Daily Journal Entry with Plan of Care & Chart Note

Student Name: ____Hannah Smith_____ Day/Date: __6/16_____

Number of Clinical Hours Today: __8__

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

Preceptor: __Dr. Spivak & Kerry Sherman_____

Clinical Focus: Wound ____ Ostomy ____ Continence __X__

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.

80-year-old female patient with anal prolapse; discussed surgical options, pt choose abdominal rectopexy and was educated
23 year old female patient with POTS, no muscle tone when rectal exam done, difficult defecating, pt scheduled for permanent stoma placement
74 year old patient with 20 year history of fecal incontinence, non compliant with interventions and treatment, manometry done
55 year old patient with fecal incontinence, Medtronic education(see below)

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 55 year female with a history of colonic polys presents for a scheduled consult for colonoscopy need and fecal incontinence. Pt had her last colonoscopy on 2/24/21 in OR for repair of rectal

prolapse. Done was excision of redundant rectal mucosa with sphincteroplasty and reanastomosis of the rectal plus colonoscopy. Colonoscopy was done in the cecum. No abnormality was seen. Pt presents calm and pleasant. Rectal exam done. Muscle tone is moderate. Small amount of white, thin mucous noted around the anus. No breakdown or other skin issues noted. Current medication list includes calcitiol, levothyroxine, citrucel oral, and crestor. Pt expressed no need to take laxatives or stool softeners. Pt states occasional use of immodium. Pt expressed has been working with a nutritionist and expresses no issues at this time. Pt expresses frustration with managing her fecal incontinence. Pt becomes tearful discussing losing daughter and husband to cancer. Pt given and educated on information on Medtronic. Pt to get labs and colonoscopy and follow up.

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)

Education was provided to pt on all aspects of Interstim. This includes the trial vs. permanent implant process. During the trial, limit bending, stretching, or twisting to prevent lead displacement; keep dressing dry and intact. No showers, sponge baths only, keep a bowel symptom diary by tracking bathroom visits and episodes of incontinence, and schedule a follow up to assess trial effectiveness and discuss results. In the event of a permanent implant, Incision care includes, keep clean and dry & avoid soaking the site (no swimming or baths for 2-4 weeks), No strenuous activities for 2-6 weeks & Avoid pressure on the implant site. The pt would be shown how to use the Device and how to use the remote control to adjust settings and to Report any unusual sensations or reduced effectiveness and that the device battery is

non-rechargeable, battery life is 5-15 years (depending on settings utilized).

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

The patient was educated in a clear and efficient way and all questions by the patient were answered. As aforementioned, the patient started off calm and pleasant but became tearful in the middle of the visit discussing hardships. I would have asked the patient more open ended questions in order to help gauge how to help manage this stress the best, which could potentially help with the stress of managing fecal incontinence. I would recommend support groups and stress relieving techniques.

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?

Goal on monday with new preceptor will be to continue to gain confident in my WOC skills. Goal Met. Gained confident in communicating with patient during tough times regarding frustration with incontinence. Learned good techniques from preceptor.

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

Do an ostomy pouch change independently with light preceptor guidance.

For instructor use only. Do <u>not</u> 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: _____