



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Sharon Murphy Day/Date: 10/13/2025

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

Care Setting: Hospital Ambulatory Care Home Care Other Dr. Spivak's

Preceptor: Jessica Sankovic P.A-C

Clinical 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.

I had a positive experience, seeing a total of seven patients. Among them, three were post-operative cases: one had a diverting stoma, and two involved takedowns. Additionally, I treated a patient experiencing stool incontinence, who required a replacement battery for their fecal incontinence stimulator. There was also a patient with Crohn's disease who was currently inflamed, with a stoma and seeking a J-pouch; however, this option is not feasible at the moment due to the inflammation and challenges with pouching. Lastly, an anorectal manometry was conducted on a patient suffering from anal seepage, accompanied by some noted blood and discomfort. There were originally eight patients, but the last one declined to have a student present during the examination. 4

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
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Moisture	2
Activity	4
Mobility	4
Nutrition	2
Friction/Shear	3
Total	19

Chart Note:

Age/Sex: Female/56 yrs

Patient Medical History: The patient has a history of fibromuscular dysplasia, constipation, GERD, anxiety, depression, seizures, a history of smoking, migraines, asthma, and obstructive sleep apnea (OSA). These symptoms began a few years ago, leading to a colonoscopy, after which her symptoms were resolved. However, starting in May of this year, the symptoms resumed, characterized by daily episodes of involuntary mucus seepage accompanied by small amounts of stool and blood, which she reports she is unable to control. She maintains regular bowel movements 2-3 times daily, with stool consistency ranging between Bristol stool scale types 4 and 6. The patient also complains of upper abdominal pain. She follows a vegetarian diet and is limiting her food intake due to concerns about incontinence. Additionally, she has experienced three pregnancies, two of which were vaginal deliveries involving episiotomy and tearing.

CC: There are daily instances of involuntary expulsion of mucus and stool, accompanied by occasional traces of blood. Additionally, there are reports of upper abdominal discomfort.

Meds: Celexa, Lorazepam, topiramate, Valtrex, Albuterol HFA

Social History: Former smoker of cigarettes, no alcohol use, no drug use.

Labs: Colonoscopy 06/2023: No significant findings. Stool testing: None detected.

Assessment/Encounter:

LOC/General Appearance: Alert and awake, well-hydrated, well appearing, no acute distress

Interview: Conducted with the patient and their significant other present. Significant other stepped out during the procedure. Perianal skin intact. No erythema, no induration or excoriation noted. No fissure, fistula, or hemorrhoids noted—no abnormal findings with digital rectal exam. The Anoscopy showed internal hemorrhoids and a moderate amount of mucous in the rectum/anus, otherwise normal findings. The Manometry findings were all within normal ranges as well.

The patient tolerated the procedures today without any concerns noted.

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)

- Order: Colonoscopy to evaluate for underlying causes of increased mucus production and change in bowel elimination.
- Refer to gastroenterology for further evaluation and management.
- Start fiber supplement (Metamucil or benefiber) to help bind mucus and improve stool formation. Begin with ½ tsp in 4-8 oz fluid daily for 1 week, then gradually increase to 1 tbsp daily as tolerated.
- Instructed on completing a 2-week bowel diary using the My Journey app to track bowel movements, accidents, leakage and other symptoms. Email completed diary to pelvicfloor@ccf.org.
- Follow up after colonoscopy to review findings and adjust management as needed.

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

The care provided was thorough and well-considered. I would also suggest incorporating dietary recommendations, particularly for a vegetarian diet, which can sometimes lack adequate fiber. It's important to consider what types of foods she is consuming, as these choices may impact her good gut bacteria and, subsequently, the mucous levels within the gut. Is her diet high in fats, low in fiber, or rich in sugary foods? (Suriano et al., 2022). Keeping a two-week dietary diary could also be advantageous for a better understanding of her nutrition.

Suriano, F., Nyström, E. E. L., Sergi, D., & Gustafsson, J. K. (2022, September 13). Diet, microbiota, and the mucus layer: The guardians of our health. *Frontiers in immunology*.
<https://doi.org/10.3389/fimmu.2022.953196>

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?**

Today, I will successfully obtain my name badge, which is crucial for establishing my presence and gaining access within the facility. I will confidently locate my designated clinical station site, enabling me to

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familiarize myself with the environment. Additionally, I will acclimate quickly to my surroundings, ensuring effective interactions with my colleagues and patients. My goal is to absorb as much information as possible, empowering me to excel in my clinical experience going forward.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
Tomorrow, I will be in the S1 building with the WOC APRN Consult team. I would like to participate in stoma site marking if that is being conducted there. If not, I am interested in learning more about debridement or assessing and staging/classifying a new wound.

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: _____

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