

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

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

Student Name: Rebekah Wakeman Day/Date: 1/4/2023

Number of Clinical Hours Today: 8 Care Setting:    Hospital     Ambulatory Care    Home Care    Other:

Number of patients seen today: 4 Preceptor: Coleen Potts

**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. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

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. Provide thorough documentation on the patient encounter. 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 by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

<p><b>Today’s WOC specific assessment</b></p>	<p><b>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</b></p> <p>76-year-old African-American male approximately 5 months s/p end-ileostomy construction. Patient had presented to CCF ED with 2 days of crampy abdominal pain, nausea, bilious emesis, and constipation. Remote history of subtotal colectomy with ileosigmoid anastomosis for colon CA in 2010 at OSH. PMH significant for cardiomyopathy, CAD, A-Fib, ESRD-DD. CT scan showed a SBO, with possible bowel <b>ischmiaischemia</b>. After developing increased tenderness in the R mid-abdomen and elevated WBC with moderate NG output, patient was brought to OR to rule out ischemia. Exploratory laparotomy was performed with reduction of small bowel volvulus in an internal hernia, resection of terminal ileum and ileosigmoid anastomosis, end ileostomy, and primary fascial closure. He was then admitted to SICU in serious condition secondary to hypotension and A-Fib with RVR.</p>
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**Chart Note:** Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

**The WOC nurse 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. Write in a manner others will be able to understand and be able to interpret your plan of care.**

This is a follow-up visit added on to the WOC Nursing schedule for evaluation and management of complaint of pouch leaking. 76 y/o male is approximately 5 months post-op end-ileostomy. Currently resides in a skilled nursing facility, escorted here in W/C by a facility staff member. Patient empties his own pouch, but SNF nurses change ostomy appliance. Patient is AA&Ox4, pleasant, and agreeable to appliance change and assessment. Denies pain at ostomy site. Appliance removed, pouch 1/3 full of brown liquid stool and skin barrier wafer noted to have effluent circumferentially under barrier extending to about 1 cm. Peristomal skin and stoma gently cleansed with warm water and gently dried

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with gauze. End ileostomy with stoma located in RLQ, measuring 7/8" x 3/4", flush with peristomal skin. Mucosa is beefy red, moist, and mildly flaccid. Mucocutaneous junction is intact. Peristomal skin with pseudoverrucous lesions from 5-8 o'clock and pink excoriation from 3-5 o'clock, extending approximately 1 cm from mucocutaneous junction. Peristomal contour is flat. Supportive tissue is soft. Patient reports emptying pouch 3-4 times daily. Current pouching system is 1 3/4" Hollister New Image flat flange with drainable pouch and clamp closure. Current wear time per patient is 3-4 changes **bummer** per week. Peristomal skin dusted with stomahesive powder and sealed with 3M Cavilon No Sting skin barrier film. 2x2 Hollihesive washer applied, followed by stomahesive paste and 1 3/4" Hollister New Image convex flexible flange, cut-to-fit, and drainable pouch with belt. Wear time expected to be 3-4 days. Demonstration of opening and closing pouch given to patient. Patient encouraged to practice with staff at SNF. Patient provided with homegoing supplies and ostomy supply order form. Patterns provided for SNF nursing staff to trace onto Hollihesive washer and skin barrier flange. Step-by-step instructions on how to change the two-piece pouching system sent with patient for SNF nursing staff to perform. Will follow-up as needed.

<b>WOC specific medical &amp; nursing diagnosis and concerns</b>	<b>WOC Plan of Care (include specific products used)</b>	<b>Rationale (Explain why an intervention is chosen; purpose)</b>
<p><b>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</b></p> <p>Skin impairment secondary to leakage of effluent underneath skin barrier flange as evidenced by pseudoverrucous lesions and excoriation at peristomal skin.</p>	<p><b>Statements should be directive and holistic relating to the problem/concern.</b></p> <ol style="list-style-type: none"> <li>1. Gather supplies including washcloths, non-oily soap, scissors with at least 1 blunt tip, plastic waste bag, new pouch, new skin barrier flange, adhesive remover, stoma paste, stoma powder, custom cut washer, and belt.</li> <li>2. Prepare new pouch               <ul style="list-style-type: none"> <li>- Trace the pattern (sized to fit within 1/8" of stoma) on the cover paper of the skin barrier flange.</li> <li>- Cut out the skin barrier flange.</li> <li>- Close the end of the pouch.</li> <li>- Remove the skin barrier cover papers from adhesive surface of the flange</li> <li>- Apply stomahesive paste around the opening (on the back of flange)</li> <li>- Set prepared flange assembly aside, sticky side up (set pouch next to it)</li> <li>- Cut Hollihesive washer according to the pattern, set aside</li> </ul> </li> <li>3. Remove the worn pouch               <ul style="list-style-type: none"> <li>- Holding pouch upright, open end of pouch &amp; empty into toilet or bedpan</li> </ul> </li> </ol>	<p><b>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</b></p> <p>Proper fit of pouching system and utilization of convexity will help to prevent leakage of effluent onto the peristomal skin and consequently preventing peristomal skin irritation. Use of Stomahesive powder, 3M Cavilon No Sting barrier film, and Hollihesive washer protects the skin thus enabling pseudoverrucous lesions and excoriation to heal.</p>

