

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Celia Jennifer Rodriguez MSN, RN _____ Day/Date: 11/28/22 _____

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 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 69-year-old female with a history of HTN and diverticulitis, respiratory failure requiring intubation.</p> <p>Surgical history: s/p ex-lap and Hartmann procedure (2005) and colostomy reversal, with a complex incisional hernia, recurrent small bowel obstructions and was admitted for complex intra-abdominal infection, requiring multiple surgeries.</p> <p>Tests: -CT with PO contrast suggests the presence of enterocutaneous fistula -CT abdominal scan for interval redevelopment of extraluminal anterior abdominal fluid collection. The intra-abdominal fluid collection grew; polymicrobial including enterococcus faecalis and faecium. LFTs improving; SGPT (ALT); 45 (0-41IU/L). Alkaline Phosphatase 245 (35-129 IU/L)</p> <p>Medications Carvedilol (Coreg) tab 25 mg BID w/ meals Ergocalciferol (Vitamin D2) cap 50,000 Units on MWF Fat emul-soy-mct-oilv-fish oil (Smoflipid) 20 % IV 240 mL MWF 20ml/hr Fluoxetine 20 mg/5 mL soln 40 mg PO daily furosemide tab 20 mg PO daily levothyroxine tab 75 mcg PO daily losartan tab 50 mg PO at bedtime Nifedipine tab (sustained release) 30 mg PO at bedtime Pantoprazole DR EC tab 40 mg PO BID Pregabalin cap 25 mg PO TID Saliva stimulant agents Comb.3 (Biotene moisturizing mouth) 1 Spray QID Tylenol 500mg PO BID prn pain</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:

WOC nurse initial referral for management of mid-abdominal fistulas and catheter drainage.

Pt is a 69-year-old Caucasian female s/p partial colectomy of the distal colonic stump and loop transverse colostomy creation with two drains (Blake and pigtail) in the mid-anterior and lower abdomen. There are two enterocutaneous fistulas; one superior and one near the anterior abdominal midline that has been pouched but no documented drainage on the flowsheet. Per pt. and RN the pouch was emptied and changed at the end of the previous shift and had a moderate amount of thick drainage. The second fistula is inferior to the abdominal midline and has been managed with gauze sponges, a scant amount of clear drainage was noted. The peri-fistula skin at the superior end is pink but both are intact with no skin erosion evidence to require a pouching system at this time. The right flank inferior drain, leaks serous fluid, and is managed with StatLocks, drain sponges, **1. Do you have any suggestions for this? We used the vertical attachment drain device.....**changed as needed with documentation noted as saturated. Pt is NPO, on TPN, and has been having abdominal pains and nausea with drain positions and when touched in the vicinity of the drains but denies any burning or stinging sensations to peri-fistula skin. Both fistulas are at skin level and have 0.2cm x 0.2cm openings.

Recommendations:

- WypAll and warm water
- gauze
- skin barrier spray
- 2 vertical drain attachment device
- Maxorb AG
- drain sponges and one inch paper tape

Nursing to document the frequency of the drain sponge saturation and changes
Change the Maxorb AG and drain sponges daily and PRN saturation.

Re-consult WOC RN if drain sponges are changed greater than once per shift

Will follow up in one day and 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>)
<i>Fistula and drain management</i>	<p>Remove all drain sponges and calcium alginate. Assess and document peri-fistula and drains output</p> <ul style="list-style-type: none"> o consistency, color, amount, and odor o Assess the peri fistula and catheter skin integrity. o using warm water and Wypall, clean peri-fistula skin and skin around the catheters, and dry with gauze. 	<p><i>To begin the peristomal skin assessment.</i></p> <p><i>The output amount will assist in determining the need for pouching, and in ensuring that the pt. is not experiencing excessive fluid loss Skin integrity helps in the early prevention of skin breakdown, and in</i></p>

