



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

### Daily Journal Entry with Plan of Care & Chart Note

Student Name: Yoselyn Soto Day/Date: 9/17/2024

Number of Clinical Hours Today: 10

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Candace Beeghly

Clinical 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.

On 9/17/2024, we saw an existing ileostomy patient, performed a pouch change, addressed peristomal irritation and fungal rash, measured the stoma, selected an appropriate pouching system, and removed the bridge as per medical directives. A different patient with a leg wound we selected suitable dressing choices, with extra concerns due to the patient's homelessness. Education for new colostomy patients. Conducted a follow-up visit about the fistula pouch, evaluated pouch adherence, instructed nursing staff and the patient on the application of the ostomy clip in the event of excessively thick stool, and performed a Braden skin assessment for the patient. Candace demonstrated me different bridges and the methods of their removal. She took me to central supply and discussed different possible alternatives, specially addressing the external fecal management pouch and the retracted penis bag. I also attended a corporate wound council meeting on a presentation on skin failure.

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:

Medical history: 65 y.o. male with PMH CKD2, HTN, HLD, DM2, colon cancer s/p DLI, who presented to ORMC ED with complaints of generalized weakness and syncope. Patient states that he was just admitted to AH 9/6-9/11 for septic shock 2/2 Enterobacter and Klebsiella bacteremia felt to be due to bacteria transposition from recent colon resection as well as acute renal failure, which recovered prior to discharge. Patient states that he was discharged to home with home health on IV levaquin with EOT 9/21. Patient returns to the ED today due to continued weakness, poor oral intake, decreased appetite, chills, nausea, and vomiting. Patient also reports an episode of syncope when getting OOB today. He denies any injury or head trauma and was able to get himself up off of the ground upon awakening. Patient reports compliance with levaquin. Denies all other complaints. In the ED, patient was hypotensive and tachycardic on arrival. Obtained lab work demonstrated new leukocytosis and new renal failure compared to discharge labs from AH on 9/11. He underwent CT AP noting diarrhea, colon mass with ostomy, and adenopathy. He was given sepsis bolus of IVF 2190cc LR as well as empiric vancomycin and cefepime. IMG was consulted for admission.

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Chart note: Initial visit to evaluate and treat exiting Ileostomy. Arrived at bedside, patient sitting up in bed, daughter at bedside. Patient alert oriented able to answer questions, follow commands, turns without assistance, ambulates. Review of chart reveals patient recently had ileostomy surgery at Advent Health. Patient's daughter confirmed they did receive ostomy education at advent health, but has had several hospitalizations since then, has not yet done a surgical follow up. Noted bridge still in place. Assessment of appliance, reveals it is well adhered but noted that wafer opening is too large which is exposing his abdominal skin. Performed pouch change today, resizing appliance. Noted satellite lesions, updated Dr Golla and obtained nystatin powder order. Received order to remove bridge from Dr Golla, performed this task. Supplies left at bedside, step by step instructions below as well as itemized list of supplies needed.

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)**

## Wound-Specific Plan:

Change q 3-4 days

Nursing to assess q4h

Change immediately for leakage

Nursing to assist patient with emptying appliance as needed

Empty when 1/3 full

## Ostomy appliance orders:

1. Remove appliance with sensicare adhesive remover
2. Cleanse peristomal skin gently with warm water + gauze. No Bath Wipes... as pouch will leak.
3. Pat dry
4. Apply skin prep
4. Measure stoma with measuring guide
5. "Crust" only if skin is irritated (with Stomahesive powder and no sting Cavilon spray)
6. Mold Eakin ring around stoma
7. Mold and apply moldable Flat 70mm Convatec wafer #52295.
8. Connect to Transparent, drainable, filtered pouch 70mm #79323.
9. Attach appliance system to skin (make sure to remove clear backing first)
10. Have patient place hand over appliance for 2-3 minutes or apply warm blanket for good seal.

## Central Supply #'s

## WAFER:

Convatec 2 3/4 in large moldable, 70mm #79319

## POUCH:

Convatec 2 3/4 in drainable transparent pouch with velcro closure 70 mm # 79323

## ACCESSORIES:

2 in eakin ring #20704

Stomahesive powder #408

Cavilon No Sting barrier Film spray 14602 or pad #44798

Brava strips #28846

Adhesive Remover Spray 150ml #101421 or 50 mL #77872

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Nystatin powder to peristomal skin, during pouch changes.

**Supplies needed for home:**

**Accessories:**

Esenta Sting Free Adhesive Remover Wipe 423391 or Spray 423289

Cavilon No sting Barrier Film Spray #3346 or wipe #3344

Stomahesive Protective Powder #025510

Eakin Cohesive Ring 2in #839002

Coloplast Brava strips Curved #120700

**Wafer:**

Natura Durahesive Moldable Flat 2 3/4in with according flange #421041

**Pouch:**

Natura Drainable pouch flange size 2 3/4 transparent #416422 with filter

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

Patient in bed, assessed all bony prominences, skin intact. When assessing ostomy appliances, we realized the wafer opening was too large exposing peri stoma skin. Due to the patient history, I think the education given when he had the initial surgery was not enough that's why he had been having problems with the peri stoma skin and being re admitted to the hospital. More education will be provided while patient is in the hospital. We proceed to remove old appliance with adhesive remover, bridge in place and peri stoma skin noted with satellite lesions, cleansed with water and gauzes, patted dry, applied nystatin powder, dust then applied non sting barrier film follow by the eakin ring 2" molded to stoma sized (38 mm) then applied wafer (70mm) and attached pouch (70mm). After, we contact Dr Golla who gave us a verbal order to remove bridge, pouch was detached, bridge removed with no discomfort, pouching bag reattached. In this case only thing I would have change is the pouching system size to a 57mm flat moldable 2-piece system.

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 the day was to prioritize patient list, review history of patients, wound assessments/dressing recommendation including alternatives.

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

My next learning goals it is to be able to provide ostomy teaching and recommendation for primary and secondary dressing. Also to get to know the outpatient clinic and workflow.

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CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>Identifies why the patient is being seen</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies specific products utilized/recommended for use</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>	✓	
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>	✓	
Learning goal identified	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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