



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Yvan Fortunat Day/Date: 10/14/24

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Karen O'Brien

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.

Today I was placed in the outpatient section of ostomy care. On that floor we saw patients who are getting preoperative teaching and marking before surgery and returning patients who already had their surgeries and are now coming for check up and stoma care and pouching system fitting and management. Along with my preceptor, we were able to see at least 6 patients. The first patient was a cancer patient who had had chemo and now was getting prepped for surgery. She will be getting a ileal conduit so our role was to do the pre operative teaching and site marking. I was able to observe the preceptor go through the booklet of how the procedure will progress, the location of the stoma, the role of the stoma, the possibility of coming out of surgery with a jp tube, sequential compression device to help with the prevention of blood clots, IV placement etc. I was able to observe the preceptor check for proper location for a marking for the stoma placement. Preceptor placed finger pressed on the rectus muscle, had the patient turn head to one side and cough, edge of rectus muscle was able to be felt and marked was placed in the right lower quadrant inside at least 2 to 3 finger width away from the midline of the abdomen, patient was asked to lean down to see if she could see the mark, patient stated she could see it and she was told to stand up and do the same, patient stated she could see the mark. Patient was placed in a supine position, the preceptor proceeded to tattoo 3 small dots in the location that was marked. The same marking procedure was performed with another patient where two markings were placed because the doctor wanted an alternate site due to multiple scars on the left lower quadrant of the patient's abdomen. I was able to tattoo one marking and the preceptor tattooed the other. We followed the same procedure detailed for the first patient. We saw a patient who had some very bad pseudoverrucous lesions due to the wrong pouch and wafer system. Patient had a loop ileostomy, stoma is flushed to the skin. Pouch was removed, peri-wound was cleaned with soap and warm water, domeboro astringent was used to soak the stoma and surrounded excoriated peri-wound, once that was dried, powder was used followed by non-sting liquid barrier. A deep convex convatec esteembody one piece was used, flushed stoma was able to be raised into the 7/8size opening of the wafer. Patient was very happy with the result, Order for the new bag and belt and other accessories was placed. One patient was there for a first-year checkup. The patient has been doing her ostomy care well enough since skin peri-stoma skin was dry and clean, but she complained of some leakage at time, while assessing the patient we found out patient cuts wafer too big, more teaching was implemented, we informed patient to use the ring around the stoma to prevent leakage underneath the pouching system. We demonstrated how to do it and patient already had the

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

ring at home, patient stated she will try to use them.

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:

Patient is a 52 year old female who came to the clinic for perop marking and to talk to Dr. Spivak about her upcoming surgery. Patient is going out of town and wanted her marking done today instead of closer to her scheduled surgery which is at the end of the month. Patient has a history of gastroparesis, fecal incontinence, cholecystectomy, TAH/BSO chemo gastric pacemaker, Niseen fundoplication, antiphospholipid antibody syndrome, colon polyps, constipation, IBS, Psoriasis, Reflux gastritis. She had prior pelvic floor testing in 2017 which showed pelvic floor dyssynergia and non-relaxed. Sacral nerve stimulation (SNS) was placed, no improvement was reported by patient. She had a sliding mucosal flap in 2018 for anal fissure. Patient has tried Motegrity and linzess to help with bowel in the past, she is taking Neurontin 100mg 2tabs in the morning and 3 at bedtime, warfarin 7.5mg daily, cyanocobalamin (B12 vitamin) 1000.0mcg tab daily, lidocaine-prilocaine apply to affected area for pain up to 4 times daily, Xanax 0.25mg tab daily, valacyclovir hcl 1,000mg daily, calcium carbonate/vitamin D3 200mg by mouth daily, omeprazole 40mg daily, Zofran 4mg every 8hours as needed, atorvastatin 10mg daily, sertraline 50mg daily, colestipol 1 gram daily. Patient is allergic to codeine, Compazine and meclizine. On her maternal side patient has history of breast, lung and colon cancers. Patient general appearance is normal, no sign of weight loss, malaise, no coughing, wheezing, patient usually positive for diarrhea, nausea, dysuria, no vaginal bleeding, nor abnormal vaginal discharge, she does feel abdominal pressure, complained of incontinence.

Preceptor and I went into the room with the doctor present trying to decide on a proper location for a the marking for the stoma. Patient was assessed while sitting. It was observed very clearly that patient has a couple of big scars on the left lower quadrant where the colostomy would have been ideal. On top of the umbilical, to the midline was contemplated for a second but it was rejected due to the weakness in that location, a strong rectus muscle will work better in holding the stoma and to decrease the risk of hernia. Rectus muscle borders were located. Abdominal contour was evaluated in the lying, sitting and standing position. After finding the rectus muscle on the upper left quadrant a mark was placed but also an alternative mark was made at the right upper quadrant as well. That location is not going to be ideal due to the stress that can be placed on the colon to reach the right quadrant of the abdomen. With patient agreement, two markings were made. Patient allowed for tattoos on each marking for permanency. She also allowed for pictures to be taken. Patient was able to see sites in the standing, sitting and lying position.

To set up for tattooing, we washed our hands, prepared the ink, one small needle, alcohol wipes, we set them on a clean chuck, inserted our gloves, cleaned the sites with alcohol, while patient is supine. We used alcohol wipes to clean the area, we drop one drop of black ink in the center of the crossed marked we made, we picked up the needle and gently stick the skin in three dots in a small triangle pattern, we wipe the ink off

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

with the alcohol wipes, small dots can be seen faintly.

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)

Since this is not a wound, this is a preop visit, we were able to present patient with different types of pouching that will be available to her. We provided her with a brochure that described in detail what are ostomies and what to expect postop.

Plan of care includes:

Assessment of:

Vital signs to check for infection, bleeding

Stoma assessment: how does the stoma look? Pink, red, shiny, black, ashen etc.

Ostomy output: document volume, consistency, color, smell

Pain assessment: make sure patient has good pain management

How to care for the stoma:

Clean stoma with warm water and soap, dry peri-stoma, use powder if skin is red or sign of irritation noted, use a liquid sealant, use proper pouch (flat, convex, 1 piece or 2 piece will depend on condition of patient and what fit best for the type of stoma patient presents with. Monitor time frame for stoma change usually 3-5 days depending type of pouching system used

Nutrition and hydration consideration:

Patient will be on clear diet at first but she should gradually start eating low-fiber diet and foods that previously did not affect patient negatively.

Hydration is extremely important for the ostomy patient, especially early on since effluent may be very watery and voluminous at the beginning.

IN the event of complication like a temperature above 101 degrees, burning pain around the stoma, stoma retraction, discoloration, prolapse, no effluent coming out, constipation, pain in the abdomen that was not there before. Call back and follow up the office.

UOAA info given to patient for further supports

DMEs numbers are given to patient so they are able to order supplies

A supply list is given prior to discharge after we have settled on the right sets of pouching system most appropriate for the patient.

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

For this case because we had a lot of people in and out trying to talk to the patient (Two doctors), we were not able to go through the preop teaching as thoroughly as we could have been. While we were in the process of going through different bags and how it will be looking after surgery, the Spivak walked in and wanted to converse more with the patient. Unfortunately we had to move to another patient and this patient left before we could actually finish all the teaching.

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 perform a couple of ostomy changes and also to observe how the preop teaching was implemented

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

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

My next visit will be in the ostomy department still, I will like to see the patient coming out of surgery where a combination of open surgical wound and ostomy are being managed

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.