

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: 1/18/2023

Number of Clinical Hours Today: 9.5 Care Setting:    Hospital     Ambulatory Care    Home Care    Other:   

Number of patients seen today: 7 Preceptor: Megan Hincapie

**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>30-year-old female with long-standing history of colonic, ileal, and duodenal Crohn’s disease who presents with painful skin lesions. Patient had total proctocolectomy with end ileostomy in 2001 complicated by parastomal abscess s/p multiple washouts and re-sitting of stoma, recent ileostomy revision for GI bleed on 11/9/2022. On 11/28/22, patient was admitted for VZV infection after going to ED for blistered rash on her back, trunk, and arm, fever, abdominal pain, and nausea. She was treated with Acyclovir. Around 12/9/22, she developed sublingual and oral ulcers which are being treated with magic mouthwash. On 12/14/22, she was transitioned to combo therapy of Stelara and Entyvio for better management of Crohn’s. Her general well-being has been poor since September of 2022 when she began having symptoms of GI bleed leading to the ileostomy revision in November. Duodenal stricture undergoing periodic dilation and needle knife stricturotomy. Concurrent Methotrexate therapy continues, changed to PO with lower dose due to nausea. Patient has comorbid POTS, fibromyalgia, chronic interstitial cystitis with hematuria s/p cystoscopy with hydrodistension. Recent ileoscopy and EGD on 10/18/22 showed small bowel with focal areas of chronic active enteritis and ulceration consistent with abscess formation and granulation tissue at ostomy site and persistent stricturing of duodenum. Immunostain for CMV was negative. Lab values WNL.</p> <p>Meds: Acetaminophen 1000 mg PO Q6hr PRN for mild to moderate pain, oxycodone IR 5 mg PO Q8hr PRN for Severe Pain x 5 days, famotidine 20 mg PO BID, folic acid 1 mg PO daily, ivabradine 2.5 mg PO BID, loperamide 2 mg PO PRN (max 16 mg daily), Levsin 0.125 mg SL TID PRN, Methotrexate 15 mg PO Q Sunday, Multivitamin chewable daily, Lo Loestrin Fe 1 tab daily, Zofran ODT 4 mg PO Q8hr PRN for nausea/vomiting, triamcinolone acetonide 55 mcg nasal inhaler 2 sprays in each nostril daily, triamcinolone acetonide 0.146 mg/gram topical spray to peristomal skin with each pouch change (no more than twice daily), Stelara 90 mg/injection SQ Q 8 weeks, Entyvio via IV infusion.</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**

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**be able to interpret your plan of care.**

Follow-up visit with WOC nursing in Outpatient Clinic for evaluation and management of new wound below stoma with purulent drainage and severe pain at site. Patient drank activated charcoal last evening per MD instructions to determine if new wounds were fistulas and would produce black effluent. Assessment revealed new small fistula opening 0.5 cm from stoma at 3 o'clock, and partial thickness wound adjacent to partial shallow separation extending from fistula opening to 8 o'clock without any visible drainage at this time. Multiple red macular lesions noted at peristomal skin under tape collar of flange. A peristomal ulcer at 5 o'clock measuring 0.3 x 0.3 x 0.1 cm and ulcer at 7 o'clock, measuring 0.5 x 0.5 x 0.1 cm, both with 100% yellow slough in wound bed, periwound skin is red, indurated and swollen. MD and PA-C came in to see patient and assess wounds and order topical medication. Patient tolerated assessment with several pauses due to pain.

End ileostomy located in LLQ with stoma measuring 1 ¼", stomal fistula present at 1 o'clock with mix of black pasty to semi-liquid effluent draining, os at 6 o'clock and produces moderate amount of mucous. Stoma is budded with mucosa red and moist. Peristomal contour is slightly rounded with semisoft supportive tissue. Patient empties her pouch 3-4 times daily. Current pouching system is Hollihesive triangular washer cut-to-fit 1 ¼" stoma size and then Coloplast Sensura Mio Flex Light Convex with drainable pouch and small smear of Stomahesive paste around aperture. Picture frame flange with Mefix tape. Current wear time is 2 days with seal intact.

Recommended Skin care: Cleanse peristomal skin with soap and water and rinse thoroughly with water, and gently dry. Apply 3M Cavilon advanced skin protectant to adjacent peristomal skin, not over yellow slough. Allow to dry. Apply Medline Maxorb II silver alginate, cut-to-fit wound bed, to ulcers at 5 and 7 o'clock and cover with Hollihesive wedges. Caulk Hollihesive edges with Stomahesive paste.

Recommended Pouching system: continue same pouching system. Wear time goal is 1-3 days.

Consult placed to Dermatology. Consult placed to Pain Management. Scripts sent electronically to pharmacy for patient: Doxycycline for peristomal abscess/cellulitis, Flagyl topical cream to red skin lesions.

