

**Daily Journal Entry with Plan of Care & Chart Note**Student Name: Stacy Scott Day/Date: 8/9/2024Number of Clinical Hours Today: 12Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor: Jennifer SchieleClinical 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.**

42-year-old female, with past medical history of Autism, CVA with ICH conversion, paraplegia with bowel and urinary incontinence, seizures, sleeve gastrectomy, recurrent starvation ketoacidosis, protein malnutrition. Admitted for significant leaking around the gastrojejunostomy tube (GJ tube) and redness to the skin.

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:**

The WOC nurse was informed by the bedside nurse that the patient is very childlike. She has been biting staff and has a pacifier that she chews to meet her need for chewing without harming others. The patient speaks in a very high-pitched voice and incomplete sentences. She answers questions appropriately using one-to-two-word answers. She states, "no bite" and places the pacifier in her mouth. The WOC nurse talks to the patient in very simple terms. The GJ tube is leaking a moderate amount of thin green exudate. The skin has contact dermatitis, red viable tissue, partial thickness skin loss. Patient reports that it is very tender. It does not appear to have a fungal component. The insertion site is larger than the GJ tube and does not appear to be well stabilized. The GJ tube instability appears to have eroded the insertion site, leading to leaking. The GJ tube has a large undetachable triple lumen distal port. The WOC nurse place an adsorbable pad under the tube. The WOC nurse gently cleansed the skin with warm water and 4x4cm gauze pads. She talked to the patient about everything she was doing, anything first in easy-to-understand terms. She applied Cavilon Advanced Skin Protectant and allowed it to dry completely. She held the G J tube bumper away to allow it to dry. She then collects a Coloplast 2 piece cut to fit, oval yellow colostomy pouching kit, a few small Tegaderm's, hemostats, and a baby bottle nipple. She cut the barrier wafer from the outside towards the center started hole. Next, she cut the starter hole to 20mm. Then, she slides the barrier wafer around the GJ tube. She rubbed her hands together until they were warm and applied her hands to the wafer to help it adhere to the patient's abdomen. Next, she cut a hole in the pouch and pushed the nipple through it. Then she applied Tegaderm around the nipple on the inside and outside of the pouch. Then, she cut most of the nipple off, leaving only the base of the nipple, having removed the protruding portion. Next, the WOC nurse used the hemostats to pinch the triple lumen distal end of the G J tube and pulled it through the opening made with the nipple, with great difficulty due to the width of a

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three pronged lumen. Once through, she wrapped Tegaderm around the tube securing it to the pouch, similar to securing an NG tube to the bridge of the nose. One part of the Tegaderm was on the pouch and then wrapped around the tube. The use of the Cavilon Advanced Skin Protectant and ostomy barrier wafer will protect the skin and allow it to heal. The ostomy pouch is then a reservoir for drainage leaking around the G J tube. The baby bottle nipple gives the G J tube some more stability and a port to exit the pouch so that the ports can still be accessed. The patient was well pleased with the pouch and reported that she felt better. There was no family or caretakers at bedside at the time of assessment and application to give further education on how to re-create.

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)

The plan of care is to replace the containment system the WOC nurse made every 3 days and to continue the use of a skin protectant, Cavilon Advanced Skin Protectant to be applied with each change until denuded skin is healed. The patient is established with a home health agency to provide care twice a week. The primary nurse reports that the patient lives at home with her husband and will be returning home when discharged.

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

The WOC nurse used her medical expertise and crafting skills to create a one-of-a-kind containment system for this patient. She made a plan that was customized for this patient. She protected the impaired skin and diverted the drainage, without impeding access to the triple lumen ports. It was impressive to observe. I would have liked to have family or a caretaker to educate on what she was doing and why so that they could understand what they were looking at when they saw the ostomy pouch on. I was concerned that the Cavilon Advanced Skin protectant may not be enough to protect the broken skin. I thought the WOC nurse would use ostomy powder as well to crust the area. I am also concerned that the patient does not have a follow up appointment with a wound care clinic to monitor the progress of the contact dermatitis or to assist in managing the containment system. Furthermore, I feel that the patient may eventually need to see a surgeon to evaluate if the G J tube needs to be adjusted, possibly a larger tube or increase the balloon, to stabilize the G J tube to slow down the erosion of the insertion site. My concern is that the containment of drainage and protecting the skin, is a temporary fix, and more of a side effect from the instability of the tube.

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?

My goal for today was to see a complicated wound that required coordination between different departments. I met my goal but not in the way I expected. I have not seen anything like what the patient has or the McGiver method the WOC nurse used to help her. I am not sure if this is considered a wound or an ostomy, since it is a little bit of both. I am glad that I got to see this. The WOC nurse was using her skills to resolve an issue for this patient. This was further complicated by the safety concern of being bitten by the patient. In addition, to the limited cognitive and physical impairments of the patient.

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

My goal is to see a complicated wound, possibly negative pressure wound therapy in a difficult place to obtain a seal or needing to apply it to multiple wounds.

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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:		
• 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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