Cleveland Clinic

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 __x__ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: _Sarah Yount

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.

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.

Patients seen- Loop ileostomy, loop colostomy, J-pouch, colostomy **,** urge incontinence, bowel incontinence , Crohn's disease

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:

The patient is a 24-year-old female with a history of Crohn's disease complicated by multiple abdominal fistulas. She has been experiencing chronic abdominal pain, diarrhea, and persistent fistulas despite multiple rounds of antibiotics (metronidazole and ciprofloxacin), and surgical fistula drainage which have failed to provide significant relief. Her current clinical course is complicated by ongoing fistula formation, which has led to significant bowel dysfunction. WBC elevated at 14,000, Normal electrolytes and kidney function, albumin 2.6 g/dL, CRP Elevated at 12.3 mg/L, ESR Elevated at 45 mm/h, Stool Culture Negative for infectious causes. CT Abdomen/Pelvis with Contrast**:** Revealed multiple abdominal fistulas and evidence of terminal ileitis consistent with Crohn's disease. Fistulogram-Confirmed presence of complex abdominal

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

fistulas with communication between small bowel loops. Patient was seen in clinic for pre operative teaching and stoma marking. She has been scheduled for ileocecal resection with ileostomy placement on 1/13/2025 to manage the complications of her disease and prevent further fistula formation. Patient reports she is in good overall health for the procedure, with no acute complications or signs of infection at the time. Patient and RN watched video at bedside about what is ileostomy, how its created, dietary considerations after placement, durable medical equipment (ostomy supplies) how to order, care after surgery and follow up care. Stoma marking was performed after discussing the procedure and ensuring patient understanding. The patient rectus abdominis muscle was identified, RN palpate the lower abdomen, and have the patient gently twist and bend to one side. WOC student and RN felt for the contraction of the muscles that lie diagonally along the sides of the abdomen. A pen was used to create a circular mark on patient right lower quadrant**,** avoiding potential areas of skin folds and ensuring a location that will optimize appliance placement and fit. The patient was educated on the importance of choosing a site that avoids surgical scars, abdominal folds, and areas of increased pressure to ensure ease of stoma care and improved quality of life post-operatively. Patient was asked to sit in a chair, lean forward, stand, and point out if she could see the pen marks on her abdomen. Patient was marked 3 cm away from the iliac crest to avoid issues with movement and to prevent irritation from clothing or belts. This was done to ensure that patient could see the stoma to complete ostomy care. The site was discussed with the patient, ensuring the location is one she feels comfortable with. Once the patient agreed with site she was asked to lay of bed. One drop of India ink was place at the location that was marked and a 25-gauge needle was used to place 3 punctures marked in a triangular shape. Excess ink was clean with alcohol swab. Patient tolerated procedure well no pain or discomfort voiced.

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 is scheduled for ileocecal resection and ileostomy placement on 1/14/2025**.**
- Stoma marked on the right lower quadrant of patient abdomen.
- Patient will follow-up with the WOC nurse post-surgery for stoma care education and adjustments as needed.
- Referral to a dietitian for nutritional assessment and support due to malabsorption related to Crohn's disease and the planned surgery.
- Continue with current pain regimen and adjust if needed post-surgery. The patient was educated on pain expectations post-ileostomy and instructed to follow up with pain management if needed.
- Patient was informed that stoma marking is a tattoo that will leave a permanent mark and if the surgeon is unable to place the stoma at the site that is mark them the tattoo will remain permanently on her skin.
- Patient to return for post-operative stoma care and nutritional counseling after surgery. Discuss with patient foods to avoid after surgery corn, raw fruits, food with seeds and raw vegetables.
- Discuss with patient if she is taking any extended release or enteric coated medication to discuss with her prescribing doctors to have then change as enteric coated or sustained release drugs may not be effective because such drugs can pass unabsorbed through the intestinal tract.
- Discussed the role of the ileostomy in managing her Crohn's disease and improving quality of life. The patient was informed about post-operative care including stoma care**,** monitoring for

complications, and lifestyle adjustments**.**

- Patient had questions and concerns about intimacy after surgery discuss with patient, she can regularly resume activities after surgeon clears her after surgery, discuss product like ostomy wraps with patient that can be used to conceal pouch.
- Ileostomy handouts given to patient.
- Patient was informed that home health nurse will place her first medical supply order and she will be given and order form to order additional supplies once she is discharged from home health.
- Patient verbalized understanding and was encouraged to reach out to the clinical team and stoma clinic with any questions.

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

My preceptor stopped and allowed the patient to asked question while watching the ileostomy video. All the patient questions were answered, and my preceptor was empathic to the patient ongoing medical complications and how she can adjust to having an ileostomy. My preceptor gave the patient several resources and advice the patient they can communication with stoma clinic by sending messages via my chart and someone will get back to her.

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 assist with stoma marking and provide patient education. I aimed to ensure that the stoma was appropriately marked in a location that would allow for optimal pouching and ease of care post-surgery. During the visit, I focused on educating the patient about the importance of proper stoma placement, how to care for the stoma, and how to choose the right pouching system to prevent leaks and skin irritation. I also addressed any concerns regarding post-operative care and emphasized the need for ongoing follow-up to assess stoma function and skin integrity. I was able to independently complete two stoma marking under supervision of my preceptor.

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

Stoma pouch changes and selected the correct appliance to patient experience leakage or other stoma complications.

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		

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

• 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:

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.