



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: 9/19/2024

Number of Clinical Hours Today: 10

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: June Acevedo

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 9/19/2024 I went to an outpatient wound healing center the first patient was a lady with a J-Pouch she was having leaking problems due to some creases she had. The other one was a young male maybe on his 30's with an Ileostomy he was having leaking problems as well stoma was budded but flush and a crease below stoma, so the ostomy nurse used a soft convexity and a stofom (new for me) to create a good seal. Another lady came with a colostomy complaining of smell trough the bag, when asking how she clean when emptying the bag, she said she soak the bag with Clorox for a few minutes, so the ostomy nurse spoke and oriented patient on proper ways to clean bags, she also provided patient with flushable ostomy pouch liners, the patient was really happy with the recommendation. In between those patients I was able to pass to the wound side of the clinic and saw a patient with a venous ulcer the APRN taking care of the patient applied a GrafitPL PRIME (new for me), then collagen (promogram), followed by mepitel and compression wrap (Coban 2). Another patient had multiple venous ulcers on bilateral lower legs, wound nurse took measurements, cleansed with Vashe, patted dry, applied Aquacel AG, then ABD pad, followed by compression wraps (Coban 2).

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: 61 y.o. female patient presenting for initial postoperative evaluation s/p PROCTECTOMY WITH ILEO-ANAL POUCH CONSTRUCTION AND ANASTOMOSIS, EXTENSIVE LYSIS OF ADHESIONS, TAKEDOWN AND REVISION OF ILEOSTOMY performed on 08/20/2024. Patient was diagnosed with Ulcerative Colitis early in 2023. She was having 15 to 20 bouts of diarrhea daily and has moved forward with J Pouch surgery in three stages. The initial end ileostomy was placed April 1, 2024 by Dr Williamson, who is the surgeon for the third stage surgery as well. PMH: iron deficiency anemia, PONV

Chart note: Follow up visit for J-pouch care. Patient able to handle ostomy well prior but this DLI behaving differently and is "more leaky and more irritating." Patient wearing flat system but needing soft convexity as she has consistent area of irritation

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dermatitis below stoma. However, new shipment of flat supplies arrived so attempts to modify current product line used this morning. Used gentle technique to remove pouch using adhesive remover. Cleansed with warm water and gauze, Vashe cleansed, and 5 min application used to cleanse wound. Marathon crusting with antifungal powder used to area below stoma with denudation. Eakin barrier ring wedge to 03 and 09 and circumferentially with thinning of ring and beveling of inner rim to create ramp like effect. Ref#421040 placed over this with drainable pouch and one barrier ring to cover exposed wedge laterally. No belt desired. Patient reports recent weight gain (which she is pleased with). Abdomen with scar tissue over lower apron line and midline abdomen. Umbilicus no longer present. Firmer tissue in these areas. 03/09 have deep creases with overhanging lip of abdomen forming when patient is seated/activating core to get in seated position. DLI (27mm), round in the RLQ, flush to minimally budded, productive os is centrally protruding, color: red/moist, mucocutaneous junction: intact but erythema is present with sutures still visible, peristomal skin: irritant dermatitis and element of raised satellite lesions with pruritus also present in band from 04 to 07 about 2 cm wide, peristomal contour: slightly rounded when supine, becoming creased at 03 and 09 when seated, character of output: thin, emptying frequency: every 3 to 4 hours usually, removed system: Flat ConvaTec 421040 57mm accordion moldable, current pouching system: same with drainable pouch.

Topics Discussed: J Pouch surgery/what to expect. Patient has her father-in-law with a 40 yr pouch sans complications, food thickening strategies, B12 vitamin monitoring and supplementation needs, checking with pharmacy regarding any newly prescribed medication to determine if usable without a colon. She has had stage 2/3 of IPAA formation surgery. Ileostomy teaching and IPAA teaching with social support group information provided.

Recommendations: Consider belt usage, consider use of soft convexity with next shipment

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)

Return as needed for ostomy/peristomal skin concerns.

Change ostomy appliances every 3-4 days

Instructions:

1. Remove appliance with adhesive remover
2. Cleanse peristomal skin gently with warm water + gauze. No soap or Bath Wipes as residue decreases pouch
3. Pat dry
4. Measure stoma with measuring guide
5. Apply Nystatin powder to peri-stoma skin then
- 6) Spray with no sting barrier film
7. Mold Eakin ring around stoma
8. Mold and apply moldable Flat 57mm Convatec wafer
9. Connect to Transparent, drainable, filtered pouch 57mm
10. Attach appliance system to skin (make sure to remove clear backing first)

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11. Place hand over appliance for 2-3 minutes or apply warm blanket for good seal.
Change immediately for leakages

Empty ostomy pouch when is 1/3 full

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

In this case I loved that she used the Marathon crusting with the antifungal in the peri-stomal area, since marathon bonds directly to the skin to create a strong barrier. I would have done differently the use of a soft convexity pouch.

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 provide ostomy education, which I accomplished with the patient experiencing odor complications related to her colostomy. I participated in the wound healing center, familiarizing myself with their workflow and processes.

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 recommendation for primary and secondary dressing.

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	✓	

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• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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