



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

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

Student Name: Stacy Ann Bruce Day/Date: 1/9/2025

Number of Clinical Hours Today: 8

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Sarah Yount

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.**

Today, my rotation was in the ostomy clinic, where I had the opportunity to work with my preceptor and see seven patients. Most patients presented with concerns related to ostomy care, such as stoma site leakage, pain, and bleeding. While some patients already had a stoma, most were new evaluations seeking guidance on continence-related issues. I had the opportunity to assist in stoma markings and provide patient education alongside my preceptor. This hands-on experience allowed me to learn more about the pre-operative preparation and ongoing care involved in ostomy management.

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 is a 69-year-old female with a history of diverticular disease who presented to the clinic for a second opinion regarding diverticulitis complicated by an abscess. Her history of diverticulitis spans over 2 years, with symptoms progressively worsening, including multiple hospitalizations, abdominal pain, and fecal incontinence. The patient has had several CT scans, which have shown ongoing abscesses requiring multiple drain placements by interventional radiology (IR). However, the abscesses recurred after drain removal. The patient underwent a diagnostic laparoscopy on 10/11/2024, which converted to an open surgery for drainage of intraperitoneal and intrapelvic abscesses, along with the creation of a loop colostomy. Due to surrounding phlegmon, the planned sigmoidoscopy was not completed.

The patient arrived in the clinic accompanied by her daughter. She has an established loop colostomy, with

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the stoma visibly retracted and the mucosa barely visible. The daughter reports that they have tried several different pouching systems, and the Hollister 2-piece convex system has been mostly successful. The MD performed dilation of the colostomy at the bedside. Due to the retracted stoma, the patient must change her flange and ring daily to manage leakage and skin breakdown. MD plan to do surgical revision in OR with was unable to tolerate MD attempts to protrudes stoma at bedside under local anesthesia (lidocaine).

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)

- Apply ConvaTec Stomahesive powder to any areas of skin breakdown until healed
- Dust off excess powder
- Applied sealed with 3M no sting
- Apply Hollister New Image Convex 2 ¼ Ceraplus flange with tape border
- Return to clinic for follow up after surgical revision

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

The care provided to this patient was appropriate given the complexity of her case. The **ongoing** diverticulitis, complicated by abscesses, and the **recurrent nature** of her condition despite interventions highlight the severity of her underlying disease process. The decision to create a **loop colostomy** was likely necessary to manage her bowel function and prevent further complications. It's understandable that the patient has had difficulty with her **retracted stoma**, which makes pouching and leakage management more challenging, especially given the skin breakdown. The MD and RN provided the patient with several options to manage her conditions patient and family was treated with dignity and respect and all their questions were answered. The only thing I would have done was asked the daughter if she wanted to be in the room for the dilation, daughter was visible affected my MD dilating the stoma, the administration of the lidocaine injection and the bleeding at the stoma site. Even with the lidocaine patient was in pain when MD attempted to protrude stoma at bedside.

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 the day was to assess and manage a patient with a stoma in a ostomy clinic setting, focusing on addressing stoma-related complications such as leakage, peristomal skin irritation, and abdominal discomfort. Perform a thorough stoma assessment, including evaluating the peristomal skin, stoma appearance, and pouching system to identify any issues contributing to leakage and irritation. Provide appropriate care by adjusting the stoma appliance, using the correct flange size and application techniques, and addressing

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peristomal skin integrity.

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

Stoma marking and education.

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: \_\_\_\_\_

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