Cleveland Clinic

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

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

Student Name: ___**Jonathan Rybka**_____ Day/Date: ___October 8, 2025____

Number of Clinical Hours Today: _7.5__ Number of patients seen _**3**__

Care Setting: Hospital __ Ambulatory Care _X_ Home Care ____ Other ___

Preceptor: ___Stephanie Norman___

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, and any additional activities.**

Today I followed one of the colorectal NPs during her office visits. The majority of the visits were related to post-op care and did not have much direct impact on continence nursing. Most were wound checks for closed stoma sites, surgeries related to an abscess, etc. These patients are not included in the journal or total patient count. A few patients did present with issues related to fecal incontinence or fecal incontinence was an issue that was raised during the visit, so those patients are addressed below. The first patient had a sacral stimulator implanted in 2021 to manage fecal incontinence, however it had not been working as intended for the past 3 weeks. The patient reported that before the stimulator was implanted, she had five incontinence episodes per week and was currently at three episodes a week when she was normally at one episode every other week. The patient mentioned that she does not have an anal sphincter and typically does not have any sensation before an incontinence episode until it is happening. The NP connected to the stimulator via a device provided by the manufacturer to discover that it had been turned off. The patient was unable to determine when this happened as nothing out of the ordinary occurred around the time she noticed her incontinence worsening. The stimulator was reset to previous programming and the patient was instructed to call the manufacturer first if she noticed any other issues, and then call for an appointment if they were unable to help. The second patient will be covered in the chart note. The third patient was seen for concerns regarding external hemorrhoids. He had a colonoscopy that was supposed to occur a few weeks prior, however it was not performed as the patient forgot to have someone else available to drive him after the procedure. The patient had no hemorrhoids diagnosed, however was complaining of perianal pain, burning, and constipation. He is currently undergoing chemo for lymphoma and has a history of a perianal carcinoma. The patient reports that when he does have a BM, there is typically a sense of urgency with very little output and occasional bleeding. He has been using OTC hemorrhoid cream for treatment at home. The NP attempted to perform a digital rectal exam with the patient's consent, however the patient expressed discomfort during the exam so it was abandoned before a full assessment could be performed. Hemorrhoids could not be positively identified either, so the patient was sent home with orders for symptom management. A hydrocortisone cream

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was prescribed to reduce perianal irritation. The constipation was likely a combination of the perianal irritation and chemo, so the patient was instructed to make sure he is drinking enough water and sent with bowel regimen to promote soft stool formation. A stool softener was prescribed to help reduce constipation, with instruction to add ½ a cap of Miralax daily and increase ½ cap every five days until 1.5 caps per day if symptoms do not improve. The patient was instructed to call the office if any new symptoms were noticed. The difficulty with outpatient clinical experiences not in a dedicated setting (i.e. wound clinic) is that they can be hit or miss and it is largely due to chance. While there were a few relevant patients, I did not get to see as much as I hoped.

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:**

This patient is a 55-year-old female seen for complaints of ongoing fecal incontinence since January of this year. This patient has a PMH of gastric bypass, hernia repair, pelvic floor dysfunction, a herniated disc from a MVA, idiopathic systemic inflammation, and gastroparesis. An outpatient colonoscopy was performed in March, with diverticulosis as the only finding. No biopsies were taken. The report mentioned bowel prep as "fair", indicating it was adequate but not ideal without any specific details. The patient sees PT for her pelvic floor dysfunction and mentioned that PT said her abdominal muscles were "too tight" during recent sessions. An anorectal manometry was performed in late June of this year, with bowel dyssynergia as the only finding reported. The patient is complaining of no solid BMs recently with small liquid BM leaking throughout the day and occasional sharp left sided abdominal pain. The most recent imaging is a CT of the abdomen and pelvis from early September showing large gas collection in the ascending colon and stool collection in the descending colon. The patient denied any flatus, however she stated that this is also normal for her. A full bladder was also noted on the exam, and when asked about urinary symptoms the patient described symptoms consistent with stress urinary incontinence. The NP reasoned the most likely cause for these symptoms is overflow fecal incontinence based on prior imaging and symptoms, however it is difficult to know for certain without current imaging available. An abdominal x-ray was ordered, which the patient said she would do on her way out right after the office visit was complete. The NP informed the patient that she couldn't make any final recommendations until she was able to look at imaging from the x-ray, but she did mention what she would recommend if her suspicion was confirmed. The patient reported taking a stool softener, which the NP recommended continuing. The NP also said she would recommend daily fleet enemas until the stool passed with the possibility of regular (though not daily) enemas afterwards depending on the cause for stool blockage and how well it is managed. The patient did not seem like she would be compliant with long term enema use, so alternatives for long term management will be explored once x-ray results have finalized and the current problem is resolved. The NP stated she would call the patient with recommendations once she

reviewed the x-ray results and also mentioned a stool study she ordered that would be sent to the patient's home through the mail.

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)**

- Abdominal x-ray ordered with the patient stating her intention to get it done as a same day appointment. NP will call patient with results and recommendations (anticipating daily fleet enemas available OTC until stool passes with continuation of Senna stool softener). Patient told to reach out for follow up appointment to discuss long-term management once current complaint is resolved or if symptoms are not resolved within 10 days.
- Stool panel kit ordered and sent to home address on the patient's file for collection. Review results when available.
- Patient instructed to continue seeing PT for pelvic floor muscle training.
- Monitor UI symptoms and see if they improve after management of suspected overflow fecal incontinence. Promote adequate hydration and regular toileting. If UI symptoms do not resolve, refer for urodynamic testing.
- A second outpatient colonoscopy will not be covered by insurance this calendar year. Discuss an outpatient colonoscopy with the patient in early 2026 with a biopsy to investigate potential causes for suspected decreased motility (this recommendation may be reconsidered if another cause is discovered).

**Describe your thoughts related to the care provided. What would <u>you</u> have done differently**

I agree with this plan of care, largely because it is based on current assumptions that haven't been confirmed so some guesswork has to be involved. The hope is that the fecal incontinence will resolve once stool blockage has passed, and from there the plan needs to focus on long term management. Again, this is difficult as the cause for blockage (or confirmation that there still is a blockage) has not been confirmed, and there is the possibility that even if the suspected cause is accurate the current treatment may not be effective. Dietary considerations were not discussed, so I would emphasize adequate hydration and possibly consider a GI soft diet if motility seems to be a potential issue. Based on this patient's medical history, diverticulosis is the first potential cause I would investigate and then work from there.

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?**

As mentioned previously, I was a little disappointed with the lack in patients seen for issues related to incontinence. Most of the patients seen today were seen for surgical concerns and were not related to continence nursing, which was disappointing, and I was hoping to see more related to testing. I was glad for the patient with the stimulator, though in her case the problem was easy to solve.

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| **What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**<br><br>This is my last in-person clinical session and the rest of my clinical hours are to be completed virtually. I plan the first case I choose for continence care to be related to fecal incontinence with testing involved if that is among the options (I haven't looked through all of them yet). |

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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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