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: 09/20/2024

Number of Clinical Hours Today: 8

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

Preceptor: Heather Bates

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.

Today, my preceptor and i saw a total of four patients. Three of them were ostomy patients, and one was continence patient. The first patient had a recurrent complicated diverticulitis of the left colon. Loop ileostomy was created four days ago. Patient may be going home today, discharge education given.

The second patient was diagnosed with colorectal cancer. An end colostomy was created four days ago as well. Patient going home tomorrow. We went over discharge teaching and how to order supplies. We spent more than 45 minutes with patient as she redemonstrates how to perfume pouch changing, cleaning and reapplication.

The third patient that I saw had a Paget's disease of the anus and vulva. A loop colostomy was created two days ago. This was an initial visit to educate her on how to manage the pouching system. Patient have had ileostomy in the pass. I explained to her that colostomy is easier to manage than ileostomy. I demonstrated the step-by-step dressing change to her and she verbalized understanding.

The last patient was seen for leak pouch. Patient has gastrostomy in the RUQ and jejunostomy in the LUQ and a nephrostomy tube. End gastrostomy leak was managed with the use of Hollister hollihesive washer, bead of stomahessive paste at 9 o'clock, convatec surfit natural durahesive convex-IT 1 ½" molded back to 1 5/8', high volume output pouch, connected to Hollister large bore gravity drainage pouch, then hytape. The end jejunostomy leak was managed appropriately as well.

Types of patients: Loop ileostomy, End colostomy, loop colostomy, leak pouch management of gastrostomy and jejunostomy, and discharge teaching.

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:

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This was an initial visit for a 70 y/o male who was admitted for recurrent complicated diverticulitis. He has a history of myoclonus, HLD, DM II, enlarged prostate, diastolic CHF (EF 60%), GERD, marijuana user and anxiety. Surgical history of cholecystectomy (2022), EGD and colonoscopy, laparoscopic and adhesiolysis x3 (most recent 5/2024). Laparoscopic creation of loop ileostomy RLQ (9/16/2024). Medication reviewed, patient receiving fluids and electrolyte replacement (potassium, magnesium), lactated ringers IV infusion, pain managed with oxycodone, and ondansetron q 6 h and prn for n/v. Patient assessed lying in bed and agreeable to assessment and dressing change. Spouse by the bed site, both willing and ready to learn.

Supplies gathered and brought to the bedside. Pouch gently removed, peristomal site cleaned with water and pad dry. Stomal is budded, red, moist and edematous. No erythema to peristomal skin, contour; flat and soft. Thin green liquid effluent, half way full in the pouch. Rod was removed yesterday, dissolvable sutures present and visible. No sting skin prep applied to peristomal, and let it dry. A Hollister New Image Convex 2 ¼" Ceraplus Flange with tape bordered #11403 was measured and cut to 1/8" larger than the stoma diameter. Ceraplus ring applied around the stomal. Pouching system applied and sealed around. Abdominal laparoscopic sites visible to outer area around stomal. All sites 100% approximated with staples, faint erythema currently covered by tape border of ostomy pouch. Patient informed of expected wearing time of 3-4 days. Patient tolerated procedure well, with no complain of pain. Patient and spouse verbalized understanding of step-by-step process of application and pouch change. Dietary needs discussed, patient on clear liquid diet. Discharged pending diet advanment/toleration. Anticipated discharge on Saturday.

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)

- Gather supplies to the bedside.
- Gently clean around the pouch with a soft paper towel soaked with and pat dry.
- Apply no sting skin barrier and let it dry.
- Ceraplus ring applied around the stomal
- Measure Flange and cut to 1/8" larger than the stoma diameter.
- Peal and place the cut Frange on top of the Ceraplus ring.
- Attach the pouching system to the Frange and sealed around.
- Patient needs diet advancement prior to discharge home.
- Monitor lab and notify MD for electrolyte imbalance.
- Keep Lap. Co. incision clean and dry.
- Out of bed and ambulate at least 5x/day
- For pain management, take Tylenol as ordered by the physician.
- JP drain to gravity.
- Wear SCD when in bed to prevent DVT.

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

Patient is very compliant, cooperative and willing to learn. I think I did what was required for this patient's care. It was anticipated that patient may be going home on Saturday. Based on his progress, his diet should have been advanced on Thursday to give us enough time to monitor how well he tolerates them before his discharge. I will recommend his discharge to be postpone to Mondy.

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 was to see patients with pre-op stomach marking. Unfortunately, my preceptor and I did have any. Thus, goal not met.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My learning goals for Monday is see some continence patients. Also to be able to observe pre op stomach marking.

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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