Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Elaine Darling_____ Day/Date: __12/3/234____

Number of Clinical Hours Today: _9.5_

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

Preceptor: __Jessica Lawson __

Clinical Focus: Wound ____ Ostomy _x___ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

Today was an outpatient clinic setiing. There were 4 stoma markings, 2 patients with social and psychological factors impacting stoma care that required education and assistance with peristomal skin irritation. 2 patients had yearly stoma assessments and required assistance with stoma orders. One patient had a large pilonidal wound with a wound vac.

Chart note:

DW is a 33 year old M who was recently hospitalized for 5 days and the second time this year for ulcerative colitis diagnosed earlier this year during his first hospitalization. He has been having 15 BM's a day, low appetite, accidents, abdominal pain and cramping. He had been on Rinvoq and steroids without improvement. He has not had perianal disease. Has been taking mesalamine enemas without relief. He has lost 20 lbs over the past 10 days and was called by the surgical team yesterday to urgently plan for total colectomy with ileostomy creation tomorrow. He has had poor quality of life with interruptions in work. Has two small children aged 1 and 4. He states he has not been able to process the idea of needing a stoma because he was called 24 hours ago and drove from Columbus this morning for his preoperative visits.
No PMH, hx of inguinal hernia repair at age 14. CBC, CMP are all within normal limits. CT AP demonstrated thickening

WOC Plan of Care (include specific products used)

Reviewed preoperative instructions for end ileostomy.
The stoma marking purpose and procedure explained.
Patient verbalized understanding and agrees to the marking.
Rectus border muscles located.
Abdominal contour evaluation was performed in the lying position, sitting position and standing position.
The stoma marking was made according to the ET/WOC Nursing procedure #401 in the RLQ.
Patient is able to see the sire in the following positions: lying, sitting, standing.
With the patient's permission a tattoo was placed in the RLQ with India Ink and a #25 guage needle.

Ostomy care stoma appearance and function, purpose of pouching system, postoperative WOC nurse, postoperative self ostomy care instruction, discharge equipment ordering and support options, diet, fluid intake, ADL's, work, clothing adjustment, exercise and sexual intimacy reviewed.
Did not use specific products to show the patient, did not use brands. Gave educational material for review and discussed how to order supplies. Encouraged to make an account with 3rd party provider that works with his insurance.

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

The patient understood his procedure. He knew that surgery was a possibility since his diagnosis about a year ago, but did not expect to have surgery planned in an urgent fashion. This has caused some stress and difficulty processing or which the patient is

aware. He understands that he will be processing the surgery and presence of a stoma throughout the postoperative period. Jessica was very good at listening and validating his concerns. It would have been nice exploring his feelings more, but the patient had other preoperative appointments and will have close follow up after his surgery.

Goals

What was your goal for the day?

Was to mark at least two patients, provide preoperative stoma education and manage a peristomal skin complication. The goal was met. 4 patients were marked and had preoperative education provided. I tattooed all 4 patients.

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

- Educate for new stoma
- Postop care

-Mark 1-2 more patients

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: _____