



R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Birgitte Kammerdiener Day/Date: Friday September 19th

Number of Clinical Hours Today: 8 Number of patients seen 5

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Adam Shaw

Clinical 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, and any additional activities.

Today was spent in-patient with the WOC team. My preceptor was Adam Shaw CWOCN. Today I felt as though I had gotten the full wound, ostomy and continence experience as I had seen at minimum one patient for each. Part of the day I was able to experience and be hands on with NPWT changes. Many of these patients were premedicated for pain by the bedside nurse prior to taking down the wound vac. A few of them did need breaks throughout the change due to pain with either drape or foam removal. I took measurements and assessed each wound for tissue type, depth, undermining and tunneling. A couple of the ostomy patients I saw were for leaking pouches. We took the time to assess where the leaking was occurring and how we could change the pouching system to prevent the leaks from occurring. A large part of my clinical day was spent educating a patient who has both a Monti conduit and K-pouch due to neurogenic bowel and bladder from a cervical injury. The patient had limited movement in her hands but was very determined to complete care hands on. She required minimal help throughout cleansing, irrigation and care of the catheter. This patient is also to be discharged soon so I was able to experience the education and watch as the patient performed emergency extubation and reintubation. This patient was a great learning experience for the continence focus and how these two procedures allowed her to become continent and experience control over her bladder and bowels again. This patient is who I have chosen to write my journal on as the K-pouch and Monti bladder are not seen very often.

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient

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encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that was **done** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:
Braden Risk Assessment Tool

Sensory Perception	2
Moisture	3
Activity	2
Mobility	2
Nutrition	3
Friction/Shear	2
Total	14

Chart Review/history

Age/sex: 31 year old female

PMH: asthma, ADHD, depression, C6 cervical fracture, neurogenic bladder, neurogenic bowel

HPI: Patient presents to clinic for planned surgical creation of K-pouch/continent ileostomy and revision of Monti conduit. Patient had a cervical injury that resulted in paraplegia and neurogenic bowel and bladder. Patient was experiencing neurogenic bowel and severe hemorrhoids. Patient was given the options of a colostomy, ileostomy or K-pouch. Patient was educated on each surgery and wished to proceed with the K-pouch.

Social hx: Resides at home with 24hour nurses and family nearby. No tobacco use, occasional alcohol use, prescribed medical marijuana edible as needed

Assessment/encounter:

Patient being seen for continued education of K-pouch. patient presents alert and oriented and sitting up in bed. Patient is paraplegic and requires assistance with transferring from bed to wheelchair. Patient also has limited use of her hands. Patient is familiar with care of Monti conduit and continues education with urology and WOC nursing. Patient chose to focus today's lesson on the K-pouch and due to planned discharge is requiring education on emergency extubation and reintubation

Stoma: red, moist, flush, mucocutaneous junction intact. Stoma intubation in place with Marlen 30 Fr.

Straight catheter and secured with face plate, baby bottle nipple, adhesive tape and turbot belt

Stoma size: 7/8"

Shape: Round

Drainage: watery green/brown with flecks of mucous shreds. Draining through catheter connected to gravity drainage bag

Peri-stomal skin: fungal rash circumferentially. Applied stoma powder and skin barrier wipe. One package of split gauze placed around catheter and in between skin and face plate, secured with tape.

Abdominal plane: Flat, soft

Education:

- Dressing change
- Cleansing of peristomal skin
- Securing catheter to belt

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- Irrigation of K-pouch through catheter
- Emergency extubation and re-intubation

Treatment

- Peristomal skin irritation cleansed and pat dry, applied stoma powder followed by skin barrier wipe.
- Catheter secured to belt to prevent pulling.
- Catheter irrigated with 60 cc of normal saline x 3 (orders for irrigation every 4 hours with 60cc increments of normal saline allowed to drain in between each instillation) return of irrigation brisk, complete with small amount of mucous shreds, catheter not moved during this visit

Chart Note:

