Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Belinda Chapa Day/Date: 8/26/24

Number of Clinical Hours Today: 12 hrs

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

Preceptor: Jennifer Scheile

Clinical Focus: Wound X Ostomy ____ Continence ____

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.

First patient of the day was a 25 y/o female who was diagnosed with rectal cancer and needed stoma marking before surgery. We went into patient room with 2 tegederm and marking pen. Assessed the patients belly for creases or folds while laying, sitting, and standing. We located the abdominal muscles and base of ribs and marked their edges with a small line. We explained reasoning behind marking and patient verbalized she wants to make sure she can see her stoma and if we can mark 1 for first choice and so on. We explained to her that yes we will do that. Per doctors order he stated to mark on all 4 quadrants. We started with 1 on top left within the muscle, 2 at bottom left, 3 at top right and 4 at bottom right. We had the patient sit and stand after marking to ensure location is optimal and placed tegederm over markings. We informed patient that teachings will begin after surgery and wished her well. Second patient we saw was a consult for 68 y/o male with a mechanical device pressure injury to his lower lip. The patient was in the ICU for 48 days and developed injury from endotracheal tube that was now repositioned. The pressure injury was stage II and measured 1cm x 0.8cm x 0.1cm. We applied mouth moisturizer with cotton tipped swab and informed the primary nurse and placed order to offload the wound and apply moisturizer 3x a day. We changed the patients colostomy bag well. Removed the pouch with adhesive remover, cleansed the peristoma with warm water and gauze, assessed the stoma and took a photo, measured the stoma size, cut the skin barrier to size of stoma, dried the peristoma area, applied the skin barrier, then applied the pouch. The third patient we saw was 75 y/o male day 1 post op of ileal conduit due to bladder cancer. The patient is currently employed and frequently was receiving phone calls but was very active in managing his stoma cleaning and pouch changes. Day 1 we provided patient with handouts that include accessible videos to pouch changes, stoma care, and complications. We wrote all steps for pouch change and cleaning on a patient “chuk” with supplies to use next to steps. The patients wife was very involved as well and taking pictures of steps and application. We educated on the night time drainage bag which he was attached to and educated on how to remove and clean. We talked the patient through all steps and he was able to remove, clean, and change the pouch on his own. The patient has 2 stents currently in place and was informed that they will eventually be taken out in the next few weeks but to continue to place them into the pouch and careful not to pull on them, that they are there for patency and healing. The patient did have some mucous around stoma and informed that it is normal to have some mucous since is part of small intestine and is ok to clean off with paper towel. The patient was satisfied with learning and we informed day 2 we can go over complications. The fourth patient we saw was a 65 y/o female with moisture associated skin damage to bilateral groin and abdominal folds. The patient was of large habitus and had urinary incontinence. The patient was recently placed on purewick device to manage her incontinence and help relieve her MASD. Upon assessment the abdominal fold damage were healed bilaterally. We cleaned with wash cloth and warm water and placed interdry under bilateral abdominal folds to absorb moisture. The groin folds did have areas that were open the left measuring 0.4cm x 5cm x 0.1cm and right 0.5cm x 4cm x 0.1cm. The wounds were gently cleaned with vashe and gauze using a dab not rub technique. The periwound had erythema and small patchy rash such as candidiasis. Nystatin powder was applied and interdry in the folds to absorb the moisture. The fifth patient we saw was a 67 y/o retired teacher who underwent surgery for ileal conduit due to bladder cancer. The teaching for the day was for post op day 1 teaching. We educated the patient on the removal, cleansing, and reapplying of her pouch. We also talked about removing the night time drainage bag and being attentive to her pouch and emptying it regularly throughout the day.

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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:

