

and the bedside nurse had acquired the correct catheter for this patient (the patient has a latex allergy and prefers the ones she has ordered for her home so the patient supplied the catheter for the exchange). Went to the patient's bedside to exchange the catheter. Patient refused to allow us to change the catheter without getting the same amount of medication she uses at home when the change occurs. Patients use Dilaudid 5mg at home, and we only had 1mg ordered. Patient states she has spasms, and she will only allow the change if she has the correct dose of medication and her anxiety medication (Xanax) to allow use to exchange the tube. Went out and spoke with the bedside nurse, and had to contact the provider to see if we could get the medication she requested to complete the change. After contacting the doctor and having him speak to the patient at bedside, we were able to obtain the medication she requested. I scheduled a time that she was willing to do the exchange in the afternoon. Went into the patient's room at the requested time, which was 1300. She wanted to do the exchange after lunchtime. OS pink. Peristomal skin intact. Using sterile technique, peristomal skin was cleansed, a new 20F 5ml balloon silicone catheter was inserted, a small amount pink-tinged urine returned upon insertion. The balloon is inflated with 10ml sterile water.

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	2
Mobility	3
Nutrition	4
Friction/Shear	2
Total	19

This patient is at risk for skin breakdown related to activity and friction/shear. The patient is a paraplegic patient who is not able to walk or feel sensation in her lower extremities. Patient needs to be on a strict turning and repositioning schedule to make sure no pressure injury occurs. Patient is alert and is able to move the upper extremities and does realize the importance and necessity of shifting weight in bed is also able to advocate for herself and alert the nursing staff to when she needs to change position to get her in and out of her wheelchair.

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. so do staff nurses change SP catheters or is it just medical staff & WOC team? If just a select few then what nursing orders will you write to the staff about the SP tube? I left a long boring voicemail about this!!

Correct order for suprapubic catheter change supplies and time from catheter placement.

20F 5ml balloon Silicone catheter to be changed Q 4 weeks.

Patient has a latex allergy. Make sure that all supplies are latex-free when replacing a catheter this including gloves and other supplies as well.

Since the patient had a latex allergy, all supplies had to be gathered for the exchange. Need latex-free gloves, sterile water, drape, syringe, urine bag, betadine swapes, leg strap to attach tube to leg.

1. Went to set up a time with this patient and made sure patient was medicated before exchange.

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2. Set up sterile field and gathered all supplies at bedside making sure to be all latex free supplies for patients' allergy.
3. Clean hands and clean site around suprapubic catheter tube.
4. Apply sterile gloves and attach catheter to urine collection bag. Open lube and apply to tip of catheter. Fill syringe with 10ml of sterile water. Set up all supplies in sterile fields without contamination and make sure all supplies are within reach before you start to exchange tubes.
5. Deflate the catheter balloon by removing the water.
6. Gentle remove tube.
7. Clean area with betadine.
8. Insert tube back into suprapubic opening making sure not to advance tube too far.
9. Wait until you see urine return before you fill the balloon with 10ml of sterile water.
10. Make sure tube is secure to patient leg and has room that it will not pull at the site.

I am glad you included this information about the patient and the patient's skin. It definitely belongs in the plan of care for this patient. So good catch. However, 2. I would like you to write this section as nursing orders. How do you tell the staff? What they need to do and be specific. So turning someone every two hours is fine, but should she be on all turning surfaces? Or not? Should she have specific orders for out of bed? The megaplex is a great addition and so you want to be directive. Apply Mepilex to sacral area and change Q3 days or PRN if soiled if there is no skin breakdown. Do you all have a protocol to look under the Mepilex every shift as long as the skin is not open? If so, write it.

~~Patient is at risk for skin breakdown. Please provide Q2 turning schedule for this patient. Be sure to be assessing pressure points for injuries and be assessing area at least Q8 hours. Please make sure all preventive Mepilex are in use on patient sacrum and change Mepilex Q3 days or PRN if soiled.~~

Assess the suprapubic catheter and site.

Monitor the catheter and urine output.

Contact the provider if any problems occur, bleeding, blockage, or pain.

Secure the tube to the patient's leg and place the bag below the bladder for drainage.

Maintain the Q2-hour turning schedule to decrease the risk of pressure injury.

After the patient is turned, check all pressure points for injury and assess that the areas are offloaded.

Apply preventive Mepilex to the Sacrum and change Q3 days or PRN if soiled.

Assess skin Q8 hours, looking for any new injuries.

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

This patient is very aware of her care and what she wants. I needed to work with the patient, nursing staff and the provider to have this patient allow me to change the catheter. To be honest at first, she was refusing the change because she was mad about her care here at the hospital and her not being allow the exact medications she wanted like at home. It was not just about the exchange but her having control over the situation and all of her care. She needed to be heard and her feelings validated. It took a large part of my day speaking with her and going back a few times before we were able to come to a solution and exchange the catheter. She has been to the facility many times and this seems to be the same pattern each time she is at the facility. Overall she just needs more time spent with her, you need to explain each thing that is needed and why, and making sure she is having all of her needs and feelings validated. The actual exchange was easy just need to make

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sure we had a latex free environment. Yes, validation of our patients is so important! Good work w this.

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 to learn something new or look for an interesting patient for the day. I was happy to have the opportunity to care for a patient who needed a suprapubic catheter change and to practice this skill.

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

I would like to see more continence patients with my preceptor. I need to work on discussing these patients and the needs they face more effectively.

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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	✓	
• 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: Patricia A. Slachta Date: 10/13/25

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