



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Danielle Rising Day/Date: 1/23/24

Number of Clinical Hours Today: 10 Care Setting: x Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 14 Preceptor: Janie Renaud

Journal Focus: Wound Ostomy Continence Combination Specify: x

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>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>70-year-old female with a past medical history of DM2, seizure disorder, anxiety disorder, GERD, and pyloric stenosis. Nissen fundoplication and Heineke-Mikulicz pyloroplasty was performed on 12/11/23. Patient presents to the ED 12/20/23 with c/c of tachycardia, hypertension, abdominal distension and tenderness. CT scan with contrast revealed surgical site defect and intra-abdominal abscesses tracking along the left anterior abdomen. Patient now s/p exploratory laparotomy, distal gastrectomy with creation of loop gastrojejunostomy, cholecystectomy, and abdominal washout. On 12/24/23, exploratory laparotomy transverse colectomy, mobilization of splenic flexure, and creation of ascending end colostomy was performed. Patient seen in the SICU for ostomy education and wound vac dressing change. Stoma presents in the RLQ as beefy red, measuring 1 5/8” diameter, and is budded. The mucocutaneous junction is fully separated from 1:00-3:00 and measures 3.0cm x 1.2cm x 0.3cm. 200ml of brown semi-liquid effluent noted in the appliance. Patient reports pain with appliance and dressing changes.</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>This is a follow up visit to provide the patient with ostomy education as well as a wound vac dressing change. The patient presents with an ascending end colostomy in the RLQ. The ostomy measures 1 5/8” in diameter with the os located centrally. The stoma is beefy red and moist, budded. Separation of the mucocutaneous junction is noted at 1:00-3:00 measuring 3.0 x 1.2 x 0.3cm. The separation was filled with calcium alginate to contain exudate in a moist healing environment. The peri-stomal skin is clean, a</p>
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midline incision present in the abdominal plane. A liquid skin barrier was placed to the peri-skin to protect from wound drainage as well as potential pouch leakage. An Eakin seal moldable barrier ring was applied snugly around the stoma. A Hollister two-piece 2 ¼” flat cut-to-fit barrier with a closed end was placed. The patient receptive to learning, participated in the demonstration and asked questions. All questions and concerns were answered during this time. The abdominal midline incision was then assessed. The midline incision is approximated distally; the proximal portion of the incision noted to be dehisced. The wound bed measures 7cm x 5.3cm x 0.4cm. The wound bed is filled with 25% slough and 75% granulation tissue. Wound bed was probed; undermining and tunneling absent at this time. Minimal serosanguineous exudate was noted. Deep incision sutures present in the base of the wound bed. After cleansing the wound, transparent film was placed to the peri-wound in a picture frame fashion. UrgoTul contact layer was placed to protect the sutures. The wound vacuum foam was cut to fit the size of the wound and covered with a second layer of transparent film. The vacuum track head was applied and suctioned to 125mmHg.

Recommendations: Wound/Ostomy nurse to continue with ostomy education, lifestyle education, and pouch care. Ostomy care nurse to follow up with the patient every other day.

Continue with wound vac dressing changes on a Monday/Wednesday/Friday schedule. Dressings to be performed by Wounds care team. If a malfunction of wound vac occurs, notify the wound care team immediately. No more than 2 hours of an inactive wound vac status should be held. If wound care nurse unable to assess patient in a timely manner, remove wound vac and initiate a wet to moist dressing.

Assist and reinforce education regarding routine ostomy care.

Appreciate dietary recommendations regarding colostomy requirements and to assist in wound healing.

Reposition patient every 2 hours while in bed. HOB less than 35 degrees.

TruVue pressure reducing boots while in bed.

Apply zinc barrier paste to the perineum to prevent moisture associated skin damage.

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) Risk for wound degression related to complexity of care.</p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>1) Perform dressing changes every Monday, Wednesday and Friday using clean technique.</p> <p>Gently remove dressing using adhesive remover to prevent MARSI.</p> <p>Cleanse wound thoroughly. Allow VASHE wound cleanser to soak in wound bed while preparing the new</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>1) Scheduled wound vac dressing changes are performed to decrease bacterial growth. Medical grade adhesive remover will prevent pulling and tearing on the skin, furthering skin damage. Thorough cleansing and allowing VASHE to soak in the wound bed limits</p>

