Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Darleen Olsen_____ Day/Date: __7/25/2024_____

Number of Clinical Hours Today: _8___

Care Setting: Hospital ___Inpatient Wound_ Ambulatory Care _x___ Home Care ____ Other ___

Preceptor: _____Caitlyn Deckard_____

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.

The first patient I saw was for planned anorectal manometry. The patient has been having issues with constipation. She previously had some fecal incontinence leakage a couple weeks ago most likely related to constipation per NP. The patient was found to have weak pelvic floor muscles. The patient in the past has not responded well to Miralax and had incontinence. The provider recommended increasing her fiber intake and fluids as she does drink 2 cups of coffees and water with a total of fluids being 1.5L. An x-ray, squatty potty, and pelvic floor muscle exercise with PT was recommended for the patient.

The second patient I saw was also having constipation issues and had a planned anorectal manometry for lifelong constipation. The takes Metamucil daily with 8 ounces of water. The patient is unsure of how much fluids she drinks but thinks it is 1 L. Recommended increasing fluids to 2L per day as well as fiber. The patient has diarrhea with high fiber foods and tries to avoid them. The perianal and perineum skin looked healthy. The patient was found to have high resting and squeeze pressures. PT was recommended for relaxation of pelvic floor muscles.

The third patient I saw had anorectal manometry scheduled severe rectal pain. She has two anal fissures. The patient results showed she has rest pressures and squeeze pressures about the same. Patient had digital rectal exam. Per NP, this was evident in DRE. Patient referred for pelvic floor muscle with physical therapy for strengthening and for coordination of pelvic floor muscles and anal sphincter as patient did have some paradoxical movement.

The fourth patient I saw was for a follow up of a colostomy closure about a month ago and is having urgency for bowel movements. She has stool incontinence 1-2 times per day. Per NP, this is not abnormal as it may take around 6 months to return to regular bowel movements. The patient had an abdominal wound partial thickness from colostomy closure. The looks to be progressing well towards healing.

The fifth patient I saw had a change of an implantable nerve stimulation device due to low battery. The patient has surgical incisions appear approximated and are scabbed over. The patient stated she feels very full from her bladder and only dribbles. She said she is also sometimes incontinent. NP provided a referral to Urologist for possible urinary retention.

The sixth patient I saw had a virtual consult as patient is having increased drainage from abdominoperineal resection (APR) and a new colostomy two months ago. The patient had this done for Crohn's disease. The patient sent an image through the chart and a virtual assessment of the perineal wound was conducted by the NP and myself. There seemed to be a small bulge on the left buttock close to the incision. The patient said it felt hard. Discussed with patient to monitor for signs and symptoms of infection including chills, fever, increase in drainage, erythema, increase in swelling, and odor to drainage. Patient education to keep area clean and dry and to call with any changes of possible infection. Patient scheduled for August 1, 2024 to be seen by Colorectal surgeon.

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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:

Reason for Visit: Follow up Postoperatively 1 month and fecal incontinence

Age/sex: 47-year-old Female
Allergies: No known drug allergies
PMH: Diverting colostomy, posterior intersphincter fistula, necrotizing fasciitis requiring debridement of the perineum and diverting colostomy with flap placement, and laparoscopic closure of enterostomy w/resection and anastomosis.
CC: "I have stool 6-8 times per day with 1-2 of this incontinent smears of stool"
Social hx: Denies drug, smoking, and alcohol use.
Meds: Ibuprofen 200 mg PRN every 8 hours for pain and Acetaminophen 1,000 mg PRN every 6 hours for
Labs: WBC 4.9 k/uL, RBC 3.9 m/uL, Hemoglobin 12.6 g /dL, Hematocrit 38.9 %, Platelet count 224 k/uL, Protein 6.8 g/dL, Calcium 9.5 mg/dL, BUN 15 mg/dL, Cr 1.1 mg/dL, Glucose 86 mm/dL

LOC: Alert and oriented x 3.

