

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

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Zachary Goodin Day/Date: 1/16/2025Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Lauren FornerisClinical 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 we met with many patients in the outpatient office. Majority of the patients seen were pre op consultations for upcoming surgeries with an ileostomy or ileal conduit creation. These patients were given education for their specific upcoming surgery, caring for their ostomy, and what to expect. One patient was seen within the ostomy clinic for a peristomal wound.

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:

Follow-up visit for a 21 year old male that is 2 weeks postop from the second stage J-pouch procedure. 1/2/25 the pouch was form and anastomosed to the anus with loop ileostomy creation. The patient presents to the clinic for a follow up visit with concern for a peristomal wound. The patient has a history of Ulcerative Colitis and otherwise is healthy. Upon meeting the patient they are alert, oriented, and accompanied by their parents. Assessing the abdomen there are laparoscopic sites x3 that are 100% approximated with staples. There is also a lower midline incision that extends into the pubic area that is also 100% approximated with staples. Removing the pouch from the loop ileostomy in the RLQ there is a dehiscd incision adjacent to the ileostomy at the 9 o'clock that was closed with staples, however 2 of the 3 staples were no longer grasping the inferior edge of the incision. The wound measures 0.5cm x 1cm x 0.5cm with pink, moist tissue, flat wound edges, and a moderate amount of serous drainage. An order was obtained from the providing physician to remove all staples from the patient. Discussed with patient and family that wound care would need to be incorporated into their pouching routine to promote healing and maintain a pouch seal. A small piece of ConvaTec AQUACELL Extra was placed into the wound bed as the primary dressing. A Custom cut piece of Hollister Hollihesive was then placed over top as the secondary. This was then followed by the patient's already established pouching system which is a Hollister CeraRing on a Hollister New Image 2 ¼" flat cut-to-fit flange and lock n'roll drainable pouch. Patient and family were both given education on the products used to address the wound and given ample supplies. The ileostomy is red, moist, and viable appearing. It measure 1 ¼" and slightly edematous. The mucocutaneous junction is intact – The wound is well approximated directly next to the stoma. Patient endorses having leakage within the past week near the 9 o'clock area. This is likely due to the serous drainage

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occurring from the 9 o'clock wound. Pouching may need to be at more frequent intervals such as every 2 days depending on wound drainage amount. Expect the wound to heal within 2 weeks.

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)

Change pouching system and provide wound care to peristomal wound every 2 days. Remove previous pouching system with ConvaTec ESSENTA adhesive remover wipes. The 9 o'clock wound may have a gel appearance due to the hydrofiber dressing. Irrigate the wound with normal saline. Cleanse periwound and peristomal skin with soap and water. Place a cut to fit piece of ConvaTec AQUACELL Extrta with the base of the wound. Cover with a Hollister Hollihesive wedge cut to-fit over the wound and around a portion of the stoma. Apply the pouching system – apply a Hollister CeraRing on a Hollister New Image 2 ¼" flat cut-to-fit flange with a lock n roll drainable pouch. Follow up with patient in 2 weeks scheduled for wound assessment. Contact information provided to patient and family should the wound worsen or any questions or concerns arise.

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

I thought that a hydrofiber dressing was an appropriate treatment option to address the dehiscence. Reflecting back on this, I would have liked to add a skin protectant to the periwound skin and the peristomal skin. This would have added another layer of protection for the patient's skin. Additionally, much of the visit was spent providing education to the patient and family. They were very concerned for infection given how close the wound is to the ileostomy.

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?

Provide wound care and education for patients. This goal was met.

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

Focus on wound and continence care.

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	✓	

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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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