Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Tracy Leal_____ Day/Date: _07/10/2024___

Number of Clinical Hours Today: __8_

Care Setting: Hospital __x__ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: _Elizabeth (Betsy) Kulling__

Clinical Focus: Wound ____ Ostomy _x___ Continence ____

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

1. 36 y/o F with PMH significant for FAP with stage III rectal CA, s/p robotic total proctocolectomy and end ileostomy (2019) with adjuvant chemo and radiation to the remaining 4 cm of rectum. Complicated by perirectal abscess requiring EUA (2021 and 2022). Growing desmoids on sorafenib and doxil. FDG uptake on surveillance PET scan and pt underwent "distal gastrectomy and duodenectomy, Billroth 2 gastrojejunostomy reconstruction and R adrenalectomy". Pt then developed "duodenal stump leak, large retroperitoneal hematoma, and fistula at GJ anastomosis refractory to attempted surgical and IR closure". Pt has recently developed an SBO and several abdominal wall and mesenteric desmoids. Has a venting G tube to relieve obstruction symptoms and recently underwent radical resection of abdominal and mesenteric desmoid tumors, s/p total enterectomy and creation of end gastrostomy and jejunostomy with takedown of ileostomy, lysis of adhesions, and takedown of multiple ECFs. Patient now admitted for removal of right retroperitoneal desmoid tumor and right ureterolysis and resection of a tumor surrounding the right ureter that was completed 6/24/24. WOC team consulted for urine leaking from midline abdominal incision that is also undermining the seal on patients end gastrostomy and end jejunostomy appliances. Pt with midline incision from pubic bone to sternum, sutures in place, mostly well approximated, but with a wound to the midline roughly where the umbilicus would have been that is producing urine. There is also urine coming from the inferior portion of the incision (4 sutures from the bottom). Patient has significant MASD to lower abdomen. The patient has very deep abdominal contours here where the urine is pooling All affected areas treated with a Domeboro soak. End gastrostomy in RUQ. Stoma red, moist and budded. There is a MCJ partial separation from 7-9 o'clock with a mucosal implant at 12 o'clock. These sites were treated with Aqucaell and pouched over. Peristomal contour mildly rounded and soft in this area. The patient was pouched with 2 ¾ Holister New Image Convex Flange CeraPlus, Coloplast Stomahesive paste, and a Holister HVOP pouch connected to gravity. Framed with Hy-tape that was trimmed to avoid midline incision. End jejunostomy located in LUQ. Stoma red, budded, moist. MCJ intact. Peristomal skin intact, contours are concave with soft surrounding tissue. Patient pouched using 2 ¾ Holister New Image Covex flange CeraPlus cut off center and trimmed to avoid a nearby wound at 7 o'clock. Holihesive triangular shaped washer applied, followed by Coloplast Stomahesive paste, followed by Holister New image 2 ¾ convex flange with HVOP pouch to gravity. Aquacell applied to small wound at 7 o'clock. The 2 fistulas to the midline were pouched with a Coloplast one-piece drainable pouch with the very deep abdominal contours built up with Holihesive wedges, Holister strip paste to creases at 12, 7 and 8 o'clock. Windowpane with Mefix tape. The patient was tired and had some pain with care. Patient's aunt was at bedside and very supportive. Patients 4 daughters are away at summer camp, patient seemed happy when speaking of them. Overall, patient appears to be coping well and supported by family at this time.
2. 77 y/o M with PMH significant for prostate CA s/p RALP (2018), salvage XRT (2020) c/b urosymphyseal fistula with abdominal wall and left groin abscess. Pt now s/p open radical cystectomy with loop end ileal conduit diversion on 6/19/24. Admitted from home on 7/9/24 for FTT. WOC team consulted today to obtain sterile urine specimen for C&S from ileal conduit. Previous pouching system was placed 7/6 with no evidence of leaking. Unable to ascertain from charting which lumen to catheterize, but urine then clearly visualized from inferior lumen. Site sterilized with betadine and

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catheterized with 14 Fr catheter. Sample obtained using sterile technique, labeled at bedside and sent (tubed) by bedside RN. Loop stoma located in LUQ, oval and budded, red and moist. MCJ intact. Mild erythema at 3 and 9 o'clock that was dusted with Convatec Stomahesive powder and loose powder brushed off. Pouching system replaced using Coloplast Sensura MIO light convex one-piece urostomy pouch, cut to fit up to 1 5/16' with Coloplast adapter and gravity drainage bag. Patient had his "friend and professional caregiver" at bedside. Caregiver reports no issues with stoma care and requested more Coloplast adapters which were provided. Patient continues to report poor appetite and abdominal pain with eating.

