Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Tracy Leal____ Day/Date: _7/9/2024_

Number of Clinical Hours Today: __8_

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

Preceptor: __Heather Bates___

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.

1. 30 y/o F with permanent end ileostomy. Patient was distended with mild abdominal pain and woke up this morning with nausea and vomiting. Patient does have some output through the stoma, but not enough. MD placed an order for the WOC to intubate the stoma. Patient was alert and oriented. No longer with N/V but distended and mildly painful abdomen. The stoma was round and budded with some devitalized tissue to the medial border, but otherwise healthy, red, and moist. Os centrally located. Peristomal tissue intact. Midline abdominal incision with staples present and some dried bloody drainage. No evidence of dehiscence or infection noted to incision line. I intubated the stoma with a 16 Fr foley catheter (flushed with 60 cc of water and got a 200 cc return) secured with dental floss and pouched with CeraPlus flat 2 ¼ barrier and clear, drainable, lock and roll seal. The patient was very pleasant, able to look at her stoma and watch the procedure. She asked if it would be painful and we assured her it would not hurt, but there might be some pressure. She tolerated the intubation well.
2. 71 y/o F presented to ER with abdominal pain, prealbumin of 12. Admitted for tube feeding and GI workup. Found to have a pelvic mass. Underwent an exploratory laparotomy and debulking which the surgeons had to abort related to inability to mobilize the bowel r/t mesenteric carcinomatosis. Two liters of ascites drained, small bowel "massively dilated". The mesentery of the small bowel was involved with the tumor and the ileocecal valve was fibrotic. The patient needed an ileostomy related to the small bowel obstruction. The plan is for neoadjuvant chemotherapy and a debulking if she responds well. We were consulted for rod removal for her distal loop ileostomy. The stoma is located in the RUQ, round, budded, and protruding. There was a small amount of devitalized tissue to the border of the stoma between 5 and 9 o'clock. The patient was educated this was normal and would slough away. The rest of the stoma is red and moist. Lumen located centrally. Peristomal tissue intact. Liquid brown effluent noted. The rod was sutured in medially. I clipped the suture without issue and was able to remove the rod. The patient tolerated this well. The patient is discharging soon so we taught her to drain her pouch. She was able to cut the wafer to fit and was given a template and educated that her stoma would shrink, and she will need to measure it with pouch changes. She was taught this as well. She was given written information about diet, ordering supplies, and steps for ostomy management. She was emotional, but able to verbalize her feelings. She did not go into her surgery thinking this would happen to her. She was able to use imagery at one point to feel calmer and is overall coping well. She asked questions, was able to repeat the information shared, or ask more questions to clarify. She asked about clothing and noise of flatus in the bag. We answered her questions. She thanked us and said our presence was calming and reassuring, which felt nice to hear. ***WOC nurses have a different relationship with pts and are often able to assist them in coping, expressing feelings, etc.***
3. 30 y/o F with a PMH of UC with dominant involvement of the rectum diagnosed in 2019. She was admitted with a one-month history of Cdiff and a UC flare. We were consulted for site marking for a temporary ileostomy in preparation for a three stage J-pouch surgery (IPAA). See chart note below for more details.
4. 80 y/o M with a h/o prostate cancer. He is s/p radical prostatectomy followed by XRT. He has required multiple Direct Vision Internal Urethrotomy procedures related to vesico-urethral anastomotic stenosis. One procedure with rectal injury

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requiring temporary colostomy. The patient presented with pain in his pelvis and was found to have a "large urosymphyseal fistula". Patient was admitted for a cystectomy, ileal conduit creation, and bone resection. The patient's fistula had tracked to the pubic bone resulting in osteomyelitis and the need for bone resection. We were consulted to see the patient for teaching and removal of foley catheter from the ileal conduit. I removed the patient's previous pouch. Stoma was red, moist, and budded. Foley catheter and 2 stents noted to be sutured in place. MCJ intact. Mid abdominal incision well approximated, free from signs of infection, and secured with surgical glue. Peristomal skin cleansed with soap and water, rinsed, and patted dry. Moistened gauze used to gently remove mucus from stoma so I could visualize the sutures. I removed the 2 sutures holding the foley in place and removed the foley without incident. The 2 stents were undisturbed and placed within the clean pouching system. This was a CeraPlus soft convexity wafer with a small amount of stoma paste to caulk around the stoma as well as a small bead placed to the medial edge where there was a small crease. The patient has been using this since surgery and has not had issues with leaking. ***Achieved wear time of?*** The patient was able to cut his wafer to fit and attach the bag to it. He was shown how to empty his bag as well and is familiar with ho to change an appliance as he had a colostomy previously. The patient's wife was also at the bedside. She watched the procedure and asked appropriate questions and showed understanding. They were given discharge instructions on how to change the pouching system, how to order supplies, and general information regarding urostomy care (foods to avoid, what the urine should look like, staying hydrated, etc.). The patient and his wife voiced understanding and are happy to be going home tomorrow. ***Will there be a follow-up visit prior to discharge? If this was my patient, I would do so for any additional clarifications, questions, etc.***

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:

This is a 30 y/o F being seen today for preoperative site marking for a temporary ileostomy for a 3-stage IPAA. The patient has a PMH of UC with dominant involvement of the rectum. She is currently on Remicade. She was admitted with Cdiff infection x1 month with UC flare up. She had been treated outpatient with po Vanco and has been on 40 mg Prednisone po x 3 weeks. The Patient was also performing Mesalamine enemas with no improvement. She has had a 30 lb weight loss in the last month and was sent to Cleveland Clinic by her PCP. WBC 8.9, Hgb 14.8, Alb 4.3, and crp 0.6. Patient has a past surgical history of a lap chole for gall stones and a lap appy when she was three. The patient is otherwise healthy. The patient is alert and oriented x3 with husband at bedside. He is supportive and asks questions that show insight and some understanding of the procedure.

