Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Tracy Leal_____ Day/Date: __07/18/2024___

Number of Clinical Hours Today: __8__

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

Preceptor: __Sarah Yount___

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. 74 y/o F with a PMH significant for colon CA. Patient seen today for leaking appliance. Patient has a loop transverse colostomy and was changed from a flat wafer to a convex at her last appointment. Patient reports improved peristomal tissue. Upon removal of previous appliance, stoma noted to be oval, budded, red, and moist. Stoma located in RUQ, closer to midline of abdomen. MCJ intact, peristomal skin intact, but pink where rash had been. Skin no longer denuded. The site is so close to the umbilicus that there was not a way to avoid pouching over it and there was a fungal rash noted to this area. This was treated with Nystatin powder and Cavilon no sting skin prep. The peristomal skin was prepped with Convatec stomahesive stoma powder, the excess brushed off and sealed with Cavilon no sting skin prep. A Hollihesive wafer was placed as before, but a crescent shape was added on top of this to the inferior border to give more support for a crease that appears when seated. Patient was then pouched in a Hollister 2 ¾ convex CeraPlus wafer with accompanying clear drainable pouch with a lock and roll closure.
2. 69 y/o F with endometrial CA. Patient with previous end colostomy, but now has an established end ileostomy with a mucus fistula after a hernia repair in 2022. Patient reports no issues with leaking until about a month ago. She reports a feeling of pulling and pain with activity that reminds her of having a hernia before and leaking at 5 o'clock. She also reports stool from her mucous fistula. Ileostomy located in the RUQ, peristomal skin intact, MCJ intact. Stoma is red, moist and budded. There are small growths covering the entire stoma, possibly granulomas. Patient has already spoken to her surgeon about this, and he is unconcerned per her report. Photo taken for chart to aid in monitoring any changes in appearance. Site pouched with 1 3/4" Hollister CeraPlus convex skin barrier with ½ a Cera Ring to the inferior edge to accommodate a crease and the accompanying Hollister clear, drainable pouch with spout closure per patient preference. The patient was also fitted with a Brava ostomy support belt. After placement of this and walking around the exam room the patient voiced immediate relief from the pulling sensation and was so grateful. The mucous fistula is located in the LLQ, stoma is red, moist, and flush, but retracts when seated. There was a small amount of stool coming out (pea sized, but very malodorous). The WOC nurse asked me later what I thought about this. I was very confused and thought that was either older fecal matter coming out or was concerning for a fistula. She agreed, but the patient stated her surgeon is also aware of this issue and is not concerned. Peristomal skin intact, but hyperpigmented. Patient prefers to pouch the site as she feels it controls the odor. Site pouched with Hollister CeraPlus 1 ¾" convex skin barrier with accompanying clear drainable pouch with a lock and roll closure.
3. 73 y/o M with ischemic colitis. Patient had a colostomy which was closed on 6/28 and loop ileostomy created at the old colostomy site to let the anastomosis heal. Stoma in LUQ, slightly budded, red and moist. There is a dehisced incision line at 3 o'clock. There were sutures here that were not effective and were removed by the PA at this visit. This is also where the bag leaks. Patient has red, irritated skin to the left side of his abdomen in this area. It is erythematous, but not open. Wound, and surrounding skin, treated with Convatec stoma powder and Cavilon no sting skin prep. A small piece of aquacell was also laid over the dehisced area. A triangular piece of Hollihesive was placed over this area up to the stoma. Patient was then pouched with a 2 ¾ Hollister CeraPlus skin barrier with the accompanying clear drainable pouch with a

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

clip closure per patient preference. A belt was also added to help with the seal. Patient was amenable to trying this and was educated regarding the risks of pressure and allowing for 2 finger widths between the belt and his skin. The patient and his wife (retired RN) voiced understanding. Patient was also seen by PA at this appointment for suture and staple removal to the midline abdominal incision. Incision well approximated with no signs of infection, abscess, nor ischemia.

