacral pressure injury that was healing, and there was a second trochanteric PI. Both wounds were being treated with NPWT, so I got to bridge them for the VAC. Bridging is not something I often do. I did well and the NPWT system sealed had a good seal on the first try. The practice that benefits me the most is in wound assessment. Seeing the pictures of change over time is fantastic as this patient's PI's had improved with debridement, NPWT, and time. Another great opportunity was in evaluating a leaking Gtube. Initially the nurses had tried to pouch the tube. This was unsuccessful. We tried to re pouch the tube unsuccessfully. The G tube bumper had been removed—not sure why. This was not a new Gtube, but a Gtube in a recently admitted patient. IR is changing out the tube tomorrow and may float it into the Jejunum. The patient, a wonderful thirteen year old male Arab was very knowledgeable about his tube and was hoping that surgery would sew the skin down tighter around the tube. He was waiting for surgery to round so he could tell them this. That is not likely to happen. The patient also reported that the tube is leaking non-stop, but works better if it is advanced to 8cm at the skin. When we assessed the tube is was 3cm at the skin. A CT report done the day before reported the Gtube was in the stomach and the balloon was appropriately down on the wall of the stomach. As the WOC, we would not re-position that tube, but it will be interesting to see if the new tube is a Gtube or a GJ tube. He had copious amounts of gastric drainage on his skin, but clearly the nurses

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	had been frequently cleaning his skin, protecting it with Cavilon, and changing the drainage sponges, because he had no peristomal MASD. WOC consult recommended Cavilon Advanced Q3D and Drawtex sponges PRN. Additionally, we applied a Hollister drain tube attachment device to keep the Gtube form moving in and out. Two other stoma patients were seen and stoma care teaching provided, and several wounds were re-evaluated. Today, there were a couple of patients that were either sleeping or were not available when the WOC was available. However, for those patients, the nurses were providing wound care and were able to take pictures. It became clear to me that when floor nurses are able to tak pictures, measure and describe wounds, virtual WOC consults are possible. In fact, my preceptor works remotely for part of her job. How she is able to do remote work suddenly became clear to me today.

Reviewed by: _____ Date: _____

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