Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Sophia Salaita_____Day/Date: 1/30/24

Number of Clinical Hours Today: _10___ Care Setting: _x__ Hospital __x_ Ambulatory Care

Number of patients seen today: __5___ Preceptor: __Michelle Harris-Farrell_____

Journal Focus: _____Wound _____ Ostomy __x ____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.** The patient assessed today will be referred to as "JM". JM is a 31-year-old male presenting with bleeding from the stoma, which is also prolapsed. Patient has a history of Burkitt lymphoma EBV positive, hypertension, Tetralogy of Fallot with repair, renal transplant in 2020 with chronic kidney disease, ileostomy formation in 09/2023 from a small bowel obstruction. Last round of chemotherapy reported to have taken place on 12/26/2023. Patient presented to ambulatory ostomy clinic directly from a follow up appointment with colorectal surgeon, Dr. XYZ. Patient reports that Dr. XYZ suggested that patient present to emergency room due to bloody output from stoma. Labs were drawn yesterday and revealed several abnormal values, including red blood cell of 2.41m/uL, hbg 7.5 g/dL, hct 22.8%, and platelet count 17 k/uL. Patient reported that these values were observed and assessed during his follow up appointment with Dr. XYZ. Patient also reports that stoma and peristomal area assessed by Dr. XYZ. The stoma does present to be prolapsed. Patient reports stoma has been prolapsed for approximately three months. Stoma was reported to be pushed back into place partially during assessment by primary surgeon. After the assessment, Dr. XYZ repeated need for patient to present to the emergency room due to suspected dehydration and irregular lab values.

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.

Ostomy nurse consult in for follow up assessment of patient's ileostomy. Patient presented into the ostomy clinic with bloody output, prolapse of the stoma, bleeding of the stoma itself. Patient reports prolapse of the stoma occurring approximately three months ago, primary surgeon, Dr. XYZ, is aware. Patient reports coming directly from follow up appointment with Dr. XYZ for concerns of stoma prolapse, and bleeding produced by stoma. Patient reported due to bloody output, as well as externally from the

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stoma itself that Dr. XYZ strongly suggested for patient to visit the emergency room for a more thorough assessment. Patient reported desire for new ostomy appliance placement by ostomy nurse prior to visiting the emergency room. Patient presenting with high levels of output, approximately 600cc, which some presents to be blood tinged. Patient reports baseline for high output from his ileostomy. Patient is unable to report specific measurements when at home; however, reports having to empty the appliance approximately nine to 11 times per day. He also stated that the bloody output first appeared on Friday afternoon, after he was discharged from the hospital. Area of prolapse measured to be 5-6 cm. Patient reports growth and shrinkage of prolapse throughout the day. Original appliance was removed, using the push, pull method and adhesive remover wipes. Large amounts of liquid, light brown stool noted with hints of red in portions. Stoma and peristomal skin were cleansed using a soft gauze wipe which was moistened with normal saline solution. Area was patted dry, then skin prep was applied to peristomal area. Maceration noted to peristomal skin. Ostomy powder applied and was set using additional skin prep and the crusting method. 4-inch barrier ring applied. Patient was set using holster two-piece system of 2 ¾ wafer and a high output bag appliance. Patient's appliance belt refastened onto new appliance. High output bags are not used by the patient at home. Patient reported needing to order more home supplies. Patient was provided with three additional sets of everything needed for a routine change, including additional high output appliance. Patient reports that his sister typically changes his appliances for him; however, his sister is out of town at this time and is unable to perform these tasks. Patient reports leaking from his appliance due to an inappropriate application process by himself. Patient educated on how to change the appliance, using the supplies listed above. Patient educated on crusting method in order to protect peristomal skin. Stoma prolapse education provided, including avoidance of incidences of increased abdominal pressure and the need to use an ostomy appliance belt. Patient verbalized understanding and was able to perform the teach back method in identifying the application process. Patient left office and headed for the emergency waiting room.

