

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Alexis Faria Day/Date: January 15th, Wednesday

Number of Clinical Hours Today: 10

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Brittany Gesing

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.

Was able to see multiple complex patients in the outpatient stoma clinic today. Assisted with pouching of very complex fistulas. Also, able to watch a stoma marking and complete two stoma markings on my own. Was able to trouble shoot pouching issues with a couple patients and assist in the procurement of more appropriate products for patient use. Stopped over to the cancer center to aide in the pre-op education of a patient who may come out of surgery with a stoma.

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:

75 year old male presents to the outpatient stoma clinic per referral from Dr. Weight for pre-op stoma marking for ileal conduit. Patient is accompanied by wife. Patient with past medical history of iron deficiency anemia, hydronephrosis, CKD, mitral regurgitation, BPH, malignant neoplasm of left renal pelvis metastatic to both lungs and bone. Patient has history of chemotherapy. Patient is scheduled for transurethral bladder neoplasm resection on 01/22/25. Patient and wife both watched pre-op education video. Patient and wife both asking pertinent questions. Time was spent to answer questions. Educational literature was provided. Patient extremely focused on recovery and time until back to regular physical activity. Education provided and discussed that this will be determined per the surgeon based on patient status post-surgery.

Patient agreeable to assessment and tattoo placement for stoma marking. Patient was assessed in lying, sitting, and standing positions. Patient was asked to bend forward to locate natural body creases. Patient belt line taken into consideration. Patient abdomen was flat, soft, and flabby with loose skin. Patient was asked to cough and rectus muscle was located. When patient bends forward creases noted to superior aspect of RUQ. Site was selected in RUQ at the peak of the infraumbilical fat mound – leaves enough space above belt line and below crease for footprint of barrier ring to be applied successfully. Patient verbalized that he is able to see and access the location in all positions. 1 drop of india ink was placed on marked site and 25g needle used to make three small marks in triangle fashion, wiped dry, and covered with bandaid. Patient and wife deny further needs or questions.

Patient does have neuropathy due to chemo and did show some dexterity issues with buttons and belts. Provided a Coloplast urostomy pouch for patient to practice with. Patient was able to return demonstration on how to close pouch and open for emptying.

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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 marked for surgery
 Education provided
 Patient will need post-op education and lessons for assistance with learning stoma care and pouching
 Literature provided and questions answered
 Coloplast urostomy pouch provided for patient practice

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

I was able to take the lead for this patient while being overseen by the preceptor. Given that it was my first time tattooing – I would have used a bit more pressure when using the needle. The first poke was very soft and although it held the ink – was very light and small compared to second two dots. After instruction by preceptor – was able to successfully poke the second two pokes.

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?

Marking stomas was my goal for the day and it was met. The instructor was a big help and allowed me some independence with patient care with her supervision.

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

I would like to do more wound vacs and assess more patient with continence issues.

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	✓	

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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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