4. 56 y/o M with a presacral mass. PMH significant for diverticulitis with perforation, and an elevated PSA. The patient is being seen for site marking for a possible ileostomy. The patient is scheduled for a sigmoid colectomy and colorectal anastomosis. The surgeon wanted the patient site marked in case he needed the ileostomy to allow the anastomosis to heal. I marked the patient in the RLQ within the rectus muscle and avoided any creases. There is ample room for pouching. The patients abdomen was viewed seated, standing, and bending over. Patient was educated on why site marking is important with good understanding. The patient was educated to not wash off the mark. He was given a surgical pen to darken the mark if it fades and extra Tegaderm should he need to replace it. Patient also provided education on his upcoming procedure, what and ileostomy is should he need one, diet restrictions for his abdominal surgery, hydration should he need an ileostomy, and post-op activity restriction for his upcoming abdominal surgery. Patient voiced understanding and had no further questions.
5. 77 y/o M s/p cystectomy and end ileal conduit creation on 6/27/24. Patient has been struggling with leakage since the surgery. He was seen by his surgeon this morning and his stents were removed. Stoma is located in the RLQ. The stoma is slightly budded, red, and moist. MCJ intact. Peristomal plane is soft, concave and the stoma completely disappears into the crease when sitting. At the patient's last visit, he was placed in a Marlen 1 3/8" deep convexity one-piece drainable pouching system and reports a current wear time of 3-4 days. The peristomal skin with mild fungal infection that patient states has greatly improved with use of miconazole powder and Cavilon no sting barrier film to seal. Patient is very happy with his current system and wear time. Follow up as needed.
6. 28 y/o F with Crohn's disease. G1P2 (twins turn one on Saturday!) Patient is s/p total abdominal colectomy with end ileostomy. Biopsies taken and confirmed Crohn's disease. The terminal ileum was clear, however. Patient reports she empties her pouch 3-4 times daily. She also states she gets very dizzy and had a syncopal episode while home with her children. She awakened on the floor of her bathroom with a bloody nose. We were in the room to assess the pouching system as she was telling this to her surgeon. Had he not been there, I would have discussed what and how much she was drinking, asked her to keep track of her output volumes and call her surgeon if >1200 ml/24 hours. I would have educated her regarding dietary changes and medications to thicken the stool (pasta, cheese, bananas, Imodium). I would have also given her information regarding oral hydration solution. She is the mother of twin one-year old girls, and it can be very easy to forget to take care of yourself with children. I would have spoken to her about making sure she takes care of herself (set alarms to drink if you have to!) and maybe asking for some help. The patient also needs a nutrition consult as she is continuing to lose weight, even though she states she is eating (she is likely forgetting to do that too). Stoma is located in the RUQ, is round, red, budded, and moist. There is a very small separation at 12 and 5 o'clock and patient reports mild discomfort here. Treated with Convatec Stoma powder and Cavilon no sting barrier film to seal. Abdomen is soft and flat. She is small in stature and stoma is close to her umbilicus. The tape collar was cut, and the wafer placed in a diamond orientation, to accommodate this. Patient is currently using a 1 3/4" flat CeraPlus skin barrier with a Cera Ring to get a good seal. She uses a clear lock and roll drainable pouch and reports a 3-day wear time with this system, which she is happy with.
7. 50 y/o F with end ileostomy related to UC. See below for chart note.

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.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

Chart note:

Patient is a 50 y/o F with a PMH significant for T12-L1complete paraplegia, neurogenic bladder requiring self-intermittent catheterization, UC, rectal bleeding, CAD, cardiac stenting, DMT2 (blood sugars are not well controlled), and anemia. BMI >35. She is a former smoker with a 24 total pack year history. PSH significant for laparoscopic total abdominal colectomy with end ileostomy and flex sigmoidoscopy on 9/15/2023. Ileostomy revised on 3/13/2024. Patient also with h/o peristomal PG ulcers. She received a Kenalog injection at her last visit and has been using Flonase steroid spray to the peristomal skin.

