



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Nicole Railsback Day/Date: 2/20/24

Number of Clinical Hours Today: 7.5 Care Setting: Hospital Ambulatory Care Home Care Other: _____

Number of patients seen today: 5 Preceptor: Molly Mesch

Journal Focus: 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</p>	<p>75 M admitted 2/18 with AKI, UTI, hematuria. Was previously admitted for same diagnosis, discharged to SNF on 2/13, presented to ED 2/17 with fever, chills, flank pain. Complicated hx, frequent admissions since November 2023. Hx of malignant neoplasm to the rectosigmoid junction requiring a total pelvic exenteration with end colostomy and ileal urostomy in November 2023. Pt with colonic fistula and non-healing surgical wound to perirectal region. Other hx includes ETOH use, cirrhosis, a fib, hyperaldosteronism, dementia. BMI at time of first admission 25.4, 22.94 at time of discharge, now with BMI of 21.79. Current albumin level of 2.0, glucose 118, Cr of 4.80, HGB has been consistently low, required several transfusions of PRBCs on last admission, currently 7.8.</p> <p>Imaging now with abscess with loculation to pelvic region, colovesical fistula, likely reason for persistent kidney issues. Loopogram revealing reflux of urine.</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>Initial visit for current admission, pt followed by wound, ostomy care during previous admissions. Pt with colostomy, urostomy, non-healing surgical wound to perirectal area. Unexplored fistula emptying into proximal wound bed, difficulty visualizing d/t depth of wound, cotton tip applicator no long enough to fully explore wound. Plan during previous admission was to discharge to SNF, follow up with surgical team at facility that handled initial pelvic exenteration, however pt presented to our ED and has not been able to transfer yet.</p> <p>2/19 pt had bilateral nephrostomy tubes placed as well as indwelling catheter to urostomy. Per urology, catheter placed to urostomy to manage the minimal urine output that will occur while nephrostomies are in place and to allow for healing of peristomal skin by providing a break from pouching. Urology concerned peristomal skin to urostomy was broken down and at risk for worsening condition if pouching system is used.</p>
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At time of visit, indwelling catheter in place to urostomy, covered by abd pad secured with plastic tape. Removed abd pad after moistening with saline as it had dried onto peristomal skin after coming in contact with output leaking from around tube. MASD noted to peristomal skin, however, not significantly changed from last assessment prior to discharge on 2/13. Redness noted circumferentially to stoma, however, as this has been stable, suspect that this, at least in part, is hyperpigmentation. Removed colostomy pouching system, peristomal skin issues noted on last visit resolved and skin is now CDI. Cleansed colostomy and peristomal skin, applied new pouching system. As urology would like indwelling catheter to remain in urostomy, will leave in place for now, urologist notified of ostomy care findings and concerns. Per MD, catheter to remain in place, will reevaluate tomorrow 2/21. Applied Calvinon skin prep to peristomal skin, recommending not to reapply abd pad d/t previously noted issue with drying on skin.

Packing in place to perirectal tube removed, no significant changes to wound appearance since previous admission, however, decreased in exudate and no more purulent drainage noted at time of assessment or documented in chart. On imaging, abscess and loculation noted, Suspect decrease in drainage likely due to this, not indicative of true improvement. Wound cleansed with normal saline, gauze. Filled wound with Dakins soaked gauze strip, covered with abd pad, secured with medipore tape. Orders to change daily, or prn.

Hospitality, urology, nephrology, colorectal surgery, and nutrition all following pt.

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
Colostomy pouching system	<p>Remove old pouching system using adhesive remover and push pull motion from top to bottom, cleanse stoma and peristomal skin gently, removing old product without scrubbing</p> <p>Ensure peristomal skin clear of hair, use electric surgical clippers if hair is present</p> <p>Cut Coloplast brava protective sheet to allow for approximately .5cm space around stoma, apply sheet, does not need to be exactly, open space around stoma will be covered by ring and wafer</p> <p>Cut Hollister wafer to 1 inch, apply ring and mold to size, apply wafer and ring to stoma</p> <p>Apply Hollister drainable bag to wafer, snap in place</p> <p>Change every 4 days or as needed</p>	<p>Remove the old system carefully to avoid stripping the skin with the adhesive, causing further damage</p> <p>Hair under both skin barriers responsible for seal issues during previous admissions. Surgical clippers used instead of a razor as use of a razor can lead to ingrown hairs, and cause small cuts</p> <p>Protective sheet designed to facilitate pouch seal, to be used under skin barrier and ring, as skin is clearing up, may trial without sheet on next change completed by ostomy care nurse</p> <p>4 day seal achieved with pouching system during previous admission</p>
Urostomy peristomal skin	<p>Gently cleanse stoma and peristomal skin with warm water</p>	<p>Skin already fragile, at risk for increased breakdown due to no pouching system and occasional</p>

