

12/16/24 # 6 Ostomy
KF**Daily Journal Entry with Plan of Care & Chart Note**Student Name: Marina DeRosa Day/Date: Monday, 12/16/2024Number of Clinical Hours Today: 12Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Karen Francis APN CWONClinical Focus: Wound Ostomy Continence

This assignment should be WOC focused and approached as 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.

Five patients were seen today by my preceptor and I. She also had two meetings. Once for a HAPY on a medical/surgical floor and another about introducing Vashe as par stock on the hospital med/surg, and tele floors. One patient seen was 60 y/o male with ostomy marking. One patient with multiple wounds. DTI to bilateral heels and buttocks and a reopening pressure injury that had been healing. Wounds were evaluated and treated Sacrum: Allevyn foam and secured with Allevyn life daily change. DTI to bilateral heels treatment with no sting barrier with EHOB boots Two patients with sacral stage 2 which were evaluated and treated with no sting barrier and Allevyn foam secured with Allevyn Life dressing changed daily. One patient who is being treated for IAD with erosion and stage 2 pressure injury

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:**INTERVAL HISTORY:**

60 year old male arrived from home, related to abdominal pain. Patient admitted for metastatic rectal cancer. Patient is now referred by surgery for ostomy marking in all four quadrants. History reviewed. No pertinent past medical history. Patient seen at bedside alert, awake in no distress or discomfort.

Past Medical History: No past medical history

VITAL SIGNS:

Patient Vitals for the past 8 hrs:

	BP	Temp	Pulse	Resp	SpO2
0757	116/82	98.1 °F (36.7 °C)	68	18	97 %
0300	111/77	98.4 °F (36.9 °C)	68	18	97 %

Temp (24hrs), Avg:98 °F (36.7 °C), Min:97.2 °F (36.2 °C), Max:98.4 °F (36.9 °C)

I/O last 3 completed shifts:

In: -

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Out: 1271 [Urine:1200; Drain Output:70; Stool:1]

No intake/output data recorded.

Body mass index is 21.72 kg/m².

EXAMINATION:

Physical Exam

Vitals and nursing notes were reviewed. The exam was conducted with a chaperone present.

HENT:

Head: Normocephalic.

Mouth/Throat:

Mouth: Mucous membranes are moist.

Pulmonary:

Effort: Pulmonary effort is regular.

Skin:

General: Skin is warm.

Neurological:

Mental Status: He is alert and oriented to person, place, and time.

Psychiatric:

Mood and Affect: Mood Normal

Infusions:

PRN:

oxyCODONE immediate release, HYDROmorphone, ondansetron

Restricted Diets Effective Now

Nutritional Status: Does not meet criteria for malnutrition at this time

Comprehensive Problem List

Diagnosis	Date Noted
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- *Metastatic rectal cancer 12/14/2024

Resolved Hospital Problems

No resolved problems to display.

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)

Patient was referred by surgery for stoma marking in all four quadrants. Pre-operative education /counseling and Stoma site selection. Stoma site marking was explained to the patient and he was agreeable to the process. The patient was examined in the sitting, standing, lying and bending positions. No scarring or other impediments were seen. The patient had a flat abdomen with no folds or creases noted. The rectus borders were identified with the patient doing a gentle sit up. Using a blue operative marker the

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patient's rectus abdominal muscles were marked. A blue marker was used to mark from the iliac crest to the navel and from the navel to hip bone. Four sites were marked A,B,C, D. Sites were marked to the patient's preference. Site A and B being the optimal, for sight and position. The patient trialed a 2.25 Hollister wafer for positioning, and comfort, in the sitting, standing and bending positions as he is very active and expressed how he likes to go to the gym. Small Tegaderm x 4. Blue operative marker. Alcohol pads. Hollister marking kit.

Education: Education packet from Hollister for the patient to start to read.. The patient and family were given the number to WOC Services. Patient is to be NPO after midnight

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

After we did the marking on this patient, I discussed with my preceptor what some of the psychological effects a patient can be facing who has a diagnosis of metastatic cancer. I want to do more reading and research on that subject, for both female and male patients. My preceptor agreed that being armed with information on what a patient can potentially be facing would help my practice. For example How to approach the subject. How to get them engaged in the process. etc,

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?

This patient is relatively young and my goal for the day with my preceptor was to try and put the patient's mind at ease in light of his current diagnosis. My goal for this day was to learn how my preceptor so effortlessly moves from one complicated case to another without missing a beat and still has 2 or 3 meetings in a day. I need to still work on my prioritizing .

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

My next clinical will be marking another ostomy

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:		

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● 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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