



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Pamela Pirrello Day/Date: 01/10/2024

Number of Clinical Hours Today: 10 hours Care Setting: (Hospital X) Ambulatory Care Home Care Other:

Number of patients seen today: 4 Preceptor: Cindy Cisneros

Journal Focus: (Fistula) Wound 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>Today’s WOC specific assessment Fistula x2 change of appliance</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. PMH: anxiety, depression, Roux-en-Y gastric bypass in 2012, multiple complications following gastric bypass, requiring abdominal surgeries, SBO, Behcet’s disease, DVT, PE, enterocutaneous fistula, prolapsed bowel fistula HPI:-obtained from chart This is a 43 y.o. female who presented with abdominal pain not relieved by her home regimen opiates, associated nausea, decreased appetite, leg swelling, and weakness. She has a complicated medical/surgical history including anxiety, depression, Roux -en-Y gastric bypass in 2012 with multiple complications and abdominal surgeries, SBO, enterocutaneous fistula, severe protein-calorie malnutrition, short gut syndrome, failure to thrive, Behcet’s disease, DVT, and PE. She was recently discharged from the hospital for SBO treated medically for this. She was afraid she had another SBO. On arrival she had a complete work up. Abdominal xray showed possible ileus pattern followed by CTA CAP negative for PE, mural thickening and mucosa hyperenhancement of the proximal jejunum.UA was negative was. Flu/COVID/RSV is negative. Labs today WBC 5.9, Hgb 7.6, creatinine 0.44, albumin 1, total protein 3.9. The patient was started on TPN. According to the patient she is tolerating a regular diet but does not have a good appetite. According to the patient she has had abdominal fistulas for over a year and in the past was caring for it at home with 4x4 gauze dressings and securing it what she describes as Montgomery straps until recently. Wound care was consulted for multiple wounds (LLE, abdominal fistula, and sacral wound). Following up today for continued care and change of abdominal fistula appliance change. Labs: WBC 5.9, Hgb 7.6, Hct 22.5, Platelets 223, Nas 140, Potassium 4, Chloride 110, CO2 26, BUN 7, Creatinine 0.44, Glucose 111, Calcium 6.8, Albumin 1, 3.9 total protein, ALT 17, AST 13, Alkaline Phosphatase 93</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.

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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.

Reason for Consult: Follow up and appliance change for fistula x2.

History of Present Illness: -obtained from the chart.

This is a 43 y.o. female who presented with abdominal pain not relieved by her home regimen opiates, associated nausea, decreased appetite, leg swelling, and weakness. She has a complicated medical/surgical history including anxiety, depression, Roux -en-Y gastric bypass in 2012 with multiple complications and abdominal surgeries, SBO, enterocutaneous fistula, severe protein-calorie malnutrition, short gut syndrome, failure to thrive, Behcet's disease, DVT, and PE. She was recently discharged from the hospital for SBO treated medically for this. She was afraid she had another SBO. On arrival she had a complete work up. Abdominal xray showed possible ileus pattern followed by CTA CAP negative for PE, mural thickening and mucosa hyperenhancement of the proximal jejunum.UA was negative. Flu/COVID/RSV is negative. Labs today WBC 5.9, Hgb 7.6, creatinine 0.44, albumin 1, total protein 3.9. The patient was started on TPN. According to the patient she is tolerating a regular diet but does not have a good appetite. According to the patient she has had abdominal fistulas for over a year and in the past was caring for it at home with 4x4 gauze dressings and securing it what she describes as Montgomery straps until recently. Wound care was consulted for multiple wounds (LLE, abdominal fistula, and sacral wound). Following up today for continued care and change of abdominal fistula appliance change.

Physical Exam:

General: in good spirits, motivated, not in acute distress

Appearance: ill-appearing, cachectic

Abdominal: no abdominal distension, abdomen is non-tender, midline incisional scar right lateral fistula with prolapsed bowel healthy, red, moist, left lateral enterocutaneous fistula with small amount of yellowish/greenish effluent output, peri-fistula skin with irritant dermatitis and associated fungal rash throughout surrounding fistulas

Wound Team Summary Assessment

Patient resting in bed, comfortable, and in good spirits. She reported doing well with Iron Eakin Pouch for midline fistula and enterocutaneous fistula. She was agreeable to have Iron Eakin pouch exchanged today. I gathered all the supplies. She verbalized step by step process to change pouching system. I assisted her with using Esenta adhesive releaser spray to gently remove Iron Eakin Pouch with a push-pull method. After removal I assisted her in cleaning the skin with Anasept spray. She has a right midline chronic fistula below the umbilicus wound with exposed bowel that is healthy, red in color, and moist. She also has a chronic enterocutaneous fistula on the left side of the midline draining a small amount of yellowish/greenish effluent output. The skin surrounding the fistulas has irritant dermatitis and associated fungal rash. I assisted the patient with the application of Nystatin powder around peri-fistula skin and brushed it off, followed by application of Convatec stoma adhesive powder brushed off, then sprayed in Cavilon No Sting Barrier Film. I previously sized the fistulas using a plastic shield from the wafer appliance to create a template to cut the appropriate size of Iron Eakin Fistula pouch. This template was left with supplies for future use. I then assisted the patient with molding the Eakin ring and made Eakin strips. I assisted with the application of Eakin around the bowel fistula and enterocutaneous fistula wound and applied Eakin strips around the creases. A thin layer of Stoma paste was applied along the border of the Iron Eakin Pouch before attaching it to the Eakin that was previously applied on the border of the fistulas. After the Iron Eakin pouch was applied I assisted the patient in making sure no creases where in the wafer and reinforced her to apply light pressure with her hand for 3 minutes to help with binding. I then assisted the patient in the application of Brava Elastic Strips along the border. She did well. She was able to redemonstrate with assistance.

