

12/21/24 # 8 KF

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Marina DeRosa Day/Date: 12/21/24Number of Clinical Hours Today: 12Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: K Francis, APN CWONClinical 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 the course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Today's clinic had a total of six patients that I saw with my preceptor. Since we were on the lookout for ostomy patients, I saw 2. One ostomy patient was an AAOx3 and I continued teaching with him. He showed me how he empties his bag, and he changed his ostomy appliance for me. The second ostomy patient lives in a nursing home and has dementia. I assessed her ostomy and changed her pouching system. Third Patient was a stage 3 with moderate serosanguineous drainage. dressing used NSS cleansing daily Aquacel hydro fiber with 4x4 gauze over it, No sting skin barrier to peri wound, daily wound change. The fourth patient had a skin tear to the right upper extremity. The skin was still intact over the wound. Wound cleansed with NSS, pat dry. Apply oil emulsion to the wound base. Cover with rolled gauze, change oil emulsions every 5 days and rolled gauze every 2-3 or PRN soiled. The last two patients had stage 2 pressure injuries. One patient had multiple stage 2 pressure injuries. Bilateral buttock stage 2 pressure injuries cleansed with NSS, pat dry, skin barrier to peri wound, Allevyn foam over wounds. Secured with Allevyn live dressing change daily. The other patient also admitted with a stage 2 pressure injury is a wheelchair bound patient AAOx3. Thoracic spine stage 2 pressure injury. The patient stated he started to feel something on his mid back and that he had lost some weight in the last few months. The weight loss was intentional when I inquired. Upon exam he had a shallow stage 2 pressure injury. Dressing cleanse wounds with NSS daily, pat dry. No sting barrier to the peri wound let dry. Allevyn foam over the wound, then secured with Allevyn Life dressing.

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:**INTERVAL HISTORY:**

90 y.o. female white, Cuban, Spanish speaking Fitzpatrick scale 2 from a Nursing Home. Related to abdominal distention. Patient admitted for Severe abdominal distension possibly 2/2 Ogilvie Vs Distal LBO vs rectal stricture. The patient is now referred by nursing for evaluation of Colostomy. The patient is awake in no distress or discomfort.

Diagnosis

- Elevated cholesterol
- Hypertension

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- Psychoactive substance-induced organic mood disorder (HCC)
- Thyroid disease

Past Surgical History:

Procedure Laterality

- ABDOMEN SURGERY N/A
LAPAROSCOPIC DIVERTING COLOSTOMY
- BREAST LUMPECTOMY
- BREAST LUMPECTOMY
had radiation years ago
- CESAREAN SECTION

ROS:

Review of Systems

Unable to perform ROS: Dementia

Temp (24hrs), Avg:97.4 °F (36.3 °C), Min:96.1 °F (35.6 °C), Max:98.2 °F (36.8 °C)

I/O last 3 completed shifts:

In: 650 [I.V.:150; IV Piggyback:500]

Out: 500 [Urine:500]

No intake/output data recorded.

Body mass index is 28.77 kg/m².

EXAMINATION:

Physical Exam

Vitals and nursing notes reviewed. Exam conducted with a chaperone present.

Constitutional:

Appearance: She is obese.

HEENT:

Head: Normocephalic.

Pulmonary:

Effort: Pulmonary effort is normal.

Abdominal:

Comments: Stoma left lower quadrant with small hematoma and bowel sweat. Bowel sounds hypoactive.

Genitourinary:

Comments: IUC

Skin:

General: Skin is warm and dry.

Neurological:

Mental Status: She is alert. Mental status is at baseline.

