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: 02/13/2025

Number of Clinical Hours Today: 8

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

Preceptor: Elizabeth Kulling

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.

This day I saw with my preceptor and cared for six patients, each presenting with unique needs. One patient required a NPWT dressing change, and others for ostomy pouching system changes due to leakage issues. Another individual presented with a retracted stoma, we also performed colostomy irrigation for one. Another patient required a fistula pouch and dealt with the additional challenge of urine incontinence, which required special attention and care.

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 was the initial visit for a 71-year-old male patient diagnosed with a sigmoid mass invading the bladder. The patient, who resides in a nursing home, underwent a palliative diverting colostomy on January 10, 2025. His medical history includes hypertension (HTN), a cerebrovascular accident (CVA) with right-sided residual weakness but able to turn and reposition himself, prostate cancer, type 2 diabetes (DM), and peptic ulcer disease. A sigmoidoscopy in December 2024 showed invasive adenocarcinoma. He also has a surgical history of a diverting loop colostomy in January 2025.

WOC nurse was contacted to irrigate the colostomy. we reviewed the patient's medications, and his vital signs

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were within normal limits. The patient was alert and oriented to self only and was lying in bed in a supine position. we introduced ourselves, explained the reason for our visit, and the patient did not object. He denied any pain. On removing the colostomy pouch, noted that the stoma was red, moist, and protruding well. The peri-skin was intact, with no erythema.

For the irrigation, 1000cc of warm tap water was put into the irrigation bag, which was hung on a stand. A cone was attached to the bag and the air removed from the tubing by allowing water to run through. Using a water-soluble lubricant, lubricated the cone and gently inserted a lubricated finger into the stoma to determine the direction. Then carefully inserted the cone into the proximal stoma. While holding the cone in place, the clamp on the tubing was opened to allow 500cc of water to flow slowly into the colon. After clamping the tube and removing the cone, the irrigation sleeve was closed to prevent any possible splash of effluent. We waited for the results. Within 10 minutes, a significant amount of gas was expelled, but no fecal matter was observed. After waiting another 20 minutes with no further return, we applied a drainable pouch. The patient was left comfortable and results communicated to the provider. Staff advised to monitor the patient for colostomy return, and to document the amount, consistency, and odor.

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)

- **Gather Supplies and Equipment:**
- Irrigation kit: Bag with flow regulator, Soft cone. Water-soluble lubricant, Irrigation drain sleeve, warm tap water (1000cc). Stand to hang the bag
- **Procedure:**
- Ensure the patient is comfortable. Protect the bedding
- Remove the colostomy pouch and inspect the stoma for any changes or irritation. Fill bag with 1000cc of warm water, attach the cone, run water through to remove air.
- Apply water-soluble lubricant to the soft cone.
- Insert a lubricated finger into the stoma to identify the correct direction.
- Gently insert the cone into the proximal stoma, holding it securely in place.
- Open the clamp on the tubing and allow 500cc of warm water to flow slowly into the colon.

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- After instilling the water, clamp the tubing and carefully remove the cone.
- Close the top of the irrigation drain sleeve to prevent possible splashing of effluent.
- Wait for the return for up to 45 minutes.
- **After the Procedure:**
- Apply a new drainable colostomy pouch.
- Wash all equipment (irrigation kit, bag, cone) with mild soap and water.
- Hang the equipment to dry and store it in a clean container.
- **Special Considerations:**
- Cramping may occur when instilling water; this may be due to the water being too hot or too cold. If cramping occurs, stop irrigation until the cramping subsides.
- If water leaks around the stoma, readjust the cone and ensure proper placement.
- If no return occurs after 45 minutes, consider dehydration as a possible cause. Discontinue irrigation, increase the patient's fluid intake, and apply a drainable pouch.
- Perform irrigation at the same time each day for consistency and to maintain the routine.

This plan of care should be followed daily to ensure proper management of the colostomy, with close monitoring of the patient's response to the procedure. Communicate any issues or changes to the provider. Contact WOC nurse for any concern or questions.

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

Reflecting on the care provided, I believe the approach was thorough and patient-focused, especially considering the patient's condition and the procedure being performed in the hospital setting. Since the patient was oriented only to self, we made sure to communicate clearly, explaining the procedure and ensuring comfort throughout the process. The methodical steps taken inspecting the stoma, using appropriate equipment, and monitoring for any complications were in line with standard practices for colostomy care, ensuring both effectiveness and patient safety.

However, if I had to do anything differently, I would have involved the hospital staff more in the process, especially in terms of understanding how to monitor the patient's progress with the irrigation, follow-up schedule to monitor the patient's condition after the procedure, ensuring that he is adjusting well and that

there are no emerging issues.

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?

Managing complex cases was my goal for this day.
Overall, I feel that the goal was mostly achieved, though there are areas where I can further improve, particularly in selecting the appropriate pouching system products and managing more complex cases.

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

Today was my last day, but I will continue working on my assignments.

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: _____

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