

Daily Journal Entry with Chart Note & Plan of Care

 Student Name: Sharon Murphy Day/Date: 10/20/2025

 Number of Clinical Hours Today: 10 Number of patients seen 5

 Care Setting: Hospital Ambulatory Care Home Care Other

 Preceptor: Sarah Yount

 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.

It was a very good learning experience with a lot on new things learned. 1) Abdominal wall abscess with colo-rectal fistula and Stage 4 coccyx PI. 2) End Ileostomy teaching. 3) Stoma marking for celiac disease prepping for Total colectomy. 4) Irrigation of Indiana pouch and Colostomy pouch change. 5) New post op K-Pouch not producing back irrigation normal saline that was irrigated with.

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	4
Moisture	4
Activity	4
Mobility	4
Nutrition	2

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Friction/Shear	3
Total	21

Age/Sex: 22 yrs, Female

Past Medical History: Celiac disease., IDA, Ulcerative colitis, and IBD,

Meds: Magnesium, Reglan, Protonix, Simethicone, Bactrim, Rinvoq.

Allergies: Gluten and Lactose.

Social History: No tobacco use, alcohol use and denies illicit drug use.

Labs: WBC: 8.27, HB: 9.3, HCT: 29.8, PLT: 269, NA:140, K: 3.9, Chlor: 104, CO2: 24, BUN: 28, CREAT: 0.67, GLUC: 77, CA: 8.9. CRP: 16.5,

Vitals: 98.4, Pulse: 66, Respirations: 17, B/P: 109/56, Oxygen level on room air is 100%

Weight: 137#, Height: 5'8

Colonoscopy: done on 9/18 shows severe, diffuse, pattern-most pronounced in the transverse and descending colon-with relative rectosigmoid sparing. Biopsies were consistent with ulcerative colitis and negative for CMV.

CT AP with IV contrast. 9/23/25 Showed improved colitis compared to prior CT AP from 9/16 w/o any complications. CT AP 10/6/25, similar to diffuse colitis as before.

Assessment/Encounter

Alert and Oriented x 3. Pleasant and cooperative. Mother is present with the patient at this time. This patient presents to the hospital from Corewell Health-Beaumont Hospital for a second opinion on Ulcerative colitis and the need for colectomy. Patient and mother asked appropriate questions and were answered with good verbal understanding from Sarah Yount, RN-BSN, CWOCN. Stoma marking site done at this 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)

Stoma Site Marking:

Initially, the surgeon was asking for four possible markings. However, with assessment, only two options were good for stoma placement. The surgeon was notified of this. The patient was lying flat on their back, and the abdomen was cleansed with alcohol. We identified the rectus muscle as the patient raised her head up off the bed. Then we had the patient sit up and instructed her to have poor posture. Initially, she was sitting up straight with her back arched a bit to give the appearance of a flat abdomen. With poor posture noted, the abdomen was folded across the middle. Had her stand and adjust her pants belt line where she normally wears them. Had her sit back down and placed two marks in LLQ and LRQ. Sarah Yount, RN-BSN, CWOCN, explained to the upper quadrants that it is not an option, as her rib cage in a lying position is positioned too low to have a good ostomy fit in those quadrants. Had the patient stand again, and we remarked the sites a little farther apart, as noted, if they had to open her up and have a midline abdominal incision, it would give more room to stay away from the incision for pouching, but still plenty of room in the quadrant for the stoma.

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Instructed patient to place a finger on each mark to verify she is able to see them in which she was. The site was then cleansed again with alcohol and marked with a surgical marker, and a Tegaderm was placed over each site. The patient had no scars, tattoos, or any irregularities to work around.

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

This was a very thought-out stoma marking. It was a good, straightforward marking. A lot goes into it, as you also need to account for what if. Like the midline abdominal incision. A lot of education and answering questions go into this marking. This procedure took approximately 1 ½ hours to complete. Time well spent. It was my first stoma marking. I feel it went very well and would not add or change anything.

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?

To work on some lavage or irrigation techniques. I got all of this in, plus some very exciting experiences today.

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

Working more with peristomal skin and or collecting specimens from urinary diversions.

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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	✓	

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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: _____

Reference
Reference:

Cleveland Clinic. (2025, March 03). Ankle-Brachial Index.

<https://my.clevelandclinic.org/health/diagnostics/17840-ankle-brachial-index-abi>

 Mayo Clinic. 2024, August 9). Peripheral Arterial Disease (PAD). <https://www.mayoclinic.org/diseases-conditions/peripheral-artery-disease/symptoms-causes/syc-20350557>

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