

Daily Journal Entry with Plan of Care & Medical Record Note

 Student Name: Wendy Kye

 Day/Date: 05/10/2023

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 you are acting as a nurse specialist; 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. Include pertinent past medical & surgical history and medications.	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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Write a comprehensive and understandable medical record note for the medical record for this patient encounter. Be sure to include specific products that were used/recommended for use:

<p>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 with identification of urinary and fecal incontinence. Constant oozing of loose stool. External catheter placed by nursing. Appetite is poor and requires to be fed. Patient appears comfortable in bed positioned on back, with eyes open. Non-verbal and follows commands. Cooperative. Noted to have disposable blue underpad in place. Small amount of clear to yellow urine noted on underpad. External catheter in place and connected to gravity drainage. Draining yellow colored urine without sediment. Skin assessment notes intact, blanchable, erythema to perineal area. Pt repositioned onto left side. Noted to have 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.</p>
<p>Assessment: Fecal and urinary incontinence</p>
<p>Recommendations: -Hourly checks to include evaluation of incontinence devices -Initiate bowel program to bulk stools if no medical contraindication - pressure redistribution measure</p>

WOC Nursing Problem pertinent to this visit	WOC Directive Plan of Care (Base this on the above data. Include specific products)	Rationale (Explain why an intervention was chosen; purpose)

What are the disadvantages of using this product(s)?	
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What alternative product(s) could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	
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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/types of patients seen today: _____ Preceptor: _____

Reviewed by: _____ Date: _____

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