

**Daily Journal Entry with Chart Note & Plan of Care**Student Name: Alice Pownall-Gray Day/Date: 9/17/2025Number of Clinical Hours Today: 8 Number of patients seen 5Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor: Aaron FischerClinical 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 another outpatient clinic day with a different preceptor Aaron Fischer. We saw 2 patients whom both needed to be marked for possible ileostomy creation. The first was a woman who was 74 yrs old and was having surgery due to diverticulitis and may require an ileostomy. The second patient for marking was a black male who had colon cancer. (this patient I will discuss later in my follow up note). Both patients were given education, were allowed to watch an education video on ileostomy. They were given the option of marked with pen or tattoo marking and both chose tattoo marking. We also saw a patient who was discharged from the hospital the 5 days ago after s/p ileostomy creation, hemicolectomy and oophorectomy due to ovarian cancer. and was accompanied by her sister. The patient needed a new convexity wafer and pouching system. She and her family were assisted with ordering the correct supplies and educated on use of new appliance and how to change it. The next patient was a 55-year-old male who was a follow up appointment s/p loop ileostomy. He had a musculocutaneous junction separation, at the 9 o'clock position clean and granulating well. This patient was appliance was not changed as patient was doing well with his current system, we did however give him M9 drops to try for odor control. The last patient was 67-year-old female with a ileostomy and ad been having some pain. She was s s/p right hemicolectomy. Upon removal of her appliance pt had a very inflamed skin with visible satellite lesions around the stoma. She was treated with nystatin powder and instructed how to use it when she did her own car at home.

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:**

**Braden Risk Assessment Tool**

Sensory Perception	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
<b>Total</b>	<b>2</b>

Pt is a 68-year-old male with an overlapping neoplasm of the colon, malignant neoplasm of the rectosigmoid junction, and malignant neoplasm of the ileocecal valve. He also has hypertension, type 2 diabetes non - insulin dependent, umbilical hernia, pulmonary nodules and has undergone antineoplastic chemotherapy. The patient came into the outpatient clinic today for preoperative education and marking for a possible ileostomy creation. The patient and his daughter were present for the visit. The patient and daughter were greeted and introduced by the idea of an ileostomy and its function. The patient and his daughter were set up to watch an ileostomy education video. The patient was asked if he would like to have pen mark for his ileostomy marking or a tattoo. Pt was educated that since his surgery was not until late October, he would need to take care of the marking site. He was educated that the tattoo would have no upkeep. He chose to have the tattoo after he discussed the options with his daughter. The pt was then asked to sit in his chair with his shirt lifted so a marking spot could be found. He then was asked to stand as well, and finally, he was asked to lie on the examining table. An appropriate spot was found that was free from belly creases on the left lower quadrant of his abdomen. Due to the patient's abdominal hernia, the mark was decided to be put about an centimeter more lateral on the right side of lower abdomen. The area was prepped with an alcohol wipe then a guide was used to secure the spot of where the tattoo would be, then a drop of India ink was placed then a 25-gauge needle was used to make three pricks into the area where the India ink was. After that the area was wiped clean with an alcohol wipe then a picture was taken for the chart so the surgeon could visualize the area. The patient was educated on taking of the band aide that covered the marks within 24 hrs.

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)**

Pt to return to clinic after surgery for ileostomy training s/p new ileostomy creation.  
 Assessment of patients coping of new ileostomy.  
 Assess output, stool consistency and hydration.  
 Assess patient's nutrition discuss dietary restriction for ileostomy and some food choices. May need referral to nutritionist if not coping adequately.

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Assess stoma and peri stoma area.  
 Assess if appliance is fitting correctly and adjust if needed.  
 Review supply ordering process and provide updated supply list to patient and if home care is involved.  
 Provide emotional support if needed and supply list of support groups and online support resources.

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

I think the visit went very well. The only thing I might change would be to allow the patient to touch and hold an ostomy appliance and discuss its use. I think this might help with the process. good idea

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 mark a stoma sight with a tattoo. To gain increased knowledge regarding stoma care and different appliances, and how to treat skin conditions related to the peri stoma.

**What is/are your learning goal(s) for tomorrow?** Tomorrow I will be in the clinic again but following an APRN. I hope to see more ostomy and continence patient care and understand the role of a mid-level provider who works in the WOC area, participate in care of the patients and education process.

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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	✓	

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Learning goal identified	✓	
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Reviewed by: Patricia A. Slachta Date: 9/24/25

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