Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Birgitte Kammerdiener___ Day/Date: __Tuesday, September 16th___

Number of Clinical Hours Today: _**8**_ Number of patients seen_**5**_

Care Setting: Hospital __**X**__ Ambulatory Care __ Home Care ____ Other ___

Preceptor: _Bobbi Jo Killing CWOCN____

Clinical Focus: Wound ____ 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, and any additional activities.

Today was spent with the in-patient WOC nurses at Cleveland Clinic main campus. I was able to see many different patients with my preceptor Bobbi Jo. She allowed me to look through the list of patient for that day so I could pick a wide range of patients to see. Before each patient she would pick my brain of what I should prepare prior to entering the room. She would talk through different products and why stoma may work for one patient and not another. We started the day with a more emergent stoma marking that was brought to the OR very shortly after we finished our marking (this is the patient I have chosen to write about today). Following the marking, the list showed a patient whose pouch was leaking. The patient has been leaking almost daily. Bobbie Jo and I reviewed multiple previous notes and different systems that were tried. We chose to go in with a clean slate and assess. During this visit we talked through different options for pouching system. We chose an easy to replicate pouching system for the patient (it did not leak after, I am back at the in-patient again tomorrow and I will be interested to see if the pouching system is still intact). During our day we also saw an NPWT to the sternum and ended the day with a few pouch changes. Today was spent talking through the importance of a stoma marking and different products. I learned that the location of the stoma and avoiding any depressions or creases can allow for an easier time pouching the stoma, making it easier for the patient or caretaker of the stoma upon discharge.

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.

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

Chart note:

Chart Review/History:

Age/sex: 56 Year old female
PMH: Diverticulitis, End stage renal disease, GERD, Severe PAD, Hypothyroidism, Hypertension, Total Hysterectomy, Neuropathy, Iron deficiency anemia, Type 2 Diabetes, and congestive heart disease
HPI: Patient with history of diverticulitis presented to ER with abdominal pain, nausea and vomiting and abdominal distention. Patient was seen by colorectal team and found to have diverticulitis of large intestine with perforation and abscess with bleeding. Patients worked up for surgery and marked for a potential stoma. Patient was taken to OR where a laparoscopic colectomy of sigmoid with anastomosis was performed on 9/5 and no stoma created. Patient began recovery, started passing gas and bowel movements and tolerating GI soft diet. 9/14 bowel movements stopped; patient sent back to full liquid diet. 9/15 no bowel movement or flatus. Patient complaining of abdominal pain and bloating, NG tube placed overnight. 9/16 scans showed a large intestine anastomotic leak. Patient scheduled for same day OR for creation of ileostomy.
Social hx: former tobacco smoker for 1 pack/day x15 years, no alcohol use, no drug use

Assessment/Encounter:

Patient being seen for stoma marking for creation of ileostomy due to anastomotic leak.
LOC: patient awake and alert, slight confusion at time of visit.
Assessment: abdomen distended, lower quadrants not appropriate due to creases and disappearance when patient is in a sitting position
Education: purpose of stoma marking

Chart Note:

Patient is a 56 year old female being seen for stoma marking for creation of ileostomy due to anastomotic leak. Patient has a history of diverticulitis, GERD, hypertension, type 2 diabetes and end stage renal disease. Patient was admitted to hospital due to abdominal pain, nausea and vomiting, and abdominal distention. Patient was found to have diverticulitis of large intestine with perforation and abscess with bleeding. Patient was taken to OR where a laparoscopic colectomy of sigmoid with anastomosis was done. Patient began having complications following surgery and was found to have an anastomotic leak. Patient seen in room, lying in bed with NG tube in place. Both Colorectal Pa and fellow in room at time of visit. Patient was experiencing slight confusion at time of visit. Colorectal fellow had patients daughter on the phone, fellow explained situation, need for surgery and stoma creation. Patients daughter stated over the phone she is agreeable to the surgery to help her mother get better. Patient stated “I am scared”. Colorectal fellow further explained that the stoma would be temporary while the anastomosis heals. Patient was agreeable to surgery and Colorectal fellow obtained patient signature. WOC nurses then presented to bedside where stoma marking was explained to patient. Explanation involved that stoma marking location is to provide patient with the best possible location to allow for easy visualization, pouching and to provide the best quality of life

while having the stoma. Patient was agreeable to stoma marking. Patients abdomen was then uncovered and observed in both the lying and sitting position. The patients ribs were then identified. Patient was asked to cough and rectus boarder was identified. It was noted that when sitting patient up, both lower quadrants disappeared and patient was unable to visualize the lower quadrants. While keeping the patient in a sitting position, transverse creases were noted on both sides of the abdomen at the level of the umbilicus. This left the upper quadrants as the most appropriate locations. Marks were made in the LUQ and RUA withing the rectus boarders and ribs and three finger widths away from the midline. Patient was able to see markings in the sitting position. Colorectal fellow observed stoma markings which were then covered with Tegaderm. Patient did not have any questions at time of visit. Patient was then taken to OR shortly after.

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)

1. Ensure stoma markings do not get washed off or moved
2. Consult ostomy team post surgery to begin care and teaching
3. Consult psychology for coping with ostomy
4. Refer to case management for home health care with ostomy
5. Consult nutrition for diet education post surgery
6. Consult physical therapy for post surgery assessment

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

If allowed more time prior to surgery, I would have provided the patient with further teaching. Unfortunately, this was more of an emergent case and only allowed time for minimal teaching. If given more time, I would have brought in a pouch to show the patient how it would be worn and emptied. I also would have provided the patient with a booklet or pamphlet on the type of stoma that is being created. I would have explained how the stoma is created (which the fellow had covered earlier) and what to expect after surgery. Since the stoma would be an ileostomy, I would have also begun some teaching on expected output and the need for oral rehydration solution.

I would have also placed a consultation for psychology as the patient stated they were scared prior to surgery. I think this would benefit the patient in finding coping mechanisms and assessing for any emotional needs by the patient while having the ostomy.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

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Goals

What was your goal for the day? My goal was to be able to observe a stoma marking. This goal was met. The stoma marking I observed was on a more complex abdomen requiring consideration for creases and easy visualization for the patient.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) I am with the WOC in-patient tea again tomorrow. My goal is to learn more about peristomal skin complications and different ways to help heal them.

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For instructor use only. Do not 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: _____

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