

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Terryann Simpson Day/Date: 12/5/25Number of Clinical Hours Today: 8 Number of patients seen 5Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Jill MichalakClinical 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.

- 40-year-old female with colostomy related to Adenocarcinoma of the descending colon (see chart note).
- 71-year-old male for Ileostomy follow-up and skin check. Ileostomy is related to Crohn's disease. Patient has a prolapse ostomy, using 2 2-piece soft convex. Skin issues resolved, continue using the same appliances, and apply a skin prep barrier before application.
- 72-year-old female for skin check, colostomy related to colon cancer, currently doing chemo. Denuded peristoma area, as well as a small wound to the umbilical area from retained suture since July. Currently using antifungal powder on the denuded area without improvement. The plan is to apply collagen with silver to the umbilical and cover it with a foam dressing every other day. Triamcinolone and antifungal powder to the denuded area, soft convex pouch with barrier ring and barrier strips around the ostomy pouch.
- 28-year-old female with a history of stage 4 colon cancer, complete chemo in October. Currently changing ostomy every 3 days and using a 1-piece flat flex wear with skin prep and ostomy ring as well as barrier strip. Plan to continue the same treatment and products.
- A 48-year-old female had a G-tube placed due to malabsorption syndrome related to juvenile rheumatoid arthritis. Present for tube site check, hypergranulation, silver nitrite treatment completed.

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

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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	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

40-year-old female with colostomy related to Adenocarcinoma of the descending colon. Medical history includes hyperlipidemia, depression, and type 2 diabetes. Patient presented for an ostomy and wound check around the ostomy site. She has a retracted stoma, which makes pouching difficult, and she has been changing her ostomy 2-3 times per day. This is complicated by the use of the wrong supplies because her supplies were ordered and never delivered. She is currently wearing a flat one-piece ostomy with a ring.

She is currently undergoing chemotherapy, and the plan is for reversal early in 2026 if things continue to progress as they are now. She has multiple wounds around her stoma of unknown origin. She reports that it started as one blister while she was incarcerated about 6 months ago, and it was never addressed, and it kept increasing in size. Now she has a total of 3 wounds and denuded areas around her stoma. Right upper stoma, 3cm x 2.5cm x 0.2cm, right lateral 1.1cm x 1cm x 0.2 cm, and right lower stoma 1.5 cm x 1.2 cm x 0.2 cm. Wounds are moist, red, fragile, with serosanguinous drainage and no odor.

She is currently using Hydrofera Blue on the wounds. She is reporting itching in her umbilical area, no wounds. Wound biopsy completed using a 3mm punch, pick-up, and scissors, after local anesthesia using 1% lidocaine without epi, and hemostasis achieved using pressure to the site. A sample was obtained from the right upper wound at 7 o'clock, labeled, and sent to the lab to rule out pyoderma, as the wounds were increasing in number. Patient tolerated the procedure well. Supplies were re-ordered from a different company so that the patient will have access to appropriate supplies promptly; in the meantime, she was given supplies in the office to take home.

Braden scale not completed because the patient was seen as out outpatient.

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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)

- Cleanse all 3 wounds with VASHE and pat dry every 3 days and as needed when completing a dressing change.
- Cut hydrofera Blue to the size of each wound and apply directly to the wound bed, change every 3 days and as needed.
- Apply Cavalon Advance to the denuded skin around the stoma and wounds every 3 days.
- Cover the hydrofera Blue with comfort plus hydrocolloid dressing and change every 3 days and as needed.
- Coloplast Sensura Mio Deep Convex Ostomy Pouch 16767 for stoma
- Use the Coloplast barrier ring on the ostomy pouch before application of the pouch
- Apply Coloplast elastic barrier strips around the ostomy pouching system.
- Change colostomy pouching system every 3 days and as needed
- Follow up in the clinic in 1 week for ostomy/wound check.
- Consult with a dietician for adequate nutrition to promote wound healing and diabetes control
- Consult with home care for ostomy/wound management.

Alternate wound care option:

Apply calcium silver to all 3 wounds, cover with hydrocolloid dressings, and change every 3 days and as needed.

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

The care provided was appropriate for this patient. Non-healing wounds of unknown origin were biopsied appropriately. I would have also cultured the wound to rule out infections and fungus. The patient developed 2 new wounds since her last visit. These could be from frequent ostomy changes, leaking pouch, and worsening denuded areas. I would have used a calcium alginate with silver to the wound for its moisture adsorbent properties as well as broad-spectrum antimicrobial. This will enhance wound healing and provide skin protection 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?

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Goals
What was your goal for the day?

My goal for today was to see an in-person irrigation of a colostomy. Unfortunately, my goal was not met, but I gained other valuable experiences.

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

My goal for my next visit will be stoma site marking.

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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