Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Patrick Willis_____ Day/Date: Fri, 5/2/25

Number of Clinical Hours Today: __8__

Care Setting: Hospital ____ Ambulatory Care __x___ Home Care ____ Other ___

Preceptor: __Jeanine Mosby_

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.

Today was spent in the outpatient ostomy clinic, which was a very enjoyable experience and change of pace from the typical inpatient setting. We saw patients ranging from 29 years of age up to 78 for varying reasons. One patient was there to be marked for an ileal conduit procedure later this month. Another patient was seen for routine post-op follow-up. He had been unable to get his supplies and had been wearing his present pouch for 2 weeks. Fortunately, only minor peristomal breakdown was present and we were able to get him the needed signatures to release his supplies. A unique patient involved a pancreatico-cutaneous fistula that was referred to us for pouching vs dressing changes multiple times a day. Another patient traveled in from Indiana and reported she had no access to home health nurses with ostomy experience. She was encouraged and reassured that the ostomy team here could help her troubleshoot problems via phone.

Types of patients: pre-op and post-op visits, end ileostomy, end colostomy, ureterostomy, pancreatico-cutaneous fistula

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

Chart note:

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Patient seen today in outpatient ostomy clinic for pre-op site marking prior to cystectomy and ileal conduit coming up on 5/14.

Patient is 62 y/o male with malignant neoplasm of urinary bladder. History of prostate cancer, urethral stricture, incontinence, bladder cancer, hypertension, hyperlipidemia, hypothyroidism, and six back surgeries (most recent 03/2024). Current smoker x 50 years, 0.5 PPD, plus medical marijuana at night. Medications and labs reviewed. Patient is non-compliant with BP meds. BUN 25, CREAT 1.5, TSH 40.3

Accompanied today by his wife for site marking. The patient was able to verbalize and describe the surgery he was preparing for, the date of the procedure, and expectation of a three-to-four-day hospital stay following. He and wife then watched an 8-minute educational video explaining the ileal conduit surgery, pouching overview, lifting restrictions for 4-6 weeks, and dietary precautions for 6 weeks. The patient asked questions about hernia risk. Lifting restrictions were reinforced and he was introduced to hernia support belts. Wife clarified diet recommendations including no raw fruits or vegetables for 6 weeks as these increase risk of blockage. A handout listing foods to avoid and a printed overview of soft low-residue diet was provided. Following assessment in lying, sitting, and standing, the optimal site was tattooed with patient's consent in the RUQ d/t to protuberant abdomen restricting line of sight to lower quadrant. Patient and wife were told to expect to see an ostomy nurse POD 1 for first lesson.

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 used)

To mark patient for ileal conduit, the patient first was asked to lie flat to assess abdomen for optimal location. To palpate abdominis rectus muscles, patient was asked to tuck his chin to chest and cough. An ostomy marking disc was placed over a flat area in the RLQ and a mark was made in pen, but due to protuberant abdomen, patient was unable to visualize the marking. A second pen mark was thus created in the RUQ, which patient still struggled to visualize, so the pen mark was moved further superiorly until patient was confident that he could see this site. The patient was then evaluated sitting upright and standing in front of a mirror. He is confident in his ability to visualize the chosen area, which is flat and without any creases or folds. After cleaning the site with an alcohol wipe, a drop of black ink was placed at the chosen site and three small intradermal tattoos in a triangular pattern were created via needle injection at 90-degree angle. Site was then cleaned with alcohol again to remove excess ink and band-aid applied.

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

It is standard practice here to tattoo the surgical site marking rather than using indelible marker and educating

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the patient on how to maintain that mark until surgery. The WOCN Society position statement on marking describes tattooing as invasive, painful, and an increased risk for infection. Additionally, if the surgeon ends up needing to choose an alternative site, the patient is left with a small, but permanent tattoo. The rationale given today by my preceptor was that pen marks easily get scrubbed off in the OR prior to surgery, but I would be interested in learning more about this choice, as it no longer seems to be a recognized best practice.

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 perform a site marking, which I was able to accomplish with my first patient of the day. The tattoo technique was new for me, but my preceptor talked me through it and gave me the confidence to perform the procedure.

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

Goal for final day of ostomy clinicals is to continue to gain experience with atypical or complex stomas.

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	✓	

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• 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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