Medications: Novolin insulin 70-30 20 units SQ BID with meals, ergocalciferal1 capsule po Q week, loperamide 2 mg capsules po before meals and at bedtime, ASA 81 mg po QD, baclofen 10 mg po QD
Labs: (most recent from 3/7) HH 10.3/34.3, WBC 7.16, plt 321, Na 138, K 3.7, Glc 418, BUN 15, create 0.72ALT 7, AST 16 HgA1c 9.6

Patient is A+O x3, well looking. Patient is being seen for follow up on her end ileostomy and wound checks for her peristomal pyoderma gangrenosum. Patient received a Kenalog injection at her last visit and has been using Flonase spray on the peristomal skin. Her ulcers have improved significantly since her last visit. Patient also seen by PA at this visit who wants patient to continue with Flonase spray to the peristomal tissues. No need for another Kenalog injection at this time. Patients end ileostomy stoma is located in the RUQ, stoma is round with a 1" diameter, budded, red, and moist. MCJ is intact. Peristomal wound at 9 o'clock is nearly closed. There is an open wound just under where the tape collar would be at 6 o'clock that is shallow, no tunneling, with a red, beefy, moist wound base. Patients peristomal contour is rounded, with semisoft tissue, and shallowly concave adjacent to the stoma. Effluent is green and slightly mushy. Peristomal tissue treated with Convatec Stomahesive stoma powder, the excess was brushed off and sealed with Cavilon no sting skin prep. Aquacell was cut to fit over peristomal ulcers. Hollihesive half moon wedge placed at 9 o'clock. Patient pouched using Coloplast SenSura Mio soft convex cut-to-fit (5/8" – 1 5/16") drainable pouch, Convatec Stomapaste, and framed with MeFix tape. Patients wear time has been 3-4 days. The seal on the removed system was intact, with some areas of moisture noted likely to perspiration (no stool leak noted). Patients' midline abdominal incision is almost completely closed except for a small scabbed over ulcer to the distal end. This scab gets retraumatized with gauze changes. Site covered with urgotul contact layer and gauze. Patient educated on this change as she is independent with care. She voiced understanding.

Patient reported a healed wound to her sacrum. Author noted patient did not have a clean depression transfer from the exam table to her chair. The patient will benefit from a PT consult for more transfer training and strengthening to avoid shearing injuries to her skin.

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. Cleanse peristomal tissue gently with warm water and pat dry.
2. Dust any denuded, open or irritated skin with Convatec Stomahesive stoma powder, brush off the excess and seal it with Cavilon no sting skin prep and allow to dry.
3. Apply Aquacell cut to fit to peristomal wounds.
4. Apply Hollihesive half-moon wedge at 9 o'clock, followed by Coloplast SenSura Mio soft convex (5/8" – 1 5/16") cut-to-fit drainable pouch with Convatec Stomapaste to wafer, and frame with MeFix tape. Change every 3-4 days and as needed for leakage. Empty when 1/3 to ½ full. Call surgeon for output >1200 ml/24 hours or other signs of dehydration.
5. PT consult
6. Nutrition consult
7. Endocrine consult
8. Refer to diabetic educator
9. Reconsult WOC nursing for leaking or issues with stoma

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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

The patient reported high blood sugars when in the hospital. Upon chart review her A1c was also high at that time. I would have asked what her current diet looks like, how often she takes her blood sugars and what they are. If she didn't know or reported them to be as high as they were inpatient, I would have taken a fingerstick (if available in A30) and let the PA know. I noted she did not have a clean transfer from exam table to wheelchair. She stopped midway through a scoot/depression transfer and her sacrum was resting on her siderail and she was dragging herself instead of lifting. This could be related to strength or poor technique, or both. I would have discussed this and asked if she was willing to see PT. I would have also asked if she is performing at twice daily skin checks and assessed her knowledge of pressure injury prevention and maintenance of skin integrity. It would have been easy to help her check her skin on the exam table and provide this education. I am not sure if there is a WC scale for A30, but I think they should have one. It is very hard for those WC bound to get a weight at home, so a reported weight might be very outdated. Her chart reported a BMI>35, but she did not look that overweight to me.

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?

My goal was to troubleshoot appliance leakage and learn more about the products. I feel like I did achieve this goal. I was able to bounce ideas off my preceptor and I understood why she was choosing what she did.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

I would like to find a patient appropriate for a complex case study for ostomy.

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	✓	
• 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	✓	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.