Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Lynette Gorniak Day/Date: 11/15/23

Setting: _____ Acute Care _____ Outpatient __X___ 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, 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	This is a 77-year-old female with a history of diverticulitis, bowel resection, ileostomy placement, hypertension, rheumatoid arthritis, and depression. Patient was experiencing symptom exacerbation related to her diverticulitis diagnosis to which she went to the ER. Work up discovered part of her bowels had fused together. Patient had a RUQ loop ileostomy placed approximately 8 weeks ago along with a bowel resection. Independent in ostomy care with appliance changes every 3-4 days. Using a Hollister two-piece cut to fit, flat skin barrier wafer with throw away pouches. No additional accessories in use. Patient's incision line to mid abdominal region, superior to the umbilicus, non-healing with progression to a large abscess/wound. Within the last 7 days, patient has a newly formed fistula inferior to the abscess/wound. Pt performs daily wound care with home health care following. Home care nurse expressing concern for progressive abscess and fistula with request for evaluation and reevaluation of ileostomy. Requested consult from WOC nurse.	

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.

This is an initial assessment for the evaluation and management of a progressing abdominal abscess with a fistula and reevaluation of loop ileostomy. A joint home visit was made with the home care nurse. Dressing removed from abdominal abscess. Wound measures 8.2 cm x 9.3 cm with protruding 4 cm beefy red tissue which appears to be hypergranulation tissue. Moderate amount of drainage with 80% of dressing saturated. Periwound skin to abscess intake and without irritation. No change from previous nurse visit. Stomatized fistula inferior to abscess measures 1 cm x 1 cm. Fistula with small circumferential erythema, moderate foul-smelling exudate. Pain noted with palpation to perifistular area. Reports as 10/10. Patient denies fevers or chills. Patient changing dressing daily. Discussed option to pouch wound and/or fistula. Pt declined. Abscess wound cleansed with NS. Wound and fistula dressed separately with xeroform gauze followed by abdominal pad as per current orders. Paper tape utilized to secure dressings. Patient verbalizes ability to care for wound and fistula with daily dressing changes. Explained need for daily temperature checks, signs and symptoms of an infection including changes to wound and fistula (increase drainage, foul smelling, redness, heat to palpation). Notify MD of any changes to site. Verbalized understanding. Pt has follow-up visit with physician in 2 weeks. Encouraged to call MD and request earlier appointment. Patient verbalizes understanding.

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Loop ileostomy with intact pouching system. Skin barrier wafer noted to be window taped. Pt states "I feel better with the extra tape". Stoma opening noted to be cut larger than stoma. States "been cutting appliance to 2 ¼". Appliance removed. Back of skin barrier wafer assessed and without evidence of drainage/leakage. Stoma measures 1 1/4". Protrudes with centrally located os. Beefy red in color. Stoma effluence dark brown, liquid stool noted in pouch. States empties pouch about 6 times per day. Peristomal skin denuded, weepy clear exudate from 1 to 4 o'clock and 7 to 9 o'clock. Patient denies pain to area. Patient currently using Hollister two-piece *Ceraplus* skin barrier wafer, cut-to-fit with closed end pouch. No additional accessories in use. States wear time of 2-3 days. Denuded skin crusted using stomahesive powder and Cavalon skin barrier wipe. Two layers applied. Demonstration and explanation given to patient. Verbalized understanding of how to perform and need to do with each appliance change until areas resolved. Skin barrier wafer opening cut to 1 ¼" with patient instruction to do same. Verbalized understanding. Discussed appliance options. Patient unwilling to utilize drainable pouch. "I can't stand the odor". Discussed methods of odor control. Verbalizes understanding and states "I'm good with what I am doing". Discussed diet and fluid needs with need to increase fluid intake including electrolyte replacement fluids such as Gatorade or Pedialyte. Patient verbalizes understanding of importance. Patient informed of plan for nursing to call physician regarding clinical findings today with request management changes and sooner office visit. Patient verbalizes understanding and plan to call office for new appointment.

