Cleveland Clinic

Virtual Journal Entry with Plan of Care & Chart Note

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Setting: Hospital ☒ Ambulatory Care • Home Health Care • Other: _____

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, a chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History	*Age/sex:* 14-year-old female *PMH:* severe ulcerative colitis. PMH of UC, rectal bleeding, malnutrition and failure to thrive. Patient is amenorrheic. No further significant history. Patient active in sports previously and has been unable to participate this year. Reported unmanageable UC symptoms x 2 years that were beginning to affect her schooling. Reported up to 20 bowel movements per day and "unmanageable" abdominal pain. Medical management of UC has been unsuccessful. Patient and parents agreed upon surgical intervention to try to regain quality of life. Pt received pre-operative education and stoma site marking in outpatient clinic prior to surgery for IPAA. Three step surgery indicated due to present severe malnutrition. Underwent 2nd step of 3 step IPAA with loop ileostomy two days ago. *CC:* UC, Post op IPAA step 2 *Medications:* IV morphine (PCA) *Social hx:* Denies smoking, ETOH or illicit drug use. Patient parents are very involved in care. Patient's mother does not want the patient to see her new stoma and states she will be the primary caregiver. It is documented that she has expressed concerns regarding the availability of nursing staff at the patient's school, as the patient will be returning soon. *Labs*: Na 135, K 4.8, Cl 100, BUN 10, Glu 79, WBC 8.0, Hgb 8.8, HCT 29.9.2 %, PLT 251

Assessment/encounter:

Ostomy nurse consulted for routine post op day 2 assessment

LOC: Patient sleeping in bed. Mother, at bedside, anxious. Patient aroused easily but sleepy, medicated.

Interview with the mother who states the patient

- Has been having "10/10" pain managed with ordered medication
- Has not ambulated since surgery
- Has had "black poop come out already"
- Had a pouch leak last night that the she (the mother) "fixed" with copious amounts of ostomy paste
- Has many concerns regarding leaking

Stoma: Budded, moist, red, edematous. Rod noted in place.

Stoma size: 2.0 x 1.5 in

Shape: oblong, edema noted, both lumens visualized

Peri-stomal skin: Intact. No erythema or denuded areas noted.

Abdominal plane: semi-soft, edematous, smooth and flat. Post op pouch appears to have creased when the patient sat up.

Pouch:

- Coloplast Sensura post operative drainable ostomy appliance
- In place to RLQ with dark green effluent in pouch and on abdomen

Education

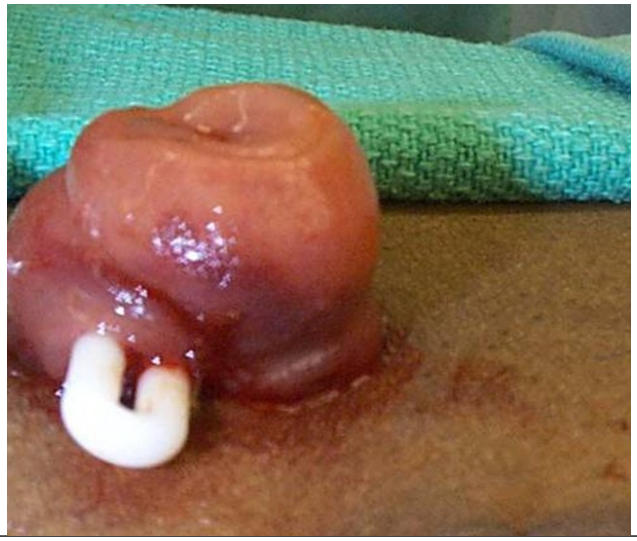
- Develop in plan below

Patient has no immediate discharge plans at this time.

What specific system would you choose as the Ostomy provider? Make sure to include below, considering both short

and long term plans for this patient.

Photo



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Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. One thing I may have done differently regarding assessment data collection in this patient situation is waited for a time when the patient was more awake/alert. While all the information was received from the mother, and the parents are very involved in the patient's care, an assessment should be done on how ready to learn the patient herself is. The patient is at an age where she can start being more independent in the care of her body and have more autonomy.
2. A second thing I may have done differently is assess the patient's mobility level further. How mobile is she in bed and what has prevented her from getting out of bed since the surgery?
3. A third thing I may have done or considered would be further education on the IPAA procedure timeline, and ostomy and pouching education now that the patient is post-op.
4. A fourth thing I may have done differently is further assess the patient's nutritional status, refer/consult nutritional services, and determine if supplemental nutrition (tube feeding, tpn) has been tried before and if it is needed now.
5. A fifth thing I may have done or questioned is obtaining more lab work, specifically obtaining nutritional lab work (total protein, liver and kidney panel, electrolytes, mag, Phos).

Using the information from the encounter and your critical evaluation 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. (For example: *What ostomy pouch change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

- Change pouching system every 3-4 days and as needed with leakage.
  - Gather needed supplies, prepare new pouching system
  - Remove old system using adhesive remover and a push-pull method
  - Cleanse the peristomal skin with a soft cloth moistened with warm water, gently pat dry
  - Measure the stoma size using the paper guide, cut the skin barrier to the new pouch 1/8" larger than measured stoma size
  - Check that skin barrier opening is correct size before applying new system
  - Apply thin layer of stoma barrier paste around the cut opening of the skin barrier

