



R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Plan of Care & Chart Note

Student Name: H. Alexis Seris Espinal _____ Day/Date:
6/4/25_____

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other Out patient

Preceptor: Megan Hincapie BSN, RN, CWOCN_____

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.

Today we saw a total of 5 patients. All of the patients seen were in the outpatient clinic to follow up about pouching issues such as leakage, peristomal skin damage, or damage to the stoma. These patients had Loop ileostomies (one temporary and the rest permanent), an End colostomy, an Ileal Conduit, fistula, and one patient had an Ileal Conduit and a Loop colostomy. Each patient had their pouch changed, required a new pouching appliance, convexity, skin barrier, or change in pouching products such as extender or use of ostomy belt.

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

Chart note:

Outpatient Consultation:
82-year-old male presents to clinic for WOC nursing consultation for lesion to peristomal skin of RLQ Ileal

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conduit. PMH of urothelial carcinoma HGT1. Explained role to patient. Patient able to enter exam room independently.

Provided patient privacy. Patient seated on the exam table and the patient unfastened pant buttons and belt independently. Draped and tucked a blue chuck pad into the patient's waistband. Removed ostomy belt. Removed a 2-piece urostomy pouch, wafer, and ½ of moldable adhesive ring with adhesive remover. Applied and Cleansed stoma and peristomal skin with mild soap on non-woven gauze pads. Surrounding hairs were removed with razor. Wiped away soap and hair with plain water-moistened sterile gauze. Pat dry and apply dry non-woven gauze to the Ileal conduit site for leakage of the stoma.

RLQ Ileal conduit Assessment:

Stoma is round, budded, red, and moist, with white laceration at 11 to 1 O'clock on the stoma. Peristomal skin reveals denudement to 12 O'clock with white, purple, thick, pseudoverrucous lesion at 4 to 8 o'clock. Mucocutaneous junction is intact. Surrounding tissues are soft to semi soft. Measured at 1in with stoma measuring device. Clear yellow urine in the urostomy pouch.

Pt reports, " I usually change my pouch about every 3 to 4 days. As of about 8 months, I feel as though my pouch slides down."

Pouch Change:

Applied light dusting of stoma powder and removed excess. Cut the hollihesive skin barrier washer in the center to 1 in and cut edges to round pointed edges for a triangular shape. Applied hollihesive skin barrier washer to peristomal skin. Applied patient's own Convatec 1in Convex wafer and attached urostomy pouch to flange. Applied and connected ostomy belt to urostomy pouching system.

Time spent with patient 50 minutes with Megan Hincapie BSN, RN, CWOCN.

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)

Recommendations:

1. Skincare: Apply stoma powder to irritated and denuded skin. Brush away excess powder. Apply skin sealant to create a stoma powder crusting.
2. Pouching system: apply a triangular piece of hollihesive skin barrier washer followed by Convatec 1 in the convex wafer. Attach urostomy pouch to flange.

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3. Patient to follow up outpatient with ET/WOC nursing team in 2 weeks

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

This patient will follow up in 2 weeks to see if the pseudoverrous lesion and surrounding tissue have improved. It will be determined if the Hollihesive skin barrier washer assisted in keeping the peristomal skin dry. Also, the patient is continuing with the current pouching system and belt. This seems to be the best option for this patient and the main goal is to keep the peristomal skin and lesion dry. If this does not help we may need to try a different pouching system. This is the other alternative we may try if this patient's issue does not improve.

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 today was to assess stomas and gain an understanding of convexity/addressing pouching issues. This was met by applying convexity through Eakin rings and the use of pouches with convexity. It was also met by discussing options with my preceptor and the patient to find or trial a product and or strategy.

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

Tomorrow I would like to perform more ostomy care and or address skin issues that may fall under continence related skin damage or incontinence associated dermatitis (IAD).

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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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