

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

 Student Name: Sharon Murphy Day/Date: 10/16/2025

 Number of Clinical Hours Today: 9 Number of patients seen 5

 Care Setting: Hospital  Ambulatory Care  Home Care  Other 

 Preceptor: Elizabeth Kulling

 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.**

It was a very good experience today. Had a total of five patients who were seen. 1) Was a female who had a very large fistula with a penrose drain with a lot of weeping that the team was trying to decide the best way to pouch this and have it last 7 days. 2) Elderly lady with a double-barreled ileostomy, new on 10/2/25. 3) A developed delayed individual with a leaky pouch. 4) A middle aged male with a leaky pouch. 5) Education for discharge.

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:**
**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	3
Activity	3

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Mobility	2
Nutrition	2
Friction/Shear	2
Total	15

**Chart Note:**

Age/Sex: 82yrs/Female

Patient Medical History: Rectosigmoid adenocarcinoma, Arthritis, DJD of spine, Diabetes Type II, GERD, High cholesterol, Hyperlipidemia, Insomnia, Myositis, Seborrhic dermatitis.

Meds: Omeprazole, Zocor, Cozaar, Zetia, Creon, Spiriva, Glucotrol, Lasix, Lidoderm, Atrovent, Hygroton, Singulair, Xanax.

Allergies: Codeine, Crestor, Darvon, Lipitor, Metformin

Social History: Previous Smoker of Cigarettes, Quit 2000. No drug use. No alcohol use. Lives alone. Does have a boyfriend.

Labs: No current labs available.

**Assessment/Encounter:**

LOC/General Appearance: Patient is awake, tired, pale, and weak. A&O x 3. Pleasant and cooperative. No acute distress noted at this time. Requires the assistance of 2 to get up to the chair. The patient has an ileostomy hooked up to a drain bag. Drains a greenish liquid stool with an applesauce consistency. She is continent of urine. Appetite is fair. No nausea or vomiting. Midline surgical incision with staples intact. Measures approximately 13cm L. A small amount of serosanguinous drainage was noted. Vitals were: Temp: 97.4, Pulse: 89, Respirations: 18, B/P: 134/64, Oxygen level on room air is 95%. Weight: 66.5kg. Height: 5'1. Patient denies any pain at this time. Noted slight discomfort when changing the Ileostomy. Removed Ileostomy pouching system of Hollister New Image 2 ¼" convex flange cut to 1 3/8", moldable ring, HVOP pouch, trimmed tape collar at midline. It is intact with minimal circumferential undermining. Present wear time was 2 days. Cleansed with a pH-balanced soap and rinsed with H2O. The stoma is a double-barreled ileostomy. Diameter is 1 ¼ in the Right Lower Quadrant. It is Budded, Red, moist, and edematous—noted separation at 6 o'clock at the mucocutaneous junction. Peristomal skin shows some erythema and an immediate peristomal rim. The abdomen is semi-soft.

The patient requires cues for pouch change and experiences difficulty cutting the flange and removing the plastic backing. She struggles with the push-pull system to remove the pouch and uses wipes as if she is cleaning her skin to try to remove it. She is unsure if anyone at home can help her. She will be going home with home care services.

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.

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**WOC Plan of Care (include specific products)**

- Use Conva Tec Sensi Care No Sting Adhesive Remover Wipes (#413500) to release the worn pouch from the skin gently.
- Apply Conva Tec Stomahesive powder (#25510) to denuded/irritated skin as needed with each pouch change until healed. Brush off loose powder from intact skin before pouching.
- Use Hollister New Image 2 1/4" convex flange (cut to 1 3/8"), moldable ring, HVOP pouch, trimmed tape collar at midline.
- Cleanse midline surgical incision with pH-balanced soap and water, cover with 4x4 gauze and tape.

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

The care provided was very good, with pouching and how-to steps. Additionally, the education on peristomal skin care that was provided was excellent. I believe that more education on diet and fluid intake should have been discussed, given that ileostomies are high-output and carry a high risk of dehydration. This should have been addressed. Review of medications and foods to help bulk the stool if it is too liquid.

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?**

Stoma site marking. I was informed that they usually do that in the clinic. Hopefully, we will get that in the clinic.

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

Learning more about wounds and identifying different wounds, such as venous versus arterial. Etc. Maybe some diabetic wounds. Seeing some wound cultures being done would be beneficial as well.

**For instructor use only. Do not remove or edit:**

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>• Identifies why the patient is being seen</li> </ul>	✓	
<ul style="list-style-type: none"> <li>• Describes the encounter including assessment, interactions, any actions, education provided and</li> </ul>	✓	

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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: \_\_\_\_\_

C. Baisden (Personal Communication, October 15, 2025).

Aime, M., Bagby, K., A. Farquharson, Faust, T., Gamboa, A., Jenkins, M., Marshall, S., McCoy, A., Montgomery, S., Mooney, R., Roberts, A., Sams, J. (2024). Nurse Insights: What are the best practices for wound care in nursing. *Nursing Education*. <https://nursingeducation.org/insights/wound-care/>

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