Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Kara LaTouche_____ Day/Date: __12/24/2024____

Number of Clinical Hours Today: _10__

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

Preceptor: _Cynthia Cisneros, CWOCN_____

Clinical Focus: Wound __X__ Ostomy ____ 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.

Today we followed up on a new ileostomy patient for post-operative and discharge education. We followed up on a patient with a newly spontaneous closure of their abdominal fistula as well as pouched a drain site that is leaking feculent drainage. Also implemented wound care concepts for a blister around the peri-tube skin. We also saw the patient that will be described below in this journal entry.

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:

This is the initial consult visit for this 64 y.o male with history of atrial fibrillation (on Eliquis), ESRD (HD T/Th/Sat), HFrEF, hyperlipidemia, hypotension, normocytic anemia, osteomyelitis, peripheral arterial disease, pressure injury of both heels, protein calorie malnutrition, pulmonary hypertension, right bundle branch block, chronic respiratory failure with trach dependence (s/p partial lobectomy), Type 2 DM, chronic stage IV pressure injury, bedbound status, chronic incomplete quadriplegia, CVA, and chronic dysphagia (Dobbhoff in place) who presents from skilled nursing facility for due to their facility policy that they cannot feed through Dobbhoff tubes. Patient is nonverbal and unable to provide any detailed history and therefore history was gathered by reviewing epic chart as well as records from rehab and previous hospitalizations. Patient was admitted to previous hospital from 6/25/24-7/22/24 due to leakage of PEG tube. PEG tube was taken out during that admission and patient had a EGD guided postpyloric Dobbhoff tube placement on July 5, 2024. Per the ER, patient has not had any tube feedings at the rehab. He was noted to be hypoglycemic with blood sugar of 30 upon arrival to the ED. Physician started D5 NS and given treatment via hypoglycemia protocol. In the ED, patient was also noted to be hypotensive cuff pressures. ED resident placed a left femoral arterial line which showed elevated blood pressures in the 130s. ED ordered one-time dose of IV vancomycin and cefepime for possible infection his pressure injuries and hypotension. Patient however has remained afebrile in the ED. He has not had any elevation in white count and lactate is within normal limits. Patient is on ventilator via tracheostomy. Diverting colostomy created 11/13/2023.

Arrived bedside with Cindy Cisneros CWOCN, patients primary RN, and Wound MD. Patient on ventilator via tracheostomy, he follows some commands and able to nod/gesture but is not consistent with responses. Patient is not teachable for his colostomy and is dependent on nursing for all of his care. He is on a low air loss mattress and has 15 degree turning wedges and bilateral heel suspension boots in place. Our team is not managing patient's multiple wounds, please page Wound MD for any wound questions

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or concerns.

Patient's current Braden score of 9 indicates patient is at risk for development of additional pressure injuries. Offloading surfaces and PIPP order set have been implemented and skin care products in place. See plan of care below.

We assessed patients existing diverting colostomy which appears to be leaking beneath the wafer at the inferior aspect of the pouching system. There is a small amount of Bristol stool scale type 6 effluent noted in ostomy pouch which was measured at 100cc. We removed old appliance with Esenta adhesive remover spray, then cleansed peristomal skin and stoma gently with warm water-soaked gauze and pat dry. The stoma was measured with measuring guide and is 1 ¾ by 1 ¼ inches. Crusted peristomal skin with a light dusting of Stomahesive powder then sprayed Cavilon no-sting spray on top of the powder. Mold and applied a strip of Eakin cohesive to inferior part of stoma to fill in the creases in the abdominal fold from the parastomal hernia. Then molded and applied a 2in Eakin ring around entire stoma. Cut to fit the Hollister 1-piece flat pouching system by cutting the opening 1/8 inch wider than the stoma size. Removed clear backing and paper from appliance system, then affixed to skin. Placed warm blanket over pouching system for 2-3 minutes to activate adhesive.

We then assessed patients previous PEG tube site which is now a gastrocutaneous stomatized fistula. The fistula was covered with 4x4 gauze and Medipore tape which was completely saturated with dark green and transparent drainage. Patients gown and bed sheets were also saturated with this drainage. We removed the gauze and cleansed the peristomal skin with saline moistened gauze and pat dry. The stomatized fistula measures 7/8 inch. There is peristomal skin maceration with multiple superficial skin erosions noted circumferentially around stoma which measures up to 3 inches. We treated the area with the crusting method by applying a light dusting of Stomahesive powder then Cavilon no sting barrier spray. The Stomahesive powder is a hydrocolloid and will assist with healing. We then applied a 4in Eakin cohesive ring around stoma, which is a hydrocolloid and will also assist with healing. We then cut the wafer to fit the stoma size, cutting 1/8 inch wider to accommodate the fistula. We cut slits in a "starburst" pattern around the opening for improved appliance adherence. Then applied the Hollister 1-piece flat cut to fit pouching system over the stomatized fistula to contain the drainage and allow the peristomal skin to heal as well as allow nursing to measure the output. Extra pouching system supplies left at bedside.

