



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _____ Dana Cooper _____ Day/Date: _____ Day 2, 1/9/26 _____

Number of Clinical Hours Today: _____ 10 _____ Number of patients seen _____ 4 _____

Care Setting: Hospital _____ Ambulatory Care _____ Home Care _____ X _____ Other _____

Preceptor: _____ Stephanie Legare CWOCN _____

Clinical Focus: Wound _____ Ostomy _____ X _____ 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.

During this clinical day we started with 76 y/o woman who had been seen by nursing early in the week and was found to have IAD and candidiasis due to urinary incontinence. It was stated in the previous nurses' note that the skin was erythematous with denuded areas. During the previous nursing visit they had applied miconazole powder, then a layer of Calmoseptine. Today her skin to her groin was intact with no erythema noted. The patient's skin was cleansed with water, and a fresh layer of zinc paste was applied. Education was provided to the patient and her PSS worker regarding proper hygiene and the importance of continued use of a barrier cream. This patient had functional urinary and fecal incontinence, she was chairbound and requires moderate to max assist to transfer from wheelchair to toilet. The patient wears both incontinence pads and briefs during the night and just a brief during the day.

The next patient we saw was a 70 y/o male who had a motor vehicle accident when he was 23 resulting in paraplegia. He underwent elective colostomy surgery on 11/11/25. This patient was adjusting well to his new ostomy; he demonstrated independence with ostomy care and pouching system change this visit. This patient also uses condom catheters to manage urinary incontinence; he is independent with the management of this device as well. This patient will be discharged from home health services soon. We discussed with him where to order ostomy supplies once home health will no longer be ordering it. This patient also initiated conversation about intimacy with an ostomy. He started dating recently and would like to find the best methods to keep his ostomy pouch from getting pulled off during intimacy.

We saw a 65 y/o female with a new colostomy and NPWT to a coccyx wound. This patient had a wound on her coccyx for the past five years without significant progress towards healing despite surgical intervention. Recently it was discovered that due to history of gastric sleeve surgery she was having malabsorption, preventing her from absorbing the nutrients needed to heal the wound. This patient was put on TPN and the providers decided a colostomy would be beneficial for wound healing to prevent stool from getting in the wound. Once the wound has healed, they plan to do an ostomy reversal. The patient is still requiring some assistance from the RN and family for pouching system changes. She did one success change herself this on

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Tuesday she reports and did not have any leaks until the change we performed today. I was able to assist with ostomy care, cleaning the peristomal skin and stoma, as well as measuring the stoma. She used a two piece system with cut to fit convex wafer with moldable ring and ostomy belt. This patient also reported UTI symptoms of dysuria as well as urgency and frequency, she reported she has frequent UTI's. The patient was able to provide a urine sample that we dropped off at the lab for a urinalysis.

The last patient we saw this day was an 80 y/o male who was referred to nursing services for suspect stage 1 pressure injury to his buttocks. The patient had home care PT services who discovered an area of redness on his buttocks and the requested a nursing evaluation. On assessment this patient had symmetrical erythema noted across the buttocks and gluteal cleft. After discussing with the patient it was found that he struggles with urinary and fecal incontinence and is not always able to get himself washed up after. This patient was also ambulatory, he was getting up and moving around the house often throughout the day. The area of redness was blanchable. We determined that this area appeared to be IAD and not a stage 1 pressure injury. Education was given to this patient on proper hygiene, cleansing the skin after an episode of incontinence and protecting the skin with a barrier paste.

We also spent time going over how to order free samples for patient when wanting to try new products. Companies like Coloplast and Hollister with sent free samples to patients if requested to help them find a product they like and works well for them. We also discussed insurance coverage of products, which insurances work with different supply companies.

