Cleveland Clinic

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: __10/27/25_____

Number of Clinical Hours Today: ____ Number of patients seen____

Care Setting: Hospital ____ Ambulatory Care __x__ Home Care ____ Other ___

Preceptor: _____

Clinical Focus: Wound ____ Ostomy ____ Continence __x__(Urodynamics)

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.

It was very interesting today. Had one patient that came in for a Urodynamic procedure. She has no feeling that she needs to urinate. Does have some leakage. It is amazing how you can determine the information from this procedure. Overall a very good experience.

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	
Moisture	
Activity	
Mobility	
Nutrition	

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Friction/Shear	
Total	

Age/Gender: 72yrs/Female
History: Alzheimer disease, Anxiety, Arthritis, Atropic vaginitis, CAD, CHF, Degeneration of posterior vitreous body of left eye, DVT, Dysuria, Epilepsy, HTN, FI, GERD, Glaucoma, Hemorrhoids, Blood clots, Lacunar infarction, mixed hyperlipidemia, OAB, OSA, Peripheral neuropathy, Pulmonary embolism, rectal prolapse, right bundle branch block, seasonal allergies, TIA, UI. Chronic constipation. Mixed incontinence.
Surgical History: Appendectomy, Bladder surgery, Choleysystogram gall bladder, Colonoscopy, EGD w/o BRSH SPEC varicies inj, Hysterectomy, Hip replacement, shoulder replacement, surgical history of foot, surgical history of bladder/urethra x 4, removal of gall bladder, removal of cataract, Repair rectocele and cystocele, Tonsillectomy.
CC: Patient presenting with recurrent UTI's and UI with no control over her urine stream. Patient states that she has to use the bathroom consistently with using multiple pads per day. "When I have the feeling to go it is too late." Patient wears depends every day. Denies pain, fever, hematuria, dysuria but does report being raw in her genital area.
Meds: Norvasc, Lipitor, Zyrtec, Voltaren, Estrace, Allegra, Flonase, Xalatan, Synthroid, Cozaar, Narcan, Coumadin, Aldactone, Aricept, Namenda, Desyrel, Lyrica, Fosamax, Magnesium, Aspirin, Lasix, Cyanocobalamin, Multivitamin, Oxybutynin, Singulair, Requip, Parcopa, Protonix, Lexapro, Tizanidine, Zonegran, Neurontin, EPIPEN, Albuterol sulfate, Coumadin.
Allergies: Ether, Penicillins, Shellfish, Vancomycin, Adhesive tape-silic.
Social History: Former smoker of cigarettes 1992-2007. No alcohol, no drug use.
Labs: Urine: Abnormal Hemoglobin/Blood UA had large amount. Glucose, Bilirubin, Ketone, Protein, Nitrate, Leukocytes, all negative. Specific Gravity was 1.025, PH UA: 5.5, Urobilinogen: 0.2, Color: Yellow, Clarity: Clear.
Physical Exam: Digital Rectal: Perianal skin intact, no erythema, swelling, tenderness, induration or excoriation. Small external hemorrhoid, moderately enlarged internal hemorrhoids, no fissure, no fistula, rectocele noted. No prolapse, urinary incontinence with Valsalva. Anus: Closed, Resting tone: weak, Squeeze tone: Weak.
Weight: 237#, Height: 5'5, BMI: 39.44 kg/m2, BSA: 2.2 m2.

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)

Due to recurrent UTIs and Urinary Incontinence with no control. Plan Cysto.Panendo and Rectocele. Possible sling rectocele repair vs rectocele and OAB management weight loss.

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

They instilled 404 she had 221.4ml out during procedure with a PVR of 179. Total time of procedure was 25 minutes. First leak noted at 9:19.8, 2nd leak at 15;36.1, 3rd leak at 16:01.1, Urge at 20:23.9, with 4th leak at 20:34.9. Permit to void at 22:50.1. Pressure at peak flow was -10.6 cm H2O, Flow at peak pressure was 0.1 ml/s, Peak Pressure was 59.0 cm H20, Mean Pressure was 11.7 cm H20. Voiding time was 8:47.3 mm:ss.S, and Flow time was 58.8 mm:ss.S, Time to max flow as 7:08.3 mm:ss.S. Primary Diagnoses Mixed incontinence. 2nd person was for an ENST Electrical Nerve Stimulation Therapy. Hooked up to electrodes at the ankle brachial and then sat for 30 minutes and was disconnected.

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?

The goal for the day was more with incontinence. Urodynamics established the day's goal.

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

Would like to learn more about different skin conditions, such as MASD, contact dermatitis, and follicular conditions.

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:		

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• 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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