Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: Kyle Aniol Day/Date: Tuesday, September 16th

Number of Clinical Hours Today: **8** Number of patients seen: **7**

Care Setting: **Outpatient Ostomy Clinic**

Preceptor: **Jessica Lawson**

Clinical Focus: **Ostomy**

**Reflection: Describe your patient encounters, types of patients seen, and any additional activities.**

I worked in the outpatient ostomy clinic today and saw 7 patients. Patient A was an 81 y/o female with an ileal conduit requiring assistance with leakage and poor adherence. Patient B was an 80 y/o male set to have his descending colostomy reversed. A new stoma site was marked in case the procedure ends up converting into a loop colostomy. Patient C was a 48 y/o male with an end colostomy and a hernia. Patient is due to have a hernia repair and required evaluation for a possible new stoma site. Patient D was a 38 y/o female with an end colostomy being evaluated for abdominal pain and decreased output. Patient E was a 70 y/o female with diverticulitis that required stoma site marking for a possible loop ileostomy. Patient F was a 70 y/o female with an end ileal conduit that just started leaking. Patient G was a 74 y/o male that was sent to the clinic from a doctor's appointment on site due to his pouch overfilling and starting to detach. I provided a large amount of the hands-on patient care for 6 of the 7 patients. Patient F was more comfortable with a female staff member, so I only reviewed her information and discussed the situation with my preceptor.

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

## Chart Review, Assessment, Encounter

Age/Sex: 81 y/o Female
PMH+: Hypertension, CVA w/out residual deficits, bladder cancer
Chief Complaint: Leakage around the stoma site causing poor adherence of pouch to skin
Social Hx: Patient is dependent on spouse for ADL's, lives in a house with spouse, denies tobacco use, confirms 1-2 alcoholic drinks per week
Current Medications: Atorvastatin 40 mg (nightly), Dexamethasone 4 mg (weekly on Wednesdays), Duloxetine 20 mg (twice daily), Olmesartan 20 mg (daily), Rivaroxaban 20 mg (daily)

**Assessment:** Pt states that they have been experiencing some leakage around the stoma, and the pouch has not adhered to the skin as well it usually does.
On assessment, the stoma appeared smaller than the aperture and there was moisture on skin and wafer around the stoma.
The stoma is located in the RLQ, was round, red and moist, and measuring ¾ inch. The peristomal skin is light grey and saturated, but the mucocutaneous junction is intact. The abdomen is flat with no creasing or folds near the stoma site. Clear, yellow urine present in the urostomy pouch. Hernia noted midline in the lower quadrant, does not appear to affect pouching system.

**Encounter:**
The patient stoma site was measured at ¾ inch, which is smaller than her current appliance. The peristomal skin was treated using silver nitrate. The skin was dusted with stomahesive powder and a film barrier over top. Hollihesive square with a ¾ in hole cut in the middle was placed around the stoma to protect the skin and prevent leakage. A 7/8 in urostomy pouch was applied to the patient as it was the smallest available in the clinic. The pouch was the same as the patient currently uses, a ConvaTec Durahesive Convex-IT. The patient was given the reference number for the new size aperture and will be ordering.

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)

**Skin Care**
Clean skin with warm soap and water
Dust peristomal skin with stomahesive

**Ostomy Care**
Cut a 2x2 square of hollihesive, and then ¾ in hole in the middle
Place the hollihesive on the skin with the stoma protruding through the hole
Apply ConvaTec Surfit Natura Durahesive Convex-IT ¾ in urostomy pouch

Continue use of hollihesive until no signs of moisture damage are present

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

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

| |
|---|
| I think the care provided was excellent. The patient did not have any questions, but I don't feel like the education provided was sufficient. There could have more information provided on the effects of over-hydrated skin and how to manage it. |

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?**<br>My goal was to work with multiple urostomy patients. My only experience with ostomies has been bowel diversions so I am hoping to work with some urinary diversions. I was able to meet this goal today as I worked with multiple patients that had an ileal conduit. |
| **What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**<br>My goal for the next ostomy clinical is to be able to identify complications and implement appropriate interventions without guidance. This applies to all forms of urinary and fecal diversions. |

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

**For instructor use only. Do <u>not</u> remove or edit:**

| 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 | ✓ | |
| • Completes Braden Scale for inpatient encounter | ✓ | |
| • 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 | ✓ | |
| • Braden subscales addressed (if pertinent) | ✓ | |
| • 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: _____

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **<u>48 hours</u>** following the clinical experience day.