

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

Student Name: Jennifer Young Day/Date: 12/28/2021

**Directions: WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, select one patient each clinical day and complete *plan of care and chart note*..** This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. **Journals should be submitted to your dropbox by no later than 48 hours following the clinical experience day.**

<b>Today's WOC specific assessment</b>	<p>The patient is a 68 year old male that I am seeing initially for a possible pressure injury but also has a Peg tube. <u>Noted.</u></p> <p>The patient had numerous teeth pulled at the end of October 2021. He came to the ED on 11/11/21 for an increase in swelling to the right side of his face, increased pain to his jaw and mouth. <u>Noted.</u> He states he went to an outside hospital where they "gave him mouthwash" and sent him home. The patient had X-rays and was scoped by ENT. A 5.3x4.5x4.8cm tumor was seen in his right masticular space concerning for malignancy. Biopsies were taken. The patient was diagnosed with moderate erosive esophagitis and positive for invasive squamous cell carcinoma. <u>Oh, my!</u></p> <p>Oncology was consulted and the patient had a Peg tube placed on 12/15/21. He had started chemo with his last treatment on 12/23/21. The patient came to the hospital on 12/26/21 for increased weakness and confusion and was admitted to the ICU. <u>Noted.</u> His Sodium level was 114. <u>Noted.</u> There was some coffee ground drainage coming from around his Peg tube. GI saw the patient and ensured that his Peg was in the right place, the physician moved the bumper from #3.5 to #4. He was placed on a PPI, his H and H is stable. <u>Noted.</u></p> <p>The patient has smoked cigarettes for 50 years, a pack a day. He admits to occasional alcohol and no illicit drugs. He lives with his wife at home. He has no previous surgery history other than his teeth extractions. <u>Noted.</u></p>
--	---

**Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:**

I entered the room and found the patient sitting up in bed with his wife at bedside. I initially looked at the patient's skin including his buttocks as that was my initial reason for the consult. He has a small 1.2x1cm reddish area (I would just give the dimensions and leave out the small; folks can tell it is small by the dimensions). to the middle of his left buttock. It is blanchable and there is no open tissue. The patient states it feels like he "scraped" the area and has been in bed more often lately due to feeling weak. Noted. His wife states this is true - that he is typically ambulatory, but the last few days he has been in bed. I don't believe this is a pressure injury, but I will monitor. By definition, blanchable erythema is NOT a PI.-I agree. I would simply state this is not a PI (although it is your opinion, it is also by definition). I would state this is not a PI, but the person is at risk for developing a PI, so the following interventions will be initiated: then list out what you want done/recommend.

The patient's skin is intact except for the area around his LLQ Peg tube. There is a 0.3cm erythemic ring around the tube insertion site. Noted. There is minimal tan drainage present around the tube, on the bumper and on the abdominal binder. I cleansed the area with warm water. The patient's wife tells me the GI doctor moved the bumper from #3.5 to #4 yesterday as

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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

there was a lot more drainage then and it was darker in appearance. Okay. She is worried about how she will keep his skin clean and intact. There is no open tissue. The peritubular skin appears irritated from the drainage. I demonstrated to her how to cleanse the skin simply with warm water, and then applied a thin layer of barrier ointment to the peritubular skin. Okay. I rotated the bumper but made sure the bumper stayed at #4 per the physician. Good. I taught the patient and his wife to keep the area by simply wiping any drainage, keeping the skin dry. Okay. Barrier ointment will be ordered per physician for skin protection.

The patient's abdominal binder was reapplied being careful to keep the tube stabilized and not pressing in to the patient's skin. A cotton cloth was placed around the tubing for extra protection. Okay.

The patient was awake and cooperative. He appears to understand to keep the skin around the tube dry. Tube feeding was infusing and there appears to be no clogging. The patient is comfortable, does not complain of pain and states he feels better than he did at admission. (He is being gently rehydrated). Okay.

We discussed if he is able to eat. His doctors tell him he can eat whatever he can tolerate. His wife has been making him soups, he will eat scrambled eggs. His appetite is poor, but he tells me he is trying to eat a little more each day. Okay.

