Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Theresa Farley Day/Date: Wednesday, 7/9/25

Number of Clinical Hours Today: 10

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

Preceptor: Bobbi Jo Killing and Sarah Weisz

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.

I arrived early to participate in on-unit inservices and discussion with bedside nurses related to changing ostomy systems and placing consult orders for the WOC team. We then had a huddle to review the inpatient cases for the day. Patient encounters included ostomies, mature and fresh post-op, and ostomies and fistulas, from standard to extremely complex with multiple fistulas and ostomies. The ages of patients varied greatly, the acuity ranged from routine appliance changes and check-ins when hospitalized for non-related acute issues to new ostomies, including rod removal and stoma intubation and initial assessment, pouching and patient education.

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:

41-year-old female seen inpatient for recurrent ostomy leakage. Patient has prior medical history that includes chronic pain syndrome, chronic anemia, diabetes, PAD, gangrene, L transmetatarsal amputation, end ileostomy, ESRD on HD, and ileostomy in 2015. HPI includes replacement of transhepatic dialysis catheter in 3/2025 with subsequent traumatic injury to SVC. Vascular reconstruction was initiated, and case of

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ischemic colitis required partial omentectomy, total abdominal colectomy and creation of end ileostomy in 3/2025.
Patient is seen lying in bed with 14 year-old son at bedside. She reports that she is unable to move in bed due to significant pain with movement, and reports that she is most comfortable only on the left side. She reports that ileostomy site is leaking. RUQ stoma observed with pouch reinforced with tape and abdominal pad. Pouching system is arranged in a way that leaves contents pooling over stoma, instead of draining downward toward drain of pouch. Patient reports that ostomy requires changing daily since surgery.

Green effluent noted in pouch. Peristomal skin is intact and without evidence of maceration or irritation at present. Stoma is moist and red with mucocutaneous junction intact and protrudes slightly. When patient is raised to sitting position, stoma noted to be within a slightly concave fold. Removed prior pouching system with use of adhesive remover without complaints of discomfort. Wafer is intact and not degraded. Skin cleansed with soap and water. Patted dry. Peristomal area wiped with skin barrier wipe. Noted concave area medial to stoma that is causing difficulty with obtaining a seal and requires build-up. Applied Cera ring to medial aspect of stoma to build up. Applied 20mm Hollister convex ring to medial side and applied Hy-tape to secure. Applied Hollister 1 ¾" 2-piece flat high output drainable pouch. Discussed importance of ensuring pouch is draining, frequent repositioning, and the techniques used to prevent leakage. The situation is complicated due to patient's difficulty in shifting position due to discomfort and slightly concave area very close to stoma.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	1
Mobility	2
Nutrition	3
Friction/Shear	1
Total	13

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)

1. Cleanse the stoma site with water and pat dry. Cut Cera ring in half and apply to medial aspect of stoma to build up lower side. Apply Hollister convex ring and apply Hy-tape to secure the area. Apply Hollister 1 ¾" 2-piece flat high output drainable pouch and ensure drain is closed.
2. Apply hand to stoma site for 2-5 minutes following pouch change to allow products to warm up and adhere.
3. Assess and inspect skin every shift and report any redness, breakdown, leakage from stoma site, or change in condition.
4. Obtain a specialty mattress to prevent skin breakdown due to immobility (active with alternating pressure or reactive/CLP).
5. Follow up with dietician for counseling on nutritious meals for diabetic diet and slowing transit for ileostomy.
6. Reduce friction and shear by using a draw sheet product, such as a Maxi-Move slide sheets, when repositioning patient. (This may also help to ensure that the pouching system is not pulled off during transfers).
7. Continue to manage chronic conditions (anemia, chronic pain syndrome, DM, PAD) with inpatient hospitalists and with PCP upon discharge.
8. Follow up with WOC Nursing team for any leakage, change in weight, change in stoma size, change in bowel habits, severe cramping, or changes in output quality or volume).
9. Slowly increase activity each day. Set goals for increasing daily movement by using a calendar. Start slowly with allowing repositioning in bed each day, work your way up to sitting in the chair at bedside.
10. Follow up with hospital social worker to explore community resources and additional support options for patient and son.

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

This particular case was a complex case that was made much more challenging due to the patient's pain level. Pain with the pouching change was not the issue, but general pain with any movement was quite challenging. We did not review med administration, so I cannot say when this patient last had pain medication, but I think it could be helpful to look at alternative options for managing pain. The only pain medication on her med list was a low dose of Gabapentin twice per day. Given the serious consequences that immobility can have and her young age, getting her up and moving is a critical point. Pain may require better management to make that happen.

I was also a little concerned about the 14-year-old son at the bedside, and did include follow up with a hospital social worker in my POC. I think there may be some social determinants of health at play, and this patient, and her son, will need resources to ensure a safe discharge and full recovery.

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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 was to become more comfortable with the acute side ostomies, including techniques used in the immediate post-op period. Patients that are in the immediate post-op period are not patients that I see in my normal practice, so it was very helpful to take part in this.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Tomorrow I will be in the CORS Surg NP rotation. I am looking to have a better understanding of colorectal cases from the provider perspective, including surgical and non-surgical options for management of incontinence and ostomies.

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)	✓	

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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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