Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Carla Edeh Day/Date: Friday 10/10/25

Number of Clinical Hours Today: 8 Number of patients seen **4**

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

Preceptor: Jeanie Osby

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.

10/10/25 We saw 4 patients.

First patient had an end ileo conduit s/p bladder ca day #1. WOC was consulted for patient's first pouch change.

The second patient had a decrease in stoma output. He had a loop transverse colostomy. WOC was consulted to do a colostomy stimulation.

The third patient had a substernal wound vac. The WOC was consulted to do a dressing change.

The fourth patient had a loop end ileal conduit. The WOC was consulted to remove the rod and foley and do 1st teaching.

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

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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:

75 y.o. male patient with hx of htn,T2DM, BPH, smoking, etoh, and crack cocaine in the past. He was admitted on 9/27/25 with c/o bloating, increased lower abd pain, nausea, and abd distention. His last BM was 9/13/25.

Meds:

Trospium 20 mg BID

Loperamide 2 mg QD PRN

Fluticasone 50 mcg/ actuation nasal spray. 1 spray in each nostril QD.

Hydrochlorothiazide 25 mg QD

Metformin 500 mg BID

Tamsulosin 0.8 mg QD

Sildenafil 100 mg QD PRN

Atorvastatin 40 mg QD

Finasteride 5 mg QD

Allergies:

Lisinopril

CT of ABD 9/27/25 Findings:

Large bowel obstruction, secondary to an infiltrative rectal mass.

Diffuse hepatic metastatic disease

Abdominopelvic lymphadenopathy as above.

On 10/01/25 patient underwent a diagnostic laparoscopy, exploratory laparotomy, and a Loop transverse

colostomy brought up to the RUQ.

WOC was consulted today 10/10/25 to perform a Colostomy stimulation for significantly decreased stoma output.

Assessment/encounter:

Patient A&O X 3, abd firm and distended

STOMA ASSESSMENT:

Stoma Type: Loop transverse colostomy

Location: RUQ

Diameter: 1 3/4 "

Protrusion: Budded

Mucosal condition: Red and dry

Mucocutaneous Junction: Intact

Output: NO

Peristomal skin: Clear and intact

Peristomal Contour: Rounded

Supportive tissue: Firm

Current Pouching System: Removed- Coloplast sensura flat drainable pouch, ceraRing

Pouching system evaluation- Seal intact.

Colostomy stimulation Procedure completed by the woc:

The stoma was intubated using a lubricated 18 fr foley catheter, along with a total of 500 cc of 0.9 % normal saline, 60 cc at a time with back and forth peristalls mimicking movement. A total of 500 cc of fluid (light brown with a scant amount of flecks of stool) was returned with little to no peristalsis noted.

Peristoma skin was then prepped for the new pouching system using mild soap and water and then patted dry. 2 1/4 " Hollister New Image CeraPlus cut to fit flat flange (cut inside of 2 ") CeraRing, with a High Volume Output Pouch (HVOP).

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)

If no bowel movement from stoma within the next 24 hours, consider stoma irrigation.

Also, consider and decompression with NG tube.

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

The care provided to the patient was appropriate and effective. The healthcare team did an excellent job identifying the bowel obstruction and performing the necessary surgeries. The involvement of the WOC nurse for stoma stimulation was timely and critical for managing the patient's condition. I believe the provider did a great job, and I wouldn't have done anything differently in this case.sz

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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?

I was actively involved in this case. I removed the old pouching system using adhesive remover, I prepped the supplies needed for the stimulation (lubricating the 18 fr foley, pouring the saline in the Toomey container and filling the 60 cc syringe with normal saline, I prepped the patient with the blue chux, assessed, monitored and prepped the stoma and peristomal site and actively performed the stimulation after my preceptor). I applied the new pouching system after prepping the peristomal site and measuring the stoma.

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

My goal for the next clinical day is to place a wound vac.

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:		

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• 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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