WOC specific medical & nursing diagnosis	WOC Directive Plan of Care (Base this on the above data. Include specific products)	Rationale ( <i>Explain why an intervention was chosen; purpose</i> )
<p><i>Wound/skin care – at risk for skin breakdown</i> <u>Okay.</u></p> <p><i>Tube stabilization</i> <u>Yes.</u></p>	<ol style="list-style-type: none"> <li><i>The patient/caregiver should inspect the peritubular skin at least daily – possibly 2-3 times a day. <u>If there is drainage I would agree more would be okay; otherwise once a day is okay.</u> Inspect the skin for any redness, ulceration, drainage present on skin. Ensure that the external bumper is where it is supposed to be. <u>Yes—write what number they should be looking for.</u></i></li> <li><i>Cleanse any drainage with warm water and a cotton cloth. Soap and water may be used if needed. <u>Yes; if there is crusting, you can use a cotton tip applicator to help clean around the tube. Works well.</u></i></li> <li><i>If the peritubular skin is irritated, you may apply a thin layer of barrier ointment/paste to the tissue. <u>Okay; be sure people know what you mean by paste (not ostomy paste).</u></i></li> <li><i>If a fungal infection is indicated by <u>white pustules on an erythemic base with itchiness,</u> an anti fungal powder may be prescribed by the provider. <u>Be sure to brush off excess. Apply after cleansing skin and prior to applying any skin protective ointment.</u></i></li> </ol>	<p>The patient already had some drainage that has irritated his skin. I want to make sure his skin remains as dry as possible and that his Peg tube is stabilized. I understand that stabilization is key to preventing skin breakdown. <u>Yes.</u></p> <p>I used Calmoseptine to provide a thin layer of barrier. <u>Okay.</u> We should use a product that will protect skin. Hypergranulation and ulcers under the bumper are potential complications. Assessment of the skin daily and more will help to deter this. <u>Yes; hypergranulation occurs if the tube moves or there is a lot of moisture.</u></p> <p>The binder should fit tightly but not too tight that it is uncomfortable to</p>

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

<p><i>At risk for dehydration/nutritional deficits</i></p> <p><i>Potential for tube being clogged <u>Okay, very real problem.</u></i></p> <p><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:</i></p>	<ol style="list-style-type: none"> <li>5. <b>Monitor for signs of hypergranulation or ulceration. <u>Okay.</u></b></li> <li>6. <b>Rotate the external bumper daily, ensuring that the bumper remains at the prescribed number per the physician, which is . . . <u>You want the external bumper to rest without tension on the skin. .</u></b></li> <li>7. <b>You may cover the external bumper to absorb moisture using a hydrocolloid or foam dressing over the bumper. <u>Can use gauze if there is no to minimal drainage. If there is no drainage, you can leave the site open to the air after a week. DO not place these products under the bumper unless advised to do by the physician. I would just use the foam or gauze (I personally think this will work better—hydrocolloids will gel with moisture, so they may actually contribute to the problem. I also think they will be harder to remove from the bumper (personal opinion).</u></b></li> <li>8. <b>(You may want to e) Ensure stabilization with a binder. <u>Remember you are telling staff/patient what you want them to do; I would just write it as a statement. If you are not using a binder, you can stabilize the tube with a tube stabilization device, such as one used with indwelling catheter tubes.</u></b></li> <li>9. <b>Assess the patient for skin breakdown to bony prominences secondary to poor nutrition, bedrest. Fluid immersion or low air loss bed should be ordered and well as teaching and encouraging the patient to rotate side to side, limit lying on his back and sitting for long periods of time. <u>Okay. Why are you using the fluid immersion/low air loss bed? What is his Braden risk score? If he is turning from side to side and getting up, another choice might be beneficial i.e. air mattress or gel pad, depending on what your facility has. If you do not have these available to you, I would go with the low air loss as the fluid immersion is more in line with high air loss (bead beds). I would also use of a seating cushion when up. Make sure a turning schedule is in place (the nurses may need to remind the patient instead</u></b></li> </ol>	<p>the patient and does not cause more skin irritation with the tubing/bumper. <u>Yes.</u></p> <p>The patient already has a decreased appetite, Due to his diagnosis, he may not be able to take much in orally. It will be important that his labs are monitored (electrolytes, prealbumin), intake and output are monitored. He is at risk for decreased appetite secondary to nausea due to chemo medications. <u>Okay.</u></p> <p>If the patient’s Peg tube becomes clogged his nutrition will be affected as will his ability to take medications. Keeping the tube clog free is <u>I</u>important for this patient. <u>Agreed.</u></p>
---	--	--

