Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jane Frances Nassaka Day/Date: 02/11/2025

Number of Clinical Hours Today: 8

Care Setting: Hospital x Ambulatory Care ____ Home Care ____ Other ___

Preceptor: Karen OBrien

Clinical Focus: Wound x Ostomy x Continence x

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 had the opportunity to observe and assist with 7 patient encounters under the guidance of my preceptor in the outpatient unit. The majority of the patients were seen for review appointments or for issues related to leakage from their pouching systems. A key aspect of the visits involved providing patient education, often alongside family members, to address concerns, particularly for those undergoing stoma site marking. One notable procedure performed was the removal of a Negative Pressure Wound Therapy (NPWT) system, followed by wound dressing using Aquacel, which was then covered with an ABD pad and secured with paper tape. Additionally, stoma site marking was conducted on a patient with a persistent stricture at the afferent limb and mucocutaneous junction. This patient, who had undergone multiple revisions and had a K pouch, previously had a stoma site at the right pannus fold, so the new mark was placed in the LLQ as the patient refused a site in the LUQ.

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:

This 44-year-old patient has been seen multiple times for recurrent pouch system leakage. Her medical history includes Crohn's disease, ulcerative colitis, depression, fibroids, hypothyroidism, nephrolithiasis, ovarian cysts, and obesity. Her surgical history includes a colectomy with ileal pouch-anal anastomosis, pouch excision due to recurrent pouchitis, total hysterectomy with bilateral salpingo-oophorectomy, anal-

(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.

vaginal fistula repair, total colectomy, proctectomy, and an end ileostomy.

During today's visit, the patient's chief complaint was abdominal pain, high ostomy output, leakage, and concerns about a potential recurrent vaginal fistula. She reported pain at a level of 6/10, as she had already taken pain medications prior to the visit.

On assessment the patient was alert and oriented to person, place, time, and situation. An end ileostomy was noted in the left upper quadrant (LUQ), slightly protruding, red and moist, with intact mucocutaneous junction. The peristomal skin, however, was denuded between the 4 and 7 o'clock positions, with liquid brown effluent output.

The area was gently cleansed with soapy water, thoroughly rinsed, and patted dry. Stomahesive powder was applied to the denuded skin, followed by a 3M No-Sting Prep film for protection. A Hollister New Image 1-1'3/4" convex pouch was then applied, cut to 1 inch with a ring to lock and roll, secured with Mefix picture framing tape, designed for a wear time of 3-4 days.

The patient was fully explained about the procedure and verbalized understanding. Additionally, supplies were provided to last the patient for three months, along with an ostomy supply order form, which the patient requested to be sent to her embassy.

The patient was advised to consume oral rehydration solutions regularly to prevent dehydration. She was advised to monitor for signs of dehydration, such as dry mouth, increased thirst, and reduced urine output. To minimize the risk, the patient should avoid caffeinated beverages, drink fluids between meals, and aim for approximately 8 glasses of liquid each day. Additionally, the patient was encouraged to incorporate starchy foods like pasta, rice, bananas, and creamy peanut butter into their diet to help thicken ostomy output. They were reminded to continue taking Lomotil as prescribed by the clinician to manage the output effectively. This comprehensive approach will help maintain hydration, regulate stoma output, and ensure the patient's comfort and well-being. Ongoing education and monitoring will be essential to support the patient in adhering to these recommendations.
Provided patient with telephone contact to call WOC nurse for any concern or question.

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 prescribed pain medications as needed for pain management
- Reassess pain level during each follow-up visit and adjust pain management as necessary.
- Monitor ostomy site for leakage, skin breakdown, and changes in appearance and document.

(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.

- Clean peristomal skin gently with soapy water, rinse thoroughly, and pat dry. Apply stomahesive powder to denuded areas. Apply 3M No-Sting Prep film over the denuded skin to protect and enhance adhesion.
- Apply Hollister New Image 1-13/4" convex pouch, cut to 1" with ring to lock and roll for secure fit. Secure pouch with Mefix picture framing tape, ensuring a tight seal, for a wear time of 3-4 days or sooner if leakage occurs.
- Educate the patient on signs of skin irritation, infection, and proper pouch care. Continue to monitor for signs of peristomal skin breakdown (denudation, redness, irritation).
- Instruct the patient on skin care techniques and proper use of barrier products.
- Evaluate the peristomal skin during follow-up visits and adjust care plan based on findings.
- **Patient Education:**
- Reinforce ostomy care education, focusing on proper pouch application, peristomal skin care, and leakage prevention.
- Review signs and symptoms of infection or complications (e.g., persistent leakage, stoma irritation).
- Provide emotional support and address any concerns regarding body image, lifestyle changes, and ongoing care.
- **Supply Management:**
- Ensure the patient has enough supplies for the next 3 months
- **Follow-Up and Communication:**
- Schedule follow-up appointment in 1-2 weeks to reassess ostomy care, pain management, and overall condition.
- Contact WOC nurse for any concern or question.

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

The care provided to this patient was thorough, addressing both her physical needs related to ostomy management and her emotional concerns. Given the complexity of her condition, which includes multiple surgeries and ongoing issues with pouch leakage, it is essential to offer continuous support and education. However, in reflecting on her care, I believe a more proactive approach to her pain management could have been taken by involving a pain management team. Additionally, given her history of depression, it would have been beneficial to refer her for follow up. This young woman's life has undoubtedly been affected by her medical conditions, and her concerns about the recurrence of the vaginal fistula, despite healing on tests, point to a need for extensive psychotherapy. She requires more than just physical care, emotional support, counseling, and regular follow-ups to address her psychological well-being which is vital to her recovery.

(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.

Cleveland Clinic

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

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? Stoma site marking, and I need more of these to practice
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) More stoma site marking and I have shared this with my preceptor

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: _____

(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.