Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Elisa Weil Day/Date: 7-18-24

Number of Clinical Hours Today: 10

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

Preceptor: Michelle Harris-Farrell

Clinical Focus: Wound ____ Ostomy x 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's patient load included 7 ostomy and wound care patients. We started the day seeing a 54 year old male admitted for a colovesical fistula. The patient was admitted on 7/17 with plans to go the OR for a laparoscopic colectomy of the sigmoid colon with colorectal anastomosis. To prepare for possible ostomy creation, we were consulted for stoma marking. The patient was examined while in the supine, sitting, and standing position. The abdominal rectus muscle was identified as was the waste line. Two areas were identified on the LR and LL quadrants. The areas were marked with skin markers and protected with Tegaderm dressing. Education regarding what to expect was provided to the patient with a stoma model and pouch. The patient's spouse was present for teaching.

The next patient we saw was a 62 year old male admitted with inflammatory bowel disease, small B-cell lymphoma, and ulcerative pancolitis. The patient has a total proctatectomy with ileal pouch anal anastomosis and diverting ileostomy on 7/12/24. The stoma nurse changed the pouch on 7/15 but the patient was not ready for education at that time. Today, the patient was agreeable and spouse was present. The products were laid out in front of the patient and spouse prior to starting, and they were educated on what everything was. The patient also assisted in emptying the pouch prior to pouch change, 200 ml of yellow, watery effluent was emptied. The pouch was then removed using adhesive remover wipes. The stoma was 1 ½" in diameter, budded, pink, and moist. Mucotaneous junction was intact. Peristomal skin was intact. Patient was educated about the crusting technique if skin breakdown was present. Skin prep was applied to peri-stomal skin and allowed to dry. Hollister Cera Ring was applied, and then Hollister 2 piece, 2¾" flat appliance was applied. The patient and spouse were educated on all of the products, the steps to changing an appliance, when to empty, showering, diet, and being aware of signs of dehydration. The patient was extremely appreciative and felt more comfortable with his appliance.

We saw a 75 year old patient POD #7 for an end ileostomy. This is a second post operative visit. The pouch was changed on 7/15 and the patient refused education at that time. The patient was agreeable to education this visit however, he did not want to participate in changing the appliance. 100 mL of green pasty effluent was emptied from the pouch. The pouch was removed with adhesive remover wipes. The area was cleaned with a soft cloth and water. The stoma was 1 1/8" in diameter, budded, pink, and moist. The peristomal skin was intact. Skin prep was applied. Once the skin was dry, a Cera barrier ring was applied around the stoma. A Hollister 2- Piece 2 ¼" Flat pouching system was applied. Further education included when to empty, showering, measuring and recording output, and when to contact the physician or stoma nurse. The patient verbalized understanding.

Next we saw a 59 year old male admitted for cellulitis and sepsis. The patient was seen by wound care team last month for a brown recluse spider bite to the anterior portion of the LLE. Wound measures 0.4 cm x 0.4 cm, and is dry, brown, and crusted over. The patient now has a wound to the RLE that he is unsure how he obtained. Wound to the lateral RLE is 4cm x 1 cm x 0.1 cm. The wound bed is dry, pink, and crusted. Peri-wound is peeling. The surrounding skin is tight and warm to the touch. The patient is on systemic Vancomycin and Zosyn. The wounds were cleansed with normal saline and painted with iodine. No further

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recommendations at this time.

Next up was a 78 year old female for a second follow up visit for an end descending colostomy. We attempted to see this patient 3 times before she would allow us to assess her ostomy and refused any teaching or participation. This patient had surgery on 7/13/24 and has not had any output. She has received an enemas via foley through the stoma today. With another enema scheduled for later this afternoon. Patient's daughter was at bedside for pouch change. The appliance was removed with adhesive wipes. The area was cleaned with soft cloth and warm water then dried. The stoma measured 1 1/8" in diameter, pink, moist and at skin level. Peristomal skin was intact. Skin prep was applied and allowed to dry. A Cera Plus barrier ring was applied and then a 2 piece Hollister 2 ¼" soft convex pouch was applied. The patient nor daughter participated with pouch change.

Then we saw a 58 year old male admitted for complicated UTI. This patient is a paraplegic from MVA and has a neurogenic bladder. The patient intermittently self catheterizes himself, however currently has an indwelling urinary catheter with a Quick Change Continence wrap due to leakage. The patient has a healing stage 4 POA wound to the right ischium. The wound measures 4.9 cm x 1.3 cm x 1.3 cm. The wound bed is pink and moist with small serosanguinous drainage. The peri-wound is scarred and hyperpigmented. The wound was cleansed with normal saline. Hydrofera Blue was applied to the wound bed and then covered with bordered foam dressing.

