

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jennifer Lemert Day/Date: 4/26/2023

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

Number of patients seen today: 3 in ostomy clinic and 2 pi evaluations inpatient and one scrotal infection consult for dressing
 Preceptor: Kimberly Mauck/ Ann McArdle

Journal Focus: X Wound X Ostomy Continence Combination Specify: 1

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>Established peristomal skin rash under pouching system</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>CC: skin rash of peristomal skin</p> <p>HPI: C.P is a 62 yo female with colon inertia and short gut syndrome who started to have problems with constipation in 2009. It was managed with MiraLAX and she was told she had IBS-C. Her constipation continued to worsen. She was trialed on several medications for her IBS, but did not improve. In 2011, she suffered a small bowel obstruction and required resection. In 2018, she visited with a specialist and was diagnosed with colon inertia, with “30 pounds of retained stool” in her colon. She required proctocolectomy with end ileostomy as well as small bowel resection. Since, she has suffered with short gut syndrome. She has a high output ileostomy. A couple of years after her surgery, she started to have a rash around her stoma. It was dry, red, and intermittently itchy. She used flonase intermittently for years to reduce rash. In the last 2 months, the flonase is no longer working to control the rash. Her psoriatic arthritis currently treated with cosentyx SQ Q30days.</p> <p>Ileostomy pouching system changed every 2-3 days, leaking for last 3-4 days and skin burning at inferior stoma skin junction, not currently using powder or skin barrier.</p> <p>PMH: ADHD, Anxiety and Depression, Asthma, AV re-entry arrhythmia-treated with ablation, Chronic back pain, DVT, GERD, Hypertension, Hypertriglyceridemia, Meniere’s, Psoriatic Arthritis, Short gut syndrome, Vitamin D deficiency</p> <p>PSH: Small bowel resection 2011, Proctocolectomy with end ileostomy and small bowel resection, Cardiac ablation 2018, PICC 2019, right chest central line January 2023, Ileoscopy-2020</p> <p>FH: Hypertension, CAD, CHF, Depression</p>
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	<p>SH: non-smoker, alcohol abuse in remission, no drug uses Lives by self in own apartment Occupational history: disabled by back injury and subsequent chronic back pain</p> <p>Medications: Cosentyx 300mg Q 30 days Lomotil 2.5mg QID Creon 24,000units TID Cyanobalamine1000mcg Qmonth Dicyclomine 10mg BID Loperamide 4mg QID Omeprazole 40mg BID Singulair 10mg QD Tramadol 50-100mg BID Albuterol MDI PRN Amlodipine 5mg BID Atorvastatin 40mg QD Adderall 10mg po QD Baclofen 10mg QHS Trazadone 100mg QHS Nadolol 40mg QD</p> <p>Allergies: Diclofenac, Latex, Morphine, Percocet, Valium, Vicodin, Xanax</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 be able to interpret your plan of care.

Physical exam: well groomed, pleasant, and cooperative, appears well nourished

Neuro/Musculoskeletal: alert and oriented, moves extremities equally and well, walks with walker

Resp: even and unlabored

Abd: soft, right lower quadrant ileostomy, coloplast mio- 2 piece click lock system with high output bag is removed using adhesive remover. Circumferential hyperpigmented, pink peristomal skin is noted in the shape of the barrier; there is some hyperpigmentation. There is maceration with partial thickness moisture associated skin damage present from 4-6pm, immediately extending out from stoma skin junction 0.5cm. This is area that patient feels burning. Barrier is eroded minimally in this areal. No satellite lesions. Once barrier is removed and area is observed for 5 minutes, the pinkness around the stoma fades about 50%

Assessment: Peristomal contact dermatitis-chronic-sub acute with small area of moisture associated skin damage. She has no psoriatic skin lesions and no peristomal erythema, plaque or scaling. Dermatitis is classic subacute contact in appearance with no evidence of psoriasis.

Reported concern over central line insertion skin. She is instructed to discuss this with her surgeon later today at a scheduled appointment. If her line needs to be changed, she can ask the surgeon if a long term central line option is available to her.

For contact dermatitis, trial Luxiq foam (budesonide) to peristomal skin with pouch changes, apply foam sparingly and let dry before reapplying pouch. Good RX consulted and she can get product for \$30-\$100 dollars, I showed her the Walgreens price and sent to Walgreens.

Pouching system: Observing patient connect her drainage bag revealed that she had trouble getting the click lock system to stay

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clicked together. She admitted that she does not change her drainage bag except when she is also changing the skin barrier wafer. She may want to switch to a one-piece system which has less moving parts and would be less expensive. She will consider and let us know

For the Peristomal moisture associated skin damage, crusting with no sting Safe and Simple skin barrier film spray and Coloplast stoma powder is demonstrated and patient verbalized understanding.