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	<ul style="list-style-type: none"> <li>- Remove the pouch by applying gently pressure on the skin with 1 hand and gently pulling the pouch away from the skin with the other (remove top to bottom)</li> <li>- Use adhesive remover as needed</li> <li>- Wrap the worn pouch in plastic waste bag</li> </ul> <p>4. Cleanse the skin around the stoma</p> <ul style="list-style-type: none"> <li>- Wash the area around the stoma with non-oily soap and warm water</li> <li>- Rinse the area thoroughly with warm water</li> <li>- Gently wipe dry with soft washcloth or gauze</li> <li>- Use skin barrier powder to sore skin as needed. Brush off excess powder.</li> <li>- Apply 3M Cavilon No Sting barrier film to peristomal skin.</li> </ul> <p>5. Apply prepared Hollihesive washer to skin around stoma (paper side down).</p> <p>6. Apply the prepared skin barrier pouch and pouch</p> <ul style="list-style-type: none"> <li>- Center flange opening over stoma and press into place</li> <li>- Smooth the sticky surface of the skin barrier flange onto the skin</li> <li>- Center the pouch opening over the flange and snap into place</li> <li>- Hold the pouch firmly in place for a few moments to ensure adhesion</li> <li>- Apply belt</li> </ul> <p>7. Change pouch flange every 3-4 days.</p>	
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<p><b>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the</b></p>	<p><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p> <p>1 ¾" Hollister New Image Convex flange- standard wear pouch that may not be durable enough for liquid stool; consider Hollister New Image Convex Ceraplus extended wear flange.</p> <p>Stomahesive powder-may not be available to patient; consider using any stoma barrier powder.</p> <p>3M Cavilon No Sting barrier film- may not be available to patient; consider using any liquid skin</p>
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<b>product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</b>	protectant that is alcohol-free. Hollihesive- expensive and possibly not available to patient; consider using Coloplast Brava Moldable Ring. Hollister New Image drainable pouch- may not have adequate capacity; consider using Hollister New Image High Output pouch to accommodate higher output ileostomy, especially useful if patient is relying on staff to help him empty, as it may be delayed or less frequent. <a href="#">good plan!</a>
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b>	My goal was to practice a new skill in ostomy nursing care. I met my goal. I assisted with marking a patient during pre-op visit for duodenostomy. I measured oval shaped stomas and assisted with re-fitting patients for different pouching systems. I also took initiative when asked to re-apply a pouching system with a patient's pre-cut 1-piece system that I noted was too large for the stoma. With the approval of my preceptor, I utilized a moldable stoma barrier ring to protect the peristomal skin and still utilize the patient's pouch which she desired to use.
<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	My goal for tomorrow is to assess the complex nursing management needs of a patient with fistulae.

<b>Reflection: Describe other patient encounters, types of patients seen. Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b>	We assessed and re-fitted the pouching system for a patient with complex peristomal skin issues. She had healing pyodermal ulcerations, pink/red cutaneous candidiasis, scattered flaky, dry sensitive skin, denuded areas and significant scar tissue with creases. Patient was using A+D ointment on the reddened areas beyond the peristomal plane. Patient educated on keeping skin clean and dry, not using thick occlusive ointments, and using prescribed Nystatin powder. Rerefitted with 1-piece light convex pouch and belt to prevent leakage.
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Reviewed by: Patricia A. Slachta Date: 1/5/23

Rebekah, great opportunity with this patient. Also, don't forget if you do a journal on an ostomy marking you do not have to do the ostomy site marking video...

I think I agree with you re the barrier & that an extended wear system might be helpful. This pouch change is actually a little complicated for staff in long-term care...powder, skin prep, ring, paste & finally convex pouching system (convex obviously a good first choice to extend wear time)!

**1. IF you were there alone, what would you choose for his ostomy?**

I might not fully understand what you mean by the question. If you want to know what I would have chosen for his pouching system if I was alone, then I still would have chosen the Hollihesive washer and a convex flange based on what I have learned in the last 2 days. The Hollihesive is an excellent choice for moist peristomal skin to protect it from further irritation. The patient had very soft supportive tissue and flaccid, fatty subcutaneous tissue in the abdomen; the pouching system had to be changed to convex.

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