

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Scott Strazzella Day/Date: Monday 12/22/2025Number of Clinical Hours Today: 8 Number of patients seen 3Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Moira GarrityClinical 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 in clinicals, we saw 3 patients for our assignment. My first patient was an individual with an end colostomy that was experiencing pain and bleeding from the peristomal skin, along with a midline abdominal wound that had dehisced and required dressing recommendations. The second patient was a gentleman requiring a new wound vac following debridement of his right plantar foot due to a diabetic ulcer. The third patient seen today was a gentleman with a stage II sacral wound, difficulty with ambulation due to weakness, was continent but required assistance with toileting. After seeing my patients, my preceptor and I returned to the office to do our documentation and order recommendations for the patients we had seen. After documentation, my preceptor and I did photo validations for new patients on the WOC list.

Types of patients: Peristomal skin irritation, Wound Vac, Sacral ulcer

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:

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Braden Risk Assessment Tool

Sensory Perception	2
Moisture	3
Activity	2
Mobility	2
Nutrition	3
Friction/Shear	2
Total	14

The patient is a 60-year-old female who was admitted to the hospital following a fall at her rehabilitation facility and after being assessed by the Rehab nursing staff was found to have left sided weakness, concerning for a stroke, in which EMS was called as a possible stroke alert. The patient has a past medical history of colon cancer with metastasis with a recent admission in October for perforated cecal mass requiring a right hemicolectomy. Patients had multifocal strokes likely due to hypercoagulability of malignancy. The patient was seen by the WOC team in October 2025 for ostomy teaching post colostomy placement. Today the patient was seen by WOC to treat peristomal irritation due to a leaking ostomy pouch with family member at the bedside. After removing the pouch, red irritated peristomal skin was observed around edges of the oval shaped stoma with small amount of effluent on peristomal skin, along with a small crease in the abdomen next to the stoma. Patient family member states that since the creation of the colostomy, there has always been a small amount of leaking from the pouch. The peristomal skin was cleaned with warm water, then patted dry. Stoma powder was generously applied to the irritated skin with excess lightly brushed off. WOC then used 3M skin barrier and dab it on the powder, letting it dry for approximately 5 minutes to form a crust over the dermatitis. A small piece of Eakins ring was placed into the crease to fill the void. A large Coloplast one piece pouch was fitted and placed over the stoma. A brief teaching session of skin care and ostomy pouch application was performed to the bedside RN and family member. The patient tolerated pouch change and skin care and agreed to the treatment recommendations. Bedside nursing was informed of the complete treatment and recommendations. The WOC team will continue to monitor for leaking ostomy pouch in coordination with patient's bedside nurse. The goal wear time for the ostomy pouch is 3 days. Contact the WOC team for any new ostomy related issues.

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)

- Gather your ostomy supplies, including Coloplast one piece pouch, 3M skin barrier, Stoma powder, small Eakins barrier ring, Ostomy scissors, stoma measuring template, and hazardous waste bag for old appliances.
- Remove the old pouch using the push/pull technique, pulling the old appliance toward the stoma.
- Have the patient lay flat on their back as tolerated.

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- Clean the peristomal skin gently with warm water, allowing it to completely dry.
- Using the template, measure the size of the stoma and cut the pouch wafer to fit around the stoma leaving 1/8" of peristomal skin exposed from the wafer edge.
- Generously apply the stoma powder on the irritated peristomal skin.
- Lightly brush off excess powder.
- Using the 3M skin barrier, dab the powder until all the powder absorbs 3M skin barrier liquid, allow it to dry for 5 minutes.
- Measure and cut Eakins ring barrier and place it in the crease of the abdomen.
- Apply the Coloplast one piece ostomy pouch over the stoma.
- Ensure all areas of the pouch wafer is adhering to the skin with no gaps.
- Cup your hand over the pouch to ensure adhesion.
- Change pouch every 3-5 days or as needed for leaking.
- Contact the WOC team via Vocera for any issues with pouch leaking or further deterioration of the peristomal skin.

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

I thought that the care that was provided took a very long time because the family member had many questions regarding care of the ostomy and how the peristomal skin could become so raw and irritated. I basically had to do a full ostomy teaching session with the family member. I suppose I could have provided the family member with our standard ostomy education kit and education booklet to answer the many questions.

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 for the day was to provide continence care for a patient. My goal for the day was met.

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

I have not done many stoma marking, so my learning goal would be to do a stoma marking.

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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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