

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Birgitte Kammerdiener Day/Date: Thursday September 25thNumber of Clinical Hours Today: 8 Number of patients seen 6Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Stacy Bisler-Theus MSN, APRN-CNP and Jessica Sankovic PAClinical 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, and any additional activities.

Today was spent following the outpatient CORS NP and PA. I was able to get time following both as they had mixed schedules of patient times so I was able to see both. I started the day with Jessica Sankovic PA. the first patient we saw presented for constipation. A rectal exam was done and compared with the results of the manometry exam that was done prior. Jessica stated that the muscles felt tight and were not relaxing well. Her recommendation was for pelvic floor therapy to help with stretching and relaxing the pelvic floor as well as use of stool softeners. The next patient we saw had concerns of incontinence of mucous and bleeding. A rectal exam was done where internal and external hemorrhoids were noted along with prolapse. I then went and followed Stacy Bisler-Theus NP. The patient we saw together had started a new medication and developed pustules on the perianal area. Believed to be unrelated to the medication, Stacy took a swab of a pustule to send to the lab as a rule out and ordered antibiotics. The next few patients I saw were for stoma concerns. One patient had concerns of bleeding, and it was found to be from a granuloma. The other patient has concerns due to prolapse. The final patient I saw was for a large hemorrhoid causing a large amount of pain. It was a thrombosed hemorrhoid and the patient opted to have it removed during the visit and a very large clot was expelled. The CORS NP and PA saw a wide range of patients during my day with them.

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.

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

Chart note:

Chart Review/History

Age/sex: 79 year old female

PMH: three pregnancies and three births, tore and episiotomy and forceps used. Previous rectocele repair in 2019. Irritable bowel syndrome, migraines and Raynaud's.

HPI: Patient presents to the outpatient clinic for concerns with incontinence of mucous and bleeding. Patient states she does not have a regular bowel routine. States bowel habits are constantly changing and can have no bowel movement one day and three the next and consistency ranges between hard dry stool and diarrhea. Patient had a rectocele repair in 2019. Patient states she has to change a pad twice daily or more due to mucous. Patient states having to splint for feeling of emptying completely

Social hx: No history of tobacco or drug use, states having one glass of wine with dinner 3 to 4 times per week

Assessment/Encounter

Presents to clinic for concerns of mucous leakage and occasional bleeding

States having to change pad at least twice daily for mucous leakage

States no fecal incontinence or stool leakage

Previous rectocele repair in 2019

Requires splinting for feeling of complete bowel movement

No skin breakdown on assessment

Patient underwent an anorectal manometry test and presented for review of results. All results were within normal range. The PA performed a rectal exam as well. From the rectal exam, pelvic floor muscles were noted to be tight, and rectocele was small.

Chart Note:

Patient is a 79 year old female with a history of three pregnancies and three vaginal births, tearing and potential forceps use, irritable bowel syndrome, migraines, Raynaud's and a previous rectocele repair in 2019. Patient has no history of tobacco or drug use, states having one glass of wine with dinner between three and four times per week. Patient presents to the clinic for concerns of mucous leakage and occasional bleeding. Patient was referred due to rectocele noted on a previous exam. Prior to this visit, patient presented for anorectal manometry testing. During assessment patient states that she leaks mucous multiple times a day and has to change a pad at least twice a day. She states having occasional bleeding but no leakage of stool. She does not have regular or consistent bowel movements and does not currently have a bowel regime. Patient states having to splint to have a feeling of emptying completely with a bowel movement. PA then performed a rectal exam to compare assessment with results of manometry exam. Upon external exam, hemorrhoids were noted. On exam, patient has a good squeeze but had a hard time relaxing the pelvic floor muscles with pushing. Patients rectocele was noted to be small on assessment. A scope was then inserted into the rectum when large amounts of mucous were noted, potential mucosa prolapsing and internal hemorrhoids. Patients manometry exam was reviewed and all values were within the normal limits. It was determined that patients mucous build up was most likely due to internal mucosa prolapse causing more mucous to form.

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Occasional bleeding was due to the present hemorrhoids. Due to patients rectocele being small on exam, recommended to hold off on defecography test. Patient was recommended to begin physical therapy for pelvic floor relaxation exercises and techniques. Patient also recommended to begin taking MiraLAX at night as needed for hard stools. Patient is to follow up in two to three months to reassess symptoms and need for further exams or treatments.

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)

- Consult to physical therapy for pelvic floor therapy to improve relaxation and muscle movement
- Keep a two-week bowel diary and dietary intake diary and send via mychart
- Begin stool softeners- MiraLAX once nightly as needed for hard stools
- Increase fluid intake-minimum of 2L of water per day
- Increase and maintain a high fiber diet to reduce mucous production-intake should be between 22 and 25 grams of fiber per day, use daily fiber supplement if needed
- Apply skin barrier cream as needed if skin breakdown occurring with mucous incontinence
- Apply preparation H cream or wipes for hemorrhoids as needed for symptoms such as itching, burning or pain
- Follow up appointment either in-person or virtual in three months to discuss symptoms and further exams or treatment options

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

I would have had the patient keep the defecography exam. If the patient is not emptying their bowels completely and is requiring splinting and there is suspected rectal prolapse higher in the intestine, the exam would give a good image of where the prolapse is occurring and even though the rectocele is small, it would show if stool were getting caught during bowel movements.

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?

My goal for the day was to learn more about what the CORS NP/PA do during their assessment and time with patients in the outpatient area. This goal was met. They assess many different patients for different concerns as well as perform outpatient procedures in office when needed.

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

I am back at the in-patient WOC side tomorrow and my learning goal is to get more hands on with NPWT and assessing wounds

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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:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 		
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 		
<ul style="list-style-type: none"> Completes Braden Scale for inpatient encounter 		
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 		
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 		
<ul style="list-style-type: none"> Identifies overall recommendations/plan 		
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 		
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 		
<ul style="list-style-type: none"> Braden subscales addressed (if pertinent) 		
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 		
<ul style="list-style-type: none"> Directives are written as nursing orders 		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 		
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 		
Learning goal identified		

Reviewed by: _____ Date: _____

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