Cleveland Clinic

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

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

Student Name: Kyle Aniol Day/Date: Friday, September 19th

Number of Clinical Hours Today: **8** Number of patients seen: **6**

Care Setting: **Hospital Ostomy**

Preceptor: **Chizu Sakai-Imoto**

Clinical Focus: **Ostomy**

**Reflection: Describe your patient encounters, types of patients seen, and any additional activities.**

Today was spent rounding the hospital and seeing patients for negative pressure wound therapy or ostomy related needs. Patient A was a 41 y/o male, quadriplegic r/t GSW, with an end descending colostomy. He is being seen for pouch leakage. Patient B is 72 y/o female, diverticulitis and a colovesical fistula, being seen for stoma site marking. The patient was marked in both upper quadrants for an ileostomy. Patient C was an 86 y/o female with an end descending colostomy r/t diverticulitis. The stoma team was consulted for pouching system management as the patient has multiple pouching challenges. Patient D was a 67 y/o male scheduled for routine management of his end ileal conduit, loop colostomy, and negative pressure wound therapy system for a coccyx wound. Pouching changes and skin care was performed for both stomas. The wound vacuum dressing, foam, and tubing were all changed. Patient E was a 68 y/o female with an end ileostomy being seen for pouch leakage and education prior to discharge to in-patient rehab. Patient F was a 68 y/o female with a right thigh wound that had a scheduled wound vacuum change.

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.

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## Chart Review, Assessment, Encounter

**Age/Sex:** 68 y/o female
**PMH:** Patient has a history of GERD, HTN, DVT/PE on Eliquis, metastatic adenocarcinoma of ascending colon s/p diverting loop ileostomy (4/19/2024). Prior admissions earlier this year for small bowel obstruction that was resolved NG tube placement. She underwent palliative surgery on 9/4/2025 for extensive peritoneal carcinomatosis.
**CC:** Constipation r/t small bowel obstruction
**Social Hx:** Lives with son and required minimal assistance with ADL's, patient was a 20-year smoker, no ETOH or illicit drug use.
**Family/Surgical Hx:** Liver, colon, and renal cancer, leukemia, lymphoma, and renal cell disease
Lap cholecystectomy, colectomy w/ ileocolic anastomosis, total knee replacement.
**Medications:** Unable to obtain a home medication list.

**Assessment/Encounter:** The patient was seen for 45 minutes to improve the current pouching system and provide eduction before discharge to an acute rehab facility. The patient was switched from flat to soft convexity, the high-volume pouch was attached to gravity drainage for easier management, and education was provided on the additional products needed for management (strip paste, hollihesive, aquacell, Domeboro powder).
Stoma: End ileostomy, 1 ¼' X 1 5/8', RLQ, slightly protruding, red and moist, oval shaped
Mucocutaneous Junction: full separation from 3 to 6 o'clock
Peristomal skin: blanchable but denuded from 2 to 10 o'clock, wound from 3 to 6 o'clock
Contour: skin is semi-soft, rounded, and has a transverse crease one finger below stoma
Output: large amount of yellow, liquid effluent

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)

Use Domeboro soak on gauze pads and leave on skin for 20 minutes
Dry the skin completely
Apply stomahesive powder to irritated skin and dust off the excess
Apply No Sting Liquid Skin Barrier to skin around stoma
Place a piece of strip paste into the skin crease below the stoma, use a hollihesive strip over top
Place aquacell strips into the peristomal wound until skin level, use a hollihesive strip over top
Use a ring barrier around stoma and caulk edges with paste
Apply pouching system and apply pressure with hand or warm pack for 2 minutes
Use Mefix tape around all edges (form a frame around the pouch)
Connect pouch to gravity drainage bag
Pouch should be changed every 3-4 days, or as needed for leakage or poor adherence

Pouching System:
Hollister New Image 2 ¼' convex flange
High Volume Output Pouch
Gravity drainage bag and tube

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**Describe your thoughts related to the care provided. What would <u>you</u> have done differently**
I wish the consult would have been placed earlier. This patient had a complex set of pouching complications and multiple teaching sessions would have been ideal before discharge.

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?**<br>My goal for today was to be able to identify when a change in the pouching system is necessary. The size of the aperture for the stoma, the type of wafer for the anatomy around the stoma (convex, flat, etc.), and the type of pouch (high output vs. normal).<br>This goal was met as we had multiple consults for pouch leakage and had to make changes to the current pouching system. |
| **What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**<br>My goal for tomorrow is to do a dressing change for a negative pressure wound therapy patient primarily on my own. |

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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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