



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

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

Student Name:    Tatiane Abud Pimentel    Day/Date: 01/04/2024

Number of Clinical Hours Today: 8h Care Setting:  Hospital  Ambulatory Care  Home Care  Other:           

Number of patients seen today:    3    Preceptor:    Candance Beeghly RN CWOC nurse   

Journal Focus:  Wound  Ostomy  Continence  Combination Specify:    Stoma Marking   

**Directions:** WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse’s absence. For this assignment, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. Provide thorough documentation on the patient encounter. 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 by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

<p><b>Today’s WOC specific assessment</b></p>	<p><b>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</b></p> <p>Patient with no pertinent past medical history presented as trauma alert due to Motor Vehicle Collision (MVC) rollover and was found to have a L humerus fracture and abdominal contusion with a small amount of free fluid in the abdomen. He was admitted to the step-down unit for monitoring and kept in NPO. Serial abdominal exams overnight and patient was advanced to ICU. Orthopedic evaluation of the patient recommended non-operational management, a plan of care NWB LUE in cuff and collar, and out-patient follow-up. Day 2 abdominal exams show condition worsening; patient taken for Exploratory Laparotomy, Ileocectomy, small bowel resection, and partial sigmoidectomy. Patient was left with abthera in discontinuity. Day 4 Consult placed for the WOC nurse for Stoma Marking.</p>
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**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. Write in a manner others will be able to understand and be able to interpret your plan of care.**

On 01/04/2024 was the initial visit to the patient this admission. The reason for the consultation was stoma marking. WOC nurse assessed patient, left upper extremity in a cuff and collar, no significant pressure on the neck. Umbilical region 15x10cm Abthera open abdomen negative pressure therapy, working properly continuous pressure 125mmHg, NPWT dressing with no signs of leakage.

After assessment, WOC nurse determined exact surgical procedure; identified anatomical location and type of stoma; and located belt line. WOC nurse had the patient lie flat and determined the edge of rectus muscle; had the patient in the sitting position using the bed hydraulics and assessed abdomen for creases, folds and infra umbilical fat mound. WOC nurse avoided creases, folds, scars, bony prominences, costal margin, belt line, umbilicus not visible due to Abthera, however WOC nurse used landmarks to confirm ideal placement for two stoma markings. WOC unable to stand the patient upright due to overall condition and difficulties with mobility. Patient confirmed that could see the proposed spot, two bilaterally stomas was marked, areas cleansed with Chloraprep, marked with indelible marker, and covered with thin film.

During our time with patient, he was educated about purpose of pre-operative stoma site marking, digestive system, understanding ostomies, briefly after surgery expectance of stoma, briefly about pouching system, and ADLs having an ostomy. Patient was able to repeat back key points of stoma marking process correctly and verbalized understanding of education provided about ostomies, and pouching system. All questions were answered to their satisfaction. An Informative brochure with subject Preparing for Ostomy Surgery was provided to increase the accuracy of his recall of important medical details provided during teaching section.

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

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WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <p>1. Impaired physical mobility</p> <p>2. Ineffective Coping</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>1. Plan of Care</p> <p>1.1. Assess for conditions the contribute to impaired mobility, for example pain, range of motion, strength.</p> <p>1.2. Schedule repositioning and planned ADLs and physical activity according to his overall condition</p> <p>2. Plan of Care</p> <p>2.1. Assess patient feelings in regard his new diagnosis and fear about the procedure. Observe for non verbal signs.</p> <p>2.2. Assess patient support system, all network people that can provide practical and emotional support</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>1. Expected Outcome:</p> <ul style="list-style-type: none"> <li>- Scheduling repositioning and exercises will help patient to remain free of contractures and decubitus ulcers from impaired mobility.</li> <li>- Assessment of conditions that contribute for impaired mobility will help nurses and caregivers to provide adaptive equipment and eliminate discomfort barrier, this way patient will be able to perform exercises and planned ADLs to improve his overall mobility.</li> </ul> <p>2. Expected Outcome:</p> <ul style="list-style-type: none"> <li>- Patient dealing with life altering situation and uncertainty of the future is the one of the main cause of ineffective coping, assessing patient regarding his feelings will guide health care providers and caregivers how to identify appropriate coping strategies, and how do deal with present and future stressors.</li> <li>- Support network (as family and friends) can be helpful in this situation, patient can have active communication and nurses will explore barrier to his ability to cope, and then teach patient how and when ask for help.</li> </ul>

<p><b>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</b></p>	<p><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p> <p>Indelible surgical skin marker pen: This pen is a regular surgical marking and has several benefits as quick drying, does not run, and contain all sterile surgical marker rules. However, this patient has Abthera, which will be removed before surgery, in pre-op is most likely to use adhesive remover or alcohol to release NPWT dressing. In this case, there is a change of accidentally remove stoma marking locations. I would suggest Tattoo Method for stoma marks, this procedure the WOC nurse use a drop of India ink and a 25-gauge sterile needle to mark patient skin, this way there is no risk of the ink fade way. (Off course we would assess for beliefs and permission).</p>
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<p><b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b></p>	<p>GOAL: To learn more about colostomy</p> <p>MEET GOAL: Yes, I met my goals I had an amazing experience with a difficult patient for stoma marking, and met a patient that had a colostomy</p>
<p><b>What are your learning goals for tomorrow?</b></p> <p><b>(Share learning goal with preceptor)</b></p>	<p>My next journal goal is to learn more about complicated wounds and focus also in incontinence patients</p>

<p><b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b></p>	<p>In situations like this, unexpected stoma, it can be helpful to allocate more time with him to discuss potential lifestyle adjustments and provide psychological support for adapting to this new challenge. The patient's condition was unexpected and may require additional attention to ensure his mental well-being, the majority of nurses focus in physical well-being, but we also should care for mental and emotional support.</p>
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<b>Reflection: Describe other patient encounters, types of patients seen.</b>	We were consulted for 2 extra new patients  1. Continent patient: Buttocks denuded area had MASD with secondary infection appearance of fungal rash 2. Stoma teaching: Patient with new colostomy, demonstrated system appliance change, emptying pouching, ADLs with stoma, pouch options, stoma care, and complications.
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_