

**Daily Journal Entry with Chart Note & Plan of Care**

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Student Name: Nian Wan Day/Date: 5/01/09/2926Number of Clinical Hours Today:      Number of patients seen     Care Setting: Hospital      Ambulatory Care   X   Home Care      Other     Preceptor: Jessica Kirksey, BSN, RNClinical Focus: Wound      Ostomy   X   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 we saw markings for ostomy as well as troubleshooting a leaking pouch. These are the following patient encounters:

Patient #1 – Patient comes to get marking for ileostomy. Mark on right hand side with surgical marker and covered with Tegaderm.

Patient #2 – Patient struggling with leaking due to abdominal crevice and folds. Placed wedges and extended laterally. Gave patient more supplies.

Patient #3 – Patient will see surgeon as patient states has a working bladder and unsure why here.

Patient #4 – Patient marking for potential stoma for ileal conduit. Patient deciding whether to do neobladder or stoma. Wife believes that a urostomy is simpler to care and likely less potential for complications.

Patient #5 – Patient is getting revision of ileostomy and have it closed. However, patient reports stomach acid is bothering skin secondary to leaking. Changed pouch, placed washer and paste around pouch flange.

Additional activities included watching videos regarding ileostomy, urostomy, and colostomy again. This time had a better grasp of what is being said now that have had hands on experience. Today was really focused on marking and becoming proficient in removing ostomy pouches. I was thrilled when the ostomy nurses felt that my marking was in the correct location. From starting this week and having no experience with marking until now. It felt like an incredible accomplishment.

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,

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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	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

This was an outpatient stoma clinic, so Braden Risk Assessment tool was not performed.

History of present illness: Possible ileal conduit site marking.

Focused history: 68-year-old male presented to the stoma clinic with spouse for possible ileal conduit secondary to muscle-invasive bladder cancer [MIBC]. The patient selected treatment with gemcitabine/cisplatin/durvalumab [gem/cis/durva] and radiation therapy. CT urogram on 07/16/2025 suggested large bladder mass, no upper tract or metastatic disease. A transurethral resection of bladder tumor [TURBT] procedure on 08/15/2025 showed MIBC. CT scan of chest on 09/05/2025 showed no evidence of disease and bone scan on 09/05/2025 showed no evidence of metastatic disease. Patient completed chemotherapy on December 10, 2025.

Patient came to the stoma clinic accompanied by his wife. Per patient's chart, the patient is considering the neobladder vs the ileal conduit. Therefore, patient presents with his wife for an outpatient site marking session.

Procedure explained to patient after watching the video outlining urostomies. Patient then removed shirt to expose abdominal area. A slight crease noted in right quadrant in the mid abdominal line when sitting down erect. The rectus abdominus borders located. Patient was directed to sit and lean forward, a tentative "X" was placed approximately 2 inches to the right of the umbilicus at the 10 o'clock location in the right upper quadrant [RUQ]. The patient then stood up to evaluate whether the patient could see the marking – which he could. Then patient was asked to lie down to confirm the patient could still see the mark. The abdominal contour throughout the patient's position change remained smooth and without creases. The marking was then converted into a darkened circle and covered with Tegaderm – per patient's request. Provided education regarding importance of keeping the marking covered and marked at all times up to surgery. Both the patient and spouse expressed understanding.

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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)**

Patient provided the following:

Maintain the marking done in the during the stoma marking and kept continuing with Tegaderm. A surgical marker provided so can darken if the marking fades during washing or bathing. Then, cover with extra Tegaderm provided. Contact the wound ostomy service with any questions or concerns about the stoma marking.

The patient and spouse will speak with the surgeon for any additional information regarding the neobladder and urostomy to help make a better informed decision.

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

This was indeed an “ideal” patient for a Patricia Benner’s “novice” nurse to start. Both the patient and spouse were agreeable to having a student and preceptor during the stoma marking. I chose the marking that eventually was determined to be the best site, as the preceptor chose a slightly lower mark and asked another ostomy nurse to get a second opinion. Of course, I felt elated inside that my site was chosen. However, I then started to question myself whether I was actually “lucky” or made an informed decision – aka “beginner’s nurse internal voices of doubt.” However, I did perform the steps necessary to select an optimal site: The patient was getting a urostomy marking, which should be on the right upper/lower quadrant. I made sure the site was within the rectus abdominus to minimize risk for hernia. I also visualized creases to avoid marking on a crease and ensured the patient could see the mark. The next time, I will be more confident in my assessment and decision.

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 today was twofold: One, I wished to perform markings for continued practice to gain proficiency. Second, to become confident with removing ostomy pouches, cleaning surface, and placing new one.

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

To become more confident in stoma marking. Also, start to be more active in removing old ostomy pouches, cleaning the peristomal skin, ensuring the skin dry and dusting stomahesive powder followed by skin prep. Patient #2 had a number of creases in her abdomen that made stacking and wedging prior to placing a pouch rather challenging. Also, I learned today that the patient's often has to purchase supplies out of pocket to supplement what insurance allows DME vendors to provide. In this case, the patient had excess Hollister Cera Ring, and how to use these rings to fill in deep creases versus using new supplies that the patient would need to purchase. Like many patients, insurance has limited the number of supplies they are willing to pay, leaving patients needing to pay out of pocket for additional supplies. To include new supplies only adds to the patient's economic burden. I think I will need to start being confident in asking pertinent questions such as what supplies these patients, especially those with longstanding ostomies, have at home. Being fiscal stewards is also an important nursing function.

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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>	✓	
<ul style="list-style-type: none"> <li>Completes Braden Scale for inpatient encounter</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies specific products utilized/recommended for use</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>	✓	
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Braden subscales addressed (if pertinent)</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>	✓	
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>	✓	
Learning goal identified	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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