Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Unni Mary Kurian_____ Day/Date: __4/29/24_____

Number of Clinical Hours Today: _10___

Care Setting: Hospital _☑___ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: _Jennifer Scheile_____

Clinical Focus: Wound _☑___ 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, my preceptor and I saw 7 patients. Most of the patients were focused on wound today and 2 of them with ostomy. We started the day with rounds with a Wound care physician (WCP), and we had to see 2 patients with the WCP. One of those with a right calf abscess, post I and D, with central area of necrotic tissue . I was able to observe sharp debridement by the WCP, and another 2 wounds over left hip. I was able to assist with my preceptor for the debridement and applied iodosorb with gauze and foam dressing after cleansing with wound cleanser. The wound on the hip were packed with iodoform strip and covered with gauze dressing .Pt also had moisture injury and DTI on the sacral/coccyx region. Foam dressing applied over DTI and barrier (cavilon advanced) over the MASD. Advised primary RN to request for low air loss mattress, discontinue use of disposable briefs and encourage external female catheter and bedpan. Another patient was a paraplegic patient with multiple wounds, including a healing partial thickness burn on left lower extremity(granulating),stage 4 pressure injury over sacrum and healing stage 3 over the left ankle.Used collagen over the granulating tissue and covered with hydrofiber(silvercel) and foam over the lower extremity wounds.For stage 4, used collagen over granulating areas and used black foam NPWT dressing.I was able to assist in doing the dressing almost 50% with this patient.We saw another pt with consult for an established pt with ileostomy complication, bleeding from somewhere. Noticed mucocutaneous region intact.Noticed bloody ,foul smelling output.Since no complications externally noted,notified the primary provider and the RN the observations and further care.Patient was competent to do the ostomy pouching by herself,which we observed.I noticed she was using a precut ostomy wafer (convatec)which I am seeing for the 1st time.My preceptor explained how those kinds of flanges comes and how easy it is for patients to use.
Next patient was a pt with stage 4 HAPI to coccyx, with instillation NPWT, due to change.It tool almost 2 hrs for us to complete that pt as there was discussion on pt going to hospice care and difficult decision making for family and patient,and who was also on a air fluidized bed, and with tracheostomy.Since the goal for the patient was not wound healing,my preceptor explained to the family regarding the other options for the wound dressing using silvercel and foam, as patient was not co-operative enough to do the NPWT and disturbed with the on and off non functioning VAC machine,which the floor nurses had to trouble shoot often. I was able to assist and see how to do the instillation with the NPWT and the difference in the foam used.
Our next one was an end ileostomy patient who is with a new ostomy and got teaching for 2 days postoperatively.This was the 3rd education day and also the last one before discharge from a WOC nurse.I observed how the education was given and what all aspects are covered.Patient was first asked with the steps how to do the change of the pouching system, Along with it pt was asked to do the change step by step and corrected and added more tips on taking care of the ostomy.Also he was provided with information on insurance and list of agencies where he can get supplies, Gave information on UOAA and how to access resources with the group.Explained on intimacy and care at home and whom to reach out if more questions arise.Gave supplies for 3 weeks from the hospital, as per the policy asked to reach out if more questions before getting discharged.This also was the first encounter with an ostomy teaching, which I felt I should be more knowledgeable and confident when I do myself for a patient.
We received a notification for a pt with leaking ostomypouch with failed 3 attempts.Nect we went to that patient,which will be more detailed in my careplan. Our last pt for the day was a lady with arterial insufficiency with ischemic foot and ended up in

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

amputation of the ischemic tissue and with a NPWT due for change.Assisted for it and was able to gain more confidence in doing npwt changes.It was a day where considerable time was dedicated to patients grappling with complex wounds, necessitating deeper level of attention and care.
Types of patients/scenarios:sharp debridement for necrotic tissue,DTI, MASD,Stage 3 and Stg 4 PI with NPWT,Partial thickness burns,unknown complication with ostomy,Stg 4 HAPI with instillation NPWT,New ileostomy with day#3 teaching,NPWT for foot, Leaking end colostomy.

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 a notification received for leaking ostomy with failed 3 attempts by the primary RN. The pt is with history of CKD,BPH, HTN, aplastic anemia who presented to hospital with fatigue, epistaxis, bleeding gums and palpitations and found to have sigmoid volvulus, who underwent extended left colectomy and end transverse colostomy on 4/9/24.
Patient is lying in bed, awake and alert and agreeable to ostomy pouch change. Patient had finished his ostomy education, but changing the ostomy pouch independently at this time was difficult due to high output ostomy and the fatigue. Patient verbalized no pain.
Previous pouch was removed gently with adhesive remover spray.It was noted to be a flat pouch appliance and no ring applied. Liquid stool noted. Peri-stomal skin was gently cleansed with gauze moistened with tap water and patted dry with dry gauze. The budded stoma looked red, round, intact warm and moist, with intact mucocutaneous junction. Peristomal area is irritated. Red weepy peristomal skin noted at the 9 o'clock position was treated with stoma powder and barrier spray (Cavilon advanced), using the crusting technique. Alight convex barrier was cut to fit the size of the stoma to 50mm. A barrier ring was applied to the barrier. Used strip paste to the creases distal to the stoma at 9 o'clock position. The barrier was applied to the skin and pressed gently around the barrier ring to get it adhere quicker to the skin. The ostomy pouch (high output) was applied to the barrier at an angle. Explained to the patient regarding the frequency in emptying the pouch to prevent leakage of the barrier, and the use of light convex ring and use of stoma paste to seal the creases.(By the preceptor) Patient was showing lack of interest in learning due to fatigue. Need reinforcement and follow up for education.

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)

Change the ostomy appliance every 3-4 days and as needed.Use light convex barrier. Use 2 piece light convex skin barrier with high output. Cut to fit the size of the stoma at 50 mm.Place barrier ring to the barrier.Use crusting technique over the denuded peristomal area at 9 o'clock position by Applying stoma powder lightly.spread out ,followed by barrier spray(cavilon spray).Leave it to dry and repeat once more.Use strip paste to the creases at the distal side at 9 o'clock position. Apply barrier to the skin and press gently around the barrier ring.Apply the high output ostomy pouch to the barrier.
Empty the pouch when 1/3rd full(to prevent leakage).Encourage involvement of patient in taking care of the pouch. Monitor the output for the color, consistency and the amount. Encourage nutritional intake within the renal diet limitations.Monitor the peristomal area for not improving/worsening of the skin.Monitor the color, stoma integrity and for any complications with the

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

stoma.Ostomy team will follow up weekly for assessment of appliance and further ostomy teaching.Notify provider &enter Wound Ostomy Nurse Eval/treatment for worsening or not improving.

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

The ostomy was taken care of appropriately. The patient was comfortable and made sure there was no leak at the ostomy site and that it was secure. We should have enquired regarding the family/close friends who can assist the patient and teach ostomy care as the patient has a lack of interest in learning and fatigue related to the disease condition. The primary RN attempted 3 times and failed to replace the ostomy appliance. In this case, we should also have asked the primary RN to observe how the pouch was fixed to avoid further leaks.

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 was to see an NPWT with instillation and to see few ostomy patients and how education given to a new ostomy patient.

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

I would like to see patients with leg ulcers-venous, arterial or neuropathic and identify and differentiate .And to watch how a complex fistula is managed if any.

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		

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.