Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Day/Date: _____

Number of Clinical Hours Today: ____

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

Preceptor: _____

Clinical Focus: Wound ____ Ostomy ____ 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.

a.b. 23F
Car vs. Motorcycle
patient was seen for NPWT dressing exchange patient was agreeable with this patient was premedicated prior to dressing change. although patient was pre medicated with pain and anxiety medication patient still exhibited anxiety one was assessed once dressing was removed wound was initially one big wound with with a skin bridge once dressing was removed it was noted that the area below the skin bridge had started to close up it is expected that the one wound will become two smaller separate wounds by the next fact change patient tolerated wound vac change with no issues

W.C. 55M
Patient was seen for Colostomy, Ileal Conduit, and NPWT dressing change. Patient was agreeable. Patient was premedicated prior to dressing change.
Esenta adhesive releaser was used to aid in Ileal Conduit appliance. Stoma and peristomal skin was cleansed with warm water and gauze.
Peristomal skin was dried with dry gauze. Peristomal skin was dusted with Stomahesive Protective Powder and crusted with Cavilon No Skin Barrier Film Spray to protect peristomal skin from possible effluent if the appliance were to leak. A 2-inch Eakin ring was molded and applied on the peristomal skin, snug around the stoma to aid with wafer adherence and creating a secure seal. A 70 mm moldable wafer was applied over the stoma adhereing well. A 2 3/4 inch Urostomy pouch was connected to the wafer. Coloplast Brava Strip was applied to the wafers adhesive tape border around the edge, half on the tape border and half on the skin to aid in securing the edge from lifting. Urostomy pouch was attached to bed side drainage. Patient tolerated pouch change well with no signs or symptoms of discomfort. Esenta adhesive releaser was used to aid in Colostomy appliance removal. Stoma and peristomal skin was cleansed with warm water and gauze. Peristomal skin was dried with dry gauze. Peristomal skin was dusted with Stomahesive Protective Powder and crusted with Cavilon No Skin Barrier Film Spray to protect peristomal skin from possible effluent if the appliance were to leak. A 2-inch Eakin ring was molded and applied on the peristomal skin, snug around the stoma to aid with wafer adherence and creating a secure seal. A 70 mm moldable wafer was applied over the stoma adhereing well. A 2 3/4in pouch was applied to wafer. Coloplast Brava Strip was applied to the wafers adhesive tape border around the edge, half on the tape border and half on the skin to aid in securing the edge from lifting. Patient tolerated pouch change well with no signs or symptoms of discomfort. WMST will follow up with patient on 1/20/25.
Esenta adhesive releaser was used to aid in dressing removal. Wound bed and peri-wound skin was cleansed with Anasept and gauze. Peri-wound skin and wound was dried with dry gauze. Peri-wound skin was dusted with Stomahesive Protective Powder and crusted with Cavilon No Skin Barrier Film Spray to protect peri-wound skin from effluent. Eakin strips were molded and applied on the skin around the wound edge, to flatten the surface to aid in creating a secure seal. 6 pieces of White foam to wound bed, including 1 inch tunneling underneath retention sutures to 6 o'clock and 1 in a tunnel at 3 o'clock.
White foam covered with 1 piece of black foam. Incision to 6 o'clock open approximately 1cm in width with retention sutures in place. This was bordered with Eakin and drape prior to application of a strip of black foam on top of incision/sutures. In total: 2 pieces of black foam, 6 pieces white foam. VAC drape applied. Track pad applied. NPWT was initiated and attain a secure seal. Patient tolerated dressing change well with moderate signs and symptoms of discomfort.

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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:

obstruction r/o
Chief Complaint: Abdominal Pain
History of Present Illness: This is a 69 year old female who is coming in for abdominal pain, distension, and n/v and diarrhea. She has been having this problem for the past two weeks since she was discharged from the hospital for sepsis. In December, she was admitted to Advent Health for sepsis days after receiving a ureter stent removal procedure. In the hospital, cause was pyelonephritis vs osteomyelitis. She was discharged on the fourth and has been getting different antibiotics, most recently ceftazidime. She is endorsing nausea, vomiting, and diarrhea. The abdominal pain is worse any time she moves. She denies fevers.
Past Medical History:
has a past medical history of Asthma (CMS/HCC), Diverticulitis,

• Study Result
Exam: CT ANGIOGRAM PULMONARY EMBOLISM ABDOMEN PELVIS PEAP
TECHNIQUE: Non-contrast topogram and pre-monitoring image were performed for positioning. Bolus tracking accompanied contrast media injection.
Following the intravenous administration of iodinated contrast media, serial contiguous 1.0mm and 3.0 mm helical images were acquired and reconstructed from the thoracic inlet through the upper abdomen without complication. Axial maximum intensity projection lung window images, mid-coronal and sagittal MPR and 3-D volume rendered images were also acquired. This was tollowed by venous phase acquisition ofthe abdomen and pelvis. reconstruction images were also reviewed
CLINICAL HISTORY: PE suspected, high prob. abdominal pain
COMPARISON STUDIES: None.

IMPRESSION:
Marked diffuse colonic wall thickening involving long sigmoid segment distally with high-grade upstream obstruction with fluid-filled large bowel loops and distal small bowel loops. There is background of sigmoid diverticulosis and underlying related stricture cannot be excluded. No ancillary findings to suggest malignant nature however not entirely excluded, surgical and GI consultation is recommended.
No central or segmental PE, evaluation of subsegmental level is limited.
No heart strain.
Right upper lobe 7 mm nodule, consider follow-up in 3 months to document

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)

Ostomy care orders:
Change q 3-4 days
Nursing to assess q4h
Change immediately for leakage

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Nursing to assist patient with emptying appliance as needed
Empty when 1/3 full

Ostomy appliance orders:
1. Remove appliance with sensicare adhesive remover
2. Cleanse peristomal skin gently with warm water + gauze. No Bath Wipes... as pouch will leak.
3. Pat dry
4. Apply skin prep
5. Measure stoma with measuring guide
6. "Crust" only if skin is irritated (with Stomahesive powder and no sting Cavilon spray
7. Mold Eakin ring around stoma
8. Mold and apply moldable Flat 57mm Convatec wafer
9. connect to Transparent, drainable, filtered pouch 57mm
10. attach appliance system to skin (make sure to remove clear backing first)
11. Have patient place hand over appliance for 2-3 minutes or apply warm blanket for good seal.

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

This is the first time I've experienced a quick change in the need to change the pouching system with previous patients it usually took about four or five days before we noticed that the pouch will the pouching system would need to be changed to another this is the very first time in which it took about 24 hours when patient was seen January 15th it was noted that the pouching system was lifting from the center and not the edges and the decision was made to change the pouching system itself upon looking at the wafer the eakin ring showed leaking from 3:00 to 7:00 on the on the skin when examining the skin the skin was intact with no breakdown but a depression was noted from 3:00 to 7:00 when reproaching the skin the skin was prepped with stomahesive powder and skin sealant in ekin ring was placed around the stoma and then another layer of econ was placed just above the previous Eakin ring from three to seven and tapered off to seven in order to create a flatter plane for the flat piece for the flat one piece cut to fit

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?
I guess my goal for the day was to see something different this is the first time that I've encountered a pouching system needing to be changed entirely so quickly

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
my goal for the next ostomy day would be to see other problematic issues with the stoma I've seen a lot of straightforward issues and I know I would benefit from seeing more complex issues

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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	✓	

Reviewed by: _____ Date: _____

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