Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: **Kyle Aniol** Day/Date: **Wednesday. September 24th**

Number of Clinical Hours Today: **8** Number of patients seen: **7**

Care Setting: **Outpatient Colorectal Clinic**

Preceptor: **Jessica Sankovic**

Clinical Focus: 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 was spent at the out-patient colorectal clinic with some of the NP's and PA's. Patients were seen in the clinic setting for a variety of continence, pelvic floor, and post-surgical related appointments. Patient A was a 78 y/o female being seen for a routine follow up. The patient is post hemicolectomy and end colostomy related to Crohn's disease. There are no stoma, peristomal, or pouching related complications and the patient is doing well. Patient B was a 44 y/o female also being seen for routine follow up post operation. She has a new loop ileostomy related to ulcerative colitis, and reversal is planned for December. The patient has had no complications since surgery with the stoma or pouching system. Patient C was a 56 y/o female being seen for pain, bleeding, and burning during bowel movements. The patient has a history of hemorrhoids, endometriosis, and anal fissures. On examination, external hemmorhoids were present but not tender, further assessment revealed an anal fissure. Patient D was a 66 y/o male with an end colostomy related to rectal cancer. His follow up appointment got moved up due to irritation at the stoma site. Patient E was a 73 y/o female with a fistula status post a Seton drain. The patient was being seen for increased pressure and pain with bowel movements. The drain was intact, there was a couple hemorrhoids present, and she was prescribed Hydrocortisone cream. Patient F was a 57 y/o female being seen for a surgical consult; she was referred to the clinic for trouble voiding and rectocele. Pelvic floor physical therapy was recommended over surgery. Patient G was a 73 y/o male with colon cancer. He is getting a partial colectomy with ileorectal anastomosis tomorrow and required a pre-operative screening.

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,

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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	4
Activity	4
Mobility	4
Nutrition	3
Friction/Shear	3
Total	26

Age/Sex: 57 y/o female
PMH: Patient is G5P0 and postmenopausal. She has a history of depression, anxiety and polysubstance abuse. Other medical diagnosis include hypothyroidism and rectocele.
CC: Constipation and incomplete evacuation
Social Hx: Patient has a history of drug and alcohol abuse. No illicit drug use for 10 years, no alcohol use for the last 2 months. Patient has smoked cigarettes for 7 years (1 pack/day).
Family/Surgical Hx: Polycythemia, drug abuse, diabetes; thyroid, breast, and ovarian cancer.
Right Breast Lumpectomy (2018)
Medications: Mometasone 0.1% (BID), Lidocaine 5% patch (Daily-12 hrs on, 12 hrs off), Omeprazole 20 mg (Daily), Levothyroxine 25 mcg (Daily)
Assessment/Encounter: The patient is being seen for constipation and incomplete voiding. She reports 1 small, soft bowel movement per day and intermittent abdominal pain. She also reports urinary hesitancy and incomplete emptying. She does not currently use any stool softeners or laxatives and admits to having a poor diet. Manometry testing was completed today and showed hypo-contractility. On digital examination, the squeeze tone was noted as weak, and a small rectocele was present. The perinatal skin was intact with no signs of erythema or excoriation.

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.

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WOC Plan of Care (include specific products)

Start a daily fiber supplement (e.g. Metamucil or Benefiber) Increase oral fluid intake (6-8 8 oz cups/day) Avoid straining or splinting during bowel movements Refer to physical therapy for pelvic floor exercises Schedule defecography for evaluation of incomplete evacuation Contact clinic for worsening symptoms

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

I thought the care provided was excellent. Although, I would have stressed more about a healthy diet to the patient. The patient admitted to having a poor diet and nothing was discussed further on the topic.

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 today is to recognize the underlying problem related to the incontinence. This goal was met as I was able to determine the likely cause based off symptoms and manometry testing.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) This was my final continence clinical.

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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: _____

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