Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jennifer Biggs RN Day/Date: Wednesday, June 12, 2024

Number of Clinical Hours Today: 8

Care Setting: Hospital ____ Ambulatory Care 8 Home Care ____ Other ___

Preceptor: Kerrie Sherman

Clinical Focus: Wound ____ Ostomy ____ Continence X

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 had the rare opportunity to see a neuromodulation Medtronic InterStim wire implantation procedure and sit on on the education for this procedure as well …..this is a complex case that I would like to do my complex care plan on for continence. I am interested to see if I will have the chance to follow up with this patient's success with the text in a week despite being back at home. I have my preceptor's contact inforamtion in order to stay in touch about this case so that I can really write an elaborate care plan about this patient's processes and outcome.
I was also able to sit in on an appointment to discuss treatment for colo-vaginal fistula (this entry).
I was able to sit in on a post-operative appointment for a post-op prolapse
I was able to sit in on a lecture with the surgeon to the new colorectal fellows about different case studies for incontinence and constipation viewing test results on menometry, defecography, and colon transit time.
I was also about to learn about rubber band litigation of hemorrhoids.
I sat in on 2 manometry exams with their consultations as well.

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 58 year old female with a colo-vaginal fistula in office to discuss possibilities for treatment. She has a history of obesity, 2 strokes in 2019, right sided weakness, facial drooping with fatigue, HTN, history of open heart surgery in 2020. History of hysterectomy for heavy bleeding. Diverticulitis flairs multiple times per year. Patient has a hobby of moving heavy furniture and books and reports that when she does this, she is more likely to have a diverticulitis flair up. 6 months ago, she realized that she has stool leaking from her vagina when she lifts heavy furniture.
Patient has 8-10 bowel movements a day of mixed consistency; more if she is having a flair up.
Rectal exam performed and imaging reviewed which included defecography. Although the fistula wasn't visible on imaging, the symptoms of stooling through the vagina for a few days after lifting heavy furniture informed the surgeon that the patient was likely experiencing a colovaginal fistula that was not permanently open.
Surgical option of fixing the fistula was discussed. However, due to possible surgical complications due to comorbidities, it was not recommended at this time. It was emphasized that the patient could live with the fistula and alter the behavior of lifting heavy things which is the trigger for leaking.

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Patient was satisfied with this plan and verbalized understanding.

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)

When patient has a diverticulitis flair-up:
Go to the ER and request a CAT scan so that imaging can be captured of the flair up and assist in determining need for antibiotic treatment.
Antibiotics might be needed; take as presdcribed and request a perscription for a probiotic as well.
Bowel rest diet of clear liquids for 3 days. Slowly introduce soft foods resuming to a normal diet within 1-2 weeks that is high in fiber.
For fistula care:
Do not lift heavy things. Straining irritates bowel and causes disruption of the fistula causing leaking through the vagina.

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

This was all new information and tests that I had never heard of or experienced. The communication with patients with these sensitive topics was professional, thoughtful and thorough.

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?
To experience menometry and this goal was more than MET - I was able to experience multiple other diagnostic tests.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Tomorrow is my last day with ostomy. I have experienced most competencies. However, I would like more experience in as much as possible. I have not seen the stomal complications of mucocutaneous separation or prolapse yet. I have not seen a hernia during this experience but have experienced them in my professional career. I plan to ask to see anything with complications in the morning and another fistula if possible.

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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