Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Kathleen Fetters Day/Date: Tuesday 7/30/24

Number of Clinical Hours Today: 8

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

Preceptor: Erica Aiken

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.

Today we saw 5 patients with continence focus. First patient was a sacral NPWT dressing change. This patient was previously being taken back and forth to the OR for serial debridement and today was first day WOC nurse was doing dressing change. Patient also with fecal and urinary incontinence and nursing was having concerns of dressing integrity due to previously having to page surgery team for sooner dressing change due to stool undermining dressing. Wound looked much improved with 100% granulation tissue. We changed dressing and bedside RN stated she was having frequent liquid stools but did not void due to being on HD due to CKD. We discussed use of external fecal collection device as she had enough surface area for application. We applied pouch. Second patient was a wound consult for IAD. This patient was admitted for UTI on IV ABX also with diarrhea. Stool sample was negative. At baseline is incontinent of bladder only. She reports she recently ran out of her usual incontinence pads she uses so had to get an off brand and was irritating her skin as it was sticking a lot. She then got a stomach bug and recently lost insurance so had not been taking her diabetic medications. We assessed her skin, and she had satellite lesions consistent with fungal etiology so ordered nystatin ointment. We discussed in detail bladder irritating fluids and foods as well as uncontrolled blood sugars effect on continence. We also discussed considering a workup with a urology/gynecology provider regarding cause of her incontinence and evaluate her pelvic floor to determine if therapy may be indicated or other urodynamic testing. We also discussed skin protectants to use to prevent further skin breakdown after fungal rash heals up. She was very receptive to talk to. She declined use of purewick due to her anatomy was not fitting well. After the visit my preceptor and I discussed possible testing we would order if in outpatient Uro/Gyn office for testing. Third patient was wound consult for stage 3 to left buttocks and IAD to perineal/perianal area. She was confused but her daughter was present. We educated nurses on importance of using Imodium to help mitigate liquid stool as she couldn't use a external collection device due to her perianal skin with IAD. Next we attended a meeting with our Convatec representative regarding internal and external fecal management devices. He put a lot into perspective. He told us about some recent incidences they have seen with the internal flexiseal including one facility overfilling balloon to over 500mls due to instilling an enema into the balloon port and caused severe rectal damage to the patient. He went over criteria for internal vs external collection devices. It was good to hear that they do not want everyone to have these devices and that it really should be last resort if unable to manage externally and should be used for the least amount of time to prevent damage. Fourth patient was problem ostomy patient, she is well known to the team here she has a flush ileostomy high output and has adhesive related skin damage due to her changing her pouch 7-12 times a day. We tried to assess her peristomal skin and discuss alternative pouching techniques, but she refused and says she has tried it all and is having her reversal next week so declined our visit. My preceptor and I discussed alternative pouching steps based on the photo the nurses took and put in our note in the event she is willing to try different pouching and requested they reached out if something changes. Fifth patient was dry gangrene to right great toe and right fingers. Patient was on an impella pump which they believe cause these abnormalities to occur per the vascular surgery team as vascular studies of BUE and BLE was intact. It was stable and dry, educated RN on monitoring if becomes unstable, wet gangrene, loss of pulses to notify provider immediately. We recommended to leave open to air and dry.

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Patients seen: NPWT stage 4 pressure injury with fecal incontinence placed external rectal pouch, IAD with fungal rash education on bladder stimulating foods/fluids/diabetes impact, Stage 3 pressure injury with IAD, Convatec Flexiseal Meeting, high output ileostomy patient, dry gangrene on toes and fingers

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:

