Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Chelsea R. Castro Day/Date: 1/26/2024

Number of Clinical Hours Today: 8 Care Setting: X Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: Preceptor: Bobbi Jo Killing

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.** 61 y/o male with a past medical history of rectal cancer managed with APR and chemoradiation, colostomy, penile tumor s/p excision, urethrocutaneous fistula, s/p urethroplasty, and suprapubic catheter. Patient presents with recurrent urethrocutaneous fistula. Labs notable for WBCs 11.9, Plt 387, UA (+) E. coli. Current medications include Macrobid 100 mg PO BID, PEG 1 pkt PO QD, oxycodone 5 mg PO q8h, oxybutynin 10 mg PO QD, prochlorperazine 10 mg PO q6h.

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.
WOC nurse consulted for request for colostomy pouch change. Patient with established colostomy, states he is typically independent with ADLs, reports wife typically assists with colostomy pouch changes but d/t running out of supplies from home requested assistance from WOC nurse. Supplies provided to patient and wife who was at bedside as requested. Colostomy present to LLQ, pouching system intact. Patient declines pouch change, prefers to have wife assist with change at later time d/t c/o nausea. Patient describes reason for current hospitalization d/t "fluid leaking out all the time", reports experiencing persistent leaking of small amounts of fluid from perineal wound following APR, requiring suprapubic catheter (inserted approximately 5 months). SPC secured with tape and securement device to thigh. Skin surrounding insertion site of SPC is clear and intact. Urinary drainage bag with 150 mL clear, yellow urine. Patient refused assessment of posterior aspect of skin d/t c/o nausea. Primary nurse notified of patient's c/o nausea. Provided patient with emesis bag. Patient and wife denied any further needs.

WOC specific medical & nursing	**WOC Plan of Care (include specific products**	**Rationale (Explain why an**

diagnosis and concerns	used)	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.**
Total Incontinence	Provide suprapubic catheter care: • Assess skin surrounding SPC insertion site each shift *– and document*. Cleanse skin surrounding SPC insertion site daily with gauze moistened with water and pat dry. • Monitor UO q2h and empty urinary drainage bag when ½ to 1/3 full • Ensure catheter is secured and tubing is positioned to permit drainage of urine/avoid kinking or accidental dislodgement, has sufficient slack to prevent tension at the insertion site • Maintain drainage bag below level of bladder at all times • Change catheter system as directed by provider or if there is a breach in integrity of system (leaking, catheter obstruction, UTI) • Monitor patient for complications r/t long term SPC and report findings to provider (hematuria or foul/cloudy urine, minimal or no urinary output, low abdominal pain/pressure/cramping, skin breakdown at catheter insertion site, urine leaking or foul drainage at catheter insertion site)	SPC helps to decrease intravesical pressure which may help promote closure of UCF, provides ongoing monitoring of UO, and means of diverting urine until UCF can be repaired. Ongoing monitoring of UO may help in identifying complications such as dehydration, obstruction, and infection. Avoiding kinks/twisting of the tubing and maintaining drainage bag below level of bladder may help prevent CAUTI from pooling of urine and reflux of urine back into bladder. Securing catheter and avoiding tension may help prevent skin breakdown, hypergranulation tissue formation, and accidental dislodgement. Minimizing catheter and drainage bag changes and performing when necessary may help prevent infection by decreasing introduction of bacteria during catheter exchanges. Common complications associated with SPC includes UTI, obstruction, and skin breakdown/infection at insertion site.
	Maintain perineal skin integrity: • Assess for areas of skin breakdown – *what is done with this assessment?* • Keep skin clean and dry, provide peri care, linen/protective pad changes PRN • Apply moisture barrier to peri area BID and PRN • Reinforce teaching on adjusting position in bed q2h, turning and offloading side to side	Continuous urine leakage d/t VCF exposes the skin to moisture and can promote IAD. Implementing interventions to protect skin, protect from exposure to moisture, and reducing exposure to prolonged pressure may help to prevent skin damage and pressure injury.
	Reinforce teaching on maintaining hydration by consuming around 8 glasses of fluids per day and	Consuming adequate fluids throughout day may help prevent obstruction and infection by increasing flow of UO.

	keeping skin clean and dry. Collaborate with other members of interdisciplinary healthcare team: • Nursing and nursing assistants- can provide ongoing assessment and monitoring of suprapubic catheter, provide care to help prevent skin breakdown r/t total UI • Urologist- can direct care of SPC and order pharmacological agents for managing discomfort associated with SPC • Oncologist- can provide patient and family counseling on risks vs benefits of treatments and help form goals for plan of care • Surgeon- can perform surgical repair/create urinary diversion to manage UCF *– make sure that this only directive, not rationale in this section.*	Coordination between members of healthcare team is required to develop plan of care to address patient's complex needs.

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. <u>Alternatives should be from a different category or classification</u>. 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.** SPC adhesive backed securement device- may be difficult to remove/reposition d/t adhesive and can lead to skin irritation or damage on removal. An alternative product would be to use elastic thigh strap with silicone grip to secure SPC or Hy-tape. *ok*

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?	Yes, I was able to meet my learning goal for the day. My learning goal was to provide care for a patient with a continence issue I have not yet encountered during the clinical rotation.- *good!*
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	N/A

Identify/describe thoughts related to the	The majority of consults were for patients with ostomy issues and I had hoped to

mini case scenario, anything you might have done differently, etc	encounter more patients with wounds or continence issues.
Reflection: Describe other patient encounters, types of patients seen.	Other patients encountered during the clinical day included patients requiring routine ostomy pouch changes, patients having difficulties achieving adequate pouch seal/leaks, a patient requiring ECF pouch change, and a patient with a new ileostomy requiring intubation of stoma.

Reviewed by: __Mike Klements Received 2/6/24_____ Date: ___2/8/24

Hi Chelsea, see my comments throughout this journal. It does qualify as your 5th continence focused journal and illustrates growth into the role of the specialist! Reach out with further questions – this completes your journal requirement (120 hours) for the course! -Mike__