

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Terryann Simpson Day/Date: 12/8/25Number of Clinical Hours Today: 8 Number of patients seen 6Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Jill MichalakClinical 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.

-85-year-old female with a new colostomy to the LLQ with Hartman's procedure related to bowel perforation. The stoma is above skin level, and the ostomy is functioning at the skin level. Pouching with a 1-piece Coloplast flat soft convex with a stoma ring.

-A 47-year-old female consulted for pouching; she has a new enterocutaneous fistula that developed from an abdominal surgery. She is currently using a wet-to-dry dressing (gauze and ABD pads). Not effective due to high output that requires frequent changes. The plan is to trial a 1-piece flat ostomy with a barrier ring and discharge home with home care. *←we know Wet to dry is not evidence based or indicated in most cases. Make sure more appropriate interventions are advised.* This is what the patient came in with from home: an ostomy pouching system was applied. She will have home care for evaluation and continuation of pouching system.

-67-year-old female with a new colostomy related to a small bowel obstruction, she is 8 days post op. Plan a 1-piece Coloplast flat pouch with a filter and an ostomy ring. Will be seen for daily ostomy care while in the hospital.

-73-year-old female with a history of adenocarcinoma of the colon stage 4, consulted for stoma marking (see chart notes).

-86-year-old male in the ICU with an existing colostomy admitted for septic shock. He has a prolapsed stoma and is currently using a 2-piece Hollister ostomy. Plan to change to a flat soft convex 1-piece Coloplast pouch with filter and barrier ring.

-67-year-old female with a new colostomy 4 days post op, with ostomy to LLQ related to small bowel

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obstruction. She also has a midline incision with staples, was consulted for ostomy education. Plan is for a 1-piece Coloplast flat pouch with filter and ostomy ring, post-op ostomy education provided.

ok

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	3
Mobility	4
Nutrition	3
Friction/Shear	3
Total	21

73-year-old female with a history of adenocarcinoma of the colon, stage 4. She has a medical history of type 2 diabetes that is currently controlled with an A1C of 5.1. Morbid obesity, gastric leiomyoma, renal cell carcinoma of the left kidney, stricture of the descending and transverse colon, and a non-obstructing tumor. An enterostomal nurse was consulted for stoma marking for colostomy placement. The patient has completed 1 year of chemotherapy without any complications. The surgeon is requesting 4 sites to be identified for possible placement. The plan is for diagnostic laparoscopic surgery. During assessment for stoma marking, an abdominal hernia was identified in the right upper quadrant of her abdomen, and an abdominal crease at the mid abdomen when she sat upright. These were clearly marked with a surgical marker and labeled, as well as 4 sites identified, 1 in each abdominal quadrant. The 1 in the right upper abdomen is marked above the hernia; the patient was able to see and identify all quadrants and markings. *←make sure a prioritized area is identified when multiple marks are made. What positions was the patient marked in? When documenting a marking – make sure you mention how your areas were located (how was rectus muscle identified?). If a policy is in place (it should be) alluding to marking per the policy is safe documentation.*

Patient is currently hospitalized, awaiting her surgery; her Braden score is 21. Sensory perception is fully intact, no moisture identified; her activity is limited due to her hospitalization; prior to this, she had no limitation or impairment. She is able to ambulate independently without any assistive device or assistance.

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Nutrition is adequate; she had no issues with her diet prior to being hospitalized, even during her chemotherapy. Currently, NPO and waiting for surgery at noon today. Friction is not a problem because she moves independently in bed and chair, and is not at any risk for skin issues right now.

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)

The plan for this patient is diagnostic exploratory surgery today at noon
4 possible ostomy sites were identified and marked as requested by the surgery team, 1 site marked in each quadrant with RLQ #1, LUQ #2, LLQ # 3, and RUQ # 4.

The above states what was done (it should be in your note)

Your directive plan here should be what needs to be done – it will be short given these circumstances.

What should the patient do re: adls?

What warrants a reconsult for you prior to surgery?

Diet?

etc

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

Assessment was appropriate, and markings were completed with the patient in different positions to identify different areas of concern. *←be specific, consider documentation from a legal review standpoint. How was this done? Mention above.* This will guide the surgeons towards the best site for this patient to promote independence and quality of life after surgery. There is nothing that I would have done differently with this marking.

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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 was to see a stoma marking; yes, I achieved that goal and saw an enterocutaneous fistula.

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

My goal for my next clinical urostomy because that is one thing that I have not seen as yet in clinical. *←good to see! This ostomy is less common, but a critical point of understanding for us as WOC nurses!*

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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	✓	
Learning goal identified	✓	

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Hi Terryann – see my comments throughout this journal – the highlighted areas need some attention. Once complete, this journal will qualify as your marking journal. Please make sure an Eval is turned in from your preceptor from this day. Reach out with any further questions, as usual!

Reviewed by: Mike Klements 12/12/25

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