

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Jasmine J. Lee Day/Date: January 21, 2025Number of Clinical Hours Today: 8Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: MaldonadoVillalobosClinical 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.

S.D. 23F

Patient seen as a follow up after Patient seen yesterday for pouch change and patient began to complain of a sore abdomen and easily brought to tears with the slightest touch. Dressing over midline incision removed and purulent drainage noted along the wound bed. Reached out to MD with this information and CT was ordered. CT A/P showed abscess within the abdominal cavity. Patient was seen today and for pouch change and midline dressing change. 1 piece cut to fit pouch offset away from midline and place onto prepared skin. Aquacel AG rope applied to wound bed covered with gauzed and secured. Jackson-pratt drains x 2 noted to right lower quadrants

B.B. 69F End colostomy

Pmhx:

diverticulitis, nephrolithiasis, and asthma who presented to ED on 1/15/25 for abdominal pain/distension, nausea/vomiting, and diarrhea for 2 days. She was recently hospitalized at another facility on 12/23/24- 1/4/25 for sepsis/Pseudomonas aeruginosa bacteremia likely secondary to osteomyelitis with epidural phlegmon; and discharged on meropenem, with treatment to end 2/3/25. CT a/p with marked diffuse colonic wall thickening involving long sigmoid segment distally with high-grade upstream obstruction with fluid-filled large bowel loops and distal small bowel loops. She underwent an emergent exploratory laparotomy, bowel resection, ostomy with Surgeon on 1/15/25. Throughout her admission, she has been afebrile but with leukocytosis. She received cefazolin, metronidazole, and piperacillin tazobactam. Over the past few days, her ostomy output has been copious with increasing leukocytosis. She received laxatives (senna-docusate) for 4 days. C. difficile screen was indeterminate. Denies any fevers, chills, or abdominal pain. Infectious Diseases was consulted for further management. Patient on Enteric isolation for C. diff

Arrived at patients room with patient in bed. Appliance removed, peristomal skin intact, mucocutaneous separation noted from 4-9 0'clock. Skin and separation prepped with stomahesive power and skin barrier spray and eakin applied over the peristomal area. Appliance replaced with 70mm high output pouch in order to accommodate large volume of liquid stool. Patient declined to help with pouch change today. Will continue to follow up

S.C. 31M

Hidradenitis Suppurativa with excisional debridement 12/13, Lap. Loop colostomy 12/15. Wound vacs applied until bilateral grafting of buttocks on 1/9

PMHx per IMG note: 31 y/o M w/ ? Homelessness (reports lives w/ brother), HIV (not compliant w/ ART for last 2 months), T2DM, hidradenitis suppurativa-> requiring prior I&D of buttock/ perineum Nov.2024 (did not follow-up as outpatient), anemia of chronic disease, and protein calorie malnutrition who presented w/ worsening buttock wound w/ foul-smelling drainage. Sepsis alerted (febrile/ 101.3 w/ soft BP and WBC 20.6)->s/p IVF, iv ABx. CT a/p consistent w/ skin soft tissue infection. General surgery

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

consulted - S/p excisional debridement 12/13 and S/P laparoscopic loop colostomy 12/15. ID following for antibiotics - on IV ertapenem
EOT 1/30/25.

S/p 1/9 OR for bilateral grafting of buttocks with surgeon, Will continue IV ertapenem for 6 weeks end of treatment 1/30.
Pt reevaluated patient and recommended SNF however no accepting SNFs. Patient's preference is to go home however does need a hospital bed to be arranged as well as family training for his extensive wound care. Hospital bed is being arranged but patient ok with going until it is delivered Training for wound care complete. ID has set up daily infusion abx until 1/30/2025 at hospital since Home Health IV abx taking so long to set up. Replaced midline. Pt will follow up with Wound MD ID and surgery. Pt with stool in ostomy. Medically stable for discharge.

Patient seen for ostomy check, arrived to patients' room to find the patient fully dressed in street clothes and speaking to case manager. Patient slated for discharge today. Ostomy appliance checked; no leakage noted. Ostomy has been changed exclusively by patient while inpatient. Ostomy supplies for discharge given to patient

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:

P.K. 74M ileostomy

Patrick A Keen is a 74 y.o. male with h/o atrial fibrillation on anticoagulation with Eliquis, hyperlipidemia, and hypertension who came to the emergency department initially as a trauma gray after he suffered a mechanical fall, slipping on some wet tile, and struck his head, arm, and back. His trauma scans were negative, and the patient was being considered for discharge when he was found to be in atrial fibrillation with rapid ventricular response. Upon further probing ED physician reported that patient was experiencing some chest pain while having episodes of A-fib RVR, he said this chest pain was different from the way it normally feels when he has atrial fibrillation.

We plan to admit him to cardiac progressive care unit for close monitoring on telemetry and possible initiation of intravenous antiarrhythmics for atrial fibrillation with rapid ventricular response. In addition, we will get echocardiogram and cardiology consultation for atypical chest pain associated with atrial fibrillation with rapid ventricular spots.

