Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Tracy Leal_____ Day/Date: __7/17/2024__

Number of Clinical Hours Today: __8__

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

Preceptor: _Tim Marsek__

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.

1. 62 y/o F, G0P0 discussed in am conference. PMH significant for breast CA 10 years ago, hemorrhoids, and redundant colon. PSH significant for hemorrhoidectomy and colectomy 20 years ago. Patient is now 6 months out from an Altemeier procedure for a partial full thickness rectal prolapse and concurrent hemorrhoidectomy. On day 4 pt had an anastomotic dehiscence requiring abdominal washout and drain placement. Patient ultimately had 50% circumferential dehiscence of anastomosis and pelvic sepsis. Patient required a colostomy, had an inflamed pelvic floor, AKI, abdominal wound dehiscence, and decompensation requiring intubation. She is now 7 months out from hospital DC and has lost 20 lbs. After discussion plan is for EUA with colonoscopy to determine how much colon is left, if there is a good vascular supply to the colon, mucosectomy, and a sitz marker study to r/o slow transit constipation. Patient will need to be one year out from surgery and gain back some of the lost weight prior to revision of ostomy.

2. 50 y/o F G2P2, both vaginal deliveries one complicated by “periurethral tears with repair at bedside”, discussed in am conference. Patient with right offline fistula s/p episioproctotomy. PMH significant for rectal bleeding and prolapse in 2018. Pt also with rectal pain, finding of an anal fissure treated with steroids and pain management. In 2020 pt had diagnosis of anal fistula and underwent LIFT procedure. In 2022 patient had a rectal abscess with placement of a seton along the LIFT line. In 2024 pt had another LIFT procedure with primary repair of openings and TAR. Per presenting MD pt with good rectal tone, moderate squeeze, and good descent/relaxation with PFM feeling “scarred”. Plan for EUA, rectal US/TAR with stoma.

3. 19 y/o M with spina bifida discussed in morning conference. Patient with cecostomy tube that is no longer functioning well after significant weight gain, mostly in the abdomen. Patient also with mitrofanoff for bladder management that he now has difficulty intubating, also likely related to weight gain. Treated by urology with placement of a cone that stays in place for pt to intubate through. Working, but patient is now getting frequent UTIs. Per team discussion plan is to first do a Sitz marker study (per discussion the colon is usually working, it is the pelvic floor that is the issue), followed by a nutrition consult for weight loss and referral for weight loss medications as patient would be at great risk for hernia and difficulty placement of a stoma with his current BMI in the mid-30s. Proctocolectomy and ileostomy would be elective and therefore can wait until optimization for surgery.

4. 63 y/o F seen in clinic for proctitis, rectal bleeding, and ongoing constipation. Patient recently admitted to OSH for C diff treatment. Patient reports CPP and pressure and pain in her anus. Patient had colonoscopy in 11/2023 to r/o UC. Colonoscopy showed proctitis, no signs of UC, and biopsies were negative. Patient is currently using steroid enemas for inflammation and Valium suppositories to relax the pelvic floor. Patient also has EMLA cream for rectal/anal pain. MD performed rectal exam, patient was able to complete exam, but it was very painful for her. Per MD anal exam is WNL. Plan is for a repeat colonoscopy, start PFMT next week and continue with soap suds enemas for constipation, mesalamine enemas for inflammation, and Valium suppositories. Patient encouraged to speak to her PCP about empiric treatment for UC.
5. 70 y/o F being seen for lifelong constipation. Was taking senna tea x30 years which stopped working. Linzess gives the patient

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diarrhea, and she is housebound when she takes this. She also struggles with urinary urge incontinence and frequency. She is G2P2, both vaginal deliveries and both >8lbs. She restricts her fluid intake related to this, which is likely contributing to her constipation. The patient also reports food sensitivities to gluten and diary. Patient reports SIBO, bloating and abdominal pain with po intake. Most recent colonoscopy showed a tortuous colon and polyps. Patient reports good bowel control (even when on Linzess), no accidents and can control gas. Enterocele noted on defecography. Patient manometry shoed PF dysfunction, high tone. Sitz markers confirm slow transit constipation. POC put forth by MD was to take Linzess every three days (if she never had a BM daily, why try for that now), eat smaller meals throughout the day instead of the large single meal she reports, improve water intake, PFMT, follow up with already established urologist regarding UI. PFMT and follow up visit after three months of these changes to discuss any changes in POC.

