

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Birgitte Kammerdiener Day/Date: Monday September 22ndNumber of Clinical Hours Today: 8 Number of patients seen 5Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Karen O'Brien CWOCNClinical 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.

Today was spent in the out-patient WOC clinic. My preceptor today was Karen O'Brien CWOCN. Each of the patient we saw today were post-op follow up appointments and one was a patient with an established stoma who has been having difficulty finding a pouching system that works for them. For the patient with the established stoma, we assessed them both lying and sitting and determined that they needed a deeper convexity pouch. The next patient had an established stoma and the pouching system remained appropriate but they had recently undergone an abscess drainage next to their stoma. We assessed the drainage, the depth and how often the patient was having to change the dressing. Patient's wound was slowly healing and was provided with Mesalt gauze to pack into the wound for the next two days to help draw out the excess fluid as the gauze was saturated each time it was removed multiple times a day provided to wet of a wound environment for healing. The last patients were there for the postop appointments. Each of the abdomens and stomas were assessed and all of them had to be fit into a new pouching system due to their abdomens softening. They were all measured and educated on the new system. The patient I wrote my journal on today was one of the post op patients who needed a new system. The interesting thing about this is that I had fit the patient for a pouching system when they were in the hospital and had a firm abdomen. I was grateful to be able to see how much the abdomen can soften and the stoma can change within just a few weeks of surgery and discharge.

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

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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:

Age/sex: 39 year old female

PMH: stage 3 colon cancer, Hashimoto's thyroiditis, anemia, postpartum depression

HPI: patient presents to the clinic for a post operative appointment with both surgeon and WOC nurse. Patient has a history of colon cancer and had a sigmoid resection in 12/2023. Patient received chemotherapy, later developing peritoneal disease. Patient underwent further resection, and a loop ileostomy was created. Patient now presents to the clinic 1 month postop.

Social hx.: Resides in a house with husband and children. Independent with ADLs prior to surgery, requires minimal assistance with ADLs post-surgery. No history of tobacco or drug use. Patient states she has two standard alcoholic beverages per week.

Assessment/encounter:

Patient being seen for postoperative assessment of new loop ileostomy. Patient alert and oriented. Gets around with minimal assistance. States she has home health care but has been changing her own pouching appliance. Patient states she has also been experiencing peristomal skin irritation. Pouching system removed and peristomal skin and abdomen assessed during this visit.

Stoma: red, moist, budded (buds more with convexity), mucocutaneous junction intact

Stoma size: 1 ¼" in

Shape: Round

Drainage: semi-liquid/mushy brown effluent in pouch

Peri-stomal skin: denuded from 2-6 o'clock, denuded skin causing small wound at 3 o'clock

Abdominal plane: soft, rounded when supine, creases at 3 and 9 o'clock when sitting up

Education:

- Application of stoma powder and skin barrier wipe to form crusting around stoma and extra over wound at 3 o'clock
- Application of new pouching system
- Opening and closing of new pouching system

Treatment

- Cleansed peristomal skin with warm water and pat dry
- Peristomal skin denuded, used powder and skin barrier wipe to crust
- Coloplast Mio one-piece precut 1 ¼" deep convex drainable pouch, Coloplast Brava moldable ring, Mefix picture framing.

What specific system would you choose as the Ostomy provider? Make sure to include below, considering both short and long term plans for this patient.

Patient would like a simple pouching system. Recommended a precut one piece to reduce ostomy appliance application time: Coloplast Mio one-piece precut 1 ¼" deep convex drainable pouch, Coloplast Brava moldable ring, Mefix picture framing

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Chart Note:

Patient is a 39-year-old female with a history of stage 3 colon cancer, Hashimoto's thyroiditis, anemia, and postpartum depression. Patient resides in a house with her husband and children. She was independent with ADLs prior to surgery, now requires minimal assistance post-surgery. Patient has no history of tobacco or drug use, admits to two standard alcoholic beverages per week. Patient presents to the outpatient clinic for a 1 month post-operative follow up with the surgeon and WOC nurse. Patient has a history of colon cancer and in December of 2023 underwent a sigmoid resection and received chemotherapy. This was complicated by peritoneal metastasis. In August of 2025 patient underwent further resection and creation of a loop ileostomy. Patient seen by both the surgeon and WOC nurse during this visit. Patient states she has home health care but has been recently changing her pouches independently. Patient also states that she has been experiencing peristomal skin irritation. Pouching system removed during this visit and abdominal plane and peristomal skin were assessed. Patient had firm abdomen while in the hospital and was placed in a Hollister New Image 2 ¼" convex flange with CeraRing and a drainable pouch. Patients abdomen is now soft and rounded when supine but has creases at 3 and 9 o'clock when sitting up. Peristomal skin is denuded from 2 to 6 o'clock with a wound from irritation extending out at 3 o'clock. Patient has been overwhelmed with having a stoma and states that she does not like having it and would appreciate as simple of a pouching system as possible. Peristomal skin cleansed with warm water and pat dry. Applied and educated patient on using powder and skin barrier wipe to form crust on peristomal skin irritation. Patient then placed in a Coloplast Mio one-piece precut 1 ¼" deep convex drainable pouch, Coloplast Brava moldable ring, and Mefix picture framing. The deep convexity made the stoma bud up further. Patient educated on how to set up new pouching system. All questions answered during this visit. Patient provided with a step-by-step pouch change instruction sheet and a new supply order form. Patient instructed to follow up with WOC nurses at the outpatient clinic as needed and if new pouching system does not work and/or peristomal skin irritation does not heal or worsens.

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)

- Consult to psychology and group therapy for coping mechanisms
- Continue using powder and skin barrier wipe to form crust
- Change pouching appliance every 3 to 4 days
- Cleanse peristomal skin with warm water
- Continue to oral hydration solutions
- Notify surgeon or present to ER if experiencing signs of dehydration (feeling thirst, dizziness, headache, muscle cramps, dark urine)
- Follow up with surgeon in outpatient in 1 month for assessment of healing and beginning discussion of reversal
- Follow up with ostomy nurse as needed, return if new pouching system continues leaking or if peristomal wound and skin worsens

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

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Since this patient has a new stoma and has never had one in the past, I would have reviewed the use of oral rehydration solutions with her. It is very important with an ileostomy that the patient uses oral rehydration solution to prevent them from becoming dehydrated. I would have reviewed the kinds of oral rehydration along with making it about half of her oral fluid intake each day. I would also have suggested for her to sip on them throughout the day rather than chug them in a short sitting.

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 today was to see more stoma markings and pre-op education. This goal was not met, but I did enjoy seeing many postop follow up patients and how their abdomens had changed since surgery and required a new pouching system.

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

Tomorrow I am with urodynamics. My goal is to see their different kinds of testing and treatment options for the patients that present to their clinic. I would also like to be able to ask when and why they choose a specific exam for a patient and how much it really tells them and how much requires further testing.

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

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