



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: 10/29/25

Number of Clinical Hours Today: 8 Number of patients seen 6

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Kerry Sherman/Dr. Spivak

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.

1) Congenital abnormality where her urethra, rectum, and vagina are all connected into 1 opening. 2) Person c/o prolapse, 3) person f/u year appointment for post-constipation with pelvic floor therapy. 4) Patient having discomfort in the vagina and also the rectum, constipation. 5) Patient having issues with urination and constipation. Having urination with exercise and also sometimes difficulty starting the stream.

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	

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Nutrition	
Friction/Shear	
Total	

Sharon, this is the note I said was not done in my response to the submission on 10/29.

Age/Gender: 78 yrs/Female

History: Hypertension, arthritis, anxiety, high cholesterol, vaginal prolapse, incontinence,

Surgical History: Total left hip replacement.

Social History: Denies smoking, occasional alcohol 1-2 glasses per week, Denies drug use.

Medications: Tylenol, Lipitor, Amlodipine, Citalopram, Multivitamin.

Labs: No current labs available.

Assessment: Patient is A&O X 3, pleasant and cooperative. Accompanied by granddaughter. Patient continues to work as a hair dresser. Patient reports she is not ready to quit working yet so that is not an option. C/O constipation she reports that she will try to have a BM several times and pushing very hard to go, sometimes sitting for up to 45 minutes straining to go. Also discomfort in her vaginal area when having sexual intercourse and noticed something hanging down in that area. Would like to have it fixed. During physical exam, slight redness noted, no open areas or sores noted. Did not the vaginal prolapse with visualization on the physical exam.

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)

~~The one patient, Female 78, is still working as a hairdresser and has issues with constipation and vaginal prolapse with incontinence. They are recommending the Medtronic neuromuscular stimulator, hoping it will strengthen the pelvic floor muscles to help with constipation and urinary incontinence. They also prescribed Apply estrogen cream what are the instructions herefor vaginal prolapse as she was irritated and still sexually active. Also, baclofen suppository to help relax the anal sphincter 1 x daily, and may do a 2nd dose during the day if needed. Doing a bladder diary for 2 weeks. Starting a bowel training program with and discussing diet with her to help soften and promote stool, high fiber diet such as fruits, beans, whole grains, and nuts. Limit the time spent sitting to no more than 20 minutes on the toilet and no straining to have a BM. They will start with lifestyle and diet recommendations, exercise regimen, and begin the InterStim test for the neurostimulator. This is a trial run to see how her body responds and how effective it is at treating her symptoms. As they need to demonstrate that it helps relieve 50% of symptoms to qualify for insurance coverage, since this device costs approximately \$25,000.~~

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

I was in Dr. Spivak's office today with Kerry Shermann and rounding with 2 fellow MD's. It was an enjoyable day. Seen a prolapse of rectum, abnormal congenital defect, also, learned that Nurses, Physicians, Teachers, and Hairdressers are at heightened risk for constipation and tight anal sphincter muscles due to the constant contraction of holding defecation due to their jobs. Dr. Spivak is an experienced doctor who explains everything clearly to her patients and students. She is also quite funny! She covered everything very well.

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The only thing I can think to add would be a protective barrier cream for her skin to prevent irritation from incontinence use twice daily and PRN. Ok!

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?

I am just willing to learn anything, but need two continence journals and one more wound journal. Should get one continence journal tomorrow as I will be in Manometry.

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

I need 1 more wound journal and one more continence journal. I am up for anything!

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 		<u>✓</u>
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 		<u>✓</u>
<ul style="list-style-type: none"> Completes Braden Scale for inpatient encounter 	N/A	
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 		<u>✓</u>
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 		<u>✓</u>
<ul style="list-style-type: none"> Identifies overall recommendations/plan 		<u>✓</u>
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: Patricia A. Slachta Date: 11/4/25

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