

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Miranda Prawdzik Day/Date: Monday, September 16, 2024

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Megan Hincapie

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.

My clinical experience in the ambulatory WOC clinic was mainly with assessing patients in both the pre and post-operative phases of ostomy creation, routine pouching changes, managing supply issues and altering pouching routines, and peristomal wound care. I had the opportunity to see a wide range of patients with numerous types of ostomies. I assessed many jejunostomies and ileostomies, however I did have the chance to see a urostomy as well. From assisting in stoma site marking for surgery, to providing education to a patient on the reversal of their colostomy, I was able to encounter ostomy care in all stages. I was also able to provide wound care to two patients that had non-healing peristomal ulcers.

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:

The patient is a 60-year-old male being seen for a follow up to begin ileostomy education and site marking pre-operatively. The patient will be undergoing loop ileostomy creation with total proctectomy the following week, 9/23. The patient has a history of local advanced rectal cancer diagnosed 2023 following complaints of bleeding and discharge from the rectum as well as alternating diarrhea and constipation. The diagnosis was confirmed with colonoscopy. Patient then underwent both radiation and chemotherapy from 4/24-7/24. Also of note, patient is an active, every day smoker.

Patient was alert and oriented upon visit assessment, identified by name and date of birth. Staff interview with patient represents a willingness to learn and patient states acceptance of procedure being performed.

Physical Assessment:

- Skin clear and intact
- Abdominal plane rounded, soft, with slight crease noted at the umbilical line while standing
- Patient asked to cough while WOC nurse palpated abdomen to identify the abdominal muscle
- In the seated position, numerous creases and skin folds noted to make the right lower quadrant a non-favorable choice for marking; patient unable to visualize marking in the right lower quadrant in the sitting position
- Right upper quadrant noted to be number one choice of ileostomy site; area from creasing and skin folds, free from pant

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waistline; patient verbalized ability to visualize marking site in both the sitting and standing position

Procedure:

Once optimal stoma site was identified (RUQ), patient instructed to lie flat. Verbal consent was obtained to perform permanent marking of the site. Marking procedure was explained and all questions addressed prior to beginning. Site was cleaned with an alcohol swab, India ink applied, and a 25G needle was used to mark the area. Mark was then covered with a band-aid.

Education:

- Review of ileostomy formation and intestinal anatomy
- Discussion of rationale for surgical procedure
- Discussed dietary changes (oral rehydration solutions and soft foods)
- Ostomy care post-operatively and follow up care
- Stoma appearance and function, effluent appearance/consistency
- Pouching system purpose, appearance, and discharge equipment ordering
- Site marking procedure and purpose

Education was provided to the patient via verbal instruction and written handouts. Patient verbalized understanding of the pre-operative teaching. No need for follow up. Surgery scheduled for 9/23.

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)

- Encourage active patient participation in ostomy care
 - Emptying pouch, output measurement
 - Performing pouching system changes
- Change pouching system every three to four days, or as needed with leaking
 - Gather necessary supplies
 - Remove pouching system using adhesive remover and push-pull method
 - Cleanse the stoma and peristomal skin with warm water and thoroughly pat dry
 - Assess skin intactness and stoma appearance
 - Measure stoma and cut pouch wafer to fit stoma
 - Apply skin barrier products (powder, liquid sealant)
 - Apply skin barrier wafer and pouch
- Encourage patient questions and discussion
- Notify doctor/medical team of changes in stoma appearance (dark red, purple, pale, black mucosa)
- Schedule post-op appointments for follow up after discharge
- Refer to nutrition services for further dietary needs and nutrient requirements
- Refer to social services for discharge planning and insurance coverage of durable medical equipment
- Encourage smoking cessation and provide patient education
 - Offer alternative treatments to aid in the cessation of smoking
- Identify patient support persons to aid in ostomy care
- Refer to social services to set up home health ostomy care
- Identify healthy patient coping techniques
 - Participating in ostomy care and examining stoma
 - Open discussion of surgical procedure and life modifications, patient asks appropriate questions
- Instruct patient to refrain from strenuous activity until six weeks post-op, no heavy lifting

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

With all the information and education we addressed during this visit, I may have ensured adequate patient understanding before moving on to the next set of topics. We moved quickly through the required pre-operative education, and I had concerns of lack of understanding evidenced by lack of patient questions and patient dismissal of offered supplemental teachings. The patient refused to watch the informational video, as well as refusing to examine a pouching system. Utilizing the teach back method may have helped to determine if there was adequate learning and if the patient fully understood procedural information.

I would have encouraged patient to actively engage with the content and with the physical pouching system provided to gain a better understanding of bodily appearance changes.

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 for the day was to learn about the steps to stoma site marking and help in performing the stoma site marking for a patient. My goal was met for the day. I reviewed the steps with my preceptor beforehand. I was able to identify two possible sites with my preceptor and chose the best site option taking into account the patient's anatomy and body type.

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

My learning goals for the next clinical day are to learn more about peristomal skin irritation assessment and treatment, and peristomal wound care.

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	✓	

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Reviewed by: _____ Date: _____

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