Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Studnicka Day/Date: 12/26/24

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 73-year-old female admitted to the hospital following an ischemic stroke. She is an established ileostomy of 18 years. She is having appliance leakage issues. Appliance was changed by primary nurse during the night. She reports "this isn't on right." She reports "I don't want to use those appliances." Patient informed that they are her own appliances from home and she states "okay." Patient is disoriented to time and place. Upon assessment, appliance is almost completely off and leaking, hernia belt slid up to just below breasts and not around appliance at all. Appliance removed and peristomal skin cleansed with warm water. Peristomal skin denudement present with distal skin stripping. Stoma is red with center os. Stoma appears to be telescoping with her hernia and retracting down. Marathon skin protectant applied to denuded skin and allowed to dry. No sting skin prep. spray applied over Marathon and allowed to dry. A Hollister 1-piece soft convexity cut at 1" and no sting paste applied circumferentially to the back of the wafer. Appliance applied and center ring massaged. Patient's hernia support belt applied. Will need to assess for draining appliance every 1 hour while awake and empty appliance when 1/3-1/2 full. Patient has an ileostomy that will drain a lot, especially after any oral intake. So please monitor closely and empty as previously directed. Patient needs to wear a hernia support belt over and around her appliance 24/7 (it fits over the appliance and the drain part of the pouch comes through the hole). When appliance needs change (every 3 days and with leakage and before and after therapy sessions), patient is wearing a Hollister 1-piece soft convex appliance. Extra pre-cut to 1" pouches at bedside. For appliance change: lay patient down flat in bed, apply Marathon skin protectant and allow to dry followed by no sting skin prep and allow to dry. Apply a ring of paste circumferentially around the opening of the wafer. Apply the pouch around the stoma and hold in place and massage for 10 minutes. WOC will follow up tomorrow.

-A pleasant 71-year-old male patient admitted to the hospital with abdominal pain. He has a history of an end ileostomy from previous bowel issues and perforation. He is 8 days s/p ileostomy take-down with colostomy resection secondary to enterotomy adhesion repair. Patient states he is having more output from his colostomy and much less from midline incision separation and JP drains on the right side of abdomen. Effluent from colostomy is soft yellow stool. Appliances removed. Colostomy peristomal skin cleansed with warm water as well as skin around midline incision and JP drains. Colostomy stoma is pink and protrudes with center os. Surgeon in to assess patient's abdomen. Abdomen is flat. No leakage of stool/drainage from anywhere but at colostomy site. Peristomal skin intact. Unfortunately, as soon as surgeon left, green (bile) drainage started coming from mid abdominal incision separation site. A 2 ¼" Hollister wafer and pouch applied to colostomy using a thick circumferential bead of no sting paste. A 2 ¾" Hollister appliance applied over midline incision separation using an Eakin seal to the back of the wafer. Site warmed with hands and massaged for 10 minutes. Continue to pouch as long as midline incision continues to drain bowel/bile effluent. Dry gauze dressings applied over JP drain sites per surgeon request, change daily. Surgeon called and updated about bile drainage. Plan to change appliances every 2-3 days and as needed leakage. WOC will reassess tomorrow.

-A pleasant 73-year-old female presents to the outpatient WOC clinic for evaluation of peristomal skin irritation. She is s/p loop colostomy in July 2024 secondary to complicated diverticulitis and small bowel obstruction. She is living at a SNF but will return

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to her ALF on Monday with assistance from home health. Stoma to left abdominal quadrant measures 1 ¼", protrudes above the abdomen with a down tilt. Patient has a reducible hernia developing. Significant peristomal skin irritation present. She is wearing a moldable 2 ¾" 2-piece Hollister appliance and wafer. She denies leakage when asked. She is knowledgeable and proficient in emptying the appliance. She prefers to burp the appliance from the bottom vs lifting the wafer edge. Appliance removed and skin cleansed with warm water. Tenderness noted to peristomal skin. Peristomal skin crusted with powder and no sting skin prep spray. A flat 1-piece Hollister appliance cut slightly larger than 1 ¼" with an Eakin ring (per patient's request) applied. Appliance applied to abdomen with pouch pointing between her legs to allow emptying in the toilet. Patient taught how to work the inner ring and instructed to hold hands over appliance post application for 10 minutes. Home health to assist with appliance changes twice weekly. Trial 1-piece for simplicity and add back Eakin ring per patient's request. Patient to call if she would like WOC to order her supplies upon home health discharge and if she would like measured for a hernia support belt. Follow up with outpatient WOC as needed. Available by phone if needed also.