3. 72 y/o F with PMH significant for rectal CA, s/p resection with temporary loop ileostomy at OSH on 4/25/24 and type 2 DM. While at the OSH patient went into septic shock related to anastomotic leak and intra-abdominal abscess requiring exploratory laparotomy and washout x2. Patient was tolerating po intake, advancing diet and DCd home in stable condition. Patient required readmission a few days later for abdominal pain and intractable N/V. Pt remained in OSH in May and June for TPN r/t N/V accompanied by 40 lb weight loss. EGD showed esophagitis with no bleeding and diffuse inflammation of duodenum. Patient transferred to Cleveland Clinic for ongoing management. Patient received Reglan, PRN Zofran, IV protonix, D5NS until TPN started. Patient did not have recurrence of abscess. Patient seen for routine pouch change. She is A+Ox3, daughter at bedside. Patient was able to move from chair to bed independently and voiced that she is grateful for the care she has received. She is scheduled for DC tomorrow. Patients' daughter is her caregiver and feels very comfortable with ileostomy care. The patient remains on tube feeding and daughter requested more information on managing this at home. Patients nurse made aware. Patients loop ileostomy located in LUQ. Previous pouching system removed and showed no signs of leakage. Placed on 7/5. Patients' stoma is red, moist and budded. Peristomal skin intact. Patient placed in Holister New Image CeraPlus flat wafer 2 ¼ inch cut to fit, with Cera ring and HVOP. Printouts provided to the patient and her daughter regarding how to order supplies, step by step instructions on how to change her bag, and what to do in case the patient has high volume output and what that means. The patients' daughter voiced understanding. She also has the contact information for the WOC nurses at Cleveland Clinic for help even though she is from out of state.
4. 60 y/o F POD #14 open low anterior resection (LAR) and diverting loop ileostomy. See chart note below.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. 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. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

60 y/o F POD #14 from open low anterior resection (LAR) and diverting loop ileostomy. The patient is being seen today for reintubation of the stoma requested by the surgeon. Patient with PMH significant for rectal CA, COPD, asthma, CAD, Malignant neoplasm of the colon, and former smoker. Patient remains inpatient now with PNA on IV Vanco and Zosyn, pending ID and pulmonary recs. Chest CT with nodules to be reassessed in 4 weeks. WOC team consulted today as patient's output from her ileostomy has slowed (<100 cc overnight) with associated abdominal distention with emesis x1. The surgeon has requested reintubation of the stoma.

WBC 7.15, HH 9.0/28.3, glc 95. AM vital signs: 168/82, pulse 108, Temp 98.2, resp 22, SpO2 98% on RA. Midline incision well approximated, free from signs of infection with staples in place. Pouch removed, stoma red, moist, and budded. Peristomal tissue and MCJ not visualized as flange left in place. Abd distended, but soft, only mild discomfort on palpation. Proximal stoma reintubated using lubricated 16 Fr foley without incident. Flushed with a total of 150 cc NS with a return of 60 cc of green effluent with sediment. Patient did pass some flatus at this time. The flange did not get soiled (was changed yesterday) and was therefore not changed. The pouch was replaced with a new HVOP and the catheter secured with dental floss between the flange and pouch and then taped in placed with wrapped gauze. Supplies were left at bedside. The patient tolerated the procedure well, just reported feeling bloated and disappointed that her discharge was being delayed by her low fecal output and PNA. Family at bedside and

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supportive. Patient was very interactive with family. Patient grateful for help from WOC team.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products used)

1. Remove appliance using ConvaTec Sensi Care No Sting Adhesive Remover wipes and using a push pull technique.
2. Cleanse peristomal skin with warm water and pat dry.
3. Dust any denuded or irritated skin with ConvaTec Stomahesive stoma powder and dust off excess.
4. Measure stoma and apply Holister CeraPlus flat skin barrier wafer 2 ¾ cut to fit, with Cera Ring, and coupled with Hollister HV clear drainable pouch to gravity (while in bed). Change every 3-4 days.
5. Encourage patient to ambulate as much as tolerated to improve gastric motility.
6. Encourage patient to participate in ostomy care.

Describe your thoughts related to the care provided. What would you have done differently?

I would have been more proactive with patient ambulation. I know she doesn't feel well, but her O2 sat is 98% on RA. She seemed resistant when her daughter brought up walking. I would have offered to help stand the patient up and really backed her daughter up with the encouragement for ambulation, it seemed like it would have been a good opportunity. I also noted that the patient did not look at her ostomy when we intubated. I would have asked the patient how she was feeling about the ostomy and how confident she was with performing self-care. She had some recent setbacks with her health but was previously nearing discharge. Her interaction with us did not make me feel like she was too ill for a discussion regarding ostomy care post discharge. The patient might have felt encouraged feeling like we were still planning for discharge.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?
A difficult stoma marking. This did not happen as it did not come up.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
More practice with stoma site marking for a difficult abdomen

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	

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• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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