Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Studnicka_____ Day/Date: 11/28/24

Number of Clinical Hours Today: __8__

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

Preceptor: Corey Smidt__

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.

A 93-year-old gentleman with established urostomy presents to clinic to evaluate his ostomy routine. He is a routine patient that calls a couple times a year when he is in town. He struggles with pseudoverrucous lesions. He recently moved into an independent living facility and has limited space. He reports the appliance change is difficult in his smaller environment. He changed the appliance at midnight because it was leaking. He arrives with the appliance intact so it was not changed. Pictures from previous visits were discussed. Patient reports his peristomal skin is better than the last photo where he had denudement from 6-9 o'clock. His wear time is a week. He soaks in a whirlpool bath (without appliance) weekly. Prior to that he was applying vinegar soaks before bathing. Recommend patient to change the appliance twice a week on schedule (he likes Wednesdays and Sundays if he has to do twice a week) and then he is to perform vinegar soaks for 10 minutes (1:3 ratio vinegar to water) prior to whirlpool. He uses a 1 ¼" precut convex appliance. No further visits at this time. Follow up as needed.

A 68-year-old female patient admitted to the hospital with abdominal pain. She is seen POD #2 after undergoing a sigmoid colon resection with colostomy and Hartmann's pouch placed due to stricture of sigmoid colon with obstruction. She has a history of diverticulitis and IBS. She has been having a moderate amount of loose-liquid brown stool out of ostomy. The appliance is intact. Her granddaughter is present and will be assisting with cares at home. Stoma measures 1 ½" from 12-6 o'clock and it measures 2" from 9-3 o'clock. The stoma is dark red in color. The os is in the center. The midline incision is approximated with sutures. Cleansed incision and applied folded gauze 4x4's and applied a Tegaderm over area. A Hollister 2-piece 2 ¾" flat wafer and 2 ¾" pouch applied. Patient given handouts regarding colostomy care and living with a colostomy. Demonstrated and gave instructions on changing pouch. Briefly review diet and bowel patterns. Goal is to have patient practice unrolling and resecuring the pouch and then begin emptying pouch prior to discharge.

A 66-year-old female with a history of complicated diverticulitis s/p colostomy and end ileostomy. She is admitted with abdominal pain. She is well known to the WOC team after her first surgery in June 2024. Her midline fistula wound manager is leaking. I will expand upon her case below.

Types of patients: Established urostomy, new colostomy with Hartman's pouch, and colostomy with ileostomy and enterocutaneous fistula.

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

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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:

Background (initial visit):
A pleasant 66-year-old Caucasian female patient presents to the hospital with abdominal pain, shortness of breath, and nausea. She is s/p colostomy and end ileostomy with fistula formation. WOC was consulted to assist with ostomy cares and fistula management. Patient is pale and thin. She thinks the wound manager has been leaking "all night." She feels achy and has mild abdominal pain. Her supplies are in the room.

HPI:
Patient has a long history of complicated diverticulitis. On 6/09/24, she underwent an end colostomy secondary to a perforated bowel. After deterioration, patient went back to OR on 6/11/24 for a perforated cecum with end ileostomy creation with subsequent enterocutaneous fistula formation. She has a history of atrial fibrillation (not on anticoagulation), hypertension, malnutrition, and thrombocytopenia. She has been short of breath for the past 5 days prior to admission. She denies fevers but reports chills. She is complaining of nausea and not being able to tolerate much oral food. She reports burning pain with micturition and decreased ability to urinate. She was found to be hypotensive and tachypneic in the ER. She is on the sepsis protocol and being treated with broad spectrum antibiotics. She quit smoking about 30 years ago. She is allergic to sulfa and Augmentin. Family history is noncontributory.

Medications:
Tylenol, amiodarone, Benadryl, iron, miconazole powder, Remeron, omeprazole, Zofran, Zoloft, Flomax, and Imodium.

Labs:
Labs significant for leukocytosis with WBC 18.0. CRP 145. Creatinine 4.5 with baseline 1.2. Glucose 121, BUN 39, NA 132, K 3.3, albumin 1.8, phos 1.1, and GRF 19.

