Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Alexis Faria__ Day/Date: __Tuesday January 7th, 2025__

Number of Clinical Hours Today: _8_

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

Preceptor: __Shaw, A__

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.

On this day, I was able to follow a WOC nurse and round on inpatient ostomy patients. We saw a variety of patients including patients with fistulas, new and established ostomies, and wound vac patients. I was able to assist with a complex fistula pouching, a wound vac change, a stoma site verification, and multiple appliance changes including urinary diversions and fecal diversions. Attempted to complete a stoma marking but patient had an old ostomy site scar that was reliable and predictable and preferred to use this site if able, so additional marking was not necessary – will attempt again at next opportunity.

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:

60-year-old female with leaking fistula pouch and adherence issues. Patient admitted for dehydration and electrolyte depletion. Patient with past medical history of Crohn's colitis > 40 years, increased output of ECF, severe malnutrition, dehydration, small gut syndrome, and anxiety. Patient with extensive abdominal surgery history including colectomy complicated by EC fistulas. Upon entering room, patient tearful and verbalized anxiety over trip home and concerns regarding pouch adherence during trip. Patient must be able to make flight home with pouch. Agreeable to assessment and appliance application at this time. Patient able to independently present abdomen for assessment, no appliance in place at this time. Patient abdomen is soft, non-distended, with mild tenderness. Patient has 3 small openings – 1 at midline and 2 smaller openings in LUQ. Given the space between openings – it was suggested to use 2 separate appliances to pouch separate sections. Patient adamantly refused two appliances, stating "having 1 is bad enough". Education provided, but patient insistent on using on 1 appliance. Options presented to patient who chose smaller of the two appliances. The clear stencil was used to map the area and trace fistulas for proper cutting of barrier. Stencil was placed over barrier and cut accordingly. Abdomen was cleansed with soap and water and dried gently at this time. Midline fistula with small amount of thick, yellow/tan effluent. The midline fistula with a concave medial aspect from which patient states most of her leaking occurs. Patient also with natural body creases at 3 and 9 o'clock. Eakin cut-outs and Hollister Hollihesive petaling applied to areas of concern. Convatec stomahesive paste was used to caulk seams. Once an even application field was obtained, Eakin Iron Fistual pouch was applied diagonally with mouth laying inferiorly between legs. Coloplast barrier sheet was cut in strips and applied to border for additional adherence and support. Patient instructed to stay in laying position with heat to activate barrier for

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optimal adherence. Patient verbalized understanding. Patient quickly removed heat and started getting up and walking around room. Reminded patient of need for heat and to stay lying to optimize adherence. Patient states she is having anxiety. Spoke with unit nursing for anxiety medication. Patient again noncompliant and removed heat and started walking around room and picking up items to throw away. Discussed with patient that follow up would occur next day to assess adherence prior to discharge following day. Supplies were provided for discharge. Patient denies further needs at this time.

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)

Expected wear time 3-4 days. Change at this interval and prn for leaking.

a. Remove old pouch from top to bottom with push/pull method
b. Provide site care by cleansing with warm water and gently drying
c. Trace stencil including all 3 fistulas, cut barrier accordingly
d. Use Eakins cut outs and Hollister Hollihesive for petaling, caulk seams with Convatec Stomahesive
e. Apply barrier and use Coloplast barrier sheet (cut to strips) to enforce border
f. Apply heat to optimize adherence

Educate patient on compliance with appliance change and maintenance

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

The care provided was well thought out and considerate of patient needs and requests. Took into consideration the patient preferences. Explanations were given thoroughly to ensure all patient questions were answered. The pouching system was carefully considered to ensure it would be replicable by staff and patient at discharge. The only thing I may have done differently would have been to have the patient physically participate more in the actual process as she is discharging in the next two days and will have to complete this at home.

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 primary goal for today was to see and complete a stoma marking. An attempt was made but patient circumstances led to no marking necessary. Patient had a scar from previous stoma that was reliable and predictable for patient so that site was chosen to re-use. Discussed with preceptor – will have another chance to complete. Was able to go through process of assessment though.

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

To properly stage injuries and chose appropriate wound dressings based on wound presentations.

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,	✓	

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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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