

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

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

Student Name: \_\_\_\_\_ Sommer Saddler \_\_\_\_\_ Day/Date: Wednesday, 1/11/2023

Number of Clinical Hours Today: \_\_\_\_ Care Setting: 9 Hospital \_\_\_\_ Ambulatory Care \_\_\_\_ Home Care \_\_\_\_ Other: \_\_\_\_\_

Number of patients seen today: 8 Preceptor: Therese (Terri) Cobb

**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.

<b>Today’s WOC specific assessment</b>	<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><i>Pt. is a 59 year old male with a PMH of paroxysmal atrial fibrillation, Right thoracotomy with RLL and RML lobectomies (involving pericardial dissection, LA, mediastinal and hilar LND and pedicle flap buttress of the bronchial stump), and esophageal stricture. Pt. had been getting food stuck in his throat back 7/2022, around 10/2022 pt. had a CT of the chest which showed esophagopleural fistula within the right lower lobe, loculated right pleural effusion with some gas and debris layered. Pt. then ended up with a PEG tube from undergoing a EGD, NG was placed into the abscess cavity, bronchoscopy. In 11/2022 pt. underwent surgery for a Right Claggett window, intercostal muscle flap buttress repair of the esophago-pleural fistula, and esophageal stent placement with extension J tube. The following day pt. had to return to surgery for an Esophagogastroduodenoscopy, repositioning of the esophageal stent.</i></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.

<p>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.</p> <p>Initial assessment consisted of assessing the site, and surrounding skin. Pt. wife stated that she had been changing the packing/dressing 3 times a day and noticed that the surrounding skin over the last couple days become a very angry red, and was causing the pt. some discomfort; also, there was a different color drainage, browner tinge than normal, typically the pt. drainage is that of saliva, clear. The old dressing was removed and the surrounding skin of the Claggett window was red, itching per the pt. appeared moist. Pt. wife has been using a kerlix wet to dry dressing, at this time the thoracic service does not want kerlix dressings but would like a pouch applied over the Claggett window.</p> <p><b>Recommendations:</b> Remove old appliance/dressing/pouching system with ConvaTec Sensi Care No Sting Adhesive Remover wipes and gently release the previous worn pouch from the skin, cleanse/soak to surrounding skin if redness, skin irritation or</p>
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itching occurs with Domeboro's soak for 15-20 minutes (continue as needed until the skin feels better and or is healed), lightly and gently pat the surrounding skin dry with a gauze, apply 3M Cavilon No-sting skin prep to the surrounding/denuded/irritated skin of the Claggett window lightly. Then with one full sheet of the Hollihesive cut in half, round the corners and arch into a wedge with radial slits. Pull the pt. skin superiorly above the Claggett's window upward, and apply Hollihesive wedges, the wedges should overlap at the corners where there is a deep crease at 3 and 9 o'clock. Then apply Coloplast SenSura drainable pouch with inner radial slits, Mefix tape and a warm pack if needed or overlapping hands over the pouch for warmth and to ensure adherence is ok. The goal is to not allow anything to get into the Claggett's window, so no strip paste used, but may consider. The goal of the pouching system is to last 2-4 days.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen, purpose)
<p>Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.</p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p> <p><b>Impaired Skin Integrity</b></p> <p><b>Claggett window pouching</b></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <ol style="list-style-type: none"> <li>1. <b>Remove the old pouching system, with ConvaTec Sensi Care No Sting Adhesive Remover wipes, to gently remove the worn pouch from skin.</b></li> <li>2. <b>Cleanse the peri skin with Domeboro's soak if the skin remains to have denuded and macerated skin, redness, or irritation for 15-20 min. (no solutions to get into the Claggett's window).</b></li> <li>3. <b>Lightly and gently pat the peri skin dry with a gauze. Apply 3M Cavilon No-sting skin prep, to the surrounding area of the Claggett window lightly.</b></li> <li>4. <b>Then, cut to fit one full sheet of Hollihesive in half, round the corners and cut an arch into each wedge with radial slits around the opened area/surrounding skin to prevent leakage and protect the irritated skin. Gently pull the superior edge of the wound upward, the wedges should overlap each other at the corners due to deep crease at 3 and 9 o'clock.</b></li> </ol>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Removing the pouching system and changing the pouching system will prevent any skin breakdown or worsening skin issues and maintains skin integrity. Applying appropriate skin barriers such as Hollihesive wedges will protect the skin and use of Domeboro's soak will provide a soothing relief of skin irritations, redness, itching and discomfort to the affected area.</p>

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	<p>5. <i>Apply Coloplast SenSura drainable pouch with inner radial slits, and Mefix tape.</i></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 product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</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> <ul style="list-style-type: none"> <li>• <b>ConvaTec Sensi Care No Sting Adhesive Remover wipe: disadvantage, could function as an irritant to the skin, alternate option is to use an alcohol swab.</b></li> <li>• <b>Domeboro's soak: disadvantage could be the active ingredients within the product, such as aluminum sulfate and calcium acetate being an irritant to the pt. skin and worsening of the current skin issue, and not providing relief. Therefore, using just a gentle mild soap and water is an alternative option that should cause no adverse effects.</b></li> <li>• <b>3M Cavilon No-sting prep: disadvantage could be skin irritation to the surrounding skin, an alternate is to not use any barrier if the peri wound is intact, and ensure surrounding skin is thoroughly dry before placing dressing on.</b></li> <li>• <b>Hollihesive wedges: disadvantage, pt. could also be allergic to the product resulting in increased skin irritation, or leakage affecting the seal of the aperture. An alternative could be a moldable ring or stomahesive paste.</b></li> <li>• <b>Coloplast SenSura drainable pouch: disadvantage, primarily saliva is going to be draining, but due to the contour of the pt. body it may not properly drain into the drainable pouch, so an alternate would be to use basic dressing, reconsidering packing the Claggett window for absorption of the fluid.</b></li> <li>• <b>Mefix tape can also cause skin irritation, and an alternate would be Sterofix retention tape.</b></li> </ul>
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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><b>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</b></p>	<p>To critically think of alternate ways to manage leakage and skin issues related to wounds, ostomies, or fistulas, and in this case scenario, I was able to think of a pouching system that could be easy for the pt. wife to implement and manage, and something comfortable for the pt.</p>
<p><b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b></p>	<p>Continue to become familiar with the products for ostomies and fistulas.</p>

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**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**

An additional pt. seen was a 72-year-old male with a recent loop ileostomy. Pt. had colon polyps and diverticulitis with an abscess and colovesical fistula; surgery consisted of an open lysis of adhesions, with takedown of colovesical fistula and drainage of the abscess; sigmoid colectomy with primary anastomosis, then a takedown of the small bowel to colonic fistula and repair of the small bowel and omental pedicle graft. Pt. supplies was set-up at the bedside, rod removal was performed and stoma intubation was initiated. Pt. stoma was red, moist, and edematous with some separation to the stoma from the exit sites of the rod, no effluent was present with the intubation, only flatus after the stoma intubation. The pouching system applied based upon assessment and size of the stoma was a ConvaTec Durahesive Solid 57 mm Flat Flange; hollihesive wedges were placed to the peri stomal site at 3 and 9 o'clock due to subtle depressions in the contour of the abdomen with paste at the seams, and a Coloplast 4.2 mm Brava ring and drainable pouch. This was a good experience, getting to see a rod in the stomal and actually removing the rod. The outcome went well, there were no complications or anything I would have done differently; I would prepare for teachings and lessons for next visit, once determining removal of stoma intubation.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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