Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Blaine McKinney Day/Date: 9/17/2025

Number of Clinical Hours Today: 8.5 Number of patients seen 10

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

Preceptor: Jennifer Postle, BSN, RN, CWOCN, CFCN

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.

The day started once again with a marking, this time was for a neobladder procedure. This marking was done as a "just in case", as the planned procedure would result in a neobladder but complications can always arise.

Today was quite busy overall, we changed the wound VAC from Monday, did two drop ins for first day post operative patients – one with a colostomy and the other with a urostomy. The patient with a urostomy unfortunately was having leaking from their pouch, so we removed the pouch and changed it. This was difficult due to the stents that were in place following the ileal conduit surgery. My instructor encouraged me to do the initial teaching, which was pretty limited. She encouraged me to discuss why we were there and what we planned to do, as well as introduce the kits we had prepared. A bit nervewracking!

We also did several first lessons, which was great to observe and my preceptor allowed me to do some of the pouch changes. The first patient we did a lesson with was very disinterested in the stoma. My instructor and I put our acting skills to the test as she walked me through the basics of colostomies, how to empty a pouch, and how to change a pouch. I thought it was a clever way to passively introduce the subject to the patient who was disinterested. Another patient, who we think also may be fearful or disinterested in their ostomy, had their wife assist in the pouch change and empty. The third lesson we taught she had more get much more involved, which was very educational for me. Seeing these lessons and how each person reacted, the questions they asked, their family's reactions, and how my preceptor broached certain topics was really helpful. The third patient was unique because of her body size. Typically, my preceptor discusses how to empty the pouch over the toilet while at home, but due to this patient's abdomen and breast contours, this would likely be extremely difficult so discussing different options was super helpful for me to see! We discussed a two-piece closed end pouch as a viable option for her, which she was happy about because she was most interested in that type of pouch from the beginning.

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Additionally, we saw several wounds. We saw a malignant wound to a patient's face, as well as scrotal fistula. The fistula we were pretty removed from as the patient was going to surgery for a Seton placement later that day. Overall, a great day and the variety of experiences was helpful!

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:

WOC Consult Note:

V.L. is a 41-year-old female with a past medical history of benign hypertension, recurrent rectal cancer, morbid obesity (BMI 51). She is being seen as a consult for permanent end colostomy in the left upper quadrant, post op day 2 s/p abdominoperineal resection (APR) surgery.

Patient alert and oriented, actively engaged, mother and husband at bedside for the teaching. Patient was conversational and ready to begin the lesson. Abdomen and pouch were assessed, abdomen with midline incision, pouch intact.

To begin the lesson, the patient's husband assisted in emptying the patient's pouch into graduated cylinder. Taught how to empty the pouch and was able to successfully demonstrate the skill in return. Supplies needed for pouch change were discussed and prepared, then with assist the patient's husband removed the pouch successfully. Upon assessment, stoma was pink, moist, and edematous; flatus and stool were present; peristomal skin was intact with some ecchymosis from 1:00 to 3:00. Patient, husband, and mother were taught how to clean around the stoma with paper towel or washcloth with soap and water. Discussed avoiding baby wipes, creams, and oily products to peristomal area to promote adhesion of the pouch.

Stoma was then measured with a measuring guide, stoma was round and measured between 38cm and 41cm. Husband was assisted in cutting pouch to fit, then demonstrated how to determine if the pouch was the appropriate size, leaving 1/8th of an inch between the edge of the wafer and the stoma. Once the pouch was appropriately cut, adhesive backing was removed and Convatec Esteem Body Soft Convex (3.5mm) 10 to 55mm pouch was applied to stoma by patient's husband. Patient then placed her hand over the appliance for 1 minute to promote adhesion.

Discussed peristomal skin care, timing and frequency of ostomy pouch change and emptying, showering/bathing, diet, and pouch types. Patient gave consent to share contact information with ostomy

supply manufacturers to obtain samples. Patient expressed interested in 2-piece pouch with closed end.

Braden Risk Assessment Tool

Sensory Perception	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

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)

Remove pouch with Essenta adhesive remover provided or adhesive remover wipes. Clean peristomal area with soap and water. Cut Convatec Esteem Body SoftConvex 3.5mm convexity, 10-55mm wafer size to fit stoma. Change every 3 to 5 days and as needed for leaking.

Patient to follow up via phone call 1 week after discharge, follow up in ostomy clinic as needed. Samples to be sent to patient's home.

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

Honestly, I thought today was very helpful and was a great patient for a first lesson. She was involved, as was her family. I'm not sure I know enough to know yet to know what I would have or could have done differently from what my preceptor did. I think the only thing I could think of to do differently would be to bring a sample 2 piece pouch just to let the patient see it.

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 observe an ostomy teaching and change a pouch with assist from my preceptor. This was met, I was able to change a couple different types of pouches, observe multiple teachings, and provide some teaching myself!

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

My goal is to create a wound care plan for a patient with assist from my preceptor.

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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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