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: __7/26/2024_____

Number of Clinical Hours Today: _8___

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

Preceptor: _____Aaron Fischer_____

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 a very complex patient with a gastrostomy, jejunostomy, vesicocutaneous fistula, and urinary incontinence. This patient was consulted for leaking pouch in 24 hours. This patient has multiple leak issues and can leak twice in a day to a wear time of 36 hours. The patient has significant depressions and creases in her abdomen from multiple surgeries and her abdomen has a large depression. The patient has urinary incontinence as well.

The second patient I saw has a colostomy who is not having output and has firm hard stools. She is currently requiring irrigation. I did a colostomy irrigation with her. She had spurting out stool with the irrigation. She also had very firm stools of output appearing to be like nuggets of stools. The patient tolerated the irrigation well. She currently has an indwelling urinary catheter in the ICU as she is incontinent and requires hourly monitoring of urine output for medical reasons.

The third patient I saw was a colostomy who was having leaking from the pouch. The patient stated she felt wet underneath her Chux pad after she sneezed. Upon assessment, I revealed a small amount of urine on the Chux pad. I inquired of how often she is incontinent and she stated with sneezing, coughing, or even laughing. I discussed with her pelvic floor muscle exercises and assessed her perineum area.

The last patient I saw was a consult for negative pressure wound therapy for a sternal incision. The patient had bleeding at sternal incision yesterday and Surgicel was applied to help stop the bleeding. Today, we went to assess if negative pressure wound therapy may be applied. The wound had been packed due to bleeding. We removed the packing content of the wound and left the Surgicel intact. I applied pressure for 15 minutes at the sight of bleeding. We applied Surgicel over the area that had blood oozing and I applied pressure for 10 minutes. After I removed my hand for pressure at this time it was not bleeding anymore. We packed the wound by applying Hydrogel on the Kerlix and covering with ABD pad and securing with Kind Tape. We discussed with nursing of negative pressure wound therapy not being able to be applied today due to oozing of blood during visit with patient. Discussed with nursing to continue packing BID and PRN for strikethrough and plan for WOC stoma nurse to follow up tomorrow and assess for negative pressure wound therapy.

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:

Reason for Visit: Consult for leaking colostomy pouch

Age/sex: 61-year-old Female
Allergies: No known allergies
PMH: Sepsis, hyperkalemia, CKD stage 4, Hypotension, Anemia, Acute kidney injury, small bowel obstruction, end colostomy, and stress urinary incontinence (per patient report)
CC: "I peed myself. I am wet now."
Social hx: Per medical chart review, denies smoking, alcohol use, and drug use.
Meds: Calcium carbonate 500 mg TID PRN, Norepinephrine 0.6-10 mc/min continuous, Potassium chloride ER 20-40 mEq PO PRN, Magnesium sulfate IV piggyback 2 g PRN, Acetaminophen 500 mg every 6 hours PRN, Enoxaparin 40 mg SubQ every 24 hours, and Polythylene glycol 3350 17 g PO PRN
Labs: WBC 9.8 k/uL, RBC 3.21 m/uL, Hemoglobin 11.1 g /dL, Hematocrit 30.1 %, Platelet count 258 k/uL, Protein 5.4 g/dL, Calcium 8.7 mg/dL, BUN 30 mg/dL, Cr 1.3 mg/dL, Glucose 83 mm/dL

LOC: Alter and oriented x 3.

Patient assessed in conjunction with WOC stoma nurse. Patient is laying on her back. Pouch found to be leaking at 10 o'clock. Pouch system removed with Esenta no sting adhesive remover by push pull method and supporting skin. The patient has denuded skin from 8-10 o'clock. The patient states she was previously using some convexity and not a flat pouch. Patient switch to convex system. The stoma looked healthy, red, moist, and budded. The peristomal skin was cleansed with mild soap and nonwoven soft gauze gently. The area was pat dried gently. Stomahesive Protective powder applied on peristomal skin and excess dusted off and sealed with 3M Cavilon. Then 2 ¼" Hollister New Image CeraPlus convex was cut-to-fit flange to 1 1/8," and connected to 30 mm Hollister Adapt convex ring. Then connect to 2 ¼" Hollister New Image pouch. Then applied to peristomal skin appropriately. Patient was content with new pouch system.

