Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _ Amy DeMattio_____ Day/Date: 04/27/23

Number of Clinical Hours Today: ___9_ Care Setting: _X__ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: _6____ Preceptor: ____Karen O'Brien_____

Journal Focus: _____Wound ___X__ Ostomy _____Continence _____Combination Specify: _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. 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 by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.** **49 yr old male recently diagnosed with a sigmoid mass at another facility. Patient had noticed blood in his stool for a while but did not think it was actually blood. He has not experienced any weight loss. The report from the biopsy from the colonoscopy did not reveal invasive cancer however it was suspicious. Past medical history are burns on his entire chest, abdomen, and back from 1996 and skin grafting was done to the left side of the abdomen most of the burns are superficial markings. He does have a folic acid deficiency. Medications included Vitamin D2 and folic acid 1 mg tablet daily. Has no known allergies. No lab work available at this visit.**

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

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. Write in a manner others will be able to understand and be able to interpret your plan of care.

This is the initial visit for pre-operative teaching and site marking. Patient watched the preop video for ostomies from Cleveland Clinic. Questions were asked by the patient after the video. Patient had questions about his post op education and would his wife be able to be there so that she can help him when he goes home. Explained that depending on his length of stay the inpatient ostomy team will try to be at least twice as they will cover with him how to empty his colostomy pouch, how to change the pouching system and when and decide on what type of pouching system to send him home with. Education was

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done with the patient on the basics of ostomy care, explained that the stoma will be edematous after surgery and that the swelling will go done and size of the pouching system will change. Discussed how to empty the pouch, that it should be emptied when the pouch is 1/3 to ½ full, how to clean the pouch after emptying it, and when to change the entire system. Stressed the importance of keeping the peri-stomal skin clean and cleaning it with soap and water prior to putting on a new pouching system. Complains of skin tissue breakdown and ordering supplies was also discussed.

Explained about the purpose of stoma marking and the procedure was explained and the patient agreed to the marking and verbalized that it was ok. The recuts muscle boarders were located and abdominal contour evaluated in the lying, sitting, and standing position for stoma marking. The stoma marking was made in the RUQ and the patient was able to see the site in the following positions, lying, sitting, and standing. Patient tolerated well. Patient had no further questions at this time. Was very nervous but thankful for the information. Explained that he can follow up in the clinic after discharge if he is having any problems and that he could make an appointment when he follows up with his surgeon since he lives 2 hours away. Talked with him about looking into a home health agency near his residency as they can also help him when he goes home.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
Risk for Impaired Skin Integrity	The patient will maintain the skin integrity around the stoma by instructing patient to clean the peristomal area with soap and water. Educate patient on how to apply stoma powder and barrier if needed, along with the entire pouching system. Patient will identify individual risk factors such as skin changes, color of the stoma, size of the stoma. Patient will measure the stoma size for appropriate 6 weeks after surgery to make the appropriate pouching system changes as the stoma will decrease in size	Ensuring that the patient has is educated on maintaining a healthy peristomal area to optimize adequate wear time for the pouching system. Ensuring that the pouching system fits appropriate and that leaking does not occur will help to protect the peristomal skin from moisture associated dermatitis. Patient will inspect the skin around the stoma noting any rashes, bruises, or irritation at pouch changes. Postoperative edema will cause the stoma to shrink and the size of the

		pouching system will need to be altered to ensure proper fit so the effluent collects and flows from the ostomy and into the pouch to prevent the skin coming intact with the effluent.
Disturbed Body Image	Verbalize of change in body image and fear of rejection or reaction of others.	The patient will verbalize acceptance of having a stoma. Encourage patient to verbalize feelings about ostomy and how their significant other feels about the ostomy. Review the reason for surgery and what the expected outcome will be as if there is a possibly of a reversal in the future.
Risk for Acute Pain	Disruption of the skin and tissues from the surgical incision. Psychological fear and anxiety.	Notable observations such as patient reports pain, guarding and restlessness, changes in vital signs need to be monitored to medicate the patient appropriately. To assess if comfort measures or medication is needed for the pain. Use the pain scale to access the serverity. Provide comfort measures such as a back rub, repositioning and assure the patient that the position change does not injure the stoma. This reduces muscle tension and promotes relaxation.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** **Tattoo ink was used for the marking. If the patient had an allergy and the surgery was the next day a surgical marker could be used and apply an opsite over the marking.**

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

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	Goal for the day was to do a stoma site marking. Yes I met the goal but I would like to do the education and marking with a little less assistance.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To develop the plan of care for pressure wound.

Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc .	43 year old male with a NPWT for a pilonidal cyst, measurements 7 x 3 x 4, black foam used in the wound, cleansed with saline. Continuous suction at 125mmHG. Patient reinstructed not to have the NPWT disconnected for more than 2 hours. 68 year old female for a return post op visit for a colovaginal fistula repair. Education on a different pouching system done as the patient was having leaking issues due to the location of her stoma. 69 year old female who is a reoccurring patient and has a distal pole. This patient has continuous leaking from her pouching system and the last change done at the clinic resulted in a wear time of 3 days which is the longest that she has gotten. 28 year old male post op first visit for skin irritation. After examining the stoma and the peristomal area the patient was put in a smaller pouching system as the stoma is not as edematous 56 year old male that arrived due to leaking the night before and unsure of how to solve the issue. He does have home health but he questioned as if there was something wrong with his stoma. Education done again about how to change the pouching system, complications to look for as a color change in the stoma, fluid output, etc.

Reviewed by: _____ Date: _____

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