We saw a 92 year old male in the ED that was being admitted for pneumonia. The patient is incontinent of urine and feces. The patient presented with MASD and friction related partial thickness wounds to the right buttock. Wound bed is pink, red, and blanchable. The patient was cleaned with bathing wipes and Triad cream was applied to the wound. A sacral foam dressing was applied for preventive measures and the patient was offloaded.

At the end of the day, I was able to attend an Ostomy Support Group. The attendees to the meeting were very vocal on how helpful these group meetings are. A colorectal physician attended and was able to answer questions pertaining to surgery, and ostomates were able to relay their experiences. My facility is working on creating a group in our area and one of our outpatient clinic nurses attended to see how the program was run.

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:

A.M. is a 58 year old male, admitted on 7/10/24 for complicated UTI. The patient has a past medical history significant for paraplegia, neurogenic bladder with intermittent self catheterization, recurrent UTI's, and a present of admission Stage 4 pressure injury to the right ischium.

Pertinent lab values include BUN 32, Creatinine 1.64, Hgb 8.7.

The patient's current medication regiment is Meropenem every 8 hours, lactulose 3 times daily, polyethylene glycol daily, Colace twice daily, Trospium twice daily, and Percocet every 6 hours for chronic back pain.

CT of the abdomen from 7/17/2024 shows moderate urinary bladder wall thickening and associated ill-defined stranding of the perivesical fat consistent with cystitis, and prostatomegaly. The patient has a large fecal load suggestive of fecal impaction. Decubitus ulcer to the right ischium with associated focal sclerosis consistent with chronic osteomyelitis.

Urology was consulted for management recommendations for hydronephrosis. An indwelling urinary catheter was recommended and placed on 7/13/24. Leakage around the catheter site was noted and a Quick Change Incontinence Wrap was in place. The

patient is on Trospium twice daily for overactive bladder.

The patient is currently on a bowel regiment of lactulose 3 times per day , Miralax once daily, and Colace twice daily to stimulate bowel movement.

The patient has a stage 4 pressure injury to the right ischium that is present on admission. The wound measures 5.0 cm x 1.2 cm with an unknown depth. The wound is pink and moist with small amounts of serosanguinous drainage. The peri-wound is scarred and hyperpigmented. The wound was cleansed with normal saline and Hydrofera Blue was applied to the wound bed, then covered with bordered foam dressing.

The patient has refused offloading of the coccyx and heels. The patient was educated on the importance of turning, repositioning, and offloading to prevent further pressure injuries. The patient is on a pressure redistribution surface.

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)

- Dressing care: Every 3 days and PRN if dressing becomes soiled. Clean wound to right ischium with normal saline. Pat dry. Apply Hydrofera Blue to wound bed, shiny side away from the wound. Covered with Allevyn 4 x4 bordered foam dressing.
- Inspect skin every shift.
- Nutrition consult
- Q2 turns, repositioning, and offloading
- Apply Allevyn bordered foam heel protectors every 3 days. Check skin under dressing each shift.
- BID and during periods of fecal incontinence, clean patient with Sage Shield Barrier wipes and apply Coloplast Citric-Aid moisture barrier
- Once indwelling catheter is removed, patient needs education on proper technique for self-catheterizing to minimize the risk of infection
- This patient may need manual disimpaction if pharmacological interventions (Miralax, Colace, and Lactulose) do not stimulate bowel movement.
- Once constipation resolves, patient should be on a targeted toileting schedule. Since this patient is paraplegic, the patient should not be left on the bed pan for more than 5 minutes to prevent pressure injury.
- Hill-Rom Low Air Loss Mattress
- Quick Change Incontinence Wrap should be changed immediately when it becomes soiled.
- Only one absorbent sheet should be placed under patient at all times.
- Turn and Position System to be placed under patient to aid with turning and repositioning.

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

I agree with the interventions in place. The patient needs to be continuously educated on the importance of turning and repositioning even though he is resistant to it. Another option for the dressing would be to pack the wound with Hydrofera Classic as opposed to Hydrofera Ready.

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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? My goal for today was to work with NPWT. Unfortunately our assigned patients did not include any NPWT. I did get to work with many ostomies and several incontinent patients.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) I am hoping to spend some time learning about urodynamics.

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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