-A 69-year-old female presents to clinic for stoma remarking. She underwent a colostomy in February 2024 secondary to fecal incontinence. Patient presents requesting new marking be done for a planned location change to her current colostomy site. Her case will be expanded upon below.

Types of patients seen: hospitalized established ileostomy, post-operative ileostomy take-down with colostomy and midline incision, outpatient loop colostomy with peristomal skin issues, and outpatient colostomy stoma remarking.

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:

Background:
A very pleasant Caucasian 69-year-old female presents to the outpatient WOC clinic for stoma remarking. She is s/p colostomy formation in February 2024 secondary to fecal incontinence and lymphocytic colitis. Patient has struggled with leakage issues ever since. Patient states frustration with the location of the stoma and voices she is tired of dealing with all her leakage issues. She is unhappy with how high and near the umbilicus the stoma is. She has seen numerous ostomy nurses since surgery but still hasn't had satisfactory success. She comes to clinic her husband and is ready for stoma remarking. She has an area in mind she would like the new stoma placed. She states she has been doing "okay" with her current appliance but has reoccurring peristomal redness. Her wear time is 1-2 days. She recently added back no sting powder. Patient is feeling well. Her surgery is scheduled for next week.

HPI:
Patient has a history of fecal incontinence, pelvic floor dysfunction, and lymphocytic colitis since 2013. Despite medical management for lymphocytic colitis, she continued to struggle with full fecal incontinence most days of the week. Patient participated in pelvic floor PT and had been on antidiarrheals and biologics without significant improvement. She underwent laparoscopic sigmoid colostomy creation in February 2024. Patient has struggled with keeping appliance on and requests stoma remarking. Colostomy revision surgery is scheduled for next week at Nebraska Medicine. Patient feels well. She has a history of hypothyroidism, anxiety, hyperlipidemia, IBS, microscopic colitis, osteopenia, osteoporosis, peptic ulcer disease, depression, GERD, gastritis, and allergic rhinitis. She denies constitutional symptoms including fevers, chills, or sweats. She denies chest pain. She is a retired nurse. She lives with her husband on a farm. BMI is within normal range.

Medications:
Vitamin C, calcium carbonate, clonazepam, Prolia, hyoscyamine, levothyroxine, meclizine, mesalamine suppository, multivitamin, omeprazole, rosuvastatin, sertraline, and Imitrex.

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Labs:
BMP- glucose 126, creatinine 1.15, sodium 127, calcium 7.8, GFR 52, the rest are normal.
CBC- all are normal.
TSH- normal at 0.534.
Lipid panel- cholesterol 236, HDL 73, the rest are normal.
HgA1c- normal at 5.3%.

Assessment and Plan:
Patient signed consent for treatment of stoma remarking and verbalized understanding of the procedure. Orders from surgeon in Omaha scanned into Epic. A brief description of the marking process was explained. Marking kit obtained and hand hygiene performed. Patient is ambulatory with no use of assistive devices. Patient was assessed clothed and in the sitting position to assess beltline. Patient removed clothing to expose abdomen. Patient's abdomen was observed while laying, sitting, standing, and bending to avoid creases, valleys, and folds. While laying on back, patient lifted head and shoulders while abdominus rectus muscle was palpated. Location within the rectus and two inches from umbilicus chosen within in the LLQ based on patient's preference site. Scars and bony prominences were avoided. Site in her visual field and on a flat area. Site was on summit of infra umbilical mound. Site was cleansed with alcohol wipe and allowed to dry. Indelible marking pen used to make a dark circle and a transparent film dressing applied over the site. Marking pen and extra transparent film dressing given to patient if she needs to darken the area or if the film falls off. Lifestyle habits taken into consideration making sure marked site is not too high or close to umbilicus. Patient has normal dexterity. Patient states understanding that this is just a suggested site, and that the surgeon has the ultimate decision. Preoperative physical has been completed by PCP. Patient will have stoma revision next week at Nebraska Medicine.

