

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Paige Newquist Day/Date: 5/8/24Number of Clinical Hours Today: 8-24 OstomyCare Setting: Hospital Ambulatory Care Home Care Other Preceptor: Deanna ActonClinical Focus: Wound Ostomy 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.

The first patient of the day was a stoma marking. She was being marked for a possible loop ileostomy from diverticulitis and provided education about what the stoma would look like, what the pouches look like and their function, and basic information regarding having an ostomy. The second patient has a new ileostomy. He is doing extremely well, changed his pouch independently with very little help, demonstrated emptying successfully, and felt confident in his abilities to manage his ostomy care. The next patient had two fistula dressing changes. I performed one completely independently, which made me feel more confident in the skills I gained through the clinical experience so far. I took down the previous pouch and applied a new one with a wax ring and strips to fill abdominal creases. The pouch was a flat Coloplast pouching system. I assisted with the other fistula because it is extremely complex and the care team is trying to divert the output from the fistula to the PEG tube. For this visit, we inserted an 18F red rubber into the fistula secured with a Coloplast drain port through a soft convex Coloplast pouching system. The red rubber was placed to medium wall suction. When tested, all contents were diverted to the PEG tube and we're hopeful this will help keep her skin dry and give it an opportunity to heal. The fourth patient was a wound and ostomy patient. We started by removing the wound vac system and assessed her wound. It is healing great and is even to the point where NPWT is no longer needed because it was doing more harm to the periwound skin than good. To dress this wound we cleaned it with gauze and NS, then treated the yeast on her skin with miconazole, crusted it, and then applied Opticell Ag covered with dry gauze and Optifoam 4x4s. The ileostomy was changed without issues and I performed it independently. A soft convex high-flow pouch was used and miconazole applied to help manage yeast. The last patient was an outpatient visit because the patient had a leaking ostomy pouch and a new hernia. The hernia changed the size of her stoma so we resized it, did teaching for how to apply the new pouch to obtain the best seal, and educated her about how to get new pre-cut pouches to fit the new size. The recommended product was the Coloplast SenSura mio convex flip closed pouch to help fit the contours of her abdomen from her hernia.

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 patient was a 55 yo female presenting to the hospital for a preoperative stoma marking for a possible loop ileostomy from diverticulitis. PMH of anemia, colon polyps, diverticulosis (2/2023), heel pain, hyperthyroidism, ingrown toenail, foot numbness, and osteopenia. Three cases of diverticulitis with one including abscess in the last few months. The abscess resolved with abx treatment. Her latest CT scan in 03/2024 showed acute sigmoid diverticulitis with pockets of pneumoperitoneum compatible with perforation, but no drainable abscess cavity found. Past surgical history of an appendectomy. Colonoscopy was not listed, but likely

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done. Current medications are vitamin D3, iron, levaquin, synthroid, flagyl, and zofran. Preoperative stoma marking was performed. Patient was assessed in supine, sitting and standing with 2 potential ileostomy sites identified and marked in the RLQ with permanent marker labeled 1 and 2. Tegaderm dressings were placed over top. Care was ensured to avoid the ribs and stay within the rectus abdominis muscle as this female was petite with a short abdomen. Verified that the patient was able to visualize the locations for pouching system changes. Potential ileostomy sites avoided all body creases, pant line, navel, and was comfortable for the patient. Education was provided about healthy stoma appearance, what a pouching system looks like and does, purpose of a temporary ileostomy, when an ileostomy pouch should be emptied, and how to darken the potential ileostomy sites and reapply Tegaderm dressings should the spots lighten. Patient was not very engaged (appeared distracted) and further education will be needed if an ileostomy is created. Plan for follow-up care in the hospital was discussed and the patient verbalized understanding.

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)

- WOC nurses- 5/10/24- Assess ileostomy stoma and change pouching system. Assess periwound skin, patient coping, and suggest appropriate pouching system.
- WOC nurses- 5/10/24- Provide basic ileostomy education about pouching systems, how/when to empty, what output looks like, and how much output is normal (</=1,000 in 24 hours).
- Monitor and document ileostomy output. Empty pouch when 1/3-1/2 full
- Call WOC nurses for pouch leakage and reinforce as needed. (Product choice unknown at this point)
- Contact provider if stoma is pale or dusky.

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

I thought the stoma marking went well. All steps to ensure a correct and effective marking were followed and I tried to engage the patient as much as possible. The patient had little interest because it seemed she was counting on not having an ileostomy created, despite the real possibility that her surgery could result in a temporary one. There wasn't anything I would have done differently, but I wish I had more tools and strategies to help engage an uninterested patient who may end up with an ostomy, but that will come with practice and experience.

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?**
- Independently perform a stoma marking
 - Independently perform a pouch change
 - Continue learning new products and uses- especially topical therapies for PIs, rashes and infections
- What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**
- Identify a patient for the ostomy-focused complex care plan
 - Provide patient teaching about an ostomy if an appropriate patient is available

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		

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● 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		
● 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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