



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Doris Elliott Day/Date: 10/08/24

Number of Clinical Hours Today: 10

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Patti Grossnickle

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's patients consisted of one patient who was returning with a skin tear to the left lower leg that occurred after he hit his leg on a dishwasher. An attempt to save the skin flap was made by using steri-strips, however the flap died, and the patient developed some increased redness to the peri-wound. The provider decided to remove the flap and change the dressing care orders to hydrofera blue ready covered by gauze and wrapped with kling. The next patient was an ileostomy patient who presented with frequent leaking and will be the focus of the daily journal. Another patient presented with a skin tear/laceration to the right arm that she stated occurred when she fell and a heavy gold bracelet caused a large skin tear. She originally had sutures placed in the ER, the sutures were removed ten days prior to the out-patient appointment, and today her wound was healed! Some scarring was noted but no further dressing recommendations needed. The patient was told she could now have shower water touch the area but it was recommended that she pat the area with soap and pat to dry. The next patient was a podiatry patient who presented with a wound to the left lateral lower leg that occurred over two years prior when he cut his foot on a seashell. The patient developed necrotizing fasciitis and underwent lateral and medial fasciotomies to the lower leg. The wound now is full thickness and the podiatrist was hoping to place a graft today, however bright green drainage was noted when the previous dressing was removed. The dressings were modified from hydrofera blue and changed to a 50/50 vashe/hibiclens scrub, followed by the application of gentamicin and aquacel AG, then wrapped with kerlix. The dressing changes were increased from twice weekly to three times weekly and a follow up appointment for one week was scheduled for closer monitoring. The last patient has peripheral vascular disease with hemosiderin staining noted and venous ulcers to the left lower leg. The wound was treated with a vashe soak, then covered with an even-parts mixture of collagen, gentamicin, and blastx. It was then covered with dry gauze and wrapped with kerlix before compression therapy using urgok2 lite was applied from the toes to two inches below the knee.

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:

The patient is a 35 year old female who presents today with concerns of leaking from her ostomy appliance. The ileostomy was created in 12/2020 after bowel perforation caused by severe ulcerative colitis. The patient reports a recent 40 lb weight gain, and is observed to have crevicing at 3 and 9 o'clock when sitting and standing. She currently uses a one-piece coloplast deep convex appliance. There is peri-stomal skin irritation noted in the 3 o'clock position believed to be irritant contact dermatitis and further

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

irritation noted at the edges of the appliance believed to be Medical adhesive related skin injury from frequent pouch changes due to leaking and improper removal. The patient states that she has not been using the crusting technique though she is familiar with the steps. The patient stated she typically cuts the appliance to size 32 mm, yet a new measurement reveals an oval shape of 35 mm. Trialing the use of Hollister adapt oval convex barrier ring to be used with coloplast deep convex appliance. Patient educated on the new stoma size needed and proper removal of appliance using adhesive remover wipes and gently pushing the skin away from the appliance. Patient encouraged to utilize the crusting technique to further protect the skin and that the ostomy belt may provide further protection against leaking.

Assessment:

Stomal appliance- One piece

Appliance status- undermining of effluent

Site assessment- red

Stoma construction- end

Stoma color- Red

Mucocutaneous junction- intact

Stoma appearance- moist

Stoma shape- oval

Stoma protrusion- at skin, flush

Stoma size- 34 mm

Lumen location- central

Type of effluent- brown, moderate, watery

Peristomal assessment- partial thickness skin damage caused by contact irritant dermatitis and traumatic skin damage related to inappropriate removal of appliance

Treatment- Adhesive removed, cleanse with CHG and warm water, crusting technique with ostomy powder, Hollister oval convex barrier ring, coloplast deep convex appliance

Output- 50 mL

Education:

Stoma size and expectations in peri-stomal skin plane changes with weight changes.

Peri-stomal skin status

contact irritant dermatitis and MARSII noted.

Pouch change frequency

Key points in removing the appliance

Stoma powder crusting technique

Ostomy accessories: Ostomy powder, ostomy paste, barrier rings, curved barrier strips

Ostomy support belt

Prevention of blockage in ileostomy

Patient expressed understanding.

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)

Continue with present appliance

Cut appliance to 35 mm

Add convex ring or use barrier rings to fill circumferential depth

Include crusting technique

Include usage of ostomy belt

Continue education

Follow up appointment scheduled for two weeks, encouraged to call with any concerns before then

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

I thought the care provided was great, the patient was rushed to get to another appointment and time was limited on figuring out which modifications in the appliance should be made but the patient seemed very familiar with the crusting technique and ostomy belt. If the patient had more time to discuss why she is reluctant to use these other products I think more barriers to care could be addressed and she could be properly encouraged.

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 learn more about how patients were prepared for hurricanes and wound dressings when home health appointments may not be available. Fliers with instructions were readily available with goodie bags of normal saline, gauze, and tape that could be given to patients who had wound VACs and what to do if the power was out and the machine died. This I think is a great thing to implement within the hospital as part of the regular discharge process as these patient's may experience problems such as a leak or dressing dislodgment and should be provided with basic instructions and supplies on what to do until they can be seen for a dressing replacement.

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

My goals for Friday are to get more hands on experience with the ostomy patients to better understand the various issues encountered once healing has occurred. It was great to have a patient who has had the ostomy for years but is now seeking help as her situation and body have changed.

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	✓	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.



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

Reviewed by: _____ Date: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.