Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Yoselyn Soto_____ Day/Date: _9/12/2024_

Number of Clinical Hours Today: _10___

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

Preceptor: _Candace Beeghly_____

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.

On my first day of practicum, we treated a patient for a wound vac dressing change, another patient with a fistula experiencing leakage issues with the pouching system, and a third patient who was consulted for the placement of an internal fecal device and a suprapubic catheter exchange. **1.** So Candace saw 3 patients on the 12th? Oh I'm sorry no. We had a consult to evaluate a surgical incision but it was healed and an Urostomy before discharge that's why I didn't add them.

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:

Medical history: 44-year-old female with cerebral palsy, chronic muscle spasms, multiple sclerosis, chronic physical debility mostly wheelchair-bound, history of traumatic brain injury, history of TIA, chronic tremors, migraine headaches, seizure disorder, asthma, allergic rhinitis, recurrent UTI, neurogenic bladder status post suprapubic catheter placement, chronic daytime sleepiness, GERD, hypothyroidism, chronic right buttock pressure ulcer, anxiety, depression, history of LLE DVT, history of kidney stones, chronic peripheral neuropathy, and obesity, PEG J dependent along with oral intake.

Chart note: Initial visit for internal fecal device placement and suprapubic catheter exchanged. When arrive at patient room, patient resting in bed, alert and oriented no signs of distress, mother at bedside. Assessed patient head to toe with focus on all bony prominences areas patient with irritant dermatitis due to the exposure of body secretions (feces), patient having diarrhea. Internal fecal device requested by IMG. Explained procedure to the patient/family. Inpatient wound management team assessed for contraindications and rectal tone. Proceeded to placed flexi-seal internal fecal device per manufacture specifications, inserted device rectally, balloon inflated to 35ml, position indicator line visible, catheter with no kinks and/or obstruction. Cleansed patient with protective barrier wipes and applied calazime zinc oxide for moisture barrier. Patient suprapubic catheter exchanged under sterile techniques per protocol, 24fr 10ml catheter inserted, inflated balloon with sterile water, no resistance to insertion, bleeding or pain. Appearance of the stoma site, clean, urine returned yellow with some sedimentation. Nursing to continue skin monitoring, promptly clean after incontinence episode, internal fecal device precautions, offload of bony prominences.

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.**

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WOC Plan of Care (include specific products used) Yoselyn, write your journal plans as 'nursing orders'- see the highlighted area above. You could write something like below

Check fecal tube for leakage Q 2 hours
Cleanse stool from skin w protective barrier wipes PRN
Apply thin layer of Calazime zinc oxide barrier ointment to buttock area
Keep fecal tube between patient legs
Inspect fecal tube for kinks or blockages of fecal tube
Irrigate tube if blockage suspected w purple syringe, filled w water in irrigation port & gradually depress plunger
Remove tube if stool consistency becomes more solid
Remove tube in 29 days

Leakage of stool could occur with an internal fecal device nursing to promptly clean after each episode of incontinence with protective barrier wipes, following by calazime zinc oxide moisture barrier. Flexi-seal/Internal fecal device nursing to regularly monitor changes in the position of the indicator line, as this may signify the necessity for repositioning the balloon or device. Place the catheter between the patient's legs. Regularly inspect the device for blockages caused by kinks, solid fecal matter, or external pressure. Position the pouch below the patient's level. To irrigate the device, fill the syringe (purple) with water and gradually depress the plunger. For irrigation purposes, do not use the white inflation port. Cease device usage if the patient's bowel control, stool consistency, and frequency normalize. Do not utilize for more than 29 consecutive days.

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

Calazime contains zinc and is excellent for denuded skin; however, for this patient with significant denuded skin, I would like to use a hydrophilic paste that also has zinc oxide, such as Triad. Good thought **This paste helps dry the affected area and facilitates autolytic debridement.** This is a slightly contradictory comment because autolytic debridement occurs in a moist environment! **2.** What does hydrophilic paste mean to you? It is contradictory I did not realize, for me a hydrophilic paste is a moisture barrier.

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?
On my 1st day of practicum my goal was to get to know the department, WOC nurses, the workflow at the hospital, set up future practicum date schedule for ORMC, Ostomy Clinic, and Pediatric Hospital. **3. Yes, please send me your schedule**

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
Prioritize patient list, review history of patients, wound assessments/dressing recommendation including alternatives.

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	✓	✓

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Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: Patricia A. Slachta Date: 9/16/24

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