74 yo M with PMH: A Fib (on Eliquis) & leostomy, presented to ORMC ED (12/27) after mechanical fall. CT A/P with evidence of ischemic colitis. Gen Sx consulted.

12/29: s/p Ex-Lap with schematic Cecum, R Hemi-Colectomy & End-Ileostomy.

12/31: NGT for SBO vs ileus.

1/7: Re-opening of Laparotomy, ileostomy revision 2/2 tight fascial opening

1/8: RRT due to lethargy. Intubated for airway protection. A Fib RVR s/p Amiodarone infusion. Levo initiated. Heparin infusion initiated.

1/9: Care Tx to SCC.

1/12: Off pressors, postop ileus improving. Ongoing AKI. PNA on cefepime. Weaning vent support.

1/13: Ileus resolved. Afib RVR overnight. Restarted on amio gtt.

1/15: Extubated. Rocephin course complete. Amio gtt do'd. Transitioned to PO amio

Continue with diltiazem drip at 15 mg/h, Lopressor 5 mg IV every 6 hours as needed, amiodarone IV and heparin drip

Per surgery Replace NGT/hold on any tube feeds until distention resolves

Repeat KUB 1-2 days after NGT placed to assess progression On IV reglan for gastric motility

NPO

Intermittent WTD packing to midline laparotomy, change BID if drainage, obtain culture/ monitor ostomy output

1/20 Started CLD per surgery / Wean card drip / start PO

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Labs:

WBC 17.2, Hgb 11.3, Ca 7.9, Mag 1.5

XR ABD- Persistent air distended small bowel loops measure up to 3.9cm, mildly improved in comparison to prior study

Consult PT, SLP

Arrived to patients' room, with patient in bed. Primary RN at bedside. Appliance is leaking, green colored stool leaking out of a male urinary retracted penis pouch and onto the midline abdominal dressing. RN made aware that this is the wrong appliance and was shown the proper appliance that was in the room and made aware that all supplies are provided in the orders with central supply numbers given and if it is unavailable on the floor, central supply can send them to the floor. Incorrect appliance removed revealing satellite lesions throughout the peristomal skin. Skin, cleaned, crusted and nystatin powder applied to area prior to pouch application. Dressing to midline incision soiled, and dressing changed per surgical orders (moistened kerlix lightly packed within the wound bed and covered with abdominal pads and tape. This wound is not being managed by WCOCN). Moisture wound to right buttocks. Cadaxomer Iodine gel and mepilex dressing to reduce biofilm with dressing to be changed every two days. Small deep purple area observed to right trochanter. Etiology DTI. Opitview applied to hip for added protection and to provided cool microclimate.

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 care orders:**

Change q 3-4 days

Nursing to assess q4h

Change immediately for leakage

Nursing to assist patient with emptying appliance as needed

Empty when 1/3 full

Ostomy appliance orders:

1. Remove appliance with sensicare adhesive remover
2. Cleanse peristomal skin gently with warm water + gauze. No Bath Wipes... will leak.
3. Pat dry
4. Apply skin prep
5. Measure stoma with measuring guide
6. "Crust" only if skin is irritated (with Stomahesive powder and no sting Cavilon spray)
7. Mold Eakin ring around stoma
8. Mold and apply moldable Flat 57mm Convatec wafer
9. connect to Transparent, drainable, filtered HIGH VOLULME pouch 57mm
10. attach appliance system to skin (make sure to remove clear backing first)
11. Have patient place hand over appliance for 2-3 minutes or apply warm blanket for good seal.

Nystatin to peristomal skin with appliance changes until lesions have resolved

Right trochanter: Cleanse the area with saline or Anasept wound cleanser, pat dry completely. Apply Optiview to right trochanter.

Do not remove for 7 days unless dressing becomes cloudy or dislodged. Step by step instructions for application are on the package. 7x7

CS#103401.

Right inner gluteal cleft: Cleanse with Antimicrobial Spray to manage wound bioburden.

Apply Cadexomer Iodine gel (Iodosorb Gel) to wound bed for broad spectrum antimicrobial action and desloughing.

Cover with Mepilex Border 4x4

Change once daily.

Pt has no known allergies

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

I was happy that I was able to provide education to the RN who was also a new graduate in a manner that she was receptive to. I am hoping that the time spent educating the RN gives the nurse more confidence with pouch changes

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?

In addition to educating the nurse, I was also approached by a surgical P.A. via chat at the end of the day regarding A.B. 23F seen yesterday regarding her wound vac. Recommendations for alternative was provided although it was provided on the chart. P.A. was able to remove the dressing in order to address the hematoma he observed under the foam. He also replaced the dressing. P.A. began to ask questions regarding the accessories used when applying the vac dressing. The rationale for the use of stomahesive powder, skin prep and eakin was explained.

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

Next practicum day, my preceptor and I will be headed to the critical care unit so we can focus on other wounds besides vacs.

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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