

Daily Journal Entry with Plan of Care & Chart Note

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Journal Completion Date: 07/10/23

 Setting: Acute Care Outpatient HHC Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today’s WOC specific assessment	14 year old female patient with a history of severe ulcerative colitis. PMH of UC, rectal bleeding, malnutrition and failure to thrive. Patient is amenorrheic. No further significant history. Patient active in sports previously and has been unable to participate this year. Reported unmanageable symptoms x2 years at home that were beginning to affect her schooling as well. Reported up to 20x bm per day and “unmanageable” abdominal pain. Medical management of UC unsuccessful and patient and parents agreed upon surgical intervention to try to regain quality of life. Pt received pre-operative education and marking in outpatient clinic prior to surgery for IPAA. 3 step surgery indicated due to present severe malnutrition. Underwent laparoscopic 1 st step of 3 step IPAA total colectomy with end ileostomy. Post op day 2.
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Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

<p>Consulted for post-operative evaluation of ileostomy and to begin education.</p> <p>Patient sleeping in bed upon with parental figure, Mother, at bedside. Agreeable to visit at this time. Patient aroused easily reporting 10/10 pain to abdomen. RN to bedside and patient medicated per PRN order. Patient laid supine and exposed abdomen. Laproscopic sites noted to be intact with surgical glue. Coloplast Sensura post operative drainable ostomy appliance in place to RLQ with dark green effluent in pouch. Pouch emptied and effluent measures 200 ml. Patient declined participation, but watched closely. Patient educated on need to monitor and empty pouch when 1/3 of the way full. Mother states ostomy appliance leaked overnight and patient has “retaped the side”. Buckling noted to flange congruent to hip, no leak noted. Pouching system removed using push pull technique and no sting adhesive remover. Peristomal skin cleansed with water and patted dry Pt tolerated with wincing. Stated she was “ok” and to proceed. Using deep breathing. Mother attentive to change, asked no questions.</p> <p>Ileostomy stoma red and edematous, budded, measured 1 ¼” in right lower quadrant. Mucocutaneous junction intact. Peristomal skin smooth, even and unremarkable with diffuse tenderness. Patient moved to seated position and limited space noted between right hip and peristomal plane. Microcreases also noted to peristomal plane. Abd changes accommodated with fitting of a smaller profile system. Coloplast Sensura cut to fit one piece light convex drainable pouch with no accessory products applied. Patient instructed to gently hold hand over the pouching system for a few minutes to allow for adhesive to “melt” to contours. Patient requesting WOC nurse return at a different time for further “practice”. She states she is confident she can care for her stoma and likes her new pouching system more than “the huge one after surgery”. Encouraged patient and Mother to write down questions and actively participate in care.</p> <p>Recommendations:</p>
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Change pouching system q3d and PRN
 Have patient participate in all ostomy care as tolerated
 Continue dietary education
 Encourage ambulation
 Will follow to continue teaching
 Notify WOC nurse for persistent leaks or questions

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>1. Readiness for coping and learning as evidenced by active participation in, and independence with, ostomy care.</p> <p><u>Remember, there are no risk dx used in</u></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Review written questions and necessary steps in changing the appliance with the patient.</p> <p>Encourage and allow patient to take control during appliance change by being allowing patient to be “hands-on”. <u>excellent!</u></p> <p>Assess patient’s attitude towards, and ability to look at, the stoma. <u>& document</u></p> <p>Instruct/reinforce teaching to patient & mother regarding how to change the new ostomy appliance:</p> <ul style="list-style-type: none"> ● Change pouch every 3-5 days or when leaking. ● Remove pouch using a push/pull technique Cleanse Peristomal <u>skin</u> with warm water and pat dry. ● Measure stoma & cut Barrier 1/8 inch larger than the stoma ● Apply skin protectant to periwound skin & allow to dry ● Apply wafer over stoma ● Attach pouch ● Empty pouch when 1/3- 1/2 full ● Do not reinforce a leaking pouch w tape but change system 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Verbal teach-back is a good method for determining comprehension of education provided. Having questions written down shows a willingness and readiness to learn.</p> <p>Indicates effective coping and a readiness/willingness to learn.</p> <p>Reinforcing education is key during the initial days post-op, trying to avoid information overload and promote comprehension.</p> <p>How often the pouch needs to be changed will depend on the amount and consistency of the output and if it is being emptied appropriately. Emptying ½-⅓ full prevents overfilling and addition weight/gravity on the back. Cutting the barrier appropriately as instructed allows for expansion of the stoma while not exposing too much skin to stool.</p>

