

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Kelly Shemonis Day/Date: 1/13/26 Number of Clinical Hours Today: 8 Number of patients seen 6 Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Urodynamic Shaune Kovachs team/ Jessica Kirksely 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.

This morning, I was in the urodynamics lab with Shaune Kovach's team. There were 4 urodynamic studies scheduled, and I followed 2 RN's and observed complex cystometry testing. Patients included 3 males with a history of BPH and retention, and one female patient with overactive bladder experiencing urgency, frequency, and urge incontinence. I will discuss the female patient in more detail in the chart note. It was very interesting to see how the patients were prepared for the study. The catheters appeared much smaller in person than they did in the book's illustrations. While studying, I viewed these tests as separate; however, I was able to see how they are all interconnected and conducted during the same session. Seeing the setup in its entirety and how the measurements fluctuate on the computer screen in response to what's occurring with the patient was especially helpful. This allowed me to gain a better understanding and conceptualize the process. In the afternoon, I was in the A30 outpatient WOC with my preceptor, Jessica Kirksey, and saw 2 patients. The first patient was a 76-year-old male with a loop ileostomy and small mid-abdominal surgical incision dehiscence for a follow-up visit related to pouch leakage. Home health was following the patient post-discharge and was using a piece of hydrocolloid to cover the wound with the Hollister 2-piece pouching system, overlapping on the edge. Upon removal of the pouch, the WOC nurse noted exudate from the wound undermining the pouch wafer, likely contributing to leakage and necessitating pouch changes every 1-2 days. In addition, there was a small ulceration (likely device-related) from 5-7 o'clock. WOC nurse recommended a Coloplast 1-piece convex pouching system and a Mepilex dressing for the dehisced area separating the 2 sites. Education and supplies provided.

The second patient was a 58-year-old female with hx of ulcerative colitis and total proctocolectomy with end ileostomy in 11/2025. Patient had made a follow-up appointment r/t an ulceration to the peristomal skin. Upon assessment, there was concern for pyoderma gangrenosum. Two small ulcerations at 9 o'clock, with a bluish-purple border. The NP was notified. She assessed, then treated the area with a Kenalog injection. We then cleansed the area, applied stoma powder, and a small piece of Aquacel Extra over the ulcerations. Then a hollihesive wedge was applied. A Coloplast SenSura Mio convex one-piece drainable pouch (which the

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

patient has been using) was then applied. Patient will have a follow-up in 4 weeks. If ulcerations worsen, the patient is instructed to call and come in sooner. I also had the opportunity to observe one of the other WOC nurses fit a patient for a hernia belt with prolapse support. At the end of the day, I observed several return phone calls to patients.

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:

Pt is a 57-year-old female with a hx of MS, Trigeminal neuralgia, and Overactive bladder seen today for urodynamic testing r/t urinary frequency, urgency, and urge urinary incontinence. Pt was referred to CC Urology by the patient's urologist in hometown for more specialized care. Previous treatment included lifestyle modifications, including avoiding caffeine and dietary bladder irritants. Previously trialed oxybutynin (Ditropan) in 2022, pt didn't notice a difference and stopped the medication about a year ago. Seen at CC on 1/6, H&P and physical exam completed by LIP, genitourinary exam with no abnormal findings. Denies constipation. No history of UTIs in past year. UA on 1/6/26, negative for leukocytes and nitrates. Creatinine 0.6. Cystometrics: filled to 225ml, DO: No, SST: No, Urge at 150ml. PVR 0 with bladder US. Current medications include: Oxcarbazepine 300mg by mouth daily, Atorvastatin 20mg PO daily, losartan 25mg by mouth once daily, Fingolimod 0.5mg 1 capsule by mouth once daily, Vit D3 4,000 units by mouth once daily. Patient presents in office for urodynamic testing. Reports symptoms of frequency, urgency, and urge incontinence, which have worsened over the past year. Pt reports "constantly going to the bathroom", with 2-3 episodes of urge incontinence per week, and nocturia 2-4 times per night. Expressed that episodes of incontinence are very distressing. Patient uses a front wheel walker and has had two falls over the past year related to urgency and trying to quickly make it to the bathroom. Provider notified and home safety reviewed. ID verified and procedure instructions reviewed, pt verbalizes understanding, consents to testing, and denies questions. Allergies: none. Denies pain.

Uroflowmetry:

Voided volume: 82.2ml
Flow time: 21.8 sec.
Q max: 12.9 ml/sec
Q avg: 3.7 ml/sec
PVR: 70 ml

Cystometry:

First sensation: none
Strong desire: no strong desire felt

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Max capacity: 174 ml
Max filling detrusor pressure 8cm of water
Detrusor overactivity associated with urge: Yes
Detrusor overactivity associated with leakage: Yes
Was patient assessed for VLPP/UPP: Yes
Leaks urine with Valsalva: No
Lowest leak point pressure: N/A

Pressure-flow voiding study:

Did patient void with catheters in place: Yes
Voided: 146ml voluntary
Max voiding detrusor pressure: 45cm H2O
P det @ Q max (Max flow): 30cm H2O
Max flow rate: 13ml/sec
Average flow rate: 5ml/sec
Vaginal packing for prolapse support: No

Procedure well tolerated. Pretest uroflow completed with a PVR of 70ml. Patient filled for testing. Stressed patient x 1 with no leaks noted. Urges felt with rise in pdet, with 2 leaks to completion, despite slowing filling rate. Permission to void with first desire to void on 3rd attempt to fill, voluntary void of 146ml.

Procedure well tolerated. Patient given printout of testing/graphs and verbal post-procedure instructions. Patient verbalizes understanding. Has an appointment with the provider at 11 am.

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)

- follow-up appointment with provider on 1/13/26 @ 11 am.
- Mild discomfort and possibly small amounts of blood may be present after testing. Increase fluids for 24 hours after the procedure (Dickinson, 2022).
- Drink fluids steadily throughout the day. Approx. 8-10 cups of water per day; aim for light yellow urine. Avoid restricting fluids, as this can lead to dehydration and constipation, worsening urinary symptoms.
- Continue lifestyle modifications, including limiting caffeine intake and bladder irritants (caffeine, alcohol)
- Continue to limit fluids 2-3 hours before bed.
- Start practice urge suppression techniques at home: when urgency hits, stop activity, take deep breaths and do 5-6 quick, strong, pelvic muscle contractions (Kegels), distract yourself (ex. count backwards), wait for the urge to pass. Then slowly walk to the bathroom (Thompson, 2022).
- Safety: reducing risk for falls in the home: wear non-slip footwear when walking, clear pathways and secure or remove throw rugs, keep electric cords away from walkways, use assistive devices as recommended.

Dickinson, T. (2022). Advanced assessment of the patient with urinary incontinence and voiding dysfunction. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 68-82). Wolters Kluwer.

Thompson, D. L. (2022). Management fundamentals for incontinence. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 83-110). Wolters Kluwer.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

I would have reviewed urge-suppression techniques with the patient and given a printout/instructions. She had done pelvic floor therapy in the past, but urge suppression was not mentioned. I feel she could benefit from it because she denies stress incontinence and had no leaks during the test when asked to bear down and cough. I would have also reviewed specific home safety considerations, such as clearing pathways to the restroom, removing throw rugs, and keeping electrical cords away from walkways. (as listed in the WOC POC). Both of her falls occurred at home r/t to urgency, so these would be important to include in a holistic plan of care.

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 was to gain a better understanding of the different urodynamic tests and observe how they are performed. I met my goal

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

My goal is to assess and stage a pressure injury and determine the best topical treatment.

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	✓	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.