Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Susan Warner Day/Date: 9/19/2025

Number of Clinical Hours Today: 8 Number of patients seen 9

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

Preceptor: Heaven Hess, RN, CWOCN

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.

1. Patient with abdominal wound s/p debridement who was seen on Wednesday and reassessed today. There was a large blood clot under his dressings, and some areas that were still bleeding, so general surgery came to the bedside for cauterization.
2. New consult for "possible DTI," turned out to be just a bruised area to right posterior thigh.
3. New consult for left foot wound, turned out to be just a calloused area with no signs or symptoms of infection, she is aware that she needs to follow up with podiatry outpatient.
4. New consult for non-blanchable redness, none noted at time of assessment.
5. New consult for multiple wounds- right BKA stump site, left knee, left lower leg, left 5th toe. Wound care recommendations- cleanse with sterile saline or vashe, apply adaptic to left leg and left 5th toe wounds, apply medihoney to left knee wound firm slough, apply foam dressings to all wounds, change three times a week and PRN.
6. Reassessment of patient with left lateral lower leg wound, was debrided yesterday in OR, looks much better today, wound care was performed, and patient will be discharged to skilled nursing facility.
7. Reassessment of patient who came into ER on Wednesday with wound deterioration and change in mental status, with existing colostomy. Wound vac still on hold due to tunneling and visible sutures underneath. PA-C removed drains, we packed the midline abdominal incision and applied a new dressing and performed ostomy appliance change. He is doing much better as far as his delirium and will likely go home with home health today.
8. New consult for patient with new loop ileostomy (patient who had surgery yesterday- see below).
9. New consult for patient in the ER with high output ileostomy, here for an unrelated issue, but needed ileostomy appliance changed due to leaking, and was particular about the type of appliance requested.

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	3
Moisture	2
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	2
Total	13- High risk for pressure injury

Patient is a 63-year-old female with history of colon cancer, s/p total colectomy and end ileostomy on 3/19/25, and past medical history of anemia, DVT, and PE. She presented to the OR on 9/18/25 for ileostomy reversal. Patient underwent takedown of ileostomy with small bowel resection, partial colectomy, lysis of adhesions, flexible sigmoidoscopy, and loop ileostomy. CWOCN post-operative assessment was done today. Patient is on clear liquids, having some output from ileostomy, transferring from bed to chair with assistance. We removed ostomy appliance and surgical dressing, no complications noted. Used skin prep spray for some slight maceration to the peristomal skin, used pieces of a barrier ring to fill in creases at 9 o clock and 3 o clock, used convex 1 piece barrier which needed to be cut off center to avoid placing over the new midline incision. Staples to incision with small amount of serosanguinous drainage. Translator used- patient is Spanish-speaking.

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)

Cleanse incision with sterile saline and change surgical dressing (island dressing) to midline abdominal incision daily and PRN. Change ileostomy appliance 2-3 times a week and PRN for leaking or dislodgement. Cleanse the stoma and peristomal skin with warm water. Dry thoroughly (pat dry, do not vigorously rub). Apply skin prep to peristomal skin, can use stoma powder prior to the skin prep if there are any areas of raw or denuded skin. Use pieces of barrier ring to fill in creases at 9 o clock and 3 o clock. Apply Convatec 1 piece convex barrier pouch, cut to fit, cut off center so barrier is not placed over the midline incision. Bleeding precautions due to risk of bleeding (history of anemia, on anticoagulant, incision, post-operative period), closely monitor for signs or symptoms of GI bleed, early mobilization and DVT prophylaxis due

history of DVT and PE, monitor I&O and for signs or symptoms of dehydration due to liquid output from ileostomy. Currently on clear liquids. Monitor skin closely for signs of breakdown due to high risk Braden score. Use translator, patient is Spanish-speaking (using family/visitors for translation may not have accurate results).

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

We had to do the ostomy appliance change twice. The patient had requested a specific type of appliance (coloplast, with a rigid silicone barrier), and I cut the opening to the appropriate size, but not off-center, and it resulted in overlapping the surgical incision. My preceptor tried to cut the barrier to avoid the incision, but due to the rigidity of the barrier, it could not be manipulated to adhere around the incision once it was cut. She then cut the new appliance off-center so the barrier did not need to be cut and it did not overlap the incision. It's not ideal to have to re-do the appliance change, but if we had left the appliance in place without being confident in the seal, it likely would have leaked, causing not only skin breakdown to the peristomal skin, but risking contamination of the fresh surgical incision.

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?

Gain more confidence with making recommendations, and more experience with ostomy care. Yes, I was able to continue with ostomy care and wound care recommendations under the supervision and assistance from my preceptor.

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

Gain more independence with the consults and recommendations, continue practicing different wound care treatments and ostomy care.

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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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