

Daily Journal Entry with Plan of Care & Chart Note

 Student Name: Celia Jennifer Rodriguez MSN, RN _____ Day/Date: 11/25/22

Directions: *WOC nurses function as consultants and develop plans of care for other caregivers as a guide to providing care in the WOC nurse's absence. For this assignment, select one patient each clinical day and complete the **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 data and preceptor, and submit it 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.**

Today's WOC-specific assessment	<p>Be sure to include data that supports the identified problem and interventions. Include PMH or state no other history, pertinent labs, etc</p> <p>PMH: This is a 57-year-old male admitted with urosepsis. Pt has a history of smoking 30 packs of cigarettes per month, rectal cancer with bladder invasion; s/p ileostomy. Failure of his bladder to heal s/p resection, radiation therapy, DM2, CAD, HTN.</p> <p>Tests: Cystogram was concerning for non-healing bladder secondary to radiation, tumor/location, foley failure post-up, and the dislodgement of diversions at home therefore the ileal conduit was planned.</p> <p>Admitting CT scan showed right PCNT had been pulled out.</p> <p>No significant lab results</p> <p>Surgical history: CAD s/p CABG, s/p partial cystectomy/ureterolysis/stents in August 2022, and attempted bladder repair and B ureteral reimplant later the same month. History</p> <p>Medications: Magnesium sulfate 2 g IV one-time dose Potassium chloride 40 mEq PO twice daily Enoxaparin 40mg SC daily Ertapenem 1 g IV daily stop 11/26 Polyethylene glycol 17 g PO daily Oxycodone 5-10mg q6h PRN Alvimopan 12mg PO BID Docusate 100mg PO BID Sodium Chloride flush 10-20ml flush q8h and PRN Folic acid 1mg PO daily Pantoprazole DR EC 40mg before breakfast Metoprolol tartrate 50mg PO BID</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:

Consider how you would document this information in 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 nurse initial referral for urostomy education and pouch fitting.

This is a 57-year-old male with bilateral ureterolysis, simple cystectomy, and a Wallace-type ileal conduit urinary diversion on 11/22. This is post-operative day one and the pt is alert to name, place, and time, lying in bed in no acute distress. He shares that management of his ileostomy appliance changes is done by his girlfriend and he only empties the pouch. Furthermore, he states any teaching regarding his urostomy needs to be done with her as he will not touch it. Nursing explains that the urostomy appliance leaks and have had to be changed three times since surgery. The stoma is at skin level, red, with a small amount of maceration noted to the peristomal skin, and there are two stents in place. No urine is in the pouch which is attached to a 24-hour foley bag but there is tea-colored urine in the bag, and the chuck under him is wet. Bilateral nephrostomy tubes capped no drainage or s/s infection noted around them.

Recommendations:

2 1/4 inch **soft Convex 11703** two-piece urostomy pouch with floating flange and urostomy transparent pouch18403

Gravity drainage bag with adaptor

Stoma powder

Non-alcohol skin barrier spray

Cut aperture 1 3/8" x 1" oval shape **1. Just wondering, if this is the stoma size why is a 2 1/4" wafer used?**

Warm water

WypAll wipes

Paper tape measure

Re-consult WOC RN if unable to maintain pouch

Will follow at intervals

WOC-specific medical & nursing diagnosis	WOC Plan of Care (include specific product used today)	Rationale (<i>Explain why an intervention is chosen; purpose</i>)
Peristomal skin breakdown related to the urostomy.	<ul style="list-style-type: none"> ○ Assess the 2-piece urostomy pouching system for leaks between pouch changes, and change if there is a leak. ○ When changing the urostomy pouch, assess the back of the barrier for signs of erosion. 	<p>Early recognition of a leaking pouch prevents peri-stomal skin damage from urine sitting against the skin</p> <p>Assessing the back of the skin barrier for evidence of urine starting to leak underneath will help to identify if the output is making contact with the skin to cause skin injury. + You know</p>