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:

Braden Risk Assessment Tool

Sensory Perception	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

Pleasant 70 y/o male was seen today for a routine CWOCN visit with colostomy assessment, and education. Patient with paraplegia from T11 injury from a motor vehicle accident when he was 23. Past medical history

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includes neurogenic bladder, recurrent UTI, unilateral nephrectomy, urethral structure due to infection, HTN, neurogenic bowel, stage 3 chronic kidney disease, and osteoarthritis. Pt. underwent elective colostomy on 11/11/25. Pt has been building confidence with ostomy care and pouching system changes. At this visit he states “I feel like I’ve got it down. The stuff we are using now works really well”. Pt. is using a two-piece system with closed end pouch. Patient reports he has a bowel movement shortly after meals, he prefers the closed end pouch so that he can dispose of it after a bowel movement and place a new one. Pt. gathers his supplies; he prepares a skin barrier wafer by cutting a hole to fit his stoma. Pt. demonstrates removing pouching system with gentle push pull motion. Skin barrier wafer assessed, no note of leakage areas. No leakage reported by the patient. He cleanses his peristomal skin and stoma with a water dampened paper towel, then dabs dry. The stoma is budded, beefy red, moist, round, measuring at 1 ¼” this visit. Open area noted to skin- stoma junction at 6 o’clock. Pt. applied stoma powder to open area, then sprays with skin sealant to create a crust. He applies a moldable ring around his stoma, then places the Coloplast sensura convex skin barrier wafer. He attaches the Coloplast close ended pouch, then applies an ostomy belt. Pt. uses a mirror in the bathroom to visualize his stoma and apply the pouching system. Pt. wears a condom catheter to manage urinary incontinence. He states he is able to manage this himself without issue. Educated patient to cut hole for stoma slightly larger as it appears to have irritated the skin. Discussed with patient ordering samples of different products to try. Reviewed plan for upcoming discharge, how to order ostomy supplies. Pt. began conversation of intimacy with an ostomy, he states he has started dating. Educated patient on using a support belt during intimacy to keep pouching system in place. Instructed pt to contact home health agency with any new question or concerns. Plan for visit next week.

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 2 x weekly and PRN
 - a. Remove pouching system using push pull method
 - b. Cleanse skin and stoma with warm water, pat dry
 - c. Measure stoma, cut skin barrier wafer to fit stoma with 1/8th inch space
 - d. Apply stoma powder to open peristomal skin, then spray with skin sealant to crust
 - e. Apply moldable ring around stoma
 - f. Apply skin barrier wafer (Coloplast SenSura® Mio Convex Soft with Flex coupling #16886), and pouch (Coloplast SenSura® Mio Click Closed Pouch, #11412)
 - g. Secure in place with ostomy belt
2. Encourage patient to participate in pouching changes/ care
3. Notify PCP with any concerns, change in stoma color, lack of output, increased pain.
4. Educate patient regarding incontinence care, assess penis at every condom catheter removal and prior to reapplication.
5. Notify PCP with signs and symptoms of UTI, fever, chills, dark or cloudy urine

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

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This patient was very capable and independent with almost all of his care at the time of this visit. This patient has found a pouching system that works well for him without leakage issues. One thing I would change would be the size that the patient is cutting the hole in his skin barrier wafer. On assessment it appeared that the open area at the stoma- skin junction was caused by the wafer being slightly too tight on the stoma causing irritation. The patient was hoping to try samples of pre-cut skin barrier with the new measurement from today's visit.

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 goals for today was to see a peristomal wound, I was able to see this. The patient what was the focus of this journal had small peri stomal wounds that required crusting. I was able to discuss with my preceptor treatment options for larger wounds. I learned that dressings can often be applied to the wound and covered with the skin barrier wafer.

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

I would like to see and or discuss patients with a catheter at my next clinical day

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)	✓	

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<ul style="list-style-type: none"> • Statements direct care of the patient in the absence of the WOC nurse 	✓	
<ul style="list-style-type: none"> • Directives are written as nursing orders 	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> • Critical thinking utilized to reflect on patient encounter 	✓	
<ul style="list-style-type: none"> • Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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