

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Lily Lane _____ Day/Date: _____ 1/20/21 _____

Directions: WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, select one patient each clinical day and complete *plan of care and chart note*.. This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. **Journals should be submitted to your dropbox by no later than 48 hours following the clinical experience day.**

<p>Today's WOC specific assessment</p>	<p>History: 53 year old patient with hx of HTN, HLD, DM2, anxiety and bipolar. Brought in by Carolina air care to ED for ejected MVC, GCS 14 on admission, VSS. Pt was noted to be confused and had slurred speech, documented concussion. Of note, he was not able to move both LE on exam, no withdrawal to pain, reflexes not intact. Labs significant for Hgb 12.5, lactate 2.9, unremarkable tox screen. CT imaging showing cord compression at T11-12, b/l T1 and T2 TP fractures and T2 compression fracture.</p> <p>Injuries:</p> <ul style="list-style-type: none"> -T11(12?) chance fx -Severe cord compression of T10-T11 -Grossly displaces L 1st rib -T2(T3?) compression fx <p>*Hx per H&P note. Admitted 11/21/20*</p> <p>Met with patient today for ostomy teaching and pouch change. Patient is unwilling to participate at this time, and patient's son (who is involved with care) is engaged in an important phone conversation.</p> <p>Assessment: Left abdomen stoma showing adherent tan necrotic tissue. Some red moist mucosa also visible. Stoma measures 1 ¼ inches in diameter. Producing loose, brown stool. 570 ml output recorded in previous 24 hours. Peristomal skin is denuded at 3 and 9 o'clock where red rubber loop was present. Received permission from primary team for removal today. Mucocutaneous suture line is intact. Pouch applied 5 days ago is intact with moisture noted circumferentially.</p> <p>Stage 4 sacrococcygeal pressure injury with abscess formation, s/p debridement. The wound was assessed earlier today by PT, pulse lavage therapy provided and dressing changed. See note with included photos. Dressing not changed again this afternoon.</p> <p>Abdominal gastric tube. Peri-tube skin is clean, dry and intact. Gauze dressing in place and bumper sitting snugly on top.</p> <p>Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc</p>
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

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Met with patient today for inpatient ostomy teaching and pouch change. At this time, patient is unwilling to participate in teaching and may also have limited ability to assist with pouching. Son is at bedside and usually involved with care, but is otherwise engaged in an important phone conversation. Pouching system removed using adhesive releaser and skin cleansed with warm water. Left abdomen stoma shows adherent tan necrotic tissue and some moist red mucosa is also visible. The stoma measures 1 ¼ inches. Stool is loose and brown, with 570 ml output in the last 24 hours. Red rubber loop is present-- received permission from primary team to remove during this encounter. Ring is cut with sterile scissors and removed. Denuded skin is noted at 3 and 9 o'clock. Mucocutaneous suture line is intact. Pouch applied 5 days ago shows circumferential moisture on the barrier.

Denuded skin crusted using Stomahesive powder and No sting spray. Ostomy pouch changed using ConvaTec 1-piece flat pouch cut to 1 ¼". Also reviewed pouch change emptying procedure and frequency (change every other day until denuded skin healed and then twice weekly), stool and stoma characteristics, crusting of denuded skin and use of moldable rings for caulking prn. At this time, patient looking away and does not acknowledge stoma. Will have WOC check back in for ostomy teaching with son tomorrow, and over the weekend if present.

Patient also has stage 4 sacrococcygeal pressure injury with abscess formation, s/p debridement. Wound was assessed earlier today by PT, pulse lavage therapy provided and dressing changed. See chart note and photos. Dressing not changed again during this encounter. Patient will likely return to OR tomorrow for additional debridement. Patient currently on Sizewise bed, but have requested HUC to order Envella bed after consulting with PT. Bed will be delivered this afternoon and care nurse to assist with transfer to new bed.

Gastric tube in place. Peri-tube skin is clean, dry and intact. Split gauze dressing changed and bumper securely positioned against it.

Consider how you would document this information into the medical record. Will others be able to interpret your plan of care? Consultant/specialist note should begin with why you are seeing the pt; Initial visit for..., follow- up visit for..., evaluation and management of..., etc Then, describe the visit.

