



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

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name: Benjamin Larson Day/Date: October 18, 2024

Number of Clinical Hours Today: 9

Care Setting: Hospital  Ambulatory Care  Home Care  Other  (We were in both inpatient and outpatient)

Preceptor: Lauren Forneris

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.**

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With our first patient, we received a leaking pouch notification. Patient has perineal cancer and has been inpatient for about 1 year. Patient is not a candidate for surgery at this time per my nurse. Patient had Eakin pouch in place. Pouch and last been changed 10/14. G-tube catheter in place within pouch, and is not being used or flushed at this time. Pouch plastic window had not been completely closed, so we cleansed and dried the pouch. Hy tape applied around the edge of the pouch window to ensure that it stays closed. The patient thanked us. After leaving the room, I asked my preceptor if the g-tube could be removed since it is not being used and is an extra foreign body object but she verbalized that they will keep it.

67 yo male post op new ileostomy evaluation. Stoma red, budded. Peristomal skin clean, dry, intact. Patient emptying the pouch independently and had just emptied it before coming. Changed pouch.

Our next patient had a large abdominal fistula. Comes in for pouch changing weekly with wedging and stoma paste. 31 yo male who came in for a routine ileostomy pouch change. He is not able to do it on his own. The ostomy was in the RLQ. Skin clean dry and intact. New one-piece pouch applied with barrier ring.

I got to join with another preceptor to called to me to observe a stoma marking as the other preceptor knew that I had asked about doing a stoma marking. We provided education to the patient and watched a comprehensive video about an ileostomy. The patient had a history of Crohn's, and had a previous ileostomy. She had extensive abdominal scarring. We were able to find a location in her RLQ that was free from scarring and that was above her belt line. We marked the spot with a marker and applied a transparent dressing over it.

Next, we had a patient come in for a urine culture from her stoma. She had reported that her urine was cloudy and that it had a foul odor to it. We removed her pouching system. Her stoma was red and budded, the mucotaneous skin was intact, and her peristomal skin was intact without redness. She manages her ostomy independently at home, and her mother also helps her with some basic ADLs as well as transportation as the patient uses a wheelchair. We used a straight cath kit to obtain the sample. Her urine appeared clear and yellow. Sample obtained and new patient-supplied Coloplast pouch applied with stoma powder and barrier ring.

We went back to the inpatient units and received a notification for a leaking pouch for a female patient. The patient had been changing her colostomy pouch independently at home. She also had an Ileostomy placed on Monday 10/14. The ileostomy had leakage around the 9 o' clock part of the seal. Both pouches changed today. My preceptor changed the urostomy pouch and I changed the colostomy pouch. The urostomy had 2 stents in place. The urostomy had a large amount of clear yellow output, and the colostomy had a small amount of brown liquid output.

Our last patient we saw was for a routine wound vac change on bilateral lower extremities. He has wound vac changes Tuesdays and Fridays. He had developed compartment syndrome in bilateral lower extremities after cardiac surgery, so his team had created a 9 cm incision on his right lower extremity, and two 8 cm long incisions on his left lower extremity. His chart had said to call the primary nurse at least 30 minutes before coming to do to the wound vac change. We called his nurse who gave him IV Fentanyl and PO Oxycodone. We performed the wound vac changes over 2 hours with both legs hooked via Y-site connection to one NPWT machine, staying late due to his pain and anxiety. His primary nurse was giving him IV Fentanyl q15 minutes to help him with his pain. We encouraged him to talk with his team as he does not want these dressing changes anymore. He did thank us and said he would ask for us again if he ever needs the dressing change. We explained that we work as part of a team and if his care plan stays the same that he will have another NPWT change on Tuesday.

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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:**

Patient presented for a pre-op mark and discussion of ileostomy stoma site marking. Site marking was completed with a sterile surgical marking pen and covered with tegederm dressing.  
The stoma marking purpose and procedure was explained: yes.  
The patient verbalized understanding and agrees to the marking: yes.  
Rectus Muscle borders are located: yes.  
Abdominal contour evaluation was performed in the lying position, sitting position, and standing position.  
The stoma marking was made according to ET/WOC Nursing Procedure in the RLQ.  
Patient is able to see site in the following positions: lying position, sitting position, and standing position.  
Comments: Patient had a prior ileostomy and did not have a good experience. Educational video provided to patient on ileostomies and what to expect. Education provided and emotional support provided.

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 including blue marking disks, alcohol wipes, transparent dressing.  
Obtain consent for the stoma marking, photographs, and if necessary tattoo  
Place pad or sheet under clothing  
Ask patient to lift their shirt to expose abdomen  
Assess patient's abdomen in supine position. Avoid scaring and creases.  
Palpate edges to assess for abdominal muscles. Ask to tighten muscles and cough.  
Ask to patient sit on the side of the chair and assess contour change and summit of infraumbilical mound.  
Ask patient to stand and assess in standing position.  
Mark site with sterile marker using blue marking discs to give a reference for the size of the marking.  
Cover site with transparent dressing.  
Take pictures of site marking in lying, sitting, and standing position and place them in the chart.  
Ask patient to put their shirt down and assist them to a comfortable position.  
Answer any questions and address next appointment time.

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

I thought it was excellent that the nurse I was with asked a second nurse for her input on the stoma site location- this is one of the excellent parts of working as a team. If I was unsure about a site marking location, I would have asked the second nurse to come evaluate prior to marking other sites on her abdomen. We did cleanse the other marks off of her abdomen after getting a second opinion.

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 do a stoma site marking. I was able to accomplish this goal with another nurse caring for the patient.**

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My goal for Monday is to be able to perform a fistula pouch dressing change independently.**

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>• Identifies why the patient is being seen</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Includes pertinent PMH, HPI, current medications and labs</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Identifies specific products utilized/recommended for use</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Identifies overall recommendations/plan</li> </ul>	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> <li>• POC is focused and holistic</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Statements direct care of the patient in the absence of the WOC nurse</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Directives are written as nursing orders</li> </ul>	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>• Critical thinking utilized to reflect on patient encounter</li> </ul>	✓	

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• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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