Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Nancy Ndamukong Day/Date: 09/19/2024

Number of Clinical Hours Today: 8

Care Setting: Hospital Yes Ambulatory Care ____ Home Care ____ Other ___

Preceptor: Bobbi Jo Killing

Clinical Focus: Wound ____ Ostomy YES Continence YES

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.

We saw 5 patients today. The first patient had ileostomy to RLQ due to stage III mucinous adenocarcinoma of the colon and ileal conduit to RUQ of the abdomen due to prostate cancer. Assessment of the skin shows erythema and skin damage to the peri-stoma site. This was managed appropriately by performing a peri-stoma skin care and application of stomahesive powder around the stoma. The two pouches were removed, skin cleaned with water, gently pat dry and clean pouches reapplied.

Second patient had a history of FAP/Gardner syndrome with stage III rectal cancer s/p robotic total proctocolectomy and end ileostomy. Due to all these problems, an end gastrotomy and end jejunostomy was created to drain out fluids. Patient seen today for leak pouch consult. Upon assessment, RUQ end gastrostomy was leaking. Jejunostomy pouch undermining. Pouching systems were modified to contain the effluent. Peristomal skin was protected appropriately. Patient remain positive, with a great sense of humor while we were doing the dressing change.

The third patient we saw today was an 83 y/o female a colostomy to LLQ created due to colovesical fistulas problem. She also had a JP drain to the RLQ and a suprapubic catheter. The pouch system was changed and the peristomal skin cleaned with water. Skin intact, no irritation. Flange applied to the skin, barrier ring applied on top of it and the bag attached to it. Education given for 10 minutes on how to remove dressing, how empty bag and how to apply a new pouching system. Patient had no support system but was willing to learn how to care for the colostomy when she goes home. We assess her ability to perform the dressing change and she did well.

Patient number four was admitted for recurrent small bowel volvulus. An end ileostomy was created. Due to blockage, the ileostomy stopped producing effluent. Stoma intubation (insertion of 16F foley catheter in to the stoma) was done to drain out the effluent. This has been in place for the pass days. Today patient started passing out effluent from the stoma and not through the catheter. This means that the stoma is now working and the catheter have to be removed. So, patient seen today for the catheter removal. Patient tolerated procedure well.

The firth patient had Crohn's disease, laparoscopic cholecystectomy done, and RLQ ileostomy was created. Patient seen today for day 1 post-operation teaching.

Types of patients: Ileostomy, ilea conduit, gastrotomy, jejunostomy, Management of pouch leakage, management of peristoma skin irritation, Removal of stoma intubation and day one post-op education.

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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:

Today was an initial visit for an 87 y/o male was admitted with medical history of stage III mucinous adenocarcinoma of the colon s/p hemicolectomy and end ileostomy (02/2024), history of prostate cancer, prostatic fistula s/p cystectomy with creation of ilea conduit and omental flap (2017), CKD, BPH and AKI. Lab results show Albumin level of 3.1, WBC 15.58, urinalysis shows some bacteria growth, protein and blood in the urine. He is currently taking Piperacillin tazobactam (Zosyn) for kidney infection.
Assessment was done with patient lying in bed. Patient agreed for the dressing to be change.
Starting with the urostomy in the LLQ of the abdomen, the whole system was removed using adhesive removal. Stoma and peri stoma skin cleaned and pat dry, assessment done, no erythema noted, skin intact. Yellow urine with mucous flecks. Urine emptying per nursing and gravity drain. Stomahesive powder applied and dusted, no stink skin prep applied on top and flange placed on top of the skin. Then the pouch is attached to it.
Next, the LUQ end ileostomy system was removed, with thick yellow effluent. Skin cleaned with tap water and pat dry. Erythema noted in the peri-stoma. Site cleaned with water and pat dry. Stomach is soft and has creases. Stomahesive powder applied to the skin. Flange cut to a fitting size of 1.5 inch, barrier ring attached to the flange. The two pieces convexity pouch applied to the stoma. The function of the different pouches were explained to the patient, how and when to empty the bag (when it's ¾ full). He verbalized understanding and stated that he has been managing them for a while now. Patient covered with a blanket as requested, bed in a low position, bedside table and call light within reach.

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)

- Gently remove the pouch seal from the skin
- Use adhesive removal spray at all time
- Assess stoma site after each dressing change
- Report any abnormal changes to the peristomal site (redness, swelling, increased pain)
- Consult ostomy nurse for a change in a stoma color (black, purple)
- Clean stoma site with water and soft paper towel
- Pat dry and apply no sting skin prep, and then apply stomahesive powder on top
- Measure flange and cut to fit to the size of the stoma
- Apply barrier ring to the peri stoma, then attaches the bag to it.
- Assess patient's understanding of stoma care and management
- Change urostomy system every 3 to 4 days
- Notify a the WOC nurse if you notice abdominal cramps lasting more than 2 or 3 minutes
- Report any excessive bleeding from the stoma
- Report an unusual change in stoma size
- Notify an ostomy nurse when there is no output for 4 to 6 hours or more output(normal ileostomy o/p less than 1200cc)
- Drink enough water to prevent dehydration (2-3L in 24 hour)
- Take small bite of food and chew it thoroughly to prevent food blockage

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- ❖ WOC nurse to perform ileal lavage in case of food bolus blockage
- ❖ Secure ostomy bag with an ostomy belt.
- ❖ Follow-up tomorrow

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

Patient developed redness to the peristoma site for ileostomy. This happened because one of the nurses changed the dressing using a flat fecal management system. It failed to seal well and the stool leaks to the skin. Patient stated that the pouching bag that was placed in the morning hurts his ribs and that he did not want them. We changed the dressing to Coloplast convexity system. The leakage stopped and the patient was fine. I will recommend separating the products for urostomy and ileostomy in two different bags and labeling them before putting them by the bedside.

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 see more complicated cases. Goal met.

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

My goal for tomorrow is to see pre-surgical stoma marking if possible.

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	✓	

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Learning goal identified	✓	

Reviewed by: _____ Date: _____

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