

**Daily Journal Entry with Plan of Care & Chart Note**Student Name: Regina Averyanova Day/Date: 07/11/2025Number of Clinical Hours Today: 9Care Setting: Hospital Yes Ambulatory Care      Home Care      Other     Preceptor: Aaron Fischer, RN     Clinical Focus: Wound      Ostomy Yes      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.**

Today I had an opportunity to shadow preceptor Aaron in the acute care setting. We were able to see six patients.

Patient A is a 29 y. o. female with the history of ulcerative colitis who had total proctocolectomy with ileal pouch anal anastomosis (J-pouch) and diverting loop ileostomy. Today was day 2 post-op, and patient required stoma intubation.

Patient B is a 67 y. o. female who was s/p kidney transplant, and unfortunately her abdominal wound dehiscid. Patient required NPWT placement.

Patient C is a 70 y. o. female who had a Hartmann's procedure and required to have an ileostomy. WOC nursing team was contacted for a scheduled pouch change.

Patient D is 76 y.o. male who had bladder dysfunction and required to have bladder resection. Patient now has an end ileal conduit and day one post surgery. Patient required to have a teaching session from the ostomy nurse on how to change the pouch. Patient's stoma was very dark red in color, still moist, not retracted. Foley and two stents were in place. Ostomy nurse notified MD of the assessment findings (dark red, almost black stoma). Education was provided to the patient.

Patient E is a male patient with the double barrel ileostomy. Patient developed mucocutaneous separation and required a pouch change.

Patient F is a 54 y. o. female who had intra abdominal abscess c/f colonic perforation. Patient required a stoma site marking.

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical

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assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

**Chart note:**

**Braden Risk Assessment Tool**

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

Patient is 29 y.o. female. She presented to the hospital for the surgical evaluation due to failed therapies for ulcerative colitis (UC). Patient had UC for 12 years and tried numerous biologic and medical treatments, such as Entyvio, Remicade, Humira, Rinvoq, Sayora, Asacol, Zeposia, and mesalamine enemas. Patient experienced 20 plus bowel movements per day with mucous/blood, abdominal pain, and discomfort. Patient is a mother of three, in nursing school, and experienced challenges with her daily responsibilities, and that is why she wanted to be evaluated for surgical intervention.

Patient had a two-stage procedure. The first surgery involved total proctocolectomy with J-pouch creation and temporary loop ileostomy. Second surgery might take place in about 3 months, and the ileostomy would be reversed at that time.

Present medical history: ulcerative colitis and GERD. Past surgical history: three c-sections and one ectopic pregnancy removal. Home medications: fluoxetine 40 mg 1 cap PO daily, omeprazole 40 mg 1 cap PO daily before breakfast. Pt does not take anticoagulants. Current medications in the hospital: acetaminophen 1000 mg PO every 6 hours. Lactated ringers IV infusion 75 ml/hr. Patient also has PRN pain management, anxiolytics, and antiemetics. Vital signs have been stable and labs unremarkable.

Consult was placed to the WOC nursing team to intubate the stoma.

On assessment: patient has a loop ileostomy in the RLQ, and it is 1-1/4" in diameter. It is budded, red, moist, and edematous. There is a red rubber rod that is sutured in place. Peristomal skin is intact. Small peristomal depressions are present at 3 and 9 o'clock. Peristomal skin is semisoft.

Intubation was done using 14 Fr lubricated catheter, and the catheter advanced without resistance. Irrigated the intestine with 10 ml of normal saline. Received small green clear liquid effluent. Catheter was left intact, and secured with the floss when the new pouching was applied. Patient tolerated intubation and irrigation well.

The following pouching system was applied over the stoma: Adapt cera ring, Hollister new image cera plus flat cut to fit 1-3/4", and Hollister new image wide bore HVOP. Education was provided to the patient on how to change the pouch. Patient verbalized understanding. Patient tolerated pouch application well.

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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)**

- Day three post op (7/12/2025) The red rod must be removed by the ostomy nurse. Foley 14 Fr catheter might need to be removed from the stoma; it is important to assess stoma output and functioning. Patient would require additional hands on session in pouching system application.
- Remove the pouching system with push pull method and cleanse the skin with water. Then pat dry.
- Measure the stoma. Previous diameter 1-1/4”.
- Assess the skin.
- Apply the Cavilon skin prep. Allow skin to dry thoroughly, about 30 seconds.
- Apply the adapt cera ring # 8805
- Apply the Hollihisive New Image Cera Plus Flat cut to fit with paper rape collar # 14202, Hollister New Image wide bore HVOP # 18022
- Pain management as ordered
- Encourage adequate fluid consumption/hydration (straw/yellow color urine).
- Record stoma effluent on a daily basis for the next two weeks; if the effluent is more than 1200 in 24 hours, notify LIP.
- Encourage regular activity, avoid heavy lifting (more than 10 lbs) for 2 months to avoid hernia formation around the ostomy.
- It is important to avoid bath soaks, hot-tubs, and pools until incisions have healed completely.
- Notify LIP of potential complications, such as pouchitis.
- Notify LIP of signs and symptoms of infection such as fever, generalized malaise, abdominal or flank pain, changes in urine characteristics (dark, purulent, presence of blood), etc.
- It is important to follow a soft diet for 3 weeks.
- It is important to walk every 2-3 hours
- Continue with the incentive spirometer 10 times every hour while awake.

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

The stoma intubation, irrigation, and pouch changes were done in the morning. Patient’s husband was at the bedside, and both were open to learning how to care for the newly created stoma. Aaron carefully explained every step of the procedure and clarified all the questions that the patient and her husband had. Aaron prepared all the supplies prior to starting and was efficient and showed empathy toward the couple. Patient was not in pain and tolerated the procedure well. I think the procedure and pouch selection/application went well, no need for a change.

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**

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**What was your goal for the day?**

My learning goal was to learn how to efficiently provide WOC nursing care to hospitalized patients. My goal was to learn how to assess a newly created stoma, how to intubate and irrigate the stoma, and to practice applying NPWT. I believe my goal was met because I was able to observe/perform the above skills.

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

On Monday, I am scheduled to be on A30 for the manometry testing with Dr. Spivak/Kerry Sherman. I am looking forward to learning about continence related conditions, recommended treatments, and patient counseling.

**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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