    - Apply new pouching system and ensure good seal by pressing warm hand over the area
        - Pouching system= Coloplast SenSura Mio 1-piece drainable maxi pouch (12") with cut-to-fit barrier
- Empty pouch when 1/3 to ½ full, monitor and measure output closely for 1-2 weeks post-op
    - Notify provider if output is >1,200ml in a 24 hr period
    - Notify provider if output is <500ml in a 24hr period, or complete lack of stoma output
- Notify provider of changes in stoma appearance.
    - Pale or dusky in appearance
    - Purple, blue, or black in color
    - Stoma becomes retracted or prolapsed
    - Notify provider if rod becomes displaced or removed
- Consult nutritional services for patient evaluation and supplemental nutrition recommendations.
- Obtain daily weight and lab work.
- Initiate dehydration prevention techniques.
- Initiate low fiber/low residue diet for 6 weeks post-op.
- Consult WOC team as needed for leaking concerns, pouching issues, or other stoma care needs.
- Consult PT/OT for mobility assessment and rehabilitation needs.
- Consult social work services to aid in the transition back to school and providing medical assistance on discharge.
- Consult child life services to aid in coping management of medical and emotional experiences.
- Involve patient in hands on care of stoma.
    - Goal to have patient visualize stoma, and empty pouch under the supervision of medical staff.
- Assess for patient and parent understanding of education through teach-back method and demonstration.
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Write a chart note giving careful consideration to the chart review information, 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 used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

The patient is a 14-year-old female with a past medical history of severe ulcerative colitis, rectal bleeding, malnutrition, and failure to thrive. The patient recently underwent IPAA surgery, step 2 of 3 with loop ileostomy creation for quality-of-life improvement secondary to unsuccessful ulcerative colitis management. Three step surgery was indicated due to the degree of malnutrition. The patient has no other pertinent surgical history.

The patient presents for post-operative day 2 stoma assessment by the WOC team. The patient originally seen pre-operatively for stoma site marking and ileostomy education. Assessment performed bedside with mother present. Chief complaints/concerns upon time of assessment include post-operative pain, concerns about the transition back to school, and pouch leaking and management. The patient's mother reports pouch leakage overnight that she claims to have fixed with stoma paste.

Physical Assessment:

- Patient seen inpatient with mother present at bedside.
- Patient is drowsy, but easily arousable and oriented. The patient and mother requesting to remain sleeping at this time, not ready to work WOC team secondary to reported increased pain and tiredness.
- Interview obtained through patient's mother.
- Reported 10/10 pain at surgical site, being managed well with morphine PCA pump.
- Patient laying comfortably in bed, has not ambulated since prior to surgery.
- The patient's mother reported feeling overwhelmed and anxious about pouching needs, possible leakage, and transition back to school with limited nursing assistance available at school.
- Review of systems deferred.
- GI visual and physical examination performed. Abdominal contour smooth and flat, semi-soft, and edematous. Stoma with post-op pouch in place in right lower quadrant.

- Stoma functioning, with green effluent present in the pouch at time of visit.

Loop Ileostomy:

- Right lower quadrant loop ileostomy
- Stoma red, moist, and budded. Stoma edematous. Surgical rod intact.
- Stoma size 2.0 in. x 1.5 in., oblong in shape.
- Both lumens visualized.
- Dark green liquid effluent noted in pouch and on peristomal skin.
- Peristomal skin is intact, with no noted evidence of skin breakdown or erythema.
- Abdomen smooth and flat, semi-soft to palpation.
- Post-operative pouching system in place, slight creasing noted to the skin barrier seemingly from patient sitting up.
- Current pouching system= Coloplast SenSura post operative drainable ostomy appliance

Social History:

- Denies drug or alcohol use. Denies smoking or tobacco use.
- Patient reportedly lives active lifestyle, participates in sports at school.
- Patient is amenorrheic.
- History of malnutrition and failure to thrive. Unknown diet, weight, and present nutritional status.
- Current in school but had taken a short leave from classes prior to surgery due to UC symptoms becoming unmanageable at school.
- Lives at home with mother and father, both parents very involved in patient's care.
- Mother reports she will be the primary care giver upon discharge.

Current Medications:

- Patient receiving intravenous morphine via PCA pump

Most Recent Lab Work/Testing:

- Sodium 135, Potassium 4.8, Chloride 100, BUN 10, Blood Glucose 79
- WBC 8.0, Hgb 8.8, HCT 29.9.2 %, Platelets 251
- No vitals obtained at this visit
- No recent testing or imaging available
- Most recent height and weight not available

Reviewed WOC Patient Education:

IPAA procedure, expectations, and course of treatment.
Loop ileostomy care review, characteristics, and pouching needs.
Stoma pouching techniques/steps (verbal explanation at this time).
Pouch emptying and measuring output (verbal explanation and physical demonstration at this time).
Role of WOC team in treatment plan.
Nutritional needs with loop ileostomy.

Recommendations:

Pouching system- *Coloplast SenSura Mio 1-piece drainable maxi pouch (12") with cut-to-fit barrier*
-wear time goal of 3-4 days without leaking
**Alternative pouching system- *ConvaTec ActiveLife 1-piece drainable 12" pouch with cut-to-fit barrier*
Follow-up, hands on education lessons with patient and parents prior to discharge.
Consult social work team to begin discharge planning and medical support in transition back to school.
Consult nutritional services for patient evaluation.

WOC team will follow up routinely for ostomy needs while patient remains admitted inpatient.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

4. What was your goal for choosing this case?

I chose this virtual situation because during clinical hours I was unable to care for a pediatric patient with ostomy needs. I was also unable to care for a patient post-op from IPAA procedure. I am less familiar with the course of this procedure and wanted to learn and review best practices. I feel I was able to do so and brush up on the information needed through reviewing class notes, the textbook, and online information.

Reviewed by: _____ Date: _____

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		