Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jane Frances Nassaka Day/Date: 2/5/2025

Number of Clinical Hours Today: 8

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

Preceptor: Adam Shaw

Clinical Focus: Wound x 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.

During this clinical day, I had the opportunity to see five patients with varying needs. Two of the patients had leaking ostomy pouches, one of whom was post-op day one, while the other patient had been managing her ostomy independently at home, her husband had to drive an hour back and forth from home to gather supplies since the nurses were waiting for the WOC nurse to address the ostomy pouch leak. This highlighted a need to empower the floor nurses to handle some of these issues independently, as they can address many of the challenges that arise with ostomy care. We also saw a patient with fistulas, and we spent approximately two hours working with them. Another patient required a NPWT dressing change, which we performed after the administration of pain medication, This patient was non-verbal but alert with stable vital signs, and tolerated the procedure well. Lastly, an ICU patient with an esophagostomy, who according to my preceptor did not require a dressing change.
Types of patients: Post op day 1 with loop ileostomy, NPWT dressing change for 2 abdominal wounds, Multiple enterocutaneous fistulas, and Esophagostomy

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 a 47-year-old male with pseudomyxoma peritonei and multiple enterocutaneous fistulas, who was admitted from an outside hospital to the ICU due to shock. A CT scan revealed an enlarging fluid collection

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in the abdomen. The patient has a complex surgical history, including hernia repair, multiple X-laps, tumor removal, splenectomy, ileostomy, gastrojejunostomy, peritoneal chemotherapy, and a near-total small bowel resection resulting in short bowel syndrome. He is currently on TPN. Medications were reviewed, and staff reported difficulty in achieving a seal on the pouch, which caused the patient frustration.

Upon examination, the patient was alert and oriented, lying supine in bed, and denied pain. The pouch was removed to reveal several significant findings, including a LUQ gastrostomy tube, a large upper midline enterocutaneous fistula, two pinhole fistulas in the lower abdominal midline, and a LUQ end jejunostomy with a fistula superior to it. All these fistulas were managed with a single pouch. The peri-skin was noted to have scattered erythematous and denuded tissue, with maceration around the gastrostomy and jejunostomy sites. The fistula contours showed transverse creases along the abdominal plane.

The drainage characteristics included yellow, white, and clear thick liquid mucus from the fistula superior to the jejunostomy, dark brown drainage from the two lower abdominal fistulas, and thin yellow drainage from the jejunostomy. Peri-skin care was provided by gently cleaning the area with saline, patting it dry, and applying stomahesive powder followed by 3M No Sting barrier film. Hollihesive wedges were applied circumferentially to all fistulas, and a 40mm convex adapt ring was placed around the jejunostomy, with seams caulked with paste. A vertical Eakin pouch was cut to accommodate all the fistulas, framed with Mefix tape, and connected to a large-bore gravity drainage system. The dressing change schedule was set for every one to two times a week or as needed. Throughout the procedure, the patient covered his face.

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)

- Assemble equipment: pouch with integrated skin barrier, pattern, skin barrier paste, scissors, closure device, attachment for bedside bag, and soft gauze.
- Trace pattern onto skin barrier surface of pouch providing at least ¼ inch clearance of wound to prevent undermining of drainage under pouch edges
- Remove the pouch using the push-pull technique gently pressing down on the skin with one hand while pulling up with the other hand
- Control any discharge with soft gauze
- Clean skin with water or saline, pat to dry gently and thoroughly then apply a stomahesive powder followed by 3M No Sting barrier film, apply Hollihesive wedges circumferentially around all fistulas paste around fistulas, filling any uneven skin surface with paste, barrier rings or strips as needed
- Apply a new pouch, centering fistula sites in the openings cut, attach pouch to bedside bag.

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Change the pouch once or twice a week or as needed, ensuring proper fit and sealing. If leakage occurs, reassess pouch fit and skin integrity.

Assess for signs of infection like fever, redness, pain, tachycardia, document and notify the provider.

Monitor and document fistula drainage characteristics, including volume, consistency, color, and odor. Assess for dehydration signs like dry mucous membranes, low urine output, and weight changes, and notify the provider for fluid and electrolyte replacement. Continue TPN as prescribed and collaborate with the dietitian for adjustments. Assess and manage pain related to fistulas, distension, or irritation, administering pain medications as needed. Provide education on wound care, pouch management, and emotional support, encouraging open communication. Maintain accurate documentation of care and changes in condition, promptly informing the healthcare team, and consulting the WOC nurse for concerns.

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

The care provided to this patient was inadequate, as they were left waiting with soaked incontinent pads for the WOC nurse to manage the pouch leak. In-service training on fistula care should be prioritized to equip nurses with the necessary expertise to handle such situations effectively, ensuring timely and compassionate care for patients in need.

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 fistula management

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

For the following day, I would love to manage fistulas with NPWT, and I shared this with my preceptor.

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	✓	

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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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