

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

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

Student Name: Amy Harlan

Day/Date: 10/14/2024

Number of Clinical Hours Today: *Additional journal on stoma marking*

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Kerry Sherman

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.

*Done on original journal!*

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:

This is a pre-operative visit on a 45-year-old female for a planned permanent colostomy on 10/31/2024. She had a gastric pacemaker placed on 01/15/2024, developed a hematoma on 01/30/2024 and gastric pacemaker was moved up higher on abdomen on 02/21/2024. She has had the batteries replaced three times already. Patients' gastric pacemaker is not helping anymore, struggling with frequent diarrhea and poor appetite. She is currently taking Skyrizi for her UC. Dr. Spivak concerned about placement of stoma due to pacemaker location and intestine not reaching to do colostomy to her right abdomen. Upon assessment, there is plenty of space to put stoma on left lower abdomen between umbilicus and pacemaker that is within the rectus abdominal muscle. *← make sure to choose verbiage here in a way that clearly states how this was done.* Stoma site tattooing was chosen due to her surgery still being 2-weeks away and probability of regular markings to wear off beforehand *←was this per protocol? We want to remain as objective as non-presumptive as we can in documentation.* . Patient in-agreement with this plan. Stoma site marked with tattooing done today per protocol. Pro-op education was done as well on colostomy. Educated on medications to discontinue prior to surgery such as blood thinner or NSAIDS. Bowel prep required and need to have driver with her on day of surgery d/t anesthesia. Wear loose fitting clothing, bathing evening before or morning of surgery, NPO after midnight, valuables and jewelry to be left at home, post-op recovery and what to expect before/ after surgery, how to care for colostomy and diet restrictions that are temporary. She will be doing pre-op testing on the 30th, prior to planned surgery on the 31st.

*Regarding the above note: In general, we must consider our WOC documentation from a legal review standpoint. This marking is your role, and we must state actions clearly. Nothing is to be inferred and information must be objective, focused, and complete. Marking is an invasive procedure. Make sure it is noted that the patient is consented, and in detail state how you came upon the chosen site and if there are any backup sites. We must identify the patient in the sitting standing and supine position. Rectus muscles should be identified through specific documented actions. Marking must be done per protocol, especially when performing*

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*an action that may not be backed by the most recent evidence (as tattooing). This information can be inferred above, but is not clearly written. I hope this makes sense – reach out with any further questions.*

*As the ostomy specialist, our main role in this situation is to identify marking method and defend our actions. Make sure the note states how the mark was decided upon. Could the patient verify/were they agreeable? This is an invasive procedure and we must protect ourselves through documentation. Tattooing is not considered ideal practice in many settings, although it is often used – make sure to state this was done per protocol. Please clarify the above in this note.*

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)**

- Attend pre-operative educational session with stoma nurse including medications to discontinue, bowel prep, bathing knight before/ day of surgery, NPO after midnight, what to expect day of surgery, post-operative recovery expectations, stoma care (emptying/pouch change, appliance change), problem solving, temporary diet restrictions, pain, diarrhea/constipation control.
  - Keep stoma site marking area on abdomen clean and covered. Monitor for any signs of infection (redness, warmth, red streaks, edema, or increased pain).
  - Attend stoma education class before being discharged from hospital.
  - How to obtain supplies and sending x2 weeks’ worth. Of supplies home with patient
  - Phone number to call with questions or concerns.
  - HHC referral until comfortable with stoma care
  - Potential skin complications post-operative period and managing them.
  - Post-operative follow-up visit with Dr. Spivak/ stoma nurse
  - Provide list of social groups for stomas.
- what about the site mark itself? Make sure to keep clean and covered.*

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

This was a lot of information to give to the patient all at once. I would send informational sheets and/or video home with patient to review and not be so overwhelmed. Let patient know that she is not alone, only a phone call away. *←very true, support doesn’t stop after this visit.*

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?**

*Done on original journal!*

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

*Done on original journal!*

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>		

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<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> <li><b>(Do not have any of this information)</b></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>		
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>		
Learning goal identified <b>(Done on original journal)</b>		

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

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