



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 10/29/2025    

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

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor:     Denise Santos    

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.**

Our clinical day began in the ostomy clinic to do a pre-operative stoma marking. We then saw 5 patients in the acute care setting of the hospital. Our first patient in the hospital had a nurse referral for evaluation and treatment recommendation of hidradenitis suppurativa. The patient refused the evaluation due to the chronic nature of her condition. She brought in her own supplies and products from home stating “I will manage my condition; this is not what I was admitted for”. The next patient on our list needed stoma bridge removal and ostomy teaching for a new end colostomy. We then had a patient with a sacral wound that needed to be debrided after noted deterioration from their time of admission. For this patient, we had to get surgery involved to assist with the plan of care. We then had a patient with a superficial coccygeal fissure. This wound only needed normal saline cleanse and a Mepilex border foam for pressure injury prevention. My last patient was another full thickness pressure injury that needed validation and treatment. This wound required Medihoney gel for necrotic slough and a Mepilex border foam dressing.

Types of patients: new colostomy education, sacral pressure injury, presurgical colorectal stoma marking, chronic skin conditions (hidradenitis suppurativa)

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.

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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	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

WOC seeing patient for pre-surgical stoma marking in the RUQ and RLQ. The patient is scheduled on Monday 11/3/2025 for restorative proctectomy with coloanal anastomosis that will result in the creation of a loop ileostomy. Patient is a 47-old-female diagnosed with advanced carcinoma of the rectum. Patient has a past medical history of rectal cancer, premature ventricular contraction (PVC), anemia and anxiety disorder.

Patient greeted in the room and ostomy nurse role explained. Patient's mother, who per patient, will be her primary caregiver at home is present at this time. Stoma marking process explained and patient is asked to transfer to the examination table and remove her upper clothing. While laying supine, patient asked to touch chin to chest to palpate the rectus muscle. The patient's abdomen was then evaluated while laying, sitting, and standing. Sitting upright, a horizontal crease is noted directly superior to umbilicus extending to both the middle of the RUQ abdominal plane and LUQ abdominal plane. Patient admits to wearing her belt slightly above the level of the hip. No scars or any other folds or creases noted. The umbilicus and abdominal crease were avoided when marking within the rectus muscle of both the RUQ and RLQ. The sites were cleaned with alcohol then marked with a black "X". The patient agrees to the placement and confirms being able to visualize both sites. Both sites were then covered with Tegaderm. Patient made aware the colorectal surgeon will make the final site determination. The patient was instructed not to remove the transparent dressings.

Ostomy Skills Kit and Information Booklet given and reviewed with the patient the following:

- Bowel anatomy and physiology
- Clothing
- Diet
- Ostomy skin care
- Stoma characteristics
- Stoma marking

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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)**

- \*Shower as you normally would, taking care not to soak or remove the transparent dressings on your abdomen
- \*Read over the educational material given and write down any questions or concerns to address with the doctor or the ostomy nurse

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

I was very relieved today because we had a stoma marking patient. We did not have a heavy day due to the types of wounds. The only thing I would have done differently is assessing the patient with the hidradenitis. I am curious about her wound care regimen. I believe it is a lot you can learn from patients who take care of their wounds successfully at home.

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 was to do a stoma marking. I am happy the team was accommodating to allow me to do it because it was in a different patient assignment. My goal was met.

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

I have one last clinical day which requires a wound journal.

**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 responses</li> </ul>	✓	

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• 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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