Assessment and Plan:
Patient assessed in the supine position. Abdomen is soft and flat. Midline fistula wound manager is leaking liquid green stool at 6 o'clock. Removed appliances and cleansed skin with warm water. Applied Marathon barrier around fistula area, around abdomen, and over all areas that are very slightly red. Midline fistula open, very small and sits below skin level in a divot area. Distally she has a stomatized fistula near her umbilicus. After Marathon was dry, skin tac wipe applied. Non-alcohol-based paste applied around fistula opening and down into crevice. Cut out Hollister 2 ¾" wound manager (#80070) into an oval opening. Applied a thin layer of non-alcohol-based paste to the back of appliance around opening and then applied a stretched Coloplast Brava protective seal convex ring to the back of the appliance. Applied over fistula area and massaged. Held in place for 10 minutes with patient's hands. Right ileostomy is draining minimal dark brown effluent and the stoma is near skin level. Stoma measures 3/8". Cut a Hollister pouchkin (#3797) a little over 3/8" and applied around ileostomy. Left stagnant colostomy stoma covered with dry gauze and tape. Extra supplies at bedside. Patient to empty wound manager appliance frequently and as needed. She has a graduated container at bedside. Primary nurse updated on cares. Instructed patient to make sure to let nurse know ASAP if pouch is leaking so it can be changed. WOC will follow daily while hospitalized.

Patient is very pleasant with cares. She tolerated change well with no added discomfort. She likes to tilt to her left side with a pillow for some pain relief. Discussed appropriate pressure redistribution measures and titling in bed at least every 2 hours side to side. Surgeon planning to see patient later today.

Patient is on a low-fiber diet. She was encouraged her to eat smaller meals throughout the day. She is to thoroughly chew food. She likes white toast with butter and eggs. Monitor I&O's. Dietary consult to make further recommendations and plan to start clear Ensure.

The rationale behind the treatment plan was to increase wear time and protect peristomal skin. Goal is for patient to start eating and drinking. She needs to start participating more in cares. She is knowledgeable and education evaluation was verified with the teach-back method. Patient is able to empty her pouching system. Patient will be monitor closely by WOC for ongoing needs.

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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)

Appliance change as follows (ideally twice a week and as needed per leakage):
-Cleanse skin with warm tap water and washcloths.
-Cut 1 piece Hollister wound manager (#80070) to fit around midline fistula (pattern in room).
-Heat the back of the wafer prior to application (Patient can put in axilla area).
-Apply Marathon barrier all around wound perimeter of midline fistula and allow to dry.
-Apply skin tac wipe over Marathon barrier and allow to dry.
-Apply non-alcohol-based paste around the back of the wafer and allow to set up for 1 minute.
-Apply Coloplast Brava protective seal convex ring to the back of the appliance over the paste.
-Apply over fistula area and massage.
-Hold in place for 10 minutes with warm hands.
-Cut Hollister pouchkin (#3797) a little over 3/8" and apply over right ileostomy site.
-Apply folded dry gauze 4x4 over left stagnant colostomy.
-Extra supplies at bedside.
-Encourage patient to empty appliance frequently and if ½ to 1/3 full.
-WOC will check patient tomorrow but don't hesitate to call with questions/concerns #7048.
-Continue to monitor I&O's as previously ordered.

-Surgeon to follow up today.
-Patient is being managing by hospitalist team with IV antibiotics and fluids.
-Promote dietary intake. Dietary consult ordered with recommendations for a low-fiber diet. Patient will be started on protein supplements (clear Ensure). She was encouraged to chew food slowly and thoroughly.
-Imodium as previously ordered.
-Encourage patient to lay on left side with head of bed slightly elevated and reposition every 2 hours.
-Patient to be seen by pastoral care today.
-Open curtains in room. Patient likes to see outside.

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

I'm naturally a cheerleader and I love encouraging patients to do the very best they can. The first two cases we saw needed support and encouragement. I was able to empower them and reinforce the treatment plan.

I was told about the trick of having a patient warm the pouch in their axilla or under their thigh. I forgot to do this during the visit but I did add this step to my nursing orders.

I wish I would have gone up at the end of the day to check on this patient again. Just for a quick visit. She was sick. I would like to follow her if she is still in the hospital next week.

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?
I wanted to troubleshoot and be proactive in addressing peristomal skin issues. I was able to mostly complete this goal. I wish I could have seen the urostomy guy's lesions in person, not just photos.

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I was able to measure a stoma!
What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)** Finish reading the Hollister ostomy booklet. Order supplies through DME company for patient. Follow up with recurring hospital patients if possible.

Reviewed by: _____ Date: _____

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