



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

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

Student Name: Birgitte Kammerdiener Day/Date: Wednesday September 24th

Number of Clinical Hours Today: 8 Number of patients seen 5

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Megan Hincapie CWOCN

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, and any additional activities.**

Today was spent in-patient with the ostomy team. My preceptor today was Megan Hincapie CWOCN. Patients we saw today included a colostomy irrigation for a small bowel obstruction which is who I have chosen to write my journal on. The other patients I saw today were for those who were experiencing leaky pouches. Some of these patients were ileostomies and others were fistulas. Megan and I worked together to find where the leaks were occurring and how the pouching system either needed to be built up or changed to provided a good seal and prevents leaks and undermining from occurring. I had a lot of practice with cutting wedges, using paste as a caulk between the seams of the wedges and using different pouches like Eakin fistula pouches and post op pouches due to the size of the wound and fistula or contour of the abdomen around the stoma.

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.

**Chart note:**
**Braden Risk Assessment Tool**

Sensory Perception	4
Moisture	4
Activity	4
Mobility	4
Nutrition	3
Friction/Shear	3
Total	22

**Chart review/History**

Age/sex: 69 year old female

PMH: Hypertension, hyperlipidemia, depression, hysterectomy, end descending colostomy, takedown of abdominovaginal fistula

HPI: Patient had a hysterectomy complicated by a sigmoid perforation that required OR take back where the patient had creation of an end descending colostomy and Hartmann's procedure in December of 2024. Patient presented to the emergency department with complaints of abdominal pain. CT scan showed a small bowel obstruction. Patient had a previous admission in August for a small bowel obstruction that was resolved without surgical intervention.

Social hx: Patient resides at home with her husband and is independent with her ADLs. No tobacco or drug use. Has a drink of alcohol occasionally.

**Assessment/encounter:**

Patient being seen for colostomy irrigation due to small bowel obstruction. Patient presents alert and oriented and sitting up in bed. Started by explaining irrigation process and purpose to which patient was agreeable. Before starting patient did state that a small "pellet" of stool came out followed by about 100 mL of liquid brown stool. Spoke with colorectal PA who asked for the colostomy irrigation to still be done. Patient was still agreeable to irrigation. Patient home system was removed and patient was placed into a new system for the irrigation to which an irrigation pouch sleeve could be attached.

Stoma: red/pink, moist, budded, LLQ, mucocutaneous junction intact

Stoma size: 1 ½"

Shape: Round

Drainage: Scant liquid brown stool in pouch

Peri-stomal skin: peristomal clean and intact. No signs of irritation. Cleansed with warm water and pat dry.

Abdominal plane: rounded, semisoft.

Education:

- Purpose and procedure of stoma irrigation

Treatment

- Old pouch remove, peristomal skin cleansed with warm water and pat dry
- New pouch with irrigation sleeve placed
- Using colostomy irrigation cone, 500 cc of normal saline instilled into colostomy

**Chart Note:**

(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.

Patient is a 69 year old female with a history of hypertension, hyperlipidemia, hysterectomy, sigmoid perforation resulting in creation of end descending colostomy with Hartmann's procedure. Patient does not use tobacco or drugs, has an alcoholic beverage on occasion. Patient has had her colostomy since December of 2024. Patient is independent with ADLS and pouch changes at home. Patient presented to the emergency department for abdominal pain. CT scan showed small bowel obstruction. Patient was previously admitted in August for similar complications that were resolved without surgical intervention. Presented to patient's bedside for irrigation of colostomy. Procedure and purpose explained to patient who was agreeable. Patient did state that prior to ostomy nurse arrival that a small hard "pellet" of stool came out, followed by about 100 mL of liquid stool. Spoke with colorectal PA about patient's ostomy functioning, requested for irrigation to still be done. Patient was still agreeable to irrigation and stated she was not currently experiencing any abdominal pain but did feel slightly distended. Pouching system removed and peristomal skin cleansed with warm water and pat dry. Stoma reddish pink, moist and budded. Peristomal skin clean and intact. Mucocutaneous junction intact. Abdominal plane rounded and semisoft. Pouching system with irrigation pouch applied around stoma. Using a colostomy irrigation cone and bag, 500 cc of normal saline was placed into instillation bag and ran through line until all air was removed. Irrigation cone was then lubricated and gently placed into stoma. Irrigation clamp was opened and began irrigating into stoma. Patient did not experience any abdominal cramping during irrigation. See irrigation fluid did begin to come out around the cone and was noted to be tinted brown. Once all 500 cc was instilled, cone was removed. Irrigation fluid mixed with stool began to come back. Ensured irrigation sleeve was intact and secure. Left room for a few minutes. Upon return to room noted output to be watery brown liquid and some mucous and small food particles were noted. Pouch with irrigation sleeve removed and patient placed back into home system, Convetec flat flange precut 1 ½" with drainable pouch, which remains appropriate for patient. Measured output from irrigation sleeve for a total of 600 mL. instructed patient that more output may follow and if patient is emptying pouch to measure and record how much and provide to bedside nurse. Patient provided a graduated cylinder for measuring. Communicated with bedside nurse that irrigation was complete and to monitor and record output.

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)**

- Consult to nutrition to educate on GI soft diet, avoiding foods that cause blockages and adequate fluids intake
- After discharge have patient keep a bowel diary and food intake diary for two weeks and bring to outpatient follow up appointment in two weeks
- Continue to monitor and record all ostomy output during hospital stay, empty pouch when 1/3 to ½ full
- Notify colorectal if abdominal pain begins or ostomy output stops
- Change ostomy pouch every three to four days and as needed-Convetec flat flange precut to 1 ½" and drainable pouch
- Encourage patient to continue to be independent with pouch changes
- Order follow up CT scan to assess blockage ASAP

(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.

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

I would have educated the patient on the GI soft diet and provided her with hand outs of what foods to avoid helping prevent a blockage from forming. I would have assessed how much fluids she drinks a day and encourage her to increase fluid intake to help prevent blockages/constipation. I would have also educated and encouraged the patient to keep a bowel diary for two weeks after discharge and track how her output is. I would have also encouraged her to keep a food diary to assess if there are any specific foods that may be contributing to blockages/constipation and then bring them to a follow up outpatient appointment to be reviewed.

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 see irrigation or intubation. This goal was met by being able to perform a colostomy irrigation using the cone

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

Tomorrow I am with the CORS NP. My goal is to learn more about their routine in the outpatient location and how they assess and help patients in their role.

(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.

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

CRITICAL ELEMENTS	Completed	Missing
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: \_\_\_\_\_

(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.