Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Kelsi Critzer_____ Day/Date: 9/22/23

Number of Clinical Hours Today: __8__ Care Setting: __X_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: ____

Number of patients seen today: ___4__ Preceptor: _P.Clay RN, CWOCN_____

Journal Focus: _____Wound _____ Ostomy ___X___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.** The patient is a 31 y.o. male with a past medical history of seizure disorder. On 7/28/2023 he was in a motorcycle accident (unhelmeted) and sustained a T12 burst fracture with complete spinal cord injury. On 7/31/2023 he underwent T9-12 fusion. Following the ASIA assessment, He was evaluated as having and T11 ASIA A complete type SCI injury, with paraplegia, neurogenic bowel and bladder requiring CIC every 4–6 hours and nightly bowel program.

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.*

Reason for consult: New consult for establishing a bowel and bladder routine for patient with new T11 complete spinal cord injury.
Pressure Redistribution Support Surface: Standard, Accumax Mattress
Nutrition: Regular diet, Juven orange twice daily, and power core shake daily
Braden Scale: 14 (moderate risk)
Wound Team Summary Assessment:
Patient assessed with P.Clay RN, CWOCN at the bedside. Patient is current experience multiple bowel and bladder incontinent episodes throughout the day. Patient has recently been admitted to inpatient rehabilitation program. Due to therapy hours, bowel programs are completed nightly but may be switched to patients' preference following discharge. Clean intermittent catheterization was discussed in-dept with patient. A bowel and bladder diary were left with the patient to record urine volumes, urine leakage, time of catheterization and other associated details. The bowel and bladder diaries will help identify patterns of voiding and stooling as well as keep track of time between. Patient was educated on the importance to adhering to proposed schedule to prevent accidents and regulate bowel movements. Patient understands it may take time to regulate and establish stooling pattern, patient understands accidents may occur during regulation period and if scheduled programs are not adhered to. Additionally, due to patients' level and nature of injury, everything below the level of injury is flaccid. Pt educated on the importance of managing stool

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consistency to avoid accidents. The bulbocavernosus reflex was negative, implying the lesion is consistent with lower motor neuron lesion. A lower motor neuron bowel program has been identified as the most beneficial for this patient's specific needs.

Wound Team Plan:

To determine if patient is retaining urine after spontaneously voiding (this should be assessed within 24hrs and reported to physician):

1) Measure post-void residual, if possible.
2) Bladder scan patient immediately post void
3) Clean intermittent catheterization if > 400mL volume.

Bladder management: Pt currently using Coloplast Flex set 12fr catheter for all CIC's

If patient is consistently retaining urine (three consecutive >400mL PVR's):
In and out catheterization Q4 hours. Goal is to obtain no more than 500 ml of urine per catheterization. If more than 500mL is obtained, frequency of catheterization should be increased (Q3 hours). If less than 200mL's of urine is obtained, the patient should be encouraged to increase water intake. If volumes continue to be low (<200mL's), catheterization may be extended to Q6 hours. Do not follow Bladder scan protocol to determine need to perform in and out catheterization. Only use bladder scan if patient has any voiding of urine in between in and out catheterization to determine post void residual.

Patient has been instructed to keep bladder diary to track incontinent episodes (leaking between catheterizations), PVR's, volume of urine post catheterization, fluid intake, and time for each of these occurrences to better establish voiding patterns.

LMN nightly Bowel Program:

1. Assess patient for the presence of stool in the rectum, if present stool should be gently removed with gloved and lubricated finger
2. Patient should be transferred to bedside commode
3. Instruct patient to gently bear down and shift weight to help move stool out
4. Encourage patient to sip on a warm beverage to promote peristalsis to encourage a forward push of gastric contents
5. Allow patient to stay seated on bedside commode repeating these steps for 30-45 mins
6. Assess patient for the presence of stool in the rectum, if present stool should be gently removed with gloved and lubricated fingertip
7. Once no stool is felt, patient may be cleaned and transferred back to bed

LMN Bowel program tips:

1. For best results establish and adhere to routine (ex: same time every day/night) otherwise increase chances of having an accident
2. Complete program even if patient has stooled already that day
3. Patient may benefit from rectal checks following meals to ensure stool isn't in rectal vault (essentially mini bowel programs following meals to keep rectum empty and prevent unintentional stooling)
4. Adequate water and fiber intake is essential in managing stool consistency- stool should be formed but not hard

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**

Constipation prevention	Administer stool softeners and laxatives as ordered (hold if patient is experiencing loose stool)	The purpose of these PRN medications help prevent stool from becoming too hard and potential impaction from occurring
Bladder management	In and out catheterization Q4 hours. Goal is to obtain no more than 500 ml of urine per catheterization. If more than 500mL is obtained, frequency of catheterization should be increased (Q3 hours). If less than 200mL's of urine is obtained, the patient should be encouraged to increase water intake. If volumes continue to be low (<200mL's), catheterization may be extended to Q6 hours. Do not follow Bladder scan protocol to determine need to perform in and out catheterization. Only use bladder scan if patient has any voiding of urine in between in and out catheterization to determine post void residual.	The purpose of adhering to scheduled catheterization routine is to prevent incontinent episodes that could lead to skin damage. Additionally, the patient has lost the ability to communicate the need to void due to SCI and requires other means of eliminating urine.
Bowel Management	LMN nightly Bowel Program: 1. Assess patient for the presence of stool in the rectum, if present stool should be gently removed with gloved and lubricated finger 2. Patient should be transferred to bedside commode 3. Instruct patient to gently bear down and shift weight to help move stool out 4. Encourage patient to sip on a warm beverage to promote peristalsis to encourage a forward push of gastric contents 5. Allow patient to stay seated on bedside commode repeating these steps for 30-45 mins 6. Assess patient for the presence of stool in the rectum, if present stool should be gently removed with gloved and lubricated fingertip 7. Once no stool is felt, patient may be cleaned and transferred back to bed	The purpose of a bowel program is to effectively establish a time to evacuate stool. The bowel program helps minimize the chance of accidental stooling at unplanned time. Bowel programs help prevent incontinent episodes that may lead to skin damage and poor quality of life for the individual.
Stool consistency	Administer fiber as ordered Encourage water intake	This helps bulk stool Helps prevent stool from becoming

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	Administer stool softeners as ordered if previous stool is hard and if ordered narcotic administration is utilized more frequently	too hard and impacted Narcotics are known to cause constipation, this can be counterbalanced by giving stool softeners to prevent constipation

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. 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.** Coloplast Flex Set 12 Fr: This product is currently being piloted on this specific unit due to high rates of UTI's related to CIC. The Bart Unisex Touchless Catheter kit was previously the most common option available. These systems with attached bags are convenient but more expensive. A pre-lubricated straight catheter could be used in its place and drained into a urinal or toilet.

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?	My goal for the day was to create a continence plan for a patient with a new SCI. I feel as if I met my goal and included as much information as possible while also getting to the point.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	This week I believe I will be learning about Urodynamics in the clinical setting. I still want to get more comfortable with G-tubes.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	If I had more time, I would have reviewed this care plan with the patients PT and OT to ensure this plan meets the patients needs and allow for collaboration if changes needed to be made.
Reflection: Describe other patient encounters, types of patients seen.	Other patients included stage 3 sacral pressure injury, new AKA following multiple infections of a traumatic knee injury, and GSW's to the abdomen.

Reviewed by: _____ Date: _____

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