



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 22, 2025

Number of Clinical Hours Today: _____

Care Setting: Hospital Ambulatory Care _____ Home Care _____ Other _____

Preceptor: Elizabeth Kulling

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.

Saw patients with fistula pouching issues. Able to assist with care of external female catheter and placement. Also, post op ostomy lessons.

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:

62 year old male. Patient with past medical history of DM and metastatic cancer. Patient had a bowel resection a few years ago and wife has been managing stoma care at home. Patient recently admitted for surgery where bladder was removed due to metastasis and ileal conduit was formed. Patient being seen at this time for post op lesson 1. Patient wife at bedside for education as well. Patient states wife does stoma care at home, although he assists at times. Patient with colostomy in LLQ of abdomen – stoma is budded, red and moist. Peristomal skin and mucocutaneous junction are both intact. Wife and patient state they are both familiar and comfortable with care of this stoma. They state they receive a reliable and predictable seal with the appliance and they both like the Hollister brand and hope continue to use Hollister for both stomas if possible. They have named both stomas and seem very comfortable with stoma care. Ileal conduit in RUQ. Stoma is pink, moist, and slightly protrudes. Stoma foley and stents are in place with clear yellow drainage. SensiCare wipes used to remove old appliance and discard. Stents held in place with sutures. Explained role of stents and foley to patient and wife. Also explained that foley will be removed prior to discharge but the stents will remain in place until follow up with surgeon so they will need to be included in the pouch change. Peristomal skin and mucocutaneous junction both intact. Warm water and gauze used to cleanse peristomal skin. Wrapped foley and stents in gauze during cleansing to prevent urine dripping onto clean skin. Skin dried thoroughly. Hollister new Image barrier applied – keeping foley and stents together. Hollister urostomy pouch applied over top, straightened out foley and stents so flow is not obstructed. Explained to patient and wife how to ensure urostomy pouch is open to drain and how to close it and that the drip picture will show them which way to turn. Adaptor used to connect pouch to gravity drainage bag. Patient and wife were attentive throughout lesson. Daughter joined lesson and asked questions as well. Informed all parties that if mucous is seen in bag it is normal, as the small bowel that was used to create conduit will continue to form mucous. Patient will be seen for additional lesson prior to discharge and supply list will be provided at that time. Patient may need some convexity as stoma does not protrude very much.

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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)

Continue colostomy care as prior to admission

Urostomy Care – expected wear time 3 – 4 days

1. Use SensiCare wipes to removed adhesive with pouch removal
2. Cleanse peristomal skin with warm water and soft cloth
3. Dry thoroughly
4. Cut Hollister New Image barrier to fit (will need to measure stoma weekly), apply (keeping stents within)
5. Apply Hollister urostomy pouch, click into place (ensure stents are downward facing and unobstructed)
6. Ensure port is set to closed position

Use adaptor to connect to drainage bag when needed

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

Since the patient and wife are already familiar with ostomy care – I would have had them try this first lesson hands on. That way, prior to discharge they would have had two hands on lessons. Especially since the stents can require additional dexterity and care. I also would have tried to encourage the patient to participate in his own care. The patient states he had his wife do it because he doesn't like to – but if something ever happened where she couldn't he would need to be comfortable doing so himself.

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?

Goal was met, I saw patients with continence issues and got to assist with complex fistula pouching.

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

Goal for final clinical experience is to follow up with complex wound vac patient.

| 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: | | |

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|--|---|--|
| • 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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