



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: MARISA MILLSAPS Day/Date: 9-19-2024

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Lauren Forneris and Therese Cobb

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.

Today I precepted between 2 stoma clinic nurses.

I participated in 2 patient encounters with Therese Cobb. One stoma marking encounter for patient scheduled to undergo a Studer diversion but pending events during surgery, could also have an Indiana Pouch or Ileal Conduit. The other patient was returning for assessment of a peristomal ulcer and possible pouch fitting.

I participated in 4 patient encounters with Lauren Forneris. One stoma marking encounter for a patient scheduled to undergo loop ileostomy. Another patient was in clinic for a visit with the surgeon for an ileostomy takedown, but wanted to be seen by the stoma nurse and request the nurse “take a look”. This patient was assessed, and no issues were identified. Another patient presented with leakage issues to her LUQ ileostomy. This patient was fitted for a new pouching system that provided a wider convexity and scheduled to return in one week or sooner if needed. The last patient was an add-on by request of her daughter. Patient previously had leakage issues, and the daughter decided to change one aspect of the pouching system and wanted the stoma nurse’s “opinion”. The change was appropriate, and no leakage issues found on assessment.

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:

Patient seen today for follow-up visit to manage peristomal ulcer. J. Sankovic, PA also present for visit. Patient is a 73yr old Caucasian male, lives alone, he travels from WV for appts, last appt on 9-5-2024. Patient with PMH of Crohn’s Disease, osteopenia, coronary atherosclerosis, paroxysmal A. Fib, CAD, MI, recurrent complex parastomal hernia with repairs. Weight has reminded 240-243lbs. Patient reports current wear time of 2 days due to leakage. Current peristomal ulcer treatment is cleanse with soap and water, pat surrounding

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skin dry, apply 3M Cavilon No Sting Skin Prep to surrounding skin, cut Hydrofera Blue just slightly larger than ulcer then moisten with NS and squeeze out excess NS, then place Hydrofera Blue to ulcer wound bed, cover with Hollihesive. Then apply pouching system: Coloplast SenSura MIO Flex RED flat flange, cut to fit, with a Hollister Ceraplus barrier ring and a drainable pouch.

End Ileostomy present to LLQ, measures 1 1/8 x 1 1/4, stoma is budded moist and red, Os is center, mucocutaneous junction is intact, peristomal skin with peristomal ulceration present (first assessed 6-17-2024), peristomal skin is round with semisoft supportive tissue, effluent is liquid brown. Patient reports emptying pouching 6-8 times a day. Peristomal ulcer measures 4.0cm X 1.8cm X 0.2 (decreased in size from last visit), wound bed 100% red, edges flat, moderate amount of serosanguineous drainage, no odor.

Photo of peristomal area without pouching system in place taken and added to patient's chart with patient's permission.

Peristomal ulcer treated with silver nitrate by J. Sankovic, PA.

Recommendations:

Skin Care: wash with water and seal with 3M Cavilon No Sting Skin Prep

Pouching System: stop Hydrofera Blue, cover ulceration with a piece of Urgotul and continue using Hollihesive (place over Urgotul) and continue with the same pouching system.

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. Change appliance every three days and prn for leakage
 - a. Remove pouching system using push pull method
 - b. Cleanse skin, stoma and peristomal ulcer with warm water. Pat dry
 - c. Measure stoma. Cut skin barrier wafer opening to fit stoma
 - d. Apply Hollister Ceraplus barrier ring to back of barrier wafer (on side that is sticky and touches your skin
 - d. Cut Urgotul to fit ulceration opening
 - e. Cut Holihesive to place over Urgotul
 - f. Apply skin barrier wafer and pouch
2. Notify CORS team if ulceration appears to be worsening
3. Return to clinic in 2 weeks, may also call Stoma Nurse Line for stoma questions or concerns.

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

The patient has been coming to the clinic since 6-17-2024 for assessment and treatment of his peristomal ulceration. The ulceration is healing. I would not have done anything differently based on this visit.

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 was to observe how the WOC nurses navigate their day in the stoma clinic. I was able to observe how report is given, how patients are assigned, and how add on patients are managed. The stoma clinic can be very fast paced. The patient encounters averaged about 1hour long.

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

I will split my time tomorrow between the stoma clinic and manometry testing. (I was not able to observe manometry on Wednesday due to patient cancellations) My goal is to increase my knowledge of manometry testing and fecal incontinence management.

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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