Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jessica McAndrew Day/Date: 6/21/24

Number of Clinical Hours Today: 8

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

Preceptor: Denisse

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.

We saw/discussed 5 patients today. A majority of these patients were wound-focused, but we did see one patient with a gastrocutaneous fistula. We saw a patient with venous ulcers that had increased fibrinous exudate since my preceptor's last evaluation. We discussed with nursing that these wounds should be cleansed and lightly buffed with gauze to remove slough/exudate, dressing changed from Aquacel AG to Xeroform, ABD and Kerlix since there was less drainage. There was a patient we discussed that had necrotizing fasciitis of the sacral wound and also had multiple other wounds, photos and chart reviewed together. We did not see her because she was debrided by surgery today. We saw another patient with an unstageable pressure injury to the heel – eschar was beginning to lift and there was an odor, recommended imaging to rule out osteomyelitis and a podiatry consult, no ABIs on file and signs of possible undiagnosed arterial disease. We attempted to see a patient in the ICU who had a healing stage 4 pressure injury to the sacrum and arteriovenous ulcers to bilateral extremities, but she was undergoing a procedure at bedside. We discussed the characteristics of her wounds with the nurse and reviewed the photos in the chart, and provided temporary dressing orders for the weekend until she could be seen by my preceptor next week. We were also sent samples of Zetuvit (which is not currently on par) by a Hartmann representative so we reviewed and discussed them.

Types of patients seen/discussed: venous stasis ulcers, sacral wound with necrotizing fasciitis, unstageable pressure injury to heel, stage IV pressure injury to sacrum, arteriovenous ulcers, gastrocutaneous fistula

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.

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Chart note:

WOC consulted for fistula management. Patient is a 21 year old female with a history of gastroparesis, opioid use/on methadone, bipolar disorder, ADHD, anxiety/depression/PTSD, and history of seizures. She initially presented to the ED with severe abdominal pain. She has a fistulous tract from old GJ tube site, which was dislodged during her hospital stay. There was initially some concern for infection of the tube site, was treated antibiotics and ID is following. Patient is currently refusing GJ reinsertion. She has been unable to tolerate PO intake, and has been getting TPN. Other pertinent medications include hydroxyzine for anxiety, ondansetron for nausea, and tizanidine for muscle spasms. Notable labs were triglycerides elevated at 188 mg/dl, hgb low at 11.2, all other labs WNL.

Muprocin was previously ordered by provider for tube site skin irritation. At the time of our evaluation, an ABD pad and microfoam tape was covering the fistula. Her nurse had just changed the dressing, but patient reported that the ABD dressings were getting saturated after a few hours. No output has been recorded, and there are 2 dressing changes documented in the past 24 hours. Patient's perifistular skin was erythematous and denuded, with satellite lesions, characteristics consistent with fungal infection. Discussed pouching the fistula with patient, she is in agreement with plan of care. No nystatin powder available at bedside, but will order for subsequent pouch changes. Crusting technique utilized with Stomadhesive powder and 3M Cavilon No Sting Barrier film. Eakin ring rolled and used as paste to fill in creases at 03:00 and 09:00. Eakin pouch then applied. Patient was taught how to help nursing perform this pouch change, and she was able to teach back steps. Will place detailed pouch change instructions for nursing below. Additionally, photos were taken of these steps, these can be found in MultiMedia Manager.

The importance of documenting output was discussed with patient and unit RN. Eakin pouches and rings need to be ordered, as they are not on par. Order information given to unit RN. Will provide extra supplies for the weekend. In the event that there are no Eakin pouches available, the same steps can be performed with the standard Coloplast 15821 colostomy pouch. Will d/c Muprocin, as that will only prevent the pouch from adhering. Discussed plan of care with CCHP providers, patient and unit RN. WOC to follow up early next week.

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)

RECOMMENDATIONS:
- Lay patient flat
- Remove and cleanse perifistular skin with disposable washcloth and warm water only (no wipes or soap).
- Dry skin thoroughly, wiping effluent away as needed.
- Dust peristomal skin with Nystatin powder, wipe excess away with dry disposable washcloth.
- Blot/dab powdered area with 3M no sting skin prep, sealing in powder.
- Allow to dry completely.
- While patient holds abdomen flat/taut, tear off a piece of Eakin ring and mold it into a flat strip, using it to "caulk" the creases on each side of the fistula at 03:00 and 09:00, ensuring this is adhered to skin.
- Cut to fit Eakin pouch slightly larger than fistula and apply.
- Use warmth of hands to mold pouch to skin. Recommend that patient lie flat for about 15-20 minutes with hands over pouch.
- Notify WOC if pouch is not lasting at least 48 hours.

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

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Would have recommended use of drainage bag to attach to pouch to prevent effluent from refluxing back up towards the top of the pouch. If pouch does not get appropriate wear time, can consider adding small Eakin ring circumferentially, or Brava strips circumferentially around the pouch.

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 learn more about the care of fistula patients.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) I hope to experience a more complicated fistula patient that requires creativity with pouching recommendations so I can get practice treating these complex patients.

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	✓	

Reviewed by: _____ Date: _____

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