Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Alexis Buehler Day/Date: Monday, December 9, 2024

Number of Clinical Hours Today: 8

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

Preceptor: Heather Lucas BSN, RN, CWON

Clinical Focus: Wound ____ Ostomy _X___ Continence ____

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

Today I saw a good mix of wound and ostomy patients. Our first patient had a large abdominal surgical wound that dehisced and was receiving negative pressure wound therapy (NPWT) with instillation of ¼ strength Dakin's solution that was due for a dressing change. The wound had a 9 cm tunnel communicating with a prior drain site. A small pocket of purulent fluid was in one corner of the wound. We did a whole new setup for the NPWT installation, including changing the canister, the installation bottle, and the cleanse choice honeycomb black foam dressing specific to this type of NPWT used with instillation for the removal of wound debris.

We saw a patient in their early 20s for new loop ileostomy education who had a lot of special considerations that needed attention for education to be successful. The patient is a transgender male who is wheelchair-bound, living with autism and requires an in-person American sign language interpreter for their education due to hearing loss. Fortunately, the hospital already had an in-person translator at the bedside available for this patient daily from 0700 to 1700, and we did not have to coordinate an interpreter ourselves, which could have delayed education. The patient was terrific and had done some research before admission. Their mom was at the bedside, but only as an observer; the patient was very independent and prepared. They also had a small stuffed dragon for which they'd made a tiny stoma, and a small ostomy pouch for the dragon that was full of brown glitter, one of the cutest things I've ever seen. This education took about twice as long as our other education visits because of these extra considerations, but it was clear that our time was well spent.

I also saw a patient today who was consulted for possible fistula management. While with the patient, we incidentally discovered a hospital-acquired pressure injury underneath their gastrostomy tube, just adjacent to their fistula site. This patient will be the focus of my clinical journal.

Chart note:

Age/sex: 62 year old female
PMHx: hypertension, asthma, GERD, depression, type 2 DM, esophageal adenocarcinoma s/p minimally invasive esophagectomy (MIE) at outside hospital in December of 2023, now s/o multiple revisions and debridements of her esophagostomy in January, May, August, and September of 2024
HPI/Surgery: In October of this year, the patient had an EGD with dilation that showed stenosis at the level of the skin of cervical esophagectomy. She was admit to the hospital at the end of November for surgical intervention with the goal of a therapeutic outcome. She was hospitalized for about a week before going to the OR, and she is now s/p left neck exploration, clavicular reconstruction and sternectomy, cervical esophago-jejunostomy with supercharged free flap, exploratory laparotomy, J-tube removal, lysis of adhesions, g-tube insertion into the remnant stomach, roux-en-y jejunojejunostomy, and bilateral pec flaps. On POD 6 the patient had to return to the OR for a mispositioned g-tube (tip found to be in the abdominal wall). The g-tube was replaced with a larger, 20F tube, and a penrose drain was placed in the abdominal wall exiting through the old j-tube site. Since this return to the OR, bilious contents have been draining from the old j-tube site.
Social history: The patient lives in a single family home with her two adult daughters and her granddaughter. She has not worked in over a year since her initial diagnosis and surgical procedures. She has no significant history of alcohol, or drug use. She smoked cigarettes for 30 years and quit in December of 2023 just before her esophagectomy. At baseline she walks with a cane. She identified her family as her strongest support system.

(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.

Labs: Patient has serial CBC, BMP, magnesium, and phosphorous lab draws ordered. While many of her lab values are out of range, they are consistently out of range and there are no dramatic changes in these values that need to be addressed at this time. She is receiving TPN for baseline nutritional needs and is on Q6 blood glucose checks with subcutaneous insulin managed by the glucose management team. Insulin is ordered Q6 to align with blood sugar checks. Blood sugars have been stable and within the defined range of 70-120. Vancomycin troughs are ordered for vancomycin therapy, and renal function is being monitored by the unit pharmacist with no acute concerns. Vancomycin and all other IV antibiotic therapy recommendations have been provided by the infectious disease team.
Meds: As mentioned, patient is on vancomycin therapy. She is also receiving courses of intravenous ceftriaxone, cefazolin, and flagyl. She is on subcutaneous insulin for blood sugar control, and a hydromorphone PCA for pain management.