The surgical procedure was explained in detail and the patient was given a booklet on ileostomy. Education included the procedure, GI anatomy, normal digestion, what her stoma will look like postoperatively (including the possibility of a rod) and how it will change, and what her stool will look like immediately postop and how it will change. The patient voiced that her mother had had a colostomy and suffered quite a bit with leaking. The patient and her husband were educated that there are many different products on the market now that control leaking and that a WOC nurse would be following post-op and helping if there were any issues with leaking or otherwise.

The reasoning behind site marking and the site marking procedure was explained. The patient was laid supine, and abdomen visualized. The rectus muscle borders were located, and a site chosen in the RLQ and a stoma barrier applied. ***Be specific; what type of barrier-wafer, sealant, etc?*** The patient's abdomen was then visualized sitting, standing, and bending over. There were shallow creases noted just barely inside the tape collar at the top of the barrier. This is unlikely to cause a problem as this is above the stoma and the creases were shallow. Deeper creases were noted superior to this in the bilateral upper quadrants. There was very little flat surface for pouching there so no other sites were marked.

The patient and her husband were given ample time to voice questions and concerns. They verbalized understanding regarding the information given. The patient is understandably nervous, but hopeful for an improved quality of life with her upcoming procedure.

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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)

The patient will be seen by the WOC nurse POD 1 for assessment, then return postop day 2 for the first pouch change and likely rod removal. Most of my patients today were discharging or would require the WOC for the pouch change. I am going to make a POC for this post-op patient assuming an uncomplicated post-op course after rod removal. ***Ok.how might you include some of these comments into POC while keeping in mind the POC is for others in your absence.? Assess stoma after return from surgery. Use as baseline for additional assessments. Begin teaching pouch changes on post-op day 2.***

1. Remove pouch using push pull technique.
2. Assess the stoma. It should be red, moist, and produce stool. Call the surgeon if the stoma is dusky, black, or hard to the touch. Call the surgeon if there is no stoma output.
3. Record stoma output in I+Os. Call surgeon for output greater than 1200 cc in 24 hours.
4. Cleanse peristomal tissue with warm water and pat dry.
5. Measure stoma with measuring device and cut wafer to fit. ~~**Please**~~ measure the stoma with every pouch change for 4-6 weeks post-op as the ~~**patient's**~~ stoma will be shrinking in size. ***Be directive***
6. Apply ***skin barrier wafer?*** barrier with clear drainable pouch. Assess pouch with all rounding and empty whenever 1/3 to one half full. Chek for flatus and burp when needed.
7. Encourage the patient to look at stoma and perform as much of her own care as possible in preparation for discharge. Include spouse with education if the patient is comfortable.
8. Change appliance every 3-4 days and as needed. ~~**Please**~~ call WOC team for any concerns with leaking or fit of appliance. ***Being directive helps to decrease your liability should an adverse event occur.***

This POC focuses on post surgery. What about time between your visit and surgery? You need to develop a POC for this time period.

Pre-operative plan of care:

1. It is ok to shower prior to surgery, but do not wash off stoma site mark. Should the protective dressing come off it is OK to darken the previously marked spot with the surgical pen left at bedside and apply a new Tegaderm.
2. Encourage patient to review preoperative literature regarding the upcoming procedure left at bedside. Should patient need any information clarified, place consult for patient education with the WOC team.
3. Reinforce patient education regarding preoperative orders (NPO, IV fluids, etc.) placed by the provider.
4. Encourage patient to ambulate if able. This aids in gut motility both pre-op and post-op, as well as avoiding deconditioning
5. Allow time for patient to express fears and anxieties with nursing interactions. Should the patient need to speak to the WOC nurse regarding fears related to ostomy creation, place a consult. If the patient needs more extensive help with coping consult psychology and stay with the patient if needed.

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

The consult asked for the patient to be marked in all four quadrants. Her torso was very short and there was not enough space to mark the upper quadrants as the flange would have been too close to the rib cage. There was a good spot in the RLQ and the WOC felt this was sufficient. I think I would have marked the LLQ as well just in case the surgeon needed a different spot (I doubt this will happen) as he had requested all four quadrants. ***This is important info to include in the chart note since the surgeon wanted all quadrants marked. You would indicate such with reason you did not mark other areas; unable to mark RUQ and LUQ as requested related to short torso and closeness to rib cage. Why was the LLQ not marked then?***

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

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Goals

What was your goal for the day? Stoma site marking. I was able to meet this goal.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) I would like to get more practice with stoma site marking. I would like to try a patient with a difficult abdomen to mark.

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: Kelly Jaszarowski Date: 7/10/2024

Overall, this journal is well done. You have identified it as a stoma site marking and I have recorded it as such. However, you do need to resubmit with POC directives focused on time from marking to surgery.

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