Cleveland Clinic

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

**Daily Journal Entry with Plan of Care & Chart Note**

Student Name: _____Kris Rosu_____ Day/Date: 3/ May 7/25

Number of Clinical Hours Today: _10_

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

Preceptor: __Amparo Cano RN 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.**

Today I was able to be with Amparo in the Ostomy Clinic. We saw a total of seven patients and I did get to do a stoma marking.
Patient #1 was a 25 year old female with an end ileostomy s/p colectomy and takedown of her loop ileostomy March 3, 2025. She has a hx of Dyssynergic Defecation and Neurogenic Bowel. Her reason for visit today is that she states that she is only getting approximately 24 hours with each barrier, due to leaking. Pt has been through a variety of different barriers and she has on now the Marlen convex 2 piece. She does like it, reports it feels lighter for her and she has had the current one on for just over 24 hrs. It is to her RLQ, her abdomen is slightly rounded, soft and there are no scars or deformities that would make the pouching difficult. Her stool is a brown semi pasty to liquid. I removed the pouching system and she has a red moist budded stoma without any sign of leaking to the peristomal skin. The OS is centered up. The peristomal skin is CDI, no rashes, no itching and no pain. I remeasured the stoma and the size is a bit smaller now than previously measured. She is down sized from a 1 1/8 to a 1. After cleaning the area with warm cloth I crusted with stoma powder and skin barrier and placed a new ring. The new smaller barrier was placed and the pouch attached. We offered a belt in which she was not using and she did accept this to try. She is to continue to perform the care as done here today with the crusting. She is to be sure the area is dried well after that step to ensure good seal. While in the office we had her call another company to order some samples that we did not have today that may also help with her leaking. She was able to do this and we verified with the supplier that she needed the samples and they would be out this week to her. We provided her with the Marlen barriers in the new size for now. She is following up with her surgeon next week. She has all the numbers she needs if she is to need anything or have any questions.
Patient #2 is a 35 year old female who I took as my focus patient and will discuss in the next box.
Patient #3 is a 67 year old gentleman who is s/p a Sigmoidectomy s/p rectal mass in April. He does not have an ostomy. His complaint is an abscess formation to his mid abdomen that started very small 2 weeks ago. He and his wife made several calls to schedule with the surgeon, but they were unable to get any call backs

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

and scheduled so as the abscess got larger they were placed on the ostomy schedule per the surgeon's office. The abscess is near his midline scar that has Dermabond on it, 5.5 cm long. The scar is healed. The patient denies fever, chills and aches. He is tender to palpation. It has come to a slight head and is red around the edges. The GI clinic resident who knows the patient was able to come bedside and perform an I/D in the room. I assisted with this. We drained approximately 75cc of serosanguinous liquid that flowed out as soon as the scalpel hit it. I cleaned the wound with NS and we lightly packed it with one piece of gauze, skin barrier around edges and paper tape. His wife is bedside and able to perform this change daily. The patient is encouraged to shower as normal, hydrate and eat well. Pt to start antibiotics and take Tylenol if he has pain. They are to follow up within one week here. (Amparo is slightly annoyed with this situation, as she feels that the patient should have had the follow up with the surgeon for and I/D and not the ostomy clinic and his follow up should be with the surgeon as well.)

Patient #4 is an 81 year old female who arrived with her very supportive spouse. She is having some issues with a rash and some bleeding on her stoma. She has not been seen in some time, she has had her ostomy for over a year now. She reports that the rash started two days ago with a burning and itch. She denies pain, fevers. She uses a 2 piece closed bottom pouching system. She does report taking blood thinners for a PE and they are seeing vascular to see if they can stop this soon. Upon assessment, the rash appears to be fungal, it is at the 3 o'clock to 6 o'clock portion of the peristomal skin. The stoma is budded and moist and red, 7/8 size. I cleaned the stoma an surrounding skin with a warm soaked cloth and there is a blood tinge from the stoma. Amparo discussed that this is normal from the blood thinners. We used anti fungal powder to crust the area and explained this care to the spouse. He is very involved in all the care of his wife's ostomy and verbalized understanding of the use of the new powder. We gave him the bottle to use at home. A new pouching system was applied and the patient is to follow up in one week and she is to be seeing the vascular surgeon within this time.

