Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ___Anna Saylor_____ Day/Date: _Monday 8/11/25____

Number of Clinical Hours Today: __9__ Number of patients seen__**6**__

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

Preceptor: _Brittany Gesing_____

Clinical Focus: Wound ____ 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, and any additional activities.

Today was day one of clinical time. I followed a stoma nurse. We started the day with a 68-year-old male with a leaking loop ileostomy. We spent time doing the system change and discussing his home care routine, and if he was able to get products. We changed his product to a wafer with convexity and a high output drainable pouch. Hi, I need to keep track of numbers too so you saw 6 patients total?

The next patient was a 69-year-old female with an abdominal surgery in June with placement of a colostomy. The midline incision had dehisced, and she had developed a fistula in early August. Pouching was lasting less than 24 hours. We change the fistula pouching. Two teams of doctors rounded on her while we were working with her. We did a Domeboro soak, then dusted with antifungal powder due to the fungal rash around her peristomal skin. Then placed holliHesive in a petaling fashion. Then Stomapaste was used around the edges of the hollihesive. Then we applied the Eakin fistula pouch.

The next patient was a 67-year-old male who was post-cystoprostatectomy with an ileal conduit creation. This was post op day 4 for him, and we were doing a second lesson. The lesson consisted of a brief verbal review of the steps to change the pouch, then he did the system change with verbal cueing.

The next patient was a 69-year-old female with an established ileostomy who was hospitalized for a liver/kidney transplant. We did a pouch change only. The skin barrier had been changed the day prior. We were following up because it was a different system than she uses at home, and wanted to see if she was comfortable in it.

The next patient was an 84-year-old male who needed marking for a possible ileostomy and a possible colostomy. The consultant asked that all 4 quadrants be marked. We checked with the physician prior to seeing the patient to make sure there had been a discussion already for surgery. We then proceeded to

examine the patient lying, sitting, and standing. He had recent weight loss and had a prior abdominal surgery. The markings changed once he was seated due to skin folds. His RLQ had a scar and scar tissue, so only three quadrants were marked. We marked with a surgical skin marker and placed Tegaderm over the sites. We gave him some written material and a brief lesson.

The last patient was a 35-year-old with a fistula to her left flank area. She has an existing colostomy, and this fistula has been present for several months. We pouched this area in the same fashion as the prior fistula patient. Her skin around the fistula was intact, so we did not do the soak.

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Ostomy nurse consulted to see patient (GL) for an ostomy lesson.
PMH: GL is a 69-year-old AA male with a past medical history of DM2, prostate cancer, TURP, atonic bladder, and obesity.
HPI: Patient was admitted for a radical cystoprostatectomy on 8/7/25.
Social history: GL lives alone at home. He states he has been using a walker prior to surgery. He has worked with PT /OT, and they are recommending short-term SNF at discharge. GL is in agreement with this plan.
Labs: No abnormal labs
Medications reviewed
Assessment: Patient seen for new ostomy and 2nd lesson.
LOC: Patient is awake, alert, and oriented. Sitting in a high Fowler's position in bed.
Interview: Patient denies pain and is connected to a Dilaudid PCA pump. Is willing to participate in the second lesson.
Assessment: Appliance in RLQ
Stoma: Protrudes above skin level, is red and moist, with darkened maroon skin at the outer circumference of the stoma. The patient has a red catheter in the stoma and two white stents. A moderate amount of mucus is cleansed away from the stoma.
Stoma size: 1 ½"
Shape: round
Drainage: Moderate amount of red-tinged urine w mucous? ~~drainage~~.
Peristomal skin: 2x2 clear fluid-filled blister to 6 o'clock and eight o'clock at the edge of the barrier tape. Red denuded skin with small scattered blistering to the peristomal skin where the barrier was placed. Mucocutaneous junction intact
Abdominal plane: Firm rotund abdomen. No skin folds or creases in the peristomal plane.
Education: Educated on appliance change. Patient completed appliance change with cueing and minimal assistance with cutting and attaching the appliance to the drainage bag. Education given on how to care for the drainage bag and how to empty and clean it. Discharge information given on where and how to order ostomy supplies once the patient is discharged home.

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Treatment: Old Hollister system removed per patient with cueing. Peristomal skin is cleansed with water and soft gauze per patient. Peristomal skin dusted with stoma powder and Cavalon skin barrier by the patient with minimal assistance from the ostomy nurse. Appliance changed from Hollister to 57 MM ConvaTec Surfit Natura Durahesive cut-to-fit skin barrier with urine drainage bag to gravity drainage. Patient able to cut skin barrier to 1 ½". Attached the skin barrier to the pouch with moderate assistance. The system was placed on the per patient. The note should be typed in the box below as I copied it there

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	2
Nutrition	2
Friction/Shear	2
Total	15

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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. Change appliance every three to four days and prn for leakage
   a. Remove pouching system using push pull method and adhesive remover.
   b. Cleanse skin and stoma with warm water. Pat dry
   c. Measure stoma. Cut skin barrier wafer opening to fit stoma
   d. Crust peristomal skin with stoma powder and Cavilon skin sealant until irritation and blistering healed
   e. Apply skin barrier wafer and pouch. 57 MM ConvaTec Surfit Natura Durahesive cut-to-fit skin barrier with urine drainage bag to gravity drainage
2. Notify surgeon for increase in darkened maroon skin on stoma is this really a plan or something you did?
3. Encourage patient to participate in care; emptying pouch, pouch changes
4. Encourage to review teaching packet. Write down questions
5. Pain management:
   a. Encourage deep breathing
   b. Pre-medicate as needed prior to system change

you identified that the patient has issues w mobility, nutrition, & friction & shear. As a wound/ostomy nurse you need to address those scores in your plan

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

I thought the care was great. My original thought was that the tape border of the skin wafer was causing the skin irritation, and I was going to suggest cutting the tape away and using just the adhesive barrier. Good thought However, my knowledge base of products is not very good. So I felt as though my preceptor made the correct choice. Because she selected a different system w less tape or ????Reviewing the discharge instructions for ordering supplies seemed rushed but the patient was receptive.

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 goals for day one of ostomy was to complete an ostomy site assessment.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
My goals for ostomy day 2 will be to have more hands on with the patients and with education of the patients.

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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: <u>Patricia A. Slachta</u> Date: <u>8/13/25</u>

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