



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

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

Student Name: Tisha Weech Day/Date: Tuesday, October 14

Number of Clinical Hours Today: 8 Number of patients seen 6

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Megan Hincapie

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 was with the Wound Ostomy team. We saw 6 patients – 3 with ostomies, 2 with NPWT, and 1 with an urostomy. I watched, and then performed pouch changes and NPWT dressing and cannister changes.

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:**

Age/sex: 86y female  
  
PMH: diverticulitis, T2DM, CDK 3, HTN, neuropathy, HLD, sickle cell trait, malnutrition, hyperparathyroidism, and Grave’s disease  
  
Social hx: worsening dementia per son, no smoking or alcohol use  
  
Surgical Hx: colostomy

(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.

Medications: pt not taking any prescribed medications according to admission documentation

**Assessment/encounter:**

LOC: alert and oriented x2, drowsy

VS: n/a

Initial Interview: Patient admitted on 10/10/25 for altered mental status, found unresponsive at ophthalmology appointment. Pt was hospitalized in September 2025 for perforated colon. Colostomy was placed during that admission. Family changes appliance at home. According to son, pt has worsening dementia and has not been able to perform ADLs independently since previous hospitalization. Patient seen today for pouch change and stoma assessment. Current pouch placed 10/14/25 but with a large amount of exposed skin. This makes area susceptible to irritation and breakdown.

ROS:

Did not engage with team during pouch change

Respirations even and unlabored

Did not appear to be in pain or discomfort during activity

End descending colostomy to LUQ, stoma measured at 1 3/8"

Stoma moist, red, bud

Surrounding skin intact, warm to touch, mild erythema noted to sides of stoma

Stoma draining soft, brown stool

Removed pouching system: Coloplast SenSura flat drainable pouch.

Current pouching system: 2 1/4" Hollister New Image convex flange with tape collar, Hollister Adapt Cera ring

Pouch removed. Area cleansed with soap and water, pat dry. Skin prep applied to area around stoma. New appliance placed. Pt tolerated activity well. Son was at bedside. Extra supplies left.

**Braden Risk Assessment Tool**

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

(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 pouch change supplies. Cut 1 3/8" ring around colloid gel of Hollister New Index convex pouch. Place Hollister Adapt Cera ring around cut hole. Empty and document drainage in existing pouch. Remove pouch using adhesive remover. Cleanse area with soap and water. Pat dry. Sprinkle a light dusting of stoma powder on skin surrounding stoma. Wipe off excess powder. Apply skin prep to area. Place new pouch. Change every 3-4 days unless appliance leaks or inadvertent removal.

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

Patient did not appear interested in the activity. She does not provide care or manage her ostomy at home. The pouch change seemed straight-forward. The patient did not have any wound or skin issues that needed to be treated.

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 stated goal was to learn more about products to protect the skin around the stoma. I used items that are not available at my current workplace, such as Hollister Cera ring, barrier sheets and putty sticks that help even out the skin for appropriate pouch placement. I also learned how to properly lay a wound border when replacing NPWT dressing.

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

Learn more about stoma marking, appropriate placement, stoma issues that wound ostomy nurses will need to be aware of and how to mitigate them beforehand surgery.

(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.

**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: \_\_\_\_\_

(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.