Patient is a 31 year old female with a history of asthma, ADHD, depression, a C6 cervical fracture resulting in paraplegia and neurogenic bladder and bowel. Patient currently resides at home with 24 hour care and family nearby. Patient requires a wheelchair to get around and has limited movement of her hands. Patient presents to the clinic for construction of a K-pouch and revision of her Monti pouch. Patients neurogenic bowel resulted in chronic constipation and severe hemorrhoids. Patient was offered and educated on different surgical procedures. Surgeon discussed a colostomy, ileostomy or K-pouch. patient ultimately decided on the K-pouch as she felt it would provide her with the most control and continence. Patient educated on the risks but was still agreeable and wanting to proceed with the creation of the K-pouch. patient now presents on a regular nursing floor multiple days postop. Patient has begun teaching for both her Monti conduit and K-pouch. While patient has limited movement in her hands, she is extremely motivated and wants to take the time to learn and become as independent with her care as possible. During today visit, patient presented sitting up in bed and stated she is very eager to continue education. Patient also stated she wished to only focus on care of the K-pouch during this visit as she feels less comfortable with it than the Monti conduit. Patient is also nearing discharge, case management is working on the facility that will accept her. Prior to patient discharging, she must complete and emergency extubation and re-intubation of the K-pouch. Patient began by removing old gauze form around the catheter. The stoma was observed and cleansed with warm water and pat dry. Peristomal skin is red and irritated and there is a present fungal rash. Stoma powder and skin barrier wipe were applied prior to the placement of a new packet of gauze. She then disconnected the face plate from the belt. Patient was educated when emergency extubation and reintubation may be required. Patient was also educated on keeping the abdomen relaxed to prevent any resistance of the catheter going back in. the patient then slowly removed the catheter, inspected the end for any signs of blockage and then reintubated to stoma with ease. The face plate was then reconnected to the belt. Patient then disconnected the catheter from the gravity drainage bag and irrigated the catheter with 60 cc of normal saline three times while allowing the catheter to drain between each installation. Return was brisk and complete with a small amount of mucous shreds. Patient then reconnected to gravity drainage. Patient stated she felt much more comfortable having completed emergency extubaton and re-intubation, along with irrigation herself. Patient will require continued education until date of discharge. Both Monti conduit catheter and K-pouch catheter remain connected to gravity drainage. Notify surgeons of any lack of drainage from catheters. Continue to irrigate K-pouch every 4 hours with 60 cc of normal saline and allowing to drain between each instillation. All questions were answered during this visit. Patient encouraged to continue completing hands on care of both catheters while in the hospital.

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)

- Consult primary for fungal powder, apply daily and with each dressing change as needed
- Continue education of both Monti conduit and K-pouch until patient discharges
- Cleanse peristomal areas with warm water and pat dry. Use stoma powder and skin barrier wipe as

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needed.

- Apply one package of split gauze around each catheter and stoma
- Continue irrigation of K-pouch every 4 hours with 60 cc increments, allow to drain between each installation
- Continue connection to gravity drainage bag for both catheters
- Turn and reposition patient every 2 hours while in bed
- Up to chair daily
- Continue to encourage patient to participate in hands on care
- Notify urology if Monti conduit no longer draining
- Notify colorectal if K-pouch no longer draining
- Consult occupational therapy for assessment and treatment of ADLs
- Consult to case management for discharge plans and potential LTACH vs acute rehab
- Consult to physical therapy to continue improving strength
- Consult to psychology for emotional support and coping mechanisms
- Patient to return for post operative visit in two weeks following date of discharge

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

The only thing I would have done differently during the visit with this patient would be to have assessed their ability to care for the Monti conduit. The patient is very motivated to learn and be able to care for themselves. The patient had chosen to focus on the K-pouch during the visit. I would have rounded back to the patient later to observe and continue education with the patient on their Monti conduit.

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 for the day was to see an irrigation. In a way I definitely did so I would say my goal was met and exceeded. The patient I saw was a great example of continence concerns and the surgical procedures that can make the patient continent again.

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

Monday I am back in the outpatient clinic with the ostomy nurses. My goal is to see more stoma markings and pre-op education on the stoma that will be created.

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For instructor use only. Do not remove or edit:

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

Reviewed by: _____ Date: _____

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