Patient reports her stool is fairly thick and pancakes out the side of the wafer and at times requires daily changes. Patient is removing the pouch and cleaning the stool from around the wafer. Appliance removed. A nearly flush stoma near and above her umbilicus is noted with a dipped down os. Peristomal skin is slightly red circumferentially. Peristomal skin cleansed with warm water and washcloth. Crusted peristomal skin with powder and sealed in with no sting skin prep spray. Cut 1 piece with filter soft convexity Convatec appliance to 1 ¼" (32mm). Eakin ring applied to back of wafer and no sting paste applied at the 3 and 9 o'clock crease. Paste allowed to dry. Applied wafer on flat abdomen and massaged seal. Patient heated site with hands. Lubricating jelly into pouch. Belt applied, but patient states she does not like it.

Patient is well-informed about how a colostomy looks, feels, and functions. She understands peristomal complications can still occur including leakage and skin irritation. She plans to continue with current Convatec appliances and receives supplies through Triumph. Patient is ready for an improved quality of life and seems positive the new marking will help her overall well-being. Patient and husband verbalize understanding and stoma marking note documented in Epic.

The rationale behind the treatment plan was to explain the stoma marking procedure, mark the optimal site, and minimize any potential post-operative complications.

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)

Patient seen for stoma marking and reapplication of appliance to current colostomy site.

Ostomy appliance change as follows every one to three days and as needed leakage:
-Remove appliance using the push-pull method.
-Gently cleanse skin with warm water and pat dry.
-Crust peristomal skin with Adapt stomahesive powder and seal in with no-sting Smith & Nephew skin prep spray.
-Cut 1-piece with filter soft convexity Convatec appliance to 1 ¼".
-Apply Eakin ring to back of wafer.
-Apply no-sting Coloplast paste to 3 and 9 o'clock creases. Allow paste to dry.

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-Apply wafer on abdomen and massage seal.
-Heat appliance with hands for 10 minutes.
-Add lubricating jelly into pouch.
-Consider support belt.

-Supplies previously ordered from Triumph.
-Change appliance at the first sign of leakage and empty pouch when 1/3 to 1/2 full.
-Patient to eat four to six small meals a day and chew foods thoroughly.
-Avoid odor and gas producing foods (beans, cabbage, onion, beer, sprouts, broccoli…).
-Consider Chlorophyll tabs and/or bismuth subgallate to help with odor.

Stoma marking:
-Consent was obtained.
-Abdominal assessment made with identification of the rectus abdominis muscle.
-Assessment made in all different positions.
-Creases, folds, bony prominences, and scars avoided.
-Marked in patient's visual field two inches away from umbilicus on a flat area of the LLQ.
-Site marked with a dark circle and covered with transparent film.
-Marking pen and extra transparent film dressing given to patient.
-Only 1 site marked which was patient's preferred site.

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

I provided very detailed and thorough care for the confused ileostomy patient. I involved the primary nurse, even though she was busy but I felt this patient would need frequent reinforcement and assessment during hospitalization. I wanted to empower the primary nurse and patient! I wonder if this patient was messing with her appliance system. I didn't think of it until later to ask the primary nurse if that could be the case due to patient's ongoing confusion.

I had well-informed patients but I wondered if the stoma remarking patient ever went to an ostomy support group. I think even though she is getting the stoma moved, if she struggles or has any postoperative issues, I think she would need the support. I should have mentioned this.

I forgot to put a stoma marking kit into my ostomy tool kit.

I should have given the colostomy patient transitioning to ALF written dietary information in regards to her colostomy.

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 mark another stoma. I was able to meet goal! Interestingly enough, it was a remarking!

I wanted to see an infant with an ostomy or help someone with a different cultural background. I was unable to meet goal. I did talk with Corey about her experience. I found out we have Spanish Hollister kits.

I was able to make an ostomy kit and take it to the floor!

I wanted to perform colostomy irrigation. Corey said it is rarely done. I talked with another ostomy nurse who had experience with the procedure. She discussed that patients often find the irrigation process takes so many hours and in our fast-paced culture today, patients don't want to spend hours irrigating. But on the flip side, then they don't have to worry about pouching. I think for the right motivated patient with a stable sigmoid colostomy it could be a game changer so I'll have to remember to routinely add this to

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my practice when appropriate.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
I want to participate in extra learning opportunities as clinical time is wrapping up. I want to explore past ostomy situations (like the mini case study) and make recommendations providing Corey with rationale.

I want to look up if the hospital has policies for ileostomy lavage and colostomy irrigation.

I want to practice ordering supplies again.

I would like to go over different products on contract as well as other products available while discussing pros and cons and cost-effectiveness of each category.

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: _____

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