Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Jessica Whelen_____ Day/Date: _7/11/2025__

Number of Clinical Hours Today: __9__

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

Preceptor: ___Adam Shaw_____

Clinical Focus: Wound ____ Ostomy __X__ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

Today was inpatient with the ostomy team, my preceptor and I saw 4 patients. 1 leaking ostomy, 2 wound vacs and a esophagostomy. The ostomy patient was a little complex with a barrel stoma, and midline non healing surgical wound with a fistula. The first wound vac was straight forward, however as we just finished the job one of the Doctors came in to remove sutures out of the incision, that was under the NPWT. I would have thought that I would need to replace the whole dressing but instead we pulled back the area the MD need access to, so she could remove the sutures, trimmed the drape we pulled up and replace the drape. The other NPWT was a little more complex. The patient had abdominoperineal resection from cancer. His abdominal became infected and his perineal wound dehisced and was also infected. His wounds were deep. It was interesting to remove the packing that he had done in the clinic by a physician. I felt the wound was over packed, the WOCN I was with, mentioned that it was over packed as well. I have bridge wound to one vac normally today I learned about a Y connecter. This is not something our surgent prefer, so I don't use this specific technic, but I can see the benefit of utilizing a Y connector to the protect the patients skin giving how obese he is. I found it interesting to use the Coloplast barrier around the wound, like a pre-drape, to protect the peri-wound. His other wound is in the perianal area, it was interesting to see a different technic used to fill in the cracks and creases. The esophagostomy is something I have seen but never really been able to successful pouch. Meaning the pouch, I place literal fall of 5 minutes later. So, I was grateful for the opportunity to learn how I could better manage one. My preceptor and I also had so good conversation about barriers patient face with esophagostomy, and patients with multiply ostomies and fistulas with obtaining supplies.

Chart note:

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	2
Activity	3

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Mobility	4
Nutrition	1
Friction/Shear	3
Total	16

Patient is a 49 y.r. old male, per epic, PMH of DM, RCC, CKD s/p 3 renal transplants (1996, 2005, 2016), chronic pancreatitis, C.diff colitis s/p total abdominal colectomy with end ileostomy (2006) and takedown in 2007. SBO secondary to internal hernia s/p ex-lap with Lysis of adhesions and small bowel resection (4/24/2025) complicated by and anastomotic leak, s/p ex-lap LOA, SBR and end jejunostomy and mucus fistula creation (5/26/2025), enterocutaneous fistula. Patient was seen at OSH diagnosed with splenic collection and anasarca volume overload, upon discharged patient was disch instructed to remain NPO and was discharged on TPN. Patient reports that he has been snacking and eating 3 small meals a day, patient reports despite eating he has lost 10 lbs. Patient presented to the E.D. for high ostomy output with pouching difficulties and failure to thrive. He reports that he is still eating. This is a consult for continued leaking pouch.

Arrived at bedside patient is in bed sleeping lying in the fetal position on the right side. Patient is familiar to the WOC service with a history of frequent leaking and unable to keep appliance on for more then 1-2 days. Patient states that his pouch is currently leaking, and that he tried to patch the leak with stoma paste and Mefix tape. Patient is currently wearing ConvaTec Eakin fistula and wound pouch. During assessment patient stated that he was extremely tired, this nurse provided therapeutic communication and listening. Patient fell asleep during the visit.

Patient's medication was reviewed, it is noted that patient outpatient medication does not include antimotility medication. Patient has been started on antimotility medications here while in the hospital

Appliance was taken down using warm wash cloth and adhesive remover. Back of the appliance was inspected for areas of leakage. Abdomen cleansed with soap and water. Abdominal skin is intact and unremarkable. Patient has RUQ end ileostomy, LUQ mucus fistula and enterocutaneous fistula located in the superior portion of the midline incision.

Assessment:Ileostomy
Stoma type: End ileostomy
Location: RUQ
Diameter: 11/4" round in shape, Os is center of stoma
Protrusion: Budded
Mucosal condition: pink and moist, granuloma ay 7 o'clock
Mucosal Junction: Intact, no signs of irritation
Peristomal skin: intact
Peristomal contour: mildly concaved
Supportive tissue: Soft
Character of output: thin brown liquid effluent

Assessment: Mucons Fistula
Stoma type: Mucous Fistula
Location: LUQ
Diameter: 1" round in shape, Os is center of stoma
Protrusion: Budded
Mucosal condition: pink and moist
Mucosal Junction: Intact, no signs of irritation
Peristomal skin: intact
Peristomal contour: mildly concaved with transvers crease at the 6 o'clock
Supportive tissue: Soft
Character of output: unknown

Assessment: ECF
Fistula type: small bowel
Location: midline abdominal incision
Wound bed: yes
Perifistula: intact
Perifistula contour: Flat with multiply small creases at 1-3 and 7-11 o'clock
Character of output: thin brown liquid effluent
Supportive tissue: semisoft

Treatment
Skin prep applied to peri-stomal, MF, ECF skin, hollihesive was used to create a keyhole washer to apply around stoma, and MF. stoma paste was then utilized to create a caulking effect around stoma and MF. Strips of hollihesvice was use to picture frame exposed skin surrounding the ECF, stoma paste applied for chalking effect. ConvatTec eakin pouch was cut with 3 holes to fit stoma's and ECF, radial slit where made, pouch put into place. Appliance was picture framed with MeFix tape.

Patient education included maintaining NPO statues. Purpose of NPO was explain to patient that is allowed to give his bowel a rest and allow time for his small bowel to heal the fistula naturally.

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)

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Change pouching system every 3 days or as needed for leaking and soiling. Use ConvaTec Sensi care no sting adhesive remover to gently release the worn pouch from the skin. Cleanse skin with warm wash cloth. Utilizing templet at bed side, cut new pouching system to fit. Apply no-sting skin prep to skin surrounding the stoma. Cut Hollihesive to create keyhole ring to fit around stoma and MF. Use stoma paste applying a thin bead around stoma and MF. Use strips of hollihesive to picture frame the ECF apply stoma past in a thine beaded, apply skin barrier wafer and pouch. Hold in place while adhesive activate to ensure good bond. Use Coloplast barrier strip or MeFix tape for extra securement on skin barrier to help hold pouch in place.

-Encourage patient to participate in care
-Encourage patient to maintain NPO diet
-Encourage patient to remain flat for 20 min after appliance is changed to allow proper adherent.
-Encourage patient to be OOB to chair.
-Encourage patient to ambulate.

Patient was supplied with 3 extra pouches and supplies for pending discharge.

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

I love a good ECF challenge. Although I had a plan in mind when I assessed the patient to what the best plan is, I must keep in mind the patient's preference and what he can manage. I would have stress that importance of diet, I know enough that a patient will ultimately do what they want when home. As far as treatment, I would have like to pouch the ile and ECF separately and cover the MF with gauze and tape. Having that huge pouch seems excessive, however it sounds like this is what the patient found works best for him.

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? The goals for the day were to see an intubation, which I have never seen and a lavage. Although I did not see this, again I am learning, I to utilize stoma paste more in my practice. My preceptor also showed me a different way to pre-drape for a wound vac.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
My next clinical day is the urodynamic clinic, this is be a complete learning experience, since this is not in my wheel house.

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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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