Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Erica Crenshaw Day/Date: Day 3 6/5/24

Number of Clinical Hours Today: 8

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

Preceptor: Sarah Yount

Clinical Focus: Wound __X__ 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.

My preceptor and I visited a total of 5 patients at the outpatient clinic today. The first patient, a 55 year-old female presented to the clinic seeking alternative ostomy supplies. She has had an existing LUQ Ileostomy in place for a little over a year and reports experiencing multiple episodes of leakage while swimming, at work and other inconvenient locations. She openly expresses how frustrated she has been since the creation of her stoma and also states that the Karaya pouch has been the only pouching system small and sturdy enough to resist leakage. The Karaya pouch has been discontinued by Hollister. A couple of Stoma nurses reviewed the Ostomy catalog and the Stoma RN was able to present the patient with a 1-piece Drainable Mini-pouch with clamp closures included. The patient was ready to order a full month's supply rather than trying samples and willing to make a follow-up appointment within 2 weeks. The second patient was a 58 year-old female presenting to the clinic for a follow-up visit to a peristomal mucocutaneous separation and alternative selection of ostomy supplies. The stoma had some evidence of mild hypergranulation noted to which silver nitrate was applied to the hypergranulated areas, the rest of the stoma was red, moist budded throughout. The patient currently wears a soft convex, one-piece however; her abdomen was assessed to have a mixture of firm and soft areas to the peristomal skin.. The recommended ostomy supply was a One-piece Light Convex option and to follow-up within 2 weeks. The third patient was a 69 year-old female with an extensive 51 year history of Crohn's disease and has had multiple resections, stricturoplasties and an end ileostomy placed in 1977 which has since been removed. The patient presents to the clinic for a pre-op site marking in case the Surgeon decides that the patient needs a jejunostomy following the Colonoscopy. Placement was originally marked on the RUQ, Surgeon requested a site on the LUQ. Both sites were covered with tegaderm and the patient was instructed to leave in place until the day of the surgery. The patient was given an Ostomate video to watch, an Ileostomy and GI soft diet handout. All questions and concerns were addressed by the Surgeon, Stoma nurse and Nurse Educator. The following patient was a 58 year-old female with an end ileostomy to the LLQ presents to the Stoma clinic with poor attachment due to convexity issues and mild stomal prolapse. Her current pouching system was a Coloplast deep convex and a Marlin shallow convex was recommended for its flexibility and softness. The final patient, a 54 year-old female had an existing LLQ Loop Ileostomy presents to the clinic for concerns of high, liquid output and a lack of home supplies. She reported rapid weight loss within a short amount of time, decreasing appetite and intermittent nausea & dizziness. The Stoma Nurse and I were able to assess the current flange for appropriate fit and measure the stoma to ensure that the current pouching system remains appropriate. Patient was advised to consume small amounts of foods in helping to thicken the output, increase protein intake and to follow-up with Oncologist regarding decreasing appetite and potentially incorporating a bowel stopper such as Imodium back into regimen. Extra supplies including an overnight gravity bag was provided to the patient.

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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:

Patient is a 54 year-old female with a PMH polymyositis and recurrent cervical cancer. The patient was recently found to have metastatic cancer and was initiated on chemotherapy with Taxol, carboplatin and bevacizumab on 4/8/24. Further chemotherapy treatment options to be considered at a later date. On 4/29/24, the patient presented with symptoms related to urosepsis due to an enterovaginal fistula. Because of the recent bevacizumab therapy, procedural options were limited to a proximal ileal diversion resulting in a loop ileostomy to the LLQ. Patient presents to the outpatient clinic today to receive treatment for high output with liquid consistency and supply needs. Patient reports frequent liquid output at about 1300ccs daily. She also reports recent weight loss from 135 lbs before surgery to 90-95 lbs as well as decreased appetite and solid intake but has increased fluid intake regularly taking in G2 gatorade, water and juice.

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)

Nutritionist/ Dietary consult

-Provide list of food/ snack options for decreased appetite

-Recommend list of soluble food options to thicken output

-Emphasize the recommended daily fluid intake

-Recommend small portioned snacks or meals to help increase protein intake

WOC Nurses

-Assess to ensure appropriate sized pouching system is in place

-Assess for output amount and output consistency

-Assess for further changes in appetite and dietary needs

-Pouching system in place: Hollister New Image Convex 1 ¾" Ceraplus Flange with Tape Border #11402, ceraplus ring, HVOP,

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framed wtih orange tape. Wearing time of 2-3 days.

-Follow-up on level of effectiveness of interventions including: dietary changes, bowel stoppers

-Follow-up on notes from f/u appointment with Gyne/ Onc Specialist, Dr Rose's office

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

I thought that it was great that the obstruction was relieved with intubation and irrigation rather than putting the patient through another procedure. The patient denied pain and was relieved of symptoms related to obstruction with such a simple procedure. I would have incorporated more patient education on fluid and solid intake suggestions to avoid obstruction and even ask the patient if she would like a Nutrition consult.

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?
On my second day, my goal was to provide more hands-on care especially during pouching changes. I also would like to work on proper assessment of the stoma and pouching system once it has been removed in order to determine appropriate quality and fit for the patient.

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

My goal will be to change a pouching system and identify appropriate needs of care for the patient.

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	✓	

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● 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	✓	

Reviewed by: _____ Date: _____

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