

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Lindsay ChristensenDay/Date: Monday / 2.2.2026Number of Clinical Hours Today: 10Number of patients seen 7Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Sarah YountClinical 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 focused on ostomy and fistula care. I was able to participate in pouching two abdominal colostomies. One of these encounters was further complicated by the proximity of an existing colostomy near the fistula. This case was interesting in that the patient had his colostomy for many years and only in the past week developed a fistula distally. The other patient with a fistula for pouching was very complicated (by my standards). It was a job for two WOC nurses to work together manually and mentally. Both of these patients required a lot of product. "Petals" were cut out of hydrocolloid (Hollisive) and used to form a more firm pouching surface. Cracks were filled with stoma paste. I had an interesting discussion with my preceptor about this because I am often unsure when it is appropriate to use paste. She told me to think of it as a caulk which is helpful.

We did a teaching session with a new urostomate. A resident from surgery arrived at the same time as we did. The patient had reported decreased urine output overnight. The resident flushed the stoma and a large amount of urine was subsequently expelled. It was likely clogged with some mucous, made worse by post operative swelling. I am glad we got the timing right for that. We then proceeded with education for the patient and his wife. They were reassured about the extensive follow up and support they will receive after discharge.

We did a marking for a possible ileostomy for a patient having an ex-lap tomorrow. There was much discussion about whether or not to mark all four quadrants and ultimately my preceptor could not recommend placing a stoma in either lower quadrant due to skin folds and loose skin.

We saw two patients who care for their long-standing stomas independently. They just needed supplies.

Lastly, we saw a critically ill patient with a new loop ileostomy and recent mucous fistula. This patient is described below.

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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	2
Moisture	3
Activity	1
Mobility	1
Nutrition	1
Friction/Shear	1
Total	9

Consulted for ileostomy pouch leakage

Patient FG is a 74F with no reported medical history due to a lack of previous healthcare. Her only prior surgery is a hysterectomy 20 years ago. On 1/24/26 pt presented to emergency room for weakness. She was found to have a large pelvic mass and hiatal hernia. She had an exploratory laparotomy with evacuation of feculent fluid, and descending loop ileostomy placed. On 1/28 pt was taken back to OR for ex-lap, sigmoidectomy, mucous fistula creation, pelvic mass excision, and right salpingoophorectomy.

Loop ileostomy is in RLQ, slight protrusion, red, moist, slough circumferentially which appears superficial. 1 1/8" round. Mucocutaneous junction intact. Peristomal skin is intact. Abdomen is concave, crease at 3:00, which is where leaking as occurred. Effluent is thin, green.

Strip paste was placed in 3:00 crease. A triangular washer was cut from Hollihesive and placed around stoma. A strip of Hollihesive was placed inferiorly to stoma where tissue is soft. Stoma paste used for caulking. Sytem applied: Hollister Convex 2 1/4" Ceraplus flange. Medial edge was trimmed to avoid covering midline abdominal incision which is sparsely sutured. Hy-tape use for reinforcement and a high volume pouch was applied.

Mucous Fistula is 7/8" round in LUQ, flush with abdominal wall, pink, moist. Mucocutaneous junction intact. Peristomal skin intact, ecchymotic at 9:00. Crease at 9:00. Tissue is soft, contour is concave. Output blood tinged mucoid.

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Strip paste to 9:00 crease. Hollister Convex 1 3/4" Ceraplast flange with adapt convex ring. Paste for caulking. High volume pouch applied. Hy-tape to medial edge near abdominal incision.

Abdominal incision 1" plain packing strip replaced and covered with ABD

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)

Apply stoma powder as needed to any skin breakdown, dusting off excess

Ileostomy: Strip paste to 3:00 crease, Hollishesive triangular washer, long strip inferior to stoma, paste to caulk. System: Hollister New Image Convex 2 1/4" Ceraplast Flange with Tape Border #11403. Reinforce with Hy-tape, high volume pouch. Attach gravity drainage bag if needed. Change every 3-4 days or if leaking.

Mucous fistula: Strip paste to 9:00 crease, Hollister New Image Convex 1 3/4" Ceraplast Flange with tape border #11402, 30mm Adapt convex ring, paste to caulk. Reinforce with Hy-tape, high volume pouch. Change every 3-4 days or if leaking.

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

I was trained in ostomy by a nurse who told me never to use stoma paste. I have always wondered what situations it is good for. After today I do see its place. I will likely utilize it more in my practice.

When we did the marking today the order said to mark all four quadrants. However, we only marked spots in the upper two. I discussed this with my preceptor as I would feel compelled to mark all four areas even if some of the marks were less than ideal. She explained to me that she simply will not mark a spot she cannot recommend. She contacted the surgeon to let them know. They work closely together and though sometimes the surgeon will really need lower spots marked, they typically rely on the stoma nurse to let them know if this is not recommended. After all, we all want good outcomes and a manageable stoma for the patient.

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

My goal for today was to see as many complex fistula cases as possible. Complex cases are what I came here for as I see so little of it back at my job in a smaller hospital. Many basic principles are reinforced when pouching something complex so it is experience on multiple levels. I definitely met my goal today as there were a couple of these cases on our list.

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

Tomorrow I hope to participate in fluid instillation / irrigation of an ostomy. I would also like experience with drains / tubes.

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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	✓	

Reviewed by: _____ Date: _____

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