



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: 9/24/2024

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 9/24/24 we followed up a fistula patient, changed pouch and looked for alternatives due to insurance not covering actual pouch system. For another patient we sized for Tubigrip, performed wound care, instructed bedside nurse and patient on correct Tubigrip placement. Observed day 1 ostomy teaching for a new ileostomy patient, pouch change, pouch selections made, measured stoma. I was able to chart on 2 patients. I carried the ascom and rover.

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: 63 y/o F with complex surgical history with an enterocutaneous fistula admitted for abdominal pain (history of ileosigmoid stricture s/p resection and ileorectal anastomosis complicated by missed enterotomy and ECF development June 2024). High output fistula, now on TPN and NPO.
Plan: ECF output 800 mL in 24 hours.
Patient now on standing loperamide, lomotil, and fiber.
Will start subcutaneous octreotide today, 100 mg BID.
Continue strict monitoring of ECF output
Cont NPO/TPN until output < 500 mL
IV benadryl PRN for itching
WOCN assistance appreciated
CM for home TPN arrangements

Chart note: Follow up visit to evaluate pouching system. Arrived at bedside pouching system edges well adhered without obvious signs of leakage. However, upon closer inspection did note that inner edges to the wound/fistula are beginning to appear lifted

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which could allow for silent leakage. Gathered appropriate supplies. Patient discussed that current eakin fistula pouch is not covered by her insurance. Sent epic chat to Case Manager regarding this concern, will attempt alternative pouch to allow to options for patient. Removed pouching system, did note that there was silent leaking occurring beneath pouching system. Performed pouch change (see steps below for specific details). Did note that area at 6 o'clock it is now a tunnel with drainage, brown/cloudy purulent vs effluent? Probed gently, but not to full extent of tunneled area and there is an open space. Decided to cut a piece of MESALT (sodium impregnated gauze strip) in half-length wise and tucked within this area to allow drainage. A good seal was obtained. Sent epic chat to Dr Kerner with the new finding of this area @ 6 o'clock. He is aware.

Step by Step Pouching systems change:

1. Remove with adhesive releaser spray
2. Cleanse with wound cleanser.
3. If periwound skin is intact apply cavilon no sting barrier film spray. If it is irritated then crust (stomahesive powder + cavilon no sting barrier film spray)
4. Using template (or make new template) cut appropriate size opening to 4 in Hollister cut to fit pouch with Window CS#103306. Cut radial slits to opening.
5. Crust periwound skin if irritation noted, otherwise just cavilon no sting barrier film spray.
6. Cut strips of eakin and apply within creases and around wound/fistula to build up the area for pouching system.
7. Create dough (mix stomahesive powder + stomahesive paste) and apply thin ring around base of wound, from 7-3 o'clock.
8. Apply additional strips of eakin around entire periwound/fistula to build area up.
9. Apply paste to seams to eakin strips and to back of pouching system.
10. Stomahesive powder to the paste, dabbing to help mold and solidify.
11. Apply bonding cement to back of pouching system and on top of eakin. Allow to dry until not tacky.
12. Apply pouching system, pressing down on edges and perimeter.
13. Open window and caulk edges of pouching system with stomahesive paste and then lightly cover with stomahesive powder.
14. Apply brava strips.
15. Cut mesalt ribbon 82673 in half lengthwise and tuck lightly within 6 o'clock opening.
16. Close pouch window.

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)

Bedside Nursing Fistula Pouch Instructions:

1. Empty pouch when full ~1/3- 1/2. May connect to bedside drainage is liquid effluent. If effluent becomes too thick to drain through spout, cut spout off and use ostomy clip.
2. DO NOT ALLOW POUCH TO GET TOO FULL, ensure tubing is free of twists/kinks/dependent loops to help facilitate drainage
3. If pouching system leaks, and Inpatient Wound Management is unavailable, remove pouching system and do Aquacel Ag (silver hydrofiber) dressings once per shift & prn for saturated until can be reevaluated by Inpatient wound management team.

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

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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 goals for the day were to be able to provide recommendations for primary and secondary dressing. Also to be able to complete documentation and manage rover.

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

Goal for next week, be able to carried and manage by myself the ascom/rover, make the initial and alternative dressing recommendations, participate in ostomy education.

| 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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