Assessment/Encounter:
Patient seen for: new consultation for pouching bilious fluid exiting from old j-tube site with c/f fistula formation; incidentally found a hospital acquired pressure injury on patients abdomen underneath the bumper of her new g-tube secondary to the bumper being tightly sutured to the abdomen
LOC: awake and alert, sitting up in the recliner watching videos on her phone
Subjective interview: Patient reports frustration over her multiple hospitalizations and returns to the OR over the past year. She is very seasoned to the healthcare environment and states to the wound care team that she prefers caregivers "who know how to do their job". Wound care team discussed ideas of management for bilious drainage exiting from old j-tube site and patient was agreeable. Reports that her pain is well controlled with PCA. She has been NPO "for a while now" and expressed that she "would do anything to eat a pickle. Even just a sip of pickle juice would be amazing", but also states that she understands why she cannot have anything to eat or drink at this time, even for comfort.
Physical assessment: Patient is neurologically intact, alert, and oriented. She reports having numbness and tingling in her LLE secondary to a patellar injury she sustained years ago, which is why she uses a cane at baseline. Her abdomen is soft and rounded, and she has active bowel sounds in all 4 quadrants. She is continent of urine and has been having multiple loose BMs. C.diff has been ruled out. She is deconditioned but working with physical and occupational therapy.
Wound assessment: Full thickness wound found at site of previous j tube, full assessment of tissue type was limited on exam due to depth and presence of penrose drain that is sutured to the abdominal wall. Visible tissue is moist, pink/red non granular, and there is a moderate amount of bilious drainage, indicating need for further focused assessment by surgical team and diagnostic imaging to rule out fistula formation and/or anastomotic leak. Periwound is slightly denuded with maceration. There is poorly defined moisture-associated skin damage extending laterally from the periwound, that appears to follow a LLQ abdominal crease and the path of gravity - per patient, this is secondary to bilious drainage free flowing down patients' abdomen while sitting up in the chair. Newly placed g-tube visualized superior to the old j-tube site. G-tube is sutured tightly to the abdominal wall. Upon further inspection, the wound care team incidentally discovered full thickness tissue loss with slough underneath the g-tube bumper, which was declared as a hospital acquired pressure injury secondary to a medical device. The tube was not stabilized with an anchoring device and was also found to have a significant amount of drainage exiting from the insertion site that was trapped underneath the bumper, further contributing to the injury. Following discussion with the patient and the surgical team, wound care nurses removed the sutures from the g-tube bumper and relieved tension at the insertion site. Please follow plan of care (POC) for both the old j tube site and the new g tube site as outlined below.
Education: Discussed POC with patient as outlined below. Educated to notify bedside nursing if dressings put into place become saturated between scheduled dressing changes. Educated patient on steps taken during wound care, and provided patient with printed out hard copy of wound care instructions per patient request. Educated patient to advocate for herself if she has any concerns. Please contact the wound care team with any questions or concerns related to wound care and moisture management.

WOC Plan of Care (include specific products used)

To wound at previous j-tube site:
***Supplies Needed:*
Washcloths
3M Cavilon skin barrier film
Hollister stoma powder
Measuring template (taped to patient's white board)

(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.

Medical adhesive remover spray
Eakin Fistula pouch 4.3 x 3
Eakin 4 x 4 square, cut in to strips
Scissors

