

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Bria Coil Day/Date: Thursday, June 20, 2024Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Janelle HoltzClinical Focus: Wound Ostomy Continence

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. 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 no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Today's practicum was in the inpatient setting with the WOC nurse seeing patients for follow-up and initial visits in the hospital setting. Patients included one discharging home today but experiencing a fungal rash and leakage due to decreasing swelling of stoma. Another patient required marking for diverting colostomy tomorrow due to sigmoid colon cancer and the marking was completed by me under the supervision of the WOC nurse. I completed a follow-up visit on a patient I saw the first day of inpatient clinicals who had leakage due to 2 fistulas and an ileostomy. I briefly switched to assisting the wound nurse practitioner with a particularly difficult case requiring four people to roll and complete dressing changes for a patient with multiple pressure injuries and a fistula, resulting in increasing skin breakdown and immense pain. I finished the day seeing patients for additional leakage issues of their pouching systems and supply set-up.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. 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. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

Follow-up visit completed for this 71 yo M with an end ileostomy due to diverticulitis who notes, "there is redness around my stoma." PMH includes diverticulitis, HTN, asthma, anxiety, HLD and former hx of smoking. Patient has had two previous hands-on lessons and was signed off to complete dressing changes by himself on 6/14/2024, with weekly follow-up planned for tomorrow, however, bedside RN notes that the patient is scheduled to discharge home today with home health care.

Upon arrival to bedside, pouch system intact with no leaks noted. Patient states he changed the pouching system yesterday afternoon and noticed redness around his stoma. Stoma is beefy red, budded from the abdomen and moist, with os at 6 o'clock. Peristomal skin is intact but reddened from 9-4 o'clock with satellite lesions noted indicative of a fungal rash. 250mL of brown/green liquid effluent noted in pouch. Stoma was remeasured and stoma has shrunk approximately ½ cm since last WOC visit, resulting in patient cutting the pouch too big for his stoma as it is difficult for him to see the lower half.

Discussed with patient changing pouching system and adding convexity since abdomen also has considerably softened since last WOC visit. Patient initially hesitant and suspicious of changes in pouching system but allowed suggestions to be utilized. Peristomal skin cleansed and patted dry. Nystatin powder applied to reddened skin and sealed with Cavilon skin barrier wipes. Hollister Adapt ring applied to the back of a 2-piece, Hollister New Image convex pouching system, with wafer cut-to-fit 1 ¾. Pouching system applied and seal obtained with help from patient. Supplies provided to patient along with new script. All questions

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answered. Patient will be discharged in the next two hours per bedside RN.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products used)

1. Sprinkle Nystatin powder over reddened peristomal skin and seal with Cavilon skin barrier wipe prior to applying pouching system during scheduled pouching system changes x the next 10 days.
2. While sleeping, attach stoma pouching system to nighttime drainage bag due to high output
3. Empty pouch PRN when 1/3 - 1/2 full
4. Follow-up with WOC team and colorectal surgeon in 2 weeks
5. RUQ end ileostomy
 - Remove old pouching system using adhesive barrier removal wipes
 - Cleanse peristomal skin with water, then pat dry
 - Perform crusting, if applicable
 - Apply Hollister Ceraplush barrier ring around stoma
 - Cut opening in Hollister New Image Ceraplush convex 2 1/4" wafer to 1 3/4", attach Hollister 2 1/4 high output pouch
 - Change twice per week on Monday and Thursday and if leaking occurs

Describe your thoughts related to the care provided. What would you have done differently?

The nurse crossed out the previous pouching system numbers/names and wrote in the new ones on the patient's old script, along with adding in the directions for applying the Nystatin powder and sealant. Had I been the one doing the visit, I would have printed the patient an entirely new script as he came across as very anxious and overwhelmed and I believe that would be easiest for him to understand and recall what was done if it was updated and reprinted.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?

Perform some independent stoma and NPWT care under supervision of WOC nurse

We did not see any patients requiring NPWT, but I did do so independent stoma care under the supervision of the WOC Nurse.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

Perform independent stoma care under supervision of WOC nurse.

| CRITICAL ELEMENTS | Completed | Missing |
|-------------------------------------------------------------------------------------------------------------|-----------|---------|
| Medical record note reflects that of a specialist: | | |
| • Identifies why the patient is being seen | ✓ | |
| • Describes the encounter including assessment, interactions, any actions, education provided and responses | ✓ | |
| • Includes pertinent PMH, HPI, current medications and labs | ✓ | |
| • Identifies specific products utilized/recommended for use | ✓ | |
| • Identifies overall recommendations/plan | ✓ | |
| Plan of Care Development: | | |

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|--------------------------------------------------------------------------------|---|--|
| • POC is focused and holistic | ✓ | |
| • WOC nursing concerns and medical conditions, co-morbidities are incorporated | ✓ | |
| • Statements direct care of the patient in the absence of the WOC nurse | ✓ | |
| • Directives are written as nursing orders | ✓ | |
| Thoughts Related to Visit: | | |
| • Critical thinking utilized to reflect on patient encounter | ✓ | |
| • Identifies alternatives/what would have done differently | ✓ | |
| Learning goal identified | ✓ | |

Reviewed by: _____ Date: _____

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