Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Birgitte Kammerdiener_____ Day/Date: ___Friday October 3rd, 2025_____

Number of Clinical Hours Today: __9__ Number of patients seen__**6**__

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

Preceptor: ____Terri Cobb CWOCN_____

Clinical Focus: Wound ____ Ostomy ____ Continence __X__

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 was my last day of clinical and it was spent in the outpatient WOC clinic with Terri Cobb CWOCN as my preceptor. Today was a very busy day and I was able to see a lot. The first patient we saw had stoma concerns. Patient stated there was irritation to one side of the stoma. After assessing the stoma, the pouch was undermining but the patients' skin was intact. Taking a further look at the pouch we realized the opening for the stoma was too small, but the pouching system was appropriate. The patient's stoma was measured, and the patient was placed into and provided a larger cut-to-fit pouch. The next patient we saw came in for pre-op appointments and stoma markings. One marking was for an ileal conduit and the other was for a Colostomy vs ileostomy. I was able to practice more stoma markings and really assess any potential creases or depressions based on where the stoma would be and try to provide the patient with the easiest location. One patient came in for a urine culture, so I was able to observe the collection process. We saw a patient that was in for a post-operative two-week assessment. The final patient we saw was for a stoma marking for stage one in creation of a J-pouch. The patient was marked but also stated having irritation in the perianal area due to multiple episodes of diarrhea a day and occasional leakage. I was able to give the patient information about oral rehydration and foods to help thicken the stool. I was also able to provide the patient with a barrier cream option to help protect the perianal area and help it heal from the irritation.

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.

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The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Chart Review/History

Age/sex: 37 year old female

PMH: Anemia, Anxiety, Depression, Diarrhea, cluster headaches, POTS, Ulcerative Colitis

HPI: Patient presents to clinic for stoma marking for creation of a J-pouch. Patient was diagnosed with ulcerative colitis 20 years ago and was medically managed until recently. Patient states multiple medications were tried but have no longer been effective. Patient states having to used the bathroom between 5 and 6 times a day and has recently developed irritation. Patient is scheduled for surgery in the next week for step one of the J-pouch creation.

Social hx: patient resides in a house with her husband. Patient is independent with all ADLs. Patient has no history of tobacco or drug use. Patient states drinking alcoholic beverages only socially, one alcoholic beverage or less per week.

Assessment/Encounter

Presents to clinic for stoma marking for J-pouch creation and concerns for irritation due to diarrhea
States having to use the bathroom between 5 and 6 times per day
States having occasional leakage of stool when unable to make it the restroom in time
Patient states wearing absorbent pads for stool leakage and bleeding, changes once or twice on a bad day
Previous medical management is no longer effective, has tried multiple medications without success

Chart Note:

Patient is a 37 year old female with a history of Anemia, Anxiety, Depression, Diarrhea, cluster headaches, POTS and Ulcerative Colitis. Patient resides in a house with her husband and is independent with all ADLs. Patient has no history of tobacco or drug use, states drinking alcoholic beverages only socially, one alcoholic beverage or less per week. She presents to the clinic for a stoma marking for step one of creation of a J-pouch. Patient was diagnosed with Ulcerative Colitis 20 years ago and has been under medical management. Patient has recently been unsuccessful with medical management after trying multiple medications. Patient states having to use the bathroom between five and six times a day and stool is diarrhea consistency. Patient states she has to wear a pad due to occasional leakage of stool when unable to make it to the bathroom and occasional rectal bleeding. She states on a “bad day” she has to change the pad once or twice. Patient states having some irritation in the perianal area due to the leakage of stool and diarrhea consistency. Patient declined physical exam at this time but described the area as red and burning on occasion. Patient was marked in the right lower quadrant for stoma. Patient was then given recommendations for what is assumed is IAD and diarrhea. Patient was provided with the BRAT diet (Bananas, Rice, applesauce and toast). Patient did state that she has many food allergies and intolerances making it more difficult to help bulk up her stool. Patient was provided a list of foods the assist in thickening stool and was educated to avoid any foods that cause reactions. Patient was then educated on hydration due to all stool being diarrhea consistency. Patient was educated on and provided packets on different forms of oral rehydration solutions to help avoid dehydration. Patient was then provided a list of ways to help manage and heal the IAD she has been experiencing around the perianal area. Patient was educated to replace pad as soon as possible when leakage

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does occur and as needed to prevent trapping moisture against the skin. She was then recommended to wash with a pH balanced soap/cleanser when showering to help from disrupting the skin barrier. Patient recommended to use any over the counter pH balanced soap. Barrier cream was also recommended to use after each episode of diarrhea. Patient was recommended Coloplast Critic Aid Clear barrier ointment as it can be bought over the counter and will not leave a stain in clothing like some zinc barrier creams. Patient was also recommended to look into pelvic floor exercises to help prevent leakage of stool from occurring and to prepare patient for later stages of J-pouch creation. Patient stated she had no further questions for WOC nurses. Patient will be followed by colorectal and WOC nursing post surgery inpatient.

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 BRAT diet to help with thickening of stool (Bananas, rice, applesauce, toast)
- After each episode of diarrhea or leakage use a pH balance cleanser to perianal area and irritation
- When showering use a pH balance soap to prevent further breakdown of skin barrier – ex: Dove or Cetaphil, over the counter pH balanced soap
- After each episode of diarrhea or leakage apply Coloplast Critic Aid clear barrier cream to perianal area and irritation in thin layer per order
- Change pad after each leakage episode and as needed to prevent from trapping moisture against the skin
- Started pelvic floor exercises tohelp prevent leakage and prepare for later stages of J-pouch creation
- Call or make another outpatient appointment with colorectal or WOC nursing if IAD worsens
- Colorectal and WOC nursing to follow patient post surgery while inpatient

Describe your thoughts related to the care provided. What would <u>you</u> have done differently

There is not much I would have done differently for this patients situation as their IAD from description did not seem to be severe. I probably would have asked her if she was already using any products for the redness, burning or irritation to ensure she was not using any products that may be irritationg to the area or preventing it from healing.

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 see something continence related. This goal was met. I was able to discuss treatment for IAD and also do my own looking into the later stages if the J-pouch and how patients may be incontinent in the later stages while relearning bowel habits after being reconnected.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
This was my last clinical so no more learning goals, but I will be applying everything I have learned into my job.

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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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