



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

### Daily Journal Entry with Plan of Care & Chart Note

Student Name: Katrina Covello Day/Date: Friday, December 13th

Number of Clinical Hours Today: 10

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Nancy Bollero, NP, COWN

Clinical Focus: Wound  - 4 hours of time Ostomy  - 6 hours of time Contenance

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 this day, Nancy was making rounds on the inpatients as well as seeing patients within the clinic. Only one of the patients on the inpatient service had a new ostomy. This patient will be discussed further below as I was able to help with the education as he worked on changing his ostomy for the first time on post-op day two. The next patient was an established ostomy patient. He was hospitalized for an ostomy reversal, but once under, the surgery was aborted at surgeon's discretion. We were rounding on this patient the following day and while he verbalized disappointment, he said he was eager to get to traveling since he will "have an ostomy forever now" and had postponed trips so that he could not travel on airplanes with an ostomy bag.

In the clinic, there were two patients that were being seen for follow-up. Neither had any issues. In fact, it wasn't immediately clear why they were being seen except that they had made an appointment "just in case" they needed it. No new supplies or anything were needed and while they were both checked to ensure good skin integrity, good seal, etc., there were no signs of issues and the patients both denied any trouble.

After clinic patients were seen, we went back to the inpatient part of the hospital to make rounds on wound consults. This included one post-op patient who had an incision and drainage due to an staph infection in the left upper thigh. The general surgeon had placed this consult for wound nurse(s) to provide recommendations for promotion of leg wound healing. A wet-to-dry dressing with Vashe was order to be changed every 12 hours (every shift) until Monday so that a wound vac could be placed. The next patient had peripheral artery disease and was receiving treatment in the wound center for statis ulcer on the left leg. Patient was medically doing fine and was going to leave the hospital that afternoon. Area had previously been addressed, so this was a routine check by wound nurse to make sure patient and wife did not have any questions or concerns. They denied having any. The next patient was a patient who had previously had osteomyelitis in the right foot, resulting in toe amputation. She had previously had other toes removed and up to the metatarsals, so this was the removal of the last two toes on that foot. Patient had wound vac on, but nurse had noticed substantial drainage increase consulting both the wound nurse and the surgeon. Upon removal of the wound vac and wound vac dressing, patient began "spurting" blood. Surgeon had made rounds with the wound nurse (a standard practice when the surgeon is not in the operating room) and so she held pressure on the site. Pressure was held for several minutes and then examined again. The plan to re-establish a wound vac was aborted a saline-soaked gauze dressing with kerlix and ace bandage wrapping was ordered by physician until it could be re-evaluated by wound nurse(s) on Monday. Surgeon voices she would come back around over the weekend to monitor it and patient was agreeable to the plan.

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.

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**Chart note:**

Type of visit: new ostomy

Hx: diverticulitis, HTN

Patient has previous history of diverticulitis flare, but without perforation

Physical assessment: Upon rounding, patient is sitting up in recliner visiting with wife. Denies significant pain since he was medicated with Norco within an hour of ostomy nurse visit. Stoma is noted in left lower quadrant, 2 inches to the left of the umbilicus. Stoma is noted to be a dark red “bud” sitting upon the abdomen. No significant bleeding noted. No signs of tissue ischemia. Nancy notes that there is a darkened area towards the bottom (6 o’clock) that may eventually “slough off,” but no signs of deeper ischemia or tissue compromise. Patient and wife deny concerns other than a need for “more practice.” Wife is an Occupational Therapist, but says that she doesn’t do stuff with ostomies since that’s a “nursing thing.” Patient reports feeling like he physically see the stoma and ostomy bag without the need for his glasses. He verbalized that the smell of the stool being produced was “unpleasant,” but that he felt that he would get used to it. He also verbalized that the stool just “runs out,” but that it is “not pure liquid.” Ostomy nurse reassured him that this is all to be expected and nothing was abnormal. Patient has normoactive bowel sounds in all four quadrants. He verbalized readiness to do the ostomy bag change since he had only discussed it prior to surgery.

Interactions: See above. In addition to the physical assessment which took place at the same time as identifying any patient needs, preferences in ostomy supplies was also discussed. For now, patient and wife verbalize that they are ok with the “see through bags,” but that they’d both prefer opaque ones in the future.

Education: Specific product (see below) was applied. Education was done as to why this was being tried. A convex ostomy wafer is being used to decrease the likelihood of leakage since the stoma is not above skin level based on current physical assessment. Patient verbalized understanding. He verbalized he has all of the other products needed at his apartment and denied any needs or concerns at this time. Samples of this product is being sent to the patient via the Hollister® site as only two bags were available to be applied (including the one placed on the patient). The other wafer on the other pouch was cut based on the original template so the patient did not have to have a roommate cut the wafer to size. The template was sent home with the patient to refer to for future wafer cutting which will be done by his mother when he is home over winter break from university.

Specific products used/recommended for use: Coloplast® products are what was readily available on this inpatient unit (and throughout the hospital). Therefore, the patient (who performed his own ostomy pouch change with some assistance from ostomy nurse) used a SenSura® Mio Flex Barrier and a SenSura® Mio Flex Drainage Bag creating a “two-piece” ostomy system. Brava® powder was applied by ostomy nurse after patient applied the ostomy wafer. Patient was provided with Brava® Adhesive Removal Wipes and Brava® Skin Barrier Wipes (see WOC Plan of Care below for more details).

Patient and wife verbalized that they would like to discuss supply options once “things have settled down a bit” and they have had “more practice” with the current system. Appointment to be seen in clinic on 12/23/24 by ostomy nurse has been made for this purpose.

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)**

Bi-weekly ostomy pouch changes (unless pouching system becomes compromised, then change PRN): SenSura® Mio Flex Barrier, SenSura® Mio Flex Drainage Bag, Brava® powder (PRN), Brava® Adhesive removal wipes for previous pouching system removal and Brava® Skin Barrier Wipe prior to applying new pouching system.

Pt to call ostomy nurse’s office if any questions or concerns arise. Keep appointment on 12/23/24 in clinic for post-op assessment and evaluation of pouching system/supply needs.

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

It was nice to be a part of the “teach-back method” for this ostomy patient. He had review information (at he and his wife’s request) prior to surgery and he felt ready to get the hands-on experience. It was challenging keeping up with switching between patients in both the clinic and inpatient settings since I also had to switch between wound and ostomy. I believe it is a matter of practice and exposure before I become more comfortable switching back and forth. I am interested in seeing more and expect that more of my days will be split between the two specialities moving forward.

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?**

Ostomy education/teaching re-inforcement (PRN)

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

Continue switching between wound and ostomy to get more familiar with addressing whatever comes up throughout the day.

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>Identifies why the patient is being seen</li> </ul>		
<ul style="list-style-type: none"> <li>Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>		
<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies specific products utilized/recommended for use</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>		
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>		
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>		
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>		
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>		
Learning goal identified		

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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