

**Daily Journal Entry with Chart Note & Plan of Care**Student Name: Yvette Enciso Day/Date: Wednesday February 4, 2026Number of Clinical Hours Today: 8 Number of patients seen 10Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor: Christina Scott, APRNClinical 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 Manometry results- pt was having chronic constipation, however, anorectal manometry exam was WNL. Patient will not need PFT.

Patient #2- Anal fissure follow up. Pt was present for a follow up an anal fissure. Pt had been prescribe Nefedipine, NTG and. Lidocaine, however, was non compliant with Nefedipine. Anal fissure had improved from last visit and was c/o burning and was advised to continue using NTG since patient had stopped and was educated that NTG can cause a burning sensation. Pt was also advised to not look up on google about symptoms since patient thought he may have a mass.

Patient #3 manometry results- Pt has been having chronic constipation. Pt has a BM about 2x/week. Per patient states that when she drinks alcohol that it urges her to defecate. On Friday she had 3 glasses of wine and Saturday she used that bathroom about 5 times and did not leave her home as the more she defecated the urge increased with incontinence. Patient also states that there have been a few times where she has had to defecate in a public park and in front of someone's lawn.

Patient #4 Post op stoma appointment. Pt has loop ileostomy. Pt is on Imodium 3-4x a day to slow motility. Skin is intact.

Patient #5- follow up appointment for fissure. Fissure is improving, pt has anal skin tags, however pt is non compliant with medications. Pt stopped medications because she felt better, NP advised to continue for another 3 months.

Patient #6 Telehealth for manometry results. Pt c/o of constipation. Pt is unable to relax going to the bathroom, pt has type 1 and 2 on the Bristol chart. Pt has dyssynergia and she will be going to PFT and

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returning in 6 months for follow up of effectiveness.

Patient #7- Pt has stooling from rectum with stoma. Pt has a loop colostomy from GSW and has a sacral 4 pressure wound and continues to experience frequent stool from rectum.

Patient #8 Pre-op for rectal prolapse. Pt will be having laparoscopic proctopexy. No complications currently.

Patient #9 bumps on anal region. Pt c/o of anal bumps on anal region, no itching, no leakage, no pain. No suspicion of STD's, patients pap was normal within the last 2 years. Pt has had these bumps previously on pelvic region which were sebaceous cysts, therefore, pt is being referred to dermatology.

Patient #10 manometry results. Pt c/o of intermittent incontinence with urine and has history of constipation. Pt is on daily senna, results were WNL.

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	2
Moisture	3
Activity	2
Mobility	2
Nutrition	3
Friction/Shear	2
Total	14

PMH: Anemia, severe malnutrition, GSW, paraplegia, neurogenic bladder with chronic foley, hepatitis C

Allergies: Tetracycline, Vancomycin

Medications:

Docusate sodium 100mg BID

Linezolid 600mg BID

Oxycodone 10mg 1 pill every 8 hours as needed for pain

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Baclofen 10mg BID  
Bisacodyl 10mg Insert 1 suppository daily as needed  
Senna 8.6mg 2 pills BID  
Miralax 17g I packet BID  
Pantoprazole 40mg QD  
Melatonin 3mg QHS  
Gabapetin 300mg 1 pill every 8 hours as needed  
Sanctura 20mg BID  
Ondansetron 4mg every 8 hrs as needed  
MVI QD  
Ferrous sulfate 325mg QD  
Narcan 4 sprays as directed

Patient is 30-year-old male who lives in a SNF. Patient able to verbalize all needs and make decisions for self. Patient is full code.

Patient is A&O x4. Both eyes PERRLA. Well-groomed and well dressed. Breathing even and unlabored. Abd soft, non-tender. Pt has a retracted loop colostomy. Pt is a paraplegic and is confined to wheelchair. Pt is present with caregiver from facility. Pt has a foley that is draining clear yellow urine. Pt has a decubitus stage 4 sacral ulcer that was not assessed. Pt is present with complaints of persistent stool per rectum despite having colostomy. Pt is also inquiring about suprapubic catheter placement. Stoma 1in in diameter, red/pink and moist, retracted, located in LLQ, peristomal skin with erythema.

Pt was hospitalized recently due to sepsis and was placed in SNF where he received IV antibiotics via PICC line and has completed course. Per medical records colostomy was irrigated during hospital stay which effluent was expelled through both proximal and distal limbs.

Pt underwent loop colostomy 4 years ago in Atlanta to divert stool from sacral wound. Pt states that stool has been passing through rectum since colostomy, however, is more prominent than output via stoma. Pt also states pouch has been leaking.

Dr. Goldenshluger was asked to see the patient and spoke to patient about having surgery. Surgery has been planned for 2/10 for revision.

Patient left in stable condition upon leaving room and had no further questions at the time.

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)

Patient was educated on removing pouch with adhesive remover, wash skin with soap and water, pat dry,

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apply stomahesive powder, dust off and apply skin barrier prior to applying pouch.

Pouch was removed and skin was prepped as mentioned above. Applied half a cera ring around the stoma, Hollister 1 ¾ convex drainable pouch was applied.

Pt was educated on diet to include high protein diet to promote wound healing for stage 4, also recommended to add Juven 2 packets BID and patient to follow up post op.

Pt was also given prophylactic antibiotics for upcoming bowel surgery and bowel prep of Golytely.

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

The care that was provided was appropriate. Christina was exceptional is consulting with Dr. Goldenschluger which resulted in patient being scheduled for surgery. Pt was in a flat drainable pouch and switching to convatec was appropriate to prevent leaking and due to retracted stoma. Other products that I would recommend would possibly stoma paste in addition to the ring.

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 for the day was to see the role of the NP and how they communicate with the patients. It was a pleasure to see how comforting they are towards all the patients especially for the patient with the colostomy issues. My goal was met and I was able to see how their day plays out.

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

My goal for tomorrow is to see the WOC nurse's day in an inpatient setting and how the day flows including the different procedures that can be done.

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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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