

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

 Student Name: H Alexis Seris Espinal \_\_\_\_\_ Day/Date:  
 6/2/2025\_\_\_\_\_

 Number of Clinical Hours Today: 8

 Care Setting: Hospital  Ambulatory Care  Home Care  Other 

Preceptor: Kerry Sherman APP Coordinator \_\_\_\_\_

 Clinical Focus: Wound  Ostomy  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.**

All patients were encountered in Dr.Spivak's colorectal surgery for women in the outpatient clinic. Today, patients are seen for a variety of diagnoses and symptoms. These patients all had a chief complaint of fecal incontinence or chronic constipation. All symptoms were related to or a result of perianal fistula, rectal prolapse, gastroparesis, and cancer treatment or diagnosis.

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:**
**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	3

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Activity	4
Mobility	4
Nutrition	2
Friction/Shear	3
Total	19

**Manometry Procedure:**

First, encountered a patient in exam room. The patient's chief complaint of chronic constipation and inability to completely evacuate. PMH of HTN, HLD, and Chronic Constipation. Pt reports, "My last bowel movement was two days ago." Pt declined the use of a fleet enema before the Manometry procedure. Explained procedure and Pt was agreeable to undergo manometry. Procedure and instruction provided by Jessica Sankovic PA-C and RN in clinic.

Provided patient privacy to remove pants and underpants. Instructed Pt to lie on the left side and cover with sheet as draping. Digital rectal exam performed by RN. The presence of stool noted during digital rectal exam and on the gloved index finger.

Applied water-soluble lubricant to balloon on the end of the catheter. Catheter slowly inserted into Pt anus to rectum. Allowed balloon to adjust to rectum's pressure at rest for 2 minutes. Then asked Pt to squeeze rectal muscles and allow Pt to rest. Pt then asked to squeeze and hold muscles for 30 seconds, 1 and 2 minutes. Pt instructed to cough one time. Repeated this part as Pt coughed multiple times. Next, instructed Pt to bear down as if trying to have a bowel movement. Pt was provided with rest breaks in between periods of squeezing and bearing down.

The balloon at the end of the catheter was then filled with air from manometry machine. Pt asked to state when pressure or sensation is noted. Once noted change in pressure, more air is inflated into the balloon. Pt is then asked to notify us when pressure is increased to where it feels like a bowel movement that can be held. Lastly, more air is inflated in the balloon. The Pt is asked to notify us when the sensation of urgency is felt. The balloon is then deflated and slightly inflated.

Pt assisted to the commode by RN. Pt instructed to attempt to evacuate the balloon catheter on the commode. The Pt is given 2 minutes to try on their own. The 2-minute mark was reached without success of evacuation. RN then deflates the balloon and assists in balloon catheter removal. Pt cleanses the anal area with dry sterile gauze. Provide Pt with privacy to get dressed. Reviewed future orders from today's visit with Dr.Spivak. Pt tolerated the Manometry procedure well.

Time spent with Pt 35 minutes with Jessica Sankovic PA-C and RN present.

Dr.Spivak is made aware and agrees with POC.

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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)**

1. Continue to follow up with Dr.Spivak outpatient
2. Continue current CT and Sitz marker capsule for Transit Time Study without the use of bowel stimulants orders
3. Follow up with Primary Care Provider and Gastrointestinal Provider Outpatient

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

The only comment I have is based on timely care. This patient was scheduled for a follow-up appointment and manometry Procedure. There was a delay in the manometry procedure due to the patient not having financial clearance. The patient was able to see the Provider first but it caused delays in clinic appointments and manometry procedures. At times these situations occur, in which we have to be cognizant of the order of things. I may have aided in the coordination of care to improve timeliness and prevent frustration of patient and staff.

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?**

The goal today was to identify issues of incontinence symptoms and options to relieve or diminish these symptoms. This was met as we discussed and obtained an H&P for the patient. Discussed treatment options and testing to determine causality as well as the appropriate treatment options.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**

Tomorrow may be stoma and skin-related issues. I would like to determine appropriate treatment options such as skin care products, pouching devices, and or need for convexity.

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**For instructor use only. Do not remove or edit:**

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: \_\_\_\_\_

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