



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

### Daily Journal Entry with Chart Note & Plan of Care

Student Name: Mara Michalski Day/Date: 5 10-10-2025

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

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Shellie Bush

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.

The first patient we saw was a patient with a history of ovarian cancer and being seen for post abdominal abscess drainage, which was left open. We saw patient to place a wound vac. Patient also had 2 bulb suction in place in her R/L UQ. We removed the moist saline gauze and ABD pad from the wound. The wound was irrigated with normal saline, Adaptic non adhesive was placed in the wound bed followed by foam, and strip paste applied in the belly button. Transparent film was placed on the foam and a hole was cut for the suction tubing. The second patient we saw was a post op patient with a colostomy that was supposed to be reversed but it was postponed due to the patient having a CHF exacerbation. The patient was having severe pain and it was discovered that she had a peristomal wound, which was worsening due to the convex wafer that she was using that was applying pressure to the wound causing her a lot of pain. The wound was cleansed with normal saline moistened gauze and Aquacel Ag was applied to the wound. Then covered with duoderm, ring and a flat top 2 piece pouch was applied to help relieve the pressure from the periwound. We also saw a patient that we saw last week as well who had a end colostomy and new seroma that recently opened. It was having excessive drainage. The colostomy pouch was removed and the wound cleansed with VASHE and packed with VASHE soaked gauze and packed. Stoma powder was placed on top of the gauze and the PA that was following the patient was notified and came to bedside to evaluate. The wafer was cut to include the stoma and the seroma opening so that nurses could removed the pouch piece to change and repack the wound and evaluate it, without having to change the entire pouch system.

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:**

**This female patient was seen to evaluate a peristomal wound. Hx of colostomy with future reversal, currently postponed until December due to recent admission for CHF exacerbation. The patient was having severe pain and it was discovered that she had a peristomal wound, which was worsening due to the convex wafer that she was using that was applying pressure to the wound causing her a lot of pain. Pictures of the wound were taken for her chart and the wound was measured. The wound was cleansed with normal saline moistened gauze and Aquacel Ag was applied to the wound. Then covered with duoderm, ring and a flat top 2 piece pouch was applied to help relieve the pressure from the periwound.**

**Braden Risk Assessment Tool**

Sensory Perception	4
Moisture	4
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	19

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)**

- Remove old pouch with adhesive spray to protect skin integrity
- Cleanse periwound and stoma with normal saline soaked gauze
- Pat dry
- Take picture of wound and stoma for chart
- Apply Aquacel Ag to wound bed cut to size
- Apply duoderm over periwound, and stoma cut to size

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- Apply flat top 2 piece pouch
- Change every 72 hours or as needed for leakage

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

The only concern I had today was if the 3<sup>rd</sup> patient we saw, that had the seroma and stoma both cut under the wafer, possibly leading for stool to go into the wound, since it was packed with gauzed and stoma powder on top. My preceptor stated the wound was properly packed and the powder on top would stop any stool from entering the wound. The nurses would be changing the packing since there was heavy exudate so I maybe would have used absorbent packing such as Aquacel. I will be interested to check on the patient the next clinical day I have to see if the course of treatment was effective or needed adjustment.

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? To become more familiar with wound vacs and different wounds and treatments. This was the first time I saw a seroma and helped form a treatment for it.**

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

Continue practicing changing ostomy bags, and cutting wafers to size with different stomas, and trying different combinations of paste, rings, or other ways of placing ostomy bags, and hands on seeing what works best for patients.

**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,	✓	

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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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