WOC specific medical & nursing diagnosis	WOC Plan of Care (include specific product used today)	Rationale (<i>Explain why an intervention is chosen; purpose</i>)
Disturbed body image related to presence of stoma and loss of bowel control.	Encourage patient to verbalize feelings. Continue to assess willingness to acknowledge stoma and begin to participate in care. Place consult to chaplain or stress management. Continue to involve patient's son in care and teaching during this adjustment period.	Provides emotional and psychosocial support to the patient. Patient's willingness/readiness to learn can be hindered by psychological factors. Provides emotional support and opportunity for patient to verbalize feelings.
Altered skin integrity related to skin breakdown at colostomy site. <i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:</i>	Crust denuded skin with Stomahesive powder and No Sting spray at 3 and 9 o'clock prior to new pouch application. Utilize ConvaTec 1-piece flat Cut-to-fit, Durahesive Plus® Skin Barrier; 12" pouch with 2-sided comfort panel, InvisiClose® Tail Closure and filter, cut to 1 ¼". Change every other day until skin is healed and then twice weekly. Can also apply ConvaTec Eakin Seal –	Powder absorbs moisture on denuded skin providing surface for pouching. No Sting spray enhances seal of barrier powder. 1-piece pouching indicated for flat peristomal profile on patient. Skin barrier ring enhances seal of

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<p>Impaired skin integrity evidenced by stage 4 sacrococcygeal pressure injury.</p>	<p>SLIM prn for caulking.</p> <p>Until OR tomorrow, change sacrococcygeal dressing q-shift using loosely packed Vashe-moistened Kerlix, gauze covering, and sacral-shaped Mepilex foam dressing over sacrum and perianal wounds. Change foam q2-3 days and prn for soiling, peeling back q-shift for wound care. Apply No Sting Barrier Film to intact peri-wound skin.</p> <p>Turn patient q2h on left or right side, avoiding back. Offload heels using air boots or pillows. If using Prafo boot, alternate boot q2h with turns, and use pillow or airboot for opposite extremity. Pad Achilles areas with Mepilex foam dressings. Offload/pad/rotate all medical devices per policy.</p> <p>Switch to Envella® Air Fluidized Therapy Bed.</p> <p>Place drain sponge gauze under gastric tube stabilizer (disk). Secure disk snugly on top of drain sponge by pushing down. Change drain sponge daily with routine site care.</p>	<p>skin barrier.</p> <p>Vashe is noncytotoxic and cleanses the wound. Gauze absorbs exudate. Foam dressing promotes moist healing environment while absorbing excess exudate. No Sting Barrier Film protect peri-wound skin from erosion.</p> <p>Avoiding pressure on sacrococcygeal wound is priority for pressure injury healing. Padding and offloading of additional bony prominences assists with protecting at risk skin areas and preventing new pressure injuries from forming, especially with limited mobility.</p> <p>Air fluidization minimizes pressure and shear, helps control microclimate and promotes wound healing.</p> <p>Gauze absorbs exudate in case of leakage and helping to prevent peri-tube skin damage. Disk stabilizes the tube and helps prevent irritation.</p>
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<p>What are the disadvantages of using this product(s)? What alternatives could be used and why?</p>	<p>Goal is for patient's son, and eventually patient, to be able to manage ostomy care independently. Using a one piece appliance may make it more difficult to ensure an adequate seal around the cut barrier and stoma as you aren't able to visualize gaps as well as with a two-piece. Stomahesive powder, No Sting Barrier Film and Eakin ring (if necessary) are extra steps in the process, and can also increase costs.</p> <p>An alternative would be switching to a two-piece system, using a ConvaTec Natura® Moldable Accordion Stomahesive™ Skin Barrier with Acrylic Collar and a 12" Natura® + Drainable Pouch with InvisiClose® Tail Closure System and Filter (in opaque). The two-piece system would allow for better visualization of the seal around the stoma and ease of application. Additionally, the moldable barrier eliminates the cutting step, and may eliminate the need for additional barrier rings. Accordion style allows the pouch to be snapped on to the barrier without placing excess pressure on the abdomen. Using an opaque pouch may increase patient's satisfaction and help to decrease anxiety as he adjusts to new stoma. Can also use just Stomahesive powder (dusting off excess) to help reduce cost and steps involved in pouch change.</p>
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Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	I was able to observe urodynamic testing, but it was interrupted a couple times, as the patient had two vasovagal episodes. After the second episode, the testing was discontinued. The second appointment ended up canceling. Still, it was interesting to observe. It is something I will definitely need to spend some more time studying to gain a better understanding of.
What are your learning goals for tomorrow? (Share learning goal with preceptor)	Goals for next time include setting time aside to review organization for documentation and care plans with my preceptor.

Number of Clinical Hours Today: 8 hours

Care Setting: Hospital Ambulatory Care Home Care Other: _____

Number of patients seen today: 4 Preceptor: Katie Smith

Reviewed by: _____ Date: _____

****References are not generally required for daily journals**

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