

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

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

Student Name: Janet Barylski Day/Date: Wednesday, 7.12.23

Number of Clinical Hours Today:      Care Setting: 8h50min Hospital      Ambulatory Care      Home Care      Other:     

Number of patients seen today: 4 Preceptor: Jeanine Osby

Journal Focus:      Wound X Ostomy      Continence      Combination Specify:     

**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>Patient is a 59-year-old male who came to Cleveland Clinic on post-op day 11 (7/8/23) for further management of his care after dissatisfaction with outside hospital treatment of his muscle invasive bladder cancer s/p end ileal conduit placed in his RLQ.</p> <p>Past Medical History: bladder neck cancer with radical cystoprostatectomy and ileal conduit on 6/27/23 with takeback bilateral ureteral anastomosis leaks repaired on 7/1/23 and takeback fascial dehiscence on 7/7/23 closed with retention sutures and packed with packing strip.</p> <p>Labs: daily CBCs ordered; blood cultures x2 WNL results; urine culture results pending. Abnormal results from 7/11/23: HB 8.1; HCT 25.5; K 3.5; Gluc 115</p> <p>Medications: ondansetron; docusate sodium; lactated ringers IV; hydromorphone; oxycodone IR; acetaminophen; melatonin; piperacillin-tazobactam IV; NaCl 0.9% IV flush; enoxaparin injection.</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><b>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.</b></p> <p>Visited patient at bedside for hands on pouch application lesson as part of discharge preparation. His wife and daughter are at bedside. Ileal conduit stoma in his RLQ with a urinary foley inserted. Internal stents are externalized and working their way out. Urine was observed to be coming out of stoma around foley and stents, not through them. Dr Anna Zampini contacted and</p>
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instructed to leave foley catheter in place. Stoma protrudes slightly above the abdomen, is red and moist. Ureteral stents and catheter are not sutured or functioning. Urine is yellow with mucus. Mucocutaneous junction is intact. Peristomal skin presents with scattered erythema. Shaved peristomal skin and applied Stomahesive powder during bedside visit. Patient verbalized stating he did not know why the doctor did not just remove his penis. Patient also verbalized not wanting to remain hooked up to the overnight drainage bag and all the tubing because it weighs him down.

Hands on education completed. Patient did well with pouch change. Pouch connected to gravity drainage bag at end of lesson. Diet, hydration, and supplies for going home reviewed. Handouts for step-by-step instructions, diet, dehydration prevention, resource packet, and WOC nurse contact information provided. If patient is still in the hospital on Monday, 7/17/23, a pouch change will be scheduled for that date. Patient is appropriate for discharge from WOC nurse standpoint.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
<p><b>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</b></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>1) Nursing interventions for knowledge deficit related to ileal conduit care secondary to health status change.</p> <p>2) Altered body image secondary to surgical procedure related to bladder cancer as evidenced by verbalizations.</p>	<p><b>Statements should be directive and holistic relating to the problem/concern.</b></p> <p>Skin barrier powder 2 ¼” Hollister New Image CeraPlus convex cut to fit flange Urostomy pouch Gravity drainage bag</p> <p>1) Educate patient on how to care for his ileal conduit and health status change needs.</p> <p><b>**Gather your supplies: (teach patient to keep their supplies together in a bag or on a shelf)</b> Skin barrier powder 2 ¼” Hollister New Image CeraPlus convex cut to fit flange Urostomy pouch Gravity drainage bag (for at night) Scissors (2) disposable blue pads Gauze No-sting adhesive remover Liquid skin barrier Measuring guide</p> <p><b>**Use adhesive remover to ‘break the seal’ between the wafer and skin by saturating the wafer. Gently remove pouching system using “push/pull” method from top down while gently wiping the skin-to-wafer line with adhesive remover.</b></p> <p><b>**Be sure to assess the back of the ostomy wafer upon removal. Look for any signs of erosion,</b></p>	<p><b>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</b></p> <p>Avoid alcohol-based or oil-based solvents. Alcohol can irritate the skin. Oil can interfere with the pouch seal.</p> <p>If soap must be used, it needs to be a gentle moisture/oil free soap such as Ivory or Dial.</p> <p>Abdominal hair will interfere with wafer adhesion or cause discomfort with wafer removal. Clip hair to prevent this. Using an electric razor reduces irritation to skin.</p> <p>Abnormalities in peristomal skin can cause leakage which causes the wafer to leak. It also creates a risk for infection or wounds. Early intervention can minimize these risks.</p> <p>Changes in stoma color, junction, output, or ongoing bleeding indicate complications such as blockages, strangulation, or injury and need immediate attention to prevent adverse outcomes.</p> <p>Stoma edema recedes over 4-6</p>

