



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Sherrie Powell Day/Date: Wednesday 9/24/2025

Number of Clinical Hours Today: 8 Number of patients seen 5

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.

My day started in the Ostomy clinic, where we followed up on ostomy-related issues for three patients. The first two patients had pouching issues. One patient had burning and pain on the peristomal skin near the base of his stoma. We measured the circumference of his stoma and noted that he was cutting his pouch too small around his stoma. The second patient had an issue with her pouch sticking and a decrease in wear time. We removed her pouch and noted scattered areas of denuded skin. Crusting technique was performed on the open skin, and a new pouch was applied. Patient education was reinforced for both patients. The last patient at the clinic, however, required treatment for granulomas noted at the base of his stoma on the peristomal skin. The last part of the day was spent in the acute care units of the hospital, where I did a wound VAC dressing on an open abdominal wound, then assessed and gave wound care recommendations on a patient with Xylazine wounds to the bilateral lower extremities. The patient with the wound VAC required application of Santyl to the wound and a contact layer before application, but the VAC application was pretty simple. The patient with the Xylazine wounds admitted to being non-compliant with her wound care and follow-up. Education about her wounds and healing was reinforced, and a consultation and referral to the outpatient Wound Care Clinic was initiated.

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.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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

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	4
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	23

62-year-old male being seen in the outpatient ostomy clinic for continued treatment of peristomal granulomas. Patient has a past medical history of gastro-esophageal reflux disease (GERD), hydronephrosis, urinary retention, non-ischemic cardiomyopathy, rectal cancer, and tumor removal with end colostomy creation. The patient was greeted and assisted onto the examination table. During the interview, the patient states that pouching remains consistent and granulomas have decreased in size since the last office visit. Patient brought in own supplies, stating he will soon need new supplies. Patient's abdomen has an excessive amount of hair; however, it is flat with no identified creases or folds. Patient admits to redness and irritation after shaving. When requested, the patient removed the pouch independently with the use of an adhesive remover. No evidence of leaking around the pouch barrier wafer. Stoma located in the LLQ and is red and pink, retracted~15mm; granulomas x 2 located at 1 and 9 o'clock. The granuloma at 1 o'clock measures 4mm, and the granuloma at 9 o'clock measures 7mm. Peristomal skin is intact with a small ring of redness directly around the stoma. The stoma and peristomal area were cleaned with warm water and allowed to dry. Both granulomas were treated with an application of silver nitrate with special care to avoid the patient's stoma. Peristomal skin was then wiped with 3M no-sting barrier film and allowed to dry completely. Convatec Esteem Body deep convexity 2-piece drainable pouch cut to fit and applied. Patient's ostomy is established with a 4-5-day wear time. The patient has weekly appointments at the ostomy clinic for continued management of peristomal granulomas. Patient advised to continue with current pouching routine and to contact his surgeon for a prescription for ostomy supplies to place an order.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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)

- *Gather your supplies, including pouch, adhesive spray, 3M no-sting barrier film, Eakins small barrier ring, ostomy scissors, and a bag for old appliance disposal
- *Remove old pouch using spray adhesive remover and pulling the bag toward the stoma using the push/pull technique
- *Clean the peristomal skin gently with warm water and allow it to dry completely
- *Measure your stoma and cut the pouch barrier wafer to fit around the stoma, allowing 1/4"-1/8" of peristomal skin exposure from the barrier wafer's edge
- *Apply 3M no-sting barrier to peristomal skin in the direction of hair growth and allow to dry completely,
- *Apply Convatec Esteem Body Deep Convexity 2-piece drainable cut-to-fit barrier pouch
- *Empty pouch when 1/3 full and change every 3-5 days or as needed for leakage
- *Follow up in the outpatient ostomy clinic for your weekly appointment for Silver Nitrate application to the peristomal granulomas until discharged from the outpatient clinic
- *Call the ostomy clinic for any stoma-related issues

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

I was able to work with silver nitrate and see granulomas of various sizes. I treated the ones on the peristomal skin, and we discussed different instances of why a granuloma would appear on the actual stoma and why those are only monitored for an increase in size with surgical involvement if they become too large. For my patient, the only thing I would have done differently is add the Eakins barrier ring around the stoma for added protection of the reddened area. I did, however, place the recommendation in his plan of care.

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 see ostomy patients in the outpatient setting. My goal was met.

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

My learning goals for my next clinical day are to do preoperative stoma markings in the ostomy clinic with teaching.

For instructor use only. Do not remove or edit:

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.