

**Daily Journal Entry with Chart Note & Plan of Care**Student Name:  Lisa Katrowski  Day/Date: 10/08/2025Number of Clinical Hours Today:  8  Number of patients seen  3 Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor:  Kristine Woodworth 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.**

Started my morning off at the Ostomy Clinic, with only two patients at the clinic today. Was able to see a colostomy and a urostomy patient who were having problems with pouching and leaking. Work with both individuals, listening to the problems and going over strategies and changing pouches. Next went back over to the hospital, had an in-service on new beds and mattresses coming to the facility. Meet with the vendors, and they brought the bed and frame in to go over all the functions and features of the bed. The last patient I saw for the day was an emergency ostomy marking for a patient, and I had to complete a stoma marking for this patient.

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:**

Patient is a 71-year-old female with past medical history of dementia, COPD, atrial fibrillation, coronary artery disease, dysphagia with g-tube placement, hypertension, hyperlipidemia, and diagnosed with adenocarcinoma of the colon. The patient came into the hospital for persistent GI bleeding. She was scheduled to have her colon resected for next week, but because she has active bleeding, she has been

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rescheduled for 10/9/2025. We were consulted for stoma marking. Went to the patient's bedside and introduced myself to the patient and stated why I was in the room, and was going to mark her for surgery. Patient was very pleasant but had forgotten what had brought her into the hospital and did not remember she was having surgery the next day. Patient was aware of her own name but was unsure where she was and why. Tried talking to her about her clothing and where she liked to wear her pants, but could not get a straight answer from the patient, but she was able to point out that normally she had the pants higher on her waist. The patient is currently living in a nursing home. Spoke with the nurse beside about the patient and making sure that the patient was able to follow simple commands and able to stand with assistance. The doctor requested to have the patient be marked in the RLQ. The patient was assessed in bed, and the bed was placed in a lying position. While the patient was lying flat did not see any scars but did see a crease running midline at the umbilicus. Explained to the patient that I needed her to do a modified sit-up so I could feel and locate her rectus muscle. I also asked the patient to cough so I could verify the location. Using a colostomy bag was able to locate a good placement of the bag, avoiding the midline crease as well as the patient's g-tube, and place a small mark at this site. Next, asked the patient to sit on the side of the bed. Helped in assisting the patient to sit on the side of the bed. Looking at the stomach I did not see any new creases when she was sitting. I verified that the bag was able to sit flush on the skin and did not see any new creases, divots, or hanging skin. I asked the patient if she could see and point out the mark I had on her stomach. She was able to verify by looking and pointing out the mark. This allowed me to be sure that the stoma would be visible to the patient. Was still able to assess where the rectus muscle was able to be palpated and that the mark was away from any bony prominences. The next step was to stand the patient up to see and verify that the stomach plain was flat and no new creases. I was surprised to see a new crease when standing. Her stomach had a crease midline running down from the umbilicus to the bottom of the abdomen. Taking the ostomy pouch again, checking that the mark on the stomach is located in a flat plane and is not in the crease on the stomach, as well as verifying it is still visible to the patient. Once I was sure of the placement, I had the patient sit back down to place a mark at the site. Next, use 3m film barrier around the area, allow it to dry, and place a clear Tegaderm over the mark to help protect the mark on the patient's stomach. very thorough!  
So the 2 for F& S is because she needs assistance turning or something else?

I did choose 2 because she is incontinent, and she is unaware of when she needs to use the restroom. When assisting this patient, she was weak and needed help and support when moving from the bed to standing. Patient was able to turn in the bed and shift weight.

### Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	17

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.

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**WOC Plan of Care (include specific products)**

The patient is going to surgery tomorrow. I did bring educational material and a sample pouch into the room. After performing a marking on the patient, we usually take the time to help educate that patient on the stoma and give a small teaching session, as well as answer any questions the patient is having at that time. With my current patient and her dementia, I was unable to do this because she was pleasantly confused and did not know what was happening at this time. I was able to still leave educational information in the room. No family members or caregivers were available at this time to go over this information. We will continue to keep this patient on the WOC list and follow up when her surgery is done. We will reach out and contact the family or caregiver to work on education about a new stoma. We still take the time to go over the information with the patient and help teach her about the stoma and how to work the pouch. So do you need to give any instructions to staff about the F&S score of 2. Always think of the big picture w all of your patients from a WOC perspective. 1. And since she is confused, is she able to identify when it is time to urinate and to go to the bathroom or is something else going on?

Patient is unaware of when she needs to use the bathroom. The patient would need support from staff because of the incontinence issues. The patient is able to stand and follow simple commands this patient might be suitable to try a toileting schedule to see if this help to decrease the amount of time she is incontinent and help to decrease moisture perianal areas. This will also give the patient an opportunity to be more mobile and shifting positions during the day.

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

The marking went well, since it is more of an emergency, I was unable to set up a time to talk with family or caregiver at this current time. I think it is important to give the information on the surgery, stoma, and ostomy as much as I can to each patient, family, and caregiver. I was sorry that the patient's dementia was so far advanced that she did not fully understand what was going to happen to her. I did take the time to speak with her while I was there, but I feel that nothing we talked about was able to be retained at this time.

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 work with an Ostomy patient, and I was happy to have a stoma marking on my clinical day. This is the second one I have done with my preceptors in the room.

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

I want to focus on a patient with a continence issue.

**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"> <li>Identifies why the patient is being seen</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>	✓	

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

• 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: Patricia A. Slachta Date: 10/10/25

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