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	<p>which may indicate the pouch has been on too long. Contact the WOC nurse with any signs of skin breakdown, leakage, or erosion.</p> <p><b>**Cleanse skin with warm water and gauze/paper towel. If soap must be used, it should be rinsed off thoroughly. Wipe the peri skin with warm water and pat dry. The stoma does not need to be cleaned. Any stool can be removed with gauze/tissue. If the peristomal skin has a lot of hair, clip the area with an electric razor.</b></p> <p><b>**Assess peristomal skin. It should look very similar to surrounding skin. Look for areas of redness, rashes, open skin, irritation, or changes in color/tissue appearance. Report any severe skin irritation or deep ulcers to WOC nurse.</b></p> <p><b>**Assess stoma. It should be red and moist. Report any unusual change in stoma size and any purple, gray, or black stoma discoloration to WOC nurse. Also assess the junction of the stoma and skin. Report any continuous bleeding to the WOC nurse. Report minimal to no output to the WOC nurse. An ileal conduit should flow constantly.</b></p> <p><b>**Measure the stoma. You will have to resize the barrier for the stoma for up to 4-6 weeks. Allow for a small rim of skin 1/8” between the stoma and the edge of the opening. Trace the proper size/pattern on to the back of the wafer paper.</b></p> <p><b>**Prepare pouch for application. Using your scissors, put the blunted end through the center of the wafer and cut. Use your opposite hand to turn the wafer into the scissors when you cut. Snap the two-piece set together (if applicable). Ensure the drainage spout is closed by the drip drop being invisible. If you use barrier paste, apply it directly to the back of the wafer around the opening and allow it to set up approximately 2 minutes (depending on manufacturer). If you use a barrier ring, apply it to the back of the wafer and stretch it to fit tight with the hole you cut out, then press it to the wafer.</b></p> <p><b>**Apply skin barrier powder to peristomal skin. Gently rub the powder over the skin. It will stick to moist and denuded skin without hurting the</b></p>	<p>weeks post op, at which point the size of the stoma should stabilize. Until then, stoma size will change.</p> <p>Leaving a 1/8” gap between the stoma and the wafer opening allows for flexion of the stoma during peristalsis without irritation while minimizing skin exposure.</p> <p>Putting the blunted end of the scissors through the hole prevents poking a hole through the bag (ie one piece system). Using your opposite hand to turn the wafer when cutting creates more stability and a smoother cut, which is gentler on the stoma.</p> <p>Gravity drainage bags are used at night to allow for uninterrupted sleep related to the pouch needing to be emptied. The gravity drainage bag also prevents the pouch from overflowing which may result in leaks.</p> <p>No sting adhesive remover does not contain alcohol. Alcohol containing products can cause skin irritation.</p> <p>The stoma will need to be measured with each bag change for the first 4-6 weeks as the stoma swelling recedes causing changes in the stoma size.</p> <p>Allow barrier paste to dry to ensure any alcohol contained in the product does not irritate your skin.</p> <p>Skin barrier powder is used to promote skin integrity where there is moist or denuded skin by protecting the area and adding pectin for healing.</p> <p>‘Crusting’ the skin barrier powder with liquid skin barrier protects the skin from the effluent and adhesive. It also provides a sealing surface when powder is used. Allow the</p>
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	<p>stoma. Brush off all excess powder. Use the liquid skin barrier on top of the powder to seal/crust the powder. Allow it to dry for at least 30 seconds.</p> <p><b>**Visualize the seal to ensure it is fully snapped into place. Standing, center the cut out of the wafer over the stoma and ease the pouch system on to the skin. Hold your hand against your stoma for a few minutes. Point the drainage spout down to the 6 o'clock position. If you wear a pouch belt, ensure that the belt tabs are at the 3 o'clock and 9 o'clock positions.</b></p> <p><b>** To empty the pouch, flip the tab at the bottom of the spout so the drip drop is visible. Put some tissue in the toilet water. Drain the pouch into the toilet water when the collection bag is 1/3-1/2 full. Be sure to flip the tab back so the drip drop is no longer visible, indicating the drainage spout is closed.