Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Yvan Fortunat Day/Date: 10/25/24

Number of Clinical Hours Today: 8

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

Preceptor: Aaron Fisher

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.

Today I was with the outpatient ostomy team. We saw 6 patients. They varied from patients who needed to be marked and provided preop education to recurrent cases of patients who come twice weekly to the clinic because they are unable to change their pouching independently or because they are having serious issues with leaks. One of our habitual patient came in for a ostomy change because his ostomy pouching has not been able to last more than a maximum of 2 days. Patient has stoma on the RLQ for an ileostomy, stoma is flush to the skin in a small crater, peristomal skin has denuded skin and granuloma. Domeboro was used in a soaked gauze for 15 minutes on the peristomal skin, followed by cleansing of the skin with soap and warm water, pat dry, followed by Stomahesive powder, sealed with Cavilon sealant. Stomahesive strips used in the deep creases on the right and left side of stoma, covered with pieces of Stomahesive skin barrier. Skin barrier washer used to fit around stoma, pouched with SenSura mio flex extended wear convex light 2piece, with belt to secure system in place. Patient tolerated treatment well and refused to try other pouching because he stated this one is the only one that gave him at least a couple of days. One patient had a fistula that also needed to be pouched. After prepping the skin well, a Convatec Eakin Fistula and wound pouch suitable for wounds 9.7”x6.3” was connected to a gravity drainage bag which patient tucked under very loose pants into her sock for anchoring.

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:

Patient is a 61 female, A&Ox3, self-directing, comes to clinic for appointment for new fitting. Patient has a history of HTN, ulcerative colitis, she has a permanent ileostomy. Patient states she had a blockage a few days ago. She went to the ER, but while waiting her bower started working and as she states she felt immediate relief. She was still checked at the hospital and sent home without any complications. Patient just

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started incorporating more solid food in her diet. Diet reinforcement implemented. I Advise patient to be careful about food that are hard to digest like nuts, raw fruits and vegetables, apple with skin etc. I Reinforce the importance of chewing food to a very fine bolus before swallowing to decrease the chance of chucky pieces of food going through the stoma, as well as hydration. Stoma protrudes out about 1'' , it is moist and red, no abnormality observed, peristomal skin is dry and clean, skin is cleaned with soap and warm water, patted dry, Convatec SUR-FIT Natura stomahesive flexible pre-cut skin barrier for 1" stoma with corresponding pouch. Patient is satisfied with the pouching system she currently has; she has been able to self-pouch independently. Patient tolerated pouching change without pain or discomfort.

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)

Maintain daily fluid intake 2 to 3 liters of fluid (a combination of water and electrolyte solution low in sugar like sport drink, oral rehydration solution or soup/bouillon)
Nutritionist consult
Contact WOC team for any complications

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

In the outpatient clinic, I have seen many markings for upcoming surgery and continuation and reinforcement of teaching. For the case I presented, the patient had no problem with the actual hardware for the ostomy, however she needed more teaching and reinforcement about the nutritional requirement and restrictions that are needed to mitigate issues like blockage and dehydration etc. In addition, I believe the care provided was targeted and went to address the concerns of the patient. I would change nothing of the interaction we had.

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 was to either complete my 5th colostomy journal or get a case that can be focused on continence. I was able to get more practice in marking and ostomy changes.

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

My goal on Monday is to see some interesting cases that can serve as continence cases even though they may be ostomy or wounds.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	

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• 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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