Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Kyle Aniol Day/Date: Thursday, September 18th

Number of Clinical Hours Today: **8** Number of patients seen: **7**

Care Setting: **Hospital Ostomy**

Preceptor: **Jeanine Osby**

Clinical Focus: **Ostomy**

Reflection: Describe your patient encounters, types of patients seen, and any additional activities.

Today was spent rounding the hospital and seeing patients for wound vacuum therapy or ostomy related needs. Patient A was a 62 y/o female with a loop transverse colostomy and a colovaginal fistula that was pouched. Overnight the colostomy pouch started leaking. Patient B was a 31 y/o female with a continent ileostomy (K-pouch) and a continent urinary reservoir (monti conduit). The patient was being seen for continued education on irrigation and management of both sites. Patient C was a 64 y/o male with negative pressure wound therapy on a surgical incision midline chest. Patient D was a 62 y/o male with a 12-year-old colostomy due to diverticulitis. The patient was independent with ostomy care but was in need of more supplies. Patient E was a 37 y/o female with an end ileal conduit being seen for a scheduled pouch change. Patient F was a 43 y/o female with a loop transverse colostomy that started leaking. Patient G was a 70 y/o female with diverticulitis requiring stoma site marking for a possible loop ileostomy.

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

(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.

Cleveland Clinic

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

Chart Review, Assessment, Encounter

Age/Sex: 70 y/o female
PMH: Patient is pre-hypertensive managed with diet and exercise. Past surgical history of mesh hernia repair in 2011. A colonoscopy was done in 2021 that showed sigmoid narrowing. Further testing was ordered but never completed per chart review. Constipation has managed for the last 5 years with miralax BID and stool occurrences at least every other day.
CC: Constipation r/t Diverticulitis- procedure will be a sigmoid colectomy, may have to form a loop ileostomy
Social Hx: Patient is G2P2 with two natural deliveries. She is widowed and not sexually active. Her son lives down the street from patient and will be able to help her at home.
Medications: Lactobacillus acidophilus (daily), Vitamin B-12 (daily)

Assessment/Encounter: Patient is being seen for stoma site marking r/t a possible ileostomy. She states that her constipation has worsened, along with an increase in abdominal discomfort, nausea, and vomiting over the last few months. Admitting colonoscopy showed severe diverticulitis with sigmoid narrowing. On appearance, her abdomen is flat with minimal contour or creasing, rectus muscle easily identified. Stoma site marked in the RUQ.

Patient was educated on the purpose of the stoma site marking and watched a video on the creation of an ileostomy. Tegaderm dressing was placed over site and patient was given supplies to maintain the mark until surgery. Patient stated that she cared for her son with a colostomy and is comfortable with pouching and stoma site care.

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)

Place new tegaderm over stoma site mark if old dressing comes off
Use a marker to darken the site if current marking starts to fade
Follow pre-operative plan set in place by your surgeon
Contact your consulted rehab service for Pelvic Floor Physical Therapy post-operation
Contact WOC nursing office, or ask your nurse for a consult, if the marking is no longer visible (do not remark site on your own)
Do not submerge site in water, showering with clear dressing is recommended instead

(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.

Cleveland Clinic

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

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 today was to work with a patient that has a complicated stoma site or multiple diversions. This goal was met as I performed pouching changes on a patient with a colostomy and an enterocutaneous fistula requiring a pouch. I also worked with a patient that had a continent ileostomy and continent urinary reservoir.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My goal for tomorrow is to be able to identify when a change in the pouching system is necessary. The size of the aperture for the stoma, the type of wafer for the anatomy around the stoma (convex, flat, etc.), and the type of pouch (high output vs. normal).

(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.

Cleveland Clinic

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

For instructor use only. Do <u>not</u> 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	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **<u>48 hours</u>** following the clinical experience day.