

**Daily Journal Entry with Chart Note & Plan of Care**Student Name: Teresita Duran-Servin Day/Date: 11/17/25Number of Clinical Hours Today: 10 Number of patients seen 9Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor: Patty HarrisClinical 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 saw 9 patient today including

1. PI trigger of mucosal pressure injury, confirmed mucosal PI related to ET tubing.
2. Second pt is further explained below
3. Follow up pt with blisters on left ischium and bilateral buttocks
4. Colostomy bag change after wafer was removed by surgical team to inspect midline incision. No education able to be completed due to altered mental status.
5. PI trigger for stage 1 pressure injury on coccyx, pt evaluated but no presence of PI seen.
6. PI trigger for injury on sacrum, pt assessed with bedside nurse, ITD observed and treated with zinc paste.
7. Initial consult for POA PIs for newly admitted pt. Unstageable to midline coccyx, treated with Exufiber and gauze bordered dressing.
8. Reconsulted to see failed pouching system. Pt was previously in a flat Hollister and was switched to convex Coloplast with a belt due to retracted stoma, however, this pouching system failed. Pt was switched back into a flat Hollister and seal was able to hold for the remainder of the day.
9. Consulted for stoma marking for possible colostomy creation.

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:**

This was a follow up visit for a 77 y/o Caucasian female being seen for continuous management of ECF and colostomy s/p multiple repair of AAA leading to mesenteric ischemia. Pt has a h/o HTN, AAA, GERD, diverticulitis w/ diverticulitis c/b perf x2, axonal polyneuropathy, kidney stones, urinary urgency, c.diff. Prior to admission pt was living independently with a rollator walker. Pt intubated and sedation during this visit, but this RN and WOCN continued to verbalize assessment and treatment. Primary RN at bedside with us during this visit and assessment. Pt's previous dressing composed of a Coloplast colostomy pouch, Brava Protective Seal rings, Brava Protective Sheet, but was unable to hold a good seal due to an increase in output. Surgery team also at bedside and requesting superior wound to be pouched in conjunctions its inferior wound for better management and visualization. Dressing over fistula and colostomy pouch was removed carefully using Brava Adhesive Remover Spray, peri-fistular/peri-stomal skin was cleanse with a wash cloth and warm water, gently dried with gauze. Peri-fistular/peri-stomal skin was dressed with Cavilon Advanced Skin Prep (allowed to dry), Slim Brava Protective Seal applied to immediate wound edges, and around stoma. Wound stencil was drawn on plastic and used to trace on a large Eakin Wound Pouch. Eakin Wound Pouch was cut to stencil shape and then warmed with warm packs to establish a more moldable application. Eakin Wound Pouch was then applied to midline abdomen ensuring to encompass inferior and superior wounds and then warm packs were reapplied to help establish a good seal. Window was cut and placed over superior wound for easy access and assessment. Attention was then turned to pt's colostomy which was within a close range of Eakin Wound Pouch therefore decision to use the Pediatric 1 piece urostomy flat pouch was used. Warm packs were lifted and decision was made to add Coloplast Comfeel as a boarder to the Eakin Wound Pouch for a more secure seal. Staff aware of need to notify surgical team of new changes and WOC team of problems with the pouch. Will continue to monitor stoma and ECF with staff and surgical team. Pt did not display changes of discomfort during care (non-verbal, vital changes). Will continue to follow on a weekly basis and as needed.

**Braden Risk Assessment Tool**

Sensory Perception	1
Moisture	3
Activity	1
Mobility	1
Nutrition	3
Friction/Shear	1
Total	10

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)**

1. Change appliance every 3 days and PRN for leakage

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- a. Remove pouching system using push pull method and using Brava adhesive removal spray.
  - b. Cleanse peri-fistula/peri-stomal skin with warm water and pat dry with gauze.
  - c. Apply Calivon Advanced to peri skin and allow to dry until irritation has healed
  - d. Using stencils in pt basket, cut Coloplast pediatric flat 1 piece urostomy pouch to size and Eakin wound pouch to size
  - e. Warm Eakin wound pouch for easier application
  - f. Apply Eakin wound pouch over superior and inferior wounds first and then apply urostomy pouch over stoma
2. Notify surgical team for increased drainage, lack of output, dark/black colored area

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

With the umbilicus being between both pouches, I would have considered a stoma paste to fill in lieu of/in conjunction with the ring to help create a flatter surface and ensure all creases are filled evenly. This could help fill some of the new creases created by the rings around the wound edge as well.

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 learn more about ostomy care in terms of complex stomas and more pre-operative teachings. I was able to see one complex stoma and learn about different levels of convexities and what works for those in peri-fistular sites. I was able to observe a two RN pre-operative site marking and pre-operative education.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**  
 Tomorrow I will be at a new hospital and hope to assess/observe and help treat complex fistulas that were mentioned by the WOC team at this site.

**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	✓	

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● 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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