Cleveland Clinic

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

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Catherine Gordon_____ Day/Date: __12/2/2024_

Number of Clinical Hours Today: _8___

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

Preceptor: __Sarah Younts___

Clinical Focus: Wound ___ Ostomy __X__ 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.

All patients were ostomy patients.

1. 69-year-old loop ileostomy patient receiving lesson #2 of discharge teaching. She was s/p hysterectomy with sigmoid/ileal resection, and requested assistance with assessing and changing bag.
2. 53-year-old surgical candidate for loop ileostomy secondary to liver and rectal cancer. Pre-op teaching and site marking done
3. 69-year-old s/p end colostomy placement due to Crohn's disease with history of APR. Patient returned demonstration of pouch change with teaching for family, and pouching system was adjusted per patient need.
4. 77-year-old s/p end ileostomy and G-tube placement. Concerned about leaking from high output pouch, and needing stabilization of G-tube.
5. 64-year-old s/p Indiana pouch placement with JP drain, stents and suprapubic catheterization. Taught irrigation and changed plan for pouching of stents.

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:

Follow-up visit with patient and family to assist family in learning ostomy care and reinforce previous teaching with patient.

Patient is a 69-year-old female with history of coronary artery disease, uncontrolled hypertension, asthma, glaucoma, peripheral neuropathy. Current smoker, and history of angioplasty with stent placement in 2018. Loop ileostomy placed 11/15/24 s/p intussusception. Patient has returned demonstration once before and was concerned about the length of the high volume output pouch (HVOP). At the start of the session, the patient was upbeat, stating she was ready to attempt to change her pouch. Previous pouch was removed (Hollister New Image 2 ¼ "convex flange with tape color, moldable ring and HVOP), no leaking noted when disk was examined. The peristomal skin was clear and intact on a soft, rounded abdomen. The stoma was budded at 1 3/8 inch diameter. Tissue was red, moist and edematous with intact mucocutaneous junction. Output the previous 24 hours was 447ml

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mushy green effluent. WOC nurse praised patient for having put the pouch on so well three days prior and asked what she remembered about the process.

With verbal coaching, patient was able to clean peristomal skin and apply Hollister New image Convex 2 ¼" Ceraplus Flange with tape border, ceraplus ring, and a drainable lock'n'roll pouch. WOC nurse then adjusted DME order to reflect new pouch choice. Discussed need for frequent emptying, allowing the pouch to fill no more than 1/3 to ½. The family member videotaped the process for future reference. Expected wear time is 3-4 days; patient was instructed to change the pouch twice weekly. Patient and family were asked what further questions they had, and they both stated they felt comfortable with the procedure.

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)

Equipment: Hollister New Image CeraPlus Convex cut-to-fit, 2 ¼ inch flange with tape border. CeraPlus ring. Drainable lock'n'roll pouch. Cavilon no-sting skin prep, adhesive remover, soap and water.

Strategies: Prepare all materials prior to beginning process. Moisten previous flange with adhesive remover and remove slowly, pushing skin away from flange. Gently wash and dry peristomal skin with soap and water. Apply Cavilon skin prep, and allow to dry. Cut flange according to the pattern provided, and apply the ring under the flange (on the sticky side) at the interior edge of the cut area. Apply the flange to clean, dry skin, and gently press all the way around. Snap the pouch onto the flange, making sure to feel the connection all the way around. Roll and seal the drainage port on the bag. Have the patient hold a warm hand over the flange for several minutes to improve adherence.

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

I probably would have applied the bag to the flange prior to applying the flange to the skin, because the patient struggled to snap it on correctly.

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 for today was to become familiar with how care is provided to patients with various ostomies.

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

My learning goal for to morrow is to provide hands-on care for a full pouch change, and to provide two incidences of education to families.

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		

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*Includes pertinent PMH, HPI, current medications and ~~pertinent~~ 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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