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<p><i>Coping secondary to fear of the unknown</i></p>	<ul style="list-style-type: none"> o <i>Apply skin barrier spray to peri-fistula skin and around the catheters, and allow it to dry.</i> o <i>Cover both fistula sites with drain sponge and secure with paper tape.</i> o <i>Apply the Hollister Vertical Drain Tube Attachment (VTAD) Device around each drain site.</i> o <i>Cut a strip of Maxorb Ag and wrap around the drain insertion site and secure it with a drain sponge and tape.</i> <p><i>This sounds as if you are putting gauze under the vertical drain attachment. 2. Am I reading this correctly?</i></p> <p><i>Oh, I see what you mean. Application of the Vertical attachment device is actually what we did first then place the drain sponge over the attachment device.</i></p> <p><i>Give the pt. the chance to express her feelings, fears, and concerns.</i></p> <p><i>Encourage the pt. to participate in her care such as holding the dressings, securing the tubing, and participating in activities. good</i></p> <p><i>Do not give her more information than necessary, only provide the information requested. did she tell you this is how she wanted to get information? I agree that too much can be overwhelming but I do worry if people aren't getting the total picture... She did not specifically say that. Apart from listening to my pt.s, I tend to practice observation of body language and by certain cues the pt. may give. This pt had been through so much already that by me asking her open ended question, its gave her the opportunity to express her feelings. She was also feeling me out which I wanted to use to assist</i></p>	<p><i>avoiding pain, and suffering in the patient.</i></p> <p><i>The skin barrier spray helps to protect the skin from epidermal stripping, it is a moisture barrier and a skin sealant.</i></p> <p><i>Securement of the tubes from the drain site to stabilize the tube is standard of care to prevent complications such as from positional changes pain, irritation around the site, and leaking of drainage from the insertion site that can lead to subsequent fungal rash or peristomal skin breakdown. The VTAD will also work better than a Statlock because it was meant to secure a urinary catheter and not a drain site, and was not properly stabilizing her tubes as it did not secure them directly at the drain site.</i></p> <p><i>Maxorb AG and drain sponges are used for their high absorbency level as well as antimicrobial benefits and it's potential for odor control .</i></p> <p><i>Active listening will open communication with the pt and decrease her anxiety. This will help in promoting her self-esteem and a feeling of control.</i></p> <p><i>Too much information may be overwhelming</i></p> <p><i>This sheds light on progress made that pt. may not see.</i></p>
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	<p><i>her in future visits.</i></p> <p>Show the pt. the progresses or changes made.</p> <p>Yes, it is definitely a great idea to share progress with patients—do you need to share w the staff what you are thinking here? <i>Yes, and they did this by allowing her to participate in her care. I actually had a second follow up with her on Tuesday for her ostomy care and she was tickled by the idea that she was teaching nurses how to apply the pouch. They use those opportunities to boost her ego.</i></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><i>The disadvantages of using the drain sponge is that it may not hold heavy exudates. An alternative would be bordered Mepilex for its high absorbency, its contact layer protects the skin from leaks, and maceration, and minimizes pain.</i></p> <p><i>An alternative to Maxorb Ag is Calcium alginate for its high absorbency.</i></p> <p><i>An alternative to the Vertical Drain Tube Attachment Device with the zip tie securement is the Hollister Drain Tube Attachment device with the adjustable securement clamp for changes in tube positioning and allows for better access for site care.</i></p> <p><i>Paper tape is used to protect the skin from stripping.</i></p> <p>3. Do you think there should be any referrals for this patient to anyone? You didn't mention any within this journal. Social worker checks on her occasionally but she has been offered other support services, but she is a naturalist and currently spends her days reading books and meditating and have expressed not feeling ready for psych support.</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.

<p>Were you able to meet your learning goals for today? Why or why not?</p>	<p>Yes. My learning was the same as the nurses in many ways as we trialed drain sponges instead of foam, placed a vertical drain attachment device which immediately stabilized the catheter to assist in relieving the pain the pt. was experiencing with the positional drains and the anxiety she had from any attempts to touch them which protectively held in a bag. Also, in assessing the need for a pouch and at least eliminating it temporarily, to determine the need, helped in not only freeing up the nurses' time but it helped them to realize that certain steps should be made before pouching begins for fistula management. The hope was that with less time caring for the drains would free up time to engage with the pt.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>To follow up on her positional drain pain and exudate, the fistula output to assess the need for fistula pouching and to begin ostomy teaching.</p>

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other:

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Number of patients seen today: 5 Types of patients seen: Types of patients seen: Loop transverse colostomy with two drains and two enterocutaneous fistulas, ileostomy, a retracted ileostomy with a fistula and two colostomies.

Preceptor: Megan Berry BSN, RN

Reviewed by: Patricia A. Slachta Date: 12/14/22

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

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