***Steps for pouch change, please read carefully (may refer to photos in most recently filed wound care team note):*

1) Gather supplies, perform hand hygiene and put on gloves. Remove pouch using medical adhesive remover spray
2) Cleanse skin and wound gently with washcloths moistened with warm water. Pat skin dry.
-Please do not use premoistened incontinence wipes or soap. This will prevent proper adherence to the abdomen and can lead to leaks from the pouching system.
3) Use pre-made template from wound team (taped to white board in patient's room). Trace pattern from template onto the back of the Eakin fistula pouch and carefully cut out the tracing. Save new template for next pouch change.
4) Create crust around wound site: apply stoma powder liberally to periwound irritation, and brush off excess powder. Pat Cavilon skin barrier film over areas with powder. Allow to dry, and repeat once more with a layer of stoma powder and a layer of Cavilon skin barrier film. Allow to dry.
5) Use cut strips of Eakin 4x4 sheet to fill abdominal creases located at 3 o'clock and 9 o'clock
- In the 3 o'clock crease, please place the Eakin strip *underneath* the penrose drain. This will help with the seal and adherence.
6) Trim off the edge of the pouch that is in close proximity to the g-tube bumper
7) Remove backing from Eakin pouch and line the edges of the cut opening with the remaining cut Eakin strips
8) Carefully apply Eakin fistula pouch over old j-tube opening, including the penrose drain, and gently press to mold into the abdominal skin
9) Place a warm blanket over the patient's abdomen and the appliance to further enhance adherence and provide a better seal.

***Tips to help make a successful dressing and pouching system:*

- Change pouch every 48 hours and as needed for leaking. Expect 24-48 hours of wear time.
- Replace pouch following the steps above if burning or itching is reported by the patient, as this may indicate leakage.
- Empty pouch when 1/3 to 1/2 full and have patient practice this skill. Do not allow pouch to overfull, as this can lead to leakage.
- Never reinforce dressing. If the pouch is leaking please change the dressing following the above steps. Document dressing change in flowsheets for tracking of wear time. Wound care team will check in daily on Monday-Friday to assess seal and wear time, but overall care of this site is the responsibility of the primary nurse.
- Please follow all instructions provided exactly. Do not deviate from this order so that future troubleshooting needs can be focused and successful.

To G-tube site:

1) Gently cleanse the site with normal saline moistened gauze. Allow to dry.
2) Cut two small rectangular pieces from a 4x4 sheet of Mepilex lite, and gently place under the bumper
3) Stabilize g-tube with a tube anchor to help reduce tension and risk for erosion at the tube insertion site
4) Change dressing every other day, or as needed for soilage, saturation, and/or dislodgement
- patient may change mepilex lite in between scheduled site care for increased management of drainage if indicated

The wound and ostomy care team will return daily to assess pouching. Please notify the team if the pouching system leaks, or if you have any questions or concerns. If the wound care team is not available, please notify the primary team.

Measure oral intake of fluids and meals and document in the intake and output flowsheet every 6 hours.

Empty the pouch when it is half to one-third full, measure output in a graduated cylinder, and document the amount, color, and consistency in the intake and output flowsheet every 6 hours. While emptying the pouch, educate the patient on the actions performed and encourage them to participate if they would like.

Ambulate the patient short, progressive distances 3 times per day.

(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?

This was a great learning experience for me to have during clinical. Since we received the consult, we were the first to see the patient and had to initiate the plan of care. Pouching abdominal drainage is unique to each patient and their needs. This situation was a good example of patient advocacy and interdisciplinary collaboration with the surgical team and the patient. It also required a lot of critical thinking and knowledge of wound, fistula and percutaneous tube care. It's also important to note that while the patient did not have a confirmed fistula, many situations are successfully managed as such until reaching any further conclusions and selecting further treatment or management options that may be indicated. Due to the complexity of the dressing change, I think I would have placed the photos within the steps of the printed step by step instructions that were placed at the bedside for nursing to reference when performing pouch changes. I think providing the photos to nursing this way will help reduce risk for potential errors or inconsistencies when carrying out the order, or if the patient discharges or transfers to a new unit or facility.

Goals

What was your goal for the day?

My goal was to see peristomal breakdown or ostomy pouching complications/troubleshooting. While this was not *exactly* within my goal it was still a wonderful learning opportunity and incorporated information related to fistula pouching and percutaneous tube management and care.

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

I would still really like to see or discuss peristomal skin breakdown and discuss techniques other than crusting that are used to help a patient manage this type of issue.

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	✓	

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.