INPATIENT MEDICATIONS:

Scheduled:

- divalproex 125 mg Oral Q12H sch
 - [START ON 3/1/2024] escitalopram 5 mg Oral Daily
 - enoxaparin 30 mg Subcutaneous Q24H sch
 - Ensure Clear Oral Daily
 - insulin lispro (HumaLOG) BEFORE MEALS HIGH DOSE CORRECTION SCALE 4-14 Units Subcutaneous
- TID - AC
And

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- insulin lispro (HumaLOG) BEDTIME HIGH DOSE CORRECTION SCALE 2-7 Units Subcutaneous
Nightly
- carvedilol 12.5 mg Oral BID - WC
- levothyroxine 50 mcg Oral Daily (6 AM)
- mirtazapine 7.5 mg Oral Nightly
- risperiDONE 1 mg Oral Daily

Infusions:

- LR 75 mL/hr (12/19/2024)

PRN:

HYDROMorphone, acetaminophen

DIET CLEAR LIQUID

Nutritional Status: Does not meet criteria for malnutrition at this time

ASSESSMENT AND PLAN:

Comprehensive Problem List

Diagnosis

- *Severe abdominal distension possibly 2/2 Ogilvie Vs Distal LBO vs rectal stricture
- Acute deep vein thrombosis (DVT) of both lower extremities (HCC)
- Recurrent breast cancer, left (HCC)
- Chronic constipation
- Parkinson's disease
- Primary hypertension
- Hypothyroidism
Chronic
- GERD (gastroesophageal reflux disease)
Chronic
- Uncontrolled type 2 diabetes mellitus with hyperglycemia (HCC)

Resolved Hospital Problems

No resolved problems to display.

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)

Ostomy Assessment

Location : Left lower abdomen

Type : Sigmoid loop colostomy

Shape : Oval

Overall appearance : boggy, moist, smooth, red

Sutures : visible to mucocutaneous junction intact without separation

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Size : 42mm x 40mm Height
Peristoma skin : 2 cm above skin level
Odor : none
Effluent : bowel sweat
Peristomal skin : intact without erythema or signs of irritation.

The patient was alert and awake. No acute distress. The patient is resting in bed with a pressure redistribution surface in place, positioned on supine. Patient rec's clear diet for which she has eaten little. The patient has a IUC in place for incontinence management. The patient has Laparoscopic incision closed with Dermabond clean without edema or erythema. 2-piece Convatec Sur-Fit pouching system in place with visible leakage. Ostomy care done. The patient has dementia and only verbalized tenderness. The patient receives Coreg and LovenoX relevant medications which may delay wound healing. The patient was left comfortable in no distress or discomfort.
Braden Scale Score:10

Patient/family education provided:

The patient's niece was called and given an update on her aunt's ostomy care. All questions were answered. An education packet on "Understanding your colostomy" and written step by step instructions for changing the pouching system was left at the patient's bedside for her niece. Upon speaking with the niece a time and date 14:00 12/22/2024 was set so that WOC can meet with her and go over educational material, giving the niece an opportunity to see the ostomy care and ask any questions she may have. Niece verbalized understanding of the importance of reviewing material and was very receptive to this conversation.

Ostomy Care Plan

Continue monitoring of appliance q shift
If leakage occurs, remove pouching system
Clean stoma and peristomal skin with warm water. Pat dry.
Apply Stomahesive powder and brush away excess
Apply Cavilon skin prep to the peristomal skin after brushing away powder
Use a diagram of wafer to cut out new wafer as needed.
Apply 2.75" Hollister New Image 2- piece pouching system

Call WOC Services with any questions or concerns 908-674-5477

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

The only thing I think I may have done differently was to call the patient's niece first before I did the ostomy care and see when she was able to come in so she could be part of the teaching first hand.

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 on this day was to make sure that I connected with the ostomy patient's niece and sit down with her for follow up teaching. Even though the patient lives in a Nursing home it is important that the niece knows signs and symptoms of stoma issues. This

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family member is very involved with her aunt's care. She was the person who called attention to her aunts abdominal distention and discomfort so I want her to have all the information possible.

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

To try and see more complicated wounds and focus on patients from nursing homes, as I have seen that they are a most vulnerable population.

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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