

Daily Journal Entry with Plan of Care & Chart Note

 Student Name: Erika Martin

 Journal Completion Date: 12/14/22

 Setting: Acute Care Outpatient HHC Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	89 year old male, PMH of afib, CAD, diabetes, and dementia. Patient is non-verbal and not oriented. Patient presented to emergency room via ambulance from nursing home for left-sided facial drooping.
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Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

WOC nurse consulted by primary nurse due to concerns for red skin on buttocks and perineal area after arriving from nursing home in urine-soaked brief. Chart reviewed. History of urinary and fecal incontinence, poor appetite requires to be fed. Patient appears comfortable in bed positioned on back, with eyes open. Non-verbal and follows commands. Cooperative. Prior to this visit, nursing placed external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment. Skin assessment notes intact, blanchable, erythema to perineal area. Pt repositioned onto left side. Constant oozing of loose, brown stool. Area cleansed with pH balanced cleanser and patted dry. No evidence of skin breakdown. Evaluation finds pt is appropriate for FMS. Male external fecal pouch applied to patient and attached to drainage bag. Clean disposable blue underpad placed under patient. Patient remains positioned on left side.

Assessment: Fecal and urinary incontinence

Recommendations:

- Hourly checks to include evaluation of containment devices
- Initiate bowel program to bulk stools if no medical contraindication
- pressure redistribution measures

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.	Statements should be directive and holistic relating to the problem/concern.	Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.

(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>1. Impaired skin integrity related to poor nutritional status and incontinence as evidenced by alterations in skin color.</p>	<p>Perform hourly checks to evaluate function of containment devices.</p> <p>Perform frequent bed turning for at least every 2 hours. Prescribe a pressure-relieving mattress and trochanter rolls on bony prominences.</p> <p>Perform skin assessments every shift using the Braden Skin Assessment Scale to assist in determining the patient’s risk for pressure injuries.</p> <p>Evaluate the patient’s own strength to move, shift weight while sitting, turn over in bed, and move from bed to chair.</p>	<p>To ensure the devices are properly functioning, positioned correctly, intact, and not obstructed.</p> <p>To reduce the pressure from the affected area and other bony prominences.</p> <p>This is a widely used scale. It consists of six subscales: sensory, perception, moisture, activity and mobility, nutrition, and friction/shear.</p> <p>The greatest risk factor in skin breakdown is immobility.</p>
<p>2. Imbalanced Nutrition: Less Than Body Requirements</p>	<p>Obtain the patient’s exact body weight, height, BMI, and determine weight loss by reviewing medical records.</p> <p>Assess the patient’s nutritional status using the Nutritional Risk Screening 2002 (NRS-2002) and obtain serum albumin levels.</p> <p>Offer high protein and liquid energy supplements based on individual needs and capabilities.</p>	<p>A very low BMI can signify various health problems, including malnutrition, anemia, decreased immune function, vitamin deficiencies, and bone loss.</p> <p>Nutritional assessments help distinguish if there is a nutrition issue, identify the problem, and determine the severity. An albumin level less than 2.5 g/dL is a grave sign, indicating severe protein depletion and at high-risk of skin breakdown.</p> <p>Such supplements can increase calories, protein, and weight gain without conflict with voluntary food intake.</p>

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not?	
What are your learning goals for tomorrow? (Share learning goal with preceptor)	I would love to apply an external or internal fecal management system.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	N/A
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Reviewed by: _____ Date: _____

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