Nursing Instructions For Fistula Wound Care

- 1) Remove appliance using Esenta adhesive spray to gently remove fistula pouching system. Use a push-pull method.
- 2) Cleanse the skin around the fistula using a wet gauze, gently cleanse the skin, cleanse the peri-fistula skin with Anasept spray,

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- and pat dry
- 3) Apply Nystatin powder around skin surrounding the peri-fistula brush off, then apply Convatec stoma adhesive powder and brush off, followed by Cavilon No Sting Barrier Film
 - 4) Use template to cut appropriate size of Iron Fistula Eakin Pouch
 - 5) Mold and place Eakin ring around the skin surrounding the fistula, cover creases with Eakin ring strips
 - 6) Use stoma adhesive paste around the Iron Eakin pouch that will be attached to the Eakin ring
 - 7) Apply Iron Fistula Eakin pouch (6.9 x 4.3", # CS73622), Press down firmly making sure the skin has no creases when applying the pouch, hold light pressure using your hand for 3 minutes to assure a good fit
 - 8) Apply brava strips at the edge of the wafer
 - 9) Empty the pouch when 1/3 to 1/2 full. Avoid emptying at higher amounts to prevent appliance from detaching from the skin

Supplies

Esenta adhesive releaser spray #73537 150 ml
 Stomahesive powder #408
 Stomahesive barrier film spray #14602
 Affix pouch Iron Fistula Eakin pouch (6.9x 4.3", # CS73622)
 Eakin seal 2" #20704
 Eakin cohesive rectangle #69409
 Brava elastic strips #74269
 Stomahesive #568

Wound Management Plan

Will follow up tomorrow to assure fistula appliance not leaking and reinforce education/redemonstration techniques.

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.The patient has failure to thrive with</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>1. Encouraged her to eat small frequent meals. Ensure shakes that are brought to</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>1 Patient needs education to understand her condition of malnutrition. She has a lot of issues that are working against her including her past surgeries and</p>

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<p>severe protein -calorie malnutrition Eats small quantities</p> <p>2. Noted was her low hgb of 7.6 which had trended down from Hgb of 10 on admission. Per primary physician notes, there were no signs of bleeding, and they were working up anemia.</p> <p>3. She has a history of depression. She is on antidepressions.</p>	<p>her and she is unable to eat she can save for later time. She can drink sips of Ensure throughout the day. Education about wound healing given including the need for protein in the body to heal.</p> <p>2. Asked patient if she had noticed bleeding in fistula pouch effluent or stool during BMs. She denied this.</p> <p>The patient had expressed previous frustration in the way she was doing her dressing changes by herself with 4x4 gauze and Montgomery straps. Educated the patient as to what caused leakage of effluence and irritant dermatitis with associated fungal infection from previous type of dressing changes.</p> <p>Discussed with the patient that learning how to change her fistula pouch will empower her and she can gain more confidence and control her situation.</p>	<p>complications that contribute to her malnutrition.</p> <p>2.It is important for nursing assessment to assure no signs of bleeding that patient may have noticed and would need to be discussed with the physician.</p> <p>As her skin heals, she will feel better and become more confident. This will help her mood. (She was in very good spirits when I saw her. I was told by my preceptor when she first arrived she was very agitated by her situation. This is very understandable. When I saw her she was very nice, happy to be seen, and expressed being very grateful).</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. <u>Alternatives should be from a different category or classification.</u> 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>For the fistula patient I thought the product of Iron Eakin Pouch was a good one. Since I never used it and it worked well I didn't really find a fault to it. I think the stoma adhesive paste is something I need to work on. It is a little cumbersome to use trying to apply it in a thin layer.</p> <p>If the Iron Eakin Pouch was not available I would have to use a different size fistula pouching system. If I were in a hospital/clinic location with no Iron Eakin pouch I may have to use a moldable stoma pouching system.</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 for the day was to experience caring for a fistula wound. I think I accomplished this goal.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	

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Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<p>She does get OOB but I don't remember seeing a recliner. I think ambulation is important. I know that she has PT but I think I would have gotten a nurse to bring her a recliner so that she can get OOB and stay OOB for a while.</p>
Reflection: Describe other patient encounters, types of patients seen.	<p>I was able to do another stoma marking for an ileostomy- young patient with UC was scheduled for subtotal colectomy. This was a transgender male patient. It took a very long time not because of the patient but because of the patient's grandmother. We were actually there for about 2 hours. The patient's grandmother was insisting and could only focus on the belt line. She wanted it way above the umbilicus and would not budge with the explanation the reasons for appropriate site markings. The patient tried on personal pants that were too big because of recent weight loss so it was not even helpful. My preceptor had to intervene in letting the grandmother know that she had 15 years of experience and also was advocating for the patient. Finally we were able to get a good site that the patient agreed on.</p> <p>I also saw an ileostomy patient – complicated surgical case, had been there for 90 days. She previously had had robotic hysterectomy with BSO and came back to the hospital after discharge and needed emergency surgery because of perforated bowel during the first surgery. Long story short she has an ileostomy that she has never emptied by herself or tried to change the appliance. She actually refused to do it. She did agree to listen to the teaching and follow along during the change. I also had to emphasize that she listen so she can empower herself as a human being. This is her body and she needed to learn what was happening and eventually would be doing it on her own. I'm not sure what happened there. She must have had multiple wound nurses see her. This was my preceptors first time meeting her so I am not sure what happened.</p> <p>I also saw skin wound injury decubitus wound.</p>

Reviewed by: _____ Date: _____

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