6. 72 y/o F with rectal prolapse seen for manometry. PSH significant for anal tumor removal in 1990. Rectal prolapse repair in 2015. A second rectal prolapse repair in 2022 and she now has another prolapse. Per PA patients rectal exam showed low tone. Patient also noted to have sensation and max tolerable volume at low pressures indicative of hypersensitivity seen with rectal prolapse. Patient also noted to have IAD around the anus. She reports constant fecal leakage, as well as urinary urgency and incontinence. POC to include zinc barrier cream, continued use of BWAP, and trial of SNS (though this improves symptoms and is not curative). Per NP patient will ultimately see colorectal surgeon and likely plan will be a loop ileostomy followed by PFMT, and then possibly a reversal.

7. 26 y/o M with UC. Please see below for further details.

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:

26 y/o M with PMH of UC, hyponatremia, small bowel obstruction, sinus bradycardia, AKI, anemia, increased ileostomy output, postop N/V, and Cdiff colitis in 9/2022. PSH is significant for total colectomy and J pouch creation in 2/2024. Patient required anal dilation x1 post procedure. Patient is scheduled for reversal of ileostomy on 8/8/2024. Patient does not smoke, vape, or drink EtOH and is otherwise healthy.

Medications: acetaminophen 650 mg po Q6H, loperamide 2mg po before meals and at HS, multivitamin po QD, ondansetron 4 mg QD prn for nausea
Labs: HH 12.6/37.6, HCT 37.6, WBC 10.7, PLT 333, Na 138, K 3.9, Ca 9.1, Chl 103, Gluc 98, eGFR 124, BUN 18, CREAT 0.84, PT 13.4, INR 1.3, APTT 29.9, ALT 17, AST 21

Patient is A+Ox3, well looking, but underweight. Patient reports good po intake, no N/V, no abdominal pain. Patients ileostomy pouch is intact, he reports no issues with leakage. Pouch is clear and loop stoma noted to be budded, red, and moist, and producing liquid stool. Patient reports emptying pouch 2-3 times daily. Peristomal skin and MCJ not examined as appliance left intact. Patient reports he cares for this independently. Abdomen is flat, soft, and non-tender. There is a transverse closed incisional scar to the lower abdomen. No signs of dehiscence, abscess, or infection. Patient assisted to exam table and placed in left side-lying position for rectal exam. Patient was able to tolerate this exam with deep breathing exercises but did report pain with exam. MD performed rectal exam and noted mild stricture. Patient does have reversal scheduled in 3 weeks, so no plan for dilation at this time. Perirectal skin intact and free from signs of irritation. Patient reported to have this at last visit, and this has resolved. Patient is scheduled for gastrografin enema today to assess healing of J-pouch and assess for any anastomotic leaks. Patient educated on procedure and verbalized understanding of procedure and rationale. Patient also given preop education for upcoming closure (clear liquid diet the day prior to surgery followed by NPO after midnight the day of), assessed for understanding of preop education and of the procedure itself. Patient consented for procedure to avoid another trip into the hospital prior to surgery. MD to have video visit the day before surgery to discuss procedure again and answer any more questions the patient may have. Patient and his mother have no

further questions or concerns at this time.

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)

1. Cleanse peristomal tissue with warm water and dry gently, but thoroughly
2. Continue with patients current pouching system as he is reporting no issues with leakage. Apply Hollister New Image Cera Plus flat skin barrier with aperture cut to fit stoma with no larger than 1/8" space around the stoma. Couple this with Hollister clear drainable pouch of the same size with lock and roll closure. Empty when 1/3 to ½ full.
3. Administer loperamide before meals and at bedtime to help thicken stool and avoid high output
4. Monitor stoma output and notify surgeon for output greater than 1200 ml in 24 hours.
5. Monitor patient for any signs of dehydration such as dizziness, thirst, tachycardia, low BP, or concentrated urine and notify the surgeon.
6. Address any questions or concerns preoperatively and consult WOC nursing as needed for education.
7. Post-operatively assess patients' po intake, stool output, bowel sounds, and perianal skin.
8. Provide patient a diet and stool diary post-op.
9. Place WOC nurse consult for education post-operatively.
10. Nutritional consult for diet appropriate to IPAA and calorie protein needs.

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

Overall, I thought the care and education provided to this patient was excellent. One change I would have made was I would have used lidocaine jelly for the rectal exam. It seemed that he had a painful exam at his last appointment as well and I think this might have helped him tolerate this better.

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?

I wanted to gain more experience in developing a POC for different types of colorectal patients. I feel like this goal was met. Dr. Spivak lays out a POC for her patients, and I was lucky enough to sit in on the morning conference where the doctors worked out a POC together for patients they wanted to discuss.

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

If I see a patient coming in for pouching issues, I would like to trouble shoot this and discuss it with the WOC nurse. I would also like to apply everything independently (especially if there is a need for Hollihesive, I don't always understand how they choose the shape they have decided on).

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,	✓	

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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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