

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

Student Name: Hannah Smith Day/Date: 6/18

Number of Clinical Hours Today: 8

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Terri Cobb

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.**

Pt 1 month post op, follow up pouch change  
Pt transitioning from her current colostomy to a permanent ileostomy, education about different output to expect and need to include more electrolyte to nutrition to avoid dehydration  
Pt with a stoma prolapse, given a flip pouch, education on belt and binder options

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 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:**

Pt is a 74 year old female with no significant past medical history presents 1 month following loop ileostomy placement. Plan for reversal in August of this year. Pt underwent a sigmoidectomy for diverticulitis. Current medications include tylenol PRN, amoxicillin, eliquis, aspirin, lipitor, buspar, calcium carbonate-vitamin D3, cipro, synthroid, mag-ox, melatonin, metoprolol, and multivitamin. Pt presents with her husband who states helps at home with pouch changes. Pt and husband state they are very happy with the

current pouching system and express no issues. They are calm and pleasant throughout visit. Pt brought her own supplies to clinic today. Stoma is 1 ¼" in diameter slightly oval shaped in the RLQ. It is red, moist, and budded with mucocutaneous junction intact. There is a narrow rim of mild, blanchable erythema noted on the peristomal skin. Pt with a healed midline abdominal incision. Pt states use of Domeboro at home with pouch changes (every 3 days). Peristomal contour is rounded, supportive tissue is soft. Output is characterized as thick, brown liquid effluent. Pt states she empties at least 6-8 times per day. Current pouching system is Hollister new image 2 ¼" convex flange, cut to fit, with a Hollister Ceraplus barrier ring and a drainable pouch. Current wear time is 1 day, removed for assessment, there was some effluent undermined on the back of the flange already, per pt, the stoma was very active at the time of the pouch change.

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)**

Pt is happy with the current pouching system, which was applied today: Hollister new image 2 ¼" convex flange, cut to fit, with a Hollister Ceraplus barrier ring. Use stomahesive powder and then no sting skin barrier as needed for any denuded skin or erythema, although patient prefers not to use this and it was not applied today. Pt has supplies to use up before the reversal surgery. Advised pt that she can use both the flat and systems with the thicker barrier ring, or use the Hollister 2 ¼" convex systems with the thinner ring.

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

I think the care provided was thorough and precise to order to help the patient achieve the best outcome. What could have been done differently was have a discussion regarding the patient's nutrition to be sure she has reach optimal nutritional status as well as discuss her activity level and she if she is in need of any accessories such as a belt. I would be sure she has adequate protein intake as well as electrolyte intake and give her some examples to help to include in her diet. I would've also asked more open-ended questions to be sure she feels best supported and could have perhaps referred to a support group.

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?**  
Do a pouch change independently with light preceptor guidance.  
Goal Met. I did this pouch change using the proper supplies and proper technique with preceptor watching.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**  
Gain confidence in properly and thoroughly educating patients who are to get a new stoma.

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
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Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>Identifies why the patient is being seen</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Completes Braden Scale for inpatient encounter</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies specific products utilized/recommended for use</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>	✓	
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Braden subscales addressed (if pertinent)</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>	✓	
Learning goal identified	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_