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*** 1. Fluid/electrolyte imbalance due to high output ileostomy, as evidenced by large amounts of output observed during visit and reported by patient. 2. Knowledge deficit of application process, as	**Statements should be directive and holistic relating to the problem/concern.** 1. Bedside nursing staff to educate adequate hydration due to presence of high output ileostomy. Bedside nursing to record and document patient input and output. Physician will be notified of negative amounts noted. Dietician to be consulted for assessment and education of ileostomy positive foods to consume. 2. Nursing staff will educate on routine application of the patient's appliance. Bedside nursing will perform routine ostomy appliance changes every 2-3 days, due to maceration and breakdown to peri-stomal skin. Remove the appliance gently using adhesive remover, cleanse the area with soft gauze and normal saline solution. Pat dry. Perform the crusting method to the areas of maceration and irritation. Apply 4-inch barrier ring. Apply 2 ¾ inch wafer, followed by snapping the bag onto the appliance. Hold a warm hand over the appliance for approximately 5 minutes to secure the appliance to the patient. Nursing	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** 1. Bedside nursing will need to educate the patient on adequate hydration to prevent deterioration of the patient's medical conditions and risk for readmission. Bedside nursing to log I/O's to track and identify negative fluid amounts. Physician is to be notified of negative fluid amounts to assist in preventing/resolving patient dehydration. Dietician to be consulted for assist patient in identifying food that support his ileostomy function, as well as hydration levels. 2. Nursing staff to reinforce education of how to apply the ostomy device. Written materials may be supplied to the patient, including the steps of the changing process and the materials involved. Ostomy changes are to be performed more frequently at 2-3 days due to risk for leakage due to high levels of liquid output. Steps of how to change patient's appliance are listed within the order to be followed step by step to

evidenced by reported leakage, caregiver absence, and maceration of the skin peristomal skin.	staff will involve patient in changing process for hands on experience. The ostomy nurse will continue to follow patient inpatient every two to three days for additional education needs, as well as in the ambulatory setting upon set appointments.	decrease confusion and ease in the changing process. Nurse will attempt to increase patient involvement in changes, thus increasing independence. Ostomy nurse to continue to educate patient to build patient independence in appliance changes.

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.** **Hollister Adhesive Remover Wipes –** A disadvantage of this product includes the possibility of the product, not being available to the patient. An alternative material includes mineral oil. **Hollister Skin Prep Wipes –** A disadvantage of this product would include the possibility of the patient not having one available for usage. An alternative is to use ostomy paste as a sealant and barrier for the skin. However, it is necessary to ensure that the alternative option does not contain alcohol. **Hollister 4-inch Barrier Ring -** A disadvantage of this product is, the ring may swell and may absorb moisture from the patient's output. Due to the patient having an ileostomy, output will present to be more liquid. If the product stays moist and in place for too long, it may cause for skin breakdown. With the size of this particular barrier ring, moisture has an additional increased chance of moisture development and skin breakdown. An alternative option for a barrier ring would also be ostomy paste, as it creates a sealant to the skin, as well as protection from possible leakage. Ensure that the ostomy paste does not contain alcohol, as this is harmful to the skin. **Hollister High Output Appliance with 2 ¾ wafer -** a disadvantage of this appliance would include the patient need to empty materials frequently, despite the increase capacity of the appliance. An alternative would be to place a patient in an appliance that may be connected to a bedside collection appliance.

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?	Today, my goal was to participate in the assessment and plan of care development for a patient presenting with an ostomy complication. Yes, my goal was reached as I was able to participate in the care for JM.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I discussed with my preceptor the learning goal for tomorrow to observe a wound patient and to be able to independently identify a plan of care for the patient and his/her wound.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	The assessment with the patient today was well-rounded and through assessment. One additional step that should have been taken wound to have been to assess the patient's emotional and coping needs. Due to the patient's long history of complications regarding the stoma, it would be beneficial for the ostomy nurse to assess emotional needs, as well as needs for coping mechanism education.

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Reflection: Describe other patient encounters, types of patients seen.	Today, we saw many ostomy patients. One was a stoma site marking in the emergency room. He was able to be educated on the operation and what a stoma is. His wife was at bedside and was also able to be educated. It was also discussed when to empty an appliance, how to change an appliance. Unfortunately, due to the patient's pain levels, the maximum level of education was not able to be provided. The patient's wife was receptive; however, she was comforting him in his pain and did not wish for continued education, as well. Another patient that stands out is the one, of which, this journal is based on. He is a patient that I was able to observe as a patient within the hospital last week, as well. It was very educational to be able to assess him in the outpatient ostomy clinic this week to see how different the type of visit is from the inpatient ostomy visit. He is an established ostomy; however, he does have many complications involving his ostomy.

Reviewed by: _____ Date: _____

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