



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Susan Warner Day/Date: 10/16/2025

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

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Andrea Heisey, RN, CWOCN

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 preceptor is working on a quality improvement project on prevention of DTI in the inpatient setting. She and her colleagues gathered data on DTI occurrences, along with the presence or absence of potential contributing factors such as hypotension, the head of bed elevated over 30 degrees, if death occurred within 2 weeks of the DTI, and multiple other factors. Once trends are identified, they can work to initiate preventative measures to see if that can help decrease incidences.

76-year-old female s/p knee surgery at another hospital, who came into the ER for an unrelated issue. She had a Provena wound vac in place, and we had to research the chart and speak with the surgeon's office to determine whether the Provena vac should be removed or not.

33-year-old female s/p C-section for post-operative teaching and dressing change.

45-year-old female s/p C-section for post-operative teaching and dressing change.

82-year-old female with right ankle wound which is improving.

66-year-old male in ICU who is nonresponsive and NPO. He has NG tube for enteral feeding and an internal fecal management system in place due to incontinence of frequent loose stools and high risk of skin breakdown.

At the end of the day, we went to the outpatient wound care center for an appointment with an ostomy patient who is having stoma complications and pouching issues.

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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:

Patient who is 1-month post-op with colostomy, presents to the wound care center for outpatient follow up with WOC nurse for stoma and pouching concerns. Stoma is retracted, with significant mucocutaneous separation. Retraction is worse today than last office visit, and stoma is almost completely visually obstructed by the tissue of the mucocutaneous separation. It appears that there is also stomal stenosis. Peri-stomal skin has improved since last office visit, patient has been using Nystatin powder and skin prep spray. Patient is able to perform pouch changes, but typically begins leaking under the skin barrier after 2 days. She brought samples of different convex ostomy barriers from home. Applied a barrier ring and 2 piece deep soft convex barrier pouching system with filter. Patient will see surgeon next week. Instructed to call surgeon right away if she notices decreased output or any signs of obstruction.

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)

Recommendations- Change ostomy pouching system every 3 to 4 days or as needed for leaking or dislodgement. Remove the old pouch and wafer, cleanse the skin with warm water, pat dry. Apply Nystatin powder if needed for fungal rash to peristomal skin. If able, apply stoma powder and barrier ring to area of mucocutaneous separation around the stoma. Cut opening to size of stoma (may need to be cut slightly larger if not able to visualize the stoma). Apply convex barrier pouching system. Call WOC nurse or surgeon if any other issues or concerns. Follow up with surgeon to discuss stomal retraction and stenosis and possible need for dilation or other surgical intervention. Follow up with WOC nurse at ostomy clinic in 2 weeks or sooner if needed.

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

This was a difficult case, initially the area of mucocutaneous separation looked like it was a healthy stoma, when actually, the stoma was not visible, and the tissue that is visible was the mucocutaneous separation. This highlights why it is important to know the history of the patient, the complications, and to view photos to see the progression of healing, in order to more easily identify these issues. I think the only thing I would have done differently is to try to encourage the patient to see the surgeon sooner, to discuss possible surgical interventions, and hopefully prevent additional complications.

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? Make inpatient recommendations and gain new skills. Yes, I was able to get more experience with stoma complications and internal fecal management systems.

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

Continue to build on theory that I have learned and apply to the clinical setting.

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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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