Stoma Type: End colostomy Diametere: 1"
Location: LLQ
Protrusion: Budded
Mucosal condition and color: Red and moist
Mucocutaneous junction: Intact
Peristomal skin: Denuded at 8-10 o'clock. Stomahesive Protective powder and sealed with 3M Cavilon no sting barrier film.
Supportive tissue: Soft
Character output: Brown paste stool
Emptying frequency: per pt/nursing staff

Patient sneezed during pouch system change and stated "I peed myself. I am wet now." WOC student inquired of when patient has urinary incontinence and patient stated only when she sneezes, coughs, or laughs. Patient stated she has been told by her PCP that she has the starting stages of stress incontinence. WOC student discussed patient performing pelvic floor muscle training. Patient stated she had been working with a physical therapist for Kegel/pelvic floor muscle training for a month before being admitted in the

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hospital. Patient turned to right side with assistance of WOC nurse. WOC student assessed the perineum area and there are a couple of satellite lesions of yeast noted on the perineum area, no open areas or prolapse noted. Patient cleansed with bath wipes pH balanced Ready Bath Fresh Medline and allowed to dry. Desitin applied. Per patient bedside nursing has been utilizing Desitin with pericare. Discussed with bedside nursing recommendation of Nystatin powder and continued use of Desitin. Desitin to be applied over the Nystatin powder once the excess is dusted off. Chux pad changed underneath patient. Patient turned to left side with assistance of WOC nurse by placing wedges on the right and offloading the sacrum. Patient has Tru-Vue heel on bilateral lower extremities. Bedside nurse discussed with Primary Service of Nystatin powder and per chart review, Primary Service ordered Nystatin powder after visit. Discussed with patient to continue working with PT for pelvic floor muscle exercises for management of continence. Discussed with patient and bedside nursing for patient to continue pelvic muscle floor exercises while she is admitted in the hospital and patient as well as bedside nurse in agreement. Patient stated she has noted mild improvement of stress incontinence, urinary incontinence with coughing, sneezing, and laughing, after starting pelvic floor muscle training began with PT. Patient was told by PT outpatient, before being admitting to the hospital to do pelvic floor muscle exercises TID for 8-10 repetitions. Patient to continue same regimen here in the hospital. Bedside nurse and patient in agreement. Patient covered with blankets for comfort. Patient tolerated assessment, pouch change, and cares well.

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)

-Perineum incontinence associated dermatitis: Gently cleanse with bath wipes pH balanced Ready Bath Fresh Medline and allow to dry. Apply and sprinkle Nystatin powder, dust off excess. Apply a layer of Desitin over the Nystatin powder. Apply BID when Nystatin is scheduled. If Nystatin is not scheduled and patient has an incontinent episode, after cleansing with pH balanced bath wipe and allowing to dry, apply a layer of Desitin. Continue Nystatin powder until satellite lesions of yeast resolve and per Primary Service discretion for discontinuation. Once resolved and Nystatin and Desitin has been discontinued by Primary service, continue utilizing pH balanced Ready Bath Fresh Medline bath wipes, after allowing to dry apply Critic-Aid after each incontinent episode.
-Pelvic floor muscle exercises 8-10 repetitions TID as patient tolerates
-Monitor incontinence associated dermatitis of perineum BID and PRN for worsening and consult WCCT for any worsening
-Monitor labs CBC, electrolytes, and BMP for abnormal lab values and notify Primary Service for management.
-Consider physical therapy consult for increase in strength and mobility
-Continue utilizing Tru-Vue heel protectors on bilateral lower extremities.

Recommendations for pouch change:
-Remove with Esenta no sting adhesive skin remover with push pull method from top to bottom. Cleanse with nonwoven soft gauze and tap water. Pat dry. Apply Stomahesive Protect Powder on peristomal skin and dust off excess. Seal with 3M Cavilon no sting barrier film. Then cut 2 ¼" Hollister New Image CeraPlus convex cut to fit flange to 1 1/8," and connect to 30 mm Hollister Adapt convex ring, and connect to 2 ¼" Hollister New Image pouch.
-Change very 3-4 days PRN for leaking
-Consult WOC stoma nurse for any leakage issues
-Encourage patient of participation in pouch change
-Continue emptying pouch when 1/3-1/2 full
-Monitor peristomal skin for worsening and reconsult WOC stoma nurse for any worsening for management
-Monitor and notify Colorectal surgeon for dark red/black coloration, lack of output, pale coloration

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

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I thought the care provided has been wonderful. Reflecting back on something that could be improved is the patient did not have any wedges or pillows to help offload the sacrum or coccyx. I think this may be improved by offloading the sacrum and coccyx with wedges for prevention of a pressure injury. We did do this for the patient before leaving the room.

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 an incontinence issue and identify how to manage. I believe I met this goal as I discussed pelvic floor muscle exercises with the patient and she has been doing PT for PFM training. I discussed with the patient continuing PFMT with PT and to continue doing them while she is in bed here in the hospital.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Today was my last day of clinical. I am grateful for everything I learned and continue to learn.

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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