Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Hannah Peterson_____ Day/Date: ____5/3/24_____

Number of Clinical Hours Today: __8.5__

Care Setting: Hospital ____ Ambulatory Care __X__ Home Care ____ Other ___

Preceptor: ____Sarah Yount_____

Clinical Focus: Wound ____ Ostomy __X__ 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 I saw three patients with my preceptor. Over two hours of our day was spent with the patient who I've discussed below. Our other patients were a loop urostomy post operative day one teaching session and a patient with an ileostomy that resulted from C. diff that he contracted after a double lung transplant last year. The patient required pouch refitting as he had not remeasured his stoma since last year. Although he had been cutting the opening in the wafer too large and a strip of skin was visible, he had no peristomal irritation. We were able to educate the patient about this and he stated understanding. He was able to remain in the same flat wafer and high output drainable pouch. The new urostomate was amenable to education but was not fully engaged. The ostomy team plans to conduct his second education session when his partner of 20 years (who is a nurse) is present. During today's session, I learned strategies to pouch over urostomy rods, when paste is appropriate in an urostomate, and use of soft convexity on a freshly postoperative urostomate.

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:

SM is a 67-year-old male admitted for preoperative evaluation for an exploratory laparotomy and revision of the nipple valve of his Koch pouch continent ileostomy. The patient is diagnosed with ulcerative colitis and had an ileostomy for 40 years before the creation of the Koch pouch (K pouch). The patient tolerated the revision on 4/24/24 well. He was advanced to full liquid diet on Wednesday 5/1/24. In the afternoon, he began to feel nauseous and constipated. He experienced a large amount of emesis on Wednesday evening. He was placed on nasogastric decompression and NPO. The K pouch continent ileostomy protocol of flushing the pouch every 3-4 hours with 120 cc of NS was maintained. The ostomy team has seen the patient daily, moving the catheter in 1 cm one day and out 1 cm the following day as well as irrigating the pouch. Today, the tube was irrigated, then moved in 1 cm. irrigation after insertion was sluggish with poor return. The tube was pulled back out to original position, though this did not improve return. The patient stated that he was able to feel pressure and distention. The tube started to fill with thicker effluent when pushed in, so WOC RN move tube in 2 cm. The patient changed positions, turned to either side, sat on edge of bed and stood up. Very sludgy return started to move into tube when sitting but would not flow freely out of tube. WOC RN decided to stop irrigation at this point due to lack of return and the surgeon's PA was notified. The catheter was manually milked to remove the sludgy effluent until a net return of 0 was reached, then started irrigation again. Surgeon's PA was at bedside and assisted with decision making. Large amount of sludgy green effluent returned with subsequent irrigations. There was a new return of +485 cc by end of

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visit. Return was brisk, pale green, and clear by end of visit. Patient reported feeling less pain and distension. Ostomy team to follow up 5/4/24 for daily care, and to move catheter out 1 cm. The stoma is 1 ½", flush, located in RLQ, red, moist, intact. Peristomal skin is overhydrated, pink. Treated with stoma powder. Catheter type: ileal reservoir catheter (Waters catheter). Stabilizing sutures removed at earlier visit. Catheter depth position change: outcome of visit was catheter being moved in 2 cm. Catheter irrigation: done with NS in 60-120 cc increments for a total of 900 cc. The rate of return was brisk at completion of visit. Catheter stabilization system: Torbot convert-a-pouch face plate, baby bottle nipple, adhesive tape, and Torbot belt. One package of split gauze under face plate was changed. The catheter was connected to gravity drainage at end of visit. The patient has a JP drain in LLQ with serosanguinous drainage. Output measured by floor nurse staff.

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)

Catheter stabilization system: Torbot convert-a-pouch face plate, baby bottle nipple, adhesive tape, and Torbot belt.

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

Due to the patient's fatigue, we did not begin repositioning the patient until 30 minutes into the appointment time. Because there was poor return with the patient lying supine, and intraabdominal pressure is low in the supine position with relaxed abdominal muscles, I would have initiated repositioning earlier in the appointment, despite the patient's stated fatigue. The patient advised that he walked in the halls five times yesterday, further supporting that he was able to reposition and stand at bedside.

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?

I met my goals of acquiring answers to the following questions: pouching wound and ostomies together, when using a ring is not necessary, and how postoperative education differs for patients with continent ostomies, to name a few. Unfortunately, I did not have the opportunity to see negative pressure wound therapy but did have some questions addressed.

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

I really hope to see some negative pressure wound therapy on Monday. While many of my questions like when to use a contact layer with black foam as opposed to using white foam can be addressed verbally, seeing a specific case or two would help me integrate the knowledge.

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		

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• 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		

Reviewed by: _____ Date: _____

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