

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Courtney Grams, RN, BSN Day/Date: 10-9-24Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Tasha, Howard, RN, BSN, CWOCNClinical 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.

J.L. 75 yr old female. First follow up visit post op day 1. Patient had a laparoscopic RUQ loop ileostomy creation surgery on 10-8-24. Patient was diagnosed with adenocarcinoma of the colon in August of this year. Patient was admitted on 10-7-24 for bowel obstruction, the surgeon attempted to perform a right colectomy with removal of the adenocarcinoma mass with loop ileostomy creation however the mass was unable to be removed due to being heavily intertwined with the mesentery of the colon. Successful creation of a RUQ loop ileostomy was able to be performed. Patient has 3 lap sites that are glued and intact along with her new ileostomy site. Stoma measures 0.8 x 1.5, is oval shaped, beefy red, moist, budded and producing small amounts of dark green output. Patient has Hollister Cut-to-Fit One-Piece Flat skin barrier with tape boarder with drainable pouching system with Lock n' Roll Microseal Closure. Stoma appearance and function, healthy stoma characteristics, pouch change procedure demonstrated with model, fluid intake and dietary restrictions were discussed at bedside with patient and her husband present as secondary learner. Both patient and husband verbalized understanding.

V. G. 68 yr old male. Initial visit for evaluation and management of high out put ileostomy. Patient was admitted on 10-9-24 for dehydration and electrolyte imbalance. Patient has history of Crohn's disease, total colectomy (September 2024), and HTN. Patient reports having consistent output of 2,000 to 2,200 per 24 hours at home over the last few weeks. Stoma and peristomal skin assessment was preformed, pouching system was changed using Hollister Cut-to-Fit Two-Piece Drainable pouching system (30 cm pouch length) with soft convex CeraPlus (extended wear) skin barrier with tape boarder with Lock n' Roll Microseal Closure. Stoma is round, measures 1 x 1, beefy red, moist, and budded. Peristomal skin has mild irritant dermatitis noted from 5 to 9 O' Clock. Patient is using crusting method with stomahesive powder and skin barrier wipes to compact skin breakdown.

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:

This is an initial visit for a 68 yr old male (V. G.) who was admitted for dehydration and electrolyte imbalance on 10-9-24. Patient is being evaluated for management of high output RLQ ileostomy (created September 20, 2024). Patient has history of Crohn's

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disease, total colectomy (September 20, 2024), and HTN. Patient reports having consistent output of 2,000 to 2,200 per 24 hours at home over the last few weeks. ← *this is high!* Patient lives at home with his wife, is independent in his ostomy care. Patient was agreeable to appliance change and stoma/peristomal skin assessment. Large amount of yellow/green, liquid output noted in ostomy pouch. Appliance was removed from RLQ. Peristomal skin and stoma gently cleansed with saline moistened gauze and patted dry. Stoma round, measures 1 x 1, beefy red, moist, and budded. Peristomal plane noted to have slight indent at base of stoma at the mucosal edge, mild irritant dermatitis noted from 5 to 9 O' clock. Etiology appliance leakage most likely ← *usually from high output/high enzyme output*, no indication of allergic reaction present. Hollister stomahesive powder dusted onto area of irritant dermatitis, excess brushed off. Hollister skin barrier prep wipe applied over top; this process was performed x 3. Hollister Cut-to-Fit Two-Piece CeraPlus (extended wear) with soft convex appliance cut to fit stoma size using template and applied. Drainable pouch (30mm) with Lock n' Roll Microseal Closure snapped onto appliance. Patient tolerated appliance change, mild discomfort expressed when removing and reapplying appliance related to skin breakdown. Patient rated discomfort at 1-2 out of 10. Patient was instructed to intake at least 8-8oz glasses of fluids (water, juices, and/or electrolyte replacement drinks) per day and incorporate foods such as potatoes, rice, pasta, and marshmallows into his diet daily to help thicken his ileostomy output and slow down the motility of his intestines. Patient verbalized understanding, all questions answered to his satisfaction. Discussed clinical findings with Hospitalist, agreed initiation of Imodium would be beneficial for patient as well as maintained fluid intake and diet modifications. Bedside staff will continue to monitor irritant dermatitis, staff aware of the need to notify hospitalist of worsening skin break down. Will continue to follow at intervals.

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 3 days and PRN for leakage.
 - a. Remove old pouching system using the push pull method.
 - b. Cleanse peristomal skin and stoma with warm water, pat dry.
 - c. Assess stoma, measure size. Cut skin barrier wafer (Hollister Cut-to-Fit Two-Piece Drainable pouching system with soft convex CeraPlus (extended wear) skin barrier with tape boarder with Lock n' Roll Microseal Closure) opening to fit stoma leaving 1/8-inch clearance around the stoma.
 - d. Dust irritant dermatitis skin break down areas with Hollister stomahesive powder, brush off the excess.
 - e. Apply Hollister no sting skin prep wipes, allow to dry (repeat application of powder and skin prep up to 3 times to create a crust).
 - f. Apply skin barrier wafer and pouch.
 - g. Gently hold hand over appliance for 5 minutes to ensure the wafer conforms to abdominal contours and to enhance the seal.
2. Notify Hospitalist for worsening skin breakdown. ← *you will want to be alerted here too*
3. Instruct patient to measure output each time he empties his pouch.
4. Encourage patient to intake 8-8oz glasses of water, juice, or electrolyte replacement drink daily. ← *importantly these beverages will not do the same thing to correct electrolytes. Oral rehydration solution is best here. Make sure this is clear in direction.*
5. Encourage patient to incorporate foods such as potatoes, rice, pasta, and marshmallows into his diet daily.
6. Encourage patient to write down any questions or concerns they may have.
7. Pain Management:
 - a. Encourage deep breathing exercises and use of time outs when needed.
 - b. Pre-medicate as needed.
8. Monitor blood pressure. Treat/medicate as needed per provider order. ← *yes, but keep this WOC focused.*
9. Initiate Imodium per provider order.
10. Continue IV fluids and electrolyte replacements per provider order.

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

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I feel the care provided for this patient was appropriate and effective in educating him on management of a high output ileostomy. I would suggest the use of a high output pouching system with bedside drainage until clinical management is able to decrease ostomy output. This would decrease tension on the appliance and allow skin breakdown time to heal. *← yes! A high output system can do wonders to help the skin, as it decreases the risk of overfilling (the patient must remain vigilant). In extreme cases, it can be attached to gravity drainage.*

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?

To provide ileostomy/stoma management/education to our new ileostomy patient and her husband. And to provide mental and emotional support for the patient and her husband as they adjust to this new aspect of their lives together. I feel this goal was accomplished through our teaching session with our new ileostomy patient and her husband. – *good, this is a good example of holistic care – caring for more than just the physical ostomy.*

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

This was my last clinical day however my learning goal going forward is to continue to grow in my knowledge base and skill level in regard to an Wound Ostomy Nurse role.

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	✓	

Hi Courtney, see my comments throughout. This qualifies as your 4th ostomy submission. Your last submission should be your complex ostomy care plan. Continue to apply feedback 😊
Reach out with any further question.

Reviewed by: Mike Klements 10/10/2024 received Date: 10/10/24

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