



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Belinda Chapa Day/Date: Thursday 08/08/2024

Number of Clinical Hours Today: 12 hrs.

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Jennifer Scheile

Clinical 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.

In this acute care setting we were able to experience patients pre and post ostomy surgical intervention due to a variety of different cancer locations such as bladder and colon cancers. We were able to provide pre and postoperative education, stoma markings prior to surgery, ostomy care and pouch change education. We were also able to see wound follow up consults and conduct head to toe skin assessments, dressing changes, and EMR documentation.

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 initial visit consisted of a 54 y/o female who is alert and oriented x4, she is steady on ambulation, and is currently employed as an attorney. The patient would be undergoing a (surgical procedure) to treat her chronic sigmoid diverticulitis that is recurrent and is no longer responding to conservative therapy. The patient has a medical history of hypertension and hypothyroidism. The WOC nurse was consulted prior to surgery for stoma site marking. Upon assessment of the patient, it is apparent by her facial expression that the patient is in pain and has firm distention of her abdomen. Bowel sounds are absent in all 4 quadrants. The patient rates her pain 10 out of 10 and is waiting for the primary nurse to administer her pain medication. The patient expresses her concern and anxiety for the stoma and the care of it. Her husband is at bedside for support and my preceptor and I assure the patient that we will visit her and her husband daily until they are fully educated and feel comfortable before discharge. The patient was informed that we were there to perform stoma site marking to help the surgeon make a decision where the best place is for stoma placement. We informed the patient about the importance of stoma site marking for her to be able to comfortably visualize her stoma, be able to access it, clean it, and pouch it. The patient was open to us performing our assessment and marking but was not open to get too much information about the stoma and it's care at that time but verbalized that after her surgery she will be more open. We proceeded to ask the patient to lay in bed in supine position, while raising her gown up and exposing her abdomen, and covering her lower half with a flat sheet. Using a marking pen to locate the patient's midline abdomen I draw a dotted line from 12 o'clock to 6 o'clock to keep the midline marked and easily visualized. Then I place both of my hands about 4 to 5 inches outward from the

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naval and the midline and ask the patient while she is in bed to perform a sit-up or a cough to bring out her abdominal muscles to identify the best site to mark within the muscle. The patient stated she cannot cough due to her pain but was able to perform a slight sit-up. After identifying the abdominal muscle (which we marked lightly with marking pen) and the horizontal fold where the patient waistline sits, a mark is placed on top left abdominal quadrant within the abdominal muscle, mark #2 is placed a few inches to the right of the 1st mark, a mark #3 is placed to the right upper quadrant of the midline, and #4 on right lower quadrant under abdominal crease. Each mark is labeled 1, 2, 3 to distinguish which is the best choice over the next. The patient is informed that ultimately stoma placement will be the surgeon's decision as he or she will be the one to visualize what area of the bowel will need bowel rest and which location is best; all while taking into account the stoma markings from the WOC nurse for best location. As we continue to assess we then ask the patient to sit on the edge of the bed to assess skin folds or creases and remove markings if necessary. At this point all markings are on no skin folds or creases. We also assess the patient while standing and ask where she normally pulls her pants or slacks up to. This is to ensure that a stoma will not be made right where her pants or slacks pull up to. At this point we cover each stoma mark with a clear transparent dressing and inform the patient that we are finished with marking, and she can relax, lay back down, and we will follow up back with her after surgery the next day. We ask if she has any questions, and the patient responds with not at that time.

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)

Day 1 postoperative teachings should include emptying the pouch and changing the pouch. What is to be expected as far as appearance and output postoperatively should be discussed. Pamphlets and videos should be provided and hands on return demonstration should be performed to determine learning accuracy. Inform what a normal stoma and output should look like and what is abnormal.

Day 2 complications such as leakage issues and irritation can be discussed and what to do for them. Teach the patient and family member to assess skin, stoma, and pouch to determine the cause of irritation or leakage. Crusting technique should be taught on day 2. Pamphlets, UOAA website, and outpatient ostomy/wound clinic to be discussed if further care or information is needed.

Day 3 the WOC nurse can discuss and show different product types and pouching techniques. Provide patient with information on suppliers and how to order ostomy supplies.

Day 4 the WOC nurse can discuss lifestyle and dietary modifications and when to seek assistance if there is an issue with their stoma or output.

All throughout the patients hospital stay and their teaching days the patient is encouraged to perform ostomy care and pouch change to ensure he or she will be capable of performing ostomy care at home.

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

I believe that the amount of information and education that was provided was effective considering the circumstances due to the patients anxiety and pain. I would not have done anything differently. The follow-up teachings on the following days I would make sure to make time for this patient and her husband in their teachings. I would make sure to not overwhelm them with information and stagger the basic ostomy teachings to Day 1 teachings, Day 2 teachings, Day 3 teachings and so on until the patient is discharged.

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 for the day with my preceptor was to witness, experience, and provide pre and post op teachings for ostomy patients and to perform stoma site marking with my preceptor. My goal was successfully met with the entire day full of ostomy consults for the preceptor WOC nurse.

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

For the following day I'd like to see more wound consults and negative pressure wound therapy consults. I'd like to be able to be hands on in the application of negative pressure therapy devices.

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	✓	
• 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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