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<p>Knowledge deficit of patient and caregiver related to urostomy care.</p>	<ul style="list-style-type: none"> ○ Remeasure the length and width of the stoma. Draw the shape of the aperture on the skin contact side of the barrier and cut to shape. I remember that the nurses on many of the units who saw ostomies frequently were very adept at pouch changing. Even with that, I would always include the cut 1/8 inch larger than measurement. ○ Apply stoma powder to macerated areas, and dust off. Apply skin barrier spray and allow to dry. ○ Apply the soft convex skin barrier, and hold using warm hands to seal it in place. <p>Teaching initiated on;</p> <ul style="list-style-type: none"> ○ infection control; <ul style="list-style-type: none"> ○ the importance of performing urostomy care before ileostomy care ○ hand washing before pouch change ○ urostomy anatomy ○ stents <ul style="list-style-type: none"> ○ stent care ○ purpose of stents ○ peristomal skincare ○ emptying pouch when it is 1/3 full and why. ○ Frequency of pouch change ○ Appropriate use of accessories; <ul style="list-style-type: none"> ○ why stoma paste should not be applied to the urostomy peristomal skin. ○ When/how to use stoma powder and skin prep ○ how to secure the tubing from 	<p>where the leak is occurring based on the erosion of the wafer.</p> <p>Remeasuring the stoma size continues for six weeks as swelling decreases post-op, and the stoma size may change.</p> <p>Stoma powder absorbs moisture from the peristomal skin before placing the skin barrier. The skin barrier spray offers skin protection and acts as an adhesive to strengthen the adhesion of the pouching system. Just a note, most of the skin barriers I know are definitely not adhesive. The point of the barrier over the powder is to achieve a surface to which a pouch or wafer can adhere. Adhesive based products do not really adhere to powder. You allude to this later</p> <p>The soft convex is appropriate for post-op stoma for the prevention of mucocutaneous junction separation and to assist in preventing leakage.</p> <p>To prevent bladder infections one must begin with the urostomy pouch change first. To understand the changes from what was normal to what to now expect. Stents are to help with healing, prevent ureter stricture, and provide bladder drainage postoperatively. To maintain healthy skin without irritation, soreness, or redness and to avoid pouch seal problems. 1/3 pouch emptying prevents urine backflow into the stoma and potential bladder infections.</p>
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	<p>urostomy to gravity drainage bag</p>	<p>+ excess weight of urine or stool in a pouch breaks the seal of the system</p> <p>Pouch changes allow for skin assessment.</p> <p>Urine erodes stoma paste which weakens the seal.</p> <p>If stoma powder is inaccurately applied the stoma barrier will not stick. It also helps with moisture and in protecting and healing the skin. The skin prep acts as a skin sealant, and moisture barrier and protects and prevents epidermal stripping. Yes!</p> <p>To prevent kinks and maintain patency.</p>
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<p>What are the disadvantages of using the <u>product(s)</u>? What alternatives could be used and why? Identify each WOC product in use. This is an opportunity to communicate product knowledge and critical thinking.</p>	<p>There are no known disadvantages for use of convexity skin barriers Celia, that is not exactly true as actual device-related pressure injuries may occur more readily with convex wafers but there is a concern about it causing a mucocutaneous separation from the pressure of the convexity. 2. Oh, interesting...do you have a source for this?</p> <p>Alternatives are skin barrier rings if convex is unavailable because they are made from Pectin or sodium carboxymethyl cellulose base product which is soft and moldable. It also comes in different sizes, and is flat or convex Skin barrier rings can be molded to any shape, they prevent leakage, can use instead of stoma paste, can prolong wear-time, leave less residue on the skin, and can be cut, bent, or stacked.</p>
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Develop one learning goal for each clinical day, a document on this form then share your goals with your preceptor.

<p>Were you able to meet your learning goals for today? Why or why not?</p>	<p>Yes, my goal was to help the patient and caregiver to understand the importance of providing urostomy care with a basic understanding of the anatomy, stents, and prevention of kidney/bladder infection or contamination. I felt I was successful when they both expressed surprise at the new urostomy information and rationales of the care to what they previously knew for the ileostomy.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>To follow up on the urostomy for leaks and troubleshoot as needed.</p>

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Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 5 Types of patients seen: Urostomy with ileostomy, ileostomy, and retracted ileostomy with a fistula and two colostomies.

Preceptor: Megan Berry

Reviewed by: Patricia A. Slachta Date: 12/5/22

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

Well done! I did have two questions within the body of the journal. Please answer in the journal w another color & re-submit this through this Dropbox date

We need to resolve the date and the hours... according to your schedule, Nov. 25 was a 2-hour day and you did a log for this day already on a pt w a perforated sigmoid..

I am OK with a log and a journal for the same date on these different patients but, the hours don't match up as you said there were eight hours today on this journal but your log with the same date and your schedule say it was only a 2-hour day on November 25.

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