Patient assessed in conjunction with Colorectal Surgery NP. The patient previously had necrotizing fascitits that required debridement of the perineum and a diverting colostomy for the perineum to heal. The patient subsequently had a flap placed and healed. The patient had laparoscopic closure of enterostomy with resection anastomosis on 6/27/2024 and is present for follow up postop with stool incontinence. Patient is sitting on chair and requested for patient to lay on bed. Patient independently got onto bed safely. The patient had a Med Pride Waterproof foam dressing on the wound. Removed dressing with Essenta no sting adhesive remover. The patient has a LUQ closure site on the abdomen healing well and is partial thickness measuring 0.8 cm x 1.6 cm x 0.1 cm. The peri-wound is healthy and pink with scar tissue present. The patient had been covering with Med Pride Waterproof foam dressing every other day per direction of Colorectal surgeon and are content with price and number of dressings in box. The wound was cleansed with soap, water, and nonwoven gauze. Then pat dried. The patient's perianal area has mild incontinence associated dermatitis present with mild erythema and all areas closed. The area was cleansed with mild soap and tap water. Applied Cavilon 3M to affected are of erythema as no Desitin available. The patient has 6-8 stools with urgency. The patient has 1-2 incontinence episodes of stool small amount of stool smear like. The patient has been using pads to help absorb any incontinence of stool and switches pad right after stool incontinence and cleansing. Discussed with patient of utilizing Desitin BID after cleansing with pH balanced foam cleanser and drying by patting gently. Discussed with patient to also use PRN with any stool incontinence after cleansing with pH balanced foam cleanser and patting dry. Discussed with patient of continuing to use pads and changing after each incontinent episode. Discussed with patient oral intake and fluid intake. Discussed with patient of Nutrition consult referral for nutrition optimization with frequent loose stools and for wound healing. Patient has bene on soft food diet. Discussed with patient to continue drinking 2-2.7 L of fluid per day for adequate

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hydration as well as follow increase of food intake as directed by NP. Per NP to start adding new foods each day high in fiber one at a time to see how patient tolerates. Patient to follow up in 2 weeks to assess fecal incontinence and incisional closure wound. NP stated the amount of fecal incontinence at this time is within normal limits of with closure of colostomy. No other bowel management methods or medications recommended by NP at this time. Upon completion of visit. Patient walked out of the office safely. Patient tolerated assessment and did teach back of education for wound care of abdomen, monitoring, and incontinence associated dermatitis care of perianal area. Patient in agreement with plan.

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)

-Perianal area incontinence associated dermatitis: Gently cleanse with pH balanced foam cleanser, Remedy PhytoPlex no-rinse and clean wash cloth by gently patting. Pat dry. Apply Desitin BID and PRN with any incontinence of stool.
-Abdomen closure site wound: Cleanse with soap and water and soft nonwoven gauze Medline. Pat dry. Cover with Med Pride Waterproof foam dressing every other day and PRN for strikethrough or if wet.
-Consult Nutrition for nutrition optimization for wound healing and progression of diet as patient tolerates.
-Monitor labs CBC, electrolytes, and BMP for abnormal lab values and notify Primary Service for management at next follow-up visit.
-Patient to monitor for cramping, weakness, numbness, or tingling as this may be a deficiency of potassium. Call your Primary Care Provider if these signs/symptoms are noted for management
-Monitor wound for induration or boggy wound, erythema, increase in drainage, foul odor drainage, fever, swelling, and warmth.
-Introduce new foods one day at a time and do as patient tolerates and follow up on follow visit in 2 weeks
-Bowel diary for 2 weeks and assess on follow up visit in 2 weeks. Bowel diary to include date, time, urgency, quantity of stool, accidental leakage, stool consistency, and any management for bowel movements
-24-hour recall of food and drink intake on follow up visit in 2 weeks
-If increase in fecal incontinence call Colorectal surgeon NP for further management

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

I think the care provided was great. One of the patient's I saw with the provider stated the patient was drinking caffeine and should know to not drink caffeine and did not discuss lowering caffeine intake. I think sometimes we may think patients know but they may not know or not remember. I think a gentle reminder to the patient of lowering caffeine intake in the presence of urinary incontinence is beneficial as reinforcement of education can help a patient.

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 the day was to identify continence issues and management. I was able to identify urinary incontinence, fecal incontinence, and a patient that appeared to have urinary retention. The NP agreed with my thought of plans for these issues. I also created a care plan for incontinence for one the patients I saw as described above.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
My goal for tomorrow is to identify and learn about a patient who has continence issues who would benefit from a management plan as well as any skin issues associated with this.

CRITICAL ELEMENTS	Completed	Missing

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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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