Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name**: Jen Ennyl E. Gomez** Day/Date: **Tuesday – January 15, 2024**

Number of Clinical Hours Today: **8**

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

Preceptor**: Amy Folk**

Clinical Focus: Wound ____ Ostomy ✓ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

Today, we successfully evaluated five patients, highlighting our commitment to providing exceptional care in both ostomy and wound management.

Patient #1: A 92-year-old male with a past medical history of multiple abdominal surgeries including subtotal colectomy with ileorectal anastomosis and takedown of diverting loop ileostomy who presents to ED last 1/7 with recurrent SBO and AKI on CKD and on foley catheter. He underwent a ex lap, lysis of adhesion and small bowel resection with one side to side staples anastomosis. Fascia closed while midline incision on wound vac therapy on continuous suction at 125mmhg changed every MWF (POD 10).

Patient #2: A 52-year-old male with a history of metastatic adenocarcinoma of the colon to lung, liver, and bone c/b Colo-vesicular fistula s/p loop diverting colostomy currently on FOLFOX, who is presenting for surgery for colon resection, urology c/s for preop stents, possible bladder repair. He underwent surgery last 1/14/25 for takedown of loop colostomy, resection of sigmoid and bladder, hepatic artery infusion pump insertion, and creation of diverting loop ileostomy. (POD 1)

Patient #3: A 63-year-old male with history of metastatic pancreatic cancer status post 5 cycles FOLFIRINOX (last cycle 12/31/2024) who presented as a transfer from outside hospital after having a severe upper GI bleed, found to now have tumor invasion into his duodenum, presumably causing the bleed, as well as abutment vs invasion into IVC. With wound consult for pink tailbone area with previous pressure injury which is now well healed and patient is ambulatory, Skin intact and on low air loss mattress.

Patient #4 A 80 year old male with extensive past medical history of follicular lymphoma (Dx 07/2023) initially lost to follow up but reestablished care 07/2024 s/p XRT left groin mass with recent prolonged hospitalization for urinary retention now on foley catheter, found to have thoracolumbar spine compression fracture s/p percutaneous posterior spinal fusion of L2-L5 and T12 kyphoplasty with spine jack device (of note at one point there was a c/f L3/L3 discitis at OSH where biopsy was done and was negative), he received 2 cycles of chemotherapy last one on 12/24.
Hospital course was also complicated by various infections including Pseudomonas UTI and VRE bacteremia (possible source was small dehiscence of lumbar spine wound). Patient was discharged on 1/4 to skilled nursing facility but returned again on 1/10 initially to outside hospital for fever and altered mental status. Found to have acute hypoxic respiratory failure requiring supplemental O2 with nasal cannula with imaging showing new lung opacities concerning for pneumonia. There was also concern for spine infection for which he was transferred to UPMC Shadyside on 1/11. WOC consulted for a bilateral upper back wound from spine jack device and an unstageable pressure injury in sacrum/coccyx area with scattered areas of slough measuring 0.5x0.5x0.1cm.

Patient #5 A 82 year old male who was admitted last 1/6/25 directly from outside clinic for surgical management of a new choroid plexus mass. Per chart review, patient has had 4 to 5 months of cognitive issues as well as difficulty walking and left-sided weakness last 6 months. Of note, he has also lost 25lb in the past 2 months. No known prior cancer history. MRI brain without contrast was completed 1/2/25 noting a choroid plexus mass for which he was referred to neurosurgery by his PCP. A CT CAP was obtained once admitted which showed a 1.2 cm RUL mass and surrounding LAD as well as b/l adrenal nodules. Oncology has been consulted given findings confirming metastatic malignancy. WOC consulted for deep tissue injury in sacrum area.

Chart note:

Patient #1
Type of Visit: Follow-up visit (post-op day 10)
LOC: Upon arrival in the room, the patient was confused, comfortably lying on bed with daughter in bedside trying to reorient patient, daughter verbalized a willingness to undergo the assessment and changed of wound vac dressing. She also stated that patient just had pain medicine and was confirmed of the bedside RN.
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Assessment:
Patient is on a low air loss mattress
Wound vac is intact and functioning at continuous suction at 125mmg with scant serosanguineous drainage in the canister and then turned off.
Upon removal of the wound vac dressing, wound measures 9 x 1 x 0.5cm. Wound is healing proximal and distal portions and is pink moist with mid portion of wound closed with surgical glue.
Sacrum with preventive foam without any open areas, back and heels are assessed and are dry and intact.

Nutrition: Pt is on a cyclic TPN and on strict NPO because of risk in aspiration.

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Intervention/Treatment:

Patient is on a low air loss matress..
Surgical wound is cleansed with vashe.
Adaptic was place in the surgical site.
1 pc Granufoam black was attached on top of the Adaptic
Granufoam sealed and attached to wound vac with continuous suction at 125mmhg as per MD's order.

WOC Plan of Care (include specific products used)

Skin

1. Use pressure redistribution chair cushion every time out of bed to char.
2. Keep head of bed elevate <30 degrees.
3. Slightly elevate foot of bed to minimize shearing and use pillow to elevate heels.
4. Apply skin prep to bilateral heels twice a day.
5. Monitor skin for episode of fecal incontinence. Apply barrier cream as needed.
6. Check the wound vac settings and assess for any air leaks.
7. Call and contact WOC department for any questions or clarification.

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

Given that the patient experiences fecal incontinence, I advise against using foam products, as they may not provide adequate protection for the skin. Instead, I recommend implementing a fecal collection bag, which can effectively manage the incontinence and help prevent potential skin injuries associated with prolonged exposure to stool.

Additionally, since the patient is currently utilizing a low air loss mattress, I suggest adjusting the settings to facilitate more frequent repositioning. Specifically, setting the mattress to rotate the patient every 10 to 15 minutes can significantly reduce the risk of pressure injuries by ensuring that no single area of the skin is subjected to prolonged pressure. This proactive approach will help maintain skin integrity and overall comfort for the patient.

Goals

Today was an exceptional opportunity for me to assist in changing a wound vacuum assisted closure and actively participate in a teaching session for the patients and their families. During the procedure, I was able to closely observe the meticulous steps involved in the wound vac change, from preparing the equipment to ensuring proper adherence to the wound site in creating a good seal. Additionally, I engaged with the patients and their loved ones, providing them with valuable information about the purpose and care of the wound vac. This hands-on experience not only enhanced my technical skills but also boosted my confidence in patient interactions and education. I feel increasingly knowledgeable and better equipped to support healing processes in the future.

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

In the coming days, my main goal is to engage in hands-on experiences that effectively connect my theoretical knowledge with practical applications. I firmly believe that actively participating in patient care scenarios and collaborating with my preceptor will continue to enhance my understanding of evidence-based practice. I am eager to explore the latest research and best practices regarding various products available for ostomy and wound care. I recognize that enhancing my critical thinking skills will not only benefit my personal growth but also improve the quality of care I provide on a daily basis. My genuine hope is to gain insights into how evidence can inform clinical decisions as I strive to strengthen my ability to deliver compassionate, high-quality wound and ostomy care grounded by solid evidence.
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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	✓	

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Reviewed by:_____Date: _____