

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Nina Perel Day/Date: 2/10Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Heather BatesClinical 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 I worked with a stoma nurse in the hospital and got to do so much hands on work with ostomies. I completed all of the pouch changes while helping with the education to the patients. After hearing the education provided to the patients so frequently, I feel confident giving it myself. We had on small fistula that I pouched, many pouch changes and lessons given, I removed a stoma foley, and I irrigated a stoma as well.

*I still have one more day with a stoma nurse so that's why I haven't done the ostomy complex case yet. I'll complete that with my last ostomy day.

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:

Pt is a 77 year old female who has been seen by a stoma nurse prior on the 6th of February. Patient is presenting with a new stoma and is POD #2 from a partial sigmoidectomy and diverting sigmoid colostomy. Pt has a history of stage 3 ovarian cancer, PE, ascites, and anxiety. Order placed for stoma nurse to irrigate stoma because stoma hadn't functioned since surgery. Pt had new order for miralax to soften stool. Patient is lying in bed and is agreeable to lesson and irrigation. Husband declined staying for the lesson and left. I removed the pouch and placed a drape around the stoma keeping the flange in place to apply the irrigating pouch to. A 16F catheter was inserted in the stoma with lubricant on the end until it reached the bifurcation. 60cc of lukewarm tap water was inserted at a time slowly and solid stool was coming out of stoma. Continued until stool had passed and water was running clear. Total of 1500cc were inserted and 900 came out with solid stool. Pt denied pain, nausea, cramping, or fullness during procedure. Patient then had a hands on lesson to demonstrate draining the pouch, attaching pouch to flange, and cutting the flange to proper size. Pt uses a Hollister New Image Ceraplus 2 1/4" flat with a ceraplus barrier ring attached. The pouch is a Hollister drainable. Pt to be discharged to rehab today and was encouraged to empty pouch at rehab on her own and request assistance for the appliance change on the 13th.

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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)

- Hollister New Image Ceraplush 2 1/4" flat, ceraplush barrier ring, Hollister drainable pouch
- Continue miralax once per day
- If no stool for more than a day and patient is nauseous, stop taking solid foods and stick to liquids. If cramping and nausea continue with no stool, call surgeon or go to ER
- To irrigate, use lubricant and a 16F catheter
- Oncology following
- Nutrition following once per week
- Empty pouch when 1/3-1/2 full (roughly 1-2 times per day)
- Change pouching system every 3 days or prn if leaking
- Measure stoma once per week for first 6 weeks
- Reconsult stoma team if patient isn't discharging today and wants another hands on lesson before discharge

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

This patient was overwhelmed with the information and didn't have her husband there because he walked out when he didn't want to "deal with" the stoma. I feel as though he should have been encouraged more to participate because she seemed unmotivated to learn and not completely alert. Other than that, we did what we could to support the patient and irrigate the stoma properly to disimpact the bowels.

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 was to feel confident teaching someone else about ostomies. I feel as though I met this goal because I was providing education throughout the day to patients about taking care of their ostomies at home and living with it.

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

My goal for tomorrow is to learn more about urinary functioning and how different diagnoses are found.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> • Identifies why the patient is being seen 	✓	
<ul style="list-style-type: none"> • Describes the encounter including assessment, interactions, any actions, education provided and responses 	✓	
<ul style="list-style-type: none"> • Includes pertinent PMH, HPI, current medications and labs 	✓	
<ul style="list-style-type: none"> • Identifies specific products utilized/recommended for use 	✓	

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<ul style="list-style-type: none"> Identifies overall recommendations/plan 	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 	✓	
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 	✓	
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 	✓	
<ul style="list-style-type: none"> Directives are written as nursing orders 	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 	✓	
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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