Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Brendan Agatisa-Boyle_____ Day/Date: ___6/19/2025_____

Number of Clinical Hours Today: __8__

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

Preceptor: __Karen O'Brien_____

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 I was in the outpatient ostomy clinic and saw six patients with my preceptor. The first patient we saw had a loop ileostomy and a chronic abdominal wound that he came into to have assessed by the WOC team and the NP, I will talk about him further below. The next patient we saw came in for a marking due to having a hernia repair tomorrow and potentially needing to move her stoma. Her loop ileostomy was in the RLQ and we decided the best place for a marking was in the LLQ due to deep creases and/or scarring in her other quadrants. Our next patient was a mark and talk for a patient getting a loop ileostomy due to rectal cancer. My preceptor allowed me to handle the education and the marking and just double checked my spot. The next patient we saw was a follow up visit a week after her surgery for loop descending colostomy. She was having issues with her pouches leaking and came for tips and tricks. Upon assessment it appeared she was cutting her pouch openings to small and that was causing it to back up and leak. We next saw a patient that I educated in the hospital post-surgery. She has an end ileal conduit and loop descending colostomy and was coming in for her three-week checkup with her surgeon. We went in to see her once the doctor was done and saw how she was doing with pouch changes. She was concerned about her pouches standing up too much and was hoping for something more subtle, so we changed her from the two piece Hollister to the more subtle Convatec Convex-It. The last patient we saw was coming in for a check up prior to the second stage of J-pouch formation. She was doing well with pouch changes and didn't have any questions considering the next step of the process.

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

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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	4
Moisture	4
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	23

This 74 year old male came in for management of a chronic wound to his midline abdomen. He has a past medical history of CAD, CHF, OSA, DM II, CABG and diverticulitis with perforation leading to loop ileostomy. The patient had an abdominal dehiscence which has been having difficulty healing. NPWT was initially recommended to help the wound heal from the bottom up, however the patient did not tolerate the procedure and refused its use. The wound had been present on the patient for nearly three months. The NP was in the room for assessment of the wound. Upon assessment the patient's foam dressing was saturated with serosanguinous fluid. The dressing was removed and the two pieces of packing was removed from the wound. The packing was noted to be extremely saturated with the wound bed very moist. The patient was asked when the last time was he changed the dressing and it was discovered that the dressing was only being changed once a day instead of the prescribed three times daily. The wound bed was cleansed with saline and thoroughly dried with gauze and the periwound skin cleansed with soap and water. The wound measured 2.7 cm x 1.4 cm x 2.7 cm, with a tunnel at 12 o'clock that was 4.2 cm long and a tunnel at 6 o'clock that was 7.2 cm long. Due to the wound being very moist it was determined that the wound should be packed with Mesalt to help pull the moisture out of the wound. A Mesalt gauze was opened and stretched to activate before being inserted into the wound using a cotton tipped sterile swab to work it into the tunnels. A small amount of the Mesalt gauze was left out to make it easy to remove and it was covered with a new foam dressing. The patient was walked through each step of the dressing changed so that he could feel comfortable changing it himself at home. The patient was given extra Mesalt gauze, foam dressing and cotton tipped applicators to go home with.

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.

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WOC Plan of Care (include specific products)

-Further the patient's education on performing dressing changes at home
-Encourage patient to change his dressing three times daily
-Continue to educate the patient on wound healing and the effectiveness of NPWT
-Encourage the patient to bathe at least once a day
-During any check ups with the patient assess for signs and symptoms of infection
-Consult with physical and occupational therapy to improve patient mobility and self-care
-Consult with dietary to promote a healthy high protein diet
-Consult with infectious disease if any signs of symptoms of infection occur
-Consult with pain management team to assist with managing the patient's pain
-Consult with general surgery if the patient agrees to NPWT to open up and debride the wound bed prior to beginning negative pressure therapy
-Consult with psychology to help with anxiety associated with the wound
-Educate the patient on the symptoms of infection and have them bring up any concerns to his doctor
-Have the patient have a follow-up visit with the WOC nurse and covering NP to assess the effectiveness of Mesalt gauze TID dressing changes
-If questions occur with dressing changes, please call the WOC nurse hotline number and leave a voicemail detailing your concerns. I WOC nurse will call back in the afternoon / early evening the same day or following workday

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

From my understanding the patient had really bad anxiety when his wound was initially much larger. The suggestion of NPWT was raised to the patient but upon hearing they would need to make the wound initially larger to open up a tunnel he flat out refused. NPWT would be appropriate for this patient and would likely be able to improve healing time to a few weeks but with simple wet to dry packing it had been three months by the time we saw him. My preceptor had seen him previously and along with the NP a week prior made a deal that if the Mesalt dressing showed improvement they would hold off on NPWT, and the measurements were slightly smaller than the previous visit. However, the measurements were shorter by less than 0.5 cm difference which in my opinion is within measuring error and in reality the healing of the wound may have stalled, especially when you consider how wet the wound bed was observed to be. I think that psychology should have been brought in much sooner with this patient to help him deal with the concerns he was having about having this wound so that a more appropriate dressing could be applied. We of course must respect the wishes of the patient when it comes to their care but I believe this patient's decision was made by an anxiety based decision not that of informed consent.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

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Goals

What was your goal for the day?

I am in the outpatient ostomy clinic tomorrow and hopefully I will get to see an interesting incontinence issue or wound as I need one more journal for each. I was able to get to see an interesting wound today and now only need one more incontinence journal.

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

I am with the inpatient ostomy team tomorrow and I am hoping that I will be able to follow up with the Yang-Monti patient I saw yesterday for my final incontinence journal

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)	✓	
• 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	✓	

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Reviewed by: _____ Date: _____

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