With pouch changes, she can apply Luxiq, allow to dry and then crust with stoma powder and skin barrier to MASD before replacing pouching system.

Follow up PRN

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>Contact dermatitis-subacute on chronic, switch to budesonide from fluticasone recheck PRN</p> <p>Peristomal Moisture associated dermatitis from barrier pulling away from stoma peristomal junction, I suspect this is from manipulation of her pouch initially and now inadequate crusting of peristomal skin. Patient agrees to plan does not want to change appliance, but will consider and let us know</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Remove pouch using adhesive remover, and clean skin with water. Allow to dry before applying small amount of budesonide foam (Luviq). Allow this to dry</p> <p>Once Luviq dries, sprinkle stoma powder over area of MASD, Tap off or wipe off excess powder and lock in with skin barrier film. May crust 2 layers. Once crusting is dry, apply skin barrier side of pouching system</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Adhesive remover reduces risk for skin stripping and reduces pain. Budesonide foam is designed more for skin than mucous membrane and is likely more expensive, but patient would like to purchase out of pocket, so Good RX used to check cash pay prices</p> <p>Crusting dries out MASD and allows pouch barrier to adhere better. If pouch stays on, and leaks minimally, the MASD will heal between pouch changes. Additionally, the powder and skin barrier protects the MASD area while it is healing</p>

<p>Identify each WOC product in use/identified in POC. State at least one disadvantage of the</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>Coloplast 2-piece Sensura Mio Click lock soft convex was clearly difficult for patient to click down</p>
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<p>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>and was somewhat cumbersome. An alternative is this would be the one piece Sensura -mio soft convex MAXI drainage pouch with soft outlet. This product would be less cumbersome and I believe, less expensive. The disadvantage is that she could not get it precut.</p> <p>Discussed Flonase and alternative of Budesonide in above plan Alternative to the Skin barrier and stoma powder used would be Marathon skin barrier. This is markedly more expensive and more appropriate if MASD was worse.</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>My goal today was to see a variety of ostomy related complaints in the setting of an outpatient ostomy clinic staffed by an ANP. Specifically, I hoped to see treatments of parastomal wounds and possible fistulas. Only three patients were scheduled. However, I felt I reached some of my goal as we were able to discuss other complex cases seen and discuss marking for a stoma. I also was looking forward to working with an NP, WOC-RN, who had been in practice for years. It turns out that she had been an NP for a bit longer than I, and prior to her WOC certification, she had similar practice experience. She had similar challenges completing additional nursing education and she was also preparing to re-certify and was able to share her study tips for passing the tests. Interestingly, she is near retirement and will be taking the RN test, whereas, I plan to take the NP test.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>Tomorrow is my last day for primarily seeing patients with stomas. I am independent in care. I have written notes for my case studies. I do not have log in for the Georgetown system but I would like to see more documentation by the WOC nurse I am shadowing. I would also like to consider using one of the patients we see tomorrow for my capstone. Most of the patients here are also dealing with continence issues, so it should not be too difficult to find a patient who has a stoma, a wound, and is incontinent of urine and/or stool.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>This patient was incredibly tangential in her history. Reviewing the importance of crusting over MASD was important and accomplished, however, patient was distracted. She verbalized understanding of crusting and confirmed that she had done it before, but then as we were discussing pouch options, she was still sharing details of her history, so it is likely that she will have to return to clinic. She wanted us to check her central line dressing. She is changing this herself at home. We explained that since her follow up appointment this afternoon is with the surgeon who put her line in, she should discuss her line with them. She reports a scab or crust is on the skin where the line enters the skin, she may need the line replaced. I encouraged her to discuss this with surgeon and ask if there were long term central access options, as she has not committed to intestinal transplant and may be permanently dependent on TPN.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<p>It was nice to be in the outpatient clinic. The complaints were different, and because there were only three patients, I was able to fully review charts before seeing patients. The disadvantage was that I did not get exposure to a lot of outpatient stomas, and I was unable to see any peristomal wounds or fistulas. We did talk through cases, though and that was helpful. Great opportunity to see chronic ostomy care in an outpatient setting by an NP. We were also able to talk about billing.</p> <p>At 1230 I ate lunch and then went back to inpatient WOC office and rounded on two PI evaluations and on scrotal infection that was being evaluated for a dressing. The scrotal wound was recurrent in an immunocompromised patient. The patient</p>

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	<p>was admitted to medicine, urology had consulted and was treating him for scrotal skin infection possible early Nec Fasc in an immunocompromised patient. Medical resident did not feel urology had advised on wound care so had consulted WOC. The wound was yellow, dry, rough with surrounding erythema and induration. We recommended barrier cream to continue and consider derm consult for biopsy as the lesion did not resolve after similar infection in July. This was a bit concerning for skin malignancy.</p>
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Reviewed by: _____ Date: _____

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