



R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _____ Alice Pownall-Gray _____ Day/Date:
_____ 9/18/2025 _____

Number of Clinical Hours Today: 8 Number of patients seen 5

Care Setting: Hospital _____ Ambulatory Care x Home Care _____ Other _____

Preceptor: _____ Stacy Bisler-Theus APRN and Jessica Sankovic PA-C _____

Clinical Focus: Wound _____ Ostomy x 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, and any additional activities.

Today I was supposed to precept with a NP all day however, her schedule fell apart and the Pac in her office had me follow her most of the day. The patient encounters I had today included a 75-year-old- female with a history of stool incontinence being seen for anorectal manometry testing, and a subsequent visit with the APRN for a plan of care and results of testing. I will write up this patient, as I was able participate in her education of pelvic therapy education and planning. The next patient we saw had a 70-year-old male who was seen following a J-pouch creation due to Crohn’s disease. The next patient was a 34-year-old pt with Crohn’s disease who had been suffering from pouchitis and had a difficulty emptying her J-pouch, she also had an anal fissure. This patient had not made follow up appointments and she was not adherent o her follow up care. This patient was challenging due to her not following through with plan of care, however during the visit she was very receptive to the education. She was agreeable for nutrition counseling as well as the possibility she may need to have her J-pouch revised and need a ileostomy in the future. The next patient was a 69-year-old male with a history of Crohn’s disease who had an anal fistula. He described he was having pain with his bowel movements and wanted a surgical repair using a fistula plug like one he had had a few years ago. The patient was having body image issues as he was a newlywed. The pt was examined and scheduled for a colonoscopy. He was educated on use of antidiarrheal use. The patient was educated on the risk of the surgery and that it may not work. The patient was then scheduled for a follow up appointment. The next patient I saw was a 59-year-old male with s/p hemorrhoidectomy and was having hyper granulation around his anus. The patient was treated in office with silver nitrate application. The patient tolerated the procedure well. He was educated on reporting any signs or symptoms of infection, wearing pads for any drainage and skin care around his anus as well as diet modifications including fiber intake and use of Metamucil.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was done* during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Braden Risk Assessment Tool

| | |
|--------------------|----|
| Sensory Perception | 4 |
| Moisture | 2 |
| Activity | 3 |
| Mobility | 4 |
| Nutrition | 4 |
| Friction/Shear | 4 |
| Total | 22 |

The patient I saw in clinic today was a 75-year-old female who came in for a manometry test, rectal sensation testing and EMG recruitment. She was accompanied by her husband. The patient has a history of bladder cancer, with Studer pouch in 2001, sigmoid resection for diverticulitis in 2018, multiple small bowel obstructions, depression and arthritis, 3 pregnancies and two vaginal births with tears and stiches, no forceps. She reports her fecal incontinence worsened following her bowel resection. She discussed her stools being rarely formed and having consistency of mush or liquid. The patient has a recent colonoscopy that showed a inflammatory polyp. The patient was offered a defecography

The patient had taken her prep prior to her manometry test. The test was explained to her identification was verified. The patient tolerated the test well; she was however unable to expel the ballon and was assisted by the APRN to remove it. After the test the patient was met in the clinic room, and the test results were explained. During the meeting the patient described that she has stool incontinence daily with defecation or exercise. with some rectal prolapse. She manually pushed the rectum back into her body. She reports some blood at times. She also reports she occasionally had bladder incontinence.

The manometry test revealed she had some weakness in her pelvic muscles.

The patient was referred to pelvic floor physical therapy, to address weakness and improve symptoms She was educated on benefits of fiber supplements to bulk her stool, to start low then increase slowly as needed.

She was asked to take a photo of her prolapse in privacy per her choice and send it into her chart for review. The patient was given an appointment for 3 months return to see if her symptoms improved after having the pelvic physical therapy.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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)

Pt to return in 3 months
Assess effectiveness of her pelvic physical therapy
Assess if rectal prolapse has improved or worsened.
Assess diet and nutrition and use of fiber supplements and effectiveness of the
Assess pt coping as has hx of depression
Offer her defecography test again
Assess skin in peri area to determine if intact and if she needs skin barrier and discuss absorptive pads and other incontinent wearable protection

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

I think the patient tolerated her exam well. She and her husband listened carefully to the education provided and she was open to going to the pelvic health physical therapy. I think I would have offered her a referral to mental health to discuss her feeling as her past included depression, and I would have explored this a bit more.

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?**

To see more ostomy and continence cases, I was glad I was able to see a peri stoma with a fungal rash and how it was treated I also as glad I was able to see another manometry tests and follow the patient to the visit and get the full perspective.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

My goal for tomorrow is to care for pediatric patients with urinary diversion. I also want more inpatient experience.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.