Initial visit with 67 y/o female who is a retired teacher for day 1 education of removal, cleansing, and reapplying of ostomy pouch. Upon assessment the patient is pleasant and oriented x 4. She informed us that she is open for learning and education but would like her husband to be present due to her feeling "a little weak" she stated. She is on IV fluids NS for hydration and oral pain medication. She then calls her husband to come back as he had gone for a walk. The patients skin was assessed and everything is intact with no injuries. Her stoma appears red and moist through the pouch and her output at this time is pink tinged, which she was informed is normal. While her husband is making his way back, we draw out the steps of removal, cleansing, and repouching on a "chuk" with the supplies to be used next to each step. On her husband's arrival we notice he was not wanting to actively present in the teachings and rather sit in the corner of the room. The husband states he was listening. We started by talking about the nighttime drainage bag which holds larger volume for night to be emptied in the morning. We informed that this bag can be cleaned with vinegar and water and most insurance companies will provide 2 bags per month. This bag is the one the patient is currently connected to and we grabbed a towel to place on patients lap and had her disconnect the bag and close her pouch. The patient chose to stay in her bed during day 1 teaching due to pain and feeling weak. We pulled the table with all supplies close to the patient and informed to always have all her supplies ready and close to her. We started by handing her the Brava adhesive remover to spray the top of the pouch and pull down gently. Once the pouch is removed it can be disposed of. We recommended having several paper towels due to the continuous drainage from the stoma. Next the patient was able to clean the peristomal area with warm water and gauze. We informed her that she will have to measure the stoma using the measuring guide in the 2 piece sensura mio flex kit for the next 4 to 6 weeks or until the stoma has kept the same size for a few weeks. After this she will be able to order pre-cut skin barriers, and she will eliminate that sizing step. For now, she will measure and cut the barrier to fit stoma size. The patient measured 38mm round. She then asked for help with cutting due to her feeling weak but was able to apply the Coloplast Brava protective ring to the sticky side of skin barrier. She was taught to stretch the ring to fit around the opening of skin barrier and this ring would help with providing better seal and less chance of leakage. The patient then made sure with dry gauze that the periwound is dry and applied the skin barrier. The patient then took the pouch and removed the sticker seal and decided to fold it out in half to attach the bottom half and to able to visualize the sticker at it attaches slowly towards the top and within the inside the blue line of the barrier. While the drainage spout is at 6 o'clock the patient is taught to close this end and that is what she will use to drain throughout the day into a toilet. For today, the patient is in a lot of pain and not getting up as much and she reconnected to her large volume drainage bag. The wife informed us that she would like to continue practice tomorrow and was informed we will continue teaching tomorrow. The husband was asked if he had any questions and if he was able to follow and he informed yes that he got it all. The patient states she is looking forward to tomorrow when she is less tired.

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)

Plan for Day 2 teaching with patient should include:
Complications such as hydration, UTI, peristoma irritation, dietary considerations, mucous blockage.

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1. The patient should be taught that their output is continuous, and they should be continually drinking water throughout the day to keep from dehydration or infections. 8 to 10 glasses of water daily is recommended.
2. Urine is best to be kept acidic to keep away from infections. Cranberry juice or cranberry tablets daily will aid in the acidity of the urine.
3. Peristoma irritation may be due to leaking of the pouch, sweating, moisture or allergy. A careful assessment of the stoma, peristoma, skin barrier upon removal, wear times, and activity is important to consider. Typically, 3 to 4 day wear time is optimal for urostomy but depending on activity and sweating this may need earlier pouch change. Along with peristoma moisture and irritation crusting should be taught to the patient and a visual guide be provided in case they have future need. Crusting technique can be taught using the patients hand and beginning with cleansing the periwound (hand) with warm water and paper towel to dry. Next, the use of a moisture absorbent powder such as Brava powder to be lightly sprinkled onto the reddened area and brush off the excess lightly (too much powder can interfere with barrier seal). A barrier film such as cavilon barrier film spray, wands, or wipe is then sprayed or dabbed on the reddened area over the powder and allowed to dry. This same process can be applied to create 2 to 3 layers of crusting. Once the reddened skin has healed and redness is no longer noticed then discontinue use of crusting materials.
4. There is no dietary restriction to having an ileal conduit but there are foods to consider that can cause odors and color changes. Foods such as beer, broccoli, asparagus, and medications can cause odors and color changes. It has also been noted that orange juice and grape juice can cause urine to become too alkaline and cause infection problems. The patient should be given a pamphlet with urostomy information guide and provided United Ostomy Association of America website for more resources.
5. If stoma has large development of mucous the patient is informed to increase fluid intake and clean stoma with warm paper towel or wash cloth and leave sitting on stoma for a few minutes or take a warm bath and massage around stoma. If mucous does not clear then call your doctor or WOC nurse for help.
6. The patient should be informed of when to seek additional help from a doctor or wound ostomy nurse such as:
   Mucous blockage that has not resolved after intervention.
   Bleeding or injury to stoma.
   Change is size or shape of stoma.
   Proplase or retraction of stoma.
   Vomiting without ability to hydrate.
   Inability to keep pouch on longer than 2 days.

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

I believe that our care and education was useful but the patient was tired through the entire teaching. We believe that the pain medication was also a contributor to her tired feeling and her husband was not supportive. I feel that some education is better than no education. The next day once the patient is less tired and weak it will be better learning for the patient and if need be the WOC nurse will have to spend more time teaching pouch change and complications. All circumstances are different and some people have more support from their families and some have less. Day two education if possible would be to get the spouse and patient to be more attentive and interactive.

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 provide effective ostomy education including removal, cleansing, and repouching. Also, educating on what is a normal stoma and peristoma, complications and how to address them.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
To be able to assess wounds that require negative pressure wound therapy. Cleanse the wounds and apply the negative wound

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therapy device with supervision of my preceptor.

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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