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

	<p><u>of doing an actual turn as the patient seems alert/oriented/capable of changing positions).</u></p> <p>10. <u>Head of bed elevated</u></p> <ol style="list-style-type: none"> <li>1. <u>Consult dietician for correct tube feeding rate, free water flushes and necessary nutrients/electrolyte/caloric intake. Yes. Flushing is usually done with 30 mL of water before and after each feeding; with medication administration, one should use 15 mL water before and after medication administration of each med.</u></li> <li>2. <u>Encourage fluid intake as prescribed by provider. Yes. This needs included in free water amount if such is prescribed by the LIP.</u></li> <li>3. <u>Monitor for diarrhea. Dehydration and electrolyte imbalances can be a concern. Yes.</u></li> <li>4. <u>Encourage oral intake as indicated by provider. Supplements may be advised not only due to Peg tube and decreased PO intake but for chemo/radiation treatment nourishment. Okay. Need to monitor intake ingestion of supplements (we see a lot of cans of supplement at the bedside that the patient does not actually get ingested!).</u></li> </ol> <ol style="list-style-type: none"> <li>1. <u>Speak with the physician to see if any medications can be changed from pill to liquid form. Crush any pills prior to administration being careful to identify any extended release pills. Yes. You can touch base with the pharmacist about this as well.</u></li> <li>2. <u>Flush Peg tube with water prior to and after medication administration. See above for amount of water to be used. Be specific.</u></li> <li>3. <u>Ensure free water flushes are programmed in to tube feeding infusion. Good.</u></li> <li>4. <u>If the tubing becomes clogged, flush with warm water or carbonated beverage. Carbonated beverages are not</u></li> </ol>	
--	--	--

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

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

	<p><u>recommended as they can further the obstruction. You should use warm water, using a 60 mL syringe with a push pull motion. If that does not work, the Clog Zapper can be used or you can pancreatic enzyme tablet and one sodium bicarb tablet crushed and mixed in 5-10 mL of water.</u> Clog Zapper is a product that may be useful to have on hand in case of a clog. <u>Okay.</u></p> <p>5.—</p>	
--	--	--

<p><b>What are the disadvantages of using this product(s)? What alternatives could be used and why?</b></p> <p>(This is your opportunity to share your product knowledge and apply critical thinking)</p>	<p><i>I am not sure that there are other Peg tubes that would be better. If this becomes dislodged, the patient should go to the ED for replacement as soon possible. <u>True.</u> The tube shouldn't be replaced by the patient as it could be placed in the wrong area (between the abdominal wall and stomach). <u>Yes; this type of tube is placed by the GI doc under scope observation.</u> Placement should always be checked by a professional. <u>Yes, usually an x-ray is take after tube placement.</u> At my hospital, the policy is that we do not replace the tube <u>Okay.</u> A rubber catheter has been recommended as an alternative. However, these catheters are not designed to stand up to gastric drainage so should not be utilized for any length of time.</i></p>
---	---

**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<p><b>Were you able to meet your learning goals for today? Why or why not?</b></p>	<p>I am glad I had the opportunity to work with a Peg tube that is fairly new for the patient and his wife. They had a lot of questions about care of the Peg and I was able to answer them. They both were grateful that I came to see them. <u>Noted.</u></p>
<p><b>What are your learning goals for tomorrow?</b></p> <p><b>(Share learning goal with preceptor)</b></p>	<p>I am hoping to complete pre op stomal marking with a patient. If that is not available, I will perform this on a "volunteer" and submit. <u>Okay.</u></p> <p>I also want to continue learning about challenging ostomies – convex, high output, flat, 2 piece systems. Prolapsed stomas, peristomal hernias, belts....<u>Excellent.</u></p>

Number of Clinical Hours Today: 0700-1530, 8 hours Noted, thank you!

My clinical dates so far have been: 12/10/21 - 0700-1530 12/16/21 - 0700-1530 12/21/21-0700-1530 12/28/21 - 0700-1530 Each day I have completed 8 hours of clinical time. Let me know if you need any thing else from me. Thanks, Jen

Care Setting:  Hospital  Ambulatory Care  Home Care  Other: \_\_\_\_\_

Number of patients seen today: 12 Noted. Preceptor: Rose Konsel

Reviewed by: Barbara J. Hocevar, MSN, RN, CWOCN; December 3, 2022

**\*\*References are not generally required for daily journals**

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.