

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___ Stacy Mariano ___ Day/Date: Monday 2/6/23

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

Number of patients seen today: ___ 6 ___ Preceptor: Aaron Fischer

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>Today’s WOC specific assessment</p> <p>Open abdominal wound with ECF.</p>	<p>Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.</p> <p>PMH: 31 yo female with history of Vascular Ehlers Danlos Syndrome, pneumothorax, ruptured hepatic artery, bullous emphysema, 2 cranial aneurysms, CVA, anxiety GERD, HTN, migraines and thyroid disease. Surgical history of hernia repair, surgery to repair hepatic artery rupture and pneumothorax, splenectomy.</p> <p>HPI: seen at OSH for abdominal pain, N/V eventually diagnosed with emboli in mesenteric vein with bowel ischemia, patient had small bowel resection with subsequent multiple bowel surgeries ending with ileostomy creation, midline incision left open due to VEDS. Patient has visible deep tissue exposure with mesh (prior surgery) and has developed an ECF in the wound with large amount of drainage making pouching difficult. Ileostomy noted on RLQ, separate from wound.</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 visit for evaluation of open abdominal wound with ECF, ileostomy on RLQ, separate from wound. Patient has rare genetic disorder contributing to multiple medical problems which has necessitated several abdominal surgeries, the most recent of which abdominal incision had to be left open to heal by secondary intention. Patient has visible mesh supporting internal abdominal structures and has recently developed a spontaneous ECF that is draining copious amounts of brown colored, liquid drainage. Wound is a large midline surgical wound with even, open edges, pink tissue with some yellow adipose tissue noted, mesh is sutured</p>

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in place and is visible in wound bed. Mesh is brown in color due to ECF drainage. Periwound skin intact with no maceration, slight redness noted in slim border around edges, moderate pain during wound care, patient was premedicated and was having PCA delivered towards end of visit. Patient has loop ileostomy in RLQ that is functioning and has no notable issues. Stoma is beefy red and moist with no periwound maceration noted. Abdominal wound was cleansed with mild soap and water, gently dried with gauze, unable to isolate ECF, wound pouched with Eakin fistula pouching system with Holliheasive wedges applied to periwound skin, patient has skin sensitivities so minimal product was used. Seal was obtained, patient repositioned for comfort.

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>Knowledge deficit related to wound/ileostomy care.</p> <p>Impaired skin integrity, actual vs potential</p> <p>Pain, acute vs chronic</p> <p>Fluid/electrolyte imbalance related to fluid loss.</p> <p>Knowledge deficit related to nutrition.</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Nursing to remove pouching system with Allkare adhesive remover wipes (per patient these do not irritate skin), cleanse wound with mild soap and water, pat dry with gauze, apply Holliheasive wedges to skin surrounding wound bed, may use 3M no sting barrier wipes (per patient) to denuded skin as needed, do not use stoma paste due to skin sensitivity. Apply Eakin wound pouch with window to abdominal wound only. (Ostomy to be pouched separately.) May instruct parents/caregivers on wound care as able. Ileostomy pouching system to be changed in same manner using Convatec Mia Convex Light 1 ½ CTF, 2 piece pouch. Nursing may use additional Holliheasive wedges to “tape” leaks if needed. No tape is to be used.</p> <p>Have patient changed to First Step Mattress system and repositioned/turned every 2 hours to prevent pressure injuries due to decreased mobility. Nursing to complete full skin assessment every shift for breakdown and moisture.</p> <p>Patient pain to be assessed regularly and prior to wound/ostomy care. PRN medication to be offered for pain at 4 or higher. Nursing to ensure PCA is working and has adequately filled cartridges at all times to maintain patient comfort.</p> <p>Patient to drink 6-8 8 oz cups of fluids daily avoiding caffeine and sugary beverages to maintain fluid/electrolyte levels due to increased drainage. Nursing to offer a variety of beverages, popsicles, jello, broth.</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Education related to self-care enables patient to regain a sense of control over their health status, improve overall outcomes and reduces risk of re-hospitalizations.</p> <p>Specific instructions for bedside staff ensure continuity of care and maximum wear time of pouching systems. Skin needs to be assessed every shift for breakdown as patient is at increased risk due to nutritional status, wound/ostomy drainage, and impaired mobility. Patient also requires frequent repositioning as she is not moving much independently due to pain and weakness.</p> <p>Adequate pain control during wound care improves patient well-being and wound healing.</p> <p>Fluids are lost through heavy wound drainage and ileostomy output. It is important to monitor I&O and encourage increased po fluid intake to prevent dehydration.</p> <p>Increased protein is necessary for wound healing at the tissue and cellular levels. Instructing the patient to make healthy protein choices is important to overall health and wound healing.</p>

