



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Rochelle Schadegg Day/Date: Sept. 15, 2025 (Day 1)

Number of Clinical Hours Today: 8 Number of patients seen 4

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Sarah Weisz

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.

There was a last-minute change of preceptor from the APRN wound consult team to the Wound and Ostomy team, so preceptor worked to choose patients who had stomal wounds or required NPWT dressing changes. We had four patient encounters: patient with a leaking fistula pouch and peri wound skin concerns, a pediatric who developed a wound on the lateral aspect of a recently placed stoma, a stoma site marking, and a NPWT dressing change. The pediatric patient had developed a wound of the peri stomal skin where the surgical incision with a slough wound base from frequent leakage of the pouch. This patient posed some challenges as they experienced significant discomfort with site care and required application of Vashe wound cleanser for 15 minutes, they were petite and had a small abdominal surface area to work with and a vesicostomy which required some creativity to dress the wound and pouch both stomas. The patient who required stoma marking also posed some drawbacks as they were sedated and intubated in the ICU which limited the ability to do a full site assessment because we could only assess the abdomen in the lying and a reclined seated position, we could not assess the sites in the standing position, make sure that the patient could visualize the sites, had the dexterity to change the pouch or provide any education to the patient. The patient requiring the NPWT dressing change also posed a challenge as the wound was on the patient's coccyx and the patient was having frequent bowel movements, four just during the dressing change. My preceptor discussed the possible need for a fecal management system to keep the dressing clean and intact but that this options may not work as the patient's stool is semi-formed.

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	4
Moisture	2
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	2
Total	16

This was the initial assessment for a 61 y/o female who was readmitted for GI bleeding s/p transverse loop colostomy complicated by the development of an enterocutaneous fistula. Past medical history includes Lupus, ESRD r/t lupus nephritis s/p renal transplant rejection on dialysis, rectosigmoid colitis, and rectovaginal fistula. Past surgical history includes the above abdominal surgery and multiple digital amputations. Medication list reviewed, patient currently on TPN. Consult was placed for leaking fistula pouch and peri wound skin complications. Patient encountered in hospital bed speaking with primary care team about plan of care, patient agreeable to skin and stoma assessment and treatment. Primary team able to visualize stoma and fistula during assessment, express plan for scope of stoma and fistulography. Colostomy stoma with intact peristomal skin, stoma is edematous and red with some pink and an area of dark/black tissue toward the center, the red/pink areas are moist and dark area is dry. Stoma measures 2 ¼ inches x 2 inches. There is no active stool output during assessment or pouch change but there is scant dark maroon output. Colorectal surgery team rounded during assessment and were informed of findings of stoma and fistula assessments. Midline enterocutaneous fistula pouch found to be leaking, moderate amount of greenish-brown effluent noted from fistula and on surrounding skin. Peri wound skin found to be with erythema and denuded skin, wound 3 ½ inches x 2 inches with noted stomatization. In noting the abdominal contours there is creasing and dips to the abdomen that are contributing to the pouch failure. Adhesive removed was used to remove both pouches and the stoma/peri stomal and peri wound area were cleansed with soap and water. No sting skin barrier was applied to peri stomal skin then Hollister cera ring applied to protect peristomal skin and gaps caulked with stoma paste and a Hollister flat drainable two-piece pouch was applied. For the fistula stoma powder was applied to the denuded skin, then no sting skin barrier. The wound area was “picture-framed” with Hollihesive skin barrier wedge and abdominal creases/dips were filled with skin barrier strips and caulked with stoma paste. A Coloplast post-op pouch was applied and attached to gravity drainage bag. Post-op pouch and two-piece pouch used for easy access for planned tests/procedures. Ensured all effluent had been cleaned from patient’s skin and the linens were clean and dry. Patient asked several questions regarding closure/resolution of the fistula, answered questions within scope of practice. Patient is agreeable to reassessment and goal wear time of 3 days.

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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)

- Transverse colostomy: remove old appliance and cleanse stoma and peri stomal skin with soap and water and pat dry. Assess stoma color, moisture and measure. Apply no sting skin barrier to peri stomal skin. Shape and apply Hollister cera ring around stoma and use stoma paste to caulk. Cut pouch wafer to fit stoma and apply Hollister flat drainage pouch, trimming adhesive tape as needed to fit contours of fistula.
- Midline enterocutaneous fistula: cleanse peri wound skin with soap and water and pat dry. Apply stoma powder to denuded skin, then apply no sting skin barrier. Use strips of Hollihesive barrier wedge around the fistula to protect skin, and Hollister barrier strips to fill in abdominal creases, use stoma paste a caulking between barrier wedge and strips. Apply Coloplast post-op pouch and attach to gravity drainage bag.
- Change pouches every 3 days or as needed for leakage. If leaking occurs the pouch should be changed promptly.
- Notify Colorectal surgery of any changes to the stoma (i.e. changes in color, worsening of dark area).
- Complete new supply form for discharge back to facility.

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

This patient was a complex case, and I think the creative choice to use pouching systems that allowed for easy access to the stoma and fistula without taking down the entire appliance was a great example of patient centered care. The only additional aspect I would have added would be more patient education, some of the questions the patient expressed indicated some potential knowledge gaps/misunderstanding of her current diagnoses. I think providing some re-education would help the patient process her current situation and help with expectations.

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?**

I want to gain an understanding of how the workflow for the wound/ostomy nurse is structure and how patients are triaged.

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

I would like to see a greater number of patients and see how the wound care APRNs workflow differs in comparison to the wound/ostomy staff.

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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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