



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:  
6/13/25\_\_\_\_\_

Number of Clinical Hours Today: 8\_\_\_\_\_

Care Setting: Hospital \_\_\_\_\_ Ambulatory Care \_\_\_\_\_ Home Care \_\_\_\_\_ Other \_\_\_\_\_

Preceptor: Heather Bates\_\_\_\_\_

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 a total of 6 patients were seen. All of patients seen were for scheduled pouch changes. There was a new End Ileal conduit with stents in place, Loop Colostomy, Loop Ileostomy, established End Ileostomy, and established End Colostomy and Colon conduit. The last patient had an End Ileostomy and Calciphylaxis wounds that were pouched due to copious amounts of drainage.

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:**

<b>Braden Risk Assessment Tool</b>	
Sensory Perception	3
Moisture	4
Activity	2

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Mobility	3
Nutrition	3
Friction/Shear	2
Total	17

#### Pouch Change and Stoma Assessment:

In to see a 51-year-old female for pouch change new RUQ Ileal Conduit before discharging to SNF at 3 pm. Pt was admitted for Neurogenic bladder. PMH of neurogenic bladder with chronic Foley catheter, MS, HTN, and s/p Cystectomy bladder radical and Ileal conduit on 6/2/25. H&P reviewed, NKDA. Pt is alert and oriented x4 and pleasant. Explained reason for visit and Pt agreeable to pouch change and stoma assessment. Attempted to follow up with primary RN.

Pt reports, "I have been feeling nauseous this morning. The PA from the surgical team came by to change the packing in my belly incision." Contacted primary RN via call light to provide the Pt with antiemetic at this time.

Pt has a 19 Fr JP drain in place on LLQ.

Midline abdominal incision with partial dehiscence, recently packed this AM by Surgical Team PA.

#### RUQ Ileal Conduit:

Stoma is round, budded, red, and moist. Diameter of 1in, measured with stoma measuring guide. 7 Fr urethral stents x2 in place with no external sutures noted at this time. Peristomal skin reveals dry, intact, and blanchable. Mucocutaneous junction is intact. Surrounding tissues are rounded and semi-soft. Clear yellow urine with mucous was noted in urostomy pouch and gravity drainage bag.

#### Pouch Change:

Removed current 2-piece pouching system with adhesive remover. Cleansed with mild soap and tap water on nonwoven gauze. Pat dry. Measured stoma to 1 in with stoma measuring device. Cut the convex wafer to 1 in and apply a moldable barrier ring to the wafer. Applied stoma powder and dusted away the excess. Applied 2-piece urostomy pouch to flange and checked seal. Attached pouch to the gravity drainage bag.

Pt given additional supplies such as urostomy pouches, barrier rings, stoma powder, gravity drainage bag, adhesive remover, and skin sealant. Pt also given a new supply order form and tip sheet for urostomy.

Time spent with Pt 1 hour with Heather Bates BSN, RN CWOCN.

Alexis Seris Espinal BSN, RN WOC nursing student.

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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)

1. Skin Care: Apply stoma powder to denuded or irritated skin and dust away excess powder. Apply no-sting skin sealant to create a stoma powder crust. Apply during pouch changes Q 3-5 days.
2. Pouching system: Removed current pouching system with adhesive remover. Cleansed with mild soap and tap water on nonwoven gauze. Pat dry. Measured stoma to 1 in with stoma measuring device. Cut the convex wafer to 1 in and apply a moldable barrier ring to the wafer. Applied stoma powder and dusted away the excess. Apply a 2-piece urostomy pouch to the flange and check the seal. Attached pouch to the gravity drainage bag. Change Q 3-5 days and PRN for leakage.

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

The care provided for this Pt went well. The stoma and peristomal skin looked great and was WNL. As a preventative, we recommended stoma powder and create a stoma powder crusting. The output of urine puts the Pt at risk for peristomal skin breakdown. The technique of stoma powder crusting will help to keep the area dry and protect it from moisture. The use of the skin barrier ring is also helpful to provide a better seal. Again, the main goal was to create an effective seal, protect the peristomal skin, and keep the peristomal skin dry.

Prior to our visit, this Pt did receive initial teaching of stoma care and additional educational points. Something we may have done differently is review some teaching points about life with the Ileal conduit and additional pouching education. As mentioned above, more educational materials and order forms were given to the Pt at the time of the visit.

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 stoma site mark and provide recommendations/treatment to Pts with peristomal skin damage. These goals were not met today as there were no stoma site markings to conduct. Pts also did not have any peristomal skin breakdown but some may be at risk. The only Pt with a high risk of leakage and

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more skin breakdown was the Pt with Calciphylaxis wounds. They were not due for a pouch change of their Ileostomy but the pouches to the wounds would have leaked. Thus, creating more skin damage to these lesions.

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

The goal for Monday will be to stoma mark and or see patients with wounds.

**For instructor use only. Do not remove or edit:**

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	✓	

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

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