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	<p>Nursing to keep track of I&O to monitor po fluid intake. Maintain IV hydration as ordered by PMD. Note increases in wound/ECF or ileostomy output. Notify PMD if output is greater than 500ml intake. Nursing to monitor labs and notify PMD of electrolyte imbalances per hospital or electrolyte protocol.</p> <p>Add Ensure High protein to each meal tray, offer patient quality sources of protein such as chicken, fish, or lean beef. Plant based proteins and dairy products may be offered as well. Target protein intake daily should be 100-150 grams. Instruct patient and family on importance of protein in wound healing and muscle/tissue health. Consult Nutritionist for evaluation and further treatment recommendations.</p> <p>Nursing to monitor for signs of infection due to open wound including monitoring vitals, fever, malaise, purulent drainage, increased pain at wound site, labs, cultures, confusion. Report any s/s of infection or abnormal labs to PMD. Consult ID if not done so yet.</p> <p>WOC nursing to follow intermittently for pouch changes 2 times weekly. Nursing to re-consult for leakage problems or changes to skin.</p>	
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<p>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?</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Patient's current system removed using adhesive remover, skin cleaned with mild soap and water, 3M barrier film applied to periwound area, Holliheasive wedges around wound edges, creases at 3 and 9 o'clock filled with holliheasive wedges 4 layers deep, Convatec stoma paste applied over Holliheasive wedges ONLY, ConvaTec Eakins fistula pouching system applied to abdomen over entire midline wound.</p> <p>**Patient is very sensitive to adhesives so no tape or stoma paste should be used on skin.</p> <p>For this patient, any product with adhesives will irritate the skin to some degree. The goal is the least amount of skin damage with maximum wear time. Per the patient most of the mentioned products have been used by her; the exception being the paste and the Eakin pouch which is a ConvaTec product. Coloplast also carries fistula systems that are CTF up to 8 1/8 x 11 3/4 in. and may be</p>
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	<p>connected to a gravity drainage system but since she already uses ConvaTec her skin will probably tolerate the Eakin system. Coloplast Brave adhesive removers are alcohol free and may be better for the patient. The Convatec stoma paste does contain alcohol and could be replaced with Brava Strip paste to seal the wedges. Even though the paste was only used on the wedges, it could potentially migrate to the skin causing further irritation. Stoma powder may also be used to crust denuded/irritated skin. A major disadvantage of these products is just the number and amounts required to pouch the wound/ECF (the wound is very large measuring 10.5 x 6.25 cm) and removing this much product each time the system needs to be changed is going to cause irritation. The ileostomy is currently well managed as long as it is kept isolated from the wound and ECF drainage as it has a relatively low output. A wound vac may be an option if the fistula could be isolated and pouched separate from the wound; however this has proven difficult and the risk of additional ECFs evolving is high given the nature of this patient's condition. A gastric rest with TPN may be something worth discussing with her medical team.</p> <p><i>This is a complex case and this patient has many products in use for a reason here. ECF is not ideally managed with NPWT. As the WOC professional we need to take the individual picture into account here- I only know details provided here regarding this patient.</i></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>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>Goal today was to see wound or continence patients. We were able to see this patient along with several other wound patients today. This was a challenging wound care patient with a very complex history.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>Goal for tomorrow is to see continence patients.</p>

<p>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</p>	<p>Along with today's journal patient we saw a NPWT patient to change the dressing along with several ostomy patients that had wounds complicating their ostomies which I have noticed does become a problem for many patients. If pouching seals are not maintained and leakage occurs the patients end up with skin problems which then lead to additional pouching problems and it becomes a nasty cycle. Fitting patient's properly at first is so critical to the success and positive outcome of their surgeries! - <i>absolutely</i></p> <p>For today's journal patient, I wondered why the surgeon was not considering NPWT but perhaps it was too soon after surgery. It seems to me that a wound vac would better manage this wound. – <i>there are many variables here. Could this fistula be isolated and pouched with NPWT around it? This sounds like a viable option. NPWT is not used to manage fistula output except in some very particular cases. NPWT over abdominal wounds/non-intact facia carries an extreme risk for fistula.</i></p>
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Reviewed by: ___Mike Klements 2/8/23 reviewed

Hi Stacy – see my notes above. I left many comments in this journal – these are meant to be supportive and help develop your POC development and writing as the WOC professional directing care. As the WOC nurse, we need to be directing holistic care within the specialty. This journal is missing some components – please address my questions/comments throughout the POC and the product section. Reach out with any questions.

-Mike

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