

Daily Journal Entry with Plan of Care & Chart Note

 Student Name: Jessica Whelen Day/Date: 7/14

 Number of Clinical Hours Today: 9

 Care Setting: Hospital Ambulatory Care Home Care Other

 Preceptor: Jeaninie Osby

 Clinical Focus: Wound Ostomy Continence
Reflection: Describe your patient encounters & types of patients seen.

Today was a good day. I learned a lot of useful information about the care of an ostomy patient. Today I was able to pouch a patient with a MCJS. I learnt about K-pouches, this was new to me. My preceptor showed me how to flush the k-pouch. And did some teaching with my preceptor. I removed a foley from a urostomy patient and educated them on how to complete a pouch change. I sized two patient who were having leaking issues and almost go to remove a stoma bar. Lot of ostomy experience.

Chart note:
Braden Risk Assessment Tool

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

Met with 67y.r. old male at bedside. Per Epic patient has PMHx of Crohn's disease of the large intestine, DM, Left ventricular diastolic dysfunction, s/p R AKA, BPH, Proctocolectomy, K-pouch creation s/p 40yr. On 7/8/2025 patient underwent an exploratory laparotomy with lysis of adhesions, pouchoscopy and K-pouch revision for K-pouch stricture. Today is post-op day one. Upon arrival to patient's room, patient is lying in bed, wife is at bedside. Patient states he "feels like a car ran him over". Patient states that he has had his k-pouch for over 40 yr and is well versed at managing it. Patient's wife is his support system.

Permission asked to assess his stoma and flush his catheter, patient agreed. Upon positioning the patient for assessment, it is noted that the was not a tube holder in place and the catheter kinked. Patient educated on the

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importance of keeping the catheter tube straight and kink free.

Stoma assessment**Stoma location:** RLQ**Stoma Diameter:** 7/8**Stoma protrusion:** Flush**Mucosal color and condition:** Pink and moist**Mucocutaneous junction:** intact**Peristomal skin:** clear and intact**Abdomen:** soft and tender**Catheter type:** Ileal reservoir catheter (waters catheter)**Stabilizing sutures:** intact**Catheter depth position change:** no**Catheter irrigation:** yes: done 40cc x 3 and solution used: normal saline**Effluent return:** Brisk**Consistency effluent:** pink tinged clear liquid with clots**Color of effluent:** Watery**Catheter stabilization system:** Stabilizing sutures**Catheter anchored to:** right thigh**Drain:** yes**Type:** JP**Location:** LLQ**Drainage:** serosanguineous**Drain insertion site:** not observed

Continent ileostomies care complete: Catheter irrigated with 40 cc of normal saline until effluent returned clear with no clots. Peri skin cleanse with pH neutral skin cleanser and water allowed to air dry. One pack of split gauzed placed around tube secured with paper tape.

Plan of care: return Wednesday 7/16/2025, to snip supporting sutures, place belt securement device, irrigate and move catheter out 1cm.

Discharge needs: Continued lesson for review (patient has experience with ostomy).

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)

Nursing order:

Please flush Continent catheter every 2 hrs with 40 cc of normal saline, until drain is clear. Cleanses peri

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stomal skin with ph balance skin cleanser, rinse with warm water, allow to dry. Apply one pack of split gauze around tube insertion site.

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

Patient was very pleasant and well versed in the care of his k-pouch. I feel if he was feeling better he could teach me a few things. So, I am not sure what I could have done different aside to a little research on K-pouch and how to care for them since this was a first one for me. My preceptor did a fantastic job of explaining how a k-pouch functions and the post -op care, as well as routine maintenances.

Goals

What was your goal for the day? My goal for the day was everything ostomy. I was hoping to experience a lavage. But I was able to flush a k-pouch catheter, remove a foley from a urostomy, resize two patient and discharge education.

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

I believe I am in the outpatient clinic tomorrow. I am eager to learn about pre-op teaching and learn how to complete a marking, and the opportunity to mark a patient.

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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	✓	

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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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