Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Hannah Smith_____ Day/Date: __6/3/25_____

Number of Clinical Hours Today: _8___

Care Setting: Hospital ___ Ambulatory Care _X___ Home Care ____ Other ___

Preceptor: __Karen O'Brien_____

Clinical Focus: Wound ____ Ostomy _X___ 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.

Bladder CA: stoma mark
Post op: new system applied, difficult d/t folds
Yearly visit: slight irritation, system change
Stoma marking

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

Chart note:

Pt is a 70 year old with no significant PMH, with a new diagnosis of muscle invasive bladder cancer. CTU done showing prostatomegaly. CT chest showing pulmonary nodule in L upper lobe. Pathology review revealed invasive high-grade carcinoma with squamous and sarcoma differentiation. Pt with a two-pack a day smoking history. Current medications include zinc sulfate, multivitamin, fish oil oral, and ascorbic acid. Pt presents for preop pmarking with scheduled OR on 6/5/25 for cystoprostatectomy with end ileal conduit creation. Pt here with daughter. Pt very anxious throughout visit and daughter extremely supportive.

Patient watched preop stoma videa and all questions answered. Patient approved tattoo and is aware is permanent if no stoma is placed at that site.

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)

Explained to pt stoma marking purpose and procedure. The patient verbalized understanding and agreed to the marking. Rectus muscle boarders were located. Abdominal contour evaluation was performed in the lying, sitting, and standing position. The stoma marking was made according to ET/WOC Nursing Procedure #401 in the RUQ. Pt is able to see the site in the lying, sitting, and standing position.

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

It was very rewarding that the thorough education provided to the patient allowed him to be more at ease throughout the visit. Looking back, more resources could have been provided to the patient, such as information on support groups, to let him know he isn’t alone.

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? Gain confidence with stoma marking
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Gain confidence with establishing a wound plan of care

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CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
• Completes Braden Scale for inpatient encounter	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	
• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Braden subscales addressed (if pertinent)	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		

• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____