

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Aislinn Van Tyne Day/Date: Tuesday June 3, 2025Number of Clinical Hours Today: nineCare Setting: Hospital Ambulatory Care Home Care Other Preceptor: Terri CobbClinical Focus: Wound Ostomy Continence **Reflection: Describe your patient encounters & types of patients seen.**

A patient with a new ostomy requiring a pouch change and initial teaching. A patient with multiple types of stomas that required assistance on how to pouch and teaching. Patient requested reevaluation of potential stoma site markings that were done prior to a body composition change, we assessed and moved the sites higher before surgery schedule for tomorrow, also discussing with patient the life changes that will occur after surgery and the ease of cleaning and emptying pouch. A patient whose pouch was leaking overnight and had been changed prior to our arrival to cover until we could assist, pouch found to not be sealing because floor staff were not using the methods in the plan of care for pouch application.

Chart note:**Braden Risk Assessment Tool**

Sensory Perception	4
Moisture	3
Activity	2
Mobility	3
Nutrition	2
Friction/Shear	2
Total	16

Patient history of recurrent rectal cancer with colostomy, TURP procedure, and now presenting for intrabdominal abscess.

Patient required a pouch change for all three pouches and education prior to discharge to skilled nursing for rehab.

Ileal conduit, skin intact with stoma beefy red, moist, and budded, stent is in place. Nursing team reached out to the provider as the stent was mostly out of stoma but did not receive communication back. Skin was cleaned and pouch system was replaced.

Loop ileostomy located in the right upper quadrant, stoma is red, moist, and edematous, peristomal skin

(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.

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

showing light erythema superior to stoma with deep creases at three and nine 'clock due to healing separation from rod end sites. The surrounding skin is semisoft. Output is liquid green.

Colostomy located in the left upper quadrant, flush with the skin, red and moist in appearance, mucocutaneous junction is intact, peristomal skin is intact. A small amount of output noted by nursing staff requires emptying once per day. Expressed to patient that on next assessment colostomy output will likely have decreased further and may only require a dressing and no longer need pouching.

During teaching we also expressed that staff at the skilled nursing facility (SNF) will assist in pouch changes but the goal after discharge is to follow up in the outpatient ostomy clinic.

WOC Plan of Care (include specific products)

Ileal conduit:

- Use ConvaTec Sensi Care no sting adhesive remover wipes to remove the old pouch
- apply ConvaTec Stomahesive powder to irritated skin as needed with each pouch change, making sure to brush off loose powder and apply 3M skin barrier prep over powdered areas.
- Apply Hollister Ceraplast barrier ring, Hollister new image 2 and 1/4 "convex flange, cut to fit two patient's ileal conduit and connect pouch to gravity drainage
- goal for wear time is 3 to 4 days

Ileostomy

- use ConvaTec sensi care no sting adhesive remover wipes to remove the pouch from skin
- apply ConvaTec Stomahesive powder to irritated skin as needed and apply 3 M barrier prep over powdered areas
- apply Hollihesive wedge at three and nine o'clock and caulk edges with stomahesive paste
- apply a 40mm convex ring and Hollister Sarah plus barrier ring to Hollister new image 2 1/4 convex drainable pouch wafer, then connect wafer to pouch and apply to Austin
- apply Hytape to pouch edges as needed

Colostomy

- use ConvaTec no sting adhesive remover wipes to remove all pouch
- apply stomach use of powder as needed for irritated skin, then apply 3M barrier prep to powdered areas.
- Cut Coloplast drainable pouch # 15521 to 2 1/4 in, around opening apply Stomahesive paste then apply pouch

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

The patient had just completed physical therapy and seemed very tired. Although the patient was in good spirits and was up for, he and his wife to learn, I would have rather coordinated with the therapy team to come at a better time when the patient was more awake. There were many questions of whether a stent was allowed to be removed from the ileal conduit and we did not receive communication from the team until after

(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.

pouching, if it was a known possibility I would reach out to them in the future prior to starting treatment so that the pouch change could have been easier for the patient and staff.

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?

Gain experience pouching different types of ostomies, Terri provided me with an ample amount of opportunities for education. She was also very approachable and made me feel comfortable asking questions as they arose during different clinical, scenarios.

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

My goals for tomorrow in the outpatient urology clinic are to observe any testing and patient care opportunities that arise.

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record notes reflect 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"> Completes Braden Scale for inpatient encounter 	✓	
<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 	✓	
<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"> Braden subscales addressed (if pertinent) 	✓	
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 	✓	

(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.

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

• 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.