

Daily Journal Entry with Plan of Care & Chart Note

Student Name:

Day/Date:

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.***

Today's WOC specific assessment	<p>A 45 y/o female with past medical history of anemia, anxiety, fibromyalgia, hypercalcemia, major depressive disorder recurrent with severe psychotic symptoms, and tongue carcinoma. S/P surgery and chemoradiation. Patient admitted on 05/10 and discharged 05/25 to home. Patient returned to the emergency room on 06/04 with recurrent tongue lesion with metastasis to the lung, altered mental status. Chest CT demonstrated pneumoperitoneum, pneumomediastinum, and right pneumothorax secondary to perforated sigmoid colon. Patient was taken to the operation room for exploratory laparotomy, right chest tube placement, evacuation of a large pelvic abscess, and creation of a LUQ colostomy. Being followed by HHC.</p> <p>Labs: Na 133mmol/L, K 4.3mmol/L, Cl 101mmol/L, BUN 20mg/dL, Glu 125mg/dL, Cr. 0.72mg/dL, Ca 8.5mg/dL, Mg 1.9mg/dL, WBC7.0 10e9/L, Hgb 9.7g/dL, HCT 30.2 %, PLT 245 10e9/L</p>
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Write a chart note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

WOC services consulted by plastic surgery service for ostomy evaluation and management. Patient presented to the clinic accompanied by spouse. Patient reports she changes her own ostomy appliance with wear time of 1-3 days and empties pouch 2-3 times per day. Utilizing one piece cut to fit Hollister pouching system with flat skin barrier wafer and Eakin ring. Reports pain of 5/10 with appliance in place. Using OTC acetaminophen to manage with dose of extra strength taken 1 hour before visit. Reports pain as 2/10 at present. Voices desire to learn about irrigations and if this in an option for her. Patient also reports she is on tube feeding Isosource 1.5cal 4 cans per day via G-tube. Reports weight loss of 25lbs since surgery. Weight 148lbs before surgery and 123lbs currently. Patient instructed to continue tube feedings as ordered and to call PCP. Dietician consult placed. Pt agreeable to assessment. Spouse remains at bedside. "He wants to learn too since he is my support at home." G-tube site gauze dressing removed. Site cleanse with water, pat dry.

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Periostomal skin intact and without irritation. No leakage noted. Site left open to air. Education provided regarding tube securement. Tube securement device applied. Colostomy pouch with brown pastey output. Skin barrier wafer noted to be cut larger than stoma size. States "I've been cutting it the same size since I left the hospital." Appliance removed to colostomy. Back of skin barrier wafer assessed and noted to have area of erosion at 6 o'clock. Skin barrier ring enlarged. Area cleansed with warm wash cloth. Periostomal skin red, denuded, and erythematous circumferentially to stoma. Stoma red, moist, and protrudes slightly above skin level. Abd soft to palpation. Voices increase of pain to 8/10. Encouraging deep breathing and using distraction to manage. Thin hydrocolloid dressing applied to periostomal irritation followed by firm convex one piece Hollister appliance. Demonstration and explanation of procedure along with appropriate sizing of stoma opening provided. Verbalized understanding expressing ability to perform. Written instructions provided for g-tube and ostomy care. Extra appliance provided. Information provided regarding colostomy irrigations for pt to review. Aware of need for formed stools before can consider as an option. Pt and spouse verbalize understanding of teaching and POC. Agreeable. HHC and plastic surgeon provided visit information and note. HHC to begin supplying new products. Follow-up apt made for one week.

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>What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why?</p> <p>(This is your opportunity to share your product knowledge and apply critical thinking)</p>	
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Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	
What are your learning goals for tomorrow? (Share learning goal with preceptor)	

Number of Clinical Hours Today:

Care Setting: Hospital Ambulatory Care Home Care Other: _____

Number of patients seen today: ___ Preceptor: _____

Reviewed by: _____ Date: _____

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

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