Patient #5 is a 49 year old female with an extensive history. She had a sleeve gastrectomy in 2015 later followed by a Rue en Y in 2017. She reports several small bowel issues and surgeries since she was 12 years old. She has an ostomy due to a sigmoidectomy due to a perforated bowel eight months ago. She is in today for follow up on treatment of her fungal rash and skin breakdown due to leaking. She reports that she is getting two days now from her current device which is a soft convex 2 piece. She has been using the anti fungal powder to crust the area when changing and the rash is now gone upon inspection. Her stool is soft brown, her stoma is slightly budded with a centered OS red and moist. Her peristomal skin is intact but her contour is not flat but loose and there are multiple creases to her abdomen due to her significant weight loss. She is to stop the antifungal powder and use stoma powder now. She is independent in all her care and lives with her father who is also able to assist her if needed. The patient only needs to return if needed, she has all the numbers to contact the ostomy clinic if needed in the future. She was provided with a belt and instructed on its use during this visit as well.

Patient #6 is an 18 year old male who is in South Florida for college. He is following up on a non-healing wound that was a pilonidal cyst that was removed in NY prior to coming down to school, 8 months ago. He is able to care for the wound himself. He denies fevers and chills, little pain. The wound was assessed and cleaned with NSS and gauze. It is 5 cm long, very little depth, blood drainage and red. There is no odor. The peri wound skin is CDI. After cleaning the wound, I used silver nitrate to control some bleeding and I used Drawtex hydroconductive dressing to the area and covered with gauze. The patient is to continue to shower daily, soap and water and cover using this same method. He is returning to NY in a week and will follow up with the original surgeon then.

Patient #7 was the stoma marking, a male 42 year old. This patient has a hx of UC. He had a 3 stage IPAA

done in 2016. Recent dx of UC with pouchitis. He is having a pouch revision, with a possible stoma for diverting loop ileostomy. He has had a loop ileostomy in the past and has an old scar in his RLQ. He is familiar with the marking process. I did his abdominal assessment sitting and palpated his old site. The area was soft, he could see it and there are no folds or creases in the area that would make it hard to pouch. I measured the area from his hip bone to his midline and went to the middle of this spot and his old scar fell in this area. The patient would be happy with a site again in the same area as last time. I made a mark on this spot. We also looked to the left quadrant and made a second choice marking with the same measurements from his hip bone to the midline and chose a spot in the LLQ where there were no creases or folds. After sitting, I had him lie down and perform a "crunch" to identify his rectus muscles. Both marked spots were within the area of his rectus muscles. I asked the patient if he could see the two marks with his head raised while lying down and he was able to. The patient then stood and I assessed the marks and the contours of his abdomen. Both sites were without creases and folds and he was able to see the areas and reach them from a standing position. I then placed an adhesive stoma on the first choice area in his RLQ. He again said he could see the area and reach it. I pouched the area while educating the patient on this and he was able to see what the result would be. The patient felt comfortable with the two marked spots. The patient is comfortable with the pouching technique, as he has done it in the past. I went over the one piece and two-piece systems. I discussed the output and the amount expected. The patient is due next Thursday for Surgery, and I am hoping to see if I can follow up with him post op.

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: Ostomy clinic does not do the Braden scoring for out patient.**

Patient #2, my focus patient has a Braden score of 23, no impairment.

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | 4 |
| Moisture | 4 |
| Activity | 4 |
| Mobility | 4 |
| Nutrition | 4 |
| Friction/Shear | 3 |
| Total | 23 |

My focus patient is patient #2 that was seen at ostomy clinic. She is a 35 year old female who on 4/11 had a

loop ileostomy placed s/p ex lap with 15cm pelvic mass removal, lysis of adhesions and ureterolysis. The mass was a mature cystic teratoma and there was abscess formations, inflammation and fat necrosis. She just had her foley removed this past week. She is scheduled for post op teaching and stoma assessment today. The patient reports that she is feeling tired and very tender to her midline incision, she moves slowly to avoid any increased pain. She is and she reports she is very anxious. She reports she is eating well and she does hydrate with water adequately. She takes Tylenol for pain as needed. Her spouse is with her and they report they have no issues with the stoma care and pouching. She has been receiving HHC with nursing for stoma and pouching education, and this is now one time weekly. She is getting all supplies needed.