</b></p> <p><b>**At night, you will connect the pouch to an overnight collection bag. Using the adapter, place it on the end of the tubing to the collection bag. Drain your pouch. Leave the pouch spout open and clip the adapter you placed onto the collection bag tube onto the drain spout of the pouch. Make sure your pouch is flat. If it gets twisted, you can swivel your pouch back into the proper position. In the morning, disconnect from the overnight bag. Wash the overnight bag out with vinegar and water by soaking in tub or using condiment squeeze bottle to instill solution. Hang overnight bag to dry. Keep two bags, alternating nights.</b></p> <p>2) Patient assisted in incorporating changes in ADLs and occupational activities by teaching him how to utilize the pouching system independently of the overnight drainage bag.</p> <p>Maintain a nonjudgmental attitude while giving care, and help the client identify positive behaviors that will aid in recovery.</p>	<p>liquid skin barrier to dry so the pouch seals to the surface.</p> <p>Convex flange is used to help the stoma protrude further into the bag so that effluent drains into the bag, minimizing contact of skin with effluent and help avoid leakage.</p> <p>Use the warmth of your hands held against the stoma to help seal the pouching system to the skin.</p> <p>It is best to have your abdomen as flat as possible when applying the pouch to enhance the seal. Therefore, it may be best to stand when applying your pouch.</p> <p>Gravity pulls the effluent to the bottom of the pouch; therefore you want the spout of the pouch to the direction it will be drained.</p> <p>Tissue is used in the toilet water to prevent splashing back of effluent. and then drain the urine into the toilet.</p> <p>Overnight collection bags are used to allow for uninterrupted sleep and to prevent leaks from overfilling of the pouch.</p> <p>1)Confusion or lack of understanding regarding one's health condition can interfere with their participation in care and their ability to make informed decisions.</p> <p>2) Expressing feelings can enhance coping strategies.</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>Stomahesive powder – if not applied properly, leaving too much powder on can cause the pouching system not to adhere properly.</p> <p>2 ¼” Hollister New Image CeraPlus convex cut to fit flange – if cut too small the stoma may be</p>
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<p><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></p>	<p>injured. If cut too large, the skin may become damaged.          Urostomy pouch – requires hook-up to nighttime drainage bag.          Gravity drainage bag – another apparatus to contend with. Creates another source for infection via tubing contamination.</p> <p>I cannot think of an alternative in this case. Pouching will become easier for this patient once the catheter and stents are out.</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 why not?</b></p>	<p>To see things I have not seen before; to do and learn things that will help me with my certification exam.</p>
<p><b>What are your learning goals for tomorrow?</b>   <b>(Share learning goal with preceptor)</b></p>	<p>To see things I have not seen before; to do and learn things that will help me with my certification exam.</p>

<p><b>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b></p>	<p>This patient has suffered through a lot of surgical procedures and has a cancer diagnosis to contend with. He is a ‘manly man’ who was more in tune to “football” than “paper and scissors.” He was resilient and persevered in learning how to perform the necessary tasks for self-care. His frustration was still evident as was his diligence. He seemed to feel better once he knew how to perform the pouch changes. I wish I had a way to prompt his communication of his feelings without prompting a negative conversation about the outside hospital. I feel this would have been helpful for him in addition to the supportive listening and education for his knowledge deficits regarding his stoma.</p>
<p><b>Reflection: Describe other patient encounters, types of patients seen.</b></p>	<p>Male – geriatric patient; newly placed ileal conduit, JP drain; post op day 1; short term memory issues; his brothers help him to remember and understand things.          Female – geriatric cancer patient; ileus secondary to narcotics; flushed stoma; r/o blockage or folding over of foley in stoma foley (not visible like it is with urinary indwelling foley); angry due to NPO status.          Female – geriatric patient who needed a pouch change. Staff nurse did it before we arrived. Seal checked and intact.</p>

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

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