



R. B. Turnbull Jr. M.D. WOC Nursing Education Program

### Daily Journal Entry with Plan of Care & Chart Note

Student Name: Patrick Willis Day/Date: Monday, 5/5/25

Number of Clinical Hours Today: 8

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Sarah Weisz

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.

Today was a bit of a disjointed day with a few roadblocks to patient care but was still a good look inside normal barriers for the inpatient ostomy nurse. We saw 4 patients in total, but did not get to see our care through completely on 2 of them due to various circumstances. One patient we saw first for colostomy irrigation, but her stool was so impacted it was hard to tell whether we were successful or not. We tried several different catheter sizes and types, along with a traditional cone irrigation kit, but still struggled to bypass the stool and our return fluid remained clear. We reached out to the team for a cottonseed enema order, but the patient began having some cardiac issues that needed to be prioritized, so this enema was not able to be administered during my clinical time. Another patient was needing his second lesson for discharge, which is typically hands-on training of ostomy care. We had coordinated a time for his wife to also be there, but when we arrived, she was not there. This teaching was ultimately deferred so she could learn as well. On a visit for a routine pouching change of an enterocutaneous fistula, we noticed a change in output to bloody clots and were able to notify the surgery team who came to assess at the bedside. We placed an access window into the wound manager pouch for simpler assessments without removing the entire pouch. Lastly we completed ostomy discharge teaching for a Spanish-speaking family utilizing interpreter. This family was uninsured, so we were able to connect them to resources providing them with free or discounted ostomy supplies.

Types of patients: end ileostomy, end colostomy (irrigation), enterocutaneous fistula, discharge teaching

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 beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical

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assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

**Chart note:**

Patient seen today at MD request as patient received discharge orders for today but still needs to complete second and final teaching session for ostomy care. Ostomy team has been waiting for husband to present to the bedside as he will be assisting with most of the ostomy care.

Patient is 55 y/o female now POD #5 – LOA, TAH/BSO, bilateral ureterolysis, L ureteral stent, total omentectomy, distal pancreatectomy, sigmoid colon resection, creation of end descending colostomy.

History of malignant neoplasm of ovary, hypertension, hypothyroidism, asthma, LBO 10/2024 with diverting loop sigmoid colostomy, anemia, AKI. Labs and medications reviewed. Postassium 3.4, Calcium 8.0, BUN 9, Creat 0.4, Hgb 9.1, Hct 26.6. Daily Eliquis, PRN lidocaine patch and oxycodone for pain.

Met with patient, husband, and daughter today for final teaching session prior to discharge. Family is primarily Spanish-speaking but understand most English. They decline interpreter services initially as they state familiarity with ostomy care and terminology from previous colostomy. Husband states he prefers just receiving a visual refresher today vs performing the hands-on care himself. Current pouch has been on since 5/1 and has slight leakage of effluent visible on flat skin barrier upon removal. Patient reports pouch coming loose during PT session earlier today. This RN demonstrated removal of pouching system with adhesive remover wipes and gently cleansing site with warm water. Emphasized large crease present at 9 o'clock indicating need for a soft convex pouch to help create flat pouching surface that will effectively direct output into pouch. Stoma measures 2” in the LLQ, budded, red, moist, and still edematous, producing mushy brown output. Educated family that stoma will continue to shrink over the next 4-6 weeks as swelling goes down. They should measure the stoma at pouching changes during this period to promote ideal pouching system fit. Slight separation of mucocutaneous junction present from 4-6 o'clock, but superficial and able to be protected with Hollister Cera moldable barrier ring. A piece of Coloplast Strip Paste was gently molded and applied over the barrier ring at 9 o'clock to achieve flatter pouching surface over site of abdominal crease. New Coloplast Sensura soft convex pouch placed over stoma. Demonstrated support belt connections and encouraged belt use when ambulating or if leaks persist and extra support/security desired. Utilized interpreter via telephone at conclusion of session to confirm there were no questions or confusion best addressed in preferred language. Family endorsed confidence with care at home but expressed concern over supply acquisition as they are uninsured and previously purchased supplies out of pocket. They were directed to the major supply manufacturers who provide 3-months' free supplies once annually and other websites that may be more affordable. Additionally, family given 2-3 weeks' worth of supplies.

**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	3
Activity	3
Mobility	2

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Nutrition	3
Friction/Shear	2
Total	16

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)**

Colostomy, every 3-4 days:

- Remove old pouch with adhesive remover wipes, pulling toward stoma with gentle push-pull technique
- Cleanse peristomal skin with warm water and pat dry
- Measure stoma and cut hole in 1-piece drainable Coloplast Sensura soft convex pouch.
- If skin soreness/breakdown present, apply light dusting of stoma powder and seal with no-sting liquid barrier film
- Wrap stoma with Hollister Cera moldable barrier ring. Roll small piece of Strip Paste to supplement barrier ring at 9 o'clock divot to promote flat surface for pouching system.
- Apply pouch and secure with Hollister barrier extenders if needed.
- Wear ostomy belt as desired for support when ambulating.

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

Overall, I felt good about the care provided, though a couple of factors complicated things. Since the woman has had an ostomy before, it was harder to figure out what the family did and didn't know already. With first-time stoma patients, you can assume they know very little. In this case, the husband claimed to be good-to-go on stoma care and just requested a quick visual demonstration. I would have preferred in this case to respectfully request the caregiver to "prove it". If they truly are competent, then a standard pouching change should be simple and only take a few minutes. Then I can say I witnessed their care versus simply taking their word for it. Additionally, this Spanish-speaking family initially declined interpretation resources which we respected. There were a few moments where it was unclear if they truly understood, so we reinforced at the conclusion of the session with interpretation services via a telephone call. Ideally, an in-person interpreter would have been scheduled to arrive to the bedside for the most effective possible teaching. Since the family was uninsured, our prescription for supplies and list of DME suppliers was not helpful. We were able to direct them to free 3-month supplies from the major manufacturers which the family greatly appreciated.

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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 for the day was to gain further experience with atypical or complex stomas. I got to see significant peristomal hernias, attempt colostomy irrigation, and pouch a difficult fistula. I felt like I met my goal and saw a handful of things I do not typically encounter in my pediatric setting.

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

Complete my virtual case studies. 😊

**For instructor use only. Do not remove or edit:**

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	

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Learning goal identified	✓	
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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