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 2 6/4/24

Number of Clinical Hours Today: 8

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

Preceptor: Adam Shaw

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.

My preceptor and I visited a total of 3 patients today. Although the roster was full of patients needing to be seen for various problems, a couple of the cases were more time consuming than others. We also rotated between visiting patients within the Stoma Clinic and patients admitted within the hospital. The first patient, a 34 year-old female presented to the Stoma Clinic with a LUQ end descending colostomy and 3 primary wound areas including fistulas located in the upper midline, midline and lower midline of the abdomen. The patient was denied coverage for wound vac and pouch changing assistance within her area so she drove to Cleveland Clinic's Stoma Clinic 1.5 hours away twice weekly to address care needs. Multiple supplies were needed during dressing change including Hollihesive wedges to be packed into umbilicus and over wound sites, White foam to pack smaller tunneling sites, Black foam for NPWT and transparent drape dressing. The total amount of time spent during the dressing change was 2.5 hours. The patient complained of minor pain with pressure to the lower umbilicus but overall tolerated care well and was able to make her preferences and needs known. The second patient was a 55 year-old male admitted inpatient following an intestinal transplant 2 days earlier. The WOC team was paged due to pouch leaking from an Ileostomy. The patient complained of pain prior to the initiation of stoma care and quickly resolved when patient was medicated by nurse. The stoma was red, moist, functioning and active during care. Strip paste was applied to a very slight depression within the umbilicus, a Hollister 2 3/4" Flat Ceraplus Flange with a ceraplus ring and drainable pouch was applied. The patient tolerated the pouch change well, denied pain and was able to eat following treatment. The final patient was a 37 year-old female presenting to the hospital with symptoms of nausea, decreased output within the existing end ileostomy and a potential SBO. The WOC nurse prepared to intubate the ileostomy using a 16 French retention foley which resulted in net return and ongoing flow thereafter. The patient tolerated well, denied overall pain and was in good spirits following irrigation.

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 37 year-old female presenting to the hospital for symptoms of nausea, vomiting and decreased output. PMH includes colonic dysmotility and outlet obstruction constipation. The patient's End Ileostomy was created in 2017. Assessment of the stoma and pouching system demonstrate minimal output to date. WOC nurse to intubate stoma using a 16 French foley catheter to the

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bifurcation without forcing catheter into stoma followed by irrigation with normal saline until sufficient return is noted. Nursing staff expected to monitor and document patient's I/Os until discharge. Erica, a chart note is to be about what was done. So did Adam do this procedure? What were the results of the procedure, how did the patient tolerate it, etc. Then your actual chart note would discuss the application of the new pouch

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)

Nursing staff

- Monitor for symptoms related to outlet obstruction.

-Monitor for leakage, skin inconsistencies including redness, bleeding or injury.

-Contact WOC team if changes occur.

-Emptying frequency is every 2 days per nursing staff why are you saying per nursing staff? I did not question this on previous journal as I thought it was about the J pouch. Ostomy pouches for typical ostomies of any kind are to empty when 1/3 to ½ full

WOC Nurses

-Assess stoma for symptoms of obstruction

-Direct 16 French catheter into stoma to relieve obstruction

-Applied pouching system includes Hollister New Image 1 3/4 inch convex with ring and paste to drainable pouching system

-Reinforce patient education on diet intake following consult with Nutritionist

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 patient.
On my first day, my goal was to observe the flow of the staff and coordination of patient care in visualizing how the WOC nurses were assigned patients. I also wanted to observe and take notes on patient interaction, care and education.

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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		Not enough info
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use		Not in note
• Identifies overall recommendations/plan		Not in note
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: Patricia A. Slachta Date: 6/7/24

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