



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Lisa Katrowski Day/Date: 9/10/2025

Number of Clinical Hours Today: 8 Number of patients seen 3

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Kristine Woodworth

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, and any additional activities.

Today, I completed my hours at a colorectal surgical office. The wound care team at my facility offers free office visits to help patients experiencing ostomy issues. The types of issues that are addressed can be leakage issues, skin damage and care, or help and reeducation on pouching. Any person who has an ostomy that has been created can make an appointment regardless of who the doctor was or where the surgery was done, but is open to any person in the surrounding areas who needs help. Three patients were scheduled today for appointments. The first patient was being seen for continued treatment of granulomas, and silver nitrate was applied. The second patient came in for issues related to pouching. The third patient came in with a question regarding ostomy care. After the office visit was done, I went back to the hospital with my preceptor and worked in the office, working on photo validations and identifications of wounds in the hospital.

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:

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This is a visit for a 79-year-old female who presents today at the ostomy center with issues related to pouching. Patient's past medical history includes Crohn's disease, peripheral neuropathy, HLD, and emphysema. Patient underwent an emergency Hartmann procedure due to perforation related to Crohn's disease. Patient lives at home with her husband; she is his caretaker after he had a stroke 10 years ago. She has had Bayada home health, and her son has been coming over and helping with her ostomy care. She stated that she has not been making her own pouch changes because it is hard for her to cut the bags. Bayada had ordered her pre-cut pouches, and she had them with her and wanted to be taught how to apply the pouch on her own. She also wanted to go over all the styles of bags and products she had and make sure that she was picking the right one for her. Patient walked into the office on her own and brought all of her supplies from home. We started off the conversation with what brought her in today. Patient stated she was excited because she was not aware that anyone had a place to come to that could help her with the teaching about her stoma. She was concerned that she had not been able to change her own pouches and wanted more independence from others, and did not want to keep inconveniencing her son with changing her bags. The first question that was asked was about her stool consistency and how long her bag was lasting. She reported that she was emptying the pouch twice a day, once in the morning and once at night. The consistency is thick, and she was unhappy because she felt she could not clean the bag well. It is hard for her to fully empty the bag each time. She had no complaints about the surrounding peristomal skin, stating it was intact and no irritation, and her pouches were staying on for 4 days. She is upset about how far out her stoma was sitting, and during an evaluation of her stoma site and surrounding area, a hernia was noted in her peristomal plane. This was explained to the patient, and what a hernia was, and why it may have happened in the area. After looking through all of the supplies she had and explaining what they are used for, we looked at her new bag that she wanted to try. She had a two-piece Coloplast Sensura Mio Flex System. This is a closed-end pouch so she could change bags twice a day and leave the barrier in place. Patient performed the pouch change with WOC supervision. All products were laid out for the patient in an area and way she could reach all of the products, and a mirror was provided for her to change. Her old bag was removed by the patient, and the area of the stoma and skin was cleaned by the patient. The stoma was red, moist, and measured 38mm with peristomal skin intact. The size of the cut pouch was 38mm, which was too small for the patient's current stoma. The barrier was cut to fit the stoma, which went to the 40mm line on the barrier. This fits around the patient's stoma well. Patient was able to line up the barrier and apply it on her own, as well as attach the bag. Patient did well and felt confident with the change; her only concern was the fit of the barrier. Was able to explain that she can have her family cut the current box, and she can order the next size up when it is time to order again. Went over the changing of the bags and supplies was able to help write down her questions so she didn't forget later. Was able to answer all the questions that the patient had at this time. Time spent with the patient was an hour and a half. Help pack up all of the patient supplies and escorted her to the front desk.

Braden Risk Assessment Tool

Sensory Perception	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	

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Total	
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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 seen at Ostomy center with issues related to pouching.
The patient states she would like to review the types of pouches, confirm she is using the correct pouch, and practice pouch changes.
The patient performed a pouch change with WOC supervision.
Pouch removed, skin cleansed with warm water
Stoma red, moist, budded, 38mm
Peristomal skin intact
Peristomal plane with hernia

Patient is planning to use a precut pouching system (samples she had needed to be slightly bigger, cut to fit 40mm). Will be using the two-piece Coloplast Sensura Mio Flex system so that she can change the pouch twice a day while leaving the barrier in place (changing this every 3 to 5 days).
Advised to continue with the above routine, obtaining a larger precut barrier.
Plan to return to the ostomy center only as needed for new or worsening issues.

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

The patient seems still very overwhelmed about having a stoma and how to care for it. The patient came in with many different styles of pouches and products that had been given to her to try from home health. We went over all the products she had and how they should be used, and in what situations they are needed. I was able to help write down many of her questions and answers for her to keep. For this patient, a handout or books with instructions might have been a more helpful teaching tool. Most of the information that I did write down for her, but it would have been nice if I had typed out the information and given her a printed copy. This patient was in the office for an hour and a half, and she still felt like she needed more time. Patient was

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able to change the pouch on her own with guidance. The patient might have benefited from having another educational session to make sure she understands how to change her pouch and to assess how her new pouch is working for her.

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 the day was to education and assist in a pouch change for one of the patients who was seen at the clinic today.

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

My goal is to hopefully find a patient to perform a stoma marking on.

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For instructor use only. Do not remove or edit:

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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