Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Miranda Prawdzik_____ Day/Date: __9/19/24

Number of Clinical Hours Today: __9__

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

Preceptor: ____Brittany Gesing_____

Clinical Focus: Wound ____ Ostomy __X__ 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.

This clinical day was spent providing stoma care, teachings, and markings in the inpatient setting. My preceptor and I were able to see many different patients throughout the course of the day. I was able to assist in stoma marking for 3 patients, gaining further practice with that skill. I was able to assist in changing numerous pouching systems as well for several types of ostomies (urostomy, colostomy, ileostomy, jejunostomy). I was also able to provide care to two patients with a mucous fistula. For both, we opted to change from a bag to a sterile gauze dressing as they had very little output. A large portion of afternoon was spent providing education to patients, both for discharge and for new stomas. This was interesting to gain more knowledge on how these teaching lessons are performed. For one specific patient my preceptor and I were doing a hands-on lesson teaching how to change the pouch and prepare supplies.

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:

This patient is a 60-year-old male with extensive past medical history (see below) being seen for an initial visit post-op from exploratory laparotomy, drainage of pelvic abscess, and revision of ileal conduit 9/18 (urostomy created 10/23). WOC team bedside to manage leaking ileal conduit pouch. Patient had previous surgery 6/24 for creation of diverting loop ileostomy to manage a contained anastomotic leak from prior surgery and experienced a continued anastomotic leak and stricture. A mucous fistula/colostomy was also created 7/24 to drain fluid from the leak. Currently the patient is in the ICU for post-op acidosis and pain control in the abdomen.

At the time of assessment, the patient was in bed and awake. Patient was oriented to self and situation, however not oriented to time, date, or place. The patient was eager to participate in stoma care at this time, stating "oh good its you guys, I've been waiting" referring to WOC team. Medical history and events obtained from patient electronic chart.

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Pertinent Medical History:

- Recurrent rectal adenocarcinoma
  - Received chemotherapy and radiation
- Chronic pelvic abscess
- anastomotic leak
- Hypertension
- CAD
- NSTEMI
- BPH
- Iron deficiency anemia
- Current every day smoker
- Multi-drug resistant Enterobacter cloacae

Physical Assessment:

- Neuro
  - Patient mentation waxing/waning, not fully oriented, confused
- Respiratory
  - Patient on high flow nasal cannula
- General appearance
  - Patient in bed, complains of abdominal pain at time of assessment
- GI
  - Patient NPO
  - Loop diverting ileostomy in the left upper quadrant with pouching system intact
  - Mucous fistula/colostomy in the lower left quadrant with pouching system intact
- GU
  - Urostomy/end ileal conduit in the right lower quadrant, pouching system not intact and leaking from 9 and 6 o'clock
  - Ureteral stents and stoma foley in place in the urostomy and left intact

Urostomy/End Ileal Conduit:

- Stoma type is an end ileal conduit
- Stoma diameter 7/8"
- Located right lower quadrant
- Budded, red, and moist
- Ureteral stents and stoma foley in place post-op, not sutured, left in place
- Mucocutaneous junction intact
- Peristomal skin intact, red, semisoft
- Urine blood-tinged/pink with mucous
- Pouching system applied- 45mm Hollister convex flange cut to fit, moldable ring, urostomy pouch with stents and foley inside pouch, connected to a gravity drainage bag

Ileostomy:

- Stoma type is a loop ileostomy
- Stoma diameter 1"
- Located left upper quadrant
- Stoma protrudes slightly, red, and moist
- Rod not in place
- Mucocutaneous junction intact
- Peristomal skin intact with redness, semisoft
- Peristomal contour is softly concave
- No output at this time

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- Pouching system applied- 45mm Hollister convex flange cut to fit, moldable ring, high volume output pouch per the patient's request

Colostomy:

- Stoma is a mucous fistula/colostomy
- Stoma diameter 1 ¼"
- Located left lower quadrant
- Stoma protrudes slightly, red, moist
- Mucocutaneous junction intact
- Peristomal skin intact
- Peristomal contour flat
- No output at this time, patient reports having very little output on a daily basis
- No pouching system reapplied, dry sterile gauze applied and secured with tape

Patient tolerated pouch change fair, complained of some pain upon application of new pouching systems.

Plan:
Wear time of urostomy and ileostomy pouching systems of 3-4 days with no leaking. Change pouches as needed with leaking or every 3-4 days. Change dressing over colostomy/mucous fistula daily and as needed with output.

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)

- Change pouching systems (urostomy and ileostomy) every 3-4 days and as needed with leaking
  - Gather supplies needed and remove old system with adhesive remover using a push-pull method
  - Cleanse the peristomal skin with non-scented pH balanced soap and warm water
  - Rinse peristomal skin with water and gently pat dry
  - Measure stoma and cut new 45mm Hollister convex flange 1/8" larger than stoma size
  - Apply stomahesive powder and liquid skin sealant to the peristomal skin
  - Apply moldable ring to new flange, then apply flange around stoma
  - Secure pouch to flange (urostomy or high volume pouch)
- Change dressing on ostomy/mucous fistula daily and as needed
  - Remove old dressing
  - Cleanse peristomal skin with non-scented, pH balanced soap and warm water
  - Rinse area with warm water and gently pat dry
  - Apply clean sterile gauze over stoma and secure with tape along the edges
- Maintain adequate pain control with pouch changes
  - Pre-medicate patient with pain medication as ordered
  - Encourage non-pharmacologic pain management techniques (deep breathing, guided imagery, distraction)
- Refer to nutrition services for dietary needs and dehydration prevention measures initiation
- Refer to the physician for removal of ureteral stents and stoma foley, remove as ordered
- Consult WOC team as needed for leaking concerns, pouching issues, or other stoma care needs

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

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One patient seen during the clinical day required hands on lesson prior to discharge on how to change and manage their colostomy. This patient was older and had decreased mobility. They also were going to be caring for this new ostomy independently with no familial support. We chose a one piece pouching system to make changing the pouch simple. However, at this time, the patient was having difficulty utilizing the scissors to cut the flange chosen. While more lessons would be conducted, I maybe would have chosen a pre-cut flange to the correct size of her current stoma. This would even further simplify pouch changes and would get rid of the issue of trying to cut the flange when dexterity is impaired.

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 perform or lead a pouching changed independently. This goal was mostly met. I was able to provide education to a patient, help pick a pouching system best for them, and was able to change the pouching system with minimal assistance from my preceptor. The only area I needed extra help with was deciding the proper system and choosing accessory products.

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

My goal for the next ostomy clinical day is to gain more knowledge on the type of phalanges/wafer options available, and to further discuss the qualities of them (flexibility, convexity, compressibility, etc.).

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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