Follow-up visit scheduled for 1 week to see CRS and WOC Team

<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>Impairment in skin integrity related to Crohn's disease process as evidenced by peristomal ulcer.</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 and cut skin barrier and Hollihesive washer according to templates provided during 1/18/23 office visit.</li> <li>2. Apply small smear of Stomahesive paste around aperture of skin barrier.</li> <li>3. Remove old pouch.</li> <li>4. Cleanse peristomal skin with soap and water and rinse thoroughly with water, and gently dry.</li> <li>5. Apply 3M Cavilon advanced skin protectant to adjacent peristomal skin, not over yellow slough. Allow to dry.</li> <li>6. <b>Apply Medline Maxorb II silver alginate, cut-to-fit wound bed, to ulcers at 5 and 7 o'clock</b></li> <li>7. <b>Cover alginate with Hollihesive wedges.</b></li> <li>8. Caulk Hollihesive edges with Stomahesive paste.</li> <li>9. Apply Hollihesive triangular washer and then</li> </ol>	<p><b>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</b></p> <p>Prepare supplies before removing the old pouch to minimize the amount of time that the ostomy may be functioning without a pouch in place to contain the effluent. Stomahesive paste used to caulk seams to prevent leakage of effluent.</p> <p>Do not use pH-balanced no-rinse cleansing foam (as the moisturizer in the foam will prevent adherence of pouching system). Non-oily soap such as Ivory or Dial is effective at removing stool and can easily be rinsed from skin surface with water. It will not inhibit adherence of the pouching system.</p>

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	<p>Coloplast Sensura Mio Flex Light Convex skin barrier.</p> <p>10. Attach CSM Flex drainable pouch.</p> <p>11. Picture frame flange with Mefix tape.</p>	<p><b>3M Advanced Skin Protectant will protect peristomal skin from effluent and drainage to prevent further breakdown and allow skin to heal.</b></p> <p><b>Maxorb Ag will absorb moderate amount of exudate from wounds and turn into a gel that allows for a moist healing environment while inhibiting microbial invasion.</b></p> <p><b>Hollihesive- protects open areas from effluent while absorbing small amounts of exudate without swelling in order to protect sensitive weepy peristomal skin from further breakdown.</b></p> <p>Coloplast Mio Flex Light Convex flange helps the stoma to remain budded despite sitting, giving flexible support to semi-soft supportive tissue while preventing the slightly rounded abdominal contour from lifting the flange away from the skin surface which could cause effluent to undermine the skin barrier.</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> <p>Convatec Stomahesive powder- if unavailable, use Hollister Adapt Stoma powder</p> <p>Stomahesive paste- if unavailable, use Hollister Adapt Filler paste</p> <p>Coloplast Sensura Mio Flex Light Convex with drainable pouch- if unavailable, use Hollister New Image 1 1/4" Convex flange with Lock 'N Roll drainable pouch.</p> <p>Mefix- if unavailable, use Hytape</p> <p>Stomahesive powder-may not be available to patient; consider using another brand such as Hollister Adapt stoma powder.</p> <p>3M Cavilon Advanced Skin Protectant- may not be available to patient; consider using Medline Marathon No Sting Cyanoacrylate Skin Protectant.</p> <p>Hollister Hollihesive- expensive and possibly not available to patient; sent home with patient from outpatient clinic. There is no equivalent to this on the market. No other product holds up to moisture without swelling in order to protect sensitive peristomal skin breakdown.</p> <p>Medline Maxorb II silver alginate- may not be absorbent enough if large amount of drainage develops; if so, consider Convatec Aquacel Ag Advantage for extra absorbency while still offering infection prevention. Also maintains moist healing environment.</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><b>What was your goal for the day? Were you able to meet your learning goal for today? Why or</b></p>	<p>My learning goals for today were to be more independent in selection of appropriate pouching systems and treating peristomal skin irritation as necessary. I met my goal as I took initiative in selecting dressings for a peristomal wound. I was also independent in refitting a pouching system that needed more convexity.</p>
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<b>why not?</b>	
<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	My goal is to experience care for an ostomy issue I have not yet seen or cared for.

<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>	<p>First patient of the day was a 68-year-old male who lives by himself with significant tactile and finger dexterity deficits that inhibited his ability to apply a pouching system by himself although he reports no issues other than pouch leaking and denies changes in his condition (although he admitted to weight loss later in the appointment). He was wearing a flat pouch that was bought on amazon and it had leaked from 3 to 9 o'clock. He had dried stool on the lower half of his abdomen. We re-fitted him for Hollister New Image Flexwear light convexity 7/9" CTF with Lock 'N Roll drainable pouch; however, the patient had difficulty applying the system. Unable to cut skin barrier or attach pouch to flange. Pt. could not remember what medical supply company he had ordered from in the past, and his daughter, who accompanied him was unable to help. We sent him home with precut wafers with attached pouches and "winged" adhesive backings in order to make it as easy as possible for him to apply those pouches for the next 4 changes. We then ordered samples of a comparable system from Coloplast that would be covered by his Medicaid, to be sent to his address. He was set up with a follow-up appointment with Outpatient clinic for WOC nursing evaluation in 1 week.</p> <p>I would not have done anything differently today. I had 7 patients, and I performed above my own expectations in an area I am still quite new to. I also re-fitted a patient who had effluent undermining her skin barrier circumferentially with a deeper convexity and Hollihesive washer to protect the pseudoverrucous lesions and denuded skin. My preceptor praised me for doing so well; everyone on the ostomy team has told me that I have grown so much in these last 3 weeks.</p>
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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