



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Zhane Ceasor Day/Date: Friday 1/9/26_

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

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

Preceptor: Aaron Fischer, BSN, RN_

Clinical Focus: Wound _____ **Ostomy** * Continenence _____

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.

Age/sex: 73 y/o African American male

PMH: Obtained from previous hospital admission. Pt. has a PMHx of prostate cancer w/metastases to bone/liver, s/p cystoprostatectomy w/ileal conduit, anemia, PE

HPI: Pt. underwent robotic radical cystoprostatectomy, bilateral pelvic lymphadenectomy, ileal conduit on 10/29/2020. Last hospitalization documented from 6/2025 for increased chest pressure, was found to have metastatic disease from initial prostate cancer diagnosis to liver.

Social hx: Resides at home with his wife, who assists him with his ADLs. Patient ambulatory with walker Denies history smoking, ETOH, or illicit drug use.

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.

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Chart note:
Braden Risk Assessment Tool

Sensory Perception	4
Moisture	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	3
Total	19

Assessment/encounter:

Patient being seen today in outpatient colorectal office for a urine specimen collection. Patients has an order for urine culture. Primary diagnosis states attention to urostomy. Specimen collected and pouch change completed.

LOC: Patient awake, alert, oriented. Sitting up on exam bed.

Interview with patient who states:

- “I’m currently not experiencing and issues with my ostomy. “I’m not sure what the urine sample is for either”
- Talked with nurse about recent retirement and previous employment

Assessment: End ileal conduit located in RLQ. Mucutaneous junction is intact with some hyperpigmentation noted around peristomal skin. Tissue soft, with rounded stoma red and moist in color. Dark yellow urine noted in bag

Stoma: Budded

Diameter: 1’

Stoma size: 2 x 2 in

Shape: Round

Current pouching system: 1 3/4’ ConvaTec Sur-Fit Natura Durahesive Convex-lt 1’ precut opening w/flexible flange and urostomy pouch

Emptying frequency per day: 4-6 times

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)
Education:

- Completed appliance change procedure; took a measurement of stoma to ensure correct pouching size, provided cut-out to patient so he could refer to sample when completing his own pouch dressings at home. Area cleansed, Convatec skin prep applied to peri-wound skin, patient requested stomahesive powder around stoma.
- Skin care Education: Instructed patients to cleanse site with soap and water, dry thoroughly; apply stomahesive powder as needed. Complete pouch changes every 3-4 days

Treatment

- Urine obtained using sterile technique for foley insertion per CCF policy
- Hand hygiene performed, privacy provided for patient
- Previous urostomy pouch removed, and stoma site and surrounding skin cleansed with soap and water
- Gloves changed and sterile gloves placed on this RN. Stoma site draped
- Lubricant added to tip of catheter tube

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- 14 French catheter inserted into stoma. Urine returns noted flowing into specimen containers. Patients have no complaints of discomfort
- Urine specimen was obtained and labeled. Patient site cleansed again with soap and water
- Previous pouching system applied to patient stoma site.

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

Something I would've done differently is to try and find out why the patient needed the urine sample. His urine looked normal, and he wasn't having any discomfort. I would've tried to look more to determine the purpose of the sample: Any update in lab work? Is it due to him having a history of recurrent UTIs? Also, ask provider for the purpose of sample.

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 today was to become more comfortable with performing pouching changes, which I was able to do. With the 6 patients I seen in clinic today, 4 of them required a pouching change, which my preceptor allowed me to take the lead and just aided when necessary.

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

For Monday I would like to be able to see/perform more markings on patients preparing to have an ostomy placed.

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	✓	

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• 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	✓	

Zhane Ceasor

Reviewed by: _____ Date: _____

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