

Daily Journal Entry with Plan of Care & Chart NoteStudent Name: Aislinn Van Tyne Day/Date: Wednesday June 11, 2025Number of Clinical Hours Today: 9Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Jessica LawsonClinical Focus: Wound Ostomy Continence **Reflection: Describe your patient encounters & types of patients seen.**

Today we saw a patient with a high output stoma that needed assistance placing their pouch due to weakness from dehydration. A patient who required 3 separate pouches to be changed, one a high output ileostomy, another for a leaking g-tube, and another for an old drain site. A patient who had recently had surgery and will be returning to the OR that had prior experience with a past stoma but needed to be refit for their new stoma near a fresh incision. One patient was too uncomfortable and nauseous to let us attempt a lesson or pouch change and requested to be seen another day. We also saw one patient that was in the emergency department and needed a urine sample from their urostomy and the ED nurse requested that we complete the request because they had never performed one, it was rather straight forward and similar to a regular straight catheterization, I enjoyed getting to learn how to complete the procedure. Lastly, we saw a patient who provided the first post operative teaching for themselves and their spouse for a newly made colostomy.

Chart note:**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	3
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	1
Total	12

Patient with a PMH of nephrolithiasis, pulmonary embolism, LAMN s/p R hemicolectomy, omentectomy, splenectomy, and peritoneal stripping c/b recurrence s/p 12 cycles exploratory laparotomy, LO, TPC, EI, HIPEC. The patient recently was found to have a perihepatic capsular disease burden and pelvic masses in the bowel loops.

Surgical history:

-Mucinous adenocarcinoma

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-lap RT, hemicolectomy, splenectomy, stripping diaphragm RUQ, LLQ, Peritoneal layer, Omentectomy
-Debulking

BP 102/69, Pulse 73, Temp 36.7 degrees C oral, RR 16, SpO2 97% on room air

Height 185.4 cm, weight 73.4 kg

Assessment within normal limits except,

Lungs; RML & RLL diminished lung sounds

Abdomen: soft, non-tender, abdominal mass felt during palpation,

Abdominal CT:

Pseudomyxoma peritonei appears mildly increased compared to prior scan. No bowel obstruction.

Redemonstrated extensive right and lesser left lung pleural disease burden Trace left pleural effusion.

Patient is in the ICU post exploratory laparotomy, extensive lysis of adhesions for greater than 4 hours, takedown of end ileostomy and small bowel resection with creation of new end ileostomy, cystoscopy, and bilateral ureteral catheters by urology.

Surgery showed the presence of residual disease in the abdomen that will require patient to go back to the OR for further debulking.

Patient is being seen today for initial post operative pouch change, they are familiar with pouching as the patient had an end ileostomy prior and was fully independent with changes. Family members are at bedside.

Assessment

Type-ileostomy

Location- RUQ

Protrusion- Budded

Mucosal condition and color- red and moist

Mucocutaneous junction- intact

Output- bowel sweat.

Peristomal skin- clear and intact

ET peristomal contour- rounded with multiple small skin creases between 3-4 o'clock close the midline incision.

Supportive tissue- semisoft

Incision:

Degree of approximation: 100%

Approximating devices: sutures

Drainage- Serosanguinous

Method of management- dry sterile dressing

During the pouch change the incision dressing became saturated with serosanguinous drainage and stool, a dry sterile dressing was replaced on top and adhered with paper tape around the edges.

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Patient was placed in a similar pouching system to what they wore prior to surgery, due to the possibility of patient returning to the Operating Room tomorrow, the pouch was cut and placed away from midline incision.

Placed pouching system- 2 ¼” Hollister New Image Convex Flange cut to fit 2 1/8” (trimmed close to incision) with a Cera Ring placed around the flange opening, Hollister New Image high output pouch, and Coloplast Brava Strip paste to skin creases. With Hy-type strips applied around the outside of the pouch.

WOC Plan of Care (include specific products)

-Request that the patient be given pain medications at least 30 minutes prior to pouch changes

-Prepare the pouch

Hollister new image Convex Flange (With 6-11 o'clock cut off to allow for incision space to stay open)

Hollister high output pouch

Coloplast Brava Strip paste

-Remove the worn pouch.

Apply an ample amount of adhesive remover liquid or spray to the exterior of the pouch to decrease the risk of patient discomfort.

Apply light pressure on the skin with

Gently pulling the pouch from the skin with the other hand

-Cleanse the skin around the stoma with warm water and non-moisturizing soap, rise skin, and gently pat dry

Apply Hollister Cera ring directly to around stoma and place a small strip of Coloplast Brava Strip paste to the skin crease located between 3-4 o'clock. Apply Hollister New image Convex flange over top of the cera ring making sure to achieve a budding stoma in the middle of the flange, then connect the Hollister high output pouch to the flange (making sure to fully achieve a good connection between pieces)

Apply hy-tape on area beside incision where flange was cut short to prevent pouch leakage.

Patient will need to be reevaluated for correct pouching system after returning the Operating Room in case additional changes the patient's skin occur.

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

I would have given the patient more pain medications and asked the patients' family to step into the hallway. The patient was experiencing some discomfort when the pouch was being removed and when pressing to help the pouch to adhere, due to the wounds being new. If I had the opportunity I would have had the patient medicated shortly before our arrival. There also were some concerns with us moving around the bed in such a tight space, it would have been more efficient for our time to request the family to step out, as teaching would not be occurring at this time and it was instead a scheduled pouch change.

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Goals
What was your goal for the day?

To see and care for wounds. My goal was not fully met today, NPWT dressings are often changed by WOC nurses on Mondays and Fridays so I will get more opportunities to see wounds inpatient on Friday.

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

I am told that most of the wounds are only treated by APRNs so hopefully tomorrow I will get the opportunity to see some outpatient.

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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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	

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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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