Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: H Alexis Seris Espinal _____ Day/Date: 6/3/2025_____

Number of Clinical Hours Today: ____8

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

Preceptor: Adam Shaw RN, CWOCN_____

Clinical Focus: Wound X____ 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.

All patients were encountered in Hospital inpatient units. A total of 3 patients were seen today due to the complexity and or inability for patients to be seen. Patients were seen for abdominal NPWT with new Esphogastomy (pouch change), stoma marking (educational material for loop ileostomy provided but the patient declined to mark at this time as the procedure may or may not occur.), and intubation of catheter for ileostomy to relieve blockage symptoms and pressure.

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:

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2

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Activity	1
Mobility	2
Nutrition	3
Friction/Shear	1
Total	11

NPWT of mid abdominal incision and Pouch Change for Esphogastomy:
First encountered a 43-year-old male in a semi-flower position in bed. Patient was admitted for esophageal perforation. PMH of seizures intellectual delay, and cerebral palsy. Reviewed H&P. Explained reason for visit and patient unable to agree due to mental delay. Pt is alert and oriented to self and responds to painful stimuli. Followed up with Primary RN before dressing and pouch application.

Esophagastomy Stoma Assessment on Left Clavicle region and Pouch Application:

Removed dry dressing and tape with adhesive remover. Cleansed stoma and surrounding tissues with NS and dry sterile gauze. Removed a small amount of clear saliva. Pat dry with dry sterile gauze. Stoma is round, pink, moist, and flushed to the skin level. Mucocutaneous junction intact and approximated with 9 sutures. Peristomal skin is intact, blanchable, and dry. Measured with stoma measuring device as 1in. Cut wafer to size and offset medially. Applied circle piece that was cut from wafer to center opening of wafer. Cut hollihesive skin barrier to size of opening on the wafer and pointed edges of the product. Applied hollihesive skin barrier to site and applied barrier paste to divot in hollihesive skin barrier at 3 O'clock. Applied one-piece urostomy pouch to hollihesive skin barrier. Successful seal noted.

NPWT to mid-abdominal incision dressing change: Site has an irregular shape, full thickness, 100% red granulation tissues present, 2 sutures present medially in the wound bed with dry, intact, blanchable surrounding tissues. Small amount of bloody exudate noted. Measurements are not due at this time. Small amount of about 100 cc of serous drainage in the Canister. Canister is not due to be changed at this time.

Removed dressing with adhesive remover. Cut tract pad tubing and installed 10cc of NS to moisten black foam. Repeated x5 times and slowly removed the black foam. Allowed break for Pt as they expressed pain through grimaces and moans. One piece of black foam was removed which was bridged over Umbilicus. Cleansed wound bed and surrounding tissues with NS. Pat dry. Applied skin sealant and drape to surrounding tissues. One piece of non-adherent adaptive gauze and one black foam bridged from the umbilicus were applied. Covered with a drape followed by a tract pad. Applied skin sealant surrounding dressing. Machine was set to 125mm Hg on continuous. Successful seal achieved.

Pt tolerated the dressing change fairly well. They were repositioned in bed by this RN and Adam Shaw RN CWOCN. Bed in a low and locked position. Updated Primary RN on POC.

Time spent with Pt 45 minutes with Adam Shaw BSN ,RN, CWOCN present.

Dr. Feczko was made aware and agreed with POC.

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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. NPWT to mid-abdominal incision: Remove dressing with adhesive remover. Moisten black foam with NS. Cleanse wound bed and surrounding tissues with NS. Pat dry. Apply skin sealant and drape to surrounding tissues. One piece of non-adherent adaptive gauze and one black foam bridged from the umbilicus applied. Cover with a drape followed by a tract pad. Apply skin sealant surrounding the dressing. Machine set to 125mm Hg on continuous. Change dressing Q T/TH/Sat. Upon troubleshooting the machine, if the dressing is interrupted for >2 hours, apply NS moistened wet to dry dressing and notify the physician.

2. Stoma Care for Esophagastomy: Cleanse the stoma and surrounding tissues with plain warm water. Pat dry. Measure with a stoma measuring device. Cut wafer to size and offset medially. Cut hollihesive skin barrier to size of opening on the wafer and pointed edges of the product. Apply hollihesive skin barrier to the site. Apply one piece urostomy pouch to hollihesive skin barrier.

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

The stoma site and NPWT incision both looked great. The Pt is heading in the right direction in terms of healing.
An important aspect of NPWT dressing application and removal is pain management. This was my first encounter with this Pt and was not familiar with their pain level. Looking back I would have talked with my preceptor and asked the primary RN if this Pt could have received medication for pain prior to the dressing removal.

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?

Today my goal was to be hands on and complete skills pertaining to ostomy care and or wound care.

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

Tomorrow I may see stomas and skin-related issues. I would like to determine proper treatment options such as skin care products, pouching devices, and or need for convexity.

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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: _____

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