Cleveland Clinic

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

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: __Sheila Guzman_____ Day/Date: _8/15/2025_

Number of Clinical Hours Today: __8__ Number of patients seen__**3**__

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

Preceptor: __Christopher Eddun_____

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 I participated in "Skin Rounds" with my preceptor. We rounded on the SICU, assessing 16 patients from head to toe. We saw patients who had both hospital and community acquired pressure injuries, medical device related pressure injuries, unstageable PI, a dehisced wound and a patient with MASD. We were then consulted to see 3 ostomy patients for pouch changes and teaching. We did a lot of teaching today along with pouch changes. We were consulted for pouch change on a 60yo female with an enterocutaneous fistula, admitted on 8/11/25 for lower back and hip pain due to a fall. She is used to doing her pouch changes independently at home but has been febrile and in too much pain to do it herself while in the hospital. PMH roux-en-y gastric bypass (2008), s/p multiple revision requiring subtotal gastrectomy with gastrojejunostomy (2013) complicated by candy cane syndrome requiring redo gastric bypass (7/2012) c/b leak requiring permanent enterocutaneous fistula. Pt knows how to cut skin barrier, fill in folds and creases with skin barrier ring and apply it around the opening of her new pouch system. Slight redness noted during pouch change because the pouch had not been changed for 7days. Pt stated she last changed it few days before being admitted to the hospital. Next patient was a 76 yo male diagnosed with malignant neoplasm of urinary bladder. We were consulted for teaching and pouch change of the pt's ileal conduit urostomy. This patient stated he initially wanted to receive radiation instead of having surgical diversion. He stated that he changed his mind "pretty quickly" when the surgeon told him that with surgery he could live another 10-15yrs vs 2-3 with radiation. He stated he was familiar with urinary diversions because both his ex-wife and daughter had one. Last patient and the one I will go into more detail about was for a 66yo female whom we did teaching and pouch change for her temporary colostomy.

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

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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:**

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | 4 |
| Moisture | 4 |
| Activity | 3 |
| Mobility | 4 |
| Nutrition | 4 |
| Friction/Shear | 3 |
| Total | 22 |

Follow-up visit for 66yo female who presented to the ED on 7/30 with worsening chest, abdominal pain and bloating for two days; s/p peritoneal lavage and drain placement on 7/31 for possible diverticulitis and EPEC infection; s/p IR drainage of peritoneal fluid collection 8/8 and now s/p sigmoid colectomy and end colostomy (8/11) for perforated diverticulitis, with areas of induration and abcess formation. Initial visit with the WOC nurse on 8/13. Patient has history of HTN, HLD, CVA, TIA, chronic anemia and obesity. Patient is sitting in bed, awake and alert x3 on room air. VSS, no signs or symptoms of acute respiratory distress noted. Patient complains that she is having gas pain and is feeling weak. Patient is tolerating her diet and ostomy has green soft stool. Stoma is pale pink, round and flush to the skin, measuring 45mm at this time. Peristomal skin is intact. It was reported to my preceptor that the patient is having a difficult time adjusting and needs teaching, motivation and resources to use after discharge. Patients significant other was at the bedside and refused to participate in learning how to change the pouch and refused to even look at it. The patient was active in learning despite being frustrated with her significant other. We went over what was done during surgery, diet and walked the patient thru step by step on how to change her pouch and empty it. We used Hollister 2 ¼ inch convex barrier with the 2 ¼ inch Lock N Roll pouch.

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

This patient was briefly seen postoperatively because patient cut the visit short and was then found to be sleeping later that day. I believe follow-up visit should have been done the next day again, this is very important because the patient was already having difficulty accepting and adjusting to her new ostomy.

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?**

Last week we discussed the differences between urostomy, ileostomy and colostomy, how to identify and assess them. This week we had the opportunity to see patients with these different types of ostomies and fistulas.

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

My preceptor would like to show me how to prepare for discharge by ordering supplies, collaborating with social worker and/or case manager and going over insurance coverage. If possible, we would like to visit the outpatient clinic by coordinating with one of the WOC nurses to be able to see the kind of patients and issues that are seen after discharge.

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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: _____ Date: _____

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