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: 6/16/25_____

Number of Clinical Hours Today: 8____

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

Preceptor: Amy Simmon (Sarah Weisz was not working today)_____

Clinical Focus: Wound X____ Ostomy ____ 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 we saw a total of 4 Pts. There were 2 others that we attempted to visit. One Pt already had their pouch changed and wanted to defer the next change to Thursday. The other Pt was an established ostomy Pt that had their colostomy reversed and now has a new Ileostomy. They wanted their spouse present for teaching as they are not familiar with the Ileosotmy care. They deferred the teaching to tomorrow afternoon. The first Pt we saw had x3 pouches to change (RLQ Ileostomy, LLQ old drain site, and Midline gastric tube site). The second had a pouch change due for a revised RUQ Loop Ileostomy as they had issues with previous J pouch. The third Pt has a gastrocutaneous fistula from an old PEG tube site that was previously being pouched. The last Pt had a new End Ileostomy.

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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Braden Risk Assessment Tool

Sensory Perception	3
Moisture	2
Activity	1
Mobility	1
Nutrition	2
Friction/Shear	1
Total	10

Initial Assessment and Pouch Change for Gastrocutaneous Fistula to Mid Abdomen:

In to see a 62-year-old male for pouch change of gastrocutaneous fistula to mid abdomen r/t PEG tube site that was dislodged on 2/2. Pt was admitted for Necrotizing pancreatitis. PMH of DM Type 2, HTN, COPD at home, CKD stage 3, CAD, HF, chronic lymphedema, chronic left foot wound, and sacral stage 4 PI s/p debridement on 6/12/25. H&P reviewed allergies to Penicillins. Pt taking insulin, Heparin subcutaneous, and IV antibiotics at this time. Pt is drowsy and opens their eyes to verbal stimuli, oriented to self. Pt in a semi-flower position in bed. Explained reason for visit and Pt unable to agree to pouch change and Fistula assessment. Attempted to follow up with primary RN.

The Pt NPO at this time, a Registered Dietitian is currently following the Pt. NG tube in L nares placed on 4/27/25. Tissue of nares surrounding and under tube WNL.

Pt has a tracheostomy in place and was placed on 4/28. The tissue surrounding and under the tracheostomy collar WNL.

Soft restraints in place to bilateral wrists. Removed to assess, tissues under and surrounding restraints WNL. Reapplied restraints.

Bilateral scapulas, pectoral girdle, elbows, trochanters, ischial tuberosities, patella, and medial/lateral malleoi are dry, intact, and blanchable.

Mid Abdominal Gastrocutaneous Fistula:

Round, full-thickness tissue loss, open moist, pink, red granulation with dry, intact, pink, blanchable, surrounding tissues. Moderate amount of thick yellow exudate. Measured at 2cm x 2.5cm x 1cm in size. Removed 2-piece pouching system with adhesive remover. Cleansed with warm water and mild soap. Pat dry. Depth was assessed with a sterile cotton tip applicator gently applied to the wound base. Cut calcium alginate sheet to size. Lightly pack calcium alginate piece with a sterile cotton tip applicator. Covered with silicone-bordered foam dressing.

R calcaneous dry, intact, blanchable with dry, intact, blanchable surrounding tissues. Removed heel lift boots to BLE to assess and reapplied.

Chronic L foot PI and Stage 4 sacral PI not assessed at this time, surgical team assessed and provided wound

care this AM per chart notations. Pt also being followed by wound care consult team at the time.

Low air loss mattress on and functioning.

Pt able to turn side to side with 2 assists. Pt repositioned by this RN and Amy Simmon MA, BSN, RN, CWOCN. Bed in low and locked position. Primary RN updated on POC.

Time spent with Pt 30 minutes with Amy Simmon MA, BSN, RN, CWOCN.

H. Alexis Seris Espinal BSN, RN WOC nursing student.

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. Skincare: Cleanse with NS. Cleanse with NS. Apply a light dusting of stoma powder and wipe away the excess. Apply skin sealant to the surrounding tissue.

2. Dressing Change: Cleanse with NS. Cut calcium alginate sheet to size. Lightly pack calcium alginate piece with sterile cotton tip applicator. Covered with silicone bordered foam dressing. Change dressing daily.

3. Turn and reposition to maintain offloading of bony prominences to the spine, sacrococcygeal, buttocks, and ischuims Q 2 hours.

4. Obtain and apply turning wedges when turning the patient to the side.

5. Apply heel lift boots to bilateral heels for offloading. Remove Q shift to assess heels.

6. Maintain a low air loss mattress while Pt is in ICU.

7. Obtain and apply low air loss bed pump when Pt is transferred out of ICU to a general medicine unit.

8. Physical therapy and Occupational therapy consults are recommended when is appropriate to be seen.

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

This gastrocutaneous fistula continues to heal as noted in photos from the chart. Before pouch removal, the pouching system appeared clean. It looked as if it was not emptied at all. Upon pouch removal, the wound appeared to have a moderate amount of exudate that pooled in the wound bed. The back of the wafer did not appear to have moisture and therefore no leakage occurred. After cleansing it was noted that there was pink/ red granulation tissue. The wound also had full-thickness tissue loss. This warranted the wound to be lightly

packed to fill in dead space. The cover dressing will protect the area/absorb exudate and moisture. This is why I chose to lightly pack with calcium alginate followed by a silicone-bordered foam dressing.

We ordered the dressing for daily dressing changes. Due to the absorbency of the cover dressing, we could also have recommended it for every other day.

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 get more experience with wounds. The consults today only consisted of pouch changes, lessons, and 2 NPWT dressing changes. I was able to meet my goal of caring for a gastrocutaneous fistula. As noted above, the fistula was not have a large amount of output anymore. After removing the pouch and cleansing the wound, I realized the treatment should be revised. It no longer needed a pouching system and required wound care which we provided.

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

Tomorrow I would like to stoma mark and or assess for peristomal skin issues.

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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• 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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