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)

Ostomy and Fistula care orders:
Change q 3-4 days
Change immediately for leakage
Empty when pouch is 1/3 full
Nursing to assess q4h for leakage and for emptying
Notify surgeon for stoma color changes such as dark red/black colored area, lack of output, or liquid output
Patient currently unable to assist with appliance changes or emptying. Include family in teaching.
Referral sent to outpatient ostomy clinic for patient to follow up after discharge. Case manager following while inpatient for ordering supplies for discharge.
Consult was already placed for nutrition by attending.

Colostomy appliance orders:
1. Remove appliance with Esenta adhesive remover spray
2. Cleanse peristomal skin and stoma gently with warm water + gauze. No Bath Wipes… as pouch will leak.
3. Pat dry
4. Measure stoma with measuring guide and use measurement to assist with cutting wafer to appropriate size
5. "Crust" skin with a light dusting of Stomahesive powder then spray Cavilon no-sting spray on top of the powder
6. Mold and apply a strip of Eakin cohesive to inferior part of stoma to fill in the creases in the abdominal fold from the parastomal hernia.
7. Mold and apply a 2in Eakin ring around entire stoma

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8. Cut to fit the Hollister 1-piece flat pouching system as well as cutting the opening 1/8 inch wider than the stoma size.
9. Remove clear backing from appliance system, then affix to skin.
10. Have patient place hand over appliance or apply warm blanket for 2-3 minutes for good seal.

Fistula pouching appliance orders:
1. Remove appliance with Esenta adhesive remover spray
2. Cleanse peristomal skin gently with saline moistened gauze. No Bath Wipes… as pouch will leak.
3. Pat dry
4. "Crust" peristomal skin with a light dusting of Stomahesive powder then spray Cavilon no-sting spray. Repeat this step 3 times to treat and protect peristomal skin irritation
6. Mold 4in Eakin ring around stoma
7. Cut to fit the Hollister 1-piece flat pouching system. Cut slits in a "starburst" pattern around the opening for improved appliance adherence.
8. Remove clear backing from appliance system, then affix to skin.
9. Have patient place hand over appliance or apply warm blanket for 2-3 minutes for good seal.

Pressure Injury Prevention Protocol:
- Implement pressure reducing surfaces I.E. seat cushion, offloading boots, low air loss mattress ordered.
- Reposition using lift sheet/pad every 2 hours, limit number of layers beneath to no more than 2 if possible.
- Provide position changes while up in chair.
- Remove pressure reduction devices per shift to assess the skin.
- Keep heels off bed and on chair cushion when in recliner.
- Apply transparent gel silicone border sacral dressing 9x9 to sacrum with good contact. Dressing can be left in place for 7 days but should be removed if dressing becomes cloudy, dislodged, or soiled underneath the dressing. If applying to sacrum be sure to bend dressing to fit into gluteal cleft. Step by step instructions for application are on the package. Wounds can be assessed through the transparent dressing qshift.
- Notify physician of any skin alteration and initiation of this protocol.

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

Patient is in critical condition and unable to contribute to the plan of care. During next visit may need to reach out to family to determine their involvement once closer to discharge. Will reassess patient next week to assess peristomal skin around gastrocutaneous fistula to determine if crusting method was enough to heal the wounds. Otherwise, may need to escalate care and apply alternative dressings such as a solid hydrocolloid.

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 for today was to evaluate a patient with a complex history including a fistula, colostomy, and multiple wounds. We successfully completed the plan of care for this patient. This patient has both an ostomy and fistula that is being managed by our team. The patient's ostomy is slightly complex due to a parastomal hernia and the gastrocutaneous stomatized fistula is exhibiting peristomal irritation and requiring pouching. I met this goal by completing the direct patient care and creating a plan of care for the patient's hospital stay.

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

My learning goal for my next clinical day would be to complete a day of teaching for a new ostomy patient by reviewing our discharge education instruction packet.

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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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