Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Sherrie Powell Day/Date: Thursday, 9/11/2025

Number of Clinical Hours Today: 8 Number of patients seen **2 Inpatient, 6 Outpatient**

Care Setting: Hospital ~~8~~ this is just an X Ambulatory Care ____ Home Care ____ Other ___

Preceptor: Erica Aiken

Clinical Focus: Wound X Ostomy X Continence ____ Sherrie, going forward you need to declare ONE focus for the day even though you see a variety of patients

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.

My clinical day began in the acute care part of the hospital to manage two patients admitted under the surgical trauma service. Both patients had traumatic wounds ending in ostomy creations and open abdominal surgical incisions with complications. The first patient had an enterocutaneous fistula (ECT) x2 that needed pouching along with the colostomy pouch change and dressing to the surgical wound in her vaginal area. The second patient required pouching of and ECT formation within a healing abdominal surgical site, as well as a colostomy pouch change. The second half of my day was spent in the trauma surgical clinic in the outpatient setting within the hospital. I was surprised to see a few patients I had taken care of on the inpatient side, and I was pleased to see their progress. One was a patient for whom I did her ostomy marking; most of her wounds were healed so well that there was a plan to discharge her from the service with cessation of the dressing changes as early as two weeks from the day that we saw her. I assisted with two wound VACs. One of the VAC patients had to get a bedside sharp debridement before reapplying the VAC. The second wound VAC was placed without any difficulty because the wound had fully granulated and was healing appropriately. The next patient had an open abdominal wound that required packing with a wet-to-dry packing dressing, and right after, I saw a foot wound where I had the chance to obtain and send a wound culture due to deterioration. The last patient also had an open abdominal wound that was mostly healed and required silver nitrate application over a portion of the wound that remained wet. I could not apply the silver nitrate myself; however, it was interesting to witness the reaction on the wound.

Types of patients: diabetic foot ulcer, ostomy patient pouch changes, ECT fistula pouching, Stage 3 Pressure Injury, surgical abdominal wound care treatment and dressing changes, sharp debridement

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	2
Moisture	2
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	1
Total	10

71-year-old female being seen and examined at bedside for follow-up and management of ECT fistula and routine ostomy pouch change. Patient has a past medical history of Tumor-Derived Recognition Factor (TDRF), colovesicular fistula, cardiomyopathy, pleural effusion, atrial fibrillation, HTN, PE, renal vein thrombosis, and necrotizing soft tissue infection. Greeted the patient while in bed and explained the WOC role. Patient agrees to examination and denies any pain or discomfort at this time. The fistula pouch was removed to reveal a fully healed midline surgical incision with small ECT fistula openings x 2 at the inferior base of the wound. Both openings have decreased in size in comparison to the previous photos. Perifistular skin is intact, cleansed with normal saline. New fistula pouch placed and secured. Old 1-piece drainable pouch noted as poorly fitting, and leakage is noted at the base of the pouch's barrier. Pouch removed to reveal red, moist, flush stoma; peristomal skin is reddened and denuded inferior to stoma. Peristomal skin is cleaned with warm water and allowed to dry completely. Reddened area wiped with no-sting barrier film, barrier ring applied around the parameter of the stoma, and a new 1-piece drainable soft-convexity pouch applied. Dressing to vaginal incision noted to be saturated with brown, foul-smelling fluid. The old dressing was removed. Wound base with red tissue, small amount of serosanguineous drainage; no odor noted. Wound edges are poorly defined; periwound with no fluctuance or induration. Wound cleansed with normal saline solution. Silver Hydrofiber strip packed loosely in the wound. The wound was then covered with ABD pad and secured with paper tape. Patient tolerated pouching and dressing changes. Patient made aware of pouching modification and agrees with the new plan of care and the goal wear-time for the ostomy pouch of 3-5 days.

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)

*Monitor for an increase in drainage from the fistula and contact the surgical service for any changes.

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*Continue fistula management with a fistula pouch and change with a goal wear time of 4 days
*Change the pouching system to a soft convexity 1-piece drainable bag with a goal wear time of 3-5 days
*Manage peristomal skin with application of no-sting barrier film; apply barrier ring around stoma before applying new ostomy pouch. Sherrie, this section is to be 'nursing orders'-what *specific directions* would you give the staff for the pouch change since you are relying on them to do this
Fistula pouch change Q 4 days or if leaking
Remove fistula pouch (do you want them to use adhesive remover or warm water or what)
Cleanse peri-fistula skin w warm water & gently dry
Apply no sting barrier film & allow to dry
Apply XXXX pouch
Ostomy pouch change Q 3-5 days
Write the step by step for the nurses – how do you want this done
Vaginal wound dressing
Again write the steps for the nurses
She had a lot of low subscales – it is our job to address these areas…
*Please contact WOC for any ostomy-related issue

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

The staff was not aware of the need for a different barrier to fit the characteristics of the stoma. The pouch the patient had on was our very basic pouch for a round, budded stoma. Due to the stoma being flush to the skin, the use of the flat barrier ostomy pouch is more likely to have leaks under the barrier. This happened in this case. The peristomal skin was negatively affected by exposure to the fecal material, and it also drained, soiling the vaginal dressing. Adding convexity and a barrier ring will give a greater chance at avoiding leakage under the barrier and potentially infecting the vaginal wound. What we did differently was give the product and item numbers of the pouches and accessories we used to the bedside nurse, as well as place them in the note for easier reference. Ok. Also re the patient you saw outpatient w an abdominal wound and the wet to dry packing, one of our roles as a specialty nurse is to make evidence-based suggestions for better patient care. Based on what you learned in class **1. What else could have been done for this wound?**

In this case, with the open abdominal wound, negative pressure wound therapy could be used. Unfortunately, this patient had recently relocated from another state and had out of state Medicaid. She was not approved for the VAC machine. The dressing recommendations, if I can recall, were based on the fact that she could not get the machine.

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 for the day was to see the outpatient side of wound care. I wanted to witness the progression of the wound after discharge. My goal was met and I was pleased to see the results of the efforts of efficient wound care.

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What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
I would like to see more of the continence side of wound care. I have not had one single urostomy since entering the WOC role. I want to get out of my comfort zone and experience this side of wound ostomy and continence.

For instructor use only. Do not 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: Patricia A. Slachta Date: 9/26/25

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