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<p><u>our plans – you would just put this under the education, esp. since this is evidence of a need for education & reminders</u></p> <p>2. Risk for altered skin integrity related to improper management of appliance as evidenced by reports of leaking and reinforcement with tape and complaints of diffuse tenderness to peri stoma skin.</p> <p>3. Knowledge deficit related to <u>risk for dehydration ileostomy output amount</u></p> <p>4. Knowledge deficit related to ostomy management <u>Ok, you did this above</u></p>	<ul style="list-style-type: none"> Notify WOC nurse of any signs of stomal/peristomal complications. <p>Utilize Coloplast Sensura cut to fit one piece light convex drainable pouch. Gently hold hand over the pouching system for a few minutes to allow for adhesive to “melt” to contours.</p> <p>Change pouching system q3d and PRN for leakage.</p> <p>Do NOT reinforce with tape.</p> <p>Instruct/reinforce teaching to patient & mother regarding how to change the new ostomy appliance as addressed above.</p> <p>Review signs and symptoms of dehydration:</p> <ul style="list-style-type: none"> increased thirst dry mouth/skin decreased urine output fatigue feeling faint stomach cramps nausea or vomiting <p>Notify your surgeon for lethargy, headache, dark/smelly urine or decreased urine output/dry mouth.</p> <p>Call surgeon if experiencing nausea or vomiting.</p> <p>Reinforce to patient and family proper pouch system change:</p> <ul style="list-style-type: none"> Change pouch every 3-5 days or when leaking. Remove pouch using a push/pull technique Cleanse Peristomal with warm water and pat dry. Measure stoma & cut Barrier 1/8 inch larger than the stoma Apply skin protectant to periwound skin & allow to dry 	<p>Utilizing the proper appliance and "melting" to the contours of the body are crucial to promoting good adherence and preventing leaking, thereby preserving skin integrity.</p> <p>To avoid altered skin integrity, it is crucial that if any leaking is noted, the entire appliance is changed immediately.</p> <p>These are late signs of dehydration and should be seen in the emergency department for further intervention.</p> <p>How often the pouch needs to be changed will depend on the amount and consistency of the output and if it is being emptied appropriately. Emptying ½-⅓ full prevents overfilling and addition weight/gravity on the back. Cutting the barrier appropriately as</p>
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<p>5. Knowledge deficit related to monitoring output</p>	<ul style="list-style-type: none"> ● Apply wafer over stoma ● Attach pouch ● Empty pouch when 1/3- 1/2 full ● Do not reinforce a leaking pouch w tape but change system ● Notify WOC nurse of any signs of stomal/peristomal complications. <p>Use a measuring container to measure your output. <u>record & take to follow up appt. Call surgeon if daily output is <xxx or > XXX</u>. Actual measurements are important.</p> <p>Record your input and output daily. Take this to your follow-up appointment with your surgeon.</p>	<p>instructed allows for expansion of the stoma while not exposing too much skin to stool.</p> <p>The first successful step towards preventing dehydration at home is to close monitoring of ostomy output at home. The more fluid you lose in your stool the more likely you are to become dehydrated.</p> <p>Recording just the number of times a bag is emptied is not enough information, since some bags are emptied when 1/2 full while others at 1/4 full.</p> <p>After the initial postoperative period, if ostomy output continues to be under 1200ml you may discontinue measuring. You may want to remeasure for accuracy when the output increases due to diarrhea or flu.</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>1. Coloplast Sensura cut to fit one piece light convex drainable pouch was used. A disadvantage is that this product is not always readily available and they do not offer as much flexibility as a flat appliance woul. If this were not available, a flat cut to fit one piece could be used in combination with a moldable ring, this will provide some soft convexity and will help to fill in creases and mold/ “melt” to the patients contours with the same gentle pressure.</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.

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<p>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</p>	<p>Developing a plan of care for a patient with difficulty coping, viewing the stoma, participating in care, etc. I feel that with patience and helping to normalize the situation, the chosen plan of care would be effective.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>A goal for myself, moving forward in my practice as a WOC nurse, would be to take the time and provide holistic care, addressing psychosocial needs of the patient as well.</p>

<p>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>I think it is important to always provide holistic care. In this instance, it would be important to consider the patient's psychosocial stage due to the effect that her mental health and social environment has on her overall health and coping abilities. A 14 year-old girl would likely be concerned with her body image. She is active in sports and was unable to participate this past year due to her ulcerative colitis, so a likely concern would be that she would still be unable to participate. Providing education and attempting to normalize the situation will help tremendously. Helping her to understand that this ileostomy will actually help her to return to her "normal" life, playing sports etc. Showing pictures of other team players that have an ostomy would show her that it is something she can have with discretion of who she lets know that she has it. good</p>
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Reviewed by: [Patricia A. Slachta](#) Date: [7/17/23](#)

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