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<p>2) Risk for wound contamination during dressing changes related to proximity to fecal diversion system.</p> <p>3) Risk for anxiety and fear related to invasive wound procedure.</p>	<p>dressing.</p> <p>Apply wound vac and track head and begin suction at 125mmHg. Assess seal for air leaks.</p> <p>2) Leave ostomy appliance in place until wound vac application is completed with an exceptional seal.</p> <p>Doff gloves and don new gloves before caring for the next site.</p> <p>3) Politely knock and enter patients' room and inform him/her of who you are and the procedure you are about to perform.</p> <p>Allow the patient time to ask questions regarding the procedure prior to starting.</p> <p>Have the patient rate their current pain on a scale of 0-10 and determine the need for pain medications. Coordinate pain medications with dressing changes.</p>	<p>bacterial growth. Keeping the wound covered while prepping the vacuum supplies is beneficial to prevent infection. Determining the presence of air leaks will prevent the risk of bacteria or other contaminants invading the wound. This will also provide optimal suction of the wound vac.</p> <p>2) Performing an adequate seal will prevent possible effluent from entering the wound bed.</p> <p>Removing dirty gloves and applying clean gloves will prevent cross contamination.</p> <p>3) This allows the patient to know that someone is entering the room. Informing the individual of who you are and the reason why you are there will allow them to understand.</p> <p>Allowing patients to ask question about the dressing change may calm the nerves of the individual. The patient may want to feel the dressing.</p> <p>The patients pain needs to be assessed prior to initiating the dressing change. Pain medication need to be coordinated with each dressing change to decrease the chance that the medication was previously given leaving the patient with no pain medications. Encourage alternative methods to pain reduction such as distraction,</p>
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<p>4) <i>Risk for anxiety and fear related to fecal diversion.</i></p>	<p>If the patient allows, talk through the wound dressing change, and inform the patient of each step you are taking.</p> <p>Allow the patient to set the pace of the dressing change.</p> <p>Determine patients' willingness and ability to participate in ostomy pouch changes.</p> <p>Begin with educating the patient on basic anatomy. Be sure not to overwhelm the patient with a deep anatomy lesson.</p> <p>Remove the adhesive backing using adhesive remover. Push on the skin while pulling at the wafer tab.</p> <p>Gently cleanse the area using water and mild soap. Be sure there is no fragrances, lotions, moisturizers, or alcohols!</p> <p>Apply the Hollister two-piece 2 ¼ flat cut-to-fit barrier with a closed end.</p>	<p>music, visualization, etc..</p> <p>Walking the patient through the procedure may decrease stress and anxiety related to the fear of the unknown. Always ask the patient first if they would like to be talked to through the procedure.</p> <p>Allowing the patient to set the pace of the dressing change gives the individual a sense of control during an anxiety driven time.</p> <p>Determining the willingness and ability to participate in ostomy care education can aid in determining readiness which can ease patient comfort.</p> <p>Understanding basic anatomy is crucial in adequately caring for an ostomy. Adequate care can ease anxiety and fear.</p> <p>Gently removing the adhesive properties of the wafer can ease comfort during appliance changes. Limiting discomfort can aid to diminish anxiety.</p> <p>Avoiding fragrances, lotions, moisturizers and alcohol will lessen discomfort beneath the wafer.</p> <p>Using a soft, flexible wafer will allow the appliance to contour to the body with movement and flexibility. The drainable end will allow the individual to empty effluent to their preferred route. Ex: graduated cylinder, toilet.</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</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>VASHE: A gentle wound cleanser available over the counter that is intended for cleansing, moistening, irrigating, debridement, and removal of microorganisms from wound beds. This wound cleanser can be costly. Alternative: Normal saline. Normal saline is greatly used as a wound cleanser</p>
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<p>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 can be purchased over the counter at a more affordable price.</p> <p>Wound VAC: A wound vacuum utilizes negative pressure to assist in closure of the wound bed. This sub-atmospheric pressure also aids in removal of exudate while maintaining a moist wound healing environment. This dressing is effective in wound healing, however, can be extremely painful and costly. Taking this patient’s specific wound into consideration, an alternative wound care dressing can be performed using Hydrofera blue classic with a silicone foam boarder dressing. This dressing would be financially cheaper and elicit less pain for the patient.</p> <p>Adhesive remover: Adhesive remover can lessen pain associated with removal of medical devices that utilize adhesive properties to adhere to the skin. Disadvantage: can be costly and not readily available for use. Alternative: baby oil or mineral oil. These gentle oils can remove adhesive properties quickly and are available over the counter. Once removed, the area should be gently cleansed using un-fragranced soap.</p> <p>Hollister two-piece appliance: These appliances can aid in comfort and security while wearing you appliance. This easily removable pouch can be worn and thrown away discretely without the fear of potential leakage. Although convenient, these appliances can be costly as they are not reusable. Alternative: If the patient prefers the convenience of the two-piece appliance, a two-piece drainable pouch can be applied. This will allow the individual to empty the pouch multiple times a day. The pouch can be changed to a new transparent pouch.</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 today was to learn and use a two-piece appliance. My primary facility uses one piece appliance. During work, I rarely use a two-piece appliance. Today I was able to use multiple two-piece appliances on different patients. This that being said, I was able to exceed my goal.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>My goal for tomorrow is to treat for an unstageable pressure injury.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>Although the patient was compliant and willing to perform dressing change and ostomy appliance change, I should have ensured patient comfort. The patient never told us to stop the care provided, however grimacing was noted at only one point. She has had a wound vac for longer than one month and insisted that we continued the dressing change, however, based off of facial expressions, a pause was needed.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<p>As mentioned above, many ostomy patients were seen today. It was phenomenal to care for and educate these understanding patients.</p>

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