Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing
Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Kara LaTouche_____ Day/Date: _01/29/2025_

Number of Clinical Hours Today: _10___

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

Preceptor: ____Cindy Cisneros, CWOCN_____

Clinical Focus: Wound ___ Ostomy ____ Continence __X__

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.

I saw 5 patients today with my preceptor. We saw the patient I am discussing in this journal. We saw a pediatric patient for a follow up for their ileostomy. This patient is receiving pelvic floor therapy for possible reversal depending on their results from anorectal manometry exam that is tomorrow. We also saw a 3-month-old patient with a colostomy and ureterostomy's and assisted the parents with pouching system techniques as they have only been able to achieve a 1-day wear time. We saw a patient with suspected perianal streptococcal dermatitis that is currently being managed with barrier cream until patient can be cultured and likely started on antibiotics. And we saw another patient with severe kyphoscoliosis causing a thoracic spinal deformation that protrudes outward and now has a stage 3 pressure injury to the area due to difficulty offloading the spinal deformity.

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 is the initial visit for this 86 y.o. male with past medical history of dementia, atrial fibrillation, prostate cancer s/p suprapubic catheter placement 13 years ago, peripheral vascular disease, and right total hip arthroplasty presents to the hospital with neck pain. MRI showed cervical discitis/OM and possible epidural phlegmon at C2-6. Patient started on Vancomycin by infectious disease. Patient also recently finished a course of ciprofloxacin for pseudomonas UTI. Patient's family reports last suprapubic catheter change was on 1/16/25 in the ED and they would like to continue with twice daily catheter irrigations due to tubing chronically being clogged with white thick sediment per daughter at bedside.

Wound care team were consulted by urologist for suprapubic catheter exchange for collection of urine specimen for urinalysis.

Arrived bedside after speaking to patient's primary RN for clinical updates. Patient observed drowsy in bed and had just received pain medication. Daughter at bedside who states she has been routinely exchanging patients suprapubic catheter at home. Daughter provided verbal consent to suprapubic catheter exchange. Patient has had a SPC for 13 years. The patient has a 20Fr. Suprapubic catheter that is intact with approximately 200 yellow urine output in bedside drainage bag. Insertion site skin noted to be intact and without redness or leakage around tubing.

Procedure: Explained the sterile procedure to the patient/family. Performed hand hygiene and donned clean disposable gloves. Placed patient in supine position and ensured waterproof pad is underneath patient. Opened catheter kit only as far as the first tab and removed castile soap cleansing towelette. Assessed insertion site skin condition. Cleansed peristomal skin area with towelette.

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Used a clean syringe to deflate old catheter balloon ensuring catheter is left in place. 5cc saline removed from catheter balloon. Removed and discarded gloves and performed hand hygiene. Opened remainder of catheter kit maintaining sterile field. Donned sterile gloves. Positioned fenestrated drape over patient's abdomen. Dispensed sterile lubricant into plastic tray. Removed protective covering from catheter and place tip in lubricant. Attached sterile water syringe to balloon port. Opened betadine package and used sterile betadine swabs x3 to cleanse opening around catheter on patient's pubic area while old catheter is still in place. Used non dominant hand to remove existing catheter and dominant hand to immediately insert new sterile catheter into opening approximately 3 inches, pointing towards the spine and angling towards the symphysis pubis. Catheter inserted without force and no resistance noted. 5ml of urine return observed in catheter tubing. Inserted catheter an additional 2 inches to confirm placement in bladder. Inflated catheter balloon by using 10mL of saline in the syringe provided. Connected catheter tubing to gravity bedside drainage bag and secured with Statlock to patient's inner thigh. Collected the 5ml into sterile specimen container for primary RN to send to lab once additional urine is collected in new sterile bedside drainage bag.

Current medications include:
acetaminophen 650mg tablet take 1 tablet by mouth every 4 hours as needed for mild pain
aspirin EC/DR 81mg tablet take 1 tablet by mouth every day.
carvedilol 3.125 mg tablet take by mouth 2 times a day with meals.
ceftriaxone 2gm via IV every 24 hours
donepezil 10 mg tablet take 10 mg by mouth every night at bedtime.
furosemide 20 mg tablet take 1 tablet by mouth 1 time each day.
levothyroxine 25 mcg tablet take by mouth 1 time each day before breakfast.
morphine 2mg IV every 4 hours as needed for pain
pravastatin 20 mg tablet take 20 mg by mouth every night at bedtime
senna-docusate 8.6-50mg tablet take 2 tablets by mouth every night at bedtime
vancomycin 1.25gm via IV every 24 hours

Pertinent labs include WBC 10.2, hemoglobin 9.7, sodium 134, GFR 85, glucose 123, Hgb A1c 5.5, albumin 1.9, urinalysis results pending.

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)

Nursing suprapubic catheter care:

- Cleanse with Surestep post-insertion foley care wipes every 12 hours and PRN if soiled.
- Qshift whole-body bath with Sage 2% CHG wipes.
- Keep the urinary drainage bag below the waist and without dependent loops
- Maintain a closed system whenever possible
- Empty the drainage bag when 1/2 full or every 3 to 6 hours.
- Flush suprapubic catheter tubing with 30cc saline twice daily
- Notify urology if any leakage of urine around suprapubic catheter.

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

Patient had pressure injury prevention interventions already in place, some modifications were recommended. Alternatives to manage patient’s MASD include application of a Cavilon skin protectant wand which I would have preferred as it wouldn’t need to be applied as often and will protect the skin. However, we chose Triad because our facility does not have the Cavilon wand on formulary and it is only special order, so it would need to be applied by the wound team weekly. Either dressing will protect the skin from moisture.

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?

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My goal for the day was to evaluate a patient with a continence issue and this goal was met. This patient had a chronic suprapubic catheter that needed to be changed prior to obtaining a urine specimen. Patient's suprapubic catheter is not new and therefore doesn't need to be changed by urologist as typically done during the initial exchange.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) During my next clinical day, I hope to be able to attend a urodynamics evaluation appointment.

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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