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. ***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.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Pain Management	Take oral analgesic 30 minutes prior to home health visit dressing changes and as needed for wound pain. Report to RN or MD if there are any changes to pain such as increased pain, radiating pain, or not relieved by oral analgesic.	Patient should take oral analgesics prior to dressing changes to prevent increased and uncontrolled pain. Increased and uncontrolled pain can be an attributing factor for delayed wound healing. Patient should report any changes to pain and if current oral analgesics are ineffective. Pain management care may need to be reassessed by their MD.
Knowledge deficit of measuring stoma	Demonstrate measuring stoma and cutting flange with RN. Teach back the importance of measuring stoma,	The patient should be educated on when to measure stoma because the stoma size can change due to dehydration or swelling. Also, including education on how the flange should fit around the stoma will be beneficial in preventing peri stomal breakdown.

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	when to remeasure stoma, and assessing the peri wound with each pouch change to the RN.	When the patient provides teach back, it is reinforcing the education the RN has provided and demonstrates the patient's understanding of the lesson.
Fluid/electrolyte imbalance due to high output	Log amount of oral intake and effluent output daily.	Keeping a log of oral fluid intake and effluent output is beneficial to see if the patient is having too much or not enough output and their hydration status.
	Oral intake should reach goal of 10-12 cups daily and incorporate 500mL electrolyte replacement fluids such as Gatorade or Pedialyte.	The normal adult should consume 8-10 cups daily while patients with ileostomies should consume 10-12 cups daily. Including electrolyte replacement fluids such as Gatorade or Pedialyte can prevent electrolyte imbalances. Since the effluent from ileostomies is typically liquid and the body can have difficulty absorbing nutrients from food.
	Notify WOC RN or MD if you experience these signs of dehydration: increased thirst, lethargy, muscle cramps, dry mouth, abdominal cramping, dark urine, decreased urine output, and effluent output greater than 1200mL a day.	Notifying their care team earlier on when these types of symptoms occur can catch and treat dehydration.

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 not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Xeroform gauze-Will keep wound bed moist but can dry out and stick to the wound. A hydro fiber dressing may be more appropriate due to the moderate drainage. Hydro fiber dressings are non-adherent and are absorbent. Abdominal pad- This type of absorbent dressing is appropriate as a secondary dressing for this wound. If this dressing is not available or if the secondary dressing becomes saturated too quickly, then there are other more absorbent dressings such as exu-dry which is similar to an abdominal pad, but more absorbent. Paper tape-Tape sensitivity is a disadvantage for some patients. Another alternative would be to use a gentler type of adhesive such as a silicone based taped or porous type of tape. Hollister 2-piece Ceraplus Skin Barrier Wafer cut to fit with closed end pouch-Depending on if this flange being used is a flat flange, then a soft convex flange may be more beneficial in preventing leakage as an alternative. The disadvantage of the flat flange is if there are changes in the contour of the patient's abdomen, then there is a greater increase for leakage to occur. The soft convex is flexible with changing body contours. An alternative to a closed end pouch would be a high output pouch. The closed end pouches are smaller and may need frequent changing with high output. Stomahesive powder and Cavalon skin barrier wipe- Both products can be used to create a crusting

	barrier over skin breakdown. An alternative that could be used is Hollihesive skin barrier. The Hollihesive can protect the denuded peristomal skin from output and can absorb exudate from the area.

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?	The goal for this patient scenario was to address the progression of the abdominal fistula, reassess the loop ileostomy pouching system, and provide additional patient education. The goal was met. The ileostomy pouching system needed to be changed by remeasuring the stoma and providing education to the patient on when the stoma should be measured.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	N/A. See next virtual journal entry.

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

Number of patients seen today: _____ Preceptor: _____

Clinical Reflection: Identify/describe other patient encounters, clinical experiences from today, thoughts.	This mini case scenario helped me learn and critical think of alternative dressings or pouching systems. It also expanded my thinking to include more patient education due to their pouching system not fitting correctly and creating peristomal skin breakdown. The scenario gave a very real situation where the patient has preferences in their care and pouching systems. So, navigating those patient requests did challenge my thinking and it was a beneficial learning experience.

Reviewed by: _____ Date: _____

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