Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Nnechi Chidueme_____ Day/Date: __sept 28 2021_____

Directions: ***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, s***select one patient each clinical day and complete ***plan of care and chart note.*** This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment	**Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc.** ***PMH: Urothelial carcinoma, of the bladder s/p radical cystectomy, with In, s/p Indiana pouch, vaginal fistula, poly substance abuse, Hep C, rectovaginal fistula, AKI, acidosis. On hospice.*** ***Medications*** ***Nystatin 100,000 units/g 1 app BID, Dexamethasone (DoT) 10mg, Enfortuma Vedotin (DoT) In sodium chloride 100ml IVPB, Zofran 8mg, 4ml. Pantoprazole 40 mg tab QD. Oxycontin 20mg 2-tab P.O q 8hrs Quetiapine 100 mg, one tab q nightly, Gabapentin 300mg BID.*** ***Labs*** ***CBC: WBC 14, H/H 7/21.4, Platelet 464, BMP: Sodium 127, Potassium 4.3, Chlorine 100, CO2 19, BUN 23, CR. 1.39, Glucose 88, Mag. 1.7, Phos 5.8, calcium 8.4, LFTs Total Protein 7.0, AST 10 , ALT < 7, Bilirubin 0.2, Alk. Phos. 18, Platelet 464.*** ***Pt is a 56 y/o female with urothelial cancer with Indiana pouch also have rectovaginal fistula , she was seen by urology who recommended that Pt is not a candidate for surgery given her prognosis, Palliative care was recommended .Wound care consulted for management of the fistula and Indiana pouch. An external urinary bag was applied to collect stool and urine draining from her vagina, but she took it out stating that it irritates her skin This is a follow up visit.***

Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? 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.

Pt noted with stool and urine oozing from her vaginal orifice at the fistula site, perineal area and gluteal noted with denuded skin r/t incontinence associated dermatitis, Pt verbalized pain of 10/10 around the site with denuded skin, Pain medication administered as ordered. Stoma site for Indiana pouch noted to be beefy red with a urinary catheter inserted to continuously drain the urine with periodic irrigation to flush out mucous. The goal is to have patient straight catheterize herself periodically as it should, but patient is too overwhelmed to perform catheterization. Denuded skin cleaned with soap and water , pat dry, then nystatin powder applied then cavilon no sting barrier film sprayed on it , covered with Calmoseptine ointment . Pt encouraged to start catheterizing every 4 hours and to irrigate with120 ml of sterile water every 6 hrs. Pt encouraged to drink 8-10 glasses of water every day. She is encouraged to eat meals high in protein carbohydrate, fruits, and vegetables.

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WOC specific medical & nursing diagnosis	WOC Directive Plan of Care (Base this on the above data. Include specific products)	Rationale
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:	**,**	
Alteration in skin integrity r/t IAD	***Wash denuded skin with soap and water, pat dry then apply skin barrier powder dust off excess powder then spray cavilon no sting barrier film. Apply calmoseptine ointment BID and PRN after episode of incontinence. Assess Pt ' s skin and incontinence every two during turning and repositioning***	This will protect the skin from further deterioration. Acidic PH of stool and urine can cause further deterioration
Infection r/t IAD	***Treat infection with nystatin 150,0000 units topical to denuded area BID***	It will facilitate healing . IAD & fungal infection do coexist.
Hypovolemia and weight loss r/t high output drainage from the fistula and Indiana pouch	***Instruct patient to choose foods that have protein, carbohydrate, fruits, and vegetables, avoid carbonated, caffeinated drinks. Initiate a diet consult as patient may be losing weight. Encourage Pt to eat healthy preferred foods. Encourage Patient to drink 8-10 glasses of water daily.***	Increased food intake will result in increase calorie intake and increase weight gain and decrease weight loss Increased fluid intake will decrease the risk of dehydration.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	***This will increase patients' level of pain but will help with healing of denuded areas. Alternative would be placing an external fecal or urinary pouch to divert the fistula drainage early before perineal skin became so bad.***

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	Yes, I was able to see this patient that had an Indiana pouch and a fistula
What are your learning goals for tomorrow?	Going to see a hyperbaric chamber and shadow a nurse delivering therapy

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(Share learning goal with preceptor)	

Number of Clinical Hours Today: eight

Care Setting: __ Hospital X ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _eight_ Preceptor: __Kim Mauck_____

Reviewed by: _____ Date: _____

**References are not required for daily journals

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