I assessed the patient and as she was assisted with moving her clothing, she felt a wet spot and became very upset and she was unsure why it was wet. After providing emotional support I was able to assess the pouching and this was intact, there were no leaks. Upon further assessment, the bottom of her midline incision was leaking a moderate amount of pus. She states that she did not notice this in the am when she was getting ready. It is near the area of where she is tender. I removed the steri stip to find a 1cm dehisced portion of her incision and a 0.3cm one 1 cm distal to that. Her abdomen is soft, non-distended and she has not had any fevers although reports malaise and just a feeling of unwell. The staples were removed on 4/25/25 and the steri strips placed and the incision was approximated then. The colorectal surgeon who did her surgery was available in clinic to come bedside to assess. He separated the two areas into one wound and washed out the area with NSS and Vashe wound cleaner. The wound now measures 4.5cm x 2.5cm x 2cm. The wound bed is moist sub cutaneous tissue, red and pink. The wound is now clean with open edges and the peri wound is CDI with some redness circumferential. There is no odor. The surgeon packed the wound with Vashe wet gauze and lightly packed it. It is covered with an ABD and paper tape. The spouse is able to verbalize understanding of this care and it is to be performed daily. A new Rx to the HHC agency to increase nursing visits for new wound will be sent. She is to start antibiotics and RTO in one week for follow up and assessment. She is to splint the area upon moving to assist in pain control and anxiety, she was able to demonstrate this and it's purpose. She is eating well now, better than previously and she will continue to have high protein meals and hydrate well. Continue light activity such as walking.

In regards to her ileostomy I performed a change of her pouching system with her. The measurements are the same at 1 inch and her stoma is red, moist and budded with the OS centered. The edges are intact and her peristomal contour is flat, soft and non-distended. Her stool is soft pasty brown. She is using a two- piece and changing it every three to four days. She and her spouse are doing well with this care. I replaced the pouching system and they will return in one week. We provided supplied and a bottle of the Vashe for them to continue the wound care along with gauze, abd and tape. Her medications at home are the same with the addition of the antibiotic. She currently takes Tylenol, Ditropan, Imuran (hx of lupus) and Zofran. She is due with her Gynecologist next week and will have new labs drawn then. She is also scheduled for follow up air enema and sigmoidoscopy in Mid June. She will later have a reversal surgery in three months.

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.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

**WOC Plan of Care (include specific products used)**

Continue wound care to open midline wound with daily changes with one piece of gauze wet with Vashe, lightly packed in wound and covered with ABD dressing and paper tape.
Call MD with any fevers, chills and sweats, increased pain to the area.
Start antibiotics today and finish them until gone.
Expect HHC to call and schedule home appointment for continued care of new wound. Call if you do not hear from them.
It is ok to shower, do so before changing the midline dressing. It is ok to have the wound open in the shower.
Eat high protein diet and hydrate with water at least 8-10 cups daily.
Continue care to ostomy site, changing pouching system every three days. Inspect stoma during changes for any color and moisture change, size change or skin issues.

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

I really enjoyed the care today in the clinic and being able to follow up with patients after their surgeries. I enjoy education and being sure that they have all their needs met while at home. It was nice to be able to have the two physicians come in for the two visits we had to be able to take care of the abscesses.

I would like to know more about the patients prior to seeing them and would do more of a history review in the beginning of the day. My practice now is where I am in an hour prior to my first patient and am able to do a review of the patients for the day that I do not know. They have a quick run down in the am of what patients they have and if they are new or not and what what done on the last visit if there was one but there does not seem to be time to do a more holistic look at the chart prior to meeting the patient, or even after.

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?**
I wanted to do a stoma marking and I was able to do this with some help from Amparo. The patient was agreeable to have me involved, he was no so nervous so it was a good patient to do this with.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

| |
|---|
| **What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**<br>Thursday I would like to increase my charting language and work on how notes are going in with proper terminology for wounds and ostomy. |

**For instructor use only. Do <u>not</u> 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: _____

(Save the document by <u>clinical date & preceptor last name</u> before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **<u>48 hours</u>** following the clinical experience day.

Cleveland Clinic

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

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.