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<p>Non-healing surgical wound</p>	<p>Assess stoma under indwelling catheter tubing</p> <p>Apply skin prep swabs to peristomal skin, repeat daily or prn</p> <p>Maintain indwelling catheter per urology orders, tubing secured with stat lock to RLQ</p> <p>Cleanse wound and periwound skin with saline and gauze.</p> <p>Wet roll gauze with Dakins solution and lightly fill dead space</p> <p>Apply skin barrier wipes to periwound skin</p> <p>Cover wound bed and filling with abd pad, secure with medipore tape</p> <p>Change q24 hours or prn</p>	<p>leaking around indwelling catheter, skin prep applied to provide moisture resistant film and protect skin</p> <p>Concern that application of paste or cream, such as triad, may pose issue if decision is made to repouch and ostomy nurse is unavailable as floor staff may not adequately remove cream first and therefore create seal issues</p> <p>Stat lock, type of tube securing device, used to protect catheter from tugging or movement, check any skin or part of the stoma in contact with the tubing to prevent a medical device related PI</p> <p>Gauze used to fill dead space in wound to allow for filling in with granulation tissue, Dakins used for antimicrobial properties</p> <p>Skin barrier used to protect friable periwound skin from moisture from dressing and exudate</p>
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<p>0.125% Dakins solution</p> <p>Roll gauze</p> <p>3M Cavilon skin barrier film wand</p>	<p>Dilute bleach solution used for management of wound infection, reduction of bioburden. Disadvantages include cytotoxicity, need for proper storage, shorter shelf life, and need to discontinue when wound bed is clean, will need close monitoring. Alternative would to fill dead space with silver impregnated alginate.</p> <p>Used to fill dead space in wound bed to promote filling in with connective tissue. Disadvantages include need to change before drying out, potential for maceration to the periwound skin if it comes in contact with wet gauze. Alternative would be to pack with alginate.</p> <p>Creates thin barrier on skin under adhesive product, protects skin from damage caused by moisture or use of adhesives. Disadvantages include select skin barrier wafers may not adhere as well to areas to which skin barrier films have been applied, could pose problem should urostomy need to be repouched. Alternative would be triad paste to peristomal skin.</p>
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Medline abdominal (abd) pad	Highly absorptive, non-adhesive gauze dressing. Cellulose layer to wick moisture, prevent maceration of the periwound skin. Used as cover dressing over packing. Disadvantages include need to secure with tape, large size requiring cutting. Alternative includes mepilex bordered foam.
3M Medipore tape	Cloth tape used to secure abd pad. Disadvantages include poor moisture resistance, potential for dressing to fall off. Alternatives include foam, silk, paper tape, or securing abd pad with mesh underwear.
Coloplast brava protective sheet	Moisture absorbing sheet that provides a greater area of protection for peristomal skin, provides a surface for pouching. Disadvantages include adding cost to each pouching change, potential to macerate skin if exposed to significant amounts of drainage and left in place. Alternatives include utilizing stoma powder and liquid skin barrier to create crust to manage moisture.
Hollister skin barrier rings	Reinforce skin barrier wafer to provide additional protection to peristomal skin, reduce risk of leaking. Applied under the skin barrier wafer, changed when the wafer is changed. Convex barrier rings are also available if necessary. Alternatives include barrier paste. Disadvantages can include breakdown of the ring if not cared for properly.
Hollister New Image two piece drainable pouching system	2-piece ostomy pouching system, snap on connection between wafer and pouch. Allows for emptying of stoma output, changing of pouch without changing entire system. Disadvantages to the use of this product include lack of flexibility, stretch of skin barrier wafers compare to other products such as Coloplast. Alternatives to this system include use of a 1-piece system or a 2-piece system from a different manufacturer such as Coloplast.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?	<p>Learning goal for tomorrow is to provide education on incontinence management principles to pt experiencing fecal or urinary incontinence and to provide education to floor staff working with that pt.</p> <p>Goal was met, provided education to pt and rn regarding FI r/t diarrhea secondary to radiation enteritis.</p>
What are your learning goals for tomorrow? (Share learning goal with preceptor)	<p>Goal for next shift is to continue incorporating education on the role of appropriate continence care in protection of skin and prevention of wounds and review continence care products with preceptor</p>

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<p>Pt is seriously ill and in an unstable condition, multiple specialties following, referring to one another to determine course of care. Pt not surgical candidate. Would benefit from meeting to clarify goal of care. Concern that wound will not heal without surgical intervention, risk with application of NPWT d/t unexplored wound depth and presence of a fistula. Pt unable to advocate for self d/t dementia.</p>
Reflection: Describe other patient encounters, types of patients seen.	<p>Initial visit for pt with planned sigmoid colostomy placement tomorrow. Marked 3 potential sites along L abdomen. Provided education material and reviewed post op</p>

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	<p>education with pt. Will follow up POD 2.</p> <p>Initial with radiation dermatitis to perianal region. Receiving radiation for rectal cancer. Also with IAD r/t radiation enteritis. Primary rn present at time of visit, educated pt and rn on importance of gentle skin care w/ ph balanced soap, gentle wiping. Advised against use of disposable brief while in better in favor of absorbent pad under pt to prevent trapping moisture against skin. Educated on purpose of brat diet to manage diarrhea and discussed with rn requesting loperamide for treatment of diarrhea. Applied zinc oxide and lidocaine paste.</p> <p>Follow up visit for pt with stage 2 PI to coccyx. Wound previously dressed with hydrofera blue foam, mepilex. On assessment, wound almost completely filled in with connective tissue, will apply meplix and discontinue use of hydrofera blue.</p> <p>Initial visit for pt post op removal of infected gastric stimulator for management of gastroparesis. Surgeon wants NPWT for closure of surgical incision, requested wound care placed. Wound packed with gauze while in OR, secured with abd pad. Removed old dressing. No underlying structures visible, filled wound bed with black foam, draped with transparent dressing. Therapy initiated at 125 mmHg. Pt will likely discharge with home wound vac.</p>
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Reviewed by: _____ Date: _____

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