WOC nurse consulted for stage 3 to left buttocks and IAD to perineal/perianal area. This is an initial assessment. Patient admitted with fall found to have UTI currently on IV ABX. Patient with documented past medical history of HTN, CKD stage 3. No past surgical history noted. Allergies, medications, and laboratory results reviewed. Patient was also found to have diarrhea on admission, Patient was ruled out for C. Diff and enteric pathogens with stool sample which was negative. Patient seen at bedside, laying in bed. Patient alert to self and pleasant. Patient's daughter at bedside, agreeable to WOC nurse visit. Patient's daughter reports patient incontinent of bowel and bladder at baseline reports prior to admission patient with increased episodes of urinary and fecal incontinence and was having difficulty manage episodes with Attends pull ups and she started to notice skin breakdown to posterior pelvis area. Patient's daughter reports the provider over the weekend was recommending a foley catheter to assist with urinary incontinence, but daughter refused due to concern of increased UTIs. Discussed benefits and risks with indwelling urinary catheters and daughter reports she would like to see if urinary frequency decreases with UTI being treated. Discussed with daughter bladder stimulating foods and foods that can help thicken the stool including the BRAT diet. Daughter verbalized understanding. Stage 3 to left buttocks and IAD noted to posterior pelvis, perineal/perianal area open to air. Per unit RN they have been using Medline Remedy Phytoplex 4:1 Barrier Cream Cloths wipes prn incontinent episodes and leaving skin open to air with use of bed pad Medline Ultrasorb Advanced Extra Strength Dry Pads while in bed and Attends pull-ups when OOB to chair or working with therapy services. Periwound of left buttocks stage 3 with IAD noted and maceration, but no fluctuance/crepitus/induration/increased warmth noted to periwound. Small amount of serosanguineous drainage noted to bed pad, no odor noted. Wound measuring 1.5cm length x 1cm width x 0.2cm depth. Adipose tissue exposed to wound base; no necrotic tissue noted. Wound cleansed with Medline Remedy Phyoplex wipes and applied Medline Remedy Protect Zinc Oxide Paste to posterior pelvis, perineal, perianal, and left buttocks. Patient tolerated assessment well, with no signs or symptoms of pain noted. Recommend switching to zinc oxide cream 40% BID and prn incontinence due to periwound maceration and inability to maintain dressing integrity due to unmanaged incontinence. Imodium ordered and per MAR review has not been administered. Discussed with unit RN to utilize Imodium per order to assist with mitigating liquid stool. Updated daughter and bedside RN on topical recommendations, agreeable. All questions answered. WOC to continue to follow patient.

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)

Wound care orders:
-Cleanse left buttocks wound, posterior pelvis, perineal, and perianal area with 3M Cavilon No-Rinse Skin Cleanser
-Apply zinc oxide 40% cream and leave open to air BID and prn incontinence

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-Do not rub residual zinc oxide cream off vigorously after cleansing as this can lead to further skin breakdown
-Mineral oil prn for removal of residual zinc oxide cream for skin inspection frequency per Braden Q 8 hours
-Document stool counts including color, consistency, and amount at minimum Q 8 hours or per I&O order per provider
-Nutrition consult to assist in optimizing patients' nutrition and evaluating need for additional protein supplementation to assist with wound healing
-Consider addition of foods to help thicken stool (BRAT diet: Breads, rice, potatoes, applesauce, whole-grain pasta, bananas, tapioca, creamy peanut butter)
-Avoid bladder irritating fluids such as caffeine, soda, carbonated beverages, citrus, chocolate, and alcohol
-Drink at least 8-10 glasses of water or liquids each day
-Administer Imodium prn per provider order for diarrhea to mitigate liquid stool
-Use Medline Ultrasorb Advanced Extra Strength Dry Pads while in bed
-Use Attends pull-ups when OOB to chair or working with therapy services.
-Turn and offload patient with wedge/pillows limiting time on left side
-Frequent incontinence rounding every two hours minimally and promptly toilet patient to prevent further skin breakdown
-Bladder scan Q 6 hours to monitor for urinary retention ;straight catheterize for volumes of 400ml of greater
-Notify WOC and provider for any deterioration of wound, necrotic tissue, odor, increased drainage

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

It was nice to be able to get a baseline from the daughter since the patient was pleasantly confused. I liked that I was able to discuss diet a little with them as well to create a more holistic visit.

Alternative: Cleansing with Smith & Nephew Proshield Foam & Spray incontinence cleanser and applying 3M Cavilon Durable Barrier Cream

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?

To be exposed to more continence related issues and troubleshooting

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

Be exposed to more problem ostomy patients and using accessory products/adjusting treatment

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	✓	

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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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